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Medical Treatment Injury and NIIS discussion paper

One of the arms of the NIIS proposed by the PC is Medical Treatment Injury. The Advisory Panel has not yet considered this in its meetings so far which have focussed on Motor Vehicle injuries.

It is worth reinforcing that the proposed NIIS would cover permanent and catastrophic injury only. This limits coverage to severe brain injury, spinal cord injury, blindness, traumatic amputations and severe burns. In a practical sense only brain and spinal injury and blindness would be expected to contribute significantly to Medical Treatment Injury claims under the NIIS.

Consistent with the other categories of injury (Motor Vehicle, Workers' injury and public accident) the PC proposed that the NIIS cover medical treatment injury via State based schemes. It was proposed that there would be two broad categories of injury associated with medical treatment.

1. Injury occurring as a result of treatment which followed all accepted standards and which is an unavoidable consequence of the appropriate treatment of an illness. The medical treatment "did not substantially cause the adverse outcome, and the outcome could not have been prevented"

An example of such an injury is an operation on a patient who has developed an appendix abscess. In spite of appropriate diagnosis, antibiotic treatment and surgery, the patient develops septic shock which despite appropriate care results in multi-organ failure. The patient survives, but has permanent severe brain damage.

Such an injury is considered not amenable to any risk management, and unavoidable. Such an injury would <u>not</u> be covered by the NIIS, but the patient would receive appropriate life time care and support via the NDIS, with medical and hospital care required provided through Medicare and the public hospital system.

2. Injury occurring as a result of an error or treatment recognised as substandard.

An example of such an injury is an operation on a patient who has developed an appendix abscess. At the time of surgery the patient suffers from significant hypoxia as a result of incorrect placement of an endotracheal ventilation tube which is not recognised for the duration of the operation, and survives with severe permanent brain injury. There are several individual and system initiatives which might minimise the incidence of such an injury. This patient would receive subsequent medical care including hospitalisation as well as life time care and support under the NIIS.

The above cases can focus the Panel's attention on pertinent threshold issues raised by the PC report.

Issues raised in the design of the NDIS/NIIS

1. *Is the proposed classification the most appropriate one? Who decides which injuries fall under NIIS, and which fall under NDIS? How can such a decision be timely and minimise misclassification?*

The PC proposed that an expert panel consider claims to determine the classification of Medical Treatment Injury. In the examples given above, classification is straightforward. However there are many possible examples where the extent to which the disability was the result of the underlying illness or from the medical treatment itself is much less clear. The expert panel may consult with external experts as necessary. To the extent that the NDIS and NIIS aim to provide the same level of support in terms of life time care, this classification is of no significance to the disabled individual. However NIIS covers medical and hospital costs and NDIS does not: over the life time of an individual, this may be of some significance. It may also be useful to anticipate that a finding by the expert panel that an injury arose out of the disease itself rather than failure in treatment may have some influence on any subsequent consideration of litigation to recover other costs such as economic loss and pain and suffering.

In view of these issues, it might be worth considering another basis for defining a compensable injury under the NIIS : the "rare and serious outcome" definition, which has been used in the New Zealand ACC. In this definition, the concept of error or avoidable injury is not considered, rather a threshold is defined which captures unexpected outcomes following medical treatment which therefore excludes disability resulting from the natural history of the disease being treated. This "rare and serious outcome" definition could replace the ones proposed in the PC report, or could be added to them to capture such events as well as maintaining the risk management and harm minimisation approach underpinning the PC proposal.

2. *Who contributes to funding the NIIS, and how shall such funds be collected and transferred to the NIIS*

The PC proposes that each jurisdiction will be responsible for collection of funds from appropriate sources. It would be necessary to identify appropriate sources, and establish agreed mechanisms for payment. Sources would include

    a. Medical Indemnity Insurers and
    b. Private Hospital and State Governments as insurers for public hospitals.
    c. Should there be significant cost increases associated with inclusion of claims which currently would not attract fault based compensation, how will this be managed? In this instance it is likely that state or federal governments may be asked to contribute to the cost of these matters via existing schemes, or possibly under new arrangements

It is clear that there are a significantly wider number of stakeholder organisations which will need to be involved in the NIIS. As a priority, it will be necessary to comment a process of engagement and dialogue with those organisations to achieve a reasonable consensus within the proposed timeframes.

3. *How will the principles of self directed funding apply to treatment covered by NIIS?*

a. How much will the NIIS contribute for costs of medical and hospital care? Which providers will be eligible for funded care and how will such eligibility be determined?
b. Which treatments are covered? The PC considered it might be necessary to exclude treatments obtained outside Australia, and those in Australia not covered by the MBS or PBS.

4. *Issues raised by the proposed State based structure.*

What definitions and standards shall apply to support provided by the NIIS, given that support will come via individual State managed and operated schemes. Will there be a national definition of Medical Treatment Injury?

What degree of national co-ordination is required, and how will this be managed. Will there be a national database informing risk management strategies? Will there be a single agency overseeing NDIS and NIIS, or should the two arms have separate administration and governance structures? If there are different benefit structures in different jurisdictions does this potentially open up the possibility of 'jurisdiction shopping'?

Will states agree to contribute to NIIS no fault costs arising from treatment provided in public hospitals?

Medical and other indemnity insurers typically operate in a number of jurisdictions and so could potentially be subject to different arrangements in each jurisdiction, increasing the complexity of operations

What legislative changes are required in the jurisdictions, how will these changes be co-ordinated with the introduction of NIIS coverage?

5. *Issues raised by different timelines applying to NDIS and NIIS.*
    a. Cerebral palsy is covered by NDIS, but this scheme will not be functioning until after commencement of the NIIS which will not cover any cerebral palsy. Some individuals who might be recipients of at fault compensation will miss out on support if their right to civil action to recover costs associated with life time care are extinguished prior to an entitlement to such support under the NIIS. On the other hand, if the right to recover damages in cerebral palsy cases where negligence is alleged is maintained until the NDIS fully covers such claims on a no fault basis, then costs of recovery will increase the costs to insurers beyond those anticipated by the PC.
    b. In addition it is proposed that NIIS will apply to new accidents only, while NDIS, when fully operational, will cover both past and future accidents. This may lead to some anomalies with medical and other indemnity providers, who currently provide cover on a claims made (i.e. claims reported) rather than claims occurring basis.

Recommendation

I propose that the Advisory Group noting the complex issues to be considered recommend to the Minister that work progress on this matter. This could be by way of a round table with interested stakeholders, including State governments.