

MEDICAL MALPRACTICE IN SWEDEN AND NEW ZEALAND: Should Their Systems Be Replicated Here?

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For years, proponents of wiping out the right to jury trials in U.S. medical malpractice cases have pointed to two countries with “no-fault” systems – Sweden and New Zealand – maintaining that if such systems work in those countries, they can also work here. This contention has become part of the case for so-called “health courts,” a U.S. proposal that would force all medical malpractice cases into a system based on workers’ compensation “no-fault” models.

In July 2001, for example, David Studdert and Troyen Brennan of Harvard’s School of Public Health published an article in the *Journal of the American Medical Association* called, “No-Fault Compensation for Medical Injuries,” arguing that core elements of Sweden and New Zealand’s systems (as well as those of Denmark and Finland) “could be grafted onto existing arrangements among physicians, hospitals and insurers in the United States.”¹ Similarly, in 2007, an article appeared in the American Enterprise Institute’s magazine, arguing for “health courts” based in part on what they believe are successful systems in Sweden and New Zealand.² The American College of Emergency Physicians agreed,³ as have many other industry groups.

Even the most ardent “health court” proponents recognize the difference in costs between the United States and other countries’ administrative systems, especially “the existence of other forms of social insurance, including wage loss insurance and universal health insurance, present in these countries.”⁴ However, very little analysis has ever been done to show if

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comparisons can even be legitimately made given enormous differences in health care systems. Nor has any real attention been paid to the actual patient safety records of these countries, given that patient safety improvement is a key part of the argument for “health courts.”

This paper examines some of these questions and finds that short of huge – and unimaginable – increases in government spending to greatly expand our social safety net, there is no possibility that anything like the systems that exist in Sweden and New Zealand could be replicated here in the United States. Moreover, patient safety has suffered severely in Sweden due to its failure to link compensation payments to the accountability of unsafe health care providers – a key component of all “no-fault” systems. In fact, the Swedish medical community is looking to the *United States* for help in improving their enormous patient safety problems.

In short, the United States could never replicate these systems – nor should it.

THE U.S. PROPOSAL

Over the years, mostly under pressure from insurers, states and Congress have occasionally considered proposals that would require or pressure patients injured by medical negligence to have their disputes resolved outside the court system. The ideas generally fall into the category called “no-fault,” where patients are promised compensation without having to prove the “fault” of the negligent provider. One of the more talked about recent proposals is known as “health courts” or “medical courts,” which would cover all medical malpractice claims.

As usually described, under a “health court” system, patients would file claims in special “courts” after the health care provider’s insurance company denied or low-balled a claim.⁵ This is not unlike how cases end up in U.S. courts today. Yet that’s where the similarities end. In “health courts,” judges trained by the medical establishment would decide compensation with the assistance of a panel of medical experts, without a jury and based on pre-determined “one-size-fits-all” benefit schedules for certain injuries. How these judges would be selected and what qualifications they would need are unclear. Some proposals call for judges trained in science and medicine, while others go so far as to suggest that the judges themselves be medical doctors and leave open whether they would need a law degree.⁶ Whoever they are, the fact remains that such judges would be trained or assisted by the medical establishment, creating the potential for pro-defendant bias.

In terms of the standard of proof required from patients, “health court” proponents insist that the burden would be eased with an “avoidability” standard, *i.e.*, “could the injury have been avoided or prevented?”⁷ While they claim this standard will ease victims’ burdens of proof and lessen the stigma doctors feel under the negligence standard,⁸ it remains unclear how this standard differs at all from traditional negligence.⁹ Given that a patient would still have to prove “causation,” it is likely the burden of proof would remain essentially unchanged in a “health court” forum.

Another benefit touted by “health court” proponents – reduction of the attorney’s role in representing patients, which would leave victims to navigate the process on their own. They say, for example, “Both parties would be permitted to have legal representation if desired, but claimants could easily proceed without the assistance of counsel in most cases.”¹⁰ However, keeping victims from representation while insurers or health care providers have counsel hardly benefits patients. This lack of representation only helps hospitals and physicians.

SWEDEN

While “no-fault” and “health court” proposals in the United States would eliminate the tort system for medical malpractice, this is not true in Sweden. In Sweden, the two systems exist side by side. Injured victims always retain the right to use the tort system.¹¹

In addition, any examination of Sweden’s medical injury “no-fault” administrative system must first be put in the context of its vast general welfare and public healthcare systems, which already cover a large percentage of a med mal victim’s costs before the country’s malpractice compensation system even kicks in. Sweden’s general welfare system pays for 80 percent of a victim’s sick leave and the healthcare system takes care of all medical expenses.¹² The Swedish medical malpractice “no-fault” system is, therefore, considered “on top of” the general welfare system, not in place of it, as proposed in the United States. Since the government already pays for so much, far fewer people use the “no-fault” system. Moreover, there are far fewer consequences for those who turn to the “no-fault” system and who are unsatisfied, since the government still provides for their medical care.

How The Swedish System Works

The Swedish system begins, like U.S. “health court” proposals, with an insurance component. This is where the great majority of Swedish claims are settled. The insurance adjuster confers with doctors and medical advisors who are specialists in their fields and decides within a year whether to pay the victim this extra amount above what the government is already paying.¹³ Compensation is based on each victim’s specific injury.¹⁴ Non-economic (*i.e.*, pain and suffering) damages, based on age and injury, are capped.¹⁵

If a malpractice victim is not satisfied with the decision, s/he can appeal to the independent Patient Claims Panel, which is comprised of judges and consultant doctors appointed by the government.¹⁶ The fact that only about 10 percent of claims go to this appeals court each year¹⁷ likely says more about the extensiveness of Sweden’s social safety net than patients’ satisfaction with the system’s outcome, either at the insurance adjuster or Patient Claims Panel stage. It also probably says something about the difficult burden of proof under an “avoidability” standard, as noted earlier. In fact, the burden of proof under the avoidability standard is still so significant for patients that only around 40 percent of claims succeed.¹⁸

NEW ZEALAND

New Zealand has a government-funded compensation system, called the Accidental Compensation Corporation (ACC), which covers the costs of all accident injuries, including those caused by medical malpractice. There is no right to sue for damages for any injury covered by the ACC legislation. The system is purely an insurance system and there is no “health court” component.

Under New Zealand’s system, medical malpractice claims are decided in the ACC’s national claims unit.¹⁹ The standard of proof is somewhat closer to “no-fault” than Sweden’s; yet still only 40 percent of claims receive payment.²⁰ In New Zealand, patients must show that they suffered a “treatment injury.” This includes “all personal injuries suffered while receiving treatment from health professionals.”²¹ In other words, victims must still show a causal link between the treatment and the injury. Damages awarded under the ACC system are determined by a fixed award schedule.²² If victims are unsatisfied with the decision, they can request a review. And if they are not satisfied with the review, they then have the right to court appeal.²³ Thus, while medical malpractice victims in New Zealand do not have the right to sue for damages, they do have the right to court appeal.²⁴

COSTS

In their book, *Medical Injustice: The Case Against Health Courts*, Case Western Reserve Professors Maxwell J. Mehlman and Dale A. Nance made the following observations about the potential costs of U.S. “health courts”:

- “Health courts” would “entail some huge potential increases in total system costs. ...If we take health care proponents at their word, their goal is to bring...currently non-claiming people into the process.” This, however “would multiply the number of claims involving negligence by a factor between 33 and 50.”²⁵
- “[C]laims involving error account for at least 84 percent of total system costs...so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal.”²⁶
- “[E]ven if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves total direct system costs multiplied by a factor of about 8.5, again as a low end estimate.”²⁷
- “Health courts” all involve the creation of a new judicial or administrative bureaucracy. Costs “would certainly be substantial, vastly more than the public

(taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims.”²⁸

- “Some health court advocates concede that, if the system actually compensated substantially more patients, it might not be cheaper than the tort system. The Republican Policy Committee states, for example: ‘The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).’”²⁹
- “[O]ther pressures can be expected as well. ...[A] number of processes can be expected to be implemented, processes that suppress the levels of patient recoveries below any fair measure of actual losses sustained.”³⁰

In Sweden, taxpayers foot the bill for their administrative system. General taxes fund Sweden’s safety net, which covers most of the cost of medical injuries, while a regional tax, spread across the entire population of Sweden, is imposed to pay for the additional medical malpractice system overlay.³¹

Like Sweden, New Zealand’s public health and welfare systems cover many damages that would be at issue in the United States and are on top of the general welfare system. The ACC is funded through general public taxation and an employer levy. This system has struggled with costs, however. While the system began as “no-fault,” from 1992 until 2005 New Zealand reintroduced a fault requirement because of economic and political pressures.³² The country has since returned to “no-fault.”

In the United States, “health court” proponents claim their proposal will open the door to more malpractice victims but have offered no way to pay for this new bureaucratic system which would allegedly compensate more victims. Neither new taxes on the general public (as exist in Sweden and New Zealand), nor proposed insurance surcharges that would ultimately be passed onto insurance consumers, are within the realm of possibility given today’s political climate in the United States.

PATIENT SAFETY

Proponents of the U.S. “no-fault” or “health court” system insist that “the most important advantage of moving to health courts to address medical injury would be preventing injuries and promoting safety.”³³ Yet patient safety, in both Sweden and New Zealand, has not improved. Under both systems, a malpractice victim, even if paid, has no assurance that the doctor has been reprimanded or prevented from committing the same negligent medical act on others. Aside from frustrating the specific patient, this has had a profoundly negative impact on patient safety in general.

Increased error reporting is constantly used to justify claims that administration systems enhance patient safety. More specifically, proponents say there will be more error reporting by doctors because the threat of liability will be removed. They also say, “Because involvement in an avoidable adverse event does not carry the same degree of stigma as negligence does, physicians would probably face fewer psychological barriers

to disclosing it. Physicians should also (at least over time) feel assured that disclosure of an avoidable event is unlikely to lead to disciplinary action.”³⁴ New Zealand and Sweden are cited as examples of countries that use “administrative compensation schemes to generate and use data for patient safety improvement....”³⁵ Yet closer examination of their error reporting and safety records undermines this argument.

New Zealand’s “no-fault” system ensures that doctors are protected from the threat of liability so the country should have an excellent record of error reporting. Yet, 61 percent of patients who experienced medical errors in New Zealand reported that their doctor or health care professional never informed them of the error.³⁶ That finding was consistent with data from five other countries, which showed that the majority of doctors failed to report their errors, regardless of whether the country used an administrative system or tort system.³⁷

In addition, a May 2006 article in the *New England Journal of Medicine* noted that only one quarter of doctors disclosed errors to their patients, but “the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance,” *i.e.*, no litigation against doctors, for decades. In other words, “There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges.”³⁸

Sweden’s system also has enormous problems. Because it is a “no-fault” or “no-blame” system where monetary damages are never tied to a doctor or caregiver,³⁹ the compensation aspect has been completely separated from the system that handles complaints against medical staff. In the separate process that handles complaints against medical staff, action is only taken in 6 percent of all cases.⁴⁰ The impact is clear: Medical errors kill 3,000 people each year in Sweden.⁴¹ These errors include babies overdosing on painkillers, elderly patients dying as the result of incorrect diagnoses, ambulance drivers ignoring calls⁴², injuries during childbirth, incorrect drug dosages, mixed up test results and infections following surgery.⁴³ In fact, patient safety has become such a concern that there are actually calls to look to the *United States* as a model for Sweden.⁴⁴

For example, in Sweden recently, a doctor, who missed at least 27 cases of skin cancer, was only dismissed when the hospital was unable to rule out even more missed cases.⁴⁵ In a separate incident, a doctor was not suspended after failing to detect cancer seven different times. In that case, the Swedish Medical Association admitted that hospitals rely on less secure procedures because of doctor shortages.⁴⁶

Additional problems exist with Sweden’s ambulance prioritization system, which has finally come under review. Multiple deaths include: a woman in renal failure with pneumonia who died the day after an ambulance refused her; a man who died of a ruptured spleen after an ambulance refused him; and a man who suffered a heart attack after being told to buy cough medicine.⁴⁷

Even more disturbing, the evidence suggests that Sweden’s medical malpractice record is actually getting worse. In the last five years, written complaints over treatment increased 80 percent⁴⁸ and, in the last decade, compensation payments for malpractice have

doubled.⁴⁹ Moreover, in the first three months of 2011 alone, Swedish patients lodged 700 new complaints against medical workers. These were added to 2,300 outstanding complaints that had yet to be processed.⁵⁰

In fact, Sweden has become a safe harbor for doctors who should not be practicing at all. Take Dr. Johanne Krogh, who began practicing at Hudiksvall Hospital in 2007. Her background check was so insufficient that her employers did not know she was notorious in Norway for medical malpractice. One incident in Norway involved Dr. Krogh losing her temper in the middle of a surgical procedure and storming out of the room, leaving a bleeding patient on the table. Her behavior was so egregious that the Norwegian patient insurance system paid 29 claims relating to her work and received over a dozen more claims. While Norway removed her orthopedic and surgical licenses after the first 20 payouts, nothing stopped her from moving to Sweden where she continued to practice as of 2010.⁵¹ This type of oversight hardly makes Sweden a model system for patient safety.

CONCLUSION

Sweden and New Zealand both have very costly administrative systems for medical malpractice cases that have hurt the cause of patient safety. They cannot and should not be replicated here.

The reality is that nothing prevents insurers in the United States from admitting medical errors and settling claims at low administrative costs. In fact, most claims in Sweden and New Zealand are settled this way anyway – never moving beyond the insurance process. The problem is not our jury system or our lawyers who are there to level the playing field for patients.

The current problems with our tort system are that insurers and hospitals fight claims so they can hold onto more of their money and that doctors refuse to admit their errors. Insurers and hospitals will continue to do this regardless of the system used to resolve malpractice cases.

NOTES

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- ⁸ *Id.* at 25.
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- ¹⁴ *Ibid.*
- ¹⁵ *The Swedish Medical Injury Insurance*, *supra*, n. 11; World Bank, “Medical Malpractice Systems around the Globe: Examples from the US tort liability system and the Sweden no fault system,” at 10, found at siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/Malpractice_Systems_eng.pdf.
- ¹⁶ *The Swedish Medical Injury Insurance*, *supra*, n. 11.
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- ²⁰ *Ibid.*
- ²¹ *Ibid.*
- ²² *Ibid.*
- ²³ *Ibid.*
- ²⁴ *Ibid.*
- ²⁵ “The Case Against ‘Health Courts,’” *supra*, n. 6, at 72.
- ²⁶ *Ibid.*
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- ²⁹ *Id.* at 74.
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