RACGP

Royal Australian College *of* General Practitioners

# *RACGP Submission to the First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF*

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## Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health (the Department) for the opportunity to respond to the discussion paper on the First Principles Review of the IIF and each of the schemes that comprise the IIF.

The RACGP is Australia's largest general practice organisation, representing over 35,000 members. The RACGP advocates for affordable and equitable access to high-quality health services and improved health outcomes for all Australians. It is therefore vital that the medical indemnity insurance industry supports GPs to continue to provide access to safe and affordable care for patients.

This submission covers the following topics:

- the medical indemnity insurance crisis, which led to the Federal Government's involvement in medical indemnity insurance sector
- the value of supporting procedural care in general practice
- the RACGP's position on various elements of the IIF
- the rationale for continued Federal Government involvement.

## Background

### Introduction of elements of the IIF

The RACGP acknowledges recognition regarding the uncertainty experienced by many practitioners in 2002 following the provisional liquidation of United Medical Protection. As described in the discussion paper, this uncertainty was compounded by increasing damages being awarded for claims, rising premium costs and the withdrawal of cover.

Prior to 2002, GPs were increasingly cited individually in claims by patients, as well as in cases of joint and several liability. The RACGP considers this a result of the position of GPs as the first point of patient contact within the health system.

In light of the above, it is important to recognise that the First Principles Review of the IIF has raised significant concern within the general practice sector. This concern predominately relates to the potential modification to or removal of the existing schemes, which provide valuable safeguards for GPs as well as patients. Such safeguards provide surety and confidence within the general practice sector.

Furthermore, strengthened compliance arrangements have resulted in an increase in audits and disciplinary actions through the Australian Health Practitioner Regulation Agency and the Department of Human Services (DHS). This in turn has led to the further increase of the costs of insurance and registration, jeopardising the provision of GP services and patient access to healthcare.

Therefore, while younger GPs may not be aware of the issues within the medical indemnity industry leading up to 2002, more experienced GPs are concerned about the impact of possible changes to the existing

schemes. As GPs undertake the majority of their work in the private practice setting, they would be disproportionately affected by changes to the indemnity insurance industry.

**Rising premiums and reduced procedural care**

The discussion paper notes that data up to June 2016 indicates that the average gross written premium has declined since 2004. However, members have reported the opposite. Specifically, members have noted that there has been a rise in premiums between 8 and 12 per cent during the period of the Medicare rebate freeze. In addition to the potential difficulties posed to GPs by increasing premiums, the RACGP is also concerned that increases could affect the provision of low cost minor procedure care.

Unless there is a clear need for a non-GP specialist to undertake a procedure, the RACGP considers that GPs should be supported to provide procedural care. The RACGP notes that there has been a decline in GP's undertaking procedural interventions, such as obstetrics and the insertion of intrauterine devices. This decline can partially be attributed to the rise in premiums, as insurance costs are becoming prohibitive to providing procedures.

The decline in performance of minor procedures in general practice will result in increased costs to the health system and patients and a reduction in access to healthcare overall. This is not in the best interests of patients or Government, particularly in light of recent efforts to slow increases in spending on healthcare.

## RACGP position on the elements of the IIF

**Premium Support Scheme (PSS)**

The PSS is an integral component of the IIF, supporting rural and remote GPs who provide procedural care to patients in communities who may not otherwise have access to such care (especially obstetrics). The PSS is also highly valued due to the support it offers to part-time employed GPs and female GPs, as both groups tend to have lower gross private medical income.

The RACGP considers that *all* GPs who provide procedural care should continue to receive a premium subsidy under the PSS. However, significant amendment to or removal of the PSS could specifically prevent rural or remote GPs from practising in these locations. The RACGP therefore cautions against changes to the PSS that would lead to unaffordable premiums for rural GPs, leaving them unable to provide procedural services or to practise entirely. With rural areas already facing recruitment issues, changes that make indemnity cover more difficult to access will not improve this.

The RACGP notes that the DHS has suggested that the cost of administering the PSS equates to approximately one quarter of all funds dispersed through the IIF. The RACGP therefore supports the recommendation put forward by the Australian National Audit Office, that achieving administrative efficiency should be the focus of the reviews, rather than the introduction of wide-scale change.

**Universal Cover**

The RACGP supports the concept of universal cover and remains committed to the principle that all doctors should have access to medical indemnity insurance. However, the RACGP also acknowledges that medical indemnity insurers may recommend changes to the universal cover arrangements. Any changes to current universal cover arrangements should guard against placing a disproportionate burden on certain providers by making them responsible for insuring a large proportion of high-risk practitioners. By placing such a burden on these providers, the sector may once again become destabilised, bringing about higher premiums and an unsustainable indemnity insurance industry overall.

Universal cover ensures that every medical practitioner has access to indemnity insurance, subsequently allowing for participation in the workforce. The need for the 'insurer of last resort' in instances where cover has been denied by a medical defence organisation remains. For example, in cases where a competent GP has been denied indemnity insurance, it is reasonable that they be provided with cover and therefore be allowed to register and practise.

Should the Department recommend changing the structure of universal cover, the RACGP recommends that it consider the potential impacts on doctors who require access to medical indemnity insurance specifically under these arrangements. As part of these considerations, the RACGP recommends the Department take into account the potential impacts of changes to universal cover on patients. This is particularly pertinent to patients who already experience issues in accessing healthcare, such as those located in rural or remote areas.

**High Cost Claims Scheme (HCCS)**

The RACGP considers that the HCCS provides stability to the industry, as well as the premiums paid by doctors. The HCCS provides confidence to medical practitioners, ensuring that they can practise with peace of mind. The RACGP is therefore concerned that the reforms announced in the 2016-17 Mid-Year Economic and Financial Outlook will lead to premium increases in an already stressed general practice sector.[1]

The proposed reform would constitute a breach of trust under the comprehensive agreement made by the government following the introduction of the medical indemnity insurance package in 2002. Furthermore, given that government policy (including the slow reintroduction of indexation of the Medicare Benefits Schedule) is challenging practice viability, it can be expected that premium increases will be passed onto patients, ultimately increasing their out-of-pocket costs.

**Exceptional Claims Scheme (ECS)**

In line with our position on the HCCS, the RACGP also considers that there is significant value in the current arrangements for the ECS. As with the HCCS, the ECS provides a level of stability and certainty to the medical indemnity insurance industry and contributes to affordable premiums for doctors. As a result, cost pressures for patients are also reduced. The ECS is therefore a vital safeguard that provides reassurance to practitioners, and should be considered a public policy success – not an unnecessary or superfluous scheme.

As noted in the discussion paper, there has been a decreasing demand for indemnity insurance provided under schemes such as the PSS. Significantly, the ECS has never been used. The RACGP considers the decrease and lack of use of the PSS and ECS respectively as testament to the high quality of healthcare delivered in Australia.

**Run-off Cover Scheme (ROCS)**

Changes to the ROCS could have significant impacts upon the GP workforce. As a provider can be liable until their estate is closed, the ROCS provides certainty for insurers, and peace of mind and security to practitioners – ultimately keeping insurance costs down and reducing pressures on patient out-of-pocket costs.

The RACGP is also concerned that any change to ROCS could have unintended consequences on retirement and subsequently workforce, with potentially far reaching impacts on workforce distribution and

[1] The Commonwealth of Australia. Mid-Year Economic and Fiscal Outlook 2016-17. Canberra: CanPrint Communications Pty Ltd; 2016.

GP supervisor capacity for training. It is vital that the impact on workforce and the potential for destabilisation are considered when considering changes to ROCS.

## Conclusion

The RACGP understands that a review of the schemes that comprise the IIF is necessary in order to ensure that existing arrangements offer all parties an adequate level of financial protection. However, consultation is strongly recommended prior to change to any of the schemes, and will assist in enabling the smooth transition of any changes.

If the First Principles Review leads to recommendations for significant change to the IIF, the RACGP strongly recommends that change is implemented incrementally and slowly, with extensive consultation and evaluation following each change before progressing to the next.

**Indemnity crisis in the United Kingdom (UK)**

Consultation and staggered implementation will also assist in avoiding issues similar to those currently experienced by GPs in the UK, where there has been a reduction in GP working hours due to rising indemnity costs.

According to a survey conducted by GPonline, 39 per cent of GPs surveyed have significantly reduced the number of hours that they work due to rising indemnity costs.[2] This has exacerbated existing workforce issues and could lead to the National Health Service losing 100,000 working hours per week from its GP workforce.[3]

**Continued involvement of Federal Government**

The medical indemnity insurance sector contributes to the Government's Long Term National Health Plan for ensuring access to essential medical services by enabling access to high-quality and affordable healthcare in Australia. In light of the experiences of the UK, and the current benefits to practitioners and patients, the RACGP sees little value in destabilising this crucial element of Australia's high-quality healthcare system.

Given the relatively small expenditure on the IIF since its commencement, there is little evidence to show that there would be significant savings from a reduction in Commonwealth involvement. However, there is evidence to show that such a reduction could lead to increased premium costs for doctors, filtering down to patients.

The RACGP therefore supports ongoing Commonwealth involvement in the IIF in order to continue to reduce adverse events and improve patient safety.

[2] Millett D. Exclusive: Indemnity costs strip equivalent of 2,500 GPs from NHS. GP Online. 14 August 2017. Available from http://www.gponline.com/exclusive-indemnity-costs-strip-equivalent-2500-gps-nhs/article/1441860
[3] Ibid