18 A national injury insurance scheme

Key points

- A priority for reform is the establishment of no-fault lifetime care and support for *all* catastrophic injuries. The scheme established for this purpose, the National Injury Insurance Scheme (NIIS), should:
  - provide an all encompassing system for managing the care and support needs of all people experiencing catastrophic injury
  - primarily be funded from insurance premiums and, where appropriate, include experience and risk-rating to help prevent injury
  - be structured as a federation of separate, state-based schemes.
- To coordinate the federation of individual schemes, jurisdictions will need to establish a small full-time secretariat that:
  - ensures consistency in eligibility, definitions and assessment
  - reports on services relative to the minimum benchmark of care and support services
  - manages a comprehensive database, facilitates sharing of data and ensures consistent monitoring of performance, including actuarial valuations and client outcomes
  - works to eliminate any unwarranted variations in scheme design.
- There would be merit in state and territory governments contracting out the above secretariat functions. The National Disability Insurance Agency could play an important role in this respect. It could act as a host for cooperation, assist in, and publish, benchmarking information and encourage diffusion of best practice.
- Special arrangements are proposed for cerebral palsy. For this condition, it is suggested that the NDIS have full responsibility for funding care and support. This reflects that, by far, most cases of cerebral palsy cannot be avoided through clinical practices. Moreover, it is particularly hard to reliably determine whether clinical care was the cause in any individual case.
- An independent review of the NIIS should occur in 2020. Apart from evaluating ways the performance of the NIIS might be improved, it should consider the case to expand the NIIS. This might include widening NIIS coverage to include other heads of damages and significant, but non-catastrophic, injuries. The case for merging the NIIS and NDIS should also be evaluated.

18.1 A national injury insurance scheme is needed

The previous chapter identified many flaws in the current, predominantly common law (or fault-based) arrangements for providing care, support and other assistance to people injured in accidents. It identified the general superiority of no-fault insurance arrangements to fund, manage and coordinate the lifetime care and support needs of all people acquiring a catastrophic injury at some point in their lives.

The Commission considers that, to avoid the many deficiencies of common law compensation systems, and improve outcomes for people with catastrophic injuries, governments should create a no-fault system of nationally consistent care and support arrangements for people with catastrophic injuries (a National Injury Insurance Scheme, or NIIS).

In the Commission's assessment, the priority for reform is the establishment of no-fault lifetime care and support for *all* newly acquired catastrophic injuries. (The care and support needs of people with existing catastrophic injuries, and not covered under any of the present no-fault arrangements, would be met through the National Disability Insurance Scheme — the NDIS.)

There are many choices about the scope and design of the NIIS, involving questions about:

- the severity of injuries to be covered (all, serious, catastrophic?)
- how common law arrangements might coexist with a no-fault scheme and, in turn, the various heads of damage that the NIIS should cover (lifetime care and support, economic loss, pain and suffering?)
- the interaction and interface between the NIIS and the much broader NDIS
- scheme governance and coordination across the states and territories to ensure consistency in eligibility, assessment and a minimum benchmarked level of care and support
- the timing of implementation and other transitional issues
- appropriate sources of funding, particularly those that provide efficient incentives for risk management and prevention of avoidable risks.

Given the findings of chapter 17, perhaps the least contentious issue is in relation to lifetime care and support for people experiencing catastrophic injury. This is where many of the flaws in common law, fault-based arrangements are experienced most acutely — inequity, delay, uncertainty, poorer outcomes and inefficiency. Moreover, catastrophic injuries largely affect young people, with around 60 per cent of those affected being under 30 years old, so the effects on their lives are prolonged, as well as extreme. The average

duration of a major injury claimant in the Victorian Transport Accident Commission (TAC) is projected to be around 30 years.

The Commission proposes that lifetime care and support under the NIIS would meet all of a person's injury-related needs (excluding income payments, which would sit outside of the scheme). It would fund all reasonable and necessary clinical health services, medical and social rehabilitation, early interventions, therapies, care, and home and vehicle modifications. Opportunities for self-directed funding (chapter 8) would be part of scheme design to enable greater flexibility, where that is appropriate and consistent with the scheme's objectives and improves outcomes for participants.

The NIIS would also need to involve the following:

- Transitions through the health system would need to be as seamless as possible, and care and supports coordinated over a person's duration of need. Rehabilitation and early interventions should be appropriately timed (informed by rigorous data analysis) and, where necessary, supported by clinicians and allied health professionals.
- The stream of funding provided would also help develop specialist health services necessary for rehabilitation, which tend to be under-developed and under-funded in the health system (such as specialised brain injury centres).
- Key life transition points would be anticipated and planned for, to facilitate independence and participation goals — including, where appropriate, by connecting with community groups (as under the NDIS (chapter 4)).

Such developments should facilitate the continuity and coordination of care and supports, leading to better health and participation outcomes over the course of an injured person's life. These are important benefits, even for those who may otherwise have been able to obtain a significant lump sum payment for their long term care and related costs. (Indeed, as noted in chapter 17, the lengthy process of obtaining common law lump sum damages frequently delays recovery and optimal early interventions, and generally provides a poor mechanism to manage uncertainty over future needs, health status, life expectancy and other life circumstances.)

In addition, the policy changes proposed by this chapter should:

- reduce reliance on social welfare services and supports that, given the complex and particular care needs of people with catastrophic injuries, are likely to result in inadequate long-term care and support, and lost opportunities for forward-looking injury management

- remove much of the focus on litigation as the mechanism for seeking compensation, and improve health outcomes and recovery
- provide more certain outcomes and greater fairness for all people newly affected by such life-changing injuries (as currently, only around half of people catastrophically injured obtain some compensation to fund lifetime care and support needs).

In addition to providing lifetime care and support for people with catastrophic injuries, there are various other ways that the scope of cover provided by the NIIS could be extended. The Commission has not made specific recommendations about these matters, in view of the need to ensure that the NIIS is up and running and its performance better known before additional changes are made. That said, various policy options to extend the scope and functions of the NIIS are summarised in this chapter and appendix I. In addition, to facilitate improvements to the NIIS over time, including evaluating the case for extending its coverage, an independent review is proposed for 2020 (recommendation 18.7).

18.2 Implementing a no-fault approach for lifetime care and support of all catastrophic injuries

Under the model proposed by the Commission, scheme management, operation and financing would be jurisdictionally-based. A coordinated federated approach would be critical, however, to ensure that the level of benefits and the standard of care provided by individual schemes were subject to minimum reasonable benchmarks.

State-based schemes should draw on the best arrangements already in place around Australia, and extend their scope so that all catastrophic injuries are insured. This would include motor vehicle accidents, medical treatment, criminal injury and general accidents occurring within the community or at home. A person could acquire an identical disability from an accident in any of these contexts, and as such, there is a good rationale for equal insurance and access to care and supports.

Existing institutions like the Victorian TAC and NSW Lifetime Care and Support Authority (LTCSA) should expand to include the management of other catastrophic injuries in those jurisdictions. Tasmania and the Northern Territory could also build on their existing no-fault structures for motor vehicle accidents. As a small jurisdiction — with few and unpredictable numbers of catastrophic injuries — the Australian Capital Territory could consider contracting out the management of catastrophic injuries to another serious injury scheme, using premium income as the funding source. Queensland, Western Australia and South Australia would need to either establish a

new body to administer their scheme or significantly expand the role and functions of an existing structure, such as the Motor Accidents Insurance Commission in Queensland.

Although already providing no-fault benefits, Tasmania's Motor Accident Insurance Board was particularly vexed about the prospect of expanding their 'insurance model' to a broader range of catastrophic accident risks (sub. DR687). These concerns are summarised in box 18.1 below and include several reasonable anxieties given the uncertainty of an NIIS for their well-established scheme. That said, their reservations are generally speculative, or could be adequately addressed through sensible implementation, sound scheme governance and cooperation with other NIIS schemes.

Box 18.1 **Tasmania was particularly concerned about the uncertainty of an NIIS**

The Tasmanian Motor Accidents Insurance Board (MAIB) expressed a number of concerns about an NIIS, believing that it would not be viable as an insurance model and would risk the financial position of their current no-fault arrangement for motor vehicle injury (sub. DR687). We have attempted to briefly address some specific concerns below.

- NIIS cover of motorists convicted of serious traffic offences need not compromise the insurance model of the MAIB (or, indeed, the NIIS) as such costs would be reflected in risk-rated premiums. Moreover, criminal sanctions would continue to deter such behaviour, and monitoring and enforcement capacity is rapidly expanding through technology solutions (see later).
- Concerns about cover for general injuries appear to mainly reflect the view that costs for this class of injury were underestimated in the draft report. The Commission has updated estimates to reflect new data, inflation and population changes, but recognises the uncertainty around these estimates. That said, the level of uncertainty would be unlikely to require revenue contributions from ratepayers to be 'rapidly' increased, as was the suggestion. Furthermore, the option to partially up-front fund general injuries may be desirable (see later).
- The prospect that state governments could be 'forced' into providing budget support in lieu of council contributions is entirely a matter to be decided by state governments. The Commission has identified the advantages of pursuing a levy on local council rates — as an efficient source of revenue and to help manage the risks of injury — but also notes reasons why state governments could share this responsibility.
- Concerns about reinsurance cover could largely be addressed within the federated structure of the NIIS through pooled reinsurance arrangements (see later).
- The risks posed by extreme sports may well be valid, but would largely be an empirical question that information is currently unavailable to adequately analyse. If risks materialise, these could promptly be responded to through specific regulation and risk management activity or, as a last resort, changes to scheme legislation.

While it is proposed that existing workcover schemes would stay in place, state and territory governments could consider transferring the management of the small number of people with catastrophic injuries in their schemes to their NIIS scheme — in effect, contracting these cases to the NIIS. Existing workcover schemes have performed well at preventing such injuries and would continue to have that responsibility, but they are not well geared to provide coordinated lifetime care and support for catastrophic cases.

No-fault insurance for catastrophic injury would mean that common law actions for damages associated with lifetime care and support would be extinguished. The premise for this is that the goal of a no-fault scheme is to provide high quality care and supports, making redundant the uncertain and costly process of accessing any additional supports through the common law. This is separate to whether or not the right to sue for economic losses, such as income, and non-economic losses, such as pain and suffering, should be retained — a matter taken up in section 18.5 and appendix I.

Various lawyer representatives and associations expressed concern about the removal of common law rights to sue for lifetime care and associated damages. They consider that individuals should have the right to choose whether to participate in the NIIS, or to 'opt-out' to pursue a common law claim for their care and support costs, thereby maintaining their individual autonomy (sub. DR774; sub. DR948; sub. DR713; sub. DR843). The Commission appreciates the value of choice, and agrees that people's preferences should be accommodated wherever possible unless the costs and risks of doing so are unwarranted. Chapter 17 discusses the disadvantages of common law compensation in some detail, and finds that care and support costs would be more effectively and efficiently met through a no-fault lifetime care and support scheme. On the question of an individual's choice and flexibility:

- Comprehensive needs assessment under the NIIS would take account of a person's individual circumstances and changed needs over time, providing the flexibility to accommodate individual circumstances.
- The NIIS would include a greater role for self-directed funding and self-determination of care and support to facilitate increased autonomy and choice where that would deliver better outcomes for participants.
- The legal costs of pursuing common law damages can be very substantial and are ultimately borne by society, given funding from compulsory insurance.

One participant raised the possibility that some people may seek to insure themselves for *additional* lifetime care and associated support cover in the event of an accident (Richard Tooth, sub. DR833). To the extent that supplementing cover would be an optional, private arrangement and would enable greater individual choice and flexibility, there would be no reason to preclude such an offering being available to the community

to purchase. Its existence, however, would not be a substitute for or displace the availability of comprehensive lifetime care and support under the NIIS.

Structuring no-fault catastrophic schemes under the NIIS

The creation of an NIIS should provide an all-encompassing system for managing the care and support needs of all new cases of people experiencing catastrophic injury. The structure of the NIIS, and the way it operates and interacts with its participants, will be especially significant in the context that people's care and support needs will typically be lifelong. Well-based relationships and strong governance will be decisive in realising the scheme's objectives over the long term. In particular, the NIIS should use a governance structure and case management system that:

- provides coordinated services to people and creates specialist centres of excellence that are otherwise lacking (for example, trauma centres)
- focuses on the long-term liabilities of care and support, rather than costs or payments applying to any given period (as occurs in the broader disability and health systems). As discussed in chapter 9, a longer-term focus has the advantage of encouraging scheme managers to be less tolerant of unwarranted cost pressures. While a cost shock might seem to be small at the time it appears, a long-term actuarial model can reveal the high cumulative effects that it can have on liabilities.[1] Figure 18.1 shows how the contribution to a scheme's future liabilities differs from the spending on such benefits in a given year. Long-term care is the main source of Victorian TAC future liabilities, even though other benefit types are more 'expensive' in the short term, such as one-off common law damages
- is data-rich, allowing more evidence-based judgments about the best way to improve services and outcomes for participants; and in discovering opportunities for early intervention and injury prevention. Since data are continually collected, monitoring of cost pressures and outcomes can be done in real time. Similarly, no-fault schemes acquire expertise in proactively managing care and support needs, including by predicting the potential seriousness of an injury within days of an accident, and instituting early interventions where appropriate.

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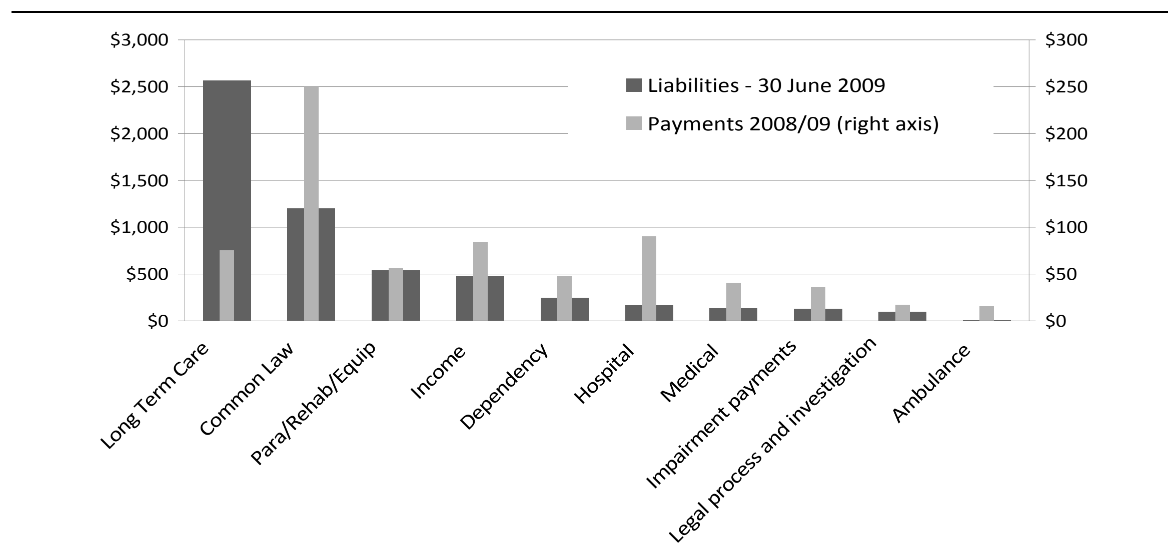
[1] Suppose that a cost of a scheme is around $500 million each year, and that costs are expected to grow by 6 per cent in nominal terms each year forever. Suppose that the discount rate is 7 per cent. In that case the present value of the liabilities can be shown to be 107×500 = $53.5 billion. Now suppose that a small (but permanent) cost pressure of 1 per cent occurs in year 1. In the year in which it occurs, it costs $5 million — not a lot relative to the overall scheme cost in that year, and easily overlooked by a manager with an eye on current performance. However, a permanent shock of this magnitude means that the present value of the stream of future costs is now $535 million more. So the present value of that 'small' cost pressure is equivalent to more than the entire cost in the year in which it first occurred.

Figure 18.1 **Liabilities are mostly long term care**
$ million



Data source: TAC estimates.

Moreover, there are significant advantages in having accident insurance schemes that are fully-funded. In such schemes, an amount equal to the present value of the expected future liabilities that relate to a newly injured person is transferred to the scheme fund. This issue is discussed more fully in the later section on financing NIIS claims (section 18.3).

Risk rating

Risk rating is an important aspect of insurance products, including for mandatory products. By reflecting higher risk in higher premiums, the consumer receives an important price signal that may affect their purchasing choices and their behaviour (Dionne 2001, Henry Tax Review (Treasury 2010a)). The capacity to risk- and experience-rate insurance to reduce accidents is a key rationale behind the mostly premium-based funding sources of the NIIS.

Existing motor accident schemes apply risk ratings to the determination of premiums, although for some classes of risk this is muted, in part, by the need to address social and economic impacts. For example, pure risk-rated premiums for young male drivers would be so high as to be prohibitive for many (affecting employment and imposing wider social and economic costs). Similarly, pure risk rating in some jurisdictions is not applied to car owners in rural areas, as this would require premiums to be significantly higher, reflecting in part the greater time spent in the car and the greater risk of serious accidents. The benefits of risk rating have to be sensibly weighed against other objectives.

However, at the margins there may be opportunities for higher risks to be reflected in higher premiums, for example with high powered motorcycles. In New Zealand, the ACC recently increased some classes of motorcycle premiums a little more than two-fold.[2] This reflected a desire to send a strong market signal to owners and would-be purchasers about the higher risks of driving high-powered motor bikes. In fact, if premiums were fully risk rated, they would have increased eight times.

Clearly there are limits on the capacity of risk rating because of the social and economic costs and because some drivers would avoid paying premiums by driving uninsured vehicles without altering their risk status. On the latter point, technologies are changing to allow easier detection of uninsured vehicles (sub. DR833). For example:

- Victoria and ACT police use mobile automatic number plate recognition systems systems, with the ACT RAPID technology leading to the issuing of over 1800 infringement notices during a six-month trial, and prompting the Government to invest around $4 million in the new technology over four years, including two additional cars and six dedicated police officers.
- Some overseas insurers are adopting new technologies to enable drivers to opt-in to monitoring devices that can measure driver habits and individual risks associated with distances travelled, acceleration, braking, speed and GPS location. Evidence of lower risks can be rewarded by premium discounts. The price of installing such technologies has fallen dramatically in recent years (from up to $1 000 to now less than $200 per vehicle).

Such new technologies can also work in tandem with other road safety measures to enable more effective monitoring and enforcement, and help prevent accidents.

For sources of catastrophic injury more generally, the Commission has been mindful of the feasibility of risk rating in its analysis of potential funding sources for NIIS claims (section 18.3). The optimal design of risk rating for the purpose of reducing catastrophic injury is both an empirical issue and one requiring fine

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[2] On average, the ACC receives 3.4 times more motorcycle claims per 10 000 vehicles than for cars, and the cost of an average claim is 2.6 times more expensive. The relativity factor of a 601+cc motorcycle (compared to passenger vehicles) is 1205 per cent, but was previously set at 150 per cent, giving rise to significant cross-subsidisation between vehicle types. Even with the significant increases proposed to the rates payable on 601+cc motorcycles (from $252.69 to $623.91 proposed by the ACC), all other car drivers would continue to subsidise motorcycle drivers and pillion passengers, adding an estimated $77 to each premium for 2010-11 (www.acc.co.nz/news/PRD_CTRB118214). For this class of motor cycle, a premium of $426.92 was subsequently approved by the Minister and, though significantly less than that proposed by the ACC, unsurprisingly, there was a hostile response from riders.

judgments about the wider impacts. In the NIIS this would be a matter for the individual schemes and state governments.

A federated approach

One way of realising an NIIS would be for each jurisdiction to set up a scheme that provides equivalent lifetime care and support for catastrophic injury as is currently available through the Victorian TAC, the NSW LTCS scheme or Tasmania's MAIB, but to otherwise go it alone. That would produce large gains, but it would also forgo some benefits from cooperation.

The Victorian Government suggested that an effective step forward would be to increase the coverage of no-fault insurance arrangements across jurisdictions, and the consistency of support provided under existing schemes. It considered that a new national partnership, possibly under the National Disability Agreement, could be the best way to encourage this:

> [It] would reward the establishment of consistent no-fault insurance schemes for transport related injuries (including for jurisdictions that already have some schemes in place, in line with the current policy approach). … Over time, this will build expertise and service capacity, in turn increasing benefits for the wider population of people with a disability. (sub. 537, p. 29)

The Commission proposes that the NIIS be structured as a federation of separate, state-based no-fault schemes. Individual jurisdictions would control the implementation and development of their own schemes, including, for example:

- funding options
- pricing of premiums, including risk rating
- investment of scheme assets
- set up of legislative infrastructure
- the level of support provided above the minimum benchmark
- oversight of service delivery, assessment and dispute management
- the balance between internal or external care coordination and case management services.

The purpose of federation membership, and the establishment of a small full-time NIIS secretariat as a national coordinating capability, would be to:

- provide an independent advisory and monitoring capability

- ensure consistency in eligibility, definitions and assessment. The fact that an accident occurs in one jurisdiction or another should not reveal gaps in coverage and other problems symptomatic of the current arrangements, particularly evident for motor vehicle injuries
- provide certainty around a minimum benchmark of services, care and supports, though benchmarking would need to be transparent and agreed
- share data (and maintain a central database), undertake cooperative trials, research studies, reporting (including actuarial valuations) and benchmarking of performance (including measures of client outcomes)
- reap economies by pooling risks where appropriate, including through a federated reinsurance pool
- eliminate other unwarranted variations in scheme design.

On the latter point, the Victorian Government acknowledged that under a national approach to injury insurance, existing no-fault schemes would 'also require refinement to achieve more consistency' (sub. 537, pp. 28–29). Jurisdictions should set premiums sufficient to meet the minimum benchmark of services, care and support. Moreover, within the federated membership structure of the NIIS, transparency of financial performance and approaches to underwriting across individual NIIS schemes would be necessary.

This implies some mechanism for cooperation — such as a memorandum of understanding or even statutory provisions that provide a framework for cooperation and joint activities. Over time, separate state and territory schemes might well coalesce to form a single Australian system. However, agreements about the extent and nature of cooperation should not jeopardise a timely transition to no-fault schemes at the state and territory level. Indeed, implementation may well need to occur in a staged fashion, jurisdiction-by-jurisdiction.

There would be merit in the states and territories contracting out the secretariat functions listed above. The NDIA (recommendation 9.1) could play an important role in this respect. (Indeed, while the NDIA itself would be a Commonwealth statutory body, all participating Australian governments would be involved in how it would be established and governed.) It could act as a host for cooperation, assist in and publish benchmarking information (for both the NIIS and NDIS) and encourage diffusion of best practice.

As already mentioned, to reduce the fixed costs of operating their own schemes, smaller jurisdictions could choose to sub-contract scheme management to another state. (It may also be possible to contract NIIS cases to a private sector insurer operating across jurisdictions or to the NDIS.)

The Australian Government's role

Some jurisdictions have suggested that the Australian Government should have full responsibility for an NIIS, particularly to ensure consistency in eligibility, assessment and care and support. Moreover, the terms of reference to this inquiry, explicitly asked the Commission to evaluate the legislative basis for a new scheme, including consideration of head of power.

The Commission has investigated the potential for a nationally legislated and governed NIIS, but foresees a number of problems. In particular, although the Australian Government could use the referral power,[3] this would require all states to agree. For example, the states agreed in 2003-04 to create a consistent public liability insurance regime, which included changes to the common law suit of negligence. While *some* jurisdictions may be willing to refer their constitutional powers to the Commonwealth, others would be far more resistant to do so.

In addition, the capacity of the Australian Government to intervene in state insurance matters is expressly prohibited under the Australian Constitution (s. 51 (xiv)), except where state insurance crosses borders. This is a general restriction — that is, the Commonwealth cannot regulate state insurance under any power.[4] For example, the corporations power could not be used even if state insurance companies were corporations.

Moreover, there does not appear to be any power under which the Commonwealth could legislate to extinguish the common law right to sue under negligence, contract or statute to recover damages for accidental injury.

- The corporations power would not permit it, because a car accident, for example, is generally between individuals.
- The external affairs power seems, at first inspection, too remote, unless Australia were to sign a treaty about no-fault accident insurance (akin to the UN Convention on the Rights of Persons with Disabilities). That said, the Commission notes previous 'remote uses' of this power to give effect to conventions and provide a basis for the Australian Government to legislate in areas of state control, including management of the Murray-Darling basin under the Federal Water Act.
- Accidents are not usually 'in trade and commerce'.

[3] S. 51 (xxxvii), along with the territories power, s. 122.

[4] For example, *Victorian WorkCover Authority v Andrews [2005]* FCA 94, at 53.

- The welfare power could be used to provide benefits to injured parties but not to stop them from suing, because it is a power to make laws with respect to the provision of allowances, not the power to make laws about claims in negligence.

As a consequence, the Australian Government would be a less important party in the NIIS than state and territory governments (that is, beyond its involvement in subsidising medical indemnity insurance, its proposed role in financing catastrophic aviation injuries, its role as a stakeholder in the NDIA and its role to contribute towards premiums in the Northern Territory where the injury risks are higher (see later)). The Australian Government's primary role would be to encourage a cooperative solution, and to assist in the creation of an NIIS that included data sharing and other common features (while not eliminating the scope for some experimental variation).

The Australian Government could also reach an agreement with the states and territories that the creation of the NIIS would be the quid pro quo for the Australian Government's substantial injection of funds into the general disability system through the NDIS (chapter 14).

Implementation could be rapid

Implementation of an NIIS should be faster than the full rollout of the NDIS. As noted above, this is because there are well-established schemes in place that could form the blueprint for the design of schemes in other jurisdictions. Moreover, while the severity of the injuries means that the costs are significant, the numbers of people affected are relatively small (around 1000 a year). Accordingly, the organisations that coordinate services would not need to be very large — and would not be likely to place excessive pressures on an already strained labour market in disability services.

While it would take some time to introduce no-fault arrangements for all catastrophic injuries, fast progress could be made in some areas. The priority for jurisdictions without a lifetime care and support scheme already in place would be to initially establish no-fault arrangements for (new cases of) catastrophic motor vehicle accidents, and expand coverage to other sources of injury within two years. Existing schemes would provide a template to make a rapid pace of implementation possible. The Commission suggests that:

- state and territory governments would establish no-fault catastrophic injury schemes for motor vehicle accidents by the end of 2013. This would be the starting point for an NIIS that ultimately covers all sources of catastrophic injury

- all catastrophic injuries would be covered by 2015, but funding for the scheme should commence in 2014 to establish a funding pool prior to any claims.

The Commission has also outlined the potential for broader changes to the common law and the coverage of the NIIS (see section 18.5 and appendix I). Realistically, such reforms are more radical and would take a longer time to implement. Moreover, they should not divert attention from the core task of establishing no-fault lifetime care and support for all people catastrophically injured. In the Commission's view, the practicability of implementing wider reforms and expanding the remit of the NIIS should be carefully tested in the independent review proposed for 2020 (recommendation 18.7).

In the longer run, there would be some logic in bringing the NIIS into the NDIS, to create one Australia-wide scheme addressing the consequences of disability and major injury. However, beyond the in-principle attractions to merging schemes, the practical case for making such a change would be a matter for an independent review to comprehensively assess the associated benefits and risks. This issue is discussed below.

Why not just use the NDIS?

The Commission's recommendation to create a new national disability insurance scheme (NDIS) that would provide high quality care and support for all people with significant disability invites the question of why an NIIS is needed at all. In theory, all compulsory insurance products providing third party cover could be removed, with all people's needs funded and met through the NDIS.

The Queensland and Tasmanian governments questioned the rationale for two separate schemes (sub. DR1031; sub. DR1032), as did a number of other participants including the Alliance of Spinal Injury Organisations (sub. DR919). The South Australian Government acknowledged the rationale for a separate NIIS scheme rather than relying on pay-as-you-go funding, but it saw the Australian Government as legislating and paying for any expanded injury scheme, rather than relying on a federated approach:

> … a no fault scheme for catastrophic injuries should be nationally legislated and funded, retaining and utilising existing State based institutional arrangements and expertise in case management and service delivery where appropriate. National legislation would ensure ongoing consistency between States and alignment with NDIS (sub. DR861, p. 2)

There are several reasons why a separate funding stream and system for managing participants' needs is appropriate. These mainly relate to the scope for accident prevention and the long-term benefits of early and proactive engagement with the

broader health and rehabilitation systems to reduce permanent disability, injury complications and scheme liabilities. In addition, there are a number of practical realities given some well-performing examples within present fabric of accident schemes, but which could not easily be replicated within the 'broken' disability system. The key arguments are summarised below.

Premium funding and accident prevention

A key goal of the NIIS will be to deter high-risk behaviour and reduce local risks that can contribute to accidents. One of the reasons for using sources of funding (premiums and state and territory funding) different from the NDIS is that these send price signals that encourage greater incentives for safety.

- As noted above, amendments to risk rating provides the opportunity for deterring accidents, whereas there would be no easy mechanism to address moral hazard through prices in an NDIS.
- Third party premiums reflect the external costs of consuming a product — that is, the likely costs of an individual causing an injury. If premiums force a driver to take greater account of the costs associated with their unsafe driving, choice of vehicle type, or other aspects of transport use that are within an individual's control, injuries can be reduced (Edlin and Karaca-Mandic 2006).
- Premiums for the NIIS would be collected at the geographic level where governments have the greatest capacity to reduce risks. Accordingly, state governments have the capacity to improve policing and the justice system to improve transport safety through laws, regulation, advertising, training, and infrastructure (thereby reducing CTP premiums); and with local government, reducing the risks of general accidents.

Moreover, if designed carefully, risk-based premium funding can also be efficient purely from a financing perspective (by minimising welfare losses associated with altered consumption and supply decisions). The Commission's evaluation of risk-based financing options, simultaneously took account of the efficiency loss of each option (section 18.3).

The value of 'fully funding' lifetime liabilities

The NIIS would primarily be 'a fully funded' scheme, drawing on its revenue sources to cover the expected lifetime liabilities of new cases. This would provide strong incentives to manage costs over time, and would provide certainty about the capacity of the fund to meet a person's future liabilities. (Such arrangements would need to include a buffer against year-to-year variations in costs and premiums (see later)).

The NIIS would establish best practice clinical treatment and rehabilitation protocols

Unlike the NDIS, the NIIS would cover a variety of health costs associated with catastrophic accidents, such as acute care and rehabilitation services. A major rationale for this is that when setting premiums or determining optimum injury prevention approaches, it is important to take into account the *full* 'external costs' of catastrophic injuries, and not only those associated with lifetime care and support.

This rationale is not (generally) present for the NDIS, especially given that another body, the Australian National Preventative Health Agency, will take the lead in trying to prevent disability from non-accidents. Moreover, it would not be feasible (practically or financially) for the NDIS to finance and coordinate all health services associated with all forms of disability.

That said, the NIIS would offer lessons for the NDIS about coordinated provision of disability support and health care. The experience of jurisdictions with no-fault accident schemes has been that coordinating optimal transitions through the health system and the availability of high quality rehabilitation facilities enhances participant outcomes and reduces the lifetime cost of injury. The NIIS should continue to be a test-bed for the coordination of care and support and, in some instances, the creation of specialist centres.

The NDIS can benefit from the NIIS experiences in determining the way it coordinates its activities with the health sector. For example, the lessons from appropriate rehabilitation for acquired brain injuries from motor vehicle accidents would be relevant to people experiencing major strokes. The MOU between the NDIS and the health system would need to reflect the importance of coordination between the two systems, and incorporate best practice knowledge from the NIIS. The NDIS would monitor the degree to which the disability and health systems interact, with NIIS arrangements providing a useful benchmark for comparison.

In the proposed 2020 review, health and participation outcomes of NIIS participants could be reviewed against NDIS participants with sufficiently similar non-traumatic injuries (matched for age and severity). The results of such analysis would help to inform the relative advantages of an NIIS, and guide areas for improvement within the NDIS.

The existence of the well-functioning structures already in place

A nucleus of existing, well-functioning no-fault schemes already exists in some jurisdictions, like those run by the Tasmanian Motor Accident Insurance Board, the

Transport Accident Commission and the NSW Lifetime Care and Support Authority. These can provide a valuable platform for learning and dissemination of skills and expertise in other jurisdictions. Such schemes and expertise can help to guide early determination of an appropriate minimum benchmark of care and support across jurisdictions. Similarly, established legislation and guidelines can be drawn on to achieve timely implementation of schemes in other jurisdictions.

The potential for later review and merging with the NDIS if appropriate

As mentioned, the South Australian Government raised several legitimate concerns about why a nationally legislated and funded NIIS approach may be preferred, including to guarantee consistency in scheme design and eligibility criteria, assessment tools, service definitions and research and data management (sub. DR861). To the extent that national consistency may not be sufficiently realised under a federated structure, the proposed 2020 review (recommendation 18.7), which recommends evaluating options for merging the NIIS into the broader NDIS, would arrest the progression of scheme 'breakouts' or unwarranted inconsistency.

There would, however, be significant legislative change required to wrap such accident schemes into a giant NDIS, and the resulting 'neatness' may not be worth the gains. When this issue is revisited in 2020, consideration should be given to:

- any imperative to pursue a more national approach due to 'breakouts' or a lack of consistency across separate state-based NIIS schemes
- the time path for achieving greater consistency if that is desired
- the transactions costs of merging schemes and potentially disrupting the continuity and quality of participants' care and support
- the distinct and complex care and support needs of people with catastrophic injuries and the performance of the NIIS in meeting those needs
- the extent that the benefit structure and standard of benefits might change under any merged arrangement, especially when the NIIS would have a separate source of funding (premiums) and be a fully funded scheme.

In summary

While there might be a case to eventually merge the NIIS and the NDIS, there are large differences in the schemes that affect whether that would be worthwhile. The gains from a merger might not be worth the costs of bringing quite different arrangements together. That question should be put off until the Commission's proposed review of the NIIS in 2020.

Nevertheless, even as separate schemes, and regardless of whether or not a merger takes place, there are clear reasons for schemes to coordinate and work towards consistency across scheme features including:

- many aspects of scheme governance
- data collection, and measurement and evaluation of outcomes
- sharing of capital infrastructure
- assessment tools.

18.3 How should NIIS claims be financed?

The NIIS should be funded from a variety of sources, but mainly from existing insurance premium income sources.

The appropriate funding sources would broadly depend on the causes of accidents. This would enable risk rating of the insurance premium, if appropriate, and can provide efficient incentives for safety and injury prevention. As discussed in chapter 17, in principle, a risk-rated premium makes adjustments for the different risk profiles of groups of individuals to reflect their expected contribution to the costs of injury.

Full upfront funding of the NIIS from insurance premiums also has the advantage of providing a sustainable and targeted funding source.

Apart from financing NIIS claims through the existing compulsory insurance in each state and territory (and a federated reinsurance pool), funding of any residual claims not specifically covered by a premium income source would need to rely on new sources of income. While this would entail additional contributions from state and territory governments, including for scheme establishment, this sits within the broader context of the Australian Government’s role in funding the significant additional resources required for disability services under the NDIS. To this end, the additional funds required for injuries are a relatively lesser burden on state and territory budgets.

For all causes of injury, a significant source of revenue would be savings and offsets from the introduction of the NIIS, including:

- savings in legal costs (which account for a significant component of premiums in fault-based systems — chapter 17)
- reduced incentives for many individuals to litigate under the other heads of damage (for income losses and pain and suffering), especially for medical negligence claims where the evidentiary burden to establish liability can be significant

- other offsets, such as reduced reliance on social welfare services and reduced reinsurance and capital costs (however, the extent of savings in social welfare services and improvements in community wellbeing has not been quantified, because of the extended time period over which budget savings will be realised, and the inherent difficulties in estimating the value of many intangible benefits associated with the NIIS).

As individual jurisdictions would be responsible for underwriting their own scheme, it would be a matter for each to choose between alternative sources of financing NIIS claims, including any other specific sources appropriate within their jurisdiction.[5] Nevertheless, this chapter suggests a range of financing options for each cause of catastrophic injury — transport, medical treatment, occupational and general injuries (including criminal injury).

Transport accidents

Motor vehicle accidents

Motor vehicle claims under the NIIS should be funded from existing insurance products that are mandatory for owners of motor vehicles (namely, compulsory third party motor vehicle insurance). Jurisdictions would select their preferred mechanism for funding. For example, in NSW a levy is imposed on the CTP premium collected by the seven private insurers operating in the market, whereas in Victoria, the entire premium is levied by the TAC as the single statutory insurer.

The potential to phase-in greater risk- and experience-rating of premiums (as discussed earlier) and prevention activity more broadly is also relevant. In addition, it is expected that the rate of catastrophic motor vehicle accidents will continue to fall over time because of improved safety and prevention strategies, with most CTP schemes achieving sustained reductions in claim frequencies. This will help to offset the increase in funds required to cover no-fault claims.

Another issue concerns whether cover (and funding) should be widened. Chapter 17 provides examples of where access to some benefits could potentially be denied if there is evidence of deliberate recklessness by a person, causing their own injury. However, it was also noted that for cases of catastrophic injury, the community may have limited appetite to restrict access to benefits, as services and supports would have to be provided in any case by family, charity and other informal arrangements.

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5 For medical injuries, however, the Australian Government is a key stakeholder.

Motor vehicle accidents on private property usually involve unregistered and uninsured vehicles. These 'off-road' accidents are usually excluded from existing schemes, but the use of such vehicles, including dirt bikes and quad bikes, is said to be rising in popularity. From a community responsibility perspective it is reasonable that these accidents be covered, and the NIIS could explore ways to obtain premium income for these claims, including by making insurance mandatory. However, any decision to pursue a specific premium income source should take account of the likely high costs of enforcement. The Commission understands that covering the cost of these injuries in New South Wales, Victoria and Tasmania could be somewhere in the order of an additional $10 million per annum, increasing CTP premiums by around $2-3 per vehicle (Martin Fry, trans., p. 195).

Bicycle accidents

Some participants have questioned how catastrophic bicycle accidents would be funded under the NIIS (for example, the MUA, sub. DR733). If bicycles were subject to an annual registration process (similar to cars), it would be a simple task to add a levy to the registration fee to help fund the NIIS (although, it is not clear what an appropriate fee would be). However, this is not the case.

Conceptually, it would be possible to set up a registration process for bicycles in order to levy a fee for the NIIS. Given that cycling is a popular fitness activity (particularly among children), there are probably sound reasons for governments to be encouraging increased participation in cycling. As most cyclists are not currently charged for registering themselves as cyclists, any levy to help fund the NIIS would act as a disincentive to participate in this form of exercise. As such, it is likely that the socially optimal level of such a levy would be low (or could even be negative).

In addition, the cost of establishing and running such a registration process are likely to be large. Given that a socially optimal levy would be unlikely to raise significant funds, it is unlikely that a registration process for bicycles would be sensible to establish — even if there would not be substantial difficulties in enforcing the registration process.

Some cyclists are already indirectly registered. Those who participate in organised races and rides are normally required to purchase insurance or membership of a club (which, in turn, provides general and public liability insurance cover under the National Program, in addition to specific accident insurance providing very limited benefits). The NIIS could explore ways of levying such insurance, but should be careful to avoid perverse outcomes (noting that insurance is a generally inefficient source of revenue when the underlying premium aligns poorly with the accident risk). In addition, most cyclists are not members of those groups.

Moreover, most cyclists own motor vehicles and pay a CTP premium, which could provide a more administratively efficient way of collecting funds to cover the relatively small number of catastrophic cycling accidents

Alternatively, another option would be to include bicycle injuries under the 'general accidents' category. This would be consistent with the recreational use of a dedicated cycle path, which would usually be maintained by local councils.

Water, rail and aviation accidents

The Commission proposes that catastrophic transport accidents more generally should be covered under the NIIS, including those relating to air, rail and water modes of transport. A variety of options is available to fund these accidents.

Funding should take account of the administrative cost of alternative approaches, the impact on efficiency of imposing a levy, and the potential to reduce the risks of accidents. For example, tracing a source of funding on an individual accident basis (within the context of current fault-based liability insurance products) would be complex and costly to administer. Imposing an ad valorem levy on an already risk rated insurance premium, on the other hand, is likely to be more straightforward, and would incorporate the risk of an accident. Other options include levying passenger tickets and registrations. In general:

- a levy on the price of each passenger ticket has the advantage of aligning usage and exposure to risk
- a levy on personal injury liability insurance would not necessarily cover non-fee-paying passenger carrying modes of transport (as regulations generally do not make insurance compulsory). However, it would broadly reflect the risk of injury
- a levy on registration would have broad coverage, but would be unlikely to reflect the individual risks of catastrophic personal injury, since risks usually reflect use and user characteristics not captured in registration. (Although, registration can support various safety regulations and revenue may sometimes help to fund and maintain a safe and efficient infrastructure network.)

Reflecting these broad considerations, the Commission proposes:

- a small surcharge on the passenger ticket price of all rail travel regulated under the co-regulatory framework administered by rail safety regulators in each state and the Northern Territory
- a modest levy (perhaps scaled on vessel size or tonnage) on domestically registered passenger vessels regulated under Australian Maritime Safety Authority (as the proposed new national safety regulator for all commercial

shipping in Australian waters by 2013). Another option would be to impose a small surcharge on the passenger ticket price on all domestically registered ferries (and other passenger carrying watercraft). For privately owned 'pleasure' vessels, a small levy on existing state-based registration would be appropriate.

As a general proposition, some governments may prefer to self-insure the risks associated with their public transport operations, but any decision to do so should be supported by an adequate level of reinsurance cover. This would be consistent with the generally low probability of catastrophic accidents from public transport operations (albeit very substantial costs in the event that a large number of catastrophic injuries occurred in a single event). Alternatively, state and territory governments could set aside or accumulate a pool of funds from the funding options proposed above, which should be at least sufficient to cover the actuarial risks.

The Commission has not specifically recommended a premium (or risk-based) funding source for catastrophic aviation injuries. This does not mean that specific sources of funding related to accident risks are unavailable, but we understand it would be extremely complex to achieve. Lifetime care and support needs of aviation injuries should, nevertheless, be covered by the NIIS, but at least in the interim, the funding of these injuries should be met by the Commonwealth. Importantly, this would:

- be consistent with the Commonwealth's breadth of responsibilities and the *potential* regulatory reach of the Civil Aviation Safety Authority
- provide an incentive for the Australian Government to examine sources of funding that could meet the NIIS liabilities associated with such accidents.[6] Moreover, for the 'general aviation' category (that is, non-carriers), such an arrangement would provide stronger incentives to moderate the risks of accidents. This could link to an NIIS funding source, such as a levy on liability insurance, registration or pilots' licences (where this could be shown to relate to accident risks).[7]

The extent that risk-based funding sources should be pursued to fund aviation accidents would depend on the costs and benefits of various alternatives. This should take account of the high costs of catastrophic injury and the value of aviation safety, but equally, the legislative compliance, monitoring and enforcement costs of changes should also be included.

The arguments behind this proposal are discussed below.

6 Some injuries may already be covered under existing workcover schemes.

7 A levy on registration and licences should be considered within the context of avoiding any 'crowding out' of private incentives to insure against personal injury liability.

Accidents involving international and domestic carriers

Requirements for domestic and international air passenger carriers to hold insurance (and the compensation that is provided through such insurance) are outlined in box 18.2. These are extremely complex arrangements, which would be difficult and potentially risky to unravel. This is especially true for international carriers, which face different liability exposure depending on the particular treaty and amendments that are common to both the departure and destination country. In some cases, liability would be unlimited and compensation would reflect the full amount of damages, but there could also be cases where compensation would be capped between $10 000 and $200 000. There is no guarantee that compensation would be even near adequate to cover lifetime care needs for catastrophic injury.

For domestic carriers, legislation caps the total amount of damages payable at $500 000. The strict liability regime and non-voidable insurance requirements means that all injured passengers would be covered in the event of an accident. However, the level of cover would, again, be highly inadequate for the lifetime care and support costs of most catastrophic injuries. Some countries have removed the limits on liability for domestic travel, but this is often associated with a shift to a negligence rule (rather than strict liability) for any compensation above the capped level. For a carrier to avoid liability for full damages, proof that they did not breach a duty of care to their passengers is required.

In principle, there is merit in removing the current cap on liability for domestic travel, but this is a complicated decision that should be supported by a thorough examination, which is beyond the terms of this inquiry. Any change in caps, the liability regime that applies (strict liability or a negligence rule) or levy on insurance would inevitably affect the cost structure for carriers. However, whether that effect would be large or a policy concern is not clear:

- there is evidence that aviation insurance costs as a proportion of aircraft value have decreased over time (Department of Infrastructure 2009, p. 15)
- the ratification of the new Montreal Convention (which increased the liability exposure of international carriers) was not expected to increase travel or insurance costs, since many international airlines had already voluntarily begun operating under more generous liability arrangements to cope with the ‘grossly inadequate liability limits’ under the previous international arrangements (Albanese 2008). This is consistent with the commercial incentives of most carriers to guarantee the safety and quality of their operations.

Box 18.2 **Aviation carriers' insurance is extremely complex**

International liability insurance

For all domestic and foreign carriers who transport passengers either to or from Australia, liability insurance for personal injury is already compulsory. The 1929 Warsaw Convention was the original treaty that gave effect to the liability arrangements of international air carriers, and still applies (with various amendments by more recent protocols) to carriers in countries that have not ratified the 1999 multi-national Montreal Convention. The Montreal Convention was ratified by Australian in early 2009, at which point, over 90 countries had ratified the agreement, including most of Australia's major aviation markets. Around 152 parties adopted the terms of the Warsaw Convention.

In the event of an accident, the amount of compensation payable is subject to caps. The amount of the cap depends upon the specific cap applying under whichever Convention (and amending protocol) both the departing and destination country are a party to. Under the old Warsaw Convention, compensation has not been adjusted for inflation and is capped in the order of $10 to 20 000, which is available irrespective of the carriers fault (strict liability regime). A major change under the Montreal Convention is that a carrier *could* be required to compensate passengers for all proven damages. The cap on liability is removed entirely for personal injury, unless the airline is able to prove the damage was not caused by negligence (in which case, a 'no-fault' compensation limit applies, which is currently set at approximately $180 000).

To the extent that an accident involves a carrier from a country that has not ratified the Montreal Convention, or the carrier is not negligent, compensation would not be near enough to fund the lifetime care costs of catastrophic injury, let alone income losses.

Domestic liability insurance

Domestic travel is regulated under the *Civil Aviation (Carriers' Liability) Act 1959* for all interstate travel (with complementary legislation enacted by each state to cover intrastate travel). The Civil Aviation Safety Authority (CASA) administers insurance requirements under this Act, but also relies on other legislation to enforce an 'acceptable contract of insurance' as part of their management of safety issues through the Air Operators Certificate (AOC) process. Without an AOC, a carrier has no authority to carry fee-paying passengers.

The insurance cover is non-voidable and liability does not require any notion of negligence or that a standard of care was breached by the carrier — it is a strict liability regime. To this end, all passengers are covered in the event of an accident. The major issue is that the level of cover is currently capped (under the legislation) at $500 000 — well below what would be required to meet lifetime care needs for catastrophic injury. Many overseas countries do not apply such caps and provide unlimited liability to domestic travel as well as international travel.

Third parties on the ground are covered by the *Damage by Aircraft Act 1999*, which imposes strict and unlimited liability on carriers, but does not mandate insurance (although it is a commercial and reputational imperative for most major airlines).

Source: http://www.comlaw.gov.au/Details/C2008B00098; Department of Infrastructure 2009.

To this end, the Commission recommends that the Australian Government should investigate options for funding NIIS claims from accidents involving air passenger carriers through a levy on domestic carriers' liability insurance, including evaluating the appropriateness of the current limits on (caps on damages).[8] In the interim, it is reasonable that the Australian Government fund, at least, the 'gap' required to cover NIIS liabilities (the amount that would be necessary to fund lifetime care and support in excess of the compensation received). To the extent that the amount of compensation under the cap might be only comparable to damages for income losses, there may be an argument for the Australian Government to fund the full NIIS liability for lifetime care and support costs, and not seek to recover compensation from the injured party.

Accidents involving general aviation (non-carriers)

Liability insurance for non-carriers is not mandatory, despite evidence that fixed wing general aviation has a significantly higher relative risk than other aviation (or indeed other transport modes). This potentially leaves the pilot (or aircraft owner), their (non-fee paying) passenger(s) and any on-the-ground third parties very vulnerable in the event of an accident causing personal injury. Although either the owner of the aircraft or the pilot is legally liable under the legislation, it does not necessarily mean that they will hold any or adequate insurance to cover their strict and unlimited liability. While accurate information about the extent of insurance is not collected, the Commission understands that a proportion of the general (non-carrier) aviation sector is not insured to cover their personal injury liabilities, particularly at the smaller end of the industry. For example, 'crop-dusters' and other aircraft for agricultural uses are a particular concern, with injury rates per million hours that are more than double that of general aviation generally (ATSB 2010).

These arrangements have recently been reviewed by the Australian Government, which has given in-principle support for mandatory third-party insurance cover for people 'on the ground' who are injured by an aircraft. However, concerns about monitoring and enforcement, and the specific party that should be required to purchase the insurance (for example, the pilot or the owner of the aircraft) has stymied progress.

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8 Funding should cover all aviation accidents to passengers and third parties. To this end, it may be appropriate to also investigate levying liability insurance associated with air infrastructure, including from the negligence of airports and air traffic controllers. There is some contention about 'war-risks' and the degree to which such insurance is not covered in standard aviation clauses, or may be voided if carriers expose themselves. This would have to be clarified when determining any levy on liability insurance.

No pending arrangements exist for no-fault insurance cover for pilots or any passengers injured in general aviation aircraft accidents. On this front, the Australian Government has limited its endeavours to exploring an 'informed consent' model to protect passengers.

Although insurance is not mandatory, general aviation craft (such as for sports aviation, private business, flying training, fire control, search and rescue, mustering and agriculture uses) are required to be registered by CASA.[9] But registration does not relate to any specific safety requirements or the risk of an accident. Some registered aircraft are not used at all (mothballed by collectors or for museum pieces), and other than a voluntary survey undertaken by the Australian Transport Safety Bureau, there is no mandatory reporting of hours flown or other characteristics of use.

Air worthiness and various safety requirements to reduce the risk of accidents are mainly managed through controls on the responsibilities of pilots and engineering organisations undertaking and approving maintenance. It may be possible to link a NIIS levy to the licensing of pilots, with potentially different risk-based levy rates related to those responsibilities. However, it is unclear that there would be enough information to observe risk ex ante, or to gauge the overall premium income required to meet catastrophic general aviation accidents in any rigorous fashion. (Notably, over the period from 1999 to 2008, there were only 180 serious injuries in general aviation, of which the number that were catastrophic is unknown (ATSB 2010).) Nor is it clear what effects any such premiums would have on risk reduction or demand for general aviation.

Given these uncertainties, there appears no clear route for financing NIIS claims from general aviation accidents.

That said, given the clear concerns about the higher relative risks of injury from general aviation[10], the Commission considers that further work should be undertaken by the Australian Government to pursue mandatory insurance cover of personal injury for pilots and their non-fee paying passengers. To the extent that personal injury liability insurance could be made mandatory for the general aviation category, there would be an option to impose a levy on this form of insurance to cover the cost of NIIS claims. The Australian Government should fund NIIS cover of catastrophic general aviation accidents, until specific sources of funding related to accident risks are established.

9 With the exception of gliding, parachute operations and acrobatics, which are registered under a different set of arrangements.

10 From 1999 to 2009, the number of serious injuries per million departures for general aviation was about double that of commercial air transport (ATSB 2010).

Medical treatment accidents[11]

The appropriate funding source for no-fault coverage of catastrophic injuries following medical treatments is more complex than for other accidents.

Consistent with the approach adopted in this chapter for other sources of injury, 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
- varying premiums depending on whether the health sector and practitioners — follow best practice protocols and have the appropriate training and credentials.

For this reason, the NIIS should fund the care and support needs of people who suffer catastrophic injuries in circumstances where changes to behaviour, systems and/or protocols could lead to reductions in the number of catastrophic injuries over time. This would go beyond issues of negligence by individual practitioners or hospitals.

In contrast, there will be some catastrophic accidents that fundamentally represent random events — 'acts of God' — that are not readily amenable to reduction through changes of clinical practice. These accidents resemble many other catastrophic disabilities that arise primarily by chance, such as rare congenital abnormalities. This group of catastrophic accidents would be covered by the NDIS.

It should be emphasised that, from the perspective of someone who is catastrophically injured, their care and support needs would be well met by either system. But the goal of a NIIS would be to prevent some people from ever facing catastrophic injury.

In considering the question of the appropriate choices of funding for catastrophic medical accidents, two main questions arise:

- Which catastrophic adverse events cannot realistically be significantly averted through better training, protocols or system improvements (systemic risk factors, not related to negligence) or through penalties on negligence? (As we discuss

[11] The Commission held a workshop on medical treatment injury following the release of the draft report. Attendees ranged across medical indemnity insurers, state government insurers, the Department of Health, representatives of clinicians and various other experts in the field, including cerebral palsy. The purpose of the workshop was to discuss options for covering and funding medical treatment injuries under the NIIS. The Commission has been heavily guided by the information and comments received from the workshop, and we are grateful to participants (appendix A) for their valuable advice. Ultimately, however, the discussion and recommendations on medical treatment injury in this chapter are those of the Commission.

later, many cases of cerebral palsy fall into this category.) The NIIS would not generally fund adverse outcomes where the most up to date protocol was properly applied or could not have reduced the statistical probability of the adverse outcome.

- Where systemic or negligence risk could be averted, what are the best funding mechanisms?

Determining whether adverse outcomes are matters of chance

Establishing that a medical treatment *caused* a particular injury is often not straightforward. Confounding factors include:

- 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
- 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)
- objectively determining whether or not an 'injury' occurred in cases such as those relating to birth, antenatal or neonatal care is especially complex, with significant potential for classification errors.

The Commission considers that questions of eligibility for people catastrophically injured following medical treatment should be decided by an expert panel within the NIIS.

- An evidence base would inform decisions of the expert panel, and the panel may choose to use external experts.
- Any persons with a catastrophic injury found not to be eligible under the NIIS would be covered under the NDIS.

For many treatment injuries, the Commission expects that classification issues could be resolved through access to comprehensive data and expert knowledge within the panel. However, the availability of high quality care under the NDIS, will temper the practical implications of any classification errors.

To support the panel's deliberations (see for example box 18.3), there should be a comprehensive database that the NIIS, medical boards, insurers, colleges and researchers could access. This would also offer broader benefits: access to good information and analysis of risks is crucial to guide continued improvements in risk management, reducing the consequences and likelihood of adverse events. The database would assist with the identification of trends based on claim information,

event notifications and information on predictors of adverse events, preventable complications and the impact of co-morbidities (for example, to analyse clinical risks by treatment type and the impact of location, practitioner, hospital, training, experience level, patient characteristics).

The NIIS could help to advance the collection and integration of data. This would involve coordinating with existing bodies charged with improving safety and quality within the health system (under the Australian Safety and Quality framework for Health Care) to ensure national consistency in data collection and reporting frequency.

The NIIS would not make any determination of a practitioner's fault, although an NIIS decision would, undoubtedly, influence the context of a common law claim (with a decision of the NIIS to decline cover likely to weaken the probability of successful litigation). In cases where there could be a risk to public safety, notification to an appropriate disciplinary and/or investigative body for further investigation should be mandatory as it could provide a useful additional measure to reinforce patient safety.[12]

The cost-effectiveness and workability of a panel as a mechanism to identify classes of injuries where risk reduction strategies have a practical role — those that most appropriately should be covered by the NIIS — will only emerge over time. In some instances, the decisions of the panel will be fairly clear, but there will be others where this is not true, and the panel's role would be important in deciding such cases. To the extent costs are included in risk-rated premiums, decisions of the panel would send important signals about what constitutes cost-effective risk reduction and best-practice clinical protocols. (The number of cases to be decided per year would be small, but the lifetime costs to the NIIS (or to the NDIS) of each new person added would be significant, perhaps amounting to millions of dollars per client.)

Over time it would be possible to refine panel processes, including the timeliness of decisions and, if necessary, its independence. The performance of the panel and scope for improvements should be reviewed in the 2020 review (recommendation 18.7).

[12] Notification would be based on the possibility of a practitioner's negligence and the risk of harm to the public. (See, for example, the New Zealand system of adverse event notification (box L.1)). Collaboration between the NIIS, the Australian Medical Indemnity Industry, Medical Boards and clinical organisations could assist with early detection of organisational and practitioner errors.

Box 18.3 **Examples of cases that an expert panel would decide**

An expert panel would make decisions about a range of claims including, for example:

1. Failure to diagnose temporal arteritis (TA), resulting in blindness: A man presents to his GP feeling unwell and with a headache. Given the patient's symptoms and various indicators pointing to a diagnosis of TA (age, history of polymyalgia, ongoing tiredness and morning headaches) the GP completes the necessary investigations, but fails to follow up on the abnormal test results. If a diagnosis of TA is suspected, the protocol would be to commence high dose steroids immediately, as waiting for the results of investigations only increases the risk of visual loss.
2. Alleged delay in diagnosis of spinal tuberculosis(TB): A lady visits her GP having experienced back pain for two months after straining her back lifting groceries. Given the initial presentation and subsequent tests revealing an apparent cause and referral to the relevant specialist, the management of the patient appears entirely reasonable. Confirmation of a diagnosis in TB commonly takes up to two years. The differential diagnosis of chronic back pain is not always straightforward, but would include consideration of TB for patients that have lived in countries with high endemic rates of TB, especially when consistent with TB symptoms (including thoracic spine pain, kyphosis and high CRP/ALP levels). That said, if the expert panel or external clinical advice indicates the treatment was appropriate (within expected professional guidelines, with no evidence to suggest that the presenting condition could or should have been treated earlier) the disability would be considered the result of the natural progression of the underlying condition.
3. Unsterile equipment and wrong patient, resulting in a catastrophic injury: A treating physician administers a local anaesthetic by injection to a patient. When the syringe is returned to the instrument table, the assisting nurse realises it had already been used on the previous patient. The theatre nurse refers to the patient's notes and sees the clinical details do not match those in the patient record. A check of the patient's name bracelet confirms the mix-up. No single individual caused the adverse event, rather it was the result of a number of easily identifiable errors — a systemic error. System failures can be prevented through better adherence to safety protocols, including surgical checklists, availability of sharp disposal boxes to encourage prompt disposal and avoid recapping. Such system weaknesses are not uncommon. For example:
   - In a simulated ward environment, one study found 39 per cent of nurses, technicians and ward clerks failed to pick-up an identity error through basic checks, and so procedures could have been performed on the wrong patients (Henneman et al. 2010)
   - Research shows wide variation in how patients are identified prior to routine but invasive procedures (Chassin et al. 2002, Henneman et al 2010)
   - Research shows not all patients have wristbands in place at the time of surgery (Seiden et al 2006) and if the wristband is present, it may be incorrect or illegible (Howanitz et al 2002).

Source: NZ ACC Treatment injury case studies, various issues 2009-2011.

The special case of cerebral palsy

In this area, there are compelling grounds for funding future care and support from the NDIS rather than the NIIS. This reflects several factors:

- the scientific evidence suggests that most cases of cerebral palsy are not accidents in the typical sense of the word. Most do not involve cases where clinical practices could avoid the disability, 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 was the cause in any individual case. Individually risk-rated insurance is not an efficient way of moderating risks and there does not currently appear to be many systemic changes to practice that would avert risk.

As in other areas of catastrophic injury, common law rights to sue for the future care and support needs for cerebral palsy would be removed. This would give people immediate support, whereas currently the particularly complex issues arising from determining fault in this area and the associated protracted litigation processes mean people can face significant delays in receiving adequate services. Removing this head of damage would not eliminate rights to sue for economic loss and pain and suffering. However, people may decide not to pursue such litigation given the difficulty in establishing fault and the fact that their most important need — adequate long-term care support — would have been met by the NDIS.

The NDIS would have an interest in ensuring cost effective early interventions are appropriately provided to participants, reducing the level of functional disability and lowering lifetime care and support costs. The NDIA should ensure agreements with health departments secure adequate provision of clinical health services, post-treatment therapies and rehabilitation programs. In particular, current bottlenecks in access to post-treatment therapies through the health system would need to be overcome (we understand these are rationed and poorly coordinated in some jurisdictions) (Appendix L).

Questions of coverage of medical treatment injury, and cerebral palsy in particular, are discussed in greater detail in appendix L.

Funding of treatment injury

Medical treatment accidents covered under the NIIS could be financed from a variety of sources including:

- savings on current medical litigation costs and other offsets associated with the introduction of the NIIS. This would include:

- reduced reinsurance costs for medical indemnity insurers
- reduced legal process costs from shorter disputes about the 'quantum' of damages available under the residual heads of damage for income loss and pain and suffering
- savings associated with medical claims that do not proceed to litigation because of the determinations of the expert panel (If the panel does not find that medical treatment *caused* the disability — causality is an important precondition for legal liability — a legal claim would be unlikely to succeed)
- weaker incentives to pursue major medical litigation under the remaining heads of damage (for income loss and pain and suffering) as future care and support costs (which account for between 60 to 100 per cent of damages) would be covered under the NIIS. Among a range of reasons why individuals bring medical malpractice claims, securing funds for future medical and care costs is consistently found to be a major motivation (Rothstein 2010).

- reduced medical indemnity insurance costs associated with the NDIS funding all cerebral palsy (and removing access to the common law to sue for long term care and related heads of damage (see appendix L))
- Australian Government subsidy schemes (box 18.4). These programs would continue to safeguard the affordability of medical indemnity cover. However, to the extent that the NIIS reduces the use (and cost) of these schemes, or they are redesigned following a review at some point in the future, any 'savings' in program costs could be transferred to the pool of funds for NIIS treatment injury. Alternatively, any reduced spend on subsidy programs could be directed to the NDIS, given the reduction in medical indemnity insurance costs from NDIS cover of cerebral palsy
- contributions from the insurance (including self-insurance arrangements) of hospitals and the medical indemnity premiums of physicians for medical treatment accidents.

Appendix L explores each of the points identified above in further detail. The discussion to follow focuses on the latter of these points, since it is central to the Commission's recommendation to fund medical treatment injury from the insurance (and self-insurance) arrangements of hospitals and the medical indemnity premiums of physicians (recommendation 18.2). In particular, if the removal of the insurance costs associated with the lifetime care and support of cerebral palsy cases does not sufficiently outweigh the additional costs associated with the inclusion of no-fault catastrophic injuries, then premium increases would need to be gradually phased in.

(State and territory governments should fund any gap between premium income and catastrophic medical injury claims.)

The Commission considers that the savings from the introduction of the NIIS, plus the reduced call on medical indemnity premiums from the NDIS funding cerebral palsy, will probably be sufficient to outweigh the cost of 'no-fault' claims (that is, the additional cost of extending cover to catastrophic injury claims where no 'at-fault' party can be identified). However, this is a complex matter and subject to uncertainty (box 18.5).

- If the current premium pool of private practitioners and public and private hospitals exceeds the premium pool required with the introduction of an NIIS (the first scenario in box 18.5), there would be an overall saving. This means that the reduced call on premiums from the NDIS funding cerebral palsy, plus other offsets in litigation, reinsurance and capital costs, would be more than sufficient to cover the increase in 'no-fault' coverage. Given that the NDIS would be funding the lifetime care and support costs of severe cerebral palsy, it would be appropriate that any 'saving' would be transferred to the NDIS. This could occur by levying the (now smaller) premiums of practitioners, or by reviewing the availability and design of subsidy arrangements.
- If, on the other hand, the current premium pool is not sufficient (the second scenario in box 18.5), additional contributions from private practitioners and hospitals would be needed.

Based on various sources of information available to the Commission, we have estimated the insurance costs of hospitals and doctors could fall by around $40 million (although the High Cost Claim Scheme already covers a portion of this cost). This is a best estimate however, with uncertainty resulting from several factors.

Box 18.4 Existing Australian Government subsidies for medical negligence claims

High Cost Claims Scheme — reimburses medical indemnity insurers 50 per cent of the insurance payout associated with each claim exceeding $300,000 (up to the limit of the practitioner's cover, at which point the exceptional claims scheme applies). This is a direct measure to ensure premium affordability and predictability, which also reduces medical indemnity insurers' reinsurance costs associated with funding large claims. In 2009-10, Medicare Australia administered payments of $21.4 million for the 98 claims received, with the 82 claims in 2008-09 costing $19.5 million. For an average obstetrics and gynaecology claim eligible for the scheme, the benefit is around $800 000; for an general practice low risk claim, the average benefit is $190 000; and for a General Practice high risk claim, the average benefit is $750 000.

Premium Support Scheme — ensures doctors pay only 20 cents for each dollar of premium beyond that equivalent to 7.5 per cent of their gross income from private billings. Government payments are made to medical indemnity insurers to cover the gap. Of the 64 000 medical practitioner clinicians employed in 2008, around 11 per cent or 7200 clinicians accessed premium support scheme payments. In 2010, the number of practitioners accessing the scheme reduced significantly to only around one-third of the number two years prior. In 2009-10, 2439 practitioners were eligible under the scheme, receiving $17.2 million in payments towards their insurance costs, and with administration expenses of $2.4 million. Of those that access the scheme, around 20 per cent are in the fields of obstetrics and gynaecology and 25 per cent are general practice, with around 35 per cent of their premium paid by the scheme.

Exceptional Claims Scheme — covers the cost of a doctor's private practice claims above the limit of their medical indemnity insurance cover (generally $20 million). No claims have been submitted against this scheme.

Run-off cover scheme — requires medical indemnity insurers to provide free run-off cover for eligible doctors (mostly those retired, with permanent disability, or through death or maternity), with the cost of associated claims funded by government from a levy imposed on insurers' medical indemnity insurance income. Run-off cover occurs because professional indemnity insurance is provided on a 'claims-made' basis, so there is a need for insurance cover, even if a practitioner is no longer working in private practise. In 2009-10, there were 28 claims received, with a total benefit of $2.1 million paid.

Source: www.health.gov.au; Medicare Australia, Annual Report 2009-10 and 2007-08. Cohen, Satchwell and Gould 2011, Medical Injuries under disability care and support schemes, Institute of Actuaries of Australia, Biennial Convention.

Box 18.5 **The impact of the NIIS (and NDIS) on the premium pool**

The current annual costs (T_1) associated with meeting 'at-fault' claims for medical 'accidents' involving individual physicians and public and private hospitals comprise:

- future care and support costs for cerebral palsy (A), other catastrophic injury (B) and non-catastrophic injury (C)
- pain and suffering and income losses for all severities of accidents (D)

That is: T_1 = A+B+C+D. The actual costs borne through premiums by doctors and hospitals (P_1) are less than T_1 because the Australian Government provides subsidies (S) to private practitioners (but not to hospitals). Accordingly, $P_1 = T_1 - S$. Currently P_1 is directed solely at parties making claims through litigation.

With the introduction of an NIIS, the costs to be met by the combined NIIS and through the tort system for medical 'accidents' would include a new obligation to meet the long-term care and support costs for catastrophic injury claims where no at-fault party could be identified (E).[13] However, there would be some revenue savings because long-term care and support costs for cerebral palsy (A) would now be covered by the NDIS and there would also be some offsets (F). These offsets would include reduced reinsurance costs, reduced frictional litigation costs, savings associated with medical claims that do not proceed to litigation because of the determinations of the expert panel (discussed above) and reduced claims under the other heads of damage given the availability of the NIIS and NDIS.

Under the assumption that S is preserved at its current value, the total premium costs to be met by doctors and hospitals (P_2) after the creation of the NIIS would be:

P_2= B+C+D+E-F-S

These premiums would be streamed to two different funding pools. The value of B+E (the costs of providing comprehensive cover of catastrophic accidents regardless of fault, based on the claim values as assessed by the NIIS in this area) would go to the NIIS. The remainder would go to the torts system.

There are essentially two possible scenarios with the introduction of an NIIS. The current premium pool either exceeds or falls short of the premium pool required with the introduction of an NIIS. The difference between the current premium pool and the one under the NIIS is P1-P2 = A-(E-F). That would be positive if the cerebral palsy savings (A) are greater than the cost of covering catastrophic injury claims under the NIIS where no at-fault party can be identified (E), less any offsets (F). Under that scenario, no additional contributions from hospitals and practitioners would be needed to fund NIIS claims. However, under a second scenario P1-P2<0, some additional funds would be required.

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[13] And would also include the gap between the full costs of providing long-term care and support in *at-fault* cases and what the litigation system actually delivers in these cases. As discussed elsewhere the litigation system does not usually fully-fund those needs, as settlements are discounted for any uncertainty over liability.

There is the complexity created by the 'long tail' of medical indemnity claims — the delay between when an injury occurs and a claim for damages is lodged and/or paid. As a government-guaranteed scheme, the NIIS would put aside an estimate of lifetime liabilities as a participant entered the scheme. Medical indemnity insurance provides cover on a 'claims made' basis — based on claims arising from incidents *notified* during the policy period. This means that when a potential claim is notified to the medical indemnity insurer, the estimated value of the claim is 'put aside' from the premium pool, with estimates adjusted from year to year. The accumulated funds are drawn down as claims are actually made.[14]

- Notifications of cerebral palsy that are considered 'insurable' by medical indemnity insurers will have funds set aside to cover the estimated cost of a later claim. But some of these will not develop into claims because the NDIS will meet their care and support needs. For example, an accident that occurred five years ago, but which has not yet developed into a legal claim, may never do so because of the NDIS. This would represent a saving for medical indemnity insurers and their members.
- On the other hand, some notifications of insurable catastrophic medical negligence will continue to develop into claims even after the NIIS has commenced. This is because the date of the injury precedes the NIIS. That said, to the extent that funds would already have been put aside based on incident notifications, premiums charged by insurers at the commencement of the NIIS would not incorporate these costs.

Why should physicians and hospitals contribute to accidents where no fault can be determined?

The responsibility of hospitals and physicians to fund claims where there has been a practitioner's error (fault-based claims) is clear. The rationale for using medical indemnity premiums and hospitals' insurance to fund 'no-fault' claims primarily relies on the capacity to link the financial contribution from physicians and hospitals to clinical risk management activity. Clinical risk management includes:

- resource allocation decisions

[14] For most catastrophic accidents, including cases of alleged birth asphyxia (cerebral palsy), an insurer would be notified of virtually all cases. There is, nevertheless, a small risk that an incident would not be notified and an estimate of the potential claim cost not put aside. In extreme cases, an insurer could fail to be notified of an incident that is only reported (and a claim for damages lodged) some decades later, and perhaps when the practitioner concerned no longer has policy cover.

- clinical knowledge, training and accepted clinical practice at the time of seeking or receiving treatment from a registered health professional
- the potential for improvements in patient safety over time.

In principle, funding 'no-fault' injuries through premiums recognises that many 'no-fault' injuries are preventable, even when the clinical care was not negligent, through system-wide improvements in clinical risk management. The extent to which improvements should be pursued is largely an empirical question that depends on both the costs and benefits of additional investment in clinical risk management activity.

The cost of lifetime care and support for catastrophic injuries resulting from seeking or receiving treatment is an important cost that should be factored into decisions about clinical risk management. Adequately including these costs would strengthen incentives for cost effective training and innovation in risk management and patient safety. It is likely that some measures need not be costly to implement, such as from ensuring better adherence to clinical protocols, safety checklists, record keeping and incident (or 'root cause') analysis. The issue is how to lever such gains in patient safety through the insurance premiums of doctors and hospitals.

Supposing there is an increased role for linking premiums to reductions in clinical risks, then arguably the cost of such injuries should be reflected in practitioner's premiums and, in turn, the price of supplying private services. There are even stronger arguments for the organisational units of public and private hospitals to contribute towards their share of no-fault claims, since they tend to be directly responsible for clinical governance to systematically prevent treatment injuries.

In cooperation with existing bodies charged with advancing patient safety and quality in each jurisdiction, the NIIS and insurers could encourage risk reduction and improved patient safety in several ways, including through:

- use of electronic health records to better coordinate health care, including clinical decision support and information about drug interactions and other relevant patient health information
- expansion of outcomes research, comprehensive data analysis (including of facts surrounding adverse events) and evidence-based medicine to improve care quality
- improvements in physicians' knowledge and skills through lifelong assessment, recertification, remediation and more intensive licensing review (Rothstein 2010).

In addition, the availability of no-fault lifetime care and support through the NIIS significantly enhances the quality of health services and the level of assurance that

can be offered to patients in the disturbing event of a catastrophic treatment injury. This is an important enhancement to the practitioner-patient relationship and the high level of trust that is relied upon between parties. Moreover, the NIIS will benefit practitioners by taking some of the heat out of medical litigation, which is currently the sole gateway to obtaining funds towards lifetime care and support costs.

Furthermore, the real price of medical indemnity premiums has dropped in recent years. This reflects a range of factors including tort law reforms and the current (apparently well-functioning and well-supported) taxpayer-funded subsidy arrangements. In an environment of generally falling claims and claim cost, a small upward adjustment in the real price of premiums and the insurance costs of hospitals as a result of the NIIS should not threaten the affordability of medical indemnity cover, doctors' incomes or continued practice.

It would be a matter for governments and medical defence insurers to decide how premiums should change across practice groups and specialties in order to fund NIIS claims. However, any changes should seek to strengthen incentives for clinical risk management and cost-effective enhancements in patient safety and be mindful of the need to ensure premium levels do not threaten continued practice.

In summary

With the introduction of an NIIS, the pool of premiums paid by private physicians and hospitals would be required to fund:

- the cost of catastrophic treatment injuries covered under the NIIS, including:
  - the cost of 'at fault' claims for future care and support costs, which are currently met through medical litigation and, hence, already reflected in premiums
  - the cost of extending cover for lifetime care and support to injuries where there is no at-fault party, and also any gap between the cost of fault-based compensation and NIIS lifetime care and support (given settlements are generally reduced to reflect issues over liability). These costs are currently not reflected in premiums.
- damages for income losses and pain and suffering for catastrophic injuries and the fault-based medical negligence costs for all non-catastrophic injuries. These costs are already reflected in premiums.

Premiums would, however, be reduced by:

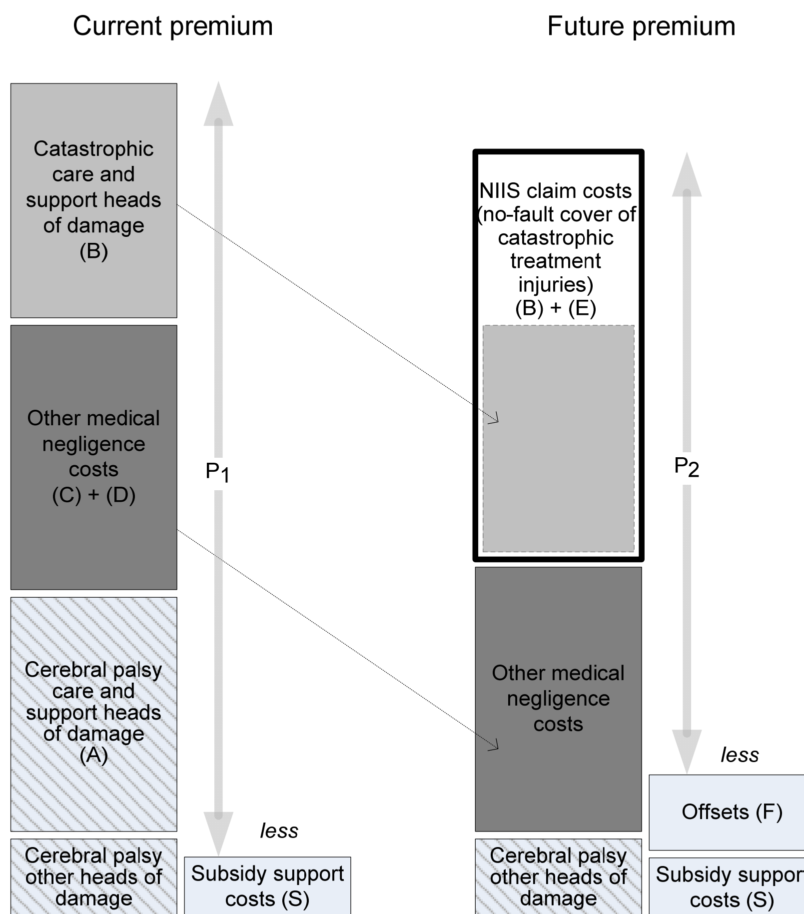
- the various offsets associated with the introduction of the NIIS, including reinsurance and cost of capital savings, fewer claims under the remaining heads of damage and savings in legal process costs
- the cost of cerebral palsy litigation for future care and related heads of damage, which would instead be met through the NDIS. These costs are currently included in premiums and we estimate could reduce insurance costs by around $60 to $100 million dollars each year. (Common law damages for pain and suffering and income losses would continue to be available where a practitioner is found 'at fault' and these costs would continue to be reflected in premiums.)
- spending on subsidy programs.

The Commission recommends that NIIS claims for medical treatment be funded by contributions from the insurance (including self-insurance) arrangements of hospitals and the medical indemnity premiums of physicians for medical treatment accidents.

  – If the removal of the insurance costs associated with the lifetime care and support of cerebral palsy cases does not sufficiently outweigh the additional costs associated with the inclusion of no-fault catastrophic injuries, then any premium increases should be gradually phased in. This would ensure premiums do not threaten existing practice, with State and territory governments funding any gap between premium income and catastrophic medical injury claims.
  – Regardless, the Australian Government subsidy schemes should continue to safeguard the affordability of medical indemnity cover.

Nevertheless, it is likely that covering cerebral palsy cases through the NDIS may put *downward* pressure on premiums and subsidies.

Figure 18.2 **What costs will be included in future medical indemnity premiums?**[a]



[a] This illustration does not include the portion of the total premium pool required for underwriting, general expenses and the net surplus. See box 18.5 for definitions of (A) through to (F).

Workplace accidents

The injury prevention gains from occupational health and safety measures means that catastrophic-level injuries are increasingly a less prevalent feature of workers' compensation schemes, with soft-tissue, muscular skeletal and work-related stress the major types of injury. It is estimated that fewer than 60 cases of catastrophic injury arise from workplace accidents across Australia each year (Walsh et al. 2005).

But the low prevalence of catastrophic workplace injury also means that current workers' compensation schemes are generally not adequately equipped to support the lifelong needs of people with catastrophic injury. Some jurisdictions address this by transferring such cases to their no-fault motor vehicle accident scheme (in effect, catastrophic claims are contracted out to a different scheme, with funding attached).

Such an arrangement exists between Victoria's Workcover and the TAC. The Commission proposes that other governments consider adopting this type of arrangement. Importantly, claims would be financed from workcover premiums, maintaining efficient incentives for injury prevention in workplaces and, where possible, vocational rehabilitation.

Some participants raised concerns about the NIIS potentially leading to the dilution or removal of common law rights. For example, WorkCover Tasmania:

> … is concerned to ensure that any introduction of a national scheme does not disadvantage the catastrophically injured by reducing or removing entitlements that may currently exist under workers compensation arrangements (sub. DR 972)

The Commission is not proposing that cover of lifetime care and support under the NIIS should reduce entitlements. In fact, the opposite is more likely, to the extent that solicitor-client legal costs (paid from the injured person's damages) reduce the funds available to the injured party and:

> … there is often a substantial degree of contributory negligence by the employee that results in damages awarded being reduced. (sub. 600)

In some jurisdictions, including Western Australia, Queensland and Tasmania, adequate funding of catastrophic-level workplace injuries would require legislative change. This is because present arrangements:

- are not sufficiently funded to provide lifetime care and support for those unable to prove the fault of their employer
- provide generally inadequate funding relative to what would otherwise be needed to fund claims in an NIIS setting (mainly due to limitations on statutory benefits, legal costs paid directly from a plaintiff's damages, reductions for contributory negligence and high discount rates).

In particular, under a no-fault approach, the head of damage associated with compensation for future care needs would need to be removed, and additional premium revenue sought to meet the lifetime care costs of additional no-fault catastrophic claims under the NIIS. In the three jurisdictions requiring additional funding:

- it is estimated that approximately double the current allocation of premium revenue (paid as common law lump sum damages) would be necessary to provide no-fault lifetime care and support
- overall, the additional impost would be very modest — estimated in 2005 at around 0.5 per cent of total premiums currently collected (Walsh et al, p. 56).

Acknowledging the inadequacies of Tasmania's present arrangements for dealing with catastrophic workplace injuries, the Tasmanian Government has indicated:

> Coverage of catastrophic injury under a national scheme would seem to offer a more equitable outcome for the very few cases of catastrophic injury (around one per year in Tasmania). (sub. 600, p. 6)

A possibility to be investigated for the management of lifetime care and support needs for catastrophic workplace injuries while in Commonwealth employment might be co-ordination through the Department of Veteran's Affairs, since they have established expertise in these matters. Alternatively, care and support needs could be contracted to the relevant NIIS scheme in the jurisdiction in which the person resides.

With the availability of comprehensive care and support through the NDIS, it is sensible for governments to move away from lump sum payments for lifetime care and support, thereby managing the potential for 'double dipping' into the NDIS in the not uncommon circumstance that a financial lump sum proves insufficient or is mismanaged (chapter 17).

Under the Commission's proposals, existing workcover schemes would continue to source premium revenue to cover catastrophic workplace injuries and manage non-catastrophic claims. Injury prevention programs would remain unaltered, and existing workcover schemes could continue to be involved in facilitating an early return to work where feasible. The only difference would be that the care and support of catastrophic claims would be provided by the NIIS under a contractual arrangement with the relevant workcover scheme.

General injuries arising from accidents in the community and at home

General injuries arise from a broad range of causes. The risk of accidents often reflects the combined effect of:

- environmental factors — for example, maintenance of footpaths, the existence of a partially submerged rock or the safety of playground equipment
- the nature of the activity being undertaking — for example, recreational horse riding, swimming, clearing leaves from a gutter or repairing a home roof, along with an assortment of 'tourist' and 'sporting' activities.

To some extent, catastrophic general injuries are already covered by public liability insurance, though this requires that an insured party be found legally liable. It is estimated that only around 20 per cent of these injuries are able to access some form of compensation (Walsh et al. 2005).

Sporting bodies and public authorities (including schools, local government, government departments and the Crown) are mainly affected by public liability insurance claims, given the prevalence of leisure and recreation activities as a source of injury. Local governments have most exposure, including through their provision and management of beach amenities, swimming pools, sporting grounds, playgrounds, community centres and maintenance of roads and footpaths. (Box 18.6 provides some examples of personal injury liability cases involving local councils.) This suggests that if these accidents were instead covered by the NIIS, the public liability premiums of local governments should fall to some extent.

Accidents also arise from activities on private residences and from violent crime and assault (both in a domestic and non-domestic setting). This raises the additional question of how best to finance NIIS claims on a no-fault basis for catastrophic injuries such as those arising from:

- falling off a ladder or being severely burnt in a house fire
- criminal violence (mainly assault) and self-harm (box 18.7).

Box 18.6 **Local governments' duty of care to prevent injury**

So called 'trip and fall' accidents are the main source of legal action against local councils. Local governments hold a position of authority that requires them to identify whether or not a potential hazard is obvious to an ordinary user, and hence, have a duty to provide appropriate warning of any non-obvious risks. It is often not clear whether or not councils adequately carry out their duty of care to the community:

- Newcastle City Council v Lindsay [2004] NSWCA 198 — This decision found that the defect in the walking path caused by raised tree roots was obvious, but that the council not warning pedestrians had not raised the risk of injury, emphasising that pedestrians also have a duty to lookout for obvious and common risks.
- Timbs v Shoalhaven City Council [2004] NSWCA 81 — permission was sought from the council to remove a large gumtree near a residence. Following inspection, the council did not provide permission for the tree's removal and suggested the tree was safe, but in a later storm the tree fell on the house and caused the death of Mr Timbs. The tree's roots were found to be decaying, and while the council could have advised Mr Timbs to seek independent advice about the condition of the tree, the council's opinion that the tree did not pose a risk in the absence of any further investigation was determined negligent. The council was found liable.
- Swain v Waverley Council [2005] HCA 4 — this case clarified the extent of local councils' duty of care to safeguard beach swimmers and surfers, including through the placement of flags and warning signs, with the injured surfer obtaining damages of $3.75 million (even after a reduction for contributory negligence).

Source: NSW Legal information Access Centre, Hot Topics: Legal issues in plain language, no. 51, p. 19.

In the draft report, the Commission recommended that state and territory governments fund all catastrophic general injuries through a levy on local government rates. It was also proposed that public liability insurance would:

- no longer be required to cover the lifetime care and support costs of catastrophic general injuries. In theory, this could reduce incentives for risk management,[15] but the Commission recommends a broader range of risk management approaches that may be better targeted at general injuries than the heads of damages most covered by public liability insurance. Moreover, levy discounts would be available to local governments that followed the appropriate risk reduction strategies
- continue to be necessary for damages for income losses and pain and suffering, as well as less serious injuries.

In effect, the Commission was looking for a low cost and efficient way to cover the cost, and simultaneously reduce risks. Local government rates meets both objectives.

State government legislation gives effect to the powers and responsibilities of local government.[16] The Commission understands that the imposition of a levy on the rating systems of local councils would require legislative change in order to collect the levy across individual households. The Commission envisages that the NIIS would determine the annual amount payable to cover the cost of general injury claims for each local council. The amount should reflect their actuarially-estimated contributions to NIIS claims, but could be adjusted to reflect risk management activity and other special considerations.

While it would be a decision for individual jurisdictions to make, on balance, the Commission still favours local government sources of revenue because:

- this could be collected reasonably efficiently, as it would be a surcharge on existing local council rates
- property-based taxes are economically efficient and have fewer distortionary effects than other transaction-based taxes (reflecting the low responsiveness of demand and supply to price changes created by the 'tax wedge').

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[15] A point made by the Municipal Association of Victoria, which argued that it would introduce moral hazard that could erode current mitigation efforts and potentially increase accidents (sub. DR913, p. 3).

[16] Local government are not explicitly mentioned in the Constitution, and hence, their authority is a 'residual power' of state governments. The jurisdiction of local government is usually enacted through specific local government legislation, but also as mentioned within other legislation, such as bushfire, domestic animal control legislation planning legislation and other bylaws. Apart from collecting local government taxes and charging fees, local governments rely on grants from state and Australian governments.

- local councils would be relieved of some of the costs of their public liability premiums, as the high-cost claims would be covered under the NIIS. As such, some of the proposed levy on ratepayers is already factored into rates charges that now cover the costs of public liability premiums. In effect, a proportion of the new levy would simply be a transfer within local government
- a council would have even stronger incentives to encourage state governments to change regulations or laws that affected local risks (such as liquor licensing conditions) and to use the mechanisms available to local government itself to encourage or discourage certain activities, taking account of the full social and economic costs and benefits within their local area. Any success they had in reducing injuries would directly affect the NIIS insurance premium they pay. This might be put into effect through rules and by-laws that affect planning, alcohol free zones, community outreach centres and women's refuges. The National Committee on Violence noted that:

  > … local governments, which are the level of government closest to the everyday lives of most Australians, are in an important position to contribute to the prevention and control of violence within their respective communities. (Chappell 2004, p. 158)

- to the extent that NIIS cover for general injuries reduces individual incentives to privately insure for the costs of disability arising from injury, there are merits in looking at new ways of individuals contributing.

Participants to this inquiry, including local councils, strongly expressed support for a no-fault approach to covering catastrophic general injuries, and many also saw the benefits of a separate NIIS for this purpose (for example, sub. DR764; sub. DR913; sub. DR861). But local councils and their associations opposed the use of a levy on local council rates to fund general injury claims. They raised concerns about:

- the nexus between catastrophic general injuries covered by the NIIS and the scope of a council's control over the risks that contribute to such accidents
- the economic efficiency of local council rates as a source of funds, including the relative efficiency of alternative sources of funds, such as income tax, the administrative ease of collecting a levy on rates, and the distributive implications of the proposed funding mechanism
- the capacity of local councils to raise revenue.

The issue of risk management is discussed below. While the economic efficiency of a levy on rates has been discussed above and, indeed, is the primary reason for proposing municipal rates as a funding source, some further comments are provided below, mainly in the context of alternative funding options.

Risk management

While local councils already undertake risk management consistent with their legislated responsibilities, the potential breadth of their legislated responsibilities is sometimes not clear and, the Commission has been told, varies significantly across jurisdictions.[17]

In some jurisdictions, there would generally be no legal impediment preventing local councils from undertaking broader risk management activity consistent with reducing 'no-fault' injuries.[18] In particular, states can enact specific legislation (other than the Local Government Act) to give effect to additional functions of local government. This includes, for example, planning and licensing laws, and other legislation relating to domestic animal control, fire safety, roads and access to swimming pools.

But in other jurisdictions, more pervasive legislative change would be needed, with the scope of local government tending to be defined more narrowly. In such cases, the state government assumes more exclusive control of the safety of the public, community activities and other civic responsibilities related to general accident prevention.

An additional issue is that councils may lack the relevant skills, information, and financial incentives and capacity to undertake risk management outside of the traditional breadth of their legal responsibilities.

The extent that state governments should seek to expand the scope of a council's risk management activity through the NIIS levy should therefore depend on:

- whether a council could cost effectively adopt practices that reduced injury. Any practice should be likely to pass a cost-benefit test, not just reduce injury. For example, while a program to reduce rates of old aged falls in New Zealand was successful at reducing the incidence of falls by nearly 50 per cent (based on a randomised control trial by Wolf et al. (1996)), its costs outweighed the benefits. State and local governments could agree on a portfolio of generally cost-

[17] In general, the service and functions of local councils can extend to: community services and facilities; public health services and facilities; cultural educational and information; sporting, recreation and entertainment; environment and conservation; waste removal; public transport; water sewerage and drainage; flood protection and mitigation; fire prevention; land and property development; housing; industry development; and tourism development. Any broader responsibilities can be enacted through specific legislation.

[18] Some restraints and qualifications on the ability of a council to exercise services and functions is sometimes imposed

effective risk management strategies, with activity in these areas periodically audited and rewarded, based on compliance

- the availability of relevant skills and expertise. While all councils undertake risk management to some extent, some are more innovative and sophisticated in their risk management activities than others. Many already employ staff specifically for risk management, or share such staff with nearby councils. State governments could facilitate knowledge transfer and learning about accident risks and opportunities for cost effective risk reduction. A regular process of auditing could be effective for this purpose
- the efficiency of administering such arrangements, including the bureaucracy to monitor progress and audit outcomes to ensure proper compliance and accountability. As noted by the Municipal Association of Victoria:

> Where levies are placed on the council and will result in a direct increase in rates, it is unlikely that there will be significant (marginal) administrative costs associated with the task. Where there is a different base applied to apportion the burden across ratepayers, such an attempt to align risks to contributions, the rating system will present a less administratively simple mechanism. (sub. DR913, p. 8)

In summary, state governments may seek to marshal positive local council engagement in risk management activity that lies outside the remit of their traditional responsibilities. This would mean different things across local councils. For example, it could include some activities to reduce alcohol fuelled violence at licensed premises (box 18.7) or address specific issues in certain neighbourhoods or tourist areas. However, to be effective, it may be necessary for state governments to:

- implement legislative change where there is an impediment to local government having broader responsibilities
- establish partnerships within the local government community and with state governments in a structured and ongoing way (see later about the shared role of state governments)
- periodically audit each local council's risk management activities, not simply to ensure compliance, but also to encourage learning and education about risk management
- apply discounts and loadings to an individual council's annual levy, subject to evidence of cost-effective risk management activity, but not necessarily claims experience (This should take account of a local council's specific circumstances to ensure that factors that can influence catastrophic injury but which are generally outside of a local council's control — such as higher rates of social and economic disadvantage — do not affect the levied amount.)
- use grant-based funding to leverage specific risk management activity.

Box 18.7 **Reducing alcohol fuelled violent injury**

Evidence shows that targeting high risk crime 'hotspots' can be effective at reducing rates of assault, including through strategies focussing on types of businesses, such as pubs and clubs, and specific street blocks or neighbourhoods. For example, research shows:

- geographic areas with higher concentrations of liquor outlets also have higher rates of crime, even when possible confounders such as level of unemployment, cultural, income and age are taken into account (Scribner et al. 1995)
- a small number of problematic licensed alcohol premises account for a disproportionate share of violence — in inner Sydney, 12 per cent of hotels accounted for almost 60 per cent of all assaults on hotel premises; in Newcastle, 8 per cent of licensed premises accounted for nearly 80 percent of all assaults on licensed premises; and in Wollongong, 6 per cent of licensed premises accounted for 67 per cent of assaults across all premises. The rate of assault aligned closely to hours of trading (Briscoe and Donnelly 2003)
- a range of public health policies could be effective at reducing alcohol's contribution to community based violence, including targeting alcohol outlet density, alcohol retail sale hours, the price of alcohol, characteristics of violent bars, and violence in emergency departments (Heung, LeMar and Rempel 2011). One study found that a one per cent sustained increase in the price of alcohol above inflation would decrease violent injuries by nearly 2200 a month (Sivarajasingam et al. 2006). Other studies have show that the price of drinks is lower in violent bars than non-violent bars (Quigley et al 2003).
- key environmental variables found to be associated with declining rates of violence include: improved comfort, the non-permissiveness of management and declining to serve to intoxication, female staff, employment of friendly and effective security staff, ID checks and the availability of public transport (Quigley et al 2003; Graham et al 2006; Homel et al. 2004; Graham et al. 2002; Hughes et al. 2011)
- a study found that changing pub closing times in Newcastle (to 3 am and later 3:30 am with a 1:30 am lockout) reduced the incidence of assault by 37 per cent compared to a control locality (Kypri et al. 2011).

The efficiency of alternative funding options

… Funding from the federal tax system or state-based revenues

Some participants have suggested that the NIIS should be a nationally legislated and funded scheme. In particular, the Queensland Government (sub. DR1031), the South Australian Government (sub. DR861) and the Tasmanian Government (sub. DR1032) all supported national funding responsibilities for the NIIS. For the most

part, this reflected concern about 'cost of living pressures' and the affordability of the NIIS through state-based funding sources. The Tasmanian Government was especially concerned that expanding their current responsibilities to general injury would bring significant financial risks:

> If premiums collected from local councils and other sources prove to be insufficient, and there is a high risk that this will be the case, the Tasmanian Government may be required to impose additional levies or fund the NIIS from the Consolidated Fund. (sub. DR1032, p. 22)

The Tasmanian Government also thought that the availability of private insurance products to cover legal liabilities should not draw government into an NIIS that would make them responsible for underwriting scheme liabilities. But, as already noted, fault-based insurance only provides compensation for around 20 per cent of catastrophic general injuries.

Local governments raised the possibility of financing NIIS claims through personal income taxes or payroll taxes (sub. DR913; sub. 766; sub. DR764). They also questioned the relative economic efficiency of municipal rates as an alternative funding source. In particular, the Municipal Association of Victoria argued that the KPMG-Econtech review of the efficiency of state and territory taxes underestimated the economic efficiency loss from the implementation of rates, since the model used does not take account of the different valuation bases used by local governments.

- On the first point, the inefficiency of personal income tax is 24 per cent and 41 per cent for payroll taxes. Both of these revenue sources are significantly higher than the measure of inefficiency for municipal rates which is 2 per cent (KPMG-Econtech review for the Henry Tax Review (Treasury 2009a)).
- On the second point, the Municipal Association of Victoria suggested that households would have incentives to move from areas with higher rates to areas with lower rates. This is not a persuasive argument, given the high transaction costs of moving and the low addition to rates from funding general accidents. Moreover, if people moved because one council failed to mitigate risks well to another council that did, it would be efficiency improving, not the contrary.

… A new mandatory household insurance product

While a householder's home and contents insurance policy generally includes some cover for personal injury, such protection against legal liability usually extends only to non-householders or visitors to a home or residence, it does not cover the householder. In addition, legal liability cover for personal injury is not universally included within home and contents insurance policies and not all households are

insured. The focus of home and contents insurance is not about managing the risk of injury.

The Commission does not recommend that household insurance be used to fund general accidents in the home:

- If it were voluntary, not all people would insure, resulting in patchy coverage (or unfairness, if taxpayers had to pick up the costs for those who did not insure)
- A compulsory levy on household insurance could be introduced, but for those households without household insurance it would need to be a separately mandated levy. (Otherwise, the price effects of a mandatory levy applied only to households with insurance would discourage such insurance in the first place, with significant inefficiencies.) A mandatory levy imposed on all households would overcome the limitations of voluntary or partly mandated levies, but it would be improbable that any realistic arrangement would reduce risks (given difficulties in calculating exposure to risk and monitoring compliance and, hence, would be generally ineffective in its goals).

In the event that a mandatory levy had few benefits in reducing risk, it would amount to a small poll tax (a community charge applied at a single flat rate per capita). Given its mandatory and universal nature, it would be relatively efficient in terms of its distorting effects on people's consumption decisions, but it would impose potentially sizeable administrative and compliance costs, and would not meet the equity goals of the tax system.

Given its inadequacy for covering household accidents, such a tax would also not be justified for coverage of catastrophic accidents in general (and would forgo opportunities for risk management that are available to local government).

… A levy on public liability insurance premiums of businesses and not-for-profit entities

A mandatory levy on public liability insurance paid by businesses and not-for-profit entities would be another possibility. It would, however, involve significant complexities and the potential for unintended impacts:

- In most industries, and especially for smaller businesses, public liability insurance is purchased as a combined product (including, for example, cover for product liability and other general insurance) with a single premium (ACCC 2005). An ad valorem levy would be inappropriate in that context since it would tax insurance that was quite unrelated to general accidents. Moreover, just as in the case of household insurance described earlier, it would be

problematic if a mandatory levy on public liability insurance policies could be avoided by foregoing public liability insurance generally.

- Any additional cost imposed on public liability insurance for not-for-profit parties could discourage certain activities, such as sport and leisure pursuits normally organised by various community groups, which could have negative impacts on public health and community wellbeing.
- It would be likely to be costly to monitor and ensure compliance, and it would sometimes be difficult to even identify the party that would be responsible for paying the premium (many 'businesses' do not hold an ABN).
- As in the case described for households above, risk management activity would be difficult to observe across individual small businesses and households, which would make risk-rating more difficult and costly to administer. That said, adherence to good practices and risk management by local governments and larger businesses could be easier to monitor.

Rather than seeking to fund the extension in coverage of 'no-fault' general injuries through a levy on public liability insurance, there is likely to be greater merit in retaining current insurance for fault-based claims. At least, in theory, it would seem appropriate that current incentives to reduce accidents (and the risk of being found liable) should be maintained by requiring a contribution to the NIIS equivalent to the cost of these claims.

However, given the NIIS would not make any determinations of fault, in practice, ascertaining the cost of fault-based claims could be problematic.[19] Although negligence would ultimately be revealed through legal claims made under the remaining heads of damage and for non-catastrophic injury, using this as a basis for applying a levy to cover the cost of fault-based claims could be very protracted.

A levy on the public liability insurance of local governments

A levy on public liability insurance paid by local government would, again, require that the personal injury component of cover be made compulsory. Taxes on insurance for general revenue raising are generally highly inefficient.[20] However, an insurance levy could be efficient if:

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[19] Although it is proposed that medical practitioners and hospitals would continue to bear costs equivalent to the value of their 'at-fault' claims, it is also proposed that their medical indemnity premiums would fund 'no-fault' NIIS claims. So, in practice, no distinction between 'at-fault' and 'no-fault' claims under the NIIS would be necessary.

[20] KPMG-Econtech review of the efficiency of state and territory taxes for the Henry Tax Review (Treasury 2009a) Inefficiency arises because taxes reduce the demand for insurance.

- it could not be evaded by relinquishing or lowering insurance cover
- it was not levied as a percentage mark-up on existing liability insurance premiums, but as a basic levy amount
- there was scope to receive levy reductions through following appropriate risk management (a point made by the South Australian Government, sub. DR861, p. 10).

Such a levy would of course need to be funded by local governments. They could do so in several ways, but the principal and most efficient revenue source would be rates. In effect, so long as it was *appropriately designed and funded*, a levy on local government public liability insurance would have identical effects to an increase in rates. Subject to the above proviso, a mandatory (non ad valorem) levy on public liability insurance could be an alternative funding source.

However, an explicit (and separately identified) levy raised through rates would have the advantage of public transparency that would be lacking for a levy on public liability insurance. Transparency would have the advantage that the public would more readily appreciate that there were costly risks in their neighbourhoods that were partly under the control of their elected government, and provide an additional pressure for risk reduction.

Moreover, it is hard to get levies on rates wrong, but there are many possible ways of imposing levies on insurance, some of which would be less efficient than the option discussed above. A surcharge on rates is a transparent and low risk financing option.

In summary

The Commission proposes that state and territory governments fund catastrophic injuries arising from criminal injury or general accidents in the community and in people's homes. One efficient avenue for doing this would be through a small impost on municipal rates. If the states do not support a small increase in rates as the means to fund this reform, they should fund catastrophic general accident costs by other means.

The capacity to reduce the risk of such accidents is greatest at the state and local government level. Local governments have generally supported the argument that they can *contribute* to risk management activity, but dispute that they should be solely 'burdened with this responsibility' (MAV, sub. DR913). Given that state governments control local government functions and responsibilities, their ultimate responsibility to fund injuries arising from general accidents under the NIIS (either

through a levy on municipal rates or other means), is consistent with supporting shared responsibility for risk management.[21]

There may be special circumstances affecting injury rates in some local areas, such as higher rates of social and economic disadvantage (including high rates of unemployment), that may warrant a contribution from state general revenues. Indeed, grants from state governments provide an important source of revenue for local governments, and state and territory finances are already the source of funding for victims of crime compensation.

This would be relatively simple to administer and would further increase the incentives of state governments to engage strategies to reduce general injuries, including by:

- partnering with local governments and, where appropriate, using grant-funding and auditing, to achieve specific risk management activities and outcomes
- reducing alcohol fuelled violence associated with the availability of alcohol at venues, restricting opening hours, crowd management, policing and public education (box 18.7)
- early intervention strategies in health, education and community services.

The additional funds required for general injuries represents a relatively small burden on state and territory budgets. However, given the significant broadening of coverage required and paucity of reliable estimates of the additional costs associated with no-fault cover of lifetime care for general injuries,[22] it is possible that liabilities could be partially upfront funded. The issue of full or partial upfront funding of future liabilities is discussed below.

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[21] The Commission is presently undertaking a study on the role of local government as a regulator. This will help to clarify the effectiveness of local government in undertaking broader regulatory functions, including as directed by, and on behalf of, higher levels of government.

[22] Rough estimates in 2004-05 indicate that the total annual cost could be in the order of $300 to $350 million (or between $415 to $485 million in current values). This was based on around 220 to 250 catastrophic-level general injuries each year, of which only 20 per cent receive public liability compensation (Walsh et al. 2005, p. 52). Revised estimates by the Commission, and based on the proposal that existing fault-based public liability premiums would not contribute to the costs of general injury, suggest the net cost could be closer to around $540 million in current values (table 18.1).

Box 18.8 How common are serious falls and assaults?

The main sources of serious but non-fatal general (or community) injuries are falls and assaults. Fires, burns and self-harm also give rise to a significant number of serious injury cases. Drowning and poisonings tend to be less common.

Falls are most represented in the statistics, with around 32 000 classed as a high threat to the person's life (consistent with a serious non-fatal injury) in 2004-05. Around two-thirds of these were by females, who had a mean length of stay in hospital of one week, which is significantly longer than for all other sources of serious but non-fatal injuries. Unlike other sources of serious injury in the community, falls are by far most commonly experienced by people aged over 65 years:

- The rate of falls for people under 65 years is around 500 cases per 100 000 population. These mostly arise from sport or recreation-related activities at younger ages, or home-related tasks and activities for people aged over 45.
- Rates almost double for each five-year increment in age up to age 80, with 10 per cent of all females aged over 90 years experiencing serious injury from a fall. These are mostly attributed to slipping, tripping or stumbling, and are consistent with a loss of agility, movement and balance associated with ageing — in fact, 10 per cent of all hospitalised falls occurred in aged care facilities.

In 2008, there were over 170 000 assaults recorded in Australia. Previous estimates indicate that around 2 per cent of recorded assaults require hospitalisation (Mayhew 2003). Other statistics show that in 2004-05, there were 4246 serious but non-fatal assaults (about 2.5 per cent of all recorded assaults).

Around three-quarters of all hospitalised cases of assault involve males, and mostly from a bodily force rather than an object or implement. For cases where the injured person was under four years old, the cause of assault in around 50 per cent of hospitalised cases was classified as maltreatment, neglect or abandonment. In most hospitalised cases of assault, the injury is to the person's head, with about 10 per cent involving an intracranial injury. Rates of assault are substantially higher in the Northern Territory than in any other Australian jurisdiction.

Source: AIHW 2008, Hospital separations due to injury and poisoning Australia 2004-05; Mayhew (2003).

Should liabilities be fully funded?

A fully funded NIIS would allocate the estimated lifetime costs of care and support associated with each entrant into the scheme at the time they entered the scheme. This provides certainty about the capacity of the fund to meet a person's future liabilities, and it also provides a buffer against year-to-year variations in costs — in effect, smoothing premiums over time and reducing reinsurance costs. Funds would be invested to generate a capital return and drawn down against as actual costs are incurred to meet participants' care and support needs. A fully funded scheme has the

highest likelihood of solvency and presents a lower risk for future taxpayers, premium payers and scheme participants.

Realistically, fully funding can only apply to the new incidence of catastrophic injuries. People who acquired a catastrophic injury in the past would continue to be supported by the existing disability and health system and the NDIS.

But because the NIIS would be government underwritten, it would also be possible to put aside only a proportion of the estimated lifetime liability, and instead draw on future taxpayer revenues to meet any unfunded gap in scheme expenses (obligations to meet lifetime care and support costs) as they are incurred. This point was raised by some participants, including Professor Richard Madden:

> There is no justification for seeking full funding of the injury compensation system, regardless of the level of integration with the broader NDIS. The scheme is a government scheme, so there is no possibility of default on benefits. (sub. DR997, p. 7)

The South Australian Government also argued that:

> Given the long term nature of the liabilities it may not be necessary for the premium setting arrangements to be slavishly attuned to a full funding requirement in relation to the entitlements that it supports. Given inherent volatility in investment and financial markets a fixed funding ratio target can introduce significant volatility in premiums when investment returns and discount rates move erratically. (sub. 496, p. 19)

Partial pre-funding of future liabilities is a common feature of government guaranteed social insurance systems, and may be equally workable to the extent that a sound governance structure ensures the scheme remains affordable. Under a partial upfront funding arrangement, scheme expenses would be funded more closely to when they were actually incurred, but the present value of either a fully or only partial upfront funded scheme is the same.

Given the well functioning insurance systems already in place to fund injuries, the Commission proposes the NIIS operates on a fully funded basis, with one possible exception. Future liabilities associated with general injuries, including criminal injuries, could be only partially pre-funded. This would lower the initial impost on ratepayers, but consideration of this alternative would have to take account of:

- expectations about intergenerational equity
- the desire to smooth financial commitments associated with a new scheme, until such time that it matures and liabilities start to stabilise
- the ease of merging the NIIS and NDIS if contemplated at some point in the future.

18.4 What might the costs be?

The annual costs of changing to a national no-fault scheme are estimated to be around $830 million (table 18.1). These are additional costs that would need to be reflected in existing premium sources and the proposed new source of funding — local government rates. However, these net costs would be less because of savings to the Australian Government from reduced use of publicly-funded Medicare and other services. These were estimated to be $70 to $80 million in 2004-05 (Walsh et al. 2005, p. 25), or up to $100 to $110 million in current values. Further savings could also be expected as a coordinated lifetime care scheme should produce better health and wellbeing outcomes, reducing long-run usage of services, including of income support.

The estimates only provide a guide to likely current costs as those will be determined by many factors, including the wage costs of attendant care[23], population growth, income effects that drive increased motor vehicle ownership and increased usage of health services, and catastrophic injury rates. (They do not reflect common law damages, other than to the extent that these are included as offsets to calculate the incremental cost of the scheme.)[24] Over the shorter run, changes in the cost of capital and reinsurance, and competition in the insurance industry also affect premium rates. Given these multiple influences, the Commission has not sought to re-estimate the costs with any great precision.

The estimates in table 18.1 are based on Walsh et al. 2005, which have been updated to reflect inflation and population growth (by age and jurisdiction), and revised to reflect new sources of data available to the Commission. The new estimates of the annual gross cost of a NIIS are estimated to be around $1800 million, which would cover an estimated 900 to 1000 persons injured each year. However, given current

[23] Estimates do not include allowance for the impact of the Equal Remuneration Case currently before Fair Work Australia. Though the impact of this case will vary across jurisdictions, in NSW it is estimated the outcome of this case could result in a 10 per cent increase in LTCS scheme costs.

[24] The costs were based on ‘bottom-up’ estimates of need for care and support across the range of severities and types of catastrophic injuries. Assumptions about the quality and adequacy of care also underlie estimates of costs, and affect comparisons of the cost effectiveness of fault-based vis-à-vis no-fault schemes. The basis for assessing damages within a common law framework varies to that of a no-fault lifetime care scheme. For example, different assumptions underlie allowances for gratuitous care, and where care is funded at commercial rates, assumptions can differ about relative requirements for clinical or nursing care. There is the additional overlay of reductions for contributory negligence and to reflect uncertainty over liability and the risk of going to court. There are greater opportunities in a no-fault lifetime care scheme for economies of scale and associated cost savings from increased effectiveness of health and rehabilitation spending. There is also greater flexibility in allowing for the availability of family care and other circumstances that change at different life stages.

spending associated with lifetime care and support for catastrophic injury of over $1 billion, the annual net cost of an NIIS will be around $830 million (table 18.1). This is the Australia-wide incremental cost of providing fully-funded lifetime care and support for all catastrophic injuries each year. On average across Australia, this represents an additional around $35 per person each year. It should be emphasised that this is an approximate figure in the absence of more detailed evidence.

Table 18.1 **Estimates of the Australia-wide *additional* costs of an NIIS**

$ million per annum, June 2011[a]

	Cause of injury				
	Workplace injury	*Motor vehicle injury*[b]	*Medical treatment injury*	*General injury*[c]	*All*
NSW	0.00	0.00	14.58	175.00	189.58
VIC	0.00	0.00	11.17	134.11	145.29
QLD	6.33	112.00	9.10	109.18	236.61
SA	0.00	36.51	3.31	39.76	79.58
WA	3.80	70.86	4.63	55.52	134.80
Tas	0.06	0.00	1.02	12.27	13.35
ACT	1.27	8.86	0.72	8.68	19.52
NT	0.00	10.12	0.46	5.55	16.14
Australia	11.39	238.34	45.00	540.07	834.81

[a] Based on estimates by Walsh et al. 2005, which were updated for inflation and population growth and then revised to reflect new data sources and more recent analysis on the annual incidence of catastrophic injury for each cause of injury, along with the age and severity distribution of NIIS participants. These were used to estimate the average cost of claims and the annual *gross* cost of fully-funded lifetime care and support for NIIS participants. Various offsets associated with spending on current accident scheme and compensation arrangements were subtracted from this gross cost to provide an estimate of the *additional* or net cost of the NIIS. The resulting costs provide a 'best estimate' of the likely incremental costs of a NIIS, but are subject to a range of assumptions and uncertainties. The cost of aviation, rail and water accidents have not been included [b] The cost of catastrophic injuries from of 'off road' accidents have not been included in estimates. It is understood this could increase costs by an addition $2-3 per vehicle. [c] includes criminal injury. Reduced expenditure on public liability insurance by local governments are not included in estimates.

Source: Productivity Commission estimates.

The impact across jurisdictions will vary, mostly reflecting the different starting points towards the ultimate objective of no-fault lifetime care for all catastrophic injuries, irrespective of cause. In jurisdictions where there is only fault-based insurance covering the costs of catastrophic injury, the incremental cost will be higher.

In Queensland, Western Australia, South Australia and the ACT, the additional cost of an NIIS is likely to be around $50 to $60 per person. In jurisdictions with existing no-fault arrangements for motor vehicle injuries — including New South Wales, Victoria, Tasmania — the additional cost of an NIIS will be around $26 dollars per person. This additional cost is primarily the cost of providing no-fault cover for catastrophic general

injury (including criminal injury), which is around $24 per person across all jurisdictions. It is proposed that this cost would be met through a small levy on a household's rate notice.

For medical treatment injury, the estimates in table 18.1 indicate that the additional cost of the NIIS would be around $45 million. However, given the substantial removal of cerebral palsy lifetime care costs from the medical indemnity system (which will instead be met through the NDIS), hospitals' and physicians' insurance costs could actually fall. We estimate that this reduction in insurance costs could be in the order of $40 million dollars. If this transpired, the Australian Government could seek to recover an amount equivalent to the 'surplus' funds and put this towards the NDIS. Alternatively, the availability of current subsidy programs could be reviewed.

While the Northern Territory already operates a no-fault scheme for motor vehicle injuries, the cost of NIIS cover for motor vehicle injuries is estimated to be significantly higher than other jurisdictions, at around $75 per registered vehicle.[25] This estimate is consistent with previous estimates of higher costs for Northern Territory motorists. For example, estimates reported in Walsh et al. indicate that premiums would be around 40 per cent higher than the average Australian CTP premium (2005, p. 53).

This higher cost reflects the special circumstances of the Northern Territory, with a high serious injury accident rate and a low number of registered vehicles per person. Moreover, rates of claiming are low among Indigenous people, who are disproportionately involved in accidents, but tend not to access the system of care and support potentially available to them (box 18.9). Addressing these issues would raise premiums, which Indigenous Territorians may well find hard to afford, and large increases might have the perverse impact of increasing rates of non-insurance among this group. Meanwhile, non-Indigenous Territorians would bear premium charges that would include large cross-subsidies to Indigenous people.

As recognised more generally in Commonwealth Grants Commission processes, there are grounds for Australians as a whole to contribute more to those jurisdictions facing special disadvantages. Such involvement would be against the background of the Australian Government's already strong involvement in coordinated policies to address Indigenous disadvantage. In that context, there are grounds for the Australian Government to provide a subsidy to the Northern Territory to reduce the costs of a comprehensive catastrophic injury scheme.

[25] Even for jurisdictions with only fault-based arrangements for catastrophic motor vehicle injuries, an additional $30 to $40 would be required per registered vehicle each year.

While addressing the consequences of catastrophic injuries for Indigenous people — who are often in remote locations with limited services and who tend not to make claims — is inextricably tied to the dilemmas in providing other services (chapter 11), reducing the rate of serious injury motor vehicle accidents should be a central focus of the Northern Territory Government. Further speed limit reductions could be an effective first step. The Northern Territory Police, Fire and Emergency Services said that, in the two years following the introduction of 130km/hr speed limits in 2007, there was a 25 per cent reduction in fatal accidents, 44 per cent fewer 'hospitalised' accidents and 77 per cent fewer 'minor injury' accidents (NTPFES, Media Release, August 2009).

Box 18.9 **The challenge of reducing serious road injuries in the NT**

Tackling the rate of serious injury and fatal motor vehicle accidents in the Northern Territory is a complex challenge. The apparent causes are multiple and often overlapping, involving alcohol and drug use, excessive speed and driver fatigue.

Overlying these factors is the difficulty that the Northern Territory is a large geographic area and has a sparse population. This makes monitoring and enforcement of road safety difficult and more costly. Attitudes among NT drivers towards responsible road use and safety are suggested to be poor, with the severity of injuries increased by the non-wearing of seatbelts and the driving of over-crowded and unsafe (and unregistered) vehicles. Indigenous Territorians are over-represented in serious injury statistics.

It is estimated that the annual cost of serious injuries caused by motor vehicle accidents in the Northern Territory is $145 million, with nine people seriously injured on average each week. This cost would be even higher if more Indigenous people sustaining serious injuries were to access services and supports appropriate to their needs.

Strategies of the Northern Territory police to address the problem include:

- intelligence-led traffic policing capacity, and increased monitoring and reporting, including building capacity within NT police and partnerships with other agencies
- targeted education of vulnerable road users
- increased drink and drug driving enforcement
- increased enforcement of speeding, not using seatbelts/restraints, using handheld mobile phones, driving unsafe motor vehicles and other unsafe practices.

Source: NT Police Road Safety Strategy 2008–2013.

18.5 The scope of the NIIS beyond 2020

Participants were divided about the prospect of expanding the cover of the NIIS to other heads of damages and levels of injury. Lawyers reacted to the hint of such a proposal very strongly; others suggested more comprehensive reforms than were

recommended by the draft report; and some were more equivocal. For example, although acknowledging that NIIS cover of lifetime care and support needs for catastrophic injuries is highly desirable, Professor Richard Madden suggested that the changes proposed did not go far enough:

> … the immediate goal must be to abolish all common law actions for care and support (regardless of whether they result from catastrophic injury or not), by providing such care and support through a no-fault system. … The lack of an income replacement system (other than social security) needs to be considered against the expense and systemic problems caused by fault based systems … (sub. DR997, pp. 4, 6)

On the other hand, the Australian Law Council indicated that the proposed NIIS 'risks generating unnecessary opposition' to the NDIS (sub. DR.948).

What about the other heads of damage?

The biggest welfare gains from reform of injury insurance will arise from covering catastrophically injured people for their lifetime care and support, regardless of whether an at-fault first party can be identified. This should be the main priority for reform over the next few years, with particular attention focussed on successful implementation of the NIIS.

However, there may still be significant gains from extending no-fault insurance arrangements to the other heads of damage ('economic losses' and 'pain and suffering') and to limit the use of the common law in these areas. Moreover, the continued availability of the common law could potentially undermine improved outcomes for participants that are specifically intended under an NIIS.

There are many variations in how current 'no-fault' schemes limit the ability to engage in civil actions. Some prohibit court action entirely; other 'hybrid' schemes permit people to maintain their common law rights for other heads of damage.

- In New Zealand, the *Accident Compensation Act 2001* prohibits access to common law damages, excluding exemplary damages for injury caused by an intentional or reckless act of another party.
- In NSW, the LTCS scheme prevents a claim for common law damages for 'future care' damages only, but enables other heads of damage under the common law. Finity (2010) recently examined historical NSW claims data and estimated that the average size of 'residual' damages for hypothetical LTCS scheme claims (in 2009 values with LTCS scheme related future care heads of damages removed) was $860 000.
- In Victoria, the TAC scheme for motor vehicle accidents provides lifetime care and support services and statutory income payments on a no-fault basis, but

also enables common law access for economic loss (above no-fault income entitlements) and pain and suffering.

- In Tasmania, the MAIB provides no-fault lifetime care and support, but allows full access to common law damages.
- In the Northern Territory, the Territory Insurance Office provides no-fault statutory benefits for residents and modified common law damages for non-residents injured in car accidents. Caps limit the amount of attendant care available.

However, any residual fault-based arrangements still use many legal resources, and based on the TAC experience, hybrid arrangements continue to divert a significant proportion of premium revenue away from actual compensation. A hybrid system may also continue to have adverse effects on health and other outcomes for those seeking compensation for these other heads of damage (chapter 17 and appendix J).

The Commission is hesitant to explore the potential for any further reform within this inquiry. This should be the subject of an independent review in 2020, which should also evaluate the performance of the NIIS in achieving its objectives. In particular, as the NIIS becomes operational, evidence will accumulate on outcomes for participants, which will enable any adverse effects from continued access to common law compensation under the remaining heads of damages to be more fully investigated.

For such reasons, common law rights for individuals to sue for pain and suffering and loss of income from personal injury should be retained. The review of the NIIS in 2020 should evaluate the costs and benefits of removing common law rights more fully and expanding the coverage and functions of the NIIS carefully.

In any event, common law fault-based systems would continue to be an important area of redress in many other areas — such as product liability.

What about non-catastrophic injuries?

There is a good case for a no-fault insurance system to cover the care and rehabilitation costs of significant but non-catastrophic injuries. This reflects:

- that the flaws of the common law still apply to this head of damage whether a catastrophic or less severe injury is experienced
- the high proportion of legal costs associated with a lesser common law lump sum associated with less severe injuries — likely to be around 50 per cent (chapter 17) — means that dealing with this group under the NIIS could generate significant efficiencies. Moreover, the costs and delays associated with obtaining common law damages would also be substantially avoided in most cases

- the potential for savings in future liabilities and social welfare costs by providing interim support for cases that are at the boundaries of catastrophic injury. Providing early access to services and supports may facilitate earlier recovery, reducing the risk of further injury, or exacerbation of the original injury, associated with sub-optimal treatment or inadequate rehabilitation. In some instances, relatively minor injuries can trigger a spiral into poor health, social and economic participation outcomes that can be difficult and costly to reverse.

As the NIIS would only include catastrophic-level injuries, the Commission sees merit in the use of a two-staged assessment to distinguish between a participant's interim (say, up to two years post accident) and long-term participation in the NIIS. This has a range of practical advantages, including the points raised above, but in particular, it would:

- limit the potential adverse consequences from any classification errors in determining a catastrophic injury, especially for suspected moderate to severe brain injury where the extent of injury and scope for recovery is initially uncertain
- align with the approach either explicitly or implicitly adopted in existing no-fault motor accident schemes, including
  - the NSW LTCSA, which manages a person's interim (up to two years) and lifetime participation
  - the Victorian TAC, which separately manages a group of what it terms 'long hospital' clients, which despite having initially high levels of care and support needs, is typically only required for a relatively short duration compared to the duration of a catastrophic injury. Nevertheless, a proportion of these clients (up to around 8 to 10 per cent) continue to access services more permanently.

Appendix I looks at how this might operate. It draws on the experiences of current schemes to show that the costs of covering participants at the margin need not raise a scheme's liabilities significantly.

That said, it is not proposed that the NIIS expand to cover all severities of accidental injury, rather that as part of the 2020 review consideration be given to covering those with significant care and support needs and where funding and coordination through the NIIS would reduce the future liabilities of the insurer. Those with only health care costs would be excluded. This separation of functions recognises the appropriate roles of the health system and the NIIS. Similarly, because existing workcover schemes offer no-fault care and support for all non-catastrophic injuries, the NIIS should not expand to cover these.

RECOMMENDATION 18.1

State and territory governments should create insurance schemes that would provide fully-funded care and support for all catastrophic injuries on a no-fault basis, and that would collectively constitute a National Injury Insurance Scheme (NIIS).

The NIIS would include all medical treatment, rehabilitation, home and vehicle modifications and care costs, and cover catastrophic injuries from motor vehicle, medical (excluding cases of cerebral palsy associated with pregnancy or birth, which would be covered by the NDIS), criminal and general accidents. Common law rights to sue for long-term care and support should be removed, though access to damages for pecuniary and economic loss, and general damages would remain.

State and territory governments should develop a national framework in which the separate schemes under the NIIS would operate.

RECOMMENDATION 18.2

State and territory governments should fund catastrophic injury schemes from a variety of sources including:

- ***compulsory third party premiums for motor vehicle accidents***
- ***a small surcharge on passenger tickets of all rail transport regulated under the new rail safety national laws***
- ***a modest levy on domestically registered passenger carrying vessels regulated under the Australian Maritime Safety Authority (as the proposed new safety regulator for all commercial shipping in Australian waters by 2013). A small levy on existing state-based registration for privately owned 'pleasure' vessels***
- ***a small increase in municipal rates for catastrophic injuries arising for victims of crime and from other general accidents (excluding catastrophic medical accidents)***
- ***contributions from the insurance (including self-insurance) arrangements of hospitals and the medical indemnity premiums of physicians for medical treatment accidents:***
  - ***If the removal of the insurance costs associated with the lifetime care and support of cerebral palsy cases does not sufficiently outweigh the additional costs associated with the inclusion of no-fault catastrophic injuries, then any premium increases should be gradually phased in. State and territory governments should fund any gap between premium income and catastrophic medical injury claims.***

– ***Regardless, the Australian Government subsidy schemes should continue to safeguard the affordability of medical indemnity cover.***

State and territory governments should fund NIIS claims directly to the extent that they choose not to fund catastrophic general accidents on a no-fault basis through local council rates.

The Australian Government should fund any catastrophic aviation accidents, until specific sources of funding related to accident risks are established.

RECOMMENDATION 18.3

The NIIS should be structured as a federation of separate state-based catastrophic injury schemes, which would include:

- ***consistent eligibility criteria and assessment tools, and a minimum benchmarked level of support***
- ***consistent scheme reporting, including actuarial valuations and other benchmarks of scheme performance***
- ***shared data, cooperative trials and research studies***
- ***elimination of any unwarranted variations in existing no-fault schemes***
- ***a national reinsurance arrangement to pool coverage of high risks among the separate schemes.***

State and territory governments should create a small full-time secretariat to further the objectives outlined above. The NIIS and the NDIA should work closely together.

RECOMMENDATION 18.4

State and territory governments should consider transferring the care and support of catastrophic workplace claims to the NIIS through a contractual arrangement with their respective workers' compensation schemes, drawing on the successful experiences of Victoria's Worksafe arrangements with the Transport Accident Commission.

RECOMMENDATION 18.5

The NDIS should fund all cases of cerebral palsy associated with pregnancy or birth, and that meet the NDIS eligibility criteria. Common law rights to sue for long-term care and support needs for cerebral palsy should be removed, though access to damages for pecuniary and economic loss and general damages would remain, where negligence can be established.

RECOMMENDATION 18.6

The initial priority for the NIIS should be the creation of no-fault motor accident insurance schemes, which should provide services and support for catastrophic injuries arising from motor vehicle accidents in all jurisdictions by 2013. Other forms of catastrophic injury should be covered by at least 2015, with funding commencing by 2014 to establish a funding pool prior to any claims.

RECOMMENDATION 18.7

An independent review in 2020 should examine the advantages and disadvantages of:

- ***widening coverage to replace other heads of damage for personal injury compensation, including for pecuniary and economic loss, and general damages***
- ***widening coverage to the care and support needs of non-catastrophic, but still significant, accidental injuries, except where:***
  - ***the only care needed can be provided by the health sector***
  - ***the injuries arose in workplaces covered by existing workplace insurance arrangements***
- ***the expert panel for medical treatment injury, evaluating the timeliness of its decisions, its independence and cost-effectiveness***
- ***merging the NIIS and the NDIS.***

18.6 Some other matters

There is scant evidence on the size of legal fees and charges

Chapter 17 assessed the issue of legal fees and charges and identified significant difficulties in ascertaining the nature and size of these costs. While the Commission was able to secure some systematic evidence and draw some useful insights, such information is not widely available and was difficult to come by.

There are good grounds to pursue increased transparency to inform policy judgments. The paucity of accurate and comparable data to analyse the frictional costs of existing common law arrangements acts as an obstacle to policy reform that might otherwise direct resources more efficiently. Similarly, it is desirable that consumers be better informed about these costs.

In the draft report, the Commission asked for feedback on the benefits and risks of requiring nationally consistent disclosure of legal fees and charges in personal injury cases. It was proposed that these could be disclosed to an appropriately charged body responsible for monitoring and publicly reporting trends. A number of participants responded and, apart from the legal profession itself, the proposal to require transparency was supported. For example, the Insurance Council of Australia supported the principle of nationally consistent disclosure of legal costs (ICA, sub. DR986, p. 3). They also raised the example of the Dust Diseases Tribunal Regulations in New South Wales, which requires legal costs to be disclosed to the tribunal within 30 days of the settlement of a claim.

The Commission strongly suggests that legal fees and charges associated with personal injury cases be disclosed to the Office of the Legal Services Commissioner (or equivalent) in each jurisdiction. (Alternatively, disclosure to the proposed National Legal Services Commissioner under the COAG draft Legal Profession National Laws would be appropriate if pursued at the national level.) While we have not recommended the mechanism for data collection, the Legal Services Commissioner should then be required to annually publish information on the average legal costs of settlements and court awards, categorised by:

- range or bracket of compensation
- the cause of injury (motor vehicle, workplace, medical, general injury)
- the proportion of party-party costs and disbursements
- the proportion of solicitor-client fees and disbursements.

Along with disclosure of legal costs, it would be relevant to obtain information about the amount of compensation awarded under each head of damage. For settlements, in which a lump sum is settled on a compromise or commercial basis, the plaintiff's original claim is negotiated down. This means that the heads of damages would need to be an estimate, based on the original heads of damage rather than the amount a court would have awarded or the amounts that are later expend by the plaintiff for different purposes. As a precedent, such information is already collected under the National Claims Policy Database regulated by the Australian Prudential Regulation Authority.

A key motivation for improved transparency of legal fees and charges would be to inform sound policy judgments in the proposed 2020 review, which would examine the widening of NIIS coverage to replace other heads of damage for personal injury compensation, including for pecuniary loss and general damages, and non-catastrophic level injuries (recommendation 18.7).

Interactions between the NDIS and NIIS

The NDIS would provide services and supports to people with a demonstrated need for services and supports within the scope of the NDIS, but not otherwise covered under the catastrophic injury criteria of the NIIS. This would include people with a common law claim for compensation in progress who would benefit from early treatments and other interventions.

- At the successful resolution of a common law claim, the costs of services, programs and supports consumed would be recoverable from the damages awarded. Beyond services already provided in the health care setting, these might include vocational assistance, post acute social and medical rehabilitation, home and vehicle modifications, and home and personal assistance.
- Importantly, this would help address the potential for suboptimal outcomes for those pursuing common law claims but without structured access to services and supports.
- Incidentally, it would provide a natural experiment to allow benchmarking of outcomes for people pursuing common law claims against those not involved in litigation proceedings. People with injuries accessing the NDIS would, of course, gain access to services and supports on the same basis as anyone else satisfying the entry requirements and assessment (chapters 3 and 7).

The NDIS would also provide benefits to people with injuries arising from accidents prior to the start date of the NIIS, including those who have received lump sum compensation. If such compensation is still available, the NDIS would attempt to recover from the lump sum the cost of services and supports provided. Similar to the benchmarking of participant outcomes mentioned above, providing services and supports to these people would allow a baseline assessment (of the both the financial and health status), which could be compared against the future outcomes of NIIS participants. Such analysis could help to inform the review of the NIIS in 2020.

Interaction of the NIIS with the aged care sector

For people over the pension age who have catastrophic accident-related injuries, as distinct from other forms of disability, the Commission's view is that:

- the NIIS would fully fund people's support needs attributable to the injury
- the aged care system would still meet any ageing-related costs as they grew older — as in the arrangements under the Victorian Transport Accident Commission and in the New Zealand Accident Compensation Corporation.

The Commission understands that it is generally feasible, albeit sometimes difficult, to identify care and support needs that are substantially the result of injury, as

distinct from those wholly or substantially related to ageing. This is unlike the case for dividing care needs between disability and ageing, because:

- the time and event of an injury is more clearly traceable, as there is usually a clearly identifiable cause — a motor vehicle accident, a fall or a physical assault
- no-fault accident schemes manage the care and support needs of a targeted group of clients. They develop familiarity and experience with knowing and, indeed, planning for needs specifically associated with spinal chord injury, traumatic brain injury, severe burns and blindness. While there are variations in needs across individuals, the source of such variation is mostly identifiable.

Perhaps the greatest impediment to well-functioning arrangements would be poor processes and protocols for agreeing to share funding between areas of government. This has been the experience of New Zealand's ACC, which since realising the impact of additional costs on its liabilities, has recently sought to improve arrangements between agencies about shared funding including by establishing:

- a stream within its National Serious Injury Unit to specifically manage the claims of clients aged over 60, including ensuring that funding for non-injury related needs are sourced from the appropriate government agency based on joint funding agreements
- inter-agency protocols and shared assessment arrangements.

Some estimates of the cost of covering older-aged falls (the major source of injury for this age group) are outlined for New Zealand's accident scheme in box 18.10.

Box 18.10 **Falls by people aged over 65 years in New Zealand**

Each year around 100 000 people aged over 65 years fall and make a new claim under New Zealand's injury scheme. Of those requiring non-acute rehabilitation:

- nearly 60 per cent are discharged home, mostly with some form of support services
- around one-quarter are discharged to an assisted living or residential facility
- around 10 per cent rely only on health sector funding following rehabilitation.

Averaged over the last five years, less than 0.02 per cent of claims for falls by people over 65 years old are at catastrophic level — severe traumatic brain injury or spinal chord injury. In 2009-10, the average spend on catastrophic level falls by people aged over 65 years was around NZD$74 000, with 88 claims covered. Between 50 and 60 per cent of claims received attendant care, around 10 percent received residential care, and nearly all accessed at least some other form of social rehabilitation.

As a proportion of all spending on attendant care, residential care and social rehabilitation for catstrophic injuries, falls by elderly people account for about 2 per cent of expenditures.

Source: Personal Communication NZ Accident Compensation Corporation.

National coordination of research to prevent catastrophic injury

Some participants raised the issue of funding and granting access to NIIS data for research purposes. In particular, the Institute for Safety, Compensation and Recovery Research submitted that data for research will:

> … provide information that can be used to evaluate the efficiency and effectiveness of the schemes, as well as improving our knowledge of the impact of disability in our community and assist in identifying preventive opportunities. We recommend that likely users of scheme data be consulted during the design of data systems for both the NDIS and NIIS. (sub. DR802, p. 2).

At present, there are a variety of state-funded bodies involved in research of personal injury insurance. Given that the federated NIIS will only cover catastrophic injuries, there may be reason for these research units to continue rather than being merged. On the other hand, the establishment of a federated NIIS could provide a stronger platform for national coordination of research.

There is an argument for any research specifically relevant to the prevention of catastrophic injury and the operation of the NIIS to be nationally coordinated, perhaps linked to an NDIA-funded research capability (chapter 12). Either way, access to the national de-identified NIIS dataset should be available irrespective of whether undertaken through coordinated state research bodies or linked to an NDIA-funded research capability. Equally, there would be value in allowing more open access to NIIS data, such as for academic research, to the extent that such research would not be specifically funded through the NIIS.

NIIS cover of overseas visitors

NIIS supports are based around *lifetime* care — this aspect is not directly applicable to the temporary stay of a tourist, as they would not be spending the rest of their life within Australia.

It would be theoretically possible to take the suite of supports usually available under lifetime care, and make them available for the duration of a person's visa. This model would resemble the approach taken in the New Zealand ACC scheme. In New Zealand, there were 1.6 million claims in 2009-10, with 3600 from injured tourists. Out of NZD$3.8 billion cost of all claims, NZD$1 million was spent on tourists (New Zealand Herald 2011).

The Commission's preferred position is that, in general, overseas visitors should rely on private travel insurance. Unlike most areas of disability, there is a functional private insurance market for travellers to cover medical expenses, and this could extend to

some disability supports required for the duration of a person's visa. In addition, overseas visitors (or their insurers) should be entitled to sue for all heads of damage where there is an at-fault party, including for lifetime care and support. However, an exception would be where there were already clear provisions for 'no-fault' coverage of overseas visitors through existing arrangements. For example, the TAC allows visitors to 'commute' the negotiated value of care and support and other benefits into a lump sum. Moreover, as discussed earlier, arrangements already exist for commercial aviation accidents.