

Statistics and the NHS White Paper

At the time the NHS White Paper was launched in February 1989, it was far from clear what impact it would have on statistics and data collection systems. It was obvious that a heavy investment in computer systems would be necessary to operate the internal market, but it was not revealed how this would relate to anything other than manipulating money. Indeed, the White Paper did not even say very much about how this was to be done, suggesting that thought had yet to be given to the subject. At the time, the Department of Health was unable to give any figures in response to a parliamentary question from Robin Cook, asking how much the information technology needed for the White Paper proposals would cost.

The White Paper came at a time when the new systems for collecting NHS data in England, which had been set up following the report of the Steering Group on Health Services Information, or Korner Committee as it is usually known, were not yet fully working. This was despite the fact that most of them had been due to start on April 1 1987 and the rest on April 1 1988. The fact that health authorities had been asked to implement Korner systems within their existing resources at a time of financial crisis made it difficult for them to meet these April Fools' Day targets. Many were not able and some still are not able to collect all the data required.

The White Paper and the Working Papers issued with it carried more than a hint that long overdue investment in information technology would at last be made. There were also more ominous signs. Hospitals and units which opted out were only to be asked to submit the minimum of information centrally. What did this mean? A parliamentary question from Frank Dobson, asking 'which sets of Korner data will be collected from National Health Service hospital trusts' received a somewhat evasive reply on March 6. The minister said 'We shall be giving detailed consideration over the coming months to the information which will be needed centrally when National Health Service hospital trusts are established.' Nearly a year later, a decision has yet to be taken about the position of units who opt out.

Meanwhile, towards the end of 1989, a number of statements emerged from Richmond House. On November 2, it was revealed that the NHS Management Executive had launched a study to assess the information needs of new district health authorities, together with the costs and benefits expected to arise from further investments in information technology. The first stage of this study, was to be done by management consultants, Deloitte, Haskins and Sells. This was to be completed by the end of the year. It was envisaged that district information systems would need firstly to maintain information about district contracts and secondly 'hold minimum data sets about residents from which Korner and other national requirements can be satisfied. Finally, in the longer term, they were to link to a master patient index which would in turn link to child health and other systems such as those used for cervical cytology recall.

Later in the month, on November 28, it was announced that an additional £ 103 million was being made available to health authorities in 1990/91 for investment in computers and information technology. Of this, £78 million was to be used to extend resource management to major acute hospitals. Only £25 million would be available more generally for hospital information and support systems. It was added that health authorities were already spending £130 million each year of their existing resources on information technology.

This was followed, on December 19, by a further announcement revealing that £31 million had been allocated in the financial year 1990/91 for

medical audit. Most of this, £ 26 million, is to be spent in the Hospital and Community Health Services, and the remaining £ 5 million will find its way to family practitioner committees.

Finally, on January 17, when the NHS and Community Care Bill was already well on its way through parliament, Working Paper 11 appeared. Entitled 'Framework for information systems: overview', it announced a consultation exercise which closes on March 31. The document and consultation were launched by Roger Freeman, speaking at a conference in Birmingham on a day when the press had more exciting things to write about. As a result it was not widely reported.

The Working Paper is just the tip of an iceberg. It was circulated to health authorities, family practitioner committees and professional organisations in a 3 inch thick box of papers. The next two papers in the pile have similar titles, 'Framework for information systems: IT' and 'Framework for information systems: information'.

The IT document is described as the 'consultative document comprising recommendations of review project 25 on information'. It is divided into short term and long term goals. The short term goals are to implement a massive list of systems, mainly for operating and monitoring contracts, by April 1991. The longer term goals include building up computer networks, something many other organisations including the underfunded universities and polytechnics have already done in the 1980s, and the design of information systems. These are things which need doing anyway. It is a pity they have to take second place to the setting up of the internal market. On the other hand, it is even more of a pity that work has not started on them long ago and that the internal market is the price we have to pay for the prospect of having them at some unspecified time in the future.

The information document, described as the 'consultative document comprising recommendations of the department review project 34 on information', forms the body of the iceberg. This is because it has no less than 13 annexes. It explains that this is to make it easy for general managers to circulate the appropriate annexes to the relevant people. The first 9 annexes deal with information about the hospital and community health service. They broadly relate to categories used for Korner systems. Thus there are separate documents for information about in-patients, out-patients, accident and emergency, waiting times and lists, community and paramedical services, finance, 'manpower', estate and availability and use of facilities. Annex 10 deals with the family practitioner services, Annex 11 with what are described as 'DH central requirements' and Annex 12 with identification codes. Finally, Annex 13, the thickest document, is entitled 'District information requirements'.

This parcel of documents can be obtained free of charge from Health Publications Unit, No 2 Site, Heywood Stores, Manchester Road, Heywood, Lancashire OL10 2PZ. Further details of the consultation, and possibly copies of the documents, can be obtained by ringing 01 972 2307 or 01 972 2297. Comments have to be received by March 30 or 31, depending on which document you read. The statement that 'because of tight schedules, the closing date will have to be adhered to strictly' summons up an April Fool's vision of Department officials spending Sunday April 1 busily reading and implementing the conclusions.

Readers who work in the NHS may have already made their way through the daunting pile of documents and are therefore invited to contribute to a fuller version of this article. Like many others I suspect, I am still on my way so cannot yet attempt to summarise the contents. Fortunately, the National Association of Health Authorities has done this job for us. It

will shortly be circulated to health authorities. For people not on their list, the address is Birmingham Research Park, Vincent Drive, Birmingham B15 2SQ.

Meanwhile there are a few major points which stand out. First there is the plan to change the basis of district health authorities' data collection activities. From April 1 1993 on, they will collect data about health care received by their resident population, instead of collecting data about the activities of services in the district. This will be done by passing to the district of residence information about the care provided together with the invoice. In principle, it seems a good idea to collect population-based statistics. The question is whether health authorities will be able to achieve this change by April 1993 as requested. Before this, they have gargantuan computing tasks to achieve by April 1991 to set up contract systems as well as making existing systems work.

Another continuing concern is whether opted out units will have to contribute to national systems. The documents show them in flow charts, along with private hospitals treating NHS patients, but the text is more guarded. If they are not included, this will leave considerable gaps in our national statistics.

This may be relevant to the announcement that the Department of Health is to review, by June 1990, its requirements for data to be submitted centrally. The argument, that this needs to be done 'to reduce the burden on health authorities' is depressingly familiar, as it was used to justify the Rayner cuts in the Government Statistical Service. It is followed by the equally dismal and familiar rhetoric about the government collecting only the data it needs for its own purposes. This again comes from the Rayner review and has resulted in many criticisms that the government does not collect inconvenient statistics. It also seems to ignore any possibility that the Department of Health could have a coordinating role in passing comparative statistics other than 'performance indicators' back to the district of residence, let alone the question of whether national statistics provide a useful benchmark with which local data can be compared.

Finally, how much will all this cost? Some estimates are made in the annex on district information requirements, which was the product of the Deloitte Haskins study. The document outlines a two stage approach with six modules. It estimates that the capital cost of installing this in a district would be of the order of £525,000 and the revenue costs of running it would be £182,000 per year. At the time of writing, there are 194 districts in England, so this would mean capital costs of £ 101.8 million if they all took this up, and running costs of £ 35.3 million per year.

This is rather more than the sums announced by ministers. In any case most spending is on systems to run acute hospitals rather than districts' population based information systems. These systems would still be very much worth having, even if we are lucky enough to have a new government which consigns the internal market to the oblivion it deserves. The crucial question is whether money will be found to pay for all the proposed new information systems without further cuts in services to patients.

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