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Healthcare liability risks in Italy 2010-2017

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1. FOREWORD

Healthcare liability is of considerable importance both from an economic and a social perspective. In fact it protects the safety of healthcare and health treatments, the economic value of which amounted in 2017 to 8.9% of Italy's GDP[1]. The social importance of healthcare liability stems from the fact that it indirectly contributes to the full realisation of the right to health protection, recognised as fundamental by our Constitution (Article 32).[2]

The importance of this sector has highlighted the need for a thorough revision of the relevant regulations, introduced by Law no. 24 of 8 March 2017 "Provisions concerning healthcare safety and patient safety, as well as professional liability of healthcare professionals" (the so-called Gelli law), the implementing regulations of which are being drafted, also with the technical contribution of IVASS.

This bulletin includes the main quantitative evidence of the two insurance plans providing cover for healthcare liability, as set forth by the law:

1. those acquired through *insurance policies* for healthcare risks, offered by insurance undertakings through payment of a premium,
2. those that the public health facilities constitute through *self-retention of the risk*[3]

The insurance policies for healthcare liability risks are part of the broader general liability class of which they represented, in 2017, about one seventh of all insurance premiums. The data on this type of policies are acquired through an annual survey conducted by IVASS at the insurance undertakings, at the beginning of each year. The data on the self-retention of the risk by public healthcare facilities are provided by the Ministry of Health, which has made available a database with the data of the budgets of these facilities.

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[1] Source: OECD: https://data.oecd.org/healthres/health-spending.htm.

[2] These arguments have been examined in depth in the reports on the activities carried out by IVASS in the years 2014, 2015 and 2016 (https://www.ivass.it/pubblicazioni-e-statistiche/pubblicazioni/relazione-annuale/index.html).

[3] The Gelli law envisages forms of self-retention of the risk also for private healthcare facilities, for which complete statistical data are not available.

2. METHODOLOGICAL NOTE

The insurance policies for healthcare liability risks

Statistical information is based on a survey conducted every year at the insurance undertakings since 2016, on the basis of specific letters to the market sent out at the beginning of each year.[4]

The scope of the survey

The survey is mandatory. All the undertakings authorised in Italy to pursue general liability insurance (including healthcare insurance) are required to respond, including those with the head office in a foreign State.

The last survey, conducted from March to April 2018, covered in detail:

1) the premiums collected in 2017 for risks situated in Italy relating to healthcare liability,
2) the prospects and obstacles in the sector from the point of view of the undertakings,
3) the main characteristics of the insurance covers placed in 2017,
4) the situation of the claims reported in the years from 2010 to 2017.[5]

103 undertakings participated in the survey, of which only 27 have declared to operate in the sector, collecting premiums in the course of 2017 (tab. 1).

Tab. 1 – Survey on healthcare liability (2017)
Undertakings surveyed and undertakings operating in the sector

	Italian undertakings[(a)]		Foreign undertakings[(b)]		Total	
	Surveyed	Operating in healthcare liability	Surveyed	Operating in healthcare liability	Surveyed	Operating in healthcare liability
	59	15	43	12	103	27
Of which operating at:						
Public health care facilities		8		7		15
Private health care facilities		11		6		17
Healthcare professionals		14		7		21

(a) Undertakings with head office in Italy subject to the prudential supervision of IVASS.
(b) Undertakings with head office in a foreign State, pursuing business in Italy through a permanent presence (by way of establishment) or directly from abroad (by way of freedom to provide services). Branches of foreign undertakings with head office in a country outside the European Economic Area (EEA), subject to the prudential supervision of IVASS, are also covered by the survey.[6]

[4] The letter to the market relating to the survey conducted in 2018 is letter no. 0050193/18 of 9 February 2018.
[5] In a limited number of cases the data relating to the provisions and payments for claims have been reconstructed and the data provided during the previous surveys were reviewed by the undertakings in the following years.
[6] The countries belonging to the EEA (European Economic Area) are the EU countries, Norway, Iceland and Liechtenstein.

Annexes “STATISTICAL TABLES”

The annex "statistical tables" contains the folder in Excel format:

“RC_SANITARIA.XLSB”, showing the main results of the survey.

Other notes

The amounts shown in the tables are indicated in euro.

The self-retention of the healthcare liability risk in public healthcare facilities

For the years 1997 to 2016, the Ministry of Health makes the budgets of public healthcare facilities available. When drafting this Bulletin, two items relating to the self-retention risk funds have been taken into consideration: one item in the profit and loss account containing the yearly resource allocation for these funds and another, taken from the balance sheet, with the amount of these funds at the end of the year. The accounts plan used by the Ministry respectively indicates the two items with the abbreviations BA2740 and PBA050.[7]

The main trends in healthcare liability, both with regard to insurance policies and to the measure of risk self-retention by public healthcare facilities, have been briefly discussed in the 2017 Report by IVASS (pages 44-46).

[7] We thank the Ministry of Health for having made the most recent data available to IVASS, earlier than the official publication times. The complete data are available on the website of the Ministry of Health, at the address: http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=1314&area=programmazioneSanitariaLea&menu=dati.

3. THE MAIN RESULTS - YEAR 2017

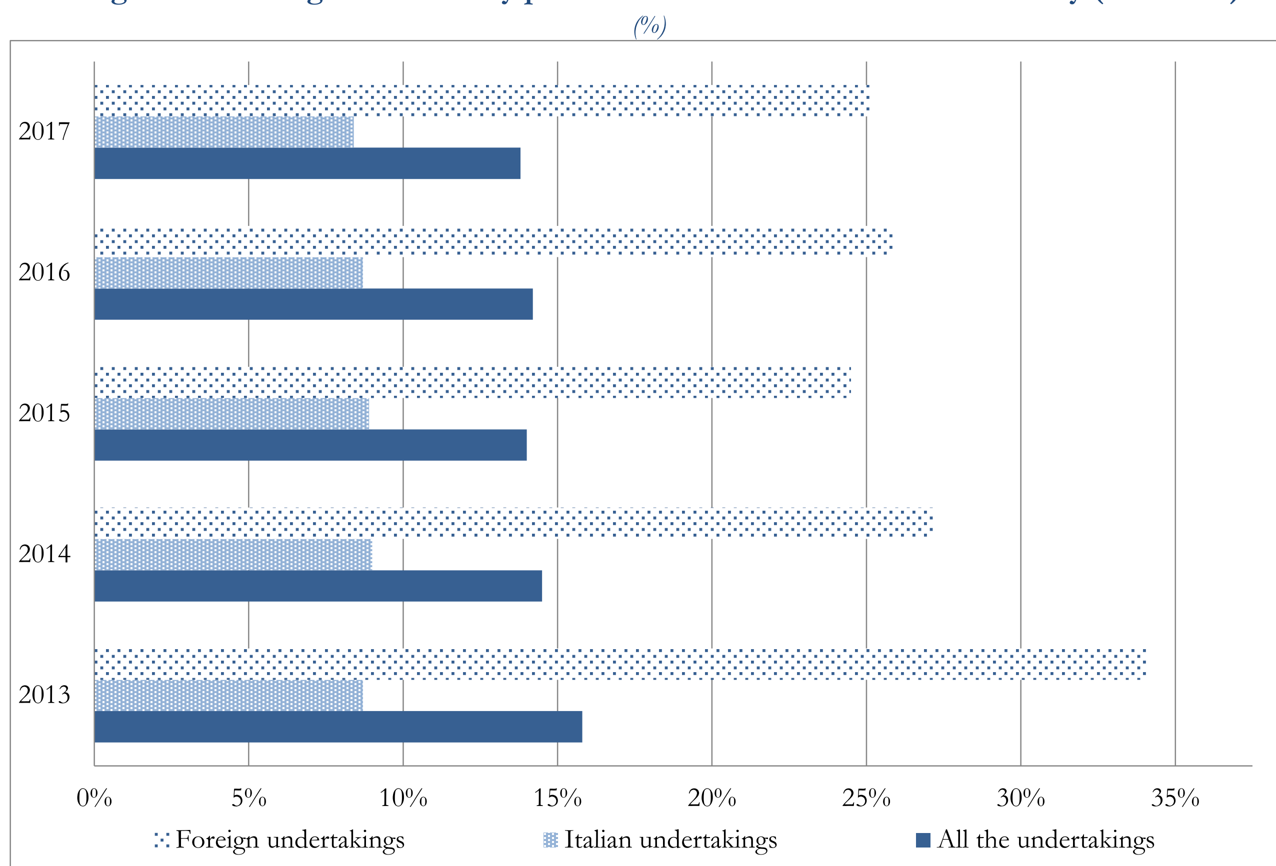
- On the whole the premiums collected in 2017 in healthcare liability amounted to 585 million euro, showing a slight decline (–2.4% compared to 2016).
- The premiums for the coverage of public healthcare facilities amounted to 272 million euro (–6.2% compared to 2016, –47.1% compared to 2010).
- The fall in the number of insured public facilities has continued (685, compared to 1,404 in 2010), while the number of those which set aside provisions for the internal management of the risk has increased.
- The management of litigations applies to 13.8% of the claims closed by final settlement between 2010 and 2017 and 27.1% of those classified as outstanding at the end of the period.
- The average premium paid by healthcare professionals amounts to 803 euro (+13.1% compared to 2016). On average a physician pays 1,040 euro, compared to 173 euro paid by healthcare professionals that are not physicians.
- The collection of premiums of the public healthcare facilities remains highly concentrated: 96.4% of the premiums are collected by the top 5 operators. The concentration of the premiums for healthcare professionals (71.4% of which has been collected by the top 5 operators) has slightly increased with respect to 2016.
- Italian undertakings mainly offer insurance covers for healthcare professionals and private healthcare facilities. Their presence in the market of insurance covers for public healthcare facilities is negligible.
- Claims closed with payments reported in 2017 were approximately 14,000, with a 21% increase compared to 2016.
- 23% of the claims with payment reported in 2010 were not yet compensated by the end of 2017, a clear evidence of the long settlement time in the industry.
- In relation to the claims reported in the 2010-2017 period, undertakings paid compensation for 1.85 billion euro. At the end of 2017, provisions of 3.2 billion euro were set aside for the future compensation of these claims.
- As to the policies covering public facilities, the cost for the claims is greater than the value of the premiums collected.
- The amount of resources allocated for the self-retention of the liability risk of the public healthcare facilities in 2016 was 511 million euro, 70% more than the amount of premiums paid in the same year for the insurance management of this risk.

4. THE ACTIVITIES OF INSURANCE UNDERTAKINGS IN THE HEALTHCARE LIABILITY SECTOR IN ITALY

Healthcare liability in the context of the general liability – The healthcare liability risk is part of the general liability class and, in this context, the 585 million premiums collected in 2017 (Annex, Table 1) represent 13.8% of the total direct premium income for the general liability class in Italy (14.2% in 2016). This share increases to 25.1% for foreign undertakings (compared to 8.4% for Italian undertakings, fig. 1).

Fig. 1 – Share of general liability premiums collected in healthcare liability (2013-2017)

(%)



Coverage of wilful misconduct or gross negligence – The insurance covering wilful misconduct and gross negligence protects the healthcare professional. It is an ancillary guarantee in healthcare liability and can be taken out together with the latter or by itself. The healthcare professionals operating in a public or private healthcare facility are required to protect themselves (article 10, paragraph 3 of the Gelli law) with a policy covering wilful misconduct or gross negligence, as a guarantee covering any legal action initiated against them by the facility itself or by the insurance undertaking covering the facility (article 9, paragraph 1 and article 1, paragraph 3 of the Gelli law). In 2017, the undertakings reported about 54,000 coverages of this type, for a total premium amount of 29 million euro.

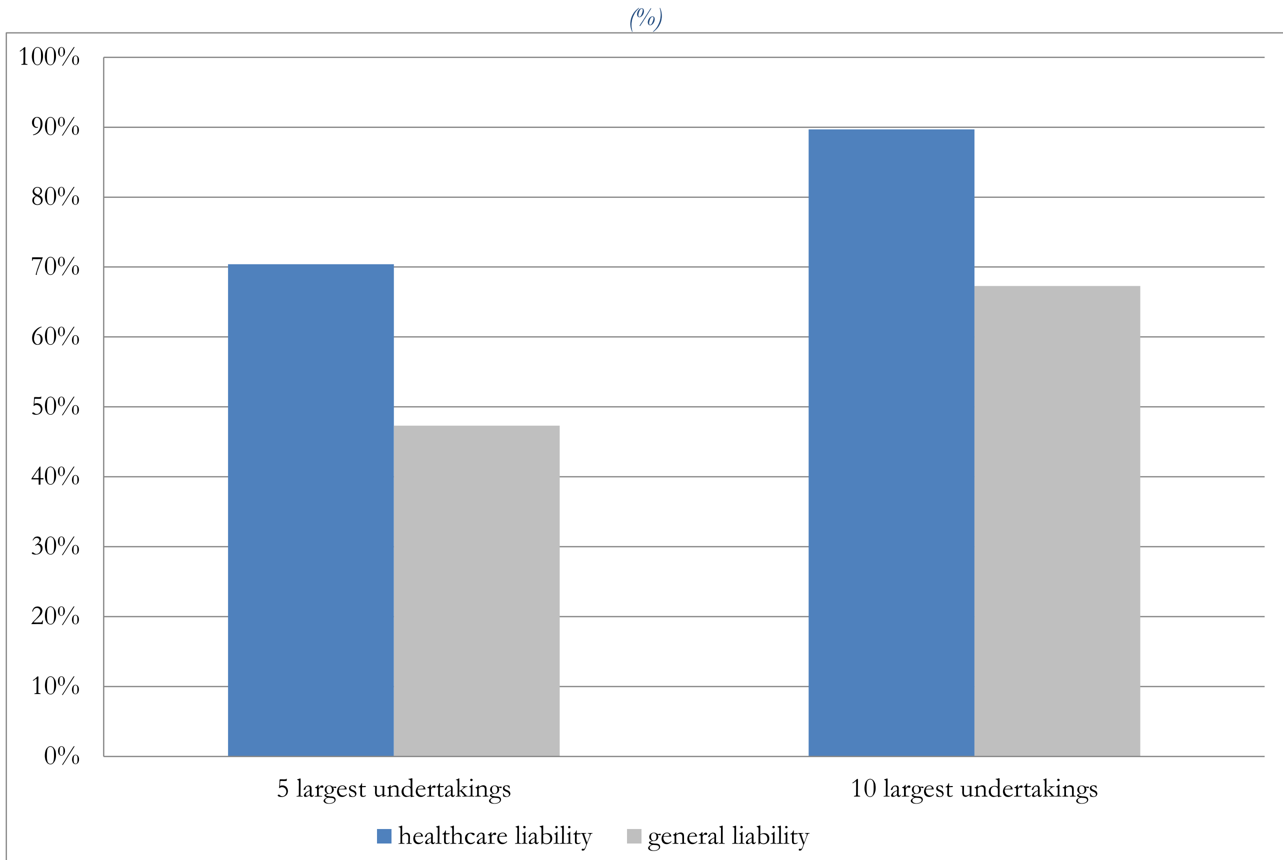
The characteristics of the undertakings providing healthcare liability – In 2017 the first 5 undertakings collected 70.4% of the premiums, this share rises to 89.7% for the first 10 undertakings (fig. 2). The degree of concentration is higher than that of the general liability class, where the first 5 undertakings collect 47.3% of the premiums (67.3% for the first 10 undertakings).

Within the area of healthcare liability, the concentration increases in the contracts entered into by

public healthcare facilities (96.4% of the related premiums are collected by only 5 undertakings). The concentration of the premiums for healthcare professionals (71.4% of which has been collected by the top 5 operators) has slightly increased with respect to 2016.

Fig. 2 – Share of the premiums collected by the major undertakings: comparison between healthcare liability and general liability (2017)

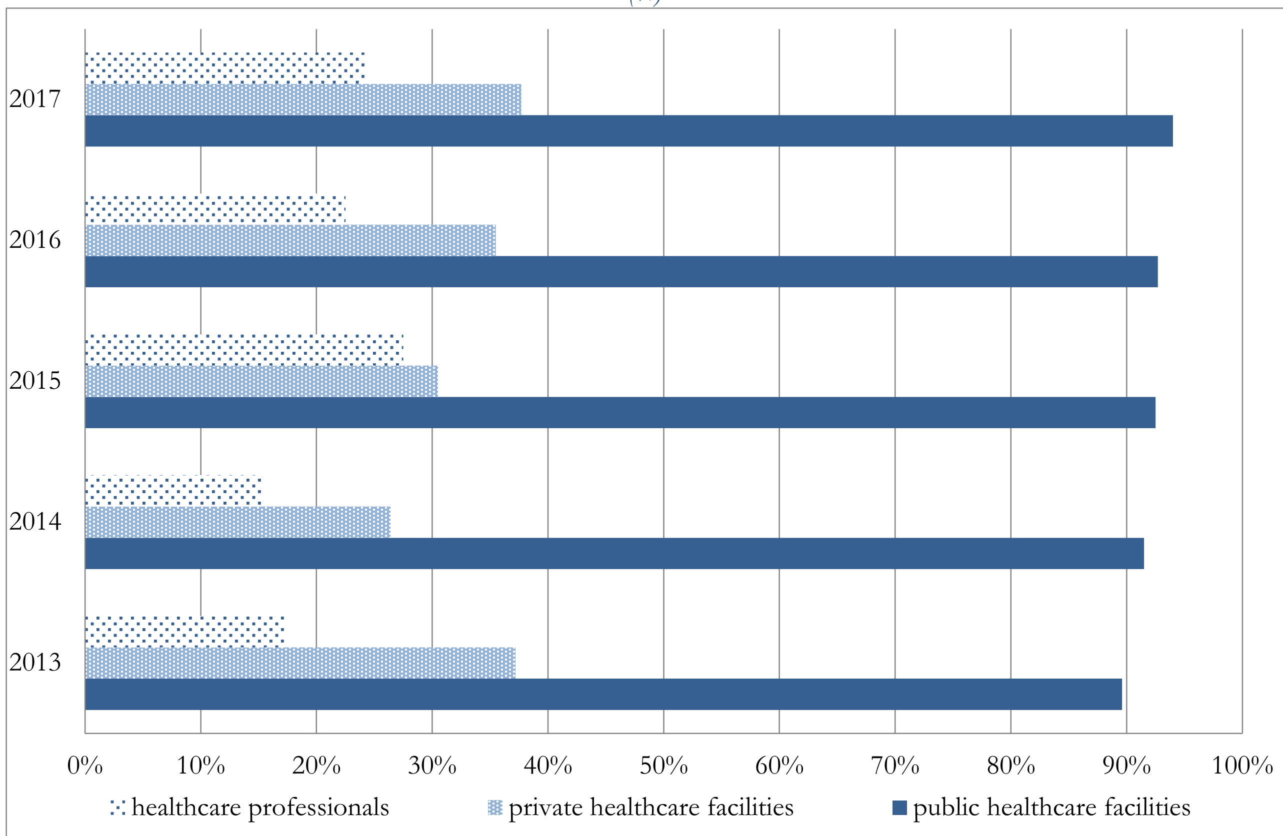
(%)



The role played by the foreign undertakings in this sector is very significant (fig. 3), in 2017 they collected 94% of the premiums for public healthcare facilities, 37.7% of the premiums for healthcare facilities and 24.2% of premiums for the coverage of healthcare professionals. Also in this sub-sector, where most of the premiums collection was carried out by Italian undertakings, the presence of foreign undertakings over the five-year period 2013-2017 has increased (their share of premiums was up from 15.4% to 24.2%).

Fig. 3 – Share of premiums collected by foreign undertakings in healthcare liability (2013-2017)

(%)

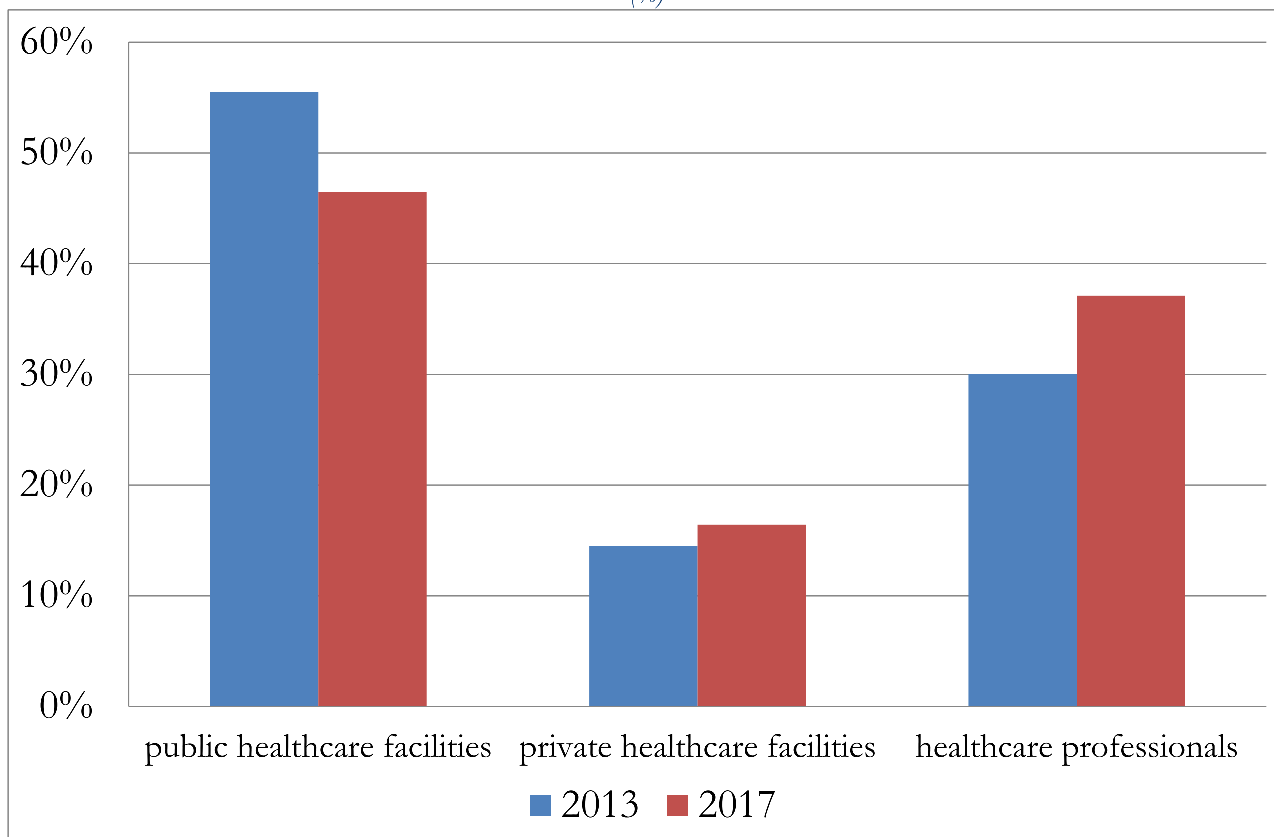


Premiums and insured units – The 585 million premiums collected in 2017 for healthcare liability (–2.4% compared to 2016) can be broken down as follows by type of insured unit:

46.5% for the coverage of public facilities,
16.4% for private facilities,
the remaining 37.1% for the coverage of healthcare professionals.
Compared to 2013, the share of premiums collected for public facilities has declined, while the share collected for healthcare professionals has increased (fig. 4).

Fig. 4 – Breakdown of healthcare liability premiums according to sub-sectors, 2013 and 2017

(%)



In 2017, 685 public facilities, 4,067 private facilities and around 270,000 healthcare professionals were insured (Annex, Table 1). An important *trend* is the constant decline in the number of public facilities covered by insurance in the period between 2010 and 2017 (-51%) concurrently with the growing use of self-insurance in these types of facilities.

The average premium paid for the coverage of a public facility was 397,000 euro, more than 16 times greater than that paid by a private facility (equal to 24,000 euro). The major difference between the two premiums also derives from the greater complexity and size of the public facilities.

The average premium for covering the healthcare liability of healthcare personnel amounted to 803 euro (+13.2% compared with 2016), whereas the average premium covering wilful misconduct and gross negligence was 540 euro. The gap between the premium paid by physicians, totalling 1,040 euro (tab. 2), and that paid on average by healthcare professionals who are not physicians (equal to 173 euro) is widening: the two average premiums had a 6:1 ratio in 2017 versus a 5:1 ratio in the previous year.

Tab. 2 – Average premiums for healthcare liability of healthcare professionals (2017)

Geographic area of residence	Type of personnel		
	Physicians	Healthcare professionals who are not physicians	**Total**
North West	1,092	202	844
North East	977	152	731
Centre	1,111	154	826
South	985	144	819
Islands	945	209	743
Total	**1,040**	**173**	**803**

The evolution of claims and compensation – In 2017 the undertakings received 18,418 claims (–35.6% compared to the claims received in 2010, Annex, Tab. 4). The decrease concerned both public and private facilities (for which it was respectively –60.8% and –39.1%), while there was a simultaneous decrease in the number of insured facilities. Between 2010 and 2017, claims regarding healthcare personnel increased (+10%) despite the decrease in the number of personnel units covered by insurance.

One of the dysfunctions affecting the industry is the high number of claims closed without payment, equal to 50.1% of the claims received between 2010 and 2017.[8] This percentage decreased to 35.9% and to 22.7% for the most recent claims in 2016 and 2017, due to the long time necessary to correctly classify a claim as being closed without payment.

The ratio between claims received during the year and risk units covered by insurance during the year provides an average number of claims by insured personnel unit (Annex, Table 4.1), taking into account that almost all coverages are for *claims made*, therefore the claims received in one year refer to risk units covered by insurance in that same year.[9] For the more recent 2017 period, a public healthcare facility has received on average 8.44 claims, of which 5.81 are likely to be closed with a payment since they already have had a payment or have been classified as outstanding. For the private facilities, the two indicators are respectively 0.82 and 0.55 (down to 0.04 and 0.03 for the healthcare professionals).

The insurance undertakings compensated, by the end of 2017, 45,129 claims reported between 2010 and 2017. Of these, only 13.4% refer to claims received in the previous 36 months, between 2015 and 2017, down to 5.8% for claims received in the previous 24 months, fig. 5.a).

In the same period of time, total compensations paid amounted to 1,851 million euro, of which 9.8% for claims received between 2015 and 2017 and 3.4% for claims received between 2016 and 2017 (fig. 5.b).

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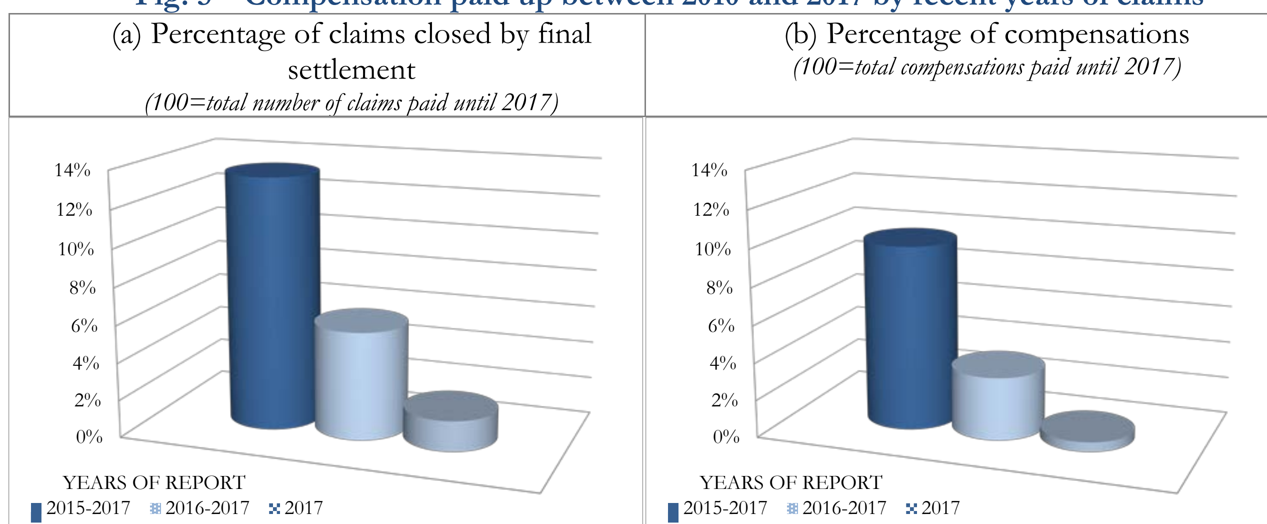
[8] In the motor liability sector, the percentage of claims closed without payment compared with all claims reported between 2012 and 2017, is between 10% and 15% (Statistical Bulletin on insurance activities in the motor insurance sector 2012-2017, October 2017, no. 12).

[9] Clause which admits the compensation of only the claims reported during the period of validity of the policy with reference to claims which occurred within the same period, even if the event that caused the claim occurred previously, up to a maximum of 10 years before the start of the validity of the cover (period of retroactivity).

Fig. 5 – Compensation paid up between 2010 and 2017 by recent years of claims



The claims settlement time – As regards public healthcare facilities (Annex, Table 7), 4.1% of claims reported in 2017 were settled and paid in the same year (the previous year they were 3.5%). As regards the private healthcare facilities, the two percentages were 9.8% for 2017 and 12.5% for 2016, while 4.4% and 5.2% applied respectively to healthcare personnel.

In terms of amounts, only 1.2% of all compensations expected for claims received in 2017 were paid in the same year (this percentage goes up to 1.7% for the private facilities and 2.7% for the healthcare personnel (Annex, Table 8). As regards the claims reported in 2016, the three percentages were respectively 0.6%, 3.2% and 2.7%.[10]

These figures, related to the settlement of claims reported in the same year, show the extreme slowness of the settlement procedures. An additional confirmation of this phenomenon can be inferred from the generations of claims reported in 2010 and 2011 (the oldest ones available): at the end of 2017, for the former, 33.8% of the compensations were still to be settled, the percentage going up to 44.8% for the 2011 generation.

The average cost of claims – Using the information available at the end of 2017, the average cost of compensations is higher for the claims reported in less recent years.[11] For the public healthcare facilities, the average compensation of claims reported in 2010 was 57,365 euro against 23,741 euro for the claims reported in 2017 (Annex, Table 9): the ratio between the two average costs is 2:4 (for the private facilities and for the healthcare personnel, the ratio is respectively 5,6 and 2,0). During the development years, the greater growth in the average compensation is most likely to take place in the year subsequent to the claim.

The provisions for claims outstanding– At the end of 2017 insurance undertakings set aside provisions for claims outstanding amounting to 3,185 million

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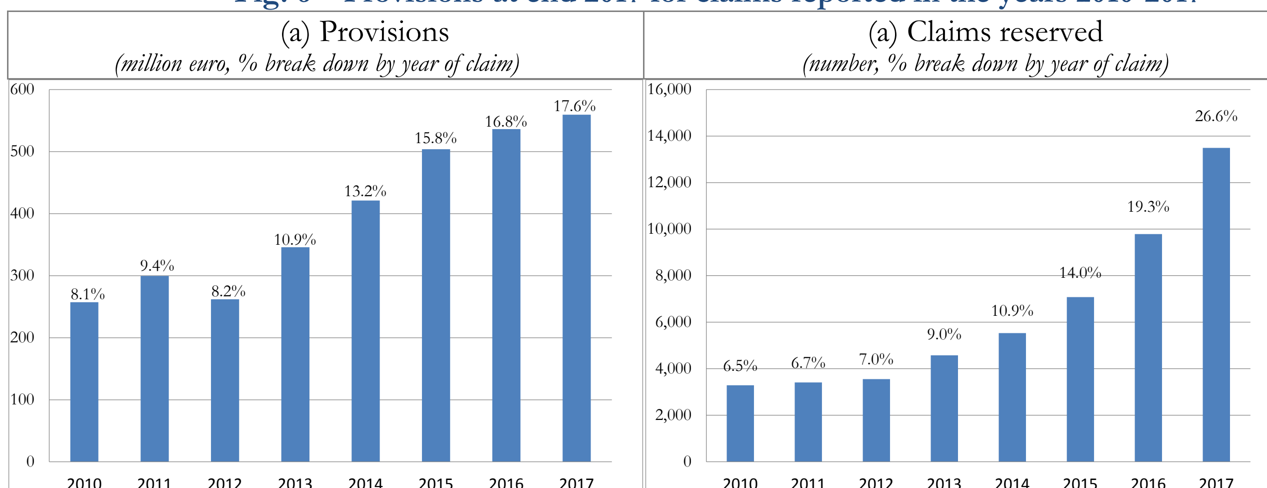
[10] See Bulletin no. 14 of 2017 for the data relating to 2016 mentioned in the section on claims settlement time.

[11] For the single generations of claims, the amounts vary as the share of claims settled increases in the course of time. Other determining factors are the complexity of the assessment of the physical impairment, which leads to underestimating the extent of the damage in the initial phase, as well as to the frequent lack of information available immediately after the occurrence of the claim, as well as the uncertainty caused by the developments in the case law concerning compensation.

for the future compensation of claims reported between 2010 and 2017 (Annex, Table 2), of which 58.1% for the claims of public facilities, 15.7% for those of private facilities and 26.2% for those of healthcare personnel.[12] Only 17.6% of the provisions regarded claims reported in 2017 (fig. 6a).

The number of claims reported between 2010 and 2017 which, at the end of 2017, were still outstanding (Annex, Table 3) was 50,713 (34.4% relating to public facilities, 14.7% to private facilities and 50.9% relating to the coverage of healthcare personnel), 26.6% of which resulted from claims reported in 2017 (fig. 6b).

Fig. 6 – Provisions at end 2017 for claims reported in the years 2010-2017



Litigation in the healthcare liability sector – One of the problems that characterises the sector is the high number of litigations. The average duration of civil proceedings forces the undertakings to maintain the provisions at a fairly high level and to make part of the final payments only after a lawsuit is concluded. 13.8% of the claims closed by final settlement between 2010 and 2017 involved a lawsuit, whereas 27.1 of the outstanding claims at the end of 2017 involved a litigation (Annex, Table 4.2).[13] The recourse to the courts mainly characterises the management of the claims referring to public healthcare facilities, for which the two indicators were respectively 16.4% and 38.5%.

Claims/premiums ratio – The profitability index used in this bulletin is the usual claims/premiums ratio (*loss-ratio*) that, also taking account of the particularities of the healthcare liability risk, is a homogeneous indicator for evaluating the technical results of the risk and indicates a technical loss for the insurance undertakings whenever its value exceeds 100.

The data updated to 2017 shows a systematic technical loss in the coverage of public healthcare facilities (for the claim period from 2010 to 2017, the index shows values

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[12] The correct calculation of the provisions is of paramount importance in healthcare liability, which is characterized by long claims settlement times and by the marked presence of foreign insurance undertakings not subject to the prudential supervision of IVASS (see EIOPA 2018-2019 Supervisory Convergence Plan).

[13] In the motor liability sector, characterised by high levels of litigation, the percentage of claims under litigation versus the claims classified as outstanding at the end of 2017 is 21.7% (Statistical Bulletin on insurance activities in the motor liability sector 2012-2017, October 2017, no. 12).

between 101 and 143, Annex, Table 12). The index values are slightly lower for the private facilities (a positive technical result is recorded for the generations of claims from 2011 to 2016). The situation for insurance undertakings is somehow better for the contracts covering healthcare personnel (the *loss ratio* is less than 100% for all the years when the claims were reported).

5. SELF-RETENTION OF THE RISK FOR HEALTHCARE LIABILITY IN PUBLIC HEALTHCARE FACILITIES

The healthcare facilities may internally manage, in whole or in part, the healthcare liability risk.[14] If they choose this option, they allocate resources that are specifically intended to compensate the patients who have undergone healthcare errors, fed by annual provisions. The Ministry of Health makes these data available to public healthcare facilities (tab. 3).

Tab. 3 – Self-retention of the healthcare liability risk in the public healthcare facilities Resource allocation and funds (2012-2016)

(million euro)

	2012	2013	2014	2015	2016
	Yearly resource allocation to funds				
Geographical area					
North	53.9	143.2	196.6	199.0	249.8
Centre	63.5	55.0	81.5	111.4	97.6
South -Islands	52.8	58.9	133.7	157.2	163.1
Type of facility					
Regional administration	144.6	225.2	380.0	410.6	443.9
Healthcare facility	25.6	32.0	31.9	57.0	66.6
Total for Italy	**170.2**	**257.1**	**411.8**	**467.6**	**510.5**
	End-of year value of funds				
Geographical area					
North	200.8	324.3	490.4	540.2	725.2
Centre	59.5	148.4	202.4	227.8	331.9
South -Islands	58.5	265.0	240.1	362.5	502.1
Type of facility					
Regional administration	247.8	608.2	758.2	936.7	1,311.0
Healthcare facility	71.0	129.6	174.7	193.8	248.2
Total for Italy	**318.8**	**737.8**	**932.8**	**1,130.5**	**1,559.2**

The resources set aside in 2016 totalled 510.5 million (+9.2% with respect to 2015), while the funds for self-retention at end 2016 amounted to 1,559.2 million (up by 37.9% compared to the previous year). Regional administrations set aside 13% of the total provisions and 15.9% of the funds.

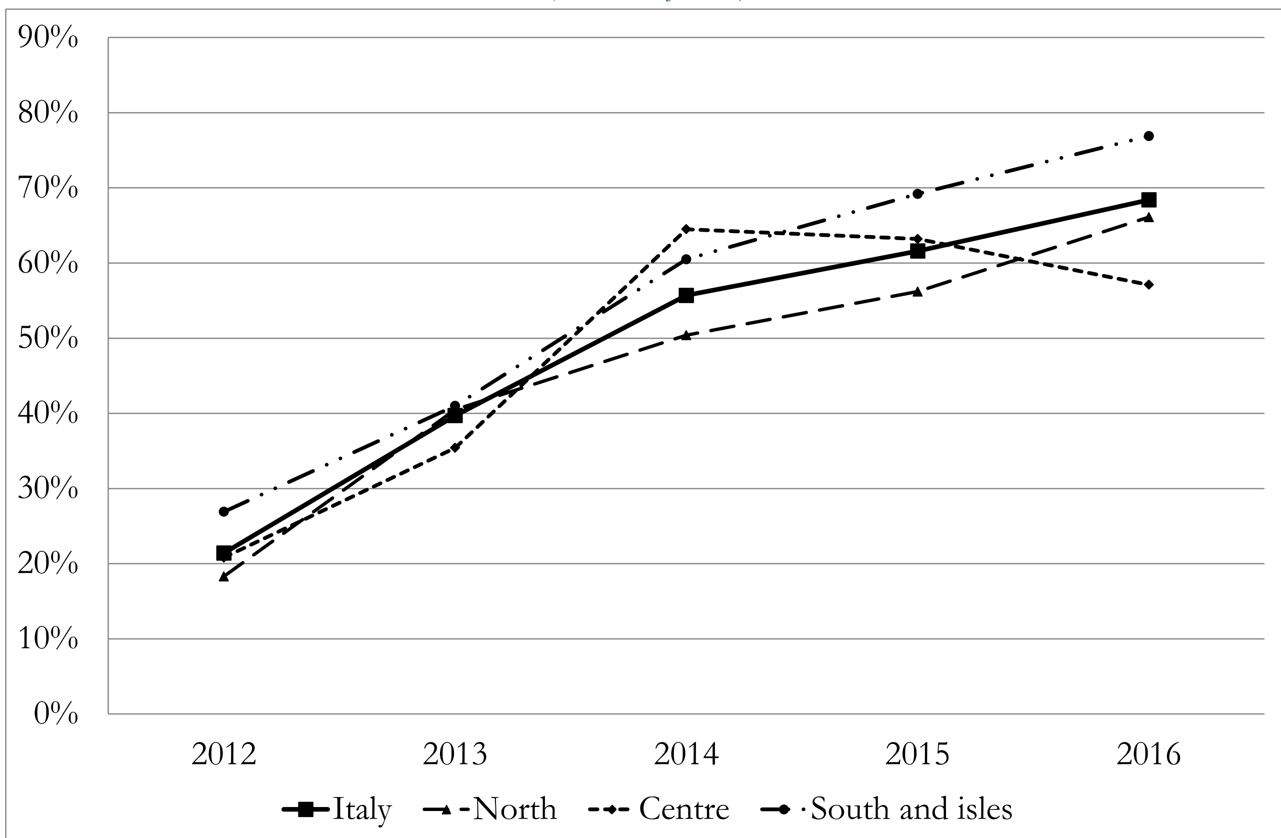
[14] Article 27, paragraph 1 bis of the Decree-law no. 90 of 24 June 2014, converted with amendments into Law no. 114 of 11 August 2014, introduced the obligation for the public or private healthcare facilities to "take out an insurance cover or have other similar measures in place for third parties liability". Law no. 24 of 8 March 2017 reiterates a similar obligation (art. 10, paragraph 1).

The increase of allocations during the five-year period 2012-2016, derives primarily from an increase in the number of healthcare facilities that have begun to set aside resources for self-insurance retention (fig. 7), a phenomenon found in all the three geographical macro-areas considered, whereas the increase in the average provision (3.3 million euro in 2016, up from 3.1 million in 2012) was relatively small (+7%).

In 2016, the percentage of facilities that set aside resources reached 68.4% (more than triple compared with 21.4% in 2012). Among the three geographical macro-areas being considered, the highest frequencies in 2016 are in the South and in the Islands (where 78.4% of the facilities have set aside provisions).

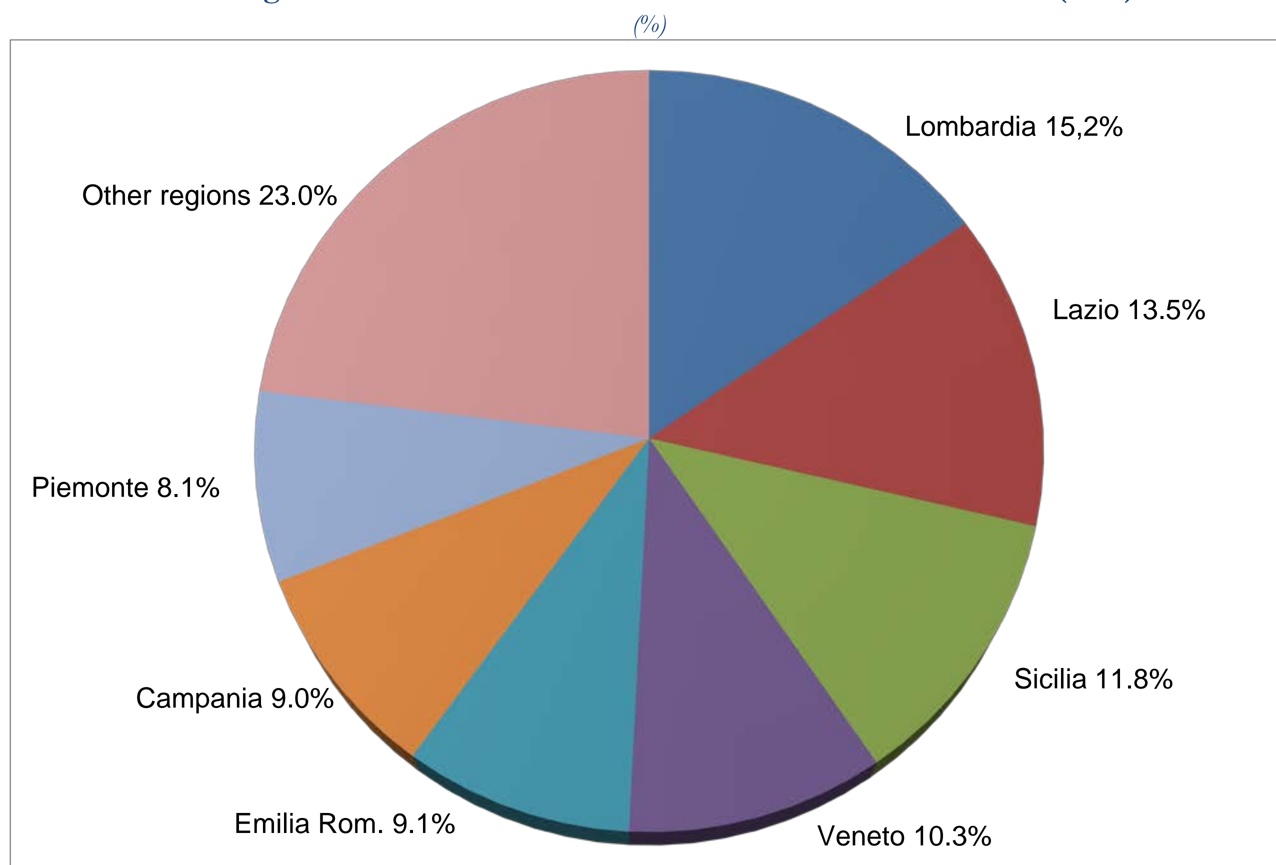
Fig. 7 – Public healthcare facilities setting aside resources for the self-retention of the healthcare liability risk (2012-2106)

(% over total facilities)



In 2016, at the regional level, the top five regions in terms of value of the coverage fund represent 59.8% of the total fund (Lombardy, Lazio, Sicily, Veneto, Emilia Romagna, fig. 8), a percentage that reaches 77% if the major seven regions are taken into consideration (i.e. adding Campania and Piedmont to the previous ones).

Fig. 8 – Healthcare liability risk in the public healthcare facilities
Regional breakdown of the funds for self-insurance retention (2016)
(%)



The resources allocated every year for self-insurance retention and the premiums paid to the insurance undertakings for healthcare liability risks of public facilities are financial indicators to some extent comparable since they represent yearly expenses for managing the same risk, either internally or through recourse to the market. Between 2012 and 2016, the two indicators had diverging trends with a decline in premiums whereas the allocations for the self-insurance funds show a constant growth. For this reason, since 2014 the yearly allocation for self-insurance have been greater than the insurance premiums (in 2016, they showed a 1.7:1 ratio, fig. 9).

It should also be noted that the system for managing the healthcare liability of public healthcare facilities is extremely heterogeneous and in many Italian regions a coexistence, also in the same facility, is noted as regards forms of risk self-retention and insurance coverages acquired from insurance undertakings. A typically adopted mixed form provides for the use of some forms of risk self-retention for claims below a given value threshold, with the intervention of an insurance-type compensation for claims of a greater value.[15]

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[15] About this matter, see the report from Agenzia Nazionale per i Servizi Sanitari Regionali [National Agency for Regional Healthcare Services] (AGENAS) "Monitoraggio delle denunce di sinistri 2015 – Rapporto Annuale – Novembre 2016" (2015 Monitoring of claims – Annual Report – November 2016).

Fig. 9 – Healthcare liability risk in the public healthcare facilities
Comparison of resource allocation for self-retention of risk and insurance premiums (2012-2016)
(million euro)