Without committing government to paying for it, President George W. Bush has pledged that his administration would work toward the goal of equipping most Americans with electronic medical records (EMRs) within ten years. In so doing, Bush reached beyond his predecessors in embracing information technology as a necessity to bring health care into the twenty-first century. Speaking at Vanderbilt University Medical Center on 27 May 2004, Bush said: "Within ten years, we want most Americans to have electronic health care records—that means your records," referring to a largely supportive audience of physicians, nurses, and others. "We're at Vanderbilt for a reason. It's because this...system is...innovative and different. And it's on the leading edge of change." At the same time, Bush issued an executive order that created the Office of the National Coordinator for Health Information Technology (ONCHIT). By articulating his vision, Bush implied that government would take a strong role in making it happen. That theme—regardless of the political persuasion of the author—dominates the papers we are publishing in this thematic issue on health information technology (HIT). But like so many of the challenges facing American health care, the plot is far more complicated. While the administration supports a prominent role for government, it prefers market-based solutions in a sector where markets have peculiar characteristics.

David Brailer, the national HIT coordinator, underscores the necessity to strike appropriate balances in the implementation of HIT in an interview with Rob Cunningham, the deputy editor who oversaw the development of this volume. Characterizing the pursuit of national HIT standards, Brailer said that govern-
ment was striving to dictate the process by which such standards would be developed but “letting the outcome go where it may.” As Brailer explains: “You can’t legislate will. And what we’re doing is a market-based process. ...It’s difficult, it’s complicated, it’s messy—but it is so much preferable to the alternative. Even if we were able to do this with regulations, as soon as we were done, the regulations would be out of date, and we would have locked in standards forever” (p. 1152).

Many authors express the belief that the health care system will fully embrace the potential of HIT only when government creates the necessary incentives that make this prospect more attractive. As many IT students, including these authors, point out, the benefits of HIT redound mostly to insurers and patients, but it is hospitals and physicians that have paid the bill for its adoption to date. In our lead paper, Richard Hillestad and colleagues conclude their analysis by asserting that “there is substantial rationale for government policy to facilitate widespread diffusion of interoperable HIT” (p. 1115). Sheera Rosenfeld and colleagues argue that Medicare should wield its considerable power to promote and pay for physician adoption of HIT. And Roger Taylor and colleagues write that federal intervention could be necessary if major market failures threaten the public welfare. Perhaps most surprising is the strong conviction expressed by J.D. Kleinke, a free-market advocate if there ever was one. He writes: “As this paper makes unambiguously clear, the marketplace will not solve the HIT problem. ...The federal government may be unable to finance and build [a national HIT] system for political reasons, but it can do far more than trying to jawbone the private sector into building it on its own. ...The obvious entry point is reimbursement” (p. 1258).

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Finally, a cautionary note seems warranted. While the potential for making rapid strides toward an improved system is great, formidable obstacles remain that have thwarted the march of progress. Many of these obstacles are cited in this volume, but no paper charts them as systematically as Ted Shortliffe, who discusses the thirty-five-year evolution of HIT in his thoughtful history. He emphasizes that the adoption of HIT “will require major cultural change, financial investment, and logistical planning” and that the competitive nature of the medical marketplace, coupled with fiscal pressures, may compel governments to take the lead in exploiting the potential of HIT.

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