what if...

FOUR SCENARIOS

WHAT MIGHT THE FUTURE HOLD FOR HEALTHCARE AND WELLBEING?

NHS
North West

Healthcare and Wellbeing: **What Might the Future Hold?** Four Scenarios

NHS North West
May 2008

This document is in no way a statement of official NHS policy.
The four scenarios described herein are simply fictional narratives designed to aid discussion and reflection with a view to encouraging more strategic, forward looking strategy making.

Developed in co-operation with OD Partnerships Network
www.odpnetwork.co.uk

Design: GM Design 0161-748-3072

Contents

For a copy of the Scenario Users' Handbook, please contact Helen Chainey, Executive Assistant to Joe Rafferty, Director of Strategy & Commissioning NHS North West

e: helen.chainey@northwest.nhs.uk

t: 0161 625 7130

"What we want to happen rarely has an impact on what will happen. However, we usually plan as if what we want to happen, will happen. But when what we want to happen, doesn't happen, our plans turn out to be totally inappropriate. Scenarios – properly used – can help us avoid this fate."

Participant comment, NHS NW Scenarios Construction Workshop 2007

Foreword

In his letter to NHS and Local Authority Chief Executives and Council Leaders of April, 2007, Mike Farrar (Chief Executive, NHS North West) stated that the SHA wished to develop strategic scenarios "… to inform future policy and strategy."

He went on to say that he hoped that NHS North West would be able to use the scenarios "…… on an on-going basis to:

- Help us make collective sense of what is happening in the strategic environment, within local NHS and social care systems and local strategic partnerships
- Develop shared views of desirable strategic directions in the short and medium term (2010 & 2020)
- Agree the necessary conditions which could trigger strategic interventions from the SHA in-order to better realise policy intent
- Help us recognise any undesirable consequences of strategic plans at an early stage and to adjust priorities and strategies accordingly."

He also stated that "The SHA wishes to foster effective strategy making, not formulate it directly on behalf of local actors."

We believe that the scenario set and supporting material contained herein can be used for all of these (and other) purposes and that they will be able to be used by organisations within NHS NW to strengthen their capacity to formulate and successfully execute more far-sighted and effective strategy.

Foreword

What scenarios are – and what they are not

To use scenarios effectively we need understand what they are and what they are not.

WHAT THEY ARE

- Interesting narratives or pictures of possible futures
- Ways to help us appraise current plans and strategies
- Ways to help generate new plans in the light of what **could** happen

WHAT THEY ARE NOT

- Predictions (although parts of the future could lurk in all of them)
- Statements of strategic intent
- Visions for organisational direction

Developing the scenarios described here took nearly a year and involved more than 350 people from the North West. This included NHS staff, Local Government officers, MPs, local councillors and others. We also held five 24-hour scenario-building workshops across NHS North West involving more than 150 participants.

This 'bottom-up' process has rooted the scenarios in the concerns, preoccupations and aspirations of many of those who will make use of them. A more detailed, graphic description of the process used to develop the scenarios can be found at Appendix I.

We expect that NHS Trusts, PCTs and Local Authorities will find these scenarios invaluable in developing their own local strategy, particularly if the inclusive approach used to generate the scenarios can be continued with local partnerships.

We are grateful and indebted to a very large number of people for their help and support in carrying out this work. We are grateful to the many very busy individuals who agreed to be interviewed and who participated in the various workshops that were critical to the scenario building process.

We owe a special thanks to the members of the NHS North West scenarios team – namely, Mike Farrar, Jennifer Butterworth, Alison Reed, Janet Collinson and Gail Green as well as to Joan Durose, Sue Gallagher, Chris Spry, Nigel Edwards, Sue Jones, Paul Harrison, Jan Freer, Alison Johnson, Gill Mullarkey and Loren Grant who all, at various times, made significant contributions to this work.

Obviously we would also like to thank the members of our Advisory Group, who, despite very busy lives, met several times during the project, made numerous valuable suggestions and really helped to shine a light when dusk was falling! The Advisory Group members are listed in Appendix II.

Finally, we owe a very special and heartfelt thanks to Tony Hodgson, the Chief Executive of Decision Integrity Ltd. who acted as an expert advisor on the scenario development process throughout the duration of the work.

Gordon Best Maria Duggan
Steve Pashley Joe Rafferty

Views on Scenarios

"The scenarios provide the Board with a new way of looking into the future. I believe that they will be really useful as we begin to prepare our new Service Development Strategy for the next 5 years".

David Dalton
Chief Executive
Salford Royal NHS Foundation Trust

"Using the scenarios with Officers and Members and other LSP partners was very challenging and thought provoking. A range of new ideas and possible solutions arose to ensure we stay ahead of the National Agenda. It is a process which we intend, based on our experience, to use more widely in the future".

Graham Burgess
Chief Executive
Blackburn with Darwen Borough Council

"If a PCT is going to succeed in improving health and healthcare we must understand what the future may bring. These scenarios are a vital tool to ensure we are able to achieve our aims".

Mike Pyrah
Chief Executive
Central and Eastern Cheshire PCT

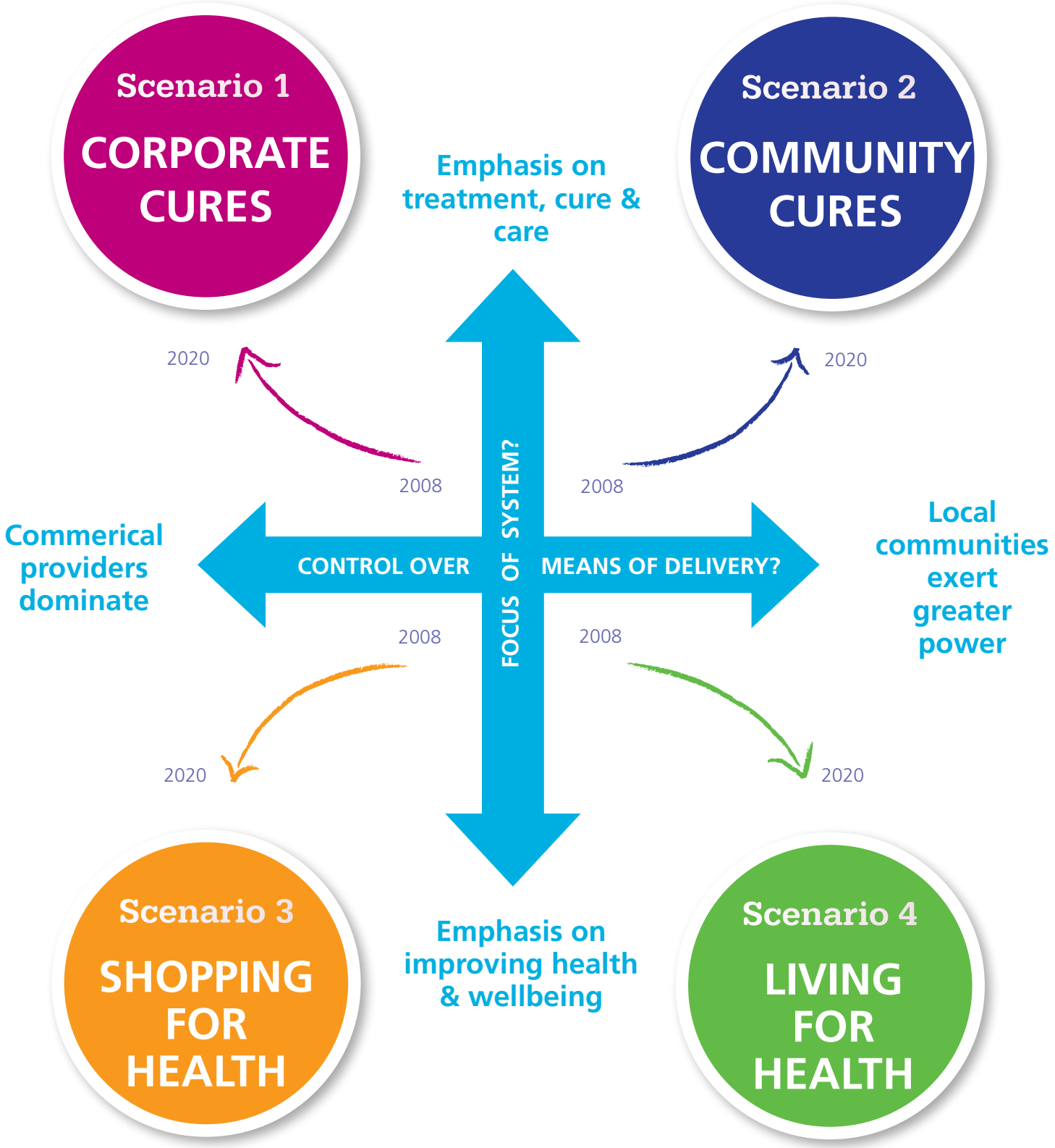
"An incredibly effective means of working with partners to join up our thinking and future plans to improve health and wellbeing".

Judith Griffin
Chief Executive
Blackburn with Darwen Teaching PCT

"One of the key roles of Public Health is to explore that which is hidden. These scenarios will help health systems imagine a wider range of possibilities for the task of Public Health Improvement".

Dominic Harrison
Deputy Regional Director of Public Health
Department of Health,
Government Office North West

The Four Scenarios



Four Scenarios: An Overview

"Prediction is extremely difficult. Especially about the future."

– **NIELS BOHR**

The scenarios, depicted in graphical outline on the previous page, should not be seen either as predictions of the future nor descriptions of desirable (or undesirable) futures.

Rather, they simply depict four different, 10-15 year futures, representing alternative, but sometimes overlapping, ways in which the healthcare and wellbeing systems in the U.K. just might 'play out'.

To be useful, they need to be imaginative and intellectually stretching (so that we are not trapped in our habitual ways of thinking) and, collectively, they should represent a broad spectrum of future possibilities.

Or, to put it another way, when the scenario set is looked at in the round, we should be able to conclude that 'the future is almost certain to be lurking in there somewhere'.

The test as to whether they are useful, is (i) when taken as a backdrop, they cause us to see the present differently; and (ii) the insights thus gained, cause us to reappraise our short-to-medium term plans and strategies and/or generate new ones.

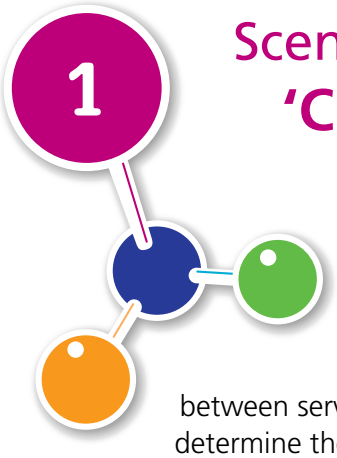
The Scenario Users' Handbook describes a number of different ways in which the scenarios can be used for these purposes.

The scenarios have been constructed, in part, by analysing how the healthcare and wellbeing systems in the UK might respond to five underlying change drivers. These drivers are:

5 change drivers

- **Reaching the limits of the welfare state;**
- **The ageing population;**
- **Increasing consumer sophistication and demand;**
- **The 'possibilities explosion' arising from the likely increase in innovations in the life sciences, pharmacology and information and biotechnology; and**
- **The exhaustion of traditional methods and tools for containing costs.**

In summary, the four scenarios are:



Scenario 1
'CORPORATE CURES' - a summary

In **Scenario 1,** the market and competition between service providers determine the most efficient way to allocate resources devoted largely to 'curing and caring' ends. In this scenario, relatively powerful commercial providers of care actively foster demand for their services.

While this tends to drive down unit costs, aggregate costs rise rapidly. Under pressure to contain healthcare spending, the Government commits itself to an explicit statement of intent concerning the future of healthcare financing that includes a five-year transition to an insurance-led system for all adults, excepting those deemed too poor to make adequate provision.

The majority of services in this scenario are provided through relatively large networks of hospitals and associated acute service providers meaning that the 'acute episode' remains the primary locus of care and care pathways serve to accelerate patients' journeys into provider networks.

Despite this, advances in pharmacology, genomics, information technology and biotechnology mean that, by 2020, there are only half the number of hospitals in the U.K. as in 2007.

In addition, the intense competition between providers means that less profitable, low-tech services are left to the state to provide as a 'safety net' serving about 30% of the population. Strategic commissioning is virtually non-existent.

Most primary care physicians have a specialist training and are employed by commercial service providers or insurance companies.

In addition, consumers registered with commercial service providers have direct access to specialists as well as specialist services provided electronically and robotically.

The Government increasingly restricts its role to the regulation of the health care market while simultaneously continuing to encourage the emergence of alternative payers.

"Telling the future by looking at the past assumes conditions remain constant. This is like driving a car by looking in the rearview mirror."

— **HERB BRODY**

Scenario 2
'COMMUNITY CURES' - a summary

In **Scenario 2,** integrated health and social care commissioning bodies act as a counter weight to service provider power in an attempt to find the most effective way to allocate resources to curing and caring ends.

In addition, successive national Governments devolve almost all responsibility for rationing these resources, and for shaping the delivery of services, to local government agencies in conjunction with increasingly informed and empowered local communities.

'Health and Social Care Commissioning Agencies', subject to re-licensing decisions by local communities, have responsibility for regulating and moderating the influence of the health care 'market'.

This in turn, means that most private service providers become more embedded in local political processes and that, as a consequence, service provision differs markedly across geographies.

In this scenario there is significant growth in community-governed ambulatory care health 'campuses' including local medical recovery suites and step-down/rehabilitation centres, with specialist clinicians incentivised to practice 'closer to people's homes'.

There is also a rapid growth in new niche 'third sector' service organisations, focused on helping people to 'navigate' the system and to acquire the skills necessary to take greater responsibility for their own care.

In addition, in many communities, the growth in 'grey power' leads to a transformation of residential care.

While in this scenario, almost all difficult rationing choices are taken locally, many communities attempt to ameliorate these difficult choices by agreeing to new, locally devised supplemental revenue streams.

Scenario 3
'SHOPPING FOR HEALTH' - a summary

In **Scenario 3,** the rising level of disposable income of the majority of U.K. citizens, accelerated consumerism and the potential scale of the 'health and well being' marketplace are the major drivers of change.

Together, these lead to a greater emphasis on the purchase of health and wellness benefits and services; hold out the prospect of leading to a reduction in, and/or the re-profiling of, the demand for curing and caring services; and creates a market space that is rapidly filled by retailer-led well being ventures and online entrepreneurial start-ups.

In parallel, large employers, incentivised by tax credits, begin to take a more strategic interest in employee health, often contracting with commercial providers of health and well being services to reduce unauthorised sickness rates and boost employee well being levels.

The state creates and invests in personal Health Funds for all citizens. Consumers in this 'New Health' economy are obsessed with health status testing, spending ever increasing amounts of their disposable income on internet or home-based predictive testing and monitoring services.

In addition, many GPs become personal health coaches while most public health practitioners become engaged in serving wellness consumers.

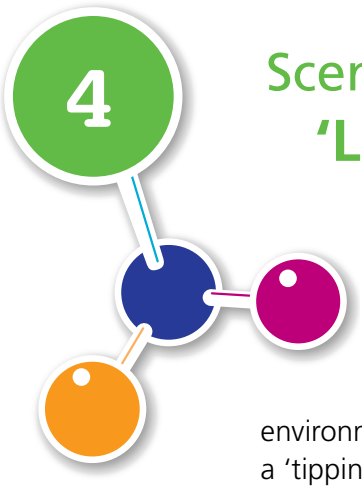
Far from reducing the demand for curative services however, these developments result in lower personal treatment thresholds, thus triggering an increase in the demand for many curative services.

While this approach to the pursuit of health and well being influences the behaviour of a significant proportion of the population, a significant minority – either by choice or because of low levels of disposal income - continue to pursue more traditional lifestyles.

In this case, individuals who are unwilling or unable to adopt healthier life styles are offered access to an NHS wellness service which compares poorly with most of those available via alternative providers.

"When it comes to the future, there are three kinds of people; those who let it happen, those who make it happen, and those who wonder what happened."

— **JOHN M. RICHARDSON, JR.**



Scenario 4
'LIVING FOR HEALTH' - a summary

In **Scenario 4,** a number of massive and sustained economic, social and environmental shocks precipitate a 'tipping point' that causes an influential and substantial minority of the U.K. population to rapidly see themselves primarily as stewards of the earth's resources rather than solely as consumers of those resources.

This change, together with devolved responsibility for NHS policy making obliges and motivates most local communities to see healthcare in a new light - primarily as the pursuit of collective wellbeing.

This new mission is made real through the introduction of 100 locally elected Health and Well Being Commissions (H&WBCs) with responsibility for healthcare policy making.

H&WBCs provide a new impetus for the adoption of enabling technologies to help local communities to support social networking and service provision for those who need care and support - particularly the elderly.

Further impetus to the pursuit of community led wellness regimes comes in the form of local authority administered Community Wellness Funds.

These Funds grow rapidly to hold billions of pounds previously administered by primary care trusts. This in turn means that PCTs must vigorously pursue productivity gains with treatment providers.

More than 175,000 jobs are lost in the NHS as a result. More wealthy communities supplement their Wellness Funds by the creation of new local revenue-raising schemes. Over time, many Community Wellness Funds are wrestled away from local authority control and instead become managed by Community Wellness Trusts (CWTs), led by local health activists.

Many CWTs become overtly political, fielding candidates in Local Authority elections and succeed in establishing sympathetic elected Mayors.

The NHS slowly evolves from a preoccupation with health care to a broader emphasis that includes designing and delivering services in environmentally sustainable ways.

Many communities with CWTs become less tolerant of unhealthy living, labelling this a form of anti-social behaviour.

This often results in sanctions triggered by local referenda which in turn, results in the liberal media referring to these communities as 'health dictatorships'.

"To predict the future, we need logic; but we also need faith and imagination, which can sometimes defy logic itself."

– ARTHUR C CLARKE

COMMON FEATURES ACROSS SCENARIOS

The four scenarios 'play out' at different speeds, with different degrees of 'drama', in response to different combinations of political, economic, social, technological and environmental influences. And although all four point, ultimately to markedly different futures, they also all share a number of features, albeit ones that manifest themselves differently in each scenario. Three of the most important of these shared features are:

1. THE 'SICKNESS' SERVICE

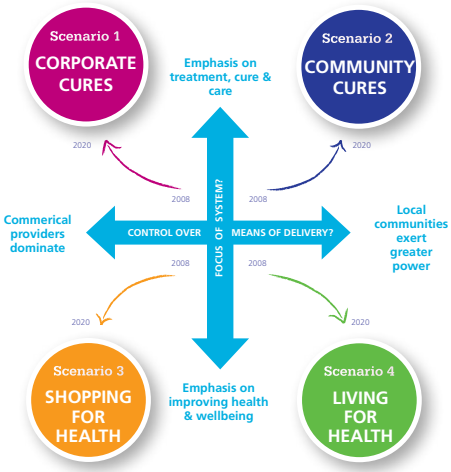
All four scenarios recognise that the U.K. population will continue to have accidents, that organs will sometimes fail, that some natural events such as birth and death will involve complications, and so on. All four therefore incorporate a 'sickness' service.

In the two scenarios above the horizontal axis, this service figures prominently – although differently – because the emphasis in these two scenarios is on curing and caring. So, for example, both scenarios elaborate on the different ways in which providers and 'consumers' of these services will interact with one another.

By contrast, the sickness service is more a part of the 'background' in the two scenarios below the horizontal axis. This is because the emphasis in these two scenarios is not on curing and caring but, in different ways, on the pursuit of health and well being.

In these two scenarios, for example, one of the ways the sickness service features is that some individuals unwilling to adopt healthier lifestyles are either offered access to inferior services (Shopping for Health) or may face restrictions on how they are able to access certain services (Living for Health).

It is also important to note that in all four scenarios, the sickness services available are very different from those available in 2007. For example, in all cases hospitals are much more specialised and smaller; many more 'curative' services are available electronically; services are more pharma-genetically personalised; general practice and family medicine are virtually non-existent or fundamentally transformed; there is much greater use of the internet and electronic health care more generally; and so on.



2. IMPACT OF INNOVATION, TECHNOLOGICAL CHANGE AND THE 'POSSIBILITIES EXPLOSION'

All four scenarios assume that advances in informational technology, bio-technology, pharmacology, genomics and the life sciences more generally, will have a fundamental impact on the utilisation and delivery of curing and caring services as well as on the possibilities available to predict, prevent and promote health and

well-being. One of the key differences between the four scenarios however is the assumption that the way in which these various changes 'play in' will be heavily conditioned by the motivations and interests of those players who have the greatest power and influence in each scenario.

So, for example, for the two scenarios to the left of the vertical axis, it is assumed that applied research priorities and the up-take of innovations will be biased toward those changes that foster and facilitate the consumption of discretely priced and packaged services. By contrast, the two scenarios to the right of the vertical axis will be biased toward those research priorities and innovations that best foster and facilitate the effective implementation of community determined priorities. For example, innovations that lead to greater user independence figure more prominently in the two scenarios to the right of the vertical axis than in those to the left of the axis.

3. INEQUALITIES AND SOCIAL COHESION

All four scenarios are characterised by inequalities between different sectors of the population and therefore, have implications for the level of social cohesion associated with each. For example, in both of the scenarios to the left of the vertical axis, those parts of the population able to afford health insurance and/or pay for wellness services will have greater access to a wider range of benefits and services than those who cannot afford to pay for them.

By contrast, in both of the scenarios to the right of the vertical axis, those citizens living in communities able to raise local revenue to supplement state funding, will have access to a wider range of benefits and services than will those that live in communities unwilling or unable to raise such revenue.

In addition, in the two scenarios below the horizontal axis, those citizens unwilling and/or unable to adopt healthier lifestyles will either have to make do with inferior services or not have the same freedom of access to some curative and caring services, as those citizens willing to do so. There may in addition, in the fourth scenario be a measure of overt community pressure – or marginalisation – of those individuals who are not compliant.

Scenario wild cards

Wild cards are surprises that we have little or no control over but that have the power to completely change how the future unfolds. Because however they are highly uncertain, they are not treated as change drivers. Rather, they are dealt with by asking what, if they do occur, will be their impact under each of the four scenarios.

The three wild cards recommended for use in relation to these scenarios are: (i) Britain Joins the Second World; (ii) Climate Change Surprises Us; and (iii) Advances in Genomic Science, Pharmacology, Biotechnology, and Nanotechnology Lead to the rapid 'Reinvention' of Health and Social Care*. Further details of these Wild Cards and advice about how they can be used in conjunction with the scenarios, is available in the Resource Aids Section and the Scenario Users' Handbook.

** Although some experts believe that the scope for short to medium term breakthroughs in pharmacological innovation and genomics have been overestimated.*

Scenario Narratives

Scenario 1

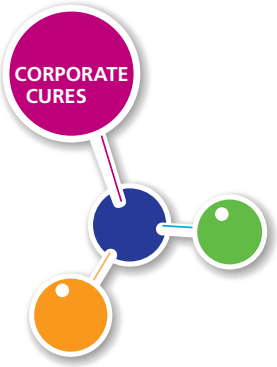
Corporate Cures

'Corporate Cures'

"..... Competition is good. It leads to increased quality and service and will reduce costs on an individual basis although it also increases demand [and therefore whole system cost]. Competition weeds out inefficient, poor quality providers but sometimes, these providers are meeting some of the greatest needs. The fittest are not necessarily the most needed."

Key Features

- Private provider networks dominate
- Aggregate costs high as providers pursue growth and market share
- Networks form geographic and niche monopolies
- Pathways accelerate patient's journey into provider networks
- Strategic commissioning is non-existent
- Transition to private insurance based system for majority
- Nearly one third of citizens served by state funded safety net
- State retreats to role of regulator
- Techno-medicine - Technology fosters demand for acute services
- Personal Medical Plans offer bespoke molecular-genetic 'cures' to members
- Specialists dominate and patients have direct access to them
- Most GPs work for provider networks or insurance companies
- Half the number of hospitals by 2020
- Healthcare is globalised



The Story So Far…….

1. 2008 sees the beginning of a significant, sustained and accelerating increase in demand for hospital-related services triggered, initially, by a policy decision, known affectionately as the 'finally free' policy, which commits the Government to 'fully allow' NHS FT providers to compete against each other for greater market share.

2. Initially the efficiency of providers varies significantly depending on their geographic location and/or the level of competition faced. Unit costs quickly begin to decrease as providers are forced to make much more strenuous and sustained efforts to increase productivity and improve patient outcomes in-order to survive or thrive. However aggregate costs also rise quickly as providers engage in a 'services race' that leads to escalating investments.

3. Fuelled initially between 2009 -2011 by a big increase in large technological investments by providers seeking to increase their share of hospital 'business', aggregate costs rise even further as provider networks become more confident at marketing themselves 'direct to consumers' and, in particular, offering patients and potential patients direct access to many specialist clinicians.

4. The economic case for the formation of networks of hospitals, able, in theory at least, to hold down cost pressures by spreading investments across larger 'service distribution centres' quickly becomes very attractive. By mid 2010, 52 FT networks have begun to emerge, collectively subsuming 80% of the original FT 'community'. Most are seeking to form regional monopolies though several are niche networks with national reach, exploiting brands that resonate with the British public. Unfortunately, competitive pressure are even more sharply felt in a networked world and cost increases, although ameliorated to some extent, still continue to occur at levels well above the traditional rate, forcing providers to prioritise the provision of high-margin specialist acute services at the expense of less profitable, less specialised low-tech services, a tactic that often succeeds in oligopolistic markets.

5. Big shockwaves are felt in late 2011 as two of the largest FT provider networks announce their intentions to merge and three more networks signal that they are, collectively, in 'end stage' merger discussions with a consortia that includes a multinational pharmaceutical company and software technology company. Many commentators see these developments as a 'watershed', and predict the emergence of a truly private delivery system within the next 10 years.

They confidently predict this trend will be facilitated by the end of the NHS final salary pension scheme, scheduled for June 2012. This merger phase also marks the end of the pharmaceuticals more covert approach to entangling itself into the core of provider networks. Sponsorship and the 'lending' staff are still part of the 'entanglement armoury' but increasingly 'front door' deals are now part of public strategic discourse.

1 what's happening now

The UK government has committed to spending $1.3 billion on stem cell research in the next 10 years.

6. 2011 also sees the majority of FT membership schemes being rethought and more aggressively promoted. Networks start to offer a range of preferential member benefits, often including a choice of lead clinician and a guarantee to wait less time than the nationally prescribed maximum when in-patient treatment is necessary. Networks also start to offer members secure access to and to some degree control over their online personal health records via proprietary, net-based software, seeking to 'lock-in' membership and prevent new online health portals from gaining a foothold. Overtly, networks begin to challenge Commissioners as being the legitimate 'voice' of local people.

7. Aggregate cost increases are further fuelled as a consequence of a 'double whammy' where leading networks compete much more aggressively for scarce 'world-class' global clinical talent with the US, Europe and other developed economies whilst at the same time being obliged to offer above-average pay increases to retain key staff, driven by enhanced global competition for qualified healthcare professionals, especially from the Indian sub-continent. Pay pressures come to public attention when Virgin News breaks a story about how thousands of 'world class' overseas doctors have contracts that include monthly return airfares home.

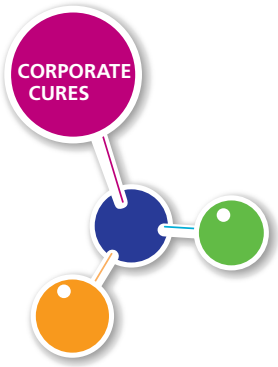
8. The era of personalised, 'boutique' medicine is officially 'born' in 2014 as twelve provider networks, located in five regions, announce a plan to collaborate to jointly market a national personalised medicine plan (PMP). Individuals willing to pay an annual subscription of 2500 Euros become PMP members, More than 450,000 people pay to join in the first year. Members enjoy a range of benefits including the ability to make appointments that fit with their lifestyle, personal physicians, few access constraints etc.

9. In 2014 political 'noise' from the CBI, and 'big business', particularly defence industry contractors and manufacturers, finally bears fruit as the new Government announces a fundamental review of healthcare financing. A significant trigger is a CBI report demonstrating that by 2015, without fundamental redesign, 13.5% of GDP will be spent on state-financed healthcare and UK plc, as a consequence, will find it nigh on impossible to compete in a global marketplace.

10. The financing review leads, in early 2015, to an explicit statement of intent concerning the future of healthcare financing. Essentially the Government commits itself to overseeing a five-year transition to an insurance-led system for adults, beginning in 2016 with the introduction of a number of co-pays (whether private contributions or via insurance payments) for a small range of services and drugs. By 2020 the intention is to have a fully insurance-led system for all adults, excepting those deemed too poor to make adequate provision or those with pre-existing conditions that exclude them from receiving insurance, (including a disproportate number of elderly people). It is envisaged that this residual 'state financed pool' will not exceed 30% of the adult population and will decline over time.

2 what's happening now

The global economy has grown sevenfold since 1950.



11. Non-insured adults who require network provided services are clearly intended to be treated as second order priorities, subject to a national residual performance agreement, negotiated by the Government with all network providers every five years.
These standards, likely to be less advantageous than those offered by insurance plans, will often require patients to travel to 'authorised service locations' some distance from their homes. Local NHS Commissioning organisations are abolished.

12. Publication of the review quickly triggers a massive growth in the uptake of niche health insurance policies , particularly those that offer preferential access to new, cutting-edge drug therapies. And over the next five years it is credited with being the catalyst for a complete transformation of the healthcare system.

13. Throughout 2016 provider networks respond to this new opportunity by quickly redesigning and exploiting their membership schemes, originally formed in the era of FTs to signal some commitment to localism. In one notable case, the largest network aggregates membership from 38 separate 'membership centres' (hospitals) to immediately form a plan cohort of 1.2 million members overnight. Over 85% of members choose not to opt-out of the scheme in year one.

14. By the end of 2018, led by a surge in voluntary membership from the 30-50 year old age group, seeking to take advantage of the reductions in personal taxation rates offered as incentives for early adopters, 62 percent of the adult (18+) population finance their healthcare via an insurance plan, offered by new insurance divisions of provider networks or by 'mainstream' insurance companies.

15. The introduction of routine genetic screening as part of the health plan application process, to determine whether applicants are accepted into plans at base premium rates or at enhanced rates, based on their higher risk profile, is now commonplace. As screening becomes more sophisticated, a growing number of applicants are deemed completely uninsurable. In such instances they automatically return to a residual group, subject to Government-negotiated contracts. Some plans now offer their members the option to opt for a 'lifetime medical sum' plan. LMS accounts, subject to complex use rules, allow named individuals to draw down on available funds to pay for desired medical treatment. Different treatments are subject to different degrees of account exposure, with the plan company or, in some cases, the individual liable for payment of the remaining amounts if not fully covered.

16. A new personalised 'pay for results' regime begins to operate in 2017. Healthcare payers agree to reimburse provider networks, on a case-by-case basis, based on the reported level of functionality gained by each patient. In some cases, this develops further so that reimbursements are split between providers and pharmaceutical companies, with pharmas receiving payments based on the success of drug regimes with individual patients.

17. In terms of the provider landscape, by 2020, 28 of the of the 35 provider networks are for-profit, market-exposed and the total number of 'hospital' facilities is about half of what it was in 2007. Information technologists and marketing executives now dominate Network Board appointments and over half of Network Medical Directors are Geneticists, Nan-technologists and other 'clinical' scientists.

3 what's happening now

Cancer drug launches have risen from just under 1400 in 2000 to over 2100 in 2007.

18. More than six million people now belong to over 40 Personal Medicine Plans attracted by the prospect of living longer, expressed by the market leading PMP Networked provider, ' LiveLong Health' as "an extra year of life for every nine years of membership.", PMPs have now evolved from offering boutique medicine into true genetically tailored treatment plans where members receive tailored advice plus access to leading edge personalised medical services, defined as therapeutic interventions tailored to each person's genetic makeup.

19. However, a worrying counter-trend to the growth of insurance coverage begins to emerge, as annual insurance 'churn' rates start to increase for the first time. Although the reasons for this are not yet fully understood, many commentators speculate that a key factor may be increasing concerns amongst policy holders in the 55-65 age cohort, as they begin to wonder if they will be fully covered in late old age, when, irrespective of technological advances, the 'compression' of morbidity occurs and people begin to suffer a number of co-morbid conditions. This concern is fuelled by the growing realisation amongst policy holders that large numbers of older people with multiple conditions are not very profitable for providers to treat. A second factor may be concerns about the consequences for quality of services as insurers take action to drive down the costs of packages of care for people with co-morbidities.

20. Family practice, as traditionally known, is by now virtually unrecognisable. About 45% of general practitioners have opted to become re-trained as sub-specialists and employed by provider networks. They practise mainly from offices built on Network campuses and act as 'tied' referral agents. Some also have admitting rights to in-patient facilities controlled by their employer Network.

These more highly trained physicians usually closely supervise the management of their patients when admitted to in-patient facilities and liase with Network technicians about patient intervention plans. One in four of GPs now work for insurance companies, as specialised case managers, seeking to ensure appropriate care and billing. The remaining 30% choose to stay in traditional roles, employed in state–subsidised clinics, offering diagnosis, advice and patient management services to any non-insured adult.

21. By 2020 the State, in response growing provider power, has more narrowed and redefined its role to that of Regulator, focused on four tasks:

- reporting to the public on service quality and safety;
- granting and reviewing licences issued to networks to enable them to offer various genomic interventions;
- setting a price tariff for services still purchased from the public purse; and
- seeking to act as a counterweight to 'business imperatives' in the prioritisation of medical, pharmacological and genetic research.

4 what's happening now

43.62% of respondents in the health sector indicated that their organisation is considering overseas sourcing to attract talent. This compares with only 23.3% for the survey results across all sectors.

Scenario 2

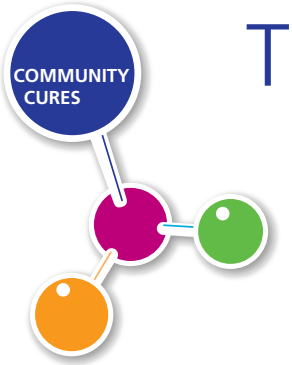
Community Cures

‘Community Cures’

“.....The choices people make about where they want to live is heavily influenced by what local healthcare looks like and whether this local service pattern and style suits their current and likely future needs. In a way it’s a similar decision process as the one new parents still make about where to live in order to give their children an opportunity to attend a particular school.”

Key Features

- Healthcare more embedded in local democratic processes
- Integrated commissioning is counter-weight to provider intentions
- Local people determine priorities and award licences to operate
- Community governance for local services
- Local supplemental financing methods become universal
- Patterns of provision differ markedly across geographies
- Explosion of local health campuses and more home-based treatment
- Localism fosters healthcare multiculturalism
- GPs are Community Specialists, led by Geriatricians
- Third sector providers / social enterprises more central ‘players’
- Aided navigation in complex local systems is critical and omnipresent
- ‘Grey power’ reshapes residential care
- Self-care and ‘third age’ volunteerism to the fore



The Story So Far.....

1 what's happening now

Eighty-two per cent of PCTs have already redesigned one or more care pathways at the primary/ secondary care boundary.

1. In late 2008 Gordon Brown's Constitutional initiative 'kicks starts' a more open debate about how to create and sustain a more vibrant, confident localism in English public affairs. This debate becomes much more pointed in mid 2009 as a hung parliament propels some of the NHS into a new, more embedded relationship with local government and local democracy.

2. The first public sign of this new localism occurs in late 2009 as 22 PCTs commit themselves to 'fully integrate' with co-terminous local authorities within the next two years, creating Health and Social Care Commissioning Agencies (H&SCCAs). The strategic agencies (and residual PCTs) all operate under a new licensing system, granted by the UK parliament. Licences are lost if local communities vote not to renew them and all local communities must be offered a vote at some point between four to seven years of a licence having been granted.

3. Further visible signs of change occur in early 2010 as Strategic Health Authorities (SHAs) disappear from the landscape. Healthcare policy making and horizon scanning is now to be undertaken on a regional basis by consortia of PCTs and new H&SCCAs. Consortia are supported by Regional Development Agencies (RDAs) that, in turn, 'house' a small number of specialist staff that previously worked for the now defunct SHAs.

4. Regionally-led policy making quickly becomes focused on creating receptive contexts to enable local cure and care systems to flourish. In addition, RDAs collectively fund and control an energetic EU Policy Office and locally orchestrate ongoing polling process to determine the public's views about relative priorities for access to new treatments, drugs and technology. Results of these polls are fed, on a quarterly basis, to all H&SCCAs operating within the sector. NICE acts as an 'arms-length' advisory body offering a commentary alongside each Regional quarterly report. There is no compulsion for H&SCCAs to act on this regionally collated information as ultimately local H&SCCAs are able to determine their own responses.

5. The shift of power away from the centre to RDAs further encourages PCTs to become locally integrated H&SCCAs. By the end of 2012 80% of PCTs are either fully integrated with local authorities or publicly committed to do so within the next three years.

6. In 2012 the new UK Parliament, under enormous financial pressure, finds the confidence to devolve almost all its remaining healthcare-related powers to RDAs. Two powers remain nationally held:

- prescribing a minimum national framework of service availability that must exist throughout all local authority areas in England, reviewable every five years; and
- determining the annual level of tax funded revenue to be made available to local H&SCCAs;

7. The minimum national framework is widely expected to reduce in scope over time as public finances 'tighten' and as Commissioners and local communities become more confident about what locally is an appropriate pattern and level of service to offer.

8. In 2013 services that meet the minimum national framework consume 80% of the national tax-funded expenditure. H&SCCAs have complete discretion over how the remaining 20% is used to best meet the particular needs and preferences of the communities

they are accountable to. H&SCCAs, on average, also spend a further 15% beyond national allocations. This is typically generated by use of three mechanisms:

- The introduction of local authority managed voluntary supplemental health insurance schemes, 'fused' with Council Tax collection processes;
- Co-pays for certain services, agreed via community referenda; and
- Professionally-led local fundraising campaigns;

9. Strategic commissioning undertaken by H&SCCAs is, in relative terms, judged to be highly effective. Some 'first wave' H&SCCAs have been able to 'dampen down' or reshape the more aggressive, commercially-driven intentions of what are quickly becoming private provider networks whilst most have succeeded in placing a much greater emphasis on treatment closer to home and a sharper focus on utilising technology and redesigned facilities to keep people away from the more traditional secondary and tertiary facilities.

10. Growing confidence amongst H&SCCAs leads to ever more localism. Commissioners in the North West and East of England demand and win the power from RDAs to prioritise access to new treatments and drugs at a more local level. Others are keen to follow, although Regions with stronger identities are less keen to cede this power.

11. The vast majority of Commissioning is now driven by Community-based Commissioning intentions. CBCs are most easily described as redesigned Practice-based Commissioning arrangements where local people are elected onto a Supervisory board that meets twice a year; once to approve or modify annual local commissioning intentions and once to re-appoint or elect new CBC officers.

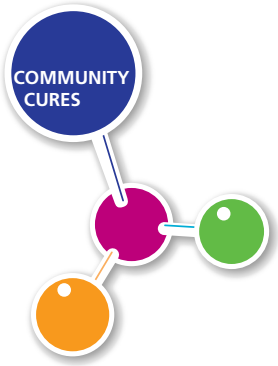
12. Consequently the 2012 – 2015 period witnesses a tremendous growth in ambulatory care health campuses, located within the centres of urban and, increasingly, rural communities, offering a wide array of diagnostic, surgical and medical services as well as medical recovery suites and step-down / rehabilitation facilities. These service trends are encouraged by a shift to five-year capitation-based contracts that incentivise providers to ensure their specialist clinicians work much closer to or in people's homes.

13. **Although the new local health campuses are usually owned and operated by local private sector provider networks, a condition of licensing often insisted upon by Local Authorities requires the new facilities to be governed by Community Boards, with a majority of Board members being local community leaders, appointed by the Local Authority for a five-year term, subject to a two-term limit.**

Several of the more recent new-build campuses are part financed by the new Community Financing Initiative (CFI), a scheme where local communities vote to guarantee repayment of capital borrowings, usually via a Council Tax precept over 25 years.

2 what's happening now

A Local Government Association survey on democratic renewal found that 73% of authorities had used new consultation techniques in the preceding 12 months.



3 what's happening now

All electors in Milton Keynes were invited to participate in a referendum on Council spending priorities. People were able to vote by post or phone. A turnout of 44.7% was achieved.

14. Supporting people to make more informed choices in much more complex local treatment and care systems is now a key competence required of local health and care systems. It is now commonplace to see more than 200 Healthcare Navigators working within a delivery system that serves 300,000 people. Often these Healthcare Navigators are employed by third-sector Navigation companies, led by a small number of GPs who have decided to make their contribution in this way rather than by offering direct clinical services. The importance of Navigators is amplified by the extension of personal budgeting schemes beyond 'social care' services. Increasingly patients with certain long-term conditions now also have control over their personal healthcare budgets are spent.

15. Shockwaves hit the healthcare industry in 2013 as the first batch of H&SCCA re-licensing votes take place. Nationally 22 local communities, fully aware of how patterns of services have changed in other parts of the country, vote not to re-license their incumbent H&SCCA.

16. By 2015, as a result of 'lost' relicensing votes, the number of H&SCCAs have reduced from 150 to 84. One successful H&SCCA now holds licences to Commission services on behalf of residents in nine local authority areas, spread throughout three northern Regions. Healthy Communities.org, a national online community of seven million healthcare 'activists', run by the IDeA under the strap-line 'Local Power for Local Services', is now the most influential 'player' in helping local people organise to influence H&SCCA re-licensing decisions and almost all H&SCCAs have Directors of Community Affairs on their Boards.

17. Collectively, the advent of a much stronger local authority strategic 'voice', coupled with the threat of local communities voting to remove poorly performing H&SCCAs and the ending of the NHS's final salary pension scheme is credited with helping to establish a revitalised and refocused third sector. In particular there has been a very rapid growth in third-sector organisations. In addition to already established Navigation companies, a range of highly professional niche 'DIY-self-care' service organisations now features. Specialising in helping people acquire access to and use e-symptom checkers, decision aids, home-based testing and monitoring systems and self-care management tools, these user-owned organisations are helping to lessen the power of larger, privately-owned provider networks.

18. In 2015 this reshaped third sector, nationally, offers services that account for 8.5% of the annual revenue budgets of H&SCCAs. Lately though a countertrend has begun to emerge where some well-known, large third sector organisations have voted to disestablish themselves as charities and become self-care arms of large regional provider networks.

19. Reacting to the general shift toward treatment closer to home, over 40% of GPs have joined geriatricians, paediatricians, general physicians and LTC specialists in forming independent Primary Care Medical Groups (PCMGs). Often PCMGs have 30-40 medics 'in membership', all of whom hold 'in-reach/ admitting privileges' in local high-tech ambulatory campuses, rehabilitation and step-down facilities and retirement villages. Most PCMGs are led by geriatricians, whose numbers have risen by 40% since 2007 and are forecast to double again in the next 15 years.

20. Mental Health services, within certain parts of England, are now experiencing a 'golden age' as lots of middle-class communities vote to prioritise the use of locally-generated funds on new services for people with

'lower grade' issues such as anxiety and depression. In a further fillip, many H&SCCAs now insist, as a condition of contracting, that all provider staff, regardless of specialism, must be able to demonstrate a good degree of psychological capability and emotional intelligence.

21. Another notable development concerns how end-of-life issues are now handled. Many local authorities have lobbied successfully to change the law to enable euthanasia to occur legally in certain circumstances. Further to this, many local communities are now preparing to hold referenda, which if supported, will require local provider networks to demonstrate that they are acting more responsibly by ending all unnecessary 'heroic' end-of-life interventions. Demonstrating compliance with this requirement will in future become a condition for networks retaining their licences to operate.

22. A small number of local communities are reported to be considering ways in which they might, in relation to a range of conditions, introduce restrictions on certain medical interventions designed to prolong life where a reasonable quality of life is deemed to be absent.

23. The provider landscape becomes even more diverse in 2017 when several H&SCCAs, acting together, agree to finance a new national network of provider ambulatory care services, led by a coalition of inspirational religious leaders from the Catholic, Jewish and Islamic faiths. This new delivery network plans, initially, to offer services in specific locations within three Regions; London, Yorkshire and Humber and the North West. Whilst proposing to serve all local people who require treatment, the ethos of each campus is inevitably to be heavily influenced by the religious beliefs of the founders.

24. By 2018, notwithstanding all the new patterns of delivery brought about by this reinvigorated localism, the most significant change in many parts of England, fuelled by the rise of organised and well-financed 'grey power', is generally acknowledged to be with what used to be called residential care. Fusing the best design and care management practices evident in leisure services, assisted living, sheltered housing, residential care and nursing homes, new community controlled retirement 'villages' are now widely seen as the 'jewel in the crown', especially in certain, relatively prosperous and aged communities.

25. Strong evidence of a more embedded form of vibrant localism emerges in 2020, when it comes to light that the largest single group of health and social care workers, for the first time, are Community Medical Volunteers. CMVs typically are local people who have retired early and chosen to retrain as CMVs for their 'third age' careers. Although CMVs have multiple roles, the most common one is as a part-time self-care supporter, offering at home training and ongoing support to people about to embark on self-care management programmes.

In a few communities a ratio of one CMV Self-Care Supporter to 100 'active' patients is now within sight. CMVs are paid 'in-kind' by Local Authorities, via reductions or exemptions from the Council Tax and discounted or free access to a range of leisure and travel services. All these benefits in kind are free of tax. In some cases, CMVs also receive bonus points to accelerate their access into desirable Retirement Villages. CMVs, in some areas also have the right, collectively, to elect a member onto all local healthcare related Community Boards.

4 what's happening now

In 2003, seven social enterprises ranked among the Inner City 100, a nationwide league table for high growth businesses in deprived areas.

Scenario 3

Shopping for Health

‘Shopping for Health’

“.....The culture in the New Health sector resembles that of the Consumer Electronics industry of 2008. Creating a ‘buzz’ and offering personalised wellness packages are core requirements for success.....Sustaining well-nourished, psychologically literate, physically fit and cosmetically enhanced individuals is the core mission. The majority of wellness seeking consumers now choose to ignore the NHS and other treatment networks for this purpose.”

Key Features

- Potential scale of health and well being market is major driver of change
- Accelerated consumerism quickly brings ‘New Health economy’ into focus
- Market space filled by retailer led wellbeing ventures and online entrepreneurial start-ups
- Customers are seen as brand ‘role models’
- Explosion of private pay predictive testing and monitoring services
- GPs no longer regarded as gatekeepers
- State invests in Personal Health Funds for all citizens
- NHS becomes minor player in well being sector and tester of last resort
- Many GPs become personal health coaches
- Public Health reorientates to serving wellness consumers
- Comprehensive personal wellness clubs thrive
- Many employers insist staff participate in wellbeing programmes
- Lower treatment thresholds fuels big increase in demand for ‘curative’ services

The Story So Far.....

1. Fuelled by ever-growing disposable income levels, rising educational attainment levels and much more health literacy, an assertive consumerist society acts as a powerful magnet to thousands of new, privately owned health and wellbeing start-up organizations who seek a direct and sustained relationship with tens of millions of health seeking potential customers.

2. Initially, almost all new entrants are 'invisible competitors' to current, treatment - orientated NHS providers and, although diverse in nature, they are particularly likely to offer services where there are low barriers to entry. Consequently the majority of new well being entrants place online testing and self-testing at home at the centre of their business models; although a few do successfully promote 'gold standard' whole-body scanning and reporting services direct to consumers with the highest levels of disposable income.

1 what's happening now

Spending on vitamins and dietary supplements has risen by 52% over the last 10 years.

3. At the same time, already established, large food, entertainment and home ware retailers more openly attempt to 'wrestle' the lion's share of traditional 'face to face' health testing markets away from GPs and other NHS providers by winning wellness contracts from Strategic Commissioners. They are especially keen to win contracts that enable them to offer services to customers who 'live the brand' and act, albeit unconsciously, in ways that promote their brands.

4. In 2009 an explosion of targeted direct to consumer wellness advertising, largely 'hidden' from the NHS via internet advertising and direct mail, stimulates a sustained increase in demand for predictive testing services, health-maintaining home products and membership of online health status monitoring clubs. The vast majority of health-literate people do want to know if they are at risk of serious illness and the many who can afford it are very willing to pay private testing companies a few hundred pounds to find out. The more successful companies rent access to MRI scanners throughout the UK and offer customers a comprehensive full-body report together with follow-up advice.

5. In 2010 the NHS, somewhat reluctantly, becomes a level one sponsor of the new annual, week-long Health and Wellbeing Show, held at the NEC. More adults visit this trade show in its first year than visit Clothes Show Live. The H&W Show quickly establishes itself as the place where industry 'buzz' is created, trends are born and new markets emerge.

6. Media channels readily promote these new 'healthstyle' possibilities to millions of English middle-class consumers and within five years two of the three Sky Health Channels are available only via premium pay packages as consumer interest rockets.

7. The NHS's primary care sector offers functionally similar testing services to new niche private providers, but struggles to retain/gain market share as it fails to escape its reputational legacy and the entrenched perception that it is unresponsive and unfriendly.

8. However, by 2012 a few of the more strategically capable and agile NHS FT networks have managed to gain a foothold in wellness markets, successfully re-profiling their activities in favour of more health sustaining offerings. They succeed especially in winning health promotion contracts with local education authorities, opening up the opportunity to develop a lifetime relationship with future New Health consumers.

9. Parts of the NHS also succeed in orchestrating wellness opportunities for less wealthy individuals and families by exploiting collective purchasing power to create Public Wellness Clubs, offering discounted wellness opportunities, such as walking holidays and rentable high-priced health products to low-income families.

10. In April 2013 the NHS, nationally, begins to market itself openly and more wholeheartedly as a full 'wellness player' by promoting a free seven-part annual health check-up to all adults aged over 25, regardless of risk profile. Initial demand for this Keep Well service is extremely high - more than 19 million adults attempt to make use of the service in the first two years - though satisfaction levels are low as customers' expressed frustration about waiting times and particularly the absence of meaningful information and follow-up support. The service quickly becomes known as the 'nothing to report' service.

11. Increasingly, local public health departments are reorganising themselves. Most choose to merge with local Trading Standards units and focus on authenticating wellness claims from new market entrants to guide consumer buying choices. Others become social enterprises seeking to compete in the market, offering health promotion and well being consultancy services.

12. Faced with such an energetic, independently-minded wellness industry and voracious consumers the State, somewhat covertly, reluctantly removes itself from wellness policy making and focuses almost entirely on ensuring effective regulation, focusing especially on the licensing of suppliers and reviewing the efficacy of wellness offerings.

13. Wellness developments in England are mirrored by developments in the EU. In 2014, the European Commission promotes a new European-wide health status assessment tool. This quickly proves very popular with large employers and a covert unofficial personal health status threshold quickly begins to operate for people wishing to be considered for employment by most medium and large private employers.

14. There is an explosion of opportunities in the employee health management field. Many large employers, incentivised by the lure of a new Government tax credit, contract with private Employer Wellness services. It's not unusual for employees to be required to complete three online personal health and wellbeing surveys a month and demonstrate compliance with follow-up 'wellness guidance' distributed by their employers.

15. Confirmation that consumer-led wellness now is the new healthcare orthodoxy happens in late 2015, when it is widely reported that, for the first time ever, 10 of the FTSE 100 companies trade, overwhelmingly in what has become known as the New Health sector.

2 what's happening now

Alternative practitioners are now more numerous than GPs. We are now increasingly likely to choose a consultation with an alternative practitioner.

Pre-eminent amongst this group is NinHealth, a wholly-owned subsidiary of Nintendo Game. Almost 75% of all adults in Europe aged over 60 own one of their brain consoles and on average, owners spend 250 Euros per year on proprietory software.

16. In 2016 the incoming Government tries again to 'catch the tide' by introducing a scheme which provides a personal health fund at birth to every UK citizen. Each year the state invests a sum of money into everyone's account until 50 years of age. Up to 5% of the fund can be spent in any one year on approved wellness promoting activities and services, once the account holder reaches 25 years of age.

17. Paradoxically the ingrained assumption that the use of traditional hospital services will diminish as illnesses are spotted earlier, and people take more responsibility for their own health proved to be only half-true. Many illnesses are 'caught' earlier but the growth of a New Health culture leads to even more strain on NHS and privately-owned provider treatment networks as much better informed and anxious consumers dramatically lower their personal thresholds for seeking treatment.

18. Treatment, cure and care services still provided by traditional NHS hospitals still remain free at the point of delivery, financed from national tax revenues. However, the growing demand, fuelled by the lowering of personal treatment seeking thresholds, means that for many people long waits have returned. Private provider networks by contrast are increasingly serving patients with insurance coverage or the ability to make substantial co-pays.

19. The private New Health industry, which incorporates the vast majority of predictive testing, prevention promotion and health education offers, is either paid for direct by consumers or by their employers. Expenditure on wellbeing has grown enormously in the last 10 years and now, in 2018, the direct-to-consumer wellness market accounts for 40% of all healthcare and wellness expenditure in England.

20. Millions of people now look to private wellness companies for first line healthcare advice. As a consequence, GPs are not generally regarded as gatekeepers anymore. Far too many people have re-orientated their healthcare relationship towards private well being service providers for this model to remain meaningful. Close to 20% of General Physicians have left the NHS completely and become re-licensed as private Health Coaches. Health Coaching Practices typically offer personal testing, comprehensive behaviour modification support packages and employer facing wellness programmes. Twenty five percent of the adult population now has a regular relationship with a personal Health Coach.

21. The NHS still offers a free Wellness service, but it is commonly thought of as 'the tester of last resort', used by about 15 million adults, aged over 25, without the personal means and/or motivation to take advantage of private services. Typically these service users receive an annual 30 minute

3 what's happening now

In 2005 annual spend on Complementary and Alternative Medicines was estimated to be £4.5 billion and the market has grown by 50% in the last ten years.

wellness check at a NHS primary care centre close to their home or work and four-week follow-up encouragement phone call. A further three million adults, who lack the motivation to use the NHS Wellness service at all are championed by a vociferous coalition of Church groups and charities who argue that having full knowledge of one's health status ought now to be a basic human right.

22. In marked contrast to the marginalisation of traditional healthcare treatment providers, NHS owned Mental Health delivery networks are earning a well deserved reputation as behavioural change centres of excellence. It is now common to see Mental Health Provider Networks employ several hundred psychologists, counsellors and personal change consultants. These people work on a fee for service basis with millions of clients directly. They also offer professional supervision support to thousands of NHS-accredited personal Health Coaches (largely ex-GPs) and they design and run anxiety management programmes for large employers and school systems.

23. In 2018 the wellness market is maturing rapidly. The private sector dominates and six New Health networks dominate the landscape after successfully acquiring almost all of the promising wellness start-ups that sprang up 10 years before. Approximately 50% of the revenues for these influential wellness businesses come direct from employers keen to enroll their employees in mandatory schemes, incentivised by an extended tax credit system introduced by Government to help improve productivity levels as competition with emerging economies intensifies further.

24. However the New Health industry has succeeded also in persuading over 9 million adult members to take out personal wellness memberships. On average a wellness network member now pays £240 per month for comprehensive screening, testing, online status monitoring, 24/7 behaviour support and advice services as well as access to niche-designed health gyms and heavily discounted wellness products via club-wide buying groups.

25. As sequencing technology improves, five-yearly genetic testing is increasingly commonplace for many personal wellness members. However this testing is largely subject to further charges and sub-contracted to three large multinationals who dominate the global commercial genetic testing market. Full genomic sequencing is now be offered for £1750 per person. Personal risk profiles are legally non-disclosable unless the owner consents. Many insurance products are discounted if applicants can demonstrate that they own a personal risk profile that it less than 10 years old.

26. In 2020 clear evidence emerges that life expectancy has increased much faster than was expected for the majority of the population. However the 'inequality gap' has increased also, especially for males. One northern city has seen its life expectancy gap for males grow from 12 years in 2008 to 17.5 years in 2020.

27. Finally, in a move which initially shocked many local residents to the core, 16 Local Authorities recently concluded a landmark 'group' deal where FrescoHealth acquires a 25- year licence to operate 63 parks and open spaces. FrescoHealth plans to invest £72m in maintenance and investment in new health-supporting infrastructure, such as walking and jogging tracks, rowing facilities and yoga pits. Revamped 'wellness parks' will be open to all local residents via a healthcard operated entry system, provided each cardholder retains a balance of 12,000 points on their card.

4

what's happening **now**

The health and fitness industry is now worth £931m and has grown more than 40% over the past five years.

Scenario 4

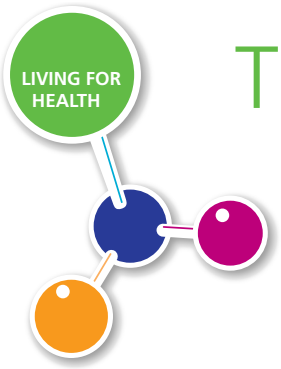
Living for Health

‘Living for Health’

“.....Massive economic, social and environmental shocks, coupled with devolved, democratised power force local communities to take far greater responsibility for rethinking what it is to be healthy. Many individuals quickly modify their lifestyles to reflect changing values. Those that do not change quickly enough experience growing levels of intolerance and community-imposed sanctions.”

Key Features

- External shocks create greater local sustainability and responsibility
- People increasingly see themselves as sustainers rather than consumers
- Health seen as product of broader policy and personal lifestyle choices
- Healthy living heavily influenced by design of built environment (transition towns and eco-villages etc)
- Policy making undertaken by Health and Wellbeing Commissions
- Community well being budgets are controlled by local people
- 22% of PCT revenue diverted to wellness activities overseen by Local Authorities
- Aggressive pursuit of provider productivity gains results in significant NHS job losses
- Technologies that enable virtual and real community formation flourish
- Local services predominate
- Devolved local democracy transforms political landscape
- Local leaders emerge from health advocate movement
- ‘Green care’ becomes organising principle of a modern NHS
- Some communities accused of introducing ‘health dictatorships’



The Story So Far…….

1 what's happening now

36 English towns and cities are now officially part of the Transition Initiative, aiming to find ways of living resourcefully in the light of peak oil and climate change challenges.

1. In 2008, the Government initiates a series of devolution initiatives as part of their constitutional reform agenda. Encouraged by these 'weak signals' a more animated public debate quickly begins about the extent to which Constitutional reform might include the further devolution of substantial responsibility for NHS policy making and resource allocation to regions and local communities.

2. The key focus for this debate is how to re-focus healthcare on the pursuit of well being so that sustaining the health of local people truly becomes paramount. Advocates of accelerated devolution point to several supporting factors:

- The EU, is seeking to 'reach around' national governments, in order to connect more directly with regions;
- Devolution within the UK means that parliaments and assemblies are already pursuing different policies across a range of areas including health;
- Developments in education and housing, including the concept of local business and parent involvement in the management of schools and the transfer of public housing to tenant-controlled Housing Associations; and
- The NHS Foundation Trust movement already has more than 500,000 local people 'in membership' with forecasts suggesting membership will increase to over five million by 2013.

3. By 2009, the continued resistance of certain cohorts within the population to changing their lifestyles leads to overt and sustained public pressure to restrict the availability of welfare services to those that are thought to be deserving. This pressure, combined with a growing appreciation within the Treasury about the growing unaffordability of healthcare in the light of the 2007 credit crunch, the needs of an ageing population and the requirement to cope better with the consequences of the obesity epidemic and continuing excess alcohol consumption causes Treasury modellers to begin to openly advocate shifting the burden of cost control (and the political flak associated with exclusion) away from the Centre.

4. Despite these pressures, national government is still somewhat reluctant to 'let go' of the NHS. It remains unconvinced that there is strong evidence of local communities having a real appetite to accept more collective responsibility for key public services. Accelerated devolution, despite the political attractions, is thought only likely if enormous amounts of new social capital can be generated and hopes are not high that this can be achieved in the next 10 years, if ever.

5. However, all this changes as the UK begins to experience a series of major stresses and challenges, lasting from 2011 – 2018, that shake it to its core.

6. 'Shocks' include:

- Extensive flooding on a regular basis, throughout English lowlands
- Oil increasing to $200 per barrel
- Major occasional disruptions to gas supplies throughout Europe as a consequence of actions by gas exporters attempting to ratchet up the prices
- The return of intermittent electricity rationing for businesses as a consequence of national grid shortages
- Stagnation of the UK economy
- The public mooting of petrol rationing for the first time since WWII and the introduction of personal air mile trading schemes to restrict use.
- Increasingly 'unfit' public infrastructure

as a result of resources having to be diverted into coping with the impact of climate change.

7. These 'shocks' begin to shift ingrained attitudes and behaviour. An influential and substantial minority of the UK population quickly begin to see themselves as Sustainers rather than Consumers and with surprising speed, they change the landscape of public debate.

8. For the first time, the requirements of integrity, justice and earned entitlements are challenging the English welfare state's longstanding egalitarian goal of seeking 'health' for everybody.

9. By mid 2012, aggressive downsizing of life styles is becoming commonplace and previously considered fringe phenomena like transition towns, eco-villages and farmers markets are quickly becoming mainstream. The associated recognition that prevention is better than cure is driven by increasingly sophisticated social marketing techniques, spearheaded by the new Department of Sustainable Living that has emerged from the break-up of DEFRA.

10. In 2013 significant levels of social and political unrest culminate in an almost complete loss of confidence in the English State's ability to organise and manage civil affairs. A new coalition Government takes power, only to quickly realise that a single central response to such fundamental change is inappropriate and that for now at least, more local solutions – and local responses to the unpalatable decisions necessitated by the crisis - are necessary.

11. By 2014, after extensive and often acrimonious consultation, the Government responds to all of these forces and factors by introducing a new Public Health Act for the 21st century – 'Towards Well Being Promoting Communities' – that introduces sweeping changes to the form of the 'welfare state' and its funding by devolving further powers to local level . Of particular note for healthcare systems are provisions in the new Act that require:

- The mandatory diversion of 7% of annual PCT healthcare revenues into Community Wellbeing Funds (CWFs), administered by local authorities and to be spent on community-determined priorities for wellness cultivation. This figure is required to increase to a minimum of 22% by 2019.
- The ability of local communities to supplement CWFs by the creation of new mutual schemes that collect and distribute additional wellness funds, according to local priorities.
- The requirement that all local healthcare investment (below £25m at 2008 prices) requires a community wellness dividend to be negotiated with the investor, with proceeds passing into CWFs.

2 what's happening now

Estimates of UK gas reserves amounted to 412 billion cubic metres in 2006, 14.3 per cent lower than the 481 billion tonnes recorded a year earlier. The level of gas extraction was 78 billion cubic metres in 2006, the lowest since 1995.

12. In 2015, in the slipstream of the new Act, SHAs are disbanded. Policy making in future is to be formulated by 100 locally elected Health and Well Being Commissions (HWCs) which have a defined membership of 99 people (one third clinicians, one third managers from local providers and one third local people elected directly from local communities). At least 50% of Commission members must be drawn from ethnic minorities, the elderly community (over 65s) or be female. Commissions must be chaired by one of the elected public members.

13. To some extent, this new policymaking process is facilitated by the grasping of the opportunities available to ambitious and determined local groups and individuals to 'make their mark'. However, this much more diffuse and contested process ensures that local systems quickly begin to have very distinct characteristics. The proliferation of belief systems and multiculturalism encourages further differentiation and frequent tensions.

14. PCTs remain throughout this period of civil unrest and continue to contract with more traditional delivery networks for treatment-orientated services, but now they are servants of their local HWC, with PCT boards subject to reappointment by the Chair of the relevant HWC. Faced with the certainty of needing to fund Community Wellness Funds in full within 11 years by releasing 22% of revenue expenditure, PCTs and providers adopt a much more focused attitude to realising productivity gains. Nationally more than 175,000 NHS jobs are forecast to be lost in the next seven years, including a sizeable number through targeted compulsory redundancies.

15. Of particular interest to H&WBCs is the extent to which PCTs seek to tackle 'head on' the reduction in 'heroic' yet futile interventions to prolong life, as this area of activity clearly offers up the greatest opportunity to divert resources from treatment activity to primary and secondary prevention initiatives.

16. Over time, the contractual currency used by PCTs with acute providers is modified to reflect widespread public concerns about sustainable development. Although difficult to see now, within four years no PCT will dare to contract with a treatment provider that is not carbon neutral.

17. By 2018 local communities with 'radical' populations and a clear consensus about core values are deemed 'eco communities' where the whole health and well being system is aligned to the promotion of self help and sustainability. Here there is widespread acceptance of the need to invest in wellbeing, supplementing state CWF allocations by, on average, a further 25% raised through local mutual schemes.

18. Most eco-communities have wrestled control of CWFs from local authorities. Typically in eco-communities, CWFs are now administered by new Community Wellness Trusts, led by elected local health activists. These new wellness commissioning organisations can be formed if more than 25% of local people sign a petition calling for their introduction. A full community-wide vote is then held and CWTs

3 what's happening now

More than half of respondents had at least five people they could turn to in a serious personal crisis (58 per cent), 18 per cent had less than three people they could turn to. One in fifty (2 per cent) said they had nobody to turn to.

are formed if more than 50% of local people vote in favour of their introduction.

19. By 2019 most Community Wellness Trusts are thought to be highly successful at making the pursuit of wellness an organising dynamic of their local communities. Compared with communities that continue to be served by Local Authorities, CWTs are much bolder at introducing principles of community development into the core of their commissioning intentions. They excel at:

- Exploiting the power of peer to peer networks by creating and sustaining large numbers of locally trained health advocates who work street by street to promote health seeking behaviour
- Investing in community-led health literacy and health awareness programmes and the development of emotional resilience embedded in educational curricula at all levels
- Introducing and encouraging discerning use of assistive technologies to support group care (a new model of self-care where clients form local groups to support each other with treatment and care needs, share expensive equipment and educate each other in disease management techniques)
- Enabling people to thrive in community-authorised virtual wellness communities of interest where the efficacy or otherwise of predictive testing is widely discussed
- Ensuring that the provision of social care for older and disabled people is validated as secondary prevention and delivered to much higher standards
- Ensuring the availability of a much broader range of complementary therapies
- Encouraging the formation of social enterprises staffed by large numbers of local people, who often have been re-trained in local wellness colleges

20. Communities with CWTs also tend to much less tolerant of unhealthy living, considering this a form of anti-social behaviour. Aided by the pervasive use of micro-surveillance technology, individuals, families and groups who refuse to modify certain health-damaging behaviour increasingly find themselves banned or having disadvantaged access to certain treatment and care services. Usually this community imposed sanction is triggered via local referenda, but this has not stopped more liberal media and societal commentators branding these communities as health dictatorships.

21. By 2020, many CWTs are overtly political in nature, regularly fielding or approving candidates in Local Authority elections. Eighteen Local Authorities now have CWT approved Mayors.

22. By contrast, in more culturally and economically diverse communities that continue to have their Wellness Funds administered by local authorities, there are real concerns about the impact of devolved decision making powers on levels of community cohesion. Social tensions are heightened and in some places police begin to record some crime as 'health-hate' crime.

23. Notwithstanding these tensions, research shows that the massive increased investment in community controlled wellness activities over the last 10 years has led, on the whole to much more contented communities, a moderate reduction in demand for 'curative' services, increased life expectancy above forecasted levels of improvement and, most significantly, a reduction in life expectancy 'gaps' for men and women in all but a few, highly problematic and well-known communities.

4 what's happening now

The proportion of household waste per person collected for recycling or composting increased from 7 per cent in 1996/97 to 26 per cent in 2005/06.

Appendices

Appendix 1

The Scenario Building Process

Building the scenarios has taken approximately 12 months. The process has had 3 broad phases.

Phase I - (3 months)

Collecting insights about what a successful NHS might look like in 2020 via 107 one-to-one interviews with senior NHS managers and clinicians, Local Authority officers and members, local MPs, third sector leaders and representatives of private sector healthcare providers.

Phase 2 - (3 months)

Creating 'sketch' scenarios in 5 scenario building workshops. Each workshop had 40 - 70 people working together over a 24 hour period, using a tested construction methodology. Participants used 24 high impact/high uncertainty questions, distilled from the phase 1 interviews, as the starting point for the generation of the various sketch scenarios.

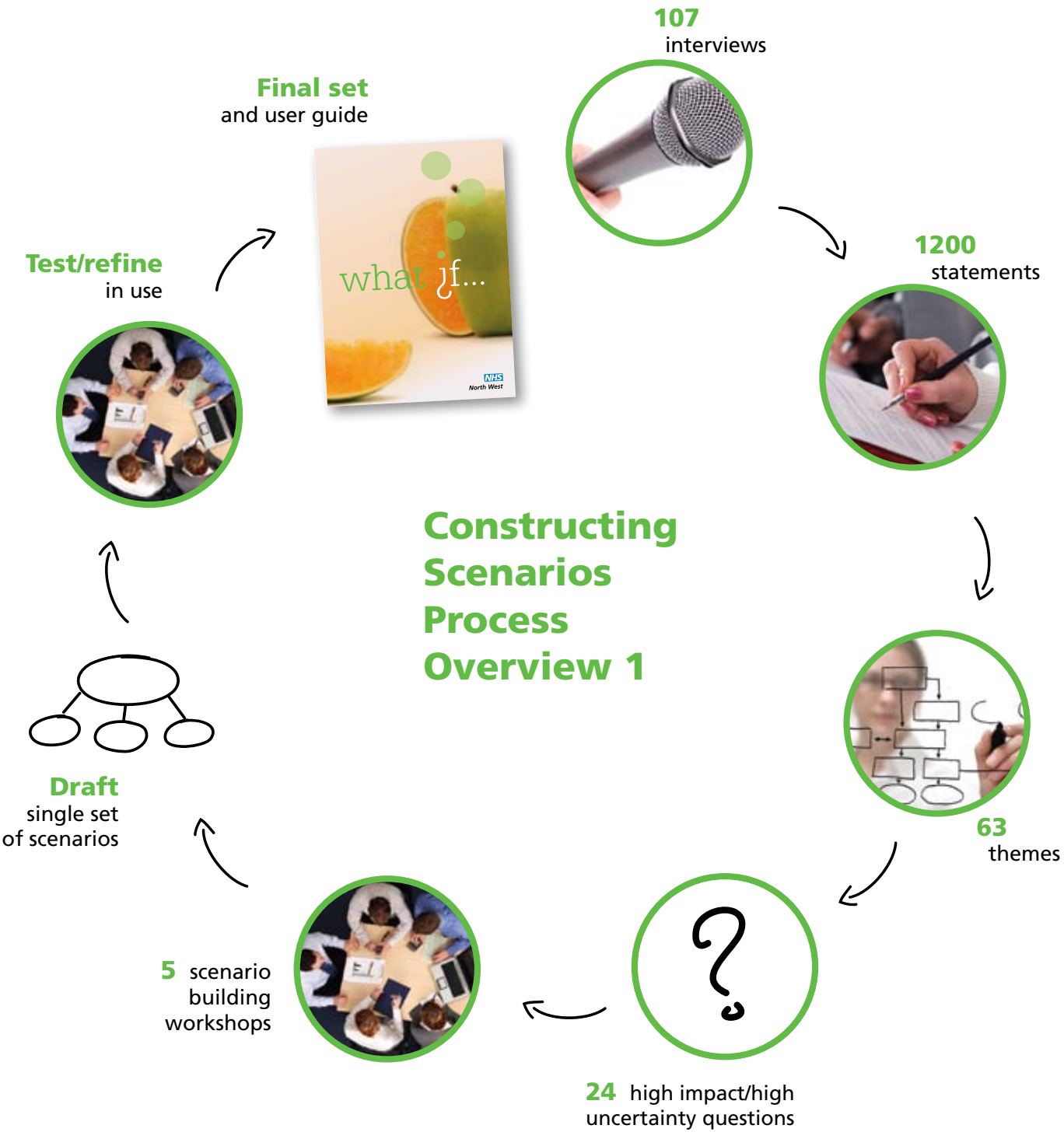
Phase 3 – (6 months)

Drafting and refining the scenarios via ongoing dialogue with members of the Advisory Group (see Appendix 2) and via early stage testing in workshops with a local NHS PCT board, a Local Strategic Partnership board and with 3 international organisations. The User handbook was also created in this phase of the programme.

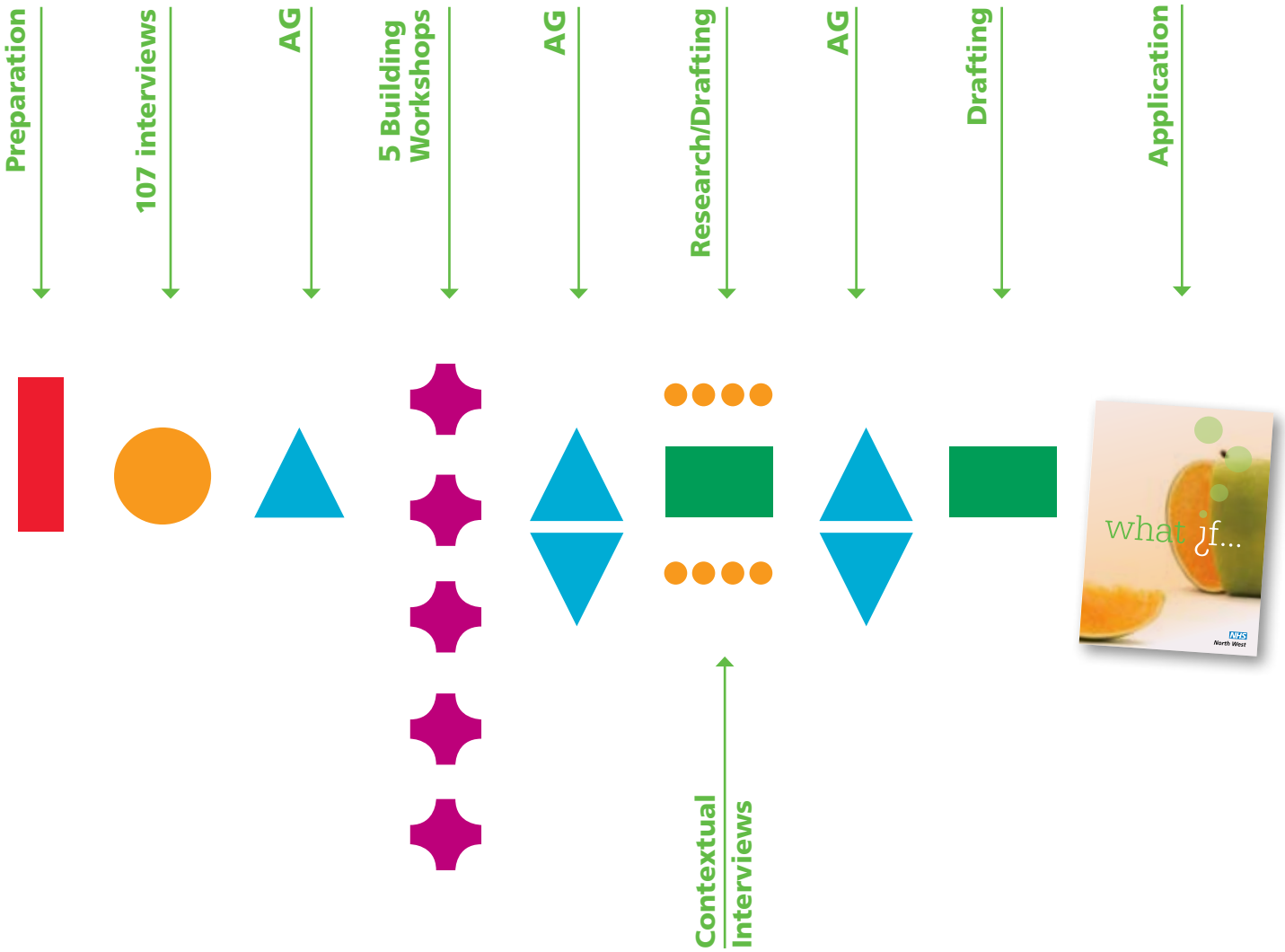
This process is illustrated by graphics overleaf.

Process

- 107 interviews
- 24 high impact/high uncertainty questions
- 5 scenario building workshops
- Draft single set of scenarios
- Test / refine in use
- Final set and user guide



Constructing Scenarios Process Overview 2



The 24 High Impact and High Uncertainty Questions

1. What might the first 10 years of our lives be like?
2. *What might the last 10 years of our lives be like?*
3. How might strategic commissioning evolve?
4. *What impact might new medical technologies have?*
5. What impact might genetics and new pharmacological developments have?
6. *What might happen if individuals became real consumers of healthcare and wellbeing services?*
7. What key new roles might emerge?
8. *How might competition and collaboration co-exist?*
9. What form might leadership of healthcare and wellbeing systems take?
10. *How might healthcare and wellbeing systems be paid for?*
11. Where might entrepreneurialism lead?
12. *How might a more informed and knowledgeable society change healthcare and wellbeing systems?*
13. What might happen if the search for better outcomes really drove behaviour?
14. *What might happen to the balance between care and cure?*
15. What might a truly efficient health and wellbeing system look like?
16. *What might a prediction, prevention and promotion system look like?*
17. What might the future landscape for healthcare services look like?
18. *How might climate change impact on healthcare and wellbeing systems?*
19. What impact might the increasing globalisation of economics have?
20. *What might be different if the priority was to reduce health inequalities?*
21. What might be different if the priority were to maximise everyone's health potential?
22. *How might accelerating population migration impact on healthcare and wellbeing systems?*
23. How might information technology impact on healthcare and wellbeing systems?
24. *How might politics exert more of an influence on the nature of healthcare and wellbeing systems?*

Workshop Outcomes

Appendix 1

5 defining characteristics

How **11** key questions are handled

3 or **4** tipping points

3 things that appeal

What values lie at the heart of the scenario?

How is policy formulated?

Who has overall responsibility for system priorities and coordination?

Where does power lie?

What are the key features of system organisation and provision?

What happens to demand?

What happens to costs?

Who pays and how?

How does technology play in?

What form do inequalities take?

What roles have changed the most?

Appendix II

Members of the Advisory Group

Val Aherne	Director of Strategy, East Cheshire Trust
Evelyn Asante-Mensah	Chair, Manchester PCT
Andy Black	Chief Executive, Durrow Consulting
John Burnside	Chief Executive, North West Ambulance Service
Neil Campbell	Chief Executive, Alternative Group
David Dalton	Chief Executive, Salford Royal NHS Foundation Trust
Shauna Dixon	Executive Director of Clinical Leadership, Oldham PCT
Mike Dwan	Managing Partner, Equity Solutions
Stephen Eames	Chief Executive, Mid Cheshire Hospitals NHS Trust
Louise Edwards	Assistant Director, Commissioning and Strategy NHS North West
Nigel Edwards	Director of Policy, NHS Confederation
Steve Henderson	Medical Director, NHS North West
Paul Hodgkin	Chief Executive, Patient Opinion
Judith Griffin	Chief Executive, Blackburn with Darwen PCT
Richard Jones	Executive Director, Adult & Community Services, Lancashire County Council
Richard Leese	Council Leader, Manchester City Council
Denis Lidstone	Non Executive Director, NHS North West
Gerry Marchand	Consultant to Strategy and Commissioning Directorate, NHS North West
Alison Norman	Director of Nursing, Christie Hospitals NHS Trust
Trevor Purt	Chief Executive, Heywood and Rochdale PCT
Mike Pyrah	Chief Executive, Central and Eastern Cheshire PCT
Sandra Shannon	Director of Operations, St. Helens and Knowsley NHS Trust
Mark Wilkinson	Chief Executive, Central Lancashire PCT
Alan Yates	Chief Executive, Merseycare NHS Trust

Resource Aids

See separate laminated sheets in folder pocket

Scenario Users' Handbook

For a copy, please contact **Helen Chainey**,
Executive Assistant to Joe Rafferty,
Director of Strategy & Commissioning
NHS North West

helen.chainey@northwest.nhs.uk

0161 625 7130