The Future of Health

Discussion paper

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International Longevity Centre ï UK

www.ilcuk.org.uk

The International Longevity Centre - UK

The International Longevity Centre - UK (ILC-UK) is an independent, non-partisan think-tank dedicated to addressing issues of longevity, ageing and population change. We develop ideas, undertake research and create a forum for debate. The ILC-UK is a registered charity (no. 1080496) incorporated with limited liability in England and Wales (company no. 3798902).

Our policy and research remit is broad, and covers everything from pensions and financial planning, to health and social care, housing design, and age discrimination.

We have undertaken a large amount of research and policy analysis over recent years including:

- **The Future of Retirement** a discussion paper considering the reasons people retire when they do and the potential future of retirement given policy change and the emergence of gradual retirement; 2010.
- **A problem shared is a problem halved? Dementia: Learning opportunities from Europe** a policy brief to stimulate debate and drive improvements in dementia research, diagnosis, treatment and care by identifying key priorities for action at the Member State and EU level; 2010.
- **Recent Progress & Innovation in Dementia, Diagnosis, Treatment and Care';** 2009.
- **Caring in the Older Population** a research brief for local authorities engaged in developing, planning and delivering services to support older carers; 2009.
- **Towards Lifetime Neighbourhoods - designing sustainable communities for all,** a discussion paper published in partnership with Communities and Local Government; 2009.
- **Weathering the storm – the impact of the 2008/9 economic downturn on the Lifetime Neighbourhoods agenda,** a discussion paper bringing together several key commentators; 2009.
- **The State of Intergenerational Relations Today,** a research and discussion paper exploring the importance of intergenerational relations in society; 2009.
- **Building our Futures,** ILC-UK toolkit for local housing planners to prepare for the UK's ageing population; 2008.

About the Author

David Sinclair is responsible for the policy and research activities of the International Longevity Centre-UK. David sits on a number of Government and voluntary sector working groups and was the former Vice-Chair of the Consumer Expert Group for Digital Switchover. He is Vice-Chair of the pan-European Age Platform expert group on ICT and Transport. David is a trustee of a small older people's charity called Openage. He is also a member of the Editorial Board for ñWorking with Older Peopleòand the NESTA Ageing Advisory Board.

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Introduction

The International Longevity Centre - UK (ILC-UK) is an organisation with an eye to the future. We are interested in how an ageing society is likely to impact on public policy. Since 2008, we have undertaken a significant amount of research and policy analysis on, amongst other things, the future of social care. Alongside this we have explored in significant detail the options for the future funding of long term care.

Care is a major challenge for the public purse. But so is health. We face a future of more demands on the health service at a time when we already see health inequalities and complaints about the non-acute care which older people receive in hospitals. This is accompanied by a greater number of older people and a future fiscal regime which is likely to squeeze public sector spending. Although the NHS budget is ñring fencedò, healthcare spending has to increase in real terms just to stand still. Even real term increases in health budgets may not meet the future demands for healthcare when you take into account a growing older population and increased incidence of chronic diseases.

This short discussion paper is not intended to answer questions about the future of health. Rather, ILC-UK are publishing this paper as the starting point for a debate on the future of health.

ILC-UK intends to follow this discussion paper up with a series of activities, exploring the future of health in more detail. Through this work we will set out the challenges in great detail and posit policy solutions to the challenges which lie ahead of us.

Through this work we intend to explore:

- The impact of an ageing society on healthcare provision and demand over the next 10 years?
- How health provision could change in the future?
- Given the changing landscape of health, how can we fund healthcare in the future?

ILC-UK would welcome comments on these issues. We are also seeking funding to support research on the questions outlined below. If you have views on this paper or would like to discuss the issues set out, please contact David Sinclair at ILC-UK.

Health today and tomorrow – unmet needs?

Key Facts[1]

In 1971 there were 52 people aged 65 and over for every 100 children under 16. In 2003 there were 81 and in 2031 it is expected that there will be 136.

The age structure of the UK population has become older in the last three decades, and will become older still in the next three decades. The median age rose from 34.1 years in 1971 to 38.4 in 2003 and is projected to rise to 43.3 in 2031.

The percentage of older people (aged 65 and over) increased from 13 per cent in 1971 to 16 per cent in 2003 and is projected to rise to 23 per cent in 2031.

The NHS employs more than 1.7 million people across Britain, including: 120,000 hospital doctors; 40,000 community doctors; 400,000 nurses

On average the NHS deals with one million patients every 36 hours -- or 463 people a minute. Each week, 700,000 people will visit an NHS dentist and 3,000 people will have a heart operation. Each GP in the nation's 10,000-plus GP practices sees an average of 140 patients a week.[2]

Research by Help the Aged[3] revealed that over the next ten years we could see:

- Nearly 7 million older people who cannot walk up one flight of stairs without resting.
- 1.5 million older people who cannot see well enough to recognise a friend across a road.
- Over a third of a million older people with major speech problems.
- Over 4 million older people with major hearing problems.
- Up to a third of a million people aged 75 plus with dual sensory loss.
- Over a million people aged 75 plus who find it very difficult to get to their local hospital.
- A third of a million older people who have difficulty bathing.
- Nearly a million older people with dementia.
- 4ï 7 million older people with urinary incontinence.
- 1.5 million older people suffering from depression.

[1] Office of National Statistics, 2010
[2] http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx
[3] Emerson, Jopling, Rowley, Rossall, Sinclair (Eds). (2008) *Future Communities*. Help the Aged

Health today

Across the world we are living longer and seeing a growth in the numbers of older old. Simply taking into account demographic change, we will see more people with a need for long term care and more people with dementia. We will also see more pressures on health and healthcare, given that we tend to be the most intensive users of health during old age, particularly during the last two years of life.

Much has changed in the UK since the reforms of healthcare 1948 with the creation of the National Health Service. Since then the system has seen evolutionary change. The Conservative Government under Margaret Thatcher began to bring competition into the NHS, a process which continued under Tony Blair and New Labour.

Over the past 15 years, health services in the UK have seen significant investment alongside further evolutionary reform. The Government of Gordon Brown introduced further reforms including a commitment to move towards preventative healthcare, making the NHS a more personalised service, the possibility of more patient friendly appointments, and regular health check-ups, alongside a continued focus on reducing waiting times. The Government also published an NHS Constitution, laying out the legal rights of patients.

In 2010, the new Government published a new strategy for the NHS[4] which it pledges will put patients and the public first, improve healthcare outcomes, deliver autonomy, accountability and democratic legitimacy, while cutting bureaucracy and improving efficiency. It is clearly too early to evaluate the impact of any proposed changes the new Government will introduce.

But despite the changes to healthcare policy and the extra investment in health over 15 years, health inequalities remain. The Marmot Strategic Review of Health Inequalities in England *Fair Society, Healthy Lives* published in February 2010*,* found a social gradient in health ï the lower a personôs social position, the worse his or her health.

At the same time it is clear that we have an urgent need for reform today. Speaking at a recent ILC-UK event, Professor Rowan Harwood argued that the health and care system is close to breaking point and some services are ñspectacularly badò. He criticised health services for too often looking at a single condition, not multiple ones.[5]

Older people experiencing physical and psychological conditions, particularly dementia, which can severely impair or disable them, are not experiencing equality of access to, or outcomes from, the UK heath system. The National Dementia Strategy in England signalled a sign of hope, setting out a road map for improvements in dementia services. In addition much of the current UK age

[4] Department of Health (2010) Equality and Excellence: Liberating the NHS
[5] ILC-UK (2010) The Future of Age

discrimination law and existing EU legislation has been consolidated and enshrined in UK Law in the new UK Equality Act.

Health tomorrow

"Over the 40 plus years of my medical career there has been progressive evolution of clinical services. The management of cardiac surgery, stroke rehabilitation, transplantation, joint replacement and IVF have all developed at the behest of medical science. The costs of these services have been added to the "bread and butter" responsibilities of trauma, obstetrics, cancer and emergency surgery, and the management of medical disorders such as pneumonia and heart attacks. While paediatric workload has diminished thanks to better obstetric care, there has been a necessary explosion of services in geriatric medicine and mental health care."[6]

As the quote above highlights, health is in a constant state of change. Alongside demographic changes, our expectations of health services are changing alongside the development of new drugs, technologies and treatments.

Across the UK and Europe, we are not just seeing a growth in the numbers of older people but also, for example, more people with dementia, long term chronic conditions and co-morbidities. The problems of plenty, associated with wealthy nations, such as obesity, are already putting additional pressures on healthcare in the UK and across Europe and without a serious effort to tackle underlying drivers, many of which relate to unhealthy lifestyles, this pressure will only continue. Alongside these changes, the potential impact of environmental challenges (e.g. climate change) on health should not be underestimated.

On the positive side, some serious conditions are now less serious than they used to be. For example, fewer people die as a result of stroke or heart disease, and long term survival rates for some common cancers have improved beyond recognition thanks to better health interventions. But many chronic diseases, although better managed today are not declining in prevalence, and there is uncertainty about the potential cost-savings of prevention.

In June 2010, the BBC reported[7] that London's Royal Brompton Hospital had begun decoding all the genes of individual patients, 10 years after the first human genome sequence was published. Such developments in genetics could herald a move towards personalised medicines.

Alongside these changes we will also see more older people living more active lives. We will probably see a new health consumer, with rising expectations. This new health consumer is likely to have better access to information about conditions and cures, have higher expectations of health services, have access to more and better self diagnosis tests and be more willing to look outside the health service if it cannot

[6] http://www.telegraph.co.uk/health/7625503/NHS-heres-the-unpleasant-truth.html
[7] http://www.bbc.co.uk/news/10370658

meet their needs. We are, for example, already seeing a growth in health tourism and of people buying drugs privately if they are not funded by the NHS.

Key Questions

- To what extent are we currently meeting the demand for healthcare?
- How will demographic change impact on the demand for healthcare over time?
- How might scientific breakthroughs change health in the future (e.g. new drugs; genetic developments; likelihood of cures)?
- What is the role for new health monitoring technologies and tele-health?
- Will we see a new health consumer and what will be the impact of this change: (health tourism; access to information and advice; choice)?
- How can the NHS truly become a health rather than a sickness service?
- How can individuals be encouraged or even incentivised to take responsibility for their own health e.g. through accessing preventative services?
- How might new technology impact on our experiences of health (the role of Web 2.0; augmented reality; the role of robotics)?
- How might major global change impact on the future of health (climate change; urbanisation)?
- What will the health worker of the future look like?

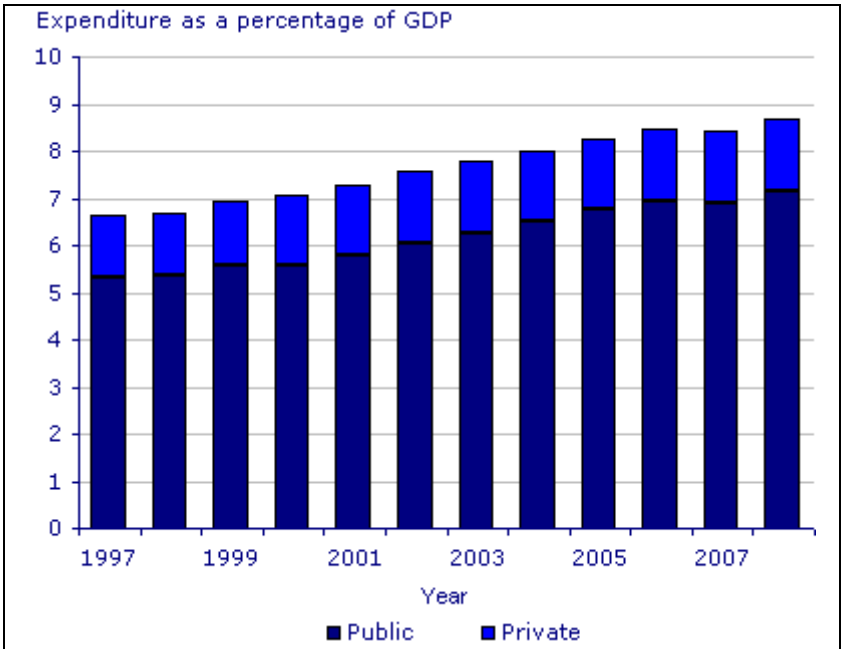
Paying for health in the future

The NHS of 1948 had a budget of £437million (9bn in today's prices). Today spending on health amounts to £125bn.

In April 2002, Derek Wanless published *Securing our Future Health:Taking a Long Term View*[8] in which he painted three possible scenarios for the cost of health up to 2022/3. He found that NHS spending would be likely to increase from £68bn in 2002/03 to between £154 billion and £184 billion.

In 2007, the Kings Fund reported that since 2002, real spending on the NHS has risen by nearly 50 per cent (£43.2 billion) and the proportion of the United Kingdom's gross domestic product (GDP) devoted to healthcare spending has grown to 9ï 10 per cent, within striking distance of the European Union average. Total UK and private NHS funding in 2007/8 stood at around £113.5 billion.[9]

[8] Wanless, D (2002) *Securing our Future Health: Taking a Long Term View*
[9] Wanless, D (2007) *Our Future Health Secured?* Kings Fund



Total, Public & Private UK health expenditure, 1997-2008

In April 2010, the ONS reported that between 1997 and 2008, expenditure on healthcare in the UK (£125bn in 2008) rose faster than spending in the wider economy. Expenditure on healthcare in 2008 represented 8.7 per cent of GDP compared to 6.6 per cent in 1997. The graph above, taken from the ONS, highlights the upward pressure on costs. [10]

These show how the health service has changed over the decades. The NHS of 1948 had a budget of £437million which amounted to about £9billion in todayôs prices.

Given the context of the changes outlined above, it is important to consider just how new drugs and technology could help health services improve the lives of older people. But it is also vital that we begin to seriously debate how we can afford health in the future.

The NHS is centrally-funded through taxation, and growing demand has come alongside record levels of investment in the past decade. The current annual NHS budget amounts to almost £1 in every £5 of public spending.

The main political parties in the UK have seemed reluctant to debate how funding for health may need to change. Over the past year we have seen the main parties emphasising their support for the NHS and implicitly, the current funding model. But it is a funding model which is increasingly under pressure. Whilst the main political parties talk of the importance of efficiency savings, it is clearly important to recognise that the cost of health is likely to continue to increase in the future. And in this context, it would seem impossible to avoid a debate on different funding models for health for the future.

[10] http://www.statistics.gov.uk/cci/nugget.asp?id=669

Speaking at an ILC-UK event on 28th April, Rowan Harwood, Professor of geriatric medicine at Nottingham University Hospital argued that if we are to reduce the long term costs of these challenges we will have to do one of (or a combination) of the following five things:

ÅReduce disease or disability
ÅReduce the impact of disease or disability
ÅReprioritise
ÅImprove efficiency
ÅSpend more

Part of the debate relates to how health services are rationed today and how this may change in the future.

Key Questions

The Cost of Health Today:

- How much will healthcare cost in the future?

Paying for Health Tomorrow:

- What are the options for paying for health in the future?
- How might health services be ñrationedò in the future?
- What is the role of generic drugs?
- Can the system be adjusted to incentivise users to take care of their own health without unduly punishing those who do not?
- What is the potential to reduce healthcare costs through
    - Reducing disease or disability (role of prevention)
    - Reduce the impact of disease or disability
    - Reprioritising resources
    - Efficiency savings
    - Investment (quality can save)
    - Improving care

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