Policy Issues in Insurance

Medical Malpractice

PREVENTION, INSURANCE AND COVERAGE OPTIONS

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Foreword

The adequate coverage of medical practitioners and health establishments' liability, the fair compensation of so-called "iatrogenic injuries" as well as the deterrence of medical malpractice are of utmost importance for patients' safety and confidence in the health care system and its smooth functioning and sustainability. Such indemnification and risk-mitigation tasks are performed through different tools in OECD countries. Yet so far, most OECD indemnification regimes rely on a combination of tort law and medical liability insurance policies to cover health professionals and institutions in case of patients' injuries. These regimes typically require proof of the medical liability/negligence through courts' settlements for victims/patients to be compensated.

Over the last years and in particular since 2002 in many OECD countries, these systems have experienced difficulties as premiums for medical liability insurance have increased by such proportions for certain specialties and hospitals that the medical profession can hardly afford them. In most cases, this surge is due to a considerable increase in frequency and size of damages awarded by courts. In return this crisis has resulted in some OECD countries in worrying adverse effects on health care quality, patient safety and higher costs of the overall system. For instance, the number of obstetricians, gynecologists, surgeons, orthopedists and anesthesiologists in several jurisdictions tends to decrease as these are considered to be high-risk specialties implying a greater possibility of law suits and a far higher level of insurance liability premiums. Some medical practitioners are also increasingly making use of defensive- and hence expensive and potentially risky medical treatments in order to avoid possible future claims.

Against this backdrop, the present study offers a unique and comprehensive overview of the various types of indemnification/deterrence systems of patient injuries in OECD countries including regimes based on a no-fault compensation of medical accidents. The second chapter of the analysis emphasizes the main reasons and drivers of difficulties faced in some countries to cover, compensate and mitigate risks of iatrogenic injuries. Various public and/or private measures designed and implemented in several OECD countries to cope with these challenges are then assessed with a view to their pros, cons and material impacts.

Lastly, bearing in mind, that national circumstances are unique and that there is certainly no ideal system, the report concludes with focused policy options, of interest

for private and public parties in both OECD and non-member countries and particularly these which are in the process of establishing a more efficient indemnification and deterrence system to cope with medical accidents.

The analytical report is completed by comparative tables sketching out the key features and evolutions of the coverage of iatrogenic injuries in OECD countries.

The completion of this report and tables was made possible thanks to the contributions and constructive comments of OECD governmental experts and insurance industry representatives as well as main observers and stakeholders of the health system. This volume was then elaborated and drafted by Ms. Flore-Anne Messy of the Directorate for Financial and Enterprise Affairs of the OECD and is current as of June 2006. The publication has been finalized thanks to the assistance and technical support of Claire Dehouck, and Edward Smiley.

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Introduction: A Supply "Crisis" in Some OECD Countries

In a number of OECD countries, mainly Australia (until 2003), the United States, and several European countries,[1] premium rates for medical malpractice insurance have been steadily rising over the last years. Percentages vary and generally high-risk specialties and public and private health care establishments have been more affected. In some extreme cases, the availability of these specific policies has dramatically dropped. Main insurers and reinsurers are withdrawing from the market, while others refuse policies with high risk-exposure, or set premiums at nearly unaffordable[2] prices for physicians, hospitals and private clinics.

This development, which has been particularly worrying for some OECD governments and major market players, has often been worsened by high-profile medical scandals with their attendant publicity. Moreover, this crisis is all the more preoccupying and complex for governments as it potentially affects the confidence of citizens in the health care system and in health care providers, and belongs as well to a more general trend towards increasing scope of liability.[3]

Against this backdrop, work on medical malpractice was initiated by the OECD Insurance and Private Pensions Committee in 2003 upon the request of the French Delegation. This project has led thanks *inter alia* to an initial stock-taking exercise to the completion of this analytical report on medical malpractice coverage schemes in OECD countries supported by comparative tables presented in Annex A. Accordingly, the study is notably based on the contributions of most OECD member countries (27 out of 30) as well as on comments of various stakeholders of the medical liability sector. In this respect, the comparative analysis first seeks to provide an overview of the main schemes established in OECD countries to cope with medical malpractice and their core features and challenges. It then outlines key factors contributing to current concerns in some OECD countries and lastly provides various policy options, which may be considered to overcome these difficulties.

Notes

1. *E.g.* Austria, Belgium, France, Greece, Italy, Spain, Switzerland, Turkey to a more limited extent and the United Kingdom (though these increases are mainly financed through the NHS).
2. Even if premiums may seem realistic from an actuarial and insurance point of view.
3. See notably OECD (2003).

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Chapter 1

Coping with Medical Malpractice in OECD Countries

1. Differences in the system of compensation for medical malpractice in OECD countries

As illustrated by the variety of wording used,[1] compensation systems for either medical "malpractice", "errors", "negligences", "misadventures" or "avoidable and adverse events" widely differ across OECD countries, in their funding practices, triggers, coverage, etc. Broadly two main types of mechanisms to compensate for medical injuries may be distinguished. A "system of compensation of damage" on the one hand implying the assessment of fault and financed through medical malpractice liability insurance markets and on the other hand a "no-fault compensation system". In this context, it should also be noted that differences in the treatment of medical liability are also a result of the differences in the provision and financing of health care amongst OECD countries.[2] Countries where most health care providers are financed by the states tend to rely less on the private insurance market to cover medical liability. In these cases, the financing of medical liability is often directly provided by the state possibly through dedicated funds.[3] On the contrary, in countries where private practices of health care are more widely developed the private market also plays a greater role in the compensation of injured victims.

The main focus of this analysis will not be to survey the detailed features of no-fault compensatory systems; rather, we will emphasise developments and difficulties in the medical malpractice insurance market. However, particularly enlightening aspects of no-fault regimes will be sketched out when relevant (see for instance Chapter 1 for an overview of this kind of schemes as well as Chapters 3 and 4).

Compensation systems based on the assessment of negligence

In most OECD countries, claims for medical malpractice need to be assessed by jurisdictions based on an evolving and broadening (through law or jurisprudence) interpretation of fault. Damage awards (if any) are then mainly paid by the concerned health care providers generally thanks to a private insurance policy[4] usually offered by general non-life insurance companies. An alternative to or a complement of this system implies that multi line mutual and/or specialised non-profit associations of medical professionals provide compensation.[5]

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Influence of the legal and tort system

In both cases, the availability of insurance coverage and the insurability of the risks partly depend on the main features of the tort system in place and, in particular, on the evolution of the notion of fault/negligence generally defined by civil law and/or used by jurisdictions or based on common law.

The two main purposes of tort law in respect of medical malpractice are compensation and prevention/deterrence. In practice, neither function can be comprehensively carried out within a single scheme and usually imply a difficult trade-off. The secular trend in OECD countries has led to an expansion of patients' rights, protection and indemnification[6] often in conflict with the objective of prevention.

Traditionally, liability and damages rules were based on the notion of fault, but the expansion of victims' compensation has often entailed a shift of the burden of proof from the patient to the medical practitioners.[7] Compensation for damages is granted not only in cases of gross negligence or when the liability can be proved, but, in some countries, as well when the error is only presumed ("liability based on causation"). In the latter case, an obligation to pay for damages arises from a connection (the causality) deemed to have existed between an event (the cause) and the injury (the effect). In extreme cases, liability based on causation is not subject to the existence of any irregularities, malfunction or failure to observe appropriate practices. Examples of strict liability are scarce in medical liability. An exception may, however, be found in Iceland[8] where the Act on Insurance Patient, 2000, states that "compensation shall be paid irrespective of whether anyone may be liable for damages according to rules on tort, provided that the damage suffered can in all probability be traced to a series of medical incidents". In other countries such as Austria, Germany and the United States or Spain[9] and France[10] to some extent, the notion of "presumed error" notion of medical liability is progressively emerging from court decisions.

Alternative and/or complementary private sources of financing

Apart from traditional insurance companies underwriting medical malpractice liability policies (see details in Chapter 2), in some OECD countries,[11] for historical and cultural reasons as well as owing to the particularities of the market, medical malpractice insurance is dominated by one or several non-profit associations of physicians or medical defence organisations devoted to the coverage of the medical liability of their members. These structures may be reinsured through insurance captives or reinsurers. In some cases, self-insurance mechanisms, risk retention groups or trusts have also emerged to provide coverage to individual establishment and consortia of establishments as well as physicians. These diverse initiatives have resulted in

wide variations in mutuals' organisations (*i.e.* their legal structures, type and scope of coverage and regulation) in the jurisdictions in which they have developed.

In Canada, the Canadian Medical Protective Association (CMPA),[12] a not-for-profit medical mutual defence association provides education, advice, legal defence and indemnification to approximately 95% of practising physicians in Canada. The CMPA was founded in 1901 and incorporated by an Act of Parliament in 1913. The CMPA model is built on a discretionary occurrence-based assistance. The long-term experience of the Association has proved successful and sustainable over 100 years in Canada: the scheme is financed through a fully funded mechanism and is actuarially sound. Fees are calculated according to an actuarial risk assessment based on physicians' specialty and region of practices. These fees are modulated using experienced funding adjustments based on investment gains and losses. Reserves are accumulated to cope with future liabilities drawing on past data and current trends. The CMPA's protection includes no limit on damages paid to patients and have rather extended assistance to member than denying help. In addition, the CMPA has supported efforts to improve patient safety and medical risk management of the overall health system.

In Japan, the Japan Medical Association (JMA), an association of physicians, created a Professional Medical Liability Insurance Programme in 1973 and extended its scope in 2001 to cover individual physicians and to resolve disputes between patients and physicians who pay a membership fee to the JMA. The JMA assesses on a discretionary basis whether the claims can be taken into account under the insurance programme and if the member will be covered in this respect. For claims eventually taken care of by the program, the JMA is covered by an insurance contract sold by a non-life insurance company.

In the United Kingdom, doctors working in the NHS hospitals are directly indemnified since the 1990s by the state in a non-insured state funded scheme.[13] The compensation provided by this scheme is based on the claimant establishing clinical negligence and associated financial loss. However, outside this scheme, NHS general practitioners and hospitals doctors in private practice are mainly covered by three Medical Defence Organisations (MDOs). The Medical Defence Union (8% of claims payments) provides indemnity on an insured basis (through Converium Insurance) backed up by a discretionary fund for claims and other medico-legal matters that fall outside the terms of the policy, while the other two MDOs (Medical Protection Society and the Medical and Dental Defence Union of Scotland) only provide indemnity on a discretionary basis. In addition there are a small number of insurance companies that also offer Professional Indemnity Insurance to doctors.

In the United States, the situation is rather specific for historical reasons and as a result of previous crises in the mid-1970s and mid-1980s. Today's medical malpractice insurance market is a mix of traditional insurers, provider-owned groups (physicians and hospitals), alternative risk transfer entities and Joint Underwriters Associations (JUAs).[14] Mutual companies, most of which are physician-owned, represent approximately 60% of the market and, in 2003, between 30 and 40 retention groups were formed in the health care field.

The development of mutual types of providers in the market for medical malpractice liability was fostered by different factors. The United States is an interesting case in which the previous two periods of a hard market in the mid-1970s and mid-1980's and the attendant lack of affordable coverage entailed the development of such structures. Actually, associations of physicians were thought to offer lower premiums than traditional insurers due *inter alia* to their mono-line and generally local specialisation. Moreover, their non-for-profit nature implies that they do not need to generate returns for shareholders. Physicians-owned structures may also be considered to have underwriting advantages over the for-profit entities, such as a closer knowledge of doctors' practices and legal customs. This comparative advantage could help mitigate the negative effects of information asymmetry. Lastly, it has been argued that by operating within a different philosophy and culture, these entities favoured better risk mitigation and assessment. (See also hereinafter Chapter 3).

Comprehensive no-fault compensatory regimes

Other, though relatively rare, alternatives that have developed in a few OECD countries[15] are based on a no-fault system of compensation. In these countries, the assessment by the court of health care providers liability is not a pre-condition for granting indemnification to the injured patients. Rather, the trigger to compensate is generally based on the injury itself or the fact that it could have been avoided.[16] These systems may be privately financed through commercial and non-for-profit insurance entities (*e.g.* in Denmark, Finland) or publicly financed (*e.g.* in Sweden and New Zealand).

In New Zealand (NZ), medical malpractice insurance has been provided under the NZ accident compensation scheme since 1972 (in force since 1974) and administered by the government-owned Accident Compensation Corporation (ACC). This unique global scheme also covers work and non-work injuries, motor vehicle injuries and medical misadventures for all New Zealanders and visitors in NZ. The funding for "medical misadventure" (until 1st July 2005) claims under this scheme is not provided by medical practitioners; it is shared between the government and the NZ working population.[17] The regulation of the ACC has been revised several times and the funding structure is being progressively transformed since 1999 from

pay-as-you-go to fully funded (in 2014). The coverage of the scheme was also extended through law and court cases and notably in 1992 and recently in July 2005. As from this date, the term "medical misadventure"[18] will be replaced by "treatment injury". Accordingly, all concept of error, fault or negligence has been fully removed from the scheme which will, from now on, cover any injury occurring as a result of treatment that is not an ordinary consequence of that treatment. The 2005 reform has also permitted to set clearer boundaries (alike in the Swedish system) between complaints/right to compensation and disciplinary or deterrence issues.

As a rule, the ACC legally substitutes for the right to sue for damages. It should however be noted that there is a potential to claim, on the one hand, for exemplary and/or punitive damages and, on the other hand, for pain and suffering (which do not form part of the statutory damages awards). The former are however awarded on a very exceptional basis by the courts if malicious intent can be proved – which is generally difficult. The latter are also provided on a scarce basis through health professional disciplinary proceedings. Given these possibilities for additional damages, some medical practitioners may wish to get insurance. As a result of the development of the ACC, the insurance market for medical malpractice liability remains limited – although it is expanding – to "top up" the coverage offered by the public scheme.

In Finland, Denmark and Sweden, compulsory no-fault systems have been in force respectively since 1987 (the Patient Injuries act was voted in 1986), 1992 and 1997. In Sweden, since 1995, the consortium of insurers has been replaced by a public mutual insurance company owned by health care regions. In Finland and Denmark, these otherwise similar systems are funded through private insurers gathered in consortium or pools aimed notably at covering compensation in certain circumstances. In Finland, the Patient insurance Center, a pool of insurers working as a guarantee fund, was created in 1987 to ensure a broad compensation of damages[19] arising from medical misadventure on a no-fault basis and to preserve the solvency of insurers in this respect. All health care professionals, pharmacies, and other businesses engaging in health care treatment operations have an obligation to insure against potential liability as defined by law. All insurance companies writing medical malpractice insurance ("Patient insurance"[20]) in Finland should be members of the Pool. The Center settles claims and determines the amount of compensation to be paid (in accordance with the damage Act). There is no compensation for small injuries; but also no ceiling for compensation. It should also be noted that compensation criteria were revised in 1999 to better reflect developments in health care and tort law. The Center should also pay compensation for injuries in cases where no insurance has been taken out (in spite of the legal requirement to do so). It should also provide insurance to a health care provider who has been denied coverage by an insurance company.

In addition, the Center has also a role of guarantee funds providing coverage to victims in case of liquidation or bankruptcy of an insurer. The Insurance Supervisory Authority regulates the Patient Insurance Center. Moreover, under this scheme, premiums rates and contract clauses for "patient insurance" policies should be disclosed to and are regulated by the Insurance Supervisory Authority.

On a similar basis, the no-fault system established in Denmark provides that all health care providers and establishments (including those in private practice since 2003 and in force as from 1st January 2004) should subscribe an indemnity insurance policy. Besides, insurers underwriting this kind of policies have to gather in an organisation, the Patient Insurance Association. Like the Patient Center, this association is aimed at settling claims and the amount of compensations according to regulation.[21] Patients have a right to appeal to the Patient's Injury Board of Appeal and further to the Danish High Court. The Association also plays a reinsurance function in case the amount of compensation goes beyond the insurance policy ceiling or in case of joint and several liability.

In Sweden, a no-fault compensation system, the Patient Compensation Insurance (PCI) was first established in 1975. This system, which is very similar to the Danish and Finnish systems, was initially based on voluntary contracts between medical providers and a consortium of insurers. Like in New Zealand, one of the main features of this scheme is the decoupling of compensation and deterrence. Patient compensation was provided by the PCI, while the discipline of medical providers was handled by the Medical Responsibility Board. The Swedish system was and is still also based on the principle of "avoidability." Typically, adjudicators investigated whether *1)* an injury resulted from treatment *2)* the treatment in question was medically justified, and *3)* the outcome was unavoidable. If the answer to the first query was yes, and the answer to either the second or third queries was no, the claimant received compensation. In 1997, this system was made compulsory for all health care providers with the adoption of the Patients' injuries Act. Besides, under the new 1996 Patient tort act (PTA) patient have the possibility to take their liability claims to court even though the system remains a no-fault one. Actually the PTA compensates injuries that could have been avoided[22] and that have been caused by health care practitioners, including conditions that are the results of the diagnosis and treatment of disease (also involving transmission of infections, accidents, defective medical devices and pharmaceuticals) as well as medical research. Under the PTA, claims must be filed within three years from the time the patient recognized the injury and within ten years from the time of injury. The PTA criteria for calculation of compensation are particularly detailed and compensation is provided only for necessary expenses, not so – called "comfort" expenses. Compensation may

also include damages for loss of future income when an injury leads to permanent harm and compensation for acute and permanent pain and suffering depending in particular on the length of hospitalization or sick leave. Moreover, $274 (SEK 2000) is deducted from patient compensation, and compensation for economic and non-economic damages is capped at an amount that approximately represents $1 120 000 (SEK 8 200 000). Yet, if negligence can be proven, a plaintiff may still file under the General Tort Act, thus avoiding the PTA deductible and the cap on compensation.

2. All systems are experiencing difficulties at various degrees

Both claims' severity and frequency for medical malpractice have increased to various extents in most OECD countries,[23] particularly since 2000 in the United States[24] and more generally since 2001-2002 in other economies. The US certainly experiences the most serious crisis in absolute and per capita figure with a global amount of damages reaching $28.7 billion in 2004 according to a study by AON.[25] Claims costs have increased nearly 10% annually[26] since 2000 and this trend is expected to continue.

In other OECD countries, growth of medical malpractice damages has also become a concern, although global figures remain relatively less spectacular. In Austria, damages rose 50% from 2002 to 2003, while in Japan, the number of new malpractice suits filed at the court of the first instance more than doubled from 1990 to 2000.[27] In Australia, a crisis materialised in 2002, when one of the main providers of medical insurance compensation UMP/AMIL[28] was put into provisional liquidation. Yet, after in-depth reform was put in place (see Chapters 2 and 3) real average premium began to fell again (see Annex A, Table A.1).

The global increase in the amount of damages for medical malpractice is one of the main reasons why insurance companies' business in this branch has been less profitable or unprofitable since 2000 in most OECD countries. Many markets have reported escalating losses. For instance, loss ratios were around 190 in Austria and 250 in Italy in 2003, 145 in the United States in 2002, on average[29] and 112 in Greece. Moreover, re-pricing the risk often leads to increases in premiums that are hardly affordable for physicians and other medical professionals.

In fact, since 2002 insurers and reinsurers in some OECD jurisdictions have decided to reduce their exposure to, or withdraw completely from, the medical malpractice market. These withdrawals have adversely affected the market by causing a massive contraction in capacity in some countries[30] and driving up premiums to even higher levels. A well-known illustration of this trend is the massive withdrawal of St. Paul from the US and European markets in December 2001. As St. Paul was one of the main medical malpractice liability

insurance carriers, its decision resulted in a sharp reduction in cover in the markets of some of the concerned countries (*e.g.* in the US, France and Ireland). In the US, two other major medical liability carriers PHICO and Frontier Insurance Group also exited from the market entirely, while the Medical Inter-Insurance Exchange (MIIX) decided to write business only in New Jersey.

In most OECD countries, the growth in premiums for medical malpractice combined with reduced scope of coverage is particularly problematic for certain types of riskier specialties. These include notably general surgeons, obstetricians/gynaecologists, neurosurgeons, plastic surgeons, anaesthesiologists, orthopaedists and public and private establishments. In some cases, these professionals can either no longer find coverage or only at excessive[31] rates. For instance, in the United States the American College of Obstetricians and Gynaecologists (ACOG) has identified 23 "Red Alert" states in which access to care is compromised.[32] Further, over 30% of cardiothoracic surgeons in a recent survey had either relocated, closed their practices, or stopped providing high-risk services, most often citing increased liability costs for their decisions.[33] Typically, premiums for the above mentioned specialists (including in particular obstetricians-gynaecologists and surgeons) in the most hard-hits states have more than doubled since 2000.

In some other countries, increases in the number of claims and in the magnitude of damages awarded did not lead to a major crisis and shrinkage of coverage availability. Yet even in these cases, increases in losses and demand for additional medical malpractice cover beyond the capacity already provided, were reported. For instance, in no-fault compensation systems like the ACC in New Zealand, a market for claims not covered by the current scheme (in particular punitive and/or exemplary damages for physical damages and non-physical damages such as mental anguish) is developing mainly through mutual entities, which provide for discretionary coverage. Besides, as mentioned above, modification of the trigger for coverage in 1992 and in 2005 has considerably widened the coverage's scope calling for a re-assessment of the funding mechanism and entailing an increase of the system's overall cost. In Japan, the mechanism offered through the Japan Medical Association was supplemented in 2001 by a special clause to extend the scope of coverage from 100 million yen per year solely for main practitioners and administrators of health care establishments to 600 million yen per year with coverage extended to medical materials and other hospital staff. In the United Kingdom, the rising size of claims is an issue both for the publicly financed fund, administered by the NHSLA, and the MDOs with the total amount of damages increasing by around 10% per year over the last few years.

3. Worrying effects

Within the framework of the tort system, the considerable growth of premiums for medical malpractice, particularly for certain types of specialties, has resulted in adverse effects on health care quality, patient safety and cost. These worrying trends are particularly noticeable in the United States, but may be increasingly encountered elsewhere (*e.g.* in Europe). A survey by Harris Interactive[34] revealed that malpractice litigation was a key concern among most physicians in the US. Some 76% of doctors stated that their concern about malpractice litigation had impaired their ability to provide quality care to patients and had caused them to practice "defensive medicine[35]".[36] These additional tests and treatments may imply a risk to the patient and take away funds that could better be used to provide needed health care. In this regard, a 2003 report by the US Department of Health and Human Services (HHS)[37] also stresses that money spent on defensive medicine also impedes efforts of physicians and researchers to improve the quality of care.

Some studies in the US have found that reform of the tort system could lead to a reduction in defensive medicine that could significantly lower overall health care expenditures[38] (see also in Chapter 3 sub-section on reform of the tort system). As a rule it is however difficult to precisely assess the costs arising from defensive medicine.[39]

Whatsoever there seems to be clear evidence that escalating damages prompt doctors to refuse to engage in risky specialties – such as obstetricians or neurosurgeons – or are even giving up practicing altogether. The Harris Interactive survey also revealed that one-third of physicians shied away from going into a particular specialty because they feared it would subject them to greater liability exposure. Nursing homes are increasingly cutting back on beds and pulling out of states known to have high litigation costs.[40] In Australia, a survey[41] has similarly revealed that young doctors avoid specialties with high contribution rates and that doctors currently in those specialties retire earlier due to the financial impact of premiums.

The (2003a) HHS report argues that physicians' understandable fear of litigation also limits efforts to report and analyse errors. According to a survey,[42] as many as 95% of adverse events are believed to go unreported. The consequent lack of data concerning actual health care weaknesses jeopardize endeavours to improve the overall quality of care of the health system and patient safety in the future (see Chapter 3 sub-section on risk mitigation).

More generally, in most countries, medical malpractice affairs have hampered confidence in the patient-doctor relationship and given rise to a situation of general distrust in the health care system and services.

Notes

1. For the sake of this document, the terminology of the concerned country will generally be used to describe a determined system since typically wordings are closely related to a defined level of coverage and a specific conception of accountability. In practice, "medical error/fault", "malpractice", or "negligence" are generally encountered in tort system, whereas "adverse" or "avoidable" medical events are more frequently used in no-fault compensations schemes. Otherwise, a generic and as neutral as possible term, will be used such as "medical malpractice or misadventure" or a more technical term "iatrogenic injury". Moreover it should be underlined that for the sake of brevity and simplicity, insurance type language will generally be used throughout the document including when referring to mutual defence organisations.
2. For a more detailed approach notably of the financing of health care, see for instance, OECD (2004), *Private Health Insurance in OECD Countries*.
3. For instance, doctors in public practices and public hospitals are covered by the state for their liability in Australia in the UK through a dedicated fund, in New Zealand and in Spain.
4. *E.g.* Austria, part of the Belgian market, Czech Republic, France, Germany, Greece, Italy, Poland, Slovak Republic, Spain, Switzerland, Turkey and part of the US market.
5. *E.g.* in Australia, Canada, Japan, the Netherlands the UK (for health care providers not covered by the National Health Services) and the bulk of the market in the United States.
6. *E.g.* Act "Droit des Malades" in France (March 2002), "Droit des patients" in Belgium (August 2002), Act on Insurance Patient in Iceland (2000) or in project Italy.
7. There are some exceptions to this trend such as Poland where courts' judgements are generally in favour of doctors rather than the injured victims. In Canada, the plaintiff must prove the negligence. Certain legislation creates strict liability for some instances, but this is not common in the medical context.
8. More generally, strict liability may be found in most non-fault compensation systems to be developed in Chapters 1 and 3.
9. In Spain, no-fault compensation may apply in case there was no informed consent of the patient.
10. In France, indemnification can be granted for presumed error or even no-fault in case of nosocomial infections resulting in disabilidity over 25%.
11. *E.g.* in Australia, Canada, the Netherlands, the United Kingdom, and the United States for a large part of the market and in Japan, France and Belgium to some (limited) extent. Actually, in France, the coverage of 70% of public hospitals in 2003 was insured by a mutual Insurance Company the "Société Hospitalière d'Assurances Mutuelles" (SHAM).
12. See *www.cmpa-acpm.ca* for further information.
13. The fund represents 85% of annual payments through a designed scheme the National Health Service Litigation Authority (NHSLA).
14. See also Chapter 3 for more details on the functioning of JUAs.
15. In New Zealand (starting in 1972 after the report of the Woodhouse Commission) and in most European Nordic Countries (*i.e.* in Sweden (since 1975 on a voluntary

basis, and since 1997on a mandatory basis), Finland (since 1986), Norway (since 1988), Denmark (since 1992), and Iceland (since 2000) on a compulsory basis).

16. For instance in Denmark and Finland, the respective Patient Injuries Act lists a series of avoidable injuries which should be compensated for.

17. Respectively contributing to 45% and 55% of costs.

18. Which typically included: 1) Medical error: failure of health professional to observer the standard of care and skill reasonably expected in the circumstances; and 2) Medical mishap: where the patient received the right treatment and it was properly administered, but the patient had a complication that was both severe and rare.

19. The Finnish Patient Injuries Act, of 25 July 1986 states that medical malpractice insurance called "Patient insurance" (to reflect the no-fault nature of this system) should cover bodily injury sustained by patients in connection with medical treatment and health care given in Finland. Typically, insurance should provide damages (also set by regulation) for bodily injuries,which are likely to have resulted from medical treatment and which meet one of the following conditions: treatment injury, equipment-related injury, infection, accident-related injury, fire and burn injury, misdelivery of pharmaceuticals and unreasonable injury.

20. The main difference between "patient indemnity insurance" (mainly a Northern Europe terminology) and medical malpractice insurance, as suggested by the wording used is that in the former case there is no need to actually prove the negligent act of the practitioner(s) for the indemnification to be granted to the victims. The focus lies on the indemnification of the victims through a procedure or trigger criteria whereas in the latter case compensation is subject to evidence (to various extents) of negligent act or adverse events.

21. According to the Danish Liability for Damages Act and only for amounts exceeding DKR 10 000 (around € 1 300).

22. Actually the "burden of the proof" is much lower in the PTA than it is under the general Tort Act in Sweden. The plaintiff must show by reasonable certainty that the health care practitioner's conduct caused the alleged injury. There is no need to prove proximate cause; that is to say that the injury was within the scope of foreseeable risk. The standard of care is that of a skilled specialist or any skilled professional within the field.

23. Yet there are some exceptions such as the Canadian experience. In fact in this country, there has been a steady decline in the overall number of claims over the past decade. However it should be emphasized that the cost of defending and indemnifying claims has only recently stabilized after a number of years of incremental growth.

24. A 2003 Tillinghast-Towers Perrin study estimates that all payouts relative to medical malpractice and associated expenses totalled approximately $27 billion in 2003, as compared with $10.5 billion, in 1992.

25. *Source:* AON (2005).

26. It should be underlined that this average growth does not reflect the huge discrepancies between states (see note 29 hereinafter).

27. *Source:* Miyasaka Yuhei (2002).

28. UMP/AMIL was covering over 50% of Australian doctors (and 90% in NSW and Queensland).

29. The situation is furthermore much contrasted in the United States depending on the specialty concerned and on the geographical situation. In some states (particularly Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New West Virginia) the loss ratio is well above the national average.

30. *E.g.* in Australia, Austria, France (particularly after the enforcement of "Kouchner Act" in March 2002), Greece, Italy, Spain, Switzerland, and the United States.

31. Even if premiums may seem realistic from an actuarial and insurance point of view.

32. American College of Obstetricians and Gynaecologists (August 2004), " ACOG's Red alert on OB-Gyn care reaches 23 states" including: District of California, Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Oho, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, West Virginia and Wyoming.

33. Society of Thoracic Surgeons, April 2004.

34. See Harris Interactive (2004).

35. Defensive medicine may be defined as care provided primarily to reduce the probability of litigation.

36. For instance, 79% of the surveyed doctors admitted ordering unnecessary tests, while 74% referred patients to specialists more frequently than they would have done, had they relied on their professional judgement. 51% have recommended invasive procedures such as biopsies to confirm diagnoses more often than they believed was medically necessary and 41% said that they had prescribed more medications, such as antibiotics, than they would based only on their professional judgement.

37. See HHS (2003a).

38. See for instance, Kessler, Daniel P. and Mark B. MC Clellan (1996). Authors notably found that reform in the tort system could reduce health care costs between five and nine per cent within 3 to 5 years of adoption.

39. Actually all studies trying to assess these costs have shortcomings. They are most often based on the incremental costs' increases associated with just two or three medical procedures or diagnoses. It is therefore not necessarily appropriate to generalise these studies' results to the whole health care system.

40. *Source: Best Week*, 19 July 2004, p. 3.

41. See AHMAC Report (2002), p. 61.

42. Maulik, Joshi, Anderson, John *et al.* (2000).

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Chapter 2

Driving Factors

Dramatic increases in premiums and limited coverage for health care providers stem from multiple factors and involve diverse parties.

1. Expanding risk: evidence of medical error?

The more or less serious difficulties of schemes to cope with medical misadventures naturally first call for an assessment of the evolution of medical errors/negligence or so called "iatrogenic injuries".[1] They also raise the question as to whether the source of the crisis is indeed a real increase in the incidence of malpractice or negligent acts on the part of health care providers. In the United Sates, various sources have argued on the basis of statistics that a small number of providers were responsible (even though not necessarily at fault) for a disproportionately high share of malpractice awards and settlements.[2]

More generally, it seems that claims expansion actually stems from two main though contradictory trends. On a positive note for patients, medical progress and technology allow for closer monitoring of doctors and ease the assessment of liability. Unfortunately new diseases are also emerging such as prion infections incurred in hospitals.[3] These developments have led both to an increase in the number of claims and a shrinkage of coverage from insurers as the risk is becoming even more difficult to assess.

Moreover, a certain number of analysis[4] including the well-known study by the US Institute of Medicine (IOM)[5] in 1999 or the Cull report in New Zealand[6] stress the increase in the number of medical errors in hospitals and in physicians' practices. The IOM report in particular estimated that 44 000 to 98 000 hospitals deaths per year in the US could be attributed to medical errors. According to some further research,[7] these adverse developments may stem from a series of factors including medical misdiagnosis, treatment problems, or other multiple underlying causes notably communication and reporting problems, inadequate or not timely referral to secondary care, inadequate safety systems, lack of knowledge and errors in judgement.

However, there does not seem to be a direct and strong correlation between actual medical errors and the filling of claims. In this respect, studies[8, 9] in the United States tend to demonstrate that most events for which claims were filed did not constitute negligence or errors in practice.

The fair and neutral assessment of medical malpractice is not an easy task. Medicine is a human science and is therefore fallible: the polemics on how to define "medical error" even amongst medical experts illustrate quite

clearly this difficulty. However, the genuine potential "imperfection" of medical practice does not preclude the view taken by some that injured victims of avoidable (and in some cases even non-avoidable) adverse events should be compensated. Without going into further details on this complex issue, it seems worth stressing here that this central ambiguity, which often underpins patient-doctor relations, should not be underestimated in the evaluation of the causes of the current medical malpractice crisis and when considering solutions related thereto.

2. Escalating damages resulting from both increased frequency and severity of claims

Increased frequency: impact of the strengthening of victims rights and development of a "claims' culture"

All things being equal, most OECD countries perceive a global expansion of consumers' demand for financial redress in the case of adverse events. First, as already mentioned the secular evolution tends toward an expansion in victims' rights to appropriate compensation for injuries or losses incurred. Second, thanks to improved communication resulting *inter alia* from activism on the part of tailored associations and, in some countries, to direct influence and information campaigns by attorneys and other providers of legal services or media, patients have become more aware of their rights to payment of compensation for injuries and of the possibility for litigation to create new "rights". Moreover, owing to progress in medical research and technology consumers also tend to expect more from health care systems. The growing number of claims in the health sector might also stem from increased longevity and the ageing of populations, which imply that a greater percentage of the population is relying on and needing health care treatment and services on a long-term basis.

In addition, some argue that the general expansion of claims (which is not confined to the medical malpractice sector) is due to a developing "claims culture"[10] whereby any injury or adverse event entails the search for a person or institution to be held at fault.[11]

Role of the tort system

Swelling amounts

The expansion in the number of claims is often supported by a favourable legal and jurisdictional environment for patients/consumers, which often implies legal uncertainty for health care providers and their insurers.

As underlined in Chapter 1, the shift from gross negligence to proven, presumed, or even – though more scarcely- strict liability within OECD tort systems (*e.g.* in France, Germany Iceland, Turkey the UK and the US) is initially

aimed at better compensating victims of injury, their beneficiaries or relatives. However, these positive developments from a consumer perspective conversely often mean for health care providers and their insurers an expanding uncertainty regarding the scope of their liability and the potential magnitude of their losses, which eventually affects all health care consumers.

Moreover, the evolution of the notion of fault has in most cases been accompanied by a series of factors reinforcing the surge in claims frequency and severity. These factors include the possibility for class actions, joint and several liability, the role of the bar and of contingency fees, and above all the escalation of damage awards in most countries and in particular of non-economic damages as well as sometimes exemplary and punitive damages.

The potential for class action has also developed not only in the United States[12] and Australia, but also in Europe through regulatory reforms (*e.g.* in the Netherlands and in project in France) or jurisprudential changes. Similarly, joint and several liability is being more widely considered and used to settle damage awards by courts in cases of medical malpractice including in Europe.[13] Actually, joint and several liability means that the victims can claim full compensation from one plaintiff who can then seek redress from other parties who contributed to the loss in proportion to their contribution. From an insurance perspective, joint and several liability is another factor contributing to claims' uncertainty since an insurer is indeed not solely insuring the risk of the insured health care provider, but potentially the risk also incurred by other health care providers activities.

Furthermore, mainly under common law regimes,[14] the "no win no fee" or conditional fee arrangements applied by most attorneys is another incentive for victims to file claims.

Finally, one of the main factors driving claims' amounts up is escalating damage awards in general, and particularly non-economic damages[15] including some retrospective effects.[16] In almost all OECD countries surveyed in this analysis, jurisdictions are now awarding non-economic damages which include damages for intangible losses such as pain and suffering, and impairment of quality life (also called "hedonic damages").[17] In some cases, juries also settle punitive and exemplary damages. This may happen for instance in Canada, Greece, in the United Kingdom (in theory but it never occurred in practice) and in the United States, but also in Iceland or in New Zealand – where these damages are not covered by the no-fault compensation regime. The inflation of non-economic and punitive damages in the US should be particularly stressed for its magnitude. This trend entails the emergence of a rather subjective compensatory system. Actually, over the last years, much of the amount of the awards (in particular the largest ones) is for non-economic damages. As stated in the HHS report,[18] this kind of damages

constitutes "an effort to compensate a plaintiff with money for what are in reality non-monetary considerations. The theories on which these awards are set are however entirely subjective and without any standards" [...] Therefore, "unless a state has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status".

A direct consequence of these trends is a global swelling of the amount of damages, which also entails a relative unpredictability of claims and of the loss incurred for a determined claim. In this respect, the US tort system is considered a particularly expensive way to compensate injured plaintiffs. According to the Insurance Information Institute, in 2004, medical malpractice damages reached $28 billion, costing each US citizen an average of $91 a year. This global figure is actually stemming from a steady increase in the median and average awards. Between 2001 and 2003, the median malpractice claim payment against physicians only (excluding settlements against hospitals) reported to the National Practitioner Data Bank increased 17.7%, with a maximum payment of US$14 million in 2003.[19] Of particular concern is the rise in mega-awards and settlements above $1 million.[20] Similarly in Italy, surveys conducted by the Italian Association of Insurers between 1994 and 2002 showed that the number of claims relative to health care providers has more than doubled while the average amount of damages increased 20%. For health care establishments, the average cost grew 70%. Global damages have also been rising considerably in other European countries. For instance, total damages awarded by courts and paid by insurers for medical malpractice accounted for €29 million in Austria and €350 million in France in 2003, €250 million in Germany in 2002 and £500 million (around €730 million) in the UK and up to €2.4 bn in Italy.

Concerns about tort system's efficiency

In addition to these developments implying increased and highly unpredictable losses for insurers and providers, some are questioning the ability of the current tort system to adequately perform its two basic functions: compensation and deterrence.[21, 22]

First, it is estimated that only a relatively small proportion of damage awards (and in particular non-economic damages) actually result in payoffs for the victims. The US legal and administrative costs of the tort system (lawyers' fees, court costs and paid experts) are considered to account for more than 70 per cent of damage awards.[23] The (2003a) HHS report showed that only 28% of what health care providers pay for insurance coverage actually goes to injured patients.

In this regard in the United States, increased costs related to the tort system seem to have contributed to drive up the cost of health insurance coverage through increased premiums paid by health care providers and the

provision of unnecessary services through the practice of defensive medicine. One conservative estimate found that tort reform in the United States could reduce the number of uninsured Americans by 1.6 million.[24]

Second, only a very tiny proportion of victims of avoidable adverse events are actually filing a claim. For instance, studies[25] made in Ireland and in Denmark tend to prove that actually only 10% of victims of medical adverse events are eventually seeking compensation and filing a claim. A 2000 study[26] carried out in Utah and Colorado, also found that only 2.5% of the patients who were injured due to negligence filed a malpractice claim. Conversely, the same study established that only 22% of claims actually involved a negligent injury. A more comprehensive US study[27] revealed that only 1.53% of patients who were injured by medical error filed a claim.

Notably in the US, awards in malpractice cases may also be inequitable.[28] Many plaintiffs with meritorious claims receive nothing, while others receive awards that seem disproportionate to the severity of the injury. Plaintiffs with similar injuries are granted quite different awards, even in the same jurisdiction.

In addition, the functioning and evolution of the tort system not only involve a spreading out of claims' size and of liability uncertainty but also a lengthening of the already long-tail medical malpractice claims process.

As regards risk mitigation and deterrence effects, there is no straightforward evidence[29] that the fear of a liability claim alone provides a sound incentive to better assess risk and improve medical practices by physicians or establishments.

Besides, the system focuses on the misdeeds of individual health care providers, but medical errors are often due to breakdowns in whole systems of care. Moreover, tort system may even have perverse effects on patient safety initiatives. The heated liability environment may actually impede patient safety improvement by discouraging physicians from participating in initiatives such as adverse event reporting which may help analysts learn why medical errors occur.

If increases in claims frequency and severity in many countries are driving trends that partly explain the difficulties faced by medical malpractice compensation systems, other factors linked to the supply of coverage are also sustaining these developments.

Supply factors

Impact of medical liability insurance market cycles, trends and structure on supply

It is worth noting that similar hard market periods – higher premiums and withdrawals of main providers – in the medical malpractice insurance sector have occurred before, in particular in the United States in the mid-1970s (affordability and availability crisis) and mid-1980s (affordability crisis).

Moreover, medical malpractice insurance cycles seem to be more volatile than the general casualty-property market cycles. One explanation for these extreme variations lies in the long-term nature of the liability medical malpractice market and of the resolution of claims. Other reasons could also be mentioned, including deterioration of the litigation environment and the more limited number of medical malpractice underwriters due to the business specialty nature.

Nonetheless, the current supply crisis in several OECD countries can not be fully explained by market cycles theory. Most OECD countries report that the current situation goes beyond the "recurrent" hard liability market period. In addition, the market for medical malpractice coverage has changed since (because of) the last hard market period notably in the US. In particular, new kinds of providers – mainly specialised non-profit institutions – have entered the market and various mechanisms have been put in place to make coverage available and affordable (see also Chapter 3 public/private arrangements).

In this respect, it should be stressed that in some OECD countries,[30] competition in the medical malpractice market led to a rather unbalanced situation, with the constitution of a "de facto" bipolar market. General non-life commercial and non-for-profit insurance entities accept to cover only the so called "good risks"for this branch: that is to say specialties less affected by claims increases, whilst "bad risks" (*e.g.* surgeons, obstetricians/gynaecologists or establishments) have often no other solution than to seek coverage through specialised non-for-profit medical associations. This means that the latter institutions, on the one hand, retain the more unpredictable and potentially severe risks and, on the other hand, can not diversify their portfolio in less risky branches. Accordingly, specialised institutions providing coverage on an insured basis (rather than a discretionary one), often need to set higher – and sometimes hardly affordable – premiums rates than their unspecialised counterpart in the insurance market.

In this perspective, both additional market capacity and possibilities to diversify risks covered in this branch should be considered in order to ease rates.

Impact of the adverse economic and insurance landscape

Reinsurance rates for medical malpractice liability policies have tended to climb since the 11th September events and the last years series of natural catastrophes. As risks and number of claims in the medical malpractice insurance business became more difficult to predict, reinsurers sought to reallocate their business to less risk-exposed insurance sectors.

Besides, increased losses in the medical liability sector lead both mechanically but also more indirectly to higher premiums in this market. As mentioned in Chapter 1, high loss ratios may also have contributed to a

massive withdrawal of main providers in this market, which in turn fathered a less competitive climate and brought about further increases in premiums.

3. Insurability concerns

This series of challenges may raise questions about the very insurability of at least certain medical malpractice risks by the market. Actually, for several reasons – some of which have already been mentioned – accurately predicting potential losses arising from medical malpractice claims and setting affordable rates is an increasingly difficult task.

A first factor is the long-term nature of the risks associated with medical misadventure. Most medical malpractice claims take an average of more than 5 years to resolve, including discovering the malpractice, filing a claim, determining (through settlement or trial) financial responsibilities, if any, and paying the claim. Surveys in Europe[31] have shown that claims are reported a long time after the injury occurs, which makes it difficult for insurers to calculate the number of claims that will eventually be reported in any given year. Moreover, we have seen that reasons for claims do not always result from actual adverse events but may also be linked to other more irrational and less predictable factors (*e.g.* role of the bar and increased propensity to claim).

Second, the range of potential losses owing to the functioning of the tort system (including the increase in non-economic damages at the discretion of the jury/judge or the impact of joint and several liability), but also to medical cost variations, is extremely large even for a similar injury.

This double uncertainty relative to the occurrence and the size of claims partly explains the difficulty in insuring the risk. Moreover, this relative unpredictability of losses is enhanced by the emergence of new risks and diseases in the medical sector that can result in injuries and compensation amounts of potentially significant magnitude (*e.g.* prion and nosocomial infections in hospitals) while not necessarily being generated by a negligent act.

Last but not least, even if insurers usually succeed in rating the risks, premiums may reach (and in certain cases have already reached) unaffordable[32] levels for health care providers (particularly for high-risk specialties[33]). Actually, policies for medical malpractice liabilities can hardly be experienced-rated[34] in the current context, particularly because of the low correlation between a negligent act and final amount of damages and, above all, from an actuarial perspective because of the insufficient number of historical data regarding suits against individual providers. Rates are more generally linked to the potential risk that a claim with a resulting considerable award will be filed than to the risk that the provider or the establishment will perform a negligent act.

Against this backdrop, even though insurability concerns surrounding medical liability may be controversial, one cannot deny that this is nowadays a

highly risky business for insurance entities. In turn, the latter and in particular multi line insurers have become increasingly reluctant to underwrite these policies in most OECD countries. Supply difficulties also create tensions in the medical sector and impair the patient-doctor relationship of trust.

Notes

1. A iatrogenic complication or injury is an unfavourable response to medical treatment that is induced by the therapeutic effort itself or more simply, injury caused by medical procedure.
2. *Source:* Public Citizen "Stopping Repeat Offenders: the key to Cutting Medical Malpractice Costs", 23 September 2002 and Association of Trial Lawyers of America, "Where's the Discipline for Doctors", 4 February 2002.
3. For more details, see Swiss Re Focus report: "Prion infection on the rise? Hospitals in need of modern risk management", 2003.
4. See also Sanders and Esmail (2003) and Bhasale *et al.* (1998).
5. See IOM Report (1999).
6. Cull H. (2001).
7. See for instance, Shaw Dr. Charles and James Coles (2001).
8. See for instance Localio A.R., A.G. Lawthers *et al.* (1991).
9. See also Jeffrey O'Connell and Christopher Pohl (1998) and Vidmar N. (1995).
10. For details on Australia see The Hon. Robert Carr, "Strong Community Response to Public Liability Reforms", Media Release, 4 September 2002, p. 1.
11. For more details on these social and cultural developments, see *inter alia* OECD (2003) by Michael G.Faure and Pr. Tom Hartlief, Chapter 2, Part D.
12. A reform enacted in February 2005, however limits the possibility of class actions at state level.
13. *E.g.* in Belgium, in France and in the UK on a case-by-case basis, as well as in the Czech Republic, Germany, Spain, Turkey and in most non-fault compensation schemes in the Nordic European countries.
14. *I.e.* in Australia before liability reform, Canada, the UK and the US.
15. Economic damages as such usually cover for economic losses including wage loss, health care costs and replacing services the injured patient can no longer perform (such as child care) and are therefore more easily to assess and quantify.
16. For instance, in the UK in March 2000, the court of appeal introduced changes in the way damages for pain and suffering were awarded to successful claimant (*i.e.* lowering the discount rate for calculating personal injury awards). Moreover on 1 April 2005 the Court Act was amended to enable courts to impose settlement of damages by periodical payments. Though potentially beneficial for claimants, this methods may present two major difficulties for indemnity providers; on the one hand there is limited coverage available for long term annuities for impaired lives whilst on the other hand it presents the possibility of everlasting liability with insurers unable to close their books on such claims.
17. See also in annex comparative Table A.2.

18. HHS report (2002), p. 8-9.
19. ASPE analysis of National Practitioner Data Bank report, 2004.
20. The President of the Physician Insurers Association of America (in testimony before the Committee on Small Business of the US House of Representatives in February 2005) reported that payments totalling $1 million or more accounted for 8.1% of all claims paid in 2003, compared with less than half that percentage five years earlier.
21. For more detailed analysis in Europe, see for instance HOPE report (2004).
22. For an analysis of the US case, see Mello Michelle M. (2003).
23. See GAO Report (2003), p. 23.
24. United States Congress, Joint Economic Committee, (2003).
25. For more detailed analysis in Europe, see for instance HOPE report (2004).
26. See Thomas EJ, Studdert DM, Burstin HR *et al.* (2000).
27. Localio, A.R.; Lawthers, A.G. *et al.* (1991).
28. See for instance, Studdert DM., YT Yang and MM. Mello (2004).
29. See Mello, M.M. (2003).
30. In most OECD countries where there is no monopoly insurer consortium or pool or set tariffs by an independent entity (except for instance in Canada and Finland where typically some kind of monopoly exits).
31. For more detailed analysis in Europe, see for instance HOPE report (2004).
32. Even if premiums may seen realistic from an actuariel and insurance point of view.
33. And in particular the coverage of risky medical specialties (*i.e.* surgeons, obstetricians/gynaecologists, orthopaedists). These physicians and establishments increasingly need to rely on the relatively more expensive coverage provided by specialised non-profit medical associations.
34. Except for some important establishments, yet coverage is generally provided at the physicians' level.

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Chapter 3

No One-fold Solution

Options to cope with the crisis should probably be designed with a view to involving the various private and public parties concerned in the medical malpractice area: government, insurers but also physicians, health care establishments and patients.

Countries where the medical malpractice compensation regime faces difficulties have discussed and/or implemented different and complementary types of private and/or public policy tools, in an attempt to tackle the various and complex issues at stake in this crisis.[1] Typically, reforms generally intend to reduce risk/claims in medical services and to strengthen the reliability of the tort system while reinforcing supply capacity with a view to improving risk insurability. Alternatives or additional measures have then sometimes been deemed necessary through a broader government's intervention and/or the re-assessment of public-private actors' respective responsibility.

With regard to OECD countries' broad experiences, no one solution is emerging as ideal or a panacea. Moreover, analysis and any project of reform of a particular medical malpractice coverage system should take account the wider health and social policy framework including individuals' culture and expectations. In this perspective, successful experience in one jurisdiction should be applied with caution to another jurisdiction and should retain a view to the particular circumstances of each system. Against this backdrop, a realistic approach would be to propose a series of possible complementary options, taking into account the fact that each solutions-mix entails advantages and drawbacks in the light of the main objectives/criteria of a medical adverse-events compensation scheme.

1. Enhancing risk insurability

Risk-mitigation

In most countries, public and private policy options have sought to improve risk mitigation in the medical sector (and particularly in hospitals, physicians' practices and high-risk specialties) in order to prevent the occurrence of adverse events. In this respect, risk management programmes are generally aimed at better identifying risks, appropriately assessing the impact of these risks and seeking solutions to better handle them as well as related claims. Even though this study is not specifically dealing with mitigation aspects, it is worth underlining a few initiatives, which have helped preventing medical risks and improving their insurability.

Many OECD countries have established monitoring/supervisory bodies[2] aimed at evaluating medical risks at large and improving the more systematic reporting of medical errors. For instance, in France, a project named "Resisrisq" under the aegis of the former "Agence Nationale d'Accréditation et d'Évaluation en Santé" focuses on ways to improve assessment and management of medical risks in order to moderate premiums rises. In the United Kingdom, to address the rising costs of compensation (principally relative to obstetrics claims), the Chief Medical Officer (CMO) led a working Group, which made recommendations for reform of clinical negligence procedures. A first review of clinical negligence was accordingly released in a consultation document on 1 July 2003. In late 2005, the Department of Health introduced the NHS Redress Bill into parliament paving the way for the establishment of an NHS Redress Scheme to offer patients an alternative to litigation for low monetary value claims.

In the United States, the publication of the 1999 IOM report: *to Err is Human: Building a Safer Health System* has brought wider attention to patient safety issue. Initiatives[3] were also launched in some states[4] and by some hospitals and/or private liability insurance companies notably to improve reporting mechanisms within the health care system, assessment of errors and patient safety in general. The 1999 IOM report also stresses in particular the importance of shifting the inquiry from individuals to the systems in which providers work. In this respect, the tort system's restricted view on individuals' responsibilities is also questioned in order to improve patient safety.

Accordingly, in July 2005 the US Congress passed legislation on patient safety legislation: the "Patient Safety and Quality Improvement Act". This bill authorizes the HHS secretary to facilitate the creation of, and maintain a network safety databases for reporting and analysing medical errors. Reporting of mistakes by hospitals is voluntary. The information remains confidential and can not be used in medical malpractice cases. The bill therefore provides the possibility for health care providers to report errors to Patient safety organisations without fear that this data could then be used for litigation purposes. This bill thus tries to remove the "culture of blame" and allows stakeholders to focus on improving patient care by learning from medical errors.

In no-fault compensation systems, deterrence mechanisms and institutions are most of the time distinguished from the compensation function. Accordingly, specific bodies or programs are in charge of deterrence initiatives[5] and the analysis of medical errors and eventually of the development of risk management tools. For instance, in New Zealand, the Patient Safety program launched on 1st April 2005 will permit use of claims' report on a more systematic basis to identify risk and develop intervention (in collaboration with clinicians) to mitigate risks. This program is meant to support and be complemented by other programs elaborated on a sector

basis on safety and quality. They will be managed by clinicians, health care providers, regulatory authorities and the ministry of Health.

Apart from these initiatives, as regards health care establishments, the Swiss Re Focus study on Prion infection,[6] for instance, underlines the importance of efficient and strengthened risk assessment and management in hospitals to overcome challenges raised by new types of diseases and thereby to enhance establishments' coverage by private carriers.

As far as the insurance of individual physicians is concerned, many highlight the need for closer medical risk monitoring, promotion of the development of medical guidelines and of policy encouraging doctors to invest in new health information technology such as electronic health records, electronic prescribing and experimental safety software.

In this respect, programmes involving the development of medical guidelines have been put in place in some countries to assess and mitigate risk for particular specialty (particularly obstetricians/gynaecologists emergency medicine, anaesthesia, radiology and other high risk area). In theory, the development of such guidelines should improve treatment outcomes and reduce injuries without the need for legislation. In this respect, the Association Arres ("Anesthésie Réanimation Risque et Solution") for anaesthesiologists in France have proved useful to ensure better insurability of this specialty's liability, which had witnessed considerable premiums' rises. In the US, in the 1980s, the American Society of Anaesthesiologists established similar programs aimed at increasing safety requirements which also had very positive effects; moderating growth rates relative to anaesthesiologists' medical liability policies.

Overall, bearing in mind that one of the drivers of increased claims' frequency actually lies on too high patient expectations coupled paradoxically with a general distrust in the health care system, the improvement of patient/doctors and health care providers' confident relationship should also be considered. This generally calls for enhancing the quality and level of medical information provided to patients through better communication on treatments and their possible outcomes as well as formalising the informed consent of patients. Although these developments have not necessarily proved sufficient to ease the medical malpractice crisis in the US, they remain a desirable objective at least to enhance patients' level of information and awareness on their health status.

Improving claims' predictability

Tort Reform: end to legal uncertainty

As stressed in Chapter 2, the current functioning of tort systems in some OECD countries may worsen medical malpractice insurance market's difficulties while not necessarily efficiently providing fair compensation to

injured victims. In this context, some countries (*e.g.* in most Australian states[7] in 2002 and in some US states[8]) have undertaken comprehensive reforms or are considering projects (*e.g.* Austria, the US at federal level and Switzerland) in order to provide prompt indemnification to victims while making losses arising from medical malpractice policies more predictable.

In this respect, three main types of reforms have been enforced or envisaged.

A first set of reforms attempts to limit excessive recourse to courts and/or to shorten settlements. This may include for instance introducing time limits and methods for resolving claims (such as reforms enforced in some Australian states). It may also imply encouraging pre-trial screening panels or other kinds of pre-arbitration or mediation mechanisms such as ombudsman.

In this respect, in the US, pre-trial screening panels[9] have been established in many states though with no tangible results. A pre-trial screening panel is a select group, typically an attorney, a physician, and a lay person, who hears the merits of the case before it goes to trial and makes a non-binding determination on the rationale of the claim. In theory, these panels could help to weed out and hopefully discourage frivolous lawsuits that clog the system. Arbitration programs have also been put in place, to offer resolution to medical liability without going to trial. Arbitration consists of a panel similar to the pre-screening panel. Although participation in these programs is also voluntary, their decisions are binding. According to GAO study in 1990,[10] the benefits of arbitration are that it generally takes less time to come to resolution and costs less for both sides to defend. Arbitration typically results in lower award payments. It should also be noted that the same study revealed a low participation rate in some of existing arbitration programs, which makes it difficult to determine their effect on medical malpractice rates. In this respect the lack of interest of consumers in the arbitration program put in place in Michigan conducted to the closure of the program.[11] However, the experience of self-administered arbitration programmes in the case of the managed health care system established in California in 1978 and known as the Kaiser Permanente arbitration process[12] seems to work efficiently. This is mainly due to the fact that the use of the programme is mandatory and its decisions binding. In Europe, the example of the Dutch ombudsman could also be cited as a fruitful experience. This institution provides for shorter settlements and avoids the publicity generally linked to trials, which often involves medical services' discredit. The Scandinavian systems also include an administrative procedure of settling claims. The cost for this administrative procedure is much lower than going to court and most claims are settled within one year.

The first category of tort reform may also imply reducing or limiting contingency fees for attorneys, introducing measures to limit unmeritorious

claims or defences by lawyers (such as making use of summary judgement or cost awards or establishing lawyers' liability in extremely serious cases), limiting attorney's publicity relative to recovery of money (*e.g.* reforms introduced in Australia in New South Wales and in the Australian Capital Territory) and requiring attorneys to provide consumers with more information about the structure of legal fees. In the US, states have taken several approaches to limit lawyers' contingency fees such as using a sliding scale that limits fees as the claimant's awards increases, designating a specific percentage of the amount recovered, or having the courts determine the limit on attorney fees to a "reasonable amount". However empirical studies[13] seem to show that contingency fees' restrictions have little effect on cost containment and even potential adverse effect relative to the length of the settlement.

A second body of reforms intends to modify liability rules. This generally involves a harmonisation of the definition of fault/negligence (*e.g.* revised Bolam tests[14]), but also better regulation of the number of claims and size of payouts by limiting for instance the use of joint and several liability. Actually, limitations on joint and several liability could reduce physician premiums by limiting the plaintiff's ability to shift liability to the "deepest pocket defendant", who may in some cases be only tangentially related to the incident.

A final set of reforms directly addresses the size of awards through caps on damages and particularly non-economic damages. In Italy, the introduction of standard disability tables (such as those existing for motor liability) is considered in order to enable courts to set economic damages in a more harmonised way over the national territory. In Sweden the scheme for establishing compensation for motor liability is also used for medical liability both by insurance providers and for the few cases that go to court.

In the US, limits have been introduced particularly on non-economic damages in a growing number of states[15] with fairly convincing results.[16] States, which have endorsed regulation to limit non-economic damage awards (with threshold at or below $500 000), have experienced lower premiums rates increases as compared to states, which did not undertake any reform.[17] Moreover it seems that discrepancies between US states "tort systems have an impact on physicians" geographical distribution. An AHRQ study[18] in 2003 found that states with caps on non-economic damages had in 2000 around 12% more physicians per capita than states without caps. The US House of Representatives is considering a bill, which will *inter alia* cap non-economic damages awards to $250 000 and also restrain the use of punitive damage to exceptional cases.

In Canada, caps on non-economic damages (approximately $300 000 adjusted for inflation) have also been introduced in 1978 through a trilogy of decisions rendered by the Supreme Court. This measure seems to

have had a moderating effect on the growth rate of the cost of defending and paying medical malpractice claims.

Additional tort reforms have also been suggested in the United States. These include netting collateral sources available to the plaintiff, allowing the use of periodic payments of awards, as well as revising expert witness rules.

A particularly enlightening experience to assess the potential impact of combined tort reform measures is that of the California system in the 1970s.[19] In the early 1970s, California had to face an accessibility medical malpractice insurance crisis. To cope with this situation, a comprehensive tort reform was enacted to make the California medical liability system more predictable and rational. The Medical Injury Compensation Reform Act of 1975 made a number of reforms, including the introduction of a cap ($250 000) on non-economic damages while economic damages remained unlimited; a shortening of the time in which lawsuits could be brought to three years; provision for periodic payment of damages to ensure resources would be available to the patient in the future. This 30-year experience proved successful. Doctors are not leaving California and insurance premiums have risen much more slowly than in the rest of the country.[20]

In-depth reform of the tort system is certainly desirable in some OECD countries notably to improve claims' predictability. Yet, these reforms will eventually succeed in constraining premiums rates increases for medical malpractice insurance and in reducing medical malpractice costs only after an expectative period and provided caps on damages particularly are not overturned by Courts.[21]

Developing insurance tools to limit risk-exposure and improve risk-assessment

Various devices are developed by some OECD countries to limit or better define insurers' risk-exposure. They mainly involve the introduction of claims-made trigger, as well as policy caps and limited coverage scope.

Medical malpractice liability policies are increasingly underwritten through claims-made coverage[22] to replace occurrence-based policies by insurers. These types of policies have been initially introduced in the United States after the first supply crisis in the mid 1970s. The main difference with an occurrence trigger is that claims-made policies cover claims reported during the year the policy is in effect, while occurrence-based policies cover claims arising out of events that occurred during the year in which the policy was in effect.

If claims-made policies curb to some extent the long-tail nature of medical malpractice policies for insurers,[23] they can however present difficulties for physicians needing or wanting to change insurers or simply

retiring. Indeed, physicians rather than the insurer retain the risk of claims that have not been reported to the insurer during the policy term. To cope with this drawback, most insurers in OECD countries also offer separate mixed policies providing coverage for claims resulting from incidents that may have occurred but were not reported before the physician switched companies. In some countries, they may also provide for claims-made policies with extended periods of coverage[24] or mixes of occurrence and claims-based policies. Following a switch to claims-made policies, Australian government introduced a run-off scheme on 1st July 2004. This scheme covers the cost of claims of doctors who are over 65 and have retired, permanently disabled, on maternity leave or permanently left the private medical workforce for three or more years. Insurers directly manage and pay for these claims, while the government reimburses insurers for the costs incurred. The scheme is funded for claims from doctors who became eligible after 1 July 2004 by a tax on insurers, which is then added to the premiums charged to working doctors.[25]

Moreover, the coverage of insurance policies is limited in some OECD countries in scope and amount. Medical malpractice policies generally cover private health providers for legal fees and economic damages and/or non-economic awards in case they are being sued, but they generally do not cover punitive and exemplary damages. Lastly most insurance policies are capped (see Table A.1 in annex), meaning that very high amount awards are partly financed directly by the health care providers. Some policy contracts also provide for deductibles.

This series of measures eases the rating of medical malpractice policies and to this extent is sensible from an insurer and reinsurer point of view. Yet in practice, it implies that health care providers retain a broader proportion of the risk. This risk transfer could be argued to reduce moral hazard and favour deterrence – and this is certainly relevant in respect of punitive damages. However these measures (except deductibles) also reassign a risk on which physicians or establishments have very little influence, since it relates to the long-tail nature of medical risks and related litigation risks.

It should therefore be noted, that the shift to claims-made coverage or other coverage limitations is not a panacea and the rationale for their introduction mainly depends on cultural considerations and on the insurance market structure of the concerned jurisdiction. In this respect, in medical liability insurance markets dominated by a mutual monopoly like Canada, occurrence-based policies with no coverage restriction, have been working well for decades. This system provides a secure protection and compensation to patients injured through negligent care regardless of whether physicians remain in activity or not. The success of this – quasi unique – experience probably lies on the very broad coverage of the CMPA (95% of practicing physicians). The long-term risk can thus be better addressed as it is pooled

amongst a larger and more diverse group of health care providers. It should also be highlighted that this system, which is fully funded, is supported by a sound financial and actuarial risk management

Beyond these market devices, some are also arguing in favour of more formal co-operation and agreement between insurance and reinsurance companies and health care providers. This closer association could take the form of a mutual commitment on the one hand from health care providers to comply with a series of good practices and risk-mitigation devices, and on the other hand, from insurers to constrain premiums rates to affordable levels including for the most affected specialties (see also in this chapter, the section on risk-mitigation). In this respect, the development and promotion of global experienced-rate policies for health care establishment (which can be rated more easily than physicians' liability insurance contracts) could also provide significant incentives for improved risk – mitigation procedures in health care establishments.

Beyond these market devices, other measures such as earlier mentioned tort reform, but also tailored policy measures to handle particularly long-tail or severe medical risks may be deemed necessary in some acute cases to ensure an appropriate and fair protection of both victims and health care providers while allowing efficient risk mitigation.

2. Seeking alternatives to enhance capacity supply through market solutions

First, it is worth noting that improving medical malpractice insurability and claims rating will probably attract new capacity supply to the medical malpractice liability sector, especially as the general investment and insurance market situation has also improved. Second, some market alternatives and/or regulatory developments could (and have) help(ed) to some extent expand coverage for medical malpractice.

As mentioned in Chapter 1, due to historical reasons or to previous hard market experiences, in some OECD countries alternatives sources of financing through general non-life mutual entities or more specialised medical associations as well as captives and retention groups have emerged and expanded. The formation of mutual organisations was and is particularly favoured in some countries, for their relatively low costs[26] and since they may allow for better risk monitoring of medical practices, often providing training and on-going education for medical practitioners. These solutions have indeed proved successful in a number of cases, such as in Canada (see previous section) and in Japan. The Japan Medical Association, for instance, seems to ensure a relatively efficient monitoring and reporting of medical errors while providing compensation through contracts with non-life insurance companies.

Whatever, the advantages of these types of structures, like stock insurance companies, they may also experience high losses – particularly specialised mutual associations- owing to the general increase in medical litigation. This development may be all the more worrying considering than the financial strength of these entities is in some cases less closely prudentially managed, regulated and supervised.[27] They also often only provide for discretionary cover[28] to medical providers' costs in case of trial. In this respect, the provisional liquidation of the specialized organisation UMP/AMIL in early 2002 in Australia created a supply crisis[29] and led to an in-depth reform of the medical liability market. Accordingly, since 1st July 2003, in Australia, medical indemnity may only be provided by non-life entities under insurance contracts and transitional arrangements were enforced to allow existing mutual organisations[30] to meet the new minimum capital requirements. It should however be noted that this collapse was also due to very specific circumstances including claims costs increases, but also chronic underpricing of policies and under-reserving by some Medical Defence Organisations, no recognition of Incurred But Not Reported (IBNR)[31] claims and the reliance of UMP/AMIL on a single reinsurer (HIH) that became insolvent.

This experience suggests that if the development of mutual organisations and in particular of specialised medical defence associations to cover medical malpractice is to be beneficial for both medical practitioners and victims' safety and protection, they must be adequately managed and sufficiently regulated and supervised in order to provide a sound, reliable and sustainable source of compensation.[32]

Making premiums more affordable

Other policy tools to mitigate the supply crisis on the short term are to help health care providers paying their insurance premiums. It should however be stressed that these measures only alleviate pressure on health care providers without addressing the main drivers of the crisis.

For instance, in France, general physicians' fees have been raised *inter alia* to allow doctors to afford the premium increases of their medical malpractice liability policies.

To overcome the temporary crisis, some governments also choose to cover a part of the premiums for particularly affected specialties. This is or has been the case in a certain number of states in the United States[33] and in France for a temporary period and for particular specialties upon compliance with requirements relative to medical malpractice. In Australia, in order to address rising premiums for health care providers above a certain threshold, Medicare Australia through the premium support scheme provides subsidies

to support the costs of medical indemnity insurance.[34] In Canada, since the 1980s a majority of physicians receives substantial reimbursement of their CMPA fees from provincial and territorial governments. The extent to which CMPA fees are reimbursed is negotiated by physician organisations, and increases in the reimbursement are often in lieu of increases in the fees physicians are paid by the government for the clinical services. This is in recognition of the fact that physicians cannot under Canadian law directly charge patients for these medical protection costs.

Situations where the market on its own faces huge difficulties in assessing and covering medical malpractice risks in the long run probably call for a more significant involvement of government. Apart from tort reform, diverse types of solutions may be (and have been) envisaged: compulsory insurance and/or creation of a pool of insurers possibly backed by a guarantee fund, creation of a compensatory system and/or switching to a no-fault compensation system to various extents.

3. Complementary or stand-alone market/policy options

Mixed private-public compensation mechanisms: Compulsory insurance and pools

In many countries, in order to ensure that physicians and medical establishments remain solvent in case of major claims, insurance coverage for medical malpractice liability is made mandatory by law[35] or through medical deontology or good practices codes.[36] Usually, this requirement mainly applies to individual physicians and to physicians practicing in establishments but not necessarily to establishments as such.[37]

Moreover, this obligation has sometimes been associated with a legal requirement mandating insurers to cover the medical liability risk without specified ceiling. In France, for instance, since the Kouchner Act of 4 March 2002, if insurance coverage has been denied twice by market carriers for a particular health care provider, the latter can refer to the "Bureau Central de Tarification", which will assess and set a rate for the insurer. Few other cases of mandatory coverage for insurers are established, but they are generally associated with a no-fault regime (*e.g.* in Denmark, Finland, Iceland and Sweden) and/or with the establishment of a pool of insurers[38] that handle risks that can hardly be afforded by a single underwriter or risks of insolvency of an insurer (Finland).

In France in the aftermath of the March 2002 law, massive withdrawal of insurers and huge premium increases (sometimes reaching 600% and threatening the coverage of around 700 private establishments) also fostered the creation of a temporary pool of insurers.[39] This pool named the "Groupement Temporaire des Assureurs Médicaux" (GTAM) brought together

19 insurance companies and 3 reinsurers. In June 2003, a co-reinsurance pool, the "Groupement Temporaire de Réassurance Médicale" (GTREM), replaced the GTAM also on a temporary basis.

Actually, the introduction of compulsory insurance (for both health care providers and insurers) generally serves the desirable purpose of adequate indemnification of victims. Yet, it also mechanically entails a greater demand for coverage by health care providers, which cannot always be appropriately sustained solely by the market. This implies that, if at all considered, the introduction of mandatory insurance[40] should probably be subject to a preliminary market capacity analysis and possibly involve other types of government support. In this respect, the French experience, in particular, as well as other situations of acute crisis in some OECD countries may call to some extent for more permanent mechanisms to be put in place in addition to compulsory insurance, if deemed relevant, or as stand alone measures. These could involve a strengthened government intervention or more structured co-sharing mechanisms to ensure an appropriate coverage of health care providers, the insurability of the risk as well as overall insurers' solvency. In this respect, solutions may imply a more tailored approach to cover potentially high-level medical malpractice claims that cause serious problems as regards insurability and/or a re-assessment of the notion of fault and accountability of health-care providers, in order to provide for a more reliable compensation regime.

In the US, in order to respond to previous medical malpractice crisis (see Chapter 1), many states also introduced Joint Underwriting Associations (JUAs) to provide a "market of last resort" for those health providers that could not obtain primary coverage at an affordable rate. These systems, which work as state sponsored pools are aimed at spreading the risk of coverage over all those members participating in the plan thus decreasing the risk to one company. In some states, the JUA was established closely to a Patient Compensation Fund (PCF)[41] (see also next section on guarantee funds). According to some studies,[42] the presence of JUA did not have a significant effect on premium increases and possibly even a negative effect.[43] Actually, JUAs are said to provide a temporary solution to the availability issue. Yet, since JUA premiums are usually flat-rate, such arrangements may ultimately increase total malpractice payouts by subsidizing the highest cost doctors. Moreover, in many states, JUAs were set up on a pay-as-you go basis, which often resulted in accumulated liabilities. To the extent that these liabilities are now being passed on to physicians in JUA states, JUAs may even have contributed to higher premium increases.

Introduction of Guarantee Funds

Another option to enhance insurability of medical malpractice while remaining in a market context rests in the introduction of guarantee funds in order to assess and cover high-level claims or limit the long-term nature of

medical risk through. In Australia, after UMP/AMIL entered provisional liquidation, a significant reform included a scheme to fund "incurred but not reported"(IBNR) liabilities. The IBNR indemnity scheme meets certain unfunded claims of eligible medical indemnity providers. At present, only UMP is a member of this scheme.[44] A levy on the membership of the provider was to finance this scheme, but a reform in late 2003 substantially reduced member contributions, to a quarter of the expected cost. Other more permanent schemes improve the insurability of medical indemnity practice. The high cost claims scheme meets half the costs of insurance payouts over A$ 300 000. The scheme has reduced the operating costs of medical indemnity insurers and given them the opportunity to make significant savings on their reinsurance costs. The government now funds around $50 million of the annual cost of insurance claims under this scheme. Where an insurance contract cap meets a determined threshold (currently $20 million), the exceptional claims scheme will meet the cost of insurance claims above the contract limit. Established in 2003, the scheme is yet to face a claim, but provides significant comfort for doctors by protecting them from personal liability for payouts above the insurance cover cap.[45]

In Finland within an otherwise no-fault compensation framework (see below), the Patient insurance Center established in 1987 is a pool of insurers underwriting patient indemnity, which also works as a guarantee to cope notably with insurers' insolvency.

In the US, to face the medical malpractice crisis of the mid-1970's and mid-1980's, in some states,[46] a Patient Compensation Fund (PCF) has been introduced as a more or less significant component of more general tort reform. Such funds, which are public medical malpractice insurance plans, are aimed at offering coverage for medical malpractice liability that exceeds the specified threshold amounts covered by the insured provider's primary insurance policy or qualified self-insured plans.[47] These funds are thus supposed to reduce losses volatility in the primary market as well as to provide adequate compensation for injured patients in the state. Over the years, PCFs have progressively moved from Pay-As-You-Go scheme to fully funded mechanisms in order to limit large accumulated liabilities (except for Pennsylvania). Only three of these PCFs are mandatory for health care providers. The funding for these schemes with the exception of New York State comes from assessments on providers (by broad specialty and territory designation) and investment returns. Providers pay their premiums either directly to the PCF or as part of the premium paid to their primary insurer. In New York, the state has subsidized the purchase of private excess insurance for physicians since 2000. There is no clear evidence of the impact of PCFs on the level of premiums on the long run.[48] However, F. Sloan[49] argues that if correctly drafted PCFs may at least have an impact on the availability of coverage. Their comprehensive study also provides

for a roadmap to design effective PCFs, arguing in particular in favour of cap on non-economic damages, and stressing the fact that PCFs should retain a clear position of excess insurer; offer some incentives for injury deterrence, and prefer fully funded to pay-as-you-go financing mechanisms.

Actually, in case where guarantee funds are financed through public subsidy, such as the scheme put in place in Australia, the burden of the risk and of the cost of claims is actually shifted from doctors and their patients to the whole taxpayer community. To that extent, the choice for guarantee funds is a political and economic choice.

Switching to partial or comprehensive no-fault compensation regimes?

Comprehensive no-fault compensation regime

The increasing severity and frequency of claims in the framework of tort systems in some OECD countries have in some cases prompted the development of arguments[50] in favour of an in-depth reform of the medical malpractice liability coverage scheme possibly involving a change to a no-fault compensation regime to cover all or part of victims' injuries.[51]

Indeed, as mentioned in Chapter 1, a few OECD countries (mainly comprising Nordic European Countries and New Zealand) have implemented comprehensive no-fault or better-named "no blame" compensatory regimes. These schemes have been functioning quite successfully for a couple of decades. In these systems, claims falling within a predefined class of avoidable adverse events[52] are automatically paid by a public fund (in Sweden) or through private resources (in Denmark and Finland) without a formal finding of negligence through the court process. Main advantages of this option are that it provides prompt redress to victims for comparatively cheaper administrative and/or legal costs than those of a litigation system (respectively 5-30% costs against around 40-60% for tort liability system[53]). Additionally, it is often argued that a focus on avoidable adverse events could help overcome the relatively negative connotations that the concept of negligence has taken on in the minds of health care providers. In this respect, according to proponents of no-fault regimes, the "avoidable standards" create the conditions for more open exchange about the circumstances that lead to errors, and hence foster the development of more efficient independent error-reporting and risk-mitigation systems.

The no-fault system also entails drawbacks that could diminish the relevance and interest of their transposition in other countries characterised by a different cultural, social and health care framework. First evidence from the Swedish system[54] demonstrates that the no-fault regime seems to result in a higher number of claims per capita. Indeed, depending on various factors including victims' propensity to seek indemnification, no-fault systems could eventually result in higher costs if put in place in other jurisdictions.[55] In this

respect, it seems that some established no-fault compensation funds have (or have had) large unfunded liabilities.[56] To the usual costs of the system should be added the cost of separated institutions performing deterrence function (*e.g.* the medical responsibility board in Sweden).

Second, some argue that the level of compensation provided by no-fault compensation systems may be insufficient. Typically, no-fault systems generally do not encompass punitive damages and scarcely include damages for pain and suffering (the ACC in NZ only provides for economic damages). In addition, their coverage is generally limited (except in NZ since the 2005 ACC reform) to avoidable adverse events.[57] This implies some definition and boundaries issues between what is considered avoidable and what is considered unavoidable and involves the decision of a group of professional experts or advisors. These schemes are also criticised for not taking enough account of differentiated situations and levels of injuries. Actually, one of the main challenges of the no-fault system is to adequately set *a priori* triggers and criteria for compensation, scope of coverage and level of damages for determined medical adverse events. These systems have indeed often experienced several reforms in order to fine-tune the main characteristics of the coverage.[58] In this perspective, tort systems could be considered to allow for a more flexible approach to the definition of trigger, scope of cover and level of damages, which can be adapted by courts according to the ongoing social and medical developments.

Furthermore, the lack of personal accountability of physicians has been said not to provide strong enough incentives for deterrence and to the contrary to possibly lead to moral hazard behaviours. This argument may be particularly relevant in the New Zealand system where physicians do not contribute to the system, which is instead mainly publicly financed through taxation. In this perspective, projects to make physicians at least partly finance the system have been proposed. For instance, in Sweden, the administrative and compensatory costs of the scheme are financed by regions via premiums that are set according to the number of inhabitants in the region. However, the lack of individual accountability could still be pointed out[59] as a factor potentially favouring moral hazard behaviours. To some extent, the no-blame system could also dissatisfy victims who would wish to have the person responsible for their injuries to be legally blamed and directly held financially accountable.[60]

In this respect, in some no-fault compensation systems (*e.g.* in Sweden and Denmark), it is generally still possible for victims to choose to sue through civil law to seek higher or more adapted levels of damages. However, in Sweden the compensation granted through civil law may be different from the one proposed through the Patient Tort Act only in case of proven negligence of the practitioner(s) or in case of insufficient information provided to the patient.

In practice, it seems that the choice for a no-fault compensation scheme also depends on the overall social, economic and health care framework of a concerned jurisdiction. The impact of the transposition of no-fault system in another jurisdiction also probably depends on consumers' behaviour and expectations as well as on the possible development of a so-called "claims' culture" in the concerned country.

Sharing medical malpractice liability between public and private actors

In some other cases, including for example risks for which negligence can hardly be proved and/or that lead to very serious injuries, the latter are financed by some kind of public fund or social security systems. For instance, in France the 19 December 2002 Act reforming the March 2002 Act on Medical Liability insurance introduces a new financial sharing of medical liability between insurers and the government through the "Office National d'Indemnisation des Accidents Médicaux, des Affections Iatrogènes et des Infections Noscomiales" (ONIAM). This regulation provides that for disability over 25% due to nosocomial infection, the ONIAM is funding damages even if the error was avoidable. However, if it can be proved that the injury was caused by a negligent act (notably if the health care provider did not comply with medical standard practices), the ONIAM may sue the concerned health care provider.

In the United States, no-fault compensation programmes have also been established in Virginia[61] since 1987 and in Florida[62] since 1988 to cover birth-related neurological injuries. These programs were notably put in place – coupled with malpractice award cap- in order to alleviate the immediate malpractice insurance crisis and possible obstetric services shortage in the mid-1980s. The Virginia Program in particular was created as an insurance alternative to the state tort system in order to provide lifetime care[63] for babies who are born with serious birth-related neurological injuries provided the concerned doctor or the hospital participates in the program. The fund has four sources of revenue coming from participating physicians and hospitals, non-participating physicians and liability insurers. This program is thought to compare favourably with the tort system offering more benefits to injured children and their parents as well as resulting in lower rates for malpractice insurance. However, the fund still presents unfunded liabilities according to the 2005 Actuarial Report issued by Mercer Oliver Wyman Actuarial Consulting, Inc. Projects. According to this report, the Grand total deficit of the fund, is nearly $120 million in 2005, and would grow to nearly $140 million by the end of 2007. This does not imply that the fund is unable to meet its current obligations. However this might be the case in the future if no corrective actions are taken. Accordingly a study has been commissioned to propose changes to establish an economically balanced approach for funding the program.[64]

In some other countries, limited no-fault indemnifications regimes directly financed by social security have also been established to cover specific health care providers (*e.g.* public health care establishments) or very low injury/claims (France).

An alternative to tort reform and comprehensive no-fault scheme: the early offer model

As an alternative to traditional tort reform, some, particularly in the US, are arguing in favour of early offer[65] programs and rapid recovery model. Early offer creates a simple device in order to mitigate incentives to get involved into heavy litigation procedures. This mechanism provides incentives on the one hand to practitioners/defendants to offer to pay on a periodical basis compensation of economic damages to the victim(s) and, on the other hand, to the patients/plaintiffs to accept this proposal which often implies a swift and easier resolution and compensation of claims. According to this program, any defendant of a medical malpractice claim (physicians or hospitals) is given the option, within 180 days[66] after a claim is filed, to offer a no-fault like periodic payment towards a claimant's net economic loss. By promptly offering to pay a claimant's net economic losses, defendants change the rules under which any possible future claims may be filed. Offers can be turned down by a claimant, who may prefer to go to Court. But in this case, the claimant will eventually get compensation out of court only if he successfully proves that defendant's injurious acts were the results of intentional or wanton misconduct provable beyond a reasonable doubt. In a 2005 article, O'Connell[67] demonstrate how the Early Offer system would give both sides strong financial incentives to settle more quickly and avoid the expenses and uncertainties of a protracted legal battle.

Developing first direct insurance?

Lastly, another, though limited solution, rests in the development of first-party insurance for victims of medical malpractice. These policies would pay compensation for injured victims without any reference to practitioners' would-be negligence or responsibility. An example of this type of policy has recently emerged in France: the so-called "garantie des accidents de la vie". These insurance policies are aimed at protecting the whole family against all types of personal injury occurring in private life, including medical malpractice. However, although this type of contract might improve the coverage and compensation of medical adverse events in the future, the current volume of contracts and demand are not sufficient to produce an observable impact. Moreover, apart from being unfair to patients unable to afford this type of coverage, this option does not address the medical liability issue. Insurers which cover injured patients will most likely turn to medical

providers to seek reimbursement for these compensations through litigation. Lastly, this type of contracts does not deal with medical-risk mitigation aspects and would call, if they were to be developed more widely to replace current medical malpractice liability policies, for the establishment of complementary and tailored risk-management mechanisms and policies.

In some very specific circumstances, first direct insurance against patient injury can however constitute a relevant alternative. For instance, in the Netherlands, compulsory direct insurance for persons who take part in medical experiments' programmes was introduced in 1999 and reformed in 2003. This is a no-fault compensation system that provides minimum coverage to victims who participate in the research project (event though causality still needs to be proven). Yet, in case of loss exceeding the maximum cover provided by the first party insurance, the injured party can still file a liability claim. Similarly in Germany, for persons taking part in clinical trials the subscription of a kind of personal accident insurance by the testing institution is requested by law (the requested cap is € 500 000). This coverage only indemnifies economic losses.

4. Conclusion

Solutions to cope with medical malpractice coverage challenges involve a complex mix of options/questions to be addressed in light of the core ***objectives*** of any such system. These objectives could be summarised as follows:

- Adequate medical-risk mitigation: involving an endeavour to curb the frequency of avoidable medical or iatrogenic injuries through *inter alia* providing appropriate incentives to prevent and limit medical risk (rather than merely punishing) while ensuring an adequate level of accountability of health care providers.
- Appropriate and efficient compensation/indemnification mechanisms: ensuring fairness among patients, health care professionals, health care institutions and main parties involved in the financing of the system (*i.e.* insurance entities and citizens).
- Indemnification/compensation mechanisms involving limited/affordable costs and offering prompt redress.

These purposes may be given different priorities in OECD countries as regards their health care provision and financing framework as well as their specific cultural, historical, social, economic and political circumstances. To fulfil these goals, different ***options*** involving various possibilities of partnerships between the main players of the medical malpractice compensation system (*i.e.* health care providers, patients, insurers/reinsurers and governments) can be examined and favoured taking into account the

needs, particularities and preferences of concerned jurisdictions (notably health care system, size of the insurance market, litigation culture, patients' expectations and the overall expected scope of state intervention and regulation).

Against this backdrop, the suggestions for policy options contained in Chapter 4 are not meant to be binding. Rather they offer some guidance and several possible alternatives to OECD countries and emerging economies faced with difficulties in compensating and mitigating medical "errors".

Notes

1. In this respect, the US is a relevant example and experience for other OECD countries. Actually, States responses to previous medical malpractice crisis in the 1970s and 1980s as well as to the current one differed widely. Some put in place broad tort reforms, other introduced Joint Underwriting Associations (JUA) and/or Patient Compensation Funds (PCF) while other focused on patients' safety and/or alternative mechanisms such as mediation.
2. For instance, the "Observatoire des Risques médicaux" in France.
3. It should however be highlighted that the concern about reporting of errors and patient safety did not emerge with IOM report. In 1985 already, States like New York district required that hospitals report adverse incidents to a dedicated system.
4. The National Academy for State Health Policy (see NASHP website: *www.nashp.org*) reports that 18 states have enacted mandatory reporting statutes or regulations, 7 states have voluntary systems in place, and 6 states have pending medical error-patient safety legislation. For instance Iowa Department of Health created in 2000 the Iowa Patient Safety Program to develop a collaborative strategy to improve patient safety and health outcomes in this state.
5. *E.g.* in Sweden, the Medical Responsibility Board is specifically in charge of the discipline of medical providers.
6. See Swiss Re Focus report: "Prion infection on the rise? Hospitals in need of modern risk management", 2003.
7. In Australia, 8 states/territories are responsible for tort law reform. After the materialisation of the (public) liability crisis in 2002, the Australian government encouraged the States to reform tort law. These reforms have mainly involved the introduction of caps for economic and non-economic damages, minimum thresholds of impairment, modified form of the "Bolam test" (standard of the ordinary skilled doctor established in the English case of Bolam v Friern Hospital Management Committee [1957]),provision of structured settlements, specified discount rates (to assess damages), reduced limitation periods for personal injury claims and limited legal costs.
8. There are 28 states that have a law that caps non- economic damages or a law that limits total damages : Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin, recently South Carolina (April 2005), and Illinois (August 2005).

9. According to the Insurance Information Institute, 31 US states have already established pre-trial screening panels.
10. See GAO (1990).
11. Early offer program provides incentives to avoid litigation (for details on this proposal, see Chapter 3).
12. More information on this process is notably available at *www.kaiserinjurylawyer.com*.
13. See Danzon (2000).
14. *I.e.* Standard of the ordinary skilled doctor established in the English case of Bolam v. Friern Hospital Management Committee [1957].
15. There are 28 states that have a law that caps non- economic damages or a law that limits total damages : Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin, recently South Carolina (April 2005), and Illinois (August 2005).
16. For further details on the impact of tort reform on premiums rates, see for instance P.M Danzon, A.J.Epstein and S. Johnson (2003), pp. 21-22.
17. See evidence from the bivariate analysis in (GAO) 2003.
18. See evidence from the HHS (2003a).
19. *Source:* HHS report (2003b), p. 17.
20. NAIC Profitability by line of State, 2001, reported an insurance premiums' rise of 167% in California from 1975 to 2001, while insurance premiums in the rest of the country have increased 505%.
21. See for instance Greg Morris, "Managing the tide tort reform in the health care industry" in *AON Focus*, 25 April 2005.
22. Except in Austria, Canada, Denmark, Finland, Germany, Iceland, Luxembourg, Poland, New Zealand and Sweden (for countries surveyed in this analysis) where occurrence-based policies still dominate the market.
23. Claims-made policies only shift the risk related to losses incurred but not reported during the policy period from the insurer to the policyholder.
24. For instance, in Belgium, claims-made policies can be extended for 3 years, and 12 to 24 months in Spain.
25. The amount to be eligible in 2004-2005 is expected to be A$ 7.646, which is projected to costs A$ 20 million (A$ 19.640 million) between 2005/06 and 2008/09.
26. It should however be noted that in the US, mutual organisations which represent around 60% of the medical malpractice insurance market, offer medical liability insurance at premium rates similar to private insurance companies.
27. It should though be stressed that this remark does not apply to the Canadian Mutual Protection Association, which as highlighted above is soundly funded.
28. Discretionary indemnity is a term used to describe an indemnity arrangement that involves no legal (contractual) obligation by the provider to meet costs of an "insure event". The provider of such indemnity merely accepts that it will, at its discretion, consider meeting such costs. Most discretionary schemes have grown out of mutual arrangements based around a group of professionals, physicians in

this case. In these schemes, the concerned group of merely accepts that it will, at physicians may jointly agree to meet the costs of a medical malpractice claim that one of their member face. This type of coverage could be found in Australia until 2003, and is still operating mainly in Canada, Japan and the United Kingdom.

29. UMP/AMIL was covering over 50% of Australian doctors (and 90% in NSW and Queensland).

30. Since the reform, the financial performances of Australian medical indemnity providers (medical defence organisations) have improved substantially. This is reflected in the fact that since 2003 some organisations have been able to reduce the premiums they charge noticeably from the levels charged in 2002.

31. When UMP/AMIL went into provisional liquidation in 2002, it had to face IBNRs of close to half a billion dollars on its balance sheet. New accounting standards in Australia now imply that IBNR have to be reported on mutual defence associations' balance sheets.

32. Yet as above mentioned, the Canadian positive experience of the CMPA in covering medical malpractice stands out as an exception where no particular additional regulation or supervision is necessary for the efficient functioning of this organisation.

33. This kind of subsidies has been used in Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas and Washington during the 1980's malpractice insurance crisis. These programs have since been cancelled as insurance premiums stabilized. These subsidies were particularly aimed at helping high-risk specialists (such as ob/gyns) or medical providers in small/rural geographic areas.

34. In general, where a doctor's gross medical indemnity costs exceed 7.5% of his/her gross private medical income, the doctor pays only 20% of the costs of the premium beyond the threshold limit. The scheme also targets support to areas of workforce shortages and rural procedural GPS. This support is directly paid to insurers so that eligible doctors' premiums are reduced directly. In 2004-05, the cost to the Government of this scheme was A$ 31 million.

35. *E.g.* in Canada (in an increasing number of provinces), the Czech Republic, Denmark (except the state, local authorities and the Copenhagen Hospitals Corporation), France, Finland, Hungary, Iceland, Poland, Slovak Republic (for health care professionals only), Spain, Sweden (through no-fault compensation system), and Turkey (draft law).

36. *E.g.* in Austria, Belgium, Japan, to some extent, in New Zealand and in US states for practice in hospitals.

37. It is actually a legal requirement for establishments only in France, Hungary, Iceland and in most US states.

38. In Denmark, the patient insurance Association (including all insurers underwriting medical indemnity insurance as well as uninsured parties – the state, and local authorities-) covers joint and several liability claims (*i.e.* when responsibility of an identified party is difficult to determine) or compensation costs that are beyond policy insurance caps.

39. *Source:* AON Conseil et Courtage: "Droit de la responsabilité médicale: les conséquences de l'évolution récente sur l'assurance des professionnels de santé.", Dossier Documentaire, January 2003.

40. It should be noted that if the introduction of compulsory insurance may be deemed relevant from a patient perspective notably in order to allow physicians to cope with cost of liability and to be promptly and adequately compensate, this measure is often strongly criticized by main insurance market players.

41. *E.g.* in South Carolina and Nebraska.

42. See Danzon, P.M., Epstein A.J., and Johnson, S. (2003).

43. According to Danzon P.M. *et al.* (2003), the highest cumulative increases in insurance premiums between 1994 and 2003 were found in Pennsylvania (+328%) and in South Carolina (+301%). Both of these states have JUAs and Pennsylvania also a patient compensation fund.

44. This measure in particular is being criticized on the ground that it constitutes a hurdle to the establishment of a level playing field between competitors in the medical liability insurance markets and notably restrains the accessibility of this market for new possible comers. The government thus introduced in 2005 a competitive advantage payment, so that providers benefiting from this scheme will pay off this advantage over a period of 10 years.

45. It should be underlined that, in Australia, this body of reforms seems to have performed well: medical liability insurance premiums have started decreasing in 2003, even though no commercial underwriter have re-entered the market so far.

46. Including, for the schemes still functioning, Indiana (1975), Kansas (1976), Louisiana (1975), Nebraska (1976), New Mexico (1978), Pennsylvania (1975,2002), South Carolina (1976) and Wisconsin (1975).

47. For further details on established PCFs, their advantages and drawbacks see Sloan Frank A., Carrie A. Mathews, Christopher J. Conover and William M. Sage (2005).

48. See Danzon *et al.* (2003), p. 15.

49. See Sloan Frank A., Carrie A. Mathews, Christopher J. Conover and William M. Sage (2005).

50. For instance in Australia (*e.g.* see the Australian Woodhouse report, 1974) Belgium, France, the UK (*e.g.* Chief Medical Officer, Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS, June 2003) and the US, in some states, some specialists and policy makers have shared this view or are currently contemplating the benefits and drawbacks of this option.

51. For a comparative analysis of no-fault *versus* liability system to cover medical errors, see for instance Drabsch, (2005).

52. See Chapter 1 for details on the definition and procedures.

53. *Source:* Brennan TA. and MM. Mello (2003), Table 2.

54. *Source:* HOPE Final report (2004), see also *www.hope.be*.

55. This may be especially true in so far as in Sweden, malpractice insurance is complementary to the social welfare systems and all health care costs for malpractice are covered by the public health care system.

56. Typically, the Scandinavian no-fault systems have a proper funding, but it was for instance not the case of the ACC in New Zealand in 1999 before turning to a fully funded scheme or of the scheme put in place in Virginia to cover birth-related neurological injury (see following section).

57. See also Chapter 1 for details on the determination of "avoidable events" in these systems.

58. For instance, in 2005, in New Zealand (to mention only the most recent reform), in 2003 in Denmark and in 2000 in Finland.

59. See for instance Hubbard, Chris (2000).

60. Yet it should be mentioned that recent research (see C.Vincent 2005) has also revealed that most of the time, patients are primarily concerned that such adverse events may occur to someone else.

61. More information on the regime established by the Virginia Birth-Related Neurological Injury Compensation Act can be found at *www.vabirthinjury.com*.

62. More information on the Florida Birth-Related Neurological Injury Compensation Association is available at *www.nica.com*.

63. The fund covers three broad categories of program benefits: Medically necessary and reasonable expenses, loss of earnings from age 18 to age 65, reimbursement of reasonable expenses associated with the filing of a claim with the program.

64. See Report of the Virginia birth-related neurological injury compensation board (2006).

65. See O'Connell J., J.Kidd and E. Stephenson (2004) and O'Connell J. (2005).

66. 180 days is considered to be a relatively short time frame compared with the current tort system, in which medical malpractice cases usually are drawn out in the courts for many years.

67. See O'Connell J., J.Kidd and E. Stephenson (2004) and O'Connell J. (2005).

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Chapter 4

Suggested Policy Options

The suggestions for policy options provide some proposals for those countries which are dealing with increasing claims frequency and severity relative to medical malpractice. They are articulated around a key first policy choice relative to the notion of fault and liability. Indeed, the features of systems aimed at dealing with medical error or so called "iatrogenic injury[1]" and the compensation of victims much depend on whether governments choose to remain in a tort system or rather opt for a comprehensive no-fault mechanism. In turn, it should be highlighted that this choice mainly relies on the particular circumstances of a jurisdiction including the existing health care and social framework as well as citizens' expectations and their cultural background in this respect.

Accordingly, a first section proposes solutions in order to enhance the insurability of medical malpractice within a tort system, while the second deals with the different options to set up a no-fault compensation scheme. A last development will address risk mitigation processes, which are relevant in both cases to assess and reduce medical errors and hazard and their consequences.

1. Remaining in the framework of a litigation system combined with medical malpractice insurance coverage

In order to cope with rising claims and premiums, various options primarily aimed at limiting the costs of claims, enhancing market capacity and the general insurability of medical liability risks may be considered. These alternatives may particularly include comprehensive tort reforms along with the possibility to make use of early offer programs, the development of tailored insurance tools and of alternative private financing mechanisms, as well as the establishment of public-private partnerships.

A) Tort reform

In many jurisdictions, while providing fair relief and compensation to victims, tort reform could help limit the frequency and severity of claims related to iatrogenic injury. These measures could involve three main types of reforms depending on jurisdictions' circumstances and culture, but taking also into account the need to maintain an appropriate level of protection of the victims:

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a) Limiting excessive and inadequate recourses to courts through:

- Encouraging alternative redress and compensation mechanisms such as:
  - ❖ pre-trial screening panels, arbitration programmes, or prompt settlement processes in dedicated courts with incentives to both parties to accept the results of decisions;
  - ❖ establishment of an administrative procedure or an ombudsman to replace and/or complement tort litigation through courts;
  - ❖ development of early offer programs could also be encouraged in order to provide incentives to health care providers to commit to a periodic payment to compensate for economic losses and to the plaintiff to accept this offer, which would result in a quicker resolution of the claims.
- Reforming the functioning of the litigation process by:
  - ❖ limiting the length of the periods to sue for medical injury, with limited exceptions;
  - ❖ restraining, when relevant, the possibility for several and joint liability possibilities;
  - ❖ limiting or capping contingency fees for attorneys;
  - ❖ requiring attorneys to provide consumers with more information about the structure of legal fees;
  - ❖ encouraging measures to mitigate unmeritorious claims or defences by lawyers.

b) Redefining the notion of fault/guilt within the medical liability litigation, involving:

- In-depth reassessment of the notion of fault/guilt and negligence (*i.e.* modification of the duty of care standard, for instance through a reassessment of the "Bolam test[2]" rule, where relevant) and in particular:
  - ❖ clearer distinction between gross fault and iatrogenic injuries, which are less preventable;
  - ❖ more generally, jurisdictions could develop a more sophisticated understanding of the nature of error and a less punitive approach addressed to single health care providers. In this respect they could adopt a more global perspective of the processes leading to errors in the overall health care systems.
- Avoiding retroactive liability when drafting new legal rules or/and in court decisions.
- Development of more precise methods of settlements.
- Analysis and better definition of injuries to be compensated.

c) Reassessing compensated damages, through:

- Setting standards and detailed criteria to assess amount of economic damages (*e.g.* fixed discount rate for the calculation of loss of earning and impairment of quality life; establishment of harmonised disability rates) and in particular non-economic damages (*e.g.* extent of the error).
- Introducing caps (on a relative or absolute basis) for economic and above all non-economic damages.
- Limiting the use of punitive and exemplary damages to very exceptional cases.
- Seeking to reduce legal costs.
- Allowing periodic payments of awards.
- Abolishing the collateral source rule.
- Allowing the use of the right of subrogation by the insurer.

B) Insurance options: techniques and providers

In order to expand market capacity and insurability specific market tools, alternative methods of financing and development of cooperation and agreements between health care providers and insurers could be introduced and in particular :

1. The introduction of *claims-made basis trigger* could be favoured where no other sustainable alternative is in place. In this case, market (tailored mixed policies) or public mechanisms (funds) should be put in place to cope with the coverage gap induced by the change from occurrence basis to claims-made basis trigger and in particular to provide coverage for retiree health care providers.
2. Insurers could further seek first to *distinguish between coverage for physicians and establishments*; second to develop *experience-rated policy*. This could imply:
   - a better and systematic data collection of medical errors possibly thanks to government implication;
   - specific agreements between physicians/establishments and insurers (including for example the compliance with medical good practices relative to their duty of care and risk-management processes in exchange of lower premiums rates);
3. Encouraging *private alternative financing mechanisms* may also imply the development of specific non-for profit structures (*e.g.* medical defence organisation, captives and risk retention groups) to cover medical providers in particular those that cannot find proper and affordable coverage within the standard insurance market. In this case, experiences show that these institutions should be appropriately managed, regulated and supervised

in order to remain financially and actuarially sound on the long run. Discretionary coverage, in this respect, should probably be used in the limited number of cases where experience proved it to be a viable and sound option.[3]

C) Government's possible role and public-private partnerships

The role of the government in dealing with medical malpractice mainly involves establishing a level playing field between insurance entities and providing incentive to enhance market capacity while making sure that sufficient and affordable coverage is available for each type of health care professionals. Against this backdrop, various public-private partnership policy options may be considered:

1. *Compulsory medical liability insurancefor health care providers and/or establishments* may be introduced in order to ensure that patient will be able to seek redress from a solvable party. However this requirement also implies that coverage is available on the market.[4]

   In countries where a *compulsory obligation to insure* is chosen, other processes should be developed to secure the provision of affordable coverage for providers and the solvency of insurers. These may include:

   - The constitution (on a voluntary or mandatory basis) of an *association or a pool of insurers* as well as a body (independent or part of the pool itself) which determines premium rates for health care providers unable to find coverage. This pool can be aimed at covering physicians and establishments that typically can not find affordable coverage through the market.
   - The creation of a risk equalization *fund* aimed at pooling further "bad risks" (particularly affected health care specialties or establishments) among a group of insurers could be envisaged in order to create a level playing field between underwriters and avoid the concentration of "bad risks" on specialised entities for instance.

2. Another option to enhance market capacity and insurability of medical liability risks would be to create a *fund* (privately or publicly financed) that would work as a *stop/excess loss reinsurance* back up (possibly combined with proportional reinsurance) to cover exceptionally high medical liability claims (per claim or/and on an annual basis per insurer).
3. Similarly, the creation of a *limited non-fault compensation scheme* to cover severe injuries or injuries where a liable party can hardly be found (*e.g.* transfer of infections occurring through health treatment) could be envisaged.
4. As part of a broader body of in-depth reforms, in case of acute crisis, governments may also wish to consider providing *subsidies on a temporary basis* to compensate for a part of doctors premiums (directly or indirectly) in order to ensure that all health care providers can afford medical liability insurance premiums.

Whatever the options chosen, governments should pay careful attention to the costs (for citizens, health care providers and the insurance industry), and sustainability on the long run of any measures, bodies or subsidies. The impact of government's involvement on market capacity and competition should also be balanced with the fair treatment of victims, health care providers and various types of insurance underwriters on the market.

2. Opting for a comprehensive no-fault system

A) Comprehensive no-fault systems

Some countries could also wish to consider opting for the introduction of comprehensive no-fault schemes. In this case, the proof of the fault or negligence is not necessary for the victims to be compensated, and deterrence functions are performed through other channels and institutions. Various criteria and possibilities should be further considered when establishing such funds including:

1. The *scope of coverage* of the funds (*i.e.* public/private health care providers and/or public/private establishments);
2. the *trigger of compensation* (types of injuries or a procedural approach aimed at defining the coverage);
3. the *type of damages awarded* (including economic/non-economic/punitive and exemplary) and the level of damages (*e.g.* flat amount/tailored to the level of the injury/to the seriousness of the negligence);
4. *processes to periodically reassess* the appropriateness of the level and quality of the compensation provided (according to medical, social and cultural developments);
5. the *sources of financing*: public financing through taxation or levies on physicians and/or establishments can be envisaged as well as full private market financing. In the latter case, various methods to set premiums are to be considered: experience-rated policies may be difficult to develop in a no-fault context and community-rating (according to physicians and establishments' income) could be preferred.

Whatever the features of the funds established, governments should pay particular attention to the possible rise of the number of claims and of the requests for extended coverage potentially arising from the establishment of a no-fault compensation scheme. In this context, periodical assessment, on the one hand, of the overall costs of the system and, on the other hand, of the satisfaction of injured patients and tax payers on the level of compensation and efficiency of the system could be envisaged. Moreover, depending on options chosen, government could wish to consider tailored incentives and deterrence processes for physicians and establishments.

B) First direct insurance

First direct insurance of the victim may lastly be considered in order to complement coverage provided by medical liability insurance or to cope with the coverage of very specific segments of the population (*e.g.* population taking part in experimental researches).

3. Enhancing medical risk management

In all systems, tailored medical risk management processes should be considered and implemented to improve patients' safety. They should particularly be aimed at enhancing reporting mechanisms, identifying risks, appropriately assessing their impact and seeking solutions to better handle them.

A) In a tort law context

Deterrence mechanisms are supposed to be an integrated part of the litigation process. However, due to the risk for economic and disciplinary actions when reporting medical injuries, this system often prove unable to analyse medical errors and often lack a global perspective on the flaw of the health care systems. Against this backdrop, the focus should probably be put on the development of efficient reporting processes and risk management procedures involving both public and private actors. These could particularly imply:

1. The development of independent and protected mechanisms/institutions aimed at enhancing the confidential (mandatory or voluntary) reporting and analysis of medical errors with the objective to elaborate recommendations relative to the development of mitigation processes;
2. the development of a risk management approach and quality process within health care establishments;
3. the introduction of requirements for physicians to study medical malpractice prevention and risk management as well as to comply with appropriate standards of duty of care as part of their licensing obligations. This could particularly include:
   - The development of tailored practice standards (according to the concerned specialty) taking into account the analysis of past errors and/or adverse consequences;
   - the participation of doctors in safety and quality activities (or the introduction of a requirement to undertake risk management activities in order to receive subsidy, in concerned jurisdictions or to be applied lower insurance premiums);
   - specific requirements relative to the necessity of appropriate disclosure to patient (*e.g.* on the disease, possible treatments and their likely consequences) as well as the development of a more systematic and formal regulation of the informed consent of patients;

- the use of appropriate technological medical devices and electronic book keeping of patients medical data;
- regular training of health care providers on new medical treatment and devices;
- medical defence organisations, in jurisdictions where they have widely developed, may also play a role to help their members move away from defensive medicine for instance by:
  - ❖ promoting cultural change within medical specialty/constituency;
  - ❖ advising doctors on effective clinical risk management.

4. Tort reform could also promote mechanisms to prevent the use of "defensive medicine" distinguishing between gross negligence and hardly avoidable injury or through the development of early offer programs. In this respect, proper care should be taken to avoid blaming health care providers at the source of "standard" iatrogenic injury while on the other hand, the development of specific disciplinary mechanisms to deal with the small proportion of doctors faced with multiple judgements could be encouraged.

B) In no-fault systems

Similar requirements could apply with a special focus on independent deterrence mechanisms, on the accountability of health care professions and the assessment of their practices. This could imply in particular:

1. the establishment of a specialised body (possibly composed of health care specialists) aimed at investigating into medical errors, at monitoring and supervising deterrence processes and possibly at withdrawing doctor's licence when necessary;
2. the introduction of some form of economic incentives for health care establishments and practitioners in order to increase patient safety (for instance through direct contribution for liability coverage or peer review).

Notes

1. An iatrogenic complication or injury is an unfavourable response to medical treatment that is induced by the therapeutic effort itself or more simply, injury caused by medical procedure.
2. *I.e.* Standard of the ordinary skilled doctor established in the English case of Bolam v Friern Hospital Management Committee [1957].
3. Such as is the case in Canada.
4. It should be highlighted that some insurance market representatives oppose to the introduction of such measure.

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ANNEX A

Comparative Tables on the Coverage and Compensation of Medical Malpractice in OECD Countries

Table A.1. **Medical malpractice liability market: main features and developments**

	Claims/damages Trends Insurers loss ratio	**Premium trends** **Specialties affected**	**Market characteristics** Size, main providers Existence of insurance pool	**Insurance policy features** Trigger guarantee system Existence of caps or other restrictions
Australia	Cost, number and frequency of claims fall in 2003-04, after increasing over preceding 5 years. Average claim size continues to increase. Gross loss ratio 2003-04 of 99.[1]	Premiums collected represent € 185 m. Premiums fell by 12% in 2003-04, excl. subsidies. They had risen each of three preceding years. Previously, premium affordability issues for obstetricians, neurosurgeons and procedural general practitioners.	5 insurers mainly covering doctors in private practice, each a captive of a mutual medical defence organisation. Since 1 July 2003, cover to be provided only by authorised insurers. Government mandated pool for retirement cover, funded by practising doctors.	Protection generally on an incident occurring discretionary basis for mutual entities before 2003. Since 1/07/2003, market supplies claims made cover by way of contract. Average contract limit of AUD20m (around € 12 m). Government provides a run-off cover scheme to cope with the cost of claims of retired doctors (the Run off cover scheme).
Austria	2003: around 3 500 claims. Increase by 30% since 2002. 2003: total amount of damages: € 29 m (+54% since 2002). Loss ratio 2003: 188.8	2003: € 5.4 m. Increase of insurance and reinsurance premiums. Difficulties for establishments, gynaecologists surgeons, plastic surgeons and anaesthesiologists.	15 companies. 5 companies have withdrawn from the market.	Occurrence basis.
Belgium	Claims in 2000: € 3.4 m.	2003: € 23 m. Difficulties or higher premiums for: anaesthesiologists, obstetricians and establishments.	17 companies including 2 mutuals. Market concentration has increased. Co-insurance may be used to cover establishment.	Occurrence basis. Claims made. Mix of both: sunset clause extended to the 3 years following policy coverage. Cap for physicians is around €5m/year or/and per occurrence year.
Canada	Number of claims is declining on average (though there are disparities between regions and specialties).	2005: CAN$ 310 m premiums collected by the Canadian Medical Protective Association (CMPA).	1 Mutual (non-for-profit structure), the Canadian Medical Protective Association (CMPA) covers 95% of practicing physicians. Small number of commercial insurers covering the remaining 5% of physicians.	Occurrence basis. No caps CMPA protection is provided on a discretionary basis.

Table A.1. **Medical malpractice liability market: main features and developments** *(cont.)*

	Claims/damages Trends Insurers loss ratio	**Premium trends** **Specialties affected**	**Market characteristics** Size, main providers Existence of insurance pool	**Insurance policy features** Trigger guarantee system Existence of caps or other restrictions
Czech Republic	No increase.		8 companies.	Occurrence basis Claims made Caps: For general practitioners (GPs), specialist, and health care establishment: US$210 000/claim; US$420 000/year.
Denmark			Insurance pool/association: all insurers providing coverage for patient indemnity should be part of the Patient Insurance Association see Table A.2).	Occurrence basis: Claims must be made within 5 years after the injury. Compensation should be provided within 10 years from the injury. Only injuries higher than 10 000 DKR (around € 1 300) are covered. Compensation is provided *inter alia* if the injury meets one of the following conditions: avoidable injury for an experienced specialist (in the examination and treatment); malfunction or failure of technical equipment; disproportionate injury linked to the examination, diagnostic and treatment. Caps for policies are settled annually by the Minister for Health.
Finland	Slight increase in number and amount of claims: in 2004: around 7 000 claims; one third is compensated. 2003: € 22.7 m 2004: € 23.4 m Loss ratio: 80.	slight premium increase: 2003: € 33.9 m; 2004: € 37.3 m.	10 companies. no withdrawal. Insurance Pool: all insurers providing coverage for patient indemnity should be part of the Patient Insurance Center created in 1987 (see Table A.2).	Occurrence basis. Only injuries higher than € 200/claim are covered. Compensation (subject to a deductible) is provided widely for bodily injury resulting from health treatment and which meet one of the following conditions: treatment injury, equipment-related injury, infection, accident-related injury, fire and burn injury, mis-delivery of pharmaceuticals and unreasonable injury.

Table A.1. **Medical malpractice liability market: main features and developments** *(cont.)*

	Claims/damages Trends Insurers loss ratio	**Premium trends** **Specialties affected**	**Market characteristics** Size, main providers Existence of insurance pool	**Insurance policy features** Trigger guarantee system Existence of caps or other restrictions
France	Claims in 2003: € 350 m.	2003: € 300 m. Difficulties or higher premiums for: anaesthesiologists, surgeons and obstetricians.	Around 10 companies including 3 mutuals. Co-insurance: from 2002 to June 2003 – "Groupement temporaire d'assurance Médicale" then replaced by a co-reinsurance group. Co-reinsurance is proposed through the "Bureau central de Tarification".	Claims made (mandatory since 2003). Caps: For GPs and specialists: € 3 m/claim; € 10 m/year. For establishments: on a case-by-case basis.
Germany	Claims in 2002: € 250 m. Big losses for certain specialties. Claims are increasing for establishments.		50 companies. Co-insurance for some high risks.	Occurrence basis.
Greece	Rapid increases of claims. Loss ratio: 112.	20 to 30% of practitioners can not find coverage; Difficulties to find reinsurance.		Claims made Caps: For GPs, specialist and health care establishment: US$30 000/claim; US$90 000/year.
Hungary	Claims increasing slightly.	US$6 m	4 companies.	Occurrence basis. Claims made.
Iceland	New class of insurance short history.	US$441 100	4 companies.	Occurrence basis. caps since 2000: For GP and specialists: US$62 500/claim; US$187 500/year. For establishments: US$62 500/claims; US$0.5 m/year.
Italy	Increasing claims. Claims around: 15 000 Amount :€ 2.4 bn Loss ratio 2003: 250	Rising premiums particularly for obstetrics and gynaecologists, surgeons, orthopaedics and anaesthetists. Difficulties in finding insurance and reinsurance coverage.	Less than 10 companies. Many withdrawals of companies.	Claims made.

Table A.1. **Medical malpractice liability market: main features and developments** *(cont.)*

	Claims/damages Trends Insurers loss ratio	**Premium trends** **Specialties affected**	**Market characteristics** Size, main providers Existence of insurance pool	**Insurance policy features** Trigger guarantee system Existence of caps or other restrictions
Japan[2]	Number of claims is rising.		The Japan Medical Association (a mutualist corporation) is backed by a non-life insurance contract.	Claims made. Deductible of 1 m yen. Cap is 100 m yen/year (around 1m US$), legal fees are paid separately. Existence of voluntary special clause insurance 2001: covers up to 200 m yen/accident and 600 m yen/year.
Luxembourg	Slight increase in the number of claims.	Slight rise in premiums Surgeons and Plastic surgeons are more affected.		Occurrence basis. Caps: For GPs and specialists: US$6.5 m/claim; US$19.5 m/year. For establishments: US$10m/claim; US$16.25 m/year.
Netherlands	Slight increase (around 15%) in the number of claims.	Gross premium € 30-35 m.	Intramural health care (hospitals): 2 mutual companies Extramural health care physicians, other individual professions: 5 companies	Claims made. Caps: Hospitals € 2.5 m/claim ; € 6 m/year Individual professionals € 1.25/claim ; € 2.5/year
New Zealand	Slight increase of claims.	Slight rise of premiums. Around US$7.2 m.	Limited market because of the Accident Compensation Corporation (ACC) (see Table A.2). 1 mutual society covering 90 to 95% of the health care providers and 1 insurance company.	Occurrence basis. Coverage on a discretionary basis.
Poland	Increase of the number and amount of claims since 2000.	Surgeons and gynaecologists are more affected.	Relatively new market (1999) 15 companies.	Act committed. Cap: For GPs and specialists: from € 25 000 to 46 500.
Portugal	Loss ratio in the professional liability insurance line: 74 in 2004.	Very limited market: Global professional liability insurance including medical liability insurance only account for 0.42% of total non-life business and 0.16% of total insurance activities.		
Slovak Republic	No increase.		11 companies.	Claims made.

Table A.1. **Medical malpractice liability market: main features and developments** *(cont.)*

	Claims/damages Trends Insurers loss ratio	**Premium trends** **Specialties affected**	**Market characteristics** Size, main providers Existence of insurance pool	**Insurance policy features** Trigger guarantee system Existence of caps or other restrictions
Spain	Increase in the amount and number of claims.	US$246 m (including 220 m for the public health system).	3 companies (insurance companies). Withdrawal from the market.	Claims made. Occurrence basis (with a sunset period of 12 or 24 months). Mix between both triggers. Caps: For GPs: US$0.75 m/claims; US$1.5 m/year For specialists: US$1.125/claim; US$2.25 m/year For establishments US$3.750 m/claim; US$7.5 m/year.
Sweden	10 000 claims/year: Approximately 35-40% are compensated. No increase.	Surgeons and orthopaedists are more affected.	10 companies whereof the mutual insurance company of the county councils covers 95%. 2 mutual companies.	Occurrence basis. Compensation is provided if the injury could have been avoided and in particular in case: the medical and dental injury was avoidable for an expert in the field; failing equipment or inappropriate medical products; faulty diagnosis; transfer of infections; accident; inappropriate ordination and distribution of medicine. Caps under the Patient Torts Act: $730 000 per claim. Deductible: $170
Switzerland	Amount and number of claims are increasing.	US$54 m. Higher premiums. 5% of practitioners and/or establishments are not covered. Exclusion of cosmetic surgeons and orthopaedic Surgeons by some insurance companies.	4/5 companies. Decline in the number of companies (failures and withdrawal).	Claims made. Caps: For GPs and specialists: US$4.2 m/claim/year. For establishments: US$8.3 m/claim/year.
Turkey	Increase in the number of claims.	Slight increase of premiums.	4 companies.	Occurrence basis. Claims made. Some restrictions have appeared in occurrence basis policies.

Table A.1. **Medical malpractice liability market: main features and developments** *(cont.)*

	Claims/damages Trends Insurers loss ratio	**Premium trends** **Specialties affected**	**Market characteristics** Size, main providers Existence of insurance pool	**Insurance policy features** Trigger guarantee system Existence of caps or other restrictions
United Kingdom	Amount of damages: £500 m/year (around € 730 m) Increase of 10%/year. Sustained increase in frequency (until the last 3 to 4 years): number is increasing at about 5%/year.[3]	Increase of obstetrics' claims in particular (though largely covered by the public scheme: 60% of expenditure on medical litigation). Midwives in private practice have difficulties in finding coverage.	Doctors working for the National Health Service are covered by the state through a non-insured state funded scheme. 3 medical Organisations (MDOs) One of them: the Medical Defence Union (MDU) provides indemnity on an insured basis (through Converium Insurance Ltd) The other 2 MDOs (the Medical Protection Society and the Medical and Dental Defence Union of Scotland) provide discretionary indemnity only. The Lloyds market may provide cover for non-standard individual risks. Saint Paul withdrew from the UK market as well in November 2001.	Fully retroactive claims made insurance coverage provided by the MDU (with free run-off for dentists) in addition to occurrence based discretionary indemnity for claims falling outside the terms of the insurance policy. Discretionary occurrence basis for indemnity provided by the two other MDOs. Small percentage of doctors and dentists insured with other providers. Caps (for policies provided by MDU): £10 million for each period insured/for each individual claim in the aggregate.
United States	US$28.7 bn in 2004 huge increase of claims severity and frequency around. 10%/year since 2000 (important variations between states). Loss ratio 2002: 143.6	Insurance and Reinsurance rates have increased steadily since 2001/2002. Differences between jurisdictions. Neurosurgeons and obstetricians/gynaecologist are more affected.	Mutual companies (mostly physicians owned cover 60% of the market). Captive and self insurance arrangements for large health care providers (hospitals, nursing home groups, large physicians groups). Joint Union Associations (JUA) have been put in place in several states. Several major insurance carriers have withdrawn from the market: St. Paul, PHICO and Frontier Insurance Group in 2002.	Generally claims made for one year. Occurrence basis. At least 7 states require physicians to obtain minimum levels of coverage: For physicians between US$100 000 and 1 M/claim and between US$300 000 and 3 m/year.

1. Gross loss ratio of 99 in 2003-04 excludes results of one insurer that significantly revalue its outstanding claims reserves. Taking these results into account gives a gross loss ratio of 45 for 2003-04.
2. *Source:* Japan answers to questionnaire and Miyasaka,Yuhei (2002).
3. These figures only cover NHSLA scheme and not private insurance underwriters.

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries**

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
Australia	Damages: economic; Non-economic.[1] Tort changes in 2002 to limitation periods, the standard of care required of medical practitioners in treating patients and caps and thresholds on damages. Also, efforts towards harmonisation of tort law across State jurisdictions: – Changes to the law governing decision on liability, including contributory negligence and proportionate liability. – Changes to the amount of damages paid to an injured person for personal injury or for economic claims against a professional. – Changes to time limits and methods for resolving claims, including court procedures, legal conduct and legal costs.	Some states require insurance as a condition of registration for medical practitioners.	Establishment of a scheme to fund unfunded claims of an insurer, partially funded through a levy on its members; – Since 1 July 2004, run-off cover indemnity scheme to cover private medical practitioners who have retired financed by a levy on medical indemnity insurers, which is met by the increased premiums of existing members. – The government funds half of a medical indemnity payout above AUD 300 000 and all of a payout above AUD 20 m. (through two schemes: the High Costs Claims scheme and the exceptional claims scheme).	Premium subsidies for medical practitioners with high premium to income ratio. Overall, Government assistance totals around AUD 545 m over 4 years. Other measures include: – Improved claims management – Better clinical risk assessments.
Austria	Burden of proof is shifted to the health care provider proven and presumed error. Damages: Economic; Non-economic Tort law reform is considered.	Compulsory by the Medical Association's code of Conduct for health care professionals and medical practitioners of an establishment.	No.	Risk management in hospitals is considered a useful tool.
Belgium	Proven error. Damages: Economic; Non-economic. Joint and several liability may be considered by courts on a case-by-case basis.	Compulsory by the Medical Association's code of Conduct for health care professionals and medical practitioners of an establishment.	No.	"Droits des patients" act (22 August 2002) implies more responsibilities from health care providers. Project to introduce non-fault responsibility in order to indemnify the victims more quickly.

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries** *(cont.)*

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
Canada	Proven error. Damages: Economic; Non-economic. Punitive damages can also be – although scarcely – awarded (they are not covered by the CMPA) Joint and several liability	Compulsory in 5 provincial medical regulatory authorities Trends towards compulsory protection for physicians	No.	
Czech Republic	Proven error; Presumed error. Damages: Economic; Non-economic. Joint and several liability	Compulsory for health care professionals or directly or through the establishment.	No.	Legislation is placing cap on the amount of compensation to be paid for pain and aggravation of social exercise damage. Above this threshold the victim may also claim for economic damage compensation.
Denmark	No fault compensation basis: Compensation includes economic Damages. Compensations for pain and suffering should only be paid if the injury resulted in incapacity for work or illness above and beyond a fixed period, which cannot exceed 3 months.	Compulsory for health care establishments and all health care providers (since 1st January 2004) – except state local authorities and the Copenhagen Hospital Corporation which are self- insured. Compulsory for insurers part of the Patient Insurance Association.	The Patient Insurance Act of 1st July 1992 established a no-fault compensation system through the Patient Insurance Association. This Association financed by private insurers underwriting patient insurance and partly by non-insured parties (*e.g.* the state, local authorities and Copenhagen Hospital corporation). The Association through a management committee is settling claims and the amount of compensation according to liability and damages Act. It should also directly compensate claims if the compensation exceeds the ceiling of the insurance policy coverage or in case of joint and several liabilities.	Patients can appeal the decision of the Association to the Patients' Injury Board of Appeal.

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries** *(cont.)*

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
Finland	No fault compensation basis: Damages: Economic; Non-economic.	Compulsory for all health care practitioners. For insurers part of the pool.	The Patient Insurance Center established in 1987 (according to the Patient Injuries Act 585/1986) settles claims and act as a guarantee fund providing coverage to victims in case of bankruptcy or liquidation of an insurer providing patient insurance or in case of failure to insure by a health provider. It also issues policies for health care providers who have been denied coverage by other insurers.	Since 2000, the Patient Injury Board assesses and provides advice relative to medical malpractice claims settlement and compensation.
France	Proven error; Presumed error (solely for nosocomial infections in health care establishments). "Droit des malades" Act, 4 March 2002, reinforced patients' rights. Damages: Economic; Non-economic. Joint and several liability may be considered by courts on a case-by-case basis.	Compulsory for health care providers and public and private establishments. Mandatory coverage for insurers: the "Bureau central de tarification" is setting the tariff of risks, which have been denied by insurers.	A public establishment is aimed at indemnifying victims of low-severity medical accidents without fault. It is financed through a grant from the budget for public health care coverage. The ONIAM ("Office National d'Indemnisation des Accidents Médicaux") is also covering victims of nosocomial infections with an invalidity over 25%.	Since 2003 on a temporary basis and since Act on "assurance maladie" passed in July 2004, a part of the increase in premiums for medical liability of some specialty is financed by the State upon compliance with requirements relative to medical practices. Establishment of the "Observatoire des Risques Médicaux", a state body aimed at assessing medical risks.
Germany	Proven error; The burden of the proof can be shifted to the health care provider according to criteria developed by case law Damages: Economic; Non-economic. Joint and several liability.	Compulsory by the Medical Association's code of Conduct for health care professionals and medical practitioners of an establishment.	No.	

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries** *(cont.)*

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
Greece	Proven error. Damages: Economic ; Non-economic; Punitive.	No.		
Hungary	Proven error.	Compulsory for health care professionals or directly or through the establishment.	No.	
Iceland	Proven error; Presumed error. 2000 Act on Insurance Patient provides for quasi strict liability provisions. Damages: Economic; Non-economic. Punitive. Joint and several liability.	Compulsory for health care professionals and private health care establishments Insurers are also obliged to provide insurance.	There is a national system o compensation for medical accidents not involving medical error handled by the Social security system.	
Italy	Proven and presumed error (evolution of fault philosophy). Damages: Economic; Non-economic.	No.	No.	
Japan	Proven error. Damages: Economic; Non-economic.	Not by law but in practice, all “class A members” are participating in an insurance system called JMA Professional medical Liability Insurance program.		
Luxembourg	Proven error. Damages: Economic; Non-economic.	No.	No.	

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries** *(cont.)*

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
Netherlands	Tort system on basis of proven error (all normal health care) Intramural health care: hospital is liable for errors committed by all medical professionals (doctors/nurses) (Clinical) trials: no fault compensation. Damages within the tort system and no fault system: Economic; Non-economic.	No-fault compensation for clinical trials (Wet medisch wetenschappelijk onderzoek met mensen).		
New Zealand	No Fault/no right to sue except for: – Exemplary and punitive damages for physical injury; – Non-physical injury such as mental anguish/pain and suffering (*e.g.* through health professional disciplinary proceedings).	No obligation by law but often through the employer or the ACC.	Accident compensation corporation (ACC) provides a no-fault state funded rehabilitation and compensation for victims of medical misadventure (*i.e.* medical error and medical mishap) caused by a health professional's negligence. As part of the regime, the right to sue for personal injury has been removed from legislation. Individuals still retain the right to sue for personal injury, such as mental anguish. The ACC has an obligation to report to the HDC.	The Health and Disability Commissioner (HDC) has competence to investigate, act as a mediator and refer the claim to other tribunals to determine cover to pecuniary loss, loss of benefits, humiliation, etc. A new reform effective as of 1st July 2005 has further extended the coverage of the scheme. Accordingly, any injury occurring as a result of treatment that is not an ordinary consequence of that treatment is covered.
Poland	Proven error only. Damages: Economic; Non-economic.	Compulsory for health care professionals and establishments.		
Portugal	Fault regime	No.	No.	
Slovak Republic	Proven error only. Damages: Economic; Non-economic.	Compulsory for health care professionals only.	No.	

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries** *(cont.)*

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
Spain	Proven and presumed error. No error in case of lack of informed consent by the patient. Damages: Economic; Non-economic. Joint and several liability.	Compulsory by law for health care professionals and establishments practicing private medicine.	No.	
Sweden	No-fault compensation basis: Damages: Economic; Non-economic. Low compensation for acute pain and suffering. Joint and several liability.	Compulsory since 1997 for all health care providers and establishments to subscribe a patient insurance.	Patient Torts Act (PTA) entered into force in 1997 reforming the previous a no-fault insurance system established in 1975.	
Switzerland	Damages: Economic; Non-economic (excluding impairment of quality life). Reform of the tort system is considered.	No.	No.	
Turkey	Proven and presumed error; No error. Damages: Economic. Non-economic. Joint and several liability.	Proposed reform to introduce compulsory insurance for practitioners.	No.	Regulatory reforms are being prepared which could entail a development of the medical malpractice insurance markets.
United Kingdom	Breach of duty and causation must be established (based on expert advice, the Bolam test and the balance of probability). Damages: Economic; Non-economic; Punitive damages Joint and several liability may be considered by courts on a case-by case basis.	Doctors and dentists are required to have appropriate and adequate indemnity (not necessarily insurance) by their registration bodies and in the case of dentists (and later in 2006 doctors) by law. Private health care establishments are required to purchase insurance under the Care Standards Act (2000).	Through the NHS a special health Authority (the National Health Service Litigation Authority (NHSLA).	The NHSA has an active risk management programme. The NHS Redress Bill was recently introduced into parliament to enable an NHS Redress scheme to be established. This scheme is intended to offer patients an alternative to litigation for low monetary value claims only.

Table A.2. **Tort system and Government role in designing and reforming medical malpractice compensation regimes in OECD countries** *(cont.)*

	Tort system Fault concept applied Damages awarded Existence of joint and several liability	**Compulsory insurance**	**Government compensation fund** **Guarantee fund**	**Other measures or projects** Subvention, risk assessment, regulated tariffs, fees
United States	Proven and presumed error; Quasi strict liability in some cases. Damages: Economic; Non-economic; Punitive and other damages. Joint and several liability or Joint Liability depending on the particular state's legislation.	Compulsory in a majority of states for physicians and establishments in order to be licensed; Hospitals often require their staff to be insured.	Patient Compensation Funds have been put in place in some states (Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina and Wisconsin). They usually play a role of insurer of last resort. In Virginia (1987) and Florida (1988), no-fault compensation schemes were established to cover birth related neurological injuries.	Federal legislation is being considered in order to introduce a cap on non-economic damages (US$250 000) and to limit punitive damages. There are 28 states that have a law that caps non- economic damages or a law that limits total damages including Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin, recently South Carolina (April 2005), and Illinois (August 2005). Early offers programs are also developed to encourage rapid settlement of deserving claims without any litigation. Some states have introduced mechanism to help physicians defray the costs of obtaining insurance. New legislation to improve patient safety and reporting mechanisms have been passed in July 2005.

1. Including pain and suffering and possibly impairment of quality life.

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Policy Issues in Insurance

Medical Malpractice

PREVENTION, INSURANCE AND COVERAGE OPTIONS

Confidence in a country's health care system, its viability, its smooth functioning and patient safety require indemnification and deterrence systems that:

- adequately cover liability, both that of the medical practitioner and the health care establishment;
- provide fair compensation of injury; and
- deter medical malpractice.

Over the last years, in many OECD countries, these systems have experienced difficulties resulting in high-risk specialty physicians and surgeons leaving the practice and the development of expensive and useless – if not risky – defensive medicine.

This publication surveys and assesses various types of mechanisms and reforms implemented and refined in OECD countries that best limit and indemnify medical accidents. Reasons for difficulties faced by some compensation and prevention regimes, given the specificities of national circumstances and in particular of health care systems, are examined.

The study offers a series of unique and focused policy options and suggestions of interest for private and public parties in countries in the process of establishing a more efficient indemnification and deterrence system to cope with medical accidents.

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