ECONOMIC VIEW

Overcoming Obstacles to Better Health Care

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AMERICANS spend far more on health care than people in other countries and we have little to show for it. And as we live longer after retirement, the share that will be paid by the government will rise.

Unfortunately, no single change will transform our health care delivery system into one that we can afford. We are going to have to try lots of new approaches that depart from standard practices.

I have several suggestions that I think would help, including an experiment that would require a change in either state or federal regulations: giving some high-quality health care providers the opportunity to practice in a world without malpractice lawsuits.

To me, the ideal health care delivery system would include:

A fee for health rather than fee for service model. Doctors and hospitals should be paid for keeping their patients well. Paying them for doing more tests and surgeries creates bad incentives.

A scientific, evidence-based approach to everything it does. Although this sounds unobjectionable, as soon as we get into some details you can see that it is easier to say than to do. For example, consider setting guidelines for when to use expensive imaging technology such as M.R.I. and CT scans.
Not only are such tests expensive, but they can lead to more, sometimes pointless, expensive procedures. A CT scan conducted to investigate a symptom will often find a small unrelated abnormality. These tiny masses are sometimes called “incidentalomas.” The vast majority of them are benign, and further testing can be expensive, worrisome and dangerous, leading to interventions that cause serious side effects or even death. But a few incidentalomas are portents of real disease. The problem is that as technology improves, it can lead to more accidental discoveries, and we need thoughtful guidelines to avoid leaving lots of patients unnecessarily anxious, scarred and broke.

More employment of midlevel professionals like pharmacists, nurse practitioners and physician assistants, to give primary care physicians more time to talk to their patients. While I don’t want to be treated by someone exceeding his level of competence, many of these professionals are underused. A goal should be to allow all members of the health care team to work to the full extent of their expertise, something that is not currently the norm. This would free primary care physicians to spend more time with patients.

A requirement that all patients meet with their doctors or trained end-of-life counselors and prepare living wills. I am not suggesting that anyone be required to make any particular choices about these difficult end-of-life questions, merely that patients talk about the trade-offs and make some choices before they are incapable of doing so.

We now spend a disproportionate amount of money during the final months of people’s lives, often with little hope of meaningfully extending them. We should at least make sure that patients are given the opportunity to opt out of spending their final days in a hospital, hooked up to tubes and running up enormous bills.

MANY fine providers do some of these things now, but they face an important impediment. They worry that if they stop administering a test that might cause more harm than good, or take steps to fully use the abilities of assistants, they will be sued for malpractice. As it is now, a doctor or hospital can be sued if the plaintiff can show that “normal standards of care” were not followed, even if those normal standards of care are inappropriate.
Thus, to encourage high-quality health care providers to adopt sensible practices, let’s offer an inducement. Those with a record of providing high-quality care at good value could apply to the government for a safe harbor from malpractice suits. Organizations that receive this status could require patients to waive their right to sue for adverse outcomes. Of course, no patient would be forced to stick with such a provider, and with the new rules on pre-existing conditions under the health care reform law, those who wanted to retain their right to sue could go elsewhere. And an organization could lose this right if its quality declines.

Courts have previously ruled that such waivers are illegal, presumably because they do not believe patients should be trusted to make this judgment, but the experiment I suggest can test this concept in a limited way, starting with only the highest quality providers.

Personally, I would gladly give up my right to sue. Maintaining it is implicitly costing me money, for which I get little in return. Over the past five years, malpractice insurance companies have paid out to patients only 37 percent of the premiums they collect, according to the National Association of Insurance Commissioners. About 40 percent of that money goes to lawyers, meaning that patients end up with less than a quarter of the dollars that doctors and hospitals pay for insurance. That is a return that makes state lotteries look like good investments.

Tort reform is a complicated subject and not a panacea. Texas capped malpractice awards for noneconomic damages at $250,000 in 2003, yet health care costs have not fallen. But tort reform deserves a better test.

To be clear, I am not proposing that this change be made universally. My suggestion is that we experiment by offering patients the option of selecting a health care provider with a record of quality that requires patients to waive certain rights to sue.

When it comes to my health, I would rather my doctor base her decisions on science rather than what she, or some lawyer, thinks will stand up in court.

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