

Is There a Business Case for  
Personal Health Records, and Is It  
Getting Stronger? Questions to Ask.

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# The Question and the Disclaimers

- There is considerable interest and some enthusiasm for providing people with private portable electronic medical records in some form: “a single person-centered system to track and support lifetime health care activities.”
- The idea passes the basic test of potential utility (no pet rocks).
- I am not an expert on the specifics but I do have some idea of the business needs, and how they are affected by changing market forces.

# The basics of a business case

- There is a case for any useful product if it can be sold cheaply enough.
- The real question: will enough people be willing to pay a price that will cover the costs incurred at that level of volume?
- Trickier when there are high fixed costs, and when “the product” can be defined in many ways.
- The case gets stronger if costs are dropping or demand is rising.

# Some benchmark numbers

- Assume that about 15% of people would be interested in a PHR (according to surveys).
- For a given physician, would a PHR be worthwhile for 50 to 75 patients?
- For \$10 per month? For \$100 per month?
- Will the answers be different in 2010?

# Uses of a Portable Record

- To store data.
- To retrieve data.
- To communicate with experts.
  
- The value is much greater if the last function can be added.
- How often will timely and accurate information matter?
- Will the PHR be useful for economic data?

# Theory: the value of information

- VOI measures how much better off you are, in facing a set of future possible situations, if you have better information and therefore take different actions than if you have less good information.
- So you want to know:
  - (1) How often will information in the record lead to a different decision than if it were absent?
  - (2) How much difference does that decision make?
- Examples: What is added by PHR to your history and physical? When was your last tetanus shot?

# Answering Q(1) Negatively

- Information in PMR matters if it is not “easily” available from another source. Are there examples of “difficult” info? Data exists *somewhere* on my immunizations, use of medical services, use of prescription meds.
- Most old medical data does not matter—either it is irrelevant or outdated. Most care is not immediate.
- The *marginal* cost of information is usually small: phone the doctor. Marginal cost of tests is small (even if prices are high).

# Answering Q(1) Positively

- Some information for some people may be hard to find: those who move a lot, those who are afraid to ask. Docs may not ask.
- People with some chronic conditions may need up to date information right away.
- Drug interactions are especially important, as are allergies.
- People with conditions requiring immediate care: diabetics, epileptics, etc., will value info.



# Answering Q(2) Negatively

- Much information will not affect medical decisions, and there can be overload or distortion.
- Decision tools for docs sometimes hinder as well as help: they are better for preventing oversights, but not much help in thinking through complex cases.
- Important decisions usually lead to a recheck of information.

# Answering Q(2) Positively

- Sometimes a key piece of information is the clue: frequency of anecdotes?
- Decisions are sometimes based on the accumulation of information and/or information about trends: the trajectory of your PSA.
- Can the record store doctor instructions, and answer questions (correctly)?

# Do PHR's respond to changing market forces?

- Are they buzz worthy? Yes.
- Do they help with HSA/CHP? Maybe.
- Is that insurance type going anywhere? Maybe.
- Will they assist adverse selection? Yes.
- Do they help with what is driving medical costs upward—new technology (forever)? No.
- Do they help with the recent growth in volume of outpatient services? No, and may make things worse.

# The Market Forces Plusses

- Many are enthusiastic about consumer directed health care (CDHC) supported by “skin in the game.”
- Still much less than 10% share, but growing.
- Would a PHR help? It depends on...
- Whether the PHR can provide economic data—comparative prices, practice patterns.
- Whether final CDHC model will be do-it-yourself or a network? PHR better in the first case.

# The Market Forces Minuses

- If PHR allows people to have good and private information, they can use it to pick the health plan that will pay the best for them; that will lead to adverse selection (which is not much of a problem now but could be).
- Not all information is good, and risk segmentation drives politicians wild.
- The real issue—how much do consumers (most of them) want to be involved (really and truly)? Do they want to be their own primary care and epidemiologist physicians?

# Some additional issues

- Privacy: hard to believe that PMR helps, but it may allow correction of inaccuracies.
- Bullet-proofing privacy for PMR's will be expensive, as will paying docs for emails etc.
- PMRs make so much more sense if they are linked to compatible medical records. A big gamble on the verdict here.
- *More feasible but less needed in an integrated system*
- What we need in our family—a computerized reimbursement counselor and advocate! I need this even more with HSA

# Research: If you wanted to do it

- Some randomized trials: do people with free but randomly assigned PMR's have better health outcomes or lower costs than those who do not? Would the FDA approve PMR's as effective?
- Demand: what would people be willing to pay for PMR's?
- Effect on costs—would they lower or raise the cost of care?
- The cost of the full PMR system itself—order of magnitude, returns to scale?

# Conclusions

- This idea is very far from a slam dunk.
- One key issue is the cost—and if it is low enough, how to collect it cheaply. Also the cost of the complementary systems and services. Integrated systems versus lock-in? Freestanding?
- The other key issue is integration with the overall process of care. Demand for self-management, control over care (not info)? Prevent or cause errors and anomalies?
- I see a small but significant market if usefulness can be reinforced. Not obviously tuned to where the market is going or where it should go. How often will people use it? Not for the really healthy or the really sick, or for the uninsured, but for the middle class with complex-to-manage conditions.
- The real test: A free PHR paid out of cost savings?