Contracts and confidentiality

Currently incompatible

However radically medical practice may have changed over the past few years the principle of confidentiality between patients and doctors has survived just about intact. Patients trust doctors with often intimate details about themselves, believing that their secrets will be used solely to ensure the best possible care. And doctors respect that trust.

The administrative requirements of the NHS and Community Care Act could change all this, although the threat to the relationship between patients and doctors is wholly unnecessary. Simple solutions exist, but the government first needs to recognise that there is a problem.

The threat to confidentiality lies at the very heart of the reforms—the principle that money follows patients. From April providers have been billing health authorities (or boards) and general practitioner fundholders for treatment: a central clearing house in the Mersey region manages billing across health authority borders. Some bills will be verified either as a random check or because the billing pattern is inconsistent with expectations. For all invoices, however, the information required by the clearing house will include clinical data, including primary and secondary diagnoses, details of treatments, medical history, and the patient’s age, sex, and ethnic origin.

What makes these “minimum data sets” ethically unacceptable is the inclusion of the patient’s full name, address, and date of birth. This clearly breaches the ethical principle that identifiable personal health information should be kept confidential and released only when the patient has given explicit consent or when strictly necessary for treatment. In these circumstances the minimum necessary information should be released only to those who “need to know.”

Exceptions to this are set out in the General Medical Council’s blue book, Professional Conduct and Discipline: Fitness to Practise, and explained further in the GMA’s Philosophy and Practice of Medical Ethics. Though the principle of confidentiality is not absolute, any breach must be justifiable.

Last year the Scottish Office produced a code of practice on the confidentiality of personal health information, which current practice in Scotland seems to be breaching. On implied consent to disclosure the code states: “Patients should be informed by means of an information leaflet or, for hospital patients, a suitable section in a patients handbook of the circumstances in which personal health information may be disclosed, the purposes for which it may be disclosed and the safeguards which will be applied.” Until patients receive specific information about the transfer of billing information such transfers therefore breach the code.

Lacking separate codes on confidentiality, England and Wales remain bound by relevant statutes including the Data Protection Act. This establishes a set of principles for data handling, such that releases of data—including those for registered purposes—should be as limited as possible. If invoicing and validating invoices can be satisfied without the release of identifiable information then the minimum dataset appears to breach the act. Currently this possibility is being investigated by the data protection registrar.

No other circumstances exist in which such sensitive data are so readily transferred for purposes other than those for which they were collected. The closest equivalent is the billing system within private medical care, although here special procedures protect patients. Clinical information is received by medical staff at invoice clearing centres and separated from what the financial departments require. Financial records contain only very limited and coded information, protecting the clinical confidences of the patients. Patients have further control over releases of information as it is they who initiate the presentation of information to the provident association. A precedent exists within the NHS for separating clinical from management and financial data: last year health departments were persuaded of the need for separation when it came to data relating to women in high risk groups being targeted for cervical screening.

Unless something is done the new arrangements for transferring clinical data threaten both the relationship between doctors and their patients and the public’s confidence in the health service. Fortunately, the solution is simple. Clinical data should be identified only by a code, protecting the confidentiality of the individual. When a need to break the code is shown—for example, to verify invoices—doctors should do it. The coding could be based on the community health index number, which could become an established single patient identifier.

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Evaluation of resource management

Costly but probably worthwhile

For a team of researchers commissioned to evaluate a complex management initiative designed to benefit patient care it must be infuriating to have the whole scheme overtaken by a series of even more radical organisational changes. In 1986 the government funded the introduction of resource management at six hospitals and commissioned a team from Brunel University to evaluate the outcome. Given the scale of the changes envisaged and the need for developing new systems it was hardly surprising that by 1989 the team could report only that a start had been made and that no assessment could be expected until 1990. By then, however, the NHS reforms had overtaken them. In the final report of their evaluation,
just published, the researchers’ frustration clearly shows through.

The theme of the report is set in its summary, in which the researchers point out that their ability to measure the impact of resource management was greatly reduced by the rapidity of subsequent, more fundamental changes in NHS organisation and management brought about by the NHS review: “The extent to which the NHS can learn from pilot initiatives such as this is vastly diminished, if the pace is such that reforms follow each other without an intervening opportunity to assess their independent impact. With hindsight the original initiative was grossly optimistic both about time scales and the costs of resource management.”

The position now is that the process of resource management has been adopted at most sites but implementation is still not complete. Much work is being undertaken in learning and practising the new systems, especially at subunit and specialty level. Apparently this effort is being made with the conviction that resource management is a realistic tool for managing patient care. There is clearly growing confidence that managers, including the doctors concerned, are gaining in understanding about costs and the effects of management decision making. As a practical training exercise of considerable complexity the initiative has been successful so far and is believed to be proceeding in a logical and useful direction.

The aim in 1986, however, was to achieve measurable patient benefits and to release 1% of expenditure for redeployment. The evaluation team found little evidence that resource management had directly benefited patients, although some organisational changes in the delivery of care improved quality or reduced costs. Both increases and decreases in activity probably resulted from resource management. The researchers believe, although it was not possible to measure, that the six resource management sites were performing above the national average.

Additional expenditure on resource management is turning out to be more than double the upper estimates made in 1986; the cost per inpatient episode has risen by 1·4% to 3·3%, not allowing for reallocation of staff time. The costs of running a fully implemented resource management process are “still not clear”; nor can it be said for certain whether 1% of expenditure has been released for redeployment.

Perhaps the most useful part of the report is the advice it offers to those embarking on resource management, to those tempted to launch costly policy initiatives, and to researchers attempting evaluation. The report is full of information on the implementation of resource management at the detailed level, which is of real interest to clinical managers. To introduce resource management is, however, to initiate a major cultural change in a complex organisation. The evaluation team emphasises the long period of teaching and learning and the effort required to bring the process to the stage where it is the accepted and the only management system for the unit. During this stage—which lasts at least five years in the experience of the six sites—clinical managers require substantial support from lay staff with skills in financial systems and project leadership. The permanent clinical staff suffered from repeated changes in staff and from diminishing central leadership over the years. The educational programme was insufficiently planned and resourced. At some sites the nursing input seems to have lacked support so that the multidisciplinary nature of the process was not properly realised. Such marginalisation of the largest clinical profession is an opportunity lost.

The very great difficulties of the evaluation team are evident throughout the report, which might be read as a warning to overconfident health services research workers. Almost nothing could be measured or costed with certainty. The research programme did not start early enough and could not be continued long enough to evaluate a cultural change. A lack of statistical comparability and continuity in the NHS as a whole made the research task formidable and frustrating. By close observation and considering the balance of evidence the team felt able to “conclude positively about the value of the management processes and organisational structures associated with resource management,” but it was less certain that the expensive infrastructure of computer systems had been responsible for service benefits. The report leaves an overwhelming impression of clinician’s taking on a great additional workload with enthusiasm in an effort to improve the use of resources for patient care. Their growing conviction that what they are doing is worth while is likely to be more persuasive to those about to start resource management than the report’s details of mounting costs.

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1 Department of Health and Social Security, Health services management—resource management (management budgeting) in health authorities. London: DHSS, 1984. (Health Notice HN86/34.)