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Chief Executive Officer
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DEPARTMENT
OF HEALTH AND
CHILDREN
AN ROINN
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Shaping a
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Medical Indemnity

The Department of Health and Children has undertaken a lengthy examination of the existing arrangements for the provision of medical indemnity cover for medical and dental staff employed in the public health service. The Department concluded that the existing arrangements for the provision of this cover are not satisfactory.

In December 1999 the Government gave its approval in principle to the introduction of "enterprise liability" as the basis on which doctors and dentists would in future be indemnified against the costs arising from claims for damages due to clinical negligence or malpractice. The Government also requested that consideration be given to the introduction of a "no fault" compensation scheme for infants who suffer brain damage at, or close to, the time of birth.

As part of the consultative process preceding this change I enclose for your information a briefing paper on enterprise liability. The paper sets out the background to this topic, a summary of the Department's analysis of the problem, the reason for the changes proposed and an outline of the proposed new arrangements. A considerable amount of work still remains to be done to develop the proposal to implementation stage. The Department has appointed Marsh Ireland Limited as its advisers on the design and implementation of the new scheme.

A formal series of consultations with all interested parties will commence in the Autumn. In the interim I hope that you will find the Briefing Paper a useful introduction to what is proposed. If you have any immediate questions which you wish to raise please contact me.



B Phelan
Personnel Management and Development

MEDICAL INDEMNITY
PROPOSALS FOR CHANGE

Briefing Paper

1. Background

All medical and dental practitioners employed in the health service are obliged, as a condition of their employment to be indemnified against claims for negligence. This is the only group of employees placed under such an obligation as all other categories of staff are covered by hospitals' public liability insurance cover

2. Consultants

Each consultant is obliged by his/her employment contract to indemnify himself/herself against claims for negligence / malpractice. Indemnity is normally taken out through membership of one of the two medical defence organisations (MDOs) which operate in Ireland. These are the Medical Defence Union (MDU) and the Medical Protection Society (MPS). Both bodies are based in the United Kingdom but operate in Ireland, Australia, New Zealand, South Africa and parts of the Middle East and Far East. It is a matter of individual choice as to which of the defence bodies a consultant wishes to join. The consultant's employing authority reimburses 80% or 90% of the cost of the subscription depending on the category of post held. This is itself dependent on the extent of the consultant's private practice outside the public hospital. Reimbursement is made on presentation of evidence of membership of a defence body. Cover is provided to consultants on an "occurrence" basis. This means that members are protected against the consequence of claims if they were members when the alleged negligent event occurred even if the claim is not made for many years afterwards.

It is important to emphasise that the medical defence organisations are not insurance companies. They are mutual societies which offer indemnity against the consequences of medical malpractice at the discretion of their governing bodies. A member of one of the MDOs has the right to apply for indemnity. They do not have a standard insurance contract. Because of their mutual status and the discretionary nature of the indemnity offered, they are not governed by insurance legislation in either Ireland or the United Kingdom.

The following table sets out the subscription levels charged by one of the MDOs (the Medical Protection Society) in each year since 1991. Rates charged by the MDU would be similar.

TABLE 1

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Obstetricians	9,300	16,500	19,000	20,425	24,400	29,980	34,240	34,240	35,950	43,000
High Risk	7,800	12,300	12,420	13,180	15,750	19,195	21,925	23,225	24,385	26,655
Medium Risk						16,490	17,660	18,705	19,640	21,465
Low Risk	2,980	3,700	3,750	3,980	4,790	5,590	6,385	6,765	7,105	7,765

The Medical Protection Society increases its rates from 1 February each year while the MDU increases rates from 1 July. In January 2000 the MPS increased its rates by an average of 9%. The rate for Obstetricians rose by 20%. In July 1999 the MDU increased the rates charged to Obstetricians by 88% to IR£68,665 (€87,186). Its other rates were increased by 12%. In July 2000 the MDU did not increase its Obstetrics rate but increased the rates for other consultants by an average of 14%.

In addition to providing indemnity cover the defence organisations provide a range of other services to their members including medico-legal advice, representation in disciplinary proceedings, at inquests and in criminal proceedings arising from the practice of medicine.

3. Non Consultant Hospital Doctors, Public Health Doctors and others

Since 1992 Non Consultant Hospital Doctors (NCHDs), public health doctors, dentists employed by health boards and some other small groups of salaried doctors have been covered by the Medical Indemnity Scheme (MIS). On the basis that these groups are salaried doctors and dentists with little or no private practice it was decided to remove from them the obligation to hold individual indemnity cover and to devise a group scheme to purchase cover for them. The contract for the operation of the scheme has been put out to tender on four occasions and has been operated by the following:

1st July, 1992 - 30th June, 1995	: The Medical Protection Society
1st July, 1995 - 30th June, 1997	: The Medical Defence Union
1st July, 1997 - 31st December, 1998	: St Paul Ireland, Ltd.
1st January, 1998 - 30th June, 2000	: St Paul Ireland, Ltd.
1st July, 2000 - 30th June, 2001	: St Paul Ireland, Ltd. *

The MIS provides indemnity on a "claims made" basis for the financial consequences of negligence arising from work undertaken as part of the doctor/dentist's activities in a post approved by the Department of Health and Children in the public health service. As a "claims made" scheme it provides cover if the incident which gives rise to the claim is notified to the operator of the MIS during the contract period. Because of the lapse of time which may occur between a negligent event occurring and notice being served of a claim the Department of Health and Children has purchased retroactive cover at each renewal of the scheme e.g. St Paul Ireland will accept liability for claims arising from events occurring between 1st July, 1992 and 30th June, 1997 but not reported to the previous operators of the scheme.

Posts in the scheme are categorised as Type A (NCHD) posts or Type B (Other) posts depending on the degree of risk. The annual cost of cover for each type of post for each period of the scheme is as follows:

TABLE 2

	Type A Post		Type B Post	
	IR£	(€)	IR£	(€)
1st July, 1992 - 30th June, 1995	1,250	(1,587.50)	475	(603.25)
1st July, 1995 - 30th June, 1996	1,495	(1,898.65)	450	(571.50)
1st July, 1996 - 30th June, 1997	2,495	(3,168.65)	620	(787.40)
1st July, 1997 - 30th December, 1998	* 2,700	(3,429.00)	* 900	(1,143.00)
1st January, 1999 - 30th June, 2000	• 2,670	(3,390.90)	• 900	(1,143.00)
1st July, 2000 - 30th June, 2001	2,010	(2,552.17)	673	(854.53)

- * The contract due to expire on 30th June, 2000 has been extended for a period of one year with an option to terminate at 31st December if enterprise liability were to commence on 1st January 2001.

Note The MIS covers posts not individuals and a post may be occupied by more than one individual in any period.

- * For 18 month period. Annual cost: A Post IR£1,800 (€2,286), B Post IR£600 (€762).
- For 18 month period. Annual cost: A post IR£1,780 (€2,260.60), B Post IR£600 (€762).

In March 2000 there were 2,820 "A" posts and 642 "B" posts covered by the scheme giving a total cost of IR£5.9m (€7.5m) per annum.

The scheme is overseen on a regular basis by officers of the Department of Health and Children and the company operating the scheme. The development of the claims portfolios of the previous operators of the scheme is also reviewed on a regular basis.

4. Health Boards and Hospitals - Public Liability Insurance

All health agencies (health boards and hospitals) take out insurance cover in respect of buildings, public liability, employer's liability etc. The public liability element includes cover against negligence / malpractice claims where the hospital as an institution, or staff other than medical staff are held to be responsible. The precise insurance arrangements are a matter for individual institutions. A number of these now co-operate to purchase insurance on a joint basis. The bulk of this insurance is placed with three insurance companies through a variety of brokers. The companies involved are Church and General Insurance PLC, Irish Public Bodies Mutual Insurance Company Ltd. and St Paul Ireland.

5. General Practitioners

General Practitioners are independent contractors who provide services to patients who are covered by the General Medical Services (GMS). They are reimbursed a proportion of their indemnity subscription which varies according to the size of their GMS panel. The level of reimbursement, which varies from 10% to 95%, is based on the net cost to the general practitioner i.e. after credit for tax allowance in respect of indemnity cover as a recognised

professional expense. General practitioners take out indemnity through the MDU, MPS, St Paul Ireland or Medisec, a group scheme operated by the Irish Medical Organisation and underwritten by Church and General Insurance Company PLC. The rates charged by these organisations in 2000 are set out below:

TABLE 3

Medical Defence Union	IR£3,425 (€4,348)
Medical Protection Society	IR£2,990 (€3,796)
Medisec	IR£2,000(€2,539)

It is not proposed to include General Practitioners in the scheme proposed in this Memorandum. Enterprise liability will be confined to employed doctors. General Practitioners in the General Medical Services are independent contractors.

6. **Total Cost of Medical Indemnity to Exchequer**

The total cost to the Exchequer of the arrangements outlined above in 2000 has been estimated at

TABLE 4

Category	Cost IR£m	€m
Consultants	25	31.7
Medical Indemnity Scheme	6.1	7.7
General Practitioners	1.2	1.7
Total	32.3	41.1

7. **Problems with Existing Arrangements**

Problems with the existing series of arrangements may be summarised as follows:

- escalating costs, particularly in relation to consultant **obstetricians/gynaecologists**, whose subscription (to the MDU) payable from 1 July 1999 almost doubled to IR£68,665 (€87,204.5) per consultant;
- lack of ability to influence costs;
- duplication of effort in the defence of claims;
- lack of incentives to introduce best practice;
- complexity of administration.

8. **Escalating Costs**

An outline of the increase in the cost of providing medical indemnity / insurance cover since 1991 is provided below:

TABLE 5

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
<i>IR£m</i>	9.7	14.8	18.7	17.0	17.5	20.9	26.1	23.9	25.4	32.3
€	12.32	18.79	23.74	21.59	22.22	26.54	33.14	30.35	32.4	41.0

It should be noted that the total cost of providing medical indemnity / insurance cover has continued to rise throughout this period despite the substantial savings arising from the introduction of the Medical Indemnity Scheme in July 1992. The decrease in 1994 over 1993 is attributed to a reduction in rates in that year by the MDU. The drop in the 1998 over 1997 cost is due to the full year effect of the contract with the St Paul.

This increase in cost has been attributed to the following factors:

- an increase in the number of claims;
- an increase in the level of awards to successful claimants;

- an increase in the legal costs associated with the process of establishing liability in negligence cases.

9. **Lack of Ability to Influence**

In the series of arrangements outlined above the Minister for Health and Children and the Exchequer are the ultimate funders of the expenditure. Where the Department of Health and Children has had a direct involvement in arranging cover (the Medical Indemnity Scheme) substantial savings have been achieved. In the largest category concerned, i.e. Consultants, the Department of Health and Children is in the position of third-party payer.

As the subscription rates are set independently by the medical defence organisations the resultant increase in cost has to be funded by the Department of Health and Children. In the most recent round of negotiations on a new consultant contract the Department has indicated its wish to see the contract changed to allow for alternative insurance / indemnity arrangements.

10. **Duplication of Effort in the defence of claims**

A person who believes that they have suffered loss or damage as a consequence of medical treatment may sue an individual health care professional or the health care institution within which the care was provided, or both. In complex cases several health care professionals and more than one institution may be sued. The presence of more than one defendant creates difficulty in constructing a successful defence of the claim. While in many cases most of the initial co-defendants are discharged from actions, considerable time and energy are expended as the several defendants attempt to have themselves discharged or disagree on the apportionment of responsibility. However, in most cases all of the defendants are indirectly funded by the Exchequer.

The presence of multiple defendants and their insurers also imposes significant but unquantifiable costs on health boards and hospitals. Administrative costs are increased as a

result of duplicate correspondence with more than one insurer, particularly in circumstances where there is disagreement as to which insured party is liable. In addition, the responsibility for reporting claims is not clear-cut, leading to higher administrative costs and the possibility of claims not being reported within the periods of insurance cover.

11. Lack of Incentives to Introduce Best Practice

While increasingly sophisticated insurance or other funding mechanisms can be introduced to reduce costs in this area, significant progress requires action to reduce the number of adverse incidents which give rise to claims and/or to put in place procedures which maximise the chances of successfully defending claims. Failure to reduce the number of claims merely perpetuates a situation in which increasing future liabilities in respect of these claims must be financed. The term "risk management" has emerged to describe a collection of policies, practices and procedures which are designed to identify, quantify and reduce the risks which health care institutions and individual practitioners face. The starting point for a successful risk management strategy is information on all adverse incidents and "near misses" which occur. Analysis of these data identifies areas of greatest risk and allows measures to be put in place to eliminate or reduce the risk. Adverse incident reporting also allows contemporaneous reports to be obtained which may be critical to the successful defence of a claim several years in the future.

The present insurance / indemnity arrangements provide no financial or other incentives to health care professionals to report incidents in a manner which would facilitate effective risk management. Failure to report an adverse incident in a reasonable period of time does not lead to a refusal of cover. In general, hospitals and doctors do not suffer any direct loss in having to meet a certain proportion of the cost of claims. As a consequence there are few financial incentives to encourage either good clinical practice or effective risk management. The multiplicity of insurers referred to in above also inhibits effective risk management.

12. Complexity of Administration

Reference has already been made to the administrative costs of dealing with multiple insurers in the defence of claims. Similar costs are imposed on health boards and hospitals in administering the membership and reimbursement requirements of the different insurers.

13. Existing Financial Arrangements

Given the extent of annual expenditure in this area there is a need to ensure that the bodies to whom this business is entrusted are capable of meeting the cost of claims made against doctors. At the outset it must be stated that the "long-tailed" nature of medical negligence claims makes the business of setting subscription rates/premia and allocating reserves for particular years a difficult one. This is one of the reasons why much of the insurance industry chooses not to engage in this line of business. As mutual bodies offering discretionary indemnity, as opposed to conventional insurance, the medical defence organisations are not subject to insurance legislation in either Ireland or the United Kingdom. Consequently, they are not obliged to meet the disclosure of information or reserving requirements of the insurance industry.

It is clear that Irish doctors and the Irish Exchequer are faced with rises in subscription rates/premia ahead of general inflation for years to come. The position now developing in relation to obstetricians/gynaecologists is particularly worrying.

14. International Experience

The medical malpractice problem in Ireland is not unique. Most developed countries are sharing the experience of a rising number of claims, an increase in the cost of claims and an increase in the legal and other costs associated with handling claims. The medical malpractice problem is often a feature of a wider litigation crisis, especially dramatic increases in personal injury claims. The reasons generally given for this increase include:

- A better educated public.
- Higher expectations of the health care system.
- Greater availability of legal aid.
- Contingency fees for lawyers.
- Changes in the burden of proof.

Countries' responses to this development are heavily influenced by factors such as their constitutional and legal frameworks, their social security systems, the nature and extent of statutory or non-statutory compensation schemes, the nature and extent of employers' liability insurance etc. In the United States, initiatives have been taken at State level. Countries (and individual States in the U.S.) have taken one of two approaches:

- A generalised attempt at tort reform introducing changes which apply to all claims for personal injury or
- Health care specific measures which attempt to deal with the particular problems of claims arising from alleged clinical negligence.

A more detailed description of some of the more interesting initiatives is set out at Appendix A.

15. Summary of International Experience

The Department of Health and Children has studied the developments outlined in Appendix A. Undoubtedly the health care system would benefit from any reforms made to the general system for handling personal injury claims. However, many of the reforms which have been made in the United States would be likely to encounter constitutional difficulties in Ireland. With the exception of the no fault compensation scheme for brain-damaged infants it does not appear that the North American reforms offer any immediate lessons.

The approach adopted in Europe in terms of rationalising the arrangements for providing compensation for victims of medical accidents is more likely to produce tangible benefits in the immediate future. The United Kingdom scheme and the arrangements which exist in Scandinavia are similar to the approach proposed in this Paper.

16. **Proposed Approach**

The Department of Health and Children has been examining the complex issues concerned for some time. As well as retaining professional insurance advisers it has also extensively studied alternative approaches taken in other countries. It has come to the conclusion, supported by its advisers, that the present arrangements cannot be sustained. In the absence of any action being taken it believes that the cost of providing this cover will continue to escalate due to a continuing rise in the number of claims, in an increasing size of awards and in the costs of dealing with claims. The increase in the consultant obstetrician/gynaecologist rate is evidence of this escalation. The Department of Health and Children believes that any alternative to existing arrangements should be based on the following principles:

- it should be firmly based on identifying and managing the risks which give rise to adverse incidents;
- individual doctors and hospitals should be given powerful incentives to manage risks;
- responsibility for financing the settlement of claims should be shared between hospitals and the Department of Health and Children;
- the management of claims should be integrated rather than fragmented between different insurers;
- comprehensive risk management programmes should be introduced in all hospitals;

17. **Enterprise Liability**

The concept of enterprise liability should be introduced to replace the present mixture of individual and corporate liability. Under enterprise liability responsibility for defending malpractice claims is placed on institutions or organisations that provide care instead of individual practitioners and their indemnity bodies. The distinguishing feature of enterprise liability is that the plaintiff would not need to sue the individual medical practitioner. Under the Constitution a plaintiff could not be prevented from suing a doctor and accordingly enterprise liability would be given effect by the employing authority agreeing to take vicarious responsibility for its medical staff. Not being personally named in a suit may remove some of the stigma attached to being sued. However, because a finding of negligence against an individual doctor could still be made, enterprise liability should preserve some of the deterrent effect of a medical malpractice suit.

The potential benefits of enterprise liability are twofold:

- it would create greater incentives and opportunities for health care institutions to introduce risk management programmes;
- it should reduce administrative costs by eliminating multiple insurers.

Enterprise liability would not extend to the private practice of doctors conducted at locations not under the management of the public hospital.

18. **Structure of Enterprise Liability**

The following structure is proposed for a system based on enterprise liability:-

- each health board or hospital would be defined as an "enterprise" for the purpose of the scheme;
- claims would be made against the relevant enterprise and not against the individual medical practitioner;
- the individual enterprise would become directly responsible for the risk and claims management practices within each enterprise;
- arrangements for general public liability (trips, slips, injuries to staff and general environmental risks) should remain as at present, i.e. insured through the commercial insurance market.

19. **Funding Principles**

In adhering to the principles outlined in above and with a view to providing maximum incentives to introduce effective risk management, the responsibility for funding liabilities should be devolved to each agency. However, as the Exchequer remains the source of virtually all health agency expenditure it is not clear that this of itself would provide the necessary incentives.

In addition devolving responsibility for the financial settlement of claims to agencies would also imply devolving responsibility for managing and settling claims. Experience elsewhere suggests that great care should be taken in devolving this responsibility to individual agencies in the early stages of an enterprise liability system. At present there is little or no claims handling, claims settlement or risk management expertise at these levels.

20. **Claims Agency**

It is proposed that the transition from the existing series of arrangements to a system of enterprise liability should be overseen and managed by a national clinical negligence claims handling agency. The initial functions of the agency would be as follows:

- to manage and co-ordinate the transition from the present arrangements to a system based on enterprise liability;
- to establish a State Indemnity Pool (SIP) as the basis for financing future settlements in respect of clinical negligence claims in the public hospital system;
- to set appropriate contribution rates for each of the enterprises participating in the system;
- to establish and maintain a national database of all adverse incidents occurring in enterprises participating in the scheme;
- to make arrangements for the handling and settlement of clinical negligence claims;
- to oversee the implementation of effective risk management programmes in each hospital;
- to report to the Minister for Health and Children on the operation of the scheme;
- to publish an annual report on the operation of the scheme.

It is proposed that hospitals and other institutions should contribute each year to a fund to be maintained for the settlement of claims. This would allow the agency to create incentives to encourage good practice in incident reporting, risk management etc. Contributions could be adjusted to match the claims experience of each hospital. It should be a matter for the agency to decide the extent to which its exposure to claims should be covered by insurance.

21. Size and Staffing of the Agency

The handling of clinical negligence claims and the implementation of risk management programmes require specific and scarce skills. These are currently distributed between commercial insurance companies, the medical defence organisations, specialist firms of solicitors and companies with risk management expertise. Accordingly, the Department of Health and Children proposes that the Clinical Claims Management Agency should only have a small central corps of staff and that the bulk of its functions should be undertaken by specialist contractors retained on fixed-term contracts.

The agency should be established on a statutory basis.

22. Cost Escalation with the Status Quo

In 1997 the M.D.U. and M.P.S. increased their rates by, on average, 15%. In 1998 both organisations increased their rates by, on average, 6.5% and in 1999 5%. In 1999 and 2000 rates have increased by approximately 12% each year. The experience over these four years illustrates the volatility in these rates. The 88% increase in the obstetrician/gynaecologist rate from 1 July 1999 is further evidence of this volatility.

23. Possible effects on Claim Frequency

It may be argued that the introduction of enterprise liability could increase the frequency of claims against hospitals as it would present a single “target” defendant to potential litigants. It is also accepted that patients are often reluctant to sue their doctors but may be more willing to consider suing a hospital. However all the evidence suggests that the frequency of claims is increasing in any event. This potential risk has to be balanced against the known and identifiable problems which the present arrangements pose for the effective management of claims.

24. Proposed Date for Introduction of Scheme

The Minister for Health and Children proposes that the new arrangements should be in place on 1 July, 2001.

Appendix A

Tort Reform

1. Tort reform has been most widespread in the United States. The general thrust of tort reform has been to make it more difficult to successfully sue hospitals and doctors and/or to place a financial cap on the maximum award of damages. The list of measures below is not exhaustive of measures taken in the U.S. but illustrates the scope of reforms already undertaken:
 - Compulsory arbitration.
 - Limits on lawyers' fees.
 - Certificate of merit required to dissuade frivolous claims.
 - Pre-trial screening panels.
 - Changes to the statute of limitations.
 - Caps on awards (overall or on non-economic losses).
 - Collateral source off-sets (damages take into account payments from any other source).
 - Introduction of structured awards (as opposed to lump sums).
 - Changes to informed consent.
 - Changes to definition of standard of care expected.

2. Opinion is divided on how effective these strategies have been. However, there is a broad consensus that caps on damages and collateral source off-sets have had the most dramatic effect on malpractice loss payments. For example, California introduced its Medical Injury Compensation Reform Act in 1975. Before the introduction of this legislation California accounted for almost 30% of U.S. malpractice loss payments. By 1994 this had fallen to 10%.

No Fault Schemes

3. The most comprehensive no fault scheme was introduced in New Zealand in 1972. The scheme covered all accidents including medical negligence cases. While a claimant no longer had to prove fault on the part of another person or body, they did need to establish a causal link between their injury and a negligent event. The system rapidly became unaffordable and a series of exclusions has been introduced which makes the scheme almost unrecognisable from the original.

Brain-Damaged Infants

4. More limited no fault schemes for brain-damaged infants have been introduced in Florida and Virginia in the U.S. Both were introduced to deal with crises in the provision of obstetric services as insurance for obstetricians became unaffordable. Both schemes have been established by statute and preclude the parents of children who are born with a defined degree of disability from suing for damages. A child who meets the criteria for inclusion in the scheme is entitled to a comprehensive package of benefits ranging from medical care, home nursing, rehabilitation, adaptation of houses and motor vehicles, supply of aids and appliances, and to income support from the age of eighteen.

5. The Virginia scheme was introduced in 1987. In 1997 it had 44 children receiving compensation from the scheme. The scheme is funded by levies on participating obstetricians and hospitals and on insurance companies in the State. A levy on all other doctors practising in Virginia has been suspended as the fund now has a considerable surplus. For the same reason the levies on obstetricians and on hospitals have been reduced. The scheme has had less claims than anticipated.

Enterprise Liability

6. Although it does not meet the definition of a tort reform, the introduction of enterprise liability has been credited with bringing about some improvements in medical litigation. Developed and promoted by Professor Paul Weiler of the Harvard Law School and others as a result of their work on the Harvard Medical Practice Study, it is based on the belief that institutions are better placed than individuals to identify potential clinical hazards, to monitor them and to put in place measures to prevent them. To provide incentives for them to do this they should be made responsible for handling and funding claims for negligence made against them.

United Kingdom

7. Prior to 1991 the arrangements for medical indemnity / insurance cover in the United Kingdom were similar to those which Ireland has at present. The significant difference was that National Health Service (N.H.S.) hospitals did not carry public liability insurance. Faced with escalating costs the Government introduced Crown Indemnity with effect from 1st January, 1991. Under Crown Indemnity individual doctors, dentists etc. were relieved of the obligation to take out personal indemnity cover in respect of their N.H.S. work. Vicarious liability was assumed by health authorities for their staff's activities. Health authorities were obliged to make financial provision for settlements and associated costs.
8. The development of the N.H.S. internal market and the introduction of the purchaser / provider split forced a radical re-think of these arrangements. The major problem was that N.H.S. Trusts with obstetric units would have been unable to compete in the internal market because of the effect on their prices of the need to provide for the cost of settlements in brain damage cases. Initially it was intended to establish a mutual fund for such trusts to enable them to pool their risk. However, this would not solve the fundamental handicap suffered by Trusts with obstetric services compared to Trusts who had no such services. It was eventually decided to establish a mutual for all Trusts and residual health authorities in 1995. This is the Clinical Negligence Scheme for Trusts (C.N.S.T.). Responsibility for the C.N.S.T. is vested in the N.H.S. Litigation Authority, a Special Health Authority responsible to the Secretary of State. The N.H.S. Litigation Authority is composed of representatives of the N.H.S. institutions covered by the scheme and nominees of the Secretary of State.
9. Membership of the C.N.S.T. is voluntary and there are complex rules governing entry and exit. Trusts can choose the level of cover they purchase from the scheme i.e. opting to handle a certain level of claims themselves.
10. While the structure of the scheme is considered a model of its type, its scope, powers and coverage have been criticised. These factors were heavily influenced by the political

values underlying the creation of the Trusts, i.e. that they were totally independent, self-financing bodies.

Continental Europe

11. Experience in continental Europe tends to be quite different from the United States, United Kingdom or Ireland. This is partly due to different legal systems but also due to different social security systems.
12. Medical malpractice litigation is rare in Europe, especially in northern Europe. In the main this is attributed to generous social security systems which compensate citizens for the consequences of all accidents, including negligent medical treatment. Typically these would cover medical care, rehabilitation, loss of earnings etc. The only non-compensatable element is likely to be pain and suffering. Claims under this heading are low (IR£5,000 - IR£10,000, €6,350 - €12,700) and fairly rare.
13. The Nordic countries have a variety of patient compensation schemes. They make relatively small payments to victims of medical negligence. They vary slightly in terms of coverage. Most are funded through insurance companies although Denmark has a State-financed system. They all use agencies along the lines proposed in the Memorandum to handle claims.