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Original communication

The Claims Management Committees trial: Experience of an Italian Hospital of the National Health System

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ABSTRACT

Introduction: In Italy, health care is mainly financed by earmarked central and regional taxes, with regions receiving their allocated share of resources from the National Health Fund. The Council of the Tuscany Region in 2009 began an experimentation aimed to enforce the extrajudicial conciliation. The Council established the Claims Management Committees (CMC) for civil liability in the Tuscan Health Service. The CMC trial provides that the damages are compensated directly by the hospital, removing the cost of liability insurance. The aim of this study is to collect and compare the liability-insurance-period and the CMC trial-period. **Materials and methods**: Data were derived from the management claims database of the Health Directorate of the Careggi Hospital in Florence between 2006 and 2012. Two main periods are considered for the comparison of data: 2006–2007–2008 during the insurance management and 2010–2011–2012 during the CMC trial. **Results**: During the insurance management period, the total expenditure was equal to the €14,846,334.44 paid in the 3-year period. The total expenditure during the CMC trial 3-years period was equal to €7.076.370,75. Under the CMC management, we observed a marked decrease in the recourse to legal action in the face of a substantial maintenance of the number of claims opened for each year. The CMC trial showed a greater speed in setting claims for damages. **Discussion and conclusions:** Under CMC management, a greater and more diligent efficiency is matched by a lower economic outlay. The use of the direct management of damage compensation may be an important tool for risk management, thus guaranteeing the recourse to targeted and appropriate interventions.

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1. Introduction

The Italian National Health System (NHS), established in 1978, is similar to the Beveridge model developed by the British NHS (Beveridge 1942; Musgrove 2000). As with the British NHS, healthcare coverage for the Italian population is mostly provided and financed by the government through taxes.[1] The organisation and provision of health care is a regional responsibility and regions must provide a nationally defined (with regional input) basic health benefit package for each of their citizens. Health care is mainly financed by earmarked central and regional taxes, with regions receiving their allocated share of resources from the National Health Fund.[2] The total public health expenditure in Italy in 2010 amounted to around €115 billion, equal to 7.4 per cent of gross domestic product (GDP), and more than €1900 per capita/year. Italian public health expenditure is much lower than that of other major European countries. In 2008, expenditure per head in Italy amounted to €1800; a similar trend is observed in the northern regions. The expenditure of the central regions is above the national average (€1.881 per capita), while for the South, expenditure amounted to €1.753 per capita[3]. Against the approximately €1.868 (per capita) spent in Italy in 2009, both Finland (€1.843 per capita) and Spain (€1.727 per capita) spent slightly less while the United Kingdom allocates nearly €2.244 per capita and France and Germany allocate a per capita expenditure of €2.370 and €2.479, respectively. The highest level of expenditure is recorded in Luxembourg (€2.860 per capita) and the lowest in Poland (€769 per capita).

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1.1. Medical malpractice in Italy and the Tuscan trial

As in many countries[4–7] such as Australia, the UK and the USA, the effects of medical malpractice in Italy are becoming a political issue. Until recently, each hospital had insurance paid for with regional money (and consequently derived from state taxes). In Italy, medical liability insurance has always been expensive and patients have expressed low satisfaction. Slow handling of claims has been revealed, including in those cases where the professional liability of doctors or hospitals was evident before a claim was filed in court. Insurance for health professionals is granted by the NHS and covers the costs of both patient compensation and legal and medico-legal management of claims, excluding court settlement expenses in cases of gross negligence or intentional crimes. The majority of disputes in civil liability pass to an ordinary judge, despite Italian legislation providing various types of ADR (Alternative Dispute Resolution). Broadly speaking, the types of ADR could be described as follows: amicable settlements, as provided in Article 1965 of the Civil Code; mediation: the parties turn to an independent third party to settle their dispute and reach an agreement; judicial or extrajudicial conciliation (as provided by sections 183, 320 and 322 of the Code of Civil Procedure); and arbitration, an alternative means of dispute resolution to a court decision, as provided for by section 806 of the Code of Civil Procedure.[8] ADRs are not widespread in Italy for health claim settlement even though Italy has tried to adapt to European standards in terms of the alternative solution of disputes. The Legislative Decree of 4 March 2010 n. 28 has been a cornerstone of this process in dispute resolution. According to the decree, mediation should be mandatory before a medical claim can be filed in court. An issue was raised in 2011 and again in 2012 when the Constitutional Court declared mediation to be unconstitutional[9] because there was an 'excess of dispensation', especially related to the compulsory nature of the procedure. Law n. 98/2013 revised mandatory mediation for health disputes providing that the first meeting of parties, addressed to explore the possibility to conciliate, must be free of costs. Despite the economic advantages provided by the recent law, mediation is rarely effective in conciliating parties in cases of health disputes so that in Italy, at present, health claims are mainly handled by insurance companies or by civil courts. Italy is divided into 21 regions and each of these is responsible for the application method of the national budget (NHS). In 2009, the Council of one of these regions (Tuscany, of which Florence is the chief town) began an experiment aimed to enforce ADR; in particular, the out-of-court settlement of health disputes. The Council established Claims Management Committees (CMCs) for civil liability in the Tuscan Health Service, having as its primary objective a reduced recourse to the courts and the reduction of litigation costs. This experiment was carried out for the purpose of both risk management and cost-saving. The CMC settlement provides that damages are compensated directly by the hospital, removing the cost of insurance management of the claim. In fact, on the basis of the documentation obtained from the competent of the Directorate-General, regional annual spending on insurance policies was around 50 million euros, compared to an annual expenditure of compensation claims not exceeding 5–6 million euros.[10]

1.2. The CMC trial

The CMC is organised according to the following steps: in any Tuscan health service unit, the Claims Management Committee is established for the discussion, definition and settlement of claims in a transactional way.[11] It is composed of:

- A person in charge of administrative and legal claims;
- The Executive Officer for the management of clinical risk and safety of care;
- The chief of the Forensic Medicine Division (CFMD);
- An expert in the liquidation of damages;
- A member of the Health Directorate.

In order to ensure transparency in the management of claims, to reduce litigation and to accelerate the settlement of all claims for which responsibility exists, in Careggi Hospital, the CMC established the following steps:

- Put the claim for damages presented by the claimant or his/her attorney into a database.
- Enclosed the medical records, the Forensic Medicine Division takes charge of the case and calls the claimant for an initial analysis, within 15 days.
- If necessary, the opinion of a specialist (often employed by the hospital) is requested, who then meets with the physician concerned with the claim.
- The claim is examined in three different steps. The first opinion is provided by a forensic medicine specialist who studies the case. The second opinion is given by a senior forensic medicine specialist and the third opinion by the chief of the Forensic Medicine Division.
- If liability is detected, the compensation payment proposal is reached within six months after the case begins, except for particularly complex cases, but not exceeding twelve months.
- The compensation costs are granted by the Tuscan region, through the Regional Health Fund.

The forensic practitioners deployed in a CMC are trained specialists in legal medicine with long experience in the field of medical liability and damage compensation, who have served as insurance advisors and are regularly appointed by civil and criminal courts in health claim cases.

The insurance settlement of health disputes generally rests on the opinion of an advisor (legal medicine specialist) and the case is then settled by the loss adjuster. Loss adjusters require a second opinion from the central medico-legal service of the insurance company in only a few cases.

On the contrary, in CMC trials three different opinions are provided: the first opinion on the alleged medical negligence and damage is formulated by the medico-legal specialist who analyses the claim and provides the visit of the patient when it is useful. The second opinion is given by a senior forensic medicine specialist who revises the case and fills in possible gaps from the medico-legal point of view. The CFMD releases the third and final opinion on the case and then takes part in the final decision of the CMC. Moreover, the CFMD is required to participate in the final settlement of the claim which may need one or more meetings with the claimant's lawyer or medico-legal experts, before assessing the final compensation for the patient. A medico-legal assessment based on three different opinions is undoubtedly time- and human resource-consuming, but it saves hospitals and the CMC itself from future judicial disputes. First, both patients and the CMC are discouraged from continuing litigation in court. From their side, complaining patients are aware that the final decision is expressed after the case has been examined by three different experts so that the possibility of rejecting a positive sentence is lower and very few patients decide to file a lawsuit. The CMC, from its side, is prone to compensate some not completely disclosed cases when doubts persist about the appropriateness of care or when the court settlement of liability or compensation is not easily predictable. In these circumstances, the

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