

Medical Liability in the Land of the Midnight Sun

PIAA's Newest International Member Sheds Some Light

By Kaj Essinger, CEO, The Regions' Mutual Insurance Company for Patient Injuries (LOF)

It is important to know in which environment a system works. If a patient is not satisfied with their healthcare, there are *three different ways to make complaints in Sweden:*

- *Complaints:* In every region there is an *Independent Patients' Advisory Committee*. They usually help the patients with problems in contacts/relations with doctors and nurses. They have no decision power but have proven to be helpful for the patients to solve problems in a practical way by talking to the medical staff. About 25,000 complaints per year.
- *Economic compensation:* According to law every care provider must have Patient Injury Insurance. About 9,000 claims a year, 45% accepted.
- *Disciplinary action against staff:* The Health and Medical Care Liability Board gets about 3,000 letters from patients asking them to give reprimands to medical staff. Every year 300 medical staff get a reprimand (notice, warning, loss of licence- only 20 cases)

From our point of view it is very helpful to have the three different systems. Normal complaints can be given direct attention locally. Claims for economic compensation can be taken care of without the need to blame somebody—the only thing to look for is the compensation to the patient. That is why we prefer to call our system a “no-blame system”. The very low number of cases where a disciplinary action is needed is not and should not be mixed with the question of compensation to patients.

There Are Internationally Three Main Ways to Decide Which Patients Should Get Economic Compensation for Patient Injuries:

- Going to *court* where the patient has to *prove that the doctor was negligent, made an error or made an omission* (did

not act)

- An *administrative procedure* instead of court where the criteria for compensation is *injuries that an experienced specialist could have avoided*. Usually called no-fault but a more correct expression is no-blame. That's the Swedish system
- *Any injury to the patient* caused by the health care. This is real no-fault. In France all injuries with a degree of incapacity over 25 % are compensated, if it is a fault by insurance companies and if no-fault by the government. In US, Ireland and England real no-fault is discussed for brain damages on babies.

Sweden Does Not Have a No-Fault System

Most people think and say that the Swedish system is a no-fault system. That is however wrong. We do not give compensation for complications/injuries that could not have been avoided.

Our main rule is that compensation can be paid only if an experienced specialist could have avoided the injury. We call that the specialist standard. If the patient goes to a GP – the experienced GP is the standard. There are other rules for hospital infections.

- There is no need to prove if the doctor was negligent or made an error or omission.
- There is no risk for the doctor to pay personally – the hospitals pay the insurance.
- There is no risk for disciplinary actions – we never tell The Health and Medical Care Liability Board about claims made to us.

Causation and Added Injury

The injury should not only be *avoidable, it should also be caused* by the health care and be an *added injury* when

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compared to the expected development of the patients basic disease.

If there is more than 50% probability for causation compensation could be paid.

How to Decide What is Avoidable?

When the claims arrive to the insurance company we ask the hospital for medical records etc.

A claims handler - administrative person who could have a background as lawyer, a nurse or in the welfare system - reads the medical record and asks questions to our consultant doctors/medical advisers. The consultant doctor's work part time for the insurance company, they are in the same speciality, they look at the medical record and gives advice. If the case has merit all consultant doctors in the speciality meet. The claims handler makes finally the formal decision whether or not the injury should be compensated.

Is There a Written "Experienced Specialist Norm?"

There are normally no written specialist standards for different medical treatments except for some national programs and treatments where there is consensus among specialist associations, for example for some cancer treatments and diabetes. This means that the consultants opinion/advice is based on her/his own experience and as said before if the case has merit all insurance consultant doctors in the speciality meet.

Do the consultants pay regard to the patients or to their colleagues in the hospitals?

To avoid that kind of criticisms we have adopted Ethics rules for consultant doctors. The rules are developed by the Association of Insurance Company Consultants and include:

- Consultants should pay no attention to the economic interest of the insurance company.
- The reimbursement to the consultant should be independent of the outcome of the case which means they are paid per hour.
- If the consultant suspects own disqualification/challenge she/he should not work with the case.

If the Patient is Not Satisfied With the Decision From the Insurance Company?

The patient can complain to the Patient Claims Panel – an independent advisory body appointed by the government with

judges and its own medical consultants. The procedure is free for the patient.

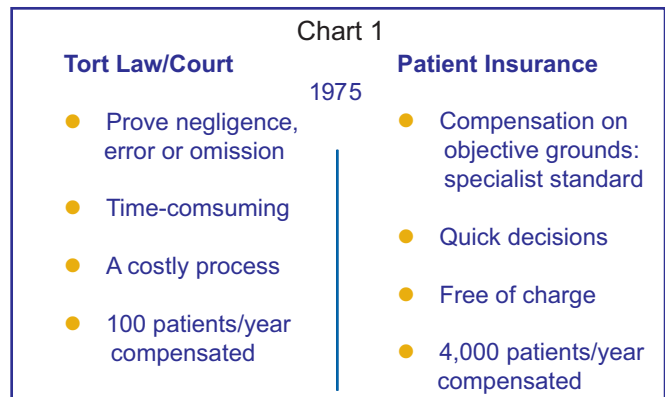
The patient could at any time go to a court of general jurisdiction, but that includes an economic risk for the patient if she/he loses the case.

Started With Voluntary Scheme – Now Replaced by a Law

The medical injury insurance in Sweden started as a voluntary insurance scheme 1975 arranged by the hospital owners, which are the regions in Sweden. The voluntary scheme was replaced by a law, the Patient Injury Act in 1997. One reason was that some of the other care providers did not have insurance.

When Sweden had a court system very few patients succeeded in getting compensation. The Patient Injury Act from 1997 gives a *legal right for the patient* to patient injury compensation. It enforces also a *duty for the care provider* to purchase patient insurance to cover patient injury compensation. *The same rules apply for compensation with tort law* except maximum compensation which is 900,000 Euro for patient injuries, and minimum compensation.

One Mutual Insurance Company Covers Public



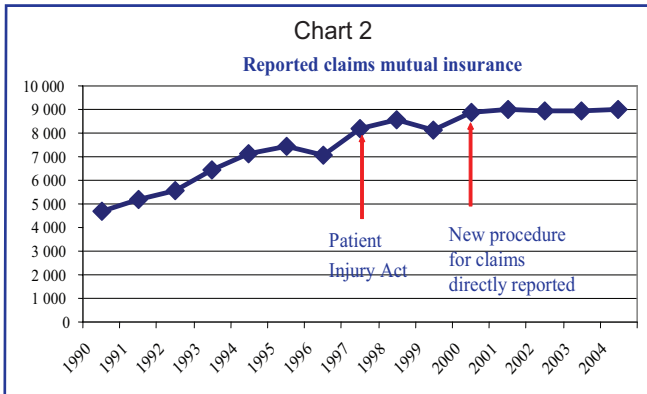
Paid Healthcare

Most hospitals and primary care centres are owned by the regions in Sweden. Most doctors are employed by the hospitals and primary care centres. A few hospitals are run by private companies but have a contract for public patients with the regions. The regions own together "the Regions Mutual Insurance Company for Patient Injuries" (LOF). The premium is based on solid arity – it is calculated per inhabitant in the region.

The insurance covers all public hospitals and GP:s etc and all private hospitals and GP:s etc who have a contract with the regions, which means *all healthcare paid by the public sector*.

There are six private insurance companies who cover private dentists, private GP:s, local nursing homes and care financed with private healthcare insurance, which is a small part.

Sweden Has a High Number of Claims Compared to Other Countries



- The number of claims has increased over time in Sweden – but has been stable the last five years.
- The number of accepted claims in Sweden and Denmark, who have the same kind of system, is much higher than in other countries.
- The total here for Sweden includes hospital care, primary care, dental care.

9,000 claims in total for 9 million inhabitants in Sweden

1 claim per 1,000 inhabitants
0,45 accepted claim per 1,000 inhabitants

900 patients who are not satisfied go to the Governments Claims Panel

1 claim per 10,000 inhabitants
0.1 accepted claim per 10,000 inhabitants

10 patients go to court

1 case per 1,000,000 inhabitants

Paid claims for hospitals differ between countries, approximations from a HOPE study

Country	Paid Claims	Inhabitants	Paid claims per 10 million inh
Sweden	2650	9 million	3000
Denmark	1500	5 million	3000
Netherlands MediRisk	500	16 million *	300*
France SHAM (public)	750	60 million *	?*
Canada CMPA	500	32 million	150
Spain	350	40 million	100

*MediRisk has the main part of general hospitals, but no university hospitals.
* SHAM is the mutual insurance for most public hospitals, except in Paris,

The Costs Do Not Seem to Differ as Much as the Number of Claims

The costs for medical risk insurance for a *university hospital* seem to be, according to the HOPE –study, approximately 1 million Euros per year in France and Sweden and almost the same in England/Scotland. Spain has lower costs but also a much lower number of accepted claims. On a *national level the cost per inhabitant* seems to be almost similar in Sweden, Canada and New Zealand, around 10 Canadian dollars per inhabitant.

Why Are the Costs Not Higher in Sweden?

The main reasons are

- a) the administrative procedure instead of court,
- b) the compensation is subsidiary to the general welfare system and the healthcare system.

Our estimation is that it is *20 times more expensive to go to court with one case than to use our administrative procedure with claims handlers and consultant doctors.*

Out of 9,000 claims a year only 10 go to court. In other countries the cost for lawyers before and in court procedures represents a very high cost compared to the total compensation to the patient.

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In the Swedish system more than 80% of the total cost goes to patients themselves. In some other systems half of the cost goes to lawyers on the doctors/hospital side and half to the patient as compensation, out of which the patient should pay her/his own lawyer.

The Swedish System Uses Short Time to Settle a Case Compared With Court Procedures

From claim to the decision accepted or not it takes:

Less than 6 months for 50 % of the claims

Less than 8 months for 70 % of the claims

Less than 12 months for 80 % of the claims

The compensation from the patient insurance is *subsidiary to the general welfare system*, including sick leave compensation and early retirement etc. General welfare covers 80% of salary during sick leave and 64% of salary during early retirement because of illness on income up to 32,000 Euros/year.

Costs for *extra hospital care etc* due to the medical injury is paid by the public health care system and not by the medical injury insurance as could be the case in some other countries.

The Swedish System in Summary

1) More claims accepted

- No economic risk for patients and doctors
- Simple and quick administration

2) Costs per hospital seem to be similar

- Subsidiary to the general welfare and health care systems
- Maximum compensation to one patient is 900,000 Euro

Euro

- Usual compensation is < 2,000 Euro
- Low cost for claims handling
- “No cost” for lawyers

What Would Be the Best System for Patients to Get Compensation for Medical Injuries?

The last years I have had the opportunity to take part in many international discussions on the development of patient injury insurance: in HOPE, the European Hospital and Health Care Federation as president for a committee on patient safety, in the Council of Europe working party for patient safety, in Europa Medica the co-operation between mutual doctors owned

insurance companies, in conferences in Luxembourg (EU), Paris (ONIAM), in Warsaw (Council of Europe), in Ottawa (PIAA) and in Nice (IHF).

From those discussions I find some elements in common for a good system:

- Enterprise (hospital liability) instead of personal liability for the doctor
- Separate economic compensation to patients from disciplinary actions against doctors
- Use an administrative procedure for claims handling instead of going to court in order to have lower cost and shorter decision time
- Compensate avoidable injuries regardless of negligence, error or omission from the doctor in order to reduce the need for court procedures
- Use maximum compensation rules for one case to limit the high costs and self risks/deductibles for patients or hospitals to avoid small cases
- Use the information from claims for learning to avoid injuries in the future in order to reduce the costs for medical injury insurance. That is the most important action to reduce future insurance costs.

The points above show some elements that could be useful if a country wants to change its own system for medical injury insurance. The discussions from the PIAA meeting in Ottawa in September – where a comparative study of systems was presented by CMPA- show that it is not possible to copy a system from one country to another. The reason is that the systems exist in a national environment of welfare systems, health care systems and culture. So the Swedish system might be the best for Swedes and Scandinavian countries that are quite similar but for example not for Canada which has a different welfare and hospital system and a different culture. But from my point of view some of the pointed elements above could be useful when discussing how to improve the national systems in other countries. ●

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