Lack Of Health IT Shows Market Failure
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By Sen. Sheldon Whitehouse
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Our health care system is in serious trouble. I have heard from countless Rhode Islanders struggling to pay for health care and afraid of losing insurance coverage on which they and their families depend. I have met nurses frustrated and heartbroken that they must spend so much time filling out paperwork and so little time caring for patients. I have talked with families whose lives and health were shaken by terrifying medical errors — misplaced paperwork, mistaken diagnoses — that should have been avoided.

And despite all of this, despite a system that produces embarrassingly low life-expectancy rates, embarrassingly high obesity and

infant-mortality rates, and leads to as many as 100,000 deaths every year because of unnecessary and avoidable medical errors, our country still spends 16 percent of our gross domestic product on health care — more than any other industrialized country and double the European Union's average. The annual cost of the system exceeds $2 trillion and is expected soon to double. More American families are bankrupted by health care costs than any other cause. There is more health care than steel in Ford cars, and more health care than coffee beans in Starbucks coffee. What is going wrong?

Health care's fundamental problem is market failure: Market forces that should work to lower costs and increase efficiency in the system are instead logjammed and misdirected. This market failure is nowhere more evident than in the lack of widespread implementation of health information technology.

Some pretty respectable folks report that anticipated annual savings from a national health information technology system range from $77 billion to $346 billion per year. Those are savings desperately needed by American businesses and American families. Considering these projected savings, you'd think there must be an organized national effort to capture them, and to achieve the win-win of safer, better and more convenient care.

But there isn't. In my state of Rhode Island, we are lucky that a doctor named Mark Jacobs took time away from his patients to pick the best electronic medical record technology, adapt it to Rhode Island's needs and try to market it to build critical mass. Thank goodness for him, but counting on the Dr. Jacobses of the world to do this is like counting on homeowners to build and maintain the streets in front of their property. We figured out long ago that that's a pretty dumb idea.

If waiting for doctors to adopt health IT on their own is not the right way to solve this national problem, what is?

I would argue first that we need to see our national health information technology as national infrastructure, not unlike the highway system, which requires a national solution proportionate to the problem. In my National Health Information Technology and Privacy Advancement Act (S. 1455), I have proposed one way to do this: a national entity with the authority and the know-how to get this process moving.

Second, we need national standards — to protect patient privacy, because people will never trust a system that won't protect their privacy; for interoperability, so the system can work from Alaska to Alabama, from Texas to Tennessee, from Maine to California; and for data quality, so wherever they load your X-ray onto the system, you know it will be at a resolution that a doctor can read properly. So a new entity must have the power to set these standards.

Third, this effort also will need startup capital. Congress could appropriate the money annually, but then we run the risk that this will get all snarled up in partisan politics every year. Better, I submit, to put this organization outside the budget process and allow it to establish its own fee schedule, access procedures and revenue stream. The financial market knows how to capitalize a revenue stream, and the market discipline on the revenues and capital will be beneficial.

Finally, if it has the power to set standards and raise capital, this entity must be accountable to the public. Traditional mechanisms of accountability can accomplish this: presidential appointment of the board with advice and consent of the Senate; application of open meetings and records laws; and requiring notice and comment rule-making procedures under the Administrative Procedure Act. And this entity will be better motivated if it is not organized for profit.

We have to face this problem head on, and we have to face it now. Senate Budget Chairman Kent Conrad (D-N.D.) has spoken eloquently and with great urgency of the tsunami of health care costs that is sweeping inexorably toward us. Comptroller General David Walker has expressed similar concerns. Their warnings are not mere predictions: The baby boom is a fact — time sweeps that population inevitably along — and the increased cost of medical care for the aged is well-established.

Sooner or later, we will have to take action to address this massive tidal wave of cost. Ultimately, we will have no choice. The real choice we have is now. If we take action now, we have more options, and more humane options. If we wait to act, we may well be left with only very difficult and unpalatable choices. So let's act now. We have many options before us. Congress should pass legislation that will help bring the promise of health information technology and a reformed health care delivery system to every doctor, every hospital and every patient across this country.

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