

# **Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again**

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**Abstract** Periods in which the costs of personal injury litigation and liability insurance have risen dramatically have often provoked calls for reform of the tort system, and medical malpractice is no exception. One proposal for fundamental reform made during several of these volatile periods has been to relocate personal injury disputes from the tort system to an alternative, administrative forum. In the medical injury realm, a leading incarnation of such proposals in recent years has been the idea of establishing specialized administrative “health courts.” Despite considerable stakeholder and policy-maker interest, administrative compensation proposals have tended to struggle for broad political acceptance. In this article, we consider the historical experience of administrative medical injury compensation proposals, particularly in light of comparative examples in the context of workplace injuries, automobile injuries, and vaccine injuries. We conclude by examining conditions that may facilitate or impede progress toward establishing demonstration projects of health courts.

Reform of the medical liability system has commanded a substantial amount of policy attention over the last three decades (Mello 2006). Through three malpractice insurance “crises” — in the mid-1970s, mid-1980s, and early 2000s — lawmakers have considered and adopted a raft of liability-limiting reforms, motivated in large measure by strong pleas from health care provider groups and liability insurers. These groups have

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sought reforms to limit access to the courts and restrict the amount plaintiffs may take as damages awards.

The types of tort reforms to which states (and, to a lesser extent, Congress) have turned through the years have generally been aimed at limiting the number and costs of malpractice claims, while leaving the general architecture of the medical liability system undisturbed. These reforms include measures such as capping noneconomic damages, shortening statutes of limitation and repose, and reforming joint and several liability as well as collateral-source rules.

Another set of reform advocates, among whom we count ourselves, have suggested that the reforms adopted to date are, to borrow Ambrose Bierce's quip (2003: 128), measures that mostly satisfy reformers who are opposed to reformation and that more fundamental reform of the system is needed.<sup>1</sup> Proposals emanating from this group of academics and leaders in the public health, nonprofit, and insurance communities would fundamentally reshape the way in which medical injury claims are adjudicated (Mello et al. 2006; Barringer 2006). Among the concepts that have consistently generated interest across successive malpractice crises is the idea of relocating medical injury disputes from the tort system to an alternative administrative forum.

Advocates of administrative compensation (sometimes referred to with the blanket term "no fault") stress its potential to expand the pool of compensable patient injuries, decrease the system's costly and psychologically battering emphasis on individual fault and adversarialism, improve reliability in determinations of eligibility for and amounts of compensation, and make the entire process faster and cheaper to run (Mello et al. 2006; Studdert and Brennan 2001). Advocates also point to other policy arenas (e.g., workers' compensation, automobile no-fault laws, and vaccine injury compensation programs) in which administrative compensation initiatives have replaced adversarial litigation models.

Administrative compensation proposals have been called "hardy perennials" (Mello et al. 2006; Kingdon 2003) for their pattern of blooming during each malpractice crisis and fading away thereafter. This article examines why administrative compensation proposals have succeeded for certain types of injuries—neurological damage to newborns as well

1. As participants in current and past initiatives designed to develop and promote models for administrative compensation for medical injury, we are not agnostic about the potential of the health courts proposal. For the purposes of this article, however, we focus not on our normative views but rather on the political and historical context of policy debates concerning this controversial proposal.

as occupational, automobile, and vaccine-related injuries — yet failed for medical injuries generally. We consider this issue through John Kingdon's (2003) framework, which posits that policy change typically involves three major "process streams": recognition that a policy problem exists that needs to be addressed (the "problem stream"); the development, refinement, and vetting of policy proposals purporting to correct the policy problem (the "policy stream"), and the flow of political events through which policy changes are erected (the "political stream"). Kingdon suggests that these process streams operate independently and that a particular issue is most likely to rise in the policy agenda when there is an intersection between problems, policy alternatives, and political opportunities. Examining the history of administrative compensation proposals through this model sheds light on the successes and failures of the various policy initiatives.

In undertaking this analysis, we consider several specific questions. What are the circumstances under which administrative compensation proposals have arisen, what form have these proposals taken, and what design choices have been important in influencing a proposal's prospects for success? How have various cultural shifts, including increased consumer empowerment and the rise of the trial bar, shaped the political prospects for administrative compensation proposals? What enabling factors account for the success of some proposals? Finally, what implications does this analysis have for current proposals, such as health courts, or other initiatives?

## **Administrative Compensation Proposals: A History**

### **Waxing and Waning Interest in the 1970s**

In the 1960s and 1970s, several developments set the stage for the emergence of a "crisis" in medical liability insurance, which, in turn, led to calls for experimentation with administrative compensation of medical injury. First, a cultural shift precipitated by consumer, feminist, and environmental groups' challenges to various authority figures contributed to an environment within which suing one's physician was more common (Sage 2004). This facilitated an uptick in claims frequency. Second, as in other areas of tort law, changing legal doctrines made it easier for plaintiffs to win lawsuits (U.S. Department of Health, Education, and Welfare [HEW] 1973; Priest 1991; Tabarrok 2006). These factors occurred in the

context of a social transformation in American medicine that reoriented the provision of health care services by, at least in part, shifting focus from charity to commerce; this in turn had consequences in the legal environment (e.g., the loss of charitable immunity) (Abraham and Weiler 1994; Canon and Jaros 1979).

As the number and costs of claims increased, so too did the cost of medical liability insurance (U.S. General Accounting Office [GAO] 1992). Increasing claims costs and volatility in the market for liability insurance led a number of the commercial carriers that had long served this market to reevaluate their operations in the early 1970s (*Economist* 1975). Facing what they perceived to be an unfavorable business environment (because of litigation, investment returns, and broader global economic factors such as the Organization of Petroleum Exporting Countries oil embargo), some commercial carriers ceased providing malpractice coverage altogether. Their exit left a gaping hole in the market, and many physicians struggled to find alternative sources of insurance. One response to this “crisis of availability” of insurance was the formation of new mutual, or physician-owned, liability insurers (Sage 2004).

Health care providers also responded to the crisis by demanding liability reform. Almost all states enacted some kind of change to their tort laws, aimed at reducing the amount of litigation and/or the level of damages paid in medical malpractice cases. The reform most favored by health care providers was a cap on noneconomic damages. The earliest and best known example was the 1975 California Medical Injury Compensation Reform Act (MICRA), which limited noneconomic damages to \$250,000 and implemented a number of other reforms to tort doctrine and insurance operations. A series of laws mimicking components of MICRA were passed in the 1970s and 1980s in most states, and federal legislation along these lines has repeatedly been introduced (although never passed) in Congress.

Although MICRA-style reforms commanded the most policy attention in the early to mid-1970s, more far-reaching reform proposals also generated interest. At that time, New Zealand had recently implemented an administrative compensation system covering medical injuries, leading some academics to suggest that the United States could follow a similar path (Havighurst and Tancredi 1973; O’Connell 1973; Tancredi 1974). In 1973, HEW called for the federal government to fund demonstration initiatives at the state level to test the feasibility of administrative compensation approaches to medical injury (HEW 1973: xxviii, 99–102). These recommendations came in the form of an exhaustive eight-hundred-page report on medical malpractice prepared by the HEW Commission on

Medical Malpractice, which included lawyers, physicians, patient advocates, and others. The report's authors were quite sanguine about the prospects for a no-fault medical injury compensation system. "Since many of the legal concepts and administrative mechanisms of the recommended system are similar to the well-established Workmen's Compensation system," they wrote, "it would appear that a non-fault-based system could be acceptable" (ibid.: 450). Despite the large amount of ink expended, the HEW report gained little traction. The high cost and reduced availability of medical liability insurance that had prevailed in the early to mid-1970s began to moderate, and as President Carter took office, the importance of medical liability as a policy issue began to wane.

Kingdon's (2003) model helps to explain why so little emerged from the discussions over administrative compensation proposals in the 1970s. The policy stream existed, with various policy proposals advanced and discussed in government and academic circles. However, the problem stream (concerns about or perceptions of a crisis in medical liability insurance markets in the mid-1970s) had substantially lessened by the end of the decade when the situation moderated. Moreover, without the political stream (political pressure for change), there was little reason for the administrative compensation proposal to rise in the policy agenda.

At this juncture, it is worthwhile to contrast this history with those of workers' compensation and automobile no fault, in which an intersection of problem, policy, and politics can be identified. Workers' compensation programs, which operate today in every state, represent the oldest and most extensive form of administrative compensation of personal injuries (i.e., outside the tort system). In these programs, employers pay insurance premiums to a state agency or quasi-public entity, which awards compensation to workers who sustain qualifying injuries in the course of their workplace duties (Moore and Viscusi 1989).

Today's workers' compensation programs have their roots in political and legal changes that took place at the end of the nineteenth century (Ehrenzweig 1966). In particular, rapid technological and economic changes in the workplace created new injuries and spurred more lawsuits. Recovering compensation from employers required lawsuits, but as the prevalence of workplace injuries and related litigation grew, the courts became clogged, and litigants experienced substantial delays. It was difficult for workers to prevail in litigation; business interests were frustrated as well, because traditional employer defenses had eroded. Workplace injury litigation also had major potential to tie up companies' assets (Harger 2007; Clayton 2003/2004).

Thus, concerns on both sides led to the passage of laws to provide to workers injured on the job a new kind of remedy that was guaranteed, equitable, and expedited (Kantor and Fishback 1998). The first such law was the 1908 Federal Employer's Liability Act, which covered certain federal government employees engaged in hazardous work as well as employees of common carriers. The states soon followed with similar initiatives. In 1911, nearly a dozen states adopted workers' compensation laws that provided an administrative remedy for certain job-related injuries (Burriesci 2001; Fishback 2001).

Although there was considerable state-to-state variation, these new regimes were built around one central bargain. Employees gave up rights to sue their employers in tort in exchange for guaranteed access to compensation and benefits in the event of injury, irrespective of fault. Employers, however, gained immunity from unpredictable and potentially costly tort judgments but had to finance the alternative compensation arrangement, including extending payments to some injuries that would not have been eligible for compensation in tort. Insurers welcomed the expanded market for workplace accident insurance (Fishback and Kantor 1996a, 1996b).

By midcentury, every state had some type of workers' compensation program in place (Fishback and Kantor 1996a, 1996b). Today, these programs remain the major source of compensation for lost wages and medical expenses incurred by injured workers (National Academy of Social Insurance 2006; Weiler 1993). And, although the operational realities of workers' compensation programs have drawn a number of criticisms (Harris 2000), there are few suggestions that workplace injuries should revert to adjudication in tort.

What factors facilitated the adoption of workers' compensation programs and account for their persistence? The perception of a problem emerged (the problem stream): inadequate compensation for injuries and business concerns about litigation. Policy proposals were advanced and vetted nationally and at the state level (the policy stream). A critical enabling factor was that the key stakeholder groups, business and labor, both perceived a problem with the status quo and saw advantages in a move away from fault-based litigation. Employers were attracted by the prospect of improved labor relations, greater predictability of accident-related expenses, and a more efficient compensation process (Fishback and Kantor 1998). Employees wanted broader, more accessible accident coverage, even if it came at the expense of reduced wages (Fishback and

Kantor 1995). Additionally, insurers saw new product markets and fewer problems of adverse selection. In sum, stakeholder interests facilitated political action (the political stream). Specifically, general agreement between key stakeholders as to the broad parameters of an alternative compensation program and recognition of certain self-interested benefits were vital ingredients to producing change.

Automobile accident insurance is another area in which policy change that lessens the emphasis on individual fault has been adopted. Shifts in this area have been driven largely by the belief that adopting some form of no-fault compensation mechanism for automobile accidents could expand the pool of injuries eligible for compensation, improve compensation of serious injuries, expedite the compensation process, reduce administrative costs, and reduce automobile insurance premiums.

From the early years of automobile travel, some argued that the remedies available to injured drivers and passengers through the tort system were unsatisfactory. In 1932, for example, a Columbia University study noted that “the generally prevailing system of providing damages for motor vehicle accidents is inadequate to meet existing conditions. It is based on the principle of liability for fault which is difficult to apply and often socially undesirable in its application” (Columbia University Council for Research in the Social Sciences 1932: 216–217; Kinzler 2006: 7). The study recommended an alternative approach: “A plan of compensation with limited liability and without regard to fault, analogous to . . . workman’s compensation” (*ibid.*: 8).

In the early 1960s, professors Robert Keeton and Jeffrey O’Connell wrote what became a seminal critique of the automobile insurance market, in which they echoed themes from the Columbia report and recommended establishment of a no-fault approach (Keeton and O’Connell 1965; Keeton 1959). In the early 1970s, the U.S. Department of Transportation (1971) released a twenty-six-volume study of the tort system that criticized the existing system for its inefficiencies and poor distributive justice and similarly recommended that states abandon tort approaches in favor of no-fault programs.

Under a no-fault approach, the recommendations explained, injury victims would be paid by their own insurance company for any wages lost as well as out-of-pocket medical and rehabilitation costs. Payment would be made regardless of who was at fault and could be expedited since the negligence question was bypassed. The trade-off was that aggrieved drivers would lose their right to sue legally culpable drivers for additional

damages, such as pain and suffering (Kochanowski and Young 1985; Epstein 1980). In addition to improved efficiency, no-fault insurance systems promised expanded access to compensation for economic losses and lower insurance premiums.

Increasing costs for automobile insurance premiums led to considerable public pressure for reform in the 1970s. Automobile no-fault proposals were backed by a broad coalition of supporters, including labor unions, consumer groups, and some insurers. Seeking to realize the promised benefits of the no-fault model, sixteen states enacted some type of no-fault automobile insurance law in the 1970s (Kinzler 2006). Today, twelve states retain some variant of no fault (Insurance Information Institute 2007); concerns about system costs contributed to several states abandoning their no-fault programs.

Cost-control difficulties appear linked, at least in part, to particular program design choices, particularly the preservation of access to the courts for certain classes of injuries (O'Connell 1986). Most regimes preserve litigation options for claimants whose injuries are above a specified severity threshold. This blending of no-fault and fault remedies is largely a product of political compromises made at the time the programs were introduced. From a system design perspective, establishing a high threshold of losses which must be sustained before a lawsuit can be filed is critical to balancing out the anticipated costs of a no-fault system. However, most states with no-fault have low thresholds, which lead to a large number of lawsuits, and in turn allow costs and premiums to rise.

Such compromises also hint at the influence of the trial bar in the political process. Trial lawyers had little love for automobile no-fault laws, because the programs contemplated restricted access to courts and a reduced role for attorneys and litigation. Indeed, an important mechanism through which automobile no fault was expected to lower insurance premiums was reductions in legal expenses (Spiro and Mirvish 1989). Emerging as a strong opponent of such changes (Rubin and Bailey 1994; Richardson 1971), the bar became a major factor in shaping the no-fault initiatives that became law, particularly by ensuring that the no-fault programs preserved access to the courts and/or added no-fault benefits onto the existing tort system without restricting the right to sue (O'Connell 1986, 1993; Collins 1979; Stark 2003; Kinzler 2006).

In short, a problem stream existed (high automobile insurance costs), and the policy stream offered a political remedy (automobile no-fault proposals). Moreover, the political stream offered opportunities for the passage of legislation, at least at the state level. Nonetheless, the automo-

bile no-fault experience highlights the formidable challenges that such alternative compensation regimes will face if they threaten the interests of key stakeholders. Although many argued that moving to a no-fault approach had potentially significant advantages in terms of easier access to compensation and lower insurance premiums, other stakeholders were not receptive to changing the status quo. This dynamic also led to structural compromises that undercut the conceptual integrity of the programs, limiting their ability to deliver on their touted benefits and in some places rendering illusory the fundamental goal of reducing insurance premiums (O'Connell and Joost 1986).

### Administrative Compensation in the 1980s

As well as ushering in a new president, 1980 marked the ascendance of a new political ideology. The Reagan administration was business friendly and favorably disposed to tort reform as a policy priority (Reagan 1986; Kelso 1993). However, the administration saw liability based on tort-feasors' fault—not the lack thereof—as a critical component of tort policy. As a consequence, the administration was no friend to administrative compensation proposals. Rather, its focus was on traditional types of tort reforms such as caps on noneconomic and punitive damages (Boyd 1986).

Then, in the mid-1980s, came a second so-called malpractice insurance crisis. Although the supply of insurance was not threatened as it had been a decade earlier, prices were high and rising, creating a “crisis of affordability.” Health care providers responded with efforts to pass comprehensive tort reform at the federal and state levels (Brinkley 1986; Glen 1986).

Although most of the political attention and effort in the context of medical malpractice reform continued to be devoted toward passage of traditional MICRA-style proposals, there was also scattered interest at the national level in the no-fault/administrative compensation approach. For example, a 1986 GAO report suggested no-fault compensation programs as a possible measure to address the malpractice crisis. In 1989, a national health care commission chaired by former presidents Carter, Ford, and Nixon recommended that the federal government take action in the area of medical liability if the states failed to do so, possibly with a national no-fault compensation system (Knox 1989). Bills were proposed in the U.S. House of Representatives in 1985, 1987, and 1989 that would have encouraged states to provide an administrative remedy for all malpractice cases (Medical Malpractice Reform Act, H.R. 2659, 99th Cong. [1985]; Profes-

sional Medical Liability Reform Act, H.R. 1372, 100th Cong. [1987]; Professional Medical Liability Reform Act, H.R. 2858, 101st Cong. [1989]). Academic work provided a conceptual foundation for many of these initiatives (Havighurst and Tancredi 1973; Tancredi 1986; O'Connell 1973).

A related but distinct initiative received substantially more press attention: a group of scholars led by Jeffrey O'Connell proposed the creation of a quasi-no-fault model resembling what is known today as the "early offer" approach (Hersch, O'Connell, and Viscusi 2006). The model took legislative form in the mid-1980s as the Alternative Medical Liability Act, which envisioned that health care providers would have a certain time after an injury had occurred to make an offer of settlement to claimants (Stein 1984). Although the proposal was advanced in several different forms in successive legislative sessions in the mid-1980s (Alternative Medical Liability Act, H.R. 5400, 98th Cong. [1984]; Medical Offer and Recovery Act, H.R. 3084, 99th Cong. [1985]; Scherf 1984), it failed to find substantial traction.

The opposition of the bar was one barrier (Stieglitz and Gomez 1985); among other things, attorneys argued that medical liability law should remain—as it has been historically—an area of state court jurisdiction rather than being federalized. No-fault proposals also garnered only a tepid response from organized medicine in the 1980s. Concerns were raised about the potential financial implications of compensating a broader swath of injuries than were eligible for compensation under the negligence standard. The American Medical Association (AMA) declined to endorse the proposals because it regarded them as prohibitively costly and because it "felt that a doctor who has done something wrong or negligent ought to bear responsibility" (Stipp 1990).

Organized medicine was, however, attracted to the broader notion of administrative compensation. Together with several medical specialty organizations, the AMA developed a proposal for an administrative compensation system that retained negligence as the basis for liability. The proposal, called the American Medical Association/Specialty Society Medical Liability Project, envisioned the elimination of jury trials and the designation of specialized adjudicators aided by independent medical experts to resolve cases. At least one state bill was introduced based on the AMA's proposal, but no substantive change came about (AMA 1992; Zweig, Perry, and Thurston 1991; Stipp 1990).

Again, Kingdon's model is illuminating. As in the 1970s, various proposals were created and discussed at the federal level (the policy stream), and there was considerable interest in addressing what is perceived to

be a problem in the markets for medical liability insurance (the problem stream). Inside the scope of this interest were alternative proposals beyond conventional types of tort reform such as caps on noneconomic damages. There was, however, insufficient consensus among stakeholder groups to support the sorts of political compromises (the political stream) that would have been necessary for substantive change.

By contrast, the requisite intersection of problem, policy, and political streams can be much more readily identified in the context of vaccine injury compensation. Vaccinating populations involves a calculable risk of injury. Because many vaccinations are required by law, primarily to maintain “herd immunity” rather than to provide a net benefit to any individual, vaccine injuries present a particularly compelling case for compensation (Mello 2008). But like persons injured in cars or on the job, persons with vaccine injuries have historically found the courts an unfavorable venue for obtaining it (Davis and Bowman 1991; U.S. House of Representatives Subcommittee on Health and the Environment 1986).

The history of administrative compensation for vaccine injuries begins in the late 1960s, when courts signaled a receptiveness to new theories of liability for vaccine injuries (Mello and Brennan 2005). This development was followed by the onset of the swine flu crisis of 1976, in which the federal government launched a mass vaccination effort to avert what was perceived to be a looming epidemic (Neustadt and Fineberg 1978; Gaskins 1980). To ensure adequate supplies of the vaccine, the federal government moved to absorb liability for any injuries resulting from the Swine Flu Program, utilizing the existing mechanisms of the Federal Tort Claims Act (Appel 1980). Although this was not an administrative compensation system, it set the stage for a future federal administrative program for vaccine injuries (Institute of Medicine [IOM] 1985).

Vaccine makers continued to face an uncertain and threatening liability environment for other vaccines throughout the 1970s and early 1980s (*ibid.*). A number of sizable verdicts drew attention from the press, policy makers, and the public (Mello and Brennan 2005). Between 1980 and 1985, 299 lawsuits were filed against companies manufacturing vaccines for the United States (Benson 2005; U.S. House of Representatives Subcommittee on Health and the Environment 1986).

Fears that lawsuits might cause manufacturers to cease production of vaccines altogether (Church 1986) proved to be well founded when, in early 1985, a shortage of diphtheria-tetanus-pertussis (DTP) vaccine, a routine childhood vaccination, occurred after two of the three manufacturers of the vaccine for the United States ceased distribution, citing

difficulties in finding liability insurance (Sun 1986). Reflecting in part the increased costs of liability, the cost of DTP vaccine rose thirtyfold between 1982 and 1986 (Blodgett 1987).

Meanwhile, parents of children injured by vaccines were also experiencing mounting dissatisfaction with the liability system. They faced two formidable hurdles to recovering compensation in tort: showing that the vaccine was defective and proving that their child's illness was causally related to vaccination. The costs of caring for injured children, many of whom had severe neurological injuries, fell heavily on families who could not recover damages in court. Thus, there was considerable interest in alternative methods of obtaining relief, both from parents of injured children and from some outspoken physicians involved in their care (Davis and Bowman 1991; Krugman 1975). In 1982, a group of parents formed an organization called Dissatisfied Parents Together and, along with the American Academy of Pediatrics, developed a proposal for a nonadversarial, no-fault process for compensating patients injured due to vaccinations.

The proposal found fertile ground in Congress because in 1986, the shortage of DTP vaccine reached critical levels (Mello and Brennan 2005). Manufacturers of the DTP vaccine formally demanded liability protection under threat of withdrawing from the market. In response, a bipartisan group of senators and congressmen introduced the National Childhood Vaccine Injury Act. Passed in 1986, the legislation created what is known today as the National Vaccine Injury Compensation Program (NVICP).

Under the program—which remains in effect today—patients who suffer a covered vaccine-related injury do not file a lawsuit against the manufacturer of the vaccine but instead file a petition for compensation in the U.S. Court of Federal Claims. Claims are adjudicated by a “special master,” a lawyer designated by the Court, who reviews the evidence and makes a decision about liability. The special master's decisions are based on a predetermined, publicly available list of covered vaccines and associated injuries. No showing of manufacturer fault or defect in the vaccine is required. Funding for the program comes from a small tax on each dose of a covered vaccine.

The NVICP has attracted criticism from a variety of quarters. Initially, the Reagan administration and others were concerned that removing liability would reduce manufacturers' incentives to produce safer vaccines, and that the program amounted essentially to a new entitlement. Department of Justice officials worried that creating a specialized compensation system for vaccine claims would invite demand for other new types of spe-

cialized compensation programs (Cimons 1986; Young 1986). Over time, the program has become quite adversarial, with proof of causation an increasing focus (effectively making the criteria for compensation more restrictive). This has led to increased concern about the degree to which the program truly is meeting its original goals of providing prompt, ready compensation to families (Fisher 1999). Despite these objections, there is no mass movement to return vaccine injuries to the general courts.

The NVICP's history highlights three factors that were particularly important in facilitating its creation. First, an atmosphere of crisis created the impetus for rapid, decisive policy action (the problem stream, in Kingdon's model). The fear that vaccine manufacturers would make good on their threats to exit the U.S. market, leaving American children without a source for critical vaccines, was a major motivating factor. The threats were credible—some manufacturers did exit, and others significantly raised their vaccine prices—and had severe consequences for a vulnerable group. Second, the other major stakeholder group, parents of injured children, was also interested in an alternative remedy for reasons of its own—principally, easing access to compensation. The recommendations they generated did not exactly match the demands of the vaccine manufacturers, who sought legal immunity without any suggestion that the government should assume it, or the Reagan administration, which was inclined to provide this immunity without creating a compensation remedy for claimants (Pear 1985; Sun 1986). But the NVICP model offered a way to satisfy manufacturers and meet the needs of the injured through a financing mechanism that was self-sustaining, broad-based, and somewhat invisible. With respect to Kingdon's model, it represented a compelling policy stream.

As a consequence, the political environment (or stream) was favorable to change. Significantly, the federal government was willing to step in, administer, and essentially underwrite the compensation program. The pressing and dramatic nature of the problem strengthened Washington's hand, and the financing structure foreclosed debates over whether the government could afford it. As a result, there were no protracted battles across state legislatures about how to address the policy problem. There was also little need to convince manufacturers or insurers because transitioning to the administrative compensation program carried limited financial risk for them.

### Emergence of the Birth Injury Compensation Programs

Unlike vaccine injury compensation, medical injury no-fault proposals found little traction at the federal level in the 1980s. However, two states did launch targeted no-fault programs during this decade. Beset by high rates of litigation and escalating liability insurance premiums for obstetrician-gynecologists, Florida and Virginia created programs to compensate families with infants who experienced certain types of catastrophic neurological injury during birth. Florida's Birth-Related Neurological Injury Compensation Association (NICA) and Virginia's Birth-Related Injury Compensation Program (BICP) were established to compensate infants with eligible injuries through an administrative process without regard to provider fault. Candidacy for compensation under the programs depends on whether the delivering obstetrician has signed on to participate, which a majority of practitioners in both states have done. For eligible claims, the programs are the exclusive avenue of redress; litigation in the courts is barred.

Both the Florida and Virginia programs were created as part of a broader set of medical liability reforms in each state during a period in which the medical malpractice environment, particularly for obstetricians, had gained considerable public attention (Baker 1987; Horwitz and Brennan 1995; Sloan et al. 1997). For example, a 1987 survey by the Medical Society of Virginia and the Virginia Hospital Association had indicated that about 40 percent of the state's obstetricians planned to stop delivering babies (Baker 1987). The legislatures sought to shore up the stability of obstetric services by improving the affordability and accessibility of medical liability insurance in this specialty. The medical society in each state supported the general idea, although they quibbled with some of the details (Blodgett 1988; Wiginton 1988). In particular, the Florida Medical Association objected to the program's mandatory assessments on non-obstetrician physicians (Gentry 1988). In short, the perception of a policy problem (the problem stream) was substantial. Moreover, there was motivation for policy makers to act (the political stream). There is little in the historical literature to suggest the extent to which the birth injury proposal was extensively vetted by stakeholders (the policy stream), although it is clear that the Virginia plan faced strong opposition from trial lawyers and property and casualty insurers (Booker 1987; Melton 1987; *Journal of Commerce* 1987; *PR Newswire Association* 1987). However, their objections did not carry the day. There was sufficient interest in and concern

about medical liability from political leaders to secure passage of an array of reforms, including the creation of the compensation programs.

These programs continue to function today and have held fast to their no-fault roots. External evaluations of the programs have generally been positive (Sloan et al. 1997; Bovbjerg, Sloan, and Rankin 1997), although significant financial solvency problems with Virginia's program have come to light (Joint Legislative Audit and Review Commission of the Virginia General Assembly 2003). There is suggestive evidence that the programs may have facilitated increased access to liability insurance, at least in their early years (GAO 1992). The programs appear to have channeled compensation to hundreds of families expeditiously and fairly, and they are known to have modest administrative costs—roughly 10 percent of total expenses (Joint Legislative Audit and Review Commission 2003: 9; Florida Legislature Office of Program Policy Analysis and Government Accountability 2004: 5). Litigation over severe neurological injury has decreased, although the extent to which this may be attributed to the programs is difficult to determine (Studdert et al. 2000). However, the programs do not have a uniformly positive record. High-cost obstetric claims have persisted in the Florida courts due to some peculiar design features of NICA (Studdert 2000). Virginia's program took off slowly, with unexpectedly low numbers of claims in early years; then, as the caseload picked up, financing to cover the considerable future costs of approved claims lagged. The program currently stands in an actuarially unsound position, largely because provider assessments were decreased in the early years of the program when few claims were filed (the authorizing legislation permitted reductions but not increases in assessments).

There is ongoing debate about the extent to which the negative aspects of these programs' track records result from flaws in design (e.g., NICA's problem with jurisdictional integrity) and implementation (e.g., BICP's inadequate financing), as opposed to shortcomings intrinsic to the administrative no-fault model. Nonetheless, the programs continue to generate interest in other states. New York, Maryland, South Carolina, Connecticut, and Massachusetts have all considered the introduction of similar initiatives (Sack 1991; Common Good 2007; DiNardo 1987). None of these proposals, however, has been enacted. For a variety of reasons, including concerns about the functioning of the Florida and Virginia programs, they have tended to engender a negative response from the bar and a lukewarm response from health care providers.

### Renewed Efforts in the 1990s

In the early 1990s, the release of findings from the landmark Harvard Medical Practice Study (HMPS) (Brennan et al. 1991; Leape et al. 1991; Localio et al. 1991), which provided new insights about the epidemiology of medical injury and malpractice claiming, sparked a fresh round of policy discussions about establishing an administrative compensation system for medical injuries. It also fueled further academic work to develop the concept (Tancredi and Bovbjerg 1991; Weiler 1993). Commissioned by the State of New York and funded by the Robert Wood Johnson Foundation, the HMPS involved a review of hospital records; its key findings were that medical injuries were common in inpatient care, yet more than nine in ten of those caused by negligence did not result in a malpractice claim. Paradoxically, many claims that were filed did not appear to involve harmful negligence (Localio et al. 1991).

Organizations of both plaintiffs' lawyers and physicians seized on these findings as support for their time-honored positions: the lawyers asserted that the study demonstrated that far too many instances of malpractice went uncompensated; physicians argued that it highlighted the litigation system's arbitrary nature and inability to distinguish negligent from non-negligent injuries. The Harvard researchers concluded that these failures necessitated a fundamental rethinking of how medical injuries ought to be compensated and urged consideration of an administrative no-fault model (Weiler et al. 1993).

Some policy makers listened. Most notably, the researchers' recommendations prompted the development of an alternative medical injury compensation plan in New York, led by the state health commissioner, Dr. David Axelrod, who had been a prime architect of the HMPS (Manuel 1990). Under Axelrod's proposal, instead of litigating in the courts, patients injured by medical treatment would submit claims to an independent panel, similar to the state workers' compensation board. The system was to be financed in the same way as the existing liability system—through liability insurance premiums paid by physicians and hospitals (HMPS 1990; Sack 1990a).

Axelrod first unveiled the proposal in January 1990 (Sack 1990b). The Medical Society of the State of New York responded positively, but attorney and consumer advocates immediately rejected it (Vibbert 1990). The Alliance for Consumer Rights, the public-affairs unit of the New York State Trial Lawyers Association, characterized it as "a license to kill and maim helpless patients" (Feiden 1993), and other consumer representa-

tives suspected that the proposal would “create a smokescreen designed to obscure public scrutiny of the state’s failure to protect patients in New York hospitals from sloppy and incompetent medical providers” (Knox 1990a). The trial bar also worried that “doctors and hospitals that kill and maim aren’t going to be held accountable” (Knox 1990b). In the face of this heated opposition, Axelrod’s proposal never took legislative form.

The then-governor of New York, Mario Cuomo, did not take a position on the proposal, but he subsequently advanced proposals of his own in 1991, 1992, and 1993 to implement a program, like the Florida and Virginia programs, for compensating birth-related injuries (Sack 1991; Lyall 1993). Although more limited in size and scope than Axelrod’s plan, Cuomo’s plan garnered little support. The New York State Trial Lawyers Association disputed that more infants would be eligible for compensation under the plan and asserted that taking away the right to jury trial would “victimize New York’s most helpless citizens” (Sack 1991). Previous concerns that a no-fault program would reduce health care providers’ accountability were also echoed by consumer groups such as the New York Public Interest Research Group (Lyall 1993). The state medical society objected to the proposal in a late iteration, on the basis that proposed assessments would cost physicians more than the program would save them in liability insurance premiums.

In the early 1990s, with the 1980s tort crisis having ebbed, consortia of liability insurers, physician leaders, and hospital administrators in Utah and Colorado became interested in developing a plan for experimentation with no-fault compensation for medical injury. To determine the costs of shifting to such a model, the consortia sought information about the incidence and costs of medical injury. The applicability of the HMPS findings in New York to the mountain states was unclear.

A group of investigators based at the Harvard School of Public Health, several of whom had participated in the New York study (and one of whom is an author of this article), took on the project, once again with support from the Robert Wood Johnson Foundation (Robert Wood Johnson Foundation 2002). Using a similar methodology to the New York study, the Utah-Colorado Medical Practice Study produced strikingly similar findings regarding the prevalence of medical injury (Thomas et al. 2000; Studdert et al. 2000). The study also estimated the budget for a program that would compensate injuries based on their avoidability, a compensation standard used in the medical injury compensation systems in several Scandinavian countries. The calculations suggested that many more injuries could be compensated for roughly the same amount as was

then expended on the states' malpractice systems, because of savings in administrative costs and lower average payments per compensated claim (Studdert et al. 1997; Studdert and Brennan 2001; Thomas et al. 1999).

The consortia used the findings to consider how a limited pilot project of administrative compensation might be established in their respective states (Mello and Brennan 2002). Under the proposal developed in Colorado, a workers' compensation–style system would have been established. In Utah, the Utah Alliance for Health Care, a nonprofit coalition of health care providers and others, developed a plan for creating what it termed "liability enterprises" which would have compensated injured patients in an expedited administrative process (Ceniceros 1994; Wagner 1996, 1997). Notwithstanding substantial discussion and interest, both proposals ultimately failed to take flight.

A major factor contributing to the demise of these proposals appears to have been the lack of any sense of a crisis in malpractice insurance in the mid-1990s (i.e., a problem stream). Many had braced for such a crisis at this time, but it never came. Insurance was widely available and premiums were relatively stable, creating little demand for far-reaching reform. Certainly, by the time the Harvard research findings were published, the political climate had shifted, and any sense of urgency among stakeholders for fundamental change had evaporated. In short, although a policy stream might have existed, the problem stream did not. With no sense of urgency, there was little motivation for political leaders to act on these proposals.

### Summary: Enabling and Inhibiting Factors

This history illuminates several factors that have facilitated adoption of far-reaching reforms to the tort liability system in the context of workplace injuries, automobile insurance, and vaccine injury compensation. In the case of workers' compensation, the main factors were (1) mutual recognition of dissatisfaction with the existing liability system by both of the major stakeholder groups in workplace injury policy—business and labor; (2) the perception on the part of both groups that shifting to a no-fault system would be advantageous to them in some important respects; and (3) general agreement over the basic parameters of the new system, especially the standard for determining eligibility for damages. In the case of automobile insurance, the primary enabling factor was, similarly, widespread recognition that a problem existed along with public demand for change. The predominant factor inhibiting the adoption and continued

utilization of these programs was and has remained the political compromises necessary to gain passage of no-fault legislation, which has been a factor in limiting the programs' ability to deliver promised cost savings. Finally, in the case of vaccine injury compensation, a wholesale shift to administrative compensation was spurred by (1) a perceived crisis with important potential health implications; (2) demands for specific reforms by the two major stakeholder groups that, although not identical, did not conflict irreconcilably with one another; (3) the federal government's willingness to act decisively and accept financial responsibility for the compensation program; and (4) the program's unusual, cost-spreading financing scheme, which did not represent an offensive "tax" on any one of the major players.

The history of these other administrative compensation initiatives also suggests a number of factors that may explain why no-fault proposals for medical injury compensation did not succeed in the 1970s, 1980s, or 1990s. First, the two major stakeholder groups, health care providers (along with their insurers) and attorneys, did not share a common view of the flaws of the existing liability system. Whereas in the case of workers' compensation and vaccine injury compensation the stakeholder groups had, at least to some degree, a common interest in rectifying a mutually perceived deficiency in the status quo, in the case of medical injury compensation, the stakeholders did not agree on the existence or nature of the policy problem. Providers complained that litigation was too frequent and too costly, whereas attorneys pointed out that most injured patients did not sue and received no compensation. From the trial bar's perspective, the problem was not that there was too much malpractice litigation, but that there was too much malpractice—and a strong tort deterrent signal was the best weapon available for trying to combat it. In summary, the stakeholders had very different perceptions of the existing liability scheme and very different visions for its future. This inhibited the consensus that facilitated adoption of other administrative compensation programs.

Second, none of the stakeholder groups saw a shift to a no-fault system as offering them a significant advantage relative to the status quo. Workers' compensation and vaccine injury compensation programs (and, to some extent, automobile no-fault programs) all offered a quid pro quo to each of the major players in the policy debate and were perceived by most groups as doing so. In contrast, no group was strongly enthusiastic about no fault for medical injuries. It involved a near-certain loss of income for attorneys, whose role in the new system would be greatly diminished. It also presented financial risks for health care providers and insurers,

because the compensation standard would change to an untested alternative (such as preventability or avoidability), with resultant expansions in claims volume that could be modeled and estimated, but ultimately were much more uncertain than the next year's exposure in the tort system. Thus, there was neither consensus that moving to administrative compensation would be mutually beneficial nor an interest group that stepped forward to strongly champion the proposal.

Third, there was no broad agreement about what the basic parameters of an administrative compensation system for medical injury should look like. For workers' compensation and vaccine injury compensation, there was a general consensus about what the basis for eligibility in the new system should be: claimants would have to show causality but not fault. But for medical injuries, even those who favored the concept of administrative compensation disagreed about the liability standard: the AMA wanted a fault-based system, for example, while others favored no-fault. Even in the case of the birth injury funds, in which legislation was successfully adopted, there were battles before and after adoption over issues such as how the system would be financed. (In contrast, this source of tension was removed by the federal government in the case of the vaccine injury fund.) These disagreements contributed to a death by a thousand arrows of administrative compensation proposals for medical injuries.

Finally, although proposals for administrative compensation for medical injuries gained currency during the successive malpractice insurance crises, proponents were not able to capitalize on the atmosphere of crisis in the way that advocates of, for example, the vaccine injury fund were. In the vaccine case, it was widely recognized that the crisis—manufacturers' threats to stop making childhood vaccines for the U.S. market—presented a clear and present danger of serious health impacts. In contrast, it was never clearly established that the malpractice insurance crises would have palpable impacts on the availability or quality of health care. (Indeed, to the extent the public has any opinion on the issue, it may be that the malpractice crisis will weed out poor performers.) Health care providers certainly strove to make the case that the system was in crisis, but they did not entirely succeed (indeed, this remains a subject of fierce political debate today). As a result, the public demand and sense of political urgency that earlier reformers had been able to muster did not emerge. In addition, the malpractice crises appeared to be essentially self-correcting within a few years' time (as has, in many respects, been the case in recent years), and the impact they had varied substantially from state to state. Thus, to the extent a sense of urgency prevailed, the considered propos-

als that it inspired did not come until the clamor for action had already begun to dissipate. In sum, proposals for administrative compensation for medical injury experienced many inhibiting factors and very few enabling forces in the late twentieth century.

### **Administrative Compensation and Patient Safety in the New Century**

The confluence of several factors has led proposals for administrative compensation systems to bloom once again in the past several years. First, the dawn of a third malpractice crisis at the turn of the twenty-first century (the problem stream) has again sent policy makers searching for solutions to the high costs and volatility of the liability insurance market (the policy stream). This crisis has been particularly deeply felt by health care providers because it has involved problems with both the availability and affordability of insurance and has arisen in a reimbursement environment in which providers have relatively little power to negotiate higher prices to cover their increased overhead (Pauly et al. 2006). Providers' distress has led to intense advocacy efforts to secure passage of additional tort reforms and extensive efforts to engage the public in the issue (the political stream). These efforts have included highly visible measures such as physician rallies in state capitols as well as more systematic strategies, such as physician surveys, to attempt to demonstrate that the crisis is forcing physicians out of practice and threatening patient access to care.

As in previous crises, physicians' and insurers' efforts, and the lion's share of policy attention, have focused on passage of MICRA-style reforms. Again, however, such proposals have been strongly opposed by trial lawyers and consumer groups. In part due to the faltering of damages caps proposals in many legislatures and in part due to growing recognition that caps address only one of several problems with the tort liability system, attention has shifted in some parts of the country to alternative proposals, including administrative compensation.

The second major force on the scene today is the substantial level of public awareness of and political mobilization around patient safety issues (Mello et al. 2006). Data from the Utah-Colorado study helped to inform a series of highly influential reports by the IOM about the poor state of quality and safety in the U.S. health care system, beginning with the landmark 2000 report, *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, and Donaldson 2000). The IOM's findings have stressed the role of health care systems in contributing to medical errors and inju-

ries, challenging the traditional focus of the tort law on the role of individual doctors' negligence. Indeed, in a later report, the IOM explicitly recommended experimentation with administrative compensation systems on the basis that they would be better able to channel compensation to patients whose injuries could not be neatly traced to the acts of a lone physician and to hold institutions accountable for the harms caused by poorly designed systems of care (Corrigan, Greiner, and Erickson 2002). Additionally, replacing negligence with a less punitive liability standard would, the IOM said, address the tendency of health care providers to submerge information about errors out from fear of the legal consequences (ibid.). "There is widespread agreement," the IOM stated, "that the current system of tort liability is a poor way to prevent and redress injury resulting from medical error" (ibid.: 82). The IOM's reports have generated considerable publicity (Millenson 2002; Leape 2000), raising the public profile of patient safety and its connections to the liability system.

These combined forces—and the intersection between the problem, policy, and political streams—have provided a foundation for legislative action on the health court proposal and related schemes of administrative compensation for medical injury. In the 108th, 109th, and 110th Congresses, bills have been introduced in both houses that would provide funds for states to experiment with alternative compensation approaches such as health courts (Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. [2005]; Medical Liability Procedural Reform Act, H.R. 1546, 109th Cong. [2005]; Reliable Medical Justice Act, S. 1518, 108th Cong. [2003]). In 2007, bipartisan House and Senate bills were introduced in Congress that would support state demonstration projects of alternative approaches to resolving medical liability disputes (Fair and Reliable Medical Justice Act, H.R. 2497 and S. 1481, 110th Cong. [2007]). Additionally, legislation has been introduced in a number of states to develop alternative approaches for resolving medical malpractice litigation (Common Good 2007). Although there is considerable variation in specific elements of these proposals, they generally propose to create a specialized approach for resolving injury disputes, with specialized adjudicators, links to patient safety initiatives, and expedited proceedings for resolving injury disputes. Proposals for specialized state birth injury compensation systems have also resurfaced in a number of states. For example, the birth injury proposal that had been floated a decade earlier by Governor Cuomo was revived in New York in 2003 but again failed to find a footing (Satow 2003).

The political environment surrounding administrative compensation

proposals continues to evolve, and the prospects for their passage remain uncertain. However, it is possible to identify some distinctive features in the policy landscape that will be important in shaping the debate in the years to come. In particular, the positions of health care providers, their insurers, the trial bar, and consumer groups are in many ways clear.

Physicians have generally been warm to the health court proposal, and a number of national and state medical professional organizations have endorsed it in one way or another and/or called for demonstration projects (American College of Obstetricians and Gynecologists 2006; American College of Emergency Physicians 2006; Massachusetts Medical Society 2006; Twanmoh 2006). Still, as a general matter, provider organizations have been far more focused on enacting a federal cap on noneconomic damages and securing passage of other conventional tort reforms (all of which are perceived to drive down liability insurance premiums) than on fundamentally reforming the medical liability system (AMA 2007). Liability reform was a top national priority for organized medicine when the Congress was Republican led and federal tort reform seemed within reach. Under today's Democratic Congress, however, federal liability reform has dropped farther down on the agenda of most provider groups, given that passage of a federal bill now seems highly unlikely. To the extent that interest in tort reform remains, there is somewhat greater openness to consideration of alternative reform proposals such as health courts, particularly in states in which caps proposals have faltered or in which caps have passed but have failed to prevent problems in the liability environment.

As was the case with past iterations of administrative compensation proposals for medical injuries, physician organizations have reservations about the potential for increased costs associated with a broader liability standard and prefer negligence-based liability systems (*ibid.*). Not all physician organizations share the same goals or perspectives; some physicians embrace the idea of compensating more patients (National Physicians Alliance n.d.), but most worry that compensating far more patients could dramatically increase the total costs of the system (and their liability insurance premiums).

On the whole, physicians are highly supportive of efforts to enhance patient safety. The devil is in the details, however, and physicians tend not to be keen on initiatives that could reduce professional autonomy (Leape and Berwick 2005), expand mandatory reporting of information about adverse events (Altman 2000), or make such information available to the public (Guglielmo 2005; Murphy et al. 2007). They have expressed concerns that an administrative compensation system might entail one or

more of these (AMA 2007). Overall, it is very likely that most quarters of organized medicine would prefer a fault-based administrative health court—akin to the late-1980s AMA proposal described earlier—to a no-fault system.

Generally, the interests of physicians and hospitals are closely aligned when it comes to liability reform. For example, the hospital community, like physician organizations, has been a strong proponent of federal tort reforms that would limit noneconomic damages (Lee 2004). However, physicians' and hospitals' interests can diverge on some issues, such as reforms that would shift the allocation of liability between physician and hospital defendants (Sage 1997). To the extent that some versions of administrative compensation proposals contemplate greater enterprise liability, they could also pit hospitals against physicians.

Even hospitals that support the broad goals of increasing patient access to compensation, reducing adversarialism in the compensation process, and bringing the liability system more in line with patient safety initiatives, which advocates claim could be advanced by the health court proposal, will likely resist reforms that threaten to increase their liability exposure. Still, a number of hospitals have expressed strong interest in experimenting with a health court demonstration project (Common Good 2006a). In one way or another, hospitals interested in the proposal tend to have a high degree of control over risk-management practices as a result of captive insurance arrangements.

Hospitals' insurance entities must buy in as well, however, and this can be a harder sell. The predominant question for insurers is what degree of financial risk the health court proposal presents. The prospect of a greatly expanded base of patients eligible to recover compensation under the new liability standard is fearsome, notwithstanding the possibility that, as envisioned by advocates, the average award size would be considerably lower than in the tort system, as would overhead costs (Mello et al. 2006).

Liability insurers are not a monolithic group, and they take a range of viewpoints on the health court proposal. Some are more oriented toward experimentation with innovative initiatives to manage risk and improve patient safety than others (Gallagher, Studdert, and Levinson 2007; Robert Wood Johnson Foundation 2006); some are better capitalized or have a stronger market position, and consequently are able to take on riskier ventures than others; and some operate in more troubled tort environments than others. Although there may be some openness in the insurance community to exploring health court pilots (Smarr 2006), insurance lead-

ers who seek to convince their boards to participate must surmount these facts: few injured patients file claims (HMPS 1990), and defendants win about four in five cases (Studdert et al. 2006). This creates not inconsiderable inertia for insurers to hold fast to the status quo, particularly for those entities in states with relatively placid tort environments.

The position of the legal profession (especially the trial bar) on the health court proposal is abundantly clear and unlikely to change. It has emphatically rejected the proposal, criticizing it as unconstitutional, unfair to patients, and likely to erode any incentive that physicians have to be careful in rendering health care services (Niro 2006; American Bar Association 2006; American Association for Justice 2007; Mehlman and Nance 2007). As with other stakeholders' perspectives, this position likely reflects both philosophical and self-preservation principles. Plaintiffs' attorneys feel a deep ideological attachment to the jury system and believe strongly in its fundamental fairness and effectiveness (Smith 2005; New York Personal Injury Law Blog 2007). They harbor suspicion of administrative processes on the basis of perceived vulnerability to being captured by business interests. They also express concerns about the loss of deterrent signal that a shift to no fault would entail (Mehlman and Nance 2007; Doroshov 2006). In addition, attorneys on both the plaintiff and defense side have a financial stake in maintaining the present system, with its heavy reliance on attorney involvement and generous contingency fees (Carter 2006).

Consumer organizations have diverse views on the health court proposal. Some groups appreciate the potential of a health court system to expand compensation to injured patients and facilitate enhancements in patient safety (Common Good 2005, 2006b; Consumers Advancing Patient Safety 2007; Medically Induced Trauma Support Services 2007). Generally, groups with a direct interest in patient safety and health care quality tend to be quite supportive of the health court proposal, viewing it as an attractive alternative to damages caps and other traditional tort reforms that aim to limit providers' liability costs without offering patients anything in return. Other consumer groups (Center for Justice and Democracy 2006; MacCleery 2007; Alliance for Justice 2006), particularly those with ties to the trial bar (People Over Profits n.d.), criticize the health court proposal as unfair to patients, damaging to medical injury deterrence, and little more than a backhanded effort to limit noneconomic damages. The idea that the jury system best serves injured patients' interests is very strongly held among these groups.

As discussed earlier, stakeholder consensus is a key ingredient in promoting political change. Although insufficient consensus may make the core administrative compensation proposal too transformative a shift to be implemented in toto, there may well be more incremental variants of the proposal that can gain greater consensus and political traction. For example, one might well envision a voluntary administrative compensation system set up in conjunction with participating providers or insurers into which patients could opt, either through an agreement executed at the initiation of a treatment relationship or through the subscriber agreement between patient and health plan. Properly constructed, such an initiative might facilitate the kinds of patient safety initiatives contemplated in the core health court model without generating the legal issues raised by a program of mandatory jurisdiction (Mello et al. 2008). Such a program might allow for compensation of injuries below the levels at which recoveries can be made in the context of the tort system. In addition, to the extent that such an initiative was government chartered, participation from providers might be encouraged by providing a government stop-loss or subsidized reinsurance for losses above a certain level. An initiative like this might also be created through the Medicare program, as has been outlined at some length in the academic literature (Sage 2004, 2006; Kinney and Sage 2005).

Looking across the political landscape, several general observations can be ventured at this point. First, attorneys' strong interest in maintaining the status quo means that health court proposals, like many administrative compensation proposals before them, will continue to face vigorous opposition from a well-resourced, highly articulate, and politically influential group. Clearly, such opposition is not an absolute bar to the passage of tort reforms—if it were, far fewer states would have adopted traditional tort reforms such as caps, and previous administrative compensation proposals would not have passed. However, it does create a tough row to hoe for reform advocates. This is especially true given that policy makers in states in which health care providers have politically overpowered the trial bar are more likely to seek to pass or protect conventional tort reforms such as caps than to support far-reaching and uncertain proposals like the health court proposal. It can be anticipated that opponents of administrative compensation proposals for medical injury will continue to argue that such proposals are unconstitutional in any form, that the promised impacts on patient safety are illusory, and that the current jury-based system performs well in getting equitable compensation to injured patients. In the

face of such opposition, policy makers can be expected to face pressures to make compromises to any legislation that would implement some form of a health court, such as jettisoning the avoidability standard for compensation or the exclusivity of the remedy. The experience of automobile no-fault insurance demonstrates that such compromises may well have an impact on whether or not the promised goals of the reform are met.

Second, as during earlier periods in which administrative compensation for medical injury received policy attention, there is a lack of agreement among the key stakeholder groups about whether the current liability system is flawed or in crisis and what reforms are most attractive. The current system's high administrative costs, protracted proceedings, inequities in compensation, and limited impact on patient safety do provide a basis for continued policy attention to medical liability. Yet, in debates over tort reform in many legislatures over the past several years, advocates for and against reform have often employed overstated rhetoric about the malpractice crisis, relying on questionable analyses to make pronouncements about the impact of traditional reforms such as caps (Mello 2006). One can expect a similarly polarized debate in the consideration of alternative reform proposals such as the health court proposal.

Finally, there is a broad consensus today that patient safety should be a key driver of health care policy, and a widespread (though not universal) acceptance of the proposition that the liability system can be an important player in supporting and providing incentives for safety improvement. There is particular interest in initiatives that promote disclosure of adverse events. To the extent that administrative compensation proposals are to grow as a politically viable idea around which stakeholder consensus can be built, demonstration of patient safety benefits will remain critically important. We have suggested elsewhere that these benefits may include the potential for improved reliability of decision making, which strengthens the deterrent signal sent to health care providers (Mello et al. 2006); the potential to build a database of claims information that can be analyzed for purposes of studying how injuries occur and how they might be prevented; and the potential to send stronger financial incentives to hospitals to engage in safety improvement (especially to the extent to which compensation can be experience rated). Of course, stakeholder perspectives will likely vary in respect to their confidence that the administrative compensation proposal can realize these goals.

## Conclusion

The experience with administrative medical injury compensation proposals over the past three decades suggests that the political barriers to fundamental system reform are strong indeed. Continuing challenges include the energetic opposition of the trial bar and the cautious response of health care providers to proposals that might lead to an increase in insurance costs. With continued outreach, advocacy, and empirical research, the chances are good that administrative compensation proposals will continue to generate attention and interest from policy makers, interest groups, and the public. However, the diverse histories of workers' compensation, automobile no fault, and vaccine injury compensation initiatives show that administrative remedies are more likely to be established through the political process when broad stakeholder coalitions demand that policy makers take action and when reformers can demonstrate that the new system will carry advantages for all major stakeholder groups.

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