James M. Jeffords

Vermont Legislative Research Service

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No-Fault Compensation for Medical Malpractice

In the 1970s, as a result of increasing medical malpractice suits and unstable insurance premiums, several reforms were made within both the insurance industry and the legal arena in an attempt to stabilize the market. These included the introduction of statutory caps, the creation of screening panels to prevent frivolous suits, and limiting contingency fees.[1] These reforms met with varying levels of success however and insurance premiums continued to rise, threatening access to quality health care. So, some experts and governments considered no-fault compensation as an alternative to the rising costs of tort claims on both the court system and individual providers.

No-fault compensation is a system that focuses on preventable injuries, rather than on the negligence of providers. Supporters of no-fault insurance claim that by removing the need to prove fault or negligence and instead compensating based on loss, no-fault compensation can help to ensure fair and timely payments for more accident victims while reducing costs. In the United States, no-fault compensation has been implemented in some jurisdictions, such as compulsory self-insurance for automotive accidents.

With regards to medical malpractice, in a no-fault compensation system a patient is compensated for a proven injury incurred unnecessarily through treatment. Patients simply must prove unnecessary injury, file a claim, and if accepted, wait for compensation. This system has been implemented in several countries around the world, beginning in New Zealand.[2]

Malpractice Law in the United States

Federal Malpractice Law

In the United States, the federal government has exercised limited control over most medical malpractice claims, leaving each state to set its own

claims brought in the United States, including a $250,000 cap on noneconomic damages and a $500,000 cap on punitive damages, have been made.[3] According to the Congressional Budget Office (CBO), if implemented, these changes could result in a ten percent reduction in malpractice insurance, as well as savings of $13.5 billion over the next four years and $54 billion over the next ten years from the decreased use of services for “defensive medicine” by physicians attempting to avoid a lawsuit.[4]

Although the United States government does not limit most malpractice claims, it does limit the action that may be taken against its own agencies. Enacted in 1946, the Federal Tort Cen

No Fault Compensation Systems Currently in Use

New Zealand

In 1974, New Zealand eliminated medical malpractice litigation in favor of no-fault compensation. In 2005, New Zealand removed its distinction between medical mishap and medical error, instead favoring a new concept of treatment injury. Treatment injury covers all adverse medical incidents, regardless of whether or not negligence occurred during treatment, creating a comprehensive no-fault program. [9]

No-fault compensation in New Zealand is funded through a Treatment Injuries Account that is funded by an earner levy and the non-Earner's Account. The earner levy is a flat tax specifically collected for the ACC; in 2009 this was set at 1.7%.[10] All employed citizens in New Zealand will pay this tax and be covered by this for any treatment injury incurred. The non-Earner's Account is a government account funded through general taxation to cover people who do not work such as children or the elderly. The Treatment Injuries Account covers any treatment injury.[12]

Under the no-fault compensation system, patients who have suffered from an injury under the care of a doctor file a claim with the ACC. The ACC is government-run; its stated mission is to provide monetary assistance to an injured party and provide injury prevention consultation.[11] The ACC differs from the United States' current medical malpractice tort system—in New Zealand, a patient must prove only injury, not

The New Zealand system offers some benefits over the U.S tort law system. The first benefit is cost. The New Zealand system has administration costs accounting for about 10% of their budget.[15] Secondly, because eligibility for compensation is not based on negligence, more people are eligible to receive compensation without specifically faulting the licensed health services provider. The average payout for a claim is less than $30,000, much less than the United States.

New Zealand has tried to address concerns about the lack of accountability for health service providers with the implementation the Health and Disability Commissioner Act of 1994. This act established a Health and Disability Commissioner whose job it is to advocate for patient's rights and to make sure health care is being provided with the proper amount of quality.[16] New Zealand has yet to see an increase to patient safety with the implementation of this system with an adverse-event rate of 12.9%, which are similar to western countries with tort systems.[17]

Florida and Virginia Birth-Related Neurological Injury Programs

In 1988 and 1989, respectively, Virginia and Florida instituted no-fault compensation programs designed to stabilize insurance premiums in obstetrics by westerncountries

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the limited scope of these no-fault programs has prevented them from having a significant impact on the incidence of these injuries.[21,22]

Application of No-Fault Compensation to American System

No-fault compensation has been proposed as a reform mechanism to reduce malpractice costs

in the slight rise in automobile collisions following the introduction of no-fault compensation in vehicular insurance; however, effective modeling of the no-fault program within the medical field may eliminate safety problems.

Within the workers' compensation program and at some academic hospitals throughout the country, the use of an experience rating has allowed for the introduction of incentives for the maintenance of a safe, hazard free environment.[28] Hazard-prone institutions are forced to pay higher insurance premiums. The nature of malpractice coverage has limited the use of these ratings within health care; however, the adoption of no-fault compensation would allow experience ratings to be used on a larger scale. While an individual physician would not be liable for an adverse incident, the hospital or practice at which he is employed would see an increase in its premiums, providing an incentive to improve safety conditions.

Affordability/Cost

In a study released by the *Journal of the American Medical Association* in 2001, Studdert and Brennan used malpractice data from Colorado and Utah from 1992 to determine both the number of injuries eligible for coverage and associated compensation costs under tort law. These data were compared to results found using pilot versions of no-fault programs considered by Colorado and Utah during a medical malpractice study. The results indicate that these no-AyTjap>(-AyTjap>(-AyTjap>(-AyTjar0 Tc 2.72 0 Td <f 0 TcTf 0 TcTf 0 TcTf 0 TTcc 0

Conclusions

Historically, efforts to fight rising costs of malpractice insurance have been focused on tort reform, including the creation