



How Britain's health system is investing in information systems

Simon Stevens, President of UnitedHealth Europe

Britain's National Health Service has given it universal coverage and effective cost containment since 1948. But Britain has been spending significantly less on healthcare than other industrialised countries. So between 1972 and 1998 it cumulatively spent £220 billion less on healthcare than the average for the European Union (at 1998 prices). The net effect: too few health professionals, long waits and old infrastructure.

In 2000 the Blair Government decided that had to change. So it embarked on an ambitious programme of funding increases and system reform. It decided that over the next eight years tax should rise to pay for increased NHS funding. The result is that health spending will have risen from 6.8% to around 9.2% of GDP by 2008. This is somewhat in excess of the EU average, similar to French spending levels though less than Germany.

Why upgrade health IT?

The biggest single use of new public capital funding is health information technology. In addition to local IT budgets, central Government is now spending an additional £6 billion to create electronic health records for the 50 million population of England.

This programme is being nationally specified, funded and procured. The aim is to:

- improve quality of care (for example by reducing medication errors, ending problems of lost medical records, and providing online decision support);
- enhance the patient experience (for example by reducing unnecessary delays and giving patients choice and certainty over appointment scheduling);
- and boost efficiency (for example by better use of staff time, reduced duplication of tests, and allowing proactive care management).



What will be delivered?

Key deliverables are expected to include:

- electronic health records for whole population by 2008
- digital picture archiving by 2007
- ePrescribing by 2007
- eBooking of doctor visits and hospital appointments by 2006
- electronic quality measurement and payment system for general practitioners by 2005

How is it being organized?

This programme reverses the NHS' tendency of the last decade to leave individual hospitals and GPs to procure their own systems piecemeal. Although this has, for example, produced high levels of computerization in GP' offices, it has not allowed wider benefits of networking across providers, nor has it enabled the NHS fully to harness its purchasing muscle.

After high profile failures of central Government IT procurement in non-health sectors, contracts are assigning completion

risk to the supplier with large financial penalties for non delivery.

Although it is a big procurement it is not a 'big bang': contracts are being decomposed by geography (with the country split into five geographic clusters), functionality and timetable. As a matter of commercial policy, geographical contracts will be awarded to several providers so that the NHS does not become dependent on a single supplier.

Contracts have been awarded to consortia including CSC, Cerner, Oracle, Fujitsu, Accenture, BT, Microsoft, GE, Kodak, Phillips and others.

Now that the commercial procurement approach is well under way, key issues now being debated are:

- how best to ensure that clinicians and managers locally are fully engaged in implementation;
- after the initial procurements, which aspects should continue to be overseen nationally as against left to each provider to take forward, and
- where to strike the balance between effort to bring all providers up to minimum levels of functionality versus support for those wanting to move much faster to deploy more sophisticated applications.

Critically the NHS is now also turning to companies such as UnitedHealth Europe who supply analytical tools to help make better use of the data being generated, both to improve patient care and improve system efficiency. So UnitedHealth Europe (www.unitedhealthurope.com) now works with NHS payers to improve

Autor: Simon Stevens

Titel: How Britain's health system is investing in information systems

In: Hempel, Jäckel, Reum (Hrsg.)

2. Sonderausgabe Telemedizinführer Deutschland, Ausgabe 2006

Seite: 109-110



Modellregionen, Projekte und Initiativen

chronic disease management, target resources effectively at prevention, and improve understanding of different patterns of hospital and clinician performance.

Impact on patients and doctors?

What will be the long term consequences of these developments? One result will be that patients will have more information about their conditions, their treatments, and their caregivers. Type 'breast cancer' and Google offers you millions of links. Will this really deskill

doctors and 'democratise' medicine as some hope and others fear? To an extent. Over time the boundary between patient uncertainty professional knowledge will shift – a challenge all professions are likely to face. Yet as the volume of information rises, so does the need for synthesis and interpretation. Forty years ago fewer than 125 randomised controlled clinical trials were published annually worldwide; now it is over 10,000. That is well in excess of the ability of any doctor let alone patient to stay current with simply by scanning medical journals. Faced with

this cognitive overload many patients will need more not less hand holding, just as health professionals will need to rely more on computerised expert decision support. And still uncertainty will remain...

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