Much of today's NHS was unimaginable in 1948 and it is often difficult to predict what is going to happen in the NHS in two or three years' time, let alone fifty. The safest prediction is that it will continue to change and that it will do so more rapidly than before. But will this change mean that the NHS can continue until 2048?

This paper looks at some of the trends that are likely to shape health care in the future. It also assesses what impact these forces will have on the NHS as the institution we know today, and how the service might begin to respond to these changes.

Forces shaping health care in future

Many powerful and pervasive forces will bear on the NHS. To some extent, we have already come to terms with technological advance, increased public expectations and demographic change, but we are less comfortable with the media pressures driven by social and cultural change, public health trends and 'globalisation'.

Technological change

The pace of the therapeutic revolution will continue to accelerate. New and better treatments will be identified which will be less invasive, more accessible and more individualised tailored. Gene mapping and gene therapy will enable groups of previously untreatable people to halt, or delay, the onset of inherited disease.

New diseases will be identified and new groups of patients will have the opportunity of being diagnosed and treated. Three-dimensional holographic images of internal organs and tissues produced by combining information from CT and MRI scans will reduce the need for laparotomy, laparoscopy and other invasive procedures. Minimally invasive surgery and fast acting anaesthetics will allow many more frail and elderly patients to be treated. Ultrasound treatment of tumours, monitored by magnetic resonance imaging, is only a few years away. Intravenous treatment at home, controlled by a chip, is easily foreseeable. Nanotechnology, the science and technology of creating working machines on a molecular scale, is likely to mature from its present infancy. If so, medical applications will be at the forefront, for example the ability to 'repair' damaged cells by introducing nanometre sized chemical agents into the body to seek out and mend target cells. Traditional surgery may become viewed as being medieval and faintly sadistic, an overnight stay in hospital as quaint.

Developments in communications and technology will make accurate diagnosis, high quality treatment, and knowledge about both accessible to patients and clinicians in a way that is simply inconceivable now. The ability to carry out 'at-a-distance' tasks and procedures that at present require face-to-face contact will have a major impact on clinical practice in the next 50 years. Many more treatments will be carried out at home or in ambulatory settings, over the telephone, through the computer, or some future combination of the two. Being treated at home, by a specialist based anywhere on the globe, will be possible.

Better information about the costs and benefits of different treatment options, and the quality of care provided by health care professionals, will mean that treatments are tailored to suit individual preference. Every member of the public (and health care professionals approved by the patient) will have access to his or her own electronic record, and entries will be added using voice-activated devices. Electronic prompts at home will remind patients to take their medicines, to visit the virtual dentist or seek preventive care.

Technologies will also have a profound effect on how health care is managed. Health care managers - who will increasingly be practising health care professionals - will have access to accurate real-time information about the financial resources, health care, patients and staff for whom they are responsible. The chief executive of the NHS of the future will be able to sit at her desk at home and reduce waiting lists at the push of a button - or perhaps that is one prediction too far! Long established institutions and the divisions between them - hospitals, primary care, professional divisions between doctors and nurses - will feature far less. The currency of the future will be knowledge, skills, access and information. Who does what to patients, and where, will be less important than what is the best treatment and how it will be administered. In short, the watchwords for the future will be new, more, better, more accessible and less invasive treatment - the future looks bright.
Expectations

With this array of glittering prizes, it will be entirely natural for us all, as members of the public and as health care professionals, to expect to have ready access to them. New sources of information will lever up demand and reduce our tolerance of scarcity. Our expectations will be driven not only by technology but also by how we are treated as individuals. We will want more convenient services, more time to discuss our preferences, more choice, more information and far more attention to our psychologies. Health care professionals in future will not only have to be knowledgeable about health care and have excellent technical skills— they will have to be expert communicators and psychologists. They will have to be sensitive, empathic and non-hierarchical, especially as large groups of patients will know far more about their diseases than professionals. If the future looks bright, then it also looks distinctly female.

Demographic change

When the NHS was created in 1948, the over 75-year olds made up 3.4% of the population of Great Britain. In 1998 that figure has risen to 7.3%. Estimates suggest that by 2048, a hundred years after the birth of the NHS, those aged over 75 will make up almost 14% of the population. If current trends continue, more elderly people will be living alone, geographically separated from their families.

This will create enormous challenges for the NHS and we can expect a skewing of research effort towards new technologies and treatments to help this age group. Many of the advances already sketched above will naturally help older people. More treatments will be aimed at giving this population a healthier life, as the elderly as a group will become less tolerant of disability and illness, but more powerful politically, with a greater disposable income. More attention is likely to be paid to the treatment of chronic diseases and increasing the quality of life of this group, e.g. through memory-enhancing drugs.

The media

The media will play their part in increasing the information available about new treatments. Digitalisation, and other new technological advances will cause a proliferation of news channels, greater competition and a growing appetite for cheap (short, easily researchable and domestic) and sensational news. Health care is an excellent quarry—all human life is there. But growing media coverage of this nature will highlight stories of situations where care is denied, and discrepancies in access to health care across the country or between patients of different age or with different conditions, will become more stark. The promise of what is possible in health care will be cruelly checked by the reality of what can be afforded. Of course, the media will exploit this mismatch between supply and demand as fully as possible.

Social, cultural and economic change

More of us, including the elderly and frail, are living on our own; most of us are living away from our families. Fewer of us depend upon traditional, local and relatively informal support networks for advice about health care such as the family, the church and neighbours. They are being replaced by telephone advice and information on the Internet, which will radically change the pattern and volume of demand upon formal health care.

More women are working in health care, particularly in medicine, and this trend is likely to continue into the future. Younger health care professionals of both sexes have different ideas about their careers from their predecessors. They want more flexibility, more choice, more opportunity for career breaks and time with family, rather than having to follow the rigid career patterns that were designed in another era by those with wholly different aspirations.

Growth in wealth, and changes in its distribution, may erode the tolerance of scarcity by the wealthy and make them less willing to contribute to a collective pool of funds to pay for a national health service. So far there is little sign of this in the UK; there is consistently high support for the NHS and the relatively few people who do opt for private treatment also use the NHS.

Pressures on governments to keep taxes as low as possible and to increase international competitiveness will increase pressure on the NHS to become more efficient. This pressure in the past has resulted in changes to the NHS that have stretched the very notion of what a national health service actually is. Unless these changes are carefully explained to taxpayers, support for the service may be eroded.

Public health

Other pressures shaping health care systems in future will be the nature and pattern of prevalent disease. While the health of the population is now in many ways better than it was 50 years ago, new challenges are on the horizon. There has been an emergence of both new and old diseases, for example AIDS, new variant Creutzfeldt-Jacob disease and tuberculosis. Resistance to antibiotics is growing. Changes in the physical environment, such as global warming, an increase in genetically engineered crops and new biological weapons may also create unknown new challenges to the public health. Global travel increases the risk of transmission of infection. The rising prevalence of obesity amongst the young, of "recreational" drug-taking and other risky behaviours may have profound effects in the coming decades.

The 60 million citizens of the UK, using our national health service, will also be part of the 500 million citizens of the European Union. And in 50 years from now, we shall recognise that safe levels of health protection—medicines, food and measures against communicable diseases—have to be guaranteed across the Union as a whole.
'Globalisation'

Developments in communication and travel will influence all the factors mentioned above. Competition between industries will increase at a global level, reinforcing the need for governments to keep taxes as low as possible. Huge financial tides and fluctuations will sweep across the globe in seconds. The UK will be bound closer into political and economic union within Europe, partly to protect its economy from damaging instability. Our national scope to organise, finance and manage the public sector will be constrained by our involvement in the converging European economy.

Impact on the NHS

The effect of these, and other forces, on the NHS will certainly be profound, but essentially unknowable. It is a safe bet that demands on the NHS from patients and health care professionals will increase. It is also safe to predict that there will not be enough funds to pay for all we want to consume, including health care. In 1949 Bevan noted that there would always be a mismatch between the supply of resources for the NHS and demands made upon it, such that 'the NHS will always appear inadequate'. This will continue as long as the NHS is in operation, and, indeed, as long as any other health system we may choose is in operation.

Even if we could safely predict the rate of growth in resources available to the NHS, it is not possible to quantify the likely costs of the demands made on the service. In studying technological advance, most researchers have examined the costs of individual new technologies on specific groups of patients rather than the impact of a basket of new technologies, or the expanded use of older technologies, on the whole service over time. The costs of demographic change are more predictable, although several researchers have shown that in the future the rate of growth in costs is not likely to outstrip the growth in resources to the NHS. The costs from changing demography, of itself, are unlikely to scupper the NHS.

But regardless of the extent of the supply/demand mismatch, the tension between them is likely to increase. Furthermore, our acceptance of scarcity will decrease, without regard to the actual extent of scarcity. We, and the media, will have a shorter fuse when we are told 'no'. That will also be true for other public services and it is important not to forget that all health systems, whether predominantly privately or publicly funded, will face similar pressures. Life may well be tougher in the NHS in future, but we will not be alone!

In the past the tools used to help ease the tension between supply and demand in the NHS were essentially 'technical', such as increasing the supply of resources, improving efficiency, and managing demand. In future we can expect the debate about scarcity in health care to change from a sole focus on technical solutions to a more mature dialogue with the public about the legitimacy of limits to health care for populations, and for individuals. Public relations, sophisticated media management and more open and systematic dialogue with the public, will be seen as core activities for all public services if they are to retain popular support.

Conclusion

The future will be a tantalising mix. On the one hand, there will be huge advances in treatment, greater access and convenience, a more personal service. Health care will no longer be driven by institutions and hierarchy (such as hospitals and different professional groupings) and the notion of the 'patient', but by skills, outcomes and user preference. More people, particularly ostensibly healthy people, will be aware that medicine can do something beneficial for them, and will be more assertive in seeking those benefits. But far from being labelled as 'patients', we will be more like informed tourists, using health care professionals to route us, like empathic travel agents, to our preferred destinations. Health care staff will enjoy working in non-hierarchical organisations with greater job flexibility.

On the other hand, this vision will be tempered by the harsh reality of costs. Much greater scrutiny of health care activities will be the norm, curbing freedoms and preferences of users and staff. Scrutiny will be led by those who pay for health care rather than by the professions, particularly as boundaries between the latter blur. Limits will be brought into sharper focus through greater media attention and reduced public acceptance of such constraints. Public dialogue and relations will become more sophisticated, but may not convince those who have the option to pay privately. Those who do take this option will find that the climate in the private sector is little different.

Where does this leave the NHS? The service will change beyond all recognition. Relations with the three groups essential for its support – the state, the professions and the public – will change profoundly to favour the public for the first time. At present there is every sign that the enormous public support for the service and the fundamental values that have underpinned it since 1948 – equal access for equal need – will continue into the future. The message is simple: if we want it we can have a NHS for the next 50 years. Whether the public wants it or not depends on how fast the service can respond to the pressures upon it and to what extent the wishes of users can be placed at the core of all its activities. In the meantime, I look forward to being treated by an NHS as both of us move towards healthy and ripe old age.

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NEW TITLE

Enhancing the health of older people in long-term care

CLINICAL GUIDELINES

Prepared by
Research Unit of the Royal College of Physicians
British Geriatrics Society
Royal Surgical Aid Society-AgeCare

The increasing numbers of elderly people entering long-term care in the UK are straining the system and have prompted national debate. As well as the availability and cost of health care, there are concerns about the quality of care for this vulnerable group. In 1992 the RCP addressed this issue by publishing clinical guidelines on High quality long-term care for elderly people which were reinforced by the publication of The CARE Scheme — an effective, practical approach to improving long-term care using clinical audit.

For the present report, Enhancing the health of people in long-term care, these guidelines have been updated with reference to new evidence of clinical effectiveness and by taking into account the expectations of the long-term residents and their relatives. The guidelines cover the common health-related challenges in long-term care such as falls, continence and use of medication. Important new guidelines are included for the positive care for elderly people with dementia, detecting and managing depression, and recognising and overcoming a range of physical disabilities.

To enhance the long-term health care for the ageing population in Britain it is essential to have the continual informed and practical cooperation of everyone involved. These guidelines point the way to how this may be achieved and should be implemented widely by all who are concerned with providing such care for elderly people. A new version of The Care Scheme will be published shortly.

Preface by Dr John Wedgwood

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Advice for providers: implementation and outcome
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