A no-fault compensation system for medical injury is long overdue

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Summary

- The 2011 report of the Productivity Commission (PC) recommended the establishment of a no-fault national injury insurance scheme limited to "catastrophic" injury, including medical injury. The report is welcome, but represents a missed opportunity to establish simultaneously a much-needed no-fault scheme for all medical injuries.
- The existing indemnity scheme based on negligence remains a slow, costly, inefficient, ill targeted and stress-creating system.
- A fault-based negligence scheme cannot deter non-intentional errors and does little to identify or prevent systems failures. In addition, it discourages reporting, and thus is antithetical to the modern focus on universal patient safety.
- A no-fault scheme has the potential to be fairer, quicker and no more costly, and to contribute to patient safety.
- No-fault schemes have been in place in at least six developed countries for many years. This extensive experience in comparable countries should be examined to assist Australia to design an effective, comprehensive system.
- Before implementing the recommendations of the PC, the federal government should ask the Commission to study and promptly report on an ancillary no-fault scheme that covers all medical injury.

The Productivity Commission (PC) report on disability care and support published in July 2011 recommended the establishment of a national disability insurance scheme (NDIS) to provide for the long-term care and support of people with disabilities.[1] The report also recommended the creation of a separate no-fault national injury insurance scheme (NIIS) for people who experience "catastrophic injury", including catastrophic medical injury.

The PC report raises a number of issues for the medical indemnity system in Australia. It recommends that indemnity premiums be used to help fund the NIIS. It defines catastrophic injury in broad terms only (using examples, including major acquired brain injury, spinal cord injury, burns and multiple amputations), but fails to anticipate the likely difficulties in applying any definition, and the pressure that will arise to shift less seriously harmed people into this category. The PC report canvasses the eventual development of a more comprehensive no-fault insurance scheme for all medical injuries but defers detailed consideration of this issue until a proposed review of the NDIS and NIIS in 2020. We argue that this represents a serious missed opportunity to achieve the needed comprehensive reform of the compensation system in Australia, and recommend that, before the federal government takes any action on a proposed NIIS, the PC should be asked to conduct a further inquiry into the merits of moving to a no-fault system for dealing with all medical injuries.

A change to a no-fault system for compensating those harmed by accidents, including medical accidents, has long been debated. Most noteworthy in Australia is the 1974 report of the Woodhouse Committee, which proposed a no-fault "National Rehabilitation and Compensation Scheme".[2] Although similar recommendations from a prior Woodhouse Royal Commission report were fully implemented in New Zealand in 1972, the 1974 report was never acted upon by the Australian Government. No-fault insurance systems for motor vehicle accidents and workplace injury have been in place in some states for several decades. With increasing emphasis on patient safety and the need to encourage doctors to report adverse events and "near misses", now is the time to thoroughly examine the no-fault option rather than defer consideration for another 8 years.

The problems with the existing tort system for medical negligence

The current system in Australia for handling claims of injury alleged to be the consequence of medical treatment is fault based, and generally requires the pursuit of damages in the courts on the grounds of negligence. Tort law reform in Australia based on the Ipp report of 2002[3] was intended to stabilise indemnity costs, but the tort system remains a slow, costly, inefficient, stressful and often inequitable and unpredictable means of assisting people harmed through medical care. Cases can take years to be settled or decided. Duelling expert witnesses are trotted out. Many people are denied early access to appropriate care and rehabilitation because of delays. Litigation costs — estimated at 50%–66% of settlements in the United Kingdom, 50% in the United States and (for claims under $250 000) 44% in Australia — sharply decrease the real value of the settlement.[1]

Apart from the obvious stresses to litigants occasioned by the costs, delays and uncertainties, there are further structural problems in the existing system. Inequities arise where a person has clearly suffered an injury but is unable to identify the individual or entity that is legally responsible, or to meet the plaintiff's onus of proving that negligence in court. Even when successful in court, the outcome may be less than desirable for the claimant. Lump sum damages, the most common form of settlement, may fail to

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meet the long-term costs of care and other expenses, for reasons including inaccurate predictions, reduction of the settlement through contributory negligence, poor investment of the lump sum, or misuse of the funds by the recipient or others. The litigation process is also universally experienced as extremely stressful by doctors and their families.[4] This has led to some doctors giving up medical practice entirely or ceasing to do procedural work, with the attendant workforce implications.

The legal system has long asserted, on the basis of little or no empirical evidence, that the threat of a lawsuit has a deterrent effect that reduces medical errors and, thus, helps to maintain high standards of clinical care. While some negligence cases (and coroners' findings) draw attention to system failures, these do not contribute methodically to making health care safer.[5] This assertion is also illogical insofar as medical errors are rarely intentional and, hence, cannot be deterred.[6]

A more pernicious effect, for which the evidence is much stronger, is that the threat of a lawsuit increases medical costs by promoting overservicing and defensive practice, as well as deterring many doctors from engaging more actively in reporting adverse events.[7] Despite a move towards open disclosure of adverse events, doctors in general remain reluctant to take such steps, perhaps because of uncertainty about precisely what constitutes "good practice" and what their indemnity insurer expects of them. In addition, there is an important ethical issue involved when doctors are urged to be better in their approach to open disclosure and communication with patients. The emphasis seems to be on the prevention of complaints, and hence of lawsuits for negligence. Where this approach works, some otherwise deserving patients may be deterred from seeking and receiving financial redress for their injuries, to which they may well be entitled.

The existing tort system has few supporters outside those whose livelihoods depend directly on the system — mostly litigation lawyers, but also some doctors who specialise in preparing medicolegal reports.

The potential benefits of a no-fault system

Some of the potential benefits of no-fault insurance systems are spelt out in the PC report and also apply to a no-fault medical indemnity scheme. As enumerated in the PC report,[1] these benefits include:

- more predictable care and support over a person's lifetime;
- more consistent coverage of all injured people regardless of the particular circumstances in which a person was injured; and
- a more efficient system, delivering more care and support for each premium dollar.

In the context of medical indemnity, a no-fault scheme has the additional potential advantages of assisting in changing the mindset of doctors around issues of patient safety, learning from mistakes (their own and others') and preventing error.[8,9] It will encourage more complete reporting of adverse events and adverse outcomes, thereby providing better and more complete data collection. It also should encourage good clinical practice and reduce defensive medicine and overservicing.

As any model chosen is likely to be non-adversarial and involve panels of peer experts, a no-fault scheme will do away with the problems for courts in hearing from poorly qualified or biased expert witnesses. It may also avoid the documented tendency of experts to judge the performance of the doctor primarily on the adverse outcome and not on the actual care delivered.[10]

Arguments against a no-fault system

A number of arguments will be mounted against a no-fault system, some legitimate and some based on self-interest. For example, supporters of the status quo argue that a proportion of those who win compensation under the fault-based system may be financially worse off under a no-fault system.[1] If this is correct, in our view it only serves to demonstrate the inequities of the fault-based system. Supporters also argue that there is a risk that administrators of a no-fault system may be susceptible to direction from government to reduce benefits or alter coverage and that there is a risk, long term, of creating an expensive bureaucracy.[1] We argue that these points simply emphasise the importance of achieving the best design of an independent, effective, no-fault system from the start.

There is a legitimate argument around the potential cost of a no-fault scheme, based on the possibility that more claims will be made under this type of system. Whether this will happen is difficult to predict, as it depends on what the scheme covers, why people currently make (and do not make) claims and the national culture of seeking compensation. The scheme may be based on the concept of "avoidability" — whether or not an injury would have been avoided by best practice, as determined by medical experts with access to all relevant material — rather than negligence. In this case, it may be desirable that funding be made a community (ie, taxpayer) responsibility rather than come from compulsory medical indemnity cover. To gain community support, such a change would need to be offset by appropriate adjustments in medical fees.

It may also be argued that a no-fault scheme will prevent or delay the identification of problem doctors. Only a small proportion of disciplinary actions by medical tribunals concern physical harm to patients,[11] even in jurisdictions that require all negligence cases to be notified to the medical board. Nevertheless, we agree that a no-fault scheme must not incidentally protect underperforming or unwell doctors from being identified and appropriately managed.

The various models available for study

A number of developed countries now have mature no-fault medical indemnity systems that are available for study and consideration. These include New Zealand (since 1972),[5] Sweden (1975),[5] Finland (1987),[9] Norway (1988),[5] Denmark (1992)[5] and France (1994).[12] In addition, other models have been suggested or piloted in the US.[13] Most commentators in Australia have focused solely on the New Zealand regime, which has been progressively

modified over time. The Scandinavian models are not identical, but in general they have moved away from a negligence standard and instead have used the notion of avoidability. These models vary in precisely what is covered, but all have appeal mechanisms. Issues of alleged poor professional performance are dealt with by separate disciplinary assessment procedures. These countries are harnessing data to drive improvements in patient safety, in a way which is currently not possible in Australia.[5]

Some final comments

We believe that whether an injury results from a motor vehicle accident, an accident at work or an accident of medical treatment, any insurance system should focus on the ensuing needs of the injured person, without the need to prove that negligence was involved. However, we are discussing only injury related to medical treatment, as we believe that changing to a no-fault system will bring benefits to patients, the health care system and doctors.

We do not suggest that moving to a no-fault system will be simple. Difficult judgements will need to be made about whether the scheme will cover compensation for pain and suffering, whether any or all common law rights should be extinguished and whether upper and lower limits to compensation should apply. The issue of exclusion of coverage of ongoing medical care by Medicare will also need to be addressed.[14] The exact nature of any scheme, its governance, and controls to minimise waste and fraud will need close and continuing attention. Fortunately, as noted above, other developed countries have long-established schemes and experience from which Australia can learn.

Existing medical indemnity organisations, which employ a range of people with different skills and expertise, are likely to feel threatened by such a change. However, this expertise could be beneficially redeployed to a no-fault system, so any reform proposal should include these organisations and their people in its consideration. One medical indemnity organisation has already shown support for this change in its public submission to the PC inquiry.[15]

A major piece of research and modelling will be required to determine if the resources already committed to the adversarial medical negligence system (including current federal government subsidies) will be sufficient to fund a no-fault scheme — a task that is squarely within the PC's expertise and remit. Undoubtedly, there will be a good deal of scaremongering over costs and about the possibility of encouraging increased numbers of claims, although this has not been the case elsewhere.[16] The only answer to such speculation is sound empirical data. We strongly urge the federal government to take the opportunity to ask the PC to undertake this further research.

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