

# The Swedish Patient Compensation System:

## A viable alternative to the U.S. tort system?

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**A** no-fault compensation system is a possible alternative to our current tort-based professional liability system. This concept has been under discussion in the U.S. for a number of years, and it has a certain appeal. While most physicians would be happy to see our present lottery system replaced, there always has been a concern that a no-fault system would result in a rapid escalation in the number of cases brought and, as a result, in overall costs.

To understand how such a system might work we might look to Sweden. The Michigan State Medical Society did just that in 1989, when it organized a trip to Sweden. Joining the medical society were representatives of the Michigan Hospital Association, the two Michigan physician-owned insurance companies, the trial lawyers association, and the Michigan legislature. The trip was led by Marilyn M. Rosenthal, professor of sociology at the University of Michigan, Dearborn, and author of *Dealing with Medical Malpractice: The British and Swedish Experience*.<sup>\*</sup> There, the delegation studied the earlier Swedish Patient Insurance Fund, the Medical Responsibility Board ("MRB") and the Swedish health care system.

Embedded within the Swedish social system, the earlier Patient Insurance Fund was the no-fault alternative to the tort system until 1996, when the Patient Torts Act (PTA) replaced it. In reality, however, the PTA also is a no-fault system, even though

<sup>\*</sup>Durham, NC: Duke University Press, 1988.

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it does require all medical and health providers to obtain liability insurance. The question we pose in this article is whether a similar no-fault system for compensating injured patients could be adapted to meet the needs of patients in the U.S. The answer will depend on whether we in the U.S. can replicate the elements of the Swedish social and legal system that underpin the success of this alternative.

### The Swedish insurance system

Sweden's earlier Patient Insurance Fund operated in the context of a public health care system that is part of an extensive welfare state. Sweden guarantees full employment, extensive entitlement programs, and legislated social programs. The state funds all hospitals, and all but 5 percent of the physicians are employees of the state. Financial responsibility for health care services is distributed among the national government, 23 county councils, and three large municipalities. The municipalities take primary responsibility for social welfare services. Health care accounts for more than two-thirds of each county's budget. County councils operate hospitals and outpatient services.

Other social insurance systems also compensate certain medical injuries. These include public insurance, workers' compensation, collective agreement sick-leave insurance, security insurance, no-fault traffic insurance, no-fault medical drug insurance, the General Torts Act, and compensation for victims of crime.

### First no-fault system

Sweden first introduced the country's no-fault Patient Insurance System in 1975. Within this system, a Patient Insurance Fund was established, funded by county tax revenue and by organizations representing private practice doctors, dentists, and physiotherapists. A consortium of private Swedish insurance companies administered the system. Three years later, a similar insurance system was introduced for injuries caused by, or clearly related to, pharmaceuticals.

The Patient Insurance System did not require a showing of fault or malpractice in order to compensate a claim against a health care practitioner. The Medical Responsibility Board processed com-

plaints alleging physician incompetence. This function was and still is entirely separate from the system that compensates patients for injuries. In 1997, it became a legal obligation for every health care authority to provide compensation for injuries sustained in the course of clinical procedures, regardless of fault.

In a 1983 study of the Patient Insurance System, Carl Oldertz, vice-president of Skandia, showed that 60 percent of the injuries were considered eligible for compensation. Of these, about 75 percent of the claims involved procedures. Mr. Oldertz said, "Our philosophy is compensation should be paid if it's possible to have avoided a particular medical injury. And that fault is an irrelevant factor."

The Patient Insurance Fund provided compensation according to a predetermined schedule, adjusted by percentage of full or partial disability and by expected duration. It covered most injuries due to diagnostic errors, new or unproved methods of treatment or their complications, hazardous interventions performed in order to avoid a threat to life or permanent disability, injuries that could have been avoided by choosing a different treatment, and most mistakes in diagnosis.

Exclusions included minor injuries requiring 30 days of sick leave from work and a minimum of 10 days in the hospital, cases of psychological or "unavoidable" injury, or "accidental" injury. It only covered infections in clean cases, excluding infection of the respiratory or gastrointestinal tract. If an expert medical advisor held that "accepted" medical treatment was used, the injury was not compensated. Injuries due to pharmaceuticals were covered through a separate program. Fault, except in rare instances, was not a necessary factor.

Loss of income was paid when the child's future opportunities could be assessed. Pain and suffering were paid with strict limitations. Economic damages were paid in a structured settlement. The statute of limitations was three years, with the equivalent of the collateral source rule, taking into account other types of insurance payments. In the case of a death no payments were made for non-economic damages. Experienced claims adjusters used objective criteria to determine awards.

The only lawyers involved in the procedures under the Patient Insurance System were the insur-

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ance company staff or individuals who assisted patients in writing out claims. The system had an 18 percent overhead, and the whole award went to the patient. Compensation was 100 percent for economic losses, with noneconomic losses paid according to a fee schedule. Noneconomic losses accounted for two-thirds of the payments. The average claim was settled within two months and most of the rest in less than six months, although some took up to two years.

Appeals went to a government-appointed claims panel with six permanent members, including one medical expert from the government. These appeals were free of charge. Approximately 20 cases could be heard in a month. The panel reversed about 10 percent of the cases.

Arbitration was available but rarely used. The chair of the arbitration panel was a governmental appointee, usually a judge, and medical experts advised the panel. In 1989, only a handful of cases had been taken to court. In general, these were in cases where the Patient Insurance Fund had excluded payment, and the lawyers argued that the case should be covered. A series of cost-cutting maneuvers had reduced the schedule of awards, strengthening those arguments.

The American trial lawyers with us who looked at this system predicted that Swedish lawyers would soon bring more of these cases to court, but the Swedes explained that American trial lawyers should recognize that the mentality of U.S. and Swedish lawyers are poles apart. Swedes generally do not believe in “a right” to economic compensation for all imperfections or defects, and Swedish case law provides very low damage awards. Indeed, the lawyers who had brought cases to court found the damage awards under the general Torts Act to be lower than the fixed benefit schedule the Patient Insurance Fund used.

Feedback from the Patient Insurance System was returned to hospitals, physicians, and the chief of the hospital clinical service. The physician could not be fired for this reason alone, but he or she could be either reassigned or sent for additional training. All case reports went to a risk management/quality assurance database. Complaints of physician fault or malpractice also could, and still can, be filed with the Medical Responsibility Board.

## Medical Responsibility Board

The Medical Responsibility Board (MRB) is a government agency resembling a court. A patient, close relative, or legal representative may claim malpractice or allege that medical practitioners have acted incorrectly. The remedies include disciplinary warning, admonition, or removal of the practitioner from the health register.

Medical practitioners are thus held responsible for their actions in a process that is separate from the system for compensating injured patients.

Although the number of complaints filed annually has varied, it has been fairly consistent. In 1994, 2,417 complaints were filed, and this number grew slowly to 3,250 in 2001. In 1994, the board judged 2,053 cases, increasing to 3,132 cases in 2001. Thus, the board clears its dockets fairly efficiently, avoiding undue procedural delay.

The MRB decides all matters associated with disciplinary sanctions. This body consists of a chair and eight government-appointed members. In 1989, they included members of parliament, representatives from each of the three large health occupation unions, and a representative from the Federation of City Councils. The chairman must be a lawyer and should have experience as a practicing judge. In certain situations, the chair may decide cases independently of the panel.

In 1994, the chairman independently judged 684 cases, and the panel judged 902. This ratio has gradually reversed, until 2001, when the chair independently judged 1,733 cases and the panel 723 cases.

Patients, health care professionals, hospitals, a parliamentary entity, or the National Board of Health and Welfare may submit complaints in writing, using forms that are widely available in all hospitals. If a plaintiff cannot file a complaint personally, a proxy may do so. Administrative staff reviews all submitted complaints, screening out 30 to 40 percent as frivolous.

The MRB assigns investigation of the complaint to a physician in the same discipline. The physician considers written testimony from the named physician, the complaining patient, and other interested parties, as well as the hospital records. A staff lawyer writes up the physician’s summary, and the physician presents it to the MRB.

The opinions and recommendations of this physi-

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cian are granted considerable weight in the MRB's discussion, but the MRB's ruling typically is unanimous. The MRB's nonphysician majority gives the public confidence that physicians are not covering up for each other, and the physician experts give the panel credibility and validity. The MRB normally accords these physicians great deference.

The proceedings are conducted in writing, though portions may be verbal. The MRB thoroughly examines the factual findings of all complaints, considering all relevant records and associated documents. The practitioner under investigation must respond within a set time limit, indicating whether he or she accepts or rejects the allegations, and giving the basis for this position.

The appropriate city or district administrative court does have subject matter jurisdiction to order a hearing or issue an injunction.

Disciplinary sanctions may be imposed on health and medical practitioners who, intentionally or negligently, fail to discharge their duties or other obligations in accordance with Swedish law. The 1994 Health and Medical Personal (Duties) Act (replaced in 1999 by a new law with essentially the same content on this subject) is the controlling law. A complaint must be filed within five years of the alleged offense.

MRB sanctions may include warnings, admonitions, restriction of prescribing authority, or withdrawal of licensure, which latter must be requested by the National Board of Health and Welfare. Warnings are issued in some 20 percent of the cases. These admonishments are taken extremely seriously. The Michigan delegation was told that one admonished physician committed suicide.

Investigations usually last 18 months, but for license revocations they usually are completed in five to six months. The MRB usually issues a sanction for substance abuse or for mental incapacity, less often for professional incompetence. The MRB has complained of inadequate funding and insufficient staff.

The total number of warnings or admonitions varies. In 1994, the MRB warned 150 practitioners and admonished 112 practitioners. This rose to 226 warnings and 184 admonitions in 1996. In 2001, the MRB warned 120 practitioners and admonished 157.

A license to practice medicine may be revoked for incompetence, when a practitioner is shown to

be clearly unfit to continue in practice, or because of illness. A practitioner may receive an injunction requiring a medical examination. A license to practice may be temporarily withdrawn pending the final outcome of the examination or if the practitioner has failed to comply with the injunction within one year. In the European Union, revocation of a license to practice in any other member state also bars that person from practicing in Sweden.

License revocations are uncommon for doctors, dentists, or nurses, and only a few have been issued for other health care personnel. In 1994, of 48 filed complaints, the MRB revoked 20 licenses from seven doctors, two dentists, and 11 nurses. Number of complaints filed increased to 80 in 1998, with the MRB revoking 26 licenses from 16 physicians, one dentist, seven nurses, and two other personnel. In 2002, of 60 filed complaints, the MRB revoked 19 licenses from six physicians, one dentist, and 12 nurses.

Final decisions of the Medical Responsibility Board may be appealed to an administrative court within three weeks. In addition to the plaintiff and defendant, the National Board of Health and Welfare may appeal. The parliamentary ombudsman and the Chancellor of Justice may also appeal certain decisions. All parties are entitled to legal counsel. Few judgments have been appealed to the administrative court since July 1995, averaging 23 to 29 per year.

### Patient Torts Act

The 1996 Patient Torts Act requires that patients take their liability claims to court and that health care providers carry liability insurance. Whether the bill was passed because of perceived deficiencies in the previous Swedish Compensation Fund or primarily in response to pressure from the European Convention on Human Rights is a matter of conjecture. We do know that Article 6 of the Convention states, "In the determination of his civil rights and obligations...everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law." We also know that Sweden's governmental and quasi-governmental administrative systems have been criticized in Europe on this basis.

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The PTA compensates injuries caused by health care practitioners, including conditions that are the result of the diagnosis and treatment of disease, medical research, organ or tissue donations, transportation of patients, and dental care.

The burden of proof is lower than it is under the general Torts Act in Sweden. The plaintiff must show “by a reasonable certainty” that the health care practitioner’s conduct caused the alleged injury. There is no need to prove proximate cause; that is to say, that the injury was within the scope of foreseeable risk.

Under the PTA, the “but for” test may be used, meaning that the injury would not have occurred “but for” the physician’s act or omission. Also, the defendant’s conduct is considered the cause if it was a “substantial factor” in causing the injury.

Claims under the PTA may involve procedures, medical devices, diagnoses, infections, accidents, and pharmaceuticals. Compensation is paid if a different procedure or method could have prevented the injury or if the injury resulted from defective devices or products or from their incorrect use. Injuries are compensated if they result from transmission of infection, from accidents in the course of diagnosis or treatment, or from pharmaceuticals prescribed or given contrary to directions. The standard of care is that of a skilled specialist or any other skilled professional within the field.

Compensation is not offered for injuries that are unavoidable, for injuries resulting from a procedure that is necessary to diagnose or treat a disease, for life-threatening injuries, or for treatments without which there would be severe disability. This includes emergency care. If the only available treatment was provided, an injury is not compensated. Under the PTA, a claim must be filed within three years from the time that the patient recognized the injury and within 10 years from the time of injury.

Calculation of medical expenses, other expenses, loss of income, funeral costs, loss of services, and damages for pain and suffering usually are the same under the PTA as under the general Torts Act. Because the public health care system funds the hospitals and employs most physicians, actual medical expenses tend to be low.

The PTA compensates only necessary expenses, not so-called comfort expenses. There is compensation for loss of future income when an injury leads

to permanent harm. The general Torts Act provides the following criteria for these calculations: type of work, previous education and occupation, retraining requirements, age, and residence.

Compensation for acute and permanent pain and suffering take into account the length of hospitalization or sick leave, and it is generally very low in Sweden. The courts usually rely on the Traffic Injury National Board tables as a template for these calculations.

Under the PTA, approximately \$180 is deducted from patient compensation. A cap on patient compensation for economic and noneconomic damages is set at an amount that presently is about \$730,000. If several patients are injured through the same conduct, the total amount paid is capped at about \$3.6 million. If this amount does not fully compensate patients for their respective injuries, payment for each individual is reduced.

When negligence can be proven, a plaintiff may file under the general Torts Act, thus avoiding the PTA deductible and the cap on compensation. The burden of proof in the no-fault PTA system requires “reasonable certainty,” a lower burden of proof of causation in comparison with the general Torts Act, which requires “probable cause.”

Damage awards under the general Torts Law generally would not exceed those under the PTA. Courts usually are very unwilling to award high noneconomic damages to any plaintiffs. In criminal law, for example, awards to victims of serious crimes are very low in comparison to those in the U.S. This appears to be a cultural difference, rather than a legal difference.

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## Applicability to the U.S.

To evaluate whether the U.S. should change to a no-fault patient compensation system, we need to consider whether the key elements of the Swedish system could be applied under the current U.S. health care system. The questions are whether the U.S. public would accept restrictions on the types of events that are compensated, and whether they would accept a limited compensation schedule. In Sweden, these two points explain why the number of cases and overall costs remain under control.

In legal terms, the obstacle is that compensation in Swedish medical liability cases is determined in the same way as it is in all other types of cases under Sweden's general tort law, and all these awards are low. In the U.S., awards in all types of tort cases are much higher, and this has caused the American public to expect correspondingly high levels of compensation for medical liability cases.

We also need to recognize major cultural differences between the Swedish legal system and the American system. Sweden does not have jury trials. At the district court level, a judge and three laymen decide the case, and they all have an equal vote. The crucial difference in comparison to the U.S. is that Swedish case law allows judges and laymen to decide on patient compensation, including noneconomic damages, in accord with strict guidelines. Again, this is a cultural difference. Case law has been able to develop in this way because the public is satisfied with these lower levels of patient compensation and noneconomic damages. The Swedish public does not believe that any plaintiff would have the right to \$20 million in damages for any injury. The PTA cap of approximately \$730,000 sounds high enough to them. Of course, because Sweden's social system subsidizes many of the plaintiff's costs, their lower awards reflect in part a lower need.

Although the Swedish system of socialized medicine is markedly different from our U.S. system, these differences may be less relevant to this discussion than are the differences in legal environment. Medicine is virtually free of cost within the public system in Sweden, but there is a small private system that provides a significant amount of care in some fields. In contrast, although we have

a primarily private system, we too have a large public system. Medicaid now covers 47 million Americans, and Medicare is not far behind.

To build a case for change to a no-fault system, we would have to answer the trial lawyers' charge that the tort system protects the public from "bad doctors." In Sweden, the system is clearly bifurcated, and patient compensation is entirely separate from disciplinary actions against doctors who perform poorly or are unqualified. If we were to have a no-fault compensation system in the U.S., the public would likely demand something like the Swedish Medical Responsibility Board, to feel that their interests were being protected. Although we do have boards of medicine in each state, these bodies have come under attack, and they have not maintained the credibility with the public that the Medical Responsibility Board has in Sweden. We would need to carefully study this trade-off.

In summary, the Swedish system is ideally suited to Sweden. Any attempt to adopt it, in whole or in part, in the U.S. would encounter a number of problems. The trial lawyers would oppose it, and the political climate would be problematic. If awards were to be markedly higher here than they are in Sweden, overall costs might be too high, and we would have to figure out who should bear these costs. These questions demand rigorous legal and economic analysis. □

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