Australian College of
Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF

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College Details

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About ACRRM

The vision of the Australian College of Rural and Remote Medicine (ACRRM) is *Better health for rural and remote people through access to skilled rural doctors*. It progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is one of two professional Colleges recognised by the Australian Medical Council to provide vocational training towards Fellowship in the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to provide the highest quality care in rural and remote communities, which often suffer from a dearth of face-to-face specialist and allied health services.

Background

As outlined in the Discussion Paper on which this submission is based, the Australian Government announced a medical indemnity insurance package in October 2002 in response to an indemnity crisis resulting from a number of factors which impacted on the availability and affordability of indemnity insurance. The broad objectives of these schemes were to promote stability within the medical indemnity insurance industry and to provide access to affordable indemnity insurance for medical practitioners and eligible midwives.

Of particular importance to College Fellows and rural GP proceduralists are the Premium Support Scheme (PPS) which subsidises 75% of the difference between the higher premiums for rural procedural GPs and premiums for non-procedural GPs; the Run-Off Cover Scheme (ROCS) which reimburses medical indemnity insurers for 100% of the cost of claims for doctors who have ceased private practice; and the corresponding schemes for midwives.

Procedural medicine remains a cornerstone of rural and remote medical practice and plays a key role in meeting the health care needs of people living in these communities.

There is clear evidence that for low risk procedures and with appropriate risk management strategies, rural and remote procedural practice is as safe, if not safer, that urban services. It is usually the preferred option for rural patients and their families and often results in better patient outcomes.

Procedural practice is linked with the recruitment and retention of rural doctors. This is evidenced by the success of the Queensland Rural Generalist program, which has seen a significant resurgence in rural procedural practice in regional areas since its inception.

The contribution of procedural practice to recruitment and retention of the rural and remote medical workforce and consequently to improved access to a wider range of health care services in these communities, is being increasingly acknowledged. It is imperative that supports such as the IIF be maintained as a support mechanism for retired, current and future procedural GPs.

Current Issues and Trends

Economic Fragility of Rural Practices: Rural private practices, particularly procedural practices, are inherently fragile and under increasing economic pressure, with many verging on unsustainability. A number of factors have contributed to this fragility, including the MBS indexation freeze; higher overhead costs; a more complex business environment; increased pressure to bulk-bill; and the inability of many communities to afford fee increases due to adverse seasonal conditions and other factors.

These practices have limited capacity to change their business models or quickly adapt to changed circumstances. They require certainty and a secure policy environment in order to be able to continue to invest in necessary practice infrastructure and continue to operate profitably.

Any uncertainty and cost increases which might arise from a reduction or significant withdrawal of indemnity subsidy support will inevitably further jeopardise the viability and overall sustainability of these practices, with detrimental flow-on effects for regional, rural and remote communities.

Risk Management: College Fellows who continue to provide procedural services areas have noted an increasing degree of clinical caution which has been partly responsible for a reduction in the level of available services in regional, rural and remote hospitals and health facilities. There are a number of reasons for this trend, including an increasing incidence of litigation and failure to accept that some risk and adverse outcomes are unfortunately an unavoidable occurrence in medical practice.

Service cutbacks pose increased health, social and economic risks for rural and remote communities. Withdrawal of maternity and other services is often the first step in a downward spiral that can result diminished services which is exacerbated over time. Staff become de-skilled and then unfortunately then less able to respond to emergency situations when they inevitably occur.

However the absence of services does not equate to an absence of risk. Under these circumstances, procedural GPs are increasingly reliant on the underlying reassurance and support provided by the indemnity subsidy schemes.

The Federal Health Policy Environment

ACRRM strongly recommends that the Review of the IIF be considered not in isolation but in the context of the broader Federal health policy environment; the objectives of the Commonwealth with respect to regional, rural and remote health services and the contribution of the IIF in achieving these objectives.

During the past two years there has been a significant policy work to develop strategies which will provide the 'right' doctor for regional, rural and remote communities, and in particular medical practitioners who have the skills, especially procedural skills, required enable them to meet the health care needs of the communities in which they are working.

This policy shift, together with concerns about the escalating cost of health care and increasing sub-specialisation, has led to recognition of the Rural Generalist practitioner in providing effective, efficient and sustainable health care that meets community needs. The

model has continued to be very successful in Queensland and other states and territories are at various stages in adopting similar programs which are adapted to their needs and circumstances. In 2016, the Federal Government announced the intention to appoint a Rural Health Commissioner, whose first priority would be to coordinate the development of a National Rural Generalist Pathway.

These initiatives strongly indicate that rural GP procedural practice, including private practice, will be increasingly important and that procedurally trained GPs will be increasingly mobile in terms of working in a number of jurisdictions. The indemnity subsidies provided by the IIF will continue to be in demand, both to underpin the cover provided by jurisdictions and to support GPs in private procedural practice.

The Role of the IIF in supporting Rural and Remote Procedural Services

The IIF is an important component in maintaining and improving access to health care services in regional, rural and remote communities and in supporting the GP proceduralists who provide many of these services. .

More broadly, the IIF provides a strong underpinning support for State and Territory schemes and Medical Defence Organisations.

Support for Procedural GPs and Practices: ACRRM has received strong anecdotal evidence that the IIF reduces the financial and emotional pressure on rural procedural GPs. The subsidy can provide significant economic relief, with one practitioner citing a premium cost of $7,000 compared with up to $50,000 without the subsidy.

Generally income generation is not the primary motivating factor for rural procedural GPs. Many continue to undertake this work from a desire to service their communities and for the personal and professional satisfaction that it provides. However there are a range of financial and personal imposts associated with procedural practice. These include longer working hours and on-call commitments; greater limitations on family time; and the time and financial cost of maintaining skills and accreditation requirements.

In most cases, rural procedural GPs are unable to recoup increased costs through higher fees. As outlined previously, an increase in indemnity fees could well be the determining factor in a rural GP proceduralist deciding to discontinue procedural practice.

The schemes contribute to reducing the stress of working in often high-pressure situations and provide a signal that GP procedural services are valued and supported, fostering recognition and appreciation of service.

This support extends to those doctors who have retired or are considering retirement. Many of these are procedural GPs who have provided longstanding service to their communities and who are entitled to ongoing indemnity insurance support.

Consequently any additional costs such as those which would be incurred with a reduction in the indemnity subsidy may provide the tipping point at which the costs of procedural practice outweigh the rewards.

Attracting a New Generation of GP Proceduralists: Indemnity and insurance issues are a potential deterrent to many junior doctors considering entry into procedural practice. This is compounded by misconceptions and a general lack of awareness about indemnity issues.

Subsidy support needs to be maintained to provide underlying security and certainty for these doctors. ACRRM recommends that the role of the IIF in supporting procedural GPs be more strongly promoted and that this be accompanied by increased education and awareness about indemnity issues more broadly.

Maintaining Access to Services in Rural and Remote Communities: As outlined previously, procedural services provided by GPs are essential in providing efficient and effective health care in regional, rural and remote communities. They make a key contribution to addressing the current inequity in access to services which is still an issue in many rural and remote areas.

In addition to their primary roles, health care services and facilities support the broader economic and social fabric of communities.

Supporting Team-Based Care: Rural and remote procedural practice, particularly in areas such as obstetrics, relies on a team-based approach. Ongoing indemnity support for midwives is important and the Midwife subsidy support schemes should also be continued.

Structure and administration of the IIF

The structure and administration of the IIF should be based on the principle that indemnity insurance and the associated subsidy supports should be simple, transparent and understandable. They should continue to support rural procedural practice and not deter doctors from providing potentially life-saving treatment.

From a rural and remote perspective, continuity and certainty are important, particularly given the inherent fragility of rural practices and the rural medical workforce.

ACRRM acknowledges that states and territories have their own indemnity schemes and that many rural procedural practitioners are covered under these arrangements for both their public and private services. The College would support further exploration of ways in which the IIF could be coordinated with state and territory schemes to provide a more efficient and cohesive service.

The College supports any initiatives that will streamline administration and reduce associated costs. However these should be considered in the overall context of the importance of the IIF in promoting equity of access to health care services for rural communities and continuing to address the need for subsidy support for rural doctors.

Many doctors may be unaware that they are receiving a subsidy through discounted premiums with their Medical Defence Organisation, which is the primary mechanism for the provision of subsidy support. A greater emphasis on education and awareness would raise the profile of the schemes and address some of the misconceptions and concerns of junior doctors in particular. .

Recommendations

1. In analysing the benefits and the ongoing need for the schemes, the IIF be considered not in isolation or as a 'stand alone' initiative, but in the context of the broader Federal health policy environment; the objectives of the Commonwealth with respect to regional, rural and remote health services and the contribution that the IIF makes to achieving these objectives.

2. Indemnity subsidy support, and in particular support provided to current and retired rural and remote GP proceduralists through the PSS, ROCS and MPIROC, should be maintained as a priority.

3. The profile of the IIF should be increased through greater visibility of the subsidies within indemnity insurance premium payments and an education and awareness campaign. This will provide reassurance and certainty for current and retired procedural practitioners, junior doctors considering procedural practice, and the wider community.

4. Any proposed changes to the IIF and its component scheme should be subject to a rigorous 'rural proofing' process to ensure that they continue to support rural procedural practice; are 'fit for purpose'; and to identify unintended consequences.

5. Any proposed changes should be considered with further stakeholder consultation and developed and implemented using a co-design process.