

Medical Malpractice What are the Real Issues?

- **The real issue is medical economics – the ability of the medical profession to maintain an economically viable practice.**

Medical income is substantially obtained from Medicare and third party payers. Medicare reimbursements are based on what the federal government wants to spend, not on the cost of providing medical services (payment control, instead of price control). The distribution of funds/payment amounts for “diagnostic related groups” (DRGs) is based upon what is called a “resource based relative value system” (RBRVS). Payment to medical providers by third party payers is generally based on a percentage (e.g., 113%) of Medicare DRGs. It is likely that these payments are inadequate compensation for the true cost of medical services provided, but that is simply unclear.

- “Whereas Medicaid payments in 1999 were only 4% below hospital costs nationally, Medicaid payments were 20% below hospital costs in Pennsylvania (ninth lowest among states). Conversely, whereas private payment levels were about 15% above costs nationally, they were only 4% above costs in Pennsylvania (fourth lowest among states). Medicare payment levels were almost the same in Pennsylvania and the nation at large. According to this analysis, the low payment-to-cost ratios are attributable to low payments, not high costs.”¹

Moreover, the medical profession has little or no accounting control over their provider costs. They generally do not engage in cost accounting (traditional or activity based), and consequently, do not know what their costs actually are. Very reputable research has identified issues of waste, error and productivity.

- “Medical errors carry a high financial cost. The Institute of Medicine (IOM) report estimates that medical errors cost the Nation approximately \$37.6 billion each year; about \$17 billion of those costs are associated with preventable errors. About half

¹ Bovbjerg, Randall R. and Bartow, Ann. 2003. Understanding Pennsylvania's Medical Malpractice Crisis: Facts about Liability Insurance, the Legal System, and Health Care in Pennsylvania. The Project on Medical Liability in Pennsylvania (funded by The Pew Charitable Trusts). P.44.

of the expenditures for preventable medical errors are for direct health care costs."²

- "The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivering care. Research has shown that system improvements can reduce the error rates and improve the quality of health care."³

➤ **The real issue is patient safety – the ability of the medical profession to maintain quality of care.**

- "The serious problem of medical errors is not new, but in the past, the problem has not gotten the attention it deserved. A body of research describing the problem of medical errors began to emerge in the early 1990s with landmark research conducted by Lucian Leape, M.D., and David Bates, M.D., and supported by the Agency for Health Care Policy and Research, now the Agency for Healthcare Research and Quality (AHRQ)." "The November 1999 report of the Institute of Medicine (IOM), entitled *To Err Is Human: Building A Safer Health System*, focused a great deal of attention on the issue of medical errors and patient safety."⁴
- "The Chasm in Quality:
 - Between 44,000-98,000 Americans die from medical errors annually (Institute of Medicine, 2000; Thomas et al., 2000; Thomas et al., 1999)
 - Only 55% of patients in a recent random sample of adults received recommended care, with little difference found between care recommended for prevention, to address acute episodes or to treat chronic conditions (McGlynn et al., 2003)
 - Medication-related errors for hospitalized patients cost roughly \$2 billion annually (Institute of Medicine, 2000; Bates et al., 1997)

² *Medical Errors: The Scope of the Problem*. Fact sheet, Publication No. AHRQ 00-P037. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/errback.htm>

³ Ibid.

⁴ Ibid.

- 41 million uninsured Americans exhibit consistently worse clinical outcomes than the insured, and are at increased risk for dying prematurely (Institute of Medicine, 2002; Institute of Medicine, 2003a)
 - The lag between the discovery of more effective forms of treatment and their incorporation into routine patient care averages 17 years (Balas, 2001; Institute of Medicine, 2003b)
 - 18,000 Americans die each year from heart attacks because they did not receive preventive medications, although they were eligible for them (Chassin, 1997; Institute of Medicine, 2003a)
 - Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents (Institute of Medicine, 2000; Centers for Disease Control and Prevention; National Center for Health Statistics: Preliminary Data for 1998, 1999)
 - More than 50% of patients with diabetes, hypertension, tobacco addiction, hyperlipidemia, congestive heart failure, asthma, depression and chronic atrial fibrillation are currently managed inadequately (Institute of Medicine, 2003c; Clark et al., 2000; Joint National Committee on Prevention, 1997; Legorreta et al., 2000; McBride et al., 1998; Ni et al., 1998; Perez-Stable and Fuentes-Afflick, 1998; Samsa et al., 2000; Young et al., 2001)⁵
- A California study showed that 4.6 percent of hospitalizations involved iatrogenic (physician caused) injury, and 0.8 percent (1 in 126 admissions) involved injuries that medico-legal experts thought would probably give rise to a finding of negligence in court. Reviewers in a New York study found rates of adverse events and negligent adverse events (3.7 percent and 1.0 percent, respectively) that were remarkably close to those in California. Overall, it is estimated that there are 7.6 times as many negligent injuries as there are claims.⁶
 - “A flat cap has as its principal goal reducing the cost and volatility of class-rated physician liability insurance, and is a reasonable solution only if the problem is rapid premium growth

⁵ The Chasm in Quality: Select Indicators from Recent Reports, Institute of Medicine of the National Academies, <http://www.iom.edu/subpage.asp?id=14980>

⁶ Studdert, D. M., Mello, M. M., Brennan, T. A. (2004). Medical Malpractice. *New England Journal of Medicine* 350: 283-292

from meritless claims and overcompensated losses. The IOM report identifies other problems: that serious, avoidable errors occur frequently but remain undetected, that most victims receive no compensation, and that health care systems rarely learn from their mistakes. Decreasing malpractice insurance premiums without reducing avoidable errors transfers money from injured patients to medical providers but does not save social resources. In fact, the IOM report explicitly recognized that systematic safety improvement is more compatible with strict liability than with no liability - a finding clearly at odds with reforms aimed at restricting lawsuits and limiting damages."⁷

- **The real issue is not medical malpractice tort costs, which are but a very small part of medical expenditures.**

"But even large savings in premiums can have only a small direct impact on health care spending--private or governmental--because malpractice costs account for less than 2 percent of that spending." (The 2 percent figure is a CBO calculation based on data from Tillinghast-Towers Perrin (an actuarial and management consulting firm) and the Office of the Actuary at the Centers for Medicare and Medicaid Services.)⁸

"Malpractice costs amounted to an estimated \$24 billion in 2002, but that figure represents less than 2 percent of overall health care spending. Thus, even a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small."⁹

- **Finally and certainly, the impact of Act 13 of 2002, and the adoption of Court Rules (relative to expert testimony and venue) need to be taken into account.**

Much has already been done to address the issue of medical costs related to malpractice insurance. These are significant changes that will become increasingly and more fully effective over the next few years. In the interim, Act 44 of 2003 provides immediate financial relief in order to maintain medical practice viability.

⁷ Sage, M.D., J.D., William M. "Understanding the First Malpractice Crisis of the 21st Century". Health Law Handbook, 2003 Edition, Alice Gosfield, Editor. West. Eagan, MN. p. 5.

⁸ "Limiting Tort Liability for Medical Malpractice," CBO Economic and Budget Issue Brief, Congressional Budget Office, January 8, 2004.

⁹ Ibid.