Editorial

The future for primary care computing

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As we move towards the first anniversary of the award of contracts to deliver the National Health Service (NHS) National Programme for IT (NPfIT), it is timely to reflect on what we now see as its likely impact on primary care.1

Much of the concern over the past year has focused on fears that the NPfIT would result in general practitioner (GP) practices being forced to move from their tried and tested systems to unproven alternatives, with the progress that GPs have made over the past 25 years of computerisation being undermined to the serious detriment of patients and practices.

However, after this initial flurry of concern, I think that we can now be confident that there will not be any attempt to 'rip and replace' (at least in the short to medium term). We can expect the NPfIT to work more closely with existing system suppliers as the only route to delivery of their short-term targets. The National Programme has already experienced the benefits of this mode of operation with the roll-out of QMAS software to support the new General Medical Services (GMS) Contract, delivering the programme its first major success with software released on time and already operational in 90% of English practices.2,3

This has been achieved by working with the existing GP system suppliers; it seems clear that NPfIT will follow a similar path to ensure the delivery of the information technology (IT) support for the politically imperative 'choose and book' and 'electronic transfer of prescriptions' services as well as the professionally demanded GP-to-GP record transfer service.4,5

While it may take a little time for this new view of incumbent suppliers to permeate some local communities, recent remarks by the NHS Director General for IT, Richard Granger, about 'disciplining suppliers' who try to deny GP choice should have the necessary effect.

Our concern therefore has to focus on the medium to long term where the current trajectory of the National Programme stills leads to a single monolithic solution (or at best a duopoly of such systems), without the opportunity for many existing suppliers to compete to continue to provide a service. In the first instance this does not necessarily create a major problem, as these systems will have to be at least as good as current ones to gain initial acceptance. However, beyond this point 'successful' delivery of the National Programme creates an environment in which it is hard to imagine innovation or competition flourishing; this will be to the detriment of all parties (including, I would suggest, the apparent victors).

In this context it is worth noting the experience in Scotland where in the early 1980s the Scottish Office decided to adopt the GPASS (General Practice Administration System for Scotland) system, taking over its development and support from the enthusiast who had developed it and making it available free to Scottish GPs.6 At the time GPASS was arguably the most capable product available in the UK, and unsurprisingly the combination of a good product and free software meant that GPASS rapidly built the 85% market share it has today. However, a combination of the bureaucratic environment in which GPASS then found itself and the protection from competition that its status allowed it to enjoy led to complacency and stagnation and GPASS rapidly lost its position as the best or even a good product.7 Today, despite major investment to update the product, Scottish GPs complain bitterly that they are stuck with what is the acknowledged weakest of any widely-implemented system in the UK; they would probably admit that what progress has been made is down in no insignificant part to the competitive pressure from south of the border, and the remarkable fact that the English suppliers have managed to retain 15% market share in Scotland despite the odds being stacked very heavily against them.

I do not believe that anyone with an interest beyond the first phase of the National Programme wants to see the destruction of a competitive market for healthcare IT in the UK; indeed it is clear that the NPfIT structured its procurement processes and resulting contracts to try and ensure continuing competition, and to avoid putting the NHS in the same position as other public bodies have found themselves in, with incumbent suppliers too entrenched to attract competition when it comes to reprocurement. In the local service provider space they have probably succeeded but in the application provider space they have not.

However, while many good and clever people would accept much of the above – they nonetheless still support the idea of a single integrated system. Why?
My answer to this is that they consider that the only way to provide the level of integration which both they and I believe is desirable is with a single all-encompassing solution. I think this view is mistaken.

Firstly, no system can be all-encompassing, and we can already see problems at both the geographical and functional borders of the NPfIT which will force us to find ways of sharing information and workflows across these borders, outside the scope of the planned monoliths.

Secondly, in virtually any other sector (or indeed in health care in most other countries), the level of organisational fragmentation is such that there is no choice but to find ways of sharing information and workflows across heterogeneous systems. This means that there is massive effort going into the development of standards and tools to address these problems, and we will soon be able to tap into this work to develop alternative ways to achieve the level of integration most of us want to see in the NHS. As part of the British Computer Society, the Primary Health Care Specialist Group is well placed to provide a bridge between work in other sectors and work in the NHS.

Finally, even if the new systems are very good (and I see reasons to believe that they might be), it is difficult to believe that they will ever serve all of the specialist niches as well as the current best-of-breed systems in those niches. We have to find ways to allow suppliers of specialist systems, close to the needs of their end-users, to continue to meet those needs, reducing pressure on mainstream suppliers and continuing to stimulate competition and innovation.

As to where primary care sits in all this, it is not yet clear. Primary care is the major provider of health care in the UK, and it sits in, and often at, the centre of the majority of care pathways. It might well be that the needs of primary care will be best met by practices using the new mainstream integrated systems that will serve most of the needs of care communities. However, this should be in an environment where specialist systems and mainstream systems in adjacent sectors and geographies can integrate, leaving the way open for specialist suppliers to continue to provide alternative choices to GPs and thus maintaining competition and innovation.

REFERENCES
1 www.npfit.nhs.uk
2 www.npfit.nhs.uk/programmes/qmas/index.php
3 www.bma.org.uk/ap.nsf/Content/NewGMSContract
4 www.dh.gov.uk/assetRoot/04/08/83/52/04088352.pdf
5 www.npfit.nhs.uk/programmes/etp/
6 www.gpass.co.uk/
7 www.show.scot.nhs.uk/gpasslg/GPASSPringleReview.pdf

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