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Medical Malpractice: A Continuing Problem With Far-Reaching Implications

Statement of
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Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

SUMMARY

The United States is spending over a half a trillion dollars each year on health care, more than 40 percent of it publicly financed. Health care expenditures have grown from 6 percent of the gross national product in 1965 to 12 percent today and are projected to reach 15 percent in the next decade. There is little question that the costs associated with medical malpractice run into the billions of dollars and that it is having profound effects on the practice of medicine in this country.

The views of groups primarily affected by medical malpractice--consumers, attorneys, insurers, and health care providers--clearly show that the implications of the malpractice problem go well beyond insurance issues alone. In providing the leadership needed to deal with the problem, the Congress needs to address three primary issues:

-- How can we reduce the practice of negligent medicine?

-- How can we improve the efficiency and equity of our system for compensating victims of medical negligence?

-- How does the malpractice system affect the practice of medicine and quality of care and what is the outlook for the future?

GAO believes that government and private sector actions to come to grips with these issues will continue to have significant cost implications and will undoubtedly help shape how medicine is practiced for years to come.

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present our views on the implications of medical malpractice for the establishment of future health policy.

As you are aware, the United States is spending over a half a trillion dollars each year on health care, more than 40 percent of it publicly financed. Health care expenditures have grown from 6 percent of the gross national product in 1965 to about 12 percent today and are projected to reach 15 percent in the next decade. These costs have risen at more than double the rate of general inflation for nearly three decades.

The precise extent to which medical malpractice has contributed to the burgeoning health care bill is unknown. But there is little question that the costs associated with it run into the billions of dollars. Of equal importance are the profound effects that medical malpractice is having on the way medicine is practiced in this country--effects that can be expected to grow in the future.

In providing the leadership needed to deal with the malpractice problem, the Congress needs to address three primary issues:

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-- How can we improve the efficiency and equity of our system for compensating victims of medical negligence?

-- How does the malpractice system affect the practice of medicine and quality of care and what is the outlook for the future?

Our earlier extensive study of the medical malpractice problem, and work we have done since, show that these are difficult and complex issues. Efforts are underway to make improvements in each.

MALPRACTICE IS MORE THAN A PROBLEM OF COSTLY INSURANCE

During the last 20 years, the issue of medical malpractice has been defined largely in terms of the cost and availability of malpractice insurance. These are but two aspects of a multi-dimensional problem.

Medical malpractice was termed a crisis in the mid-1970s, when the premiums in some specialties rose several hundred percent in a single year and many insurers stopped selling malpractice

insurance. The crisis was one of the affordability and availability of malpractice insurance for health care providers.

In response to that crisis, all states but one enacted legislation to address the problem. The emphasis was on measures to create alternative sources of insurance and to reduce the number and cost of claims. During this period, physician- and hospital-owned insurance companies were created to provide malpractice insurance. Over the next decade, malpractice insurance was more readily available in a market dominated by these companies.

Although the number and cost of malpractice claims continued to climb in the early to mid-1980s, insurance companies kept premium increases to a minimum because investments made at high interest rates were returning high yields. This changed, however, when interest rates began to decline in 1984. In response, insurers once again imposed large premium increases on health care providers. This was labeled as a crisis of affordability of insurance.

The cost of medical malpractice insurance has increased from $1.7 billion in 1983 to $5.9 billion in 1988 for physicians and from $800 million in 1983 to $1.3 billion in 1985 for hospitals. Although premium rates have recently been reduced somewhat, they remain only slightly below their historical highs.

Physician malpractice insurance premiums vary widely depending on the specialty involved and the physician's geographic location. For example, a neurosurgeon practicing in Chicago now pays almost $196,000 annually for the same coverage a colleague in North Carolina obtains for about $20,000. (The attachment to my statement illustrates these variations in rates.) These premiums represent uniform rates paid by all physicians in a given medical specialty and defined geographical area. They are not based on an individual's own claims experience.

As we reported in 1987, the views of groups primarily affected by malpractice--consumers, attorneys, insurers, and health care providers--demonstrate that the implications of the medical malpractice problem go well beyond insurance issues alone. Consumers are concerned about the quality of medical care they are receiving and the long time required to settle malpractice claims. Attorneys believe that the large number of medical injuries due to negligence is the basic issue in discussions of malpractice. Insurers are concerned about the effects the unpredictability of the tort system has on insurance rate-making. Physicians and hospitals believe that malpractice insurance costs too much, patients' expectations are unrealistic, awards are excessive, claims take too long to settle, and legal costs to defend against claims are too high.

Mr. Chairman, all of the involved parties have expressed legitimate concerns about the malpractice problem from their own perspectives. We believe that these concerns, taken collectively, have public policy implications in at least the three areas I mentioned earlier.

NEGLIGENT MEDICAL PRACTICES MUST BE ADDRESSED

The first area to be considered in any discussion of medical malpractice is how the incidence of medical negligence can be reduced.

A recent study by Harvard University researchers of medical malpractice in the state of New York indicates that, taken as a percentage of the number of 1984 hospital discharges, the rate of negligence by providers is 1 percent.[1] This is consistent with the findings of the other major study of this subject, which involved an analysis of 1974 hospital admissions in California. While 1 percent may not appear to be large, it is significant when you are talking about the effects of medical injuries on individuals. In New York, it represented about 27,000 patients found to be injured as a result of medical negligence.

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[1] Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, A Report by the Harvard Medical Practice Study to the State of New York, Feb. 1990.

Our nationwide study of malpractice claims closed in 1984 showed that many physicians are involved in malpractice cases. In that year, 31,800 claims, involving 23,000 physicians, were closed with payments on behalf of injured patients. We recognize, of course, that a paid claim does not necessarily indicate the existence of medical malpractice or the need for disciplinary action.

Despite the relatively high number of physicians involved in claims paid to injured patients, few of the nation's 500,000 practicing physicians have disciplinary measures taken against them. For example, in 1987, state boards took only 2,700 disciplinary actions against physicians, ranging from license revocations to reprimands. These boards, which are responsible for imposing sanctions on physicians found to be incompetent or impaired by debilitating conditions such as alcoholism, drug abuse, or mental illness, are often criticized for not doing more. But, before they can impose sanctions against physicians, negligent actions or impaired performance must be reported to them. To date, many health care providers have been reluctant to speak out against their colleagues.

The Health Care Quality Improvement Act of 1986 and the Medicare and Medicaid Patient and Program Protection Act of 1987 represent recent legislative attempts to facilitate the identification and reporting of providers who are practicing

substandard medicine. The centerpiece of the 1986 legislation is the National Practitioner Data Bank, which, when implemented, will contain information on disciplinary actions taken by state licensing boards, actions by hospitals and other institutions to deny or revoke clinical privileges, and medical malpractice claims paid by insurance companies that involve a licensed practitioner. Information contained in the data bank is expected to restrict providers' ability to move from state to state without discovery of their previous damaging or negligent performance. The act also seeks to facilitate the identification and reporting of incompetent practitioners by granting immunity from liability to individuals participating in peer review activities.

The data bank, originally scheduled for implementation in November 1987, was not funded until fiscal year 1989. It is now expected to be operational in September 1990.

The 1987 legislation authorized the Department of Health and Human Services to establish national exclusions from Medicare and Medicaid of practitioners who are excluded from either program, convicted of crimes involving federal or nonfederal programs, or disciplined by state licensing boards. The Department has decided to include data regarding state disciplinary licensure actions under this act in the aforementioned data bank.

These legislative initiatives are a step in the right direction, but it remains to be seen whether they will improve the identification of providers delivering substandard care and whether appropriate actions will be taken to deal with those providers.

THE COMPENSATION SYSTEM FOR VICTIMS OF MALPRACTICE NEEDS FURTHER REFINEMENT

The system for compensating individuals injured through medical negligence is neither efficient nor equitable to those most directly affected by malpractice--injured patients. In addition, it is questionable whether the system serves as a deterrent to the negligent practice of medicine.

Since the mid-1970s, every state has revised its tort system, in some way, to address the medical malpractice insurance problem. For the most part, these tort reforms have been designed to reduce the rate of increase in medical malpractice insurance premiums by reducing the number of claims filed and the size of malpractice awards and settlements. Studies have suggested that some of these tort reforms have achieved these objectives. But the extent to which they have improved the efficiency of the system or increased the equity of payments to injured parties is unclear.

In our May 1987 report, we pointed out that it takes a long time for claims to be resolved and the cost of resolving them is high.[2] Our work showed that, for claims closed in 1984, it took an average of 25 months, with a range of up to 11 years, from the date a claim is filed until final resolution. We also found that insurers paid $800 million to investigate and defend claims closed in 1984. Such costs were in addition to the companies' total claim payments of $2.6 billion.

Finally, we found that a large proportion of claim proceeds do not go to injured parties. In over half the claims that were closed in 1984, plaintiff legal fees exceeded 30 percent of the payments to the injured party. In addition to attorney fees, plaintiffs were responsible for paying other expenses, such as court costs and the costs of obtaining evidence.

Concerning the equity of our current system, studies have shown that only a small proportion of the injuries resulting from malpractice result in claims or suits. Harvard researchers have corroborated the findings of previous research, which indicate that many claims are not being filed even though they may be justified. Specifically, the Harvard study pointed out that only 1 of 8 patients admitted to New York hospitals in 1984 who suffered injury from negligence filed a claim. About 16 times as

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[2]Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 20, 1987).

many patients suffered an injury from negligence as received compensation through the New York tort system. Thus, the tort system obviously does not reach many individuals who are injured by medical negligence.

Questions have been raised as to whether the tort system provides an effective deterrent to malpractice. One of the system's fundamental objectives is to deter negligent behavior by requiring parties causing injury through negligence to pay damages to the injured victims. However, in regard to medical malpractice, health care providers' liability insurance may insulate them from most of the financial effects of their negligent behavior. Moreover, malpractice insurance companies do not generally vary rates based on an individual physician's claims experience, and most premium costs are ultimately borne by consumers, insurers, and the public sector. This further reduces the deterrent effect. However, we recognize that insulating physicians from the financial impact of their negligent medical care may not negate the deterrent value of the tort system. Insurance does not insulate them from the loss of reputation, personal morale, and practice earnings associated with defending themselves in malpractice litigation.

Because of our concerns about the efficiency and equity of the system for resolving medical malpractice claims and compensating injured parties, we believe that it is time to take a

harder look at alternatives to the tort system as a means to resolve malpractice compensation questions. There may be advantages to moving toward some form of system that would provide compensation to injured patients when specified events occur without having to establish provider negligence.

There are many unresolved questions about the potential costs of alternative dispute-resolution mechanisms and whether they will do a better job of compensating individuals injured during medical diagnosis and treatment. Thus, we continue to believe--as we stated in our May 1987 report--that increased experimentation with these mechanisms is needed to see whether they offer viable alternatives to the tort system as means of dealing with the medical malpractice problem.

MALPRACTICE CONTINUES TO AFFECT THE PRACTICE OF MEDICINE

It is clear that the high cost of malpractice insurance and the threat of litigation have contributed to significant changes in how providers deliver care to their patients. But views differ on the extent to which these changes improve the quality of medical services provided, decrease the incidence of negligent medical practice, or unnecessarily add to the cost of delivering health care.

Numerous activities are being carried out to help maintain and improve the quality of care. Intensified peer review of provider performance, establishment of increasingly sophisticated systems to measure the quality of care delivered by individual providers, and more arduous record keeping systems to document specific diagnostic and treatment actions have altered provider practices. As these systems evolve and the information they generate becomes more available and understandable to the public, the performance of institutional and individual providers will be exposed to intense scrutiny. The implications of this for the future practice of medicine are not yet known. Also uncertain is the price the American public is willing to pay for the advances in quality expected to result from these systems.

As the quality of care delivered by institutions and individuals has become more closely monitored, providers' practices have become increasingly defensive. Placing greater emphasis on not making mistakes, providers are performing additional tests and treatment procedures, giving more attention to increased medical record keeping, spending more time with patients explaining alternative treatments, obtaining patients' informed consent, and refusing to treat certain high-risk patients. Some of these actions may, in fact, be desirable. But when defensive medicine results in providers' performing unnecessary procedures or limiting services to high-risk individuals or underserved groups, the effect is undesirable.

The extent to which physicians practice defensively and the costs of such practices are unknown. The American Medical Association estimated that in 1985, costs associated with physician defensive medicine practices amounted to about $12 billion. Much higher estimates have been cited in both the general media and medical publications.

Among the many activities being carried out to help assure that the quality of health care remains high are two that could be particularly helpful in reducing the potential for medical malpractice--the refinement of risk management activities and the development of practice guidelines.

Risk management programs were initiated in the 1970s to reduce the potential for medical malpractice in hospitals. They are used by hospital management to identify, assess, and reduce risks to patients. Many organizations that deal directly or indirectly with hospitals believe that risk management helps reduce the incidence of malpractice and are taking an active role to either require or encourage the implementation of risk management programs or functions. These organizations include the Joint Commission on Accreditation of Healthcare Organizations, several states, insurance companies, and the Department of Health and Human Services. The American Medical Association, numerous medical specialty societies, and other elements of organized

medicine are also involved in promoting the use of risk management in physician offices.

Practice guidelines assist physicians in determining how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and clinically managed. They can also assist physicians in their efforts to improve service to patients, avoid unnecessary patient injury, and reduce the frequency of litigation. The American College of Physicians has been a strong proponent of their development and, along with other advocates, believes that their use has resulted in fewer malpractice claims and lower insurance premiums. Developing these guidelines is a complex process that requires considerable consensus building among practitioners within individual medical specialties. It will be some time before their full impact can be assessed.

Developments such as those I have described are still evolving, and how they will unfold is far from certain. Much remains to be done before it is known whether they are having the desired effects and are worth the costs they will add to the nation's health care bill.

CONCLUSION

Mr. Chairman, as I indicated at the beginning of my testimony, the implications of medical malpractice are far reaching. If the availability and affordability of malpractice insurance again becomes a major problem, the Congress and state legislatures can expect to be petitioned again to take remedial actions.

In our view, however, these actions will not be enough to address the more fundamental issues of how best to (1) reduce the incidence of negligent care, (2) fairly compensate individuals injured through medical negligence, and (3) deal with the complexities involved in efforts to enhance the overall quality of care provided in this country. Both government and private sector actions to come to grips with these issues will have significant cost implications and will undoubtedly help shape how medicine is practiced for years to come.

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This concludes my prepared statement. We will be pleased to respond to your questions.

ATTACHMENT

MALPRACTICE INSURANCE PREMIUMS ST. PAUL INSURANCE COMPANY FOR SELECTED SPECIALTIES, AREAS, AND YEARS[a]

	1984	1985	1986	1987	1988	1989
Obstetrics:						
Chicago	$39,820	$56,810	$95,000	$168,100	$156,580	$155,510
Minnesota	19,240	27,580	37,990	49,280	57,130	42,330
North Carolina	9,290	12,810	15,290	19,440	20,620	16,270
Neurosurgery:						
Chicago	59,500	71,830	120,110	212,830	197,330	195,950
Minnesota	28,690	34,850	48,000	62,270	71,870	53,290
North Carolina	13,790	16,120	19,240	24,500	25,900	20,400
General practice (No surgery):						
Chicago	5,350	7,010	11,850	20,660	20,110	20,050
Minnesota	2,650	3,510	4,940	6,320	7,560	5,720
North Carolina	1,370	1,733	2,100	2,620	2,900	2,350

[a]Premiums shown are for coverage of $1 million per occurrence and $1 million in aggregate for a policy year.