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Health Information Technology in American Medicine: A Historical Perspective

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Abstract: Medical care has had great advances during and especially after the 19th century. With these advances has come the moral imperative to provide care to all in a nation regardless of the ability to pay. One of the great dilemmas of our time is how to provide this care without consuming other national priorities. There exists a debate between government-centered or patient-centered models of care and how electronic medical records could facilitate this process.

INTRODUCTION – GOVERNMENT-CENTERED VERSUS PATIENT-CENTERED CARE & COST

Aneurin Bevan was the Minister of Health in the Labor Government in Great Britain, which was elected into office in 1948. He is credited with the design and formation of the National Health Service. His motive was that all in Great Britain regardless of economic standing should be able to obtain health care free at the point of service. To do this he thought the only solution was to nationalize the health care industry putting a centralized bureaucracy with price controls in charge of the industry. With price controls set by “experts” there is no market determination of the true value of any service. Those who could afford care on their own were allowed to participate in a distinctly separate system with private insurance and co-pays. Bevan believed so strongly in free service paid for by the government that when the Prime Minister opted for the participants in the health service to pay for false teeth and some medicines, Bevan resigned in protest. Apparently Bevin was unaware that people are much more careful spending their own money than everybody else’s. The British National Health Service has been plagued with problems of quality and cost since its inception and to this day (History Learning Site, 2013; Black, 2013).

Could the same goal of universal coverage have been accomplished in a somewhat different fashion? Could a system be developed whereby all citizens would have the funds necessary to obtain health care through simple market forces? The labor government could have empowered individuals with health savings accounts (HSAs) along with high deductible insurance (HDHP) using tax policy. For instance those with no or limited income could have funds deposited directly into their HSA and a HDHP policy bought in their name and paid for by the central government. Insurance bought in the patient’s name would eliminate the problem of non-coverage for pre-existing conditions and other health insurance issues when changing employment. The HSA funds could be used to fund direct care contracts with a physician, thus allowing the poor the same access to care as all others. Those with significant incomes could fund their HSA along with a HDHP via tax credits (Fisher, 2013). With these arrangements market forces determine the value of services; individuals with their physicians develop individualized health plans conserving resources whenever possible. These plans have been extremely successful in Singapore, Switzerland, the state of Indians and function with efficiency, eliminating the need for a large government bureaucracy (Goodman, 2013; Roy, 2012). Despite the belief by some that the United States has a market driven health care system that belief is false. As the largest insurer Medicare drives pricing for health services in the U.S. However, Medicare uses an artificial pricing system, the Resource Based Relative Value Scale with a special interest controlled update committee (The American Medical Association, 2013).

In the United States a major federal and state commitment to health care took place in 1965 with the creation of Medicare and Medicaid. The situation was somewhat different than Great Britain in 1948 because during World War II employee health insurance was initiated and paid for by the employer with tax free dollars. Thus the
uninsured were mostly those over 65 y/o and the unemployed. Again there was a choice: a centralized, bureaucratic system or one with savings throughout a person’s lifetime deposited in a protected health savings account. The latter would have to be phased in for future generations. Our nation chose the government controlled, bureaucratic and in short order a price fixed option, as did Great Britain. History has shown that government centered, price fixed, bureaucratic systems produce distortions in market forces and are invariably unsuccessful (Rockoff, 2013).

Although most Western industrial nations have had problems controlling the cost of their centralized, price fixed, bureaucratic healthcare systems, the cost increases in the U.S. have been astronomical (The H.J. Kaiser Family Foundation, 2013). This is in large part due to the success of lobbying by special interests and crony capitalism with their expertise in obtaining wealth from the Federal Treasury. The more dollars at stake and the larger the bureaucracy the more the special interests are able to extract federal and state dollars. This is certainly true with Health Information Technology (Israel, 2013). There have been many attempts over the past forty plus years to control runaway Federal and State spending on health care; so far all have failed (Roy, 2013).

GROPING TO CONTROL COSTS- THE ELECTRONIC MEDICAL RECORD

Sold as a cost containment mechanism and jobs program, the HITECH ACT as part of the 2009 Obama Administration economic stimulus package, uses Medicare penalties and rewards as incentives to computerize all Medicare patient records (ARRA, 2009). Since almost all health care facilities care for Medicare patients, in effect these ‘incentives’ were in reality compulsory. These programs were designed to: 1) provide ready access to patient information regardless of location or hospital, even though hospitals would be using different commercial products, (2) collect aggregate health data for the nation, and (3) most importantly control costs. There were no controlled studies to determine if any of these laudable goals would be obtained with the commercial products available at the time. Also, there was no consideration of the possibility of far superior products that could be created by independent entities in the future. Because there were not detailed trials of these programs with their varied new requirements of such things as meaningful use, many unintended consequences are now being observed.

As of this time there is an apparent failure to accomplish success in any of these three major goals. (1) To-date there is NO interoperability between these various commercial health information technologies. It is not possible to share information for a patient cared for in one facility with electronic medical record (EMR) X now being cared for in a hospital with EMR Y; thus a major goal for patient safety and cost control is not being met. Demonstrating the difficulties involved is the Department of Defense and the Veterans Administration which has been unable to provide interoperability of their medical records despite the investment of approximately $1 billion (Branz, 2013). In Kalamazoo Michigan there are at least four distinct EMRs. Borgess and Bronson hospitals, Kalamazoo Center for Medical Studies and the Family Health Center. To date there is no ability while using one program to access any other (Personal Communication, 2013). (2) The value of the collection of national aggregated health data has also not undergone rigorous testing. It is not hypothesis driven and thus does not follow the scientific method. Its usefulness above and beyond controlled clinical trials and present day epidemiological information is unproven. (3) The ease of up-coding for more payment of services is widespread and thus instead of a cost containment device today's EMRs are actually increasing costs (Hirsch, 2013).

Many unintended consequences are beginning to emerge over the past few years while using these programs. (1) The impact on the training of young physicians in residency programs has been dramatic (Block, 2013). This study found that excellent first year residents were spending approximately four fold more time entering data into the EMR than with their patients. This time restriction with patients compromises obtaining a quality history and performing an excellent physical exam. This does not bode well for the future of medicine as history taking and physical exam skills are fundamental components of being a physician. (2) Privacy concerns are many; the security of the state Affordable Care Act exchange information has been severely questioned by the Inspector General of the department of Health & Human Services (Roy, 2013). Internet accessible hospital patient records have been compromised in many instances (Gerstein, 2013). (3) The cost and complexity of using these HITECH ACT
approved programs has forced many physicians to forgo their practices and be employed by hospitals. This change has proven extremely expensive as the same procedure done in the hospital owned facility cost considerably more than when previously billed in a private office (Mathews, 2013). There is also concern that a hospital employed physician may have more loyalty to the hospital’s bottom line than to the patient’s best interest (Pathology Education Consortium, 2013). (4) The concern for the validity of physician notes remains a problem (Hartzband & Groopman, 2008).

**CONCLUSION**

There is no doubt that electronic medical records have an important place in American medicine. However, the Federal imposition of unproven, extremely complex, vendor driven systems that preclude newer more innovative programs, is in my opinion extremely unfortunate. I expect that if a voluntary market driven approach were adopted, financial incentives would induce the introduction of many more user and patient friendly systems. I personally favor computer programs that put the patient’s medical information on a pass word protected portable device that would stay in the patient’s possession. The only internet portion would be information needed to pay for expensive care by their high deductible insurance.

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