
No NHS, Please, We're American

The computerization of Britain's National Health Service has been an expensive fiasco. Why does Obama want to emulate it?

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Liberals like big systems: mass transit, yes; the individual motor car, no. A massive electric grid, yes; regional electric grids relying on informal arrangements among companies, no. A massive government health care insurer, yes; individual customers using competing insurers, no. It has to do with control. Use your car and you can go where and when you please. Use mass transit and you get on and off at stations selected by central planners at times their models tell them are optimal. Allow local control of electric grids, and individuals will decide on standards, construction needs and the like; replace them with a national grid, and those jobs and decisions move to Washington, to a Department of Energy that has never successfully completed an assigned task.

Worst of all from the liberal point of view, let control of the health care system slip from the grasp of the central government and consumers will be confused by competing insurance offers, have to deal with doctors who might not recommend a one-size-fits-all course of treatment, or who just might order that extra life-saving test that bureaucrats relying on statistical averages deem too costly. The same sort of people who thought they could model financial risk and develop techniques to eliminate it, the people who confidently predicted that the president's stimulus package would hold the unemployment rate to 8 percent, now have a way for us to save billions on health care: an Electronic Health Information Technology System. "Barack Obama and Joe Biden will invest \$10 billion a year over the next five years to move the U.S. health care system to broad adop-

tion of standards-based electronic health information systems, including electronic health records." So says "Organizing for America"—the reincarnation of the "Obama for America" campaign organization. If Messrs. Obama and Biden have that kind of cash to invest, more power to them. Unfortunately, they don't.

So it's to be taxpayer money, "the necessary federal resources to make it happen," which is a somewhat different thing. Private investors would have an incentive to drop this massive project if it turned out that it was costing more than planned; government bureaucrats' sole incentive would be to plunge on—to them, money is free, and job preservation, rather than efficiency-maximization, is the bottom line. Doubt that, and consider the unhappy facts of Britain's National Health Service.

The goal of all this is scarier than the hubristic notion that construction of such a massive system is within the reach of even the most talented individuals. When up and running the IT system, we're told, will reduce hospital stays, avoid unnecessary testing, require more appropriate drug utilization, and garner other efficiencies. But no "system" can do that. All it can do is provide central controllers with the information to enable them, instead of your doctor, to decide just how long you should be allowed to recover after surgery, whether you might be permitted to have the tests needed to make that decision other than by using broad statistical averages that ignore individual patient differences, and which medications are appropriate for you.

Sound extreme? Consider this further promise of the Obama organization: "Barack Obama and Joe Biden will require that [disease management] plans that participate in the new public plan . . . utilize proven disease management programs." Patients suffering from diabetes, heart disease, high blood pressure, and other chronic conditions will do it the Obama-Biden way or else be excluded from insurance coverage. And decisions about whether this is good medicine or not will be facilitated by the IT system, which, in

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the unlikely event that it works, would enable your doctor—and the system’s managers—to find out all about you by pushing a button. The judgment as to what to do by way of treatment will, alas, be made by people you have never met but who nonetheless can decide whether what your doctor recommends should be covered by insurance or is wasteful or contradicts the findings in the latest statistical study, perhaps reflecting the results of a small statistical sample of patients in Norway.

Obama has made much of the fact that we spend a much larger portion of our GDP on health care than do countries such as Great Britain, which have a state-provided system covering all citizens (and noncitizens who are taken ill in Britain, including illegal immigrants). Leave aside the question of whether a richer country such as ours, which has more completely met basic food, housing, and other needs (not to mention desires), should not properly spend more on health care than a poorer country. Consider only the fact that the method used to keep health care costs lower in Britain, Canada, and other countries in which the government controls the system, is a simple one: rationing.

In Britain until very recently an expensive medication designed to arrest macular degeneration could not be administered until the patient was completely blind in one eye. Cancer patients who decided to use their own money to pay for life-prolonging drugs not covered by the National Health Service (NHS) have been denied access to any treatment by the NHS, even treatment to which they were otherwise entitled. In order to get the National Institute for Health and Clinical Excellence (NICE) to allow the NHS to make the breast cancer therapy Herceptin available, a number of patients had to take their primary care providers to court. The rationing system is quite simple: It is based on QALY, or quality-adjusted life year. As one expert student of the British system, actuary Joanne Buckle, put it, “New treatments that have a very high cost per QALY are not likely to be approved for payment because the health budget is limited.” Adding to your life span won’t get the product approved for payment—the committee has to deem that extra time of good “quality,” a decision made by people who likely have never met the physician who wants to administer the drug to an individual patient and who have not even a passing acquaintance with any individual patient.

In the event that Obama has his way with Congress and gets his health care plan and associated taxes passed, work

will begin on the IT system—unless someone in the administration has the good sense to pop over to England and learn about the experience the government has had in getting a similar program up and running.

In June 2002, when England launched plans to computerize all medical records, it was hailed as a move that would set an example for the world. Many governments may dream of such a project, but Tony Blair had the apparatus to accomplish it. Britain has the National Health Service, a fully socialized health care system that pays 30,000 doctors to look after the country’s 50 million patients. It should have been straightforward.

Seven years later and the plans for the “NHS super-computer”—as it has become mockingly known—have



A memorial to possible victims of NHS malpractice who died at a hospital in Stafford, England

become a national joke. The project was due to be completed next year but the deadline is now 2015, and slipping. The original £6.2 billion (almost \$10 billion at current exchange rates) cost of the project looks more like £20 billion (over \$30 billion)—some now say it will mount to £50 billion (\$80 billion), eight times the original estimate. And what few computer systems have been introduced have often served to bring yet more chaos to the NHS, not least in the form of the 8,000 computer viruses that were introduced into English hospitals last year.

It is easy to understand Blair’s motives. The NHS system was in urgent need of modernization, with about 660 million pieces of paper circulating in the system, many of them typed two or three times. Patients would sometimes die from wrong diagnoses, owing to missing or illegible paperwork. Blair argued then—as Barack Obama does now—that a new massive computer system would not just save money but save lives.

Fatally, Blair's analysis did not go beyond that. Instead of a rigorous cost-benefit analysis, there were just statistics, many the same sort used in a RAND report on which Obama relies for his estimate of the savings waiting to be had. In a typical week, NHS doctors see 6 million patients, administer 360,000 X-rays, and dispense 13.7 million drugs. Surely computerization would yield handsome savings. This was as far as the logic ran. Ministers wanted to do this *because they could*. So alongside those digital patient records there would be a "spine" linking the various parts of the NHS system closer together than they had been at any time since nationalization in 1948.

This massive network soon became the flagship procurement project of the Blair government. Richard Granger, a former management consultant, was brought on board and made the highest-paid man in the British government (\$400,000 a year)—more than twice that of the prime minister. Ministers were determined to sidestep the perils of central government computer procurement. This was one project, they said, that would not go over budget or deadline.

Granger certainly moved fast. Within a year he drew up and awarded contracts for what was (and remains) the largest civilian IT contract on the planet and produced four main winners from 160 bidders. Their prices—on average, half of their opening bid—were laughably optimistic. As work began, it became clear that they had no hope of meeting either the deadline or the budget. They wanted to renegotiate—and Granger played hardball. He lost.

The NHS turned out to be far more disparate than ministers imagined. Doctors and clinics come in all shapes and sizes, with different needs and priorities. Even in this socialized system, one size did not fit all—as the purveyors of this new computer system found to their sorrow.

Accenture walked away from its £2 billion contract three years ago, declaring a £260 million write-off. Last year, Fujitsu followed suit. Quietly, Granger quit too. His plan had failed. The British government is now reliant on just two companies for what is still the largest civilian IT contract in the world—BT Global Services and CSC of Virginia.

This left BT with the whip hand: If it were to drop out, then Britain's entire NHS program would be run from the Falls Church, Va., headquarters of CSC. So BT has been able to negotiate far better deals, such as a new £500 million contract to pick up the work which Fujitsu left behind. This is in spite of BT's being four years behind its own deadlines for installing computer systems in various London hospitals. Desperate overtures are being made to new bidders who might be able to get the program moving again. Costs are slipping out of control.

Meanwhile, the doctors and nurses are bitterly complaining that their shiny new software is no good, that it is designed for American hospitals, which bill patients whereas the NHS does not. The conceit of central government is again at fault: Little time, if any, was spent asking the people who would be using the systems what they want. As one doctor told lawmakers in Westminster, computerization of medical records is like "a juggernaut lorry going up the motorway—it didn't really matter where you went as long as you arrived somewhere on time."

While the records may still be years away, there have been achievements: digital archiving of X-ray scans, for example, and a new NHS email directory featuring 500,000 of its 1.3 million employees (more users than any email system in the nonmilitary world save Walmart and the Indian state railway). But few think this is worth the \$7.4 billion already spent—especially as havoc has accompanied the introduction of the new system. One hospital manager is threatening to sue the government for the disruption the new records system has caused.

The NHS medical records program is now the subject of ridicule and embarrassment in Westminster, with aspects of its unintended consequences filling newspaper pages and television documentaries. Recently declassified documents show that Blair's officials had warned about the inability to predict the costs of this starry-eyed procurement scheme. It was then, and is now, too big to succeed. Even for a supposedly homogenized medical system like Britain's NHS, there are too many variables.

The Conservatives, likely to win power in an election next year, are of a mind to scrap as much of this system as they can—and then give hospitals freedom to choose whatever records system is best for them. This includes patient-owned records like the free-to-use Google Health.

Officially BT and CSC have been given until November to make progress on the patient record system—before being threatened with what the Department of Health calls a "new plan." It is a threat unlikely to carry much weight. There is, of course, no new plan. The awful truth is that there was never a properly thought-out plan to begin with. Just a soundbite, a wing, a prayer, and an awful lot of wasted money that British taxpayers will never see again. The only promise kept is that the system does, in fact, contain a lesson for the world: Abandon hope all ye who enter here.

Development and implementation of a scheme appropriate for America would, of course, be enormously more complicated than any that would work in Britain's highly centralized, single-payer health care system. Which just might be why the president finds the British model so attractive and wants to turn the U.S. health care system over to the tender mercies of the bureaucrats who will tell your doctor just what he may do to cure whatever ails you. ♦