

Realigning Health Care Incentives

David Hyman makes a powerful case that seriously misaligned incentives underlie most of the nation's health care problems ("In Medicine, Money Matters," Winter 2010–2011). My own work corroborates his diagnosis. I have come to believe that, with a few modest changes to how health care plans operate, incentives can be realigned to create vigorous competition that would eliminate or significantly mitigate many major health care cost-drivers. Moreover, health outcomes would be substantially improved.

The system I envision would make use of a third-party administrator (TPA) of health plans to effect these changes. The TPA would motivate plan members to shop for their health care by assigning a fixed benefit to every procedure and pharmaceutical. If a plan member chooses a procedure that costs more than the fixed benefit, the member would be responsible for paying the difference. Conversely, if the member chooses a procedure that costs less than the benefit, then the member would receive the difference in cash. As a result, these health care purchasing decisions would be made on the margin.

The TPA would also help plan members determine where they can find the best treatment values. To facilitate this, the plan would separate treatment from diagnosis, as these are distinctly different activities utilizing different knowledge bases and skill sets. Operating within the TPA's network, a diagnostician would examine the patient, obtain test results, establish a diagnosis, dispense medical advice, prescribe drugs, and administer routine (low-cost) care. However, if the patient requires non-routine care, the diagnostician would enter into his computer a formal treatment plan that would then be administered by another doctor.

Diagnosticians would oversee their patients' non-routine treatment, and they would confer with the treating doctor. This team approach would reduce medi-

cal errors and improve recovery rates. The diagnostician and treating doctor would have to agree on the diagnosis, which ensures that every patient receives a second opinion for any serious illness. The treating doctor may administer an alternative treatment plan if she can convince the patient that her plan is a better value, though the total benefit amount would remain fixed. However, patients with a treatment plan may go to any licensed physician in the world for treatment without any loss of benefits because benefits are based on the plan, not on treatment cost.

When the diagnostician enters the treatment plan into the computer, its database would search for doctors who can perform the treatments. The database would contain doctors' prices extracted from the claims they submit, their patient outcomes, and their credentials. The computer would organize this information for the patient, including a chart plotting doctors' prices and outcomes. The chart would help to identify the best doctors — "best" in the sense that no other doctor on the chart shows better outcomes at a lower price. Doctors can become "best" only by lowering their prices and/or improving their outcomes. In this way, incentives are aligned.

Any activity that increases a doctor's costs without providing patients with a commensurate benefit would make that doctor less competitive. Such activities would include not only cost shifting, but also administering unnecessary treatments and treatments that are not cost-effective. Hospitals would indirectly be drawn into competition because doctors' costs and outcomes are based on all treatment inputs; hence doctors would choose their hospital and other inputs judiciously to remain competitive. Moreover, cost-effective and innovative techniques and technologies would spread rapidly as doctors scramble to remain competitive.

To measure outcomes, the diagnostician would predict how quickly and completely his patients would recover if treated by a doctor with average abilities. His prediction would become a sort of prognos-

is rating. During and after treatment, patients would periodically self-administer a survey to report their recovery progress. Over time, a powerful, unbiased database would emerge on how well each doctor's patients recover from specific illnesses, risk-adjusted by prognosis rating.

This system would feature a fully automated health plan administrator. Other than customer service representatives and a computer operator, a health plan with a very large membership could be administered by servers, with no other human intervention. This is made possible by an electronic health record system and a highly efficient claims-processing system, which would substantially reduce administrative costs for providers and the TPA.

Another desirable feature is that all plan members would own and physically possess an encrypted flash drive containing virtually all of their digitized health records. Members would take this drive with them to every medical encounter for automated updating.

I conservatively estimate that this incentive-based system would save at least one-third of personal health care expenditures, which in 2008 totaled \$1.34 trillion.

For further details on this proposal, visit www.health-usa.net.

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ERRATUM

In the Winter 2010–2011 article "Gresham's Law of Green Energy," by Jonathan A. Lesser, Figure 2 incorrectly labels two of the data series. A corrected version of Figure 2 appears below and in the online version of the article.

FIGURE 2
Cape Wind Revised Agreement and Cost-Effectiveness Threshold Price

