



Reimagine healthcare

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September 2018

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The British public love our NHS – but we don't always act as if we value it, missing appointments and squandering resources. Jason Parker proposes a system that could ensure that every patient receives the care they need, whilst improving public health and services' efficiency.

There is a strange paradox experienced by those who've tried both selling goods via online auction websites, and giving things away through community and local donation sites: it is often less hassle to sell something than to give it away.

Put, say, your old sofa-bed on an auction site, and it might only go for a fiver – but the buyer will then come and take it away. Put it on a free goods site, however, and you get lots of interest from people who then mess you around, fail to show up, and stop replying to emails. The truth is that people attach much more value to items for which they've paid a price, no matter how trifling the sum.

The same dynamic operates in the NHS, which is famously 'free at the point of delivery'. People regularly fail to show up for GP and outpatient appointments, wasting medics' time and NHS money: NHS Digital calculates that the 8m hospital outpatient 'Did Not Attend' (DNAs) cost the NHS in England about £960m in 2016-17¹; and whilst the government does not collect figures for missed GP appointments, in 2014 NHS England estimated that there were 12m no-shows – wasting over £162m².

People also consistently present at hard-pressed hospital A&E departments with minor ailments and injuries that would be better handled by NHS telephone, nursing and GP services. In 2016-17, some 9m people were sent home from A&E with just guidance and advice³ – and given that the average A&E attendance costs £138⁴, the NHS could clearly save a substantial proportion of this £1.24bn cost by diverting patients to other channels.

This highlights a real challenge for policymakers. The British public rightly love their 70-year-old institution. It was the centrepiece of our 2012 Olympic opening ceremony: the British invention that we most wanted to show off to the world. But it cannot be preserved in aspic. Today's demanding patients expect the very best care. And although the NHS was held in just as much affection in 1958, 1968 and 1978, we wouldn't now consider it acceptable to offer the levels of care that were seen as normal then. So we love the NHS, but we know it has to keep on changing to meet our needs.

And the NHS will be better equipped to meet our needs if its users improve the ways in which they access it. If people valued the NHS's time as much as they say they value the organisation itself, they'd use GPs and hospitals much more efficiently – both saving taxpayers' cash, and improving access to services for themselves and their families. There is also a political driver behind this agenda: Theresa May's promise of annual 3.1-3.6% NHS funding rises come with strings attached, including a 10-year NHS plan that "tackles waste" and "ensures every penny is well spent"⁵.

Incentivising the right behaviour

So NHS bodies are set to come under greater pressure to cut the money wasted on DNAs and unnecessary A&E attendances. One way to focus services on real needs is to impose a charge for access to NHS services. We see variations of this across a number of international health systems. Some charge 'co-payments': in Jersey, for example, the state pays about half of the cost of a GP appointment, while adult patients pay the remainder – about £20. This helps make sure that people think twice before making an unnecessary appointment.

Another system I admire is that used in Israel, in which everyone is entitled to a certain amount of expenditure across a basket of services, no questions asked – and it's a good basket. Some things aren't in the basket, and you need to insure yourself for them or pay a spot price. In turn, the providers are heavily incentivised to prevent hospital admissions using powerful analytics. For example, Clalit, the largest of the country's 'health maintenance organisations', has been very successful in moving patients to lower-cost settings of care, reducing waiting times and improving pay for physicians. Considering its expenditure on health as a percentage of GDP, Israel gets by far the best bang for its bucks of any health system.

However, I think the British public is hard-wired to resist such fees; and even a small charge would be disproportionately costly to poorer families. So is it possible to introduce incentives – and, by extension, penalties – that encourage efficient use of NHS services whilst retaining the core principle of an NHS that is free of charge and offers an equal service to everyone?

I think the answer is yes; now let's consider how we could do so.

Creating a mechanism

In poker tournaments, every player begins the game with the same number of chips – and if they spend them all, they can't 'buy in' again. In such a 'closed loop' currency, everyone – no matter their personal wealth or connections – has an equal chance of winning; and the quality of their decision-making will decide whether they win or lose. So people don't throw chips away on poor hands, instead saving them up for when they're most likely to produce a result.

There are ways to apply this concept to NHS services, whilst protecting three key principles: that medical care remains free and accessible to all; that patients making poor decisions in how they 'spend' their chips won't suffer from worse medical outcomes; and that people with physical or mental health conditions are not disadvantaged.

And if we attach it to a public sector medical insurance system, we can also use it to encourage people to adopt healthier and safer lifestyles – taking the edge off fast-rising demand for NHS services.

Let's say that everyone begins with the same number of NHS care credits – or 'carecredits'. Some of these, they'd have to spend on buying insurance for secondary and tertiary care: this would provide cover for all serious injuries and conditions, from plastering and physio for a broken leg, through antenatal and postnatal care, to cancer and heart disease treatments. And it would include provision for treating all long-term conditions, from specialist appointments to medication.

As with any sale of medical insurance, the insurer would want information relevant to the buyer's prospects of getting an injury, disease or medical condition. And at this point, we'd want to separate out the risks rooted in lifestyle choices – such as smoking, excessive drinking, poor diets and adrenaline sports – from those which stem from individuals' age, wealth, pre-existing conditions, medical history or genetics. By charging a modest additional premium for lifestyle-related risks, we'd give people a reason to live more healthy lives – preserving more of their carecredits for primary care and the incentives scheme. And as a bonus, gathering all this data on people's health and lifestyles – allied to information on their NHS care and outcomes – would provide a rich resource of health data on the population, supporting medical research and helping NHS leaders to improve care pathways.

It's worth noting here that our goal is to use market structures to change people's behaviour – both in the way they access services, and in how they look after themselves – but this scheme is not linked to private provision of health services. The whole system would be contained within existing NHS structures, with decisions about how those are provided – as currently – resting with NHS leaders and managers.

So that's the insurance aspect; let's now return to how people 'spend' their 'carecredits' in the primary care system – and examine the potential to improve the use of NHS services.

Capturing value

GPs would offer a menu of services with a 'carecredits price list' attached – with peak time appointments costing more – and patients failing to attend without good reason would be charged as if they'd accessed the service. So the number of DNAs should fall, and demand should be more evenly distributed across GPs' timetables. GPs could even begin offering other services likely to meet people's needs at a cheaper 'cost', such as nurse-led classes on diet and blood sugar management for diabetics.

Alternatively, people could access 'cheaper' appointments via less costly channels: the NHS 111 advice line could be free, with a small 'fee' for getting advice from a pharmacist and a slightly higher one for seeing a nurse. All these services could triage patients, referring them up the chain where necessary; but the sliding scale of fees should encourage people to access only the level of care required.

Hospital outpatient care would be covered by the insurance policy; but to encourage people to arrive for arranged appointments, DNAs could be charged a carecredits penalty fee. Some hospital trusts and outpatient departments might also choose to use the system to distribute demand more evenly across their schedules, perhaps charging premiums in exchange for offering evening or weekend appointments.

To encourage patients with minor injuries or ailments to access appropriate services rather than clogging up hard-pressed and expensive A&E services, those showing up at A&E departments who don't require treatment and haven't been referred there by NHS 111 would be charged a chunky fee in carecredits.

Of course, some people need to see the GP more frequently than others: those with a long-term condition, for example. So where people are diagnosed with an illness or a combination of co-morbidities requiring regular primary care, their account would be credited with enough carecredits to cover the appointments demanded by their conditions. But some people access primary care because they want human contact or have hypochondriac tendencies: in these cases, they could be diverted to suitable services offered – much more cheaply – by charities and mental health care providers.

Sharing the benefits

But why should people want to save up their carecredits? What, in short, is the incentive?

Well, if the primary care carecredits system were to prove effective, there are big savings to be had – starting with a substantial proportion of the £2.4bn wasted in England every year through DNAs and unnecessary A&E attendances. Some of this would be spent on strengthening alternatives to A&E attendance, and some would be consumed by administration costs; but the remainder could go into a pot to fund rewards that people could 'buy' with the carecredits they've saved by using NHS services as they were intended.

“The premiums attached to dangerous and unhealthy lifestyles in the insurance system should encourage people to change their behaviour”

In the longer term, the premiums attached to dangerous and unhealthy lifestyles in the insurance system should encourage people to change their behaviour – particularly if the additional ‘costs’ of particular activities were made transparent. A pricing system based on existing medical research would attach a particularly hefty additional cost to insurance covering – for example – a diabetic smoker or a heart disease patient who eats badly.

So whilst their core condition would be covered by the additional carecredits allocated within the pricing system, the incentives to change their way of life would be greatest where the behaviour is riskiest.

Over time, the general health of the population could be improved by the system’s ability to tackle the biggest single problem facing the NHS: that of an ageing population suffering from ever more co-morbidities. As this fed through into slower rises in the rate of ill health across the public, some of these savings could also be channelled into the incentives scheme.

In the spirit of the ‘closed loop’ currency system, incentives could not be cashed in for hard currency; nor could they purchase additional specialist treatments. But they could be redeemed within NHS approved services or schemes designed to improve the convenience of services or to improve health and wellbeing.

So, for example, GPs might start offering evening appointments for those unwilling or unable to visit the surgery during the day. Walk-in centres might open to respond to demands. Imagine how much less busy an A&E department would be if people knew they could spend carecredits to access a walk-in minor injury unit without the four-hour wait in reception. Charities and other providers might offer dietary advice, discounted gym memberships, or access to sporting activities. And if people saved up their carecredits over the years, they could be used to defray social care costs – or even passed on to their children.

Strengthening the system

And what if you run out of carecredits during the year? Is there a penalty? Well, doing so might suggest that the patient is suffering from an underlying condition that hasn’t been diagnosed. So the first response would be to talk to them, with the potential for referral for further medical and mental health check-ups – and if a physical issue was identified, the patient would receive the additional carecredits to cover their high use of primary care services.

Alternatively, it might be found that someone has simply been unlucky enough to suffer a number of accidents or illnesses during a particular year; in special cases, they might be offered a top-up or an advance against the following year’s carecredits.

In the case of people with some mental health conditions or other vulnerabilities, it might be decided that they lack the capacity to manage their own care; sometimes a carer or power of attorney could help manage care for such individuals. Or their GP could manage their care – effectively taking the patient out of the carecredit system and offering them the service they receive today.

This would also be the offer to people who run out of carecredits through, for example, having consistently failed to attend without good reason. Effectively, they would be demonstrating that their lifestyle or character mitigate against their ability to take control of their care. In that situation, again, the patient would find themselves taken out of the carecredit system; and as a result, they’d lose the ability to save a surplus of carecredits or access the premium or weekend services.

Introducing such a structure would, of course, require intensive work by providers to educate the population – both about how the system works, and about how they could improve their lifestyles. Meanwhile, those NHS and charitable providers which succeed in developing services and marketing them to patients would see greater demand and earn more carecredits – so there would be an incentive on the provider to make patients aware of their services.

As the population ages and the incidence of long-term health conditions and disabilities rises, we urgently need to find ways to improve public health. And as taxpayers are asked to pay more to preserve our much-loved NHS, it’s essential that we squeeze waste out of the system – starting with the services that are delivered, but not consumed. This approach would enable us to hit both goals, whilst staying faithful to all the core principles of the NHS. Our health services do an amazing job, but they can’t operate effectively without the cooperation of the British public: it’s time that we took a little more responsibility for our own health.



Contact

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References

1. <https://www.theguardian.com/society/2018/jan/02/patients-missing-their-appointments-cost-the-nhs-1bn-last-year>
2. <https://www.bbc.co.uk/news/health-42227861>
3. <https://www.theguardian.com/society/2018/jan/02/patients-missing-their-appointments-cost-the-nhs-1bn-last-year>
4. p10, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf
5. <https://www.digitalhealth.net/2018/06/20bn-cash-boost-nhs-theresa-may/>

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