**Chapter IV**

**The No-Fault System**

**Chapter 4 Part I: Comparing No-Faults System Internationally**

**Introduction to the No-Fault System**

Errors in medical diagnosis and treatment that cause damage or injury to patients and that occur in either hospitals or in community medical facilities are one of the greatest challenges health systems throughout the world now face.[[1]](#footnote-1) For the tort system, the most common system of compensation for injury in the world, there are multiple problems in granting compensation to all individuals who are injured as a result of medical complications. This is partly because the tort system rests on the principle of proving fault, while a “no-fault system” is based on the idea that proof of fault is not required.

Currently, the system for compensating those injured by medical errors in Israel is based primarily on tort law. However, the courts are increasingly unable to effectively cope with the challenges posed by the medical system arising from accidents and medical negligence. Both the number and scope of claims is rapidly growing, and the legal system is forced to deal on a daily basis with legal cases that require special medical expertise. The courts are neither the ideal arena to deal with complex medical cases nor the place to learn and gather new understanding and insights. Not only does the judicial process fail to contribute to creating mutual trust between patients, medical personnel, and healthcare institutions, but many of the approaches and results are, in their very essence, largely irrational. They often lead to a sense of unease and thus cause a further deterioration of the situation of compensation for medical injuries. Indeed, the situation today is characterised by multiple flaws and deficiencies, including:

* Ineffectiveness;
* Conflicts of interest;
* Lack of competition;
* A lack of understanding on the parts of the judges with respect to the professional material;
* A system that encourages ‘defensive medicine’;
* Dissatisfaction and grievances harboured by both physicians and patients during the legal process;
* Substantial and costs that are imposed on both the medical system and the patients, which could be avoided;
* A lack of transparency;
* Inconsistency in the rulings of different cases.

Ultimately, this often can lead to the following situations:

* The money does not reach the claimants;
* The legal process is long and drawn-out (often lasting several years), the costs of which are in the initial stages imposed on the claimant of the lawsuit;
* The parties shirk responsibility and cast blame on one another, when in fact there are several actors involved in the treatment;
* There is no doubt that the claimant is the most harmed party.

In light of all the disadvantages of the existing tort-based system and the growing calls to create a system that places the patient as the focus of the proceedings, it is nearly universally recognized that reforms to the legal system are needed; namely, the introduction of the “no-fault” method. Arguably, implementing such a system will lead to a significant change in the treatment of the victims of medical negligence and will constitute a fundamental legal, economic, and social reform.

A no-fault compensation scheme should rank at the very top of a list of long-term solutions to the crisis in medical malpractice. The form of a no-fault system most likely to be adopted would be one providing automatic compensation, not for all iatrogenic injuries, but for a limited set of ‘designated compensable events’. Such a compensation system would be closely integrated with the day-to-day activities of health care providers, individual practitioners, institutions, and health maintenance organizations (HMOs), and would link compensation closely to the outcomes of medical intervention. In addition to providing quick and equitable compensation for a wide range of medically caused injuries, a better designed system would supply strong incentives for modifying the providers’ behaviour to improve the quality of health care.[[2]](#footnote-2)

The advantage of a no-fault system is its simplicity in attaining the goal of compensating the injured party for the harm caused through certain rules and guidelines that each country determines. This provides a comprehensive solution to the state’s responsibility to its citizens that derives from social solidarity.

Various European legal systems have tried to put into place more effective schemes for compensating patients for injuries they have sustained.[[3]](#footnote-3) According to one of the concepts guiding these systems, not only should the undesirable effects of the medical procedures on the patient be funded by the state, but the related damages due to the medical procedures should also be imposed on the state. Another principle emphasises the need to introduce liability based on risk or equity principles. Contemporary no-fault compensation systems are based on the assumption, according to which, should the specific harming party be held responsible, there is no need to prove fault on their part. Considering this aspect, the systems described above, which still require proof of injury, its impact, and the causal relationship between the action of the harming party (doctor, medical facility) and the injuries that are the cause for the patient’s suffering, are commonly known as no-fault systems.

Another feature of the no-fault compensation system can be seen in the simplification of the procedures, the aim of which is to compensate the injured party and restore him or her to the state prior to the incident by transferring responsibility for the proceedings and/or opinions about the claim raised by the plaintiff to independent bodies. The model of the proceedings carried out differs, depending on the particular country’s policy.

The most prominent form of no-fault system is one providing automatic compensation, not for all injuries, but for a limited set of ‘designated compensable events’. Such a compensation system is closely integrated with the day-to-day activities of healthcare providers, individual practitioners, and health maintenance organizations (HMOs). This system makes a clear link between the amount of compensation and the outcomes of the medical intervention. In addition to providing quick and equitable compensation for a wide range of injuries, a properly designed system includes strong incentives for modifying the conduct of healthcare providers, and can therefore dramatically improve the quality of healthcare.[[4]](#footnote-4)

In this chapter, I will present the no-fault system in three sections. The first will focus on a comparison between some of the prominent no-fault systems that currently exist in the world. The second will present the core social, legal, and moral arguments for the implementation of a no-fault compensation system in the State of Israel and why it will be adaptable to the Israeli method, which currently works according to a fault-based compensation system. The third and final sub-chapter will explore the implementation of the no-fault system in Israel.

**Chapter 4 Part I: A Comparison of No-Fault Systems**

**Review of No-Fault Systems**

The “no-fault” system of compensation for medical injury is a legal approach that has been adapted in several countries throughout the world in order to regulate compensation for patients due to injuries inflicted in the course of medical treatment. However, there are often substantial differences between the mechanisms implemented in each country that has adopted the system. While common legal systems applying the tort law approach, whereby compensation is granted to the patient that has proven that the medical provider bears responsibility for the harm caused to him or her, the no-fault system is different. The common denominator and shared principle of all no-fault systems, and that distinguishes them from common tort law methods, is that the provision of compensation is contingent not on proving the responsibility or negligence of the medical provider, but rather on showing a causal connection between the treatment received and the injury. The driving principle behind the no-fault system is the removal of the requirement of liability. The simplification of the legal procedure reinforces the sense of distributive justice and fairness vis-à-vis the patients for whom the outcome of the medical treatment was not as expected.[[5]](#footnote-5)

**Different No-Fault Systems**

While reviewing the no-fault systems instituted in New Zealand, Sweden and other Scandinavian countries, France, parts of the United States, and, briefly, in the United Kingdom, the major comparison herein is between the New Zealand, Swedish and U.S. models. The New Zealand model is of particular importance, as New Zealand was the first Western nation to make the dramatic shift away from a tort-based approach to medical and accident compensation to a no-fault accident compensation law in 1974. Long part of the common law tradition practiced in the United Kingdom and the United States, New Zealand was the first to act on a long-acknowledged need to reform the tort-based system. Indeed, already at the end of the 1960s, New Zealand established the Woodhouse Commission to find alternatives to the tort approach to accident compensation, recognizing all the problems mentioned above, and motivated to introduce a reasonable, fair and economical system. In contrast to the United States, which had a fundamental mistrust of government and was devoted to defending individual freedoms against institutional and government abuses, New Zealand had a much stronger tradition of trusting and working with government to ensure fairness and social welfare all its citizens.[[6]](#footnote-6) Following the Woodhouse report, New Zealand created a government-administered comprehensive no-fault compensation scheme to compensate those who had suffered accidental injuries, even from medical malpractice.[[7]](#footnote-7) In moving away from the tort system, which applies a complex, time-consuming, expensive and unpredictable process to try to determine the justice of an injured party’s claim against an alleged injurer, New Zealand’s new system provided a process of automatically providing financial assistance to an injured party, even if blame could not be determined, representing a dramatic departure from the traditional tort approach. As Melanie Nolan has written, the five principles underlying the New Zealand no-fault compensation scheme, as set for in the Woodhouse report, were based on the unique factors of ‘community, responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency’.[[8]](#footnote-8) New Zealand, then, presents a unique case of citizens and the government collaborating in full trust to provide fair and timely compensation to accident victims.

 The Scandinavian countries with no-fault systems also provide an interesting point of comparison, as the underlying political and legal traditions there differ significantly from those in New Zealand and the United States. The Scandinavian countries, with Sweden in the lead, have long provided comprehensive general welfare and public healthcare systems, which already covered a large percentage of the costs incurred by parties injured by medical malpractice, including sick leave and medical expenses.[[9]](#footnote-9) Unlike in the United States, the Swedish citizenry and political tradition did not seek to limit government powers; instead, the focus was on maximizing government intervention as rationally as possible to ensure equality and the general welfare of all its citizens. Sweden, a few years after New Zealand’s program was instituted, and recognizing the need to more quickly, thoroughly, and efficiently compensate victims of medical malpractice, instituted a hybrid system, whereby injured parties can either request a capped amount of compensation from the government, or try to receive higher compensation by going through the court system. While the tort-based court system remains in place to an extent, the demands placed on it are greatly reduced due to the presence of the government scheme. Again, Sweden presents an example of the people and the government working together to provide a fair and reasonable solution for injured parties.

 Finally, of the fifty jurisdictions in the United States, each with its own medical regulations, notwithstanding the enactment of 2010 Affordable Care Act, this study looks at two states, Florida and Virginia, which have taken very small steps to move away from the traditional tort-based judicial process for granting compensation to medical malpractice victims by instituting no-fault compensation schemes for injuries suffered by children during childbirth. While these represent very small exceptions to the general tort-based judicial process for medical malpractice compensation in the United States, they do indicate some movement in response to decades of criticism of a legal system and political culture ‘characterized by polarization, fragmentation, mistrust of government power, and a highly individualistic, us‐against‐them orientation toward both adjudication and policy‐making’.[[10]](#footnote-10) These examples provide some insight into future directions that can be taken in the United States to move towards a no-fault system for medical malpractice compensation.

**Features of the no-fault system, as applied in various countries**

**New Zealand** was the first country that established the no-fault system in the medical negligence field in 1974. After NZ, additional countries developed their own versions of the system. These included: **Sweden** (1975), **Finland** (1987), **Norway** (1988), **Denmark** (1992), and **France** (2002). In addition, in Virginia and Florida in the United States, there is 63a no-fault system for issues pertaining to childbirth.[[11]](#footnote-11) Beyond the advanced shared principle of severing the connection between compensation and liability, there are several common characteristics of the various “no fault” systems in the world:

* All systems have determined restrictions and specific criteria of eligibility and coverage for compensation;
* There is a limit to the scale of coverage that is provided, such as a cap for compensation granted in certain categories and even an absence of compensation for non-pecuniary harm such as pain and suffering;
* The amount of compensation tends to be less in comparison to similar cases that are debated in tort law in the traditional legal system;
* Higher efficiency – the cost of bring a claim is less and there is a ruling within a short period compared with tort law;
* In the majority of countries that have adopted this no-fault method, there is a generous social welfare system.

The way in which countries meet the cost of injuries varies according to country. These personal injury compensation systems form part of broader systems in developed countries, including the social welfare system. The development and operation of both the personal injury compensation and broader systems are typically the result of numerous factors, including culture, population changes, and other societal trends. Some general characteristics of compensation systems globally are outlined. The following comments can be made about Table 2 below:

* Coverage for an injured **employer** (including occupational disease) is provided on a no-fault basis in all countries, except in the United Kingdom;
* Injured individuals in road and transport accidents are generally covered by fault-based third-party liability schemes;
* Injuries occurring to patients as a result of medical diagnosis or treatment typically have coverage through tort liability. In many countries, this requires proof of the causal link between the negligence of the health practitioner and the injury incurred to the injured party, proof that the healthcare provider had a duty of care towards the injured party, and other various criteria;
* Other injuries, such as those caused during sport or recreational activities, in the home or in other public places, generally do not have any specific coverage. Coverage may be available via tort liability, or social welfare/public health, depending on the circumstances;
* Illness is almost universally covered by social welfare/public health and/or private insurance.

In **New Zealand,** the Accident Compensation Corporation (ACC) provides compulsory insurance coverage for personal injury for everyone in New Zealand, whether a citizen, resident or visitor. The ACC also operates a universal no-fault coverage of injury, which contrasts with the coverage provided in other countries. It is therefore a particularly useful starting point in comparing no-fault systems that are already in place.

**Selected countries for the purposes of comparison of the no-fault system**

**New Zealand** –New Zealandis the flagship country and pioneer in the field of no-fault. New Zealand very successfully employs the no-fault method through the implementation of the Accident Compensation Act in accordance with the recommendations of a special committee that explored the issue. The aims of its program are to strengthen the public interest and to reinforce the principles of social solidarity and reciprocity in the country by granting fair compensation to the injured parties in accidents, including injuries caused by medical treatment. In exchange for this, a patient who files a lawsuit through the scheme surrenders the right to the involvement of the court, with the exception of special cases. It is important to note that the public’s trust in and satisfaction with the programme are beyond even the highest expectations. Many countries throughout the world are learning about the no-fault method via New Zealand.

**Sweden** – Many Scandinavian countries have adopted the no-fault system, and the first to do so was Sweden. The country is a case study for her neighbours and the wider European Union (EU). The shared goals of the Scandinavian role are:

* To determine if the compensation lawsuits are covered by the scheme and to verify eligibility when necessary;
* To pay out compensation;
* To purchase health services and support for disabled individuals as well as rehabilitation for injured parties;
* To advise the government.

Unlike New Zealand, the Swedish no-fault scheme was established on a voluntary basis, and only in 1996 became mandatory when it was anchored in the law (Patient Injury Act). Following this reform, all healthcare providers in Sweden are obligated to provide an insurance programme that covers injury following medical treatment. The insuring bodies belong to a government authority (Patient Insurance Association), which is responsible for managing the programme and is financed by a regional government budget. Each region is owner and manager of the insurance companies for injuries inflicted due to medical treatment. The region determines the policy terms and fixes the costs and the community clinics and hospitals.

Instead of proof of negligence or liability, the no-fault system in Sweden is based on the principle of “avoidability” – the programme compensates patients whose injury it was possible to prevent under the optimal circumstances, i.e., under the care and treatment of the “best possible” physician as it were or the “perfect” healthcare system. It is worth noting that, in this way, the Swedish model advances a very high standard of quality. This criteria was subsequently adopted by other Scandinavian countries. The Swedish system also covers non-pecuniary damages, such as suffering, pain, and discomfort. The amount of compensation is determined in accordance with the type of injury, its severity, and its duration.[[12]](#footnote-12)

**United States** – In the United States. the discussion on reforms to compensation as a result of medical treatment has been ongoing since the 1960s. The debate is only intensifying due to the crisis wherein the insurance market has made physicians professionally responsible. Various proposals have been raised and discussed both at the federal level and at the state level, such as a cap on claims, adopting the no-fault system, and establish a body to examine health cases. At the current time, only the states of Virginia and Florida have adopted the no-fault system for neurological coverage.

**תרשים :** היבטים עיקריים של מנגנוני ”אין אשם” בעולם - טבלה מסכמת

Dickson et al. 2016[[13]](#footnote-13)

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| **Key****components** | **United States†****(since** **1990)** | **France (since****2002)** | **Scandinavian****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 intentionalConduct’ | **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 beexpected to endure’ | Unexpected treatment injury – for those of employable age |
| Continued access toCourts | No | Yes | Yes | 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-economicDamages | Economic and non- economic damages | Economic and non- economic damages | Economic damages |

\* Schemes operating in Australia are omitted as they report non-medical compensation schemes

†Drawing on two no-fault birth injury schemes available in Florida and Virginia

†† Scandinavian countries include Sweden, Denmark, Norway, Finland and Iceland, with specific details of schemes varying across countries

**New Zealand**

Introduction

In 1974, New Zealand jettisoned a tort-based system for compensating medical injuries in favour of a government-funded compensation system. Although the system retained some residual fault elements, it essentially barred medical malpractice litigation. Reforms in 2005 expanded eligibility for compensation to all ‘treatment injuries’, creating a true no-fault compensation system. Compared with a medical malpractice system, the New Zealand system offers more timely compensation to a greater number of injured patients and more effective processes for complaint resolution and provider accountability. The unfinished business lies in realizing its full potential for improving patient safety.[[14]](#footnote-14)

New Zealand’s compensation system arose not in response to concerns about medical malpractice but through farsighted workers’ compensation reforms. A Royal Commission, established in 1967, concluded that accident victims needed a secure source of financial support when deprived of their capacity to work. Sceptical of the ability of a liability-based system to provide such support, the commission recommended no-fault compensation for personal injury.[[15]](#footnote-15) At around the same time, the United States, Australia, and the United Kingdom also debated the merits of no-fault compensation, but the idea of a comprehensive approach to injury by accident failed to gain traction.[[16]](#footnote-16) In the New Zealand system, injured patients receive government-funded compensation through the ACC. In exchange, they give up the right to sue for damages arising out of any personal injury covered by the accident compensation legislation. This prohibition applies even when a person chooses not to lodge a claim or is not entitled to compensation. [[17]](#footnote-17)It remains possible to bring actions for exemplary damages, but the courts have found that not even gross negligence warrants such damages unless there is some element of conscious or reckless conduct.[[18]](#footnote-18)

No-fault schemes operating in Australia are omitted as they report non-medical compensation schemes. † Scandinavian countries include Sweden, Denmark, Norway, Finland and Iceland. NFCSs specifically for neurological birth injury are in place in two U.S. states: Florida and Virginia††; other countries operate NFCSs for a range of medical treatments. The U.S.-based birth injury schemes 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. France has implemented two systems: a no-fault standard for serious and unforeseen medical injuries; and a fault standard for the remainder of injuries. This is the only country where access to the courts remains fully available. The Scandinavian countries operate according to 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. In these countries, it is referred to as the ‘experienced specialist’ rule. Access to the courts is available for claimants who wish to appeal against a decision, but is not available at the initial point of making a claim. New Zealand has put in place the broadest eligibility criteria, with a no-fault standard applicable to any unexpected treatment injury. The only scheme to operate without a financial cap is in France and all but the New Zealand schemes aim to cover both economic and non-economic costs. As stated, this review aims to develop preliminary theoretical frameworks of the mechanisms influencing engagement in NFCSs. Using a realistic approach, we sought to understand the connections through which different components of such schemes, operating under certain social and political systems, are thought to influence patient and clinician outcomes. This section presents a summary of our context, mechanism and outcomes (CMO) configurations based on our analysis of the material in the field. The CMOs are organised according to four main outcome categories identified in the literature and prioritised as of interest to policy leaders consulted during this review: 1) access to justice; 2) clinical practice; 3) patient safety; and 4) patient health.

**Legal and social goals**

The legal and social goals of the no-fault compensation scheme in New Zealand are to enhance the public good and reinforce the social contract underpinning New Zealand’s society by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimizing both the overall incidence of injury in the community and the impact of injury on the community. The key goals of the scheme are injury prevention, complete and timely rehabilitation, fair compensation, and a Code of ACC claimants’ rights. As part of realizing these goals, the scheme operates on the basis that individuals forgo the right to sue for personal injury in the courts, with the exception that the right to sue for exemplary/punitive damages remains. 2.5 Public trust and client satisfaction in the scheme is high. Public trust and confidence in the scheme currently stand at 65% and client satisfaction at 74%.

(ACC Annual Report 2020[[19]](#footnote-19)

**Funding**

The scheme covers personal injury generally, and is not limited to injuries arising out of medical treatment. Funding therefore comes from a variety of sources, and the ACC retains a number of different accounts for managing compensation paid in respect of various types of injuries. The accounts are as follows:

* Workers’ account: premiums are paid by all employers; this is to cover work-related personal injuries;
* Earners’ account: non-work injuries suffered by individuals in paid employment, excluding motor vehicle accidents;
* Self-employed workers’ account: work-related injuries to self-employed people and private domestic workers.
* Non-earners’ account: injuries to people who are not in paid employment, including students, beneficiaries, retired people and children;
* Motor vehicle account: injuries involving motor vehicle accidents on public roads;
* Treatment injury account: covers injuries resulting from medical treatment.

The funds in this account are drawn from the Earner and the Non-Earners’ Accounts.

* Residual claims account: This Account covers claims for work injuries that happened before 1 July 1999, and non-work injuries prior to 1 July 1992 that are still being managed.

**Eligibility[[20]](#footnote-20)**

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| --- | --- |
| **As a result of the reforms which came into effect on 1 July 2005, person has coverage under the scheme for a personal injury as follows:** | **Treatment injury is defined under s. 32 IPRCA 2001 as a personal injury that is suffered by a person:** |
| Treatment injury suffered by the person | seeking treatment from one or more registered health professionals; or  |
| Treatment injury in the circumstances described in section 32(7)  | receiving treatment from, or at the direction of one or more registered health professionals; and is caused by treatment; and  |
| Suffered as a consequence of treatment given to the person for another personal injury for which the person has cover |  is caused by treatment; and  |
| Caused by a gradual process, disease or infection that is treatment injury suffered by the person | is not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including the person's underlying health condition at the time of the treatment; and the clinical knowledge at the time of the treatment |
|  A cardio-vascular or cerebro-vascular episode that is treatment injury suffered by the person (see s. 20(2) IPRCA 2001).Treatment injury is defined under s. 32 IPRCA 2001 as a personal injury that is suffered by a person: | is not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including the person's underlying health condition at the time of the treatment; and the clinical knowledge at the time of the treatment. |

Treatment injury is intended to cover injuries suffered in the treatment process. All adverse medical events, preventable and unpreventable, are potentially included. There is no requirement that the injury must be suffered when the treatment is given or during the treatment process.[[21]](#footnote-21) It also includes a personal injury suffered by a person as a result of treatment given as part of a clinical trial in certain circumstances, including where the claimant did not agree in writing to participate in the trial. If a person suffers an infection that is a treatment injury, then coverage extends to third parties who catch the infection from the patient or from the patient’s spouse/partner.

Treatment includes: the giving of treatment; diagnosis of a medical condition; a decision to treat or not to treat; a failure to treat or treat in a timely manner; obtaining or failing to obtain informed consent to treatment and the provision of prophylaxis; application of any support systems including policies, processes, practices and administrative systems which are used by the treatment provider and directly support the treatment. It also includes failure of equipment, devices or tools which are used as part of the treatment process, whether at the time of treatment or subsequently. Failure of implants and prostheses are included (e.g., design of products), except where it is caused by general wear and tear. This was designed to close potential loophole for civil claims against manufacturers of implants/prostheses in relation to defective products, due to negligent design. Under section 2.18, if a person is accepted by the ACC for coverage for a personal injury under the general accident provisions of the IPRCA 2001, and subsequently suffers an injury caused by treatment for the first injury, then the additional injury is automatically covered under the personal injury provisions (s.20(2)). It also applies when there are two consecutive personal injuries suffered by a person. The first is covered under the personal injury provisions (s. 20(2)), and the second is either a separate injury or an exacerbation of the pre-existing covered injury resulting from treatment for that personal injury. Therefore, once covered under s. 20(2), a person remains so for any further injury caused by treatment. If there is no coverage under s. 20(2), then a person would need to satisfy the eligibility criteria under the treatment injury provisions.[[22]](#footnote-22)

**Exclusions**

There are a number of treatment injury exclusions:

 • A treatment injury does not include a personal injury that is wholly or substantially caused by a person’s underlying health condition. The fact that the treatment did not achieve a desired result does not, in and of itself, constitute a treatment injury. It is only in circumstances where the condition progresses, or a fresh injury is caused because of the treatment given (or non-treatment) that there will be coverage under the scheme. Therefore, there must be a direct causal link between treatment and personal injury. Where the injury is caused partly by the person’s underlying condition or disease, and partly by treatment, there is a need to determine which of the two is the substantial causational element was for the claimant to establish causation on the balance of probabilities.[[23]](#footnote-23)

 A treatment injury does not include a personal injury resulting from a person unreasonably withholding or delaying their consent to undergo treatment. It is acknowledged under New Zealand law that a competent patient has an absolute right to refuse to consent to medical treatment, no matter how unreasonable this may seem. The underlying policy reason behind this exclusion appears to be that while there is respect for this pre-existing legal right, the financial or other consequences of any resulting treatment injury will be borne by the patient, rather than by the scheme.[[24]](#footnote-24)

**Mental injury unaccompanied by physical injury**

The ACC does not provide coverage for mental injuries per se. In order for coverage to be provided by the ACC, then one of the following conditions need to be met: (1) the mental injury needs to be caused or a material cause of physical injuries; or (2) it was caused by certain criminal acts provided that the claimant was ordinarily resident in New Zealand at the time and treatment is being sought in New Zealand; or (3) it is an offence listed in Schedule 3, IPRCA 2001 (this covers mostly sexual offences). In addition, the claimant would also need to show that the mental injury arising from the physical injury resulted in clinically significant behavioural, cognitive or psychological dysfunction due to the physical injury.

Where mental injury is not linked to physical injury, there is no personal injury within the meaning of the IPRCA 2001, and therefore the person has no coverage under the scheme. The person is therefore free to pursue legal action in the courts for compensatory damages usually grounded in a claim of negligence for psychiatric injury.

**Physical injuries suffered before birth**

A foetus which dies in utero is not covered under the IPRCA 2001. The term ‘person’ is used in the governing legislation and it does not include a foetus, unless and until it is born alive. However, the mother is considered to have suffered a physical injury and may be entitled to coverage under the scheme if the death of an unborn child occurred in utero. This is notwithstanding the fact that she may have suffered no other injuries to herself other than the loss of the unborn child.[[25]](#footnote-25) (Manning 2006: 763).

**Health system**

New Zealand’s health care system is primarily a centrally-funded, tax-based system. The legislative framework for the system is established under the New Zealand Public Health and Disability Act 2000. Publicly-funded healthcare is funded through public taxation and levies collected by the Accident Compensation Corporation (ACC), the Crown entity responsible for the management of the no-fault compensation scheme for personal injuries. Hospital care, community mental health care, and public health services have traditionally been provided to ‘eligible persons’ (including New Zealand citizens and persons ordinarily resident in New Zealand) free of charge. Government subsidies partially fund primary health care and pharmaceuticals, with co-payments made by patients unless they are eligible for a full subsidy. Resources constraints are recognised in the governing legislation. Most public funding of the health care system is devolved through Crown funding agreements, which are made by the Minister of Health or the Ministry of Health as an agent, whereby there is agreement to provide or fund health services within specified districts. Public health and disability services are funded directly through the Ministry of Health.[[26]](#footnote-26)

**Swedish no-fault insurance model**

Sweden’s medical malpractice **injury** liability model is not based on modification (expansion) of the rules of liability in question. Instead, it is based on obligatory insurance the medical facilities must provide for the patients (No Fault Patient Insurance – NFPI or first party insurance).[[27]](#footnote-27) This insurance was created in the 1970s, on the basis of an agreement made within the National Association of the County Councils, which is responsible for the organization and provision of medical service within the Swedish territory, involving a consortium of the four largest insurance companies. At first, the insurance was obligatory solely in case of so-called public healthcare. Doctors who ran their practices privately, as well as non-public therapeutic agents, could be involved in the program at their own discretion, which led to differing patient situations, depending on the party carrying carried out the therapeutic activities. Since from 1 January 1997, the insurance has also covered the injuries caused to the patients due to provision of health care at private and public hospitals, which are administered by the county councils. This means, according to the new legal regulations, that insurance for the patients has become an obligatory insurance for all those offering health services within Swedish territory. In addition, a patient who is not party to the insurance agreement has a right to submit a direct claim to the insurance company with which the insuring party signed an agreement. The injured person, in order to receive the benefits from the NFPI insurance company, does not need to prove fault of the patient or the medical facility. If the injury has been incurred as a result of wilful misconduct or gross negligence of those subjects, the insurer that has paid the benefit to the patient may submit a recourse claim for the direct originator of the damage. The NFPI insurance scheme includes, according to its regulations, injuries that occurred during patients’ therapy and hospitalization and resulted from individuals performing a medical profession (doctors, nurses, midwives, physical therapists, laboratory diagnosticians). The issue of therapy is quite widely understood, and includes not only procedures which are strictly medical, but also prevention diagnostics, palliative and hospice care, medical experiments, as well as the use of drugs and pharmaceutical materials and ambulance services. The responsibility of the insuring party within the scope of NFPI, while much wider than in cases of classic civil liability insurances, is not absolute.[[28]](#footnote-28) In order render an insurer liable for paying the benefits, the injury, health problems, or death of the patient must take place according to the conditions defined by the Act. The damages will be granted then for:

• injuries throughout the therapeutic process, which could have been avoided, had the doctor have used other method of therapy or conducted it in other way;

• injuries resulting from using defective or ineffective equipment or medical products;

• injuries related to incorrect diagnosis;

 • injuries resulting from hospital infections;

 • injuries resulting from hospital infections, or from wrongfully administered or prescribed medication;

 • injuries, which caused by so-called hospital accidents.

Of the above categories, hospital accidents seem to be the most interesting one. This category includes cases when the person was injured as a result of sudden and unforeseen circumstances, which are beyond the scope of the undertaken medical actions and are unrelated to the patient’s health status and/or individual health characteristics. Such cases usually include falling out of the bed or down the stairs, when the patient is being transported between two different health facilities. In case of the Swedish model, injuries caused by the defective medical products, equipment and medical devices have been included in a separate category. Bodily injury as well as the patient’s health deterioration may be caused by defective medical or hospital equipment, or by improper use of that equipment during a medical examination, provision of care or conducting therapy. The Swedish system also provides for exceptions – circumstances which are excluded from the scope of insurance protection. This means that NEFPI does not include injuries resulting from the breach of the patient’s rights, including, particularly, the events in which the patient did not receive the information related to his or her health status and within the scope of provided benefits, lack of the patient’s consent for potential therapy, or breach of the medical privilege. Additionally, a specific case of a psychological health disorder resulting from therapy or hospital treatment has been excluded here, even when it has emerged that the assumed treatment method was ineffective, such as chemotherapy in case of neoplastic processes. The situation when given actions needed to be taken immediately, or the patient’s life could have been endangered, or the patient may have been seriously injured, present yet another situation, which can be qualified as actions, the aim of which was to save the patient’s life. Receiving compensation for such injuries can be realized through civil prosecution. At the moment when the injury occurs, the patient has an option of selecting the compensation system to be used in claiming damages. The patient may use the judicial process, showing prerequisites of civil liability of the originator of the injury, or use the NFPI system. Only the patient can make a claim for direct damages under the NFPI system. Should the patient be dead, the family members, who have been injured, may claim indirect damages. These persons may require reimbursement of the incurred costs related to therapy and burial, within the scope corresponding to local conventions, along with a single-time damages payment. The NFPI system imposes a limit on the damages: for each of the events, the value is as much as 1000 times the so-called base value, and 200 times in case of the individual patients. The base value is currently, as much as 4000 EUR. If the injury is caused by a subject, who, contrary to its obligation to do so, has not concluded an insurance agreement for the patients, the benefit is paid from a special fund created for that purpose, which has a recourse claim against the injuring party directly responsible for the injury. The Fund is established on the basis of the assets transferred by the Association of Patient’s Insurance Companies, created by all of the insurance companies which offer this type of insurance policy. The Swedish NFPI model has become a model for similar compensation systems used in the Scandinavian countries: Denmark (1992), Norway (1988) and Finland (1987).

**Funding**

 Under the provisions of the PIA 1996, health care providers are required to obtain insurance that covers claims being made for medical injuries. Insurers that provide such insurance belong to the Patient Insurance Association.40 3.13 There are 21 regions in Sweden, each with their own directly-elected parliaments, and each region is responsible for the provision of healthcare within their boundaries. Health care is financed by regional income tax, which represents 10% of the income of those resident within regions. A small proportion of health care (1–2%) is financed by private means or through private health insurance. Doctors are employed by regional hospitals. GPs are either employed by regions or operate as independent contractors paid by regions[[29]](#footnote-29)

 The regions mutually own and operate a medical injury insurance company (LOF). The insurance policy for medical injury is held by regions rather than by doctors or hospitals. The LOF covers medical injuries in regional hospitals and primary care centres, as well as for all private care (through contracts signed by private health providers). The premiums paid to LOF by the regions are drawn from regional income tax. They are not risk-based and are, instead, based on the number of inhabitants per region. It is estimated that LOF covers 90% of health care provision in Sweden. The remaining 10% is covered by private insurance companies which provide coverage for doctors and dentists operating in private practice, chiropractors, physiotherapists and nursing homes.

**Eligibility**

 Avoidability rule: the scheme does not require proof of fault or malpractice in order to compensate a claim against a health practitioner. The avoidability rule is used instead of negligence to determine which injuries are eligible for compensation. This alternative standard is situated between negligence and strict liability. The scheme compensates patients who have experienced injuries that could have been avoided under optimal circumstances, in that the injury would not have occurred in the hands of the best health practitioner or health system, known as the ‘experienced specialist’ rule. This higher standard, setting the benchmark at excellent care as opposed to acceptable care, is used in other Nordic countries, although Sweden pioneered the approach.[[30]](#footnote-30)

The experienced specialist rule: There are a number of aspects to applying this rule. Consideration is given to the risks and benefits of treatment options other than the one adopted, and a retrospective approach is taken in some cases in evaluating whether the injury was avoidable. In such circumstances, it is necessary to consider whether previously unknown clinical information was potentially discoverable at the time of the treatment and, therefore, whether the injury could have been avoided. 3.17 Categories of medical injury covered: eligibility is determined by reference to a number of categories of medical injury under the scheme set out below. Specific requirements on eligibility must be met in relation to injuries other than treatment or diagnostic injuries. Treatment and diagnostic injuries account for approximately 85% of all claims.[[31]](#footnote-31)

• Treatment injury – ‘avoidable’ injury; experienced specialist rule; will consider alternative and retrospective aspects of treatment provided;

 • Diagnostic injury – ‘avoidable’ injury; experienced specialist rule (no retrospective element);

 • Material-related injury – ‘unavoidable’ injury but there are special circumstances; injury due to a defect in, or improper use of, medical products or hospital equipment;

• Infection injury – ‘unavoidable’ injury but there are special circumstances; infectious agent transmitted from an external source during the delivery of care, and the infection’s severity and rarity outweigh the seriousness of the patient’s underlying disease and the need for the treatment that caused the infection;

• Accident-related injury – ‘unavoidable’ injury but with special circumstances; injury from accident or fire that occurs on health care provider’s premises where patient is receiving treatment.

 It is important to note that in the case of what could be termed drug-related injuries, only those that occur due to the incorrect prescription or administration of incorrect medication are covered under the scheme. Compensation for other drug-related injuries is covered under a separate scheme.

It is estimated that just under 50% of claims are rejected on a per annum basis under the scheme on the grounds that they do not satisfy eligibility based on avoidability.

**Processing claims**

 A claim must be filed within three years from the time that the patient becomes aware of the injury and within 10 years from the time the injury occurred.

The PFF employs claims processors to manage the claims, who typically have clinical or legal backgrounds.[[32]](#footnote-32)

**Entitlements**

 Entitlements to compensation under the scheme are determined by reference to the personal injury compensation rules set out in the Tort Liability Act 1972. The overall guiding principle behind this legislation is that an injured person is entitled to be compensated fully for their loss. Compensation payments consist of two general components – pecuniary and non-pecuniary damages. Pecuniary damages cover loss of income and medical expenses incurred due to the injury but not covered by other insurance. Non-pecuniary damages compensate for pain and suffering, disability and disfigurement, and inconvenience. Levels are set according to schedules based on injury type, severity, and duration.[[33]](#footnote-33)

When a patient has died, the family may be entitled to funeral costs, loss of financial support, and psychological support.

A claimant may also be eligible for a lump sum payment due to permanent impairment. Once it is determined that any disability a claimant has suffered is now permanent, a medical assessment takes place confirming the degree of disability. The disability compensation is then paid as a lump sum in accordance with tables produced and distributed by the Association of Traffic Insurance Companies setting out the percentage of disability for each type of injury and the amount to be paid as a result.[[34]](#footnote-34)

 Compensation for the loss of ability to work is paid in accordance with the individual patient’s employment situation. Compensation for loss of income and future loss of pension entitlements due to the medical injury are paid as annuities.

**Tort-based claims for medical injury**

Under the Patient Torts Act 1996, a claimant is entitled to bring tort-based claims arising out of medical injury in the courts. Health care providers are required to carry liability insurance to cover such claims. The claimant must show with reasonable certainty that the health care provider’s conduct caused the alleged injury.

 Where a claimant has sustained an injury due to the alleged negligent failure to provide information or obtain consent in relation to the provision of medical treatment, then a claim must be brought under tort law principles in the courts.[[35]](#footnote-36) Review and appeal mechanisms 3.28 If a claimant is unsatisfied with the decision made by the PFF regarding their eligibility and/or entitlements under the scheme, they may apply to the Patient Claims Panel. The Panel consists of a chairperson who is or has served as a judge, as well as six other members who are appointed for three-year terms. The members bring differing medico-legal and other areas of relevant expertise to the work of the Panel, which is tasked with promoting fair and consistent application of the PIA 1996 and issues opinions at the request of claimants, health care providers, insurers or the courts. The Panel is an advisory body and therefore, its opinions operate as recommendations only; nonetheless, there is a high level of compliance. It is estimated that in 10% of claims brought before the Panel, the ensuring recommendation was that coverage be granted by the PFF.

Bringing a claim before the Panel is free of charge for the claimant, who benefits from being able to have the matter heard by experts in the field before deciding whether to bring their claim before the Panel or to proceed directly to court with a tort-based claim.[[36]](#footnote-37)

**Complaints process and professional accountability**

Independent Patients’ Advisory Committees operate in every region in Sweden. The Committee assists patients who experience difficulties in their 43 relationship with health practitioners. The Committee does not have any decision-making powers, but seeks to take a practical approach to resolving complaints.

 The Medical Responsibility Board (HSAN) deals with complaints where patients allege incompetence on the part of health practitioners. HSAN has the power to issue ‘soft’ warnings (reprimands) to health practitioners, as well as bring disciplinary proceedings, which are kept entirely separate from the no-fault scheme[[37]](#footnote-38)

 Medical error and patient safety 3.32 The analysis of medical error with a view to enhancing patient safety is encouraged in Sweden through the use of root cause analysis of events which led to claims for medical injury under the no-fault scheme. This is economically incentivised by the National Medical Injury Insurance Company (LOF). Senior medical figures at regional hospitals receive regular updates providing details on all claims for medical injury under the no-fault scheme that originated in their hospitals. The reasons for such claims are followed on a regular basis through visits by LOF representatives to the hospitals. Discussions are held on the data, as well as on what can be done to avoid such medical injuries in the future. National Patient Safety conferences are also held on a regular basis and are attended by representatives from the Hospital Federation, the National Board of Health and Welfare and the medical profession. It is expected that new patient safety legislation will come into force in 2010 which will implement a range of specific initiatives to bring about quality and safety improvement in the provision of health care in Sweden.[[38]](#footnote-39)

 **United States**

**Introduction**

 In the United States, reform to legal and administrative arrangements for

obtaining compensation for (negligent) medical injury – which is commonly known as

medical malpractice reform in the American context – has been the subject of

ongoing academic, policy, and political debates since at least the 1960s. The

intensity of such debates appears to increase during periods when there are

insurance crises, which make it difficult for health practitioners, obstetricians, in particular, to obtain liability insurance. In addition, concerns have been raised

over the years regarding access to justice by individuals who have been harmed as

a result of: the (negligent) provision of medical treatment; the time taken to resolve

claims; the extent to which frivolous or vexatious claims are brought by disgruntled

patients; the spiralling number of claims, as well as costs, associated with bringing

these claims in the courts in circumstances where contingency fee arrangements

apply; and the effect on the morale of the medical profession.[[39]](#footnote-40)

Various proposals for medical malpractice reform at both state and federal

levels have been put forward over the years, some of which have been implemented.

Suggested reforms in some state jurisdictions have involved placing caps on the

categories of damages that can be claimed, the creation of health courts, and the establishment of no-fault schemes[[40]](#footnote-41)

 There has also been an increased focus in recent years on learning from medical error in order to improve quality and safety in health care, as well as on the

links to be made between medical malpractice claims and learning from medical

error.[[41]](#footnote-42) In states such as Virginia and Florida, no-fault schemes have been introduced

which are limited to coverage of birth-related neurological injury. The political

impetus for the adoption of such schemes in both jurisdictions in the late 1980s had

its origins in political and professional concerns about the growing cost of

compensation in such cases, as well as difficulties experienced by obstetricians in

relation to the growing cost of insurance premiums and in obtaining liability

insurance. This chapter examines these two schemes in detail

**Virginia**

**Legal and social goals**

The goals of the scheme are to ensure that children who have suffered birth-related neurological injuries receive the required care and reduction of the financial burden on parents and on the health system. In addition, it was hoped that malpractice insurance would become more readily available, thus increasing the likelihood that obstetricians would continue to practice.

**Funding**

The Program is financed by the Virginia Birth-Related Neurological Compensation Fund. Participation in the Program is optional for both physicians and hospitals, although participation is high. Participating physicians and hospitals receive the benefit of the exclusive remedy provision, and physicians and hospitals that participate are eligible for lower premiums for malpractice insurance. In addition, the Virginia State Corporation Commission is empowered to assess liability insurers in Virginia up to one-quarter of one percent of net direct liability premiums written in Virginia, as there is a need to maintain the Fund on an actuarially sound basis. When the program was first established, participating physicians paid an annual assessment of US $5,000. Participating hospitals paid an annual assessment equal to US $50 per live birth, subject to a maximum assessment of US $150,000. From 1995 onwards, fixed fee schedules were changed to sliding scale fee schedules under which the fees decreased the longer the participant was in the program. Beginning with the 2001 program year, assessments of participating physicians and hospitals were restored to their original level.

Non-participating physicians can also be asked to make a financial contribution to the program. Between 1993 and 2001, such contributions were not required, but were subsequently reinstated. All physicians are currently required to pay US $300 per annum in order to maintain the actuarial soundness of the program. As of 31 December 2008, the assessment income was about US $3,507,000 from participating physicians (the equivalent of 626 physicians participating for the full 12 months, each paying US $5,600) and about US $3,546,000 from participating hospitals (there are 38 participating hospitals, each paying US $52.50 per live birth subject, up to a maximum of US $200,000 per hospital)[[42]](#footnote-43) (Oliver Wyman 2009: 55). As of 30 June 2009, income from non-participating physicians was approximately US $4,179,000 (approximately 13,930 doctors, each paying US $300). Income from liability insurers was approximately US $12,273,442 for 2009, amounting to one quarter of one percent of net direct liability premiums written in Virginia, the maximum permissible assessment under the governing legislation (Oliver Wyman 2009: 56). 7.11 Administrative costs for the program for the year ending 31 December 2008 were approximately US $940,630, of which approximately US $752,504 (80%) were claims-related and 20% related to general administrative expenses.

 As of 31 December, 2008, there were 142 claimants for whom coverage had been accepted, of whom 111 had been in the program for three or more years. As of the same date, it was estimated that the program had an outstanding liability of US $341.4 million and a deficit of US $168.9 million [[43]](#footnote-44)

**Eligibility**

 Claims are evaluated by the Virginia’s Workers Compensation Commission (WCC) with input from a three-physician panel to determine eligibility. In order to be eligible, the child must meet the following criteria:

(1) the definition of ‘birth-related neurological injury’ as outlined in the governing legislation;

 (2) obstetrical services were performed by a physician participating in the program; and

 (3) the birth occurred in a hospital that was also participating in the program. In 1990, this eligibility criterion was amended so that criterion 1 and either criterion 2 or 3 needed to be met in order to qualify for coverage under the Program.

 The definition of ‘birth-related neurological injury’ under the governing legislation (Section 38.2-5001 Code of Virginia)[[44]](#footnote-45) is as follows:

Injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by the deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled...such disability shall cause the infant to be permanently in need of assistance in all activities of daily living.

The law applies only to live births. It excludes disability or death caused by genetic or congenital abnormality, degenerative neurological disease or maternal substance abuse.

**Processing claims**

 It is often the case that claimants retain legal representation in relation to an application for coverage under the program. In order to determine eligibility, there is a need to establish that a birth-related neurological injury as defined by the governing legislation has taken place. This requires medical review by both the claimant and the program itself. It is now the case that three to four specialist medial opinions/reports are usually required.[[45]](#footnote-46)

 The Workers’ Compensation Commission (WCC) administers and adjudicates on claims under the program. At a hearing, the Chief Deputy Commissioner considers the medical panel’s recommendation on eligibility and makes a finding on the issue of general eligibility. Either side may appeal this decision to the full WCC and from there to the Court of Appeals.

 By 2008, there had been adjudications on 192 cases, 134 (70%) of which had been accepted, with 38 denied and 12 withdrawn.[[46]](#footnote-47) The average annual expense per claim was US $94,400. For the financial year ending 31 December 2008, a total of US $10,778, 949 had been paid to claimants for whom coverage had been accepted under the plan. As of the same date, the cumulative total of payments made between 1988 and 2008 was US$ 84,404,276.00.[[47]](#footnote-48)(Oliver Wyman 2009: 20, 22).

**Entitlements**

Claimants submit to the program any costs not covered by private insurance or Medicaid. The program is responsible for paying these outstanding costs. The actual payments recorded by the program represent ‘net’ payments after recoveries from private insurance and Medicaid. The types of compensation available to claimants for which the Program has accepted coverage include the following:

 • Actual medically necessary and reasonable expenses – medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel;

 • Loss of potential earnings may be claimed beginning at 18-years-old and may continue through to the normal retirement age of 65-years-old. Loss of earnings is paid in regular instalments. The amount is calculated at 50% of the average weekly wage of workers in the private, non-farm sector of Virginia;

 • Reasonable expenses incurred in relation to filing a claim, including reasonable attorneys’ fees;

 • The family of an infant that suffers a birth-related neurological injury and who dies within 180 days of birth may receive up to US $100,000.

 Claimants must contact the program before committing to the purchase of equipment or incurring other expenses for which they may seek reimbursement. Failure to do so may jeopardise reimbursement from the program. Claims for reimbursement must be submitted within one year from when the injury is incurred. For expenses incurred prior to acceptance into the program, reimbursement requests must be submitted within two years of entry into the program[[48]](#footnote-49)

Review and appeal mechanisms

 Once the administrative judge on the WCC makes a decision, either party may file an appeal. The initial appeal heard by is the Full Commission of the WCC. Thereafter, the decision of the Full Commission may be appealed to the Virginia Court of Appeals, and, ultimately, to the Virginia Supreme Court.

**Florida**

**Overview**

Florida established a no-fault scheme for birth-related neurological injury in 1988. The governing piece of legislation is the Florida Birth-Related Neurological Injury Compensation Act, Fla (Stat 766.302, 766.303, 766.315, 766. 316). Many of its provisions follow the recommendations of the Governor’s Select Task Force on Healthcare Professional Liability Insurance.[[49]](#footnote-50)

**Legal and social goals**

 The Plan aims to: stabilise and reduce malpractice insurance premiums for physicians providing obstetric services in Florida; to provide compensation, on a no fault basis, for a limited class of catastrophic injuries which result in unusually high costs for custodial care and rehabilitation; to encourage physicians to practice obstetrics and make available obstetric services to patients; and to provide the requisite care to injured children.

**Funding**

There are four main sources of funding: participating obstetricians pay an annual premium of US $5000; all other Florida physicians, excluding residents, pay US $250 per annum as a condition of licensure; non-public hospitals pay US $50 per live birth (with exemptions available to those providing high levels of charity care); and the state of Florida has made a one-time grant of US $40 million to fund the scheme.[[50]](#footnote-51) The statute includes provisions for assessing insurance companies up to 0.25% of their annual net direct premiums ‘should the fund become actuarially unsound’.[[51]](#footnote-52) NICA has also purchased a reinsurance plan.

**Eligibility**

 A ‘birth-related neurological injury’ is defined in section 766.302 of the Florida Statutes as follows:

Injury to the brain or spinal cord of a live infant weighing at least 2,500 gms for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 gms at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired”

The plan applies only to live births and does not include death or disability caused by genetic or congenital abnormality. Benefits under the scheme are available only to individuals in Florida whose doctor participates in the scheme by the payment of annual premiums. The injury must be sustained in a hospital. The infant must be permanently and substantially disabled, and the infant’s impairments must be both physical and mental.

In determining eligibility under the plan, a pragmatic line is generally taken with the application of a rebuttable presumption of fulfilment of eligibility criteria where, on the balance of probabilities, the baby was deprived of oxygen during labour and has a poor neurological outcome.[[52]](#footnote-53)

**Processing claims**

 A claim must be brought within five years of the child’s birth. An application for acceptance of coverage under the Plan must be filed with the Florida Division of Administrative Hearings.[[53]](#footnote-54) In terms of determining whether the claim should be accepted into the Plan an administrative law judge examines a claimant’s supporting documentation including NICA’s recommendation based on the information provided; a medical examination 60 of the child (within 45 days of petition); and independent assessments by 2-3 medical experts. Legal representatives of successful claimants are paid on the basis of ‘customary charges, given the locality and difficulty of the case’.

 In the event that a claim is accepted into the plan, the child will be covered for their lifetime. In this situation, no other compensation from a malpractice lawsuit is available. As an exclusive compensation plan, it is available only if there has not already been a settlement in a lawsuit, given that the plan provides for lifetime benefits and care.

**Entitlements**

 The following categories of compensation are available:

• Actual expenses for necessary and reasonable care, services, drugs, equipment, facilities and travel, excluding expenses that can be compensated by state or federal governments or by private insurers;

 • Non-pecuniary compensation up to a maximum amount of US $100,000 payable to the infant’s parents or guardians;

• US $10,000 death benefit for the infant;

• Reasonable expenses for filing a claim, including reasonable legal fees.

**Review and appeal mechanisms**

In the event that a petition for coverage under the Plan is rejected by a judge within the Florida Division of Administrative Hearings, this decision can be appealed to the District Court of

Appeal.

**England**

**Overview**

In England, the reform of the existing clinical negligence litigation system and its replacement with a no-fault scheme was initially considered in the 1970s, although it was not recommended that such a scheme be established at the time.[[54]](#footnote-55) Throughout the 1980s and into the mid-1990s, however, it continued to be the subject of much debate and analysis within the relevant academic and policy literature in the United Kingdom.[[55]](#footnote-56)

**Making Amends Report**

In 2003, the Chief Medical Officer (CMO) for England published his recommendations for clinical negligence reform in the Making Amends report (CMO 2003). In the report, the CMO considered the option of establishing a comprehensive no-fault compensation scheme in England. This option was ultimately rejected primarily on costs grounds, in addition to concerns about the need to comply with Article 6 of the European Convention on Human Rights.[[56]](#footnote-57),[[57]](#footnote-58) Recommendations were nevertheless made for an NHS redress scheme to be established which would include: care and compensation in the case of birth related neurological injury (inspired and adapted from the schemes operating in Virginia and Florida) and a redress package (including financial compensation) for low value claims.

**NHS Redress Scheme**

 The government subsequently adopted the concept of a redress scheme for low value claims (£20,000 or less), the parameters of which were set out in the NHS Redress Act 2006. Despite calls for the adoption of alternative tests for eligibility (e.g., avoidability), the government preferred to retain established tort law principles as the basis for determining eligibility. It did not adopt the CMO’s recommendation regarding the establishment of a no-fault scheme for birth-related neurological injury.

 The proposed NHS redress scheme has been subject to criticism on a number of grounds. It has been argued that: if implemented, it is unlikely to bring about greater access to justice for injured patients; it lacks sufficient independence from the NHS in terms of investigating what went wrong; and it fails to provide for 65 accountability on the part of healthcare professionals. In the circumstances, it is unlikely to address issues of longstanding concern to injured patients,[[58]](#footnote-59) and would therefore be unlikely to inspire patient confidence in the scheme.[[59]](#footnote-60) To date, the redress scheme has not been implemented in England, although it seems set to be introduced in Wales in the near future.

**Current management of clinical negligence claims**

 In the wake of report by Lord Woolf (1996), as well as the centralization of the defence of claims under the NHS Litigation Authority (NHSLA), the current clinical negligence litigation system in England has undergone significant reform in the last ten years. The time taken to process claims is much reduced, with those claims under the largest scheme (CNST) taking on average 1.56 years to resolve. Only 4% of claims go to court, and this includes settlements requiring court approval. The number of claims made on annual basis has been largely static, although there was a small increase in the past year. Forty-one percent of claims do not proceed beyond the notification/investigation stages. Overall legal costs are considered high, with claimant legal costs a particular source of concern.[[60]](#footnote-61)

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