

Health Information Asymmetries

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Studies show American patients “are constantly at risk of being harmed by the healthcare system because critical information on their health status is not easily accessible.”¹ The inaccessibility of patient health data is a feature of American health care businesses, which are individually isolated by reimbursement constraints that impede the facile sharing of patient records. This isolation of patient health data occurs whether the clinical data is on paper or in an electronic health record (EHR). Passing legislation to compel the purchase of “certified interoperable” EHRs will not automatically make the patient data agile and networkable, because moving all current paper health records to EHRs will not address the financial disincentive among health care providers to share patient data² nor will it create networks to orchestrate the sharing of patient data.

The current business model for patient care imposes financial and productivity penalties on site level efforts to make health data interoperable between separate patient care systems.³ As patients circulate among health care providers, clinical data is stranded in paper charts or in EHRs at each facility. The standard practice in American health care is to maintain separated and inaccessible silos of patient data. Data hoarding, driven by an unforgiving reimbursement system, institutionalizes health information asymmetries between health care enterprises, and contributes directly to unacceptably high rates of preventable medical errors.⁴

Examples of institutional barriers to the sharing of health data:

- Closed clinical information feedback loops financially reward the hoarding and withholding of patient data⁵ (e.g., lack of access to external patient data leads to duplicate tests which reward each health care enterprise with extra revenue while increasing costs to the entire health care system)
- Despite decades of advocacy,

