The injustice of compensation for victims of medical accidents

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In most healthcare systems the need to prioritise patients for care and to ration the resources available is now well recognised. Almost the only room left for argument is how to prioritise fairly and where to make the deepest cuts. However, one group of claimants for healthcare resources have been guaranteed top priority for receipt of funds available for health care—victims of medical accidents. This fact has been scarcely noted and its justice seldom questioned.

In the United Kingdom and in many other public healthcare systems successful claims for medical negligence against hospitals or doctors are settled from the health budget and use resources that would otherwise be spent on health care. About 80% of all medical accidents occur in hospitals. In the United Kingdom in 1993-4 the resulting claims were estimated to be £125m ($200m),[1] and projections for the remainder of this century are between £250m and £1000m (K Haynes, conference of the Institute of Medicine, Law and Bioethics, Liverpool, April 1996).

Summary points

- The current arrangements for compensation of victims of medical accidents are unjust
- Compensation should not be automatically a higher priority than treatment
- Fear of litigation is not a necessary condition of efficient delivery of health care. It is unfair that awards of damages compromise patient care
- Settlement of claims to compensation should compete for priority with all other claims on the NHS budget

Aspects of law

Until the introduction of NHS indemnity in January 1990 the cost of any compensation award against a hospital doctor was shared between the NHS and the doctor's medical defence organisation. And until 1995, when the clinical negligence scheme for trusts was introduced, hospitals effectively insured themselves against claims. But now all hospital negligence claims are paid for by the NHS, reducing the amount available for all other health expenditure.[1 2]

When judgment is delivered by the courts payment becomes due immediately and hospitals have to pay the compensation awarded against them. Thus successful litigants get immediate and absolute priority in the deployment of public resources allocated for health. This guarantee of access to health resources for successful litigants highlights an important ambiguity when allocation decisions are based on scarcity. When a particular patient's life cannot be saved because there are no resources left to save it (or because there are more urgent claims on those resources) or when decisions not to treat are said to be based on scarcity of resources, the justification given is either false or misleading and usually is both. One important reason why this is so is because such an answer is never given to judges who order the payment of compensation in medical litigation. This shows that for any particular patient, resources can always be found because any particular patient could, in theory, be a successful litigant. More crucially, this raises an important issue of principle when considering the ethics of choosing between patients. Is it plausible to believe that access to law, and hence access to compensation, is always more important than access to health care and hence access to life saving or life enhancing treatment?

If people who need treatment to save their life can be told that scarcity of resources does not allow them to be treated, why, equally, should not people who need legal redress and compensation (out of the same limited pot of money) be told that the resources necessary to fund the professional help and compensation that they need are either exhausted or committed to those with a greater need?

Weighing up treatment and compensation

How can compensation automatically and necessarily be a higher moral or political priority than treatment? Why, if it is reasonable to require doctors to consider their other patients—and indeed other patients elsewhere in the healthcare system—when they are, for example, considering requesting expensive investigations or treatments or otherwise committing public resources allocated to health, should it not also be reasonable to require lawyers or the legal system to do the same?

If public resources available for patient care are to be cash limited and patients forced to compete for priority within those limits, why should not the same be true of access to litigation and compensation? Why, in short, are some victims of medical accidents given priority over the victims of all other types of accidents, injuries, and illnesses?

If these questions are pertinent the need for compensation for medical accidents should perhaps be regarded as an illness that is expensive to treat and affects comparatively few people. Many people think that such illnesses should have extremely low priority. Although I have reservations about the justice of such an approach, I think it plausible to insist that the health related needs of victims of medical accidents or negligence compete on at least an equal footing with other such needs rather than having automatic and absolute priority.

Access to justice is believed to be such a fundamental guarantee of civil liberties (and perhaps incidentally such a good way of regulating the medical profession or of regulating medical managements[3]) that its priority is justified. However, access to justice and access to the justice system are not identical. Moreover, while the moral and political importance, not to mention the social utility, of the justice system are undoubted, the justice system does not obviously have greater moral and political importance or higher priority in the public mind than does the public healthcare system. Neither is it manifestly a better guarantor of justice in the wider sense than is a properly administered public healthcare system.

One argument in favour of prioritising litigation that has some force is that fear of litigation might deter hospitals from making dangerous cuts in services. However, there are surely better ways of ensuring this, some of which are discussed below.

It is tempting to see the issue here as one of whether or not the courts have jurisdiction to award damages against publicly owned hospitals or as to whether citizens are entitled to access to legal redress for wrongs done to them. But to do so would risk obscuring a crucial point. The point at issue does not concern the scope of judicial jurisdiction but rather addresses the question of whether courts should be allowed to enforce decisions that have the effect of preempting health priorities when they have not also considered the effects of their judgments on these priorities. The courts doubtless see themselves as addressing the justice of the claims of the plaintiff before them. But in so doing they take decisions which have the direct effect of denying or postponing the, arguably, equally or more urgent and just cases of other claimants to fair access to the public resources available for health care.

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The important question, I believe, is whether it is just for awards of damages to be enforced when the effect of so doing may be to deny more important or urgent claims on the same budget. Claims that are essentially of the same sort—that is, claims to access to reasonable standards of health care or to public resources which mitigate the effects of ill health, however such ill health has been caused.

Claims to compensation for medical negligence could easily be regarded as uniquely urgent in that they come from claimants who have already been given access to health care—to whom a commitment has already been made—and who have been damaged by the exercise of that existing commitment. Neither of these considerations is compelling. For every patient in the public healthcare system each new treatment decision must be justified in terms of its urgency and its effect on the health care available to others. All such decisions are taken for patients who already have access to the public healthcare system and to whom that system has an ongoing commitment. Moreover, if the question of which causes of need for health care are the most compelling is considered seriously, being a victim of medical negligence will not always merit absolute priority. Perhaps those who are injured while on public service, those who have taken greatest care of their own health, young people, or vulnerable people have equally strong claims? My point is not to champion any one of these groups but to point out that, any impartial consideration of the merits of rival claims to priority must be just that an impartial consideration of rival claims to priority. Whereas victims of medical accidents might emerge from such an impartial review with a high place on any list of priorities for care, they might not always and inevitably successfully claim the first place.[4]

Possible solutions

My purpose in this article is not to solve this problem but to highlight an obvious and urgent injustice that requires remedy. However, two possible strategies for at least partial improvements from the perspective of justice suggest themselves.

Firstly, access to the courts could be allowed up to the point of judgment (a sort of legal equivalent of access to primary health care), when criteria for prioritisation would be applied. A professional panel would adjudicate on the priority of claims before litigation starts, with priority being given to forward looking claims for compensation to fund ongoing care and a lower priority being given to backward looking claims for retributive damages. Successful litigants would then be put on a waiting list for payment of compensation and would have their compensation paid only when there are no plausibly more urgent calls on the same resources. In this way the urgency of need for meeting these successful claims would be prioritised rather than the claims for compensation. The prioritisation would

come after diagnosis but before treatment. This is of course far from cost free, and the amounts of cash used up by the litigation process (fees and other costs) will perhaps often match or even exceed the compensation awards themselves.

Secondly, the invidious distinction between victims of medical accidents whose injury was the result of medical negligence and those whose injury was ineligible for compensation could be rejected in favour of an automatic, no fault compensation scheme. This would be separately funded and is only a partial solution.

The arguments for a no fault compensation scheme and indeed some of the difficulties with it have been well rehearsed elsewhere.[5-8] It would be fairer to victims of medical accidents and avoid the stigmatisation of doctors; whether it would also remove a degree of existing protection from negligent or callous management might depend on whether tort liability was retained alongside a no fault scheme, perhaps with a ceiling on awards and availability only on the instigation of an ombudsman. These measures would avoid the problem of plaintiffs' automatically preferring litigation because of the possibility of receiving a large awards. To meet the problems of failing to achieve a just allocation of scarce medical resources, however, any such scheme would also have to justify the awards made (even under a scheme funded separately from the NHS) in terms of their importance relative to other health priorities. But with a no fault scheme at least, huge sums would not be wasted on establishing liability.

Neither style of solution is ideal, but both are, I suggest, better and certainly more equitable than the current way of prioritising care for victims of medical accidents. In any event, it is, I believe, quite implausible to suppose that justice is served by the automatic prioritisation of the claims of successful litigants when this must have the effect of subordinating at least some, perhaps many, more urgent and important claims to health care.

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Managed care

Origins, principles, and evolution

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Summary

Managed care has entered the lexicon of healthcare reform, but confusion and ignorance surround its meaning and purpose. It seeks to cut the costs of health care while maintaining its quality, but the evidence that it is able to achieve these aims is mixed. As well as raising awareness and understanding of the issues surrounding managed care, this series considers whether managed care is desirable for the NHS. Developed in the United States as a response to spiralling healthcare costs and dysfunctional fragmented services, managed care is not a discrete activity but a spectrum of activities carried out in a range of organisational settings. Due to its constantly changing nature, managed care is a slippery concept—but all its permutations have in common an attempt to influence and modify the behaviour and practice of doctors and other health professionals towards cost effective care. Whatever potential managed care may hold in this regard, careful appraisal of its implications is essential.

Introduction

Health services are peculiarly susceptible to rapidly changing fashions and fads. Everywhere governments are seeking to limit costs without compromising quality, and parallels have been drawn between the United States and Britain. Despite the many differences in British and American health policies, growing similarities have been noted.[1] An aspect of American health policy that is attracting interest in Europe is managed care and its offshoot, disease management. Managed care has been developed in response to ever increasing healthcare costs and dysfunctional fragmented services and covers a range of activities carried out in different organisational settings. Its continually changing nature and its diversity mean that managed care remains a slippery concept. A succinct and durable definition is offered by Iglehart: "a variety of methods of financing and organising the delivery of comprehensive health

What is managed care?

- Managed care is not a discrete entity
- Managed care is a spectrum of activities carried out in a spectrum of organisational settings
- Managed care is continually evolving
- Managed care works through changing clinical practice
- Managed care has not yet been fully evaluated, so the claims made for it cannot yet be substantiated

This is the first in a series of three articles aiming to raise understanding of the issues surrounding managed care

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Glossary of terms

Disease management—Structured coordination of care over time and across healthcare settings

Health maintenance organisation (HMO)—A prepaid, organised delivery system where the organisation assumes financial risk for the care provided to its enrolled members. Financial risk may be transferred to clinicians through capitation and other financial incentives

Precertification—Clinicians must request permission to provide services to patients before instigating treatment

Preferred providers—Clinicians, professionals, hospitals, or other settings chosen to provide health care on a reduced fee basis

Preferred provider organisation—A third party company taking over the administration of utilisation management on behalf of an insurer

Prepaid health care—All-in health care for a fixed cost

Utilisation management—Managing the use of services by a variety of techniques such as precertification of care, on going case management, or second opinions

Utilisation management company—An intermediary between the purchasers of health care and selected providers

Utilisation review—Audit of the use of services

care in which an attempt is made to control costs by controlling the provision of services."[2]

Managed care has good and bad implications, and ignorance and misunderstanding abound. Little is known, for instance, about the outcomes of managed care and their impact on healthcare delivery systems and on ultimate health status. The aim of managed care is to cut costs while maintaining quality, yet the evidence that it is able to achieve these aims is mixed.[3]

Origins of managed care

Managed care developed in the United States as a response to a healthcare "system" lacking in coherence, suffering from organisational fragmentation, and consuming huge amounts of resources. Healthcare provision also suffered from a lack of preventive services, undertreatment and overtreatment of patients, and weak clinical accountability. The origins of managed care can be traced to early in this century, when railroad, mining, and lumber companies organised their own medical services or had contracts with medical groups to provide care for their workers.[4] By the 1930s prepaid contracts between employers and employee associations and physician groups were not uncommon. The uncontrollable growth of medical care costs, and increasing evidence that prepaid group practices could provide comparable care at 20-40% less cost,[6] motivated government administrators and large employers who financed insurance for their workers to look favourably on prepaid forms of health practice. Despite government encouragement, prepaid group practice grew slowly in America. Organised medicine saw the emergence of corporate medicine, and intermediaries between doctor and patient, as a threat to its potential profits and medical autonomy. Until recent decades prepaid group practice and related types of medical provision were vigorously opposed and sometimes harassed by the medical establishment. In addition, prepaid medical practice was also resisted by many patients who were reluctant to be confined to the prepaid panel in choosing their doctors. New insurance products have combined the idea of prepayment with greater flexibility and wider choice, and managed care is now growing rapidly.

Structure of managed care

The United States has so many different types of managed care structures that the system has been described as an "unintelligible alphabet soup of three letter health plans."[7] Despite this, most managed care is carried out in one of two basic types of organisational setting—the health maintenance organisation (HMO) or the preferred provider organisation (PPO).

A health maintenance organisation (see box) is a prepaid organised delivery system (a fixed amount of money is available to cover the health needs of members). The organisation therefore assumes financial risk and may transfer some of that risk to doctors or other providers. Individuals enrol with a health maintenance organisation and receive health care for a fixed premium.

The fastest growing form of health maintenance organisation has been the independent practice association or network model, which now accounts for 70% of enrolment—about 35 million Americans.[8] It offers patients a wider selection of doctors and other providers.

Preferred provider organisations act as an intermediary between the purchasers of health care and selected preferred providers, who agree to provide services on a discounted fee basis. Patients do not have to use the preferred providers in the plan but are encouraged to do so by a system of incentives and disincentives. Preferred provider organisations are technically not managed care organisations; rather, they establish a network of doctors who serve an insured population on a reduced fee basis. They use a variety of strategies to monitor and control the provision of services.

As the insurance market place in the United States has become more competitive, these generic organisational types are being combined in many ways, making it difficult to differentiate one managed care organisation from another. Large managed care companies in competitive markets increasingly offer the entire range of alternatives.

The process of managed care

There are three dimensions of managed care: health policy; systems management (how the policy is administered); and disease management (how diseases presenting to the system are dealt with).[9]

Out of a global budget determined by makers of health policy and held by a managed care organisation (an attempt at macromanagement of costs), providers are micromanaged within the system to ensure that they contain costs. More recently, providers have been micromanaged to ensure that quality is improved. Quality and cost control are becoming closely linked, and consequently the priorities of the managed care organisation may become blurred. In addition, implicit

in micro quality control is the promise of improving quality at a community level—that is, macro quality control. This is essentially the European perspective on managed care, which distinguishes it from practice in the United States.

The dimensions of managed care interact in the attempt to deliver quality health care while containing costs, but when all of the rhetoric is stripped away the common denominator is doctors. Managed care works only through modifying the actions of doctors (or other professionals initiating care) to eliminate inappropriate treatments and ensure that cost effective practice is adopted.[2] A key aspect of health maintenance organisations is the use of primary care doctors to act as gatekeepers to specialised services. Clinicians' practice can be modified in three ways: developing networks and selecting preferred providers; supplying incentives; and providing guidelines—or by a combination of these.

Ways of modifying clinicians' practice

Perhaps the best way of modifying the actions of doctors (or other professionals, hospitals, or alternative care settings) who waste resources or provide poor care is to ensure that they have no access to patients. This can be done by selecting specific doctors to provide services and providing incentives for patients to consult only these providers. The rationale is that only the "best doctors" are chosen, who will then deliver the "best care"—quality and cost will be controlled. Doctors not performing to standard (however defined) are deselected. Many observers are concerned that profit orientated managed care companies will give most priority to cost reduction and not quality of care.[10]

The basic logic of managed care for a population is to put the financial risk onto healthcare insurance organisations and providers and to give providers incentives to be judicious in the use of expensive resources. In some cases the healthcare insurance organisation assumes responsibility for most of the risk but manages providers of health care through financial incentives, profiling patterns of service use, and other such strategies.[11] Alternatively, the purchaser may transfer much of the risk to contracted groups by full or partial capitation. Reimbursement may be combined with withholds and bonuses tied to doctors' performance. Some portion of remuneration may also be based on patient satisfaction, quality measures, outcomes (such as length of stay), turnover of patients enrolled, numbers of patients from the plan, and productivity. The potential for financial incentives to change clinical practice is well documented.

Clinical guidelines are a powerful way of modifying clinicians' practice and controlling the use of services. Managed care organisations use various utilisation management strategies to control use of services. The basic idea is to review and supervise expensive decisions, ensuring that they accord with prescribed guidelines. Although guidelines are usually written by doctors, they are administered by case managers or coordinators, who are often nurses or managers. The most important types of utilisation management are precertification of inpatient admissions or the use of expensive technologies, concurrent review of length of inpatient stay or other expensive courses of treatment, management of high cost cases, and second opinion programmes. Before admitting non-emergency patients to hospital or undertaking other specified expensive treatments, doctors in managed care organisations must call the insurer's utilisation management company and have the decision approved. After admission, a utilisation manager monitors the inpatient stay to ensure the earliest possible discharge. In complex or difficult cases a case manager may work with the doctor to develop a treatment plan that substitutes less expensive care whenever possible. Utilisation management seeks to reduce healthcare costs primarily by avoiding unnecessary hospital admissions and reducing length of stay.

Most managed care plans use a combination of these methods. Doctor profiling and feedback on utilisation performance, the use of formal written practice guidelines, and various types of utilisation review are the most common.[13]

Types of health maintenance organisation

- *Staff model*—Directly employs doctors
- *Group model*—Doctors organise as independent groups and contract with the organisation to provide services exclusively for its enrollees
- *Network model and independent practice association model*—Initially different, these models are now, for all practical purposes, indistinguishable. The HMO builds a network of existing practices and providers and contracts with them to provide care for the enrollees. The enrollee must choose a primary care doctor (who acts as a gatekeeper to specialist services) from among the network members. Providers contract with HMOs to care for enrolled patients but typically retain the right to provide services for several HMOs or fee for service patients, or both
- *Point of service model*—This added option allows enrollees to seek care outside the group or network and receive partial reimbursement. Patients using point of service incur larger out of pocket expenses

Managed care in Europe

The European definition of managed care—"a process to maximise health gain of a community within limited resources by ensuring an appropriate range and level of services are provided and by monitoring on a case by case basis to ensure continuous improvement to meet national targets for health and individual health needs"[10]—differs from most American definitions in that it promotes a community perspective and is seen as a joint task of policy makers, purchasers, providers, and receivers of care. The European view emphasises community health gain as the starting point for the management of healthcare delivery; the integration of the three levels of national health policy, community based management, and individual patient care management; and disease management across all sectors of healthcare provision.

Techniques of managed care in Europe

At the level of health policy, initiatives to improve the knowledge base of purchasing have been implemented in several European countries. These initiatives have created three dimensions for purchasing health gain: assessment of populations' health status and needs, evaluation of effectiveness of treatment and cost effectiveness of services, and setting priorities. European

Evolution of managed care

First generation managed care:
- Retrospective utilisation review
- Contracts with preferred providers
- Second opinion programmes
- Little consumer information or education

Second generation:
- Proactive utilisation review
- Increased use of capitation and gatekeepers
- Prospective payment of hospitals

Third generation:
- Sophisticated utilisation management
- Management of high cost cases
- Provider profiling
- Clinical practice guidelines
- Complex financial incentives
- Full capitation or risk

Fourth generation (features now developing in the United States):
- Increasing interest in health outcomes
- Health plan report cards (league tables)
- Health system integration
- Improved information systems and system monitoring

Fifth generation (the end point toward which managed care is working):
- Anticipatory case management
- Community based needs assessment
- Targeted disease management
- Integration of clinical services
- Outcomes based reimbursement
- Informed consumers

healthcare systems vary in the way that they set priorities. In the tax based system of Scandinavia, priority setting discussions at county and regional levels seek to involve the public. In systems based on social insurance, such as the Netherlands and Germany, discussions on health priorities have focused on the coverage of basic health insurance.

At the systems management level, provision of secondary health care is increasingly being based on the contracting mechanism between commissioners and providers, resulting in performance orientated payment using case mix groupings and quality specifications. Primary care physicians are recognised as gatekeepers to, or even commissioners of, secondary and community care as the starting point for effective purchasing.

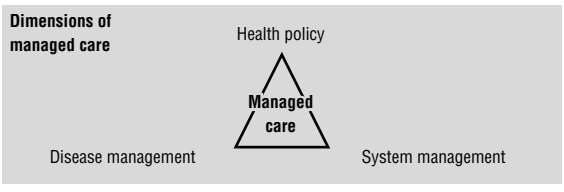
At the disease management level, effective strategies are increasingly based on guidelines for medical treatment. Managed provision of health care in the 1990s will depend heavily on information systems that can support the application of guidelines and integrate them with measures of outcome research and quality assurance programmes.

Applying managed care to the NHS

No blueprint determines the shape or form of managed care in the United Kingdom—nor is the term officially used. Rather, policy is evolving, much as it has done since the start of the NHS changes in 1991. The option of introducing pilot schemes in the delivery of primary care can be seen as a further step towards creating new forms of managed care in Britain, but we are only on the threshold of this so it is hard to be sure. Even general practitioner fundholding may not survive in its present form, giving way to locality purchasing partnerships and consortiums of various sizes and types.

The NHS already shows some of the important features of managed care. Patient choice has always been restricted by a general practitioner gatekeeper using implicit preferred providers and implicit rationing mechanisms to reduce costs. Through the research and development initiative and emphasis on evidence based medicine the NHS is actively seeking to introduce initiatives such as clinical protocols and guidelines and outcomes measurement. The development of total fundholding by general practitioners and multifunds in Britain mirrors the development of health maintenance organisations in the United States. In addition, private medical insurers in Britain are also introducing managed care into their business and may be able to provide information on managed care in a British setting.[15] The outcomes of all these initiatives remain to be seen.

The nearest to a debate on the possible use and implications of managed care in British health policy was that led by the Healthcare 2000 group. Its review on the state of the NHS, published in September 1995, ran into a barrage of criticism.[16] Although the term managed care was not used in the report, the suggestion that purchasers should compete draws on American managed care models (health maintenance organisations). The report also referred to the need for systems for delivery of integrated care and for partnerships between public and private health care. The time is now right to move the debate about managed care further into the public arena.



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