

The Swedish Medical Injury Insurance

Report 2009-02-20 Kaj Essinger, CEO, LOF

1. The Regions are responsible for health care financed by regional income taxes.

Sweden has 9 million inhabitants. The 21 directly elected regions with their own parliaments are responsible for health care in their areas. Health care is financed by regional income taxes, which are 10 % of the inhabitant's income. The national government finances mainly education and research in the health sector. The 70 hospitals are usually owned by the regions. Some small privately owned hospitals have a contract with the regions and a very small part of health care (1-2 %) is financed out of pocket or by private health care insurance.

The doctors are employed by the hospitals. Primary care doctors /GP:s could be employed by the regions or be entrepreneurs paid by the regions. The number of private doctors without a contract with the regions is very small. The patients co-payment for health care is low: Max 100 dollars a year for out patient care, Max 200 dollars a year for pharmaceuticals and 10 dollars a day for inpatient care.

2. The hospitals (regions) started the medical injury insurance themselves 1975

The medical injury insurance in Sweden started as a voluntary insurance scheme in 1975 arranged by the health care regions (hospital owners). Before that time a patient had to go to the district court in order to get economic compensation for a medical injury. 100 patients a year were successful. The regions did not have good representation in form of lawyers etc for the court procedures and the publicity in local newspapers usually promoted the patients version.

The regions wanted to make it easier for patients to get compensation than through court procedures and they wanted to have experts to look at the cases. The regions started their own insurance company with one administrative unit for the whole country, with its own expertise in claims handling and its own medical expertise.

The basic elements in the insurance are:

- Only **avoidable injuries** are compensated
- **No blame for doctors** – no connection with disciplinary actions
- **Administrative system for claims handling** (1 claims adjuster/manager and 1 consultant doctor) = **no court procedures**

The insurance includes a liability insurance for civil court cases on medical injuries, which means that LOF will represent the regions in such cases.

The voluntary scheme was replaced by a law, the Patient Injury Act in 1997 with almost the same rules as the voluntary insurance scheme. One reason for introduction of the act was that some of the private care providers did not have insurance. The Patient Injury Act is a special law based on the patients right to have compensation for avoidable medical injuries and a duty for the care giver to have medical injury insurance.

(For more info: Patient Injury Act and comments to the Act by Carl Espersson.)

3. The regions medical injury insurance company (LOF), which is a mutual, is owned by the regions. The insurance policy is held by the regions not by the single doctors (enterprise liability). The insurance company covers medical injuries in the regions own hospitals and primary care centres and also in all private care which is paid by and has a contract with the

regions, which is most of the health care in Sweden. LOF covers almost 90 % of the Swedish health care. Approximately 10 private insurance companies cover private doctors without a contract with the regions, private dentist, chiropractors, physiotherapist and nursing homes.

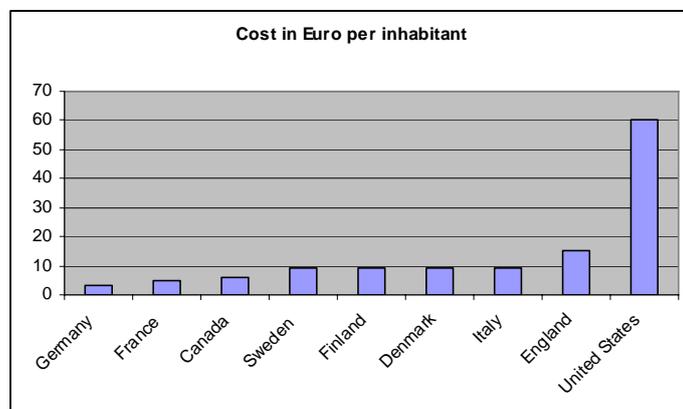
The number of staff is 110 (full time equivalents) most of them claim adjusters. About 80 consultant doctors/medical advisers work part- time (a couple of hours a week) for the insurance. The staff handles 10 000 claims of which 4 300 are accepted/paid. 4 staff work with prevention/Patient safety.

4. The regions pay 10 dollars per inhabitant/ year as insurance premium

The premiums to the insurance company are paid directly from the regions according to the number of inhabitants in the region. The premium is not risk based per region or hospital. There are no government subsidies to the insurance. The premium is paid from the regional income tax. The cost for the insurance is 10 dollars per inhabitant and year.

The cost in Scandinavian countries is similar. The cost in many European countries with court systems is lower depending on a lower number of paid claims. In United States the cost is 60 dollars, mainly depending on higher costs for lawyers and administration.

Who gets the premium?	Patients	Adm+lawyers
US	28 %	72 %
Sweden	> 80%	<20%



5. There are different ways for patients 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 proved to be helpful for the patients to solve problems in a practical way by talking to the medical staff. They receive about 25 000 complaints/year.

Economic compensation: According to the law every health care provider (hospitals etc) must have **Patient Injury Insurance**. The insurance receives about 10 000 claims a year, 45 % are compensated.

Disciplinary action against staff: The **Medical Responsibility Board (HSAN)** gets about 4 500 notifications from patients asking them to give reprimands to medical staff. Every year 300 medical staffs get a reprimand (warning or soft warning)

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.

6. Criteria for economic compensation according to the Patient Injury Act

Only avoidable injuries are compensated

The main principle is that compensation can be paid *only if an experienced specialist could have avoided the injury*. That is called the specialist standard. If the patient goes to a GP – the experienced GP is the standard. If the patient goes to an oncologist – the experienced oncologist is the standard. The injury should not only be *avoidable, it should also be caused* by the health care and be an *added injury* when compared to the expected development of the patients basic disease. If there is more than 50 % probability for causation compensation could be paid out. In court systems the burden of proof often is 70%

How to decide what is avoidable?

The patient files the claim to LOF herself/himself within 3 years from when they understood that they have a medical injury, but never later than 10 years after the injury.



When the claims arrives to the insurance company the claims adjuster asks the hospital for medical records, X-rays and doctors statements etc. A claims adjuster – an administrative person who for example could have a background as lawyer, a nurse or a person who has been working in the social welfare system - reads the medical record and asks questions to our consultant doctors/medical advisers. Experienced specialists in Orthopaedics look at Orthopaedic claims, Oncology specialists at oncology claims etc. They look at the medical record and give advice if the injury was avoidable or not. If the case is complicated it could be discussed with other consultant doctors in that speciality on scheduled meetings.

The consultant doctors work for LOF a couple of hours a week and usually work fulltime in hospitals or are recently retired, they could also be private doctors. The criterion is to have well respected experience in the speciality.

The claims adjuster makes the decision; to compensate or not and informs the patient. 70% of the patients get a decision within 6 months from the arrival of the claim and 80% within 8 months.

Is there a written “experienced specialist standard”?

There are normally no written specialist standards for different medical treatments except for a few 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 their own experience.

Do the consultants pay attention to their colleagues in the hospitals?

To avoid that kind of criticisms LOF has 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.

The experience of the Ethic Rules is that they have been valuable to refer to when patients or media question the system. As far as we know the doctors adhere to these rules.

7. Guidelines for decision of the amount to be paid

The compensation follows general Tort Law and is decided for each individual patient according to that patient's specific injury. The patient usually has a basic disease/injury which caused the hospital visit – the insurance only pays for the added (avoidable) injury that was caused by the medical treatment.

Different kinds of compensation are paid:

Extra costs for extra bed days and out patient visits (fee per day/visit)

Transportation to extra outpatient visits

Loss of income, with reduction of what the national social welfare system pays

Pain and suffering, for the short term problems

Disability/invalidity, for the final reduction in the ability to use the body



The claims adjuster asks the patient for receipts of extra costs because of the injury that should be compensated and pays.

If the patient is disabled LOF has to wait until the disability has a “permanent state”, it could take a couple of years. After that a new statement from a doctor is necessary on the degree of disability. When the degree of disability is clear the disability compensation is found in the tables and paid as a lump sum. For disability there are national tables decided by the Association of Traffic Insurance Companies. Those tables define the percentage of disability for each injury for example loss of thumb on right hand x% disability. For each percentage of disability the tables tell how much to pay for each age (lump sum payment only). The highest sums are paid to young people. Those tables are used by all insurance companies in Sweden and all courts.

Compensation is paid for the loss of ability to work according to the individual work situation of the patient. The compensation for loss of income and later on loss of pension because of the medical injury are paid as annuities.

8. Do patients think the compensation is good enough?

The patients in Sweden sometimes say that the compensation is low compared to United States. There is one difference: US has punitive damage for example to frighten doctors to do the same mistake again. Punitive damage is to my knowledge not used in European legislation. If you look at compensation for loss of income the social welfare system in Sweden compensates 80% of the loss of income the first year, so the medical injury insurance only has to compensate 20 % of loss of income. In other countries the medical injury insurance covers most of the loss of income.

Medical treatment caused by the injury is “free” in Sweden. In some countries the medical injury insurance companies have to pay to the hospitals for medical treatment caused by the injury. In Sweden local welfare and national welfare systems pays personal assistants and economic grants for example for assistance to brain damaged babies as well as to other heavily disabled persons. In other countries the medical injury insurance pays for that.

PIAA (Physician Insurers Association of America) made a comparison in October 2008 of costs for brain damaged babies in five countries. The conclusion of the comparison (I was the moderator) was that the compensation to a brain damaged baby and its parents might be very similar in those countries if you add together what is paid by medical injury insurance and social welfare. But there are important differences between the countries from which system money comes. In some countries most of the money comes from medical injury insurance in others (Sweden, Netherlands) most it of comes from social welfare.

If you explain these things for patients they understand that the compensation in Sweden:

- is the same as for other injuries for example motor car injuries or work place injuries
- differs from other countries mainly depending on a “better” social welfare system in Sweden

9. If the patient is not satisfied with the decision from the insurance (LOF)

Every year 10 000 patients make a claim and 4300 get compensation. The reason for not compensating claims is usually that the injury was not avoidable.

1000 patients are not satisfied (usually those who do not get compensation). They appeal to the independent Patient Claims Panel (a kind of special appeal court for medical injuries) appointed by the Government with it own judges and consultant doctors.

The Patient Claims Panel approves 100 out of the 1 000 and recommends LOF to change its decision which always is done.

The patient has always the right to go to court. But the procedure at the insurance company is free and also the appeal to the Patients Claims Panel.

The number of court cases is 10-15 a year, 1-2 approved.

99,9 % of the claims are solved out of court.

10. How the Patient Insurance contributes to promotion of patient safety and quality improvement of health care

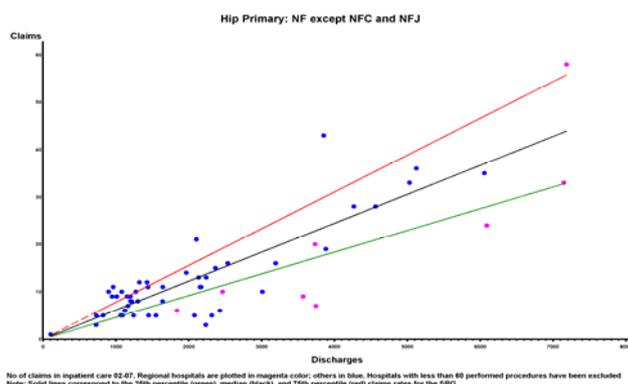
The Regions Medical Injury Insurance covers most of the Swedish health care almost 90 %.

The 10 000 claims a year including the 4300 paid claims are registered in a database.

Every month the Chief Medical Officers (doctor who is assistant hospital manager with responsibility for patient safety) in the hospitals receive an overview of the claims for their hospital last month in order to make it possible for them to initiate Root Cause Analysis for severe claims. Root Cause Analysis should be made to find out *why* the injury happened *not who did it*. The idea is by asking why many times you will find the Root Cause for the injury. Usually that is failure of routines or systems which must be changed in order to avoid that the same kind of injury could happen again. *LOF uses economic incentives to promote Root Cause Analysis*. LOF pays 1 000 dollars to hospitals who do a Root Cause Analysis of one medical injury that is reported to LOF.

Every year the Chief Medical Officers and the heads of Orthopaedics, General Surgery and Obstetrics get full information of medical details for all claims from their hospital the last five years.

They also get comparisons on medical procedures for example they get a diagram covering all hospitals that perform hip replacements.



On the diagram they can see per hospital both the number of claims and the number of performed hip replacements so they can compare with other departments doing the same thing. There are diagrams for 60 procedures per hospital. *Since February 16th 2009 some of that information is published at the LOF website: www.patientforsakring.se in order to make it easier for hospital staff to learn.*

These data are followed up by *visits from the insurance company to hospitals*. Last year about 25 visits were made to discuss the data and what could be done to avoid medical injuries.

National patient safety conferences are arranged together with the Hospital Federation, the National Board of Health and Welfare and with the medical professions. Last conference had 1 400 participants. Leadership training for patient safety has also been arranged together with one region.



The claims data are also used for scientific studies. All 500 claims since 1990 for *brain damaged babies* have been analysed and especially 177 avoidable brain damages from “normal deliveries”. The study was published in British Journal of Obstetrics and Gynaecology in February 2008. The causes for brain damages were: CTG- interpretation, Oxytocin prescription, Non optimal mode of delivery, Resuscitations. In most countries brain damaged babies cost 20-25 % of the premium for medical injury insurance.

Co-operation with the medical professions

The medical professions (Obstetricians, Neonatologists and Midwives) have now taken responsibility to make deliveries safer. They have made a self – assessment program for all 47 delivery departments in Sweden with questions on How do you secure ... that your staff can interpret CTG, ... can prescribe Oxytocin etc. This will be followed up by professional peer review and an improvement plan for each delivery department/clinic.

The insurance company will give economic incentives when the departments start with self assessment with 5 000 Euro to each department/clinic and when they have performed the improvement plan 15 000 Euro. All delivery departments have now joined the program. The cost for this program is less than the cost for 2 brain damaged babies. Every year 15 avoidable brain damages are compensated.

A similar program has started with the medical professions in Orthopaedics (doctors, nurses, physiotherapists etc) in order to *reduce infections after hip- and knee replacements* but without using economic incentives.

The WHO checklist for surgery together with a Swedish version of a film will be introduced in March 2009 by LOF and the medical professions working in operation theatres.

11. What are the opportunities for improvement for the patient insurance program?

Very good relations/trust with the medical professions, Chief Medical Officers, Heads of Medical departments in Sweden and with the political and administrative leaders of the Regions both regarding patient safety work and insurance. Good service level now to the

patients. At the moment LOF has no bad publicity in newspapers and TV. The insurance model is internationally regarded as the best solution. The number of claims is stable. This forms good opportunities to go on with continuous improvement every year.

12. Proposed New Patient Safety Law in Sweden

The government has asked a judge to make a report on new legislation for Patient safety. The proposal includes:

Focus on systems instead of individuals.

Individuals will not be punished for mistakes (no warnings and soft warnings)

But if staff are violating clear rules they will be forced to training period according to a plan and if they do not follow the plan they will lose their license (much quicker than today).

A new duty for hospitals: they must make proactive patient safety plans, they must do what necessary to prevent injuries, they must investigate why injuries happen, learn from them and take actions so they do not happen again.

If a prosecutor wants to take a medical injury to court (happens very seldom) he/she must ask the National Board of health and Welfare (in Japan probably an administrative part of the ministry of health) of their opinion which is expected to reduce “not necessary court cases” in the future. That board looks at medical injuries from a Root Cause Analysis point of view, which means they look for why the injury happened and how to avoid future injuries by changing routines and systems rather than focusing on the individual doctor.

The proposals are expected to be a new law from 1.1.2010. The ideas seem to have support from all important stakeholders in Sweden.



The Swedish model in summary

Based on the patients right to compensation

The Patient Injury Act regulates the patients' right to compensation and the caregivers' duty to have insurance.

No blame for the doctors

- 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 – the insurance never tells The Medical Responsibility Board (HSAN) about claims made to medical injury insurance.

No blame for doctors – no fear for reporting – claims could be used for learning

In order to reduce the number of medical injuries there is a need for reporting, analysing and changing routines. This is easy in a no-blame administrative system but more difficult in a court system where full information about cases is not always available.

Using “avoidable injury” eliminates the need of court procedures

It is not necessary to prove that the doctor was negligent – it is enough that a consultant doctor proves objectively that the injury was avoidable – the doctor who treated the patient only needs to write a medical statement.

The administrative model saves time and money

The process goes quick and is cost-effective compared to court procedures.

Use the information from claims for learning/patient safety

Appendix

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A list of publications/reports/ OH in English:

Most of them at www.patientforsakring.se for professionals and media.

The medical injury insurance model

Europe for Patients: Swedish System: Right to Compensation for Damage Caused by Healthcare. (Report)

Kaj Essinger October 2008

Medical Liability in the Land of the Midnight Sun. (article)

Kaj Essinger 2006

Council of Europe. European Conference “The Ever-Growing Challenge of Medical Liability: National and European Responses. (report)

Kaj Essinger 2008

The County Councils’ Medical Malpractice Insurance Scheme.(information leaflet 2003)

The legislative background and development of legal praxis

The Patient Injury Act. (translation)

Carl Espersson 2000

Comments on the Patient Injury Act. (article)

Carl Espersson 2000

The Swedish Patient Insurance – a pragmatic solution (small book)

Carl Espersson 2000

Patient Injury Compensation for Healthcare-Related Injuries.(small book)

U. Hellbacher, C.Espersson and H.Johansson 2007.

Patient safety

The Professions’ Joint Work in Preventing Birth Injuries in Children.

2008 (web article)

www.patientforsakringen.se

How to Reduce the Number of Brain Damaged Babies. (OH)

Kaj Essinger

www.patientforsakringen.se