The Chances of Patients to Be Reimbursed for Medical Errors Quickly and Easily Are Still Low

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The Medical Treatment Risk Fund, which was created to allow patients receive compensation for the damage caused by medical malpractice, does not actually fulfil its main function, as it does not operate for the benefit of patients.

The amounts available from the Fund are critical to the health and even life of many patients because they allow acting immediately to mitigate and prevent the consequences of the damage caused. In some cases, long waiting for a decision on the recognition of damage and cash disbursement resulted in the fact that already the heirs of the patients have received compensation. The State Audit Office has reached such conclusions while evaluating the functioning of the compensation system of the Fund established five years ago.

Over five years, the Medical Treatment Risk Fund (hereinafter referred to as 'the Fund') has received more than 900 patient claims, has made more than 200 decisions recognising the existence of the damage, and has paid compensation of 4.4 million euro to patients. The audit assessed the availability of the Fund, the duration of the review of patient claims, the comprehensibility of the procedure for determining the amount of compensation, and the process of formation of the financial resources of the Fund.

How and why it takes so long to receive compensation

The Fund was designed with the ultimate goal of providing the patients with the opportunity to defend their rights without the need to bring action to the court. The Fund is under the responsibility of the government, but its operation depends on the speed and capacity of the Health Inspectorate and the National Health Service (NHS) directly.

For a patient to be eligible for compensation for the damage caused, s/he must apply to the Fund with a description of the damage suffered. The Fund must verify that the required documents are submitted and that the deadlines for submitting the claim are met, and then the Health Inspectorate conducts the expert assessment and determines its amount in case of the damage stated. Afterwards, the Fund makes a final decision on the reimbursement or refusal to indemnify. The

maximum time allowed for this process is six months. Deadlines are actually met in less than one fourth (24%) of the pending cases. In cases where additional time is required to assess the circumstances, the deadline is up to one year, while 33% of the decisions are taken beyond the one-year deadline.

An absolute majority of the decision-making time (90%) is devoted to expertise by the Health Inspectorate and the preparation of an opinion. Yet, the time of conducting expertise is increasing every year instead of decreasing. If these were 8 months on an average in 2014, then that was more than a year on an average in 2017. The capacity and disorderly internal processes of the Health Inspectorate affect the latter. The audit found that the lack of doctors-experts has a significant impact on the functioning of the Health Inspectorate, which is a problem for the entire industry. To solve the problem, the Health Inspectorate has started signing agreements with professional associations and external experts on the provision of expert opinions during expertise at the end of 2018.

At the same time, one can mention the overly general regulatory framework for calculating the severity of damage caused to the health or life of patients, which is so complex and unclear that even a sufficiently attentive and knowledgeable patient cannot trace and understand the way the damage is calculated, among the main reasons for delay. Therefore, the patient will not find it fair and impartial in any case when the maximum amount of compensation is not paid.

Determination of the amount to be paid into the Fund does not comply with regulatory enactments

According to the Cabinet Regulation, the annual amount of contributions of medical treatment institutions to the Fund should be determined to take into account the number of projected justified claims, the number of people employed in the medical treatment institution, and their specialities. However, the National Health Service actually does not make any projections, but the Service relies on the same assumptions defined in 2013 every year. Namely, the assumption that one must count on ten justified claims in the amount of maximum compensation per year.

Currently, the financial flow of the Fund does not indicate that there was a shortage of funds at any point in the Fund. One of the reasons for this relatively stable situation is the delayed decision-making time, and the Fund is not liable for the infringement of the deadlines to review patient claims. As a result, the compensations paid to patients do not exceed the amount of funding available in the annual budget, and the Fund generates surplus at the same time. Nevertheless, if the claiming process were to be considerably shorter, the shortage of funds for compensations could occur at some point.

The financial engineering process of the Fund demonstrates priority taken for the state budget rather than the patient. The term of payment of compensation provided for in the Cabinet Regulation which is 90 business days is also not proportionate and does not indicate compliance with the interests of patients.

The public does not have enough information about the Fund

The second reason why money stays in the Fund is that the public is not provided with enough information about the existence and functions of the Fund and patients are not made aware of their rights. Data from the survey carried out during the audit show that only 14% of respondents have heard that such a Fund is operating in Latvia, and only 9% of respondents know what the main function of the Fund is.

Since the establishment of the Fund, the Ministry of Health has not evaluated the compliance of its activities with the interests of patients, although the Ministry has sufficient information about the delays in reviewing process by the Health Inspectorate, the uncertain mechanism for determining the severity of the damage caused, and a considerable number of appeals. There are 18% of the Fund’s decisions appealed to the Ministry of Health, and at least 48% of them are subsequently appealed to the Administrative Court.