



The Voice of OECD Business

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BIAC comments on the draft report

“Achieving Efficiency Improvements through ICTs”

We welcome the opportunity to provide comments to the draft report on “Achieving Efficiency Improvements through ICTs” and that the draft has been made available in advance which facilitates meaningful input from BIAC. Our experts would be pleased to discuss these comments further with the Secretariat if necessary.

We commend the Secretariat for a balanced, insightful analysis that we believe to be a useful tool for member governments and can incentivize the wider adoption and use of health ICTs. We hope this will be the basis for discussion at the 2010 Ministerial with sessions specifically dedicated to health ICTs in the frame of discussions both on efficiency during the Ministerial and on quality of care during the Forum.

Specific comments on the report:

p. 4, p. 15: We believe that the transformative potential of ICTs in delivering care should be added as a fourth category of objectives listed above, as is the case on page 21.

p. 19 para 68: It may be worth explaining other factors that may have led to GPs rarely reporting reduced workload as a result of using EMRs if those were shown in the case studies: e.g. was the previous system also maintained in parallel, was there training/organizational restructuring prior to EMR introduction, was there enough transition period when the case was studied to allow for a positive effect.

p.19 para 69-73: Reference to the very well illustrated points in para 54-56 would be useful here as it is important to remind governments that decisions on health ICTs investment cannot be based on a mere cost-benefit in the traditional sense.

p. 31, para 117: The Dutch example should be removed. After two years, there has been hardly any adoption by the providers, demonstrating that there is a question about the willingness of providers to make the necessary changes despite the constraining approach.

p. 32, para 119: With regard to standardization, industry believes the most successful approach would be that of an open and transparent collaboration framework amongst governments, industry, users and other relevant stakeholders to agree on and select standards and standard profiles to achieve eHealth interoperability. This effort should take into account relevant global standards and promote inter-country collaboration as much as possible. Standards should remain market driven. However, governments have a key role to play in order to provide the legal framework, recognizing the added value standardization can play in this domain. Recognizing key standard references at government level should allow for better interoperability between the various systems and products and would thus increase efficiency.

In view of the complexity of healthcare and the national/regional fragmentation of healthcare administration, the underlying procedures and terms of healthcare could not be joined or mapped into a "common standardized healthcare". As medical professionals need to be involved when establishing IT-standards for records, reports and messages in healthcare, it is more than likely that a de-jure approach will fail: Since the two ingredients of CONSENSUS and CONFIDENCE among users will be missing - such that the de-jure approach will not be accepted nor implemented by the users. Therefore, only a joint approach with users and vendors, oriented towards specific medical use-cases, can obtain the broad CONSENSUS that is required. Furthermore open, transparent and cross-vendor interoperability testing events can create CONFIDENCE among users and vendors.

With regard to the reference on "... setting a de jure standard ...", we believe that the word "setting" is misleading as it looks as if governments were creating and defining the standards themselves.

p. 32, para 120: Open source healthcare software: although we acknowledge there may be a growing interest in open source healthcare software, primarily because it can support the dissemination of core concepts in IT applications - with vendors continuing to be responsible for the products they deploy-, we believe it is also important to raise some concerns and request caution here. Open source software also raises issues on reliability, quality and its potential to stall innovation although indeed it is a lower cost option. But much of the cost to healthcare software is related to the need for solid support of ICT solutions in healthcare. Also open does not mean "lawless": if some open software is claimed by its publisher to manage medical prescriptions and some vendor is incorporating that piece of open software in his software then the publisher may be held liable when the open software fails to satisfy that claim.

We highly recommend to split the paragraph into multiple paragraphs for the topics

1. Availability of standard texts
2. Licensing models for the use standards
3. Regulation for software in Medical Devices. The complexity of this topic is often confusing:

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- i. The paragraph does not make clear what open means: Freely available? Freely usable?
 - DICOM and HL7 are available under RAND terms.
 - If the word "open" is meant to be "usable at no cost", DICOM and HL7 do not fall under "open".
 - If the word "open" is meant to be "without contractual obligations to the user", DICOM and HL7 do not fall under "open".
 - ii. Open source is still a totally different area - with the urgent need to explain the requirements of Medical Device regulation.

Para 122: should be reshaped slightly: “Mechanisms must, therefore, be found to enforce harmonized standards when assembled in implementable profile specifications such as IHE and Continua provide, if we are to have any hope to achieve interoperability (see also www.ehealth-interop.org). These standards-based profiles will need to be defined at the international level (Hammond 2008), but their implementation will be local”. Therefore, besides technological specifications, appropriate incentives, consensus building and other enabling policies all have to be in place, as further discussed in section 4.

p. 34, Privacy & security: Key barriers that need to be overcome: Clear privacy policies are fundamental to this end. Para 202 also raises a very important point on data protection laws that may not have kept up to pace with technology development. However, in many cases when there are debates about updating such laws, we see that they may become stricter based on unfounded fears of new technologies, in particular ubiquitous technologies (such as RFID, sensor networks etc). Therefore, it will be important to mention here that such policies should take into consideration technical solutions available ensuring security and privacy, but not unduly restrict the use and collection of data with legalistic approaches that limit patient choices, and always be accompanied by information and education campaigns (the importance of which is very well illustrated on p. 57 para 210 with the MAeHC information campaign).

p. 52-55, para 191: Certification Again CONSENSUS and CONFIDENCE are the keywords. Certification may be an initial step to creating CONFIDENCE. The CONSENSUS required for standards to be accepted by the market needs extra measures: For example CCHIT very much takes up the work of the Healthcare IT Standards Panel (HITSP), where users and vendors define use-cases and select standards to create profiles. The risk is that some certification body misses to certify market-relevant capabilities, which would create in a useless drain of resources towards some irrelevant scheme. We believe that only a cooperative approach of certification with market-aware consortia can be successful. Such certification schemes should be required only for a limited time, until CONFIDENCE is established in the market.

p.50, para 183: rephrase bullet 1 from “standards setting” to “standards adoption”: “Through government leadership in standard-adopting activities”. Also rephrase bullet 3: : “by setting vendor conformance requirements along with incentives for use of interoperable systems”.

The conformance requirements have to be set on vendors as well as on organizations deploying the product. Bullet 3 should be rephrased

p. 51, para 184: replace standards-setting by standards-adoption.

p.51, para 187: This point is again failing to raise the real issue which is not the vendor products themselves but the environments in which they are used and customized for. We suggest rephrasing as follows: “Despite the encouraging progress in the US towards furthering the national agenda on standards and interoperability, communities attempting to establish interoperability among competing vendor systems *customized by providers to be used with inconsistent workflows* still need to commit considerable technical and organizational efforts to achieve even the simplest clinical data exchange”.

Comments on the next steps of the Committee’s project on ICTs in the health sector

We reiterate BIAC’s strong support to the OECD Health Committee’s work on health ICTs. As previously stated, we believe that the OECD has an important role to play in encouraging and supporting governments towards wider adoption of ICT in healthcare. The OECD is a credible and influential platform that can, within its remit, elaborate tools for governments (such as the Committee’s work on the development of indicators for international comparisons of health ICT adoption and use) and enable exchanges that will ensure health systems reap the enormous benefits the health ICTs can provide.

We believe future OECD work will benefit enormously from the work suggested by the Secretariat on a standardized survey for international comparisons of adoption and use of ICTs in the health sector. As previously stated, this will be an important step in addressing a considerable obstacle to the adoption of ICTs in the health sector, namely the lack of consistent and reliable data on the benefits of the use of health ICTs and the difficulties arising from the lack of comparability of existing measurements.

As regards the themes put forward for future work, given the importance of overcoming obstacles as also described in the report above we believe it would be helpful for governments and would substantially support the wider deployment of health ICTs to look into the theme of ensuring secure access to, and use of, digital health data for quality health care. The transformative potential of health ICTs can really occur only if issues around collection and use of health data are addressed.