

View Point

The Case Against Digital Maximalism in Asian Healthcare

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Introduction

I have been practicing medicine for over three decades. In that time, I have watched the computer move from the secretary's desk to the examination room, then to the palm of my hand, and now into almost every corner of clinical life. I have also watched my residents spend more time clicking than talking, and my colleagues leave the ward at nine at night to finish notes they could not finish during the day. This is not the future we were promised.

Let me be clear about what I am not saying. I am not against digital health. I use it every day. I am not nostalgic for paper. I am arguing something narrower and, I think, more uncomfortable: that we in Asia have imported a style of digital medicine that was designed elsewhere, for other health systems, and we have adopted it without asking whether it fits. The result is not better care. It is more noise, more documentation, and more exhausted clinicians.

The Problem Is Not Too Little Technology

Every time our health system encounters a problem — long waits, missed follow-ups, poor coordination — the answer is a new app or a new platform. I have sat on committees where the first question is "which software shall we buy?" and the last question is "what problem are we

solving?" We have confused the presence of a digital tool with the presence of a solution.

A colleague of mine once showed me his phone after a morning clinic. He had received 47 notifications before noon. Four of them mattered. The rest were alerts, reminders, messages from administrators, and duplicates of information already in the record. He had learned to ignore almost all of them, which is exactly the wrong lesson to learn in a profession where missing one message can cost a life.

This is what I mean by digital maximalism: the assumption that more digital tools, more alerts, more data, and more documentation will produce better health. It does not. It may produce cognitive overload, and cognitive overload produces errors.

Subtraction Is Harder Than Addition

The hardest work in digital health is not building something new. It is removing something old. I have come to believe that our organizations need to practice what I would call digital frugality — the deliberate, disciplined use of technology, and the equally deliberate removal of whatever does not serve the patient in front of us.

This is not a theoretical claim. When I was involved in a review of documentation practices at



our hospital, we found that a large share of what clinicians were typing each day was duplication. The same history, copied forward. The same assessment, reworded. The same plan, repeated. None of it was illegal, and little of it was useful. We had built a system that rewarded volume of documentation rather than quality of thought.

The dominant response in the literature has been to call for better design rather than less technology. A recent review of human-centered design in digital health claims that digital tools succeed when they are designed around human needs, capabilities, and limitations (1). This is a valuable corrective, but it leaves a prior question unasked: whether the sheer accumulation of digital tools, even well designed, is itself part of the problem.

Workflow redesign must come before procurement, not after. In practice this means asking who should do each task — the physician, the nurse, the assistant, the administrator — and then designing the digital tools around that answer. Too often we do the opposite: we buy the tool, then reorganize the people to fit it.

A more fundamental challenge comes from those who question not the design of digital health tools but the ideological forces driving their expansion. A recent analysis of digital transformation in healthcare argues that the current trajectory of digital health is not a neutral or inevitable consequence of technological progress but a reflection of specific ideas, beliefs, and goals — predominantly those of digital capitalism and neoliberalism (2). In their account, health data become commodities, patients become consumers, and the public good of healthcare is gradually replaced by individual responsibility and private ownership. The result, they warn, is a slow erosion of human rights, dignity, privacy, and autonomy. Even a perfectly human-centric digital health system, built on the most ethical principles and protected by the strongest laws, could still overwhelm clinicians. The question of how much technology is enough — and of what we are willing to remove — remains unanswered by an approach that focuses on the terms of use rather than the volume of use.

The philosophy of design in digital health must balance wisdom, ethics, and user needs (3). Good

design can make a single tool usable, accessible, and ethically sound. It cannot tell us how many tools a clinician should be asked to use. A perfectly designed app, a perfectly designed alert, a perfectly designed documentation template — each may be defensible on its own terms, and yet their cumulative presence may still overwhelm the person at the bedside. The philosophy of design teaches us how to build well. It does not teach us when to stop building.

Why Asia Needs a Different Path

Asia is home to more than nearly sixty percent of the world's population, but that single statistic hides enormous variation

(https://en.wikipedia.org/wiki/Demographics_of_Asia).

In my own region, and across the countries I have visited, I have seen health systems with world-class digital infrastructure sitting alongside clinics that still struggle to keep the lights on. Internet access, digital literacy, and health literacy are not evenly distributed, and they never will be.

What worries me most is the casual way we import models designed for high-income Western systems. These models assume reliable connectivity, a stable electricity supply, a workforce trained in digital tools, and a patient population comfortable with remote care. None of these assumptions hold uniformly across Asia. When we import these models wholesale, we do not close the gap. We widen it, because the patients who can use digital services are already the ones with the most resources.

What we need is not a copy of someone else's digital health strategy. We need a plan that starts from our own realities — our epidemiology, our workforce, our culture, and our budgets.

The Questions We Have Been Avoiding

There is a set of practical questions that we in Asia have been deferring for too long. They are not glamorous, but no digital health system can function without answering them.

First, financing. How should digital health services be tariffed? What is a fair price for a teleconsultation, a remote monitoring session, or a secure message exchange?

Second, insurance. Which of these services should be covered by social insurance, and what documentation is required to justify reimbursement? Without clear answers, digital care will remain a private luxury for those who can pay out of pocket.

Third, platform architecture. Should governments build a single national platform, or should they set interoperability standards and let multiple vendors compete? Both approaches have been tried in our region, with mixed results.

Fourth, the unit of service. What exactly are we paying for? Is a remote monitoring session a billable unit? Is an automated follow-up message? Is a reminder? These definitions matter more than they appear.

Fifth, accountability. When an algorithm makes a recommendation that leads to harm, who is responsible — the physician, the hospital, the vendor, or the regulator? We have no clear answer, and until we do, clinicians will be reluctant to trust these tools.

On financing, I have argued elsewhere that a hybrid model makes sense for primary and outpatient care: risk-adjusted per-capita payments combined with family-physician coordination and targeted fee-for-service components (4). This is not a perfect model, but it aligns incentives better than the current patchwork. It rewards coordination and prevention rather than episodic technology consumption.

What I Would Ask My Colleagues to Do

I do not have a grand solution. What I have is a set of convictions, formed over many years at the bedside and in committee rooms.

I would ask clinicians to stop treating every new digital tool as an inevitability. Ask what problem it solves, and ask what it will cost in attention, time, and documentation. Sometimes the answer will be "nothing," and it is acceptable to say so.

I would ask hospital leaders to treat workflow redesign as the first step, not the last. Before buying, subtract. Before adding, ask who will maintain it and who will be interrupted by it.

I would ask policymakers to stop measuring digital progress by the number of platforms launched. Measure it by the time clinicians spend with patients, by the error rate, by whether a patient in a rural clinic can actually reach a specialist.

And I would ask all of us to remember that medicine is a human practice. The stethoscope did not replace the physician, and neither will the algorithm. But the algorithm can, if we let it, replace the physician's attention. That is the risk I am writing about.

The stakes are not abstract. They are my former residents who have left clinical practice because they could not bear the documentation. They are the patients who wait while their doctor finishes a screen. They are the health systems across Asia that are spending money on tools that do not reach the people who need them most.

We can do better, but only if we are willing to say no to some of what is offered to us. That is what digital frugality means to me. Not less technology for its own sake, but better technology, used with intention.

Conflict of interest

The author declares no conflict of interest.

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