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Pointmaker

HOW MUCH DO WE USE THE NHS?

INTRODUCING ANNUAL HEALTH STATEMENTS

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SUMMARY

- The cost of healthcare in the UK has long been rising significantly faster than inflation, creating a serious budget issue for governments past, present and future.
- Attempts to improve efficiency within the NHS have increasingly focused on limiting unnecessary demand for healthcare.
- This includes pressure on A&E departments, where unnecessary visits have been estimated to cost over £100 million a year, and on primary care, where there are an estimated 51 million unneeded visits a year.
- The annual cost of unnecessary or missed GP, A&E and outpatient visits is estimated at £1 billion a year.
- This paper examines the idea of Annual Healthcare Statements, a new means to limit unnecessary demands on the NHS. As with an annual bank, ISA or pension statement, each individual user of the NHS would receive a Healthcare Statement every year.
- The user would be able to see which services they had received over the past 12 months, and examine and understand the costs (and by implication appreciate the value) of those services to the NHS.
- Where the same or similar service could be provided less expensively – say by visiting their GP rather than A&E – they would also be able to see the savings to be made.
- Over time, it might also be possible to add specific incentives to encourage users to make more appropriate use of the NHS, at little or no cost to themselves.
- Healthcare Statements are simple and transparent. They have the potential to save the NHS hundreds of millions of pounds every year, by encouraging users to change their behaviour and to take greater personal responsibility.

1. RISING HEALTHCARE COSTS

The problem of rising healthcare costs can be simply stated. In the words of the authors of *Freakonomics*, Steve Levitt and Stephen Dubner:

"While the goal of free, unlimited, lifetime health care is laudable, the economics are tricky… Under a setup like the UK's, health care is virtually the only part of the economy where individuals can go out and get nearly any service they need and pay close to zero, whether the actual cost is $100 or $100,000. What's wrong with that? When people don't pay the true cost of something, they tend to consume it inefficiently… the 'worried well' crowd out the truly sick, wait times increase for everyone, and a massive share of the costs go to the final months of elderly patients' lives, often without real advantage."

How serious is this problem? In 2012 a Nuffield Trust report stated that "*Cost pressures on the NHS are projected to grow at around 4% a year up to 2021/22. These arise from growing demand for health care – to meet the needs of a population which is ageing, growing in size, and experiencing more chronic disease. They also result from increases in the cost of providing health care – of which the largest item is workforce pay.*"[1]

To address the issue, in 2009 the then-Chief Executive of the NHS David Nicholson issued what has become known as the Nicholson Challenge: to make £20 billion in savings by 2015. As a result the NHS has been budgeting for a 0% real terms increase in funding over 2011-15, and looking to make direct cost savings and productivity enhancements of 3% to fill the gap. The scale of the challenge becomes clearer given that the NHS achieved just 0.4% annual gains in productivity over the period 1995-2010.

2. SOURCES OF SAVINGS

Overall, Nicholson anticipated that around 40% of a projected £20 billion in savings would be achieved at the local level through "*traditional efficiency*" gains, incentivised through the Payment by Results (PbR) system. A further 40% would come from "*central initiatives*". The most significant of these would come through the 2010 Budget public sector pay policy, but also included cuts to some central budgets, and large reductions in managerial headcount. The remaining 20% was vague, but broadly expected to come from new ways of conceiving and delivering services.

Meanwhile political and public opposition to charging for NHS services remains strong. In November 2013 the think tank Reform published *The cost of our health: the role of charging in healthcare*, a report which noted that other countries charged for a greater range of prescriptions, for visits to GPs, and for some hospital care. Estimating that similar changes in the UK would raise nearly £3 billion a year, net of exclusions for the vulnerable and those on low incomes, the report argued that they would broaden the NHS's funding base, and reduce reliance on general taxation. In March 2014 a report for the same think tank by Lord Warner, Minister for Health Reform under Tony Blair, advocated a £10 per month membership charge for the NHS, and a charge of £20 per night to stay in hospital.[2] But these proposals attracted a good deal of public criticism, and all political parties have distanced themselves from them.

[1] Nuffield Trust *"A decade of austerity?"* 2012.

[2] Reform *"The cost of our health: the role of charging in healthcare"* 2013.

One of the authors of this paper, Jesse Norman, has previously argued that there are billions of pounds of potential savings for the NHS from the Private Finance Initiative (PFI). HM Treasury estimates that Government reforms to PFI contracting practice to date have saved £1.5 billion in future costs (most of which will fall outside the period 2011-15).[3] It remains the case that hundreds of millions of pounds, and potentially billions of pounds, could be saved by more rigorous enforcement of contracts by the NHS and by individual NHS Trusts.

3. MANAGING EVER INCREASING (AND UNNECESSARY) DEMAND

Alongside a drive for savings has come an increased focus within the NHS on nurturing more responsible consumer demand for NHS services, most notably A&E and GP services.

In 2012 it was reported that the NHS was conducting an inquiry into the reasons why people in England and Wales make more than 51 million unnecessary visits to their GPs every year. According to *PharmaTimes* "*Figures show that 51.4 million people every year visit their GP with minor problems which would clear up by themselves or through use of an over-the-counter (OTC) remedy. These include as many as 40,000 GP visits a year for dandruff, 20,000 for travel sickness and 5.2 million for blocked noses.*"[4]

The evidence of the cost to the NHS from missed appointments is compelling; this is especially clear for GP practices. For example, in March 2014 NHS England announced that "*more than 12 million GP appointments are missed each year in the UK, costing in excess of £162 million per year. A further 6.9 million outpatient hospital appointments are missed each year in the UK, costing an average of £108 per appointment in 2012/13.*"[5] If true, this would imply a further cost of some £700 million a year.

As regards A&E, visits were broadly stable overall between 1987-8 and 2002-3, when the measurement methods were changed. Between 2003-4 and 2010-11 (and allowing for the change) A&E visits have risen by 30%.[6] A further study found that visits to emergency departments rose by 20% between 2007-8 and 2011-12[7].

The reasons for this rise are the subject of considerable debate. But what is clear is that there is a significant drain on A&E resources from what is in reality unnecessary demand. A BBC survey of hospital trusts on 183 sites in 2014 found that nearly 12,000 people made more than 10 visits to the same A&E unit in 2012-13 and a small number of those attended more than 50 times.[8] Analysis by the Nuffield Trust found that "*people attending A&E more than 10 times in one year are typically between 20 and 55 years old. Patients in their 40s are particularly over-represented compared with all users of A&E… more than 90 per cent of frequent users are registered with a GP… Deprivation plays a part, but not as much as you might think. Although half of regular*

3 HM Treasury *"A new approach to public private partnerships"* 2012.

4 PharmaTimes *"NHS to probe 51 million "unnecessary" GP visits per year"* 2012.

5 NHS England *"NHS England using technology to beat cost of missed appointments"* 2014.

6 Nuffield Trust *"A&E attendances in England"* 2013.

7 Cowling et al. *"Access to Primary Care and Visits to Emergency Departments in England: A Cross-Sectional, Population-Based Study"* 2013.

8 Nuffield Trust *"Come again? What the data tells us about repeat A&E visits"* 2014.

attenders live in the 20 per cent most deprived areas, 10 per cent of regular A&E attenders live in the top fifth most affluent areas."

What is the cost of unnecessary demands on A&E? A 2011 analysis by the Co-op Pharmacy of A&E attendances over four years suggested that each year "*two million Britons visit A&E Departments unnecessarily, costing the NHS £136 million - the equivalent of employing almost 6,500 nurses or 3,700 doctors… around 450,000 people leave A&E Departments without ever being seen by doctors or nurses.*"[9] A further study by the Co-op found that "*many A&E attendances were unnecessary or inappropriate as half of those questioned admitted to going to emergency departments for minor ailments which could be treated far more quickly at a walk in centre, GP surgery or pharmacy*." The most prevalent minor conditions presented were sprained muscle, stomach ache, stubbed toe and minor burn. Other illnesses or injuries included being drunk, cystitis and insect bites.[10]

It should be emphasised that the figures above are far from satisfactory. There may well be overlaps between different categories (e.g. "*unnecessary*" and "*missed*" GP appointments). Moreover there is plenty of evidence that as with many large organisations the NHS does not have a clear understanding of its own costs – see below.

Estimates for the cost of a GP appointment range between £10 and £25, with A&E attendance costing over £100 a visit – and more in the case of an admission to hospital. Drawing all this together, the broad scale of the gross cost of unnecessary use of GP services and A&E is likely to be well over £300 million a year. If missed outpatient appointments are included, this would rise to £1 billion a year. This is a gross cost, which does not reflect the fact that the time from missed appointments may well be used valuably in other ways. But nevertheless it is a huge target at which to aim for savings.

4. CHANGING CONSUMER BEHAVIOUR

Annual Healthcare Statements would use information to try to change behaviour. This approach has achieved great prominence due to the rapid growth in the literature on behavioural economics after the pioneering work of Daniel Kahneman and Amos Tversky, and aspects of it have proven controversial on occasion. But the general idea is extremely familiar and it has proven effective in other contexts.

Take energy consumption. One of the best established behavioural phenomena is that of "*social proof*" developed over 30 years by Robert Cialdini: the idea that people will want to do what they know others are already doing.[11] The US firm Opower uses this to get its utility clients to help their customers to reduce their consumption. The firm achieves this by adding a simple three-bar graph to each electricity bill; one bar for the customer's usage, one for the neighbourhood average and one for that of the most frugal customers.

But there was a twist. The effect of the graph was twofold: the highest users used less energy but many lower users used more, as though they had been given permission to do so. Opower solved this problem by printing a smiley face on bills to 'reward' those who had saved energy. The result was a reduction in

[9] The Co-operative Group *"Reducing needless A&E visits could save NHS millions"* 2011.

[10] Ibid.

[11] Robert Cialdini *"Influence: The Psychology of Persuasion"* 1984.

energy use by 2-3%, a significant amount in cash terms.

In a similar spirit in 2011 the Coalition Government initiated a series of trials and informational changes designed to reduce energy consumption in its paper *Behaviour change and energy use.* Leading the way within the Government has been its new Behavioural Insights Team (BIT). Since its establishment BIT has been effective in using information to change behaviour. Its work highlights the value of tying information to descriptive norms – highlighting how many other people act in a desired way. To take one example, it was able to increase the timely rates of self-assessed tax payment by 5% by this means.

Separately the co-author of this article Museji Takolia has found that behavioural economists have predicted the pattern of consumer preferences and choice in the world of auto-enrolled pension schemes too. Successfully 'nudging' the behaviour of millions of consumers of pensions in schemes like the National Employment Savings Trust (NEST) has had remarkable success, with a much lower than predicted percentage of those who were automatically enrolled by their employers choosing to opt out; in some cases lower than 10% of savers. The effect of this is that today nearly 90% of auto-enrolled savers in schemes like NEST and others have started to save towards an occupational pension scheme, many for the first time in their lives.

A further important precedent is provided by Tax Statements. The brainchild of Ben Gummer MP, these Statements are now being introduced across the UK over time. Ultimately every taxpayer will receive an itemised tax bill showing how his or her tax is being spent across all major areas of public spending. Tax Statements thus improve transparency without tying information to specific norms or expected behaviour.

According to survey data from the Office of National Statistics, in 2012/2013 households on average received £4000 worth of benefits from the NHS.[12] The healthcare system is designed such that patients are not customers of healthcare, but supplicants. The true costs of the services rendered by a doctor or a nurse are never shared with those in their care. This introduces an inefficiency, as a customer is an important actor in an exchange of goods or services. If individuals were informed of the cost of their healthcare, they might begin to behave more like customers. The resulting consumer pressure would be a beneficial force for improvement in NHS services.

5. INTRODUCING ANNUAL HEALTHCARE STATEMENTS

As with an annual bank, ISA or pension statement, each individual user of the NHS would receive a Healthcare Statement every year. The user would be able to see what services they had received over the past 12 months and the cost of those services to the NHS. Where the same or similar service could be provided less expensively – say by visiting their GP rather than A&E – they might also be able to see the savings to be made. Over time it might also be possible to add specific incentives to encourage users to use the NHS less expensively at little or no cost to themselves.

5.1 Information

Like Tax Statements, Healthcare Statements are designed to present annual information to individuals in a highly accessible form. In

[12] Office of National Statistics *"The Effects of Taxes and Benefits on Household Income, 2012/13"* 2014.

principle this could be done at any or all of several levels. In informational terms four such levels can be identified:

1. Basic Numerical: including for example number of visits to the individual's GP, A&E department, outpatient facility, community hospital or district hospital, recording attendance and missed appointments;

2. Numerical Plus: including information highlighting unnecessary visits, and/or visits for conditions which do not require the level of service used;

3. Basic Cost: including the cost of different visits so that the individual can see the (local) cost of their decisions;

4. Savings: including savings achievable by the patient making lower-cost decisions with the same or similar health outcomes.

It should be noted that the scope for savings under (4) is potentially large. For example a 2013 CPS Policy Proposal by Dr Paul Goldsmith suggested that NICE drug recommendations should take into account patent expiry dates. Since two medications of identical efficacy and cost may have different expiry dates, this would allow patients to elect to be treated by a medication for which generic alternatives would sooner be available. Dr Goldsmith has estimated that this modest reform alone could save the NHS hundreds of millions of pounds a year.

5.2 Norms

However there are also at least two normative dimensions as well:

A. Normative: including graphical information relating the individual's usage to local or national averages;

B. Normative Plus: including evaluative language or symbols to identify appropriate norms or levels of usage for each service.

Here (A) gives a first degree of 'social proof', while (B) gives a clear nudge towards desired alternatives.

As this makes clear, the idea of Healthcare Statements is an extremely flexible one. In their most basic form they can be used to convey purely factual information (1, 2, 3, 4). However each level of factual information can also in principle be combined with a particular normative dimension (1A, 2A, 3A, 4A; or 1B, 2B, 3B, 4B). Altogether this gives 12 distinct possible approaches.

5.3 Roll-out

Behavioural economics is far from an exact science; sometimes approaches that have become standard fail to work while previously dismissed alternatives show unexpected value. As researchers have found, the best procedure is an experimental one: to run trials of different alternatives against a control case and see what works in the circumstances.

Healthcare Statements lend themselves to this procedure. In principle it should not be difficult to design different statement formats presenting different information and perhaps different normative cues. These could then be tested in a variety of contexts, perhaps targeting areas of the country and demographics where there is already real concern of unnecessary demand for A&E or GP services.

Over time a significant body of information would build up as to best practice, allowing for further improvement in the design and application of the Statements. The ratio of costs to benefits for the Statements

themselves is likely to be extremely favourable – as seen above the likely cost of unnecessary use of GPs and A&E, and missed outpatient appointments is £1 billion per year – but this too could be better assessed and understood.

6. ISSUES AND CONCERNS

Annual Healthcare Statements have potential as a mechanism for promoting positive behavioural change and reducing costs in the NHS. But there are several important possible concerns and issues about them that will need to be addressed before they can be adopted.

6.1 They will cost too much to implement

It is not at this stage possible to assess the cost of implementation of Annual Healthcare Statements, in part because in many areas the NHS does not have a secure understanding of its own costs at all. Undoubtedly there will be higher unit costs in the early stages, both of production and distribution. But these costs are almost certainly a small fraction of the likely benefits to be realised. Higher early unit costs will likely be more than offset by the benefits per patient that will be achieved by focusing on areas of high need or unnecessary demand, following the suggested roll-out.

6.2 Nudges are illiberal

A more general worry about behavioural prompts is that they are somehow illiberal; that people should be free to make up their own minds without being nudged in any direction. The difficulty with this view is that nudges are everywhere already: any provision of information contains potential nudges, nudges are implicit in any group activity and all commercial marketing and advertising is designed to encourage specific forms of behaviour. So the question is not whether people are nudged in a certain direction, but how they are nudged. Healthcare Statements provide useful information, and could provide useful cues to healthy behaviour as well.

6.3 Wouldn't legislation be preferable to behavioural change?

Another worry is the opposite: that nudges are too liberal and what is really needed is legislation. But what kinds of legislation could substitute for the intended effects of Healthcare Statements? Rules requiring people not to visit A&E when they could go to a GP? Or to use telemedicine rather than visit a GP's surgery? Such rules would be illiberal and counterproductive.

6.4 What happens if they nudge people away from services they need?

Healthcare Statements are informational in nature, but information alone can prompt certain actions; and the Statements can themselves include specific cues and nudges, as previously mentioned. What happens if an individual is prompted in an unintended way, say to visit their GP when they need to go to A&E?

It is only part of an answer to say that this happens already and that the net effect of Statements will be to create more resources for those who are in need. The Statements will have to be tested and rolled out carefully to minimise risk. In addition in end-of-life contexts special care will have to be taken to prevent patients from seeing themselves as burdens on their families or on the NHS if cost information is included.

6.5 Could Healthcare Statements get co-opted by special interests?

Of course Healthcare Statements are not a panacea; they are open to abuse as is any form of communication. So the possibility exists that they could be used to bolster one part of the NHS mistakenly at the expense of another. But the risk of this is surely small,

especially given a properly staged and tested roll-out.

7. COST INFORMATION

There is however one serious issue which would need to be tackled for Healthcare Statements to be optimally effective. This is that the NHS – with a total budget of £125 billion a year and 1.7 million staff – still has a surprisingly weak understanding of its own costs and cost structures.

To see this take a simple question: how much does a GP appointment cost? Intriguingly freedom of information requests have been denied by the NHS on this basic question. As previously mentioned estimates for the cost of a GP appointment range between £10 and at least £25, a factor of 2.5. One can estimate as to the direct costs – broadly speaking this is the number of appointments per year for each GP divided by the pro rata amount of the GP's salary, staff time and expenses incurred, plus the cost of any medicines or other items used in the surgery. There is then a further question of the indirect cost to be attributed including pro rata overheads, administrative costs, pensions etc. These will vary by location, quality of management and various other factors.

As this shows even basic cases of cost assessment can be complex; but now think how much harder this is for an A&E department, with all the additional one-off items, interdependencies and associated on-costs. Or for other parts of hospital care including those aimed at wider public health benefits. Moreover there is a deeper issue: the danger that even the idea of a cost becomes merely notional in a system where so many costs are attributed purely internally.

But all this constitutes a further and final argument for the importance of Healthcare Statements. After all, some parts of the NHS understand their costs quite well, as do some private hospitals and private health insurers. What is required is for healthcare providers to become much more accurate with regards to their data collection and attribution of costs.

Healthcare Statements will force key parts of the NHS itself to become more effective about cost assessment, attribution and control. That in itself is a strong reason to adopt them.

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