

# Cost-Containment and the Need for Medical Justice Reform

Philip K. Howard

The greatest ongoing challenge for health care reform in the United States is to provide better health care for less money. Both aspirations are possible, but only if the nation is willing to overhaul our unreliable system of medical justice.

The challenge is crucial: American health care may bankrupt the country unless the waste is wrung out of the system. The size of the waste is staggering: \$700 billion<sup>1</sup> to \$1 trillion<sup>2</sup> every year—an estimated 30% to 40% of total costs.<sup>3</sup>

Studies indicate that the largest drivers of waste, with rough percentages each contributing to unnecessary costs, are these: fee-for-service incentives for unnecessary care (50%),<sup>4</sup> the lack of consumer responsibility (40%),<sup>2,5,6</sup> defensive medicine (20%),<sup>2,7</sup> excess bureaucracy (20%),<sup>8</sup> and fraud (10%).<sup>9</sup> The numbers total more than 100% because the skewed incentives overlap—a doctor orders expensive tests because it is profitable and provides a potential defense in a lawsuit, and the patient has no financial incentive to question the decision. Fraud thrives in a dense bureaucratic thicket with no patient incentive to check the false invoice (see Fig. 1).

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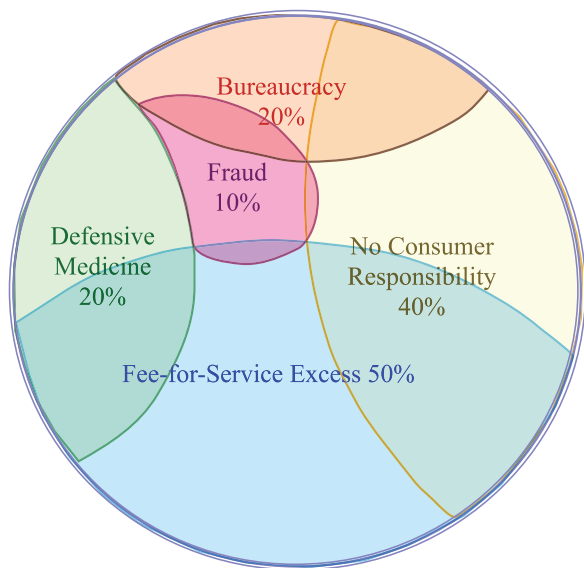
Defensive medicine alone is ubiquitous. A 2005 survey in the *Journal of the American Medical Association* found that 93% of high-risk specialists in Pennsylvania admitted to the practice,<sup>10</sup> and 83% of Massachusetts physicians did the same in a 2008 survey.<sup>11</sup> The same Massachusetts survey showed that roughly 25% of all imaging tests were ordered for defensive purposes, and 28% and 38%, respectively, of those surveyed admitted reducing the number of high-risk patients they saw and limiting the number of high-risk procedures or services they performed.<sup>12</sup>

Defensive medicine is notoriously hard to quantify, but some estimates place the annual cost at \$100 billion<sup>12</sup> to \$200 billion<sup>2</sup> or more. Quantification is difficult because defensiveness is now embedded in the culture of American health care; it is hard to separate the financial incentives from the distrust of justice. The problem of physician-entrepreneurs, vividly described in Atul Gawande's account of health care in McAllen, Texas,<sup>4</sup> is only part of a skewed incentive structure that drives providers to order care that they know will be reimbursed under bureaucratic guidelines.

Yet every physician, and most patients, can give examples of care motivated primarily by legal fear. In a July letter to the *Wall Street Journal*, a Texas doctor described how, since being unsuccessfully sued in 1995, he has "doubled and tripled the number of tests and consultations that I order."<sup>13</sup> A few years ago, I was not allowed to have minor knee surgery at an orthopedic hospital unless I went through a comprehensive "preoperative examination." There was no financial incentive to the hospital because this preoperative examination was to be done elsewhere. As it turned out, I recently had endured all those tests in my annual physical. But the orthopedic hospital would not accept month-old test results, nor even an explicit waiver by me of any liability. The result was pure waste: more than \$1,000 spent on wholly unnecessary tests.

Containing costs, as Rep. Jim Cooper (D-TN) noted on "Face the Nation" this past summer, requires





**Fig. 1.** A circle of waste. Copyright © 2009 The Atlantic Monthly Group.<sup>33</sup>

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overhauling the culture of health care delivery.<sup>14</sup> Incentives need to be realigned.<sup>14</sup>

That requires a legal framework that, instead of encouraging waste, encourages doctors to focus on what is really needed. One pillar in a new legal framework is a system of justice that is trusted to distinguish between good care and bad care reliably. Reliable justice would protect doctors against unreasonable claims and would compensate patients injured by medical errors expeditiously.

Studies repeatedly have demonstrated that the current ad hoc system of justice, with verdicts that vary widely from one jury to the next, has spawned a culture of legal fear and self-protection. Studies also show that the system fails injured patients—according to a 2006 study in the *New England Journal of Medicine*, a claim takes an average of 5 years to resolve and 54 cents out of every dollar spent in the malpractice system ends up going to lawyers or administrative costs.<sup>15</sup>

The key is reliability. Traditional “tort reform”—merely limiting noneconomic damages—is not sufficient to end defensive medicine because doctors still could be liable (in the case of obstetricians, for millions of dollars) when they did nothing wrong.

Creating special health courts is the proposal advanced by most serious observers to eliminate the incentives for defensive medicine—including support by consumer groups such as AARP, patient safety groups, medical societies such as the American Col-

lege of Obstetricians and Gynecologists and the American Medical Association (AMA), and by such thought leaders as Bill Bradley,<sup>16</sup> Mark McClellan, Newt Gingrich,<sup>17</sup> and David Brooks.<sup>18</sup> The public also overwhelmingly supports health courts<sup>19</sup>: a 2009 national survey released by Common Good and the Committee for Economic Development shows that 67% of the public favored the reform initiative.<sup>20</sup>

Nor is the idea of special courts radical. The United States has scores of special courts, precisely in areas in which special expertise is needed to achieve consistent and expeditious justice—bankruptcy courts, tax courts, mental health courts, drug courts, workers’ compensation tribunals, Social Security tribunals, vaccine liability courts, family courts, and others.

But special health courts are vigorously opposed by trial lawyers. “First you have a court for doctors, and then what? A court for plumbers?” said one representative.<sup>21</sup>

Trial lawyers, however, are agents, and their claims are only as valid as those they represent. They argue, of course, that they are champions of malpractice victims. As Anthony Tarricone, president of the trial lawyers association (called the American Association of Justice) put it: “Trial attorneys see first-hand the effects medical errors have on patients and their families. We should keep those injured people in mind as the debate moves forward.”<sup>22</sup> But under the current system, 54 cents of the malpractice dollar goes to lawyers and administrative costs.<sup>21</sup> And because the legal process is so expensive, most injured patients without large claims cannot even get a lawyer. “It would be hard to design a more inefficient compensation system,” says Michelle Mello, a professor of law and public health at Harvard, “or one which skewed incentives more away from candor and good practices.”<sup>23</sup>

Trial lawyers also suggest that they alone are the bulwark against ineffective care, citing a 1999 study by the Institute of Medicine that “[o]ver 98,000 people are killed every year by preventable medical errors.”<sup>22</sup> But the same study found that distrust of the justice system contributes to these errors by chilling interactions between doctors and patients.<sup>24</sup> Trials lawyers have not reduced the errors. They have caused the fear.

A range of malpractice reform proposals have been suggested as part of the national debate, and it is useful to examine them and identify the advantages of each. All of these reforms have significant merit, but special health courts are by far the most important in reducing defensive medicine. Each of the reforms can be combined with others, and it would be preferable



to combine the best features of each. Here is a summary:

1. Special health courts. This proposal has been developed in the past few years jointly by the Harvard School of Public Health and Common Good (an organization that I chair) with funding from the Robert Wood Johnson Foundation.<sup>25</sup> A number of public forums have been held on the initiative at The Brookings Institution and other think tanks.<sup>26</sup> The basic structure is an administrative system with judges, not juries, deciding cases in written rulings with advice from neutral experts. As with workers' compensation cases, the cases would never go to the regular courts, except for constitutional issues. The goal is a system that: 1) aspires to consistent rulings from case to case; 2) expedites proceedings, with most claims decided in a matter of months, encouraging early offers and settlements of meritorious claims; and 3) ensures that all information is compiled and fed back into the system so that doctors and hospitals learn from their mistakes. Supporters believe that the system will compensate more patients at a dramatically lower overhead cost. Most importantly, by providing a system of justice that aspires to make rulings based on accepted medical standards, special health courts should substantially eliminate the need for "defensive medicine." Tragic cases, such as with babies born with cerebral palsy, would be decided based on medical science, not emotion.
2. Caps on damages. More than half of the states have enacted "tort reform" limiting noneconomic damages, generally capping "pain and suffering" at \$250,000. These reforms have the effect of reducing malpractice insurance costs for doctors and hospitals, attracting medical professionals to the jurisdiction, and, some studies suggest, reducing defensive medicine somewhat.<sup>12</sup> But doctors still can be liable, when they did nothing wrong, for millions of dollars of economic damages (say, a lifetime of care for a baby born with cerebral palsy), and doctors in states with tort reform still say they practice defensive medicine. It is an article of faith among liberals that caps on noneconomic damages are an affront to fundamental notions of fairness (even though most states place no limit on actual compensatory damages), and President Obama has stated that he is opposed to damage caps. By way of comparison, other countries in the western world typically limit noneconomic damages but do so according to a schedule by which the pain and suffering award depends on the severity of the injury.
3. Medical screening panels. About 20 states have a requirement that malpractice cases be submitted first to expert panels. The findings of the panel are not binding, but in certain circumstances can be used in evidence. The panels have decidedly mixed reviews. In one state, Maine, the panels have improved the reliability of claims substantially. In other states, the panels seem to add time and expense without substantial improvement of reliability or efficiency. In August, the AMA released an article surveying their effectiveness.<sup>27</sup>
4. Safe harbors for following practice guidelines. The idea here is to insulate doctors from liability if they conform to accepted guidelines. There are two significant issues here. First, there is no software program that will make that determination. The doctor is dealing with a live patient with a complexity of characteristics. It takes someone with expertise and judgment to decide whether a doctor is complying with practice guidelines—that is, a special court or panel with authority to make a binding decision. Second, some health care experts believe that this safe harbor will sometimes discourage doctors from delivering the best care. Practice guidelines are accurate most of the time but not all of the time—sometimes it is best not to prescribe beta blockers after a heart attack. Sometimes the patient is too weak to endure the prescribed protocol. You would not want a system that encourages doctors to act against their best judgment because it offers the doctor a safe harbor.
5. Early offer programs. This idea, originated by Professor Jeffrey O'Connell, encourages defendants to make an early offer of compensation and encourages plaintiffs to take it because it limits attorney fees to 10%.<sup>28</sup> Most observers like this idea as an efficient way to resolve many legitimate claims. But it does not address the problem of judicial unreliability that is the main driver of defensive medicine—early offers do not protect the doctor who did nothing wrong.
6. Apology statutes. Several states have enacted laws that encourage doctors who have made mistakes to be open with patients, with the inducement that the apology cannot be used as evidence. This has the salutary effect of bringing



**Table 1. Evaluation of Characteristics of Reforms Against the Goals of Reform<sup>34</sup>**

	Reliability/Reduce Defensive Medicine	Fair Compensation	Efficient Compensation	Improve Patient Safety	Reduce Malpractice Premiums	Physician Accountability
Special health courts	✓✓✓	✓✓✓	✓✓	✓✓✓	✓	✓✓
Caps on damages	✓✓				✓✓✓	
Medical screening panels	✓	✓✓	✓		✓	
Safe harbors	✓			✓	✓	
Early offer programs	✓	✓✓	✓✓✓		✓	
Apology statutes		✓	✓✓	✓		
A combination of reforms	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓

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provider and patient together when things go wrong and of avoiding the polarization of adversarial litigation. The Sorry Works! Coalition has advocated for this proposal since 2005.<sup>29</sup> It does nothing to help the doctor who is wrongly accused of making a mistake, however, which is the fear that drives defensive medicine. Table 1 evaluates the characteristics of these reforms against the goals of reform.

Building a coherent new framework, however, is almost impossible in our political system. Devising a new health care system through hundreds of separate negotiations, with 535 members of Congress each trying to do the bidding of different constituents, is like constructing a building without any ability to make sure the walls and other elements fit together.

Containing costs requires changing the rules for all participants. Underlying incentive structures conspire to drive doctors and hospitals to do what they will be reimbursed for, not what is needed. Providers spend their days in a bureaucratic maze, focused on compliance and avoiding legal risks. Patients have no incentive to be prudent in their demands on health care providers or in their personal habits.

Because the skewed incentives reinforce each other, no reform is likely to be effective without overhauling the entire structure. A new structure should be better for most participants, liberating providers and patients alike from suffocating bureaucracy and legal fears. But the grinding gears of political deal-making in Congress make it impossible to create a coherent new structure. Piecemeal negotiations will always fail because special interests cling to their entitlements, fearful of letting go lest they find themselves in an even worse position.

Special-interest politics are almost inevitable absent strong leadership. For example, reliable insiders reported to me several months ago that the AMA had

made a pact with Democratic leadership that it would stop advocating liability reform if Congress would not reduce Medicare reimbursement rates for doctors.<sup>30</sup> The AMA is correct that costs cannot be contained by simply reducing reimbursement rates—that is like trying to fix an inefficient machine by giving it less fuel. But retaining the current system is also not an option; we cannot afford to pay doctors for unneeded services. And trading away liability reform, as doctors know better than anyone, just guarantees wasting billions in defensive medicine.

But Congress is not responding to the real needs of Americans. Liability overhaul is supported by every legitimate health care constituency, including consumer and patient safety groups, as well as by an overwhelming 83% of voters.<sup>19</sup> Congress is responding to the influence of trial lawyers.<sup>31</sup> Whom do the trial lawyers represent? They represent political money.

As I describe in my book *Life Without Lawyers*, when special interests collide, Congress maintains the status quo.<sup>23</sup> It is very hard to move, forward or backward, in a process dominated by special-interest politics. The exceptions are new programs that spend money—there is not a special interest for fiscal prudence. That is why this new legislation imposes new entitlements without significant cost containment.

This political process is incapable of creating a new, comprehensive structure to contain health care costs. Congress must delegate the responsibility to a group that has neither the debilitating political pressures nor the balkanization of responsibility.

The best model is probably a “base-closing commission,” in which a group recommends a plan that Congress can either vote up or vote down, but not alter. In health care, such a “cost-containment commission” would be given the task of recommending



overhauls that would address the core components of waste.

The components of a comprehensive reform are not a secret. Experts have been discussing them for years but without any authority to make the difficult balancing choices and without any mechanism to break through special-interest politics. Thus, a comprehensive plan likely would involve:

- New reimbursement models with bundled payments and other ways of compensating providers based on overall effectiveness, not piecemeal payments
- A requirement that patients who can afford it contribute to their care, as other countries such as Switzerland do
- Models to improve reliability of justice, such as special health courts that strive for consistency in applying accepted medical standards<sup>32</sup>
- Radical simplification of health care bureaucracy, with common reimbursement forms and regulation based on goals and principles, not micromanagement

The usual objection to special commissions is distrust—everyone fears that the deck will be stacked in favor of someone else. But a mechanism can be created that ensures representation by experts recommended by both parties and confirmation by the Senate.

The other objection to special commissions is that they make recommendations but nothing ever happens. Indeed, if Congress chooses to ignore the recommendations, rising health care costs will continue to drive America toward a fiscal crisis. The pressures here work powerfully in favor of change. The one thing that we know will not work is 535 members of Congress coming up with a coherent plan. That is why America needs a special commission to do the job.

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