

NO-FAULT COMPENSATION SCHEMES FOR MEDICAL INJURY: A REVIEW

INTERIM REPORT

NO-FAULT COMPENSATION SCHEMES FOR MEDICAL INJURY: A REVIEW

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CHAPTER 1: EXECUTIVE SUMMARY

Introduction

1.1 In order to obtain compensation for harm arising out of medical treatment received within the NHS in Scotland, the elements needed to establish negligence under the law of delict must be satisfied. Thus, pursuers need to show that there was a duty of care that was breached by the defender and that breach caused the compensable harm. Payment of compensation is either through an out-of-court settlement or through the courts. The current system covers negligence by directly employed staff of NHS Health Boards, but not that of GPs, or others within the primary care sector including dentists, optometrists and pharmacists. Problems that have been identified with the current system include the length of time it takes to resolve claims; the need to take account of the differing views of experts; and the difficulties experienced in accessing legal aid and other forms of funding for claims.

1.2 NHS Health Boards currently fund all settlements of clinical negligence claims but receive additional protection from disproportionate losses through participation in the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS), a risk-sharing scheme. The Central Legal Office (CLO) defends claims on behalf of the Health Boards. In 2008-09, the number of (potential) clinical negligence claims notified to Health Boards was 342 (medical/dental) and 20 (nursing). During this same period, 171 claims were settled with just over £26million being paid out in total, and with adverse legal costs amounting to £2.5million.

1.3 The Scottish government has expressed the view that a no-fault compensation scheme in relation to clinical negligence claims made against the NHS in Scotland could be simpler than the existing litigation system and could support the development of the concept of a mutual NHS, as well as a positive feedback and learning culture. With this in mind, the government considers that such a scheme is the favoured way forward for the NHS in Scotland.

1.4 The issue of whether a no-fault scheme for medical injury should be established in Scotland was recently considered as part of the Patients' Rights Bill Consultation, in the context of the proposed right to independent support and redress: my right to comment about my care and have my concerns addressed. The responses received to the consultation make clear that there is significant public and stakeholder support in principle for the adoption of a no-fault compensation scheme. A number of concerns were raised in relation to the introduction of such a scheme (Haslam et al. 2009, paras. 26, 3.137-3.151):

- likely resource implications;
- how it would be funded including whether funds would be diverted from the provision of healthcare ;
- whether it would be detrimental to the sense of mutuality between patients and health services;
- whether it would result in an increase in the number of claims made and encourage a culture of blame;
- what sort of redress would be provided under such a scheme;
- the inter-relationship between such a scheme and the complaints procedure.

1.5 On 1 June 2009, the Cabinet Secretary for Health and Wellbeing announced that a working group would be established to examine the issues involved in establishing a no-fault compensation scheme in Scotland. The No-Fault Compensation Review Group (Review Group) began its work in August 2009 and a report and recommendations are expected by October 2010.

1.6 As part of its examination of this issue, research has been commissioned to support the Review Group by undertaking the following tasks:

- Reviewing and providing an up-to-date analysis of existing no-fault schemes in other countries;
- Identifying implications of introducing such a scheme within NHS Scotland;
- Gathering information and stakeholder views from organisations representing; healthcare staff and NHS service users as well as from individual NHS service users who have used the current system.

This report is an interim report which addresses the first of the above tasks.

A review of no-fault schemes

1.7 A brief explanation needs to be provided regarding the use of terminology in this report. There are a variety of terms and descriptions given to compensation arrangements for individuals who have suffered harm as a result of medical treatment in various countries/jurisdictions. Where such individuals are able to make claims through the courts, they are referred to as 'pursuers' under Scots law, and as 'claimants' or 'plaintiffs' in other jurisdictions. These claims are referred to variously as 'medical negligence', 'clinical negligence' or 'medical malpractice' claims. The claims are brought under the Scots law of delict and under the law of tort in other jurisdictions. Where such individuals make claims under existing no-fault compensation schemes, they are referred to as 'claimants', '(injured) patients' or 'applicants'. As this report provides a cross-jurisdictional review of no-fault schemes for medical injury, the terminology used reflects that used in the countries/jurisdictions under examination. The decision was also taken to use the term 'medical injury' in describing such schemes as it was considered that it was sufficiently broad enough to cover the range of eligibility criteria used in existing schemes in other countries/jurisdictions. From this point on, the shortened term 'no-fault scheme' will be used, instead of the longer term 'no-fault compensation schemes'.

1.8 This report reviews and analyses existing no-fault schemes in a number of countries/jurisdictions: New Zealand (NZ); Nordic countries (Sweden, Finland, Denmark, Norway); and the schemes operating in Virginia and Florida (United States) for birth-related neurological injury. The review draws on published and grey literature, as well as academic discussions and debate in this area, over the past ten years. Where appropriate, the review has extended beyond this time period.

1.9 In relation to the schemes examined in the report, the following specific subject matters are reviewed in detail:

- Legal and social goals
- Funding
- Administration
- Eligibility criteria
- Entitlements
- Review and appeal mechanisms
- Advantages and disadvantages

Where information is available, a brief overview has been provided of the complaints process, professional accountability and discipline systems, as well as medical error and patient safety, and how they interact (if at all) with the existing no-fault scheme. Although the executive summary sets out the main findings from the review, an examination of the specific advantages and disadvantages of each individual scheme by reference to the relevant literature is also provided in each chapter.

1.10 A more detailed overview of how the no-fault scheme operates in NZ has been provided in this report. This reflects the Working Group's particular interest in this scheme, as well as the significant amount of published literature on the NZ scheme. In terms of providing background information in relation to certain aspects of the NZ chapter, we would like to acknowledge the assistance provided by a number of people at the Accident Compensation Corporation (ACC) which manages the no-fault scheme in NZ: Dr Marie Bismark, ACC Director and Senior Associate at the NZ law firm of Buddle Finlay; Ms Fiona Colman, ACC Senior Policy Analyst and Ms Paula Carr, Team Manager - Quality Assurance, ACC Treatment Injury Centre.

1.11 For ease of reference, the Bibliography set out in the final chapter of the report has been sub-divided by reference to the relevant country/jurisdiction. The final section of the bibliography contains selected publications on medical error and patient safety.

Main findings

Common features of no-fault schemes

1.12 No-fault schemes provide an alternative route to financial compensation for harm allegedly caused through medical treatment. Although there is still a need to establish causation, an important feature of no-fault schemes that have been established to date is that there is no need to prove negligence in order to be eligible for payment of financial compensation. This is in addition to the need on the part of injured patients to meet particular eligibility criteria which may differ as between existing no-fault schemes.

1.13 Common features of no-fault schemes include the following:

- All have eligibility and threshold disability criteria which need to be satisfied before cover is accepted;

- There are limitations on the extent to which cover is provided: there may be caps on certain categories of compensation and compensation for non-pecuniary losses such as pain and suffering) may not be available;
- Levels of financial compensation/entitlements tend to be lower for comparative injuries in clinical negligence claims brought under delict/tort-based systems;
- There is simpler and broader 'access to justice' in no-fault schemes, particularly in relation to the cost of initiating or submitting claims, as well as time to resolution;
- Access to the courts may be restricted;
- There is a comprehensive national social welfare/social insurance system in place.

Advantages of no-fault schemes

1.14 Advantages of no-fault schemes include the following:

- A principled social/community response to personal injury which includes a recognition of community responsibility; comprehensive entitlement; full rehabilitation; fair and adequate compensation; and administrative efficiency;
- An expanded eligibility criteria for cover that facilitates greater access to justice for patients who suffered medical injury than would be the case in relation to clinical negligence claims brought under delict/tort-based systems;
- Greater scope to collect data on, as well as learn from medical error with a view to enhancing patient safety;
- Greater access to justice for patients who have suffered medical injury, which includes providing a clearer 'road map' towards obtaining suitable redress;
- Promotion of better, as well as less defensive, relationships between patients and health practitioners when medical injury has occurred;
- Greater efficiency in terms of both time and costs than would be the case in relation to the management of clinical negligence claims brought under delict/tort-based systems;
- Rehabilitation can proceed in a more timely fashion, without having to wait until legal action in the courts is resolved;
- Easing of pressure on health practitioners with regard to escalating insurance premiums, the availability of liability and the threat of litigation;

- Works well in conjunction with well-established and well-funded national social security systems and independent patient complaints processes;
- Reduction or elimination of the right to take legal action in the courts for medical injury, thus lessening the cost and administrative burden on the courts and interested parties, as well as reducing distress and tension between injured patients (pursuers) and health practitioners/health institutions (defenders).

Disadvantages of no-fault schemes

1.15 Disadvantages of no-fault schemes compensation schemes for medical injury include the following:

- lack of affordability, particularly in the context of large national populations;
- Financial compensation/entitlements are set much lower than would be the case in successful clinical negligence claims brought under delict/tort-based systems;
- Failure to promote institutional and professional accountability in relation to (preventable/avoidable) medical injury;
- The removal of the threat of litigation which provides an incentive for health practitioners and health institutions to avoid unsafe practices in relation to medical treatment provided to patients;
- A significant increase the potential number of claims arising out of medical injury, which in turn could promote the development of a compensation culture;
- The schemes only work well in terms of providing adequate financial compensation/entitlements for medical injury in the context of a well-funded national social security system;
- There is a lack of empirical evidence that institutional and professional learning from medical error is enhanced through no-fault schemes;
- There is still a requirement to prove causation in no-fault schemes (thresholds may vary). This is often the most difficult aspect to established in clinical negligence claims brought under delict/tort-based systems. Difficulties in establishing causation may therefore act to prevent greater access to justice under no-fault schemes;
- Although eligibility criteria may be considered more expansive under no-fault schemes allowing for a greater number of injured patients to obtain cover, existing schemes have a significant rate of rejection due to a failure to satisfy eligibility criteria;

- No-fault schemes which provide for payments based on set amounts or fixed tariffs are not sufficiently responsive to the individual needs of injured patients;
- No-fault schemes do not automatically guarantee that key elements of redress desired by injured patients, such as explanations, apologies and accountability of health professionals, are provided;
- Restriction of access to the courts in no-fault schemes may potentially infringe human rights law (depending on the jurisdiction), and may also encourage injured patients to seek redress/accountability in other ways (e.g., through the criminal law).

Points for consideration

1.16 Based on our review of the relevant literature relating to no-fault schemes, we would like to highlight a number of additional points for consideration by the Working Group. More detailed discussion of these points, as well as supporting references, are contained in individual chapters:

- **Choice of model:** there are common elements to no-fault schemes that have been established in various countries/jurisdictions, however, the inclusion of certain elements reflect particular historical, socio-cultural, institutional and legal trajectories that may not easily translated into the modelling of (new) no-fault schemes in different national settings. The existence of a well-funded and comprehensive national social security system, as well as a predominantly publicly-funded health system, also appear to be important complementary elements which contribute to the success of no-fault schemes.
- **Equality of coverage:** our review suggests that two issues are important on this point: (1) there may be disparity between those who have the same injury: one which is caused through illness and the other through injury which is covered by a no-fault scheme. This may result in very different compensation and care trajectories, as well as anomalies in cover; (2) coverage under a no-fault scheme may be limited to particular categories of medical injury, as opposed to providing coverage for personal injury caused through accidents more generally (car accidents, work-based accidents etc.). While it has been suggested that it is inevitable that policy choices are made about the extent of coverage under no-fault schemes, issues of justice and fairness as between citizens may require further consideration and/or justification of such choices.
- **Costs and affordability:** it is generally accepted that administration costs associated with no-fault schemes are much lower than the legal and other costs of clinical negligence claims brought under delict/tort-based systems. Affordability of existing no-fault schemes over time remains a problematic issue, however, in countries/jurisdictions such as NZ and Virginia/Florida. This requires ongoing financial and institutional reforms to ensure affordability. This may in turn adversely affect the provision of adequate compensation to injured patients.

- **Independent patient complaints process:** in the countries/jurisdictions examined, there was variability as to the role and functions of the patients complaints process and its relationship with no-fault schemes. In NZ, the establishment of an independent patient complaints process through the Health and Disability Commissioner (HDC) and the creation of a Code of Rights, has played an important role in dealing with a range of concerns that patients may have, but which are not appropriate to be dealt with through no-fault schemes. The HDC acts as an independent 'one-stop-shop' for dealing with patient complaints which includes advocacy on their behalf, mediation between patients and health practitioners, formal investigations and referrals for professional disciplinary actions. The role and powers of the HDC are also seen as important in the context of significant restrictions on the right of injured patients to seek redress through the courts.
- **Access to justice:** differing viewpoints are offered within the relevant literature about whether no-fault schemes encourage a greater number of claims to be made than would otherwise be the case under existing delict/tort-based systems. This is likely to impact on considerations of affordability. The available empirical evidence from NZ is that there is significant under-claiming by those who would potentially be eligible for cover under no-fault schemes. Injured patients from ethnic minorities, those who are socio-economically disadvantaged and the elderly are the groups that are least likely to make a claim, despite potential eligibility. Evidence published from a review of adverse events studies arising out of medical treatment in the United States also point to the same phenomenon of under-claiming even under a tort-based system. In the circumstances, how best to ensure simpler and broader access to justice for injured patients requires detailed consideration.
- **Threshold criteria:** it is suggested that one of the more positive aspects of no-fault schemes is the removal of the requirement to prove substandard care in relation to medical injury. This is also said to facilitate greater access to justice for those who have suffered medical injury under no-fault schemes. A review of existing schemes, however, reveals a more complex picture. Eligibility criteria, threshold disability requirements, and the need to establish causation are all elements that act to screen out a significant proportion of potential claims under no-fault schemes: for example, only 33% of claims on average are accepted for cover under the no-fault scheme in Finland; in NZ, the figure is 60% under what is generally viewed as very broad eligibility criteria.
- **Professional accountability:** how best to facilitate professional accountability in the context of no-fault schemes is a recurring theme in the relevant literature. The available evidence points to professional accountability being an important objective for injured patients who have pursued a variety of legal and other avenues as a result (including resort to the criminal law). A review of existing no-fault schemes reveals a varied approach to the issue. In the Nordic schemes, the issue of professional accountability is considered to be entirely separate from the operation of no-fault schemes. While the birth-related neurological injury schemes operating in Virginia and Florida were designed to address the concerns of obstetricians about the financial and

professional burdens they faced in the context of rising numbers of claims against them, the available evidence points to the schemes having little impact on improving quality and safety in obstetric practice. In NZ, the retention of a fault-based element under the no-fault scheme in relation to injuries arising out of medical treatment, and the requirement that there be a referral to professional disciplinary bodies in the event of an adverse finding, created a significant degree of hostility on the part of the medical profession vis-à-vis the no-fault scheme. Recent reforms have removed the fault-based element and the focus is now on facilitating good relations with the medical profession, as well as enhancing quality and safety in health care. The question remains, however, as to how health practitioners should be incentivised to engage in safe practice with patients and whether, and if so what, role no-fault schemes should have in this regard.

- **Medical error and patient safety:** it is asserted that one of the advantages of no-fault schemes is that the removal of a fault-based approach offers the opportunity to collect valuable data on medical error, as well as to engage in both systems learning to facilitate error prevention and therefore enhance patient safety. While there is potential for this to be realised in the context of no-fault schemes, the available evidence from the NZ no-fault scheme suggests that this does not automatically follow. NZ experiences rates of (preventable) adverse events which are similar to those found in Australia and the United States which maintain delict/tort-based systems for clinical negligence claims. Collecting, analysing and disseminating medical error data to relevant institutions and agencies, as well as instituting incentives to encourage error prevention, are seen as necessary elements to bringing about systems improvements in the quality and safety of health care.

CHAPTER 2: NEW ZEALAND

Introduction

2.1 A Royal Commission was established in 1966 under the chairmanship of Sir Owen Woodhouse to examine and report on the law relating to compensation and claims for damages for incapacity or death arising out of accidents (including diseases) suffered by persons in employment, and the medical care, retraining and rehabilitation of persons that suffered such incapacity.

2.2 The Commission published a report in 1967 (Woodhouse Report) and recommended the establishment of a no-fault compensation scheme for personal injury based on the following principles: community responsibility, comprehensive entitlement, complete rehabilitation, real compensation, and administrative efficiency (Royal Commission 1967, para. 4; McKenzie 2003). The Accident Compensation Act 1972 (NZ) was subsequently passed with the scheme coming into effect in 1974.

2.3 The key piece of legislation currently governing the scheme is the Injury Prevention, Rehabilitation, and Compensation Act 2001 (IPRCA 2001) which came into effect on 1 April 2002, although it has been subject to amendment over time.

Legal and social goals

2.4 The legal and social goals of the no-fault compensation scheme are to enhance the public good and reinforce the social contract underpinning NZ society by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community and the impact of injury on the community (see s. 3 IPRCA 2001). 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 realising 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 stands at 62% and client satisfaction at 83% (ACC Annual Report 2009: 7).

Administration

2.6 The no-fault scheme is administered by the Accident Compensation Corporation (ACC), a Crown entity. The scheme is funded through a combination of general taxation and the imposition of levies on employee earnings, business payrolls, petrol and vehicle licensing. (ACC Annual Report 2009: 3). The remit of the ACC includes the following:

- Preventing injury
- Collecting personal injury cover levies
- Determining whether claims for injury are covered by the scheme and providing entitlements to those eligible

- Paying compensation
- Buying health and disability support services to treat, care for and rehabilitate injured people
- Advising the government.

Operating costs of the scheme, comprising the costs of claims handling and net operating costs, stand at 12% of claims paid (ACC Annual Report 2009: 21).

Funding

2.7 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:

- **Work 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 work 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 Account and Non-Earner's Account. The Earner Account funds are used to meet the treatment injury costs of claimants who were in paid employment prior to injury, whereas the Non-Earner Account funds are used to meet the treatment injury costs of claimants who were not in paid employment prior to injury. The Non-Earners' Account is used to meet the majority of costs: 90% pay-as-you-go claims and 65% fully-funded claims. The Treatment Injury Account is the smallest of the ACC's six accounts in terms of levy revenue and claims liability, accounting for 3.5% of ACC's total net levy income and 7.5% of the scheme's total claims' liability. There has been a significant increase in the number of treatment injury claims in recent years. In the last financial year, this resulted in the appropriation initially allocated to the account exceeding budget by NZ\$146.1million (161%) (ACC Annual Report 2009: 47). In relation to treatment injury claims, the ACC bulk funds the Ministry of Health for the treatment of accident victims in the public health system. The Ministry redistributes this to District Health Boards on a population basis.

- **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.

2.8 There have been ongoing problems with funding arrangements for the scheme, leading to periodic reform. It was disclosed in the current Annual Report 2009 that the scheme is currently experiencing financial problems across all accounts. Such problems are attributed to a number of factors including significant increases in costs in recent years, increasing numbers of claims, extension of coverage, and declining rehabilitation rates. It has been suggested that 'the underlying cause has been a shift from the ACC being a public insurance company to it becoming an extension of the welfare state' (ACC Annual Report 2009: 3).

2.9 In order to bring about improvements to the scheme, particularly with regard to its financial situation, the NZ government recently tabled the Injury Prevention, Rehabilitation, and Compensation Amendment Bill 90-1 (2009) in the Parliament. The primary purpose of the Bill is to improve flexibility in the scheme, facilitate cost containment, provide for closer working relationships between government agencies and the ACC, and improve financial reporting and accountability. Amendments to the governing legislation are likely to include changes cover for work-related injuries and injury-related hearing loss; weekly compensation, eligibility and entitlement; and definitions and processes around vocational independence.

Eligibility

2.10 The Woodhouse Report did not specifically recommend that compensation be paid for injury that was caused as a result of medical treatment. It was acknowledged that it was difficult to draw a line between injury by accident and injury by sickness or disease and recommended that a group of experts be appointed to examine the issue. It was concluded that cover for 'medical misadventure' should be included in governing legislation before the no-fault scheme was established. The Accident Compensation Amendment Act 1974 was subsequently passed and it defined 'personal injury' as including 'medical, surgical, dental or first aid misadventure'.

Medical misadventure

2.11 The Accident Rehabilitation and Compensation Insurance Act 1992 was passed to reflect the law and practice that had developed in relation to dealing with injuries arising out of medical treatment since the scheme was established in the 1970s. Medical misadventure was divided into medical error and medical mishap. The concept of medical misadventure was interpreted as restricting cover for injuries caused through medical treatment to those which resulted from negligence (medical error) and those resulting in severe adverse consequences of treatment occurring in less than 1% of cases (medical mishap). In the former case, this led to the retention of a fault-based element in terms of establishing cover under the scheme. In practice, this led to long delays in the processing of some claims. In addition, it also led to confusion about the role of the ACC in the health system, as it was required to report medical errors to relevant responsible authorities.

2.12 Prior to amendments in 2005, it was taking on average 5 months to make a decision on medical misadventure claims, which was longer than for other 'complicated claims'. The delay was linked to the need to find fault for the purposes of medical error. This led to a reluctance on the part of health practitioners to cooperate in the claims process. It led them to seek legal advice and to review adverse decisions because of a fear of repercussions from ACC's legal duty to report all medical error cases to the responsible authorities. The other perceived problem related to cover for medical mishap. The terms used such as 'rarity' and severity' were considered confusing and arbitrary, resulting in claimants unfairly missing out on cover (Manning 2006: 696-7).

Treatment injury

2.13 In 2005, reform to the eligibility criteria resulted in the replacement of 'medical misadventure' with the more expansive term 'treatment injury'. This reform removed the fault-based element which had been retained in the medical misadventure criteria. The 2005 reforms also promoted an enhanced focus on systems learning from medical error and the creation of a reporting scheme that was to be driven by concerns over patient safety, rather than assigning blame to individual health practitioners (McLay et al. 2004; Oliphant 2007).

2.14 As a result of the reforms which came into effect on 1 July 2005, a person has cover under the scheme for a **personal injury** as follows:

- Treatment injury suffered by the person
- Treatment injury in the circumstances described in section 32(7)
- Suffered as a consequence of treatment given to the person for another personal injury for which the person has cover
- Caused by a gradual process, disease or infection that is treatment injury suffered by the person
- A cardio-vascular or cerebro-vascular episode that is treatment injury suffered by the person (see s. 20(2) IPRCA 2001).

2.15 **Treatment injury** is defined under s. 32 IPRCA 2001 as a personal injury that is suffered by a person:

- seeking treatment from one or more registered health professionals; or
- receiving treatment from, or at the direction of one or more registered health professionals; and
- is caused by treatment; and
- 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.

2.16 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 has to be suffered at the treatment is given or during the treatment process. (Manning 2006: 698-9). 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 cover extends to third parties who catch the infection from the patient or from the patient's spouse/partner.

2.17 **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.

2.18 If a person is accepted by the ACC for cover 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 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 cover under s. 20(2), then a person would need to satisfy the eligibility criteria under the treatment injury provisions (s. 32) (Manning 2006: 708).

2.19 **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, 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 cover 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 cause (Manning 2006: 709-10). In a recent judgment by the NZ Court of Appeal in *ACC v Ambros* [2007] NZCA 304, the Court held that the correct test for causation in medical misadventure/treatment injury cases was for the claimant to establish causation on the balance of probabilities. There could be no presumption of causation under the ACC's governing legislation which could arise in circumstances where the evidence would not (without such presumption) reach the required standard for proving causation.
- **A treatment injury does not include a personal injury that is solely attributable to a resource allocation decision.** The use of the term 'solely'

is key to interpreting this exclusion. It is only if a resource allocation decision is the sole or only reason for treatment being unavailable or delayed, which itself results in injury or death, then the exclusion applies. Therefore, if an injury was caused by a resource allocation decision in conjunction with other factors, then cover may still be obtained under treatment injury (Manning 2006: 714).

- **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 NZ 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 (Manning 2009: 715).

2.20 The use of terminology such as ‘injuries that are a necessary part of ordinary consequence of treatment’ is designed to avoid consideration of statistical probabilities of likelihood. Terms such as ‘necessary part’ and ‘ordinary consequence’ are considered more flexible and responsive to the circumstances of particular patients’, although it is acknowledged this has resulted in a degree of uncertainty. It is considered that necessary injuries are those that are an intended or planned and a necessary part of the procedure or treatment. In relation to whether a particular injury is an ordinary consequence of the treatment, there are three relevant considerations:

- All the circumstances of the treatment are taken into account. Relevant factors will include time, location, urgency, the complexity of treatment, and the health professional administering treatment. What are ‘ordinary consequences’ will depend on the particular procedure or treatment.
- In determining whether an injury is an ordinary consequence, consideration will be given to the person’s underlying health condition at the time of treatment. For example, if the patient is in poor health, then it would be expected that there would be more risks attached to treatment, and therefore it is more likely that adverse consequences will be classed as ‘ordinary’ consequences of the treatment in that particular patient’s circumstances. This is likely to result in patients with poor health having greater difficulty in obtaining cover under treatment injury provisions.
- Ordinary consequences need to be determined in the light of the state of clinical knowledge at the time of treatment, and not with the benefit of hindsight or knowledge subsequently acquired. Clinical evidence of the common, normal or usual consequences of treatments, as well as the patient’s particular clinical circumstances, will be the most important considerations (Manning 2006: 703-4).

Exclusions

2.21 Mental injury unaccompanied by physical injury: the ACC does not provide coverage for mental injuries per se. In order for cover 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 it was caused by certain criminal acts provided that the claimant was ordinarily resident in NZ at the time and treatment is being sought in NZ; or 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 was clinically significant behavioural, cognitive or psychological dysfunction occurring as a result of the physical injury.

2.22 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 cover 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.

2.23 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 cover 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 (Manning 2006: 763).

Compensation for failed sterilisation/unplanned children: There has been a degree of uncertainty as to whether an unplanned pregnancy resulting in the birth of a child as a result of a failed sterilisation could constitute a 'personal injury' capable of cover under the IPRCA 2001. In a recent 2:1 majority judgment of the NZ Court of Appeal in *ACC v D & Anor* [2008] NZCA, 576 (CA329/07), it was held that unplanned pregnancy is not a 'personal injury' under the IPRCA 2001 because it is not a physical injury and therefore there was no eligibility for cover under the medical misadventure provisions of the IPRCA 2001 (prior to 2005 reforms). It is important to note that there is also no cover under the scheme for an unplanned pregnancy and birth of an unplanned child as a result of a failed sterilisation involving the father. It has also been suggested that the merits of English and Australian law on recovery of costs in a common law action for raising an unplanned child remain an 'open question' in NZ (Manning 2006: 767).

Processing claims

2.24 Filing a Claim: A registered health professional is required to assist the claimant in completing an ACC claim form and then sends the form to the ACC. 85% of all primary care providers are networked into a computer system that populates the ACC system when patient notes are typed in. Once the claim is received by the ACC, then it is registered and given a unique claim number. The claimant will need

to pay part of the cost of this first visit to a registered health professional, but they can be reimbursed for such costs if the claim is accepted for cover by the ACC.

2.25 Deadline for filing claims: In relation to a personal injury, a claimant needs to file a claim with the ACC within 12 months of the date of injury (s. 53(3) IPRCA 2001). If a claim is for a treatment injury for which cover is sought, a claimant must lodge the claim within 12 months of the date that the personal injury was first considered by a registered health professional to be a treatment injury or the date that the person suffered the treatment injury, whichever is the later (s. 53(4)(a) IPRCA 2001). The date upon which the person suffered the treatment injury is considered to be the date when the person first seeks or receives treatment for symptoms in circumstances where they may not have a diagnosis of treatment injury (see s. 38(1) IPRCA 2001).

2.26 Timeline for processing claims: The majority of claims for personal injury are assessed at the registration centre within 21 days of being lodged, except where the ACC determines that additional information is required. The maximum time limit in the event that further information is required is 4 months, except in the case of 'complicated claims' (s. 56 IPRCA 2001). Treatment injuries are considered to come within this category (s. 57(1)(c)). In the case of complicated claims, the ACC is required to notify claimants within 2 months of the claim being lodged that additional information may be required from another person (health professional/expert), and at the end of 4 months such request must have been made and the claimant informed about such request. The claimant and the ACC can agree on further extensions, but the absolute time limit for the ACC to make its decision regarding cover is 9 months (s. 57(3) and (4)). In the event that the ACC does not make a decision on cover within this specified time limit, then the claimant will be deemed to have cover (s. 58(1)).

2.27 Treatment Injury Centre (TIC): treatment injury applications are managed by the Treatment Injury Centre with regard to decisions on cover. If cover is accepted then it is referred on for management of entitlements (if appropriate). If it is a high-cost or high-risk claim such as one involving birth-related neurological injury, then if cover is accepted, it is referred to the ACC's National Serious Injury Centre which has expertise in dealing with such claims. The TIC was previously known as the Medical Misadventure Unit, but a name change accompanied the 2005 reforms. As a result of its previous incarnation, the TIC has developed significant expertise over an extended period of time in relation to dealing with medical injury claims, notwithstanding changes brought about by 2005 reforms.

2.28 Processing claims: when there is notification of a potential treatment injury, then TIC streams the claim according to whether a cover decision can be made based on the available clinical information accompanying the application. It is not required that the health practitioner who was involved in the alleged treatment injury assists the claimant with completing and lodging the claim, although this is encouraged by the TIC. It may be the case that the claimant's primary care practitioner will undertake this task. Once notification of a claim is received, the TIC asks claimants to complete an initial treatment details report where the issues involved in the claim are identified. Decisions are taken on whether it is likely to be a straightforward, moderate or complex claim. If the clinical information provided with

the application is insufficient to allow a cover decision to be made, then further clinical records or reports from relevant health practitioners are obtained.

2.29 The TIC has a set of internal controls as to when cover decisions are made on such claims. For straightforward claims, it is 14 days; moderate claims - 70 days; complex claims - 145 days. As a result of the treatment injury provisions, the TIC now receives a significant number of straightforward and moderate claims. Although cover may be accepted for such claims under the terms of the IPRCA 2001, entitlements may be minimal, if at all. These internal controls are separate and distinct from the requirements with regard to making decisions on cover under the IPRCA 2001, but are nevertheless designed to ensure that such decisions are made ahead of time limits specified in the legislation. If a decision cannot be made within the specified legislative time limits (e.g., up to 9 months) due to insufficient information, then cover is declined due to lack of information, although investigations may continue. A fresh decision can be made once all relevant information is received.

2.30 Between 1 July 2005 and 30 September 2009, 16,709 claims were accepted as treatment injury: 51% were considered minor; 40% - major; 6% - serious; and 2% - sentinel. The TIC defines these categories of claims as follows:

- **Minor:** an event which results in short-to-medium lessening of bodily function (sensory, motor, physiologic or intellectual) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: increased length of stay as a result of the incident; and/or surgical intervention required as a result of the incident. **Average award:** NZ\$2,692. One of the unexpected consequences of the 2005 reforms which were designed to expand the range of medical injuries for which cover was available, has resulted in a significant increase in the number of minor claims.
- **Major:** an event which results in short-to-medium lessening of bodily function (sensory, motor, physiologic or intellectual) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: increased length of stay as a result of the incident; and/or surgical intervention required as a result of the incident. **Average award:** NZ\$9,355.
- **Serious:** an event, or related events, that has the potential to result in death or major permanent loss of function not related to the natural course of the claimant's illness or underlying condition, pregnancy or childbirth. **Average award:** NZ\$36,495.
- **Sentinel:** an event during care or treatment that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the claimant's illness or underlying condition, pregnancy or childbirth. **Average award:** NZ\$71,026.

2.31 Once notification of a treatment claim is received by the TIC, there is an initial review by a clinical advisor who is delegated to investigate and make cover decisions on claims. There are 17 such advisors with clinical backgrounds currently

employed by the TIC. Their background may or may not be matched to the particular clinical circumstances of the claim. Based on their experience and expertise, the advisors may be able to make a recommendation on whether cover should be accepted. They may consult with internal medical advisors on particular aspects of the claim in order to reach such a decision. There are currently three such advisers employed at the TIC who have backgrounds in orthopaedic surgery, obstetrics/gynaecology and primary care. Once the clinical advisor forms a view on the claim, taking account of both medical issues and legal requirements, then they will discuss it with a senior team manager. Ultimately, it is the Centre Manager of the TIC that has the final say and must sign off on whether cover is to be provided.

2.32 In moderate and complex claims, it may be the situation that an external assessment from a peer medical expert is needed. The TIC has a database of such experts with which they consult. The TIC currently pays a fixed fee of NZ\$165 (incl. GST) for such reports.

2.33 The TIC focuses on undertaking a detailed investigation process where causation may be an issue, in particular identifying who can answer the question. If causation is an issue, then the TIC would normally refer the matter to internal clinical/medical advisors and/or request an external assessment, if appropriate. The aim is to undertake a detailed investigation to allow the legislative criteria to be satisfied, and to reach a decision on cover that takes account of such criteria and the clinical facts of the case. Case law is applied in terms of the principles that set precedent (e.g., Court of Appeal judgment in *Ambros* (see paragraph 2.19), however, all claims are considered based on the particular circumstances of each individual case.

2.34 **Managing complex claims:** the TIC has a specific protocol for dealing with what are described as high-cost or high-risk claims which may, for example, involve birth-related neurological injury claims or media- or politically-sensitive claims. A complex claims panel meets weekly and comprises a range of TIC staff with clinical, quality assurance, medical and team management/cover expertise. There are also observers on the panel (without decision-making powers) who have legal, policy and actuarial expertise. The clinical advisors for this category of claims prepares a brief for the members of the panel which, along with relevant reports, advice and opinions, are distributed before the meeting. The claim is then discussed by the panel and a decision will be taken on whether cover will be accepted or whether further information or work is required before any decision can be made.

2.35 **Eligibility where injury has occurred outside New Zealand:** New Zealanders who are injured overseas on short trips (up to 6 months) may be covered by the ACC and so can file a claim when they return to NZ. Cover is provided in this instance whether the claimant was travelling for business, visiting family/friends, holiday.

2.36 **National Serious Injury Service:** this service has been established to develop and deploy greater expertise in ACC management of serious injuries, in particular focusing on disability management and rehabilitation. This is particularly important in the case of treatment injury cases, such as those involving serious birth-related neurological injury.

2.37 Treatment injury claims represent 0.36% of all claims lodged with the ACC since these reforms came into effect on 1 July 2005. In 2008, 7,973 claims for cover for treatment injury were made: 4,973 claims were accepted and 3,000 claims were rejected (overall acceptance rate of 62%); in 2009, 6,537 claims were made: 3,827 claims were accepted and 2,710 claims were rejected (overall acceptance rate: 59%).

Rehabilitation

2.38 The ACC is required to make a decision within 13 weeks of accepting cover for a personal injury whether the claimant is likely to need social or vocational rehabilitation. If so, the ACC is required to prepare an individual rehabilitation plan in consultation with the claimant.

2.39 The purpose of social rehabilitation is to assist in restoring a claimant's independence to the maximum extent practicable (s. 79 IPRCA 2001). Key aspects of social rehabilitation include the following: aids and appliances; attendant care; child care; home help; personal care; child communication support; educational support; home help; modifications to the home; training for independence; and transport for independence.

2.40 The purpose of vocational rehabilitation is to help a claimant to maintain or obtain employment or to regain or acquire vocational independence. This should be suitable for the claimant and appropriate to the claimant's levels of training and experience (s. 80 IPRCA 2001). The ACC is required to provide vocational rehabilitation to a claimant who has suffered a personal injury for which cover has been accepted and is entitled to weekly compensation; likely to be entitled to weekly compensation, unless vocational rehabilitation is received; or is on parental leave.

2.41 The type of vocational rehabilitation assistance that can be provided includes purchasing or modifying equipment for workplace; short-term transport assistance to and from the claimant's place of work; developing a plan to gradually increase hours or tasks at work; providing a support person to monitor the claimant's progress; preparing for job seeking and re-entering the employment market; undertaking a work-ready programme to assist in regaining the ability to work and to build confidence through work experience; and providing training to build on existing skills and/or to assist a claimant in entering a new occupation.

2.42 If claimant unable to return to work, then two assessments are likely to be done: an occupational assessment to identify skills and suitable work options for the claimant and a medical assessment to examine which work options are medically suitable for the claimant. If a claimant completes rehabilitation plan and considers that they should continue to receive weekly compensation payments, then the claimant will need to take part in a vocational independence assessment in order for the ACC to assess their ability to return to work.

2.43 The ACC uses vocational independence assessments to determine if there are any occupations that a claimant has the skills, education and training to undertake. If it is found that the claimant could potentially undertake such occupation for 35 hours or more per week, then the claimant will be found to be 'vocationally

independent' and weekly compensation will cease after 3 months' notice. This is the case irrespective of whether the person is able to return to their pre-injury level of earnings or any earnings and despite fact that there may be several specialists' reports linking incapacity to injury. The onus is on the claimant to demonstrate ongoing entitlement which in many cases is expensive and stressful.

2.44 Rehabilitation has become a problematic issue for the ACC in recent years. Rehabilitation rates at three, six, nine and 12 months have all deteriorated since 2005. As a result, weekly compensation has been paid for longer periods than expected, increasing the overall cost of claims. It has been suggested that a combination of factors have contributed to the current situation including claims management, societal expectations, changes in access and gateway management, increasing contributions to treatment and rehabilitation costs, and statutory changes to the vocational independence process (ACC Annual Report 2009: 25-6).

Entitlements

Medical and like costs

2.45 **Ambulance costs:** If a claimant is taken to hospital by ambulance within 24 hours of being injured, then the ACC will cover transport costs in the majority of cases.

2.46 **Treatment costs:** include acupuncturist, audiologist, chiropractor, doctor, hand therapist, hospital treatment and surgery, nurse, osteopath, physiotherapist, podiatrist, consultation with specialists (initial consultation and follow-up). Approval must be obtained from the ACC to cover the cost of the following treatments: elective surgery, non-urgent treatment, a second course of treatment or another type of treatment, some types of dental treatment and some travel and accommodation costs. There are two main methods by which the ACC pays for treatment costs: directly to the provider or the claimant pays the provider and then claims the cost back from the ACC.

2.47 **Approved treatment providers:** only approved treatment providers can register ACC claims. These include audiologists, chiropractors, counsellors, dentists, medical lab technologists, medical practitioners (these are the only ones that that can give ACC clients a medical certificate for time off work after the first week following the injury, other than nurse practitioners), nurses, nurse practitioners, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, speech therapists.

2.48 **Urgent Surgery:** costs for urgent surgery in a public hospital are covered in bulk payments made by ACC to the Ministry of Health under an annual agreement for public health acute services. If such surgery is not covered by ACC, then the District Health Board will recover the costs of such surgery from its general funding.

2.49 **Elective Surgery:** a claimant has two options: (1) elective surgery contracts or (2) regulations. In relation to (1), the ACC pays for the surgery, but the claimant's choice of specialists or hospital cannot be guaranteed. The ACC aims to arrange for

such surgery to take place within 6 months of a supportive assessment. The ACC will not pay for special costs such as a single room and TV, and the claimant would also need to pay a refundable deposit for equipment such as crutches. In relation to (2), the claimant may choose the specialists and hospital of their choice, as well as for additional items such as a single room. The ACC will pay a percentage of the cost of surgery and the claimant pays the rest. There is a need to obtain the ACC's written consent before any elective surgery is done. The ACC usually takes 21 days to make a decision regarding surgery, although if it is complex it may take longer.

2.50 Prescription Medicine: if the claimant's treating doctor prescribes medication to help with recovery and rehabilitation, then ACC may contribute towards prescription costs. The claimant may be able to obtain special approval from the ACC for non-subsidised medication, but the claimant's treating doctor would need to explain why it is needed.

2.51 Dental costs: The ACC will cover the dentist part of the treatment, but not all costs of treatment for dental injury. Dentists can claim directly from ACC for various aspects of treatment at set prices already agreed with the ACC. Prior approval is needed from the ACC for a range of more complex dental procedures.

2.52 Hearing Loss: if a claimant suffers a hearing loss injury, then the ACC may cover costs relating to obtaining a hearing aid and batteries, as well as the claimant undertaking communication programmes.

2.53 Visual Impairment: if a claimant suffers an injury that affects their vision, then the ACC may cover costs such as obtaining training for daily living, orientation and mobility, literacy and communication, transcription aids/appliances and counselling.

2.54 Counselling: the ACC may cover the cost of counselling services for a claimant if it is determined that the claimant suffered a mental injury within the meaning of the IPRCA 2001. The ACC needs evidence of a diagnosis of mental injury from a suitable specialist (e.g., a psychiatrist). It may be the case that the ACC will only cover part of the cost of counselling sessions, which need to be face-to-face.

Loss of earnings

2.55 An ongoing incapacity to work (as opposed to earn) less than 30 hours per week must be demonstrated. Providing this can be shown, then claimants are entitled to weekly compensation payments adjusted for inflation up until they are entitled to NZ superannuation (universal pension at age 65). No distinction is made between temporary and permanent incapacity.

2.56 Weekly compensation payments are made representing 80% of the claimant's pre-injury earnings. The maximum amount that the ACC will pay in weekly compensation payments is currently NZ\$1,692.59. Weekly compensation is available for work and non-work-related injuries if a person was earning immediately prior to their injury and can establish an ongoing stream of earnings. Weekly compensation is paid following the elapse of 7 days following the injury. The claimant will need to

provide medical certificates to the ACC at least every 13 weeks to confirm that they are unable to return to work.

2.57 A claimant may receive earnings (usually for part-time work) during the period they are claiming weekly compensation. When this happens, the level of the payments is reduced, under the abatement rules. If a client receives any income during a period of incapacity, then the ACC will consider whether any part of that income is 'earnings liable for abatement'. If a determination is made that the earnings are liable for abatement, then an abatement reduction is applied to weekly compensation payments as follows: (1) no deduction is made for any earnings up to 20% of the client's weekly earnings (100%) amount; and a reduction is applied at \$NZ1 for every \$NZ1 of earnings over 20% of the weekly earnings amount.

2.58 The ACC does not provide any real compensation for loss of potential earnings, except where a claimant was a student before they were injured and therefore had not had an opportunity to earn a living. Certain conditions may apply in such circumstances to the receipt of weekly compensation payments. Weekly compensation payments for loss of potential earnings will be either 125% of the minimum weekly wage or 125% of the invalid's benefit, whichever is more.

Permanent Impairment - lump sum payment

2.59 If a claimant is injured as a result of an injury that occurred after 1 April 2002, then the claimant may be eligible for a lump sum payment. This payment is in addition to any other support the claimant is entitled to receive from the ACC.

2.60 In 1992, the right to lump sum payments was removed from the scheme, and this led to a substantial rise in the number of common law claims brought by injured persons, particularly those who were classed as non-earners and injured persons with shortened life expectancy. Non-earners were not entitled to weekly compensation which was based on earnings immediately prior to suffering the injury. This provided an impetus to seek redress in the courts (Miller 2003). Lump sum payments were re-introduced in the IPRCA 2001, although this is limited to injuries which occur from 1 April 2002 onwards.

2.61 In order to qualify for a lump sum payment due to permanent impairment, the claimant must have suffered a personal injury which is covered under the scheme and has survived the personal injury for not less than 28 days and is alive when assessed for permanent impairment.

2.62 Assessments for lump sum payments are fully funded by ACC and will begin 2 years after injury, or when the claimant's condition has stabilised. The amount to be paid will depend on the assessed level of impairment.

2.63 The claimant will be referred to an independent assessor who will determine level of impairment in line with the American Medical Association's Guide to the Evaluation of Permanent Impairment (4th edition), in conjunction with the ACC User Handbook to AMA4. The level of impairment must be 10% or more to be eligible for a lump sum payment. For example, a 32% assessed impairment would include the amputation of a leg below the knee. Paraplegia would usually be assessed as 80%

or more impairment, and would provide the maximum entitlement. If a claimant sustains more than one injury, then they would be combined for assessment purposes. The assessment process usually take 4 months to complete.

2.64 The lump sum amount is non-taxable. The minimum lump sum compensation for permanent impairment that the Corporation is liable to pay to a claimant is currently NZ\$3,016.62 and is payable to the claimant where there is a whole-person impairment assessed at 10%. The maximum lump sum compensation for permanent impairment that the ACC is liable to pay to a claimant is currently NZ\$120,664.65 and is payable to claimant where is a whole-person impairment assessed at 80% or more.

Injuries causing death

2.65 **Funeral grant:** When someone dies as a result of an injury for which cover has been accepted by the ACC, then it will contribute to the costs of burial, cremation and related ceremonies. The funeral does not have to take place in NZ, and coverage is provided for both New Zealanders and overseas visitors to NZ. The funeral grant is normally paid to the executor of the estate, trustee or directly to the funeral director. The ACC will pay either the actual costs of the funeral or up to a maximum of NZ\$5,430.00, whichever is less.

Survivor's grant: This is a one-off payment to the partner, children and other dependants of someone whose death was the result of an injury. Any other dependant is anyone who is financially dependant because of a mental or physical disability on the person who died. Payments are non-taxable and are calculated based on the date of death. The ACC will pay a survivor's grant to a surviving spouse or partner of the claimant in the amount of NZ\$5,821.55. if there is more than one surviving spouse or partner, then the ACC will divide that amount equally between them. For each child of the deceased claimant who has not yet turned 18 years, then the payment will be NZ\$2,910.79. To any other dependant of the claimant, the amount will also be NZ\$2,910.79.

2.66 **Definition of dependants:** Dependants include partners from marriage, civil or de facto unions; partners who lived together or were financially supported by deceased; natural children or children for whom the deceased acted as a parent (e.g., stepchildren); and anyone who was dependant on the deceased because of physical or mental disability.

2.67 **Evidence required to establish dependency:** The evidence required to substantiate a claim arising out of the death of an individual resulting from an injury for which cover has been accepted by the ACC include the following: a statutory declaration confirming relationship with deceased; copy of marriage certificate or civil union licence; financial records; details of living arrangement, info about children, confirmation from employer, medical certificate about health status of deceased before death where spouse not living with deceased because of health obligations, further information from medical practitioner, birth certificates of children. To be eligible as a partner, there is a need to show that they were legally married or otherwise living with the deceased person in the nature of a marriage and was financially supported by the deceased immediately prior to injury or living with the

deceased immediately prior to injury (unless separated due to imprisonment, employment or health problems). To be eligible as a dependant child, then consideration is given to the nature of the relationship between the child and the deceased. A child needs to be under 18 years at time of death and either the natural or biological child of the deceased, the adopted child of the deceased, foster child, stepchild or other child for whom deceased acted as parent. Other dependants need to show that they were financially dependent on the deceased because of mental or physical disability.

2.68 Financial dependency: Those who can establish financial dependency in relation to the deceased for whom the ACC has accepted coverage, may be entitled to weekly compensation. The ACC determines payments the deceased would have received if they were injured and had to cease work. This is generally calculated as 80% of the deceased's earnings. If the deceased was a student and had dependants, then the dependants would be eligible for weekly compensation. Weekly compensation is payable to financial dependants from the date of death of the claimant at the rate of 60% of the weekly compensation for loss of earnings to which the claimant would have been entitled at the end of 5 weeks of incapacity, had they lived but been totally incapacitated; or the weekly compensation for loss of potential earning capacity to which the claimant would have been entitled at the end of 6 months of incapacity, had they lived but been totally incapacitated. Payment of weekly compensation to financial dependants is calculated in the following way:

- **Partner:** up to 60% of the 80% calculated of the deceased's earnings;
- **Child under 18 years of age:** 20% of the amount divided between the dependant children (if under 16, then this is paid to the caregiver);
- **Child over 18 years of age:** payments will cease unless the child is in full-time study;
- **Other dependants:** 20% of the amount.

2.69 Length of time receiving payments for financial dependency: In relation to the partner of the deceased, payments will cease either at the end of 5 consecutive years from the date payments started to be received; or the date when the youngest child being cared for by partner turns 18 (who is also a dependant of the deceased). If the partner stops caring for dependants before they turn 18 and payments have been received for 5 years or longer, then payments will stop. A dependant child can continue to receive payments until they turn 18. If they are over 18, and have been studying full time since the age of 18, then the child will receive support until they either complete full-time study or turn 21. The partner can choose to receive their weekly compensation support in the form of a lump sum (converted amount) instead of weekly compensation.

2.70 Childcare payments: when a parent dies of an injury for which cover is provided, then assistance can be provided to help with the costs of childcare. Payments are made to caregiver of children for up to 5 years or until the child turns 14. All childcare payments are non-taxable.

Code of ACC Claimants' Rights

2.71 The Code is contained in Part 3 of the IPRCA 2001. It entered into force on 1 February 2003. Confers rights on claimants and imposes obligations on the ACC in relation to how they should deal with claimants. The rights of claimants are as follows: right to be treated with dignity and respect; right to be treated fairly and to have one's views considered; right to have one's culture, values and beliefs respected; right to a support person or persons; right to effective communication; right to be fully informed; right to have one's privacy respected; and the right to complain.

2.72 A claimant may make a complaint through this Code, or make a general complaint about ACC including its policies and practices, in addition to making a complaint about decisions that have been made in relation to a particular (aspect) of a claim. Complaints can be made to the ACC Complaints Investigator, who will attempt to investigate the complaint and resolve it. If necessary, the Investigator will make recommendations to ACC about its policies or its interpretation of the governing legislation. In addition, the claimant can apply for a formal review at the same time as making a complaint. If the claimant and the ACC both agree, then the formal review can be delayed until complaint dealt with on an internal basis in the first instance.

Review and appeal mechanisms

2.73 If a claim is denied, then the ACC is required to provide reasons. If a claimant disagrees with the ACC decision, then they can ask for a review. In the first instance, it is recommended that the claimant approach the ACC employee dealing with the claim at which point an internal review can be conducted.

2.74 There is also the option of a formal independent review following the initial decision on a claim by the ACC. The time limit for lodging an appeal is 3 months from the date upon which the claimant receives the ACC decision. Aspects of the decision which can be challenged during this independent review include the following: whether any entitlements should be provided, and which ones; the level of entitlements; any preliminary decisions that are necessary for the above decisions to be made; whether an unreasonably long time has been taken to deal with the claim; whether there has been a breach under the Code of ACC Claimants' Rights; or the claimant is unhappy with the ACC's response to their complaint.

2.75 The ACC uses its independent subsidiary company Dispute Resolution Services Ltd to carry out these reviews. The formal independent review is conducted by an independent reviewer who was not previously involved in the claim. A hearing is conducted for which the ACC provides copies of all details held on the claimant's file. The independent reviewer is required to make a decision within 28 days and their decision is binding, although there is a right of appeal to the District Court (unless it involved a review of an alleged breach of the Code of ACC Claimants' Rights), as well as a further limited right of appeal primarily on points of law.

2.76 The ACC pays for the cost of the independent review and the claimant is responsible for meeting their own costs (e.g., retention of a lawyer and travel and

other costs). If the independent reviewer finds that the ACC's decision was wrong in whole or in part, then they are required to order that the ACC contribute towards the claimant's costs (within set limits). Even if the reviewer decides that the ACC's decision was correct, the reviewer can order the ACC to contribute towards a claimant's costs if they consider that the claimant acted reasonably in applying for the independent review.

2.77 In the last two calendar years (2007-2008; 2008-2009), 720 claimants have sought independent review from a TIC decision on cover. Of this number, 167 related to claims for which cover was accepted, but the claimant was not satisfied with an aspect of their entitlement; 499 involved claims which had been denied cover by the TIC; and 54 were classified as 'other'. Few cases go on appeal to the District Court. If the ACC decides to appeal, it would be on the basis that it would be concerned that a precedent would be set which would affect a large number of other claims.

Hepatitis C Fund

2.78 In late 2006, a NZ\$30million package was announced by the NZ government to those who had contracted Hepatitis C through blood products. Claimants needed to establish a causal link between the contraction of HCV and the administration of HCV-infected blood products at any time before 1993. The amount of the payout was NZ\$69,000 per person. The major component of the compensation package related to additional funding to improve access to up-to-date HCV treatments. Accepting this lump sum payment did not affect HCV-positive individuals' eligibility for ACC entitlements, which are assessed on a case-by-case basis.

Medical error and patient safety

2.79 **Professional discipline:** The ACC was previously required to report individual health practitioners to professional disciplinary bodies where there was a finding of medical misadventure. This is no longer the case as a result of the 2005 reforms to the IPRCA 2001. Prior to these reforms, there was a great deal of hostility and distrust between the medical profession and the ACC as a result of these reporting requirements (Oliphant 2007: 378).

2.80 **Learning from medical error:** as a result of the 2005 reforms, there is now much more of a focus on promoting a learning environment within which open disclosure of medical errors can take place. The ACC is now only *required* to report to the authority responsible for patient safety on data collected in the case of treatment injuries in circumstances where there is likely to be a risk of harm to the public (s. 284(2) IPRCA 2001).

2.81 **Risk of harm to the public:** The ACC has established a protocol for dealing with cases where there may be issue with regard to a risk of harm to the public. Through the TIC, a panel has been established which meets on a regular basis to consider cases which may fall into this category. The panel considers cases for which cover has been accepted by the ACC, as well as those which have been notified but not accepted. Although no treatment injury may be found, it may still nevertheless raise an issue regarding risk of harm to the public. If there has been no

external clinical advice report on a particular claim, then the protocol is not to refer it to a relevant responsible authority. If there is an adverse external clinical advice report, then it may be referred to the relevant responsible authority, in addition to the Director General (DG) of Health. In general terms, if there is no external clinical advice report but the panel considers that a referral is warranted, then it is referred to the DG of Health. It is for the DG to decide what further action, if any, should be taken.

2.82 There has been some criticism of the significant degree of flexibility which the ACC now enjoys with regard to interpreting the criterion of 'risk of harm to the public'. It has been suggested that there should be a high threshold if the confidence of the health professions is to be maintained, as well as the avoidance of a blame culture that characterised the medical misadventure era. Others have argued to the contrary, suggesting that stronger monitoring is now needed because of the lowering of incentives to exercise care in no-fault schemes (Howell 2004: 868-9).

2.83 **Collection of data on adverse events:** the ACC has been gathering data on adverse medical incidents since 1992-93 and trends identified in this anonymised data are shared with practitioner groups, District Health Boards, Ministry of Health and learning institutions. A national survey of adverse events found an overall rate of 12.9% of adverse events associated with admission to NZ public hospitals. The findings from the survey were similar to those found in other adverse events studies conducted in countries such as Australia and the United States (Davis et al 2001; 2002; 2003). It is not clear that full and effective use of such data has been made by such bodies in terms of learning from medical error and improving patient safety (CMO 2003: 107; Bismark and Paterson 2006; Davis et al 2006; Oliphant 2007: 390).

General points to note

Health system

2.84 NZ's health care system is primarily a centrally-funded, tax-based system. The legislative framework for the system is established under the NZ 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 NZ citizens and persons ordinarily resident in NZ) free of charge. Government subsidies partially fund primary health care and pharmaceuticals, with co-payments by patients unless they are eligible for a full subsidy. Resources constraints are recognised in 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 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 (Paterson 2006: 4-5).

Health and Disability Commissioner and the Code of Rights

2.85 In the late 1980s, the Cartwright Inquiry investigated the circumstances involving the treatment of cervical cancer at a leading NZ women's hospital which had resulted in women being unknowing participants in a clinical research trial designed to study the natural course of the disease. Many of the women went on to develop cervical cancer as a result. The Inquiry recommended that the law be amended to 'provide for a statement of patients' rights and the appointment of a Commissioner' (Cartwright Inquiry 1988). This subsequently led to the creation of the office of the Health and Disability Commissioner (Paterson 2002).

2.86 The Code of Health and Disability Services Consumers' Rights (Code of Rights) came into force on 1 July 1996. The Code comprises six clauses and contains 10 rights. affirm the right of health care consumers to receive an appropriate standard of care. These rights include general duties (rights 1-3); standard of care (right 4); information disclosure (rights 5 and 6); consent to services (right 7); right to complain (right 10). The HDC interprets and applies the Code. The Health Practitioners Disciplinary Tribunal uses the Code of Rights as a reference point in assessing the conduct of health practitioners, although it should be noted that a breach of the Code does not of itself amount to a disciplinary offence (see below) Paterson and Skegg 2006).

2.87 The role of the HDC is seen as crucial in a legal system where injured or aggrieved patients have no legal right to take legal action in the courts arising out of medical injury (except in very limited circumstances)). (Paterson 2002: 76-78). It has a number of functions, including dealing with complaints about the quality and safety of health services provided to patients by reference to the Code of Rights; investigating and resolving such complaints where appropriate; and dealing with broader systemic quality assurance issues raised by its work. In the event that a health professional body receives a complaint about a particular health professional, then the body must refer it on to the HDC. This also applies to health care institutions who receive complaints from patients. The HDC has a range of options for dealing with complaints. It can refer the complaint to another agency such as the ACC, Director-General of Health, the Chief Ombudsman the Chief Commissioner (Human Rights) or the Privacy Commissioner; refer the complaint to the health professional involved; refer the complaint to an advocate; call a mediation conference; take no action on the complaint, or investigate the complaint (Paterson 2006b).

2.88 The creation of the HDC and the Code has resulted in a substantial increase in the number of complaints against health practitioners, however, there has been a significant drop in the number that have been referred for disciplinary action (Paterson 2002: 70). Concerns have been expressed by the medical profession about the way in which the HDC deals with complaints, in particular that it has created a hostile atmosphere between health practitioners and patients, as well as promoting defensive medicine. In the circumstances, it has been suggested that it would be best to focus on systems learning, rather than individual health practitioners (Cunningham and Dovey 2006). Recently published data, however, points to under-utilisation of complaints processes by the patient population as measured by the rate of complaints to the HDC, when compared to the known underlying rate of medical injury (Bismark et al. 2006a; 2006b).

2.89 In 2008-09, the HDC received 4,579 enquiries about a range of matters, including consumers' rights and request for information. In addition, the HDC received 1,360 new complaints. Of these complaints, 87% were closed within 6 months, and 96% within a year (Health and Disability Commissioner 2009: 3). Advocacy on behalf of patients has proved to be a highly effective means of resolution, with 91% of complaints received by the Advocacy Service partly or fully resolved with advocacy support. Most of the complaints referred to other agencies (119 of 184) related to competence or professional conduct issues needing review by a registration board (such as the Medical Council of New Zealand).

2.90 Only 112 complaints led to a formal investigation. A significant number of investigations (72 out of 112) found that there had been breaches of the Code of Rights. All investigations were concluded within two years, with 64 (57%) completed in 12 months. 17 investigations resulted in 22 referrals (involving 15 providers) for disciplinary action to be considered in circumstances where major shortcomings in the provision of health care or unethical practice had been identified. This resulted in success in 9 out of 12 professional disciplinary hearings. The HDC received 98.5% compliance with recommendations for change in a health provider's practice; 39% of group providers reported significant systems changes made as a result of HDC recommendations (Health and Disability Commissioner 2009: 1-6).

Professional disciplinary bodies

2.91 Health practitioners in NZ are regulated under the Health Practitioners Competence Assurance Act 2003 (2003 Act). The 2003 Act requires the registration of health practitioners (defined widely) by professional bodies within specified areas of practice, mechanisms to ensure health practitioners are competent and fit to practise their professions. The main aims of such legislation are:

- to create a consistent accountability regimes for all health professions through making the HDC a "one-stop-shop" for handling complaints about patient care;
- to establish professional conduct committees to investigate and make recommendations on cases which raise questions about the appropriateness of the conduct or the safety of a health practitioner;
- to create a single Health Practitioners Disciplinary Tribunal to hear and determine charges brought about health practitioners (see Paterson 2006a).

Advantages and disadvantages of scheme

2.92 Advantages:

- Promotion of social community and solidarity through the implementation of a principled approach to compensating individuals for medical injury: community responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency.

- Low administrative costs overall for managing the scheme by comparison to the costs involved in the management of clinical negligence claims litigated under delict/tort-based systems.
- The scheme works alongside a well-established and comprehensive national social security system and an independent patient complaints process (HDC).
- It can initiate and respond in a dynamic way to changing patient demands for redress, including the development a more expansive approach to eligibility through ‘treatment injury’ (as opposed to one based on avoidability or preventability as seen in Nordic schemes) (Davis et al. 2006; 316; Oliphant 2007: 375).
- Provides greater access to justice by removing established obstacles to pursuing redress through the courts: it deals with claims more quickly; it is low-cost; health practitioners and institutions are able to assist injured patients in making claims; it removes the divisiveness and tensions between health practitioners and patients created by the delict/tort-based system.
- There is greater potential for improving quality and safety in health care.

2.93 **Disadvantages:**

- Under-utilisation of the scheme particularly by disadvantaged or vulnerable groups such as the elderly and ethnic minorities (Bismark et al. 2006a; 2006b).
- Rehabilitation remains problematic, both in terms of achieving recovery and a return to work, as well as the comprehensiveness of entitlement. The onus is on the claimant to demonstrate ongoing entitlement to weekly compensation for loss of earnings irrespective of whether the person is able to return to their pre-injury level of earnings or any earnings and despite fact that there may be several specialists’ reports linking incapacity to injury. Demonstrating this ongoing entitlement has proved expensive and stressful for many claimants against a background of government concerns about the overall affordability of the scheme.
- There is a low rate of entitlements/compensation available under the scheme when compared to settlements/awards in clinical negligence claims in tort/delict-based systems (Bismark and Paterson 2006).
- It is not clear that the scheme has been any more effective in dealing with preventable adverse events within the health system. Available evidence points to similar levels of such events in both the NZ scheme and in tort-based systems such as those operating in Australia and the United States (see Davis et al. 2001; 2002; 2003b; 2006).

- It is not clear that sufficient institutional linkage is made in relation to learning from medical error with a view to improving patient safety, as well as for ensuring the accountability of health practitioners (Davis et al 2006; Bismark and Paterson 2006).
- The failure to develop appropriate institutional and other mechanisms for facilitating professional accountability may encourage injured patients and families to seek redress/accountability via other legal routes such as the criminal law (Paterson 2001: 3; Merry 2005;).
- A marked disparity has emerged between the ACC and the public health system, which leaves two people with the same injury – one caused through injury and the other illness. This has resulted in very different compensation and care trajectories, as well as anomalies in cover under the scheme. While it has been suggested that this is inevitable in a 'system that stops short of providing full social insurance' (Fitzjohn and Studdert 2001: 433), the justice and fairness of the situation is called into question.
- There are common elements to no-fault schemes that have been established in various countries/jurisdictions, however, the inclusion of certain elements in the NZ scheme reflect particular historical, socio-cultural, institutional and legal trajectories which may not easily translated into different national context or captured in modelling exercises on eligibility criteria (see Davis et al. 2006: 315).

CHAPTER 3: NORDIC SCHEMES

Introduction

3.1 In the Nordic region, the adoption of no-fault schemes for medical injury has been the preferred approach. Sweden took the lead in adopting a no-fault scheme in 1975, although the parameters of this scheme have been amended over time. The Swedish model provided the inspiration for the adoption of no-fault schemes in Finland in 1987, Norway in 1988 and Denmark in 1992. The extent to which schemes vary reflect differences in national preferences on particular issues (Kachalia et al. 2008).

Legal and social goals

3.2 The Nordic schemes all have similar legal and social goals which may be summarised as follows:

- The patient's right to compensation where they have suffered harm as a result of medical treatment
- Easy and broad access by injured patients to compensation
- The fostering of good relations between health practitioners and patients
- The promotion of safety and quality in care through learning from medical error
- An emphasis away from attaching blame to individual health practitioners with a view to promoting learning from medical error and enhancing patient safety.
- Administrative schemes providing compensation for medical injury are more efficient in terms of costs and time to resolution.

Advantages and disadvantages

3.3 Similar advantages and disadvantages in relation to the Nordic schemes have also been identified. For ease of reference, a general summary is provided. The **advantages** of the schemes are as follows:

- Claims are resolved quickly and provide easy and broader access to justice for those who have suffered medical injury (Danzon 1994; Fallberg and Borgenhammer 1997).
- In general terms, the schemes operate eligibility criteria structured around the notion of avoidability, where patients are eligible for compensation if they have suffered injury that could have been avoided. This enables a more broad-ranging approach to be taken to the circumstances in which medical injury occurs (Kachalia et al 2008: 389).
- In order to facilitate greater access to justice in relation to medical injury, patients are able to submit claims under no-fault schemes free of charge (Kachalia et al. 2008).
- The schemes aim to promote good relations between health practitioners and injured patients. Although patients are not required to obtain the support of

physicians, patients often seek their advice in deciding whether or not to make a claim. In Sweden, for example, it is estimated that health practitioners facilitate 60-80% of all claims made under its no-fault scheme (Espersson 2000a; Kachalia et al. 2008).

3.4 The **disadvantages** of the Nordic schemes have been identified as follows:

- The Nordic schemes have erected a “Chinese wall” between compensation and professional accountability/disciplinary activities. This has resulted in the separation of all information collected and used under the no-fault scheme from fault-finding or disciplinary activities in relation to health practitioners (Erichsen 2001; Kachalia et al. 2008).
- There are limitations on compensation awards with maximum caps and threshold requirements regarding the level of disability a claimant must have before being eligible for compensation (Kachalia et al. 2008).
- Levels of compensation remain relatively low by comparison to what claimants would receive for successful clinical negligence claims under delict/tort-based systems. This needs to be set against the fact that Nordic no-fault schemes operate in the context of what would be considered well-funded and comprehensive social security systems.

Drug injuries schemes

3.5 The Nordic countries all operate no-fault schemes in relation to injuries caused by medicines (drug injuries) which run alongside the no-fault schemes for medical injury. Sweden and Finland operate voluntary schemes which are described in this way because pharmaceutical companies and importers which operate in these jurisdictions voluntarily pay contributions to enable the schemes to operate. In Denmark and Norway, the schemes are on a statutory footing. In Sweden, Denmark and Finland the no-fault schemes for medical injury were introduced prior to the one for drug injuries. In Norway, both schemes were introduced at the same time. national medical scheme was introduced before the drug scheme. The wording and operation of the drug injuries schemes in all four countries are not identical, but they are broadly similar (Hodges 2006: 145-9).

3.6 The schemes cover drug-related injuries caused by pharmaceuticals and vaccines that are marketed, regardless of whether the producer, importer, or any doctor has been negligent. Compensation may be paid regardless of which drug may have been the cause, as long as it can be established that the injury was caused by one (or more) drug(s). The schemes operating in Sweden, Finland and Norway are funded by contributions from the pharmaceutical industry in the form of a percentage levy set annually based on individual companies' turnover of national sales. In contrast, the scheme in Denmark is funded by the state from general taxation. As between the four countries, there is variation regarding which body administers the drug injuries scheme. In Denmark, for example, the body that administers the no-fault scheme for medical injury also administers the drug injuries scheme, but this is not the case in the other three countries (Hodges 2006).

3.7 The drug injuries schemes should be viewed as secondary, rather than primary sources, of compensation. Potential claimants are therefore encouraged to seek financial support and/or compensation for which they be eligible under national social security systems and no-fault schemes. As a result of this approach, awards of compensation made under these schemes are relatively modest. Broadly speaking, the schemes make top-up payments for pain and suffering and loss of amenity and cover any shortfall in the provision from other sources of loss of income. Broadly similar approaches are taken in practice as between the schemes with respect to determining causation and proof (although different terminology is used). Deadlines operate with respect to the filing of claims, and appeal mechanisms are in place (Hodges 2006).

Sweden

Administration

3.8 The Swedish Patient Insurance Association (Patientforsakringsforeningen or PFF) is a public company which administers the scheme. It is financially supported through contributions made by county councils which are responsible for the provision of health care.

3.9 While compensation for injury due to drug administration or prescription error is covered by the scheme, defects in pharmaceutical products are managed through a separate compensation scheme managed by the Swedish Pharmaceutical Insurance Association (Hodges 2006). Further details regarding this scheme are provided under paragraphs 3.5 – 3.7).

3.10 Various reforms have been instituted over time in an attempt to ensure long-term affordability of the scheme, and the longevity and success of the scheme needs to be seen in the context of a well-funded and comprehensive national social security system.

3.11 The scheme was originally established as a voluntary scheme in 1975. The scheme was placed on a statutory footing as a result of the Patient Injury Act 1996 (PIA 1996). The legislation came into effect on 1 January 1997. While many of the provisions contained in the PIA 1996 draw on the earlier voluntary scheme, there were certain important changes governing the right to compensation as a result of medical injury and the obligation of both public and private health care providers to hold what is called 'patient insurance' to provide for such compensation (Espersson 2000a; 2000b).

Funding

3.12 Under the provisions of the PIA 1996, health care providers are required to obtain insurance that covers claims being made in respect of medical injuries. Insurers that provide such insurance belong to the Patient Insurance Association.

3.13 There are 21 regions in Sweden each with their own directly-elected Parliaments. Each region is responsible for the provision of healthcare within their

boundaries. Health care is financed by regional income tax, which represent 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 (Essinger 2006; 2009).

3.14 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 cover for doctors and dentists operating in private practice, chiropractors, physiotherapists and nursing homes.

Eligibility

3.15 **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 resides 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 (Espersson 2000a; Kachalia et al. 2008).

3.16 **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 the retrospectivity rule may be applied. 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 (see Hellbacher et al. 2007; Kachalia et al. 2008):

- **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 there are special circumstances; injury from accident or fire that occurs on health care provider’s premises where patient is receiving treatment.

3.18 It is important to note that in the case of what could be termed drug-related injuries, only those that arise due to incorrect prescription of administration of incorrect medication are covered under the scheme. Compensation for other drug-related injuries is covered under a separate scheme (see paragraphs 3.5 – 3.7).

3.19 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

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

3.21 The PFF employs claims handlers to manage the claims. Such handlers typically have clinical or legal backgrounds (Kachalia et al. 2008).

Entitlements

3.22 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 (Hellbacher et al. 2007; Kachalia et al. 2008).

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

3.24 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, then a medical assessment takes place confirming the degree of

disability. The disability compensation is then paid as a lump sum in line with tables promulgated by the Association of Traffic Insurance Companies which set out the percentage of disability for each type of injury and the amount to be paid as a result (Essinger 2009).

3.25 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 (Essinger 2009).

Tort-based claims for medical injury

3.26 Under the Patient Torts Act 1996, a claimant is entitled to bring tort-based claims in the courts arising out of medical injury. 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.

3.27 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 (Espersson 2000a; 2006; 2009).

Review and appeal mechanisms

3.28 If a claimant is unhappy with the decision made by the PFF regarding their eligibility and/or entitlements under the scheme, then 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. The Panel aims to promote 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, but there is a high level of compliance. It is estimated that in 10% of claims brought before the Panel their recommendation was that cover be granted by the PFF (Espersson 2000a; Hellbacher et al. 2007; Essinger 2009).

3.29 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 making a decision on whether to bring a tort-based claim in the courts. The claimant is entitled to choose whether to bring their claim before the Panel or to proceed directly to court (Espersson 2000a).

Complaints process and professional accountability

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

3.31 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. Disciplinary action is kept entirely separate from the no-fault scheme (Essinger 2009).

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 LOF (the national medical injury insurance company). 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 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 (Essinger 2009: 5-7).

Finland

Administration

3.33 The Patient Injuries Act 1986 is the governing legislation that sets out the parameters of the no-fault scheme for medical injury in Finland.

3.34 The Patient Insurance Centre (PIC) handles all claims made under the scheme. An independent Patient Injury Board has been established by the Ministry of Health to provide oversight of the PIC. The Patient Injuries Board is also under a duty to publish recommendations on the management of medical injury cases under the scheme.

Funding

3.35 The costs arising from the operations of the Patient Injuries Board are paid from funds held by the Patient Insurance Centre on the basis of the Board's budget confirmed annually by the Insurance Supervision Authority. The Centre draws its funds from insurance premiums paid by hospitals and companies that provide health services. The amount of costs and insurance paid is determined at government level.

Eligibility

3.36 Eligibility is determined by the avoidability rule, with the standard applied that of an experienced professional in the speciality they represent (see paragraph 3.15).

3.37 To be eligible for compensation, the claimant must have suffered an objectively recognised harm due to a diagnostic or treatment procedure. Five prerequisites must be fulfilled before the compensability of a 'patient injury' can be evaluated:

- A patient has sustained a bodily injury.
- The patient's injury was sustained in connection with medical treatment and health care.
- The injured party must be a patient, i.e. a person being examined or treated.
- The injury occurred during the period in which the Patient Injuries Act was in force, i.e. on 1 May 1987 onwards.
- The injury occurred within the geographical area of Finland.

3.38 The Patient Injuries Act lists seven different situations where a bodily injury may be compensable under the scheme:

- Treatment injury
- Infection
- Accident related injury
- Equipment-related injury
- Injury arising from damage to premises or treating equipment (injury must have been sudden by nature)
- Incorrect administration of pharmaceuticals
- Unreasonable injury (the consequence must be unreasonable, disproportionate to the patient's illness/injury originally treated and overall health; patient has suffered a permanent severe illness, injury, or loss of life).

3.39 Threshold disability criteria applies. What are described as 'insignificant injuries' cannot be compensated under the scheme, even if they are otherwise eligible. An injury is considered to be insignificant if it causes only slight pain and suffering, no permanent functional disability, no aesthetic injury, or the costs incurred do not exceed 200 euros.

Processing claims

3.40 A claim for financial compensation from the PIC must be filed within three years of the date when the party entitled to compensation learned of the injury. A claim may be filed later under special circumstances; however, the maximum time limit is ten years from the date of treatment.

3.41 Once the claim has been examined, the PIC issues its decision in writing. The decision is sent to the claimant, the insured health practitioner or treating institution, and to the insurer. The PIC's claims assessors deal with procedures relating to the payment of entitlements under the scheme.

3.42 When a claim is accepted, a form for compensation will be attached to the primary claims decision to be filled in and returned to the Centre. There is a separate form for cases involving the loss of life. Claimants are asked to specify their claims and to give the information needed for assessing and paying compensation. This

information should include doctor's prescriptions, receipts and documents on compensation or benefits received under other insurance schemes.

3.43 Approximately 85% of all claims brought are treatment injuries. About a third of all claims made to the PIC are accepted for cover under the scheme.

Entitlements

3.44 Compensation payable is determined by applying the provisions contained in the Tort Liability Act and guidelines issued by the Traffic Accident Board.

3.45 The claimant is entitled to compensation only for that part of the costs and/or losses due to the 'patient injury' that is not covered by other statutory benefits and insurance provisions.

3.46 Entitlements under the scheme include the following:

- Medical treatment expenses
- Other necessary expenses caused by the injury
- Temporary incapacity ('pain and suffering' prior to revision of the Tort Liability Act that came into force on 1 January 2006)
- Permanent functional incapacity
- Permanent cosmetic incapacity (permanent impairment to a person's appearance)
- Loss of income
- Certain family members and others who are particularly close to the injured person may be eligible to receive reasonable compensation for necessary expenses and loss of income as a result of taking care of the injured person during a period of recuperation.
- Loss of life (funeral expenses and other related costs; necessary maintenance may be granted to those entitled to this compensation (e.g., spouse and children under the age of 18 years and in some cases children under 21 who are students; may also be extended to cover non-married partners).

3.47 If a patient injury requires a long period of treatment or the period of incapacity for work is prolonged, then additional claims for compensation may be received over a period of several years.

Tort-based claims for medical injury

3.48 Claimants are eligible to bring a tort-based action for damages in the Court of First Instance against relevant hospitals and/or doctors involved in their medical injury. These cases will usually be defended the PIC. Such legal action must be brought within 3 years from the date on which the claimant was informed of the PIC's decision in writing.

Review and appeal mechanisms

3.49 A claimant can appeal a decision made by the PIC regarding cover to request a correction to the decision on the grounds that it was based on insufficient

documentation. A claimant may also appeal to the Patient Injuries Board. There is no time limit on when such appeal can be made, although in practice the Board does not usually consider appeals where the claimant is barred from pursuing a claim before the Court of First Instance.

Complaints and professional accountability

3.50 Health care institutions must have a Patient Ombudsman to assist patients, in addition to providing information on patients' rights and assisting with filing a complaint, an appeal or a claim for compensation if necessary. The Patient Ombudsman operates independently of the PIC.

3.51 The PIC has no legal authority to deal with complaints or professional accountability or discipline issues in relation to health practitioners. A complaint may be made to the 'supervising authorities' for health practitioners. Complaints made against health practitioners are handled regionally by Regional State Administrative Agencies and by the National Supervisory Authority for Welfare and Health (Valvira). The Regional State Administrative Agencies and the National Supervisory Authority for Welfare and Health work together to investigate and generally deal with complaints about quality and safety in care. They can both direct that a health practitioner show due care and attention in respect of inadequate treatment or professional practice.

Medical error and patient safety

3.52 The PIC clearly collects and analyses a substantial amount of data on claiming, processes and outcomes under the no-fault scheme. It is also clear that Finland has structures in place for reporting and dealing with adverse events resulting from medication errors, as well as engaging in the collection and analysis of data on patient safety indicators. It is not clear as to what extent institutional exchange and professional learning from such data takes place.

Denmark

Administration

3.53 The Danish Patient Insurance Act covers compensation for injuries caused by treatment and the Danish Compensation for Injuries Caused by Drugs Act covers those caused by drugs (PIA – Patientforsikringen 2004) (see also paragraphs 3.5 – 3.7).

3.54 The Danish Patient Insurance Association (Patientforsikringen or PIA, a public company) processes, adjudicates, and determines compensation amounts for medical injury claims.

Funding

3.55 The PIA and the no-fault schemes is government financed in accordance with the requirements set out in the Danish Patient Insurance Act in order to ensure coverage of the national health service (PIA – Patientforsikringen 2004).

Eligibility

3.56 **Avoidability rule:** the avoidability rule is used instead of negligence to determine which injuries are eligible for compensation. This alternative standard/concept resides between negligence and strict liability (Kachalia et al. 2008) (see also paragraph 3.15). 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 practitioner or system. Thus, like Sweden, the Danish scheme uses the experienced or best specialist standard for defining avoidable injury and also applies the ‘alternate treatment rule’ to compensate equipment-related injuries. Unlike the Swedish scheme, however, the Danish scheme does not make use of the ‘retrospectivity rule’ (Kachalia et al. 2008) (see also paragraph 3.16).

3.57 **Endurability rule:** compensation can be paid for unavoidable medical injury if it is an unusual and serious injury which arises in relation to medical treatment received by the patient. This must result in a level of disability that exceeds what the patient should reasonably have been expected to endure. This is referred to as the ‘endurability rule’. There are a range of factors to be considered in applying this rule including the severity of underlying disease, the need for treatment, and the severity and likelihood of the injury sustained (Kachalia et al. 2008; (PIA – Patientforsikringen 2004). In addition, compensation can be paid if a patient is injured in an accident at a hospital and the hospital was at fault (PIA – Patientforsikringen 2004).

3.58 The following categories of injury are eligible for cover under the scheme:

- **Treatment injury** – ‘avoidable’ injury’, apply experienced specialist rule (no retrospective element); or if considered to be an ‘unavoidable’ injury that is rare and severe beyond reasonable expectations, then apply ‘endurability’ rule.
- **Diagnostic injury** – ‘avoidable’ injury, apply experienced specialist rule (no retrospective element).
- **Equipment-related injury** – ‘avoidable’ injury, apply strict liability rule.
- **Accident-related injury** – negligent injury.

Processing claims

3.59 Claimants may lodge a claim free of charge. Family members can initiate the claim in cases where the patient has died or is incapacitated. Claimants are not required to obtain the support of physicians before lodging a claim.

3.60 The PIA employs claims handlers to manage the claims, who typically have clinical or legal backgrounds (Kachalia et al. 2008).

3.61 The deadline for filing claims is 5 years from the time the claimant became aware of the injury and in all cases, no later than 10 years from when the injury occurred (PIA – Patientforsikringen 2004).

Entitlements

3.62 Claimants are entitled to compensation in accordance with the provisions of the Danish Liability for Damages Act. Compensation payments consist of two general components: pecuniary and non-pecuniary damages. Pecuniary damages cover loss of earnings, loss of ability to work, permanent damage, recovery costs resulting from the treatment, and medical expenses not covered by other insurance. Non-pecuniary damages cover compensation for pain and suffering. Levels are set according to schedules based on injury type, severity, and duration (Kachalia et al. 2008; PIA – Patientforsikringen 2004).

3.63 Where a patient has died, the family may be entitled to funeral expenses and loss of dependency/financial support.

3.64 There are threshold requirements in relation to the payment of compensation: (1) in the case of medical injuries, compensation will only be paid if the claim's value exceeds DKK 10000; in the case of dental injuries caused by dentists in private practice, it must exceed DKK 1000 (PIA – Patientforsikringen 2004).

Review and appeal mechanisms

3.65 Claimants may appeal a decision made by the PFF to the Patients' Injury Board of Appeal, which is constituted as an independent public authority. The deadline for submitting an appeal is three months from the decision taken by the PIA that there was no entitlement to compensation under the scheme or in relation to the assessment of compensation. In deciding on this latter aspect, the Board can increase or reduce the assessment of compensation.

Complaints process and professional accountability

3.66 The Patients' Complaints Board deals with complaints about the provision of health care by health practitioners. It has the power to make decisions on whether health practitioners have performed to an appropriate professional standard. The Board operates completely independently of the PIA and the no-fault scheme.

Medical error and patient safety

3.67 Detailed information and coding is recorded in relation to all injury claims in line with national and international classification systems. The injuries are coded so that they can be used for research into injury prevention nationally and internationally.

Norway

Administration

3.68 The health care system in Norway is organised at national, regional and local levels. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services. The regional level is represented by five regional health authorities, which have responsibility for specialist health care; and the local level represented by 434 municipalities has responsibility for primary health care (including nursing care).

3.69 Drawing inspiration from the Swedish model, Norway operated a non-statutory no-fault scheme for medical injury on behalf of public hospitals from 1988 onwards, and on behalf of municipal authorities from 1992 onwards. This was placed on a statutory footing with the Patient Injury Compensation Act 2001 (Johnsen 2006: 26-7). The Act came into force on 1 January 2003 in relation to health care provision in the public sector, and 1 January 2009 in relation to health care provision in the private sector.

3.70 The Norwegian System of Compensation to Patients (*Norsk Pasientskadeerstatning*) (NPE) is an independent national body which was established to process compensation claims from patients who have suffered injury as a result of treatment under the Norwegian health service. NPE operates under the auspices of the Norwegian Ministry of Health and Care Services.

Funding

3.71 The NPE and compensation paid under the scheme is funded by contributions from hospitals and municipal authorities (Johnsen 2006: 28).

Eligibility

3.72 The criteria for eligibility under the scheme is determined by:

- whether a patient has suffered injury as the result of an error or omission in medical treatment, and that includes any error or omission during medical investigation, diagnosis and follow-up; or
- the injury is particularly severe or unexpected and is not the outcome of a risk to which the patient was required to accept in advance.

Processing claims

3.73 A claim for compensation must be made to the NPE no later than three years after the person became aware that the injury might be a result of the medical treatment received.

3.74 The processing of claims by the NPE is free of charge to claimants.

3.75 It may take up to a year for the NPE to determine whether to accept cover for a claim under the scheme. This depends on the complexity of the individual claim. The NPE employs a range of medical advisors, all of whom are specialists in various

medical fields. The NPE may also obtain an opinion from external and independent medical specialists.

Entitlements

3.76 Claimants are entitled to compensation for financial loss. The financial loss includes loss of earnings, loss of a provider or additional expenses for medical treatment, medication or transport. To claim compensation, patient must have sustained a proven financial loss of at least NOK 5000 as a result of the medical injury. Compensation is assessed in line with the Norwegian Damages Act, which deals with the assessment of compensation in personal injury cases generally.

3.77 Claimants are also entitled to further compensation in the event of suffering a permanent injury, and this is not dependent on whether they have suffered any financial loss. The award is made on the basis that it is intended to compensate for reduced quality of life and reduced capacity to enjoy a good quality of life. In order to qualify for this category of compensation, the level of medical impairment that has resulted from the medical injury must be assessed at 15% or more.

3.78 For a claim to be processed by the NPE, the medical injury must have become permanent, or resulted in 15% or more impairment, or otherwise resulted in financial loss of at least NOK 5000.

3.79 If the NPE accepts coverage for a claim under the scheme, then the claimant will be entitled to have their reasonable legal expenses paid in relation to the making of the claim. Claimants may request prior approval from NPE in relation to what is likely to constitute reasonable legal expenses.

Tort-based action for medical injury

3.80 A claimant may pursue a tort-based claim for damages arising out of their medical injury in the courts (Johnsen 2006: 27).

Review and appeal mechanisms

3.81 If a claimant disagrees with the NPE's decision on coverage, then they can appeal to the Patient Injury Compensation Board (Pasientskadenemnda) (PICB). An appeal in writing is required, and the decision on cover will be reassessed by the PICB. The decisions of the NPE are binding on hospitals and municipal authorities (Johnsen 2006: 27).

Complaints and professional accountability

3.82 Patients may complain to the Norwegian Board of Health Supervision in relation to medical treatment provided to them. The Board has a range of sanctions at its disposal including warnings and withdrawal of privileges against both health practitioners as well as health institutions (Fuglenes et al. 2009).

Medical error and patient safety

3.83 While Norway has adopted a national strategy for improving quality and safety in health care, and structures are in place for reporting adverse events at least in relation to drugs (Johnsen: 28-9), it is not clear that systems learning from medical error and patient safety draws on the work and/or the data collected under the no-fault scheme.

CHAPTER 4: UNITED STATES

Introduction

4.1 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 (in particular obstetricians) 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 (Weiler 1991; Hyman 2002; Studdert et al. 2004; Baker 2005; Sage and Kersh 2006; Sloan and Chepke 2008).

4.2 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 has involved placing caps on the categories of damages that can be claimed, the creation of health courts (Mello et al. 2007) and the establishment of no-fault schemes (Johnson et al. 1989; Weiler 1993; Petersen 1995; Studdert et al. 1997; Studdert and Brennan 2001b). 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 (Kohn et al. 2000; Institute of Medicine 2001; Blendon et al. 2002; Leape 1994; 2002; Mello et al. 2007), as well as on the links to be made between medical malpractice claims and learning from medical error (Brennan et al. 1991; Studdert and Brennan 2001a; Sage 2003b; Phillips et al. 2004; Brennan et al. 2004; Studdert et al. 2006; Singh et al. 2007).

4.3 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

Overview

4.4 Virginia attempted to implement various reforms to its existing tort system, before establishing its no-fault scheme for birth-related neurological injury. By 1986, it had imposed a cap of US\$750,000 on injuries related to medical malpractice and established a medical malpractice review panel to screen medical injury claims.

Nevertheless, the cost of insurance premiums for medical practitioners in the field continued to rise and there were difficulties in obtaining professional liability insurance in the wake of a number of insurers refusing to provide new coverage for the practice of obstetrics. In the absence of government action in the area, it was estimated that 25% of obstetricians in Virginia would be without insurance by 1987.

4.5 It was against this background that the Virginia Birth-Related Neurological Compensation Act, VA (see Chapter 50 of Title 38.2 of the Code of Virginia) was introduced in 1987. The Birth Injury Program (Program) came into effect on 1 January 1988. The introduction of this Act represented the first time that a birth-related neurological compensation programme had been established in the United States (Heland and Rutledge 1992: 58).

Legal and social goals

4.6 The goals of the scheme are to ensure that children who have suffered birth-related neurological injuries receive the required care; 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 and that this would make it much more likely that obstetricians would continue in practice.

Administration

4.7 A nine member Board of Directors oversees the Program. The Governor of Virginia appoints all Board members. Various other professionals assist the directors in providing the requisite services. Although initiated by the Virginia General Assembly, the Program is an independent organisation (Program 2003, 2008a). The Workers' Compensation Commission (WCC) administers and adjudicates on claims under the Program.

Funding

4.8 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, 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.

4.9 Non-participating physicians can also be asked to make a financial contribution to the Program. Between 1993 and 2001, such contribution was not required, but was subsequently reinstated and they are currently required to pay an

amount US\$300 per annum in order to maintain the actuarial soundness of the Program.

4.10 As at 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 to a maximum of US\$200,000 per hospital) (Oliver Wyman 2009: 55). As at 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).

4.11 Administration 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 administration expenses (Oliver Wyman 2009: 52).

4.12 As of December 31, 2008, there were 142 claimants for whom cover had been accepted, of whom 111 had been in the Program for three or more years. As at 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 (Oliver Wyman 2009: 1).

Eligibility

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

4.14 The definition of 'birth-related neurological injury' under the governing legislation (Section 38.2-5001 Code of Virginia) 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.

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

Processing claims

4.16 It is often the case that claimants retain legal representation in relation to an application for cover 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 medical opinions/reports are usually required (Oliver Wyman 2009: 37).

4.17 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 eligibility generally. Either side may appeal this decision to the full WCC and from there to the Court of Appeals.

4.18 By 2008, there had been adjudications on 192 cases, 134 (70%) of which had been accepted, with 38 denied and 12 withdrawn (Siegal et al. 2008). The average annual expense per claim was US\$94,400 (Siegal et al. 2008). For the financial year ending 31 December 2008, a total of US\$10,778, 949 had been paid to claimants for whom cover had been accepted under the Plan. As at the same date, the cumulative total of payments made between 1988 and 2008 was US\$84,404,276.00 (Oliver Wyman 2009: 20, 22).

Entitlements

4.19 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 cover 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 and may continue through to the normal retirement age of 65 years. 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.

4.20 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 they are incurred. For expenses incurred prior to acceptance into the program, reimbursement requests must be submitted within two years of entry into the program (Program 2008a).

Review and appeal mechanisms

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

Advantages and disadvantages

4.22 Advantages:

- A total cap (increasing annually) on damages available in medical malpractice litigation was introduced in 1992 (almost US\$2million in 2008 (Siegal et al. 2008)); this meant that similar awards of damages would be available either through court action or through the Program.
- The eligibility criteria are expansive making it easier to obtain cover/compensation under the Program than to be successful in a tort-based action (Siegal et al. 2008).
- Shortened time frame for making decisions on cover under the Program.
- Overhead costs, in particular legal fees, are lower than would be the case in relation to tort-based claims (Sloan et al. 1997).
- The number of high cost claims in the tort system has been reduced.
- There is now increased availability of liability insurance, as well as a decrease in the cost of premiums for such insurance for obstetricians (whether participants in the scheme or not) (Patel 1995; Kessler and McClellan 1997; Siegal et al. 2008).
- The 'battle of the experts' which is a hallmark of tort-based actions is avoided (Siegal et al. 2008: 506).
- There is flexibility in the Program in relation to requests for the payment of benefits not specifically addressed in the guidelines. For example, experimental treatments or therapy not typically covered by health insurance may be covered up to a maximum of US\$6,000 per year, combined with written prior authorisation from the Executive Director.
- 'No-fault schemes are a viable alternative for families where birth related neurological injury does not rise to the level of negligence yet ... substandard quality of care [is still experienced]' (Sloan et al. 1997: 64).

- Physicians in Virginia 'report significant relative declines in the perceived impact of malpractice pressure on practice patterns' (Kessler and McClellan 1997: 81).

4.23 Disadvantages:

- The statutory definition of birth-related neurological injury is narrow and therefore only a small number of potentially eligible claims have been accepted for cover under the Program (Horwitz and Brennan 1995; Patel 1995).
- Affordability remains an intermittent problem and this presents potential difficulties in terms of coverage and meeting ongoing liabilities.
- Determination of causation of injury, particularly in relation to the oxygen deprivation as opposed to mechanical route of injury, remains a complex aspect of these cases (Siegal et al. 2008: 506).
- Little incentive is provided for health practitioners to maintain standards (Patel 1995).
- The Program is not well-advertised nor targeted at potential claimants (Sloan et al. 1997).
- The potential exists for high administrative costs over time as cases are never closed (Sloan et al. 1997).
- The scheme is 'quite limited in scope and thus [does] not exist in the spirit of compensation that is ideally no-fault' (Sloan et al. 1997: 66).
- Because of the low numbers of claims, physicians have little experience of the scheme in practice and therefore it does not affect patterns of practice or develop a broad base of practitioner support (Sloan et al. 1998).

Florida

Overview

4.24 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 (Siegal et al. 2008: 503).

Legal and social goals

4.25 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.

Administration

4.26 A statutory body known as The Birth-Related Neurological Compensation Association (NICA) was established to oversee the Florida Birth Related Neurological Injury Compensation Plan (Plan) provides benefits to children who come within the statutory remit of the Plan (see Section 766.302(2) of the 2007 Florida Statutes).

4.27 A five member Board of Directors appointed by the Chief Financial Officer of the State of Florida is responsible for the administration of the Plan. The Plan employs an Executive Director. Various professionals assist the board members (Law et al. 2009).

Funding

4.28 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 which provide high levels of charity care); and the state of Florida has made a one-off grant of US\$40 million to fund the scheme (Horwitz and Brennan 1995; Siegal et al. 2008). The statute includes provision for assessing insurance companies of up to 0.25% of their annual net direct premiums 'should the fund become actuarially unsound' (Horwitz and Brennan 1995). NICA has also purchased a reinsurance plan.

4.29 In 1989 the total cost for administering a claim was US\$18,000 (Horwitz and Brennan 1995.) By 1993, NICA had paid only US\$4million in compensation, although it was estimated that an additional US\$69 million was likely to be required for future claims. By 2008, NICA had adjudicated on 636 cases, 226 (36%) of which had been accepted, with 277 denied and 96 withdrawn (Siegal et al. 2008). Total payments made up to 2008 were US\$73,300,000 with an average annual expense per claim of US\$59,000 (Siegal et al. 2008).

4.30 Administrative costs include NICA overheads, attorney's costs and the costs of adjudicating before a hearing officer. NICA uses its own counsel in the 75% of cases where the claimant has instructed their own attorney (Horwitz and Brennan 1995).

4.31 The scheme began to pay out awards of compensation in 1989. The scheme covers physicians, nurses and midwives who pay to participate. Obstetricians and hospitals to which they admit their patients are legally obliged to notify all obstetric patients of the existence of the scheme, including information about the extent and restrictions upon their rights under the scheme.

4.32 If a family chooses to continue to receive obstetric care from a health practitioner who has notified them that they are a member of NICA, any subsequent claim for compensation which falls within the eligibility criteria for the schemes must be brought within it, with no option to pursue a tort-based claim in the courts.

Eligibility

4.33 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.

4.34 The Plan only applies to live births and does not include death or disability caused by genetic or congenital abnormality. Benefits under the scheme are only available 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. The infant's impairments must be both physical and mental.

4.35 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 (Siegal et al. 2008)

Processing claims

4.36 A claim must be brought within five years of the child's birth.

4.37 An application for acceptance of cover under the Plan must be filed with the Florida Division of Administrative Hearings (Section 766.305, Florida Statutes). 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

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'.

4.38 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 only available if there has not already been a settlement in a lawsuit, given that the Plan provides for lifetime benefits and care.

Entitlements

4.39 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.

4.40 Awards are paid periodically. NICA saves costs in compensation through buying medical products through discount suppliers and negotiating on therapy rates (NICAA; NICAB).

Review and appeal mechanisms

4.41 In the event that a petition for cover under the Plan is rejected by a judge within the Florida Division of Administrative Hearings, then this can be appealed to the District Court of Appeal.

Advantages and disadvantages

4.42 **Advantages:**

- Overhead costs, in particular legal fees, are lower than would be the case in relation to claims made under a delict/tort-based system (Sloan et al. 1997).
- Compensation paid under the Plan is comparable to that paid in tort claims.
- The Plan enjoys a high level of support amongst obstetricians in Florida with 80-90% subscribing to it and it is financially stable (Siegal et al. 2008).
- There is a shortened time from filing a claim to receiving compensation.

- The number of high-cost medical malpractice claims brought under the tort system has been reduced, as have insurance premiums for obstetricians (whether or not they are participants) (Patel 1995).
- The 'battle of the experts' which is characteristic of the tort system is avoided (Siegal et al. 2008: 506).
- There is flexibility in relation to the payment of entitlements under the Plan. Requests for payment of benefits that are not addressed in the Benefit Handbook can be made by parents/guardians if they believe it would be of advantage to the child (NICAA; NICAb).
- 'No-fault schemes are a viable alternative for families where birth related neurological injury does not rise to the level of negligence yet ... substandard quality of care [is still experienced]' (Sloan et al 1997: 64).
- The existence of the scheme leads to fewer tort claims and lower malpractice premiums (Kessler and McClellan 1997).

4.43 Disadvantages:

- Statutory eligibility criteria is unclear and this leads to disputation over the meaning of 'severe mental and physical injury and mechanical injuries' and 'course of labor, delivery or resuscitation'.
- NICA's limited remit and resources has meant that there have been problems in the management and estimation of expected loss estimates (Horwitz and Brennan 1995).
- There are low claiming rates compared with the estimated number of potential claimants. 43 claims were made in the first 5 years of the Plan compared to an estimated 135 eligible claimants over this same period. Reasons for the low claiming rate may be attributable to difficulties in obtaining legal representation for claims under the scheme which require significantly less input (therefore fees) than under the tort system (Horwitz and Brennan 1995).
- Determination of causation of injury under the Plan remains difficult, particularly with regard to oxygen deprivation as opposed to the mechanical route of injury (Siegal et al. 2008: 506).
- The ability of claimants to choose whether to file in tort or no-fault means that levels of tort-based claims remain relatively high.
- The Plan is not well-advertised nor targeted at potential claimants (Sloan et al 1997).
- The potential for high administrative costs over time as cases are never closed (Sloan et al. 1997).

- The scheme is 'quite limited in scope and thus [does] not exist in the spirit of compensation that is ideally no-fault' (Sloan et al 1997: 66).
- Lawyers are using the requirement that obstetricians notify patients of the existence of the scheme before treatment as a loophole to exclude eligibility where notification has not taken place (Sloan et al. 1998).
- Because of the low numbers of claims, physicians have little experience of the scheme in practice and therefore it does not affect patterns of practice or develop a broad base of practitioner support (Sloan et al. 1998).

Evaluation of Virginia and Florida schemes

4.44 Between 1995 and 1997, researchers from Duke University Medical Center, North Carolina, received funding from the Robert Wood Johnson Foundation in the United States to evaluate the Virginia and Florida no-fault compensation schemes for birth-related neurological injury. The researchers surveyed claimant attorneys, obstetricians and parents, as well as examining maternal and infant medical records (Robert Wood Johnson Foundation 2002). Key findings from the study are as follows:

- The two programmes achieved their objectives of maintaining affordable obstetric insurance coverage for physicians with obstetrical liability premiums declining much more rapidly after the introduction of the schemes. This was achieved through removing the most expensive obstetrical medical malpractice claims from the existing tort system (Bovbjerg and Sloan 1998).
- Although it was found that obstetricians were generally happy with their experience in participating in the schemes, over half surveyed were dissatisfied with the cost of their no-fault insurance premiums. For those surveyed who had ceased practice in obstetrics, 39% said that the threat of malpractice claims was a factor, notwithstanding the existence of no-fault compensation schemes in Virginia and Florida (Sloan et al. 1998a).
- The administration of the no-fault compensation schemes were less expensive than the tort system, and there was much quicker resolution of claims than under the tort system (Sloan et al.1997).
- Only a small proportion of potential claimants sought compensation. This was particularly noticeable in Florida where only 13 claims were paid on a per annum basis compared to 497 live births which were estimated to have resulted in cerebral palsy in 1990. The diagnosis of cerebral palsy was used as a rough indicator of the likely number of claimants who might seek compensation. In terms of meeting eligibility criteria under the scheme, it was estimated that at least 53 cases on a per annum basis were compensable. The reasons for the small number of claims being made under the no-fault compensation schemes were attributed to a continuing reliance on lawyers to bring claims even though the schemes assist potential claimants with filing claims; limited outreach and public education efforts to inform parents who may be eligible to file claims about the schemes; and continued use of the existing tort system in Florida to litigate

claims covered by the schemes (Bovbjerg et al. 1997; Sloan et al. 1997; Sloan et al. 1998b).

- The schemes were too limited in scope to achieve broader access to compensation and increased prevention of medical injuries. In order to achieve this, there would need to be greater expansion of the administrative reach and support of the schemes, as well as significant additional funding.

4.45 A review of the Virginia no-fault scheme was carried out in 2003 by the Joint Legislative Audit and Review Commission of the Virginia General Assembly in order to assess whether the scheme was serving its intended purpose. It was found that while the scheme had brought about benefits by reducing insurance premium rates, the numbers of tort claims and related costs, it was less successful in achieving its social aims of ensuring availability of obstetric care in rural areas. Concerns were also expressed as to whether the Program was actuarially sound. The Commission made a number of recommendations in light of these findings including amending eligibility criteria and the processes used to determine eligibility; providing more support for families using the system; using more rigorous reviews of physicians and hospitals where claims are made under the scheme; improving administration of the benefits paid out by the scheme; and increasing accountability within the scheme (Joint Legislative Audit and Review Commission 2003).

4.46 In 2004, the Office of Program Policy Analysis and Government Accountability in Florida published a report which examined the Florida no-fault scheme, in particular focusing on eligibility requirements and whether these should be modified. It concluded that in order to meet its statutory goals of lowering malpractice premiums and providing compensation for a defined class of catastrophic injuries, eligibility requirements should be expanded in a number of ways. First, the birth rate requirement could be reduced from 2,500gms to 2,000gms; the requirement for physical and mental impairment could be relaxed to a requirement for either of those conditions; or brachial plexus injuries could be included. These options would lead to an annual increase in costs of between US\$9.5m and \$130.8m (Oppaga 2004).

CHAPTER 5: ENGLAND

Historical overview

5.1 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 (Pearson 1978). 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 UK (Ham et al. 1988; Jones 1990; Brazier 1993; Fenn 1993; McLean 1993; Oliphant 1996).

Recent attempts at clinical negligence reform

5.2 The impetus for the most recent episode of clinical negligence reform in England had its origins in the publication of two reports that were highly critical of the current clinical negligence litigation system. Against the background of a dramatic increase in the number of claims being made, the resolution of claims was seen as taking too long and, in many cases, legal costs were considered excessive (NAO 2001, cf., Fenn et al. 2000; 2004). It was also recommended that the current system be abolished and replaced by an 'alternative administrative system' which did not foster a 'culture of blame' (Learning from Bristol 2001: 442).

Making Amends report

5.3 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 (CMO 2003: 110-13). Recommendations were nevertheless made for an NHS redress scheme to be established which would include: (1) care and compensation in the case of birth-related neurological injury (inspired and adapted from the schemes operating in Virginia and Florida); a redress package (including financial compensation) for low-value claims (CMO 2003: 119-21).

NHS Redress Scheme

5.4 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.

5.5 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 accountability on the part of healthcare professionals. In the circumstances, it is unlikely to address issues of longstanding concern to injured patients (Vincent et al. 1994), and would therefore be unlikely to inspire patient confidence in the scheme (Farrell and Devaney 2007: 647-48). 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

5.6 In the wake of report by Lord Woolf (1996), as well as the centralisation 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. 41% 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 (NHSLA 2009: 10-14).

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