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13 October 2017

Ms Kate Medwin
Director, Medical Indemnity Section
MDP 951
Department of Health
GPO Box 9848
CANBERRA ACT 2601

By email: medical.indemnity@health.gov.au

Dear Ms Medwin,

ASA submission: First Principles Review of the Indemnity Insurance Fund.

Reference: 1.3.10.9.

The ASA welcomes the opportunity to provide feedback on this important issue.

Medical indemnity: A crisis managed and not forgotten
Conditions in the late 1990's culminated in a medical indemnity crisis that created great anguish for doctors, uncertainty for patients and compromised timely access to quality health care. These conditions included:

- Increasing medical litigation.
- Medical defence organizations (MDO) provided discretionary cover to their members and therefore were not regulated under APRA and the Insurance Act 1973.
- The MDO were significantly undercapitalized including inadequate cover for claims incurred but not reported (IBNR).
- Rising costs for claims were resulting in increased premiums and calls for funds.
- Many MDO were exposed to HIH through reinsurance, which went into liquidation in 2002.
- The inadequate MBS rebates had chronically underfunded the true cost of delivering healthcare.
- The proposed IBNR levy angered many doctors who seriously contemplated ceasing practice.

The consequences of this toxic environment included:

- Defensive medical practice to avoid litigation, exposing patients to increased investigations, morbidity and escalating healthcare costs.
- Escalating premium costs forcing doctors to cease practice or aspects of higher risk practice.
- Decreasing access to care for vulnerable patients including the provision of rural, obstetric, after hours, neurosurgical anaesthesia services.

- Uncertainty for practitioners facing retirement.

This crisis was averted by the introduction of the indemnity insurance fund and abandoning the IBNR levy. Guarantees were made and doctors continued to see patients.

There have been a number of developments since 2002 including:
- Tort law reform, development and implementation of a quality improvement culture including 'no blame' open disclosure and other risk management initiatives.
- Increased regulatory control through APRA.
- Improvement in the insurer's capital base.
- Improved operational costs reflected in decreased premiums.

This provides evidence that the government interventions have resulted in sustained improvements in medical indemnity. This has permitted the provision of an uninterrupted anaesthesia service to patients even in high-risk areas. Winding back the government support will reverse this positive trend by:
- Increasing uncertainty.
- Increase price pressure on premiums.
- In the current economic climate including the Medicare freeze, these increased practice costs will need to be passed on to patients.
- This will increase the out of pocket expenses for patients.
- Some patients may find the value proposition of private health insurance inadequate or unaffordable and drop out.
- This will increase demand pressure on the public sector and reduce the financial viability of the private sector.

Response to specific questions:
What other information is relevant to an assessment of the current environment and the success of the schemes in achieving the desired outcomes?
- Trends in private health insurance coverage.
- Mal-distribution of clinical services across Australia. If some practitioners decide to reduce the provision of there services due to rising indemnity costs, this could reach critical levels in some regions.

Are the current arrangements the most efficient and cost-effective way to support the affordability and availability of insurance? If not, what changes would you suggest and why? Where should Government target its efforts and resources?
- Effectiveness has been proven by stability of market, decreased premiums and continued provision of services.
- Any changes need to be evidence based.

Premium Support Scheme and Universal Cover
The key strengths of the PSS
- Support for medical practitioners through premium subsidies, universal cover and protection for patients by ensuring they will always be covered.

Are there other benefits of the PSS?
- Provides peace of mind for practitioners and patients. Assurance of affordability of medical indemnity of premiums for doctors and assurance of universal medical coverage for patients.
- PSS allows doctors to practice clinical excellence rather than defensive medicine.

- Declining participation in the scheme may reflect the success of the multifactorial approach taken to the medical indemnity crisis. Those still participating will be from high risk groups. As such the program should continue till participation rates are very low.
- Unless the MDO are able to provide a cost neutral way of achieving this same guarantee, the government backed PSS must continue to facilitate universal coverage.

Does the PSS offer value for insurers and medical practitioners?

- All MDO should be part of PSS.

Advance versus retrospective payments.

- In conjunction with MDO, structured retrospective quarterly payments may be explored if these were considered to generate administrative efficiencies.

Universal Cover

- The ASA strongly supports universal cover to provide affordable indemnity and affordable, safe healthcare.
- All indemnity providers should be required to provide universal cover in a transparent, fair and equitable fashion.
- The medical profession distinguishes itself from other industries in that the government seeks to provide universal healthcare. This can only be achieved through a stable and affordable medical indemnity industry.
- Medical indemnity providers may calculate a premium based on risk and work to reduce that risk through quality improvement activities.
- The MDO should not function as regulators. Poorly performing practitioners should be managed by AHPRA and the MBA through existing mechanisms to protect the public.
- The insurer of last resort should share the risk load evenly among suppliers.

High Cost Claim Scheme

- The ASA agrees that the HCCS puts downward pressure on premiums by reducing MDO's payouts and reducing reinsurance to fund large claims. This has had the effect to stabilize the market and make medical indemnity more affordable for practitioners.
- Any raising of the threshold, (e.g. from $300,000 to $500,000) or reduction of the Commonwealth contribution, or limitation on practitioners eligible will therefore generate instability in the sector and tend to raise premiums.
- For the purposes of transparency, good governance and cost-effectiveness, the claims made under this scheme ought to be specifically related to reasonable costs for appropriate coverage of medical practitioners.

Exceptional Claims Scheme

- This provides certainty for the industry and reduces the impact of very large claims.
- It is essential for the industry to maintain a perception of stability and security.
- Since it involves potentially large amounts of public money, it is best administered by the Commonwealth.

Run-off Cover Scheme

- The community needs assurance that medical practitioners will have indemnity cover when they leave private practice.

- It may be that MDO are better place to manage this scheme than the Commonwealth.
- There should be a mechanism in place to incentivise the settling of claims if appropriate to preserve Commonwealth funds.

Incurred But Not Reported Claims Scheme

- The IBNR scheme will have a natural history that will diminish in its relevance with time.
- It has historically provided stability within the industry.

Conclusion

The medical indemnity crisis of the late 1990's posed a significant threat to the delivery of universal healthcare in Australia. The ASA appreciates there may be some operational improvements that may be considered reflecting developments in tort law reform, reinsurance and financial management over the past two decades. Any substantial reductions in the government's support of medical indemnity will cause destabilization of the industry, premium rises, increased out of pocket expenses for patients and potential reduction in services to those most vulnerable.

Yours sincerely,

Associate Professor David M. Scott
President, Australian Society of Anaesthetists