ATTACHMENT D

Introduction

The MMAG Data and Funding Working Group was established to investigate and report back on possible funding models for the medical treatment injury leg of the NIIS.

Considered advice on funding models will need to be informed by an understanding of the potential funding requirement. The potential funding requirement will depend on:

- the number of medical treatment injury claims that might be expected under the NIIS; and
- the cost profile of medical treatment injury claims.

Information on the number and cost profile of medical treatment injury claims would enable estimation of the gross funding requirement.

To complete the picture, information on the split between the relevant cost of eligible medical treatment injuries sustained in public and private clinical settings and information on the current spend on the relevant cost of eligible medical treatment injuries will be needed.

This note reports on these issues.

Context – number of medical treatment injury claims

The number of medical treatment injury claims that might be expected under the NIIS will depend on the eligibility criteria established for the medical treatment injury leg of the NIIS. These criteria will go to:

- what is a medical treatment injury; and
- which medical treatment injuries will be covered by the NIIS.

The NIIS for medical treatment injury is intended to provide care and support to people who suffer a catastrophic injury (which will also need definition). It is intended to operate on a no-fault basis.

In respect of medical treatment injury, this suggests that the NIIS population should consist of:

- people who have suffered a catastrophic medical treatment injury and who are able to make a successful claim for damages against their treatment provider and/or the relevant institutional entity (medical/health practice, private hospital, or state government for injuries sustained in a public clinical setting). This is the fault-based section of the population; and
- people who have suffered a catastrophic medical treatment injury but who are not able to make a successful claim for damages. This is the no-fault section of the population.

Discussion of potential data sources

Australian Prudential Regulation Authority (APRA) National Claims and Policy Database (NCPD)

APRA maintains a national claims and policy database. Regulated insurers are required to submit details of certain claims in a specified format.

Details of (fault-based) medical treatment injury claims against health professionals or institutions are reported to APRA where those claims are insured by an APRA-regulated insurer.

APRA provided summary claim counts on a number of filters and on a confidential basis to Treasury.

Over the 5 years to 2011, according to APRA data, around 60 medical indemnity claims were finalised each year which related to severe bodily injury. About 40% of these claims were finalised at nil cost with another 50% being finalised for less than $500,000. For claims that were finalised at a cost of more than $500,000 the average finalised cost was around $2m. Over the same period, around 70 claims each year were reported to insurers which related to severe bodily injury. About 90% of these claims had case estimates of less than $500,000.

These claim counts need to be treated with caution for the current purpose because:

- The NCPD reporting format does not permit reliable identification of those claims which would be eligible for a NIIS. However it is conceivable that the use of proxy measures (claim size, bodily structures affected, severity of loss) might provide some insights.
- They are counts of claims and not people. For our purpose we need estimates of the number of people who are likely to enter the NIIS. The number of successful claims made by people with a catastrophic medical injury will exceed the number of people with a catastrophic medical injury who have made a successful claim. This is because these people will make more than one claim on average. We have no reliable way of adjusting the number of claims to get to the number of people.
- The claims counts provided by APRA are unlikely to provide any reliable insights into the no-fault section of the population. This section of the population contains people who have suffered a catastrophic medical treatment injury but who are not able to make a successful claim for damages. It is unlikely to be possible to get reliable insights on this group from the APRA claims data.

High Cost Claims Scheme (HCCS)

The Commonwealth's HCCS for medical indemnity insurers provides another information source. It is relatively immature and so direct experience data is not particularly helpful. However, that data can be used to build and test claim models.

The available HCCS data supports a view that around 70-90 medical indemnity claims per year (against privately practising doctors) might be expected which cost more than $500,000, of which around 20-30 claims might cost more than $1m. That is, around 1 in every 3 claims which cost more than $500,000 cost more than $1m.

If claims relating to obstetrics are removed, then around 55-75 claims per year might be expected with a cost of more than $500,000 and, of these, around 15-25 might cost more than $1m. Claims related to obstetrics appear to account for about 15% (by number) of all claims above $500,000 and about 20% of all claims above $1m.

Australian Institute of Health and Welfare (AIHW) Medical Indemnity National Collection (MINC)

AIHW maintain a medical indemnity data collection for public hospitals.

The format of the data is similar but not identical to the format of the claims data in the NCPD.

We asked AIHW about a similar filtering exercise to APRA, but on the public system data. AIHW quoted $6,900 for the task, including the time needed to obtain approval of all states and territories which provided the data.

We decided not to proceed with the AIHW request.

New Zealand (NZ) Accident Compensation Corporation (ACC)

The NZ ACC covers accidental medical injury on a no-fault basis. Furthermore, the NZ ACC operates a serious injury service. Claims that are accepted into ACC are filtered and some are 'transferred' to the serious injury service.

The description below provides an indication of the scope of serious injury claims in the NZ ACC.

If your injury means that you have a significant (usually permanent) impairment or loss of function, ACC classifies your claim as a serious injury. Injuries must meet a set of clinical criteria to be considered 'serious injury', but in general consist of the following types of injury:

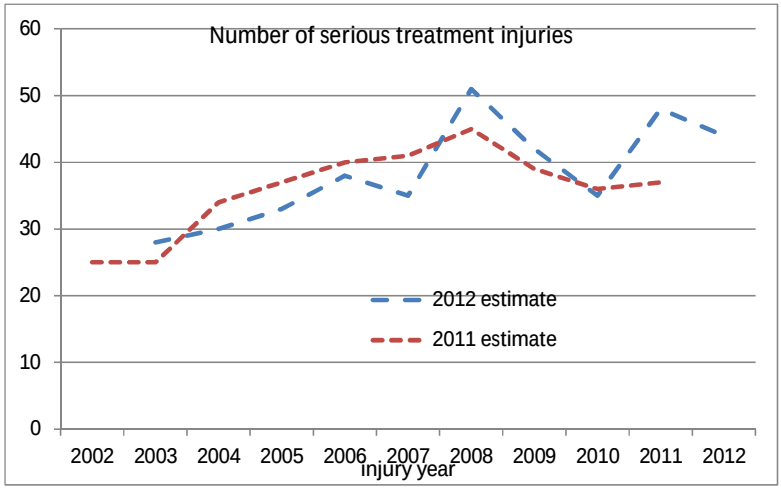
- *moderate to severe traumatic brain injury*
- *spinal cord injury*
- *other catastrophic injury (eg multiple amputations, burns to over 50% of the body, etc).*

The description suggests that serious injury claims in the NZ ACC might be similar to claims which may arise under the proposed NIIS for medical treatment injury.

The table below sets out estimates of the number of serious medical treatment injury claims – these estimates come from the two most recent financial condition reports.

	2011			2012		
	Reported	Incurred but not reported	Total	Reported	Incurred but not reported	Total
2002	23	2	25			
2003	22	3	25	25	3	28
2004	27	7	34	27	3	30
2005	28	9	37	29	4	33
2006	34	6	40	33	5	38
2007	27	14	41	28	7	35
2008	36	9	45	43	8	51
2009	28	11	39	29	13	42
2010	14	22	36	18	17	35
2011	3	34	37	19	29	48
2012				6	38	44

This data is shown graphically below.



Note again that the two curves both represent estimates of the number of serious medical treatment injuries (for injury years from 2003 to 2011), where those estimates have been prepared one year apart. The 2012 estimates were prepared in 2012 while the 2011 estimates were prepared in 2011.

Taking injury year 2010 as an example, the 2012 estimate is that, eventually, 35 serious medical treatment injuries will be found to have occurred in 2010. At the time that the 2012 estimate was prepared, 18 serious medical treatment injuries had already been identified as having occurred in 2010 with another 17 estimated to emerge in the future. By comparison, the corresponding estimate prepared a year earlier in 2011 was that 2010 would yield 36 serious medical treatment injuries. At the time of that estimate (in 2011) 14 serious medical treatment injuries had already been identified as having occurred in 2010 with another 22 estimated to emerge in the future.

There is a degree of volatility in the numbers from one year to the next. For example, the most recent estimate of the number of serious medical treatment injuries for 2010 is 35 (from above) while the most recent estimate of the number of serious medical treatment injuries for 2011 is 48. A degree of volatility is to be expected given the small numbers involved.

There appears to be a general upwards trend in the estimates. Part, but not all, of this is explained by the increase over the period in NZ's population. It is also possible that part of this can be explained by the broadening of the definition of medical treatment injury that happened in 2005. Overall rates of medical treatment injury appear to have increased very significantly, by perhaps 3 to 4 times, since the new definition was implemented. However, any increase in the rate of serious medical treatment injury has been far more modest at perhaps 20%-40%.

The experience from about 2006 onwards suggests that an estimate of around 40 new serious medical treatment injury claims each year for the NZ ACC might be reasonable.

Simply ratioing on the basis of population (Australia's population is about 5 times NZ's population) suggests an estimate of around 200 new serious medical treatment injury claims each year for the Australian NIIS.

However, this implicitly assumes that:

- the NIIS definition of medical treatment injury will align with the NZ ACC definition of medical treatment injury;
- NIIS eligibility (which is based on the injury being 'catastrophic') is in line with the filtering that the NZ ACC applies in order to identify 'serious injury claims; and

- Australian catastrophic medical treatment injury rates are in line with NZ serious medical treatment injury rates.

The first two of these assumptions relate to the rules of the NIIS around medical treatment injury being the same as the combination of the rules and filtering process for serious medical treatment injury in the NZ ACC. The third assumption relates to the Australian experience being the same as the NZ experience.

Rules

The MMAG considers that the definition of medical treatment injury should be based on the NZ ACC definition, apart from the treatment of birth-related injury (Attachment C refers).

The NZ ACC numbers include claims that relate to birth injury.

The Productivity Commission's proposal for the Australian NIIS for medical treatment injury is that cerebral palsy should be dealt with under the NDIS. The MMAG recommends that all birth-related treatment injury claims should be dealt with under the NDIS (Attachment C refers).

The most recent financial condition report for the NZ ACC suggests that perhaps 25%-40% of serious medical treatment injury claims are birth-related. Specifically, the report notes that serious medical treatment injury claims are funded from one of two accounts – the so-called earner's account and the non-earner's account. Claims that relate to birth injury are all funded from the non-earner's account and the non-earner's account makes up about 70%-75% of the treatment injury liability. Birth injury accounts for around 40%-50% of all serious medical treatment injury that is funded from the non-earner's account. Putting all of this together suggests that perhaps 25%-40% of serious medical treatment injury claims are birth-related.

Experience

It is unlikely that Australia's experience will be identical to NZ's experience. However, the NZ ACC's motor account experience appears to be broadly comparable to the NSW Lifetime Care and Support (LTCS) Scheme experience.

The NZ ACC anticipates around 110-120 serious motor injury claims each year. This represents a rate of about 0.024 per 1,000 people or about 0.034 per 1,000 vehicles. The NSW LTCS Scheme is still immature. However, the 2009 injury year appears to have resulted in around 140 new entrants to the LTCS Scheme. This represents a rate of around 0.019 per 1,000 people or about 0.030 per 1,000 vehicles. By comparison the 2010 injury year may have resulted in around 170 new entrants, which is around 0.024 per 1,000 people and around 0.037 per 1,000 vehicles[1].

From this very high level consideration, an initial assumption that the NZ experience is likely to be reasonably representative of the Australian experience does not appear entirely unreasonable.

Conclusion

Assuming birth-related injury is to be excluded from the NIIS, an adjustment to the estimate implied by the NZ ACC experience is required.

Beyond that, the high level consideration above does not point clearly to the need for any other significant adjustment. This does not mean that no other significant adjustment is required – rather, simply, that

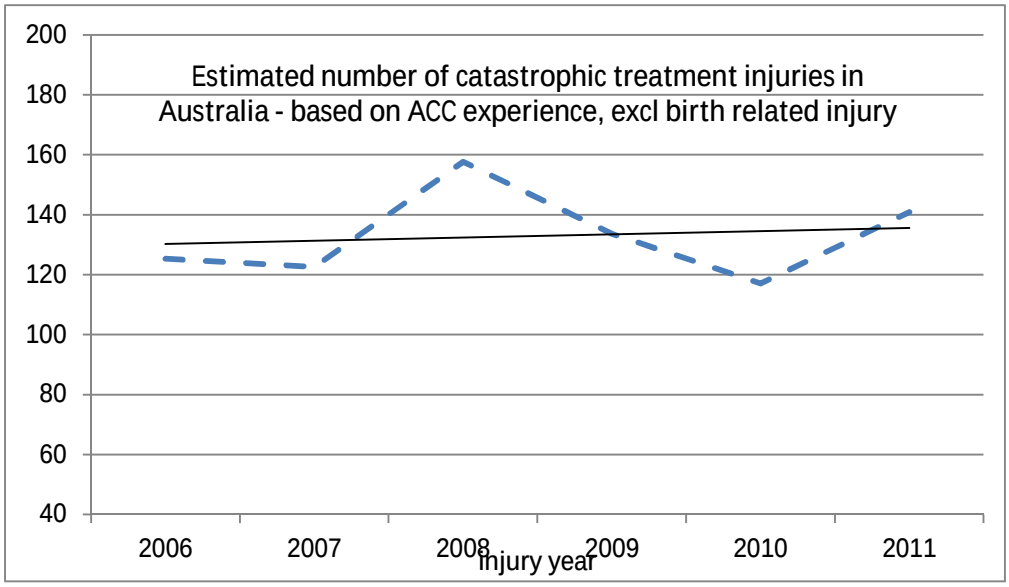
[1] Based on 2011 LTCS annual report

analysis of the comparative motor experience (NZ ACC vs NSW LTCS) did not provide conclusive evidence that a significant experience adjustment would be needed.

The chart below adjusts the NZ ACC experience for:

- population differences between Australia and NZ; and
- birth related injuries (by assuming that 35% of serious treatment injuries in the ACC are birth-related)

to arrive at a first order estimate of the potential Australian NIIS experience.



The result is that an estimate of around 130 catastrophic treatment injuries per year seems reasonably defensible on the (possibly strong) assumption that the NZ ACC experience is predictive.

Cost profile

The NIIS will cover the costs of:

- medical treatment;
- rehabilitation; and
- ongoing care and support, including aids and equipment etc.

The lifetime cost for a participant will depend upon severity of disability, level of informal support that is available and years of future life.

If claims related to birth injury are excluded, then the average age of serious medical treatment injury participants will be higher than it would otherwise be. Further, medical treatment injury might be expected to be associated with older ages to a greater extent than other injury types (motor, work, general).

On the (crude) assumptions that:

- the average annual cost of care and support for a serious medical treatment injury is $50-$60,000;
- medical and rehabilitation costs are 15% of the cost of care and support; and
- life expectancy for an average serious medical treatment injury is around 30 years.

The average lifetime cost might be about $1.5m.

Gross cost

Taking all of the above together, an estimate of the gross annual lifetime cost of new serious medical treatment injuries might be about $200m.

In other words, if the medical treatment injury leg of the NIIS is to be fully funded, then the potential gross funding requirement might reasonably be expected to be in the order of $200m.

Public-private split

Consideration of a funding model for medical treatment injury might reasonably have regard to the distribution of the source of serious medical treatment injuries between public and private clinical settings.

The AIHW publication, *Australia's medical indemnity claims 2010-11*, provides some high level insight into this question.

The numbers of closed public sector claims (excluding WA) involving major harm or severe injury and which were finalised at a cost of more than $100,000 during 2009-10 and 2010-11 were around 130 and 160 respectively. When closed private sector claims are added the numbers increase to around 190 and 210 respectively. This seems to suggest perhaps 2 to 2.5 serious medical treatment injuries might be sustained in a public clinical setting for every 1 serious medical treatment injury sustained in a private setting. However, there is very significant uncertainty around these figures.

Medical indemnity claims data maintained by Medicare Australia points to about 50 medical indemnity claims (private sector) being finalised in each of 2010 and 2011 for more than $500,000. The data maintained by AIHW referred to above has the number of closed public sector claims for Australia (excl WA) 2010-11 which exceeded $500,000 at 122. This also supports a view that perhaps 2 to 2.5 serious medical treatment injuries might be sustained in a public clinical setting for every 1 serious medical treatment injury sustained in a private setting.

An adjustment needs to be made to exclude birth-related claims. It is possible that relatively more birth related injury might occur in public clinical settings and so, subjectively, it might be reasonable to conclude the ratio of public to private claims is around 1.5-2.2 : 1.

All else equal, this might suggest that around 55%-75% of the cost can be attributed to public practice and around 25%-45% to private practice. This sort of breakdown would not be inconsistent with the overall proportions of public and private hospital separations.

Working on, say, a 60/40 split, would see about $90-$120m coming from the public sector with around $60-$80m coming from the private sector. A 70/30 split would see about $100-$140m coming from the public sector with around $50-$60m coming from the private sector.