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Healthcare AI 2025

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Australia: Trends & Developments

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AUSTRALIA

Trends and Developments

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Healthcare in Australia is undergoing a significant transformation, having to adapt to an ageing population, dealing with an increasing prevalence of chronic diseases and benefitting from many and varied technological advancements.

Australian healthcare providers continue to provide a high standard of care to patients and consumers. The industry is well regulated, with the care being provided by a highly trained workforce. It is, however, an industry that is under constant pressure, with both private and public healthcare providers having to do more on tightening budgets, and with many care providers being stretched to the point of exhaustion.

AI in healthcare is rapidly evolving, with significant research and investment focused on integrating AI into patient-focused care and creating systemic efficiencies.

Over the past few years, there have been changes in the frequency, severity and nature of claims being made against healthcare providers. The industry relies heavily upon both local and overseas insurers to meet the cost of these claims. Lloyds syndicates continue to play an important role in providing cover for the larger healthcare operations.

This overview looks at recent trends and developments in the claims and regulatory environment affecting healthcare providers, and what the next disruptions to the market might include.

Claims Against Healthcare Providers

Secondary psychiatric claims arise where a person suffers a psychiatric injury or illness as a result of witnessing, or being informed of, a traumatic event involving another person. They are also referred to as “nervous shock claims”. There is a requirement of close ties of love and affection between the injured person and the person seeking damages for nervous shock. There has been a continuing increase in the frequency of secondary psychiatric claims being made against healthcare providers. In addition, the damages awards are also increasing. Where a number of family members are seeking compensation from the healthcare provider, the quantum of the secondary victim claims may exceed the damages being claimed by the injured party.

The amounts being claimed for gratuitous care and paid care are increasing due to higher hourly rates being allowed for in gratuitous care claims, and to providers increasing their service fees for paid care. In part, this is due to the National Disability Insurance Scheme (NDIS) distorting the costs of the care market with the rates that care providers have been charging the fund. A widespread practice developed where NDIS participants were being charged more for support than non-NDIS participants, which created a two-tier system, and these higher costs have been filtering into medical negligence claims costs.

Another concerning trend is the extension of limitation periods. The limitation of actions legislation across the country generally provides that you have three years from the day the cause of action arises to issue proceedings against a defendant. There is the ability to issue proceedings outside this three-year period where the claimant is only made aware of facts that give rise to the claim later in time, including after the limitation period has expired. The courts are quite amenable to extending the limitation period by finding that a plaintiff had not discovered, or was not aware of, a material fact of a decisive character until some time after the negligent act or omission.

COVID-19 continues to have an impact on claims in two ways:

- firstly, in the way that claims against healthcare providers are managed – technology allows for better engagement with experts and witnesses, where you can share documents on your screen and have multiple people involved in the meeting; and
- secondly, in the way that COVID-19 disruption also saw a spike in claims for missed diagnoses and delayed diagnoses, which are still working their way through the system.

More recent times have seen the rise of the medical expert. There are now a number of companies with stables of medical experts. The plaintiff expert and the defendant expert divide is locked in, notwithstanding the acknowledged and obvious benefits of par-

ties resolving a dispute by the engagement of joint experts. Not only are there more experts to choose from, but the number of experts being retained in cases is increasing. With the rise of AI and technology, new experts will emerge as claims include allegations relating to the failure of a product and/or software.

The rise of the peer opinion defence is also being seen – ie, where legislation codifies the Bolam test and provides that a professional does not breach a duty arising from the provision of a professional service if it is established that they acted at the time in a way that was widely accepted by a significant number of their peers as being competent and professional practice. Two recent Supreme Court of New South Wales ("NSW Supreme Court") decisions have provided added guidance and assistance with regard to raising this type of defence. In April 2025, the NSW Supreme Court decided in favour of an ophthalmologist in the matter of Busa v Eastern Sydney Local Health District t/as Sydney Eye Hospital (2025 NSWSC 130) on the basis of peer opinion supporting a finding that the doctor had not breached his duty of care. In May, the same court made a similar finding in Nemes v South Eastern Sydney Local Health District (2025 NSWSC 418) – ie, finding in favour of the defendant hospital on the basis of peer opinion.

How is the Law Responding to Claims Involving New Technology Such as Robotic Surgery, AI Tools and Virtual Care Platforms?

As healthcare providers integrate more advanced technologies and personalised treatment, the medical negligence risks evolve and will be different to some extent to what they are today. There will be more product and software claims – and more tech claims.

With AI tools, it will rarely be the case that the doctor and/or hospital will escape all liability in the event of product failure. The doctor's non delegable duty of care remains. Healthcare providers must apply human oversight and judgement when using AI and any outputs. They will also need to carefully guard patient privacy when using AI in healthcare.

In the context of AI and technology in medicine, the healthcare professional will bear the ultimate responsibility for patient safety and wellbeing. It is no answer to a claim to blame the product or the software. The patient may choose to sue only the healthcare provider, and it will then be up to the provider to seek recovery from the AI or product manufacturer/supplier. As a consequence, the contracts that healthcare providers have with the manufacturers or suppliers of these products or technology will become increasingly important. Healthcare providers need to be careful and ideally avoid assuming liabilities under the contract by indemnifying, releasing or agreeing to insure these providers. Insurance policies will probably not provide insurance cover for such pure contractual liabilities.

Jurisdictional issues will arise from time to time with telemedicine claims. The relevant jurisdiction will generally be the place where the harm is suffered.

The next big disruptor for healthcare litigation has to be the evolution of more personalised care using advanced technology, and the rise of telemedicine- and AI-driven diagnostics. This is going to disrupt healthcare more generally. The nature and subject of the claim will generally be the same. For example, a medical negligence claim will still be a claim for damages for injury and loss made against the healthcare provider. However, the cause of the injuries or adverse event will increasingly change over time; whereas previously it may have been at the hands of a surgeon, it may now be a malfunctioning robot or failure of technology. Healthcare lawyers will need to ensure that they are able to deal with these emerging causation issues.

The law will need to catch up with AI and provide some much-needed guidance and regulation. This applies across the board, not just in relation to healthcare.

There are some laws that capture AI in a general way, as follows:

- the Privacy Act 1988 and the Australian Privacy Principles apply to AI systems that handle personal information, which includes health information;
- data protection laws cover the collection, use and storage of data used by AI systems; and
- importantly, in healthcare, if an AI system or tool is a "medical device" as defined in the Therapeutic

Goods Act 1989, it will need to be approved by the Therapeutic Goods Administration (TGA).

In August 2024, the Australian Health Practitioner Regulation Agency (AHPRA) published guidelines on "Meeting your professional obligations when using artificial intelligence in healthcare". In these guidelines, AHPRA referred to the following, amongst other things.

- AI being defined as computer systems able to perform tasks that normally require human intelligence.
- Some AI tools used in healthcare being regulated by the TGA. The TGA regulates therapeutic goods that meet the definition of a "medical device", which includes software if it has a therapeutic use and meets the definition.
- Emphasising the principle that, regardless of what technology is used in providing healthcare, the practitioner remains responsible for delivering safe and quality care, and for ensuring that their own practice meets the professional obligations set out in their codes of conduct.
- Healthcare practitioners must apply human judgement to any output of AI.
- Healthcare practitioners should inform patients and clients about their use of AI and consider any concerns raised.
- Healthcare practitioners must obtain informed consent from the patient and ideally note the patient's response in the health records.
- When using an AI scribing tool that uses generative AI involving the input of personal data, the healthcare practitioner will require informed consent from the patient. Informed consent is particularly important in AI models that record private conversations, as there may be criminal implications if consent is not obtained before recording such conversations in some Australian states and territories.
- The need to ensure confidentiality and privacy of patient/client information, as required by privacy and health record legislation.
- The need to ensure that healthcare practitioners understand the inherent bias that can exist in data and algorithms in AI applications, for example in relation to Aboriginal and Torres Strait Islander people.
- The need to have and be aware of governance arrangements in place to oversee the implementation, use and monitoring of AI.

Are There Any Signs of Australia Heading Towards Higher Damages or More Litigious Jurisdiction, Similar to the USA?

The cost of claims in Australia has increased significantly in the past few years, mostly due to economic factors. Ten years ago, the inflation rate in Australia was 1.5%, and wage growth was minimal. The country has since moved to a higher inflation economy with rising wages. These changes eventually flow into the cost of claims. In addition, the amounts being claimed by plaintiff lawyers for legal costs – and the amounts charged by experts and other providers – have increased, on occasion significantly, in recent years.

The relatively recent and often significant rise of claims reserves in Australia will, however, never extend to the claims reserves that one needs to hold in the USA.

The high watermark in the USA was reached last year in the case of Michael E Sanchez v NuMale Medical Centre LLC. The case involved Mr Sanchez, a 66-year-old widower visiting NuMale for fatigue and weight management, and ultimately being convinced into having a penile injection for erectile dysfunction. This procedure was botched. NuMale were found to have been negligent, and their conduct was found to have been unconscionable. Mr Sanchez received USD412 million, of which USD375 million was punitive damages. This type of result will never, and can never, happen in Australia.

There are prohibitions in place in most Australian states and territories on punitive damages awards. There are some exceptions, however, including cases of intentional conduct and unlawful sexual assault. In Victoria, there is no statutory prohibition, but common law effectively restricts punitive damages to intentional or reckless misconduct.

Except for Victoria, Australian states and territories do not have jury trials in civil claims. Most states and territories also do not allow plaintiff lawyers to charge contingency fees (US trial lawyers can demand con-

tingency fees, which may extend to 30–40% of the damages award). Again, there is an exception here in Victoria, where plaintiff lawyers can charge on a contingency fee basis in class actions if a court makes an order to that effect.

Medicinal Cannabis

Medicinal cannabis continues to attract the attention of regulators due to widespread poor practices. The Medical Board of Australia (the "Board"), overseen by AHPRA, has specific guidelines regarding telemedicine and online prescribing. Concern has recently been expressed by the Board about the practices of medical cannabis companies, including their online prescribing.

On 9 July 2025, AHPRA published a guidance report on the professional responsibilities of medical cannabis organisations. In this guidance, they referred to the following issues:

- there is evidence of poor practice in prescribing medical cannabis that is leading to patient harm;
- most medical cannabis products prescribed in Australia are not approved by the TGA;
- a high number of medical cannabis products in Australia contain tetrahydrocannabinol (THC), which makes them Schedule 8 medicines (controlled drugs in Australia) due to the risks of misuse/abuse and potentially addictive properties;
- the Board is concerned that profits are being prioritised over patients in some medical cannabis prescribing practices;
- business models have emerged that appear to use aggressive and sometimes misleading advertising that targets vulnerable people;
- there is an inherent conflict of interest for doctors and nurses working in an organisation that prescribes and dispenses a single product (ie, brand); and
- AHPRA and the Board will work with other regulators to better understand prescribing patterns, and may investigate the practices of practitioners with high rates of prescribing of any scheduled medicine, including medicinal cannabis.

There have recently been a number of new law firms entering the legal market that specialise in healthcare claims. The bigger firms tend to still dominate.

Few claims go to trial. Most trials take place in New South Wales and Victoria. In other Australian states and territories, there may only be a handful of healthcare trials in any one year.

Access to justice in personal injury claims is arguably open to most with the proliferation of no-win-no-fee lawyers. That is not seen to be controversial, and the community and insurance industry accept that people who do not have the means to pay legal fees upfront should not be denied access to justice, particularly where the alleged negligence has impacted their ability to earn an income.

This has been balanced by tort law reform legislation that places downward pressure on claims costs, particularly with the more minor and speculative claims. In Queensland, for example, there are restrictions on a claimant's ability to claim for legal costs and outlays where the value of their claim is below a certain amount. Following the release of the Personal Injuries Proceedings Indexation Notice 2025, if an adverse event were to happen post-1 July 2025 and a plaintiff made a personal injury negligence claim against a healthcare provider, the plaintiff would have no entitlement to costs and outlays if the claim was worth AUD58,089 or less, and would only be entitled to claim AUD4,860 for costs and outlays if the damages were between AUD58,090 and AUD96,870, beyond which there are no restrictions.

Life Sciences

In the life sciences area, medical device product liability litigation continues to feature prominently. There appear to be signs that the wave of litigation against orthopaedic device manufacturers is finally beginning to slow. Much of this litigation was precipitated by data from the Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR), which was established in the early 2000s. By 2010, there was a decade of data from this registry available publicly, including statistics indicating prostheses that had a "higher-than-anticipated date of revision". The data was used by lawyers to identify products

for mass tort litigation against orthopaedic device manufacturers, and as evidence in the case. In particular, "metal-on-metal" hip replacements produced by several manufacturers were targeted for both class actions and individual actions.

While registry-based litigation in relation to orthopaedic devices is slowing, there are signs that a similar phenomenon is happening in relation to breast implants in Australia. In 2016, the Australian Breast Device Registry (ABDR) was established. Similar to the AOANJRR, the ABDR tracks the implantation and revision surgery dates of breast prostheses in patients in Australia, including identifying implants with higher-than-anticipated rates of revision. There is now almost a decade a data in the ABDR, and this data is beginning to be used by lawyers to identify particular prostheses as targets for litigation – in a similar way to the data in the AOANJRR was used for hip and knee replacement litigation. It remains to be seen whether this will be on the same scale as the hip replacement litigation of the last decade.

Product liability in relation to pharmaceuticals in Australia has been sporadic over the last decade. This can be partly attributed to the outcome of the Australian Vioxx litigation, which was not particularly successful for the plaintiffs, especially when compared with other jurisdictions around the globe that experienced large settlements and verdicts in similar cases. This was at least partly due to the strict causation tests under Australian law, making it difficult for plaintiffs to establish that adverse outcomes were the result of a particular medication. At the same time, there was "lower hanging fruit" as a target for product liability litigation in the form of medical devices, along with products in other industries.

However, there are signs that this too is changing, and that pharmaceuticals are back in the litigation crosshairs. This has been partly prompted by the competitive litigation market in Australia.

The litigation funding industry in Australia continues to grow. Similarly, the plaintiff class action law firm market which previously had only a handful of players, now has several participants, including law firms, which would traditionally operate solely on the "defence" side. With more competition, both funders and law firms are looking further afield for targets for mass tort litigation and class actions. While no significant pharmaceutical product liability class actions have yet commenced, a number are currently under investigation.

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