



THE CANADIAN  
MEDICAL  
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ASSOCIATION

L'ASSOCIATION  
CANADIENNE  
DE PROTECTION  
MÉDICALE

Medical liability practices in Canada:

# Towards the right balance

A report prepared by  
The Canadian Medical Protective Association  
August 2005

## Of interest to:

**Advocates of the patient safety movement**, who are working towards clearly defined relationships and information reporting protocols that satisfy both patient safety and accountability requirements;

**Governments**, whose mandate is to ensure that appropriate resources are applied to the delivery of health care services, including the maintenance of a sustainable medical liability system;

**Patients**, who are interested in seeing the number of adverse events reduced and, should such events occur, in ensuring appropriate compensation and accountability frameworks are in place and that measures are enacted to ensure those same events do not re-occur in the future; and

**Physicians and other health care professionals**, for whom the maintenance of a robust medical liability system is an important contributor to their ability to deliver care and to ensuring their right to due process.

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## MEDICAL LIABILITY PRACTICES IN CANADA: TOWARDS THE RIGHT BALANCE

*Ask any number of physicians what they hope and strive for when they treat a patient, and they will no doubt profess a profound desire for a positive or optimistic outcome and, at worst, that nothing will go wrong. This is the nature of medicine: “Cure sometimes, care always, but first, do no harm.”*

*In an ideal world, no patients would suffer any harm from adverse events.*

*But the unfortunate reality is, from time to time, patients do suffer adversely from medical treatment, often because of a conjunction of circumstances, events and decisions that, individually, might not have resulted in a problem at all.*

*In an ideal world, the harm patients experience from an adverse event would never be the result of a physician's negligent breach of the duty of care. Unfortunately, however rare, negligence does sometimes occur.*

*In an attainable ideal and balanced reality,*

- ▶ *patients would feel safer because adverse events would be minimized,*
- ▶ *patients suffering harm from an adverse event caused by negligence would be compensated quickly, appropriately and equitably,*
- ▶ *physicians' rights to due process would be respected,*
- ▶ *in the event physicians made an error, they would be held appropriately accountable, and*
- ▶ *the medical liability system would be both affordable and sustainable.*

*The CMPA is continuously striving to support the balanced achievement of these ideals.*

## EXECUTIVE SUMMARY

*One of the necessary components of an effective health care system is well-designed, functional medical liability protection that assures both health care professionals and their patients that their interests and access to due process will be protected. In the event of adverse health care outcomes resulting from practitioner negligence, it enables injured patients to receive appropriate compensation.*

As the primary provider of medical liability protection to Canadian physicians, the CMPA believes that it is well positioned to contribute to discussions on improving the current Canadian system. CMPA's views are guided by five fundamental goals:

### REDUCTION IN ADVERSE EVENTS

Improve the safety of patients and minimize the number of adverse events through risk management and education.

### COMPENSATION

Ensure patients suffering harm as a result of physician negligence are compensated quickly, appropriately and equitably.

### DUE PROCESS

Ensure physicians' rights to due process are respected and their integrity protected.

### ACCOUNTABILITY

Recognize physicians' accountabilities.

### AFFORDABILITY

Maintain a cost effective medical liability system in the context of available health care resources.

Striking a reasonable balance among these five goals is a key to ensuring both continued strength in Canada's medical liability system and improved patient safety.

### LESSONS FROM CASE STUDY REVIEW

Different international jurisdictions use different medical liability models to meet their own specific national requirements. Based on a review completed, at CMPA's request, by Secor Consulting, the following lessons can be drawn from this international case study review:

- ▶ Medical liability forms one part of a complex health care delivery system and has multiple, interrelated components including the number of practising physicians, health care facilities, technology, patient compensation mechanisms, overall health care costs and other elements. *Changes to one element of the system inevitably impact on other elements, suggesting a progressive but evolutionary approach to change.*
- ▶ Medical liability models must be aligned with the prevailing health, social, legal and cultural environments. *Accordingly, there are "no plug and play" solutions that are easily transportable from one jurisdiction to another.*
- ▶ Notwithstanding the common use of the term "no fault" *there are no examples of pure no fault general medical liability systems as each of the international cases reviewed involved some element of fault determination.*

## FOUR MODELS

Four alternative models were applied to the Canadian context to determine if they offered advantages over the existing tort-based compensation model currently in use. The four models were:

### **No FAULT**

A no fault model based largely on the New Zealand experience.

### **COMBINATION FAULT/No FAULT**

Based in part on the Prichard Commission recommendations, a model providing access to both tort and no fault for significant avoidable adverse events.

### **SEVERELY COMPROMISED INFANT PROGRAM**

Segregated dealings for severely neurologically impaired children, based in part on the impaired infant programs in Florida and Virginia.

### **LITIGATION AUTHORITY**

Government sponsored indemnification of medical injuries, similar to the UK's National Health Service Litigation Authority (NHSLA).

When viewed against the five fundamental goals outlined above, each of these alternatives was found to be less satisfactory than the current model, in the Canadian context. In particular, these alternatives would cost more, thereby drawing resources away from direct patient care or from improving risk management and patient safety. Options that might appear to address one demand (such as the desire for increased access to compensation) result in negative impacts in other areas (such as greatly increased costs). Similarly, options that seek to improve patient compensation have unintended consequences and raise new challenges in other areas (such as patient safety and physician accountability). In addition, the effective portability of these models from one country or operating environment to another is questionable. Simply put, the results re-affirmed the view that the current model remains the most reasonable approach within the Canadian context.

## ACHIEVABLE INITIATIVES

While the current medical liability system may be the best available solution, there are a number of achievable initiatives for improving it; these initiatives fall into four main categories:

- ▶ Addressing information reporting and improving processes to enhance patient safety efforts;
- ▶ Reducing transaction costs without negatively impacting patient compensation;
- ▶ Enhancing the judicial processes; and
- ▶ Further exploring a segregated compensation system for compromised infants.

Patient safety, physician accountability and patient compensation have competing information reporting imperatives. These competing imperatives should be addressed to encourage full and protected reporting for patient safety purposes while, at the same time, providing for legally prescribed reporting where accountability will be determined (in effect creating an information “firewall”).

### COMMON SENSE REFORMS

Within the realm of the current tort-based patient compensation system, common sense reforms are achievable in the near term that protect the interests of all parties yet reduce the non value-added transaction costs that do not compensate injured patients but draw valuable resources away from other health care demands. Action on these pressing and sensible changes (such as the use of structured settlements and the elimination of the practice of subrogation) need not wait for wider system improvements and could make a tangible difference in the short term.

In a resource-constrained environment, the sensible approach would be to refine the existing medical liability system while focusing effort and resources on patient safety and risk management. Only a reduction in the probability of adverse medical events within the health care system will ultimately lead to decreased system costs and improved patient outcomes.

# BACKGROUND

*Quality health care is highly valued by Canadians and is widely considered to be an essential element of the Canadian way of life. However, increasing costs, shortages of health care professionals and long wait times for care are jeopardizing the effectiveness of the health care system. An effective health care delivery system is comprised of a number of interrelated components (facilities, skilled personnel, technology, medical knowledge, etc), each of which must operate in unison with the others.*

One of the necessary components of an effective health care system is well-designed, functional medical liability protection that assures both health care professionals and their patients that their interests and right to due process will be protected. It also ensures injured patients receive appropriate compensation, in the event of adverse health care outcomes resulting from practitioner negligence. It is a necessary system component that engenders public trust.

Effective medical liability protection also complements an accountability framework that requires health care professionals to provide care to a commonly accepted standard.

Different medical liability protection models have been applied in jurisdictions across the globe — with varying degrees of success. In some jurisdictions, medical liability protection arrangements are in, or are nearing, states of crisis, threatening the effectiveness of the health care system.

As identified in research commissioned by the CMPA, other countries often view the Canadian medical liability protection model as being an optimal approach. Grounded in a tort-based compensation system, the Canadian system seeks to provide appropriate compensation to patients injured by physician negligence while protecting physicians' right to due process through a defined accountability framework. In Canada, the majority of physicians receive protection through the Canadian Medical Protective Association (CMPA), a mutual defence organization. Other health care professionals and hospitals access liability protection through a variety of arrangements.

While the Canadian model appears fundamentally sound, medical liability costs have been escalating, drawing on resources that might otherwise be available for health care delivery<sup>1</sup>. This reinforces the need to move forward with achievable initiatives that further improve the existing medical liability system.

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<sup>1</sup> Based on data from the past six years, the CMPA estimates that the cost of the current Canadian physician liability system (including indemnities, legal and administrative costs) to be approximately \$225 million per year. In a study published in *Health Affairs*, the average annual real growth in total malpractice claims in Canada during the 1998-2001 period was 20% (almost 4 times higher than in the United States). See Anderson G.F., Hussey P.S., Frogner B.K., Waters H.R., "Health Care Spending in the United States and the Rest of the Industrialized World" *Health Affairs*, Vol 24, Number 4, pp 903-914, July-August 2005.

## REPORT AIM

This report seeks to facilitate constructive discussion of both alternative patient compensation models and improvements to the existing tort-based system. These discussions will be positioned within a context that recognizes the complex relationship between patient safety, physician accountability and patient compensation. This report will examine the relevant issues by:

- ▶ Outlining the relationships between patient safety, physician accountability and patient compensation;
- ▶ Reviewing medical liability protection in a number of international jurisdictions, highlighting elements that might be relevant to Canada;
- ▶ Examining alternative models within a Canadian context; and
- ▶ Highlighting achievable changes that would have an immediate and positive impact on the current Canadian medical liability system.

As the primary provider of medical liability protection to Canadian physicians, the CMPA believes that it is well positioned to contribute to these discussions. Its views on the overall medical liability system are guided by five fundamental goals:

### REDUCTION IN ADVERSE EVENTS

Improve the safety of patients and minimize the number of adverse events through risk management and education.

### COMPENSATION

Ensure patients suffering harm as a result of physician negligence are compensated quickly, appropriately and equitably.

### DUE PROCESS

Ensure physicians' rights to due process are respected and their integrity protected.

### ACCOUNTABILITY

Recognize physicians' accountabilities.

### AFFORDABILITY

Maintain a cost effective medical liability system in the context of available health care resources.

Striking a reasonable balance among these five goals is key to ensuring both continued strength in Canada's medical liability system and improved patient safety.



## BUILDING ON PREVIOUS RESEARCH

This paper builds on the results of a comprehensive survey of medical liability systems in other jurisdictions completed, at CMPA's behest, by Secor Consulting. It also incorporates many of the findings of previous studies, including:

**PRICHARD REPORT ON MEDICAL LIABILITY IN CANADA:** The Prichard Report, commissioned by Canada's deputy health ministers in 1990, reviewed medical liability systems, literature and legal precedent, Canadian malpractice claims trends, and Canadian stakeholder opinion. One of its recommendations was the institution of a no fault based system, built in part on the notion of compensable 'avoidable medical events.' No fault was to be a central component of the scheme, with access to tort retained as an alternative. The Prichard proposals were not adopted.

**DUBIN REPORT:** In 1997 and in response to increases in medical liability damages/legal costs, the CMPA commissioned the Honourable Mr. Charles Dubin to examine the Canadian medical liability system. The Dubin Report found the existing approach to medical liability to be soundly based and it recommended against broad no fault initiatives. It did suggest exploration of limited designated compensable event approaches, such as those undertaken elsewhere for compromised infants.

**THE CANADIAN ADVERSE EVENTS STUDY** (BY G. ROSS BAKER, PETER G. NORTON ET AL): This report was the first Canadian study to provide a national estimate of the incidence of adverse events in patients admitted to Canadian acute care hospitals<sup>2</sup>. The overall incidence rate of adverse events was estimated to be 7.5%; the report estimated that, of the almost 2.5 million annual hospital admissions in Canada similar to the type studied, about 185,000 were associated with an adverse event and close to 70,000 of these were potentially preventable.

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2 The results of the study were reported in the May 25, 2004 edition of the *Canadian Medical Association Journal (CMAJ)*. This study built on a previous study of leading patient safety practices in Canada by G. Ross Baker and Peter G. Norton (*Patient Safety and Healthcare Error in the Canadian Healthcare System*).

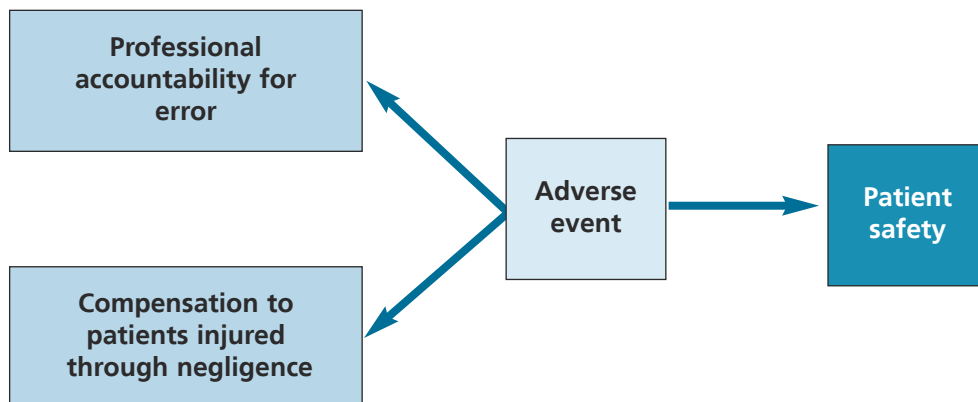
# RESPONDING TO ADVERSE MEDICAL OUTCOMES: THE RELATIONSHIP BETWEEN PATIENT SAFETY, PHYSICIAN ACCOUNTABILITY AND PATIENT COMPENSATION

*The initiating event within a medical liability system is an adverse medical outcome that may be either avoidable or unavoidable. Avoidable outcomes may result from a number of factors, including but not limited to system error or individual negligence.*

## THE MEDICAL LIABILITY SYSTEM

As depicted in the schematic below, three response elements potentially flow from an adverse event: patient safety, physician accountability and patient compensation. Appendix 1 provides a more detailed depiction of these responses.

APPENDIX 1  
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**PATIENT SAFETY:** Patients want the safest health care system possible while physicians want to protect their patients from harm. Although the medical community cannot expect to ever completely eliminate the occurrence of adverse events, it continuously strives to identify and reduce the probability of adverse medical events through education and risk management. The primary aim of patient safety is to prevent adverse events from occurring and, accordingly, patient safety efforts seek to learn from both adverse events and “near misses” in order to identify their causes. This information should lead to changed procedures and system improvement that reduce the number of adverse events and enhance patient safety. Inherent in this approach is the *full and protected reporting of all information relevant to the adverse event*, regardless of whether it is avoidable or unavoidable or whether the system or one or more individuals may have been at fault.

**PATIENT COMPENSATION:** This response seeks to compensate the injured patient in a manner that is appropriate and equitable, given both the extent of the injuries and the circumstances involved. As with professional accountability, the tort-based approach to patient compensation is founded upon *legally prescribed reporting* and the accordance of due process to all involved parties.

**PROFESSIONAL ACCOUNTABILITY:** The sound practice of medicine, along with natural justice imperatives, requires health care professionals (including physicians) to be accountable for their actions. This imperative is a common requirement of self-regulating professions and is a necessary element in ensuring public confidence in the quality of care provided. For physicians, such accountability may take the form of licensing sanctions, accreditation issues, the withdrawal of practice privileges or other inquiries (such as coroner's inquests and human rights investigations). This accountability pillar entails due process, *legally prescribed reporting of information* and assessment of an individual's actions against an established standard of care — it is necessarily a fault-finding activity.

A system that does not effectively address each of these three responses is unlikely to engender public confidence or warrant public support. This creates a challenge for decision-makers who must, as described below, seek to achieve a workable balance between competing imperatives.

### COMPETING IMPERATIVES AND INFORMATION REPORTING

Each of the three responses to an adverse medical outcome has a distinct goal: reducing the number of adverse outcomes, compensating for injuries caused by negligence or holding a practitioner to account for error.

*Reducing the probability of adverse outcomes is dependent on consistent rule sets that encourage full, protected, information reporting*

While these three responses can and do operate largely in harmony, the imperatives underlying the reporting and use of information can be competing:

- ▶ Patient safety requires full and protected reporting not only of the outcome itself but also of all actions taken prior to and after the adverse event.
- ▶ Physician accountability and tort-based compensation are based on due process and legally prescribed reporting.

These challenges impact on key tenets of the existing Canadian medical and legal environments and the competing imperatives of the three responses to an adverse event must be considered in any examination of medical liability.

# THE INTERNATIONAL MEDICAL LIABILITY ENVIRONMENT

*The current state of medical malpractice protection is of serious concern to many governments, patients, medical organizations and physicians around the world. The CMPA commissioned Secor Consulting to examine representative medical liability models in the United Kingdom, France, New Zealand, Sweden, and the United States. Appendix 2 provides a country-by-country description, of which the following is a synopsis:*

**THE UNITED KINGDOM:** A tort-based, government-sponsored indemnity program run in parallel with a private system. National Health Service (NHS) Trusts manage public hospitals and clinics and the NHS Litigation Authority (NHSLA) is responsible for insuring all work done in the Trusts. Three medical defence societies<sup>3</sup> provide medico-legal protection and advice to physicians in private practice. While this system appears to be working effectively, costs are on the rise.

**FRANCE:** A system in flux, with elements of no fault, fault, public and private health care. A fault system exists for injured patients when the physician is unable to demonstrate that the injury was not caused by his/her actions. Injured parties have access to civil, criminal, administrative and professional tribunals. A no fault system is in place for injuries resulting in invalidity of at least 25% when no fault is declared. *L'Office National d'Indemnisation des Accidents Médicaux (l'ONIAM)* is responsible for no fault payments.

**NEW ZEALAND:** A restricted version of no fault that includes more than medical injury. Unless the medical injury is a rare complication, the injured party must establish fault in order to receive indemnification. Should a physician be found to be at fault, he or she is then open to professional, financial and legal sanctions (separate from patient compensation). A recently proposed change seeks to separate the patient compensation deliberations from the accountability process.

**SWEDEN:** A top-up 'no-blame' system built on a foundation of a particularly comprehensive social welfare program. To warrant compensation, the adverse outcome must have been "unintended and avoidable," with the test being whether an experienced doctor would have achieved a different result. This model has been replicated in Finland, Denmark and Norway.

**THE UNITED STATES:** A commercial liability insurance model in crisis. Multiple factors are contributing to a crisis situation in which medical liability costs have increased dramatically. These costs contribute to spiralling health care costs<sup>4</sup> and may be negatively impacting the supply of physicians, particularly in high-risk specialties.

<sup>3</sup> The Medical Protection Society (MPS), the Medical Defence Union (MDU) and the Medical and Dental Defence Union of Scotland (MDDUS).

<sup>4</sup> From 1994 to 2001, the median medical liability increased 176%, with awards jumping 43% within one single year, rising from \$700,000 in 1999 to \$1M in 2001. With these increases, the US Health and Human Services has estimated that medical liability costs add \$60-\$108B to the total cost of health care each year.

# LESSONS FROM THE INTERNATIONAL ENVIRONMENT

## A SYSTEMS APPROACH

Health care is a complex system and adjusting one element of the system will inevitably lead to changes in the others. Medical liability protection does not exist in a vacuum but is inextricably linked with physician supply, overall health care costs and other elements of the health care delivery mechanism.

The French experience appears to highlight the dangers of proceeding without a full understanding of the system-wide implications of change. In this case, the uncertainty created by significant change has reduced the availability of specialist physician care. Within the American context, escalating liability protection costs are impacting the supply of specialist physicians and contributing to such undesirable and costly practices as defensive medicine. In the UK, the absence of a strong patient safety initiative may be contributing to rising costs.

These experiences suggest that changes should be well-considered not only from the perspective of the direct impact on liability protection but also in terms of secondary or tertiary impact on other elements of the system. In all but the most pressing circumstances, *this implies a progressive but evolutionary approach to system change.*

## NO “PLUG AND PLAY” SOLUTION

While the international review highlights certain practices that should be avoided, *it does not identify a single best practice model to be transported or 'plugged in' to Canada.* To be successful in Canada, a medical liability system must fit into our health, social, legal and cultural environment.

As an example, the Swedish model appears to work well within that jurisdiction as it forms one element of an extensive social welfare safety net. The Swedish model cannot however be viewed in isolation from that wider context and there could be significant consequences of assuming that one model is easily transportable to another jurisdiction.

It follows that an appropriate response is to examine elements of other models from a perspective of how they might work within the Canadian context. This entails an approach that builds on our existing foundations, applying international lessons where and when appropriate.

### NO PURE “NO FAULT” SYSTEM

It is evident from the international review that there are no “pure” no fault systems operating within the medical liability arena. *The so-called no fault medical liability systems all include a significant aspect of fault determination and disciplinary referral of practitioners, sometimes without the same elements of due process that characterize the Canadian model.* For example, the New Zealand and Swedish models are often described as being no fault but both include a substantial element of physician fault finding. There are likely a number of factors that contribute to this reality:

***Internationally, the so-called ‘no fault’ medical liability systems all include a significant aspect of fault determination***

- ▶ It is human nature to want to know what went wrong and who or what was to blame.
- ▶ Unless patient compensation schemes are prepared to compensate all patients with an adverse medical outcome — whether unavoidable or avoidable — it becomes necessary to determine what is an “avoidable”<sup>5</sup> outcome.
- ▶ Self-regulating professions, such as medicine, require a mechanism to ensure that all of their members adhere to established standards of practice. Inherent in the maintenance of professional standards is the ability to identify fault and, when appropriate, take remedial action (additional training, discipline, loss of privileges, etc).

<sup>5</sup> A clear and functional definition of what constitutes an “avoidable” outcome of medical care involves establishing whether the physician met the standard of care by determining whether an equally experienced physician would have made the same decisions in the same situation - a determination that must be made while disregarding any evidence gained from the benefit of hindsight.

# COMPARING CANADA TO OTHER MODELS

*The current Canadian response to adverse outcomes, with its three elements of patient safety, physician accountability and tort-based patient compensation, appears to strike a reasonable balance between competing demands. Other countries view the Canadian system as being worthy of emulation.*

However, other alternatives to tort-based compensation do exist and are worth exploring in the Canadian context. Accordingly, four models are considered based on results of the international review and prior studies performed on the Canadian situation. They are:

#### **No FAULT**

A no fault model based largely on the New Zealand experience.

#### **COMBINATION FAULT/NO FAULT**

Based in part on the Prichard Commission recommendations, a model providing access to both tort and no fault for significant avoidable adverse events.

#### **SEVERELY COMPROMISED INFANT PROGRAM**

Segregated dealings for severely neurologically impaired children, based in part on the impaired infant programs in Florida and Virginia.

#### **LITIGATION AUTHORITY**

Government sponsored indemnification of medical injuries, similar to the UK's National Health Service Litigation Authority (NHSLA).

Secor Consulting has completed a comprehensive review of these four models and their implications within the Canadian context and a summary of this review is found at Appendix 3<sup>6</sup>.

**APPENDIX 3**  
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## **FINDINGS**

The following section incorporates Secor's findings and examines the four models within the context of the five fundamental goals enunciated earlier (p. 8).

### **Reduction in adverse events**

Learning from adverse outcomes and near misses is crucial to patient safety and error reduction. Given that each model examined (including no fault) inevitably involves elements of fault-finding, no single model is more intrinsically pre-disposed to supporting patient safety than any other. This finding mirrors the international experience.

<sup>6</sup> The full Secor Consulting report is available at [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca).

Patient safety initiatives function most effectively when there is full and protected reporting of information. As patient safety initiatives can not be viewed in isolation from the accountability related responses, it is imperative that this full and protected reporting be accompanied by the knowledge that such information will be protected; this protection is a necessary element of the due process integral to an accountability framework.

### **Compensation**

Within the current Canadian model, patients injured as a result of fault receive the compensation necessary to support an appropriate lifestyle. However, access is restricted to those injured as a result of fault, leading to concerns about patients experiencing adverse medical outcomes where fault did not occur.

Limitations on indemnity in the no fault model would necessarily result in lower compensation than that currently provided (albeit with a larger group being compensated). While such a system appears to work effectively in Sweden with its very strong social welfare system, such a safety net does not currently exist in Canada. Without other expensive system adjustments<sup>7</sup>, this risks placing injured patients in the untenable position of receiving compensation that is inadequate to cover their real costs and falling back on an unprepared social safety net.

Lower compensation could create a perceived need for patients to acquire insurance to meet the gap between limited indemnification and actual compensation needs, creating potential inequities between those patients able to afford such insurance and those who are not.

### **Due process**

By limiting compensation to patients with avoidable injuries, the no fault and hybrid models necessarily introduce fault-finding — but without the due process currently accorded to physicians and patients. This mirrors the evolution of both the New Zealand and Swedish models away from a pure no fault model to one that includes elements of fault-finding. The hybrid no fault/fault model also raises the likelihood of adversarial relationships between governments and physicians as each seeks to shift compensation responsibility to the other.

### **Accountability**

Every model studied (either within the Canadian or international arena) involves elements of physician accountability, thereby debunking the assertion that “no fault equals no blame.” Each model must therefore wrestle with and resolve the challenges associated with the competing information reporting imperatives associated with patient safety and accountability. No one model appears to have inherent advantages over any other in addressing this issue.

<sup>7</sup> Secor estimates that if all medical treatment injuries were compensated, annual medical liability costs could rise from a current level of \$225 million to approximately \$40 billion. Even the application of “filters” requiring injuries to be “unintended and avoidable” could see annual system costs rise to \$2.6 billion.



The deterrent, punitive and retributive aspects of the tort process meet a societal requirement for accountability and correction. It serves to:

- ▶ Deter malpractice;
- ▶ Deal with negligent practitioners when appropriate; and
- ▶ Allow a socially acceptable avenue for the retributive feelings of injured people.

The tort system has very clear processes for determining whether the physician provided the expected standard of care. It enables doctors to defend themselves against unwarranted allegations of negligence and respects due process and the requirements of natural justice. No fault and litigation authority systems offer little in the way of explanation to an injured patient and do not provide a strong deterrent effect; they may however significantly impair due process, with a resultant negative impact on a physician's professional standing.

### **Affordability**

Even with the application of conservative estimates of compensation levels and the imposition of limitations to only avoidable injuries, the costs associated with the no fault, hybrid no fault/fault and litigation authority models represent a multiple-fold increase over those of the current system<sup>8</sup>. In an already stressed health care system, it is not apparent how such significant cost increases could be absorbed or how society would respond to this potential diversion of funds from either direct health care delivery or other national priorities. In the New Zealand experience, this appears to have led to the imposition of filters or stringent criteria to manage the number of compensation cases and the resulting associated costs.

### **Additional findings**

A segregated compensation system for compromised infants, regardless of cause or fault, would be more costly than the current mode<sup>9</sup> but poses some potential advantages. The most appealing of these advantages might be a greater degree of societal equity, particularly in many of the circumstances where cause or fault is difficult to determine. However, careful consideration and clear delineation of parameters and responsibilities would be needed if the challenges experienced in US jurisdictions are to be avoided. A segregated compensation system must be an integrated element of a social safety net and as such, a decision to proceed in this direction is one largely of social (rather than medico-legal) policy and would require political will.

The litigation authority model implies a shift in the relationship between governments and physicians towards one in which physicians are “employees.” This has impacts on the provision of health care and a patient's access to unbiased advice and treatment that extend far beyond considerations of medical liability.

<sup>8</sup> Secor Consulting has estimated that the annual costs of a no fault system could range from \$2.6 billion with filters to a high of \$40 billion with no “filters”. This latter figure can be achieved only by limiting both access to and the level of compensation. Depending on the criteria applied, a combination tort and no fault approach (the Prichard recommendations) could cost between \$1.7 and \$2.8 billion annually.

<sup>9</sup> Secor Consulting estimates that a Canadian compromised infant program (similar to that operating in Florida) could add an additional \$220 million in annual costs, approximately doubling current system costs of \$225 million per year.

**SUMMARY**

The following table summarizes the impact of the current and alternative models on the three responses of patient safety, physician accountability and patient compensation:

<b>Model</b>	<b>Patient safety</b>	<b>Physician accountability</b>	<b>Patient compensation (access and cost)</b>
<b>No fault</b>	Does not intrinsically support patient safety but can be structured to do so.	Requires a parallel physician accountability framework and clear reporting rules.	Likely to increase the number of patients compensated and result in significantly increased costs.
<b>Combination model (no fault and tort access)</b>	Does not intrinsically support patient safety but can be structured to do so.	Requires a parallel physician accountability framework.	Likely to increase the number of patients compensated and result in significantly increased costs.
<b>Government indemnification (Litigation Authority)</b>	Does not intrinsically support patient safety but can be structured to do so.	Requires a parallel physician accountability framework.	Depending upon filters applied, could (but not necessarily would) result in greater accessibility and higher costs than the existing system.
<b>Compromised infant</b>	Does not intrinsically support patient safety but can be structured to do so.	Requires a parallel physician accountability framework.	Eliminates the perceived inequity of the existing system for one group of claimants but does so at an increased cost.
<b>Current system</b>	Requires clear reporting rules to encourage patient safety while safeguarding due process for accountability and compensation.	Has a strong physician accountability framework.	Provides for appropriate compensation but limits the number of injured patients receiving it.

This examination of the existing and four alternative models highlight the challenges of dealing with a complex system of inter-related components. Options that might appear to address one demand (such as the desire for increased access to compensation) result in negative impacts in other areas (such as greatly increased costs). Similarly, options that seek to improve patient compensation have unintended consequences and raise new challenges in other areas (such as patient safety and physician accountability).

# ACHIEVABLE IMPROVEMENTS

*Secor Consulting reports that, while the Canadian medical liability system is considered to be a world-class model by other nations, it can be further improved to make it more effective and to reduce those costs that do not contribute directly to the practice of good medicine or to the compensation of injured patients. While there remains a great deal of work to be done in clarifying reporting rules and protecting information in order to meet the competing demands of the patient safety, physician accountability and patient compensation imperatives, positive changes are readily achievable in the short term.*

It is believed that a select number of achievable, evolutionary changes can improve the existing system while slowing its rising costs. These changes have only positive impacts on the overall health care delivery system and the complementary responses of patient safety and physician accountability.

## OPPORTUNITIES FOR POSITIVE CHANGE

There are a number of achievable initiatives for improving the existing medical liability system; these initiatives fall into four main categories:

- ▶ Addressing information reporting and improving processes to enhance patient safety efforts;
- ▶ Reducing transaction costs without negatively impacting patient compensation;
- ▶ Enhancing the judicial processes; and
- ▶ Further exploring a segregated compensation system for compromised infants.

### Information reporting

Patient safety efforts require full reporting and analysis of all relevant information from all adverse events and near misses and yet, as noted earlier, this often creates a perceived conflict with the right to due process imperatives of physician accountability and patient compensation. Legally prescribed reporting is necessary to enable physicians and others to adequately defend their integrity in either patient compensation proceedings or professional tribunals.

Canadian practices could be quickly improved by requiring health care professionals to fully report, within a patient safety context, all information concerning adverse events, while guaranteeing that none of this information will be made available for accountability or patient compensation processes. The two latter activities would continue to be guided by existing reporting rules. The impenetrability of this information “firewall” would largely resolve the competing reporting imperatives and greatly contribute to maintaining an appropriate balance in the system. This positive change can be readily achieved through amendments to legislation.

*The Canadian medical liability system is considered to be a world-class model by many nations, but improvements are possible*

**Reduced transaction costs**

There are also steps available to reduce the transaction costs associated with the current system:

- ▶ Some Canadian provinces have existing provisions that mandate the use of structured settlements within medical liability cases but such provisions are not widely used. Such settlements involve an annuity instrument, underwritten by the secure life insurers, that provides the injured patient with a life-time tax-free income stream. This approach ensures funds are available for the life of the patient while — in comparison with a lump sum payment — substantially reducing the costs of providing the same level of benefits. The injured patient receives the same benefit (with added benefit of it being guaranteed for life) while the medical liability system incurs lower costs<sup>10</sup>.
- ▶ Many provincial governments currently include their costs of providing health and social services to injured patients as part of the legal settlement. This practice<sup>11</sup> necessarily increases settlements costs and, by extension, medical liability system costs. However, as a significant portion of medical liability system costs are paid by provincial governments in lieu of fee increases to physicians (through their reimbursement of physicians' CMPA membership fees), this produces a circular movement of money from one government department to another department. It is expensive to administer and represents “transaction” costs that are of no benefit to the injured patient.

*In a resource-constrained environment, the sensible approach would be to refine the existing medical liability system while focusing effort and resources on patient safety and risk management*

**Judicial system enhancements**

There are several discreet and attainable changes within the judicial system that would reduce transaction costs associated with civil actions while still protecting the rights of the parties, patient, physician and hospital. These changes include but are not limited to the availability of mediation or other pre-trial settlement opportunities; appropriate pre-trial production of expert opinion; access to case management particularly in high-severity cases; periodically reviewed guidelines for the courts on damage; and a code of conduct and scientific integrity for those who agree to function as experts in personal injury cases.

**Segregation compensation system for compromised infants**

The potential benefits of adopting a segregated compensation program for compromised infants are considerable and might address the social justice challenges inherent in determining fault in circumstances where such determinations are difficult if not impossible to achieve. While the cost and jurisdictional difficulties associated with this social policy initiative would be significant, these potential implementation challenges should not dissuade federal, provincial and municipal governments from collectively examining such a model in more detail.

<sup>10</sup> A CMPA study, using benchmark assumptions, identified a potential savings of approximately \$8.9 million would have been achieved in 2004 if structured settlements were used in cases where damages exceeded \$250,000. In the province of Ontario, the projected \$3.9 million in savings would have represented approximately 7% of the total damages paid out.

<sup>11</sup> The process is known as "subrogation."

# CONCLUSION

***Medical liability is an essential element of any complex health care delivery system. As such, assuring an effective and efficient medical liability mechanism should be of utmost importance to Canadians, to decision-makers, be they federal or provincial governments, the judicial and legal communities, licensing and regulating bodies, professional organizations, practicing health care professionals, and those advocating the interests of injured patients.***

The current Canadian system responds to adverse medical events in three separate but related ways by:

- ▶ Identifying the event's cause so as to reduce the number of future events and improve patient safety;
- ▶ Holding individuals accountable for errors made; and
- ▶ Compensating patients injured as a result of negligence.

While there are necessarily competing imperatives inherent in these responses, particularly in terms of information reporting and analysis, an improved version of the current medical liability system is likely to be the most effective within the Canadian context. When models used in other jurisdictions are applied to the Canadian environment, the likely results are less than those currently being achieved. A review of the international environment also highlights the need to fully consider the wider system impacts associated with making changes to medical liability regimes.

The competing information reporting imperatives should be addressed to encourage full and protected reporting and analysis for patient safety purposes while, at the same time, providing for legally prescribed reporting where accountability will be determined (in effect creating an information “firewall”). In the short term, the establishment of such a “firewall” protecting patient safety information would be a readily achievable first step.

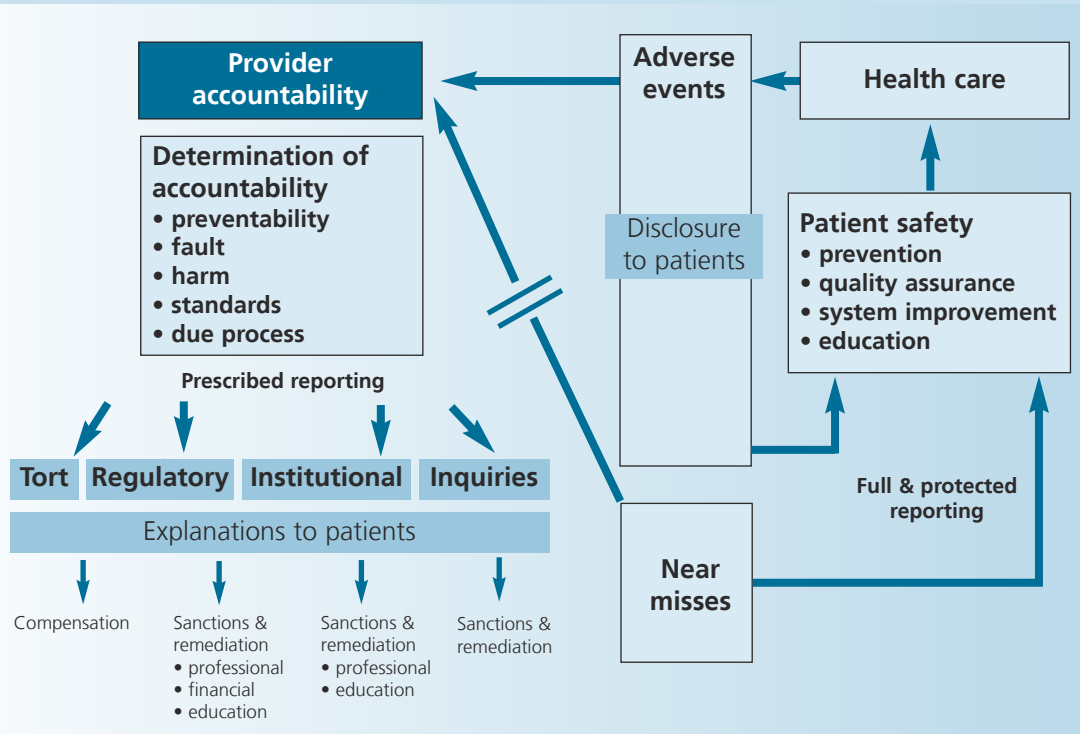
Within the realm of the current tort-based patient compensation system, common sense reforms are achievable in the near term that both protect the interests of all parties yet reduce the non value-added, transaction costs that do not compensate injured patients and also draw valuable resources away from other health care demands. Action on these pressing and sensible changes need not wait for wider system improvements and could make a tangible difference in the short term. In addition, adopting a discrete number of enhancements to the judicial system would also have a positive impact.

Few services are more vital or prized by Canadians than the provision of effective and efficient health care. Canada can be rightfully proud of the system currently in place but must also be cognizant of the many pressures being exerted on it. While medical liability issues are but one area exerting such pressure, they form an important component of the overall system and should be addressed within the context of overall system dynamics.

The current medical liability system in Canada is fundamentally sound and is very likely the best possible model for our circumstances. Alternative patient compensation models require significant additional financial resources and yet do not, by themselves, advance patient safety efforts. While this realization should cause decision-makers to pause before considering drastic changes to the existing model, it should not deter the application of common sense reforms.

The sensible approach, in a resource-constrained environment, is to refine the existing medical liability system while focusing effort and resources on patient safety and risk management. Only by reducing the probability of adverse medical events will the health care system ultimately decrease system costs and improve patient outcomes.

APPENDIX 1 — THE CANADIAN MEDICAL LIABILITY SYSTEM



The above diagram depicts the three responses that emanate from an adverse event:

- ▶ Patient safety related responses aimed at reducing the number and the magnitude of future adverse events;
- ▶ Accountability responses that include both:
  - Actions to ensure that, if a physician makes an error, that physician is held accountable; and
  - Patients injured as a result of negligence for which a provider has been found to be accountable are appropriately compensated.

## APPENDIX 2 — INTERNATIONAL CASE STUDIES

Summary descriptions of five international medical malpractice models have been drawn, in part, from a more comprehensive study completed by Secor Consulting.

**UNITED KINGDOM** — a public run litigation program providing some insight into the financial commitment required to support such a program.

**FRANCE** — a system that incorporates elements of fault, no fault public and private health care but one that has not yet reached equilibrium.

**NEW ZEALAND** — accident compensation program, often referred to as comprehensive no fault but under which, for most cases, fault plays an important element.

**SWEDEN** — a comprehensive no-blame system, supported by the pillars of its culture and strong social net.

**UNITED STATES** — a tort-based system, with multiple states in “crisis.”



## UNITED KINGDOM: PUBLIC RUN LITIGATION

### Health Care System

The National Health Service (NHS) was established in 1948 to provide free healthcare to residents of the United Kingdom (UK). Each time a patient visits a doctor in, or receives treatment at, a public hospital, the treatment is provided free of charge. The NHS is funded through general taxation and is administered by the Department of Health.

Patients also have the option of paying for private healthcare either through insurance or personal resources when they use medical services.

In recent years, the structure of the NHS has undergone considerable change. The private sector now has a role in supplying and funding some NHS buildings and services. The decision-making authority is being devolved to local communities and the NHS has adapted its practices to the different countries of the United Kingdom.

### Medical malpractice environment

The medical malpractice system in the UK is tort-based, with government-sponsored indemnification for events occurring in public hospitals. Several groups participate in the system in the United Kingdom. These groups include the National Health Service (NHS) Trusts that manage public hospitals and clinics, and the NHS Litigation Authority (NHSLA), responsible for insuring all work done in the Trusts. There also are three medical defence societies, which provide protection to member physicians in private practice, assistance to all members with regulatory (General Medical Counsel) inquiries, and general medical-legal and risk management advice.

### Performance of the system

In the opinion of the various stakeholders (doctors, claimants, defendants and hospitals), the present system is working well with claims being resolved relatively quickly and fairly. However, the Government's commitment to medical malpractice liability has risen to £7 billion (Cdn\$ 15.2 billion) as of March 2005, and, in the private domain, fees have also increased.

Recommendations from the stakeholders for changes to the system include improvements in terms of patient safety and better dissemination of information. The National Patient Safety Agency (NPSA) is responsible for monitoring all adverse incidents in the NHS, regardless of whether they are linked to a claim. The NPSA's key priorities include setting up a national reporting and learning system for adverse events, providing practical solutions to improve patient safety and promoting their adoption, and developing an open and fair culture in the NHS that encourages all healthcare staff to report incidents without undue fear of personal reprimand.

Some groups have noted a large number of physician license suspensions in the UK. Both the Medical Protection Society (MPS) and the National Clinical Assessment Authority (responsible for helping resolve doctor performance issues) believe that doctors are facing high sanctions and that suspensions are being meted out for "system" errors. These suspensions have a profound effect on reputation. Moreover, physicians, having being sanctioned professionally, can also be tried in civil and/or criminal court.

## FRANCE: A SYSTEM WITH MANY ELEMENTS

### Health care system

In 2000, the World Health Organization (WHO) classified the French healthcare system as the “best health system in the world” and it permits all French citizens access to treatment. Medical care is either entirely free, or is reimbursed 100% for more than 96% of the population. The French also have the right to choose among healthcare providers (public, private, university, general hospital) regardless of their income level.

In France, health insurance is a branch of the social security system. It is funded by workers' salaries, by indirect taxes on alcohol and tobacco and by direct contribution based on income. More than 80% of French people have supplemental insurance, often provided by their employers. The poorest have free universal health care that is funded by general government revenues.

### Medical malpractice environment

The French medical malpractice system incorporates elements of fault and no fault.

A fault system exists for injured parties when the physician cannot demonstrate that the injury was not caused by his or her doing. Injured parties have access to civil, criminal, administrative and professional tribunals and they may access one or more of these tribunals sequentially or concurrently.

A no fault system is in place for injuries resulting in invalidity of at least 25% when either no fault is declared or when the cause of the invalidity is a nosocomial infection. Claims are submitted to regional commissions that determine claim eligibility and fault. The National Office of Medical Compensation (Office National d'Indemnisation des Accidents Médicaux — ONIAM) takes responsibility for no fault payments. If the regional commission finds that there has been fault, the claimant must petition the practitioner's insurance for indemnification. Insurers can either accept the commission's findings or offer zero payment at which time the claimant can choose to enter the judicial system. While injured parties have access to the tort system for injuries regardless of the commission's ruling on fault, a victim's acceptance of an offer of compensation from the commission prevents them from making a claim through the courts.

Doctors within the public system have their premiums paid by their institution, while doctors in private practice must pay their own premiums.

### Performance of the system

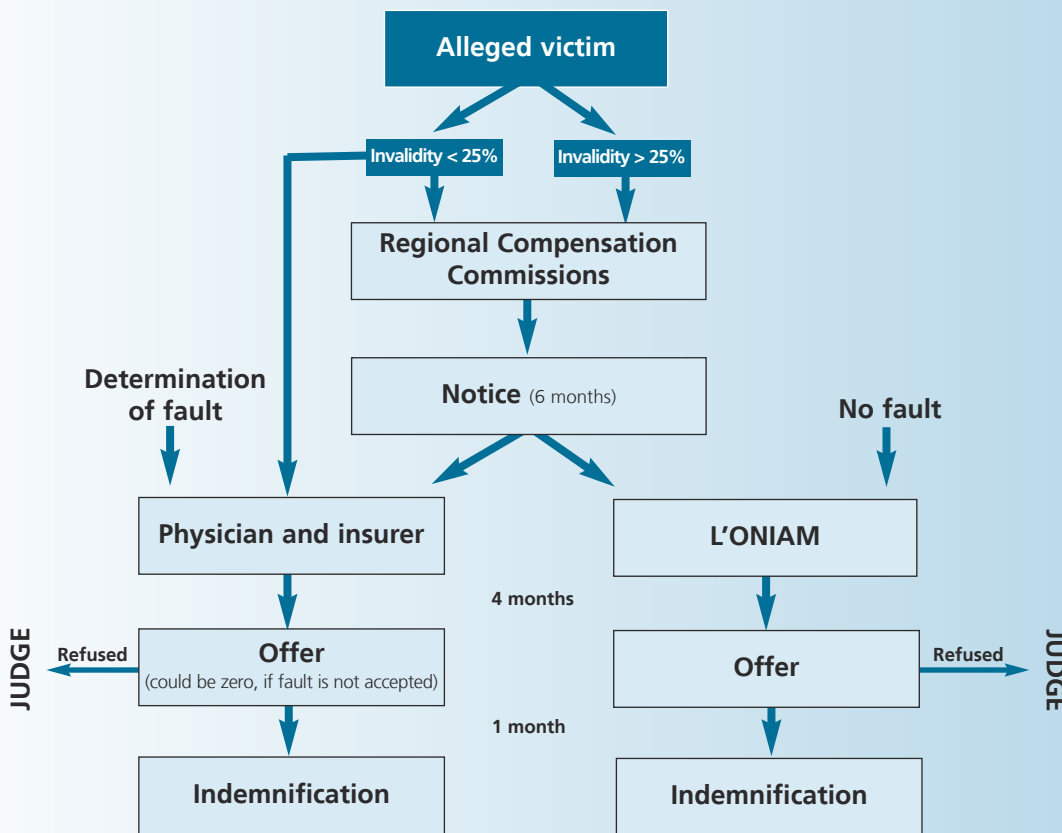
Recent changes have created uncertainty in France's medical malpractice system. The “Loi Kouchner” (2002) divided the system into the two streams of fault and no fault and made it mandatory for doctors to have insurance. The “Loi About” (2002) transferred the responsibility for hospital infections to ONIAM and changed the rules of timing for claim eligibility. These changes were implemented to attract insurers back into the marketplace. However, in the face of uncertainty, the exit of insurers has continued, driving up insurance costs to levels that have caused some specialists to manage their risks by reducing their practice, changing fields or retiring. These actions have affected the supply of medical treatment.

Despite the recent changes to the system, there remains an absence of structured risk management. This shortfall does not appear to be a priority for physicians, the Minister of Health or insurers. This is evidenced by the limited scope of the recently established Observatoire des Risques Médicaux whose role is to collect, clean and report information on accidents at an aggregated national level. The Observatoire des Risques Médicaux has no mandate to improve safety other than to share its information with hospitals and the Haute Autorité de Santé.

When an action is launched, it is the physician's or the institution's responsibility to demonstrate to the regional commission that there was no fault associated with the injury. Lacking a specific determination of fault, the state, through ONIAM, provides indemnification that results in the physician being less likely to be held accountable through professional sanctions. Unlike the other systems noted in this appendix, the French example puts the emphasis, from the outset, on the avoidance of accountability.

Exhibit 1 presents an overview of the indemnification process in France showing the paths for each of the fault and no fault based indemnification processes.

**Exhibit 1**  
The indemnification process in France



## NEW ZEALAND: ACCIDENT COMPENSATION PROGRAM

### Health care system

New Zealand has a parallel system of public and private health services. Public health care is subsidized by the New Zealand Government while the individual pays for private health care. Individuals who can afford to pay for private health insurance do so while those who cannot, use the public health system.

In New Zealand, health problems are essentially divided into two categories: health problems that arise out of an accident and health problems that do not arise out of an accident. Health problems that arise out of an accident are subsidized by the Accident Compensation Corporation (ACC).

The medical misadventure component of the ACC, which deals with the indemnification of victims of medical treatment injuries, represents approximately 2% of the ACC's claim amounts. At inception of the ACC program, the injured party's right to sue was removed with "swift, scheduled payments" being provided in its stead.

### Medical malpractice environment

Often referred to as a no fault system, New Zealand's accident compensation scheme consists of the ACC, a national insurance program that covers all bodily accidents caused by automobile, workplace, day-to-day life, medical treatment and exceptional incidents.

Under the medical misadventure component of the ACC, any victim of a medical treatment injury may apply for compensation. Claims must meet one of two conditions to be accepted: a medical error occurred and fault has been established by the ACC or, a medical mishap occurred and caused a "rare and severe" injury under an accepted treatment

For every 100 claims filed, 60 are rejected. Of the 40 approved, 15% are found to be the result of medical errors and 85% are found to be the result of medical mishaps causing a "rare and severe" injury. An appeal route exists for both sides.

### Performance of the system

The annual cost for medical misadventures has risen recently. The total cost of \$36 million (2003-2004) represents almost \$10 per capita (15% higher than the per capita cost of the current tort-based system in Canada). Despite these high and rising costs, indemnity payments are comparatively low at, on average, between \$2,000 and \$5,000. When future claims liabilities are considered, the medical misadventures account is carrying \$213 million reserve deficit (2003). The government is working to bring the account into a self-sustaining equilibrium by 2014.

The medical malpractice system in New Zealand was formally reviewed in 1982, 1992, 1998, 2001 and a new review was undertaken recently. The motivation for the reviews and their associated changes is twofold: to manage risks and to control costs. However, in some instances, the risk management and cost control objectives are in conflict.

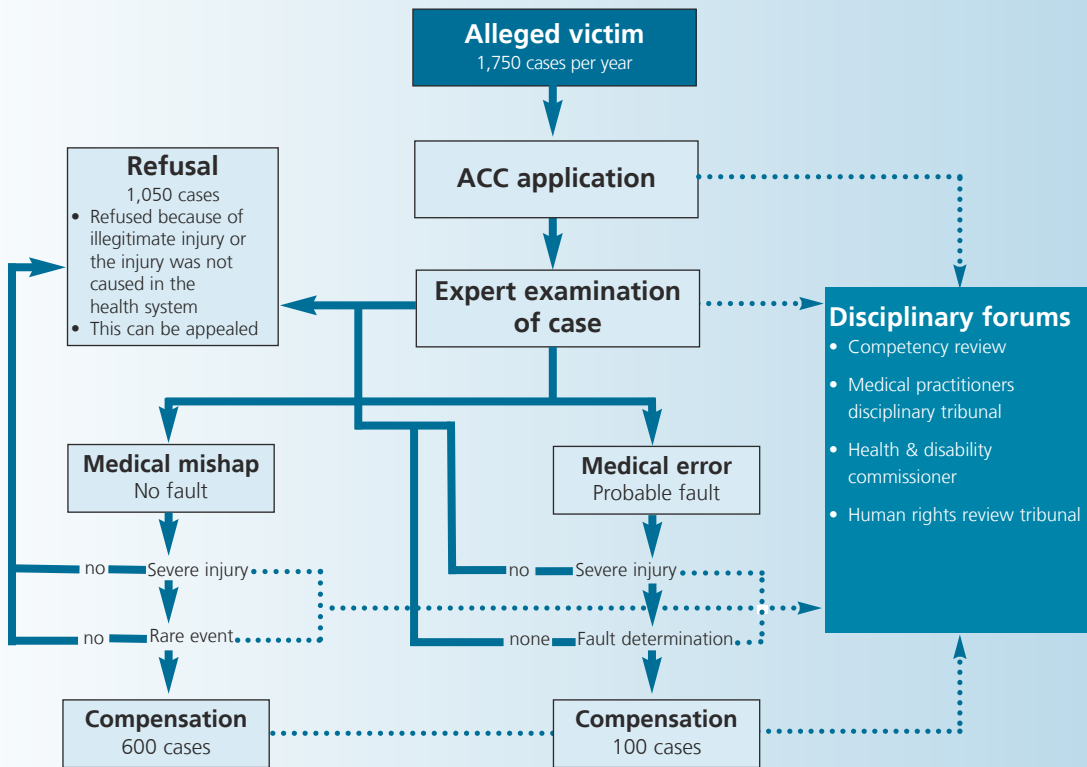
Patients' rights and physician accountability are managed by New Zealand's Health and Disability Commissioner (HDC). The HDC and several additional tribunals can all issue sanctions including suspension of license to practice and fines up to

\$200,000. Since, by definition, “medical errors” involve an element of fault, there is pressure in the New Zealand system to find fault. While the ACC provides physicians medical malpractice insurance, once fault for a medical treatment injury is determined, physicians are open to professional, financial and legal sanctions. This creates conflict in the system as open participation can result in later sanctions.

An interesting aspect of recently proposed reform in New Zealand involves the separation of injury compensation from the determination of responsibility. This important separation may serve to encourage physicians to participate in the claims settlement process and thereby strengthen the patient safety aspect of the system. For this measure to truly have an effect on patient safety, not only should compensation and responsibility have a clear separation within the ACC, but also physicians must trust that determination of responsibility will not compromise their position in other forums like the HDC.

Exhibit 2 presents an overview of the indemnification process in New Zealand, showing the two paths, Medical Mishap and Medical Error and relationship to the Disciplinary Forums, together with approximate annual transaction volumes.

**Exhibit 2**  
The indemnification process in New Zealand



Sources: interviews, ACC, Secor analysis

## SWEDEN: COMPREHENSIVE NO-BLAME

### Health care system

A fundamental principle of the Swedish health care system is that the provision and financing of health services for the entire population is a public sector responsibility. This responsibility rests primarily with the county councils. These councils operate almost all public services and levy taxes to finance them. As a consequence, health services in Sweden rest largely in the hands of local politicians in 21 geographical areas.

Health services account for almost 90% of the operations of the county councils. Approximately 70% of these operations are financed from tax revenues and the remaining 20% are financed by grants and payments received from central government finance for certain services. Patient fees amount to approximately 4% of county council revenue. To limit personal health care expense, there is a ceiling (approx. \$150 CDN) on the amount of patient fees a patient can be charged in a twelve-month period. All medical treatment for children and young people under the age of 20 is free of charge.

Sweden has an extensive system of benefits for the sick that also includes compensation for participation in labour market rehabilitation schemes and benefits payable to expectant mothers who are unable to work during pregnancy.

The system's reliance on a comprehensive social net and a non-litigious culture limits the system's portability to only those jurisdictions in which these fundamental pillars exist.

### Medical malpractice environment

In general, the medical malpractice system in Sweden is viewed very positively and it has now been replicated in Finland, Denmark and Norway. The key criterion that triggers compensation for a medical related injury in Sweden is that the accident must have been avoidable. This is determined through an evaluation of whether an experienced doctor would have had a different result. Health care providers actively participate in the claims process, with approximately 65% of all claims being made with the help of a social worker, physician or nurse.

Risk management is an important component of the system that is supported by a database of claims developed by the County Council and Region's Mutual Insurance Company available for each hospital. Sweden also works closely with other Nordic countries to develop risk prevention approaches. The various parties involved in risk management agree that most errors are caused by the system in place.

### Performance of the system

One insurance company covers approximately 95% of the medical malpractice liability protection market. Compensation for injuries ranges widely from less than 1,000 euros up to 800,000 euros, with the total, in most cases, being less than 2,000 euros. Compensation is paid on a "top-up" basis, as the strong health care and social system pay most of the costs of indemnification.

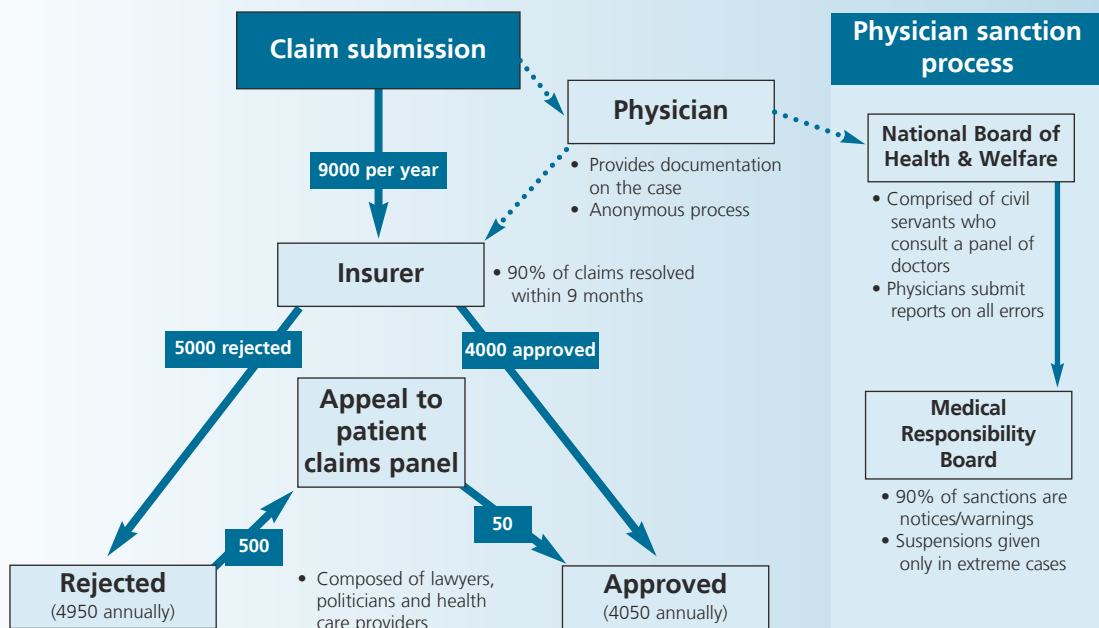
The insurer is responsible for reviewing claims, of which approximately 45% are approved. Even with the potential for moral hazard, the system seems to be functioning well, as only 10% of claims are appealed, and of those, only 10% are overturned.

In the Swedish system, the process through which physicians are held accountable is separate from the process through which compensation decisions are made. The information physicians provide to the insurer responsible for compensation decisions is provided anonymously. Physicians also submit reports on all errors to the National Board of Health and Welfare. As a result of this structure, physicians now play an important part in the claims process. However, it took approximately 10 years before physicians were comfortable participating at this level.

The most significant issue with this system is its portability. Payments in Sweden have always been low relative to other countries. The system's reliance on a comprehensive social net and a non-litigious culture limits the system's portability to only those jurisdictions where these fundamental pillars exist.

Exhibit 3 presents an overview of the claim processing system and relationship to the Physician Sanction Process in Sweden with approximate annual transaction volumes.

**Exhibit 3**  
**Claim processing system in Sweden**



## UNITED STATES — A SYSTEM IN CRISIS

### Medical system

In the U.S., the majority of health care funding comes from the private sector, most notably through insurance provided at the workplace. Two government-run programs, Medicare and Medicaid, provide health insurance to people with low income and the elderly.

### Medical malpractice environment

Multiple factors are stressing the U.S. medical malpractice system. Compensation awards have increased dramatically and the U.S. Health and Human Services has estimated that medical liability costs add \$60-\$108 billion to the total cost of health care each year. Multiple groups are pushing for reform. As of July 2005, the American Medical Association (AMA) considers 20 states as being in a full-blown medical liability crisis.

### Florida case study

Over the last few years, the cost of medical malpractice insurance increased dramatically in the state of Florida and large loss ratios contributed to the exit of insurers from the state. In response to these conditions, in 2004 more than 5% of Florida's almost 50,000 physicians had adopted the drastic measure of "going bare," that is, not taking any insurance at all.

The Florida Birth-Related Neurological Injury Compensation Association (NICA) is a no fault compensation plan that was adopted in 1988 because tort claim costs in this area were particularly high, and because a no fault system limited to this area was feasible and would involve manageable costs. The program is limited to injuries that render the infant permanently and substantially mentally and physically impaired. Compensation for expenses is structured, including payment for "necessary and reasonable" expenses.

NICA is performing well financially. The program began with a one-time appropriation of \$20 million and is financed on an ongoing basis by a combination of state funds, assessments on physicians and hospitals and participation fees.

### Performance of the Florida NICA system

Some studies have shown that NICA has under-performed by compensating fewer claimants than expected and a substantial proportion of cases (7%) still go to the tort system. Compensation for expenses is paid over the lifetime of the child and includes necessary and reasonable care, services, drugs, equipment, facilities, and travel. Compensation may also include a one-time cash award, not to exceed \$100,000, to the infant's parents or guardians, for funeral expenses and reasonable expenses for filing the claim, including attorney's fees.

In general, NICA is an efficient system, with approximately two-thirds of claims being completed within six months. The physician experts and the judge involved in NICA have participated in the program almost since its inception. These experienced experts are key to NICA's efficiency. While NICA is efficient and has slowed increases in premiums, it is not the complete solution. This is evidenced by the malpractice insurance premiums for OB/GYNs in Florida that are still among the highest in the nation.



## APPENDIX 3 — ALTERNATIVE SCENARIO MODELS

This appendix provides an overview of four possible alternative medical malpractice protection models, drawing on the understanding of international models and prospectively applied in the Canadian context. The analysis was completed by Secor Consulting through rigorous modelling of each scenario based on the elements of cost, accessibility and compensation<sup>12</sup>. A discussion of the potential benefits, trade-offs and the predicted consequences of these trades-offs is presented for each scenario.

The following four scenarios were modelled and are described in the following pages:

- ▶ A pure, all in no fault compensation system
- ▶ A combination of tort and no fault (based on the Prichard recommendations)
- ▶ Government indemnification with tort-based filter (similar in principle to the NHSLA)
- ▶ A segregated compensation program for severely compromised infants (similar to the NICA program in Florida)

For comparative purposes, based on data from the past six years, average annual costs for the Canadian medical malpractice system are approximately \$225 million, including indemnities of approximately \$110 million (49%), and for administrative costs, legal and expert fees of approximately \$115 million (51%). Hospitals carry separate property and casualty insurance and are excluded from these estimates. While the Canadian system is inexpensive in comparison to other models, accessibility to compensation is limited to cases in which either fault is proven or a settlement is made.

### OBSERVATIONS: ALTERNATIVE MEDICAL MALPRACTICE PROGRAMS IN CANADA

In order to control costs, significant compromises would be required to any system that incorporates an element of no fault. An all in, no fault system would be a multi billion dollar investment. Even limiting the program to “unintended and avoidable” injuries, as is done today in Sweden, would involve potential costs of up to \$1.7 billion per year. A government run litigation authority in Canada would commit the government to billions in future liabilities. This is supported not only by the quantitative analysis completed for this report but also by the NHSLA experience in the UK. The introduction of a segregated compensation program for severely compromised infants would remove a controversial component from the current system, but in so doing, could more than double the cost of medical treatment injury indemnification while only benefiting a small percentage of cases.

While it is true that the three scenarios that incorporate elements of no fault improve accessibility, this accessibility comes at a cost. This cost would likely be borne in part by patients through access to lower indemnity payments, in part by physicians through increased protection fees and in large part by society through considerable increases in the cost of healthcare.

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<sup>12</sup> The full Secor Consulting report is available at [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)

The implications of this analysis on public policy are significant. None of the modelled scenarios result in reductions to Canada's medical treatment related injury indemnification costs. Rather, most appear to increase costs significantly and to potentially unsustainable levels, thereby presenting a serious threat to the quality of healthcare in Canada.

It appears that there are two potential paths that reform to Canada's medical treatment injury indemnification program could take. The first path involves a funnelling of significant health care dollars into victim compensation. The price tag of such a move is high with the benefits being limited to a small group. The second path involves maintaining the current indemnification program and funnelling efforts and dollars into patient safety initiatives. This path maintains current victim compensation levels and leads to the reduction of future injuries entering into the system.

The importance of patient safety initiatives has been recognized in Sweden where the various stakeholders are engaged in the risk management and patient safety initiatives and are working to address what all agree are the most significant source of medical errors, the medical system itself. Yet, the success of patient safety initiatives is not limited to the Nordic countries. The progress made by anaesthetists in the U.S.<sup>13</sup> provides a strong example of risk, injury and cost reduction related to a focused, committed and coordinated patient safety initiative.

While this review was based on primary research (including interviews with key stakeholders in each of the systems discussed), secondary research and rigorous quantitative modelling, it is important to note that medical treatment injury liability systems do not operate in a vacuum. Their performance is impacted by social, legal, cultural and historical factors. It is difficult, if not impossible, to evaluate the performance of a medical liability protection program without considering the environmental impacts. It would be, therefore, unwise to believe that a whole system or an even the key elements of a particular international model (such as no fault) would perform similarly if was it to be "exported" and overlaid on an existing system operating elsewhere.

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13 Patient safety initiatives contributed to the reduction over the last two decades of anaesthesia related deaths from 1 death per 5,000 cases to 1 per 200,000 to 300,000. Premiums paid by anaesthetists have also reduced dramatically over this period.

## A COMPREHENSIVE NO FAULT COMPENSATION SYSTEM

### Description

A comprehensive no fault system would provide indemnification to all victims of medical treatment injuries. In the absence of a fault filter, approximately 410,000 cases would be eligible to enter the system. Under a pure no fault system, a “suitable” level of compensation would need be determined, likely through the creation of a standard indemnification table.

### Results

The cost associated with admitting all medical treatment injuries is significant. Compensating injuries at even half of current compensation levels would drive the total annual program cost up from \$225 million to \$40 billion per year. This represents an approximate 150-fold increase over the current program's combined cost of awards, settlements, administration, legal and expert advice.

### Discussion

For patients, this system would provide universal access to per case indemnities of, on average, approximately \$235,000. However, at 150 times the cost of the current program, it is unclear how the medical community could finance this program or how the healthcare system could support an almost \$40 billion dollar increase in healthcare costs. As such, the sustainability of this type of system appears to be questionable. It is also unclear how society would react to a \$40 billion dollar increase to the cost of healthcare that is neither focused on improving the safety nor on improving the performance of the healthcare system.

If implemented, few options would be available to control the cost of such a system. Either compensation levels would have to be reduced dramatically or some form of filter would be needed to limit the number of claims entering the system. To maintain the current program costs of \$225 million per year, average indemnity payments in a no fault system would need to be reduced from the current \$235,000 to less than \$1,000. Alternatively, the number of cases entering the system could be reduced by compensating only “unintended and avoidable” injuries, as is done currently in Sweden. It is estimated that 90% of injuries would not meet this criteria. However, even by applying this filter and reducing per case indemnities to 25% of today's level for smaller claims and to 50% of today's level for the few larger claims, the total cost of the program would rise to an estimated \$2.6 billion per year.

Limits would be needed to control the costs of a no fault system. However, the reintroduction of fault negates the perceived benefits of removing blame from the system. Further, determining the correct criteria for payment and an appropriate compensation level would likely prove difficult. Even with these limits in place, it remains unclear how an additional \$2.6 billion dollars in health care costs focused solely on injury indemnification would be viewed and paid for by the healthcare system's stakeholders.

## A COMBINATION OF TORT AND NO FAULT

(based on the Prichard recommendations)

### Description

The Prichard Report was commissioned by Canada's deputy health ministers in 1990 to review other medical liability systems, literature and legal precedent, Canadian malpractice claims trends and Canadian stakeholder opinion. Prichard's recommendation involved a no fault option for persons suffering "significant avoidable health care injuries." Access to the tort system would remain in place for those and all other victims. This change from the fault-based nature of the current system to "avoidable" would reduce the filter and would therefore allow more claims into the system.

### Results

Based on Prichard's own assumptions, such a change would increase the number of claims flowing into the system. If the "significant" injuries were compensated through the no fault system at today's levels, leaving the smaller claims to access the tort system, the total cost of medical liability could rise from today's level of \$225 million to \$2.8 billion per year. A significant reduction in per case no fault payments could be expected to drive the "significant" claims back into the tort system. As such, per case no fault indemnities would have to be maintained at a level that is high enough to create an incentive for victims to use the no fault portion of the system. At that level of compensation, given the predicted increase in the number of claimants accessing the system, costs could be expected to rise to \$1.7 billion per year.

### Discussion

The limits set on per claim compensation for the no fault system would result in a transfer of liability between the no fault and fault streams. This give and take relationship could contribute to friction among different parties in the system and could create an incentive for either party to counsel the potential claimants to use the other option.

Applying the "avoidable" test is similar to the idea of a fault filter and would still involve the notion of blame. This neutralizes one of the more frequently heard arguments in favour of no fault systems, namely the removal of blame from the system.

As was highlighted in the discussion of the no fault system, it is not clear how an additional \$1.5 to \$2.5 billion dollars per year in health care costs focused solely on injury indemnification would be viewed and paid for by the healthcare system's stakeholders.

## GOVERNMENT INDEMNIFICATION WITH TORT-BASED FILTER

(similar in principle to the NHSLA)

### Description

There are several compelling reasons to study the potential impacts of a government run indemnification program that applies a tort-based filter to limit the number of claims entering the system. First, this type of approach is in place in the UK and, by all accounts, is functioning well. Second, for the reasons cited in the discussion of the first two scenarios in previous pages, a significant reduction in indemnity payments is an unlikely solution to controlling the cost of a pure or restrictive no fault system.

This scenario, which follows the principles of the NHSLA system from the UK, presents a public indemnification scheme with a tort-based filter that limits the number of cases entering the system.

### Results

The financial implications of such a system would depend largely on the objectives set by the government litigation authority. If the objective was to broaden access, within five years the total program liabilities<sup>14</sup> could be expected to top \$10 billion per year. If the objective was to expand access but maintain costs, per case indemnities would need to be reduced in proportion to the increase in access. Even with this trade-off, yearly premiums required to maintain an actuarial balance would surpass today's level by year 7 before reaching \$350 million per year by the 10<sup>th</sup> year of operation.

### Discussion

The government taking on the role of self-insurer of its physician "employees" would represent a significant paradigm shift and create a relationship that neither group may accept. This shift would also transfer significant liabilities to the public sector.

This scenario could prove difficult to implement in the Canadian Federal-Provincial context. It could create issues related to territory and jurisdiction if run at the federal level and issues of efficiency and debt allocation if managed by the provinces.

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14 The amount required to cover current and future claim liabilities

## SEGREGATED COMPENSATION SYSTEM FOR COMPROMISED INFANTS

### Description

This scenario explores two alternatives for managing birth-related neurological injury compensation. In the first alternative, all “severely compromised” infant cases would be compensated at the same level as the current tort system. In the second alternative, which would be more similar in its functioning to the NICA program in Florida, significantly compromised infant cases would be indemnified at a level that covers all reasonable expenses for the life of the victim. In both options, all cases not related to severely compromised infants would continue to flow through the tort-based system that is in place today.

### Results

Indemnifying all severely compromised infants at current day levels, would add \$383 million per year to the total cost of medical treatment injury indemnification, due to the increase in the number of cases that would be indemnified.

In the second alternative, by allowing all severely compromised infant cases to enter the system and compensating at a “fair and reasonable” level, the total cost of medical treatment injury indemnification would be expected to increase by \$221 million to \$446 million per year.

### Discussion

A NICA-type program has the potential to reduce the “lottery effect” of a tort-based system for severely compromised infants. That being said, the selection criteria would be an important factor in the success of the program. While admitting all cases would be expected to add between \$221 million and \$383 million per year to the total cost of medical treatment injury indemnification, this option would take a controversial component out of the current tort system.

# THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION

## WHO WE ARE

As a mutual defence organization that provides education, advice, legal defence and indemnification to more than 66,000 member physicians across Canada, the Canadian Medical Protective Association draws on more than 100 years of expertise in managing risks in clinical practice to assist physicians in providing medical care to patients.

The CMPA is a not-for-profit medical mutual defence association founded in 1901 and incorporated by a 1913 Act of Parliament. As a mutual defence organization, the financial costs, savings and risks are shared amongst its physician members.

The original principles set out in its 1913 Act of Incorporation require the CMPA to:

- ▶ Support, maintain and protect the honour, character and interests of its members.
- ▶ Encourage the honourable practice of the medical profession.
- ▶ Give advice and assistance to and defend and assist in the defence of members of the Association in cases where proceedings of any kind are unjustly brought or threatened.
- ▶ Promote and support all measures likely to improve the practice of good medicine.

## VISION

The Canadian Medical Protective Association will be recognized as a valued national resource committed to defending the professional integrity of doctors and will lead by promoting and supporting those medico-legal and practical measures likely to improve the practice of medicine.

## MISSION

The mission of the Canadian Medical Protective Association is to be a non-profit medical mutual defence organization whose raison d'être is to protect a member's professional integrity by providing services of the highest quality including legal defence, indemnification, risk management, educational programs and general advice.



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