

clinical enterprise, the authors are in effect arguing for construction of just one leg of a health information policy stool. Health information in this construct seems to be tacitly defined as clinical knowledge, with only a passing nod to biomedical research databases, much less population data or information related to other determinants of health.

The National Committee on Vital and Health Statistics (NCVHS) recently submitted a concept paper on a national health information infrastructure to Donna Shalala, secretary of health and human services. The multiple purposes of such an infrastructure include improving patient care, monitoring public health, and educating consumers and patients. The audiences include clinicians, researchers, policymakers, medical and public health managers, and the public. The paper suggests that improving the population dimension of the data infrastructure can help to identify and analyze disparities in health status and care and support targeted educational programs, community services, and evidence-based health services. Beyond clinical information explicitly for health professionals, improving knowledge management and decision support for consumers and patients can support self-education and self-care as well as offering useful data about available care options. Three potentially linked computer-based health records—patient, population, and personal health records—might facilitate coordination, research, and assessments for both clinical care and public health and permit individuals and communities to participate more intelligently in their own health.¹

The reasons for favoring a broader view of “health information” are pragmatic. First, the rapid diffusion of Internet-based information channels supports a more ubiquitous delivery system that includes public health and people at home, work, school, and elsewhere as well as the traditional clinical settings. Innovators will build these emerging technologies to expand their market potential. Second, this same technology wave has merged with the consumer empowerment movement to create

a potential tsunami of consumer/patient health information applications that are not always linked to an explicit clinical relationship. Third, since the determinants of health are multifactorial, including social, economic, and cultural factors as well as clinical illnesses, the optimal strategy for disease prevention and/or control may transcend various of these parameters. Indeed, nonhealth factors may play a disproportionately large role for many users of the medical care system.

A national discussion of “health information policy” should include all relevant determinants of health and illness, including both the information and policy implications of the issues. A more comprehensive approach will offer the best chances of improving the health status of all Americans.

DON E. DETMER, CHAIR
MARY JO DEERING, STAFF
NATIONAL COMMITTEE ON VITAL AND
HEALTH STATISTICS
WASHINGTON, D.C.

NOTE

1. The NCVHS paper notes that similar comprehensive approaches are being actively developed in Australia, Canada, and the United Kingdom, among others. The paper is available on the NCVHS Web site at <http://aspe.os.dhhs.gov/ncvhs/hii-nii.htm>.

A New Proposal For Cooperation In HIT Development

To the Editor:

Public policy has the potential to improve the interaction between public and private sectors in developing HIT products, to the ultimate benefit of patients. Private medical software development results in products that are challenging to integrate internally, as well as into purchasing health plans' existing HIT systems. In seeking ways to share information, medical businesses eventually discover a vast desert of nonconducting silica between their HIT systems and those of others. This interface problem is a huge opportunity for the private interface developer but can also be an opportunity for the public good.

Legislation allowing Tax-Exempt Com-

munity Health Information Projects (TE-CHIPs) are one approach to deal with many problems in this area. Nonprofit corporations that qualify for TE-CHIP status would allow low-interest financing of electronic medical records (EMRs) and similar technologies that turn isolated medical encounters into digitized, structured, anonymous data. Such nonprofits, with consumer/patient representation, would be a reasonable forum to set up local privacy and security policies in the current policy void. The nonprofit community structure would reduce the incentive for inappropriate data mining ("push tactics") from the community resource (the digitized information residing on local servers).

TE-CHIPs would not exclude simultaneously developed for-profit firms that provide the same service (such as the Wisconsin Health Information Network, supported by Ameritech). They would mirror the tax structure of hospital corporations, with both private and public ownership—managed through a process similar to that put in place by the 1946 Hospital Survey and Construction Act (Hill-Burton), where the government encourages investment in population health in exchange for some control of the rules. A hybrid agency such as the model Lynn Etheredge has described (using the model of the Securities and Exchange Commission and the Financial Accounting Standards Board) could approve tested protocols and networking systems (such as HL7 or TCP/IP) as they evolve.¹

TE-CHIPs would be funded via transactional service charges between members whose representatives sit on the same board of directors. These nonprofit ventures would allocate revenues according to local priorities, which could include publishing community-wide health care performance data to assist consumers in making decisions. Consumers could see other immediate benefits, such as reduced drug interactions as demonstrated by LDS Hospital in Salt Lake City.²

Where does this idea fit into Donald Moran's health information policy concerns? Like David Kendall and and Robert Levine's Perspective (*Health Affairs*, Nov/Dec 1998), this

proposal vigorously promotes private innovation, governmental support for rapid adoption, and promotion of an evolving national standard of securing the interchange of data between HIT systems, so that providers, imaging companies, health plans, and other interested parties can be assured of the compatibility of each product.

As suggested by Kendall and Levine, a new organization that "can earn the public trust because it neither controls or is controlled by existing institutions" may need to evolve. The nonprofit TE-CHIP could be the prototype for such an organization. Policymakers should encourage development of these organizations in a way similar to how the Health Maintenance Organization (HMO) Act of 1973 encouraged HMO development. Government's health information policy and tax incentives, in concert with national funders' support for fledgling model organizations and private ingenuity in product development, as well as the input of consumers and providers, could develop the systems we envision.

GARY CANTLON

INLAND NORTHWEST COMMUNITY HEALTH
INFORMATION PROJECT (IN-CHIP)
SPOKANE, WASHINGTON

NOTES

1. L. Etheredge, "Promarket Regulation: An SEC-FASB Model," *Health Affairs* (November/December 1997): 22-25.
2. R. Evans et al, "A Computer-Assisted Management Program for Antibiotics and Other Anti-infective Agents," *New England Journal of Medicine* 338, no. 4 (1998): 232-238.

Health Information Technology: One Author Responds

To the Editor:

I appreciate the thoughtful comments of those who took the time to reflect on the wide-ranging implications of emerging issues surrounding health information technology. The comments of Don Detmer and Mary Jo Deering, read together with those of Gary Cantlon, raise a crucial question with which we must wrestle in deciding how we want health information policy to evolve. That

question is whether the proper focus of public policy is on the use of information technology to optimize the operations of the clinical enterprise, or on using technology to optimize the health care system from the perspective of the patient. As these commenters make clear, these two viewpoints are hardly identical.

The challenge for public policy is that, as I attempted to point out in my paper, the market will invest heavily in the "enterprise view" of information technology without public prodding, provided that the regulatory environment product vendors face is relatively congenial. If we want the "holistic patient-centric view," however, we face a different set of challenges, since in my judgment the private market will not automatically satisfy all potential requirements.

Today's marketplace features private companies building Web-based "patient communities," designed to provide information, advice, and peer support for patients—in exchange for the right to use demographic and clinical history data entered by the patient to support a variety of commercial applications, the value of which justifies the vendor's expenditure in supporting the "community." As long as medical records privacy regulations permit such voluntary transactions, the market will continue to invest in new ways to serve the interest of patients in exchange for their valuable data.

We are a long way, however, from the "universal medical record" that permits the blending of clinical data from all sources of care under one electronic roof—and will probably never get there under the natural evolution of the marketplace. If we want this, we must acknowledge a classic "information externality" and treat the creation of the infrastructure necessary to support this as a "public good." Doing so, of course, would raise an important but unfortunately complex array of subsidiary questions about the design and management of the interface between private and public information systems.

DONALD W. MORAN
MORAN COMPANY
POTOMAC, MARYLAND

Need To Measure Absolute, Not Relative, Access To Care

To the Editor:

In their paper, "Access to Care: How Much Difference Does Medicaid Make?" (*Health Affairs*, May/June 98), Marc Berk and Claudia Schur do not address an important policy question: the absolute, not relative, access to care of the uninsured. For example, their Exhibit 2 shows that in 1994, 15.1 percent of the nonelderly uninsured were unable to obtain medical/surgical care, compared with 8.2 percent of the Medicaid population and 4.0 percent of privately insured persons. The authors state that these figures were derived from the 1994 Robert Wood Johnson Foundation (RWJF) National Access to Care Survey, which asked respondents whether they were able to obtain the health care "they believe was needed." One conclusion to be drawn from this exhibit is that almost 85 percent of the uninsured did not have a difficulty in obtaining needed care. Similar good news could be inferred from this exhibit regarding dental care, prescription drugs, and eyeglasses.

Of course, one explanation of these numbers is that many of the respondents who did not indicate a problem did not, in fact, need care. Perhaps if they had needed care, they would have had access problems. It would be useful to see what Exhibit 2 would show if it were confined to persons who reported their health status as "fair/poor," that is, confined to persons who would more likely have sought health care. Exhibit 3 presents data in this way but for a composite of services. Even then, we are led to infer from this exhibit that 42 percent of uninsured persons who were in fair or poor health did not experience any difficulty in obtaining medical/surgical care, dental care, prescription drugs, eyeglasses, and mental health care.

STEVEN SCHREIBER
CENTER FOR HEALTH WORKFORCE STUDIES
SCHOOL OF PUBLIC HEALTH
STATE UNIVERSITY OF NEW YORK
AT ALBANY
RENSSELAER, NEW YORK

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