

Productivity Commission inquiry into a long term disability care and support scheme

Avant Mutual Group Limited

Second Submission

Friday 13 May 2011

Background

Avant Mutual Group Limited (Avant) is Australia's largest medical defence organisation (MDO). Through our licensed insurance subsidiary, Avant Insurance Limited, we provide indemnity insurance and support to more than 55,000 members.

Avant is a mutual, not-for-profit organisation and operates nationally with offices in New South Wales, Victoria, Queensland, Tasmania, South Australia and Western Australia. Avant provides insurance cover for over 50 per cent of insured doctors and also on behalf of a large number of allied health professionals.

Further details about Avant are set out in the first submission which we made to the Commission on 21 September 2010 (First Submission).

We have set this second submission out under the following headings:

1. Summary.
2. Relevant points from our First Submission
3. General observations about the Commission's proposals.
4. Responses to the Commission's further information requests.

We look forward to discussing any of the points raised in this second submission.

1. Summary

Support for NDIS and NIIS

In our First Submission, we indicated our support for the objective of a national long term care and support scheme for Australians with profound or severe disabilities.

However, we note the Commission's proposal to establish dual disability schemes (the NDIS and NIIS) (Schemes) as outlined in its draft report of February 2011 (Draft Report).

While Avant continues to support the broad objective as above, we believe that it is not best served by the introduction of dual Schemes and whilst we support the establishment of the NDIS we do not support the establishment of the NIIS as a precursor to the NDIS. Rather, we would recommend that a meaningful pilot be established for the NDIS as soon as practicable, with a view to it becoming the sole, federally-funded long term care and support scheme.

While we do not support the establishment of an NIIS, we have provided comments in relation to its design and implementation in this submission in the event that it does proceed.

We also note that some of the key proposals contained in the Draft Report remain at this stage at a relatively high level and more detail will be required before definitive views can be expressed.

Our First Submission

A number of points which we raised in our First Submission remain relevant to the design and/or implementation of the Schemes following the publication of the Draft Report. These are set out in section 2 below.

Transitional and geographic issues

There are a range of transitional and geographic issues arising from the design and/or implementation of the Schemes which we suggest require further consideration before definitive views can be expressed about certain aspects of the Schemes, including the need to determine the transitional arrangements for existing injuries and claims and the potential for "arbitrage" between State-based schemes forming the NIIS, and also between the NDIS and NIIS. These are considered in more detail in sections 3.2 and 3.3 below.

Interim funding of catastrophic medical accidents under the NIIS

In relation to the practical methods for the interim funding of the NIIS, we have canvassed a range of options for consideration by the Commission.

Criterion for determining coverage of medical accidents under the NIIS

As those who do not qualify for the NIIS should presumably get an equivalent level of support under the NDIS, we do not believe that there is logic to any criterion being applied to determine coverage under the NIIS. Anyone who suffers a catastrophic injury arising from any medical accident should find their way immediately into the NIIS if it is established more quickly and provides at least an equivalent level of support to the NDIS.

In particular, those suffering catastrophic injuries as a result of medical accidents occurring before the NDIS becomes operational should not be made to wait until it is, and should automatically find themselves in the NIIS.

Once the NDIS is established, it will be less of an issue as to which of the Schemes a person who is catastrophically injured as a result of a medical accident falls under, as the level of support and care should be equivalent. We note that the Draft Report does not expressly refer to the Schemes providing equivalent levels of support and care and suggest that a statement to this effect should be included in the Productivity Commission's final report.

That said, if a criterion is required in the "pilot" stages of the NIIS (when it covers only catastrophic injuries arising from medical accidents, workplace accidents, automobile accidents and crimes), we believe that the criterion should be designed to allow as many catastrophically injured people as possible to participate in the NIIS and that the simplest way of achieving this (although still far from optimal) would be to adopt a modified negligence test as described in section 4.2 below.

2. Relevant points from our First Submission

It is worth restating and providing further comment on the key points from our First Submission in light of the Draft Report, as these remain relevant to the more detailed design and/or implementation of the Schemes:

- Participation in the Schemes should be compulsory in the sense that there should be no other source of compensation for future care needs (be it litigation or other government schemes). It is in our view essential for the management of insurable risk that the interaction of the Schemes with civil litigation is unambiguous and stable over time. By eliminating the future care head of damage from civil litigation we would expect major civil claims litigation to be resolved more quickly, less expensively and with less stress for those involved. Notably, speedy resolution will deliver more immediate support to severely or profoundly disabled Australians than waiting until their claim for compensation is finally resolved which in our experience can take up to twenty five years from the date of the incident.

This appears to be the broad intention behind the Schemes, but there does not appear to be a definitive recommendation to this effect in the Draft Report and we suggest that the Final Report should contain a clear statement to this effect;

- All future care costs related to severe and profound disabilities as a result of adverse medical events should be fully included in the Schemes, and the right to pursue compensation through civil litigation for other damages should remain. A scheme that provides immediate and ongoing support, as opposed to lump sum compensation payments, is more likely to focus on the immediate medical, social and personal needs of those in need of support. This is particularly so given the considerable uncertainty involved in determining future care costs during consideration of heads of damage. Greater clarity in the Final Report about what future care costs are covered/not covered will assist in getting immediate support to those who need it, rather than it becoming the source of further dispute;
- Funding of future care costs associated with adverse medical outcomes that result in severe and profound disability but which do not result from negligence should be broad-based. The Schemes should not increase the existing medical indemnity costs for Australia's doctors and allied health professionals, as patients would likely bear such increased cost through higher fees and charges and given the need to encourage maximum medical workforce participation it is essential that premiums remain affordable. Our suggestions in relation to funding are set out in our responses to the Commission's further information requests in section 4 below;
- Transitional arrangements need to be carefully considered to avoid any unintended impact on the stability of the current medical indemnity insurance environment and other existing schemes which may be impacted by the Schemes. These are discussed in more detail in section 3 below; and
- The Federal Government already provides medical indemnity support (and hence support of patients with long term disabilities) through various existing schemes and indirectly through Medicare funding of health costs (which finance indemnity premiums). In our view, these existing medical

indemnity schemes should be maintained in their current form for the time being and certainly at least until the intended 2020 review, although their precise operation (ie monetary thresholds and hence overall cost to taxpayers) should be reviewed at that time once the impact of the Schemes can be more accurately assessed. It will take until at least this time and possibly until around 2025 for the impact to be more accurately assessed, given the "long tail" nature of medical injury claims. This is discussed in more detail in section 4 below.

3. General observations about the Commission's proposals

3.1 Funding reallocation for medical negligence costs

In our First Submission, we suggested that claims which result from adverse medical outcomes should be funded entirely from Federal Government's consolidated revenue. However, as the NIIS is proposed to be a federation of State-based schemes, some reallocation of funds from existing medical indemnity premiums to State governments would appear to be required and/or additional funds collected from medical practitioners by the States over and above existing premiums to meet the additional cost burden in respect of future care costs for the severely and profoundly injured as a result of medical accidents in the private sector. This is discussed in more detail in section 4.1 below.

3.2 Transitional issues

Potential inequity for those who have already suffered medical accidents at the commencement of the Schemes

Medical indemnity insurance is provided on a "claims made" basis. That is, for the policy to respond, the claim must be notified to the insurer within the period of policy coverage. Medical indemnity cover is classified as "long tail" as it may be several years (on average over 4 years but in some cases in the order of 25 years) after the accident that the claim is notified to the insurer, subsequently evolves into a claim, quantum is agreed and payment is ultimately made.

Medical indemnity insurers must calculate premiums to cover losses from claims arising from future notifications which could relate to accidents either in the past or in the future. A good example of this is where a child is born with a disability following a medical accident. The child's parents may indicate that they may at some stage sue the doctor (whereupon the doctor should notify his/her insurer), but they may not bring formal proceedings against the doctor until many years later when the child's prognosis is more reliable and the likely compensation can be more reliably estimated (whereupon it becomes a claim). It may then take in some cases many years to determine causation, agree quantum of the loss and ultimately settle the claim.

The commencement of the Schemes raises important questions in this regard such as what happens to those who have already suffered catastrophic medical accidents as at the commencement date of the Schemes. In the following paragraphs, we have raised a number of questions, but note that the answers to them will be a matter of public policy, to be determined by the designers of the Schemes and Federal and State Governments.

In terms of how existing notifications and claims are to be dealt with by medical indemnity insurers, it is proposed that the NIIS will cover the future care

component of all severe and profound disability claims which result from medical accidents occurring *after* the commencement of the NIIS. There is no difficulty with this transition as all notifications made after the start of the NIIS and all claims arising from them will exclude the future care component. This will mean however that there will be minimal impact on medical indemnity premiums in the early years of the NIIS prior to commencement of the NDIS, as most claims or notifications made in these early years will relate to incidents prior to the commencement of the NIIS.

The full impact on medical indemnity premiums will only be realised some years after the commencement of the NDIS, which will pick up all incidents prior to the commencement of the NIIS.

It is proposed that the future care component of all severe and profound disability claims which result from medical accidents occurring *before* the commencement of the NIIS will be covered by the NDIS. This appears arbitrary, and will result in profoundly injured people who are involved in medical accidents before the start of the NIIS having to wait for the full roll out of the NDIS to get the support and early intervention that they may urgently need.

We question whether it is good public policy for catastrophically injured persons who have suffered medical accidents or already made claims or notifications at the commencement of the NIIS to be left to prove medical negligence to recover any compensation or wait for the start of the NDIS, rather than being immediately covered by the NIIS.

A further, related issue which will add more complexity is how future care costs are to be unbundled from court proceedings which have already been issued.

Another related issue is whether the common law right to sue for future care costs would end on commencement of the NDIS or whether patients would effectively have the choice of suing their doctor or receiving support from the NDIS.

It is also unclear what might happen to existing claims for compensation in respect of past gratuitous care provided by families and other carers. As a matter of public policy, should victims of accidents occurring before the commencement of the Schemes be able to claim compensation for the costs of such care?

Some practical answers to such transitional issues may be found in the transitional arrangements for existing State-based accident compensation schemes, such as the NSW Lifetime Care & Support Scheme, which applies to children under 16 injured in an accident on or after 1 October 2006 and to adults injured in an accident on or after 1 October 2007.

The transitional arrangements for the NSW Lifetime Care Scheme include allowing people injured as a result of an accident before these dates to "buy-in" to the scheme. This seems to be designed to allow into the scheme people who had already received compensation but wished to have their care needs met through the scheme rather than buy it privately with their compensation. However, caution should be exercised in relation to such precedents, as they were not designed to address the transition of long tail claims such as medical accidents.

The challenge is to determine in the context of long tail medical accident claims what transitional arrangements might best avoid anomalous results and unfortunate outcomes occurring depending on the day on which an injury occurs,

is notified to a medical indemnity insurer or becomes a claim and is finally settled.

Fall in premiums?

Another important question is whether medical indemnity premiums (exclusive of levies etc) will, in fact, fall due to the transfer of future care costs to the Schemes, and if so to what extent and over what time period?

Legal costs

Assuming that civil litigation rights in relation to compensation other than future care costs remain in place, as the Draft Report suggests, while the overall settlement costs will fall by the amount of the future care costs, the other heads of damage will remain. We would expect the majority of the legal costs will still be incurred in pursuing compensation under these other heads of damage and would therefore not expect the legal costs associated with medical accidents to fall substantially. Causation, liability and apportionment issues (eg between doctors and hospitals) will still arise and require legal resolution.

In fact, in relation to the NIIS, legal costs may actually rise if there is any kind of "entry" test applied (see section 4.2 below) as those who have suffered catastrophic medical accidents after its commencement but who are initially denied access to it seek to reverse the eligibility decision. With different State-based schemes, even if the eligibility criteria are the same, different scheme administrators might interpret the criteria in different ways, leading to actions in administrative law to review the merits of the decisions made and the process by which they are taken.

We also understand anecdotally that the experience at the commencement of the New Zealand Accident Compensation Corporation Scheme was that injured persons who were denied access to the scheme due to its eligibility criteria tended to make disciplinary complaints against medical practitioners to achieve some kind of "justice" against a medical practitioner they perceived to have "done the wrong thing". Any such response to the introduction of the Schemes might also increase legal costs, at least in the short term.

Reinsurance costs

Reinsurance costs for medical indemnity insurers might ultimately be expected to fall both for excess of loss type cover and aggregate stop loss type cover, although reinsurers may well adopt a "wait and see" approach at the outset of the Schemes before committing to any substantive re-pricing of such programmes.

In the longer term, there are many factors which might mean that reinsurance costs do not ultimately, fall in line with the transfer of future care costs into the Schemes.

Short/long term impact

Overall, while one might be hopeful that medical indemnity premiums will fall once the Schemes are introduced, the reality is that they may only do so over a period of years.

In the meantime (depending on the chosen transitional arrangements), insurers may need to continue to charge premiums which reflect the uncertainties of the Schemes generally and in particular the likelihood of future notifications becoming

claims on incidents that occurred prior to the date of the commencement of the NIIS.

So, it cannot be safely assumed that medical indemnity premiums will fall, or if they do, that they will fall significantly or with immediate effect.

This may influence any decision to impose further levies or taxes on medical indemnity premiums (see section 4 below) which are likely, in any event, to be passed on to patients and might give rise to a recurrence of the premium affordability issues which beset the industry around 2002/3 threatening a drop off in medical workforce participation similar to that which led to the establishment of the PSS and HCCS.

Single scheme versus multiple schemes

We note the potential advantages of building upon existing State-based accident compensation schemes to establish the NIIS more quickly and the NDIS subsequently. However, this does create a level of complexity, risk and potentially additional short-term cost compared with the establishment of a single scheme and may well prove to be more difficult to establish without the cooperation of Federal and State governments on a number of issues.

We question whether the complexities associated with the dual Schemes might mean that the overall objective of providing no-fault cover for future care costs nationally might ultimately not be achieved. State governments might regard their schemes once established as “entrenched” and might be unwilling to yield to the broader, national NDIS once it is established, leading to a continuing duplication of infrastructure costs and continuing difficulties such as scheme arbitrage and jurisdictional/funding disputes.

While the Draft Report refers to the existing States’ accident compensation schemes as being well-placed to provide extended cover quickly and efficiently, we question whether in fact this is the case for medical accidents as they are of a very different nature to motor or workplace accidents. This concern is magnified given that a number of States have no scheme today to seek to leverage from. Issues as mentioned above such as transitional arrangements, eligibility criteria and the time taken to determine the full financial and other impacts of the Schemes all bring into question whether the existing State-based schemes, to the extent that they exist, are in fact the right place to cover medical accidents.

There may also be a high level of “sunk cost” into the NIIS if it subsequently merges with the NDIS following the proposed review of the Schemes in 2020.

Having two schemes sitting side-by-side may confuse and frustrate patients, especially if the outcomes of patients in the individual Schemes are different or unfair, whether intentionally or otherwise.

The existence of separate Schemes may lead to “forum shopping” within the State based schemes of the NIIS and between the NDIS and the NIIS and patients might well be expected to gravitate to the scheme offering, or being perceived to offer, better quality services and/or support. This may be the case in particular during the early years of the NIIS if States which do not currently have “no fault” accident compensation schemes take longer than those States which do to adjust to the new regime. Some States may not have, or may not develop as quickly, the same level of expertise or experience in dealing with the catastrophically injured or readily available systems and services to provide the

appropriate level of support. Some say this is the case today in dealing with the various existing State accident compensation schemes.

Additionally, we suggest that geographical issues may arise as a result of having different schemes within the NIIS alongside the NDIS. The Draft Report does not clarify how “boundary disputes” between the State schemes within the NIIS will be resolved, for example whether qualification for a particular scheme might be determined by the patient’s place of residence, the place in which the relevant medical accident occurred or by reference to other criteria.

We note that as a matter of principle the establishment of State-based schemes within the NIIS appears at odds with the recent establishment of a national registration regime for medical and other health practitioners which is attempting to eliminate State-based differences and make it easier for practitioners to practice throughout Australia. Different rules for different State-based schemes within the NIIS and potentially different insurance responses in different States may add a new level of complexity meaning that the benefits of national registration might be diluted.

While these differences may to some extent be mitigated by the existence of a National Secretariat for the NIIS, which should homogenise the individual schemes to a large extent, this will not lead to the schemes operating identically and in any event any equalising initiatives will take time to establish and become fully-effective. This will undoubtedly give rise to arbitrage opportunities which may not become apparent until after the Schemes are implemented. This may also be the case where there is uncertainty or overlap as to whether persons qualify for the NIIS or the NDIS or if the services and/or support provided under the respective schemes are of a different standard.

Conclusion on transitional issues

We suggest that to the extent possible such transitional issues be dealt with in the Commission’s final report, rather than addressed subsequently, as if they are left unresolved at this stage, there will be considerable uncertainty for the catastrophically injured, governments, carers, support services and insurers alike as to the impact of the Schemes and the preparations they need to start making for their commencement.

In the longer term we support a single, federal “no fault” scheme covering all catastrophically injured persons, as is contemplated may be the case following the proposed review of the Schemes in 2020. However, we caution that, for the reasons stated above, any review in 2020 may not be able to fully assess the impact of the Schemes on the care of those catastrophically injured in medical accidents and accordingly we recommend the 2020 review be an interim one and be followed by a further review every 5 years.

3.3 Public versus private sector costs

Funding of the NIIS will need to take into account the fact that the States already fund a higher proportion of catastrophic medical accident claims than medical practitioners and their medical indemnity insurers.

We note from the recently released AIHW Report “Public and private sector medical indemnity claims in Australia 2007-08” that around 70% of medical

indemnity claims related to incidents alleged to have occurred in a public sector health setting, such as a public hospital, while only 30% of such claims related to incidents alleged to have occurred in a private sector health setting, for example, a private medical clinic.

4. Responses to the Commission's further information requests

The Commission has asked for further information on a number of topics. Those relating more specifically to medical accidents are from Chapter 16 of the Draft Report and are as follows:

"The Commission seeks feedback on practical interim funding arrangements for funding catastrophic medical accidents covered under the NIIS" and

"The Commission seeks feedback on an appropriate criterion for determining coverage of medical accidents under the NIIS."

Our responses to these requests are as follows:

4.1 Practical interim funding arrangements for funding catastrophic medical accidents covered under the NIIS

Meaning of "interim"

We note that the request is for an "interim" solution. As mentioned in section 3.1 above, we believe that it will take several years for the Schemes to fully mature and for their full financial and other impacts to be assessed. We therefore suggest that "interim" funding needs to be in place until at least 2020 when the Schemes are intended to be reviewed and ideally even later, say, 2025 given the long-tail nature of medical indemnity claims. This would be ten years after the proposed commencement of the NDIS which would provide a much clearer picture of the claims "tail."

As we have stated in section 3.2 above, our view is that following the proposed review of the Schemes it would be logical for the NIIS to be brought within the NDIS.

How much funding is required?

Private Sector Medical Negligence Costs

We estimate that of the \$300m or so in annual medical indemnity premiums (excluding GST, stamp duty and other levies) paid by Australian medical practitioners, around \$30m might broadly relate to the provision of future care costs for those who are severely and profoundly injured as a result of medical negligence in the private sector.

However, this estimate may be unreliable due to the volatile nature of medical indemnity claims, both in terms of frequency and overall cost, and further work would be required to come to a more definitive view. It may be impossible to determine the actual savings with any accuracy until several years after the commencement of the Schemes.

The Federal Government also provides a level of assistance in respect of such future care costs under its High Cost Claims Scheme (HCCS), to a lesser extent its Run-Off Cover Scheme (ROCS) and in an indirect sense the Premium Support Scheme (PSS). It is not possible for us to determine with complete accuracy the amount of such assistance, but some estimates may perhaps be available from the Australian Government Actuary.

If, however, we assume that the Federal Government's contribution to such future care costs under the existing medical indemnity schemes is broadly similar, then between medical practitioners and the Federal Government there is currently funding of future care costs for those who are severely and profoundly injured as a result of medical negligence in the private sector in the order of \$60m ("Private Sector Medical Negligence Costs").

If the States are to assume funding responsibility for such costs under the NIIS, it would seem appropriate that there be some mechanism to effectively transfer the medical indemnity premiums which are actually saved by Australian medical practitioners to the State Governments. While this would require further consideration, one solution may be for the States to impose a uniform, interim levy on medical practitioners' indemnity premiums of say, 10%, to be reviewed once the full impact of the NIIS is known. If full funding is not required in the early years of the NIIS, such a levy could start at, say, 5% and be increased to 10% over time as funding requirements increase. Ultimately, the exact amount of the levy should equate to the amount medical practitioners actually save once future care costs for the catastrophically injured are covered by the NIIS.

The outcomes for medical practitioners in this respect should be neutral, in that they should neither receive a "windfall" gain from the NIIS picking up such future care costs nor have to pay a State levy such that the overall amount of the premiums they pay rises beyond the current level. It would not be in anyone's interests if there was a re-emergence of premium affordability issues for medical practitioners that nearly brought the industry to its knees, as commented upon earlier.

We believe that our members are likely to accept, as a matter of good public policy, that they should not receive a "windfall" gain and are therefore likely to be comfortable in paying a State-based NIIS levy provided it has an equivalent financial benefit for them in terms of reduced premiums in a realistic time period.

In this regard, it is also important to note that the premium burden of such Private Sector Medical Negligence Costs may not be shared equally between medical practitioners. The impact on premiums for different speciality groups may well be different.

While some speciality groups may see a fall in their premiums if Private Medical Negligence Costs are transferred to the NIIS, many may not see any fall in their premiums so it would be unwise to assume that they will be in a "neutral" position if they are required to pay an additional State levy in respect of Private Sector Medical Negligence Costs. We suggest that this issue may need to be considered further.

No Fault Medical Accident Costs

This leaves the further question of how the States might fund the additional cost of providing future care for persons catastrophically injured in medical accidents on a "no fault" basis over and above the Private Sector Medical Negligence Costs

and those medical negligence costs already assumed by States in relation to public sector claims (“No Fault Medical Accident Costs”).

The Draft Report indicates that the total additional costs of the NIIS are projected to be approximately \$685m. While there is perhaps insufficient commentary on the method of calculating this amount in the Draft Report and there may therefore be debate as to its accuracy, we have assumed for the purposes of this submission that it is correct.

The Draft Report also indicates that around 11% of catastrophic injuries arise from medical accidents, with around half resulting from motor vehicle accidents, 8% being work related and 32% being classed as “general injuries”. While “general injuries” are not proposed to be initially covered by the NIIS, they have been included in the \$685m total cost estimate for the NIIS.

While forming 11% by number of the estimated number of accidents, the Draft Report indicates at table 16.1 that the estimated incremental costs arising from “medical misadventure” are around \$95m (ie \$69m as per the table adjusted for inflation).

As such, the No Fault Medical Accident Costs might be about \$30m (ie \$95m x 0.3) if the proportion of public to private sector medical accident claims is assumed to be the same as in the recent AIHW Report referred to in section 3.3 above.

This calculation is obviously highly theoretical and our apprehension is that the No Fault Medical Accident Costs might in practice turn out to be much higher and/or imposed to a greater extent on medical practitioners rather than the broader community (see section 4.2 below).

Ultimately, the costs will depend largely on the eligibility criteria adopted for the NIIS. A much lower threshold to entry would increase the No Fault Medical Accident Costs and vice versa.

Somehow, any entry criteria for the NIIS need to be matched to its expected funding costs and we assume that the \$95m incremental costs arising from “medical misadventure” estimated in the Draft Report are based on there being some form of entry criteria in place.

It should be noted that \$30m is extremely small in the context of the \$6.6bn estimated total funding cost of the NIIS and NDIS. However, while it is possible to think conceptually about the increased costs arising from medical accidents in isolation from other costs, in practice the funding of the overall \$685m would need to be considered by the Federal and State governments to properly assess the likely political reaction to the proposed funding arrangements.

Funding options for No Fault Medical Accident Costs

The broad options for funding the No Fault Medical Accident Costs would appear to be as set out below, ranging from a broad funding base to a narrow funding base.

In putting forward these options, we note our members’ preference for broad-based funding of No Fault Medical Accident Costs as this aligns most closely with the concept of community insurance.

- **Funding by Federal Government** – the Federal Government reallocates funds from consolidated revenue or raises additional funds from consolidated revenue, eg by an increased Medicare levy or special purpose levy and transfers the funds to the States. Given the breadth of this taxpayer base, the additional burden per taxpayer would be very small and it would spread the burden for what is essentially a national scheme across national taxpayers. In particular, it would have a less significant impact on states which do not currently have a “no fault” accident compensation regime, where state-based tax increases might be significant if left to state-based funding;
- **Funding by State Governments** – each State Government increases its existing State wide taxes or levies such as stamp duty or payroll tax or imposes a new levy so that essentially all tax-payers in the relevant State provide the additional funding required. The funding requirements might be very different across the States, but each State would fund only its own requirements and there would be no “cross-subsidisation” between the States;
- **Fund by increased accident compensation premiums** – State Governments increase the premiums payable for their existing accident compensation schemes (eg CTP premiums). However, there is no nexus between the premium paid and the medical accident and a narrower taxpayer base would have to fund the additional costs;
- **Fund from a combination of the above** – It would be possible to adopt a combination of the above to spread the additional funding cost across different taxpayer bases.

Our recommendation

Funding the NIIS from Federal Government resources, presumably an increased Medicare levy or from consolidated revenue, would make sense in that the friction costs associated with collecting taxes in this way would be the lowest of all of the above options.

It would also give the broadest funding base for the NIIS, which is the most consistent with the concept of “community insurance” underpinning the Schemes and would also give the most consistency for those catastrophically injured, while reducing any unfairness possibly resulting from significantly higher tax increases in some States.

Ultimately, this might also make it more likely that the Schemes are established and fully operational in the shortest time possible, if States do not have to concern themselves with the additional funding and what is implemented for the NIIS might provide a useful funding model for the NDIS in due course.

As we have noted in section 3.2 above, if there is a realistic possibility that the NIIS will be brought under the NDIS from 2020, this would effectively remove the need for an interim funding solution, as the federal government could effectively fund it from the outset from an efficient source, rather than making changes to all of the states’ tax regimes, potentially on a short-term basis, as described below.

Should federal funding not be deemed appropriate, the next broadest funding base would be the taxpayers in each State. Existing State taxes or imposts such as payroll tax or stamp duty or existing levies such as the Fire Service Levy on insurance could be increased without significant additional frictional cost so that

the additional funding burden is spread widely among each State's residents, who would be the "community" that would benefit from the social insurance of knowing that a no-fault insurance scheme exists for the catastrophically injured.

However, there may be significant disadvantages of State-based funding compared with Federal Government funding, including higher overall friction costs of collection and the possibility that the additional tax burden for some States' taxpayers (in particular such as Western Australia and the Northern Territory where the incremental costs of moving to a "no fault" scheme may be high and the number of residents is relatively low) may be disproportionately high.

The introduction of significantly higher taxes in some States may make the NIIS more difficult and/or slower to implement, thereby defeating the purpose of building the NIIS around existing accident compensation schemes.

We do not recommend funding from increasing existing accident insurance premiums as the funding base is too narrow and this is contrary to the spirit of "community insurance".

There would be no benefit gained from increasing insurance premiums in terms of changing the behaviour of those who might best be able to mitigate the risks (which is often cited as a reason for imposing additional premiums) as by definition there is no fault involved.

In terms of medical accidents where no negligence is involved, medical practitioners should pay their share of No Fault Medical Accident Costs as part of the broader taxpaying community and not for an adverse medical outcome which could not reasonably have been prevented (ie does not result from their negligence).

4.2 An appropriate criterion for determining coverage of medical accidents under the NIIS

The Draft Report suggests for a medical injury claim to be covered under the NIIS there would have to be a "sufficiently unexpected or unusual outcome from medical treatment" and that some catastrophic disabilities would not be covered by the NIIS (but would be covered by the NDIS) if "an administratively applied criteria [sic] determines the treatment or care provided is delivered in a timely and appropriate manner and there is no clear reason for the condition other than a genetic factor or underlying health condition."

No long term criterion

Given our understanding that the Schemes are supposed to operate on a "no fault" basis, it is our strongly-held view that there should not in the longer term (ie once the NDIS is fully operational) be any criterion applied to "medical accidents" to determine coverage under the NIIS or the NDIS nor any exclusion from coverage where there has been "timely and appropriate treatment".

It is consistent with the concept of "community insurance" and the principles of social justice and fairness that in the longer term any person who suffers a catastrophic injury or who has a profound disability, howsoever caused or arising, should be covered by, and supported appropriately under, the Schemes. There should be no exclusions for medical or any other types of accidents or any conditions or disabilities provided that the disability is severe and profound.

The introduction of any criterion to determine coverage under the NIIS on a longer term or interim basis is likely to bring significant risks, including:

- Delay, as the application of the chosen criterion and the implicit causation issues are tested by plaintiffs and their lawyers and almost inevitably appealed so as to clarify the legal position;
- Increased cost, due to the above;
- Unfairness, as some will miss out on cover, in particular in the period before the NDIS is fully operational. Those who miss out may well include some of the most catastrophically injured or profoundly disabled (see below);
- Uncertainty and distress, as injured persons, their carers and insurers wait for clarification of boundary issues; and
- Obscuring of the data coming out of the "pilot" phase of the NIIS.

We note in this regard the difficulties encountered by the New Zealand Accident Compensation Corporation Scheme, which, due to the costs, delays and other difficulties associated with proving its initial "medical error" or "medical mishap" criteria subsequently moved to applying a single concept of "treatment injury."

However, even this less-stringent "treatment injury" criterion has led to complications, as there is still a need to prove "injury" which excludes many with serious disabilities such as those with Down Syndrome and other severe and chronic illnesses such as multiple sclerosis.

Others may not be able to establish a causal link between the injury they have suffered and any medical treatment, for example those suffering from cerebral palsy where the cause may be genetic and not result from an injury or if there has been an injury it has no clear cause. In this regard, the Access Economics report "The Economic Impact of Cerebral Palsy in Australia in 2007" dated April 2008 states that for 80% of people with cerebral palsy, the cause of the brain damage responsible for their disability is unknown.

There are approximately 700 babies born each year with cerebral palsy, of which about half have a severe and profound disability, with around 10% of these 350 having a compensable claim in negligence or otherwise at common law. If, due to the imposition of an eligibility criterion, the NIIS simply increases this percentage from 10% to, say, 20%, the NIIS will not in our view have served its purpose and 80% of those with a severe and profound disability will have to wait for the NDIS to commence to receive any support.

Excluding such persons from the Schemes would not, in our view, be consistent with good public policy and would contradict the very purpose of establishing a no fault disability scheme.

For these reasons, we strongly believe that there should be no criterion applied, apart from that a person has acquired, or has been born with, a severe and profound disability after the commencement of the NIIS. The impact of this on the likely funding requirements of the NIIS should be tested as soon as practicable.

However, if the Commission recommends that some kind of injury should be a precursor to coverage and that an eligibility criterion should be applied, we strongly suggest that it contain no "fault" element and no exclusions for treatment in a timely and appropriate manner (or similar).

We therefore suggest that the criterion simply be that:

"a person has suffered a catastrophic injury as a result of seeking or receiving treatment from, or at the direction of, a healthcare professional."

Temporary criterion

The only justification we can see for the application of any criterion to entry into the NIIS is that it is necessary in order to facilitate the quick and efficient establishment of the NIIS so that it can start its "pilot" phase quickly (ie motor vehicle plus medical accidents plus workplace accidents) and therefore be ready for expansion as soon as practicable to cover at least the victims of crime and those who have suffered other general accidents.

We recommend that any temporary criterion should fall away from the time the NDIS becomes fully operational so that the community can be sure that nobody with a severe and profound disability is excluded from the Schemes.

In the interim, if a criterion is applied, it should be the criterion we have suggested above.