

1993

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### Recommended Citation

Carolyn Sappideen, *No Fault Compensation for Medical Misadventure – Australian Expression of Interest*, 9 J. Contemp. Health L. & Pol'y 311 (1993).

Available at: <https://scholarship.law.edu/jchlp/vol9/iss1/20>

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# NO FAULT COMPENSATION FOR MEDICAL MISADVENTURE—AUSTRALIAN EXPRESSION OF INTEREST

*Carolyn Sappideen*

## I. INTRODUCTION

Australia now joins the list of countries considering the introduction of no-fault compensation for medical misadventure. In 1988, the Australian Health Ministers Conference requested that the South Australian Task Force on Patients' Rights ("Task Force") develop a model for a national or uniform state no-fault liability scheme for medical misadventure. The Task Force's report, issued in March 1989, concluded that "the tort system is too costly, too cumbersome, too prone to delay and too capricious in its operation to be defensible,"<sup>1</sup> and determined that, subject to cost analysis, a no-fault scheme had the potential for considerable benefits.<sup>2</sup>

In the United States, the United Kingdom, and Canada, no-fault schemes for medical injuries have been the subject of continuing academic debate and particularly in the United States, have been under active consideration for a considerable period of time. In the United States (and to a lesser degree in the United Kingdom<sup>3</sup> and Canada<sup>4</sup>) the threat of recurrent medical malpractice crises has renewed interest in no-fault schemes. The forces that motivated English and American consideration of no-fault schemes, however, are less significant in Australia. According to the usual measures, there is not yet a medical malpractice crisis in Australia,<sup>5</sup> although there is growing concern at the rapid rise of indemnity costs, and the frequency and severity

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1. SOUTH AUSTL. TASK FORCE ON PATIENTS' RIGHTS, NO FAULT COMPENSATION FOR MEDICAL MISADVENTURE 5, (March 1989) [hereinafter TASK FORCE].

2. *Id.*

3. Arnold Simanowitz, *Medical Accidents: The Problem and The Challenge*, in *MEDICINE IN CONTEMPORARY SOCIETY: KING'S COLLEGE STUDIES* 120 (Peter Byrne, ed., 1986-87).

4. See CONFERENCE OF DEPUTY MINISTERS OF HEALTH OF THE FEDERAL/PROVINCIAL/TERRITORIAL REVIEW ON LIABILITY AND COMPENSATION ISSUES IN HEALTH CARE, *LIABILITY AND COMPENSATION IN HEALTH CARE* (1990).

5. See Carolyn Sappideen, *Look Before You Leap: Reform of Medical Malpractice Liability*, 13 SYDNEY L. REV. 523, 524-527 (1991). *But see* John R. Vallentine, *Medical Litigation - Time for Change*, AUSTRAL. MED., Aug. 5, 1991, at 2, 3 (noting the increased awareness within the medical community of the risk of a malpractice crisis).

of claims. The Australian statistics, in comparison to those of the United States, suggest still quite modest levels of claims against hospitals<sup>6</sup> and medical practitioners.<sup>7</sup> The no-fault compensation issue was brought into public debate in Australia by the 1983 Sax Report, which, in the course of reviewing patients' rights, recommended consideration of no-fault compensation to overcome the inadequacies, unfairness, and negative features of common law claims for negligence.<sup>8</sup>

Although the Sax Report emphasized issues of fairness and equity in promoting a no-fault compensation scheme, the Australian medical community is increasingly interested in such a plan due to the fear of a malpractice liability explosion.<sup>9</sup> This interest is apparently based on the implicit assumption, founded in faith rather than evidence, that a no-fault system will reduce financial, personal, and emotional costs to the medical profession.<sup>10</sup> This faith may be misplaced. Although the abolition of a costly common law system of compensation will produce cost savings,<sup>11</sup> expenses may be dra-

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6. The most useful of the very limited information available covers public hospitals in the largest state, New South Wales:

Year	Number of Discharges	Approximate number of claims per 100,000.
1981	885,615	7.1
1983	890,676	18.6
1984	799,867	19.0
1985	761,224	47.6
1986	845,885	41.1
1987/88	867,146	39.8
1988/89	900,810	34.4
1989/90	948,738	28.8

See L.L. WILSON & P.G. GOLDSCHMIDT, *QUALITY MANAGEMENT - QUALITY ASSURANCE, UTILIZATION REVIEW AND RISK MANAGEMENT* (1992).

7. In Australia, medical defence unions and organizations carry almost all of the indemnity insurance for medical practitioners. The evidence available from these organizations suggests an average annual claim frequency across all states of approximately 3-4 claims per 100 defence union members, with a probable paid annual claim rate of about 1-2 per 100 members. See Sappideen, *supra* note 5, at 525-26; Vallentine, *supra* note 5, at 3. Australian medical defence subscription rates and indemnity costs are still modest in comparison to the United States, with the top medical defence union rate in Australia ranging between \$11,000 and \$15,000 for obstetricians in 1992. However, indemnity and legal costs have risen from an index rate of 100 to 1200 over the period from 1979 to 1990. CRAIG LILIENTHAL, *AUSTRALIAN DEPARTMENT OF HEALTH, HOUSING & COMMUNITY SERVICES, PROFESSIONAL INDEMNITY REVIEW* (1992).

8. REPORT OF THE ENQUIRY INTO HOSPITAL SERVICES IN S. AUSTL. 106 (Sidney Sax Chairman, 1983).

9. Vallentine, *supra* note 5, at 3.

10. See Simanowitz, *supra* note 3, at 120.

11. See AUSTRALIAN INST. OF JUD. ADMIN., *THE COST OF CIVIL LITIG. BEFORE INTERMEDIATE CTS. IN AUSTRALIA* (1992).

matically increased by a broadly based no-fault scheme that extends compensation to a potentially vast pool of patients who are not compensated under the present fault-based common law regime.

Malpractice suits represent only a very small proportion of patient injuries. Despite the rhetoric of ambulance chasers and other greedy lawyers, the available evidence in both the United States<sup>12</sup> and Britain<sup>13</sup> establishes that large numbers of negligently injured victims do not recover compensation. Most injured persons/patients do not sue or even contemplate bringing a tort action.<sup>14</sup> Specifically, in relation to injured patients who do initiate legal proceedings, there is a 60% failure rate of claims.<sup>15</sup> In a recent study, eight times as many patients suffered an injury from negligence as filed a malpractice claim, and sixteen times as many patients suffered an injury from negligence as received compensation from the tort liability system.<sup>16</sup> Negligently injured patients represent only a fraction of the total number of injured patients.<sup>17</sup> The Australian evidence regarding deaths attributed to

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12. Donald Harris, *Evaluating the Goals of Personal Injury Law: Some Empirical Evidence*, in *ESSAYS FOR PATRICK ATIYAH* 289, 295-96 (Peter Cane & Jane Stapleton ed., 1991).

13. Donald Harris et al., *COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY* (1984).

14. See Harris, *supra* note 12, at 296.

15. U.S. GEN. ACCT. OFF., *MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984*, at 18 (GAO/HRD-87-55, Apr. 1987) [hereinafter GAO REPORT] (reporting that in 1984 57% of medical malpractice claims did not result in compensation); PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 24 (1985) (60% failure rate for malpractice claims); cf. Harris et al., *supra* note 13, at 114 (45% withdrawal of all accident claims in England); ROYAL COMM'N ON CIVIL LIABILITY AND COMPENSATION FOR PERS. INJURY, PEARSON REP. para. 1326 (1978) (60% abandonment rate for medical claims made in 1973, with a similar rate suggested in Australia by the Medical Defence Union Ltd, a major malpractice insurer); LILIENTHAL, *supra* note 7; see also Vallentine, *supra* note 5, at 3. This rate may not be uniform across also states, see LEGAL SERVICES COMM'N OF S. AUSTL., *SUBMISSION TO PATIENTS' RIGHTS TASK FORCE 20* (1988); TASK FORCE, *supra* note 1, at 14 (40% failure rate in 1988).

16. HARVARD MEDICAL PRACTICE STUDY, *PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK* 6 (1990) [hereinafter HARVARD STUDY].

17. HARVARD STUDY, *supra* note 16, at 3 (studying a sample of hospitalizations in New York State and finding an injury incident rate of 3.7% for that year; with 1% of all hospital discharges (27.6% of all injuries) regarded as due to negligence); see also DANZON, *supra* note 15, at 20; cf. Leon S. Pocincki, et al., *The Incidence of Iatrogenic Injuries*, in UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE, PUB. NO. 73-89, REP. OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE apps. 50, 55 (projecting that 29% of all iatrogenic injuries were due to negligence). See generally Knight Steel, et al., *Iatrogenic Illness on a General Medical Service at a University Hospital* 304 *NEW ENG. J. MED.* 638 (defining an iatrogenic illness as any illness that resulted from a diagnostic procedure or from any form of therapy).

negligence is fragmentary, with some limited data on anaesthetic deaths,<sup>18</sup> maternal deaths<sup>19</sup> and "possibly avoidable deaths" in hospitals.<sup>20</sup> The data indicates that a significant proportion of injuries is preventable, but no overall statistics are available. There is, however, a proposal by the Australian government to fund a pilot study to assess the number and severity of iatrogenic injuries in Australian hospitals. This is an essential pre-requisite to any effective assessment of the viability of a no-fault scheme.

Against this background, this article examines the Task Force's proposals for a no-fault compensation scheme for medical misadventure. Particular reference is given to the issue of whether the proposals achieve equity among injured patients with equivalent needs.

## II. AUSTRALIAN PROPOSALS FOR A NO-FAULT SCHEME

In response to a request to develop a model for a national or uniform state no-fault liability scheme for medical misadventure, the Task Force recommended the abolition of common law liability for medical misadventure and the establishment of a statutory based no-fault scheme to be administered by a government-appointed statutory board.<sup>21</sup> The expressed goal of the proposed scheme is to attempt to restore an injured person to that person's pre-accident position having regard for the need to: (1) provide rehabilitation as a paramount objective, (2) ensure that the compensation provided does not exceed the limits of resources in the health care area, and (3) give priority to the long term requirements of people sustaining serious and permanent disability and incapacity.<sup>22</sup> The unstated, primary underpinning of the proposed no-fault scheme is the need to achieve equity between injured patients: It is wrong to compensate only those who can prove fault while leaving others injured without a remedy. The issue that arises is whether a no-fault scheme can necessarily achieve this goal? An initial barrier to achieving equitable treatment of injured patients is the definition of a compensable event. Substantial numbers of injured patients could be excluded if a compensable

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18. NATIONAL HEALTH & MEDICAL RESEARCH COUNCIL, THE REPORT ON ANAESTHETIC RELATED MORTALITY IN AUSTRALIA 1985-1987 8, 24 (Aug. 1990).

19. *Id.* at 2, 34.

20. See generally NATIONAL HEALTH & MED. RES. COUNCIL, REP. ON ANAESTHETIC RELATED MORTALITY IN AUSTRALIA 1985-1987 8.24 (1990) (reporting limited data on anaesthetic deaths attributed to negligence); NATIONAL HEALTH & MED. RES. COUNCIL, REP. ON MATERNAL DEATHS IN AUSTRALIA 1985-1987 2.34 (1991) (reporting limited data on maternal deaths attributed to negligence); S.A. Deane, *The Management of Injuries - A Review of Deaths in Hospital*, 58 AUSTRALIAN JOURNAL OF SURGERY 463 (1988) (reviewing hospital autopsy reports to determine the rate of "possibly avoidable death").

21. TASK FORCE, *supra* note 1, at 63-64, 70.

22. *Id.* at 68.

event is defined as a "personal injury by accident,"<sup>23</sup> as it was in New Zealand,<sup>24</sup> or if the scheme excludes unavoidable risks of medically indicated treatment such as under the Swedish Patient Insurance Scheme.<sup>25</sup> The current New Zealand scheme does not compensate for unsuccessful treatment if the results are within the normal range of medical or surgical failure.<sup>26</sup> However, adverse consequence from a known risk that could have been

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23. Accident Compensation Act, R.S.N.Z., § 2 (1982); *See also* Accident Compensation Act, R.S.N.Z., § 8 (1992) (providing compensation for "personal injury" that includes medical misadventure as defined). Under section 5 medical misadventure occurs when there is medical error or medical mishap. A medical error means the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances. R.S.N.Z. § 5(1). A medical mishap is defined as an adverse consequence of proper treatment administered by a registered health professional, when the likelihood of the adverse consequence is rare *and* the adverse consequence is severe. R.S.N.Z. § 5(1). An adverse consequence is defined as one that would normally occur in not more than 1% of cases, R.S.N.Z. § 5(2), unless there were greater risks to the particular individual known prior to the treatment. R.S.N.Z. § 5(3). For purposes of medical mishap, severe consequences include death, hospitalization for more than 14 days, or a significant disability lasting for more than 28 days, R.S.N.Z. § 5(4).

24. *See generally* T.G. ISON, ACCIDENT COMPENSATION: A COMMENTARY ON THE NEW ZEALAND SCHEME (1980); GEOFFREY PALMER, A STUDY OF LAW AND SOCIAL CHANGE IN NEW ZEALAND AND AUSTRALIA (1979) (commenting on the Accident Compensation Act prior to the 1982 amendments); Margret A. McGregor Vennell, *Medical Misfortune in a No Fault Society*, in NO FAULT COMPENSATION IN MEDICINE 33 (Ronald D. Mann & John Havard eds., 1989) (proceedings of a joint meeting of the Royal Society of Medicine and the British Medical Association held on January 12-13, 1989)[hereinafter NO FAULT COMPENSATION IN MEDICINE]; Craig Brown, *Deterrence in Tort and No-Fault: The New Zealand Experience*, 73 CAL. L. REV. 976 (1985); Lewis N. Klar, *New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective*, 33 U. TORONTO L.J. 80 (1983).

25. Margret A. McGregor Vennell, *Medical Injury Compensation Under the New Zealand Accident Compensation Scheme: An Assessment Compared with the Swedish Medical Compensation Scheme* (Paper presented to the 2nd International Conference on Health Law & Ethics, London, July 17, 1989). Problems of definition and causation exist under the Vaccine Damage Payments Act (1979) (U.K.). *See* Palmer, *Faults in No-Fault Compensation Schemes*, in NO FAULT COMPENSATION IN MEDICINE, *supra* note 24, at 163 (citing Lee, *Liability for Vaccine Damage in Great Britain*). *See also* Wall, comment, in NO FAULT COMPENSATION IN MEDICINE, *supra* note 24, at 116 (regarding the problems of the Florida Birth Related Neurological Injury Compensation Plan).

26. An adverse consequence is defined as one that would normally occur in not more than 1% of cases, Accident Compensation Act, R.S.N.Z. § 5(2) (1992), unless there were greater risks to the particular individual known prior to the treatment, s 5(3). *See also* Accident Compensation Comm'n v. Auckland Hospital Board, 2 N.Z.L.R. 748, 753 (1980) (distinguishing injuries caused by the mechanical failure of a medical device from injuries falling in the normal anticipated failure rate). In 1980 less than 4% of claims were rejected, K.L. Sandford, *Personal Injury by Accident* 1980 N.Z.L.J. 29, 30, but it appears that an extremely generous definition of personal injury by accident was used by health care providers whose medical certificates provided the basis of claims. REPORT OF THE ACCIDENT COMPENSATION CORP. 22 (1990). A liberal interpretation of accidental injury allows recovery of no-fault compensation and bars a common law claim. *See* Walter Gellhorn, *Medical Malpractice Litigation (U.S.) - Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 192 (1988).

avoided qualifies as misadventure by definition.<sup>27</sup> When the adverse consequence is statistically rare, it also qualifies as misadventure.<sup>28</sup> Is there a sound reason for refusing compensation when an adverse consequence is within the anticipated range of results? It is arguably inequitable to distinguish among patients with equivalent needs on the basis of common or uncommon risks. The New Zealand Law Commission, recognizing this, recommended that compensation be extended to injuries occurring as part of the normal and expected risks associated with medical treatment:<sup>29</sup> "Medical mishap should not be excluded simply because in advance there was some recognized risk of the therapy any more than the risks of using the highway could sensibly disqualify victims of road accidents."<sup>30</sup> This recommendation was not adopted in the Accident Compensation Act of 1992.

Under the Swedish plan, compensability is not cast in terms of medical misadventure. The Swedish patient insurance scheme, together with a pharmaceutical insurance scheme was introduced in 1975.<sup>31</sup> The patient insurance scheme, consists of voluntary insurance offered by health care providers, supplemented by no-fault top up compensation over and above a generous social security system.<sup>32</sup> While an insurance-based system has the advantage of flexibility<sup>33</sup> and is less susceptible to political influence,<sup>34</sup> it suffers from many of the same deficiencies as New Zealand's legislatively

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27. Accident Compensation Act, R.S.N.Z., § 5(1) (1992). A medical error is defined as the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances. R.S.N.Z., § 5(1). For the position prior to the 1992 legislation, see Vennell, *supra* note 24, at 44.

28. See *supra* note 26; see also Viggars v. Accident Compensation Corp., 6 N.Z.A.R. 235, 240 (1987) (classifying a stroke that occurred during carotid arteriogram as a medical misadventure when the risk of such a stroke was 1%).

29. NEW ZEALAND LAW COMM'N, REP. NO. 4, PERSONAL INJURY: PREVENTION AND RECOVERY, paras. 8, 27, 165-66. Under the recommended amendments, personal injury was to be defined with reference to a detailed specification of injury causes taken from the World Health Organization's International Classification of Diseases. *Id.* at xii-xiii, para. 8. This may have the result of substituting one unsatisfactory definition with another equally unsatisfactory classification. For example, classifications that refer to "abnormal," "accidental" are likely to result in exclusion.

30. NEW ZEALAND LAW COMM'N, *supra* note 29, at para. 27, 165-66.

31. For descriptions of various aspects of Sweden's tort compensation system see NO FAULT COMPENSATION IN MEDICINE, *supra* note 24, app. 2 at 216; TASK FORCE, *supra* note 1, at 42-46 (providing a useful summary of Sweden's patient insurance scheme); Jan Hellner, *Compensation for Personal Injury: The Swedish Alternative*, 34 AM. J. COMP. L. 613, (1986); Carl Oldertz, *Security Insurance, Patient Insurance, and Pharmaceutical Insurance in Sweden*, 34 AM. J. COMP. L. 635 (1986).

32. Under the Swedish social security system a worker is paid 90% of lost income during sickness or disability. TASK FORCE, *supra* note 1, at 45.

33. Hellner, *supra* note 31, at 625. Flexibility also carries some risks as the insurer is also the assessor of claims, with no representation of patient interests. *Id.* at 626.

34. Guido Calabresi, *Policy Goals of the "Swedish Alternative"*, 34 AM. J. COMP. L. 657,

based system. In addition to the difficulties in proving that the injury resulted from medical intervention,<sup>35</sup> compensation for injuries will be available in circumstances that to a substantial degree, parallel negligence tests of causation.<sup>36</sup> Like the New Zealand scheme, not all adverse injuries resulting from medical intervention are compensable. For example, unavoidable risks of medically indicated treatment are not recoverable.<sup>37</sup> Under the Swedish scheme, approximately 42% of claims are rejected.<sup>38</sup> Guido Calabresi, Dean of the Yale University Law School, in his discussion on the Swedish system, describes the choice of who receives extra compensation as "haphazard and unprincipled," and suggests that this weakness will inevitably lead to frequent, expensive case-by-case determinations.<sup>39</sup>

The Task Force Report recognized the difficulties of maintaining equity between injured patients when some patients are denied compensation simply because the injury they suffer falls within a known risk of adverse consequences. The Report also accepted that limiting the amount of compensation would be preferable to introducing illogical limitations on compensability.<sup>40</sup> However, the Report stated that certain injuries such as physical deterioration as a result of sickness or disease, or the inevitable side-effects of treatment (for example hair loss resulting from chemotherapy)

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662 (1986). These agreements are not directly regulated by the state although the state may be in a position to influence the scheme. Hellner, *supra* note 31, at 626.

35. In Sweden, for the first six months of 1988, 25,349 injuries were not compensated. Four thousand, four hundred and twenty claims were refused on the ground that the injury was not caused by the treatment. NO FAULT-COMPENSATION IN MEDICINE, *supra* note 24, at app. 6, table 19.

36. See NO FAULT COMPENSATION IN MEDICINE, *supra* note 24, app. 2 (discussing the terms of the Swedish insurance plan).

37. *Id.*

38. Under the Swedish system, during the period January 1, 1975 to July 1, 1986, 44,647 claims of medical complication were reported, of which 18,054 did not receive compensation. Oldertz, *supra* note 31, at 637, 655. Of the remaining total of 26,593 cases, 22,252 had received compensation, with the remaining balance of 4,341 cases awaiting a final decision. An estimated four thousand indemnifiable injuries occurred during 1986. *Id.* This level of indemnification contrasts sharply with the pre-patient insurance scheme average of ten cases per year receiving compensation. *Id.* The percentage of injuries that are compensated has since increased above the earlier reported level of 62%. MARILYNN M. ROSENTHAL, DEALING WITH MED. MALPRACTICE: THE BRITISH AND SWEDISH EXPERIENCE 256 (1988). Under the similar Finnish patient insurance plan, 62% of claims were rejected during the first full year of operation. NO-FAULT COMPENSATION IN MEDICINE, *supra* note 24, app. 10. See generally Brahams, *No Fault Compensation in Finland with an Overview of the Scandinavian Approach to Compensation of Medical and Drug Injuries*, in NO-FAULT COMPENSATION IN MEDICINE, *supra* note 24 (detailing Finland's legislatively based, no-fault patient insurance scheme).

39. Calabresi, *supra* note 34, at 663.

40. TASK FORCE, *supra* note 1, at 61.

should not be compensable.<sup>41</sup> The Task Force Report did not find it necessary to define the ambit for compensation in terms of misadventure,<sup>42</sup> but recommended that compensation should be payable for "any injury or loss arising out of or caused by health treatment or care."<sup>43</sup> Such language may generate expensive litigation over the scope of coverage, with disputes focusing on whether the injury was caused by medical care or was the result of a pre-existing condition.<sup>44</sup>

A second issue is whether the exclusion of certain benefits and the imposition of thresholds for recovery result in the inequitable treatment of injured patients. No system could ever hope to offer all patients who suffered adverse consequences some significant level of compensation. From the equitable viewpoint, few would take issue with the exclusion of trivial injuries and the direction of benefits to the seriously injured. Minor injuries in the United States give rise to the largest number of claims and are disproportionately costly. In the 1984 GAO study of medical malpractice, 15.7% of closed claims related to emotional or insignificant injuries, with a further 30% involving minor temporary disability.<sup>45</sup> In the Harvard study, a sample of persons injured during 1984 in New York State hospitals showed that 57% of adverse results were of a minor temporary nature.<sup>46</sup> The exclusion of minor claims might not itself be sufficient to ensure the financial viability of a no-fault scheme funded from existing indemnity costs. The Harvard study found that a no-fault scheme for hospital injuries could be feasible given present indemnity costs if compensation was limited to recovery of economic loss for death and serious injury, with no payment for the first six months of loss.<sup>47</sup> Whether these same estimates would hold true in Australia is a matter for speculation. In Australia, indemnity costs are much lower, as are medical and legal costs. However, there may be a larger pool of un-

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41. *Id.* at 60. See also HARVARD STUDY, *supra* note 16, at 5-13, 8-43 (including such adverse consequences in determining the feasibility of a no-fault plan for hospital injuries).

42. *Id.*

43. *Id.*

44. Robert E. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 614-15 (1973); Jeffrey O'Connell & David Partlett, *An America's Cup for Tort Reform? Australia and America Compared*, 21 U. MICH. J.L. REF. 443, 482-83 (1988).

45. GAO REPORT, *supra* note 15, at 24.

46. HARVARD STUDY, *supra* note 16, at 8. Death accounted for 14% of adverse events, with disabilities which lasted longer than 6 months comprising 9% of the total; the balance of 30% consisted of moderate or permanent impairment. *Id.* See also DANZON, *supra* note 15, at 21 (citing a 1977 California Medical Association study showing that "minor temporary" disabilities not exceeding a thirty-day duration comprised 59% of patient injuries which occurred during hospital stays). The Australian experience suggests that the greatest burdens on the system are not small claims but large obstetric claims. LILIENTHAL, *supra* note 7.

47. HARVARD STUDY, *supra* note 16, at 8-79 to 8-73.

compensated patients in Australia because there are great financial risks and costs that discourage malpractice actions. For instance, Australia adheres to the "English Rule," in which the losing party must pay all court and legal costs. Furthermore, contingency fees are not permitted, and legal aid is severely restricted.<sup>48</sup>

The Task Force supports its proposal to place threshold limits on compensation by reasoning that resources ought to be directed to those with the greatest need. The exclusion of small claims via threshold limits will partially offset the costs of offering a broadly based scheme. The threshold requirement is also extremely important in maintaining cost effectiveness and preventing the abuses that are common to any social insurance scheme.<sup>49</sup> Recommended threshold limits would exclude from coverage minor injuries or losses such as a few days absence from work, or minimal medical expenses.<sup>50</sup> This would enable the scheme to cover a broader range of injuries than envisaged by the Harvard study, which excluded from coverage all but serious or fatal injuries.<sup>51</sup> Under the Task Force proposal, economic losses would be compensated at a rate of 80-85% of earnings on a periodic basis, with hospital and other medical costs met as they arose.<sup>52</sup> Unlike the Harvard plan, under the Task Force approach damages for pain and suffering and loss of enjoyment of life would be compensable for permanent disability.<sup>53</sup> Putting aside policy arguments and the position that these costs may be unmanageable under a no-fault scheme, there would clearly be some dissonance in any system that allowed limited recovery for some non-economic losses under other no-fault schemes,<sup>54</sup> but disallowed them under a no-fault medical misadventure scheme. The GAO figures indicate that limiting recovery for pain and suffering to those patients with permanent disability would exclude 56.8% of all negligence claims; and presumably a

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48. The institution of a contingency fee system is under active consideration. LAW INSTITUTE OF VICTORIA, CONTINGENCY FEES IN VICTORIA (Nov. 20, 1989) (discussion paper).

49. See TERENCE G. ISON, ACCIDENT COMPENSATION: A COMMENTARY ON THE NEW ZEALAND SCHEME 73-75 (1980) (discussing the problems of "abuse control" in the New Zealand social insurance system).

50. TASK FORCE, *supra* note 1, at 69.

51. HARVARD STUDY, *supra* note 16, at 8-66. The Harvard study proposed covering only serious or fatal injuries, with a deductible for the first six months of injury. This restriction would limit coverage to approximately 10% of injuries. *Id.*

52. TASK FORCE, *supra* note 1, at 69.

53. *Id.* at 69.

54. For example, the New South Wales workers compensation system specifically provides for limited awards for pain and suffering. Workers Compensation, N.S.W. Pub. Gen'l Stat., pt. 2, § 67 (1987).

greater number of claims would be excluded under a no-fault system.<sup>55</sup> The Harvard proposal, which excludes all non-economic losses, would exclude a very substantial number of claims by the unemployed; particularly the elderly - the majority of whom are women. It is the latter that represents the largest group of health consumers<sup>56</sup> and therefore, the group most likely to sustain injury through medical treatment. This leads to the arguable but untenable conclusion that injury to the elderly and unemployed does not matter, and that these groups are dispensable. Although economic feasibility might seem to justify exclusion of these types of losses, automatic exclusion should not be justified. It may be preferable to impose more restrictive ceilings on recovery rather than reject non-economic losses as a basis for recovery. The Task Force proposal, which allows recovery of non-economic losses when there is permanent disability, is the preferable approach.

More fundamental to the equity issue is the question of whether victims of medical misadventure should be given preference over other victims.<sup>57</sup> In 1974, the Australian Woodhouse Report recommended a much wider no-fault compensation scheme for accidents and illnesses, and rejected preferential treatment of victims of certain mishaps.

It is wrong that injured persons should be treated by society in different ways, depending upon the fortuitous cause of the injury and it is equally wrong to leave other incapacitated groups of people indefinitely aside because the diagnosis of their problem is sickness or disease. Once the principle of community responsibility is applied to alleviate the plight of the injured, as it must, then the same community assistance cannot as a matter of social equity be withheld from the sick.<sup>58</sup>

If the costs of a no-fault scheme can be contained within existing expenditures by medical providers through liability insurance, then the benefits of such a scheme might outweigh the discrimination against those afflicted with illness and disease. However, it has not yet been shown that the Task Force

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55. GAO REPORT, *supra* note 15, at 24. Excluding cases in which death resulted, up to 80% of claims for non-economic losses could be excluded. DANZON, *supra* note 15, at 21.

56. DEPARTMENT OF COMMUNITY SERVICES & HEALTH, *Medicare: Summary of Selected Key Statistics for Services Processed 1984-85 to 1988-89*, in 1988-89 ANNUAL REPORT at 32, tbl. 56 (1989). In the year 1988-89, women inpatients had an average per capita user rate of medical services of 10.4 as against 6.7 for men. *Id.* Within twelve months prior to interview, persons aged 65 and over comprised 20% of hospital admissions. AUSTRALIAN BUREAU OF STATISTICS, AUSTRALIAN HEALTH SURVEY 1983 at 18, tbl. 1.

57. JANE STAPELTON, DISEASE AND THE COMPENSATION DEBATE (1986) (arguing against preferential treatment of victims of medical misadventure).

58. 1 NATIONAL COMMITTEE OF INQUIRY, COMPENSATION AND REHABILITATION IN AUSTRALIA 246 (1974) (Chairman J. Woodhouse). The recommendations of the report were never implemented.

proposal could be funded within the existing financial constraints. This is true even with economies resulting from imposing threshold limits, limiting recovery of non-economic losses to the permanently injured or disabled, and the abolishing of common law claims. In examining funding for a no-fault scheme for medical injury, the Task Force accepted the proposition that the scheme should be self funded within the health care arena.<sup>59</sup> It acknowledged that it is politically unacceptable to relieve medical practitioners of the costs of their errors. In order to encourage risk management and quality assurance programmes, the Task Force would continue to hold medical care providers financially responsible for their mistakes.<sup>60</sup> The Task Force also accepted the reality that not all costs of the scheme should be borne by health care providers. It is reasonable for the government to bear the establishment costs of the scheme. It was argued that the government should also contribute a "small percentage" of ongoing costs in compensation for those claims in which serious adverse consequences have occurred in the absence of demonstrable negligence "[C]ontributions should be based on estimated percentages of liability, (or areas of causation to use a more appropriate term)."<sup>61</sup> Contributions by the government, from consolidated revenue, would also be warranted on the ground that the scheme would save the government substantial social welfare expenses. The allocation of financial responsibility between the government and medical service providers would be intensely debated. If allocations are based on the estimated percentage of projected paid claims, then health care providers will be liable for only a very small portion of negligence injuries. In the alternative, if the allocation is based on all potentially compensable claims, then substantial increases in contributions by health care providers must be expected. The result is likely to be a political judgment rather than a serious attempt to allocate to the healthcare industry the full cost of injuries attributed to medical negligence. If costs are allocated on the basis of actual and projected successful claims, the majority of compensated claims will be paid out of public funds either by direct Commonwealth contribution or by a levy on the public hospital system representing malpractice costs. The effect is that although a few individuals injured by medical misadventure will receive compensation out of the public purse; the majority of injured persons will be left with only social security entitlement. Such a result highlights an unprincipled preference in favor of injured patients.

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59. TASK FORCE, *supra* note 1, at 4.

60. *Id.* at 72.

61. *Id.* at 73.

### III. CONCLUSION

The South Australian Task Force report is the first small step in a very long path to reform. Any no-fault scheme for compensating victims of medical misadventure can only be seriously considered when there is reasonable statistical evidence of the rate, type, and victims of medically induced injury. It is equally important that there be widespread community involvement in the central issue of whether preferential treatment should be accorded to this group of victims over others. The scope of any such scheme and the definition of compensable event will be critical to the question of cost. A broad definition of compensability will result in a more expensive scheme; however, an overly restrict definition will result in a loss of equity among victims with equivalent needs. Accountability, deterrence, and accident reduction should also be considered in conjunction with any proposed scheme. The Task Force preferred to leave the achievement of these goals to other mechanisms; thereby avoiding the dilemma that effective accountability and disciplinary mechanisms may be counterproductive to the free flow of information relating to the injury, and, therefore, detrimental to the victim.<sup>62</sup> Many issues remain unresolved not the least of which is the equitable treatment of the disadvantaged in our community. The case for preference has not yet been made out.

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62. Sappideen, *supra* note 5, at 543.