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No Fault Compensation

Advantages and Disadvantages

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Background to No Fault Compensation

- In recent years many governments around the world have been troubled by the financial and socio economic cost of Clinical Negligence
- In 2016, the Scottish Government consulted on a ‘No-Blame redress scheme’ for adverse incidents arising out of clinical treatment
- In 2017, the Law Reform Commission of South Africa included NFC in its research into potential solutions to address the rising cost of clinical negligence
- In 2018, NFC was included in the scope of an Expert Review – commissioned by the Irish Government – into how civil justice could be reformed and made more affordable
- Most recently, in our appearance before the Paterson inquiry (UK), we were asked our opinion on NFC

What is no fault compensation

Does it really exist?

If so **where** and **how**?

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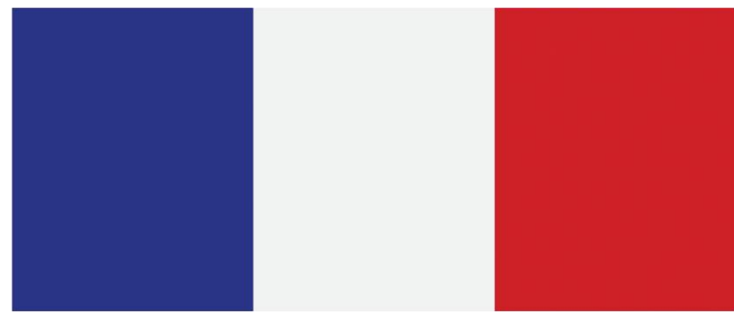
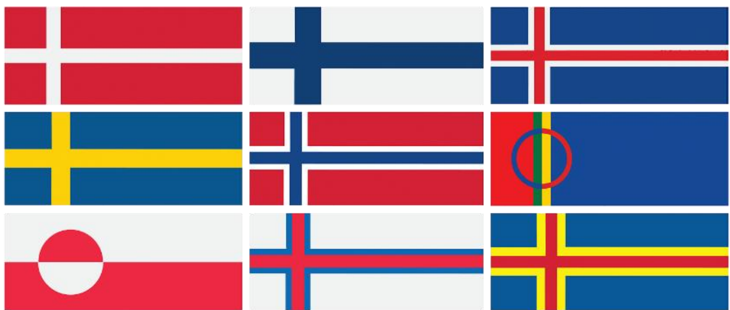
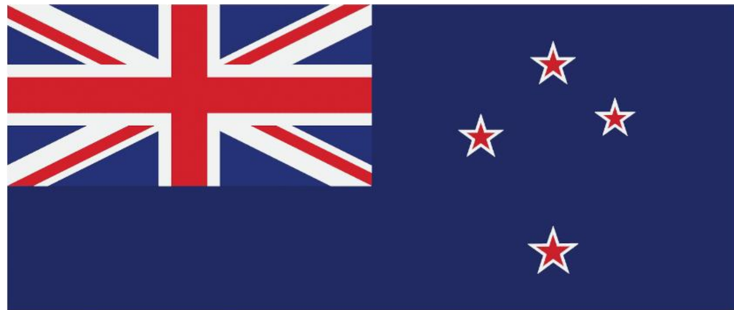
Where do no fault compensation schemes exist

USA


France


Scandinavia


New Zealand

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Report commissioned in - UK 2016, Dickinson et al

1. What individual or contextual factors contribute to people's reasons and motivations for engaging in no-fault type compensation schemes after medical injury?
2. How are no-fault compensation schemes thought to improve outcomes for people with medical injuries?

This report analysed many of the schemes around the world in order to try and attempt to answer 2 questions

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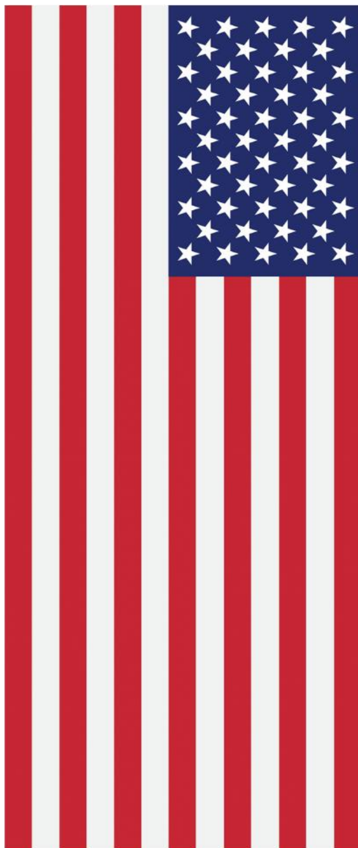
Yes NFCS operates in the US! - 1990



- NFCSs specifically for neurological birth injury are in place in **two US states**: Florida and Virginia
- To be eligible they insist that, to be eligible, the birth injury has to be the result of the birth process and they exclude injuries caused by genetic or congenital abnormality
- Funded through contributions from participating Drs and Hospitals
- There is no access to the court system
- There is a financial cap covers economic and non-economic damages

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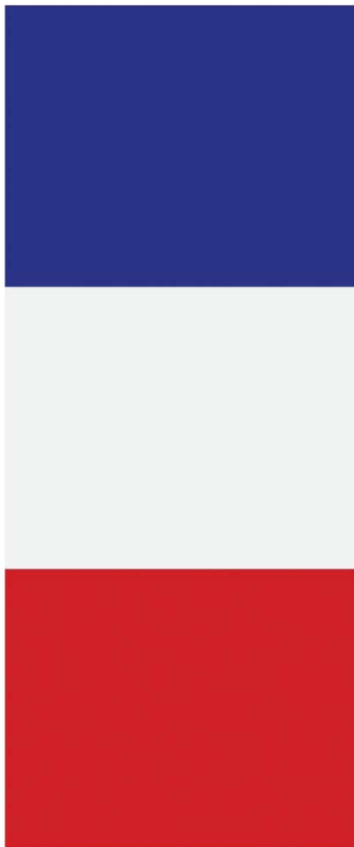
France - 2002



- **France** has implemented two systems:
  - No-fault standard: Serious and unpredictable injuries, without relation to their previous state of health and foreseeable evolution. This is funded through a tax based government funded based scheme
  - Fault standard: Failure to act in accordance with current scientific data or ‘gross or intentional conduct. This is funded through health care providers or insurers
- There is still full access to the courts
- No financial cap covers economic and non-economic damages

Nordic countries - 1975

- **The Nordic countries** operate an 'avoidability' standard, compensating patients who have experienced injuries that could have been avoided under optimum conditions, for example, where the injury would not have occurred under the care of the best health practitioner/system. It is referred to as the 'experienced specialist' rule
- The scheme is funded by Patient insurance schemes funded by a range of public and private health care providers
- Access to court is available for claimants who wish to appeal against a decision, but is not available at the initial point of claiming
- There is a financial cap covers economic and non-economic damages

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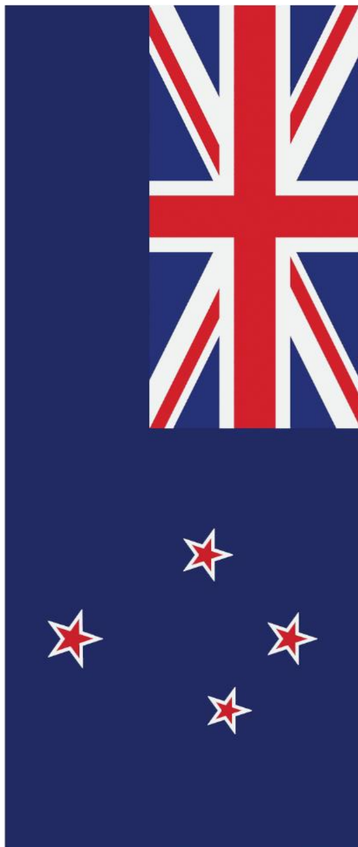
New Zealand - 2005



- Unexpected treatment injury – for those in employment
- Funded by Government via tax revenue and employer financial premiums
- No Access to the courts
- Financial cap but limited to economic damages only

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Summary of the Global compensation schemes

Key components	United States† (since 1990)	France (since 2002)	Nordic countries†† (since 1975)	New Zealand (since 2005)
Eligibility criteria for compensation	No-fault: Proof that the neurological birth injury occurred as a result of the birth process	No-fault standard: Serious and unpredictable injuries, without relation to their previous state of health and foreseeable evolution Fault standard: Failure to act in accordance with current scientific data or 'gross or intentional conduct'	Avoidability standard: Injuries could have been avoided if the care provided had been of optimal quality Unavoidable injuries (Denmark): Rare and severe consequences of treatment that exceeds what a patient should 'reasonably be expected to endure'	Unexpected treatment injury – for those in employment
Continued access to courts	No	Yes	No – they only become available if appealing a decision	No
How schemes are funded	Annual financial contribution made by participating doctors and hospitals	No-fault: ONIAM (A tax- based, government-funded administrative body) Fault: Providers/insurers	Patient insurance schemes funded by a range of public and private health care providers	Government via tax revenue and employer financial premiums
Financial cap	Yes	No	Yes	Yes
Financial entitlements	**Economic and non-economic damages**	**Economic and non-economic damages**	**Economic and non-economic damages**	**Economic damages**

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Dickinsons et al 2016 findings

Liability was still a variable in all schemes, with the concept of ‘blame’ shaping those schemes:

- In **France**, the compensation scheme was an expression of solidarity with individuals who had suffered major injury (Barbot et al. 2014) but retained the notion of blame and the litigation process for those patients who could establish liability

- In **New Zealand**, the scheme operated like a targeted social security benefit programme with its broad eligibility criterion of ‘treatment injury’ (Kachalia et al. 2008)

- In the **United States**, tort reform seemed to be the reluctant consequence of a breakdown in the compensation system when doctors could no longer afford the insurance premiums and were leaving the profession (Kessler n.d.)

Dickinsons et al 2016

There is evidence to suggest that the schemes were a product of their jurisdictions. For example:

- In **New Zealand** and **Scandinavia**, the creation of a state-run compensation scheme fitted with their conception of health care as an important provision by central government
- In the **United States**, there was understandable reluctance to deny claimants the possibility of attaining damages through the court process, since there was less of a social security safety net to support individuals with ongoing ill health and disability

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Conclusions of the review: re Access to Justice

Context	Mechanisms	Clinical practice outcomes
USA: Early-disclosure and resolution schemes France: Fault/no-fault schemes Nordic countries: Avoidable standard / unavoidable injuries Australia: Fault / no-fault schemes New Zealand: No blame compensation schemes International: Tort reform / litigation	To make compensation schemes attractive to claimants, they must offer payment and broader eligibility criteria, to ensure schemes remain more appealing than the tort-based system	Access to courts
	NFCSs that are free to access improve justice outcomes in that they are accessible to all eligible parties, unlike the tort system, which may favour those who can afford legal representation (in certain jurisdictions)	Equality of access
	Transparency of process achieves justice through the representation of the claimant, and mechanisms that improve the consistency of decision making through the use of medical experts and the consideration of precedents	Transparency of process
	Creating a ‘Chinese wall’ between compensation procedures and disciplinary procedures enables improved access to justice and a more efficient compensation scheme, since physicians are more ready to hand over the relevant information	Compensation decoupled from disciplinary procedures

Conclusions of clinical practice outcomes

Context	Mechanisms	Clinical practice outcomes
USA: Tort reform / litigation only International: No-fault schemes / litigation	Tort reform and NFCSs reduce unnecessary tests and procedures and improve access to health care for patients considered 'riskier' by clinicians, because doctors are less likely to practise positive and/or negative defensive medicine to protect themselves from litigation	Clinical practice Defensive medicine

Findings in relation to patient safety outcomes from the review

<table>
<tr><th>Context</th><th>Mechanisms</th><th>Clinical practice outcomes</th></tr>
<tr><td rowspan="2">USA:
Early-disclosure and resolution schemes

Nordic countries:
Avoidable standard / unavoidable injuries

New Zealand:
No-blame compensation schemes

USA:
Tort reform / litigation only</td><td>NFCSs improve patient safety by enabling physicians to disclose iatrogenic injury through the removal of personal liability, applying the avoidability criterion and decoupling compensation from disciplinary procedures</td><td>Patient safety
Admitting to error</td></tr>
<tr><td>NFCSs improve patient safety by enabling the pooling and sharing of information about medical errors and by reframing the compensation process as a patient safety strategy rather than a risk management strategy</td><td>Patient safety
Learning from error</td></tr>
</table>

The message that we need to understand

The complexity of the interactions between compensation processes, individual circumstances and the health systems in which the schemes are embedded, make it difficult to establish strong possible causal pathways, most notably regarding health outcomes.

The shape of the schemes will be highly influenced by the health system context, which, in turn, is affected by the prevailing political opinion about the role of the state in health care.

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The New Zealand Environment

- Health practitioners cannot be sued in New Zealand (except in rare circumstances)
- The Accident Compensation Corporation compensates patients for a ‘treatment injury’
- The Lacuna created is filled by a user-friendly complaints and review process, some examples:
  - Health and Disability Commissioner
  - Medical Council of New Zealand
  - Dental Council of New Zealand
  - Privacy Commission
  - Coroner’s inquests

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How has regulation developed in New Zealand

- In New Zealand various regulatory and disciplinary medical bodies, are afforded broad discretion in investigating, prosecuting and disciplining medical professionals and their employers accused of negligence
- The outcome of these investigations can be very serious and can, include cancellation of practitioner's registration and removal from the register
- The investigating authority can also formally require the practitioner and/or their employer to carry out quality improvement activities
- In addition to ethical reasons inherent to the field of medicine, avoiding complaints and possible serious consequences is the major incentive for doctors and hospitals to constantly work on improving quality of services they provide

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The NZ Statutory Authorities

- The Medical and Dental Councils are responsible for medical and dental registration
- There are also several other health practitioner authorities such as the Psychologists Board, Physiotherapist Board and Nursing Council
- All authorities are responsible for:
  - ensuring health professionals are competent, fit to practice... to protect health and safety of the public
  - investigating complaints sent directly from patients, relatives and colleagues, or referred complaints by the HDC
  - following a process that is supportive and not always disciplinary – eg health committee

NZ Privacy Commissioner

- Investigates complaints alleging breach of the Health Information Privacy Code
- Emphasis is on a conciliated outcome
- Complaints can be referred to the HRRT and patients can complain directly to the HRRT if they want to
- HRRT can fine up to $200,000

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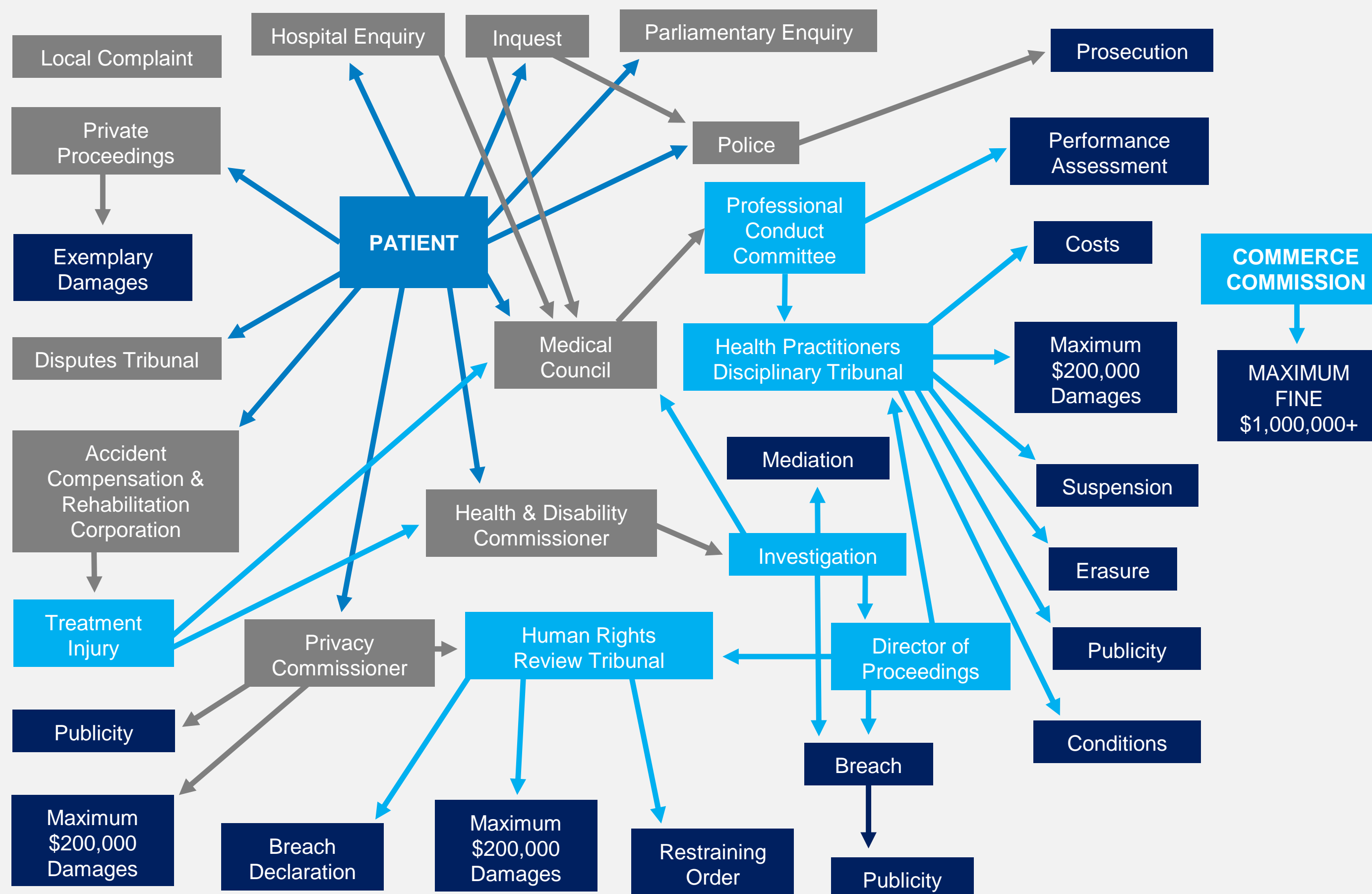
Legal - New Zealand Consequences



How should no fault compensation schemes be structured

In principle, MPS tentatively supports the notion that eligibility for NFC should be structured around the test of ‘avoidability’.

However, what constitutes ‘avoidable harm’ would require a clear and robust definition under any proposed scheme.

It would need to be decided as to whether the definition would exclude known complications. If it did, the separate question would then arise as to what would happen if the procedure had been poorly carried out – which in turn led to the complication.

The gap between an inherent risk of surgery, and negligent treatment, can be hugely significant. Such a gap can be the source of protracted legal dispute under a tort based system. It is difficult to see how an all-encompassing definition of ‘avoidable harm’ could bridge the two.

So does no fault compensation exist?

In their varying designs and forms, all NFC schemes require some level of causation to be proved, in order for a patient to qualify for access to the scheme.

When there is a question of causation, there is legal challenge and argument. NFC does not eliminate legal disputes; typically, it merely re-defines them or moves the goal posts.

In New Zealand we regularly see legal challenges against the decisions of the ACC. Our members regularly receive requests for comment from their patients' lawyers, regarding ACC decisions to not accept claims. The causation element of the legal test is where the technical arguments emerge. It is also where expert costs escalate as proof of causation is sought. It is extremely difficult for NFC schemes to avoid this.

Should NFC be integrated with other processes

A recurring theme in the NFC debate, is about whether financial redress should be amalgamated with investigation and complaint processes – both at the local and regulatory level.

Each process that ensues following an adverse event; be it a complaint, referral to the regulator, hospital review, claim for compensation and for so forth – all have different objectives.

It is quite foreseeable that the integration of all these processes, could give rise to incorrect expectations on the part of the patient that any adverse event will lead to financial redress.

Additional reading and source material

https://bjgp.org/content/67/654/38

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/595817/RRR_Dickson_et_al_2016_No_Fault_Compensation_Schemes_a.pdf

https://actuaries.asn.au/Library/Events/GIS/2008/GIS08_3d_Paper_Tess,Armstrong_Fault%20versus%20No%20Fault%20-%20reviewing%20the%20international%20evidence.pdf

Further support and information is offered on our website, in addition to our publications, booklets, factsheets and case studies.

medicalprotection.org

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