



GLOBAL
COMMISSION
FOR
21ST CENTURY
HEALTHCARE

Hosted by



In association with



Background Paper for the Singapore Convening

4th Global Health System Redesign Lab

Singapore

25 September 2026

9:00 AM to 12:00 PM

Training Room 2, Level 1, Medicine+Science Library
National University of Singapore
11 Lower Kent Ridge Road
Singapore 119083

www.parliament.health/gc21ch



Preface

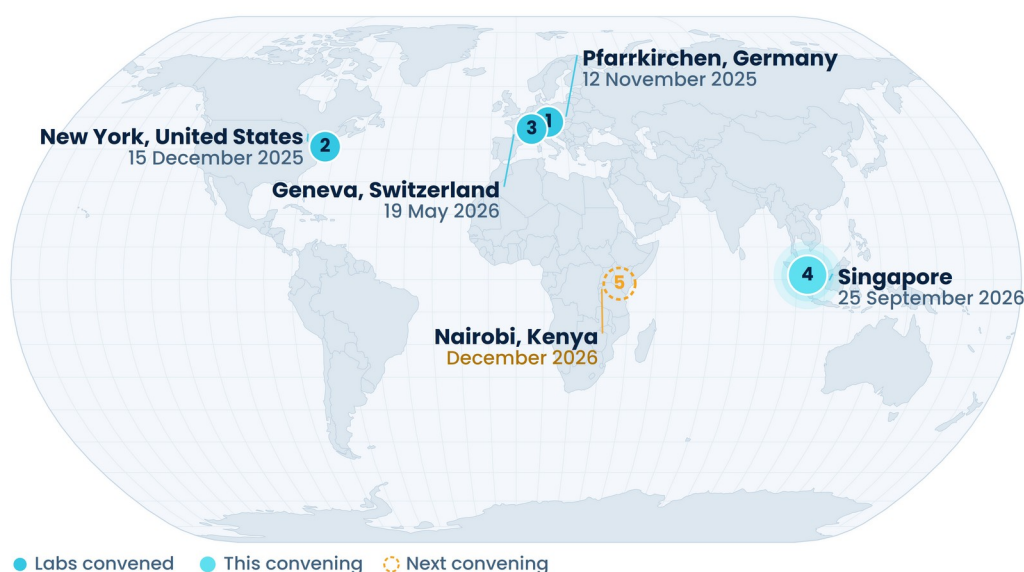
Back in 2025, during a panel at the Global Digital Health Summit, we posed a simple question that had been keeping many of us up at night: Is our global health system fundamentally broken, and can digital technology actually fix it? The answer we arrived at was candid and hard to ignore. You cannot fix a broken foundation simply by adding tech layers on top. If a system is structurally flawed, patching it up only gives you a more expensive, digitized version of a broken system. We don't need minor adjustments; we need to go back to the drawing board and redesign healthcare from the ground up.

When we launched this initiative, we knew the road ahead would be challenging. But the response from the global leadership has been deeply moving. World's foremost healthcare leaders across medicine, nursing, pharmacy, economics, public health, and digital innovation stepped forward to form our twelve-member Commission.

Together, we embarked on a journey across continents:

- Pfarrkirchen, Germany (Nov 2025): We questioned how we measure health, shifting our focus from counting hospital beds to measuring actual well-being.
- New York / UN General Assembly (Dec 2025): We set a shared global roadmap to rebuild health architecture around people, not just diseases.
- Geneva / World Health Assembly (May 2026): We tackled AI and data, ensuring technology serves humanity rather than accelerating existing systemic failures.

Now, ten months after our first gathering, we bring this global dialogue to Singapore to learn from the ASEAN region.



Reports from each of these convenings are publicly available, and they show that we are finally gravitating towards envisioning a health system of the 21st century and, as a design lab, working to create it, a system that will deliver those results.

Singapore's bold primary care reforms like Healthier SG offer real-world lessons on what happens when you shift focus from treating illness to sustaining health. During this convening, we want to address a crucial question: What should a 21st-century health dashboard actually look like for a nation?

Health systems are not one-size-fits-all. What works in Singapore may look very different in Nairobi or New York, shaped by unique local contexts, culture, and resources. That diversity isn't an obstacle; it's the core of our work. This is a massive, unprecedented effort, and no single group can accomplish it alone. We need your voice, your lived experiences, and your expertise. Whether you represent a community organization, a healthcare institution, or a policy group, we invite you to build this future with us.

Please do write to the Secretariat with any inputs you wish to share, and we will take them to the Commissioners for discussion. We expect to hold online meetings in the interim, before we convene again in Nairobi in December 2026 on the sidelines of Annual IGF Meeting.

We look forward to this meeting in Singapore, which we believe will help define the path forward for the health system of the 21st century.

With best regards,

Dr. Rajendra Pratap Gupta

Chairman and Founder, Health Parliament

Co-Chair, Global Commission for 21st Century Healthcare

Background

This background paper prepares participants for the Global Health System Redesign Lab in Singapore on 25 September 2026. It outlines the institutional origins of the Global Commission for 21st Century Healthcare (GC21CH), synthesizes key insights from prior global convenings, and establishes the analytical baseline for the Singapore proceedings. This document presents a baseline so that deliberations can focus on forward-looking system design.

Institutional Origins & Methodology

The Commission was established following a September 2025 panel at the Global Digital Health Summit, where health leaders concluded that repairing legacy healthcare architectures is no longer viable; systems must be redesigned.

1. **Leadership & Composition:** Co-chaired by Dr. Rajendra Pratap Gupta (Health Parliament) and Prof. (Dr.) Thomas Zeltner (WHO Foundation), the 12-member Commission integrates perspectives across medicine, nursing, pharmacy, economics, informatics, and public health, representing over half the global healthcare workforce.
2. **Two-Year Mandate:** GC21CH is tasked with developing actionable blueprints across four critical pillars: Governance, Financing, System Architecture, and Monitoring & Evaluation.
3. **Methodology:** Rather than extrapolating future targets from legacy performance, the Commission utilizes backcasting, defining the required future state of population health and designing backward to derive necessary system indicators and architectures.

Composition of the Commission



Prof. (Dr.) Thomas Zeltner
Co-Chair
Chairman
WHO Foundation



Dr. Rajendra Pratap Gupta
Co-Chair
Founder and Chairman
Health Parliament



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)



Prof. K. Srinath Reddy

Founding President
Public Health Foundation of India



Ms. Francesca Colombo

Head, Health Division
OECD



**Dr. Viviana Martínez-Bianchi,
MD**

President
World Organization of Family Doctors
(WONCA)



Dr. José Luis Cobos-Serrano

President
International Council of Nurses



Dr. T. Dileep Kumar

President
Indian Nursing Council; Board
Member, ICN (SEARO)



Dr. Clarice D. Aiello

Founder
Quantum Biology Ecosystem



Dr. Dean Ho, Ph.D.

Director
The Institute for Digital Medicine,
Yong Loo Lin School of Medicine, NUS

Participation in the Labs extends beyond the Commission itself to the World Health Organization, the United Nations, the OECD, The Commonwealth, UICC, IPSF, TruMerit, the Stop TB Partnership, academic institutions, digital health networks, youth-led platforms and civil society organizations [1, 4].

Opportunity Before the Commission: System Redesign

Global health expenditure reached US\$9.8 trillion in 2021 [5] and is projected to rise to approximately US\$15 trillion by 2050 [6]. Despite this expenditure, over 4.5 billion people lack full coverage for essential health services [7]. This disparity highlights an architectural design flaw: modern health systems were built to treat acute, episodic illness, yet they are now expected to manage chronic disease, population ageing, and preventive wellness without structural redesign. Continuously funding an outdated architecture simply scales its inefficiency.

The epidemiological composition of the burden has meanwhile shifted decisively. Noncommunicable diseases accounted for more than 43 million deaths in 2021, approximately 75 per cent of all non-pandemic deaths globally, with 82 per cent of premature deaths from these causes occurring in low- and middle-income countries [9]. Preventive care, by contrast, absorbs approximately 3 per cent of total health expenditure across OECD countries [10].

The Commission's structural interpretation is that this pattern is not a performance failure but a design consequence. Health systems in their present form were configured to respond to acute, episodic illness, and have subsequently been asked to absorb chronic disease management, prevention, ageing and rehabilitation without corresponding redesign. On this reading, a system allocating the overwhelming majority of resources to treatment is not malfunctioning when it fails to prevent disease; it is operating as constituted. The corollary the Commission draws is that incremental investment cannot correct a misallocation that is architectural in origin.



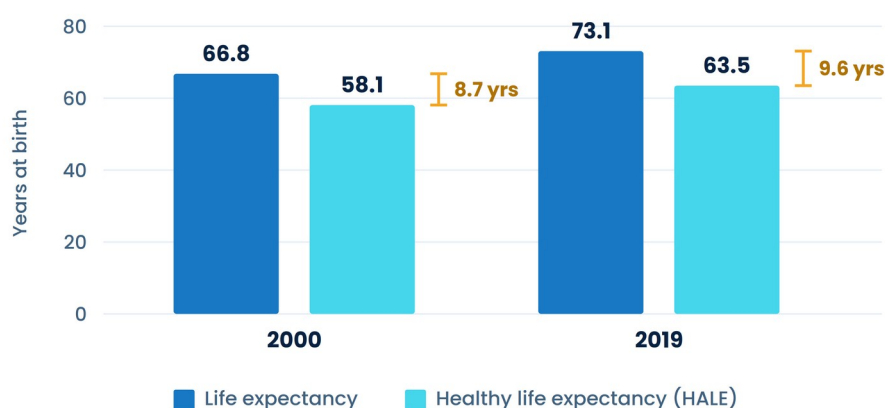
Keep investing in a broken health system, and you only build a bigger broken one. Add digital health on top, and you build a bigger broken digital health system. The fix isn't more investment in the same direction. It's going back to the drawing board.

Dr. Rajendra Pratap Gupta, Co-Chair, GC21CH

The Data Before Us

The propositions above are evidence-based. The figures that follow directly support the Commission's premise and provide a common factual basis for discussion.

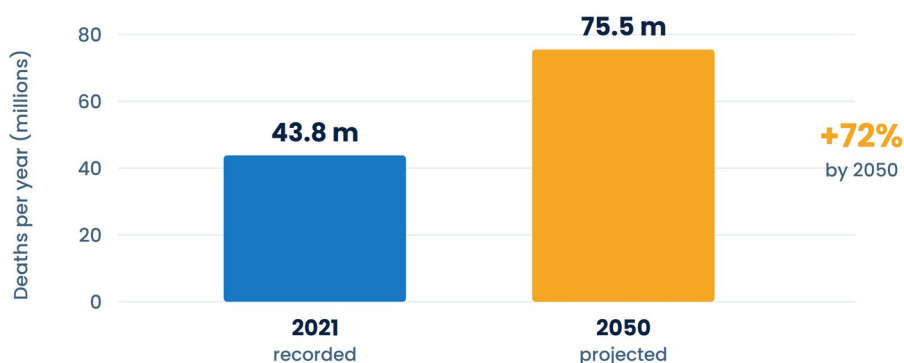
Life Expectancy & HALE



Global life expectancy and healthy life expectancy at birth, 2000 and 2019. Source: WHO Global Health Observatory [8].

Between 2000 and 2019, global life expectancy grew by 6.3 years (to 73.1 years), but healthy life expectancy (HALE) grew by only 5.4 years (to 63.5 years). The period spent in illness or disability widened to 9.6 years. The interval spent in poor health therefore widened from 8.7 years to 9.6. The system is adding years faster than it is adding health, and no indicator in routine use records that as a failure.

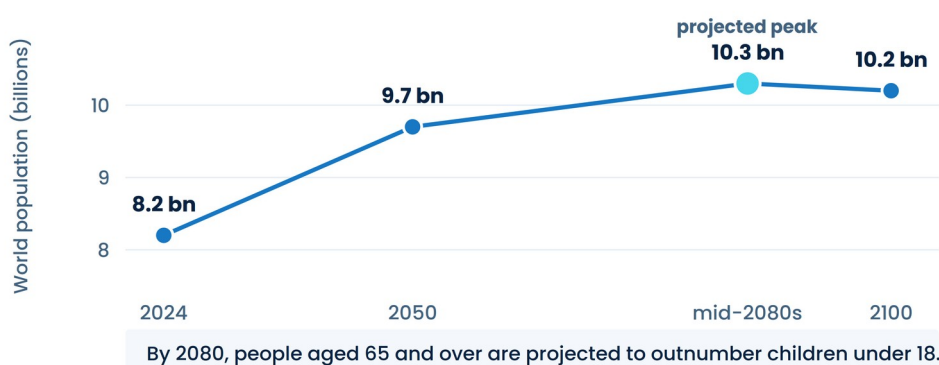
Chronic Disease Is Rising, Not Plateauing



Global deaths from noncommunicable diseases, recorded 2021 and projected 2050. Sources: WHO [9]; Freihat et al. [16].

Noncommunicable diseases caused 43.8 million deaths in 2021. On current trajectories the figure reaches 75.5 million by 2050, an increase of roughly 72 per cent, with cardiovascular disease accounting for the largest share [16]. Eighteen million of the 2021 deaths occurred before the age of 70, and 82 per cent of those premature deaths were in low- and middle-income countries [9]. The burden is not only growing; it is concentrating where the capacity to absorb it is weakest.

The Population Is Growing and Ageing Simultaneously



World population, estimated and projected. Source: UN World Population Prospects 2024 [12].

World population stood at 8.2 billion in 2024 and is projected to reach 9.7 billion by 2050, peaking at approximately 10.3 billion in the mid-2080s [12]. The composition matters more than the total.

By 2080 the number of people aged 65 and over is projected to exceed the number of children under 18. Every financing model in use was designed for the opposite ratio.

The Resource Base Is Finite

1.73 Earths

Humanity is using nature 73% faster than ecosystems can regenerate

Earth Overshoot Day 2026: 30 July



Country overshoot days, 2026



Earth Overshoot Day 2026 and selected country overshoot days. Source: Global Footprint Network [17].

The natural resources are already under strain which implies that if the health of the planet is under stress, it will impact and manifest through human health and that is why the overarching theme of one health is gaining prominence. The new health system should be holistic in its approach.

Clinical Care Is Not What Principally Determines Health

Modifiable determinants of health outcomes



Clinical care accounts for one fifth of what determines health outcomes. It receives the overwhelming majority of health system resources.

Weighting of modifiable determinants of health outcomes. Source: County Health Rankings model [18]; empirical estimates in Hood et al. [19].

The most widely used model of population health attributes 40 per cent of modifiable health outcomes to social and economic factors, 30 per cent to health behaviors, 20 per cent to clinical care and 10 per cent to the physical environment [18]. Empirical testing across more than three thousand counties produced relative contributions of 47, 34, 16 and 3 per cent respectively [19]. Whichever weighting is preferred, clinical care accounts for roughly one fifth of what determines

health and receives the overwhelming majority of what health systems spend. This is the asymmetry the Commission was constituted to address, expressed as a proportion.

Questions Before the Commission

What would a healthy population actually look like, and **which indicators** would show that it had been achieved rather than merely that illness had been treated?

What **interventions** are required, at what point in the life course?

What **infrastructure** can enable the above?

If **social and economic conditions** determine more of health than clinical care does, which **sectors** beyond health require the focus, and through what mechanism would a health system act on them?

What are the nuances that a single global framework would miss? Health means different things in different geographies, shaped by population structure, income, environment, and cultural context. Which elements should be common to all systems, and which must remain local?

What is the role of technology in the healthcare system of the 21st century?



Proceedings of the Preceding Labs

Global Health System Redesign Lab: Pfarrkirchen, 12 November 2025

The first Redesign Lab was held at the European Campus Rottal-Inn, Deggendorf Institute of Technology, with participants from fifteen countries and a deliberate emphasis on student and early-career participation [2].



Dr. Rajendra Pratap Gupta opening the first Redesign Lab, Pfarrkirchen, 12 November 2025.

Its principal contribution was a critique of health system measurement. The session observed that national assessment conventionally relies on doctor-to-population and bed-to-population ratios, mortality, morbidity, and infant and neonatal mortality rates. These were characterized as negative indicators: quantities that register the presence of disease and the capacity to treat it, but not the presence of health. The argument advanced was that indicator selection is not evaluatively neutral, since systems configure themselves toward what they are required to report. A system assessed on bed counts will produce beds. The alternative proposed comprised health-adjusted life years together with measures of preventive infrastructure, the session citing recreational and physical infrastructure as illustrative rather than exhaustive examples [2].

Three subsidiary themes were developed. The first concerned the standardization of chronic disease management and its inattention to individual metabolic variation. The second drew an ethical inference from the history of practices once regarded as clinically normal and subsequently recognized as harmful, arguing that the persistence of such practices is not confined to the past. The third addressed the erosion of public trust, noting that increased expenditure has been accompanied by, rather than protective against, declining confidence [2].



Participants from fifteen countries took part in the discussion at the European Campus Rottal-Inn.

The discussion raised several questions the Commission has carried forward. Whether quality, equity and affordability can be jointly satisfied in practice, the position advanced being that they can, and that implementation difficulty is not a warrant for lowering the specification. How accountability should be allocated where clinicians offer divergent recommendations for identical presentations. Whether digital-first models are feasible in lower-resource settings, where digital exclusion was characterized as a failure of policy rather than of technology. Whether patients can be constituted as co-designers of health systems rather than recipients of them. And how catastrophic health expenditure driving households into poverty might be prevented [2].

WSIS+20 UN General Assembly High-Level Side Event: New York, 15 December 2025

The second Lab was convened as a side event of the WSIS+20 UN General Assembly High-Level Meeting and served as the Commission's inaugural global meeting, with the Academy of Digital Health Sciences and the Disease Management Association of India as co-organizers [3]. Its governing proposition was that contemporary health challenges are being addressed through an institutional architecture inherited from an earlier period, and that inequity, fragmentation, preventable disease, workforce attrition and declining trust should be understood as symptoms of that architecture rather than as discrete problems.



The inaugural global meeting, convened virtually as a WSIS+20 side event, 15 December 2025.

The meeting recorded consensus on several points: that healthcare should be reconstituted as a coherent, people-first system prioritizing prevention and primary care; that technology should be deployed to strengthen rather than substitute for human relation in care; and that the health workforce constitutes the centre rather than the periphery of any redesign, requiring expanded professional scope, continuous skilling, and systems that treat caregivers as structural rather than incidental [3].

Three formal messages were adopted. That systems organized around negative indicators must reorient toward positive health measures, prevention and the social determinants of health. That digital transformation must be human-centered, equity-designed and trust-building, the session recording that approximately 40 per cent of patients currently trust health systems or feel confident managing their own health. And that no single profession, country or sector can accomplish the transition alone [3].

Global Health System Redesign Lab: From Proliferation to Purposeful Progress of AI. Geneva, 19 May 2026

The third Redesign Lab, titled From Proliferation to Purposeful Progress of AI, was convened at the John Knox International Centre during the 79th World Health Assembly, with a recorded message from the Director-General of the World Health Organization [1, 4]. The Lab sought to shift the discussion on artificial intelligence in health from questions of technical performance towards a more fundamental question: what happens when AI is introduced into a system whose underlying design may itself require redesign? The central proposition was that the value of AI cannot be assessed solely by how well it performs individual clinical tasks, but also by whether the health systems into which it is deployed are designed to produce the outcomes that society seeks to amplify.



Participants at the third Redesign Lab, John Knox International Centre, Geneva, 19 May 2026.

The session identified seven observations that formed the principal analytical constructs of the convening [4]:

1. Design failure precedes technology failure.

AI introduced into systems structurally oriented towards treatment may reinforce rather than correct existing imbalances. The question is therefore not only what AI can optimize, but what health systems should be optimizing.

2. AI governance is a precondition.

Countries adopting externally developed AI without domestic capacity to evaluate it risk importing the assumptions and limitations embedded in those systems. The emerging divide may therefore be between countries able to govern AI and those able only to adopt it [4].

3. Data infrastructure is foundational.

The discontinuation of digital health systems in more than forty countries following the cessation of donor funding in 2025 illustrated the fragility of systems without sustainable institutional foundations. With two in ten births and four in ten deaths globally remaining unregistered, gaps in foundational data continue to constrain the systems built upon them [4].

4. The workforce constraint is structural.

The projected global shortfall of 11.1 million health workers by 2030 [11] exists alongside substantial underutilized capacity. The session highlighted the constraints on a nursing workforce of approximately 30 million and the limited scope of pharmacists in many jurisdictions, pointing to the need to redesign roles as well as expand numbers [4].

5. Data sovereignty must be engineered.

The session cited instances of states being asked to transfer extended patient records in exchange for technology services. Meaningful sovereignty therefore depends on the technical and institutional capacity to retain control over health data – not simply on policy declarations.

6. Health financing faces demographic pressure.

The population aged 65 and over is projected to rise from 703 million in 2019 to 1.5 billion by 2050 [12]. This demographic shift places structural pressure on financing models built around very different population profiles.

7. One Health remains fragmented.

Approximately 75 per cent of emerging human infections are zoonotic, while less than 0.6 per cent of global health expenditure is directed towards animal health systems [4]. The disparity underscores the disconnect between interconnected health risks and fragmented institutional responses.



Discussion at the Geneva Lab.



The Measurement Problem as the Connecting Thread

A single analytical problem connects the three preceding Labs: health systems measure what is most readily countable, rather than necessarily what matters most for health.

Health systems continue to be assessed predominantly through measures of input and activity – expenditure, physical capacity, workforce numbers and service utilization. These measures are tractable, comparable and therefore institutionally durable. Yet, in the terms established at Pfarrkirchen, they are negative indicators: they describe the apparatus deployed against disease rather than the health of populations.

The problem, therefore, is not that existing indicators are inaccurate. They are often highly accurate within the domains they measure. The problem is that their precision can obscure the absence of what they do not measure. The gap between life expectancy and healthy life expectancy [8] illustrates this most clearly. A health system can achieve sustained reductions in mortality while the additional years of life are increasingly lived with morbidity. Yet conventional measures of system performance may register the former as progress without adequately accounting for the latter.

If the object of measurement is health rather than healthcare, the task is to determine what constitutes health as a measurable outcome, which indicators can capture it, at what level they should be aggregated, what data infrastructure is required, and where institutional accountability for those measures should reside.

The challenge is consequently not to produce more indicators, but to establish a measurement architecture aligned with the outcome that health systems ultimately exist to produce.

The Singapore Lab

Why the Asia Pacific

The Singapore Lab addresses two questions. The first is what the Asia Pacific region offers to the redesign of health systems elsewhere.

The rationale rests on three considerations. The region contains more than half the world's population and is undergoing demographic ageing at a rate exceeding that of any other region [12]. A substantial number of its systems established digital infrastructure at the outset of health system development rather than retrofitting it onto legacy architecture, and their experience therefore constitutes evidence about greenfield rather than remedial design. And several arrived at their coverage, prevention and delivery arrangements under fiscal and demographic constraints more severe than those faced by high-income systems, which bears directly on the transferability of their solutions.

The second consideration follows from the first and connects Singapore to the Commission's measurement mandate. The regional experience furnishes a test of whether outcomes that prove significant in one institutional context yield indicators that remain valid in others, and of the conditions under which they do not.

Singapore's Health System and the Healthier SG Reform

Singapore is relevant to the Commission because it combines high healthy life expectancy with comparatively modest health expenditure as a share of national income [8]. This makes its health system relevant to the Commission's focus on measuring health outcomes rather than healthcare activity.

The Ministry of Health published the White Paper on Healthier SG in September 2022, and the programme was launched on 5 July 2023 [13, 14]. Its objective is to shift healthcare delivery from curative towards preventive care through five measures: mobilizing family doctors for preventive care; developing individual health plans covering lifestyle, screening and vaccination; engaging community partners; enrolling residents with a single-family doctor; and strengthening the supporting IT, workforce and financing infrastructure [13]. Enrolment began with residents aged 60 and above and was subsequently extended to those aged 40 to 59 [13].

Healthier SG also shifts primary-care financing from fee-for-service towards capitation, with clinics receiving a fixed annual payment for each enrolled resident [15]. This reduces the link between provider income and service volume and creates greater incentive for prevention.

The reform operates across 26 government-subsidized polyclinics and more than 2,000 general practitioner clinics, many organized into Primary Care Networks. Polyclinics serve approximately 20 per cent of the population but account for up to 45 per cent of chronic care visits [15]. The programme also subsidizes recommended screening, vaccination and selected chronic disease medicines [13].

Early implementation research involving 15 primary care physicians found increased patient engagement with preventive care and improved uptake of screening and vaccination, alongside administrative burdens, workflow challenges, gaps in patient understanding, and concerns among private providers about capitation payments and medicine pricing [15].

For the Commission, Healthier SG provides a live example of a system-level shift towards prevention. Its implementation raises the measurement question central to the Singapore Lab: can the effects of such a shift be measured through health outcomes rather than service activity, and can those measures be applied across different health systems?

Questions Before the Session

What makes Singapore's healthcare system among the best in the world?

Salient positive points of a healthcare system.

Which outcomes in your institution, proved to matter and were not captured by the health indicators in use?

What is the role of traditional medicine in a healthcare system?

The Singapore Lab is convened by the Global Commission for 21st Century Healthcare and hosted by Health Parliament, in association with The Institute for Digital Medicine (WisDM), Yong Loo Lin School of Medicine, National University of Singapore, and the Global Initiative on Digital Health (GIDH), a WHO-hosted network.

The Lab is co-chaired by Dr. Dean Ho, Director of The Institute for Digital Medicine at the Yong Loo Lin School of Medicine, National University of Singapore, who serves as a Commissioner of the Global Commission for 21st Century Healthcare. It convenes on 25 September 2026, from 9:00 AM to 12:00 PM, in Training Room 2, Level 1, Medicine + Science Library, National University of Singapore, 11 Lower Kent Ridge Road, Singapore 119083.

The session is structured as a working discussion among approximately twenty-five participants. Contributions grounded in documented institutional experience, including unsuccessful attempts, which bear on feasibility as directly as successful ones, are of greater value to the Commission's output than general statements of position.

The Road Ahead

The Commission has been convening its series of Global Health System Redesign Labs, with further regional engagements planned across Southeast Asia, Africa, Europe, the United States and the United Kingdom. The Commission will also convene a redesign lab in Nairobi on the sidelines of the annual Internet Governance Forum.

The insights and recommendations emerging from these engagements will be consolidated into a blueprint outlining the key elements required to redesign healthcare systems for the 21st century.



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

Global Commission for 21st Century Healthcare

Note on Sources

The account given here draws on four bodies of material: the Commission's background paper, *Reimagining the 21st Century Healthcare System*, released on 13 May 2026 [1]; the session report of the Redesign Lab held at Pfarrkirchen on 12 November 2025 [2]; the summary record of the inaugural global meeting published by the United Nations Department of Economic and Social Affairs in the *WSIS+20 Side Events Summary Report* [3]; and the strategic policy brief issued following the Geneva Lab on 27 June 2026 [4].

Quantitative claims are referenced to their primary sources. Propositions advanced in the course of a Lab are attributed to the session at which they were made and are presented as the analytical contributions of that session rather than as conclusions of the Commission.

References

- [1] Gupta, R. P. (2026). *Reimagining the 21st Century Healthcare System*. Background Paper, Discovery Series. Geneva: Health Parliament and Global Commission for 21st Century Healthcare, 13 May 2026.
- [2] Global Commission for 21st Century Healthcare (2025). *Global Health System Redesign Lab: Germany*. Session Report. Pfarrkirchen: Health Parliament, 12 November 2025.
- [3] United Nations Department of Economic and Social Affairs (2025). *WSIS+20 Side Events Summary Report*, 15 to 17 December 2025. New York: UN DESA.
- [4] Global Commission for 21st Century Healthcare (2026). *Strategic Policy Brief*. Global Health System Redesign Lab: From Proliferation to Purposeful Progress of AI. Geneva: Health Parliament, 27 June 2026.
- [5] World Health Organization (2023). *Global spending on health: Coping with the pandemic*. Geneva: WHO. ISBN 978-92-4-008674-6.
- [6] Global Burden of Disease Health Financing Collaborator Network (2019). Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995 to 2050. *The Lancet*, 393(10187), 2233–2260. doi:10.1016/S0140-6736(19)30841-4
- [7] World Health Organization and World Bank (2023). *Tracking universal health coverage: 2023 global monitoring report*. Geneva: WHO.
- [8] World Health Organization (2024). *Global Health Estimates: Life expectancy and healthy life expectancy [Data set]*. Geneva: WHO Global Health Observatory.
- [9] World Health Organization (2024). *Noncommunicable diseases*. Fact sheet, September 2024. Geneva: WHO.
- [10] OECD (2023). *Health at a Glance 2023: OECD Indicators*. Paris: OECD Publishing.
- [11] World Health Organization (2024). *Global Strategy on Human Resources for Health: Workforce 2030*. Report by the Director-General, Executive Board 156th session, document EB156/15. Geneva: WHO.

- [12] United Nations Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024. New York: United Nations.
- [13] Ministry of Health, Singapore (2022). White Paper on Healthier SG. Singapore: Ministry of Health, 21 September 2022.
- [14] De Foo, C., Chia, H. X., Teo, K. W., et al. (2023). Healthier SG: Singapore's multi-year strategy to transform primary healthcare. *The Lancet Regional Health, Western Pacific*, 37, 100861. doi:10.1016/j.lanwpc.2023.100861
- [15] Tan, H. Y., Tan, J. K., Lam, L. T. M., Tan, D. H. Y., & Chua, Y. X. (2025). Insights into Singapore's national strategy for primary care reform: physician attitudes, facilitators and barriers to Healthier SG. *BMC Health Services Research*, 25, 1021. doi:10.1186/s12913-025-13143-4
- [16] Freihat, O., Sipos, D., Aamir, M., & Kovacs, A. (2025). Global burden and future projections of non-communicable diseases (2000 to 2050): progress toward SDG 3.4 and disparities across regions and risk factors. *PLOS ONE*, 20(12), e0336036. doi:10.1371/journal.pone.0336036
- [17] Global Footprint Network (2026). Earth Overshoot Day 2026. Oakland: Global Footprint Network and York University.
- [18] University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation. County Health Rankings and Roadmaps: ranking methodology and determinant weights. Madison: UWPHI.
- [19] Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2016). County Health Rankings: relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine*, 50(2), 129–135.



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