



Tort reform and physician labor supply: A review of the evidence



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ABSTRACT

There is a large empirical literature examining the relationship between medical liability reform and the supply of physician services. Despite the general consensus that malpractice reform leads to an increase in physician supply, usually targeted amongst a subset of physicians, debates rage at the state level over the effectiveness of any given reform. This paper reviews the evidence on the relationship between tort reform and physician supply and assess the implications for any given state. Although our difference in difference methodology prevents drawing conclusions about the impact of reforms on overall physician supply, we find that noneconomic damage caps increase the supply of physicians in high risk specialties. However, these effects, even for the high risk specialties, vary significantly across states. It is unclear whether these differences represent heterogeneous treatment effects across states, or simply random error in the estimates. New approaches are needed to estimating state-specific effects of tort reform to have the most impact on local policy debates.

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1. Introduction

There is perhaps no other area of tort law that has aroused as much political interest and action as medical malpractice. State policymakers regularly debate and frequently change the rules under which those who feel they have been injured by a physician's negligent treatment can seek redress for their claim. These efforts to change the medical malpractice liability system, commonly referred to as "tort reform," are constantly at the center of controversy. This is in no small part because two politically important groups, physicians and trial attorneys, are on opposite sides of the issue. The public and their representatives are pulled by the competing claims that changes to the rules governing the medical malpractice system harm injured patients who lose their "access to justice" and reduce doctors' and hospitals' incentives to reduce errors versus doctors and their representatives who argue that such changes are necessary to insure "access to health care."

Historically, major reform efforts have come in periodic waves following instability in the medical malpractice insurance market (Studdert et al., 2004). The last such reform wave came in the early 2000s. Events came to a head from 2002 to 2005 in a number of states. In West Virginia nearly 40 surgeons walked off the job to

protest the cost of malpractice insurance and the AMA declared 19 states to be in "full blown medical liability crisis¹." (Anderson, 2005) In response many states adopted reforms in the early 2000s, including 8 states that adopted caps on noneconomic (or "pain and suffering") damages².

In more recent years, these reforms have since come under attack in several states. There have been efforts attempting to overturn the changes, often through state constitutional challenges to limitations on the right to sue as opposed to legislative action. An argument that is frequently made is that the reforms have reduced litigation but have not delivered on their promised benefits. Specifically, it is common for opponents of the reforms to argue that they have not controlled cost nor have they had any effect on access to physician services. As these reforms are adopted and implemented at the state level, those on both sides of the debate tend to examine the evidence in terms of a specific state. For example, Texas Governor Rick Perry argued that "... 21,000 more physicians [are]

¹ In the early 2000s AMA President Donald J. Palmisano repeatedly made the link between physician labor supply and tort reform. For example, "In the 19 crisis states, physicians are taking early retirement, or abandoning high-risk services, because they cannot afford or find liability insurance." (<http://www.prnewswire.com/news-releases/ama-supports-presidents-call-for-liability-reform-59028132.html>)

² The states which enacted noneconomic damage caps are Florida (2003), Georgia (2005), Mississippi (2003), Nevada (2003), Ohio (2003), Oklahoma (2004), Texas (2004), and West Virginia (2003). Illinois enacted a noneconomic damage cap in 2006 although the cap did not take effect.

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practicing medicine in Texas because they know they can do what they love and not be sued³." Statements arguing that there was no change in Texas are frequently made by opponents⁴.

In contrast to this state-specific focus, most of the existing academic literature examines the experience of all states adopting reforms relative to those that do not (or that do, but at different times). One of the most debated, and most studied, of the potential effects of tort reforms is whether they increase the number of physicians practicing in states who adopt⁵. The findings are generally consistent with an increase in the number of physicians in states that adopt reforms for high risk specialties. We summarize the key findings from the literature and the approach used in Table 1. Kessler et al. (2005) found an overall effect of a 2.4% increase in physician supply associated with what they label "direct" tort reforms. Encinosa and Hellinger (2005) found a 2.2% increase in the number of doctors practicing in the state adopting non-economic caps, although the effects largely occurred three or more years after enactment. Klick and Stratmann (2007) found a 3.9 to 6.6% increase in physician supply in high-risk specialties when measured against a low risk control group, compared to a .8 to 2.9% increase for the same group without the control group. Matsa (2007) found a 4 to 7% increase in the supply of physicians to rural counties, but a negative effect overall. Baicker and Chandra (2006) found a negative elasticity of labor supply with respect to increases in premiums and payments but only for OB-GYN, internal medicine and surgical specialties and physicians over 55 although the results are inconsistent and not particularly robust.

Despite the breadth of the literature, there are two key limitations of these articles from the standpoint of policy analysis. First, while the effects all point to an increase in the number of physicians in an area in response to the adoption of liability reform, the effects are weak in aggregate and tend to suggest that they are centered in a subset of physicians (e.g., physicians in high risk specialties, older physicians or rural areas). Moreover, the articles typically do not address the experience of specific states. This is unsatisfying to many state policymakers and stakeholders, who are primarily concerned with what is happening in "my state." Moreover, most of the existing multi-state studies use data series ending in the early 2000s, immediately before the latest set of states adopted reforms. Thus, the academic literature has not provided conclusive evidence on the impact of tort reform on the supply of physician services sufficiently to settle debates such as the recent exchange over the effect of reforms in Texas.

In this paper, we re-examine the evidence on the relationship between malpractice liability reform and physician supply. Our goals are threefold: we examine whether the standard difference-in-differences approach provides a useful means for estimating the impact of a reform in a particular state, we study whether the effect of reform appears overall or whether it is focused in particular specialties, and we assess whether the relationship between the adoption of reform and physician supply is consistent with previous work when we expand the sample to include the most recent reforms. We place particular emphasis on Klick and Stratmann

(2007), whose methodology we follow closely in this paper. Moreover we focus on the effects of one particular reform, noneconomic damage caps, because this is the most common reform among the recent cohort of legal changes and is the most hotly debated⁶.

In their paper, Klick and Stratmann (2007) emphasize that any examination of the physician labor market must account for two potentially confounding factors. The first is that there are strong underlying trends in state physician labor markets, and these trends are likely to be highly state-specific, given that medical licenses are governed at the state level. This necessitates a control group to identify the causal effect of the policies. Given the particulars of the market for physicians compared to the rest of the labor market, Klick and Stratmann (2007) argue that the best control group for physicians is other physicians who are less likely to be attracted by the reforms. In particular, they argue that comparing physicians with a low liability risk – who therefore should care less about the presence of reforms – to physicians in specialties with a higher risk allows for the identification of the differential effect of the policy on physicians in higher risk specialties. While this approach does not necessarily provide much information about the impact of reform on the overall market, under the right assumptions it does identify the effect for those higher risk specialties.

In our analysis, we examine the effect of damage caps on the number of total physicians in a state and find little evidence of an increase in the number of physicians. If anything, we find that the number of physicians is negatively associated with caps, although this appears to be most likely due to preexisting trends in the states which passed tort reform and not caused by the reforms themselves. However, when we compare the differential impact of reforms on high- versus low-risk specialties in states that adopt to those that do not using a "difference-in-difference-in-differences" strategy, we find that the adoption of noneconomic damage caps leads to a 1.5% to 6.6% increase in the number of physicians in high risk specialties (with the variation coming in how we define high risk specialties). These findings are consistent with Klick and Stratmann's analysis from an earlier time period (1980–2002).

To put this in some perspective consider there are 54 doctors per 100,000 people practicing in Klick and Stratmann high risk specialties. Thus our estimate of 6.6% would result in about 3.6 per 100,000 more physicians practicing in one of the Klick and Stratmann high risk specialties per year⁷. It is notoriously difficult to translate the number of doctors into patient encounters, but according to the 2003–2004 National Ambulatory Medical Care Survey doctors in these specialties had an average of 96 consultations per week (Hing and Burt, 2007)⁸. This would translate into just over 344 additional total consultations per week.

In addition to the specialty-specific analysis, we explore the extent to which these estimates are consistent across states. For example, how closely did the change in the number of obstetricians per capita in West Virginia after the state adopted a noneconomic damage cap in 2004 mirror the national estimates of the relationship between tort reform and the supply of obstetricians. Our results suggest that the estimated impact of noneconomic damage caps, even on the high-risk specialties, varies widely across states. That is, the estimated effect of noneconomic caps on the supply of physicians in high-risk specialties appears to vary substantially

³ This quote was made Wednesday, August 17th, 2011 in a speech at "Politics and Eggs in Bedford, N.H.

⁴ For example the American Association for Justice "The most frequently echoed myth concerning medical negligence is the notion that doctors are fleeing states and retiring early, creating physician shortages."

⁵ It is not clear that the number of physicians practicing is either a good in and of itself or a perfect proxy for availability of high quality medical care. For example, if higher malpractice insurance rates led poor performing doctors to retire or otherwise leave the practice of medicine, social welfare and the quality of medical care might be increased, even if fewer doctors were practicing. Nevertheless, despite these limitations, the number of physicians has commonly been used as an important indicator in both the political debate and the literature.

⁶ We estimate the impact of other reforms on physician supply in our regressions, but do not discuss them in this manuscript. Full results are available from the authors on request.

⁷ That is for emergency medicine ($8.35 \times 0.066 = 0.551$) + internal medicine (2.08) + neurological surgery (0.115) + thoracic surgery (0.007) and OBGYN (0.748).

⁸ See Table 9 from Hing and Burt (2007), which includes office visits, hospital visits and telephone and internet consultations. Note that we assumed that emergency medicine and thoracic surgery had 88.4 consultations per week, which is almost surely too low for both specialties.

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