December 2002

Insurance Issues *Europe*

Impending Changes in the European Health Care Sector and the Effect on Risk Management and Malpractice Insurance

The health care industries of European countries have undergone tremendous changes over the last few years. Although the European Union continues to push for greater uniformity of the various national health care systems there can be no doubt that many differences still exist between countries. A common thread woven through most European health care systems is the steadily growing cost of care and decreasing financial wherewithal to bear that cost burden. One of the major challenges in the near future at the EU and national levels will be introducing reforms to alleviate this problem. Some reforms have already been put into place, while others are still being negotiated. The changes already implemented will affect the structure of national health care systems in many ways, some of which still uncertain. But one thing is clear, European health care is moving towards privatization.

This article is intended to highlight recent major structural changes in the European health care sector, their possible effects on health care personnel, and how they increase the need for better risk management and comprehensive malpractice insurance programmes.

Growing Cost of Care

One of the major factors driving the health sector towards privatization has been the steady growth in the cost of care. Health expenditure in the United Kingdom, for instance, rose to GBP 67 bn (EUR 112 bn) in 2000, representing 7.1% of GDP, a considerable increase over 1999's figure of 6.8%.[1] Overall spending in the German health sector stood at a total of EUR 218.4 bn (10.7% of GDP)[2] in 2000 and is expected to rise by 380% to EUR 974.4 bn in 2015.[3]

The upward pressure on overall health-expenditure has three fundamental driving forces:

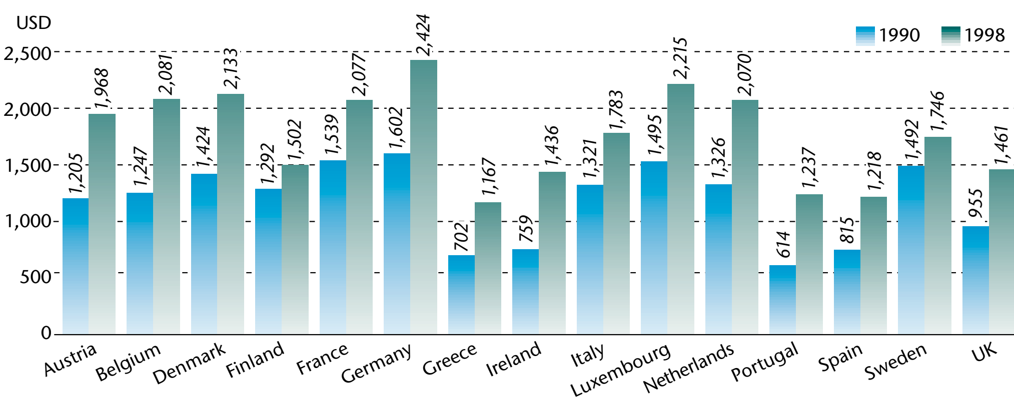
a) The aging population and the associated higher levels of chronic diseases and disability

1 *The UK's Office of Health Economics (OHE), 13th Edition of the Compendium of Health Statistics.*

2 *www.aeksh.de/shae/200207/h027006e.html.*

3 *Psychotherapie, 21.03.2000.*

Health expenditure per capita in EU countries in USD, purchasing power parities in 1990 and 1998[7]



b) the increased availability of new, sophisticated treatments and technologies, and
c) rising public expectations.[4]

The health care cost "explosion" is putting a heavy burden on national health insurers' budgets. In addition, high unemployment rates in many European countries and only minor increases in gross domestic products are contributing to lower incomes for the health care systems. Experts predict that governments will reduce their regulation of health care insurance, only providing for tax financed basic health care, and paving the way for a greater role for private health insurance. The implication is clear: A rise in premiums for European citizens.[5] In various European countries national health reforms have already been put into effect laying the groundwork for such a development. In December 2000, for example, the Greek parliament passed a reform intended, among other things, to greatly reduce state hospitals' autonomy and transfer the state health system into the hands of private health insurers.[6]

New Compensation Systems

Several European countries are introducing a new compensation system known as "diagnostic related groups" (DRGs) as a first step to try to reduce health care costs. The German Government recently decided to do the same, with implementation beginning in 2003 and completion by 2007. Instead of reimbursing costs to health care providers based on the duration of hospital stays, as has long been the practice, DRGs categorize medical services into groups and pay compensation based on illness.[8] The goal of this reform is to minimize cost without diminishing quality. But the effect will in all likelihood be a reduction in the length of an average hospital stay as, unlike under the current systems, hospital profits will actually increase if patients are more quickly released. Presently the average hospital stay in Germany stands at 10 to 11 days. This is expected to drop to approximately 6 days when the law is fully implemented.[9] In some countries DRGs are already in use within specific fields.

The new compensation system will increase pressure on hospitals to cut costs while striving to maintain the quality of care. For the majority of public hospitals such cost-consciousness is completely unheard of. Many are currently establishing new team structures and training their staff in order to prepare for the implementation of DRGs.

Market Consolidation

Financial pressures stemming from the new form of compensation will require health care providers to adjust quickly to the altered environment. Only those hospitals which have sufficient flexibility and financial resources at their disposal will benefit. Thus, a wave of consolidation is expected in the health care sector. State owned hospitals will most likely be hardest hit, barring government intervention. Given their inherently rigid structures, adapting to the new environment will be far more problematic for them. They will

4 *World Health Organization Regional Office for Europe, European Health Care Reforms: Analysis of current Strategies, 23.04.1996.*

5 *Deutsche Krankenhausgesellschaft, 18.05.2000, www.dkgev.de/1_pol/pol_0.13htm.*

6 *Kathimerini English Edition, 13.12.2000.*

7 *OECD Health Data 2000.*

8 *Süddeutsche Zeitung, 06.06.2001.*

9 *Psychotherapie, 21.03.2000.*

Utilization of DRGs in European countries in comparison[10]

Field in which DRGs are in use	Countries
Compensation	Denmark, Finland, Italy, Norway, Portugal, Spain, Sweden
Budgeting	France
Reduction of length of stay	Belgium, Ireland
Performance control	United Kingdom

Prognosis for the development of the number of hospitals and hospital beds in Germany[13]

	2000	2015
Number of state hospitals	790	400
Number of beds in state hospitals	255,000	90,000
Number of private hospitals	390	600
Number of beds in private hospitals	45,000	96,000

likely either be taken over by profit organizations or go out of business.

Arthur Andersen painted the following scenario for Germany as the biggest economy in the EU[11]: By 2015 a significant percentage of state hospitals will have disappeared. The health care provider segment will to a large extent be in the hands of private companies and non-profit organizations. The number of existing health care providers and hospital beds will have dropped immensely.[12] In many other European countries a similar development can be expected.

In contrast to many other industries mergers and acquisitions have not played a very important role in patient care – except in a few sectors. Patient care providers still operate mostly on a local or regional basis, as illustrated by recent takeover activities in Europe. Most M&A activities recorded in 1999/2000 were domestic transactions (see the "Patient care deals in Europe between 1 July 1999 and 31 June 2000 by target nation" table below). This is expected to change rapidly in the years to come due, in large part, to the above-described reforms.

Abandoning the Social Character of Health Care

The privatization, consolidation and decentralization of the health care systems could also have negative effects, including fragmented services, the total eradication of central health departments, social injustice and political manipulation to favour particular interests or stakeholders. Invested capital requires financial returns consistent with those obtainable in markets in other parts of the economy. Pressures to achieve these returns risk abandoning the social character of health services and inadvertently discriminating against people with insufficient financial resources who need care.[14]

The Impact on Health Care Personnel

Not only the management of health care providers but hospital staffs in general would undoubtedly be severely impacted by these forecasted changes in the health care sector. For many, consolidation up until now has primarily resulted in falling victim to rationalization measures. In Germany, for example, 38,000 hospital staff lost their jobs between 1996 and 2000.[15] Hospitals are already severely understaffed and doctors and nurses suffer from enormous stress. At some German hospitals, for instance, 90 to 100 working hours per week seem to be quite common.[16] The so-called burn-out syndrome is becoming increasingly apparent among medical professionals.

According to a study conducted by the Technical University of Berlin, even comparably young practitioners already hold the opinion that too much is expected of them. They feel physically and emotionally exhausted.[17] The study revealed that compared to other professions doctors suffer more often from high blood pressure, stomach cancer and depression. They are also three times more likely to develop drug addiction than those engaged in other professions. Barbitu-

10 *Bruckenberger, Ernst, Das Krankenhaus im DRG-Zeitalter, 14.07.2001, www.bruckenberger.de/doc/planung/drg_zeitalter/drg_zeitalter.htm.*

11 *Arthur Andersen, Krankenhaus 2015 – Wege aus dem Paragraphendschungel, www.arthurandersen.de/AAHome.nsf/DocID-Suffix/Bibliothek_Studien_Krankenhaus2015?OpenDocument.*

12 *Deutsche Krankenhausgesellschaft, 18.05.2000; IAC Trade and Industry Database, British Medical Journal, 15.04.2000.*

13 *Der Tagesspiegel, 10.12.2000.*

14 *World Health Organization Regional Office for Europe, European Health Care Reforms: Analysis of Current Strategies, 23.04.1996.*

15 *Süddeutsche Zeitung, 07.06.2000.*

16 *Focus, 02.07.2001.*

17 *Id.*

18 *Arthur Andersen, Deal Survey Healthcare, 1999/2000, www.arthurandersen.de/AAHome.nsf/DocIDSuffix/Bibliothek_Studien_Krankenhaus2015?OpenDocument (see page 4/5).*

Patient care deals in Europe between 1 July 1999 and 30 June 2000 by target nation[18]

Target name	Target activity	Acquirer's name	Country	Value in USD m
Belgium				
ABC Opleidingen BVBA	Health maintenance	Dregerwerk AG	Germany	n.a.
France				
Clinique des Quatre Pavillons	Nursing	Myriade	France	n.a.
Dialysis Clinics	Dialysis	Gambro AB	Sweden	n.a.
Midi Gériatrie	Nursing	Bastide-Le Confort Medical	France	n.a.
MCBIO	Provider of diagnostic and lab services	Goupement de Laboratoires de Biologie Médicale (GLBM)	France	n.a.
Siouville, Chambon, Louviers	Acute care-hospitals/inpatient	Medidep	France	n.a.
Germany				
Kreiskrankenhaus Uelzen	Acute care-hospitals/inpatient	Rhoen-Klinikum AG	Germany	n.a.
Kreisalten- und Pflegeheim Uelzen	Nursing	Rhoen-Klinikum AG	Germany	n.a.
Krankenhaus Bad Bevensen	Acute care-hospitals/inpatient	Rhoen-Klinikum AG	Germany	n.a.
Fresenius-Klinik RHM Klinik	Acute care-hospitals/inpatient	Dr-Horst-Schmidt-Kliniken GmbH	Germany	n.a.
Acquisition of 3 rehab clinics	Reha	Medica Rhein-Main GmbH	Germany	n.a.
AMD-Arbeitsmedizinische Dienste GmbH	Acute care-hospitals/inpatient	TUEV Anlagetechnik GmbH	Germany	n.a.
Medizinische Fakultät der Humboldt-Universität Berlin	Acute care-hospitals/inpatient	Investor Group	Germany	n.a.
Pro Senioren AG	Nursing	Refugium Holding AG	Germany	n.a.
Herzzentrum Cottbus GmbH	Acute care-outpatient/other	Sana Kliniken GmbH	Germany	n.a.
Stiftung Liebenau-Fachklinik Wange	Acute care-hospitals/inpatient	Waldburg-Zeil Kliniken AG	Germany	n.a.
Dresdner Hof	Nursing	Maternus Kliniken AG	Germany	n.a.
Nursing Home, Berlin	Nursing	Alexa Seniorendienste	Germany	n.a.
Rheingau Taunus Kreis (2 district hospitals)	Acute care-hospitals/inpatient	Wittgensteiner Kliniken AG	Germany	n.a.
Acquisition of 2 acute clinics	Acute care-hospitals/inpatient	Wittgensteiner Kliniken AG	Germany	n.a.
Greece				
Papadimitriou Clinic of Pendeli	Acute care-hospitals/inpatient	Sea Farm Ionian	Greece	n.a.
Diagnostic & Medical Private Clinic of Piraeus IASIS	Acute care-hospitals/inpatient	Athens Medical Center	Greece	n.a.
Mitera Kritis	Acute care-hospitals/inpatient	Axon Holdings	Greece	n.a.
Hungary				
Dialysis Clinics	Dialysis	Gambro AB	Sweden	n.a.
Ireland				
Baggot Street Hospital	Acute care-hospitals/inpatient	Eastern Regional Health Authority	Ireland	16.5
Italy				
Gavazzeni Hospital, Bergamo	Acute care-hospitals/inpatient	Nestor Healthcare Group Plc	Italy	n.a.
Donati Sollevamiento SRL	Provider of diagnostic and lab services	Mannesmann Dematic Corp	USA	n.a.
Netherlands				
Commit Arbo	HMO	Interpolis NV (Rabobank)	Netherlands	63.5

Target name	Target activity	Acquirer's name	Country	Value in USD m
Poland				
Rehabilitacja-Service Sp	Service providers to doctors, hospitals, etc.	New Brunswick Scientific Co	USA	n.a.
Spain				
Dialysis Clinic	Dialysis	Gambro AB	Sweden	n.a.
Clinica San Camilo	Acute care-hospitals/inpatient	United Surgical Partners Europe	Spain	16.1
Sweden				
Friaborg AB (Morellen AB)	Nursing	ISS Sweden AB	Sweden	n.a.
Sangtec-Medical AB	Provider of diagnostic and lab services	Altana AG	Germany	n.a.
Elekta (Image Guided Surgery Assets)	Acute care-hospitals/inpatient	Medtronic Inc	USA	11.8
Switzerland				
Clinica Santa Chiara SA	Acute care-hospitals/inpatient	HUMAINE-Gruppe	Switzerland	n.a.
Laboratorio Analisi Specialy Chimico Cliniche SA	Service providers to doctors, hospitals, etc.	Unilabs SA	Switzerland	n.a.
United Kingdom				
CrestaCare Plc	Nursing	Carat Secre Plc	UK	110.4
Forensic Medical Services Ltd	Health care services provider to the prison service	Humanitas Hospital, Milan	UK	16,688
The Eye Academ plc	Two-laser vision correction centres	Icon Laser Eye Centers Inc	USA	n.a.
Ora Dental Group Ltd	Dental practices	Existing Management (MBO)	UK	15,562
Priory Healthcare Ltd	Nursing	Westminster Health Care Holdings	UK	163
Tamaris Plc	Nursing	Omega Worldwide Inc	USA	18.2
Extendicare Inc	Nursing	Bettercare Ltd	UK	42.7
Kuwait Investment Office	Acute care-hospitals/inpatient	Columbia / HCA Healthcare Corp	USA	151
ANS Plc	Nursing	ANS 2000	UK	45.7
Kenilworth Grange	Nursing	Trinity Care Plc	UK	n.a.
Trees Park Village	Nursing	Cheadle Royal Healthcare	UK	n.a.
Nursing Homes (Kenilworth Grange)	Nursing homes	Trinity Care Plc	UK	n.a.
Hospitals (Ladywell Hospital)	Ladywell hospital at Eccles, Manchester	Wilson Bowden Plc	UK	22,222
Aspen Healthcare Holdings Ltd	Health maintenance	United Surgical Partners International	USA	n.a.
Nightingale Nursing Bureau Ltd	Provider of registered nursing and care staff to NHS trust hospitals	Transworld Healthcare Inc	USA	n.a.
PPP/Columbia Healthcare	Acute care-hospitals/inpatient	Columbia/HCA Healthcare Corp	USA	110.3
St Martins Healthcare Ltd	Acute care-hospitals/inpatient	HCA-Healthcare Co	USA	150.9
Southern Cross Healthcare Ltd	Nursing	NHP Plc	UK	n.a.
Tameside Care Group	Nursing	Investor Group	UK	n.a.

rates, preferably opiates, and alcohol rank highest among the substances consumed.

Increase in Medical Malpractice Incidents

European medical malpractice statistics are difficult to acquire. Unlike in the US, there is no official authority collecting data relative to medical negligence occurrences. Nevertheless, existing figures indicate an increase in reported medical malpractice incidents in recent years.

A United Kingdom estimate of clinical risks by University College London suggests that nowadays 3 – 4% of patients in the developed world are harmed during a hospital stay. For 70% of them the resulting adverse effect is short-lived, 16% endure permanent disabilities, while 14% subsequently die.[19] The Kellog Foundation found that Britain's medical malpractice death rate is comparable to that of the United States. Medical error is the third most frequent cause of death in the United Kingdom after cancer and heart disease, killing up to 40,000 people a year. The number of medical malpractice deaths therefore is four times greater than the number of deaths due to all other types of accidents.[20] In Germany, 1999 estimates put the number of medical malpractice incidents at 400,000 per year.[21] In Ireland, one in every 100 patients is estimated to experience some form of medical negligence.[22]

Increased Litigiousness

It is abundantly clear that litigiousness had been increasing – even before reforms to the health care industry were proposed. Insurance rates have also been on the rise due to the enormous rise in claims activity.

According to the UK's House of Commons Public Accounts Committee British doctors in 2001 were 13 times more likely to face claims of negligence than in 1991.[23] The Medical Defence Union (MDU), which represents most health professionals in Great Britain, reports that its members face increasing settlement costs for liability claims. MDU estimated that the value of known claims against its members at the end of 1999 was USD 434.1 m, nearly three times higher than the 1990 figure of USD 143.3 m.[24] As of 31 March 2000, the UK National Health Service had to meet settlements for up to 23,000 outstanding malpractice claims in England. About 10,000 new malpractice claims against the organization were filed during a 12-month period spanning 1999 – 2000. The total annual charge to NHS funds for claims has risen sevenfold since 1995.[25]

In Germany experts estimate that an average of 15,000 medical malpractice lawsuits are brought before German courts every year. Although there are no statistics it is believed that a large percentage of incidents remained unreported in the past.[26] Approximately 90% of all complaints apparently used to be settled out of court.[27]

German casualty insurance companies reported that the number of losses in the medical malpractice line of business grew by 75% between 1994 and 1999.[28] Indemnity payments sky-rocketed by 260% from a total of EUR 81.54 m in 1991 to EUR 212.3 m in 1994.[29] The Barmer Ersatzkasse registered 500 medical negligence complaints by patients in 1995 in Berlin alone. Three years later this number was 1,500.[30] The arbitration panel of the Medical Association for Northern Germany in Hannover dealt with 352 complaints in 1995, while in 2000 the figure rose to 508.[31] Last but not least the Techniker Krankenkasse registered 1,177 medical malpractice complaints in 1999, where as in 1989 only 22 patients complained.[32]

The reforms currently underway are likely to subject doctors to a further increase in litigiousness. Several factors will contribute to this development. First, more litigation is expected to result from the almost certain increase in cross-border health care consolidation, since cross-border mergers and acquisitions are likely to expose doctors to lawsuits in other countries. Second, a clear shift in patients' attitudes is expected to increase the likelihood that they will sue. Patients in Europe are striving for more say in choosing their physician and treatment facilities. Greater market transparency gives the public the opportunity to become more informed about the scope of clinical medical treatment. The 1994

19 Sunday Times, 19.12.1999.
20 Sunday Times, 19.12.1999.
21 Gelber Dienst, 10.09.1999, www.schwarzpharma.de.
22 Irish Times, 17.02.2001.
23 Business Insurance, 22.01.2001.
24 Id.
25 Business Insurance, 28.05.2001.
26 Gelber Dienst, 17/99; 10.09.1999, see: www.schwarzpharma.de.
27 Id.
28 Id.
29 Id.
30 Berliner Zeitung, 29.12.1998.
31 Berliner Zeitung, 06.06.2001.
32 Süddeutsche Zeitung, 11.05.2000.

WHO Declaration on the Promotion of Patients' Rights[33] made a major contribution towards empowering of patients in Europe, a development which has also gained momentum with the spread of the Internet.[34] Increased knowledge will most likely spark increased confidence. Patients will turn into consumers and will approach health care providers with higher expectations and demands, as well as more critical attitudes. Third, and probably most importantly, the financial pressures created by health care reform in Europe will invariably result in shorter hospital stays and less time for patients generally. It is only too clear that the likelihood of errors will increase under such circumstances. Additional lawsuits will certainly not fit in well with the increased profit-mindedness of the European health care industry.

Need for Better Risk Management and Medical Malpractice Insurance

Obviously the likelihood of further increased litigiousness in an industry becoming increasingly profit-oriented does not bode well for the bottom line. What is the solution? Clearly, medical malpractice insurance will play an important role in managing costs and keeping any sudden surge in claims activity from impacting the balance sheets of health care providers. But what form should it take? Currently, medical malpractice cover for hospitals on the European continent is offered on an occurrence basis (meaning an insurance policy is purchased to cover claims resulting from errors occurring during the policy period regardless of when a claim is made). As claims based on medical errors could (especially in the case of children) materialize years, even decades after a medical error has occurred, such coverage is inherently deficient in that it exposes the insured health care provider to the possibility of inadequate policy limits, especially given the radical increases in claims severity associated with medical malpractice. In addition, it exposes the health care provider to a greater risk that their insurer will no longer exist or be insolvent when the time comes to pay the claim. Given the recent rash of bankruptcies and mergers in the European insurance industry, this risk appears to be more than remote. In order to avoid this problem GeneralCologne Re recommends purchasing claims-made insurance coverage. Under the claims-made principle, claims are covered that are filed during the policy period regardless of when the incident of malpractice occurred. This coverage focuses more on the present day, allowing insureds to better adapt their policy limits and coverage to their current needs.

Insurance, however, can become prohibitively expensive in an environment of increasing claims. In order to keep costs under control, European health care providers will need to focus on something that has had little attention from them to date, namely, risk management. Risk management can be defined as: A proactive way of managing potential loss-producing events by understanding one's environment, identifying the risks it presents and adopting tailor-made solutions to eliminate or minimize their impact. Comprehensive risk management programmes have been widely used in the United States for many years due to the often staggering costs associated with medical malpractice insurance. In Europe, where insurance costs have traditionally been far less expensive, effective risk management usually meant purchasing a malpractice policy. The costs associated with a comprehensive risk management programme could not be justified on a cost-benefit analysis basis. Risk management will, in all likelihood, become increasingly cost beneficial and a combination of claims-made medical malpractice insurance and a comprehensive risk management programme should enable health care providers to budget more accurately in the future, when every euro of unexpected expense will eat directly into profit margins.

33 http://health.fgov.be/WHI3/periodical/months/wwhv2n1 tekst/WWH19804.htm.

34 For example, the Frankfurt University Clinic search machine allows access to 10,000 health-related web sites, with hundreds of pages from patient groups and thousands of chat groups.

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