Statement of

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on

Health Information Technology: What's the cost to small businesses?

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Madam Chairwoman and members of the Subcommittee, thank you for the opportunity to join in the debate as you consider different options for adopting health information technology (HIT) and the implementation of policies in the American Recovery and Reinvestment Act of 2009 (ARRA). We represent the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

A new study[1] in the *Archives of Internal Medicine* finds that hospitals using health information technology experience fewer complications and lower mortality. The technology studied included electronic medical records, decision-support tools, physician order entry and automated medical notes. However, the real question is whether the investment in HIT is cost effective and whether the adaption of the policy should be mandated by government fiat.

We believe the answer to the latter is emphatically no and that the calculations of the former should be left up to individual providers and the market place. In fact, after working on a study of the cost effectiveness of HIT, Peter Orszag, former director of the CBO, said in 2008, "Significant financial benefits [from HIT adoption] will never flow to individual doctors and hospitals."[2] Similarly, the CBO found that, "By itself, the adoption of more HIT is generally not sufficient to produce significant cost savings."[3] Surely, HIT can provide benefits to providers and patients, but those decisions should be driven by caregivers and patients, not government dictate. Access to quality and affordable health care will improve by giving decision rights to patients and their doctors. Health care dictated from Washington will have numerous unintended consequences and will not help Americans find quality and affordable care.

Why is it that any given auto mechanic uses a computer to track auto repairs, order parts, and diagnose problems but America's health care providers can't use a similar system in the exam room? The answer is very likely two-fold. The first being value and the second is that the guy at the local garage doesn't receive his payments from Washington. The case is clear that there is value is moving toward electronic medical records just as there is value in keeping electronic records of someone's automobile. The answer on why HIT is lacking must then lie with the differences in how doctors and mechanics are paid.

Health care providers get paid based on coding provided by Medicare and Medicaid. Since there is no code for HIT, doctors have no incentive to adopt technologies that can benefit them and their patients. Instead of spending more money without solving the problem like we did with the ARRA, it is time to revisit how doctors are paid. Under our current system, patients are almost completely removed from the payment process. Be it a government program or a third-party payer, such as employer sponsored health insurance, patients are not responsible for payment. What incentive would a mechanic have to keep costs low on a tire rotation if someone else

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1 Archives of Internal Medicine, "Clinical Information Technologies and Inpatient Incomes: A Multiple Hospital Study," Accessed at http://archinte.ama-assn.org/cgi/content/abstract/169/2/108, January 26, 2009.

2 Peter Orszag, Congressional Briefing, June 2008, taken from Rich Daly, "HIT Systems May Be Costly Initially but Have Advantages in Long Run," *Psychiatric News*, 2008.

3 Evidence on the Costs and Benefits of Health Information Technology," Congressional Budget Office, May 2008, p. 11, at http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf (March 18, 2009).

picked up the tab? He certainly wouldn't be accountable to the car owner and since the car owner wasn't stuck with the bill they probably wouldn't really care how much the final bill was either. If we are able to change the incentives and return decision making ability to the patient, doctors will be able to realize the value of adopting HIT systems because patients will see the benefits of fewer errors, ease of use and, ultimately, better care. Until we realize this and move forward with a system based on the ability of patients to drive decisions, we are going to be stuck with a system based on perverse incentives that continues to explode costs, limit access, stifle innovation and limit quality of care.

For too long, the answers to America's health care shortcomings from Washington have been, "throw more money at the problem. That will fix it." Far more likely is that the $20 billion included in the ARRA will be inefficiently spent on systems that don't effectively solve the problem. We will be sending hard earned tax dollars after yet another inefficient and wasteful government program. Even within the federal government itself, previous attempts to upgrade technology have fallen flat. Dollar after dollar has been sent to the IRS, FBI, and the air traffic control system to modernize and upgrade IT but we have seen little benefit and too much waste. And these are all relatively simple enterprises involving single federal agencies. Health IT is vastly more complex and must include hundreds of thousands of private organizations that have invested in legacy systems that work reasonably well and are as varied as there are providers.

The United Kingdom has been trying to adopt a similar information technology upgrade for its National Health Service (NHS) since 2002. This plan was far less ambitious than the U.S. version, involving merely 30,000 physicians and 300 hospitals, all of whom are already employed by the NHS. Originally estimated at 2.3 billion pounds, the cost is already at 12.7 billion pounds ($18.4 billion), or about as much as is provided in the stimulus package for the entire United States. A recent report to Parliament admitted the program is four to five years late and may never be implemented as envisioned. The project has lost two of the four vendors who were working on it, and some of the elements that have been installed are not meeting expectations.[4]

The NCPA is a strong advocate of the health care system adopting HIT as rapidly as possible, but this cannot be done from a command-and-control system in Washington. Individual providers must be allowed the flexibility to adopt whatever technology is best able to deliver value to their patients. Even ignoring that "meaningful use" is not defined in the ARRA proposal, the government should not be in the business of picking winners and losers. What works at the Mayo Clinic might not work in the Parkland Hospital system in Dallas and neither would be a sure thing at a rural hospital such as the Western Plain Medical Complex in Dodge City, Kansas.

The work of the HIT Policy Committee, the Centers for Medicare & Medicaid Services (CMS), and the Office of the National Coordinator for Health Information Technology (ONC) to help set the rules for the ARRA is, on some level, admirable. Ultimately, it will probably amount to good work after bad. No matter the level of flexibility legislators and bureaucrats in Washington try to build into a system, they are unable to match the flexibility of thousands of individual

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[4] Greg Scandlen, "Taking Another Look at Health Information Technology," Accessed at http://www.john-goodman-blog.com/taking-another-look-at-health-information-technology/, March 2, 2009.

providers. A few hundred people in Washington cannot possibly match the collective intelligence of America's patients, doctors, nurses, and countless other medical professionals.

The ARRA provisions achieved wide bipartisan support in Congress and in the health care industry, based on the hope that the investment will help improve efficiency, cut costs, and result in better care. However, the reality is likely to be far different. Small businesses, including medical providers, do their best when they have the flexibility to meet the demands of a local market. It is beyond conceit that Washington, once again, believes they can meet the demands of those local markets with new regulations and more money. Real value and quality care can be provided at lower cost when decisions are made by those in the exam room. As long as patients are bystanders to the care, all types of care and technological adaptation will suffer.

Madam Chairwoman and members of the committee, thank you once again for the opportunity to contribute to this very important conversation. I look forward to working with each of you as Congress revisits this and other issues related to health care. It appears the health care reform train is leaving the station and I would stress the importance of market forces and patient control as the best way to lower cost, improve quality, and increase access to health care in this country.