Does telehealth reduce hospital costs? Six points to ponder

Dr Jennifer Dixon *looks underneath the headline results of the recent experiments in telehealth. She argues that, while initial indications may suggest that there was no significant impact on hospital costs, there is much to be optimistic about.*

The first results of the largest randomised controlled trial on telehealth were published in the *British Medical Journal* last week. Of the five arms of the Department of Health-funded 'whole system demonstrator' (WSD) trial, the first (conducted by a team here at the Nuffield Trust) examined the impact on hospital admissions and costs.

The headline results so far: patients receiving telehealth care had just 0.14 fewer emergency admissions in the one year of follow up; and there was no significant impact on hospital costs. For those hoping that telehealth might help fill the (estimated) £20 billion efficiency gap, the results may disappoint. But hope is not all lost – look underneath the headlines.

First the intervention itself. This was not just a telehealth 'kit' but several other things: the support given to patients/carers to use the kit; the preventive care patients received as a result of telehealth signals; the specific milieu peculiar to each of the three sites being trialled (Newham, Cornwall and Kent). Of all of these it could be that the kit itself had least impact on admissions/costs. Second, the way that patients were recruited into the trial resulted in those with 'low risks' being included. It could be that telehealth has more impact in higher risks or indeed on people with particular health conditions.

Third, patients were followed up only for one year. It could be that a bigger impact takes longer. Fourth, the trial was relatively well funded and monitored. It could be that telehealth under normal NHS conditions has a different effect. Fifth, while cost of care is important to reduce, the NHS is about adding value. Although we found reductions in mortality, there is as yet no published evidence that telehealth increases quality of life (further analysis from the WSD trial is forthcoming). A reduction in emergency admissions does not necessarily mean quality of life improved. In fact, the uncomfortable truth may be that telehealth initially increases use of care as more need is uncovered. For telehealth also read case management or indeed any complex out-of-hospital intervention.

Sixth and related, as colleagues from Spain were emphasising at our breakfast on the subject at the NHS Confederation annual conference, telehealth is but one strand of a tapestry to improve care. It could be that it does not have impact unless there is progress on other strands, which takes time, seriousness and constancy of purpose and application as well as intelligence and creativity. (And our track record here relative to Spain may be as unfavourable as our Euro 2012 performance). It may be several years before this combination moves the dials in the right direction.

But we may not have years. Meantime what should commissioners, or more to the point, providers, do now? Concentrate on service redesign, craft incentives, tackle entrenched practices, use data intelligently, try telehealth soberly as part of a wider set of changes and evaluate as you go. Be reflective about progress. Don't jump uncritically at solutions – on current evidence telehealth by itself is not going to give the efficiency lift we all hope for. Most importantly, ask clinicians and patients to lead the search for better value.

This article first appeared on the Nuffield Trust website.

About the author

Dr Jennifer Dixon *has researched and written widely on health care reform in the UK and internationally. She trained originally in medicine, practicing mainly paediatric medicine, before a career in policy analysis. She has a Masters in public health and a Ph.D. in health services research from the London School of Hygiene and Tropical Medicine.*

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