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The impact of no-fault compensation on health care expenditures: An empirical study of OECD countries

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ABSTRACT

Around the world, governments are faced with spiralling health care expenditures. This raises the need for further insight in the determinants of these expenditures. Existing literature focuses primarily on income, ageing, health care financing and supply variables. This paper includes medical malpractice system characteristics as determinants of health spending in OECD countries. Estimates from our regression models suggest that no-fault schemes for medical injuries with decoupling of deterrence and compensation reduce health expenditures per capita by 0.11%. Furthermore, countries that introduced a no-fault system without decoupling of deterrence and compensation are found to have higher (+0.06%) health care spending.

1. Introduction

Over the last decades, policy makers have increasingly focused on controlling spiralling health care expenditures.[1] On average, health care expenditures as a proportion of Gross Domestic Product (GDP) have risen from 7.8% in 2000 to 9.3% in 2011 in OECD countries [1]. This increase was the highest in the United States (+4.0%) and the Netherlands (+4.0%). On the contrary, in Luxembourg (−0.8%) and Iceland (−0.5%) health spending has slightly declined over the past decade. These developments have incited many scholars to examine the determinants of health care expenditures.

Some scholars state that a country's medical malpractice system could be a determinant of health care spending. In 2002, the US Department of Health and Human Services stated that the medical liability system imposes large costs on the US health care system [2]. Kessler and McClellan [3] estimated that health care costs could be reduced by 5–9% by limiting unreasonable awards for non-economic damages, such as pain and suffering, without substantially affecting the quality of care. Hellinger and Encinosa [4] found that health care spending was statistically 3–4% less in US states capping non-economic damage awards in malpractice cases. Therefore, it is possible that differences in medical malpractice systems across countries do significantly affect health spending. The objective of this article is to assess the impact of a no-fault compensation system on health care expenditures.

In addition to the problem of increasing health care costs, another policy issue in many OECD countries is the reform of their medical liability system. A medical malpractice system has two main purposes: compensating patients suffering damages due to a health care provider's negligence and inciting health care providers to take appropriate precautions during medical treatments [5]. Until a few decades ago, injuries resulting from health interventions

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[1] In this paper health (care) expenditures and health (care) spending are used as synonyms.

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in OECD countries were settled in court applying the conventional tort rules. Under these negligence-based rules, a patient carries the burden of proving a physician's fault, harm suffered and causation between both to receive compensation.

However, the lack of a specific compensation system for medical malpractice posed problems for patients as well as for physicians. Physicians practiced defensive medicine, which the Office of Technology Assessment describes as the ordering of additional tests, extra procedures and visits, or the avoidance of certain procedures or patients, due to concern about malpractice liability risk [6]. Mello et al. [7], moreover, estimated these health care costs at approximately $45.59 billion in 2008 dollars, or nearly 2% of total health care spending. Patients struggled with the burden of proving fault, damage and causation, making the outcome of medical malpractice trials unpredictable and uncertain. Some insurers restricted their coverage package, others no longer offered liability insurances to the most severe risk categories or exited the medical malpractice insurance market altogether. Specific regulation for medical malpractice cases was therefore implemented in several countries.

The United States, for instance, established statutory tort reforms on the state level. Several states adopted caps on economic and non-economic damages, limited joint and several liability, put caps on attorneys' fees and limited collateral source rules to limit malpractice premiums and awards [8].

New Zealand and Sweden introduced a publicly financed scheme for compensating medical injuries, respectively in 1974 and 1975 [9]. The main driver behind this shift was that the conventional tort system's cumbersome nature obstructed patients' access to due compensation in Sweden [10]. New Zealand's compensation system originally arose as a consequence of the workers' compensation reforms, not in response to concerns about medical malpractice [11]. An important feature in both countries was the abandonment of their negligence-based compensation system. Instead, an out-of-court procedure was introduced, applying a no-fault rule. In Sweden, compensation is awarded to patients if the harm suffered could have been avoided under optimal circumstances (avoidability rule). Eligibility criteria in New Zealand have been revised several times. From 1974 to 1992, 'personal injuries' included medical, dental, surgical and first aid misadventures, and were compensated on a no-fault basis. From 1992 to 2005, 'medical misadventures', i.e. injuries resulting from a medical error or a medical mishap, were eligible for compensation [12]. Since 2005, eligibility is extended to all 'treatment injuries' regardless of injury severity or rarity, or error [13]. Damages are paid by a pool of insurers, while the discipline of medical providers is handled by another independent institution. As a result, deterrence and compensation are decoupled, possibly lowering the practice of defensive medicine.

It took a decade before the other Nordic countries implemented a modified medical malpractice system. Finland (1987) and Denmark (1992) established a privately financed insurance-based compensation system [9]. Eligibility of compensation is determined by the avoidability rule, though damages can also be paid for unavoidable medical injuries if they are unusual or serious (endurability rule). Meanwhile, the Norwegian government initiated the public financing of a non-statutory no-fault scheme for medical injuries in 1988 [14], though negligence remained their main criterion for compensation. Eventually, also Iceland abandoned their tort system for medical malpractice in 2001 and instead implemented an insurance-based no-fault scheme, also applying the avoidability rule.[2]

France (2002) and Belgium (2010) initiated a more restricted no-fault scheme than the Nordic countries [15,16]: only in case of the absence of negligence, a no-fault rule is applied to determine a patient's eligibility for compensation. Some countries, such as New Zealand and Iceland, moreover abolished the option of going directly to court in case of a medical injury.

Already in the 1970s, the English government acknowledged the shortcomings of their clinical negligence litigation system, though its replacement by a no-fault scheme has been rejected ever since. To date, also the NHS Redress Act 2006, adopting a compensation scheme without recourse to civil proceedings, has not been issued yet. Nonetheless, so-called pre-action protocols have been introduced to resolve clinical disputes without resort to legal action.[3] On the other hand, the Welsh NHS Redress scheme has been issued in 2011,[4] while the Scottish government currently explores the implementation of a no-fault system for medical injuries [17].

Using cross-country OECD data for the period 1970–2011, the effect of no-fault compensation on health care expenditures is estimated. In addition to the common determinants of health care expenditures, we added a variable accounting for the presence of a no-fault compensation system. This is in line with Gerdtham and Jönsson [18], who pointed out the need for testing new variables of health spending.

The paper is organized as follows. The following section presents a brief overview of the determinants of health care expenditures in existing literature and discusses the data and the regression model. Section 3 provides the empirical analysis and the results, while Section 4 discusses the impact of malpractice systems on defensive medicine. Finally, Section 5 draws some conclusions.

2. Methods

2.1. Determinants of health care expenditure in literature

The inclusion of other determinants of health care expenditures besides the presence of a no-fault compensation system was based on a review of the literature. We selected papers using the search terms "health care

[2] Act on Patient Insurance, No. 111/2000, Iceland. Available at: http://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act_on_Patient_Insurance_as_amended.pdf.

[3] Pre-Action Protocol for the Resolution of Clinical Disputes. Available at: http://www.justice.gov.uk.

[4] The NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011. Available at: http://www.wales.nhs.uk.