Editorial

Medical professional liability crisis in Asia Pacific

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Healthcare inflation normally runs at about 2% above general inflation for most countries of the Organisation for Economic Co-operation and Development. Sustainable healthcare financing has long been a subject of global concern. Countries of the Asia Pacific region must face the same economic and, in many ways, political challenge.

The main contributors to healthcare inflation are: (1) new medical technologies and their rapid obsolescence, (2) the rising cost of new drugs, (3) ageing, (4) medical indemnity costs, and (5) systems that encourage unconstrained demand and supply.

In recent years indemnity costs related to medical practice and health services have advanced to the forefront. The cost of medical indemnity insurance has soared to a crisis level, seriously deterring doctors from practising their trained specialty or subspecialty.1

To be sure, healthcare providers should bear the responsibility to compensate patients for personal injury arising from their negligence. Complaints and claims against doctors are best prevented by improving our communication skills, religiously fulfilling our duties to patients, and rigorous continuous professional development. Nevertheless, in some countries even though the number of claims has levelled off, the costs of compensation and therefore of professional indemnity continue to rise at a disturbing rate.2

In Australia, Singapore, and Hong Kong professional indemnity premiums are particularly onerous. From 1998 to 2003, premiums doubled in New South Wales, Australia. Payments in settlement of medical negligence claims led to huge losses for large insurance companies. HIH Insurance, the second largest firm of its kind in Australia, went into provisional liquidation in 2001, so did the United Medical Protection in 2002. In Singapore and Hong Kong, subscriptions for Medical Protection Society (MPS) membership increased exponentially, at 5 to 10 times, between 2002 and 2007. The 1998 rate for private orthopaedic practice in Hong Kong was US$1294. This became $3237 by 2002 and $21 400 in 2007. Orthopaedics including traumatology is classified as a very high risk specialty, while spinal surgery is described as super high risk, carrying a subscription of $24 358 (Fig.). This far exceeds the average monthly income of a private orthopaedic specialist, and is more than double the salary of a consultant orthopaedic surgeon working in the Hospital Authority. In Singapore, the corresponding MPS rates are US$12 593 for general orthopaedics and $13 838 for spinal surgery. After cost-of-living adjustments, these figures leave no room for complacency. Yet just next door, Malaysians fare better at $5105 and $6145 respectively.

While many obstetricians and orthopaedists in the USA have given up their practices, retired early, or moved to more affordable areas, orthopaedists in Asian Pacific countries still try their best to soldier on. There can be no doubt, however, that costs are eventually shifted to patients, and ultimately the taxpayers.

A most undesirable outcome of such prohibitive professional liability costs is the adoption of defensive medical practice. Two types of defensive practice are recognised, positive and negative.3 The former
refers to overcautious behaviour, including over-prescribing, over-investigating, and unnecessary referrals and follow-ups. Thus radiographs and blood counts would be taken for all patients with back pain, and magnetic resonance imaging would routinely be requested on the slightest pretext. On the other hand, in negative defensive medicine, doctors deliberately avoid any high-risk patient or procedure, even if they have adequate training and experience.

It has been shown that defensive medicine caused substantial rises in overall healthcare costs to the community. In the US state of Mississippi, defensive medical practice added 25% cost to Medicare per enrollee during 1998 to 2002. Moreover, increased investigations for fear of litigation, such as indiscriminate imaging, accounted for 60% of the increase in US government Medicare spending from 2000 to 2003 at a staggering figure of US$15 billion.

A useful lesson in tackling the medical indemnity crisis can be learned from the country of origin. Between 2000 and 2006, premiums for medical malpractice insurance increased in most US states at an average of 30% per annum. Nowhere was this more keenly felt than Florida, where the malpractice insurance premium for an obstetrician ranged from US$143 000 to $201 000 in 2001. Many physicians had to abandon their practices or move to other states. Availability of healthcare dwindled to a dangerous level. A special task force set up by Governor Jeb Bush in 2003 reported on their findings with 60 recommendations for change. The most pertinent was a cap of $250 000 on damages. This was eventually passed by the legislature at $500 000. Another bold proposal was to limit lawyers’ contingent fees, which on average took up 30% of the compensation paid. The latter required a constitutional amendment, for which doctors energetically collected the statutory 450 000 signatures from their patients, the public, and of course the politicians. Similar reforms on medical liability systems and the law of tort were carried out in other states, to the effect that the supply of physicians in local communities increased by 3.3% to 12%

Closer to home, New Zealand offers a more cogent illustration of another reform measure—no fault compensation—provided through the Accident Compensation Corporation. The MPS subscription for orthopaedists in 2007 stands at US$1243, i.e. 5.8% the subscription paid in Hong Kong. In fact eligible patients in New Zealand tend to under-claim malpractice compensation. There may however be other factors at play, and universally free health service for all citizens is one of these.

While a no fault compensation system lowers the transaction costs for malpractice compensation, it also encourages claims through ease and efficiency.
The system relies on a schedule of payments and a panel of experts who review and substantiate or otherwise reject a claim. Genuinely disabled patients may be under-compensated and so safeguards against miscarriage of justice have to be in place. In the UK National Health Service Redress Scheme, £30,000 (US$14,780) are awarded for birth-related neurologic injuries on an administrative assessment of fault. Other claims remain in the conventional tort system.

Many other reform proposals have been advanced. These include statutes of repose, periodic payment, eliminating joint and several liability and the collateral source rule, as well as procedural remedies. Statutes of repose refer to strict time limits during which claims of negligence must be filed. The current limit for obstetric cases runs out at the age of 21 years, supposing that victims may not discover related injury until they reach majority. Whether or not a case is discovered, strict time limits of 2 to 3 years are being imposed in some jurisdictions, though not necessarily for obstetric cases. Periodic payment allows for disbursement at a time when calculated future losses are actually incurred. Thus, if loss of future earnings is assessed at 100%, but the plaintiff eventually returns to gainful employment, only that proportion of earnings actually lost will be paid. Readers can obtain a good synopsis of these reforms in An Overview of Medical Malpractice Litigation and the Perceived Crisis.

Provided professional self regulation has been adequately addressed, afflicted countries of the Asia Pacific region should waste no time in starting the legislative process for tort or other reforms. Legislation will be a protracted political battle. Finally, whatever reforms regional communities opt for, they must first of all be equitable, ensuring justice and accessibility to all, especially the financially disadvantaged. The ultimate aim is to safeguard sustainable healthcare through controlling the runaway costs of rapidly unaffordable medical litigation, and not least to uphold the morale of our profession.

REFERENCES