Discovery Series

Global Commission for 21st Century Healthcare

Reimagining the 21st Century Healthcare System



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Introduction

The Global Commission for 21st Century Healthcare (GC21CH) is a landmark, once-in-a-century initiative convened by Health Parliament to redesign the global healthcare architecture for the modern age, one that is equitable, digitally enabled, and truly human-centered.

Over the past 300 years, healthcare has transformed from minimal local spending to a nearly US $10 trillion global system. Despite this extraordinary progress with longevity increasing across the world, a serious and widening gap between longevity and HALE (Healthy Life Expectancy) persists. Today, half the world still lacks access to basic care, 10 million preventable deaths occur each year, and disease burdens continue to rise.

> This is not a system problem - it is a design problem. The healthcare system we have inherited was largely designed for the 18th and 19th centuries. It is time to redesign it for the 21st.

Genesis of the Commission

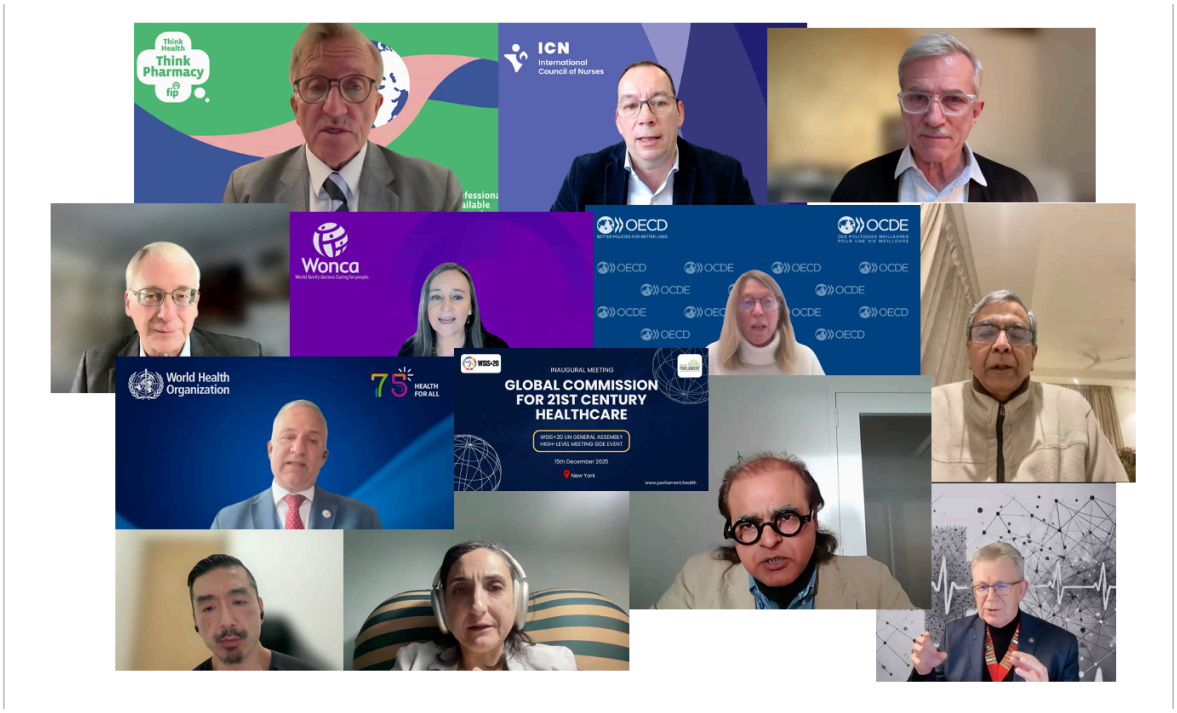
The genesis of GC21CH traces to a Global Digital Health Summit 2026 session titled: *"Broken Health System: Can Digital Health Fix It?"*

A key insight emerged from that discussion: investing more into a broken health system simply produces a bigger broken system. Layering digital health on top of a broken system produces a broken digital health system. This insight catalyzed months of global dialogue with health leaders across countries, ultimately leading to the establishment of GC21CH.

Subsequently, a Global Health System Redesign Lab was convened in Pfarrkirchen, Germany (12 November 2025) drawing participants from 15 countries. The inaugural global commission meeting was held on 15 December 2025 as a WSIS+20 UN General Assembly High-Level Meeting Side Event.



Global Health System Redesign Lab, Pfarrkirchen, Germany, 12 November 2025, participants from 15 countries.



Inaugural meeting of the Commission, 15 December 2025, a WSIS+20 UN General Assembly High-Level Meeting side event, New York.

The Origins of Healthcare Systems

Healthcare is a mirror of civilization. Every system we have today from the village Vaidya in India to Bismarck model of Insurance in Germany to the National Health Service in Britain, all have emerged from various cultural, economic and political movements, and continues to carry that DNA.

FIVE ORIGIN POINTS THAT SHAPED THE WORLD WE INHERITED

India: Ayurveda is among the oldest documented systems of medicine, with the foundational texts (Charaka Samhita, Sushruta Samhita) dating to roughly 1000 BCE–500 CE. Sushruta describes over 300 surgical procedures and 120 instruments including rhinoplasty, more than two millennia before its "rediscovery" in 18th-century Europe.

China: Traditional Chinese Medicine (TCM) is rooted in the Huangdi Neijing (~300 BCE). The WHO formally integrated TCM diagnostic categories into ICD-11, which entered force on 1 January 2022, the first time a traditional system was incorporated into the global classification of disease.

Africa: Indigenous healing systems served the majority of the population for millennia and still do today. WHO estimates about 80% of people in sub-Saharan Africa rely on traditional medicine for some part of their primary healthcare.

Germany: Otto von Bismarck enacted the world's first compulsory social health insurance in 1883, creating the actuarial template that most modern insurance systems still follow.

United Kingdom: The National Health Service was founded on 5 July 1948 by Aneurin Bevan, the first universal, tax-funded, free-at-point-of-use system in any major economy. The United States, by contrast, took a fundamentally different turn: employer-based private health insurance scaled in the 1940s after wartime wage controls made employer-sponsored benefits a tax-advantaged form of compensation.

A 2,500-year head start that we forgot about

Sushruta's Sushruta Samhita described nasal reconstruction using a forehead flap, a procedure that became famous in Europe only after a British surgeon, Joseph Carpue, performed it in 1814 having read about it in a Madras Gazette report. The world's "first plastic surgery textbook" was 23 centuries old when the West discovered it. The point for GC21CH: civilizational systems holds knowledge that the modern healthcare grammar has not yet learned to value or integrate.

How the World Organizes Care Today: The Three-Tier System

Every health system on Earth is a variant of three archetypes: tax-funded public, market-driven private, or mixed. Each makes different trade-offs across cost, coverage, outcomes and innovation.

COST, COVERAGE, OUTCOMES, AND INNOVATION

UK (public, NHS): Total health spending ~10.9% of GDP (2022, OECD); coverage universal; life expectancy 80.7 years; per-capita spending ~$5,490 (PPP).

US (private-dominant): National health spending reached $4.9 trillion in 2023 - 17.6% of GDP (CMS, Health Affairs 2024). Roughly 26 million remain uninsured; life expectancy 77.5 years lower than every other high-income peer.

Germany (mixed, social insurance): ~12.7% of GDP; statutory health insurance covers ~88% of the population; outcomes among the best in the OECD.

India (fragmented): Total health spending ~3.3% of GDP; out-of-pocket spending ~47 - 48% of total health expenditure (NHA 2020-21) among the highest in major economies; PMJAY now covers 550+ million people for hospitalization.

China (transitioning): Health spending grew from ~4% of GDP in 2000 to ~7% today; basic medical insurance covers ~95% of the population, but rural-urban disparities and ageing pressures are mounting.

Sub-Saharan Africa (under-resourced): Average per-capita health spending of $45 in low-income countries vs. $4,001 in high-income countries (WHO 2023). Low-income countries account for 0.24% of global health expenditure but 8% of global population.

> A 30-year-old American spends roughly twice as much per capita on healthcare as a German and dies, on average, three years earlier. Two systems, two political philosophies, two outcomes and the gap is widening, not narrowing. The "best healthcare system in the world" claim survives only inside the country that makes it.

The Care Seeker's World: What People Actually Need

Patients do not experience "the system." They experience four distinct journeys, each with different time horizons, decision-makers and economic logic.

THE FOUR CARE JOURNEYS, IN NUMBERS

Acute care: Pneumonia, sepsis and acute respiratory infections kill an estimated 2.5 million people a year which are most preventable with timely access. Sepsis alone causes approximately 21.4 million deaths globally per year nearly one-third of all global deaths (Lancet / Global Sepsis Alliance, November 2025).

Chronic care: Noncommunicable diseases killed 43+ million people in 2021 - 75% of all non-pandemic deaths globally. Cardiovascular disease alone accounts for approximately 19.8 million deaths annually (WHO, 2022 data).

Assistive & rehabilitative care: WHO estimates 2.4 billion people live with a condition that benefits from rehabilitation, yet rehabilitation services are unavailable to half the world.

Accident & emergency: Road traffic injuries kill ~1.19 million people annually (WHO 2023) and are the leading cause of death for 5–29-year-olds. 90% of road deaths occur in low- and middle-income countries, which own only 60% of the world's vehicles.

Patients live four lives. The system funds one.

Insurance, hospitals and most medical training are still organized around acute, episodic illness, the shortest of the four journeys. Chronic disease, which now causes three-quarters of deaths, gets a fraction of the architecture. The mismatch between what kills people and what the system is built to treat is the single largest design flaw of 20th-century healthcare.

The Provider's World: How Care is Delivered: The Distribution Challenge

Workforce shortages, training mismatches, and incentive structures shape what care actually reaches patients. The numbers are stark.

THE WORKFORCE GAP THAT DEFINES THE NEXT 25 YEARS

WHO projects a shortfall of 11 million health workers by 2030, primarily in low- and lower-middle-income countries (WHO EB156/15, 2024).

Africa carries 25% of the global disease burden but only 3% of the world's health workers.

Specialist concentration: The global majority of medical specialists are clustered in tertiary urban hospitals, while primary care where 80% of need exists is the least invested-in tier.

Burnout: A 2024 BMJ Global Health review found physician burnout exceeds 40% across most surveyed countries; nursing turnover in the US reached 22.5% in 2022 (NSI Nursing Solutions).

Where Provider and Patient Meet: The Sick Care Model

Combine providers trained for acute illness with patients who arrive only when sick, and you get the system: sick care masquerading as healthcare.

THE SICK CARE SYSTEM IN NUMBERS

In OECD countries, only ~3% of total health spending goes to prevention; the remaining 97% is treatment.

In the US, just 5% of patients drive ~50% of healthcare costs - overwhelmingly chronic-disease patients identified late.

Globally, 80% of premature heart disease, stroke and type 2 diabetes is preventable (WHO 2025) yet preventive interventions remain underfunded relative to acute treatment by more than an order of magnitude.

The Lancet "Counting the cost of inaction" series estimates that every $1 invested in NCD prevention returns ~$7 in averted treatment and lost productivity.

> Sick care is not a healthcare system; it is an emergency response system that happens to also handle chronic disease. Imagine a fire department whose only strategy is to put out fires after they reach the fourth floor and which spends 33 times more on water than on smoke detectors. That is, in proportional terms, the global health architecture today.

What Cannot Be Fixed: The Irreducible Burden

Some categories of care will exist in any system, in any era, however well prevention works. They define the floor below which spending and capacity cannot fall.

Accident & Emergency: Road traffic deaths alone (1.19 million annually) are reducible but not eliminable. WHO's Decade of Action target is to halve them by 2030; so far progress is well off pace.

Genetic and hereditary conditions: WHO estimates roughly 7.9 million children are born annually with a serious genetic disorder about 6% of total births. Sickle cell disease alone affects ~7.7 million people globally (Lancet 2023).

Geriatric and end-of-life care: 56.8 million people require palliative care annually and only 14% receive it (WHO/Lancet Commission on Palliative Care).

Even with perfect prevention, the bill never reaches zero

A radically preventive 21st-century system would still need to fund roughly 30–40% of today's acute and chronic infrastructure just to handle the irreducible categories: trauma, genetic disease, and end-of-life care. The political conversation often pretends prevention can replace treatment. It cannot but it can free up the resources to do treatment well.

The Numbers That Indict the System

Five numbers, when placed beside each other, make the case for GC21CH.

Global GDP (2024): ~$110 trillion nominal (IMF World Economic Outlook, October 2024).

Global health spending: US$ 9.8 trillion (2021) roughly 10.3% of global GDP (WHO Global Health Expenditure Report 2023). US national health spending alone reached $4.9 trillion in 2023 (CMS).

4.5 billion people, more than half the world, were not fully covered by essential health services in 2021 (WHO/World Bank UHC Global Monitoring Report 2023).

NCDs killed 43+ million people in 2021 which is 75% of non-pandemic deaths. 18 million were premature (under 70). 82% of premature NCD deaths occur in LMICs.

A trillion-dollar machine that excludes half its customers

There is no other industry on Earth that consumes 10% of global GDP and excludes half its potential users. If global aviation excluded 4.5 billion would-be passengers, it would not be called an industry; it would be called a failure. Healthcare gets a pass on a scale of dysfunction that would be intolerable in any other sector.

Longevity vs HALE: The Illusion of Progress

One of the most celebrated achievements of modern healthcare is increased life expectancy. Yet beneath this achievement lies a more troubling reality. Healthy Life Expectancy (HALE), the number of years lived in good health, has not kept pace with overall longevity.

Global life expectancy rose from 66.8 years in 2000 to 73.1 years in 2019, while HALE rose from 58.1 to 63.5 years over the same period (WHO Global Health Observatory / GBD 2021 revision). The implication is sobering; people are living longer but spending more years in poor health. Estimates suggest that individuals globally now spend between 8 and 12 years and in some contexts up to 15 years in states of illness or disability.

These years are typically marked by reduced mobility, cognitive decline, dependence on multiple medications, and diminished quality of life. In many developed health systems, longevity is increasingly being “manufactured” at the end of life through polypharmacy, intensive care, and late-stage disease management rather than preserved through earlier biological function.

The Payer Crisis: When Insurance Stops Working

Bismarck's 1883 invention rests on a single assumption: that the healthy many will always outnumber the sick few. Demography is now dismantling that assumption in front of us.

THE ACTUARIAL POOL, INVERTING

The global 65+ population will rise from 703 million in 2019 to 1.5 billion by 2050 from 1 in 11 of humanity to 1 in 6.

In advanced economies and China, working-age share will fall from 67% today to 59% by 2050. The support ratio will collapse from ~4 workers per retiree to 2.

EU old-age dependency ratio will rise from 36% in 2022 to ~57% by 2050.

Japan today: 29.3% of the population is 65+ (Statista 2024); old-age dependency ratio projected at ~80% by 2050 (Eurostat). Adult diapers have outsold infant diapers since 2014.

US insurer medical loss ratios climbed to 85.2% on average in Q1 2025 (Oliver Wyman) with Aetna CVS at 87.3%. The pure-payer business is structurally stressed.

Japan is not an outlier: it is a postcard from the future

In 2014, more adult diapers were sold in Japan than baby diapers. There was no policy announcement, no headline crisis just a tipping point on a supermarket shelf. It is the most under-rated economic indicator of the 21st century. South Korea, Italy, Germany, Spain and China are 10–20 years behind on the same curve. India, today's "young" giant, will have 347 million people aged 60+ by 2050 more than the entire current population of the United States.

Rich and Ageing, Poor and Ageing: Two Crises, One World

The ageing wave hits two very different worlds. Rich nations have wealth without workers. Poor nations have neither. Both face the same demographic clock.

TWO FACES OF THE SAME DEMOGRAPHIC TRANSITION

Closing the senior consumption-income gap entirely through transfers would require a tax-equivalent of 33% of all worker incomes today in Western Europe, rising to 46% by 2050.

80% of older people will live in low-and middle-income countries by 2050.

China is projected to grow old before it grows rich: its working-age-to-retiree ratio will fall from 4.8 today to 1.9 by 2050.

Africa's 65+ population will roughly triple by 2050 from a much smaller base, but onto a far weaker fiscal foundation than Europe or Japan ever had.

Only 3.7% of LDC populations were 65+ in 2023 (UN), but the rise will accelerate sharply in the second half of the century, reaching old-age dependency levels comparable to today's Western Europe without comparable wealth, infrastructure, or pension systems.

The largest healthcare financing challenge in human history

There is no historical precedent for what is coming. The Black Death halved Europe's population in four years, but a generation later it had recovered. What we face now is slow, irreversible, and global - a sustained inversion of the human age structure for the first time since records began. The fiscal architecture of the welfare state was designed in the 1940s for populations that looked nothing like the populations of 2050. Re-engineering that architecture is not optional.

The Trust Deficit

Trust is not a soft variable. In a system that depends on adherence, prevention and shared decision-making, trust is the operating system itself.

The 2024 Edelman Trust Barometer found that trust in healthcare institutions has fallen in 19 of 28 surveyed countries since 2020.

The share of Americans saying they have "a great deal" of confidence in medical scientists fell from 40% in 2020 to 23% by 2023.

A Lancet Commission on Vaccine Confidence found that vaccine confidence declined in over half of surveyed countries during 2018–2023.

Adherence rates for chronic medications average around 50% in developed countries - non-adherence is now estimated to cost the US system alone $300 billion annually.

A KFF poll (2024) found that 58% of US adults believe the healthcare system is rigged in favour of insurers and pharmaceutical companies.

When the operating system crashes, no app runs

Half of patients on chronic medication never finish their prescriptions. A third of immunizable parents now hesitate to vaccinate. A majority believe the system is rigged. These are not separate problems; they are the same problem. Every clinical, technological and policy intervention runs on top of trust. When trust collapses, every other lever in the system loses its grip. Trust is structural infrastructure.

The Behavior Problem Nobody Solved

Diet, exercise, sleep, adherence, screening, prevention. We know what works. We have not figured out how to make people do it at scale, sustainably, equitably.

BEHAVIOR AT SCALE: THE FAILURE LEDGER

1.4 billion adults are insufficiently physically active; 80% of adolescents fail to meet activity guidelines.

Global obesity has more than doubled since 1990: over 1 billion people now live with obesity.

Tobacco still kills over 7 million people annually including 1.3 million from second-hand smoke.

Medication adherence in chronic disease averages 50% in high-income countries and lower in LMICs.

In many high-income countries, fewer than 60% of eligible adults complete recommended cancer screenings even when they are free at point of use.

We have moonshots for drugs and napkin sketches for behavior

A new GLP-1 obesity drug attracted billions of dollars in R&D within a decade. The behavioral-change interventions that would prevent the underlying obesity in the first place receive a tiny fraction of the funding. We have built a Manhattan Project for molecules and a hobbyist workshop for human behavior. Until that asymmetry closes, behavioral change will remain as it has been for 50 years - the largest unlocked door in global health.

The Great Paradox: Spending More, Feeling Worse

Healthcare today stands at a defining paradox. Over the last century, humanity has achieved remarkable progress in medical science, public health, and care delivery. Diseases that once decimated populations are now treatable. Life expectancy has risen across the globe. Medical technology has advanced beyond what earlier generations could have imagined.

And yet, despite this progress, an uncomfortable truth confronts us: we are spending more than ever on healthcare, while populations are not necessarily healthier.

Global health expenditure was approximately USD 8.8 trillion in 2019 and is projected to reach USD 14.3 trillion by 2050 (Riumallo-Herl et al., 2021). This growth is being driven not by improved outcomes, but by the rising burden of chronic disease, aging populations, and inefficiencies embedded in system design. (WHO Global Health Expenditure Database, 2025).

This is the Cost-Value Chasm. We have built a system that is extraordinarily good at treating illness, yet remarkably poor at preventing it. In effect, societies pay a continuous “sick tax” which is a financial burden to sustain an acute-care architecture in a world dominated by chronic, lifestyle-driven disease. The fundamental problem is not a lack of resources or innovation; it is a failure of system design.

Technology: Enabler or Divider?

The same AI model that brings specialist-level diagnostics to a village clinic can also widen the gap between those who can afford continuous, AI-augmented care and those who cannot. Technology is never neutral.

TECHNOLOGY, BOTH WAYS

The global AI-in-healthcare market grew from $11B in 2021 to ~$45B in 2024 and is projected to exceed $187B by 2030 (MarketsandMarkets: AI in Healthcare Market 2025–2030).

A 2024 Nature Medicine systematic review found that AI diagnostic models now match or exceed clinician performance in over 60% of evaluated radiology and pathology tasks.

At the same time 2.6 billion people remain offline, most in the same regions where workforce shortages are most acute.

AI deployment in US healthcare is concentrated in top-quintile-income hospital systems early evidence of a digital health divide forming inside high-income countries.

In India, the Ayushman Bharat Digital Mission has issued over 886 million ABHA health IDs, the world's largest single-country digital health ID rollout.

The same chip can level the playing field or tilt it permanently

A smartphone-based AI scribe in a Lagos primary care clinic and a $40,000-per-year concierge AI health platform in Manhattan run on the same underlying foundation models. Whether the next decade is remembered as the great democratization of healthcare or the great divergence depends entirely on who builds the deployment layer, and on whose terms. That is a policy decision, not a technology one.

The Loneliness Epidemic

In the most digitally connected era in human history, loneliness is becoming a leading driver of disease, and the global health architecture has barely begun to acknowledge it.

SOCIAL DISCONNECTION AS A PUBLIC HEALTH CRISIS

1 in 6 people globally experience loneliness; loneliness is associated with ~871,000 deaths per year about 100 every hour.

Adolescents 13–17 years report the highest loneliness rates (~21%); female adolescents 24.3%.

Loneliness raises the risk of cardiovascular disease, type 2 diabetes, depression, dementia and early mortality comparable in impact to smoking 15 cigarettes a day.

In May 2025, the World Health Assembly adopted its first-ever resolution on social connection. Only eight countries currently have national policies on the issue (Denmark, Finland, Germany, Netherlands, Sweden, England, Scotland, Wales); Japan has appointed a Minister for Loneliness.

Estimated cost: US$3.2 billion per year to UK employers alone in lost productivity.

The third pillar of health and the one we built around

The Lancet now describes social health as the "neglected third pillar" alongside physical and mental health. The cruel irony of our era: technology has freed unprecedented amounts of time, but without purpose, community or face-to-face connection, that liberated time has become its own pathology. Solitary deaths in Japan, the kodoku-shi phenomenon, claimed over 37,000 people in just the first half of 2024. This is what an ageing, hyper-connected, lonely society looks like in steady state.

Who Pays?

Insurance in its 1883 form, the many healthy subsidizing the few sick, was designed for a world where illness was acute, unpredictable, and short. It was not designed for a world where everyone gets old, and getting old is expensive.

Who Takes Care and When?

A continuous, life-course view of care requires reconceiving who delivers it, where, and at which life stage. The doctor-and-hospital duopoly of the 20th century is structurally insufficient.

A NEW CAREGIVING STACK

WHO recommends one community health worker per 1,000–2,000 people for primary care delivery, a model India, Brazil, Ethiopia and Rwanda have scaled at population level.

Would Pharmacies Could pharmacists and nurses play a leading role in advancing preventive healthcare?

The "care continuum" is shifting earlier: preconception, prenatal, pediatric and adolescent interventions show the highest lifetime ROI in chronic-disease prevention.

A pre-emptive care model beginning with school-based healthcare could deliver the highest return on investment (ROI), as highlighted in the book (Health Care Reforms in India: Making up for the Lost Decades) and (Pre-emptive healthcare: The best option).

Care does not begin when you are sick. It begins decades earlier.

Reorganizing "who takes care" means reorganizing when society pays attention and that is a generational and political reset, not just a clinical one.

Where and When Do We Start?

The temptation is to wait for a perfect global framework. The arithmetic of demography says we cannot.

THE WINDOW IS CLOSING

India has 33 years before its support ratio matches today's advanced-economy levels. Brazil has 16 years. Thailand has 5.

By 2054, immigration will be the main driver of population growth in 52 countries making cross-border health-data interoperability a payer issue, not just a clinical one.

80% of premature heart disease, stroke and type 2 diabetes is preventable with interventions that already exist and are not expensive.

Healthcare systems may mean different things in different parts of the world. The Commission may therefore need to identify a common denominator or develop a universal framework for healthcare systems grounded in global science while adapting to local demographics and infrastructure.

> The cheapest decade to start was the 2010s. The second cheapest is now.

How Do We Make It Happen?

The "how" problem is not about having a good idea. It is about coalitions, accountability, and the architecture of a parallel build. We are not short of resources. The annual UHC funding gap is roughly 25% of what humanity already spends on weapons every year. The "how" is not a financing problem, it is a governance, accountability and political-priority problem. GC21CH exists to shift that priority calculus.

From Sick Care to Holistic and Preventive Care

A prevention-first system is not a slogan; it is an architecture. It changes who gets paid, what is measured, where care is delivered, and how a citizen relates to their own data.

> We are measuring negative indicators in the hope of achieving positive health outcomes. Our current healthcare systems are designed to measure and manage sickness, yet we expect them to deliver health and well-being. We must recognize that more money does not necessarily mean more healthcare, and more healthcare does not automatically mean better health. We are moving in the wrong direction, and the time to course-correct is now.
>
> DR. RAJENDRA PRATAP GUPTA, PRE-EMPTIVE HEALTHCARE: THE BEST OPTION

WHAT "PREVENTIVE-FIRST" REALLY REQUIRES

Prevention currently absorbs ~3% of total health spending even a doubling to 6% would shift global health architecture more than any drug discovery in the last 30 years.

Roughly 50% of the global disease burden is attributable to modifiable risk factors - diet, tobacco, alcohol, air pollution, physical inactivity, hypertension.

Singapore's Healthier SG (launched 2023) pairing every citizen with a family physician and shared care plan is the first national-scale prevention reset in a high-income system this decade.

Asset-Light Healthcare: Medicine Without the Building

The hospital was the 20th century's greatest medical technology. In the 21st, the most consequential advances, continuous monitoring, AI-assisted diagnosis, digital therapeutics, need almost none of it.

CARE AS A PERSONAL ASSET, IN NUMBERS

Global smartwatch shipments crossed 150 million units in 2024 and most now capture continuous heart rate, ECG and blood-oxygen data.

Continuous glucose monitors: usage among non-diabetic users in the US grew over 400% between 2021 and 2024.

Estonia's e-Health system: 99% of prescriptions are digital, and citizens own and control access to their health record.

> Healthcare will move from 4 walls to five fingers.
>
> DR. RAJENDRA PRATAP GUPTA

New Specialties, New Lines of Treatment

The medical specialties of 1950 were designed for the disease burden of 1950. The disease burden of 2050 will require professions that do not yet exist at scale.

EMERGING SPECIALTIES

Behavioral and digital therapeutics: The digital therapeutics market crossed $7B in 2024 and is projected to exceed $30B by 2030.

Longevity medicine: Global private investment in longevity-focused biotech crossed $5B in 2024.

Social and Emotional medicine: This field will play a key role in managing challenging conditions, which are just treated with medications.

Genomic medicine: The cost of a whole-genome sequence has fallen from $100M (2001) to under $200 (2024) over a 500,000× reduction.

Climate-health and planetary medicine: WHO estimates climate change will cause 250,000 additional deaths per year between 2030 and 2050 from heat, malnutrition, and infectious disease - a discipline barely staffed today.

Most of the doctors of 2050 have not been named yet

A behavioral cardiologist who manages a patient's lipid panel through a digital therapeutic and a shared kitchen plan; a planetary-health pulmonologist who tracks PM2.5 exposure across a patient's life-course; a longevity geriatrician whose KPI is disability-free years added - none of these jobs exist in mainstream medical training today. The fastest-growing healthcare professions of 2050 will be the ones that do not have curricula in 2026.

Build New and Don't Just Repair Broken

When a building is structurally compromised, you do not keep fixing individual floors. You build alongside it and you migrate. The case for a parallel new health system, rather than endless patching, rests on three observations.

WHY PATCHING HAS STOPPED WORKING

Despite roughly tripled real per-capita spending in OECD economies since 1990, life-expectancy gains have plateaued and outcomes for chronic disease have, in many cases, worsened.

Coverage progress has stagnated since 2015 exactly the period of greatest investment in patching existing systems.

25% of US healthcare spending is waste embedded in the existing architecture, structurally resistant to incremental reform.

Estonia, Singapore, Rwanda and India's Aadhaar/ABHA stack demonstrate that greenfield digital and primary-care architectures can outperform patched legacy systems within 5–15 years.

The parallel-build precedent: how the world has actually transitioned before

Mobile telecoms did not modernize the copper-wire network, it built around it and made it irrelevant. Renewable energy is doing the same to the fossil grid. Electric vehicles, the same to internal combustion. In every case, the pattern is parallel build → migration → graceful decommissioning. Healthcare is the last major sector to attempt the same transition. The longer we wait, the harder it gets.

Preparing for 2050: Proactive, Not Reactive

The choice in front of every government, every payer, every provider, every citizen is not whether the 20th-century system survives. The choice is whether we design its successor or manage its collapse.

WHAT 2050 LOOKS LIKE, ON THE CURRENT TRAJECTORY

1.5 billion people aged 65+.

80% of the elderly in low-and middle-income countries with weaker fiscal foundations than today's ageing economies ever had.

Climate-attributable deaths approaching 250,000 additional per year.

Healthcare spending pressure on public budgets in advanced economies projected at +3.0–4.5 percentage points of GDP by 2050 (European Commission, OECD).

Without action, chronic disease will consume roughly 70% of all health spending leaving little for prevention, innovation or the irreducible burden.

The 20th-century health system was an immense achievement. Its successor will be a greater one, if we begin building it now, and not when the patching has finally stopped working.

The 12-Member Commission: Global Leaders

The Commission brings together global leaders representing more than half of the world's health workforce through professional bodies, alongside leading academics, policy shapers, and practitioners from across the world:

COMMISSIONER	ROLE / ORGANIZATION
Prof. (Dr.) Thomas Zeltner	Chairman, WHO Foundation; Co-Chair, GC21CH
Dr. Rajendra Pratap Gupta	Founder & Chairman, Health Parliament; Co-Chair, GC21CH
Dr. T. Dileep Kumar	President, Indian Nursing Council (INC); Board Member, ICN (SEARO); Ex-Nursing Adviser, Govt. of India
Mr. Paul Sinclair AM	President, International Pharmaceutical Federation (FIP)
Dr. Joseph C. Kvedar	Professor, Harvard Medical School
Dr. Lars Lindsköld	President, European Federation for Medical Informatics (EFMI)
Ms. Francesca Colombo	Head, Health Division, Directorate for Employment, Labour and Social Affairs, OECD
Dr. K. Srinath Reddy	Founding President, Public Health Foundation of India
Dr. José Luis Cobos-Serrano	President, International Council of Nurses
Dr. Viviana Martínez-Bianchi	President, World Organization of Family Doctors (WONCA)
Dr. Clarice D. Aiello	Chair, Quantum Biology Ecosystem (CSO of the Quantum Biology Institute)
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Global Health System Redesign Lab: From Proliferation to Purposeful Progress of AI

Global Health System Redesign Lab: From Proliferation to Purposeful Progress of AI as side event to 79th World Health Assembly will be hosted at the John Knox Centre on 19 May 2026. This session will build on the work done in previous labs and advance the commission's two-year agenda towards designing a template for a 21st century healthcare system.

KEY THEMES FOR DISCUSSION

- Vision for the Healthcare System in the 21st Century particularly the key elements that will define future healthcare systems
- Beneficial applications of AI transforming healthcare delivery, access, patient engagement, and clinical outcomes.
- Emerging new medical specialties and interdisciplinary roles shaped by AI
- Longevity and increasing life expectancy as an emerging challenge for healthcare systems and society, and how health systems should prepare for this transition
- Re-examining the three-tiered healthcare structure (self-care / family care → primary care → secondary & tertiary care) in light of technology-driven barrier reduction
- The role of digital health in healthcare redesign converting excitement into purpose-driven outcomes

Global Roadmap

The Commission's work spans a two-year global programme of regional workshops and stakeholder consultations, with the goal of producing a comprehensive template for a 21st century healthcare system. Upcoming and planned engagements include:

Geneva, Switzerland, 19 May 2026 (WHA79 Side Event, John Knox Centre)	Southeast Asia
Africa	Europe
United States	United Kingdom
Final global report on healthcare redesign elements	

> The 20th century was about adding years to life. The 21st century must be about adding life to years.

This is a moment of choice. If we continue with the current trajectory, healthcare will become economically unsustainable, inequities will widen, and outcomes will stagnate. If we act decisively, we can create healthier societies, reduce suffering, and unlock human potential at an unprecedented scale.

The question is no longer whether healthcare should change. The question is whether we will redesign it deliberately or allow it to collapse under its own weight. The Global Commission for 21st Century Healthcare (GC21CH) is our opportunity to choose the former.

> This is the new social contract for health that the 21st century demands and that GC21CH is convened to deliver.

About Health Parliament

Health Parliament is the world's foremost executive think tank on health, dedicated to shaping the future of global healthcare through policy, innovation, and cross-sector collaboration. It has produced more than 40 reports on various important topics. It operates at the intersection of policy and practice, engaging governments, international organizations, professional bodies, academic institutions, and the private sector to build a healthier, more equitable world. Health Parliament believes that the challenges facing 21st century healthcare are not merely systemic, they are fundamentally problems of design. It is this conviction that drives its commitment to convening global leaders, generating evidence-based insights, and advocating for a healthcare architecture that is equitable, proactive, technology-enabled, and truly human-centered.

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