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***423 FOLLOW THE MONEY: THE IMPACT OF CONSUMER CHOICE AND ECONOMIC INCENTIVES
ON CONFLICT RESOLUTION IN HEALTH CARE**

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Why do we see so many conflicts in health care that require resolution?

Regardless of whether Alternative Dispute Resolution (ADR), the courts, or other mechanisms are the best way to resolve such conflicts, the first thought that strikes an outsider to the discipline of ADR is: Why does the delivery of health care in the U.S. spawn so many problems in the first place - problems that, in the fullness of time, generate such a large number of conflicts between patients and doctors, doctors and other doctors, doctors and hospitals, patients and insurers, insurers and providers, and so on, that need to be resolved through some sort of mechanism?

I. The Conventional Wisdom

The answers offered by experts in both health care and ADR seem to center on the unique nature of health care itself, as well as the unique nature of the American judicial system.

Health care, we are told, is not a science, but half-science and half-art. It is inherently imprecise. Uncertainty, probability, *424 and risk permeate many, if not most, of the decisions that doctors make. Yet patients have been educated - by "tradition," by the media (thanks a lot, Dr. Kildare!), and by doctors themselves - to expect outcomes free of imprecision and elevated above doubt. Meanwhile, doctors, though they know better, reinforce the pleasing but misleading image of professional certitude. They frequently fail (because of their training, or the legal system itself) to communicate how much they do not know and how frequently they are acting based on their best-informed guesses rather than the convictions of "true" scientists. The result is a huge chasm - a chasm that invites complaints and litigation when a patient outcome goes awry--between the reality of inexactitude and uncertainty versus the well-shielded but incorrect image of physician perfection. T.S. Eliot wrote, "Between the conception and the creation. . . falls the shadow." [\[FN2\]](#) Here the conception is perfect science, the creation is imprecision and uncertainty, and the shadow is the summons and complaint that the patient's trial attorney serves on the doctor or hospital.

The rapid advance of medicine - the growing sophistication of diagnostic tools available to doctors, as well

as the rapid emergence of new drugs (both “wonder” drugs and improved versions of existing drugs) - has also been fingered as a contributing factor. With each new advance in diagnostic imaging (or other diagnosis tools) and with FDA approval of each new prescription drug, the opportunity for a bad patient outcome increases (as does, of course, the opportunity for a good patient outcome). Back in the day, doctors had fewer tools to use. Today, as their armamentarium grows, so grows the opportunities to get the diagnosis wrong or to prescribe the wrong medicine and thus correspondingly grows the opportunities for conflict as well.

The march of progress in medicine has had another consequence that some argue is also a major contributor to the large number of conflicts in health care. As more and more *425 diagnostic, drug, or other types of improvements have arrived on the scene, the “literature” about their safety and efficacy has grown rapidly. Yet no doctor can possibly keep up with all the peer-reviewed monographs that appear each month in *The New England Journal of Medicine*, *The Journal of the American Medical Association*, and dozens of other scholarly periodicals. The gap between what patients' lawyers can plausibly argue doctors should know (about new diagnostic tools, new drugs, new procedures, etc.), versus what doctors actually know, is growing. As the medical knowledge absorption gap grows, the opportunity for conflict grows on a parallel track.

Another dimension in the march of medical progress (a dimension stimulated in part by the growing literature about new diagnostic tools, new drugs, etc., discussed above) has been the increasing tendency of doctors to practice in teams. Indeed, the Institute of Medicine has urged physicians to work in teams in order to reduce error and increase good patient outcomes. [FN3] While teamwork holds out enormous potential to prevent errors and reduce conflict, it also increases the potential for more errors and greater conflict. If the members of a team are poorly chosen, poorly trained, and poorly managed, the mistakes of the team could produce outcomes far worse than if the team members acted solo. Acting alone, Laurel and Hardy might have created a “fine mess” anyway; but their messes got worse because they were tripping over each other, or passing like ships in the night.

Some of the features of the American legal system have also been identified as reasons why there are so many conflicts in health care. Many experts in ADR believe that conflicts between patient and doctor would often disappear if, right after a bad outcome has taken place, the doctor could simply say to the patient: “I am sorry for what happened. It should not have happened. I should have done better. I will do everything I can to make sure it never happens again.” But while such simple, healing *426 expressions of sympathy and acknowledgements of responsibility might give patients - or, if the patient has died, their surviving loved ones - the balm they need to “move on” with their lives, the advice lawyers give doctors is to never, ever say or do anything that even hints at an admission of legal responsibility for a negligent act. Lawyers do not give this advice to be cruel; they offer it because of their judgment about what the “law” will say and about how juries and judges will treat such confessions by sorrowful physicians.

All of the preceding explanations for why there are so many conflicts in health have the ring of truth. They are part of the answer.

II. Normal Markets, Fewer Errors. . . Fewer Errors, Less Conflict

But they overlook a huge - and I believe the biggest - explanation for the problem.

Whenever customers buy “complex” goods or services from sellers, there is always a potential for conflicts. But in most markets, the availability of widespread consumer choice and the incentives that motivate both buy-

ers and sellers tend to drive down the level of conflict.

No market is perfect. The perfect market exists only in the dreams of neo-classical economists. In the real world, distortions and imperfections constantly intrude. Market failures crop up in a number of ways. Consumers make purchasing decisions with imperfect information; producers collaborate to defeat supply-side competition; government subsidies buttress inefficient operations; and costs that should be passed on to consumers in the prices of products are instead inefficiently externalized to third parties in the form of pollution, unsafe products, worker injuries and misled investors.

Nonetheless, even such imperfect markets (here treated as “normal” markets) typically have two things in common. First, the ultimate consumer has a wide array of choices among the goods or *427 services offered for sale by competing producers. Second, consumers' incentive to buy low-cost, high-quality goods and services interacts with each competing producer's incentive to maximize sales volume and revenue so as to impose a discipline on the competing producers that encourages more efficient production of whatever the producers makes. The result - even in a market marred by imperfections - is the creation and sale of what consumers want: goods and services that, compared to what would occur in the absence of these two market features, are low in cost and high in quality, and that tend to get more so over time. [FN4]

In such a “normal” market - the market of Adam Smith's “invisible hand” - the ultimate consumer typically has a very large number of choices. If you want to buy a box of cereal, a can of beans, a pair of shoes, a car, a computer, or a life insurance policy, you have in each case over a dozen choices. You're not a captive of a single vendor or even a small handful of vendors. If you don't like the grocery store, shoe store, auto dealership, computer store, or life insurance company that you first visit, you can keep shopping (and shopping and shopping) until you find the one you want. Your ultimate decision to obtain a product or service from a particular store or company is clearly your choice. You're responsible for your decision. If you end up unhappy with the result, you have to acknowledge that you are at least partly to blame.

The second key feature of a “normal” market is that consumers reward with their “custom,” and their dollars, those vendors who offer them low-cost and high-quality goods and services - goods and services that get to be low-cost and high-quality because they're efficiently produced. There are a lot of factors that contribute to efficiency, but some of the most important are error-free production, error-free communication, and error-free organization. In short, a “normal” market, by creating powerful rewards for the most efficient (i.e., low-cost, high-*428 quality) vendors and producers, rewards and, thus, stimulates the reduction of error.

These two core features of a “normal” market - the pervasiveness of consumer choice and the incentives that drive sellers to reduce error - combine to have the felicitous effect of reducing conflict. When, because of widespread consumer choice, consumers are intensely responsible for the product or service they buy, they are also somewhat responsible - or, at least, feel somewhat responsible - if that product or service proves unsatisfactory. Consumers are more likely to shoulder some (if not all) of the responsibility for the bad outcome. Consumers are less likely to blame the seller of the service. Less blame, less conflict.

But an even bigger reason why a “normal” market drives down the level of conflict is that a normal market (as explained above) reduces the number and the severity of errors throughout the production process. Whatever the particular good or service that an organization is making and selling, within the discipline of a “normal” market the many diverse members of its “production” team - engineers and lawyers, scientists and accountants, marketing experts and top managers - have a huge incentive to work together cooperatively, to get out of their

professional silos, to bury their “jurisdictional” biases, and to pull together for the good of the organization to drive error, waste, and inefficiency out of every step of the production process. If they do so, they can put into the market a good or service that's lower in price and higher in quality than the competition, expand sales and revenue, and increase their own job security and earnings. If they fail to reduce error (and waste and inefficiency) by pulling together, however, they risk losing their competitive edge due to the relatively higher-cost and lower-quality goods and services they have placed on offer, which means seeing their sales and revenue slump, which in turn means ultimately losing their jobs and income. So in a “normal” market the pressure to drive out error is all-consuming and pervasive.

When error declines, conflict diminishes. If the thing you bought did not break in the first place, where is your beef? To sum *429 up, the combination in a “normal” market of widespread consumer choice with powerful incentives that reward error-free (or “error-small”) production is a powerful mixture for driving down the level of conflict.

III. The Health Care Anomaly

In health care, however, there is no “normal” market. Health care not only shares many of the typical imperfections and distortions of the other markets (e.g., imperfect information, government subsidies, and externalization of certain costs), but also departs from the basic rules of a “normal” market in the two biggest ways imaginable. First, consumers - the ultimate consumers, that is, meaning prospective or current patients - have very little or no choices among competing health care networks, because of the way health insurance works in the United States. Second, producers, i.e., health care providers, have little incentive to lower cost or improve quality because the health insurance system in the U.S. currently distributes the flow of patients and revenue to providers with almost no regard to the providers' efficiency, the costs they impose, or the quality of care they deliver - including the errors they make.

A. Limited Choice

Most consumers of health care have no choice - or, at best, a very limited choice - of the health care plans they will use.

In theory, of course, all consumers have boundless choice. All they need to do is quit their jobs, give up their Employer-Sponsored Insurance (ESI), and pay for their health insurance 100% out of pocket. Or they can keep their jobs, but forgo their ESI, again using their own money to pay for 100% of individually purchased health insurance. Right.

Unlimited consumer choice may exist in this abstract sense. But in the real world of ESI, consumers - most of whom get their health insurance through an employer - have only the choices their *430 employers offer them. And most employers offer only one plan. [FN5] Even the larger employers that offer employees a measure of choice only offer them a fraction of the health insurance options that are available. And these employees are the lucky ones. Like the communist-bloc shopper who used to go out every year to shop for “the shoe” because there was only one style and color available before the collapse of the Soviet system, most American consumers are stuck with whatever plan the boss puts on the table.

For most Americans, in short, one of the two key conditions of a “normal” market--unrestricted consumer

choice--is simply missing. With rare exception, the only one who has a widespread choice of health insurance plans is the employer.

IV. Why Employer Choice Doesn't Work

But why doesn't employer choice drive down price and improve quality?

In this country, employers generally decide which health insurance arrangements will cover their workers (and, often, their workers' spouses and children). ESI provides insurance to the majority of Americans. Because employers typically shoulder the lion's share of the cost of ESI, it is obviously in their interest to choose plans that cost less money yet offer better care.

In addition, employers have a second self-interest in holding down health care costs. Most workers - and most firms - *431 view ESI in which the employer picks up the lion's share of the cost as the norm. Employers thus recognize that, if they aggressively shift costs to their workers due to the high cost of health insurance, they risk creating worker unhappiness and possibly driving their best employees to seek jobs at more generous firms. Thus, in order to hold down their operating costs and in order to avoid the adverse consequences to their businesses that arise from shifting costs to workers, employers have a clear and powerful interest in holding down the underlying cost of the health care.

Finally, firms also have a self-interest in improving the quality of care. If workers get bad care because an employer has chosen or created a poor health insurance arrangement, the company itself may suffer negative spill-over effects due to unnecessary or prolonged illness, such as missed days of work and a less productive workforce. Some of these spillover effects can ultimately boomerang and increase the employer's health care costs. Employers have every incentive to shop around and make good health insurance choices for their workers and their firms - choices that ought to put enormous pressure on the health insurance industry and health care providers to lower cost and improve quality.

So what is wrong with employer choice as a vehicle for holding down costs and improving quality? Even if the ideal would be for each individual consumer to enjoy a wide array of choices among competing health care plans and providers, why do the powerful economic self-interest of employers as they shop around among different insurers - or think through whether to self-insure - not effectively discipline the health care market? In short, why is employer choice not all the choice that is needed to make the health care market work properly?

The problem is that the self-interest of employers in exercising their health insurance choices in a manner that lowers cost and improves quality is neutralized - for most employers, canceled out - by an equally powerful self-interest that pushes employers to pay for any health providers their workers choose to *432 visit, and to pay those providers whatever the providers wish to charge, for whatever services they decide to perform, regardless of quality. While employers may desire to save money and improve quality of care, the leaders of virtually all corporations or governments equally desire a system that grants their workers - and, indeed, themselves, and their own spouses and children - the near-absolute right (1) to choose the physicians they will receive care from, (2) to accept the medical recommendations those physicians make as to what examinations, tests, drugs, hospitalizations, etc., are necessary, and (3) to accept the prices charged for those examinations, tests, drugs, hospitalizations, and other care, regardless of ultimate cost and quality.

Employers are not legally required to tie themselves in this knot. No law obligates them to neutralize their

self-interest in choosing low-cost, high-quality care with a countervailing decision to provide health insurance in a manner that grants their workers - and themselves, and their spouses, and their children - the right to select any doctor, obtain any care the doctor orders, and have the resulting medical, diagnostic, drug, hospital and other bills paid more or less at the rates that the providers charge. An employer could say:

In order to save money and improve quality, I have decided that all of us - from the newest, lowest-wage worker to the forty year old CEO, and including myself and my spouse and my children - will get all our care from a terrific panel of doctors I have chosen. All of us will use only the diagnostic tests and drugs I have approved under the circumstances I have pre-determined. All of us will go to the hospital I have selected, and only when and for the purposes I have pre-determined. Furthermore, I have decided to pay all of these providers no more than 'x' dollars, no matter what the doctor says about how much care is needed or what the doctor, lab, pharmacist, or hospital say the *433 bill is. That is this firm's health insurance plan. It will save a ton of money, and improve the quality of care. Here is an independent analysis that confirms both the cost savings and the quality of care. Take it or leave it.

But most employers are unwilling to impose these restraints - or anything close to them - on their employees' and their own choice of physicians, drugs, and hospitals. Even if it meant saving a lot of money and improving overall health care quality, the heads of private firms and governments alike have simply proven unwilling to suffer the internal organizational backlash, ranging from massive employee resentment to threats of resignation to actual resignations, that would inevitably flow from telling their workers (and spouses and children) that they cannot pick their doctors. The reluctance of employers to use their legal right to choose low-cost, high-quality care for their workers at the price of denying their employees the ability to freely choose their preferred choice of physicians is fortified, of course, by the fact that the individuals who must act on behalf of the private firm or government employer - the head of employee benefits, the CFO, the CEO, the President, or (in the case of government) the Budget Director, the Secretary of Administration, or the elected legislators and chief executives - would equally be denying themselves (and their own spouses and their own children) the freedom to choose their doctors.

So, yes, employers do indeed possess the power to make the choices necessary to lower health insurance and health care costs, while improving health care quality. But the price they must pay, in order to exercise this choice, is to severely restrict their workers' and their own choice of physicians. It's a price that, with rare exceptions, both private and government employers have been unwilling to pay, and indeed have resolutely refused to pay. And thus the theoretical power of employer choice to save money and improve quality has been annulled by the understandable *434 commitment of employers to let their workers (and themselves) choose the doctors they want regardless of cost or quality.

But why can employers not have it both ways? Why can they not hold down costs and improve quality, while simultaneously letting their workers (and themselves) select any physician they want, by (a) offering their employees a choice of health care networks, (b) paying only the risk-adjusted price of the low-cost/high-quality network, and (c) allowing any worker to choose to enroll in any other network so long as the worker pays the extra price? Would this cost-conscious "multiple choice" arrangement not allow both types of choice - first, the employers' choice to pay only for low-cost, high-quality care and, second, their workers' freedom to choose more costly and lower-quality care if those workers are really willing to pay the difference - to work harmoniously to hold down costs, and improve quality, while still permitting workers (and their spouses and children) to go to any doctor?

There are regrettably practical reasons, rooted in the American system of ESI, why the brilliant compromise

of cost-conscious “multiple choice” doesn't work on an employer-by-employer basis. The biggest obstacle is that small and mid-size employers, who constitute the great majority of firms and who employ the great majority of employees, simply cannot get insurance companies to compete against each other in a manner that lets the small and mid-size firms simultaneously offer two, three or more insurance companies' plans to their workers. Insurers balk at such “multiple choice” arrangements because each insurer fears it will enroll only a fraction of the firm's workers (and spouses and dependents) but end up with a disproportionate share of the firm's worst risks (the old and those with chronic illnesses). In other words, when it comes to the small and mid-size employers that account for much of the non-Medicaid/non-Medicare population, insurers refuse to participate in “multiple choice” arrangements because they fear adverse selection. And their fear is justified. The risk each insurer would face of getting “stuck” with a lot of high-cost patients is real, and risk-adjustment *435 methodologies (under which higher premiums would flow to insurers that ended up with higher risks) are still too new, complex, and uncertain to give insurers sufficient confidence that they will be paid in proportion to the risk they take. Thus, insurers simply tell employers: “We will not participate in any scheme that gives your employees a choice between our plan and a competing insurer. Give us all your workers, or we will not insure you at all.” Small and mid-size employers have no choice but to succumb (if they want to provide insurance), and the result is that they end up with a plan that must satisfy all their workers (and spouses and children) by allowing everyone a free choice of doctor, hospital, etc., regardless of cost or quality. [FN6]

*436 Only the biggest employers have the market power - the massive numbers of employees - to force competing insurers to participate in “multiple choice” arrangements which allow the employer to save money by limiting its per-employee contribution to the lowest-cost health insurance plan while giving its workers, if they are willing to pay the extra price, the freedom to choose among different plans and select any doctor or hospital they want at any time. Money talks. If and when a very large employer brings enough money to the table, it can force insurers to compete in this way despite the insurers' distaste for multiple choice. The trouble is that most employers have not figured out how to effectively design and implement a cost-conscious “multiple choice” program. Only a handful of large employers, e.g., Stanford University, the State of Wisconsin Department of Employee Trust Funds, and a few others, have groped their way through the fog of confusion that surrounds buying employee health care to figure out how to make a cost-conscious “multiple option” arrangement work.

Moreover, even when individual large employers do figure out how to make a cost-conscious “multiple option” work, their purchasing power is generally too small to have much of an impact on the efficiency of the health care system as a whole, and thus, on the level of errors that trigger disputes. Using the cost-conscious “multiple option” approach is a good way for large individual employers to save money for themselves. It also rewards whichever health care plans and providers are already relatively low in cost and high in quality, while still allowing workers to select any plan, doctor, or hospital they want and are willing to pay extra for. But unless such a buying method becomes the dominant method of buying health insurance--unless it drives most of the health care money within a health service area - it will not induce the magnitude of efficiency gains needed to squeeze out error and reduce disputes on a large scale. This condition has so far not been met anywhere in the U.S. (The place that comes closest is Dane County, Wisconsin, where a single huge employer, the State of Wisconsin, uses the cost-conscious “multiple option” buying *437 approach for approximately 100,000 individuals covered in a county with a population of approximately 450,000.)

In short, employer choice as a path to low-cost and high-quality care that prevents errors and thus reduces conflicts, however fine a theory, simply does not work in practice. The high price that the overwhelming majority of employers must pay to turn this theory into reality - sacrificing their workers' and their own (and spouses' and children's) right to select their own physicians and other providers - has proven in the U.S. to be an insuper-

able impediment. The large employers whose market power is big enough to have it both ways, by setting up a cost-conscious “multiple choice” plan that lets employers limit their spending to the low-price, high-quality option but allows workers to enroll in a more costly plans if the worker picks up the difference, is beyond the comprehension or capacity of most large employers (although the few that have taken this path have been glad they did). The bottom line is that when the American employer community is taken as a whole, employer choice has failed in practice as an effective device for disciplining the health care marketplace to lower its costs and improve its quality. The noble theory falls on the brutal double-edged sword of small and mid-size employers' fear of incurring their workers' wrath by depriving them of physician choice and large employers' overall lack of imagination and competence regarding the possibility of creating a cost-conscious “multiple choice” arrangements.

A. Missing Incentives

The second major way in which health care distances itself from the “normal” market is the extraordinary weakness of the incentives that drive (or, rather, fail to drive) the massive flows of money within the American health care sector. Perhaps “weak” is too kind a word to describe the incentives that govern our health care system. The adjectives “missing,” “dysfunctional” and “perverse” come to mind.

***438** The major payers for health care services - self-funded insurers, insurance companies, and government programs like Medicaid or Medicare - either pay regardless of the quality, cost, and efficiency of the health care they are paying for, or at best create only weak links between their payments and the quality, cost, or efficiency of care. Thus, the “sellers” of health care - doctors, clinics, hospitals, etc.--have little incentive to reduce error, drive out waste, improve quality, and lower cost. Doing so would make their lives difficult, yet it would deliver no commensurate economic reward in terms of their customer base, their revenue stream, their job security, and their salaries or profit. Patients keep on walking through the door regardless of whether the “sellers” of health care work hard to produce high-quality, low-cost care that squeezes out errors, waste, and inefficiency; or produce low-quality, high-cost care that suffers mightily from error, waste, and inefficiency; or wander in the vast terrain of mediocrity in between these two positions. Money keeps on flowing into health care providers' coffers. Their jobs and futures remain secure, regardless of efficiency or inefficiency and notwithstanding an absence or abundance of error.

V. Error's Grim Harvest

Because the market's “invisible hand” jams itself into a brick wall when it comes to health care, (i.e., because normal market forces do not consistently reward efficient, low-error, waste-free, high-quality, low-cost production, and do not consistently punish inefficient, error-prone, wasteful, low-quality, costly production), the level of error and waste in health care is indeed massive. According to a recent report by the highly regarded Committee for Economic Development (CED), the American health care system is awash in errors - errors that exact a terrible human toll in lives and illness and a fearful economic toll in the form of wasteful spending that depresses wages and squeezes out jobs in the non-health sectors of the economy.

The CED reported in the fall of 2007:

***439** When it comes to quality, the Institute of Medicine (IOM) of the National Academy of Sciences reported that between 44,000 and 98,000 Americans die annually in hospitals from medical errors. A re-

cent IOM report estimated that at least 1.5 million Americans are sickened, injured, or killed each year by errors in prescribing, dispensing, and taking medications. Drug errors cause at least 400,000 preventable injuries and deaths in hospitals each year, more than 800,000 in nursing homes and facilities for the elderly, and 530,000 among Medicare recipients treated in outpatient clinics. A 2003 RAND study found that only about 55 percent of the care called for under generally accepted standards of medical practice was actually being delivered. Adopting technologies to improve this situation has been very slow. RAND studies also have documented considerable overuse of care. Dartmouth studies have shown wide geographic variations in medical decisions such as the frequency of hospitalizations and surgery per capita. Thus, strong evidence indicates that some people are getting too much (that is, unnecessary or unhelpful) care, and others too little. [FN7] *440 The massive levels of error and waste that permeate the U.S. health care system are very costly. Dartmouth Medical School Professor Jack Wennberg has estimated, based on years of study, that up to one third of the over \$2 trillion that we now spend annually on health care is squandered on unnecessary hospitalizations; unneeded and often redundant tests; unproven treatments; overpriced, cutting-edge drugs; devices no better than the less expensive products they replaced; and end-of-life care that brings neither comfort nor cure. [FN8] Donald Berwick, co-founder of the Institute for Healthcare Improvement, confirms Wennberg's estimate that a third of all health care dollars is wasted. [FN9]

One might imagine that the tort system would be a potent tool in curbing the extraordinary waste and inefficiency that characterize the American health care system and causes it to squander so many billions of dollars. Alas, the tort system has almost no effect on waste and inefficiency. This is because the legitimate targets of the tort system - "malpractice" in the form of gross medical incompetence, outlandish surgical sloppiness, and other extreme breaches of professional conduct - account for only a small fraction of the system's waste and inefficiency. The vast majority of waste and inefficiency does not sit visibly on the surface of professional conduct, like a big chunk of pure fat attached to a cut of beef. Rather, waste and inefficiency are embedded within the structure of the healthy care delivery system and the thousands of daily decisions made by doctors, nurses, *441 pharmacists, and other health care professionals and organizations, much like the tiny flecks of fat that marble the finest cuts of meat.

Just as a good butcher can whack off chunks of pure fat but is powerless to exorcise the tiny flecks, the tort system can get at the small number of the grossest errors that rise to the level of malpractice or other negligent conduct, but can do nothing to squeeze out the far greater number of "bits" of waste and inefficiency that are scattered throughout the health care system, drive up its cost and lower its quality. To get at this deeply embedded waste and inefficiency, a different kind of pressure - appealing to a different form of self-interest - is necessary: the pressure of economic incentives to maximize enrollee volume and annual revenue by continuously improving the efficiency, lowering the cost, and improving the quality of health care delivery.

In short, the tort system is a blunt instrument that can punish some of the most visible outrageous examples of waste and inefficiency. But it is powerless to reach the deeply embedded tentacles of waste and inefficiency that account for most of the misspent money and quality problems in our health care system. [FN10] Because the tort system can't get at most of the system's errors, it can do little to reduce the number or intensity of health care conflicts.

VI. Limited Choice + Weak Incentives That Tolerate Massive Error = Lots of Conflict

The two major ways in which the U.S. health care system departs from the pattern of a "normal" market -

limited consumer choice and weak incentives for “sellers” of all sorts (insurers, *442 doctors, hospitals, and other providers) to drive out error, control waste, and pursue efficiency in general in order to constantly improve quality and hold down costs--combine in a kind of toxic brew to increase the number of conflicts in health care. Because consumers have so few choices, they feel less inclined to blame themselves when treatment goes wrong. Because the massive dollars that flows through the veins of the American health care system are not steered by the regular set of incentives to less error-prone health care providers and systems of health care, treatment goes wrong far more often than it should. Little wonder that our health care system cooks up so many conflicts. Of course, conflicts spawn more conflicts. When patients go after their doctors or hospitals, the providers they have fingered not unnaturally will try to find someone else to bear the blame. The toxic brew of limited choice and weak incentives to control error not only induces patients to fight with doctors and hospitals, but also induces them to fight with each other and with insurers. And because there are so many mistakes being made by so many “sellers” within the health care system, no one is shocked or surprised by this chain reaction of conflict, unjustified scapegoating and legitimate blame, and more conflict.

This outcome may be good for the ADR profession in a narrow sense. Just as more deaths create more business for undertakers, more conflict creates more business for those professionals whose job it is to resolve conflict. But in the end, it is not good for the ADR profession to gauge its “success” on an industry that denies consumer choices and is awash in error, waste, and inefficiency. Moreover, ADR professionals have the same stake as everybody else - as patients, as taxpayers, and simply as good citizens - in the transformation of our health care system into one that enlarges consumer choice and “gets the incentives right” so they control error and waste, promote efficiency, and reward high-quality and low-cost health. Like the rest of us, ADR professionals have a stake in changing the system so that it generates far fewer conflicts in the first place.

*443 VII. A New Role for ADR Professionals?

How exactly could ADR professionals help to reform the American health care system? In the short term, perhaps, they might play a useful role in encouraging companies to join together - or, in the case of very large firms, to act on their own - to adopt the cost-conscious “multiple choice” purchasing method. By thus expanding workers' choices while creating strong incentives for health care providers to lower costs and improve quality, they would also promote more efficient and less error-prone delivery of health care, which in turn would marginally diminish the number of health care conflicts.

However, given the highly decentralized nature of both employment and ESI in the U.S., it is naïve to think that employer collaboration alone can ever voluntarily get us to the point where we will have sufficient cost-conscious “multiple choice” purchasing of health insurance to create a true, rational, efficient market in health care across the country. Rather, government - perhaps state governments at first, and ultimately the federal government - will have to enact legislation to get this country to a place in which:

Consumers are all adequately insured, and all have lots of choices, but must pay 100% of the extra cost of their more costly choices;

Insurers and providers (doctors, hospitals, etc.) compete for consumers and revenue based on the risk-adjusted cost and quality of the health care they provide; and

The resulting normalization of the health care market begins to yield the same types of outcomes that we see in other “normal” markets: a steady driving out of error and waste and inefficiency, and as a byproduct a

sharp reduction in the number of conflicts.

ADR professionals could seek out an important role to play in this reform process. A score of political, ideological, fiscal, *444 legislative and administrative conflicts must be addressed and mediated in order to enact sound laws and programs that provide everyone with health insurance, control cost, improve quality, drive out error, and lower the number of health care conflicts. Who better to help than the trained professionals who make a living solving conflicts? The rough-and-tumble of forging legislative compromise may be territory that ADR professionals have seldom ventured to enter. But the rubicon that divides individual disputes from societal disputes is one that needs to be crossed. The elected leaders and other actors engaged in the legislative process have shown us for decades that they have great difficulty in producing a fair, affordable, high-quality, low-error, low-conflict health care system for this nation. Perhaps they would now be open to professional help as they struggle to overcome their own conflicts about the shape of a new American health care system that produces good results and that the body politic can accept.

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[FN2]. T.S. Eliot, *The Hollow Men* (1925). "Between the conception/And the creation/Between the emotion/And the response/Falls the Shadow."

[FN3]. See Institute of Medicine, National Academy Press, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Mar. 2001), available at http://books.nap.edu/html/quality_chasm/reportbrief.pdf.

[FN4]. Obviously, in a monopoly situation where there is only a single vendor, the market doesn't work to hold down costs or improve quality, so regulation is needed to hold down costs and improve quality.

[FN5]. Alain Enthoven, *Market Forces and Efficient Health Care Systems*, 23(2) *Health Aff.* 25, 25 (2004):

The employers of most insured Americans do not even offer a choice of health insurance carriers. That usually means they have a wide-network, all-inclusive preferred provider organization (PPO), a model that is particularly incapable of managing quality or cost. Fee-for-service (FFS) medicine is the most expensive kind of medicine: A single carrier offering three plan designs - a health maintenance organization (HMO), a PPO, and a point-of-service (POS) plan - all using essentially the same FFS doctors, is not "a choice of efficient health care systems."

[FN6]. Committee for Economic Development, *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System* 17 (Oct. 2007), available at http://www.ced.org/docs/report/report_healthcare200710.pdf, stating:

Instead, the prevailing practice is that a health insurer will ask, or demand, that an employer give that

insurer 100 percent of its business. Insurers dislike “slice business,” where they must compete for some employees within a small group, because of an understandable concern over high administrative costs per insured worker, and the instability that can be caused by “adverse selection,” when one competing carriers winds up with all of the sick employees in the small pool. Employers, in turn, appreciate the administrative simplicity and savings that come from dealing with only one insurance carrier. However, those employers are caught on the other side of the transaction by employees who want to be able to choose their own doctors, rather than being dictated to by their employer or insurer. These demands of a single insurer and employees who want to choose their own doctors leave the employer with no options. The one type of plan that can satisfy both the insurer and the employees is a wide-access fee-for-service plan. Multiplied over thousands of employers, this conundrum dictates that fee-for-service medicine dominates the delivery of health care.

[FN7]. *Id.* at 11-12. Following are the sources of the CED assertions: (a) Concerning deaths due to medical error as reported by the National Academy of Science, see Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson, eds., 2000); (b) Concerning deaths, illness, and injury due to medical error as reported by the Institute of Medicine, see Philip Aspden & The Committee on Identifying and Preventing Medication Errors, Board on Health Care Services, *Preventing Medication Errors* (Institute of Medicine of the National Academies, eds. 2006); (c) The Rand study indicating that only 55% of care called for under accepted standards was actually being delivered can be found at Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 384 *New Eng. J. of Med.* 2635 (2003); (d) for the report showing slow adaptation of technologies to improve the situation see Lucian L. Leape & Donald M. Berwick, *Five Years After to Err Is Human: What Have We Learned?* 293 *JAMA* 2384 (2005); and (e) The Dartmouth studies showing wide geographic variation in medical care, see J. Wennberg & A. Gittelsohn, *Variations in Medical Care Among Small Areas*, 245 *Sci. Am.* 120 (1982); see also John E. Wennberg et al., *Changes in Tonsillectomy Rates Associated with Feedback and Review*, 59 *Pediatrics* 823 (1977).

[FN8]. Maggie Mahar, *The State of the Nation's Health*, *Dartmouth Medicine Online* 32 (2007), available at <http://dartmed.dartmouth.edu/spring07/pdf/atlas.pdf>.

[FN9]. *Id.*

[FN10]. Some argue that the tort system actually increases the level of waste and inefficiency in the system by forcing doctors and other providers to practice “defensive” medicine that is not justified by patient treatment but that providers conclude they must engage in to reduce their risk of tort liability. Whether there is any truth to this assertion, or it's simply an excuse for attacking the tort system, the general view is that the tort system neither reduces nor increases the greater part of the embedded waste and efficiency in the health care system.