Thanks for your forbearance Terry.[My immense pleasure after years of “no interest” from people who matter.]

I’m inspired by your resilience and enthusiasm for the area, and quite certain that this particular eHealth conversation is going to yield some interesting insights. [They already have as manifested in our recent emails]I present these ideas (which tend towards the political more than technical or clinical) to you in confidence, with a view to sharpening up the thinking. In light of my political experience, I would not want to offend any past masters as they were operating within some diabolical constraints.[I totally agree but it could be said that some were operating with an inadequate knowledge base – that is a presumption on my part and may be entirely incorrect so accept my apologies in advance.]

My overarching thesis for eHealth and its myriad follies is that the systems built often correctly reflect the “true” priorities of the system. The only glitch is that these priorities are often so radically divorced from those stated by the system’s leaders and in turn expected by clinicians and/or the public.[I would like you to expand this # as I am not sure I entirely grasp your focus here.]

Applying this analysis, it makes sense that an EMR purpose built to support HIV treatment in Africa would work because the only people involved in its development are dedicated clinicians, developers and minimal funding from similarly aligned entities with the specific purpose of improving the quality of care.[The inclusion of ‘end users’ i.e. patients also became critical. For the remote clinic staff we physically and metaphorically “sat in the dirt with them for 18 months” to ‘collaborate’ all our needs.(1-3)]

It also makes sense that physician led, integrated health systems (e.g. Regenstrief, Intermountain) that understand the “triple aim” nexus between high quality care and reduced costs would employ these systems successfully.[See the wonderful dissertation by Brent James in his QMMP document on quality. I will attach.]

But finally, it also follows that systems built for governments in modern western democratic economies will never work because they are being built to get their political leaders re-elected, and make their vendors lots of money, but not really serve the community. The failure of these systems is ultimately guaranteed when the transparency they risk introducing into a system starts to threaten vested interests such as private medical providers and their associated institutions.
[This statement should be engraved on the institutions walls!]

As per your slide from Blum, the red tail wags the yellow and blue dog because this is actually what matters in modern health care.

Microsoft learned this the hard way with their health solutions group efforts that I was involved in for a few years. The analytics software (Amalga) was quite impressive, initially developed by a group of keen, inquisitive (“data curious”) emergency physicians. They used the solution to monitor all sorts of clinical quality metrics across the business Washington Hospital Center service. Microsoft executives saw it, were impressed and acquired it. They then tried for 4 years to sell it to the world, only to discover that the “world” was not as interested in “clinical quality” as they were in bottom line revenues. What emerged from this experiment was the realisation that Microsoft had found itself ambushed by the gross conceit of modern healthcare i.e. stating that it was all about patient care, when in actual fact it was all about cash. Hence the highly administrative focus of most EMRs?
[Another seminal statement. Well written.]

What has been terrific is to see US policy makers respond to this realisation by establishing "business models" around meaningful use and clinical outcomes. This is what seriously excites me now, though I suspect Australia is a decade away from adopting anything like what's going on in the US at the moment.[I will try and collate some of the on-line discussions I am involved in around the USA system of MU. Problems abound and some end points are good. It is a bit like walking on broken glass.]

One of the mantras we have here at the CRC (born in part out of our academic finance roots) is: "Healthcare is not a system, it's a series of highly dysfunctional markets". Applying this prism to healthcare really does start to clarify things, especially on the private side. On the public side, the currencies are sometimes different, but no less predictable.[You will really like the article on Variation by J. Wennberg that he sent to me to be used for educational purposes. I believe you see many of the issues correctly and one of them is that the 'models' of care –public/private/or both-are producing the same cost and quality outcomes.]

I'll pause here for fear of triggering some sort of global terrorist alert and/or offending you? Needless to say, I look forward to seeing where this conversation goes!

Best regards, Paul

1. Hannan TJ, Rotich JK, Odero WW, Menya D, Esamai F, Einterz RM, et al. The Mosoriot medical record system: design and initial implementation of an outpatient electronic record system in rural Kenya. International journal of medical informatics. 2000;60(1):21-8. Epub 2000/09/07.
2. Hannan TJ, Tierney WM, Rotich JK, Odero WW, Smith F, Mamlin JJ, et al. The MOSORIOT medical record system (MMRS) phase I to phase II implementation: an outpatient computer-based medical record system in rural Kenya. Studies in health technology and informatics. 2001;84(Pt 1):619-22. Epub 2001/10/18.
3. Rotich JK, Hannan TJ, Smith FE, Bii J, Odero WW, Vu N, et al. Installing and implementing a computer-based patient record system in sub-Saharan Africa: the Mosoriot Medical Record System. Journal of the American Medical Informatics Association : JAMIA. 2003;10(4):295-303. Epub 2003/04/02.