**Week 7: eHealth and Cloud**

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# eHealth and Cloud Computing

An eHealth system uses information and communication technologies (ICT), to enable both medical practitioners and their patients to gain insights into their total health. Many nations have implemented these systems with varying levels of success. This is due to their inherently complex nature as the medical facilities are politically and economically incentivized to be decentralized (Yang, et al., 2018).

## Core Subsystems

The three core subsystems to an eHealth system are (1) Electronic Medical Records (EMR); (2) Electronic Health Records (EHR); and (3) E-Prescription Services (ERX).

EMR systems address digitizing and storing medical information for regulatory compliance, sharing with authorized partner facilities, and simplifying record keeping. An EHR performs analytics, notifications, and patient dashboarding scenarios with the EMR data. ERX manages the treatment lifecycle such as refilling medications and billing insurance providers.

## Levels of Maturity

Stroetmann performed an analysis of fifty health care systems and loosely categorized them into different maturity levels. The levels are Patient Workflow Support Systems; Basic EHR-like Systems; Comprehensive, Complex Systems and Platforms; National Framework Systems with Common Components; and International Core Patient Data Exchange Services (Stroetmann, 2015).

# Reasons for Failure

## Scope Creep / Over commitment

Many eHealth systems have not acknowledged the existence of these levels and bitten off more than they can chew. Australia wasted over a billion dollars between 1999-2008 in failed systems that were meant to solve any issue that ever arose.

Then look at South Africa and Pakistan which focused on nationalized Patient Workflow Support Systems. Their solutions were narrow in scope-- handling only appointment scheduling and record storage. The patient experience was improved through reduced wait times, and the facility can focus on differentiating characteristics (Mandil, 2015) (Stroetmann, 2015).

## Too Much Tech Debt

Computer based medical records have been around since at least the 1950s, which has led to nearly 70 years of proprietary systems being deployed across the medical community. Each of these legacy systems requires a data format converter be created to connect them into modern eHealth ecosystems.

Australia disbanded their effort to catalog the requirements of these legacy systems after four years. Denmark took the opposite approach and mandated the support of open exchange protocols. They have also set a goal of only permitting four EMR systems on their national platform. For a country with 5.5 million residents this is easier to get agreement than across the 325 million Americans or 1.32 billion Indians.

## Insufficient Maintenance

The only thing more expensive than building an eHealth system is maintaining it afterwards. Nigeria, Uganda, Libya, and other developing countries have encountered these challenges as evident by inconsistent electricity, inadequate health policies, and shortage of qualified personal (Patience & Toycan, 2016). This has led to design requirements such as data caching at remote branch locations, allowing medical facilities to be disconnected from the network for extended periods of time.

## Cultural Barriers

Challenges caused by insufficient personal is shared by developing and wealthy nations alike. Saudi Arabia has experienced a shortage of medical professionals in part due to cultural and religious barriers.

Similarly, early attempts to bring eHealth to Ghana were also unsuccessful as they did not acknowledge these barriers. Engineering teams focused on the technical challenges of bringing Wi-Fi connectivity to remote rural communities, not devising a scheme that aligned with their religious and ethical requirements (Pagalday-Olivares, et al., 2017) (Alsulame, Khalifa, & Househ, 2015).

## Acceptance by End Users

The Taiwanese and Iraqi hospitals industry both encountered slow adoption due to the healthcare professional resistance toward the technology (Meri, et al., 2019). There was a general concern of being replaced by machines which led to avoidance of the eHealth systems. This serves as another example of the criticality of aligning personal with the technology or neither can be successful.

Australia and Malawi also experienced challenges gaining end user adoption. This was attributed to political baggage of previous failed attempts (Landis-Lewis, et al., 2015) (Stroetmann, 2015). Each platform iteration was disruptive to medical professional’s daily workflow, and there was a distrust that the system would be long lasting.

System architects can address these challenges by providing clean migration paths between major releases. This adds to the cost and complexity of design but is far superior to alienating the users. Malawi was able to later gain adoption after switching to a model that sought feedback from hundreds of doctors and patients.

## Insufficient Security and Privacy