The aim of these background papers is to stimulate thinking and debate about the future of health and care. Each paper focuses on one area, summarising key narratives, tensions and debates raised in stakeholder interviews and discussions before the event.

People

What do we mean by person-centred care?

Person-centred care has been suggested as a focus of health and care systems, but there are different understandings of what this means. One way of understanding person-centred care is **how care is organised**, rethinking the organisation and delivery of care so that it is structured around the needs of the individual, rather than the organisations and boundaries of the health system or the professionals involved. With the rise in chronic conditions and multi-morbidity such integration of care around the needs of individuals is seen as having become more important. **More biomedical understandings of person-centred care** are concerned with individualised approaches to diagnosis and treatment, such as through drawing on **genomic** information. What really matters to people, families and communities? How can we better incorporate people-centred care into health and care systems?

What today we call personalised medicine has nothing in common with what the term meant in the 1970s, which was a vision of care that integrated social, emotional and medical well-being. Today, so-called personalised care constitutes a reduction of concept of health to genomic and proteomic markers.

Informal care is a vital part of care that is provided to people, especially long-term care in old age. But wider changes in societies (eg changing family structures, dynamics and working patterns) mean that individual and social commitments are changing with a knock-on effect on the availability and sustainability of informal care. What would cause this social contract of informal care to break down? How might this be addressed, and how can informal carers be acknowledged and supported into the future?

The family in the past used to provide much more social care when people lived in closer-knit communities. The world of work means people travel and no longer live in the same communities where they used to be. We expect different people to provide social care.

Impact of organisational structures

The **organisational split between health and social care** is a widespread divide, reflecting the difference between the local, inter-personal and low-tech nature of social care, and the concentration of organisation and funding required for increasingly high-tech medicine. This divide is seen as a widespread problem, creating organisational barriers to what should be integrated services meeting the needs of the people concerned.

This organisational division in turn relates to geographical distribution of services. How can we rethink the **geographical distribution** of services and healthcare professionals? How can we re-envisage the existing model of small primary care providers combined with large hospitals providing a broad range of specialised services for a district or region? What might health and care services that are more organised around people and their needs look like, and how can we get there?

Do we need to be distributing specialisation differently in the system, with some highly specialised hospitals doing certain procedures, highly trained generalists distributing care and feeding people to specialists?

Wellbeing

Wellbeing is a term embedded in the World Health Organization's Charter. However, it has only become more widely discussed in recent years, as part of developing a broader understanding of human development and the factors affecting it. Health is clearly an important factor affecting overall wellbeing, as are others such as work and income, housing, education, the environment and community. With greater understanding of the inter-relationships between these different factors and the influence of **social determinants** on health, health and care systems have become more concerned with broader community efforts to improve health. But do communities agree? And if they do, do they have the capacity to act?

We need to start building up facilities in the community for good convalescent homes, better social care, at the same time as investing in the hospitals. The current conversation is about doing community instead of healthcare. But that's no good. We need to do both.

There are tensions between **different narratives** of how the public see health and how experts do. Experts typically see health as complex, multi-causal and embedded in health and care systems and society as a whole. The public view of health tends to be more focused on individuals' actions, and when things 'go

wrong' as being up to experts to fix. How might these different narratives productively converge in order to understand and improve future wellbeing? How can health and care systems support that?

Health and care professionals

Staff are the core of health and care systems. The existing fundamental **division between doctors and nurses** has remained largely unchanged during the life of modern health and care systems, with responses to changes in health systems coming mostly through increasing specialisation within those professions. These existing roles are well understood by the public and have built up generations of social support. There is now discussion about adapting these roles, and some additional roles emerging such as nurse practitioners and assistant physicians. These are still developing. How can the existing health and social care workforce best be used? How might existing roles be adapted and further roles be developed?

There is a bizarre division of labour in healthcare dating back 70 years: too simple a binary between doctors and nurses. We need more specialised jobs which require less training. The skills mismatch in the healthcare sector is much higher than for other industries. Entrenched interests and traditions of medical professions are partly to blame. We can learn from low- and middle-income countries which have a more differentiated health workforce, including disease specialists. We could envision chronic disease specialists in upper income countries.

Greater information and empowerment of patients also potentially changes the relationship between patients and professionals. Rising levels of chronic conditions is also a factor in the development of expert patients and patient organisations; as people live longer with chronic conditions, can they acquire more knowledge of the condition than the professionals treating them? How can the health and care system encourage and work with such expert patients?

How to transition from the idea that expertise in health belongs to doctors and health systems rather than patients? This idea is a philosophical foundation to public provision of health—the assumed disparity in knowledge between the patient and provider requires public provision to ensure patient's needs are met. But

given profusion and accessibility of information, is this paradigm changing?

Staff are the core resource of health and care systems. Hence, **pressures on health and care systems as a whole inevitably have an impact on those staff**. The global financial crisis and consequent pressures on many systems have accentuated long-term pressures on financing of health systems, and this has been felt by health and care professionals in many countries. **Social care has been particularly affected by wider social and economic change**. As in many systems, social care is relatively low paid and thus staffed by people with the weakest position in the labour market – such as migrants, the working class, women. More broadly, there are **tensions between some efforts to improve efficiency of health and care and the professional autonomy and engagement** of the staff involved.

The NHS is kept afloat by the dedication of staff. But I fear without an intervention soon, that goodwill will completely disappear and they'll give up. In any sector, people generally want to do a good job. This is true in spades in provision of health care but really difficult if you are prevented from doing that.
