Cornell University

Medical Malpractice; and International Comparisons, Part 1

PUBPOL 2350

November 16, 2023

YOU CAN SAVE A LIFE!

THURSDAY, NOVEMBER 30
6 - 7:30 PM
LOCATION: MVR 1153

LIVE NARCAN EDUCATION+TRAINING!

IN PARTNERSHIP WITH:

ADC ALCOHOL & DRUG COUNCIL OF TOMPKINS COUNTY, INC.

SIGN UP!

Assignment #3

- Assignment #3 due Tuesday, November 21st at midnight

- TA office hours via Zoom (separate links on Canvas):
  - Monday: 5:00 – 6:00pm
  - Monday: 6:00 – 7:00pm
  - Tuesday: 5:00 – 6:00pm
  - Tuesday: 6:00 – 7:00pm

- I will also hold my normal in-person office hours on Monday, November 20th from 3:00 – 4:00pm

Any Current Events?

Today's First Topic

Medical Malpractice

1. **Performance:** Discuss how well the medical malpractice system is meeting its objectives
2. **Policy:** Discuss whether policy changes could improve the performance of the medical malpractice system

Two Key Objectives of the Medical Malpractice System

1) Compensate patients who are injured due to negligent behavior.

2) Deter future negligence by creating incentives for MDs, hospitals, and other medical providers to consider their actions/behavior carefully; and to spend time/money to improve skills/processes.

How well does our system meet these objectives?

Source: Keeton et al., 1984.

How Close Does the Actual Malpractice System Come to a "Perfect" System?

Perfect

1) All patients harmed due to negligence would sue.

2) They would all win.

3) No patients not harmed, or harmed but not due to negligence, would sue/win.

4) MDs/hospitals who are sued more often would pay higher malpractice insurance premiums (so they take extra precautions)

Actual

1) Only 6% of NY hospital patients harmed due to negligence filed a claim/sued.

2) 73% of the people above who sued, did receive money.

3) 38% of claims are from these patients, but 72% receive $0, and payments are small.

4) MDs' malpractice premiums are not experience rated; hospitals' premiums are.

Source: Studdert et al., *New England Journal of Medicine*, 2006.

Why Do You Think So Few People

Who Have Been Harmed Due to

Malpractice Actually Sue?

Why Do So Few Patients Sue?

- Some patients may not know they were harmed by negligent behavior.
- Patients' lawyers usually receive 35% of any payout from a malpractice insurance company, or $0 if the suit is unsuccessful.
- Prospective lawyers will only pursue cases where the expected payout (i.e., weighted by the likelihood of winning) exceeds their expected time costs.
- 2011 study in MA: 58% of malpractice claims are eventually dropped. Primary reason: plaintiff/patient acquired info that indicated that the claim was weaker than they thought.

Source: Studdert et al., 2004, *New England Journal of Medicine;* Golann*, Health Affairs,* 2011.

7.4% of Physicians Face a Malpractice Claim/Lawsuit in a Year, on Average (between 1991 and 2005)

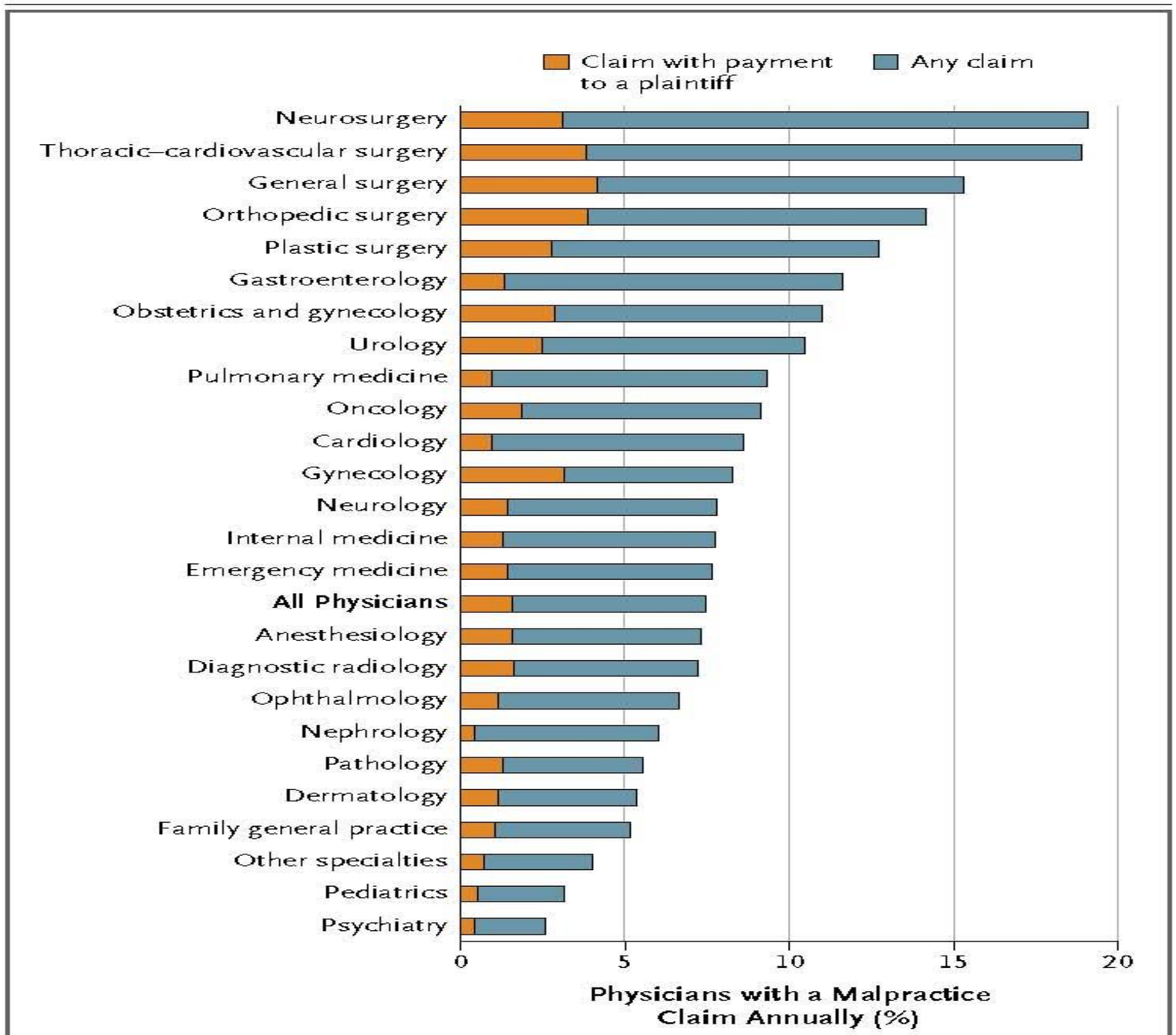


Figure 1. Proportion of Physicians Facing a Malpractice Claim Annually, According to Specialty.

- Ranges from 19% in neurosurgery to 2.6% in psychiatry.

- Lifetime probability of facing a claim:
  - 75% for low-risk specialties
  - 99% for high-risk specialties

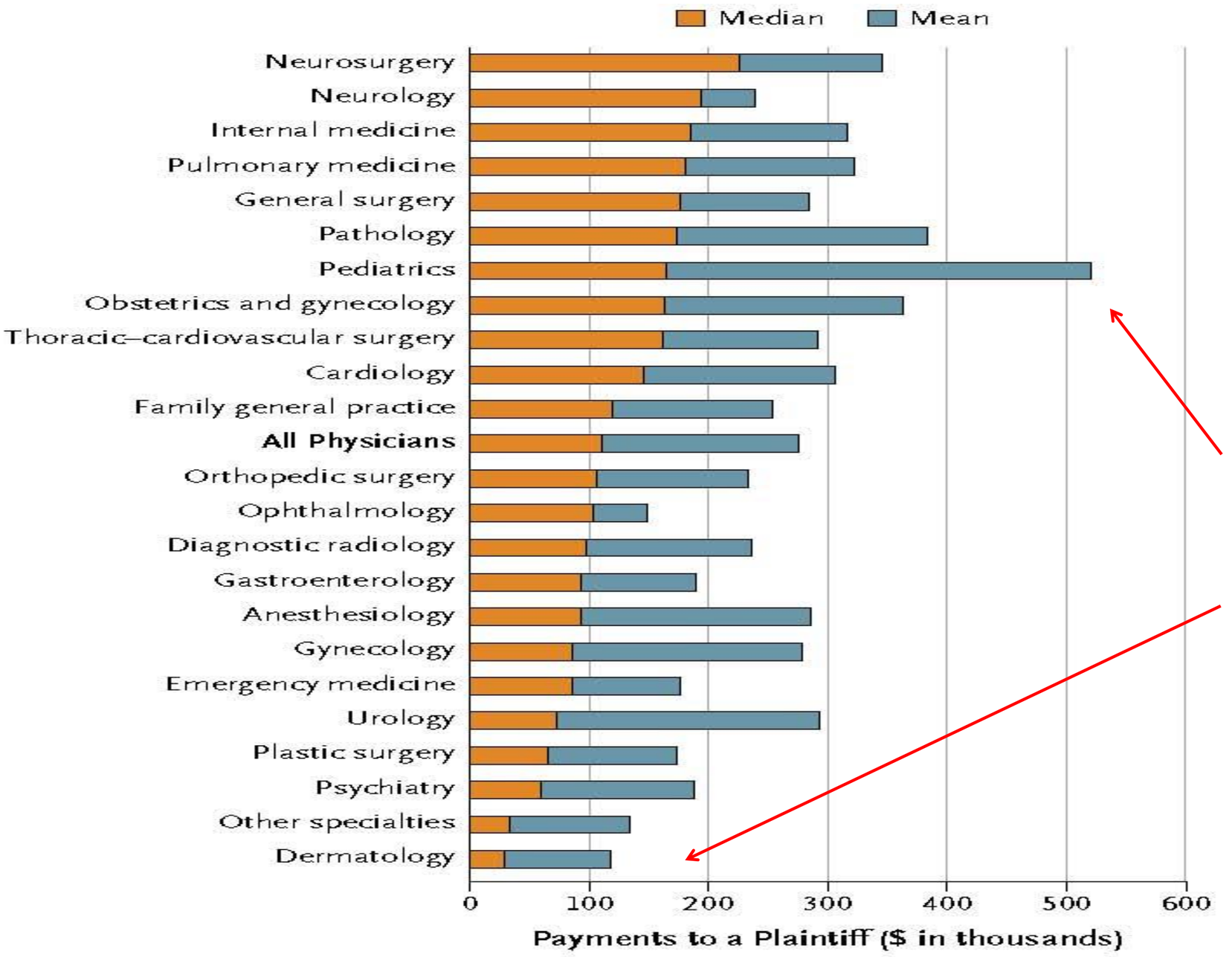
Source: Jena et al., 2011, *NEJM*.

How is Malpractice Money Paid Out?

- About 1% of all physicians account for 32% of paid claims.
- 71% of claims do not result in any payment to plaintiff (i.e., legal case is dropped, or judge/jury rules for the defendants).
- 97% of the money patients (and their lawyers) receive come from settlement payments before a case comes to trial, or before the judge/jury decides the case.
- Only 3% of the total payouts are from trial judgments, but these awards tend to be larger, on average, than settlement payouts.

Source: Carroll et al., "The Graying of America," Spring 2012;
Studdert et al., *New England Journal of Medicine,* 2016.

Mean Claim Payment ($275,000) Much Greater Than Median ($112,000): Settlements and Trial Payouts

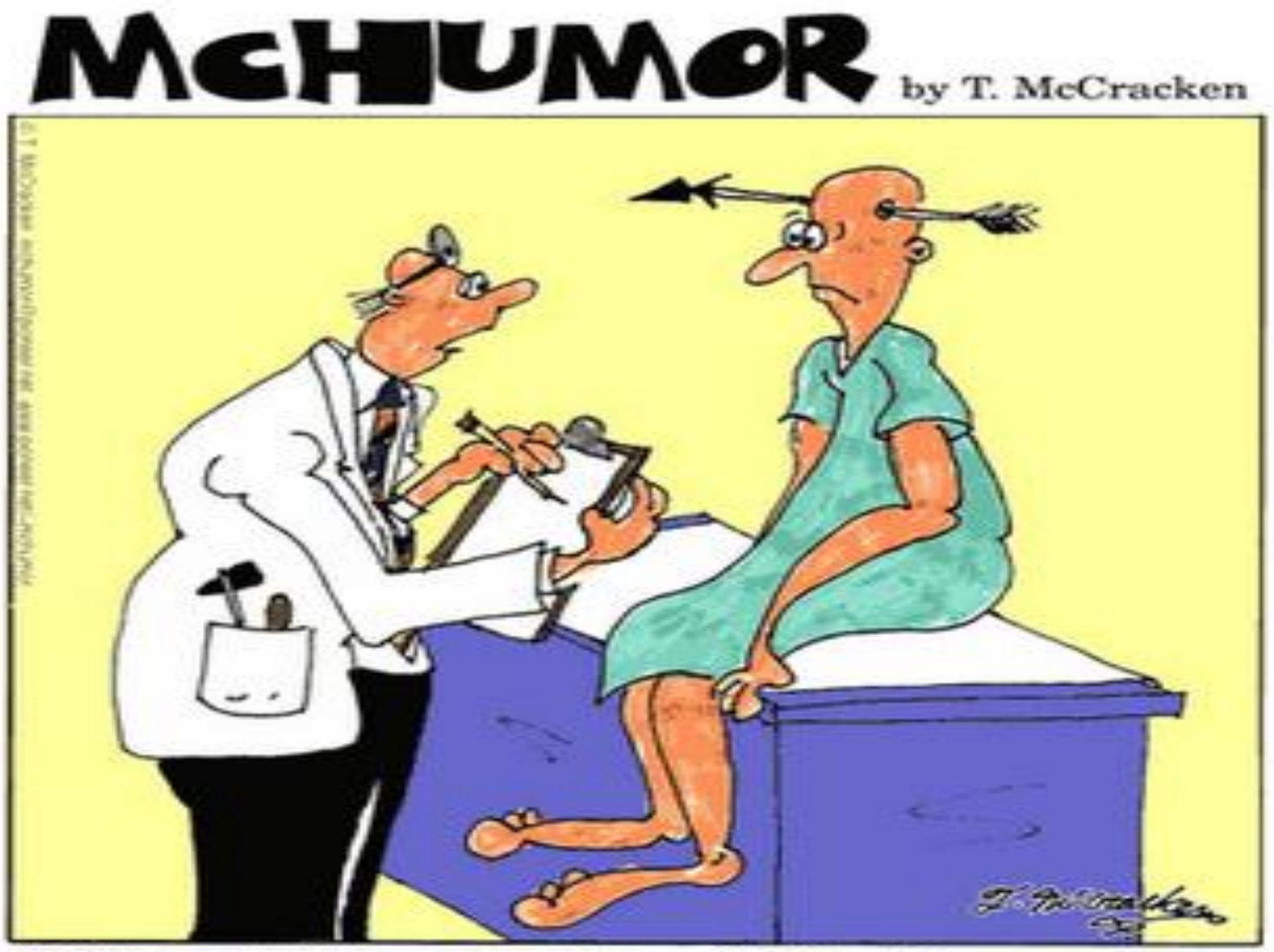


Mean payment ranged from $521,000 in pediatrics to about $120,000 in dermatology

Figure 3. Amount of Malpractice Payments, According to Specialty.
Payments are shown in 2008 dollars. Specialties that had fewer than 30 payments (i.e., oncology and nephrology) are not listed.

Source: Jena et al., *NEJM, 2011*.

Is Defensive Medicine A Big Deal? If so, the Real Costs of an Imperfect Malpractice System Could Be Much Greater Than 1.0% of Medical Spending



"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

Defensive medicine: medical care provided to reduce the probability of a malpractice lawsuit, rather than improving a patient's health

Many Physicians Believe They Provide Unnecessary Medical Care in Order to Avoid Lawsuits

- 42% of surveyed primary care physicians in the U.S. believe their patients are receiving too much medical care, versus 6% who indicate too little.

- Reasons MDs believe patients receive too much care:
  - malpractice concerns: 76%
  - clinical performance measures: 52%
  - inadequate time to spend with patients: 40%

- Providing more services to a patient in a hospital does, on average, reduce the chance that a physician will be sued for malpractice (see next 2 slides for examples).

Source: Sirovich et al., *Archives of Internal Medicine*, 2011; Jena et al., *The BMJ*, 2015.

Example: OB/GYNs Respond to a Malpractice Lawsuit by Performing More C-Sections

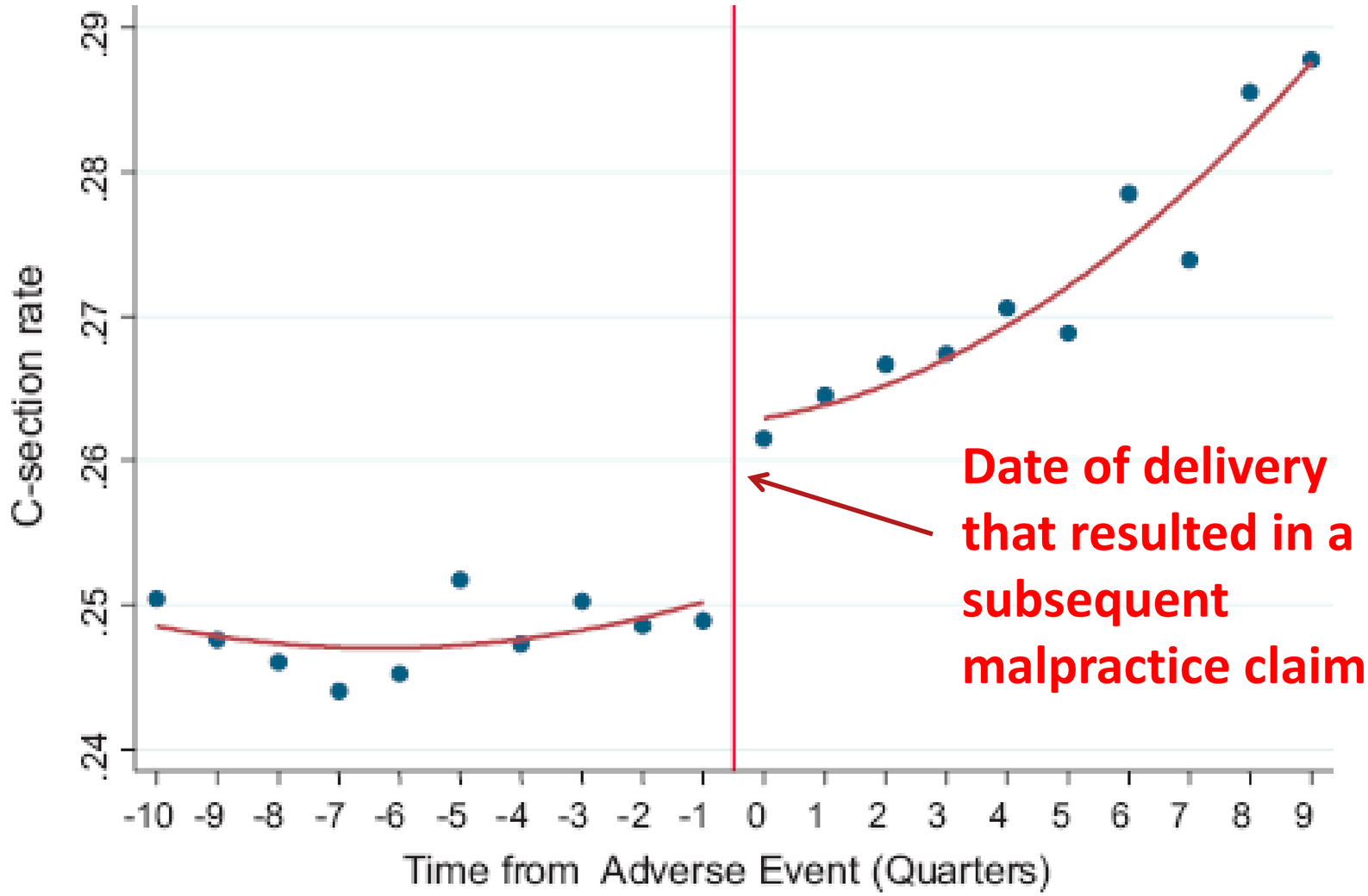
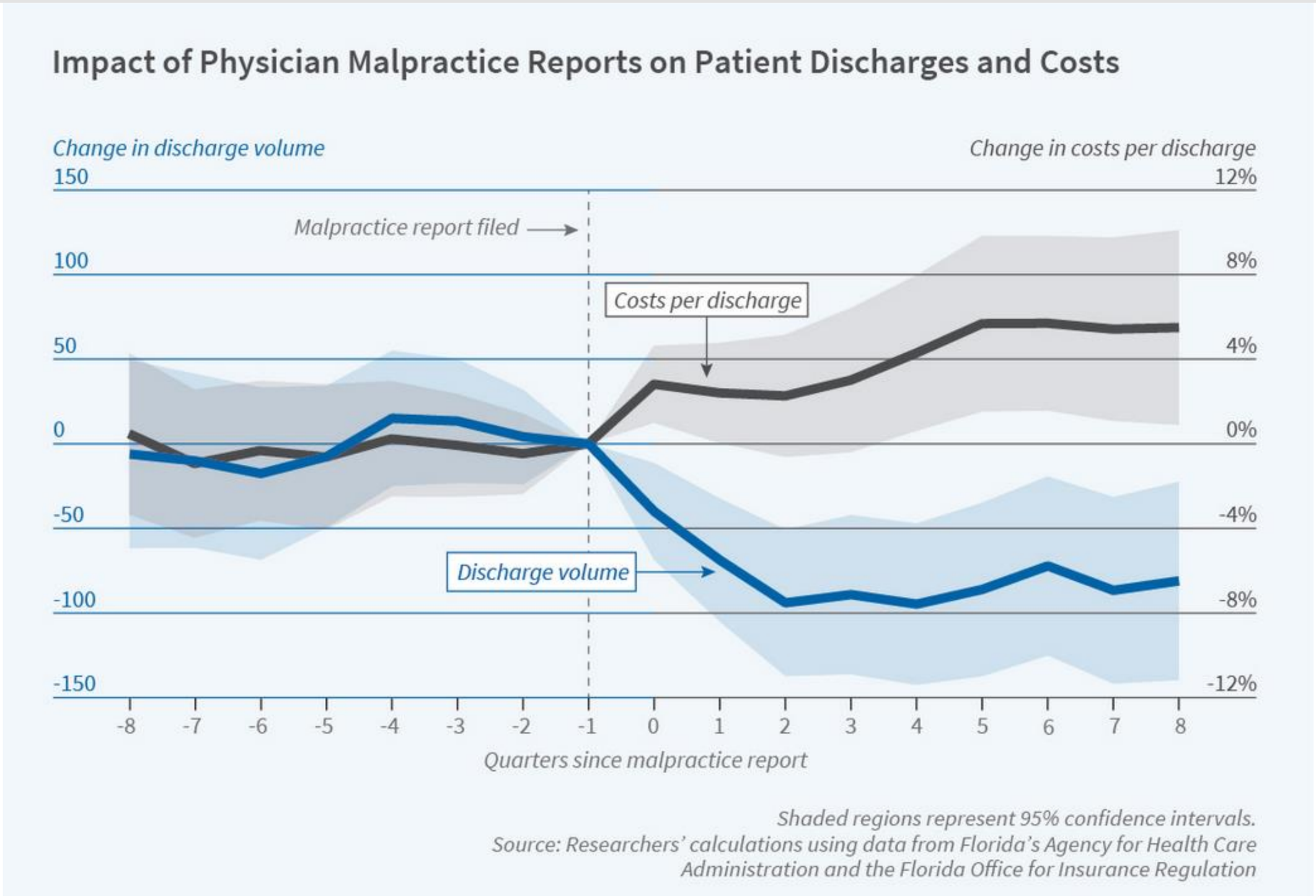


Fig. 5. Short-run effect of an adverse event. *Note*: The figure plots per-period C-section rates in the adverse event panel. The vertical line denotes the time of the adverse event.

Source: Shurtz, *Journal of Health Economics*, 2012.

Florida Emergency Room Physicians Take Longer to Treat Patients and Provide More (Expensive) Services After Being Sued for Malpractice



Source: Carroll, Cutler, and Jena, 2021. NBER working paper 28330

Economists' Conclusion: Defensive Medicine is a Relatively Small Deal: An Issue, But Not That Important

- Conclusion: defensive medicine drives up costs by 5% to 10%. Based on…
- …Comparing costs of treating patients in states that instituted malpractice reforms (e.g., caps on pain and suffering awards) vs. those that have not.
- …and comparing costs between Military Health System (historically not subject to malpractice) and civilian settings.
- No evidence that defensive medicine affects the long run growth rate of spending.

Source: Kessler and McClellan, 1996, *Quarterly Journal of Economics*; Sloan and Shadle, 2009; Frakes and Gruber, 2018.

How Well is the Malpractice System Performing Against It's Objectives?

Objective		Performance of System
1) Compensate patients injured due to negligent behavior	→	Only 1 out of every 16 hospital patients who is injured due to negligence sues, and not all of these win
2) Deter future negligence	→	Physicians do not face the full financial consequences of negligent behavior (but do face reputational harm)
3) Efficiency	→	33% of malpractice premiums go to legal system and administrative costs; takes an average of 4 years to resolve a malpractice claim.

Possible Policy and Market Changes

1) Cap damages for the patient's pain and suffering at, for example, $250,000. The award could still cover a patient's expected lifetime medical costs and lost wages.
2) Disclosure-and-Offer Programs (D&O): if an internal hospital investigation concludes that negligence occurred, hospital and physicians admit fault to patient (apologize?), and offer to pay.
3) No-fault malpractice system:
   - compensate injured patients regardless of whether or not negligence occurred
   - patients forfeit right to sue
   - payments would be based on a schedule, like Workmen's Compensation, and probably wouldn't include pain and suffering costs

Malpractice Conclusions

- MDs, hospitals, and the media often argue that there are too many frivolous lawsuits, and these lawsuits are a major cause of high health care costs and "physician flight" (to low-malpractice cost areas).
- Facts are quite different: a small % of patients who are harmed by negligent behavior actually sue, but suits are indeed somewhat random (i.e., many people who not harmed also sue).
- Defensive medicine is probably not a major cause of rising medical costs.
- Because MDs (but not hospitals) do not face full financial consequence for negligent behavior, system may not be promoting deterrence, unless time to defend oneself and reputational harm from being sued for MDs are substantial (which they probably are).
- Inefficiency: large % of malpractice premiums go to parties other than the harmed patients.

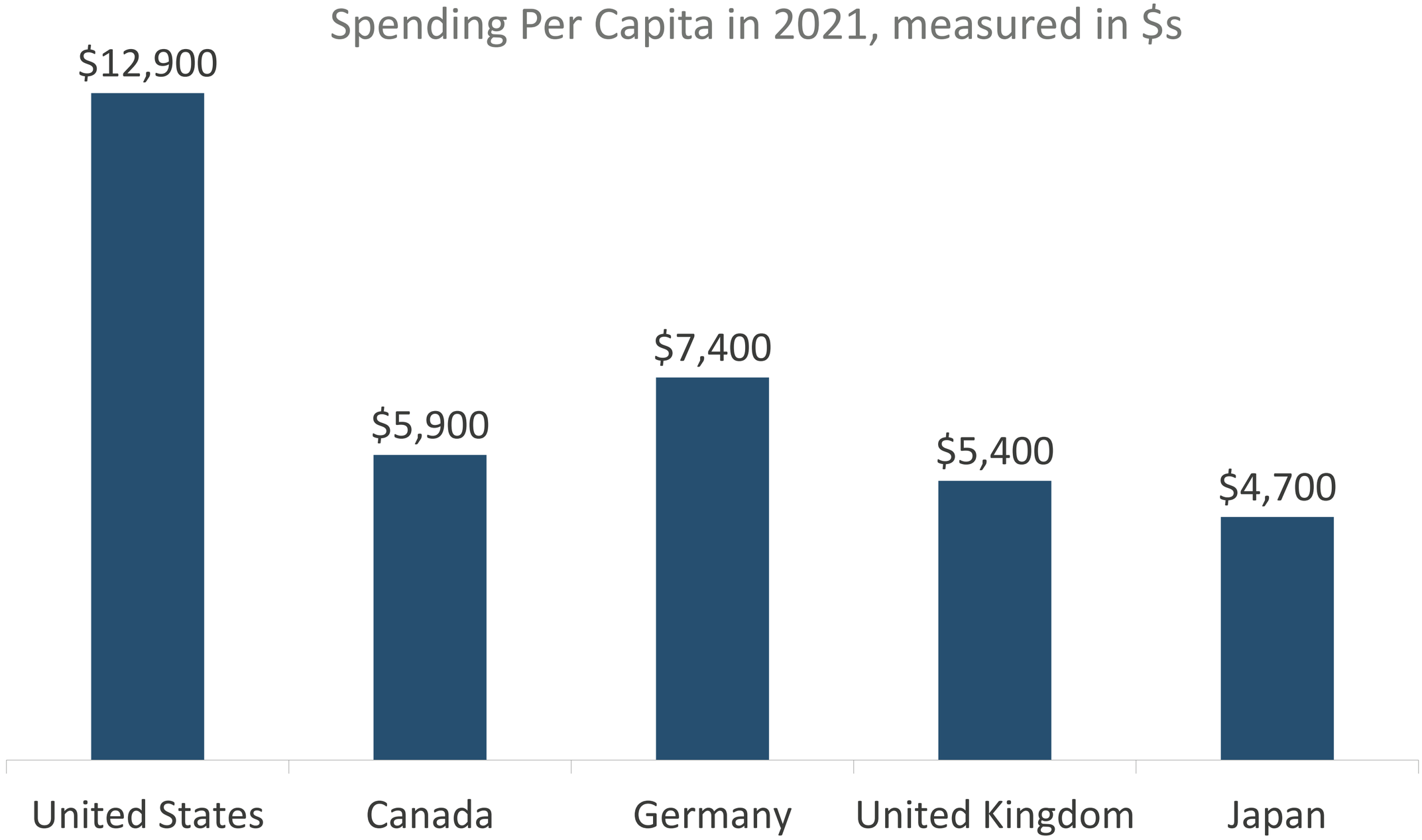
The Rest of Today's Agenda (and continued after Thanksgiving)

1. **Spending:** Define differences between the U.S. and other high-income countries regarding amount spent on medical care and the level of medical quality

2. **Structure:** Describe how the health care system is structured in 4 other developed countries that spend much less than the U.S.

3. **Lessons Learned:** Do these countries offer realistic lessons regarding how the United States could provide universal coverage, improve quality, and/or reduce medical costs?

Why Do 4 High-Income Countries Spend MUCH Less on Medical Care than the U.S.?



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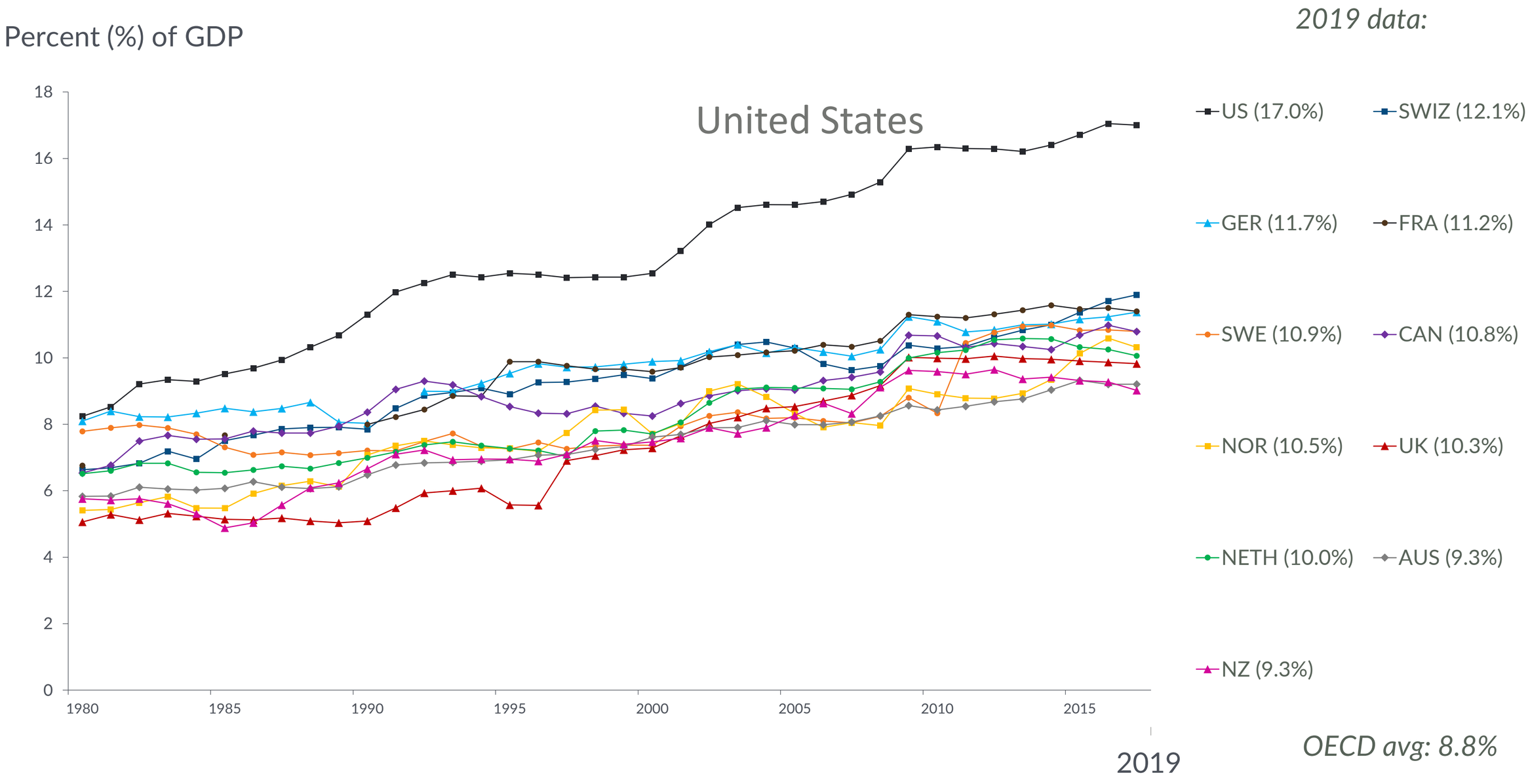
Source: OECD Health Data, 2023.

Other Countries Are Also Experiencing Lower Growth in Medical Spending

Total Health Expenditures as a Percent of GDP: U.S. vs. Comparable Countries, 1980 - 2019



- Source: OECD Health Data 2020.

Reviewing an Accounting Exercise

Formula: Medical Spending = [Quantity of Medical Care X Price] + Admin. costs

Example: Medical Spending = [Number of MD Visits X Fee per Visit] + Cost of processing payment

Possible Drivers

Quantity of Medical Care

1. Underlying Health
2. Health Behaviors
3. Cost Sharing
4. Queues

Price

1. # of Payers/Insurers
2. Role of Private Market
3. Regulation
4. Political Decisions
5. Technologies

Admin. Costs

1. # of Payers
2. Rules for MDs and Hospitals

Image Source: https://www.iconfinder.com/korawan_m

Review slides 28 – 40 in the August 31, 2023 lecture on "Health Care Expenditures_Part 2" for detail on the accounting exercise (this material could be on the final)

Summary of Why U.S. Health Care Is More Expensive Than Other High-Income Countries (which we discussed in late August)

U.S. Prices Are High

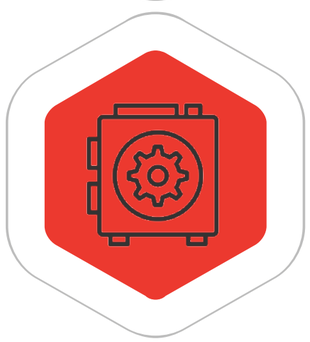
U.S. prices per care unit are high (e.g., price per drug, per day in hospital, per physician visit). Foreign governments set lower prices. Having a single dominant insurer strengthens the government's negotiating power.

Multiple Insurers

Having multiple insurers in the U.S. creates complexity and high administrative costs.

Ability to Pay

GDP per capita: higher ability to pay for health care in U.S. leads to more spending on health care.



Limited Rationing

U.S. does not ration expensive medical technology as much as other countries. Our hospital and physician visits involve more expensive inputs (surgery, imaging, drugs).

Most of These Countries Have Higher Quality Medical Care Than the U.S. Based on Many Measures

International Care Rankings Comparison

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	3	10	8	5	2	6	1	7	9	4	11
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

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Source: Commonwealth Fund analysis, 2021.

1. Canada Has a Single-Payer, Universal Health Insurance System

- Entire population is covered by the same health insurance plan, with some small differences across the 13 provinces.
- Benefits and covered services of the federal plan are uniform within a province (i.e., no ability to choose a different federal health plan).
- People cannot "opt out" and purchase private insurance as a replacement (although 67% have supplemental insurance, such as for prescription drugs, dental care, vision care, home care; this accounts for 12% of total national spending).
- Patients required to pay little (e.g., small drug co-payment) or nothing out-of-pocket, which creates substantial moral hazard (i.e., demand for medical care is high).
- Patients can choose any physician/hospital.

This Seems Too Good to be True

How does Canada control medical expenditures if everybody has coverage, there is little patient cost sharing, and no restrictions on which physicians and hospitals a patient can see?

Controlling Costs in Canada

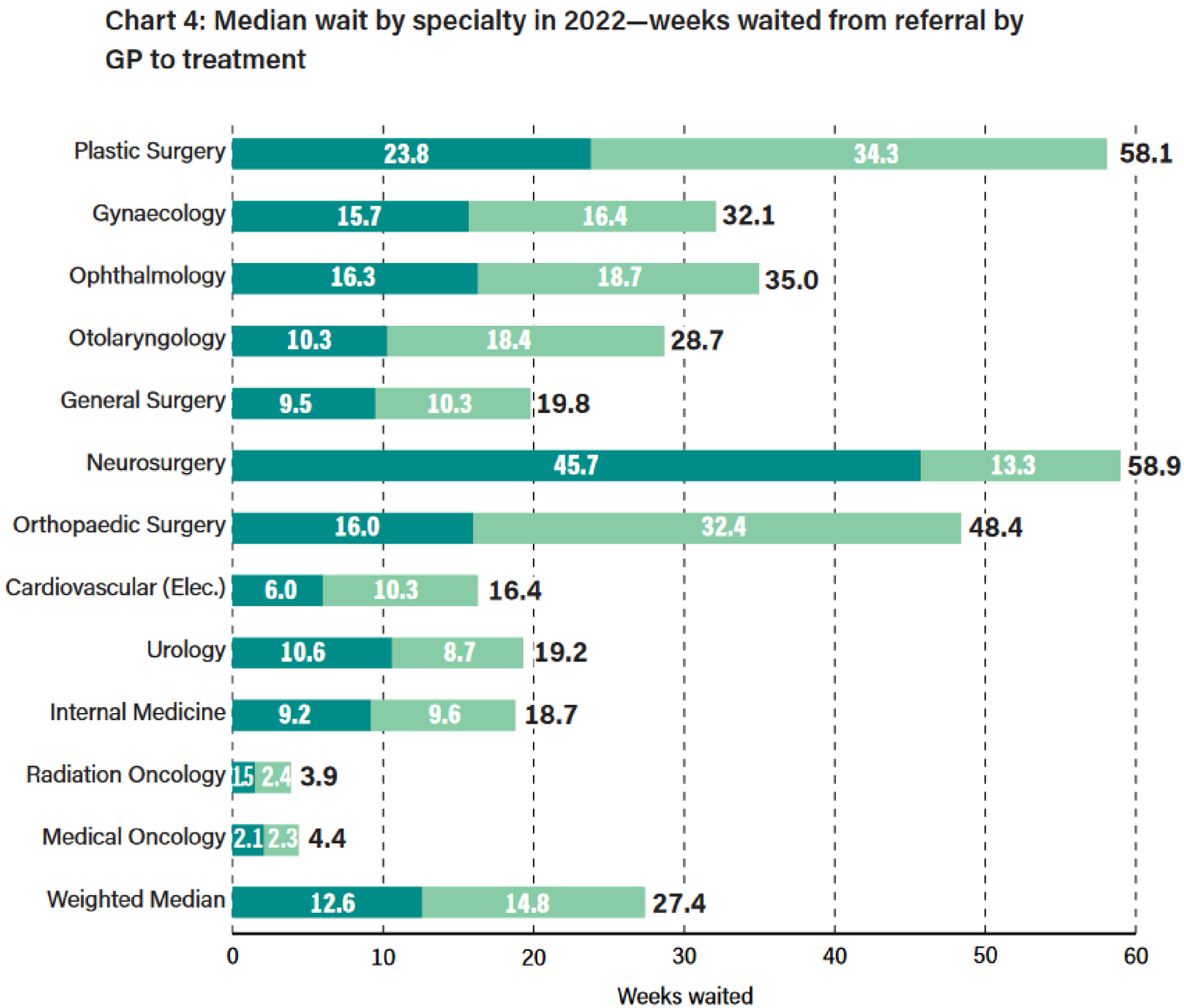
- Federal government provides each province with some funds (from federal taxes); remainder is financed by provincial income taxes.
- Provinces set a budget, which cannot be exceeded, for each hospital. Amount of hospital spending is a political decision made in advance, with resolve.
- Cost control requires rationing services, paying low fees/prices.
- Most MD are independent, not employees of government or a hospital.
- Provinces set MD fees and pay fee-for-service. MDs must accept fee as final payment. There is no negotiation.
- MD income is controlled; once a MD's practice revenue exceeds a threshold, he/she is paid 25% of the original fee per visit/procedure. One implication of price control: see next slide.
- Because costs to patients are zero/low and payments to providers are low (and set by government), demand for medical care exceeds supply (see slide 32).
- Administrative costs are low because there is only 1 payer; easy for providers to follow the rules of a single, national health insurer. (See slide from 11/28).
- 67% of people have complementary private insurance for prescription drugs and dental care, which are not included in the universal insurance benefits.

One Consequence of Price Controls: Physicians Earn Much Less in Canada Than the U.S. ($000s)

	Primary care MDs	Specialist Physicians
United States	$218	$316
Canada	$146	$188
France	$112	$153
Germany	$154	$181
UK	$135	$172
Japan	$125	N/A

Source: Papanicolas et al., JAMA, March 13, 2018.

Canada Has Long Waiting Lists (or Queues)



Canadian government pays for some citizens to receive treatment in the U.S. to keep queues from getting too long

U.S. Rations Medical Care Via Patient Cost Sharing; Other Countries (Canada and UK) Tend to Use Supply Restrictions

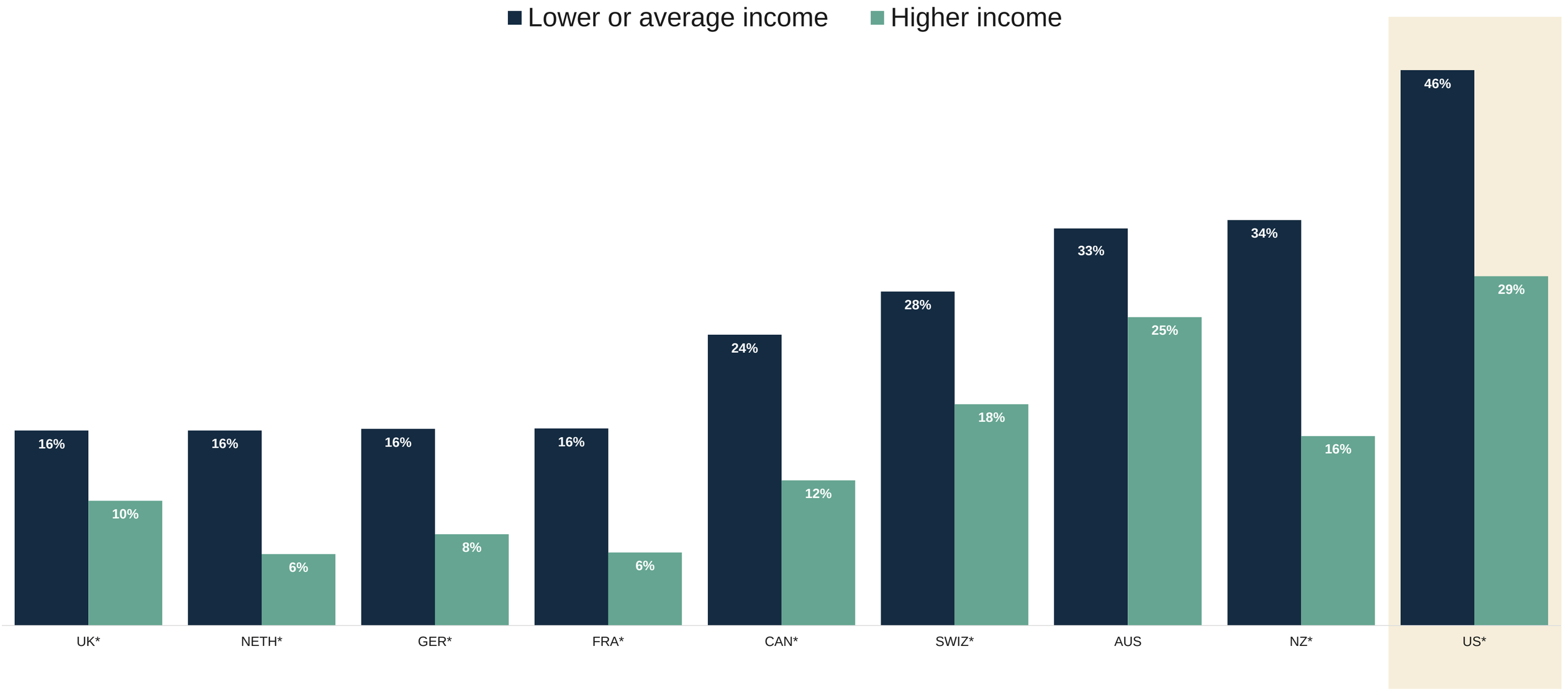
Adults' Access to Medical Care Based on Surveys, 2016

	Waited 6+ days to see an MD	Waited 2+ months to see a specialist	Elective surgery wait	
			< 1 month	4+ months
US	18%	6%	86%	4%
UK	24%	19%	60%	12%
Germany	34%	3%	61%	0%
Canada	29%	30%	46%	18%

Source: Commonwealth Fund, "Mirror, Mirror: 2017."

U.S. Rations Medical Care Via Patient Cost Sharing; Other Countries (especially Canada) Tend to Use Supply Restrictions

Percentage of adults who had a cost-related access problem in the past 12 months



^ Cost-related access problem includes responding “yes” to at least one of the following because of the cost: had a medical problem but did not visit a doctor; skipped a medical test, treatment, or follow-up that was recommended by a doctor; did not fill a prescription for medicine; or skipped doses of medicine. * Indicates the difference between lower or average income group and higher income group within country is statistically significant at p<.05 level; in Australia, that difference is statistically significant at p<.01 level.

Data: Commonwealth Fund International Health Policy Survey (2023).

Source: Munira Z. Gunja et al., *The Cost of Not Getting Care: Income Disparities in the Affordability of Health Services Across High-Income Countries — Findings from the Commonwealth Fund’s 2023 International Health Policy Survey* (Commonwealth Fund, Nov. 2023). https://doi.org/10.26099/jbe9-c870

The Commonwealth Fund

There Are 2 General Methods of Limiting Growth in Medical Spending Without Reducing Quality Too Much (i.e., reducing low VALUE medical care)

Demand-Side (patient)

- Ask patients to pay a substantial amount of the price of medical care (e.g., high deductible)
- Let patients choose which technologies/treatments are worth it (almost all technologies are available)
- "Self-rationing"
- US-favored method

Supply-Side (provider)

- Government/insurer chooses which technologies to pay for and promote
- Sets low prices, and/or restricts access to technologies (e.g., queues)
- "Payer-rationing"
- European-favored method.
  Also Canada and U.S. managed care companies tried this in 1990s.

Discussion

What would happen if the U.S. substantially reduced physician fees, hospital payments, and required long queues for elective procedures?