AUSTRALIA: AN INTEGRATED SCHEME FOR REGULATING LIABILITY FOR MEDICAL MALPRACTICE AND INDEMNITY INSURANCE MARKETS THAT DOES NOT INCLUDE THE GOAL OF IMPROVING THE SAFETY AND QUALITY OF HEALTH CARE

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INTRODUCTION

The successful regulation of compensation for harms caused by medical malpractice is an important achievement in Australia. While this is a significant achievement, it is also crucial to identify the costs of this set of regulatory initiatives. This Article outlines the two major sets of initiatives that have successfully regulated claims for compensation associated with medical malpractice. The first set of initiatives has imposed limitations on a plaintiff's right to claim compensation and the amount of damages a successful plaintiff is entitled to recover. Developments in the common law have increased the effectiveness of these initiatives. The second set of initiatives has had the aim of creating an effective and prudentially sound market for medical indemnity insurance. The aim of this set of initiatives has been to ensure that medical professionals are able to purchase reasonably priced indemnity insurance policies.

This Article also outlines the costs associated with this set of regulatory initiatives. The first tranche of costs includes payments by the Australian government to support the development of effective, prudentially sound markets for medical indemnity insurance. The second set of costs associated with this regulatory initiative includes those borne by plaintiffs who are unable to claim compensation or whose claims for damages are reduced by statutory intervention. The third set of costs is an indirect imposition on citizens who seek out and have the benefit of health care services. This set of costs arises out of the failure to integrate the system of compensation with initiatives designed to improve the safety and quality of health care. In effect, this failure represents a lost opportunity to integrate the

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right to claim compensation for health care-related harms with the regulatory initiatives that are designed to improve the safety and quality of health care.

MEDICAL MALPRACTICE IN AUSTRALIA

The vast bulk of claims for compensation for medical harm are based on the tort of negligence.[1] In general, these claims for compensation allege that health care professionals and health care organizations have failed to exercise reasonable care in the provision of health care services and that these breaches of duty have caused harm. In Australia, the tort of negligence, and the common law more generally, is a national body of law. The High Court of Australia hears appeals arising out of common law causes of action and provides authoritative statements of principle defining the state of the common law.[2] But under the Australian Constitution, individual states in the federation have the power to modify the common law as it applies in their jurisdictions.[3] Thus, tort law reform is a matter for individual parliaments in each of the states. The law governing the right to claim compensation for medical harm is, therefore, a mixture of common law principles that have been modified in different ways by each of the state parliaments.

The statutory reform of tort law described in this Article is detailed and technical. The practical capacity to use statutes to reform tort law is dependent on another feature of the common law in Australia. The majority of claims for compensation that are based on the tort of negligence are decided by judges alone—without any role for juries.[4] In deciding cases of negligence, courts make a distinction between statements of law and the application of those legal principles to determine whether a particular defendant is negligent. The former statements of principle are characterized as statements of law, while the determination of whether a particular defendant is negligent is a matter of fact. The main effect of this reliance on judges to state the common law and make judgments about the application of

1. AUSTL. COMPETITION & CONSUMER COMM'N, MEDICAL INDEMNITY INSURANCE: SIXTH MONITORING REPORT 5–6 (2009) [hereinafter MEDICAL INDEMNITY INSURANCE], *available at* http://www.accc.gov.au/content/index.phtml/itemId/870359.

2. AUSTRALIAN CONSTITUTION s 73(ii); *Judiciary Act 1903* (Cth) s 35; *Australia Act 1986* (Cth) s 11.

3. TREASURY (AUSTL.), REFORM OF LIABILITY INSURANCE LAW IN AUSTRALIA 5–6 (2004), *available at* http://www.treasury.gov.au/documents/799/pdf/complete.pdf.

4. HAROLD LUNTZ ET AL., TORTS: CASES AND COMMENTARY 128 (LexisNexis Butterworths, 6th ed. 2009); *Schellenberg v Tunnel Holdings Pty. Ltd.* (2000) 200 CLR 121, ¶ 112.

the law is that judges give highly technical and detailed statements of the common law in their judgments. This is particularly applicable to the law determining the assessment of damages, which has become highly detailed and technical. Detailed statements of the law that are made by judges have, in turn, empowered legislatures to pass legislation modifying these rules.

While tort law reform is a matter for individual states in Australia, the move for tort law reform described in this Article has a national focus. The Australian government, with the support of each of the state governments, led the move for tort law reform. In 2002 the Australian government and each state government established a committee of eminent persons to conduct a principles-based review of the tort of negligence.[5] The Australian government and each state government substantially adopted the proposals for reform that were developed by this committee of eminent persons.[6] The tort law reform described in this Article arises out of the actions of each state parliament, but the overall direction of this reform has a national orientation.[7]

This Article, however, discusses tort law reform as only one part of the regulation of compensation for medical harm. The second part of the story is the regulation of the provision of medical indemnity insurance. In Australia, this regulation is a matter for the national government. The role of the national government in the regulation of compensation was heightened because the Australian government provided funds to subsidize the provision of medical indemnity insurance. In the regulation of compensation for medical harm, it was the financial support provided by the Australian government that evened out the market for insurance. This support also ensured that health care professionals had appropriate and effective insurance policies to support claims for compensation made by patients who sustained harm in the provision of medical care.

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5. TREASURY (AUSTL.), REVIEW OF THE LAW OF NEGLIGENCE (FINAL REPORT) 25–26 (2002) [hereinafter LAW OF NEGLIGENCE], *available at* http://revofneg.treasury.gov.au/content/Report2/pdf/Law_Neg_Final.pdf.

6. *Id.*

7. TREASURY (AUSTL.), AVAILABLE AND AFFORDABLE: IMPROVEMENTS IN LIABILITY INSURANCE FOLLOWING TORT LAW REFORM IN AUSTRALIA 17–23 (2006) [hereinafter AVAILABLE AND AFFORDABLE], *available at* http://www.treasury.gov.au/documents/1200/pdf/available_and_affordable.pdf.

TORT LAW REFORM

The starting point of tort law reform in Australia came in 2002 in the form of an insurance crisis. The official account was that,

> during 2002, Australia experienced a crisis regarding the availability and affordability of insurance. In particular, public liability and professional indemnity insurance became increasingly harder to find and purchase. Many community groups, volunteers, professionals and small business operators faced the prospect of having to limit their activities due to the lack of insurance cover.[8]

This "insurance crisis" was the result of a number of different causes and had a disproportionate impact on the cost and availability of medical indemnity insurance. The official account of the causes of the insurance crisis was that,

> [b]y early 2002, a number of international and domestic, cyclical, and structural forces came together to cause a crisis in the liability insurance market in Australia. These included:
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> - the collapse of the HIH group of companies in March 2001;
> - the destruction of the World Trade Center on 11 September 2001;
> - the provisional liquidation of Australia's largest medical defence organisation, United Medical Protection, in April 2002;
> - recognition of heavy underwriting losses on policies issued in the previous decade;
> - falling investment returns due to a downturn in financial markets;
> - increasing compensation payments for bodily injury;
> - increasingly litigious community attitudes; and
> - the increased tendency of courts to extend liability for negligence.[9]

8. *Id.* at v.
9. *Id.* at 1.

In 2002, in the midst of a "liability crisis," the Australian government formed a committee to review the law of negligence.[10] The Australian government formed the committee because there was a perception that injured plaintiffs were bringing too many claims for compensation, and the courts were expanding the right to claim compensation.[11] The "Terms of Reference" for this *Principles-based Review of the Law of Negligence* stated clearly that

> [t]he award of damages for personal injury has become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another. It is desirable to examine a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death.[12]

The panel formed to conduct the review was asked to "[i]nquire into the application, effectiveness and operation of common law principles applied in negligence to limit liability arising from personal injury or death."[13]

The panel conducted a systematic inquiry into the development and application of tort law. Its recommendations dealt with all aspects of the operation of tort law, including general recommendations about the basic principles of tort law as well as a wide range of recommendations dealing with particular areas of concern. There were specific recommendations about liability for harm sustained by a plaintiff while engaged in recreational services, liability of public or statutory bodies, and liability for mental harm. The panel made recommendations about a wide range of matters relating to the conduct of litigation to recover compensation for negligence. Additionally, the panel made recommendations about the rules for assessing the quantum of damages, reduced limitation periods, and the award of costs in tort litigation. With some variation, all the states adopted these recommendations.[14]

By 2002 the High Court of Australia and the appellate courts in each of the states had already tightened up the application of tort

10. LAW OF NEGLIGENCE, *supra* note 5, at 25.

11. *See, e.g.*, James J. Spigelman, *Negligence: The Last Outpost of the Welfare State*, 76 AUSTL. L.J. 432, 433, 436 (2002) (highlighting how litigious Australian society has become in the wake of expansion in the law).

12. LAW OF NEGLIGENCE, *supra* note 5, at ix.

13. *Id.* at 121.

14. *See id.* at 18–23.

law to make it more difficult for plaintiffs to recover compensation for all kinds of harm. In 2002 the Chief Justice of New South Wales stated that

> [t]here is a growing body of recent High Court decisions in favour of defendants. Those decisions would have gone the other way if the trend [making it easier for plaintiffs to claim compensation] had continued. The number of such cases is multiplied manifold in recent judgments of intermediate courts of appeal. In my opinion the long-term trend has been reversed.[15]

The High Court has continued this process of tightening the right to claim compensation until the present day. For example, in a number of decisions, the High Court has explicitly addressed the problem of "hindsight bias" in determining what a reasonable defendant would have done in the circumstances of the case.[16] In addition, there are a number of cases in which the High Court has adopted a more critical and demanding approach in determining whether defendants have breached their duty of care.[17]

Despite this trend, tort law reforms adopted in Australia went much further in excluding liability for harm,[18] in reducing the damages that a plaintiff could claim by modifying the defense of contributory negligence,[19] and by modifying the rules for assessing damages.[20] There were three areas in which the tort law reform proposed by the panel and adopted by state parliaments was immediately relevant to claims for harm caused by the negligent provision of health care. The first of these concerned modifications to the standard of care. The second concerned modification of the principles for assessing damages. The third concerned the adoption of new rules for making orders for the payment of legal costs by the parties.

The modifications to the standard of care for professionals in negligence cases were perhaps of greater symbolic than practical value. This reform created a new defense for a defendant who was a "pro-

15. *See* Spigelman, *supra* note 11, at 433–34.

16. *NSW v Fahy* [2007] HCA 20, ¶ 125.

17. *See, e.g.*, *Woods v Multi-Sport Holdings Pty. Ltd.* [2002] HCA 9; *Adeels Palace Pty. Ltd. v Moubarak* [2009] HCA 48; *Roads & Traffic Auth. of NSW v Dederer* [2007] HCA 42.

18. *See, e.g.*, *Civil Liability Act 2002* (NSW) ss 5L–5N (immunities from liability where the plaintiff sustains injury while engaging in a "recreational activity" subject to a "risk warning" or a "dangerous recreational activity").

19. *Id.* ss 5R–5S.

20. *Id.* pt 2.

fessional." The panel to review the law of negligence recommended that "[a] medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.[21] The rationale for introducing this provision was that

> [t]he recommended rule contains sufficient safeguards to satisfy the reasonable requirements of patients, medical practitioners and the wider community. It is hoped that the test will address the sense of confusion, and the perception of erratic decision-making, which (the Panel has been told) have contributed to the difficulty that medical practitioners face in obtaining reasonably priced indemnity cover and which have, in consequence, harmed the broader community.[22]

By contrast, reforming tort law to reduce the amount of damages a plaintiff may claim has had profound practical significance in modifying the principles for assessing damages. These reforms include limits on compensation for loss of income,[23] an increase in the discount rate for calculating the size of lump sum damage awards,[24] severe restrictions on claims for pain and suffering,[25] restrictions on the amount of damages that plaintiffs can claim in respect to "gratuitous attendant care services" provided to the plaintiff by family members,[26] and the abolition of claims for punitive damages.[27] The reforms to the law for assessing damages for pain and suffering are of particular importance and include two parts. The first part limits the total amount of any claim. It requires that this maximum amount is only to be paid in "a most extreme case" and requires that each claim for damages be assessed as a proportion of "a most extreme case."[28] The second part excludes all claims for non-economic

21. LAW OF NEGLIGENCE, *supra* note 5, at 42 (Recommendation 3(a)); *see, e.g.*, *Civil Liability Act 2002* (NSW) s 5O.

22. LAW OF NEGLIGENCE, *supra* note 5, at 42.

23. *See, e.g.*, *Civil Liability Act 2002* (NSW) ss 12–13.

24. *Id.* s 14 (setting a discount rate of 5%); s*ee Todorovic v Waller* [1981] 150 CLR 402 (adopting a common law discount rate of 3%); LAW OF NEGLIGENCE, *supra* note 5, at 208–11 (common law applicable unless altered by statute).

25. *See, e.g.*, *Civil Liability Act 2002* (NSW) ss 16–17A.

26. *Id.* s 15–15B.

27. *Id.* s 21.

28. *Id.* s 16; *see also Civil Liability (Non-economic Loss) Order 2010* (NSW) s 3 (maximum amount as of October 1, 2010, is AUD$500,500 as compared to AUD$350,000 in 2002).

loss where the plaintiff's injuries are of less than 15% of "a most extreme case." The Premier of New South Wales stated that these reforms were aimed at excluding smaller claims and at discouraging plaintiffs from bringing smaller claims. It was expected that this reform would be the "biggest contributor to savings."[29]

The final area of tort law reform that is directly relevant to medical malpractice claims concerns changes in the rules for making orders about payment of legal costs. In Australia, the general rule is that the party who fails to achieve a favorable outcome in litigation is required to pay the costs of the party who prevailed in the particular proceedings.[30] Reforms in this area included a cap on the amount of costs that a legal practice could charge a plaintiff for claims under AUD$100,000,[31] penalties on plaintiffs who failed to accept an offer to settle proceedings where the amount of the offer of settlement was less than the final amount the plaintiff was awarded in legal proceedings,[32] and penalties on lawyers who either brought or defended proceedings to claim compensation where there were "no reasonable prospects for success."[33]

IMPACT OF TORT LAW REFORM

There is some evidence that tort law reform has had an impact on both the number and kind of claims for compensation for medical malpractice. The Australian Institute of Health and Welfare has produced reports on medical indemnity claims in the public and private sectors. In the public sector, the sixth, and most recent, report deals with medical indemnity claims in the period 2007–08.[34] This report identifies a trend in reduced numbers of new claims for compensation that reflects the goal of tort law reform. This report concludes that "[t]here were 1767 or more new claims in each of the three years between 2003–04 and 2005–06, compared to approximately 1300 new claims in the last two years."[35] The number of new

29. NSW, Parliamentary Debates, Legislative Assembly, 28 May 2002, (Bob Carr, Premier).

30. Marie Gryphon, *Greater Justice, Lower Cost: How a Loser Pays Rule Would Improve the American Legal System*, MANHATTAN INST. FOR POL'Y RES., (Dec. 11, 2008), *available at* http://www.manhattan-institute.org/html/cjr_11.htm.

31. *See, e.g.*, *Legal Profession Act 2004* (NSW) s 338.

32. *Id.* s 340.

33. *Id.* s 344–49.

34. AUSTL. INST. OF HEALTH & WELFARE, AUSTRALIA'S PUBLIC SECTOR MEDICAL INDEMNITY CLAIMS 2007–08 (2011), *available at* http://www.aihw.gov.au/publication/detail/?id=10737418386.

35. *Id.* at 27.

claims in the public sector remained at approximately 1300 for the period 2008–09.[36] In the private sector the evidence about indemnity claims is more limited as the Australian Institute of Health and Welfare has only released reports on the numbers of these claims since 2007–08.[37] Subject to this qualification, in the year 2008–09 the number of new claims increased by 39%.[38]

These data indicate that there has been a reduction in the number of new claims for compensation, and reducing the number of these claims was one of the goals of tort law reform. There are two other trends in the public sector data that seem to be consistent with the aims of tort law reform. In the period 2003–04 to 2007–08 there were an increasing number of closed claims that relate to serious harm and death rather than to temporary harm. One change that is evident for closed claims is a consistent decline in the proportion associated with temporary harm, from 28% in 2003–04 to 22% in 2007–08.[39] It is counterbalanced by an increase in the proportion associated with major harm from 18% to 23% and with death from 12% to 21%.[40]

Finally, there is a weaker trend in the proportion of closed claims that relate to large damage awards. There would, however, be some suggestion that the proportion of claims closed for the two largest size bands, AUD$100,000–$500,000 and AUD$500,000 or more, has generally increased between 2003–04 and 2007–08.[41]

One of the aims of tort law reform has been to reduce the number of small claims for compensation while leaving the right to recover for those who are seriously injured. While these trends are consistent with the aims of tort law reform, there are two important qualifications. First, the trends in the number of new claims have taken some time to become apparent. Second, the reduction in the number of closed claims that concern temporary harm and the increase in the number of claims concerned with major permanent harm and death are both delayed and gentle. These somewhat mut-

36. AUSTL. INST. OF HEALTH & WELFARE, PUBLIC AND PRIVATE SECTOR MEDICAL INDEMNITY CLAIMS IN AUSTRALIA 2008–09 6–7 (2011), *available at* http://www.aihw.gov.au/publication-detail/?id=10737419942.

37. AUSTL. INST. OF HEALTH & WELFARE, PUBLIC AND PRIVATE SECTOR MEDICAL INDEMNITY CLAIMS IN AUSTRALIA 2006–07 iii (2010), *available at* http://www.aihw.gov.au/publication-detail/?id=6442468360.

38. AUSTL. INST. OF HEALTH & WELFARE, *supra* note 36, at 6–7.

39. AUSTL. INST. OF HEALTH & WELFARE, *supra* note 37, at 37.

40. *Id.*

41. *Id.* at 38.

ed trends in claims for medical malpractice in Australia's public hospital sector reinforce an important characteristic of tort law reform—the practical and regulatory limitations of tort law reform.[42] The reform of tort law in Australia was integrated in the sense that it combined a number of elements of reform, including procedural reforms, reforms to legal principle and reforms in the assessment of damages. These reforms were both extensive and harsh in their application. Yet even this integrated, somewhat harsh approach to tort law reform has yielded somewhat muted results in the experience of medical indemnity claims.

THE REGULATION OF MEDICAL INDEMNITY INSURANCE

The impetus for tort law reform was a general insurance crisis in 2002, and the impact of this insurance crisis was more far reaching in the field of health care. The Australian Competition and Consumer Commission, in its role monitoring the cost of medical indemnity insurance, described the crisis in the following terms:

> In May 2002, the largest medical indemnity provider in Australia, United Medical Protection (United), was placed into provisional liquidation, which resulted in a potential lack of indemnity cover for many doctors. At the same time, medical practitioners were experiencing significant increases in subscriptions charged across all medical indemnity providers. In extreme cases, medical practitioners were paying over a third of their incomes for indemnity cover, while others left the profession or ceased high-risk procedures like obstetrics. In response to this crisis, the Australian Government introduced a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.[43]

The costs of claims incurred by insurers to indemnify health care professionals for medical malpractice liabilities in tort were a factor in this crisis. The costs incurred by insurers to meet claims for malpractice liability increased by 80% from AUD$99 million in 1997–98 to AUD$179 million in 2000–01.[44]

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42. *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH 98–117 (2005); Troyen A. Brennan et al., *Liability, Patient Safety, and Defensive Measures: What Does the Future Hold?*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 93, 98 (William M. Sage & Rogan Kersh eds., 2006); *see also* Angus Corbett, *Regulating Compensation for Injuries Associated with Medical Error*, 28 SYDNEY L. REV. 259, 261–63 (2006).

43. AUSTL. COMPETITION & CONSUMER COMM'N, *supra* note 1, at xi.

44. *Id.* at 20.

But the cost of malpractice liability claims was only one factor in producing this insurance crisis. Until 2002 the market for medical indemnity insurance was provided by not-for-profit mutual societies.[45] "Before 1 July 2003 medical indemnity cover was traditionally offered by medical defence organisations, which operated on a not-for-profit basis as 'mutuals' (i.e., owned and operated by its members). Medical defence organisations (MDOs) offered indemnity protection to medical practitioners as part of a range of services to their members."[46]

The insurance provided by these mutual societies was in the form of "claims incurred" policies.[47] Under these policies, the indemnity provided by the medical defense organizations would apply to any claim incurred during the period of the policy. The claim could be lodged with the insurer at any time in the future.[48]

In the years leading up to 2002, the medical defense organizations began to bring liability that was "incurred but not reported" (IBNR) under these "claims incurred" policies onto their balance sheets.[49] During this period, medical indemnity insurers also moved to offer insurance in the form of "claims made" policies. The crisis in 2002 was then the outcome of a number of factors.

> In common with some other medical indemnity providers, UMP ['United Medical Protection'] did not include its IBNR liability on its balance sheet. In April 2002, UMP, which was the largest provider in the market, applied to be placed into provisional liquidation. This was a result of a combination of factors: large-scale market expansion, chronic underpricing and reserving, overdependence on a reinsurer that became insolvent, an increase in claims stimulated by tort law reform in New South Wales and the inclusion of its IBNR liability on its balance sheet. Potentially, a large number of doctors in Australia were without indemnity cover.[50]

45. *Id.* at 7.

46. *Id.*

47. *Id.*

48. *Id.* at 6.

49. TREASURY (AUSTL.), REVIEW OF COMPETITIVE NEUTRALITY IN THE MEDICAL INDEMNITY INSURANCE INDUSTRY 1 (2005), *available at* http://www.treasury.gov.au/documents/965/pdf/review_cnmiim.pdf.

50. *Id.*

In 2002, when UMP was placed into provisional liquidation, it had 60% of the market for medical indemnity insurance.[51]

The most important response of the Australian government to this insurance crisis was reform of the market for medical indemnity insurance. One part of the reform package implemented by the Australian government to alleviate the impact of the insurance crisis was to indemnify UMP in relation to all of its IBNR liability at the date that UMP was placed into provisional liquidation.[52] At the time when the government put this indemnity in place, the IBNR liability for UMP was AUD$460 million.[53] The Australian government ultimately accepted an obligation to pay approximately 75% of this IBNR liability, with the remaining 25% being paid by doctors who were members of UMP as of June 30, 2000.[54]

A second part of the reform package was to bring the market for medical indemnity insurance within the general system of regulation for insurance.[55] This meant that the medical defense organizations were required to operate separate insurance corporations that were registered as authorized insurers with the Australian Prudential Regulatory Authority.[56] One consequence of this registration requirement was that medical indemnity insurers were required to meet a number of regulatory obligations. These included the adoption of valuation standards to estimate liabilities, the introduction of risk management systems, and an obligation to meet new minimum capital rules.[57] As mutual organizations, the medical defense insurers were not previously subject to these regulatory arrangements that typically apply to other organizations that conduct general insurance business. This last obligation—to meet minimum capital requirements—was particularly important because it required medical indemnity insurers to set aside premium revenue from 2003 to 2008 to create reserves to meet these requirements.[58]

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51. *See id.* at 2, 17.

52. *Id.*

53. *Id.*

54. MED. INDEMNITY POL'Y REV. PANEL, ACHIEVING STABILITY AND PREMIUM AFFORDABILITY IN THE AUSTRALIAN MEDICAL INDEMNITY MARKETPLACE 5 (2007); *see Medical Indemnity Act 2002* (Cth) ss 10–27 (describing in detail the IBNR indemnity provisions).

55. MEDICAL INDEMNITY INSURANCE, *supra* note 1, at 7–8.

56. *Id.* at 11–12; *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) ss 11–12.

57. AUSTL. COMPETITION & CONSUMER COMM'N, *supra* note 1, at 11–12; *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) s 13.

58. AUSTL. COMPETITION & CONSUMER COMM'N, *supra* note 1, at 11–12.

Several other parts of the reform package offset the impact of both the liability crisis and the obligations placed on insurers by these new regulatory arrangements. These other parts included the Premium Support Scheme, the Cost Claims Scheme, the Exceptional Costs Claim Scheme, and the Run-off Cover Scheme.

The Premium Support Scheme provided a subsidy to health care professionals whose medical indemnity insurance was greater than 7.5% of their gross private medical income. This subsidy, paid by the Australian government, took the form of a payment of 80% of any amount of an insurance premium that exceeded 7.5% of gross private medical income.[59] In the period 2004–05, 4441 doctors took advantage of this scheme.[60] This measure was designed to ensure that insurance premiums for high-cost specialties were affordable. The specialties that faced very high medical indemnity costs included obstetricians, plastic surgeons, neurosurgeons, and orthopedic surgeons.[61] This was a particularly important measure because in the period 2003–08, insurance companies were required to collect surplus funds from their premium income to meet the minimum capital requirements imposed by the Australian Prudential Regulatory Authority.

The High Cost Claims Scheme was designed to mitigate the upward pressure on medical insurance premiums created by increases in the size of damages awards to injured plaintiffs. It provided that the Australian government would pay 50% of the amount of claims above AUD$300,000 up to the amount of the cover provided to the health care professional in the contract of insurance.[62] In effect, this scheme is one in which the Australian government and insurers shared the obligation to meet the cost of claims involving the award of large amounts of damages to injured plaintiffs. The Exceptional Cost Claims Scheme was designed to provide insurance cover for health care professionals where the amount of a claim was greater than the maximum amount of cover provided by the contract of insurance. The scheme provided that the Australian government would pay 100% of the amount above a specified threshold of AUD$20 million.[63]

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59. *Medical Indemnity Act 2002* (Cth) ss 43–44B; ACHIEVING STABILITY AND PREMIUM AFFORDABILITY, *supra* note 54, at 3–4.

60. MED. INDEMNITY POL'Y REV. PANEL, *supra* note 54, at 11.

61. AUSTL. COMPETITION & CONSUMER COMM'N, *supra* note 1, at 26.

62. *Medical Indemnity Act 2002* (Cth) ss 28–34AB; MED. INDEMNITY POL'Y REV. PANEL, *supra* note 54, at 4, 13.

63. MED. INDEMNITY POL'Y REV. PANEL, *supra* note 54, at 4.

The final element of this reform package consisted of a scheme to provide run-off cover for health care professionals who retired or left their practices. The move from a system of insurance based on the issue of "claims incurred" policies to one based on the issue of "claims made" policies created the need for this scheme. If health care professionals who purchased "claims made" insurance cover retired or left their practice, they would be required to maintain insurance cover during the period of their retirement in order to ensure that they had effective insurance cover for any claims made after their retirement. This scheme required the Australian government to assume responsibility for insuring health care professionals after they retired or left their practices. In order to fund this scheme, all medical indemnity insurers were required to impose a levy on all insurance premiums that was payable to the Australian government to cover the cost of these "run-off" claims.[64] The scheme set the amount of this levy at 8.5% of the insurance premium.[65]

The measures taken by the Australian government to alleviate the impact of the insurance crisis in 2002 amounted to a systematic and integrated approach to reform and revive the market for medical indemnity insurance. The government accepted an obligation to meet the IBNR liabilities of the largest insurer that went into provisional liquidation in 2002. The government moved to reform the system of regulation for medical indemnity insurance and then used a number of targeted subsidies to offset the immediate adverse impact created by the new system of regulation.

IMPACT OF INSURANCE REFORM

There are a number of measures of effectiveness of the interaction between the reform of medical indemnity insurance and tort law reform. One important measure—in light of the manifestation of the insurance crisis in 2002—is the cost and availability of insurance for health care professionals. In 2009, the Australian Competition and Consumer Commission reported that

> [t]he real average premium increased steadily from $5263 in 1999–00 to $5816 in 2001–02, before rising sharply in 2002–03 to $7500. The real average premium then fell gradually in each of the next five years to 2007–08. In 2007–08 the aver-

64. *Id.* at 4–5, 14–15.

65. *Medical Indemnity Act 2002* (Cth) ss 34ZA–34ZX; MED. INDEMNITY POL'Y REV. PANEL, *supra* note 54, at 4–5.

> age premium fell to $5392. This gradual decline in real average premiums is attributable to a number of factors, including premium reductions and changes to membership composition over time.[66]

This finding that there was a decline in real average premiums in the five years between 2002–03 and 2007–08 is an important indication of the apparent success of the regulatory response to the insurance crisis in 2002. Another important measure of the changes in insurance premiums is to review the changes in premiums experienced by particular groups of specialists. The Australian Competi-Competition and Consumer Commission reported that "[i]n real terms the average written premium of all the selected specialties decreased over the period; over the six-year period these decreases ranged from 9 per cent for obstetricians to 39 per cent for anaesthetists."[67]

These decreases in premiums for insurance cover seem to reflect reductions in the numbers of tort claims and a more stable and competitive market for medical indemnity insurance. The decrease in premiums after 2007 may reflect that insurers were no longer using premiums to put aside surplus revenue to meet minimum capital requirements.[68]

CONCLUSION: COSTS OF LIABILITY AND INSURANCE REFORM

Australia experienced a liability crisis in 2002. This liability crisis was particularly acute in the health care industry. In health care there were real increases in the costs of insurance, and there was a significant probability that without the intervention of all of the governments in Australia, many health care professionals would not have been able to obtain insurance to indemnify them from liability incurred in tort. The responses of Australian governments appear to have alleviated the impact of the liability crisis. Regulatory reform dealt with the interaction between tort law—the source of liability—and the market for medical indemnity insurance. In the sense that the package of reforms dealt effectively and systematically with the direct impacts created by the liability crisis in 2002, reform was successful.

66. AUSTL. COMPETITION & CONSUMER COMM'N, *supra* note 1, at 25.

67. *Id.* at 27.

68. *Id.* at 35.

The success of Australia's response in dealing with the direct impact of the liability crisis did, however, impose costs on other groups and institutions. The first of these are the economic and personal costs created by tort law reform; that is, the impact of these reforms on those people who were injured and did not claim compensation. The second set of costs is the direct cost incurred by the Australian government in subsidizing the cost of premiums for medical indemnity insurance. The third set of costs is more diffuse but not less important. These include the cost of failing to articulate a connection between tort law reform and reform of medical indemnity insurance with regulatory initiatives to improve the safety and quality of health care.

The costs created by tort law reform are difficult to quantify. Determining the costs requires an analysis of victims who did not file a claim. There is evidence that there were significant numbers of potential plaintiffs who did not bring claims.[69] There is also evidence of the large number of people who suffer injuries associated with adverse events in health care and of the magnitude of those harms.[70]

It is also plain that the rationale for introducing tort law reform in Australia was largely a pragmatic one. Governments introduced reform in the field of health because of the practical impact of liability in tort; that is, the practical impact of high costs of insurance.[71] Introducing reform involved little analysis as to why those who did sustain injury in the provision of health care should be denied compensation in tort.

By contrast, the costs of subsidizing medical indemnity insurance in Australia are easily quantifiable. In the period leading up to 2006, the calculations reveal the yearly cost of these subsidies for the Australian government ranged between AUD$160 million and $180 million per year.[72] There are a number of good reasons why the public

69. David Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250 (2000) (reporting that 97% of patients in this study who suffered negligent injury did not sue for negligence); AUSTL. PATIENT SAFETY FOUND., IATROGENIC INJURY IN AUSTRALIA 25 (2001), *available at* http://www.apsf.net.au/dbfiles/Iatrogenic_Injury.pdf (reporting that 4% of patients who suffer a negligent adverse event receive compensation); BAKER, *supra* note 42, at 37 ("[R]ate of claims has held steady or even declined in relation to population and economic growth over the last 15 years."); s*ee also* Jeffrey O'Connell & David Partlett, *An America's Cup for Tort Reform? Australia and America Compared*, 21 U. MICH. J.L. REFORM 443, 457 (1988) (explaining the various disincentives for Australians to litigate).

70. Barry Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 45–47 (2011).

71. *See supra* text accompanying notes 8–9.

72. MED. INDEMNITY POL'Y REV. PANEL, *supra* note 54, at 3.

should bear some of the costs of the indemnity insurance that are paid by individual health care professionals. One reason is that tort law tends to focus liability on individuals for broader systemic failures.[73] In this sense, individual health care professionals bear a disproportionate cost of supporting the tort law system of liability based on tort law. Nonetheless, it is arguable that in an era where there are many claims upon public funds, this particular use of subsidies is either inappropriate or, at least, less worthy than other claims.

But perhaps the most significant cost associated with Australia's liability crisis response was a failure to articulate a connection between tort law reform and medical indemnity insurance reform and the goal of improving the safety and quality of health care. There are two oblique connections between the reforms in Australia and the agenda to improve the safety and quality of health care. The most notable of these reforms was the provision for potential defendants to apologize for harming potential plaintiffs without the risk that their apologies would be characterized as admissions of liability.[74] Recognizing the right to make apologies is an important step in improving the safety and quality of health care.[75] The second connection between reforms in liability and medical indemnity is that a reduction in tort liability may reduce the extent to which tort law affirmatively interferes with regulatory initiatives to improve safety.[76] In the policy-making process, neither of these factors appears to have played any significant role in the decision-making processes leading up to the introduction of the liability and reform package.[77]

There is one way in which this failure to articulate a connection between liability and insurance reform and the agenda to improve the safety and quality of health care may significantly hinder initiatives to improve the safety and quality of health care. In particular, the failure to develop an account of why a significant proportion of those who sustain harm associated with health care should not re-

73. Michelle M. Mello & David D. Studdert, *Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries*, 96 GEO. L.J. 599, 615 (2008); Corbett, *supra* note 42, at 279–87.

74. *Civil Liability Act 2002* (NSW) ss 67–69; TREASURY (AUSTL.), *supra* note 3, at 53–55.

75. ROBERT M. WACHTER, UNDERSTANDING PATIENT SAFETY 231–32 (2008); Carol B. Liebman & Chris Stern Hyman, *Disclosure and Fair Resolution of Adverse Events*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 191–215 (William M. Sage & Rogan Kersh eds., 2006); Corbett, *supra* note 42, at 276; NSW Dept. of Health, *Open Disclosure Standard* 1 (2007), *available at* http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_040.pdf.

76. *See* Corbett, *supra* note 42, at 277–85.

77. TREASURY (AUSTL.), *supra* note 7, at 31; COONAN, *supra* note 3, at 53–55.

ceive compensation may amount to an important omission in the liability and insurance reform package.

There is a very strong argument that tort law does have a role in bringing to light systemic failures and the harms caused by those failures.[78] There may, however, be an equally important role for tort law, which can provide a principled account of why those who experience harm caused by systemic failures are not able to recover compensation. The role of tort law in this sense is one of "probing our vulnerability" to harm by recognizing that systems and organizations may lack the capacity to reduce the occurrence of certain kinds of preventable mistakes.[79] A principled approach to the question of why it was just to reduce liability in tort for harms associated with medical care may have been forced to recognize both the magnitude of harm produced by the health system and the complexity of the problem in reducing that level of harm.[80] If the rationale for reducing tort liability involved recognizing the magnitude and complexity of improving the safety and quality of health, this would have had the potential of making an important contribution to the regulatory analysis of this problem.

78. *See, e.g.*, BAKER, *supra* note 42, at 94–98; TIMOTHY D. LYTTON, HOLDING BISHOPS ACCOUNTABLE: HOW LAWSUITS HELPED THE CATHOLIC CHURCH CONFRONT CLERGY SEXUAL ABUSE 190–211 (2008) (describing another system where tort law has brought to light systemic failures).

79. Angus Corbett, The Missing Dimension of Safety: Accommodating Complex Systems of Networked Governance in Tort (Feb. 8, 2011) (unpublished manuscript) (on file with author).

80. Donald Berwick, *Foreword* to CHARLES KENNEY, TRANSFORMING HEALTH CARE, VIRGINIA MASON MEDICAL CENTER'S PURSUIT OF THE PERFECT PATIENT EXPERIENCE xi–xiii (2011); *see also* JOHN TOUSSAINT ET AL., ON THE MEND: REVOLUTIONIZING HEALTH CARE TO SAVE LIVES AND TRANSFORM THE INDUSTRY 1–5 (2010); Angus Corbett et al., *The Role of Individual Diligence in Improving Safety*, 25 J. HEALTH ORG. & MGMT. 247, 248 (2011).