Medical treatment injury discussion paper

This draft discussion paper examines the issues around possible minimum benchmarks for compensation for medical injury within a National Injury Insurance Scheme (NIIS). The paper is prepared for discussion only and on a no-prejudice basis, containing a number of complex issues that have not yet been resolved. It has benefited from consultation with medical professionals, medical indemnity insurers, actuaries and the legal profession.

It is intended to form the basis of a general approach to minimum benchmarks for a medical treatment injury stream of an NIIS. These minimum benchmarks should reflect a reasonable and agreed position on scope of eligibility and level of care and support for people who suffer a catastrophic injury as a result of medical treatment which can be implemented by all jurisdictions. Jurisdictions would have the choice to provide wider eligibility and/or a higher level of care and support as the cost and impact of the National Disability Insurance Scheme (NDIS) and NIIS become clearer, or to align with their own priorities or existing state based arrangements.

The level of minimum benchmarks reflects a judgement call for jurisdictions. If the level is set too low, it will be difficult to defend the benchmarks as providing a sensible system of care for injured clients. If set too high, they may not be adopted by jurisdictions, who may opt instead for clients to be covered under the NDIS.

1 The basis of an NIIS for medical treatment injuries

The Productivity Commission recommended that State and Territory Governments should develop no fault care and support arrangements for injuries arising from medical treatment as part of a broader NIIS. Medical treatment injuries are the third category of significant disabilities caused by an accident after motor vehicle accidents and workplace accidents, where those injured would be eligible for care and support within the NDIS if no NIIS existed.

A potential funding source exists for a medical treatment stream of an NIIS - a premium on medical practitioners' and hospitals' medical indemnity insurance – whereas the NDIS will be funded from consolidated revenue. If this funding source can be accessed successfully the additional cost to taxpayers of providing support to these people may be lower. Risk rating of this premium can also provide strong incentives for medical professionals to take action to reduce the risk of injury to patients.

Under some design features, patient outcomes may also be better under an NIIS than the NDIS. For example, if a medical treatment stream of an NIIS covered the health costs associated with catastrophic treatment injuries such as acute care and rehabilitation services, this may support more integrated care. By contrast, these are costs which the NDIS is legislatively restricted from providing. The Productivity Commission also noted that the experience of jurisdictions with no-fault accident schemes shows that coordinating optimal transitions through the health system and making available high quality rehabilitation facilities enhances participant outcomes and may, in some cases, reduce the lifetime cost of injury.

2 Existing arrangements

Those suffering from medical injuries in every state currently depend on their capacity to establish a negligence claim against a GP, hospital or other provider and their access to general disability support provided by State and Territory governments, and the Commonwealth Government.

The legal arrangements suffer from the well-known problems with fault based compensation: high legal costs; delays; incentives for claimants to delay their recovery; settlements at values less than the full cost of future care and support, particularly where negligence and/or causation are in dispute or, conversely, settlements based on a "rolled gold" model of future care and optimistically high life expectancy, which may also provide a substantial benefit to others when these damages remain unspent at the time of death.

Various insurance arrangements are in place to deal with claims. The Commonwealth Government subsidises the insurance costs of medical practitioners (including GPs) to enable them to continue practising. The Commonwealth also operates a High Costs Claim Scheme which allows insurers of private practitioners to recover from the Commonwealth 50 per cent of claim costs where the claim cost exceeds $300,000. State governments provide insurance cover for public hospitals to meet claim costs. In Victoria, for example, the insurance extends to public hospitals and all of their employees who are involved in providing medical care to public patients. Coverage also extends to private patients who are treated in public hospitals, as long as the costs recovered from the patients or their private insurers are shared with the hospital by the medical provider.

In at least some jurisdictions, the total annual premium for the public sector is actuarially calculated, and is based on the predicted cost of resolving claims which will arise in the future from that year. In Victoria for example, the premium pool is allocated amongst individual Victorian hospitals on a risk rated basis. The risk rated model takes into account both the risks associated with the areas of practice within the hospital and the hospital's own claims experience. The Victorian public hospital risk rated premium is rated 75 per cent based on the hospital's clinical exposures and 25 per cent based on the public hospitals claims experience.

Insurance for private medical practitioners will typically be purchased through the private market, and will enable the practitioner to practise across Australia. There is little publicly-available data on private practitioner injuries.

In assessing the benefits of implementing an NIIS for medical treatment injury the paper assumes that an NIIS would only be rolled out in conjunction with a fully implemented NDIS. For the purposes of any regulatory impact analysis the appropriate point of comparison for assessing the benefits of an NIIS for medical treatment injury would be the NDIS supplemented by existing common law arrangements for those injured as a result of medical treatment.

3 Minimum benchmarks for medical treatment injuries

In the federated model envisaged for an NIIS, States and Territories have genuine choices about how to implement the scheme. It is likely that some jurisdictions which implement the benchmarks will choose to exceed them in some areas and simply meet them in other areas.

Minimum benchmarks for coverage for medical treatment injury would need to cover three main areas:

- Eligibility – who is covered (sections 4 and 5 of this paper);
- What is a medical treatment injury (section 6 of this paper); and
- Entitlements – the level of care to be provided (section 7 of this paper).

4 Who would be covered

The Productivity Commission recommended that an NIIS include people who suffer catastrophic injuries following medical treatment, but acknowledged the complexity of including these types of injuries.

An NIIS for medical treatment should include people who suffer the following catastrophic traumatic injuries from medical treatment, which is based on the agreed benchmarks for motor vehicle accidents:

- *spinal cord injury* – where there is a spinal cord injury resulting in permanent neurological deficit.

- *brain injury* - where the duration of Post Traumatic Amnesia (PTA), is greater than 1 week. If the PTA assessment is not available (for example, if the child is under 8 years) or not applicable (for example, a penetrating brain injury) there must be evidence of a very significant impact to the head causing coma for longer than one hour, or a significant brain imaging abnormality and one of the following criteria is met:
    - if over 8 years of age at the time of assessment, a score of 5 or less on any of the items on the Functional Independence Measure (FIM or WeeFIM); or
    - if aged from 3 to 8 years at the time of assessment, a score two less than the age norm on any item on the WeeFIM; or
    - if aged under 3 years at the time of assessment, a medical certificate from a paediatric rehabilitation physician that states the child will probably have permanent impairment due to the brain injury resulting in the need for daily attendant care services.

- *multiple amputations* - of the upper and/or lower extremities at or above the fingers (metacarpophalangeal joints) and/or adjacent to or above the knee (transtibial or transfemoral) and one of the following criteria is met:
    - if over 8 years of age at the time of assessment, a score of 5 or less on any of the items on the Functional Independence Measure (FIM or WeeFIM); or
    - if aged from 3 to 8 years at the time of assessment, a score two less than the age norm on any item on the WeeFIM; or
    - if aged under 3 years at the time of assessment, a medical certificate from a paediatric rehabilitation physician that states the child will probably have permanent impairment due to the amputations resulting in the need for daily attendant care services.

- *burns* – including:
    - full thickness burns greater than 40 per cent; or greater than 30 per cent in children (under 16 years);
    - inhalation burns causing long term respiratory impairment; and
    - full thickness burns to the hand, face or genital area; and one of the following criteria is met:
        - if over 8 years of age at the time of assessment, a score of 5 or less on any of the items on the Functional Independence Measure (FIM or WeeFIM); or
        - if aged from 3 to 8 years at the time of assessment, a score two less than the age norm on any item on the WeeFIM; or
        - if aged under 3 years at the time of assessment, a medical certificate from a paediatrician that states the child will probably have permanent impairment due to the burns resulting in the need for daily attendant care services.

- *permanent blindness* - the person is legally blind, that is:
    - visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes; or
    - field of vision is constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity (equivalent to 1/100 white test object); or
    - a combination of visual defects resulting in the same degree of visual loss as that occurring in the points above.

The data provided on high cost medical indemnity claims by each jurisdiction (**Appendix A**) suggests that these benchmarks provide coverage for *most* types of injuries which may be caused as a result of medical treatment. As such, the list of catastrophic injuries agreed for the NIIS for motor vehicle accidents represents a sound basis for determining minimum benchmarks for injuries which would be covered by a medical treatment injury stream of an NIIS.

There may be additional injuries that could be added to this base to take account of the different nature of medical treatment compared with motor vehicle injury. This might include conditions such as catastrophic kidney failure or instances where there have been misdiagnoses, failure to diagnose potentially treatable conditions (such as cancer) or diseases which arise as a result of treatment. However, these refinements might be better left to future revisions to the scheme once it has been in operation for some time.

The NDIS adopts a functional impairment approach, in contrast to the approach taken so far in motor vehicle and workplace accident benchmarks. For this reason it probably makes sense for the benchmarks for medical indemnity to adopt an approach similar to other streams of the NIIS.

5 Exclusions

a) Birth defects

The Productivity Commission recommended that the costs of care and support for babies with cerebral palsy be provided by the NDIS and specifically excluded from the NIIS because:

- scientific evidence suggests that most cases of cerebral palsy are not attributable to medical treatment , but are more akin to other birth defects which would be covered by the NDIS;
- it is particularly hard to reliably determine that medical treatment or care by the physician or medical support staff was the cause of cerebral palsy in any individual case;
- it would ensure that all children would be able to access immediate support (currently, delayed medical diagnosis; the particularly complex issues arising from determining fault and causation in this area and the need to defer litigation by reference to establishing life expectancy coupled with associated protracted litigation processes mean people can face significant delays in receiving services other than those accessible via the mainstream health and education services); and
- the transfer of these costs to the NDIS would assist the states in funding the other injuries to be covered by a state funded medical indemnity no fault NIIS.

If the proposed inclusion of individuals suffering from birth related cerebral palsy in the NDIS was accepted, it should be broadened to individuals suffering from in utero and birth related neurological impairment. This would mean that all severe neurological impairments, including those that may not meet the definition of cerebral palsy but which arise during pregnancy or are associated with the birth process and the neonatal period would be covered by the NDIS, not an NIIS, provided they meet the NDIS eligibility criteria (including age, Australian residence, and assessment of functional capacity).

However, a final decision on whether such individuals should be supported by the NIIS or the NDIS can only be made after consultation with experts about the rehabilitation, care and support needs of such individuals.

b) Unreasonably withholding or delaying consent

Injuries wholly or substantially caused by a person unreasonably withholding or delaying their consent to undergo treatment might also be excluded from the scheme. This exclusion is contained in the New Zealand *Injury, Rehabilitation and Compensation Act 2001*. The rationale that underpins such an exclusion is that people who need to fund the scheme arguably should not have to pay for support which may not have been required if participants had followed their treatment advice or addressed their underlying health conditions. There may be some parallels between this exclusion and the 'serious or wilful misconduct' exclusions contained in the draft minimum benchmarks identified for consultation for the NIIS for workplace accidents. Should this stream be funded through a levy on medical indemnity insurance premiums, excluding injuries caused by a person unreasonably withholding or delaying consent could reduce the amount practitioners would pay to fund the stream.

This exclusion could potentially be captured under a broader category of exclusions which would fall under the broad heading of "contributory negligence". Actions falling under this category could also include the withholding of information (such as pre-existing medical conditions) which could have a critical bearing on the course of treatment taken and associated outcomes.

However, the NIIS eligibility criteria require that the injury arises as a result of medical treatment (as discussed in section 6 of this paper). It may be difficult for a person seeking entry to the NIIS to argue that their injury results from medical treatment when in fact they have unreasonably withheld consent with the result that no treatment occurred. In cases where consent was delayed, resulting in the exacerbation of a specific medical condition or deterioration of overall health, these conditions should form part of a patient's assessed underlying health condition at the time treatment eventually occurs. A medical treatment injury would arise only if a practitioner failed to appropriately modify treatment in response to the new underlying health condition at the time of treatment, instead relying on condition at time of original presentation (prior to deferral of consent).

c) Individuals injured when 65 years and over

Individuals aged 65 years and over at the time they acquire a disability are ineligible for the NDIS. This exclusion could be mirrored by not requiring the NIIS to cover individuals who are catastrophically injured as a result of medical treatment when they are 65 years and over (or alternatively an age linked to the retirement age). It would mean that an individual injured while undergoing medical treatment who does not have recourse to the common law may be supported by their family, supplemented by aged care services (to the extent that the individual is eligible and the services are available). The injured individual would receive medical treatment and rehabilitation through the public health system, and to the extent that no appropriate care services are available may occupy a hospital bed for a considerable period of time. States would retain the right to exceed the minimum benchmarks by including this cohort in the NIIS should they wish to do so.

It can be argued that extending this exclusion to the medical treatment stream is not unreasonable. Firstly, it would have no financial impact on the NDIS because these individuals are ineligible for the NDIS. Further, recent roles and responsibility changes mean that the Commonwealth is now clearly responsible for care and support of individuals aged 65 and over. Including these individuals in a state funded and administered NIIS would arguably run counter to these changes. If this proposed exclusion were accepted, this issue could be revisited in a future review of the NIIS, particularly if the NDIS was expanded to include this cohort.

However, there are strong reasons to include individuals aged 65 years and over in the medical treatment stream of the NIIS. For example, it could create better patient outcomes by covering the health costs associated with the injury as well as acute care and rehabilitation services. Further, although those aged over 65 can be excluded from the NDIS on the grounds that there is a blurred line between disability and the effects of ageing, it is difficult to extend this argument to the NIIS because a catastrophic medical treatment injury is a more distinct incident. Including all individuals in the medical treatment stream regardless of their age would be consistent with arrangements for motor vehicle and workplace accidents and would support the intention of the NIIS to provide lifetime care and support to all catastrophically injured individuals, regardless of the cause of the injury.

6 What is a medical treatment injury?

In determining eligibility for a medical treatment injury stream of an NIIS, it will be necessary to define what constitutes a medical treatment injury. This includes:

- Establishing clear guidance to help determine whether the catastrophic injury was a result of the medical treatment; and
- Making a decision on which categories of health provider should be covered by an NIIS.

a) Injury as a result of medical treatment

In a no-fault scheme like the NIIS, it is desirable to avoid, as much as possible, the issue of medical negligence. New Zealand's Accident Compensation Corporation (ACC) scheme (further detail at **Appendix B**) initially required individuals to prove medical error in order to be eligible for compensation. Claimants faced some of the same difficulties facing plaintiffs in medical negligence claims, which did not sit well within a no-fault scheme.

Reforms to the ACC in 2005 introduced the current concept of a 'medical treatment injury'. These reforms abandoned the concept of medical misadventure eligibility assessments and moved towards the coverage of *all* unintended injuries that occurred as a result of medical treatment, including both preventable and non-preventable treatment injuries, provided they were unintended or outside the expected and likely range of treatment outcomes. This does not include:

- personal injury that is wholly or substantially caused by a person's underlying health condition;
- personal injury that is solely attributable to a resource allocation decision; or
- personal injury that is a result of a person unreasonably withholding or delaying consent to undergo treatment.

The definition of a *medical treatment injury* should be based on the current ACC model. It should be limited to personal injury caused by treatment (which includes a failure to diagnose or provide treatment). It must not be a necessary part, or ordinary consequence, of the treatment, taking into account all of the circumstances of the treatment, including the person's underlying health condition at the time of the treatment, and the clinical knowledge at the time of the treatment. This would include injuries sustained as a result of participation in clinical trials and, where a person's injury results in an infectious disease, third parties contracting that infectious disease from the injured person or the injured person's spouse/partner.

Even if this definition of *medical treatment injury* can largely eliminate the medical negligence question, the question of causation can never be completely avoided, if only to distinguish cases arising from foreseeable outcomes inherent in the treatment or underlying illness or disability. Establishing that medical treatment caused a particular catastrophic injury will in many cases be complicated and is currently a significant hurdle for plaintiffs at common law. The Productivity Commission suggests that a number of factors can make this step difficult:

- the impact of the underlying health status of the patient, the normal progression of a disease or illness and the normal risk of a medical intervention; and
- the inherent risks of medical treatment — there will be some adverse outcomes that cannot be avoided by the exercise of reasonable care and skill (within the confines of current medical knowledge, treatment protocols and technologies). These particular risks would commonly be the subject of informed consent from the patient prior to medical intervention.

The Productivity Commission recommended that questions of eligibility be decided by an expert panel within the NIIS, and that the panel's deliberations be supported by a comprehensive database of medical treatment injuries. The references to 'caused by', 'ordinary consequence' and 'underlying health condition' are likely to be difficult to interpret and guidance will need to be developed to make them practicable (such as defining a threshold probability for the outcome of a treatment for it to qualify as an injury to be covered by an NIIS).

Consequently, if a panel is to be the preferred method of determination, careful consideration would need to be given to the skill sets required. Given the potential impact on participation rates and consequential premium sensitivity arising from these determinations, consideration would also need to be given to what rights of review would or should be available to the affected parties, including a right of judicial review.

While requiring eligibility assessments to consider the 'clinical knowledge at the time of the treatment' may be considered to bring in some fault based undertone, this is an important element of determining causation and therefore should be included.

Under an intention to cover disabilities caused by medical treatment injury, disabilities arising **as a result of disease** may not be covered by the NIIS. This is similar to the situation in New Zealand, where the accident compensation scheme is based broadly on the distinction between human and natural causes. This exclusion is designed to keep eligibility for the scheme as clear as possible – distinguishing between medical treatment injuries and underlying health and disability conditions will be difficult enough, without attempting to draw a line around some but not all cases of disease and illness. There would also be potentially very large financial implications of including those with a disease or illness.

One exception to this rule could be where a readily identifiable disease or illness remains undiagnosed and progresses to a catastrophic state.

b) Which practitioners should be included?

In addition to determining what constitutes a catastrophic injury which was caused by medical treatment, it will be necessary to determine which categories of health professionals are to be covered by an NIIS. A catastrophically injured individual should be eligible for an NIIS when they were seeking treatment from one or more Australian Health Practitioner Regulation Agency (AHPRA) registered health professionals

and/or at a public or private hospital or other accredited healthcare facility. AHPRA registration includes a number of allied health professionals (see box below).

It should also be noted that health professionals have different insurance arrangements and that if coverage is extended to treatment from all AHPRA registered health professionals, it will be necessary to determine how premiums are charged. There is a question about whether health professionals should be charged premiums based on the probabilities of their professional stream causing a catastrophic injury. Optometrists, for example, may be unlikely to cause a catastrophic injury and may resist a levy on their professional indemnity insurance which cross-subsidises a different professional class.

Furthermore, whether or not there are grounds for including treatment by individuals who purport to be registered health professionals, but are not in fact registered, could also be considered. However, this would likely include a very wide range of medically related activities and unduly extend the reach of the scheme. It may also be very difficult to charge premiums to such individuals.

Australian Health Practitioner Regulation Agency

COAG decided in 2008 to establish a single National Registration and Accreditation Scheme for registered health practitioners. In 2010, a range of professions became nationally regulated by a corresponding National Board: chiropractors, dental practitioners, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. In 2012, Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapist joined the scheme. AHPRA is responsible for implementing this national scheme and partners with national boards for each of the professions.

Accredited healthcare services
All hospitals and day procedure services and the majority of public dental services across Australia need to be accredited to the National Safety and Quality Health Service (NSQHS) Standards. Private health service organisations will need to confirm their requirements for accreditation to any standards in addition to the NSQHS Standards with the relevant health department.

7 Entitlements

The view with considerable support amongst NIIS Senior Officials is that entitlements should be based on those provided for motor vehicle accidents (as in the box below).

What are the entitlements?

A minimum level of entitlement in each jurisdiction's NIIS will include reasonable and necessary needs for eligible persons for the following services to the extent that they arise from the medical treatment:

- medical treatment (including pharmaceutical);
- dental treatment;
- rehabilitation;
- ambulance transportation;
- respite care;
- attendant care services;
- domestic assistance;

• aids and appliances;
• artificial members, eyes and teeth;
• education and vocational training; and
• home and transport modification.

An individual jurisdiction's NIIS may provide a broader range of services, and may also provide capacity for self-managed funding by participants where appropriate.

Entitlements will only be provided within the Commonwealth of Australia.

Reasonable and necessary supports:
(a) are designed to support the individual to achieve their goals and maximise their independence;
(b) support the individual's capacity to undertake activities of daily living to enable them to participate in the community and/or employment;
(c) are effective, and evidence informed;
(d) are value for money;
(e) reflect community expectations, including what is realistic to expect from the individual, families and carers; and
(f) are best provided through an NIIS and are not more appropriately provided through other systems of service delivery and support, including services that are offered by mainstream agencies as a part of its universal service obligation to all citizens.

In determining what is reasonable and necessary the following factors should be considered:

- Benefit to the participant – to progress or maintain the participant's recovery, management and participation.
- Appropriateness – services provided are consistent with the participant's current medical or rehabilitation needs, are consistent with current clinical practices and are congruent with other services provided to the participant.
- Appropriateness of the provider – service providers are qualified, readily accessible and appropriate given the participant's age, ethnicity and other characteristics.
- Cost effectiveness of the services – the benefits and expected outcomes outweigh the costs, the cost is comparable to those of other providers, no other services would achieve comparable outcomes and alternatives to purchasing equipment or undertaking modifications have been considered.
- That the services provided relate to needs arising from the injury sustained from the medical treatment.

Whether or not the minimum benchmarks for entitlements under a medical treatment injury NIIS should align with those of other NIIS streams or the NDIS is an issue still to be resolved.

These entitlements are considerably broader than those offered under the NDIS. In particular, while NDIS clients will be provided with support such as attendant care services, aids and appliances, prosthetics and home and transport modifications, they will access medical and associated services through the usual access points in the health system.

There is some attraction in lining up entitlements across different streams of the NIIS and, as noted in section 1, there are potential benefits in offering health services such as acute care and rehabilitation services under an NIIS if this supports more integrated care, consistency of benefit delivery and benefits for scheme viability such as reduced costs of lifetime care. Lining up entitlements with other streams of the NIIS may also reduce the incentive for individuals to seek additional common law damages which may be used to supplement the no-fault care and support provided through the NIIS.

On the other hand, the NDIS supports include early intervention services, and this helps moderate the differences between the motor vehicle stream minimum benchmarks for care and support, and those offered under the NDIS.

Given the difficulties likely to be involved in defining the boundaries of this stream of the NIIS, it would be important to minimise any incentives for 'scheme shopping' by those seeking support, or cost shifting by different levels of government or duplication of benefit delivery by the NIIS and other mainstream agencies. There would be benefits in lining up entitlements with those of the NDIS.

8 Cross-jurisdictional issues

Given the nature of the scheme, and that the likely primary funding source is an insurance premium charged on health professionals in each state, it seems reasonable that the determining factor for the jurisdiction to provide cover should be the jurisdiction where treatment takes place, rather than the residency of the patient. There is some complexity in this issue where medical practitioners who are licensed in one state or territory practice in multiple jurisdictions. This is relevant for private medical practitioners, whose insurance typically covers them regardless of where they practice. Public hospitals and their employees may also be affected. For example, the Victorian Managed Insurance Authority extends coverage to care and treatment provided by the hospital outside Victoria (although not in the United States and Canada). If this stream of an NIIS is to be funded on a state based model through a premium on medical indemnity insurance, a method for distributing this revenue amongst states may need to be developed.

Foreign residency may also be an issue to be considered where the patient resides overseas but treatment giving rise to participation in the NIIS has been provided within an Australian jurisdiction. The potential financial implications of delivering benefits outside Australia and whether benefit delivery should be confined to Australia would need to be considered.

9 Funding and administration

The model for funding the medical treatment stream should be at the discretion of each individual State or Territory.

One of the reasons why it is difficult to assess funding options is because it is difficult to estimate the magnitude of the cost of this stream. Data on the number of accidents occurring in public hospitals is at *Attachment A*. In the private sphere, data is particularly difficult to attain because the Commonwealth's High Cost Claims Scheme is relatively immature. Initial conversations with actuaries suggests that a relatively small amount of claims might arise which cost more than $1 million.

One of the possible advantages of an NIIS arrangement for medical injuries is that premiums can be made dependent on claims experience and incentives can therefore be strengthened (or in the case of some jurisdictions be put in place) to help improve clinical practice. Such measures would support other well established risk management practices and reporting requirements which drive improved clinical outcomes. However, some argue that premiums based on claims experience (and related litigation) can have an adverse impact on clinical practice and access to medical services - for example where higher premiums discourage participation in a particular specialty or restricts access to services.

The Productivity Commission also suggests that an NIIS could help build on existing incentives to minimise risk by motivating the systematic collection and analysis of data that may decrease risks.

The expansion of existing fault-based insurance arrangements to a no-fault scheme is likely to involve an increase in the costs of insuring against medical treatment injury. The increase in costs arises from the need to fund care and support of a larger number of cases of catastrophic injury. In the absence of any claims experience relevant to no fault medical indemnity, particularly when coupled with an unknown level of scheme participation, this is a potentially volatile area.

The Productivity Commission suggested that the increase in costs arising from the expansion to a no-fault scheme may be partially or fully offset by a number of factors:

- the removal of care and support costs for cases of cerebral palsy (which will be covered by the NDIS) (noting this would be expanded to include care and support of all people with birth-related injuries under the approach described above). The potential for transfer of costs back to the states via common law actions brought by NDIS participants and/or compensation recovery by the NDIA may, however, to a large degree offset these funding incentives ;
- reductions in legal expenses stemming from:
  - a decrease in frictional costs (i.e. the costs associated with predicting life expectancy, a person's ongoing health status and care requirements required to determine the quantum of damages); and
  - a higher number of claims not proceeding to litigation (with support costs automatically covered by an NIIS, there may be less incentive to pursue a claim under the remaining heads of damage); and
- the two factors above leading to a reduction in reinsurance costs.

It remains to be seen whether these savings would be realised, particularly as a NIIS will be restricted to catastrophic injury cases only. Decisions about the extent to which common law rights are retained would be important influences on the extent of any savings, including the potential for cost transfer from the NDIS back to the states pursuant to the NDIA recovery provisions.

The timing of any reduction in legal and reinsurance costs envisaged by the Productivity Commission is unlikely to occur in line with the introduction of a NIIS for medical treatment. The long tail nature of medical treatment injury claims, coupled with the NIIS only applying to injuries which occur after it commences, means that there would likely be a period of overlap during which the pricing of medical indemnity insurance premiums would need to reflect incurred but not yet reported claims (notwithstanding that the care and support costs for these claims may be met by the NDIS) as well as the additional claims expected to arise under the expansion to no-fault arrangements.

The timing issues will also affect the public health sector and may mean that a state will need to (at least temporarily) increase the amount of funding it provides to indemnify employees working in relevant public health facilities.

The following individuals/entities could be levied:

- public sector in each state;

- medical practitioners in private practice;
- private hospitals;
- all other registered health care practitioners;
- health care companies that purchase insurance; and
- health care companies that buy public liability insurance.

Medical indemnity insurance, professional indemnity insurance and public liability insurance where there is bodily injury cover for medical accidents could be levied a percentage of the insurance premiums of medical practitioners covered by this stream of the NIIS. This would have the benefit of having some reflection of risk rating and could be easily calculated across contributors. This is likely to increase the cost of insurance for some medical practitioners and may have an impact on the incentives of medical professionals to treat riskier patients or perform procedures with a higher possibility of misadventure, depending on how the levy is applied.

A range of options for implementation exist, including but not limited to:

1) Funding and administration by state governments

State governments could implement the medical stream of the NIIS in full. This would likely involve both:

- Setting aside an adequate pool of funds in order to provide no-fault indemnity insurance for accidents resulting in catastrophic injury in public hospitals; and
- Levying medical indemnity insurers to cover the cost of providing no-fault indemnity insurance for accidents resulting in catastrophic in injury private practice.

The funds raised from both sources would be directed into one or more State schemes that would manage the funds and the provision of lifetime care and support.

There are a number of possible administrative options including establishing a new agency, using an existing scheme e.g., Lifetime Care and Support Authority, or some combination of the two. Each jurisdiction would be free to choose the administrative option that best suited its needs.

2) Funding and administration split between the public and private systems

State governments could provide no-fault indemnity insurance for accidents resulting in catastrophic injury in public hospitals. An adequate pool of funds would be set aside, with an existing or new scheme managing these funds and the provision of lifetime care and support for catastrophic injuries occurring in the public health system.

The Commonwealth Government could provide no-fault indemnity insurance for accidents resulting in catastrophic injury in private practice by levying medical indemnity insurers.

The funds and provision of lifetime care and support would be managed be either an existing Commonwealth agency, such as Comcare, or a new agency established.

3) Funding and administration provided by private insurers

The Commonwealth could extend the Australian Health Practitioner Regulation Agency's mandatory indemnity insurance requirements such that all health professionals would be required to hold no-fault

cover for catastrophic injuries. Relevant insurers – including state governments to the extent that they provide insurance to individuals working in the public system - would then need to amend their medical indemnity and professional indemnity insurance products to reflect this requirement.

The private insurers themselves would manage the funds and the provision of lifetime care and support.

If state governments elect to continue to self-insure, they would as per the other options, determine an amount that public health bodies must set aside to provide no-fault indemnity insurance for accidents resulting in catastrophic injury in public hospitals. An existing or new State scheme would manage the funds and the provision of lifetime care and support.

Contribution to Funding from the Commonwealth

Existing Commonwealth subsidies for medical indemnity insurance could still apply to non-catastrophic claims. Consideration would need to be given to the interaction between Commonwealth schemes – particularly the High Cost Claims Scheme – and the medical stream of the NIIS.

The Commonwealth has a substantive role in the medical indemnity insurance market through its carriage of the legislation which regulates the insurance of medical practitioners. There also currently exist substantial Commonwealth subsidies for medical insurance. These include: the High Cost Claims Scheme; Premium Support Scheme; Run-Off Cover Scheme; and the Exceptional Claims Scheme.

Under the High Cost Claims Scheme (HCCS) the Commonwealth reimburses medical indemnity insurers for each claim 50 per cent of the excess over $300,000 of each claim, up to the limit of the practitioner's cover. The HCCS currently pays about $30 million per year. This is likely to increase due to the 'claims made' nature of the scheme and the fact that the claim reporting pattern has not yet reached a plateau.

The Premium Support Scheme (PSS) subsidises a portion of eligible doctors' medical indemnity premiums. If a doctor has gross medical indemnity costs exceeding 7.5 per cent of gross medical income, a subsidy is received for part of the premium cost beyond that threshold. In 2009-10, 2439 practitioners accessed PSS payments, totalling $17.2 million towards insurance costs and with $2.4 million in administrative expenses.

Establishment of a State-based no-fault NIIS is likely to substantially reduce the number of large claims paid by medical indemnity insurers, resulting in significant reductions in payouts under the HCCS, with resulting savings for the Commonwealth Government. The PSS was established in response to a period of rising medical indemnity insurance costs, and arguably the need for this scheme has diminished since then.

A Commonwealth Government contribution to the medical treatment component of the NIIS, equal to the amounts expected to be paid in coming years under the HCCS and the PSS, has the potential to cover a significant part of the costs of care for people covered under an NIIS.

10 Common law rights

The Productivity Commission recommended that common law rights for damages associated with lifetime care and support be extinguished. This was based on the premise that the NIIS would operate as a no-fault scheme which provides high quality care and support, by extension make redundant the need to access additional support through the common law. The right to sue for the remaining heads of damage, such as

economic loss and pain and suffering, would remain, with the proposed review of the NIIS in 2020 to assess the effectiveness of these arrangements.

Issues associated with removal of common law rights for care and support are largely common across the various injury types that could be covered by a NIIS. The agreed minimum benchmarks for motor vehicle accidents and the draft minimum benchmarks for workplace accidents do not require jurisdictions to extinguish common law rights for care and support costs. The decision of whether or not to retain common law rights remains at the discretion of State and Territory jurisdictions. If common law rights are maintained it might then be necessary to allow the NIIS to seek reimbursement from clients from any damages awarded.

11 Reporting standards

The Productivity Commission suggests that a key consideration in constructing the NIIS for catastrophic medical accidents is to build on existing incentives to minimise risk by motivating the systematic collection and analysis of data that may decrease risks.

The minimum benchmarks for motor vehicle accidents establish consistent reporting standards, stating that each Scheme agree to collect information in regard to the following items and report under a consistent definitional framework. There seems no reason not to adopt the same benchmark for medical treatment injury.

Consistent reporting standards

That each Scheme agree to collect information in regard to the following items and report under a consistent definitional framework:

1. The number of entrants to each scheme and their characteristics (Age/gender/location of service provision – i.e. metro/regional/rural)
2. The classification of injuries of entrants – Spinal injuries (including level of lesion), head injuries (moderate + severe), other severe injuries;
3. The average cost of support of scheme entrants (overall and by the agreed injury classification);
4. The average cost of care in each jurisdiction (to understand variations in the cost of attendant care and monitor trends); and
5. The amount of care per claim overall and by injury classification.

Appendix A: State based insurer high cost medical indemnity claim experience

The following table lists relevant high cost (claims over $1 million) medical indemnity claims for Victoria, South Australia and Western Australia over the previous ten years, and from New South Wales since 1989.

Injury type	Number of claims	Injury type	Number of claims
Brain injury	96	Stroke	2
Cerebral Palsy	69	Coronary artery disease	1
Birth related injury	62	Neuromuscular auto immune	1
Spinal injury	21	Perforation of bowel and inability to have children	1
Quadriplegia	12	Respiratory arrest and hypoxia	1
Paraplegia	10	Kidney failure	1
Neurological injury	10	Chronic pain syndrome	1
Amputation	8	Chronic infection	1
Infection	4	Burns	1
Blindness	4	Infection	1
Mental health	3	Haematoma	1

Appendix B: Medical Misadventure in New Zealand

New Zealand's *Accident Compensation Act 1972* establishes a no fault scheme for accident victims which includes provision for rehabilitation and earnings-related compensation. In respect of medical misadventure, it seeks to distinguish between unexpected accidents and ordinary treatment of an illness or disease.

Early court decisions on medical misadventure developed a two-limb test, asking whether there had been either medical negligence or medical mishap. Compensation was provided for medical misadventure, including insufficient or wrong treatment, failure to inform, misdiagnosis, misrepresentation or administrative shortcomings such as mishandling a claim. Compensation was not provided in the case of medical mishap, an unforeseeable adverse consequence of treatment which had been properly administered and which did not involve negligence. Some unexpected or "accident-like" event was required to remove a case from the category of sickness or disease, which was not covered, to medical misadventure, which was covered.

As experience accumulated, the need to prove a medical error came to be seen as anomalous in a no fault compensation scheme. A review recommended that there be cover for unintended injuries in the treatment process, or on another formulation, outside the expected and likely range of consequences of treatment. The aim was to move away from any need by a claimant to prove fault by a registered health professional in order to qualify for compensation.

In 2005 amendments were made to introduce the concept of "treatment injury". Treatment injury means personal injury suffered by a person seeking or receiving treatment from a registered health professional that is caused by treatment and that is not a necessary part or ordinary consequence of the treatment, taking into account all the circumstances including the person's underlying health condition and the clinical knowledge at the time of the treatment. Treatment injury does not include injury that is wholly or substantially caused by a person's underlying health condition, injury that is solely attributable to a resource allocation decision, or injury that is a result of a person unreasonably withholding or delaying consent to undergo treatment.

In order for there to be cover for a 'treatment injury', the personal injury must be 'caused by' the medical treatment. That is, on the balance of probabilities it must be shown that 'but for' the treatment, the injury would not have occurred.

There is no cover for injury that is a necessary part or ordinary consequence of treatment. However, treatment may involve risks of unwanted side effects, and it is not clear what risk probabilities will be regarded as "necessary" or "ordinary".

Source: Todd, S. (2011), 'Treatment Injury in New Zealand', *Chicago-Kent Law Review* 86, p.1169.