Health information management (HIM) has changed over the years. Although a primitive disease registry and coding system was used as far back as the 1890s, HIM has become very sophisticated in recent decades. Once, patients paid the doctor for services at the time of service, sometimes in barter. In the 1920s, insurance and prepayment for services began with an early managed care model and businesses prepaying for their employees’ medical care by a group of physicians. Changes in reimbursement systems and the tradition of patients paying for medical services are ever-evolving.

Initially, hospitals had many reasons to open where they did. One rationale was to open in areas of great poverty to have assisted care for the needy and indigent, as well as access to research for the physicians. Hospitals were paid for by the wealthy via endowments and paid for marginally by the patients. With hospitals expanding to service middle- and upper-class patients, physicians began seeing more patients on a regular basis. As part of medical training, a resident physician would be expected to stay in the hospital in excess of 3 days consecutively, effectively to be able to attend to the needs of any patient at any time.

Although the attending physicians were increasingly those who maintained a private practice either outside the hospital, within the teaching system, or completely outside the teaching and hospital system entirely, changes in social welfare, including Medicare, Medicaid, and consumer-driven health care plans (CDHP), changed how physicians were paid. Doctors were increasingly paid either an agreed-upon rate, or patients paid in advance for future services rendered.