

THE ROLE OF INSURANCE IN COMPENSATION FOR MEDICAL INJURIES SINCE THE KOUCHNER ACT

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INTRODUCTION

In 2002, the French legislature reformed the country's medical liability law with the Kouchner Act (formally called the Act of March 4, 2002).¹ This reform was the result of an assessment that liability law and private insurance as they then stood had been inadequate to compensate all victims with legitimate claims.²

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† Translations are the author's unless otherwise noted. Some of the sources cited in this Article were unavailable for review by the *Drexel Law Review* but have been verified by the author.

1. Loi 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé [Law 2002-303 of March 4, 2002 on Patients' Rights and Quality of the Health System], JOURNAL OFFICIEL DE LA RÉPUBLIQUE FRANÇAISE [J.O.] [OFFICIAL GAZETTE OF FRANCE], Mar. 4, 2002, p. 4118 (Act named after its sponsor, Bernard Kouchner, the Health Minister in 2002); CODE DE LA SANTÉ PUBLIQUE [C. SANTÉ PUB.] [CODE OF PUBLIC HEALTH] art. L. 1142-1.

2. CLAUDE EVIN ET AL., RAPPORT AU NOM DE LA COMMISSION DES AFFAIRES CULTURELLES FAMILIALES ET SOCIALES SUR LE PROJET DE LOI RELATIF AUX DROITS DES MALADIES ET À LA QUALITÉ DU SYSTÈME DE SANTÉ, TITRE I: DÉMOCRATIE SANITAIRE [REPORT OF THE COMMITTEE ON CULTURAL, SOCIAL, AND FAMILY AFFAIRS ON THE BILL ADDRESSING THE RIGHTS OF PATIENTS AND THE QUALITY OF THE HEALTH SYSTEM] ASSEMBLÉE NATIONALE [NATIONAL ASSEMBLY] NO. 3263, at 14-15 (2001), available at <http://www.assemblee-nationale.fr/11/rapports/r3263-11.asp> ("Private insurance could compensate the victim of a medical accident before a determination of who is legally responsible, and the insurer could then seek compensation from the responsible party. But a medical accident is not comparable to a traffic accident, because of the relationship of trust between doctor and patient. Moreover, the relatively high cost of a stand-

In the years leading up to the reforms, significant developments in case law had improved the rights of injured patients considerably. Patients could be compensated whenever surgeons made even minor mistakes and also for harm due to hospital-borne infections regardless of whether fault existed.³ In addition, the famous *Perruche* case held that there is a right to compensation for “wrongful birth,” a situation in which a clinician negligently fails to report to a pregnant woman that her fetus has congenital defects, thereby depriving the woman of the option of aborting her fetus and requiring her to bear the extra cost of caring for a child with severe disabilities.⁴ Even when the legal system had a compensation program in place, the high amount of financial liability made it very difficult for insurers to pay claims.

For example, the *Perruche* case resulted in a \$4.25 million compensation award (\$1.5 million for the parents, \$2.75 million for the child). In the aggregate, the estimated cost for all similar cases is about \$3.15 billion. In comparison, in 2008, the total premium for liability insurance was about \$620.6 million.⁵ Consequently, the insurance-bearing responsibility for significantly elevated therapeutic risks and adverse outcomes created a need for new funding.

The main objectives of the Kouchner Act were to provide compensation for injured patients—even in the absence of negligence—and to reallocate that burden. Initially, the Kouchner Act intensified the latent tension between providing insurance and increasing liability. For some time, this tension had compromised medical practitioners’ access to insurance and, as a result, compensation for injured patients.

After Parliament passed the Kouchner Act, some insurance companies chose to withdraw from the professional liability insurance

ard ‘life risks’ policy that covers such therapeutic risks can deter the development of a wider market; and insurers have always opposed assuming the risk for an uncreditworthy market segment. *The strong and legitimate claim of compensation for non-negligent accidents finds its answer in the expression of national solidarity.*”) (emphasis added) (unofficial translation).

3. Philippe Pierre, *L’indemnisation de l’aléa thérapeutique* [Compensation for Therapeutic Hazards], in LAMY DROIT DE LA RESPONSABILITÉ [LAMY LIABILITY LAW] 410, 410 (2010); Cour de cassation [Cass.] [supreme court for judicial matters] 1e civ., June 29, 1999, Bull. civ. I 1999, No. 97-21903; Cass. 1e civ., June 29, 1999, Bull. civ. I 1999, No. 97-14254 (discussing hospital-borne infections).

4. Cass. ass. plén., Nov. 17, 2000, Bull. civ. 2000, No. 17 99-13.701; see also Brigitte Feuillet, *The Perruche Case and French Medical Liability*, 4 DREXEL L. REV. 139 (2011).

5. Nicolas Gombault, *Repenser l’assurance de la responsabilité médicale après la crise* [Rethinking Medical Liability Insurance After the Crisis], REV. LA JAUNE ET LA ROUGE, [YELLOW & RED REV.], May 2011, at 20. The statistics reported in U.S. dollars were calculated using the exchange rate of €1 = \$1.45.

market, claiming that the expansion of injured patients' rights to compensation made it unattractive. But it appears that this was pre-textual. Several insurers unofficially said that professional liability insurance had not been historically profitable⁶ and that managing the inherent legal risk was difficult. Both the official and unofficial responses of insurers were a form of lobbying for state intervention to reduce their exposure. Insurers wanted the state to bear some of the risk of medically adverse outcomes in the name of social solidarity.⁷

The insurers were partially successful. Soon after the Kouchner Act's enactment, the governing parliamentary majority changed. On December 30, 2002, the new majority passed legislation that revised the Kouchner Act.⁸ The Revised Kouchner Act transferred a lot of payments to a Public Guarantee Fund,⁹ previously created by the Kouchner Act, and shifted responsibility for compensating many injuries to the Fund.¹⁰

Nine years of experience enable one to appraise the effects of these reforms on insurance and compensation. However, to understand the present system, it is necessary to be familiar with another part of the Kouchner Act. The Kouchner Act created an option for injured patients to seek compensation via Alternative Dispute Resolutions (ADR) channels using new government-created Conciliation Commissions (CRCI) overseen by the Public Guarantee Fund.¹¹

Patients can seek compensation through regional Conciliation Commissions prior to seeking compensation through lawsuits. The

6. YVONNE LAMBERT-FAIVRE & STÉPHANIE PORCHY-SIMON, *DROIT DU DOMMAGE CORPOREL: SYSTÈMES D'INDEMNISATION* [INJURY LAW: COMPENSATION SCHEMES] 626 (6th ed. 2009) ("Premium increases that set off the crisis in 2002 were much less related to objective factors of medical claims than financial factors of the insurance industry.") (unofficial translation).

7. For a discussion of the French concept of solidarity, see Dominique Thouvenin, *French Medical Malpractice Compensation Since the Act of March 4, 2002: Liability Rules Combined with Indemnification Rules and Correlated with Several Kinds of Proceedings*, 4 DREXEL L. REV. 165, 192-93 (2011).

8. Loi 2002-1577 du 30 décembre 2002 relative à la responsabilité civile médicale [Law 2002-1577 of December 30, 2002 on Medical Civil Liability], J.O., Dec. 30, 2002, pp. 22100-21102. I refer to this law throughout this Article as the Revised Kouchner Act.

9. The French name for the Public Guarantee Fund is the *Office National d'Indemnisation des Accidents Médicaux, Affections Iatrogènes et des Infections Nosocomiales* (ONIAM). The literal translation is the National Fund for Compensation of Medical Accidents, Iatrogenic Injuries, and Nosocomial Infections. However, I refer to it as the Public Guarantee Fund throughout this Article.

10. See *infra* Part II.

11. The French name for CRCI is *Commissions Régionales de Conciliation et d'Indemnisation des Accidents Médicaux*. See *Présentation, Indemnisation du Risque Médical par la Solidarité Nationale*, <http://www.oniam.fr/crci/presentation> (last visited Dec. 8, 2011).

Conciliation Commissions assess each case and render an advisory opinion as to whether the patient is entitled to compensation. The opinion specifies whether private insurance or the Public Guarantee Fund should pay the compensation.

However, the Conciliation Commission's opinion is not binding. It is up to the insurer whether or not to offer a settlement payment. If the insurer makes a settlement offer, the patient decides whether to accept the payment as full compensation. Patients have the right to reject settlement offers that they do not find satisfactory, and they are then permitted to sue for damages. Patients can also sue for damages if a Conciliation Commission opines that the patient has no grounds for compensation.¹²

These Conciliation Commissions process over 3000 cases a year.¹³ Today, it remains unclear whether the number of claims currently processed by Conciliation Commissions is a figure representative of the number of cases which would have otherwise been brought direct to suit or if the availability of Conciliation Committees has increased the overall annual number of claims. It appears that the total number of 2010 claims, through both the Conciliation Commissions and the courts, represents a moderate increase compared to the number of claims, but we are awaiting more reliable data.¹⁴

At first sight, the Kouchner Act is not revolutionary, only an evolution toward more public guarantees and less litigation. This legislation has modified the role of private insurance in the compensation of medical injuries while creating access, under certain condi-

12. Between the years 2006 and 2009, of the 4082 cases with an amount of compensation greater than or equal to \$22,500, 70% (2875) were settled through Conciliation Commissions, and 30% (1207) through the courts. See OFFICE NATIONAL D'INDEMNISATION DES ACCIDENTS MÉDICAUX [NATIONAL OFFICE FOR COMPENSATION FOR MEDICAL ACCIDENTS], RAPPORT D'ACTIVITÉ 2010 [2010 ACTIVITY REPORT] 14 (2011) [hereinafter 2010 REPORT], available at <http://www.oniam.fr/IMG/rapportsoniam/rapport2010.pdf>. Eighty percent of Conciliation Commissions filings received advisory opinions; for cases settled through the judicial process, only 6% had previously received a CRCI advisory opinion. *Id.* In general, victims refused only 3.7% of offers in 2009; thus, most disputes stem from insurers. See OFFICE NATIONAL D'INDEMNISATION DES ACCIDENTS MÉDICAUX, RAPPORT D'ACTIVITÉ: 2ÈME SEMESTRE 2009 [ACTIVITY REPORT: SECOND HALF OF 2009] 10 (2010) [hereinafter 2009 REPORT], available at <http://oniam.fr/IMG/rapportsoniam/RapportOniam2009sem2.pdf>.

13. For the second half of 2009, 1752 requests were lodged with the CRCI. See 2009 REPORT, *supra* note 11, at 4.

14. In France, there are about 2000 medical malpractice suits per year. Compare 2010 REPORT, *supra* note 11, at 6 (reporting that in 2010, there were 4117 requests for payment through Conciliation Commissions), with OFFICE NATIONAL D'INDEMNISATION DES ACCIDENTS MÉDICAUX, RAPPORT D'ACTIVITÉ DE L'ONIAM POUR LE 2ÈME SEMESTRE 2004 [ACTIVITY REPORT FOR ONIAM FOR THE SECOND HALF OF 2004] 24 (2005), available at <http://oniam.fr/IMG/rapportsoniam/RapportOniam2004sem2.pdf> (reporting that in 2004, there were 3553 cases).

tions, to a new Public Guarantee Fund in the name of national solidarity.

I. THE ROLE OF PRIVATE INSURANCE IN COMPENSATION OF MEDICAL INJURIES

Medical liability insurance is involved in all cases where a practitioner or health care institution is declared liable, most typically when medical errors have occurred. There was a crisis between 2002 and 2006, resulting in insurers either exiting the market or substantially increasing premiums.¹⁵ The clearest example was for obstetricians who for some time risked losing access to even the most basic liability coverage. I will examine this initial crisis before turning to the current, and hopefully stabilized, situation.

A. *The Initial Crisis*

The Kouchner Act did not really alter the terms of medical liability. Rather, it alleviated the risk borne by insurers by transferring the burden for some serious injuries from private insurance to a Public Guarantee Fund. For example, private insurers are no longer responsible for compensating harm in *Perruche*-type cases.¹⁶ Nevertheless, private insurers were apprehensive about the new system and withdrew from the market for four reasons.

First, the Kouchner Act required that all providers and medical facilities carry liability insurance. Until then, even though most providers purchased policies, they were not required to do so. One might have thought that insurers would have welcomed the creation of a captive market. In fact, compulsory insurance presented a major drawback. It required insurers to bear the burden of covering high-risk physicians, whom they had previously rejected. Although insurers may reject selling insurance to high-risk physicians, after a physician has been denied coverage twice, she or he can refer the matter to the Central Indexation Bureau (BCT),¹⁷ an organization made up of representatives of both insurers and the insured. The

15. YVONNE LAMBERT-FAIVRE, LA CRISE DE L'ASSURANCE RESPONSABILITÉ CIVILE MÉDICALE [THE CRISIS OF MEDICAL LIABILITY INSURANCE] 142 (2003).

16. Cf. *infra* Part II.

17. The French name for BCT is the *Bureau Central de Tarification*. See Laurent Leveneur, *L'intervention du Bureau Central de Tarification en matière d'assurance responsabilité civile médicale* [The Intervention of the Central Indexation Bureau Regarding Medical Liability Insurance], *REVUE DE DROIT SANITAIRE ET SOCIAL* 59 (2010).

BCT then determines a higher-than-average premium for the physician but requires the insurer to underwrite the policy. The insurer has no option to deny coverage because if it does not follow the decision of the Bureau, it can lose its license to sell insurance, which would put the company out of business.¹⁸ Therefore, many companies exited the market as a precaution.

Second, insurers believed that the Kouchner Act stacked the cards against them. They noted that insurers were underrepresented on the twenty-one member Conciliation Commissions, having only two representatives, whereas patients associations had six.¹⁹ They also thought that Conciliation Commissions would increase the number of claims in addition to those filed in the courts. Furthermore, they objected to being liable for a 15% penalty to be paid to the Public Guarantee Fund if they did not follow a Conciliation Commission recommendation that they pay a claim, or if they paid less than the amount recommended, and a court later ruled in favor of the patient.²⁰

Third, and probably most important, the professional liability insurance market is highly segmented by specialty. There exists no spreading of risk across practice specialties and the medical facilities. Therefore, premiums for general practitioners—the group with the lowest risk and containing the largest number of practitioners—have been stable or even reduced over the past decade. However, when there are serious accidents in obstetrics-gynecology, for instance, premiums for obstetricians will rise, but premiums of other medical specialties are unaffected.²¹

18. CODE DES ASSURANCES [C. ASSUR.] [INSURANCE CODE] art. L. 321-1; C. ASSUR. art. L. 310-2. Companies mentioned in Article L. 310-2 can start their operations only after obtaining official authorization issued by the supervisory authority mentioned in the CODE MONÉTAIRE ET FINANCIER [C. MONÉTAIRE ET FINANCIER] [MONETARY AND FINANCIAL CODE] art. L. 612-1. However, in regards to the acceptance of reinsurance transactions, such approval is not required. Approval is granted upon submission by the company for the operations of one or more classes of insurance. The company can only perform the operations for which it is approved. C. ASSUR. art. L. 252-2 (any insurance company that maintains its refusal to guarantee the risk whose premium has been set by the central rating office established by C. ASSUR. art. L. 252-1 is considered no longer operating in accordance with the regulations and incurs withdrawal of approvals under C. ASSUR. arts. L. 321-1, 321-7-9).

19. C. SANTÉ PUB. art. L. 1142-5.

20. *Id.* at art. L. 1142-15.

21. LAMBERT-FAIVRE & PORCHY-SIMON, *supra* note 6, at 626. For these authors, segmentation presents an excessive risk and ignores the benefits of pooling. It is not possible to charge only risky specialties (surgeons, anesthesiologists, midwives, and obstetricians) the specific cost of their activities. As an important, but insufficient first step, a bill currently being discussed before the parliamentary assemblies provides that beyond \$11.5 million in damages, there needs to be a mechanism for the pooling of risk and public responsibility for insurance. It would be

Fourth, numerous factors inflated costs and increased the exposure of insurers. According to their statistics, the average damages per case were about \$180,000 in 2002 but exploded to \$384,000 five years later. Such inflation is partly due to the higher success rate of victims. Only 33% of claims against physicians were successful during the 1980s, but more than 68% are today.²² In addition, in 2006 a new system of categories was introduced to describe the types of injuries, impairments, and losses that can be compensated.²³ This system is called the *Dintilhac nomenclature*, named after the high-court judge who established it.²⁴ The new categories provided for higher compensation for injuries that require life-long assistance and help by an attendant.

B. Ways to Stabilize the Situation

Since 2002, insurers, fearful of a massive surge of claims—both in frequency and severity—have successfully lobbied for changes. Parliament and the government enacted reforms, which took several years before their full effect was realized, that at least partially calmed the fears of private insurers. In 2010, only five companies covered more than 95% of the professional liability insurance market.²⁵ This market concentration has two implications: first, these in-

financed by a surcharge of \$14 to \$37 paid by all health professionals. See Proposition de Loi 543 du 24 mai 2011 [Proposed Law 543 of May 24, 2011], Assemblée Nationale, (2011), available at <http://www.senat.fr/leg/pp10-543.html> (amending certain provisions of Loi 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires [Law 2009-879 of July 21, 2009 on Hospital Reform and on Patients, Health Care and Territories], J.O., July 21, 2009, p. 12184).

22. Nicolas Gombault, *La situation de l'assurance de responsabilité médicale* [The Medical Liability Insurance Situation], *REVUE DE DROIT SANITAIRE ET SOCIAL* 51, 53 (2010).

23. Loi 2006-1640 du 21 décembre 2006 de financement de la sécurité sociale pour 2007 [Law 2006-1640 of December 21, 2006 on Financing of Social Security for 2007], J.O., Dec. 22, 2006, art. 25, p. 19315; JEAN-PIERRE DINTILHAC, RAPPORT DU GROUPE DE TRAVAIL CHARGÉ D'ELABORER UNE NOMENCLATURE DES PRÉJUDICES CORPORELS [REPORT OF TASK FORCE WORKING TO DEVELOP CLASSIFICATIONS FOR BODILY INJURIES] 4-5 (2005) [hereinafter DINTILHAC CLASSIFICATION REPORT], available at <http://lesrapports.ladocumentationfrancaise.fr/BRP/064000217/0000.pdf>.

24. DINTILHAC CLASSIFICATION REPORT, *supra* note 22, at 4-5.

25. Gombault, *supra* note 5, at 20. Numerous insurers withdrew from the market including U.S. insurers such as Saint-Paul and ACE. *Id.* Other general insurance companies, such as AXA and AGF, have ceased to be active in the insurance market but retain some presence because of past clients. Sometimes the presence of these companies is due to regulations by BCT after these companies refused to provide insurance. *Id.* See PIERRE-LOUIS BRAS ET AL., L'ASSURANCE EN RESPONSABILITÉ CIVILE MÉDICALE, RAPPORT DE L'INSPECTION GÉNÉRALE DES AFFAIRES SOCIALES [MEDICAL LIABILITY INSURANCE, REPORT OF THE INSPECTOR GENERAL OF SOCIAL AFFAIRS] 10 (2007), available at <http://www.cngof.asso.fr>.

surers are the economically strongest; and second, these companies, for some reason, chose to remain in the market despite the previous difficulties. So, how were they persuaded to remain in the market?

First, the Revised Kouchner Act shifted responsibility from private insurers to a Public Guarantee Fund for the most serious hospital-borne infections—those that cause death or disable a person by 25% or more.²⁶ This change was significant because nosocomial infections are a major public health problem in France; they affect between 500,000 and 800,000 patients per year and result in the death of approximately 4200.²⁷ Furthermore, the Act also shifted responsibility for compensation of costly *Perruche*-type cases from private insurers to the Public Guarantee Fund.²⁸ The idea motivating this change was that these claims should be a national responsibility reflecting social solidarity.

There were also some technical changes. The Act limited the duration of time that private insurers would be responsible for covering claims.²⁹ At the same time, the Act granted individuals a right to file claims even after this period expired—the Public Guarantee Fund pays for claims that are no longer covered by private insurance and also claims that would not have been historically covered by private insurance.³⁰ Thus, the Public Guarantee Fund acts as a public reinsurer of medical risk.³¹

More surprisingly, public authorities arranged for social security to pay part of the premiums for certain high-risk specialties. For example, last year obstetricians' insurance premiums were between \$25,000 and \$38,000 under some conditions, such as being a panel practitioner.³² Social security paid for about 60% of their premiums

26. Loi 2002-1577 du 30 décembre 2002 relative à la responsabilité civile médicale [Law 2002-1577 of December 30, 2002 on Medical Liability], J.O., Dec. 31, 2002, p. 22100; C. SANTÉ PUB. art. L. 1142-1.

27. M. ALAIN VASSELLE, RAPPORT LA POLITIQUE DE LUTTE CONTRE LES INFECTIONS NOSOCOMIALES [REPORT ON BEHALF OF THE PARLIAMENTARY OFFICE FOR HEALTH POLICY AND SUBMITTED TO THE SENATE ON JUNE 22, 2006] (2006), available at <http://www.senat.fr/notice-rapport/2005/r05-421-notice.html>.

28. See Thouvenin, *supra* note 7, at 183.

29. C. ASSUR. L. 251-2. The coverage period cannot be less than five years. See Cristina Corgas-Bernard, *L'assurance de responsabilité civile des professionnels libéraux de la santé* [The Liability Insurance of Independent Health Professionals], REVUE DE DROIT SANITAIRE ET SOCIAL 75 (2010).

30. C. SANTÉ PUB. art. L. 1142-15.

31. Philippe Pierre, *Assurance, responsabilité et santé: réflexions sur une trilogie en devenir* [Insurance, Liability, and Health: Reflections on a Trilogy in the Making], REVUE DE DROIT SANITAIRE ET SOCIAL 7 (2010).

32. C. SANTÉ PUB. art. L. 4135-2.

under \$27,000 (i.e., \$16,500).³³ In effect, the public social security system subsidizes private professional liability insurers. This result unnecessarily and further complicates the issue, leaving the insurers little choice.³⁴ It would have been more logical to use public funds to publicly subsidize and manage the cost of these bad outcomes, especially since the Kouchner Act created a Public Guarantee Fund for certain medical accidents.

All of these measures represent actual State efforts to help private insurers. Additionally, the Revised Kouchner Act authorized the biggest public hospitals – those in Paris and Lyon – to self-insure as they had previously. This allows huge health centers with a real financial base to avoid litigation or patient access to the new ADR process. Their transactions with victims proceed by way of internal processes which may be quicker, and are surely cheaper. Finally, the second part of the Kouchner Act promoted national solidarity by publically insuring the most serious and unforeseeable medical complications.

II. NEW ACCESS TO THE NATIONAL SOLIDARITY FUND

France's new provisions for public compensation of therapeutic hazards do not address all victims' needs and thus still need improvement.

A. *The Contribution of Public Coverage*

The Kouchner Act and the Revised Kouchner Act created a Public Guarantee Fund for certain medical injuries, iatrogenic diseases, and the most serious nosocomial infections.³⁵ This Fund goes far beyond the previously mentioned public subsidy for private insurance.³⁶ It relieves professionals and institutions of liability for certain catego-

33. Décret 2006-909 du 21 juillet 2006 relatif à l'accréditation de la qualité de la pratique professionnelle des médecins et des équipes médicales exerçant en établissements de santé [Decree 2006-909 of July 21, 2006 on the Accreditation of the Quality of Professional Practice of Doctors and Medical Teams Working in Health Facilities], J.O. July 23, 2006, p. 11029; CODE DE LA SÉCURITÉ SOCIALE [C. SÉC. SOC.] [SOCIAL SECURITY CODE] art. D. 185-1.

34. Jérôme Monet, *Assurance responsabilité civile professionnelle médicale: l'initiative privée mise à mal* [Medical Professional Liability Insurance: Private Initiative Undermined], DROIT-MEDICAL (Aug. 31, 2006), <http://www.droit-medical.net/spip.php?article64>.

35. See generally INDEMNISATION DU RISQUE MÉDICAL PAR LA SOLIDARITÉ NATIONALE, <http://www.oniam.fr> (last visited Dec. 8, 2011) (describing the National Office for Compensation for Medical Accidents, Iatrogenic Diseases, and Nosocomial Infections (ONIAM) and the regional commissions of conciliation and compensation (CRCI)).

36. LAMBERT-FAIVRE & PORCHY-SIMON, *supra* note 6, at 843.

ries of bad outcomes and assumes the burden of compensation in these cases itself (i.e., it places the burden on the State).³⁷ Bear in mind, though, that the Fund compensates only bad outcomes that are directly attributable to medical interventions made for the purpose of prevention, diagnosis, or treatment.³⁸ Therefore, there is still a need for judges to determine whether individuals are eligible for compensation per that standard.

The scope of coverage offered by the Public Guarantee Fund has expanded greatly in recent years through both legislation and judicial interpretation.³⁹ It was only last year that legislation entitled all people with AIDS and Hepatitis C infections to public compensation.⁴⁰ Judicial extension of the Fund's coverage comes from new interpretations of the relationship between insured liability and public solidarity. Most recently, a March 11, 2010, decision by the supreme court for judicial matters established a new right to public compensation for injured patients who were not informed of serious risks entailed by interventions (and thus were unable to have given informed consent).⁴¹ In this situation, fault, even if it leads to liability and partial compensation, no longer prevents public compensation for damages uncovered by private insurance.⁴²

Alongside the Public Guarantee Fund lies a parallel system of private insurance which some people argue should be expanded as an

37. See *supra* text accompanying notes 1-13.

38. C. SANTÉ PUB. art. L. 1142-1 II; see also Sabine Gibert, *Les frontières de l'indemnisation du risque sanitaire par la solidarité nationale* [The Boundaries of the Compensation of Health Risk by the National Solidarity], *REVUE DE DROIT SANITAIRE ET SOCIAL* 29 (2010).

39. The global budget in 2010 was approximately \$190 million; in comparison, the budget in 2005 was approximately \$45 million. However, this data must be adjusted considering that actual needs were underestimated when the Public Guarantee Fund began (\$70 million of compensation, judicial, and functioning costs in 2005) and are now overestimated in an effort to keep a tight lid on spending (\$130 million in effective costs in 2010). See *Les contrats GAV en 2010* [GAV Contracts in 2010], FÉDÉRATION FRANÇAISE DES SOCIÉTÉS D'ASSURANCE [FRENCH FEDERATION OF INSURANCE COMPANIES], http://www.ffsa.fr/sites/jcms/p1_516037/les-contrats-gav-en-2010?cc=fn_7353 (last visited Dec. 8, 2011).

40. The legislature acted to address the plight of HIV sufferers in 2004. Loi 2004-806 du 9 août de 2004 relative à la politique de santé publique [Law 2004-806 of August 9, 2004 on Public Health Policy], J.O., Aug. 9, 2004, p. 14277 art. 115-I. The legislature extended social insurance benefits to people infected by Hepatitis C at the end of 2010. Loi 2010-1594 du 20 décembre 2010 de financement de la sécurité sociale pour 2011 [Law 2010-1594 of December 20, 2010 on Financing of Social Security for 2011], J.O., Dec. 21, 2010, p. 22409 art. 65.

41. Cass. 1e civ., Mar. 11, 2010, Bull. civ. I, No. 09-11270.

42. Philippe Pierre & Cristina Corgas-Bernard, *Le défaut d'information et l'accident médical, une articulation délicate* [Lack of Information and Medical Accidents, A Complicated Issue], 74 *REVUE LAMY DROIT CIVIL* 18 (2010).

alternative to public coverage.⁴³ The private system does not insure professionals or institutions for potential liability. Rather, it covers individuals to cover their losses. Individuals can purchase this coverage bundled with insurance that covers other risks of loss, such as to their homes and property.

The goal of this private insurance is to pre-finance compensation. The private insurer has the right to subrogation; it can seek compensation from the party that caused the loss. But the private insurer covers the loss if the party responsible for the harm is not held liable or is unable to pay the judgment. This type of insurance is not widespread because many people think it outrageous to ask victims to pay for access to compensation mechanisms.

The Public Guarantee Fund is mainly financed through social security and taxation. Due to the Public Guarantee Fund, the situation for victims has greatly improved. The fund receives and pays for about 800 cases per year from the Conciliation Commissions, many of which would probably never have been compensated before the reforms.⁴⁴ The Fund is also the administrative keystone of the ADR system; its budget supports the Conciliation Commissions.

The Public Guarantee Fund is subject to many of the same procedures as private insurers. For instance, if a Conciliation Commission concludes there is a bad result that is a public responsibility, the Public Guarantee Fund must offer a settlement within the same time period as would private insurers.⁴⁵ The Public Guarantee Fund does, however, enjoy some privileges.

Unlike private insurers, the Fund is not subject to penalties if it does not make an offer for compensation, makes an inadequate offer, or delays making an offer within the time period required by the Kouchner Act. As noted earlier, if a Conciliation Commission recommends that a private insurer compensate a patient and the insurer delays, does not offer a settlement, or offers less than the Conciliation Commission recommended, then the patient can sue the insurer. If a court finds that the private insurer is liable, the insurer is fined 15% of the amount of settlement that the Conciliation Com-

43. At the end of 2010, there were more than three million policies in force, covering six million individuals through *garantie des accidents de la vie* [life accidents guarantee] contracts. The global amount of premiums was around \$720 million. See *Les contrats GAV en 2010*, *supra* note 38.

44. 2010 REPORT, *supra* note 11, at 7.

45. C. SANTÉ PUB. art. L. 1142-17.

mission originally recommended, payable to the Public Guarantee Fund.⁴⁶

One concern with respect to the Public Guarantee Fund is that it assumes dual and conflicting roles. In particular, the Public Guarantee Fund is represented on the Conciliation Commissions that issue opinions as to whether an injured patient should be compensated and, if so, the amount of payment, even though the Fund may be responsible for paying the compensation. In contrast, private insurers do not take part in Commissions that issue opinions on compensation.

B. *The Need for Improvements*

Current law only provides public compensation for injuries of a certain severity; specifically, (1) injuries resulting in permanent partial disability of more than 24% of an individual's capacity; (2) disability of more than 50% of an individual's capacity lasting longer than six months (but not necessarily permanent); or (3) certain *serious difficulties*.⁴⁷ However, there is no consensus on what constitutes a *serious difficulty*—those who serve on Conciliation Commissions fiercely debate this question.⁴⁸

Many kinds of injuries are not covered by the Public Guarantee Fund because they fall under the requisite severity threshold. In my opinion, this situation will continue due to a lack of public funding. Therefore, individuals still need to purchase private disability insurance, as it compensates for injuries regardless of the cause, and coverage starts at a much lower threshold. Generally, private insurance covers partial disabilities resulting in a loss of 5% to 10% of total capacity.⁴⁹

46. *Id.* at art. L. 1142-15; *see also* Cass. 1e civ., Mar. 31, 2011, Bull. civ. I, No. 10-24547 (holding that such a fine is consistent with the French Constitution because insurers are afforded the opportunity to contest it).

47. C. SANTÉ PUB. art. D. 1142-1.

48. There is no official list of *serious difficulties*; the determination depends on the individual facts of each case. For example, such difficulties can result from the necessity of repetitious surgical operations or from moving to a house better adapted to one's disability or located nearer a doctor's office. *See* FLORENT BLANCO, LA LOI DU 4 MARS 2002 ET LES COMMISSIONS RÉGIONALES DE CONCILIATION ET D'INDEMNISATION: DES ACCIDENTS MÉDICAUX, DES AFFECTIONS IATROGÈNES NOSOCOMIALES: C.R.C.I. 148 (2005) (discussing *serious difficulties*, which constitute 19% of the victims compensated by CRCI).

49. In general, the *life accidents guarantee* of individual insurance contracts covers the consequences of falls, food poisoning, and scalding. If provided for by special terms in the contract, consequences of minor medical injuries may also be covered. HUBERT GROUDEL, ET AL.,

Another problem occurs infrequently but raises a fundamental concern: the Public Guarantee Fund and Conciliation Commissions are part of a single system. Generally, the Public Guarantee Fund provides compensation when a Conciliation Commission issues an opinion recommending compensation. However, the law does not currently provide a remedy for the situation in which the Public Guarantee Fund does not follow a recommendation.⁵⁰

In fact, in a few cases, the Public Guarantee Fund has ignored the recommendation of a Conciliation Commission and not offered compensation. It seems to have been motivated by technical reasons, and more substantially, by a desire to conserve public funds.⁵¹ Such decisions compel the victim to seek compensation through the traditional legal process after completing the ADR process (which itself was designed to provide a less expensive and quicker alternative to litigation).

French courts have upheld the right of the Public Guarantee Fund not to follow the recommendation of Conciliation Commissions.⁵² As a result, except for using traditional court remedies or suing the Public Guarantee Fund for a technical mistake—a difficult, time-consuming, and expensive process—the only alternative for compensation is through private disability insurance. When Parliament enacted this reform nine years ago, it did not raise the specter that the Public Guarantee Fund might not pay claims recommended by Conciliation Commissions. Therefore, in my opinion, a new public debate about this problem is necessary.

In practice, one of the main obstacles to individuals receiving public or private compensation is the existence of a previous condition that accounts for the deterioration of the patient's health. When injuries occur due to medical intervention, but in the context of pre-existing medical condition, it is very difficult to establish the relative contribution of each. The Kouchner Act actually made the situation worse because, to obtain public compensation for therapeutic haz-

TRAITÉ DU CONTRAT D'ASSURANCE TERRESTRE [TREATISE ON INSURANCE CONTRACTS] 1676 (LexisNexis ed., 2008).

50. See Dominique Martin, *L'indemnisation des Victimes d'Accidents Médicaux comme Politique Publique* [Compensation for Victims of Medical Accidents as Public Policy], 44 RECUEIL DALLOZ 3021, 3021 (2006).

51. From a technical point of view, one of the main objections to the Public Guarantee Fund is that some medical accidents are the normal consequence of the victim's state of health at the time of the accident. See Cass. 1e civ., Mar. 31, 2011, Bull. civ. I, No. 09-17135.

52. Cass. 1e civ., May 6, 2010, Bull. civ. I, No. 09-66947. See INDEMNISATION DU RISQUE MÉDICAL PAR LA SOLIDARITÉ NATIONALE, *supra* note 34, for access to France's complete jurisprudence.

ards, patients need to prove that their disability is not the result of a typical evolution of their pre-existing condition. In practice, if experts find that 30–40% of the disability can be attributed to the normal evolution of a pre-existing condition, the individual will be precluded from public compensation as to that condition or illness.⁵³

CONCLUSION

After nine years, the reforms set in motion by the Kouchner Act and the Revised Kouchner Act undeniably increased access to insurance and compensation. On the other hand, both Acts increased the complexity of insurance and associated law. The reforms have attempted to reconcile private and public insurance within the drifting French judicial system. The complexity of this reconciliation explains the time it took for the reforms to find balance. The solutions provided for by the reforms have since been extended to other areas where compensation needs are common; for instance, on June 1, 2010, Kouchner Act-type benefits were extended to persons with Hepatitis C.⁵⁴

53. Philippe Pierre, *Le passé de la victime: l'influence de l'état antérieur* [The Victim's Past: The Influence of Pre-Existing Conditions], GAZETTE DU PALAIS, Apr. 8, 2011, at 15.

54. C. SANTÉ PUB. art. L. 1221-14.