

Lessons From New Zealand: The “No-Fault”
Alternative to Medical Malpractice

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I. INTRODUCTION

The medical malpractice system in the United States has many flaws.¹ Patients face an uphill legal battle to obtain damages for their doctors’ negligence.² Derided as a “forensic lottery,” the tort model lacks fairness and consistency as victims with similar injuries often receive wildly disparate compensation.³ Consequently, many injured patients forgo the process entirely, deterred by the lengthy and uncertain adjudication process.⁴

Few would blame them. The rancor that flows from lawsuits can be toxic.⁵ The adversarial nature of litigation tears at the doctor-patient relationship, inducing silence and bitterness.⁶ Where mistakes are accompanied by protracted struggles to apportion blame, doctors are less

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1. Michelle M. Mello, et al., *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, THE COMMONWEALTH FUND 1, 1 (July 2011), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jul/1517_Mello_admin_compensation_med_injuries.pdf.

2. *See id.*

3. Mello, *supra* note 1, at 1; Marie Bismark & Ron Paterson, *No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety*, 25 HEALTH AFF. 278, 282 (2006).

4. Mello, *supra* note 1, at 1.

5. Marie Bismark, *No-Fault Compensation for Treatment Injury in New Zealand* 5 (Mar. 12, 2008) (unpublished manuscript), available at <http://www.tau.ac.il/law/cegl3/Bismark.doc>.

6. David Studdert & Troy Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 218 (2001); Mello, *supra* note 1, at 1.

apt to report errors.⁷ Researchers lose opportunities to reform procedures and improve training when physicians withhold data about mistakes.⁸ Some physicians feel compelled to practice defensive medicine, ordering a battery of unnecessary tests to limit their liability,⁹ which drives up the cost of healthcare.¹⁰

Ironically, there is no conclusive proof that fault actually deters negligence.¹¹ For these reasons, alternatives to the tort model deserve consideration, and New Zealand offers one such alternative. In New Zealand, victims of medical errors receive compensation without having to prove that their doctor was at fault.¹² This article will explore the pros and cons of New Zealand's "no-fault" model to ascertain its viability in the United States.

II. BACKGROUND

New Zealand abandoned personal injury torts in the 1970s as part of a movement to broaden the scope of disability insurance.¹³ Widespread dissatisfaction with the variability of coverage under the tort regime prompted calls for reform.¹⁴ Created in 1967, a special committee called the Woodhouse Commission concluded that the government should bear the cost of injuries, regardless of fault, when victims of accidents lose their self-sufficiency.¹⁵ Under the proposed scheme, injured New Zealanders

7. Studdert & Brennan, *supra* note 6, at 218; Mello, *supra* note 1, at 1.

8. Bismark, *supra* note 5, at 1; Mello, *supra* note 1, at 1.

9. Mello, *supra* note 1, at 1-2.

10. *Id.*

11. Bismark & Paterson, *supra* note 3, at 279.

12. *See* Studdert & Brennan, *supra* note 6, at 219.

13. Allen B. Kachalia, et al., *Beyond Negligence: Avoidability and Medical Injury Compensation*, 66 SOC. SCI. & MED. 387, 391 (2008).

14. Bismark, *supra* note 5, at 2.

15. Bismark & Paterson, *supra* note 3, at 279; Mello, *supra* note 1, at 2.

would waive their right to sue in exchange for compensation.¹⁶ So long as the injury qualified for coverage, New Zealanders could apply for state-funded entitlements.¹⁷

In 1974, the Accident Compensation Corporation (ACC) was created to adjudicate a wide swath of personal injury claims ranging from workplace injuries to “domestic cooking accidents and injuries sustained in sporting activities.”¹⁸ However, owing to its emphasis on workers’ compensation, the initial legislation left medical injuries inadequately defined.¹⁹ It simply provided for reimbursement in the event of “medical, surgical, dental or first aid misadventure” without elaboration.²⁰ The ACC and the courts struggled to flesh out the parameters of coverage under the medical misadventure standard until 1992, when the legislature introduced the concepts of *medical error* and *medical mishap*.²¹

A *medical error* was defined as an injury attributable to negligence requiring proof of individual error.²² Under the medical error standard, the specter of liability remained, bothering doctors who complained that it “hindered open communication and delayed compensation.”²³ In contrast, a *medical mishap* was defined as a rare and severe consequence of proper treatment.²⁴ Rare meant occurring in less than one percent of cases.²⁵ An injury was classified as severe if it resulted in more than fourteen days in the hospital, “significant disability lasting more than 28 days, or death.”²⁶

16. Bismark & Paterson, *supra* note 3, at 279.

17. *See id.*

18. Kachalia, *supra* note 13, at 391.

19. *Id.*

20. Bismark & Paterson, *supra* note 3, at 279.

21. *Id.*; Kachalia, *supra* note 13, at 391.

22. Bismark & Paterson, *supra* note 3, at 279.

23. *Id.*

24. Mello, *supra* note 1, at 4.

25. Bismark & Paterson, *supra* note 3, at 279-80.

26. Kachalia, *supra* note 13, at 399.

In practice, these criteria were difficult to apply.²⁷ In addition, only injuries sustained from “active treatment” qualified.²⁸ Consequently, injuries resulting from omissions, such as the failure to diagnose, were not entitled to compensation.²⁹

III. TREATMENT INJURY

On July 1, 2005, the ACC eliminated the vestiges of fault by adopting the “treatment injury” standard.³⁰ This most recent legislation aimed to expand coverage³¹ and remove a source of tension between physicians and patients.³² Physicians welcomed the shift because many considered the previous medical error standard “punitive and stigmatizing.”³³ Broadly defined, “treatment injury” encompasses all personal injuries that a patient may suffer at the hands of a health professional, so long as the injury is not a “necessary and ordinary” consequence of treatment.³⁴ Patients still must establish causation, but without the added burden of proving fault, rarity, or severity.³⁵ However, some barriers to compensation have endured.³⁶ Isolating the causal factor, for instance, will remain a challenge in complicated cases.³⁷ Moreover, it is not clear what constitutes a “necessary and ordinary” consequence of treatment.³⁸

Aside from these ambiguities in the eligibility criteria, the ACC has

27. *Id.*

28. *Id.*

29. *Id.*

30. Kachalia, *supra* note 13, at 399; Bismark & Paterson, *supra* note 3, at 278.

31. Kachalia, *supra* note 13, at 399.

32. *See* Mello, *supra* note 1, at 4.

33. Kachalia, *supra* note 13, at 392.

34. Bismark, *supra* note 5, at 3.

35. *Id.*

36. Kachalia, *supra* note 13, at 400-1.

37. *Id.*

38. *Id.* at 399.

made the claims process straightforward and easy to navigate.³⁹ Patients file a claim through a physician of their choice.⁴⁰ Any doctor may initiate the claim – not necessarily the one involved in the injury.⁴¹ After reviewing the medical records, a panel of neutral experts determines whether the injury satisfies the eligibility criteria.⁴² Claim handlers rely on precedent and institutional memory for guidance,⁴³ but outside experts might be consulted in complicated cases.⁴⁴ If displeased with the outcome, the claimant has the right to appeal in court.⁴⁵ Ultimately, the ACC accepts about sixty percent of the claims that are submitted.⁴⁶

A qualified claimant may obtain coverage for treatment costs, rehabilitation, weekly compensation for loss of earnings up to eighty percent of previous wages, and lump sum compensation for noneconomic losses due to permanent impairment up to \$85,000.⁴⁷ While the average compensation per claim is low (\$4,450) compared to the United States (\$324,000),⁴⁸ this figure is somewhat misleading because New Zealand's universal healthcare system shares the compensation burden with the ACC.⁴⁹ Pursuant to its "collateral-source offset" rules, the ACC avoids paying for expenses such as hospital care, prescription drugs, and other expenses, which get charged to the national insurance system.⁵⁰

While the law mandates that claims be processed within nine months of

39. See Bismark & Paterson, *supra* note 3, at 280.

40. Mello, *supra* note 1, at 5.

41. It is typical for the patient's general practitioner to serve as the filing physician. Kachalia, *supra* note 13, at 391.

42. *Id.* at 400.

43. *Id.*

44. Mello, *supra* note 1, at 6.

45. However, few claims reach this level of review. Kachalia, *supra* note 13, at 392.

46. *Id.* at 390.

47. Bismark, *supra* note 5, at 3-4; Bismark & Paterson, *supra* note 3, at 280-81; Mello, *supra* note 1, at 7.

48. Mello, *supra* note 1, at 7.

49. See Bismark & Paterson, *supra* note 3, at 281.

50. See Bismark & Paterson, *supra* note 3, at 281; see also Mello, *supra* note 1, at 6-7.

filing,⁵¹ generally, straightforward claims can be resolved within sixteen days.⁵² This quick turnaround is a distinguishing feature of the New Zealand scheme. In the United States, it often takes four to five years to resolve a negligence dispute.⁵³ Administrative efficiency contributes to low overhead costs, which account for ten percent of the total cost of the system.⁵⁴ Hence, patients receive the lion's share of every dollar that goes into the ACC budget.⁵⁵ In contrast, legal and administrative expenditures account for fifty-five to sixty percent of total costs in the United States.⁵⁶

Critics of no-fault contend that it promotes a lack of accountability.⁵⁷ Where substandard care goes unpunished, doctors have less incentive to improve their performance.⁵⁸ However, New Zealand does have a mechanism for physician discipline.⁵⁹ In the event a doctor poses a "risk of harm to the public," the Medical Council of New Zealand may request a competence review.⁶⁰ Educational rather than disciplinary, the review is meant to identify and correct deficiencies in the doctor's practice.⁶¹ Thus, New Zealand proves that a no-fault regime can be structured to promote accountability.⁶²

In theory, error reporting should increase under the no-fault model

51. Farzad Soleimani, *Learning from Mistakes in New Zealand Hospitals: What Else Do We Need Besides "No-Fault"?* 119 J. N.Z. MED. ASSOC. 1, 2 (2006), available at <http://journal.nzma.org.nz/journal/119-1239/2099/>.

52. Mello, *supra* note 1, at 5.

53. Kachalia, *supra* note 13, at 400.

54. Bismark & Paterson, *supra* note 3, at 281.

55. See *Patient Compensation for Medical Injuries: International Approaches* (July 7, 2011), http://www.commonwealthfund.org/~media/Files/Podcast/New%20Directions%20in%20Health%20Care/Compensation_transcript_final.pdf.

56. Mello, *supra* note 1, at 7.

57. See JOCELYN BOGDAN, *MEDICAL MALPRACTICE IN SWEDEN AND NEW ZEALAND: SHOULD THEIR SYSTEMS BE REPLICATED HERE?* 5 (Center for Justice & Democracy 2011).

58. See *Id.*

59. Mello, *supra* note 1, at 7.

60. Bismark, *supra* note 5, at 7.

61. *Id.*

62. See Studdert & Brennan, *supra* note 6, at 220.

because the punitive consequences of disclosure are reduced.⁶³ As reporting contributes to a database for study, quality of care is supposed to improve as well.⁶⁴ Proponents base this proposition on an analogy to other industries, such as aviation and nuclear power, where error reporting has led to gains in safety.⁶⁵ However, error reporting in New Zealand is not as robust as expected, and recent studies indicate that New Zealand's healthcare system is not demonstrably safer than that of the United States.⁶⁶ The risk is one percent that a patient will suffer a preventable adverse event, which approximates the risk of the same occurring in a tort jurisdiction.⁶⁷ One study concluded that no-fault has yet to fulfill its promise in terms of "facility of quality improvement."⁶⁸

According to a 2006 survey, doctors in New Zealand attribute their reluctance to report errors to the fear of losing patient trust and the threat of public outcry, among other factors.⁶⁹ Sensitive to negative portrayals in the media, physicians complain about "doctor bashing" that follows from disclosure of mistakes.⁷⁰ The study suggests extending confidentiality to reporting of errors to insulate doctors from unwarranted media scrutiny.⁷¹

IV. REPLICATING NO-FAULT IN THE UNITED STATES

Implementing no-fault in the United States will not be without its challenges. Controlling costs will require careful drafting of the eligibility criteria. The treatment injury standard in New Zealand may be too broad

63. BOGDAN, *supra* note 57, at 5.

64. Soleimani, *supra* note 51, at 1.

65. *Id.* at 2.

66. *See id.*; Peter Davis et al., *Preventable In-hospital Medical Injury Under the "No Fault" System in New Zealand*, 12 QUALITY & SAFETY IN HEALTH CARE 251, 254-55 (2003).

67. Soleimani, *supra* note 51, at 2.

68. *Id.* at 1.

69. *Id.* at 5.

70. *Id.* at 8.

71. *Id.* at 9.

for the United States,⁷² where it may cause an unmanageable influx of minor claims.⁷³ The survival of the ACC is attributable in part to New Zealand's universal healthcare system, which absorbs many expenses associated with treating iatrogenic injuries.⁷⁴ Furthermore, the culture is not so litigious and patients who sustain injuries due to negligence are unlikely to submit a claim.⁷⁵ One study placed the ratio of potentially compensable adverse events to successful claims in New Zealand at thirty-to-one.⁷⁶ To ensure sustainability, U.S. policymakers should consider enacting disability thresholds — similar to New Zealand's rare and severe criteria under its previous no-fault regime — to exclude claims for minor injuries.⁷⁷

Policymakers should expect resistance from the plaintiffs' bar, and it is a foregone conclusion that the legality of no-fault will face scrutiny in court.⁷⁸ Because the success of no-fault hinges on the waiver of the right to sue, planners must anticipate the legal arguments that a patient can raise to void the waiver.⁷⁹ For instance, the patient may argue that she did not give informed consent because of some defect in the notification procedure.⁸⁰ On this point, policymakers can learn from Florida's Birth-Related Neurological Injury Compensation Plan (NICA), which provides coverage on a no-fault basis for newborns who sustain severe neurological injuries during delivery at the hands of their obstetrician.⁸¹

72. Kachalia, *supra* note 13, at 399.

73. David M. Studdert & Troy A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 232 (2001) [hereinafter *Toward a Workable Model*].

74. See Bismark & Paterson, *supra* note 3, at 281.

75. *Id.*; Mello, *supra* note 1, at 8.

76. Bismark & Paterson, *supra* note 3, at 281.

77. See *Toward a Workable Model*, *supra* note 73, at 232.

78. *Id.* at 235.

79. *Id.* at 239.

80. *Id.* at 235.

81. *Id.* at 234, 240.

In *Galen v. Braniff*, the obstetrician and hospital failed to give pre-delivery notice of their involvement in NICA.⁸² Consequently, the Florida Supreme Court refused to enforce the exclusivity clause that would have made NICA the plaintiff's sole remedy.⁸³ The court found that without adequate notice, the patient could not "make an informed choice between using a health care provider participating in the NICA plan or using a provider who is not a participant and thereby preserving her civil remedies."⁸⁴ To ensure compliance with the enabling statute, the court insisted that obstetrical patients receive an informational brochure explaining their rights under the no-fault alternative.⁸⁵ In light of *Galen*, physicians in any no-fault program would be wise to put patients on notice at their first meeting to counteract the argument that the plaintiff could not give informed consent because the doctor did not timely disclose her participation.⁸⁶

However, full information alone will not suffice. Patients must volunteer their consent freely.⁸⁷ This could be problematic because courts might find that there is coercion if the patients live in a region that offers limited healthcare options or they feel compelled to agree in order to remain in the good graces of their doctor.⁸⁸ Plaintiffs may also assert a related contractual claim that the tort waiver was adhesive by arguing that an imbalance of bargaining power denied the patient a meaningful choice, thereby rendering the agreement unenforceable.⁸⁹ To address this inequality, one scholar suggests placing "an agent between the patient and

82. *Galen of Florida, Inc. v. Braniff*, 696 So. 2d 308, 309 (Fla. 1997).

83. *Id.*

84. *Id.* at 310.

85. *Id.*

86. *Toward a Workable Model*, *supra* note 72, at 234.

87. *Id.*

88. *Id.*

89. *Id.* at 236.

participating institution/provider that is capable of negotiating participation with the patient's best interests in mind."⁹⁰ The patient's employer, for instance, can serve as the third party agent if the patient obtains coverage under the employer's health plan.⁹¹

It is critical that courts reject attempts to circumvent the jurisdiction of no-fault.⁹² If courts vitiate tort waivers, it will promote duplicative claiming in no-fault and tort venues, enabling patients to game the system in order to maximize financial payouts.⁹³ Florida encountered this problem with NICA, which failed to eliminate "bad baby" cases from the tort system because the eligibility criteria were too narrow, inviting "jurisdictional disputes between common law and no-fault remedies."⁹⁴ If policymakers opt for a limited no-fault program to address a particular class of injury, they should learn from NICA's flaws by covering the full spectrum of injuries belonging to that particular class.⁹⁵ In the alternative, legislators could define the scope of no-fault coverage "according to whether the injury in question was suffered at the hands of participating provider or within the walls of a participating institution."⁹⁶

Jurisdictional wrangling aside, no-fault will also be challenged on constitutional grounds.⁹⁷ *State Farm Mutual Automobile Insurance v. Broadnax* is illustrative.⁹⁸ There, State Farm asked the Colorado Supreme Court to repudiate a state statute that remanded all disputes arising out of

90. *Id.* at 235.

91. *Id.* The patient's health insurer could also fill the role of third party agent.

92. *Id.* at 239.

93. *See id.* at 240.

94. *Id.* at 240-41.

95. David M. Studdert et al., *The Jury Is Still In: Florida's Birth-Related Neurological Injury Compensation Plan after a Decade*, 23 J. HEALTH POL. POL'Y & L. 499, 524 (2000).

96. *Id.*

97. *Toward a Workable Model*, *supra* note 73, at 235.

98. *See generally* *State Farm Mut. Auto. Ins. v. Broadnax*, 827 P.2d 531 (Colo. 1992) (illustrating constitutional arguments against Colorado statute requiring binding arbitration for controversies arising under no-fault auto insurance policies).

no-fault automobile insurance contracts to binding arbitration.⁹⁹ State Farm claimed that binding arbitration violates the right of access to the courts, “rights to a jury trial, and equal protection and due process.”¹⁰⁰ However, the court upheld the statute as constitutional.¹⁰¹ Since binding arbitration affords parties the opportunity to be heard, the court found that the right to judicial process was satisfied.¹⁰² On the due process issue, the court applied a rational basis test and ruled that the statute was “rationally related to legitimate interests in expediting dispute resolution, reducing parties’ costs, and securing prompt payment of benefits.”¹⁰³

However, there is no consensus on the constitutionality of no-fault.¹⁰⁴ In *University of Miami v. Echarte*, the Florida Supreme Court upheld a monetary cap on non-economic damages pursuant to a medical malpractice arbitration statute, but the dissent provided the counterargument, which other jurisdictions have embraced.¹⁰⁵ By dividing victims of medical malpractice into two classes — “those with serious injuries whose recovery is limited by caps and those with minor injuries who receive full compensation” — the dissent concluded that the statute violated equal protection guarantees and the right of access to the courts.¹⁰⁶

V. CONCLUSION

On the whole, the ACC has achieved the objectives of its architects.¹⁰⁷ It provides extensive coverage to a large proportion of claimants, without

99. *Id.* at 532; *Toward a Workable Model*, *supra* note 73, at 242.

100. *Toward a Workable Model*, *supra* note 73, at 242.

101. *Id.*

102. *State Farm*, 827 P.2d at 536-37.

103. *Id.* at 540; *Toward a Workable Model*, *supra* note 73, at 242.

104. *See Toward a Workable Model*, *supra* note 73, at 243.

105. *Id.*; *See Univ. of Miami v. Echarte*, 618 So. 2d 189, 198-202 (Fla. 1993) (Barkett, C.J., dissenting).

106. *Miami*, 618 So. 2d at 198; *Toward a Workable Model*, *supra* note 73, at 243.

107. Mello, *supra* note 1, at 8.

bankrupting New Zealand's healthcare system or compromising quality. Moreover, it enjoys the support of the public.¹⁰⁸ Spared the burden of establishing fault, patients find it easier to recover damages.¹⁰⁹ Doctors cooperate in the claims process because liability does not attach to admissions of error.¹¹⁰ While safety remains a concern, errors occur at the same frequency in no-fault as in tort systems, rebutting the notion that liability deters mistakes.¹¹¹

Replicating no-fault in the United States is no simple proposition.¹¹² New Zealand's treatment injury standard may not work in the United States because its broadness will open the floodgates to minor claims.¹¹³ Viability will depend on effective cost controls,¹¹⁴ but caps on damages may not gain traction. Furthermore, courts must enforce patients' agreements to forgo tort remedies.¹¹⁵ This means quashing challenges predicated on contractual and constitutional grounds.¹¹⁶ However, the survival of several states' pilot programs augurs well for the future of no-fault in the United States.¹¹⁷

108. See Kachalia, *supra* note 13, at 400.

109. David Dobbs, *Do the Swedes Have a Faultless Fix*, SLATE, Feb. 22, 2005, http://www.slate.com/articles/news_and_politics/how_they_do_it/2005/02/malpractice_mess.html.

110. Mello, *supra* note 1, at 5.

111. See Soleimani, *supra* note 51, at 2.

112. See David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1, 33-34 (1997) [hereinafter *Can the United States Afford?*].

113. Kachalia, *supra* note 13, at 399-400.

114. *Toward a Workable Model*, *supra* note 73, at 231; *Can the United States Afford?*, *supra* note 112, at 29.

115. *Toward a Workable Model*, *supra* note 73, at 239.

116. *Id.* at 252.

117. Kachalia, *supra* note 13, at 401.