

# Background

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## Health Information Technology: The Case for a Sound Federal Policy

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Congress, through its enactment of the “stimulus” bill, is committed to spending \$787 billion on various projects, including \$20 billion to encourage doctors and hospitals to adopt electronic health records (EHRs). This new spending is a component of the Obama Administration’s health care agenda, which includes the promotion of health information technology (HIT).

President Obama was quite vocal on the importance of HIT on the campaign trail last year, and called for a taxpayer “investment” of \$20 billion to \$50 billion. While the question of whether to make this commitment of taxpayer dollars was answered when the President signed the stimulus bill, there are still a number of unanswered questions about how to implement EHRs so that they create the maximum benefit for patients and the minimum disruption for America’s already stressed health care system.

**Carrots and Sticks.** While EHRs can and will be helpful to doctors and patients, it is not clear that taxpayer subsidies for short-term adoption of EHRs, followed by penalties for non-adopters afterwards, is the right approach. First, it is costly—an estimated \$20 billion. Second, it puts federal officials in the awkward position of having to determine the best technologies. Third, it raises another troublesome question: Should taxpayers purchase a good that some doctors and hospitals have already had the ability to purchase with their own money?

Beyond philosophical questions, there are a number of practical hurdles that must be overcome so that

### Talking Points

- As part of the stimulus bill, Congress is set to spend \$20 billion to encourage doctors and hospitals to adopt electronic health records (EHRs).
- The promotion of health information technology (HIT) is an important component of the Obama Administration’s health care agenda. On the campaign trail, Mr. Obama called for a taxpayer “investment” of \$20 billion to \$50 billion for HIT.
- While HIT holds much promise for improving health care delivery, it is not a cure-all and can have its own pitfalls.
- EHRs can be helpful to doctors and patients, but it is far from clear that the right approach is taxpayer subsidies for EHRs.
- A problem with President Obama’s approach to HIT is that heavy government regulation can place the government in the role of picking winners and losers, preventing certain future technologies from emerging.
- The Department of Health and Human Services should allow innovations that could transform the way doctors practice medicine.

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the implementation of this enterprise can be successful. As authorized by the stimulus bill, Dr. David Blumenthal, the newly appointed HIT “czar” at the U.S. Department of Health and Human Services (HHS), must write the payment rules, certification standards, and definitions of key terms by the end of 2009. According to Blumenthal, “[m]eeting this deadline will be challenging.”<sup>1</sup> At the same time, meeting this deadline the right way, with Congress and other federal officials helping to “level the playing field” and create opportunities to improve the way physicians practice medicine, will be an even greater challenge. It will be even more difficult to ensure that the federal government avoids a cookie-cutter, one-size-fits-all approach that stifles future technological developments.

**Next Steps.** Since Congress has already committed billions of dollars to developing a national infrastructure for health information technology, federal policymakers should ensure that the taxpayers’ “investment” is well spent. First, the Department of Health and Human Services should make sure that those dollars are put to the best possible use. In no instance should HHS rules inhibit innovation that drives productivity in the unique health care sector of the economy. Second, in any rule making, HHS should ensure it does not get into the business of picking winners and losers, but should seek to create a level playing field for firms entering the health information technology field. Third, HHS should encourage ease of use and flexibility in the application of such technology so that health care providers can adapt different components in determining what works best for them.

## The Promise of Health Information Technology

Converting medical records to electronic form has many potential advantages. EHRs have the potential to connect doctors with hospitals, labs, and pharmacies accurately and in real time; give patients

more control over their health care by allowing them to own their records; and make those records instantly transferable. This means that the records of a Vermont resident who breaks her leg in California can easily be available to the attending California physicians. Physician access to these records can greatly reduce medical errors, which kill between 44,000 and 98,000 Americans every year, according to the Institute of Medicine.<sup>2</sup> Performed properly and together, these changes can reduce costs, limit the need to maintain cumbersome paper records, improve safety and quality, and potentially improve the way American doctors practice medicine. Implemented correctly, the promotion of electronic medical records can be neatly compatible with patient-centered health care reform.

**Better Medicine.** The best-known study on this subject was conducted by the RAND Corporation. RAND estimated that an effective HIT program, properly designed and executed, could save \$77 billion annually. RAND researchers argued that HIT would improve safety through alerts and reminders that could warn doctors about possible adverse drug reactions. The authors stated that HIT would help prevent and manage diseases. HIT could scan patient charts and generate suggestions for vaccines and screening tests depending on individual risk factors. For those with chronic disease, HIT can also recommend appropriate tests tailored to an individual’s disease.<sup>3</sup>

In addition, HIT can provide doctors with the necessary information to make appropriate medical decisions. Today, even the most cutting-edge doctors are not aware of all the latest medical developments: It currently takes about 17 years from discovery of therapies to regular clinical use. With the right kind of EHRs, doctors could use electronic records to obtain what is known as decision support—real-time guidance from databases, such as the new “Medpedia,” which tries to accumulate all

1. David Blumenthal, “Stimulating the Adoption of Health Information Technology,” *The New England Journal of Medicine*, Vol. 360, No. 15 (April 2009), p. 1478. The article was written *before* he accepted his new position in the Obama Administration.
2. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000).
3. “Health Information Technology: Can HIT Lower Costs and Improve Quality,” RAND Health, 2005, at [http://www.rand.org/pubs/research\\_briefs/RB9136/index1.html](http://www.rand.org/pubs/research_briefs/RB9136/index1.html) (June 18, 2009).

the latest diagnostic and therapeutic guidelines. Armed with these tools, doctors could potentially decrease the number of misdiagnoses, errors, and superfluous tests.

**Patient Control.** Furthermore, personal health records (PHRs), which let individuals maintain their own information in a portable, Web-based platform, will also give patients a greater stake in their own care. In a recent study published in *Health Affairs* examining the Kaiser Permanente HIT system, researchers demonstrated patients' willingness to manage their health care online. Web site activity among Kaiser patients between 2004 and 2007 showed that there is a real potential for better results by getting patients more involved in their own health care through EHRs and PHRs. In 2004, 10.7 million people visited the site. By 2007, site visits had tripled to 33 million.<sup>4</sup>

More actively involved patients, coupled with better-informed doctors communicating with one another, can reduce the number of expensive office visits. According to another study of the Kaiser system, Kaiser Permanente Hawaii saw a 26.2 percent decrease in office visits in the three years after implementing a comprehensive HIT system. Patients became far more likely to rely on cheaper and faster e-mail and phone consultations, facilitated by the fact that their doctors had electronic access to all of the patient information. Applied broadly, this kind of change could generate enormous cost savings in a \$413 billion program like Medicare, which has over 40 million enrollees.<sup>5</sup>

### HIT: A Tool, Not a Magic Wand

At the same time, while health information technology holds a great deal of promise as a way of

reducing medical errors and relieving patients of the task of having to fill out the same form every time they go to a new doctor (sometimes even the same doctor), as a practical matter the technology is still in its infancy. There remain a host of questions about how effective electronic medical records and personal health records will be in improving care and reducing costs—the two key factors that American policymakers seem to value most.

It is a fair question whether or not the use of electronic medical records will save costs. In examining this issue, the Congressional Budget Office (CBO) found that, “By itself, the adoption of more health IT is generally not sufficient to produce significant cost savings.”<sup>6</sup> The CBO was also dismissive of the RAND study mentioned above, as it noted that RAND focused mainly on studies that found positive effects of HIT. The CBO concluded that RAND overstated the potential savings to the federal budget and to the health care system.<sup>7</sup>

Likewise, Drs. Jerome Groopman and Pamela Hartzband of Harvard Medical School were extremely skeptical of President Barack Obama's optimistic claim that HIT will save \$80 billion annually in health care costs. As Groopman and Hartzband stated, “We need the president to apply real scientific rigor to fix our health-care system rather than rely on elegant exercises in wishful thinking.”<sup>8</sup>

Other concerns about HIT are in the areas of safety and productivity. Researchers at the University of Pennsylvania found an *increased* likelihood of 22 types of medication errors stemming from the adoption of a computerized physician order entry (CPOE) system. According to the study, the error risks were quite common, occurring at least weekly.<sup>9</sup> A study of child mortality rates at a

4. Anna-Lisa Silvestre, Valerie M. Sue, and Jill Y. Allen, “If You Build It, Will They Come? The Kaiser Permanente Model of Online Health Care,” *Health Affairs*, Vol. 28, No. 2 (March/April 2009), pp. 334–344.
5. Catherine Chen, Terhilda Garrido, Don Chock, Grant Okawa, and Louise Liang, “The Kaiser Permanente Electronic Health Record: Transforming And Streamlining Modalities of Care,” *Health Affairs*, Vol. 28, No. 2 (March/April 2009), pp. 323–333.
6. “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).
7. *Ibid.*
8. Jerome Groopman and Pamela Hartzband, “Obama's \$80 Billion Exaggeration,” *The Wall Street Journal*, March 12, 2009, at <http://online.wsj.com/article/SB123681586452302125.html> (June 18, 2009). Note: Dr. Groopman and Dr. Hartzband are both self-identified political supporters of President Obama.

pediatric intensive care unit at the University of Pennsylvania found that mortality rates increased from 2.8 percent to 6.57 percent in the five months after a CPOE system was implemented.<sup>10</sup> Cedars-Sinai Medical Center in Los Angeles shut down its CPOE system after hundreds of doctors complained the system was difficult to use and a threat to patient safety.<sup>11</sup>

It is also not clear whether EHRs will increase doctor productivity. In one study of group practitioners with a new EHR system, doctor productivity decreased 10 percent to 15 percent for the first several months until doctors were fully trained on the new system.<sup>12</sup> These experiences, of course, do not prove that EHRs are unsafe or unproductive, only that they are a tool, and like all tools, must be used wisely in order to be effective.

### Obstacles to Widespread HIT Use

The preponderance of evidence suggests that EHRs are a good thing—although they should definitely not be oversold—and that America's health care system could benefit from greater adoption levels, which are currently quite low. According to a recent study published in the *New England Journal of Medicine*, only 1.5 percent of America's hospitals have a comprehensive electronic records system in

all clinical units, and 9.1 percent of hospitals have a basic system in at least one clinical unit. Seventeen percent have computerized provider-order entry for medications.<sup>13</sup> Furthermore, the CBO has estimated that about 12 percent of physicians use electronic systems.<sup>14</sup> That said, it is likely that the country is on an upward trajectory in terms of EHR adoption. According to the CBO, even before the stimulus bill passed, 45 percent of hospitals and 65 percent of physicians were likely to have EHRs by 2019.<sup>15</sup>

**High Costs.** There are a variety of reasons why hospitals or doctors could be reluctant to adopt EHRs. First, the cost. The initial capital investment in EHRs is estimated at between \$15,000 to \$50,000 per doctor<sup>16</sup> and \$10 million for a midsize hospital.<sup>17</sup> A First Consulting Group study found it would cost a 500-bed hospital \$7.9 million in initial costs and \$1.35 million in annual operating costs. The same study estimated a 250-bed hospital would need to pay \$3 million in implementation costs and \$700,000 in annual operating costs. They projected initial costs of \$14,500 per bed with annual operating costs constituting 19 percent of implementation costs.<sup>18</sup>

There are other economic and non-economic reasons for delay. Right now, the financial incentives in medicine do not reward doctors for performance,

9. Ross Koppel, Joshua P. Metlay, Abigail Cohen, Brian Abaluck, Russell Localio, Stephen E. Kimmel, and Brian L. Strom, "Role of Computerized Physician Order Entry Systems in Facilitating Medication Errors," *The Journal of the American Medical Association*, Vol. 293, No. 10 (March 9, 2005), pp. 1197–1203.
10. Yong Y. Han, Joseph A. Carcillo, Shekhar T. Venkataraman, Robert S.B. Clark, R. Scott Watson, Trung C. Nguyen, Hülya Bayir, and Richard A. Orr, "Unexpected Increased Mortality After Implementation of a Commercially Sold Computerized Physician Order Entry System," *Pediatrics*, Vol. 116, No. 6 (December 2005), pp. 1506–1512.
11. "Cedars-Sinai Suspends Use of New Clinical IT System," eHealthInsider, January 24, 2003, at [http://www.e-health-insider.com/news/352/cedars-sinai\\_suspends\\_use\\_of\\_new\\_clinical\\_it\\_system](http://www.e-health-insider.com/news/352/cedars-sinai_suspends_use_of_new_clinical_it_system) (April 2, 2009).
12. David Gans, John Kralewski, Terry Hammons, and Bryan Dowd, "Medical Groups' Adoption of Electronic Health Records and Information Systems," *Health Affairs*, Vol. 24, No. 5 (September/October 2005), pp. 1323–1333.
13. Ashish K. Jha, Catherine M. DesRoches, Eric G. Campbell, Karen Donelan, Sowmya R. Rao, Timothy G. Ferris, Alexandra Shields, Sara Rosenbaum, and David Blumenthal, "Use of Electronic Health Records in U.S. Hospitals," *The New England Journal of Medicine*, Vol. 360, No. 16 (April 16, 2009), pp. 1628–1638.
14. "Evidence on the Costs and Benefits of Health Information Technology," CBO, p. 11.
15. "Health Information Technology for Economic and Clinical Health Act," Congressional Budget Office, January 21, 2009.
16. Melissa M. Goldstein and David Blumenthal, "Building an Information Technology Infrastructure," *The Journal of Law, Medicine & Ethics*, Vol. 36, No. 4 (Winter 2008), p. 712.
17. Jacob Goldstein, "U.S. Hospitals Slow to Adopt E-Records," *The Wall Street Journal*, March 26, 2009, at <http://online.wsj.com/article/SB123802378615142099.html> (June 18, 2009).
18. "Evidence on the Costs and Benefits of Health Information Technology," CBO, pp. 25–26.

so improved performance using EHRs is not a priority for doctors. If Medicare or insurers paid doctors for improved outcomes, rather than per procedure, doctors might have a greater economic incentive to invest in HIT.

**Physician Resistance** On the non-economic side, cultural issues, especially among older doctors, are a challenge as well. Doctors in older practices will find it a hassle to transfer their paper records to computers, and established doctors will also have a more difficult time changing their ways. A 2008 study sponsored by the Department of Health and Human Services and the Robert Wood Johnson Foundation found that 29 percent of non-computerized hospitals cited doctor resistance as a major barrier to HIT implementation, and 42 percent claimed doctor resistance as a minor barrier.<sup>19</sup> Pamela Lane, vice president of health informatics for the California Hospital Association, sees hospital reluctance this way: “I’m not sure it’s only about cost. I think it’s also about fear.”<sup>20</sup> Dr. David Blumenthal, the Obama Administration’s recently appointed health IT czar, has written that the barriers to HIT adoption and use of EHRs include “the perceived lack of financial return from investing in them, the technical and logistic challenges involved in installing, maintaining, and updating them, and consumers’ and physicians’ concerns about the privacy and security of electronic health information.”<sup>21</sup>

## HIT and the Government

The real question is not whether doctors and hospitals should adopt EHRs, but which is the best way to encourage them to do so. In this connection, policymakers should reconsider the government’s role in the process. Recent experience suggests that the two most likely roles for the federal government are as cheerleader for HIT and as a

payer for medical services delivered through government health care programs.

**The Bush Approach.** The Bush Administration took an unabashedly “cheerleader” approach to the promotion of HIT within the framework of a patient-centered approach to health care policy. In April 2004, for example, President George W. Bush told a professional audience in Baltimore: “We’re here to talk about how to make sure the government helps the health care industry become modern in order to enhance the quality of service, in order to reduce the cost of medicine, in order to make sure the patient, the customer, is the center of the health care decision-making process.”<sup>22</sup>

This exhortation was accompanied by specific policy goals. First, President Bush declared a goal of 50 percent of Americans with access to a privacy-protected, interoperable EHR by 2014; second, the Bush Administration established a non-governmental way to set HIT standards for interoperability and privacy protection. The idea, as outlined by former HHS Secretary Michael O. Leavitt, was for the federal government to lead a process to set standards, in conjunction with the private and not-for-profit sectors, which would enable the creation of a platform allowing EHRs to thrive, but not to have the government impose a “one-size-fits-all” standard that could freeze technology in one place.

In other words, the government should not be in the position of choosing between VHS and Betamax when Americans are already in a Blu-Ray world. Third, the Bush Administration established small, targeted demonstration projects to encourage some small- and medium-sized practitioners to adopt EHRs. The demonstration projects took place in 14 communities around the country that had shown an interest and an ability to incorporate new EHR platforms, and that had community support for the

19. Catherine M. DesRoches, Eric G. Campbell, Sowmya R. Rao, Karen Donelan, Timothy G. Ferris, Ashish Jha, Rainu Kaushal, Douglas E. Levy, Sara Rosenbaum, Alexandra E. Shields, and David Blumenthal, “Electronic Health Records in Ambulatory Care—a National Survey of Physicians,” *The New England Journal of Medicine*, Vol. 359, No. 1 (July 3, 2008), p. 58.
20. Bobby Caina Calvan, “Most Capital-Area Hospitals Quickly Shifting to Electronic Records,” *The Sacramento Bee*, March 26, 2009, at <http://www.sacbee.com/business/story/1729785.html> (June 18, 2009).
21. Blumenthal, “Stimulating the Adoption of Health Information Technology,” p. 1477.
22. “Remarks in a Discussion on the Benefits of Health Care Information Technology in Baltimore, Maryland,” April 27, 2004, at <http://www.presidency.ucsb.edu/ws/index.php?pid=72611> (June 18, 2009).

endeavor. Rather than force EHRs on doctors, the idea was to build a groundswell of support for effective, integrated EHRs and to have the successful practices serve a missionary role in highlighting them.

**The Obama Approach.** Given the many hurdles and technical difficulties with EHRs, it is not clear that rapid government-financed adoption is the best way to proceed. But that is exactly what the Obama Administration is doing: subsidizing the adoption of EHRs by doctors and hospitals for four years, after which it will likely penalize doctors and hospitals that do not have EHRs in place.

The Obama approach also puts the job of setting standards firmly in the hands of federal officials. The HITECH Act, which Congress enacted as part of the stimulus bill earlier this year, codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS and directs it to “develop standards necessary to achieve interoperability; establish criteria for certifying HIT products; ensure the privacy and security of electronic health information; and help facilitate the creation of prototype health information networks.”

The HITECH Act also establishes several grant programs to provide funding for HIT infrastructure, purchasing certified EHR systems, training, and dissemination of best practices. The act also authorizes grants to states for low-interest loans to help providers finance implementation of HIT. Most important, the HITECH Act authorizes Medicare incentive payments beginning in 2011 to encourage the adoption and use of certified EHRs. These payments, between \$15,000 and \$50,000 for individual practices, and in the millions for hospitals, are phased out over time and replaced by penalties for not using certified EHRs beginning in 2016. It also expands privacy protections, known as HIPAA requirements (contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996). Specifically, it strengthens enforcement of the HIPAA privacy rule and creates a right for individuals to be notified in the event of a privacy breach.

**Pricey Pitfalls.** There are three main problems with the Obama approach: (1) It is costly; (2) it may be a solution in search of a problem; and (3) it may not have the effect intended. The goal, as laid

out in the stimulus bill, is to reach EHR adoption rates of 70 percent for hospitals and 90 percent for physicians in ten years. Yet as noted earlier, the CBO has already predicted that 45 percent of hospitals and 65 percent of physicians will have EHRs by 2019. In other words, many doctors and hospitals are likely to adopt electronic systems even without the billions of dollars of taxpayer subsidies for the adoption and “meaningful use” of EHRs, which begin in 2011.

In terms of cost, media reports on the stimulus bill typically describe the taxpayer “investment” in EHRs as \$20 billion. This is a *net* number, as it assumes \$12 billion in estimated savings for EHR adoption that may or may not happen. As a result, the gross spending estimate is actually \$32.7 billion. However, except for an initial \$2 billion in discretionary spending for HIT infrastructure, the rest of the money is in non-discretionary dollars, which means that gross spending is uncapped, and the \$32.7 billion is merely a guess as to how much it will truly cost taxpayers to finance the projected adoption rates for doctors and hospitals. Some estimates reach as high as \$50 billion, which is unsurprising, given that on the campaign trail, Candidate Obama called for an investment of \$20 billion to \$50 billion in HIT.

The second issue—that the Obama approach may be a solution in search of a problem—is inherent in the concentration of power that the HITECH Act transfers to the federal government. According to the bill, ONCHIT must establish standards that IT providers could meet by the end of 2009, and must make a compliant product available unless the market meets the need. As a result, the entire health care industry is likely to spend the next year waiting to see what develops out of the ONCHIT coordinator’s office with respect to the payment rules, certification standards, and definitions of key terms, such as “meaningful use,” upon which acceptance of the federal dollars are predicated.

Savvy HHS officials recognize the difficulty of this entire process. As noted, Dr. Blumenthal specifically said before taking the job of overseeing this process that meeting the deadline would prove “challenging.” Furthermore, Blumenthal recognizes that “much will depend on the federal government’s

skill in defining two critical terms: ‘certified EHR’ and ‘meaningful use,’” of which a draft definition was just released for public comment. The challenging nature of the deadline, combined with the difficulty in solving all of the questions involved, could mean that the federal encouragement of EHRs could, at least in the short term, have the very opposite of its intended effect. The new approach could serve as an anti-stimulus, as companies could be reluctant to develop new products until the government determines the certification standards for the EHRs. Furthermore, doctors and hospitals, seeing the promise of federal dollars 21 months away, will be unlikely to buy new record systems until the government money starts to flow.

Indeed, there is already some evidence that this is the case. *The Wall Street Journal* has reported that General Electric will offer “no-interest loans to hospitals and health-care providers that purchase GE’s health-care information technology.” The reason for this, according to Vishal Wanchoo, president and chief executive of GE Healthcare IT, is that many hospitals are cash-strapped and do not know when they will receive stimulus funds.<sup>23</sup>

### What the Administration Should Do Next

The Congress and the Administration have already enacted the stimulus bill, which funded and put into place an infrastructure for the promotion of health information technology. Given the current circumstances, federal policymakers should do what they can to promote EHR’s widespread use within a broader framework of patient-centered, consumer-driven health care reform. This can be done while simultaneously respecting the personal freedom of patients and the professional integrity of their physicians. The Administration should encourage HHS to:

#### 1. Aim Higher Than Electronic Cash Registers.

While subsidizing adoption of EHRs may not be the most free-market approach, the Administration should ensure that the \$20 billion to \$50

billion investment in HIT is put to the best possible use. Dr. Blumenthal’s office should try to use this investment to improve the practice of medicine by allowing for creativity and new ideas, while ensuring that computerized systems can communicate with one another, rather than imposing a cookie-cutter approach to this knotty problem.

2. **Do Not Pick Winners and Losers.** Former HHS Secretary Leavitt was extremely concerned about government making short-term decisions that would have problematic long-term implications on technology development. For that reason, he worked to set up the Certification Commission for Healthcare Information Technology (CCHIT), funded by a combination of federal dollars and private-sector fees, so that a non-governmental body would be making the certification decisions that established the HIT playing field. HHS should continue to use a CCHIT-like collaborative model, with key players making consensus-based decisions, rather than having the federal government decide the shape of developing technologies by fiat.
3. **Adopt a Platform Model Approach.** Drs. Kenneth Mandl and Isaac Kohane at Boston Children’s Hospital have recommended a model like the Apple iPhone platform, which would allow other software companies to develop software applications that consumers can download.<sup>24</sup> The platform stays the same, but applications compete. Such a market for HIT would encourage competition based on value and cost. Individual systems would only need to perform limited functions so providers could use a laboratory-results application from one company and a billing system from another rather than having to obtain all services from a single provider. This approach could foster innovation and competition, and allow this nascent field to develop in the most creative way possible.

23. Paul Glader, “GE Unit Offers Interim Loans to Hospitals, Health-Care Providers,” *The Wall Street Journal*, June 16, 2009, at <http://online.wsj.com/article/SB124507833147615307.html> (June 18, 2009).

24. Kenneth D. Mandl and Isaac S. Kohane, “No Small Change for the Health Information Economy,” *The New England Journal of Medicine*, Vol. 360, No 13 (March 26, 2009), pp. 1278–1281.

## Conclusion

Health information technology can lead to significant improvements in the delivery of medical care. EHRs, especially, are inherently good, and the federal government should take some steps to encourage adoption, interoperability, and to guarantee privacy. At the same time, the Obama approach has the potential to assign the government the role of picking winners and losers, thereby preventing some currently unknowable technologies from emerging in the future, to cost far more than is necessary to accomplish the goal, and to adopt technologies that do not take advantage of the full promise of HIT.

The Congress has authorized the funding for HIT, and the Administration is responsible for implementing the program. In creating the rules of the road, the Department of Health and Human Services should be very careful to ensure that its approach does not freeze out future technologies, and that it allows for creative new approaches that have the potential to transform the way American doctors—possibly doctors around the world—practice medicine.

—Tevi Troy, Ph.D., Deputy Secretary of the Department of Health and Human Services from 2007 to 2009, is a visiting senior fellow at the Hudson Institute. Jason Fodeman, M.D., Graduate Fellow in Health Policy at The Heritage Foundation, contributed to the research for this report.