A Bridge Across the 2030 Healthcare Chasm

The NHS faces dramatically different potential futures, depending on whether it adopts radical innovation and people take responsibility for their health, argue Chris Evennett and James Barlow

If Florence Nightingale walked the corridors of the NHS today, she would be amazed by many advances in healthcare. However, she would still instantly recognise how it all fits together: change has maintained the familiar building blocks of healthcare organisation, with local doctors still providing first-level treatment while mediating between patients and community-based hospitals.

She probably would not feel the same continuity when looking after her money in 2013. The Victorian reformer - seeking her bank manager - would recognise online banking as a disruptive innovation, shifting management of her money from her locality, with someone she knows, to a globalised computer system. Technology and consumer engagement have led to dramatic change and a new labour-saving, cost-reducing, service model.

By 2030, Ms Nightingale's experience of healthcare might be just as unrecognisable to her. It might feel a lot more like this banking experience, thanks to changing technology and more self-care. It is an intriguing possibility, potentially substituting the roles of some healthcare professionals, thereby cutting the costs of some services, freeing up funds to afford the demographic pressures that we face.

What might it all look like? Imagine, for example, a body scanner in a supermarket, hooked up to highly sophisticated computer software that can diagnose abnormalities more effectively and faster than a doctor today. This automated system might even prescribe some treatments and instantly book appropriate appointments.

Combine that with a revolution in knowledge about each individual: DNA profiling could identify individual risk factors while real-time health monitoring, using a wristwatch or implanted device, could take, transmit and interpret dozens of measurements daily. Put all these developments together and a significantly different model of healthcare begins to emerge, largely by-passing the traditional diagnostic and service-mediating roles of clinicians

This is just one of several potential futures that we have explored in *'Twenty-Thirty*,' a report designed to inform the Department of Health and NHS England in their strategic policy making for the next 20 years. To look into the crystal ball, the Policy Innovation Research Unit (PIRU) brought together some of the country's top healthcare managers, clinicians, academics, strategists and policy makers. Our findings are published today (Thurs 26 September) at the HaCIRIC International Conference in London.

The future of healthcare involves many unknowns around multiple issues. However, the PIRU thinkers saw two factors as having significant potential influence on future models of care. First, whether the use of new technology remains essentially incremental or we see radical adoption of technological innovation.

Secondly, whether the users of healthcare become increasingly motivated to take responsibility for their own health, exercising choice over services or whether healthcare remains dominated by powerful suppliers, with largely passive users, guided by strong professional influence. We focussed on how these different dimensions – technology adoption and the changing role of users - might influence four scenarios for future health services.

We dubbed the online banking-style future the 'gadget show', where adoption of new technologies and the public appetite for self-diagnosis and self-care reach their highest potential levels. Of course, technology could not replace all primary care services. We don't imagine maternity care being delivered much differently from now. There is no technology that will wash, change and feed vulnerable people. So, as in all our scenarios, we expect demands for such personal services to grow in line with the demographics.

A key downside of the 'gadget show' - a rapid adoption of new healthcare technologies embraced by much of the population – is its particular challenges in ensuring good healthcare for those who cannot access the technology. Inequalities, as with all the scenarios we explore, continue to challenge the NHS.

What about other possible futures? People might well have a strong appetite for the latest treatments, to manage their own health and to use the latest technology. But the NHS may be slow to adopt these approaches. So people – perhaps starting with the better-off – could increasingly eschew the traditional healthcare model and go to niche suppliers. These might become stronger, with the NHS eventually commissioning from them. Gradually, under this second 'plurality of provision' scenario, the public would drive incremental changes in NHS services. However, there would be greater fragmentation of healthcare provision, more difficulties in planning and coordination, with a greater potential for duplication of services and for resultant higher costs.

A third alternative, termed 'stability with integration', involves some fossilisation, an extension of how the NHS operates today – slow to adopt innovation and people showing no significant appetite for self-care or to drive change. GPs would still control most referrals and the plethora of private companies providing niche services might not materialise. However, the upside of a more settled environment could be greater integration of services, responding to continuing financial crises. But slow change would mean continuing service variation.

What about a fourth possibility, where the NHS embraces new technologies but people are passive about self-care? This fourth 'modern traditional' scenario would retain the paternalistic feel of the NHS, with perhaps lots of remote care – telehealth – technologies as healthcare is devolved increasingly to our homes. But a comparative lack of public engagement could leave professionally-run health providers controlling services, perhaps opting for sexier, more wasteful gadgets than people might need. It's a world in which primary care could be destabilised, possibly with hospitals providing more outreach services, even employing GPs more as specialist coordinators of care for those with complex co-morbidities. In the 'modern traditional' NHS, elderly and vulnerable people might not do well, so encouraging the current drive for local government to take over and integrate their health and social care.

Which of these scenarios is more likely? Our report does not tackle this question, but the future may involve elements from each. Which is the best future? Again, it is difficult to say. But we must surely look hard at the first scenario. Public involvement in healthcare is undeniably a good thing. And new technologies, allowing innovative models of healthcare, hold the potential for the cost-savings. They could defuse the demographic time-bomb fast ticking away for UK healthcare and open up new models of caring.

All of which raises the fascinating question of what should be done now to make the better options more likely. How, for example, do we plan strategically for greater use of new technologies? The incentives are not currently good. Today, individual GPs and hospitals, already under financial pressures, can barely look beyond the immediate one or two year horizon, let alone the next decade or more. It is not a recipe for speed or innovation.

'It doesn't work,' says the American proverb, 'to leap a twenty foot chasm in two ten-foot jumps.' The question for policy-makers, the NHS and other care services, and the private sector is: 'How do we build firm bridges to take us to the right place?'

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