HOT TOPIC

Better Health Information Technology Could Save Lives and Cut Costs

U.S. health care spending tops $1.7 trillion per year. Yet Americans have lower life expectancies than the citizens of many other countries, and our health care system is plagued with inefficiency and poor quality. Other industries have used information technology to lower costs and improve quality. Could health care achieve similar results? There is little empirical evidence about the costs and benefits of health information technology (HIT)—including electronic medical records, decision support systems, and computerized physician order entry—so RAND researchers modeled potential costs and benefits of its widespread adoption. RAND estimated that implementing HIT systems in 90 percent of hospitals and doctors’ offices would cost about $8 billion per year over 15 years; savings from efficiency and health benefits could be $81 billion to $161 billion or more per year.

Annual Savings from Efficiency Alone Could Exceed $77 Billion

Efficiency savings result when the same work is performed with fewer resources. If most hospitals and doctors’ offices adopted HIT, potential efficiency savings for both inpatient and outpatient care could average more than $77 billion per year. The largest savings come from fewer hospital stays (a result of increased safety and better coordination and scheduling), reduced administrative time for nurses, and more efficient drug utilization.

Health and Safety Benefits Could Double the Savings, Reduce Illness, and Prolong Life

HIT improves patient safety, largely by means of alerts and reminders generated by computerized physician order entry systems for medications. For example, these systems warn doctors about potential adverse reactions between a newly prescribed drug and a patient’s other drugs. If all hospitals had a HIT system that included this function and used it effectively, RAND estimates that approximately 200,000 adverse drug events could be eliminated each year. HIT can also improve disease prevention by scanning patient records for risk factors and by recommending appropriate services, such as vaccinations and screenings. The RAND team estimated that increasing adherence to five common preventive services (flu and pneumonia vaccinations and breast, colorectal, and cervical cancer screenings) could prevent more than 50,000 deaths each year.

Market Forces Present Obstacles to HIT Implementation

Current market conditions place serious obstacles in the way of HIT adoption. Only 10 to 15 percent of doctors’ offices and 20 to 25 percent of hospitals now have some kind of HIT system. Most of the existing systems cannot talk to each other, and there is no market pressure to improve connectivity.

One of the most serious barriers is the disconnect between who pays for and who profits from HIT. Patients benefit from better health, and payers benefit from lower costs, but providers pay to implement HIT and experience lower revenues after implementation. For instance, hospitals that use HIT to reduce adverse drug events also reduce bed days—and reduced bed days mean reduced revenue.

The Government Should Act Now

HIT’s potential to lower costs while improving quality suggests that it is time for the government to actively promote HIT adoption. However, aggressive use of federal purchasing power will be needed to overcome market obstacles. Medicare, the nation’s largest payer, has the most to gain from HIT’s cost and health benefits. RAND recommends that the Centers for Medicare and Medicaid Services take the lead in promoting adoption and use of HIT. The Department of Health and Human Services should continue to support development of uniform standards and HIT certification. In addition, Congress should promote hospital-doctor connectivity by allowing hospitals to subsidize portable, standardized HIT systems for doctors. This means relaxing current laws that prohibit such subsidies. The government should also develop targeted investments and incentives to promote HIT. Incentives could include a pay-for-use program for providers using HIT, which could be a first step toward a pay-for-performance system. Some direct subsidies might greatly speed HIT adoption. Finally, the government can help to guide effective adoption of HIT by gathering additional empirical evidence of its benefits and policy effects.

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FORTHCOMING

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