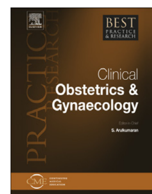
Best Practice & Research Clinical Obstetrics and Gynaecology 29 (2015) 1126–1131

Contents lists available at ScienceDirect

Best Practice & Research Clinical Obstetrics and Gynaecology

journal homepage: www.elsevier.com/locate/bpobgyn



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The role of insurers in maternity safety

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Keywords:
obstetrics
intrapartum care
insurance
litigation
adverse events
training

Adverse events in maternity care are frequently avoidable and litigation costs for maternity care are rising for many health services across the world. Whilst families for whom this injury was preventable suffer from this tragedy, there is an enormous loss of resource to healthcare in general. It is axiomatic that preventing avoidable harm is better for women, their families and society in general, and downstream this improvement should also reduce both litigation and costs. However, there are few initiatives that have reduced adverse clinical events in maternity services and fewer still that have demonstrated decreases in litigation costs. Where these data do exist, the involvement and engagement of insurers seem to have been crucial, but often unrecognized.
Insurers could play a much broader role in preventing harm, and this article explores this potential.

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Current situation

Adverse events in maternity care are frequently avoidable and litigation costs for maternity care are rising for many health services across the world [1,2]. Adverse events are common: In the USA, the rate was 3.8% in comparison to UK at 11.7% and Australia 16.6% [4], and this is no less the case in maternity care, although the overall rates of adverse events may be less in obstetric services than other acute settings [5]. One cannot conclude that just because an adverse outcome has occurred

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http://dx.doi.org/10.1016/j.bpobgyn.2015.07.002
1521-6934/© 2015 Published by Elsevier Ltd.

that it is preventable, but many adverse events in maternity care may be preventable. A multi-professional group from the US identified that 87% of their intrapartum quality problems were preventable [6]. A Swedish research group identified substandard care in labour for two-thirds of infants with a low Apgar score [7], and in Norway, human error was identified in 92% of obstetric compensation claims [8].

The NHS Litigation Authority (NHSLA), which insured almost all the NHS maternity units in England over the past decade (2000–09), published their experiences in their journal *Ten Years of Maternity Claims* [1]. This study demonstrated, with claims experience as the measure, that maternity care was safe with <0.1% of births being the subject of a legal claim. However, this low incidence of litigation should not mask the avoidable harm that resulted in serious disability and profound anguish for thousands of women, their babies, families and friends. Nor should this obscure the likely total expected cost to the NHS of £3.1 billion, which represents a £600 litigation surcharge for each and every infant born in that decade. Litigation costs are increasing, and there is now a £700 litigation surcharge for each baby born in England [9]. These are payments that no one wants to receive, or pay; it is money lost to the healthcare service and patient care. However, these payments, particularly their prevention, may be a useful fiscal lever for driving improvement.

In which ways can insurers improve the current situation?

1) Provide financial incentives, particularly for training.

Multi-professional training appears to be one of the most promising strategies to improve perinatal outcomes across the world, localised for best effect. However, training is not magic, nor is it automatically effective. Therefore, we must make sure that training improves outcomes. There are now numerous studies evaluating the effectiveness of skills training for obstetric emergencies with increasing evidence that practical training is associated with improvements in clinical outcomes [10–12]. However, not all training has been associated with such positive effects, and there are a number of studies where training either did not improve clinical outcomes [13,14] or was associated with an increase in perinatal morbidity [15,16]. It is therefore important to ensure that the training that has been demonstrated to be effective is the one that is widely implemented and included in national guidance [17]. In a review of maternity training programmes, it was identified that a common characteristic of units that had improved outcomes was a financial incentive to provide the training [3], most commonly provided by insurers. There are examples of reductions in litigation payments related to improvements in maternity outcomes. A group in Bristol has identified improvements in perinatal outcomes after training [10–12] that have been associated with a 91% reduction in litigation payments. There are similar reports from the US: One group reported improvements in perinatal outcomes and observed that the national obstetric claims experience (claims/10,000 births) was approximately 20% higher in comparison to that seen in their system [18]. Another group described a parallel reduction in poor intrapartum outcomes and the number of reserved claims per birth, which decreased at a rate of approximately 20% per policy year [19]. In another US paper, the average yearly compensation payments decreased from $27,591,610 between 2003 and 2006 to $2,550,136 between 2007 and 2009 in association with a decrease in sentinel events from five in 2000 to none in 2008 and 2009 [20]. Training requires funding, and most of these studies were supported or incentivised by insurers. However, the best way of providing these incentives is currently unclear. Payment for performance programmes has not always resulted in improved outcomes [21]; the Clinical Negligence Scheme for Trusts (CNST) process, whereby the NHSLA awarded risk management discounts, has recently been discontinued [22,23], and revised methods for calculating contributions will reward safer organisations that have fewer claims.

One of the common barriers to the introduction of training in many healthcare settings has often been the gap between local budgets and national claims, where units find it difficult to justify spending funds on training, when there is no immediate local financial benefit. It is noteworthy that the risk management reductions afforded by CNST provided a significant impetus for units to start training because managers could justify to their fund holders the direct financial benefits of training. Other successful schemes in maternity care have employed similar incentivisation methods, including

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