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AMA

06/26

27 January 2006

Treasury
Insurance Access and Pricing Unit
Attention: Medical Indemnity
Langton Crescent
CANBERRA ACT 2600

Re: AMA Response to the Treasury Discussion Paper, November 2005
Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

I refer to Ms Vicki Wilkinson's letter of 28 November 2005.

Please find attached the AMA's response to the Treasury Discussion Paper, November 2005, *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003.*

Should you have any queries, please don't hesitate to contact me at the AMA,
tel. (02) 6270 5460.

Yours sincerely

Dr E Robyn Mason
Secretary General

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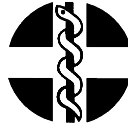

AMA

AUSTRALIAN MEDICAL ASSOCIATION RESPONSE TO THE TREASURY DISCUSSION PAPER, NOVEMBER 2005 ON COVERAGE OF THE MEDICAL INDEMNITY (PRUDENTIAL SUPERVISION AND PRODUCT STANDARDS) ACT 2003

Introductory Comments

The Australian Medical Association *("the AMA")* appreciates the opportunity to comment on the Treasury Discussion Paper, November 2005, *Coverage of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

While specific comments are made below in response to the questions raised in the discussion paper, the AMA notes that the overall cover arrangements and minimum standards as they currently stand should not substantially change, nor should there be a change to the requirement for a high level of indemnity cover for all health care providers until and unless the Long Term Care Schemes come in across the country so that future care costs are removed from the tort heads of damages. The AMA's dissatisfaction with a tort based compensation system is on the record. However, given that the government has made a decision to continue with the system of tort based compensation as the only avenue for compensation, the AMA believes that the government has a responsibility to ensure a secure insurance system is in place to meet the obligations placed on individual health care providers.

Further the AMA reiterates that while the only means for patients to obtain compensation/assistance for adverse events is by means of civil claims in the tort system, then health care providers need to be able to purchase insurance products in a secure and stable system. This is not only in the interest of health care providers but equally in the public interest.

Prudential supervision of insurers of health care providers

Question 1
What would be the implications of removing the requirement for prudential supervision of insurance provided to health care professionals other than medical practitioners, thus limiting the scope of the Act to medical practitioners?

The AMA is opposed to limiting the requirement for prudential supervision of insurance to medical practitioners. The argument for maintaining prudential supervision of insurance applies equally to all health care providers. Whether the medical indemnity cover is for mainstream practitioners such as doctors, nurses, midwives and physiotherapists or alternative practitioners like Chinese medicine practitioners, the key common characteristic is that medical indemnity is very long tail and relates to personal injury as apposed to pure economic loss. The purpose of the supervision is to reduce the likelihood of an insurer being unable to meet its obligations.

With the potential movement to role substitution and task substitution as alleged solutions to Australia's medical workforce shortage differentials in risk profiles are being eroded. Medical practitioners may be replaced with nurses and allied health workers in primary care settings. The roles are sometimes blurred. Should litigation occur in circumstances where multidisciplinary care is provided by several types of health care provider, it is important to minimise the risk of any patient's legal action being directed to the practitioner with the "deepest pocket", which in the absence of adequate cover for other health care providers is likely to be the insured medical practitioner.

The AMA acknowledges that some practitioners have lower risk profiles however risk profiling of groups does not allow for the large claim that can emerge regardless (eg the ACT case of *Black v Lipovac*, where a multi-million award was made by the court against a General Practitioner who prescribed medication to a child).

Midwives are at a higher risk of a claim for catastrophic brain injury than some non-procedural General Practitioners.

It is our submission that all health care professionals should be required to obtain cover from prudentially supervised insurers. Individual practitioners with proven lower risk profiles ought to be able to obtain cheaper cover; and those at higher risk may need to pay more. Groups genuinely at lower risk of claims will presumably see lower premiums as a competitive (but prudentially supervised) insurance market responds with insurance cover appropriately priced to cover actuarially calculated risk.

Finally now that some non medical practitioners are pushing for access to MBS rebates for patient care, they should be covered by identical indemnity arrangements. No group of health care providers should be under a lesser obligation to insure themselves against claims that might be brought against them. If allowed to do so, this will place medical practitioners who are required to prudentially insure themselves at a competitive disadvantage as costs of their services will be more expensive than practitioners who are allowed to "underinsure".

As for the reference in paragraphs 52 to 54, giving consideration to allowing discretionary mutual funds (DMFs) to offer health care providers indemnity cover, the AMA notes this contradicts statements made at the time of the medical indemnity crisis that APRA regulation is essential and that APRA could not adequately regulate DMFs to ensure stability. The AMA maintains that in the interest of security and stability, discretionary cover for medical indemnity is inappropriate. The fact that consideration is being given to altering the arrangements for health care practitioners, other than medical practitioners, is irrelevant. For example the transmission of HIV or a birth injury could just as easily result from a health care provider other than a medical practitioner.

Question 2
Would such an amendment significantly threaten the safety of indemnities provided to health care professionals other than medical practitioners?

Yes. Prudential supervision of medical indemnity insurers reduces the likelihood of an insurer being unable to meet its obligations in the absence of which health care practitioners have the potential to be exposed to liability. This may leave injured patients in the unsatisfactory position of receiving insufficient compensation.

Question 3
Is regulatory flexibility in prudential supervision necessary to allow the Government to respond to the market as it evolves, or would it introduce uncertainty for medical indemnity providers?

A degree of flexibility would appear to be sensible for both medical practitioners and other health care practitioners. However the commentary preceding this question (paragraph 55 in the discussion paper) assumes that prudential regulation for health care providers other than medical practitioners will be removed. The AMA does not support the removal of the requirement for prudential supervision of indemnity providers for any health care professional, and refers to answers to questions 1 and 2 above.

Minimum contract cover amount

Question 4
Is there any strong rationale for maintaining the Government role in setting the minimum level of cover available?

There is a benefit in maintaining a minimum level of cover. Minimum levels of cover serve as an important mechanism for patient protection. Currently this minimum amount is also used by some Medical Practitioners' Boards as a benchmark in determining the adequacy of insurance cover required to permit registration.

We are concerned that in the absence of minimum requirements, individual doctors or groups could gain cost advantage by carrying lower levels of insurance. The AMA is of the view that not only should a minimum level of cover be retained but perhaps increased to a more realistic level for some practitioners; which may vary State by State or by

practice discipline. We also believe that patients ought to know the minimum level of cover being carried by their treating doctor and the relationship, if any, to their fee structure. If the level of indemnity cover was advised as part of obtaining patient financial consent, patients would be placed in the unpalatable situation of perhaps having to choose between a less expensive service provider and a lower level of indemnity cover, and a higher fee on the off chance that they have need to sue their doctor for damages for malpractice. Assuming trust in their treating practitioners at the outset, doctors or groups of doctors will have a competitive advantage by carrying lower levels of insurance, or none at all, "going bare".

Question 5.
Given that medical practitioners are currently choosing to purchase $20 million cover, is a legislatively-imposed minimum an unnecessary intervention in the market?

For the reasons given to question 4, the AMA does not agree that the minimum level of cover should be removed. The market determined cover of $20 million allows practitioners immediate access to Exceptional Claims Scheme; it bears no relation to the minimum cover which practitioners may elect to purchase if offered by the medical indemnity insurers. The fact that the market offers $20 million is not a valid reason for removing the minimum imposed standard.

Product standards for employed medical practitioners

Question 6
Should access to the Government's medical indemnity assistance measures be limited to those contracts of insurance that meet the product standards set out in the Act?

Access to the package of government assistance being restricted to contracts of insurance that meet the product standards set out in the Act is not an unreasonable requirement. In such circumstances it is essential that practitioners who are unaware of this restriction should be clearly informed and given the capacity to rectify the situation without penalty. The AMA however prefers that all contracts of insurance should be regulated and meet the product standards. It also follows that should other health care providers obtain insurance that meet the product standards of the Act, they should have access to the package of government assistance available currently to the medical profession.

Option A: Removing the product standards for employed medical practitioners

Question 7
What would be the implications for employed practitioners of not applying the product standards to insurance offered them?

The AMA recognises that there are issues of affordability for employers to obtain cover for large groups of practitioners. However the AMA also understands that these issues existed prior to the introduction of the product standards and have not arisen recently.

Employee practitioners and their patients are entitled to the same protection as others practitioners. The AMA is concerned that if employer's insurers were not obliged to meet certain cover standards for employed practitioners, such employees will not have the security of cover. Similarly we maintain that patients ought to know the minimum level of cover being carried by their treating doctor. It is not in the public interest for practitioners to practice without adequate cover or indeed no cover. Employees should not be placed in the difficult position of needing to be constantly (at least annually upon the renewal of insurance policies) concerned with the adequacy of cover purchased by the employer. Employees will potentially have to purchase additional cover to guard against their employer having insufficient cover. Employees also need to be secure in the knowledge that their run-off cover is adequate, without any gap in coverage. Placing employees in this situation would be most unsatisfactory.

As for the movement of employed practitioners between facilities, it appears that there will be difficulties in connection with retroactive cover. It is not clear how the interests of employed doctors would be protected in circumstances where the employer's insurer is not required to offer retroactive cover. Employer policies will generally not cover claims in prior employer's facilities or any prior practice.

It is also noted that a significant number of medical practitioners are currently employed by their own practice company. An exemption for employed medical practitioners is likely to include these practitioners. Where relevant, the definition of employed medical practitioner must be considered very carefully so as to avoid practitioners altering their practice structures to obtain access to any exemption.

Question 8
If the product standards are removed for employed practitioners, are there ways to provide certainty of cover to employed practitioners who want it (for example, new insurance products)?

The AMA is opposed to the idea of employers imposing on employee medical practitioners the responsibility of carrying their own indemnity cover in such unregulated circumstances, leaving it the individual employee to decide on the level of insurance they wish to purchase. This could lead to gaps in coverage. Employers may also find themselves vicariously responsible for the acts and omissions of their employees with insufficient coverage.

Option B: Extending product standards to all medical practitioners

Question 9
Does the insurance cover for employed practitioners require product standards?

Yes. Employee practitioners and their patients are entitled to the same protection as others practitioners. See answers to questions 7 and 8 above.

Question 10
Would product standards for the insurance of employed practitioners be required in all situations, or just some?

All situations. See answers to questions 7 and 8 above.

Question 11
What are the implications for employed medical practitioners and their insurance (either purchased directly or by their employer) if the product standards were to apply to them?

They would have the benefit of certainty and security, notwithstanding when a claim was brought by an injured patient.

Option C: Extending the run-off cover scheme to employed medical practitioners

Question 12
If the run-off cover scheme were to apply to employed medical practitioners covered by a group policy (and therefore group limit) when practising, how would the run-off cover limit be set: up to the amount of the group contract limit and subject to the excess applicable to the group policy, or at an arbitrary limit?

The option of a group policy is not one that the AMA regards as feasible, particularly given the difficulties outlined in paragraphs 93 to 95 of the discussion paper. The ROCS has so far proven to be difficult in its implementation, and proceeding in this manner is likely to complicate matters further. The maintenance of standards and a minimum level of cover, which included a ROCS contribution, will eliminate uncertainty.

Question 13
If the run-off cover scheme were to apply to employed medical practitioners, what arrangements would be necessary to ensure that an insurer could issue a run-off cover contract to a practitioner for the period of employment?

See answer to question 12 above. The insurer could be required to contribute an amount equivalent to the individual doctor's ROCS contribution. This would add an appropriate amount to the ROCS pool to allow full funding of ROCS claims. As such the practitioner should be eligible, regardless of their work arrangements.

Question 14
If the run-off cover scheme were to apply to employed medical practitioners, what would be the most effective and fair way of ensuring that an appropriate amount is paid to fund the run-off cover?

See answer to question 12 and13 above.

Option D: Allowing all medical practitioners to "opt-in" to the run-off cover scheme

Question 15
Rather than restricting the product standards to medical practitioners in private practice or attempting to fit the run-off cover scheme to employed medical practitioners, would it be preferable to allow medical practitioners to choose a level of cover appropriate to their risk profile and insurance needs while practicing and in retirement?

The AMA does not support the proposal to allow individually determined run-off cover as practitioners may not purchase adequate run-off cover, risking a retired medical practitioner's personal assets and leaving patients who are entitled to compensation without access to appropriate compensation. Further this shift to personally purchased run-off cover is contrary to the current acceptance of intergenerational support and would leave a gap in run off cover of those retired or close to retirement. "Discretionary" run-off cover arrangements may lead to patients being treated by underinsured practitioners without the patient's knowledge. It is difficult to see a situation where patients will be able to differentiate a range of indemnity cover arrangements for potential treating doctors. As a result, indemnity cover standardisation is necessary for security of patients.

Flexibility in the application of the product standards

Question 16
Is the flexibility to prescribe certain classes of health care professional or insurance contracts to which the retroactive or run-off cover obligations should apply offered by regulations necessary or desirable?

A degree of flexibility would appear to be sensible should the Government need to respond in circumstances that employer indemnities do not provide employed medical practitioners with sufficient run-off cover in retirement (this includes practitioners in the public system and covered by the State government arrangements).

Training institutions

Question 17
What are the implications of removing regulation 4(1)(d) exempting training institutions, students and staff members who provide health care services to the public, through clinics and work at hospitals unrelated to training activity?

The AMA is of the view that university staff who provide health care services directly to the public, as distinct from training, should be subject to the Act. Current exemptions for medical students should be retained.

Clinical trials

Question 18
What are the implications of continuing to apply the product standards to medical practitioners who provide health care services to the public by way of clinical trials or research activities?

The AMA supports the proposal that the portion of the insurance indemnifying the medical practitioners' provision of health care (and therefore subject to the Act) could be separated from the remainder of clinical trial insurance. Currently medical indemnity insurers offer cover for liability arising out of negligence in medical trials to insured medical practitioners.

Question 19
Alternatively, what would be the consequences if the Government exempted the insurance of medical practitioners during clinical trials from the prudential supervision or product standards of the Act, or both?

See answer to question 18.

Volunteer health care professionals

Question 20
Should the exemption for volunteer organisations be maintained?

The AMA recognises the fact that Good Samaritan legislation exists in some jurisdictions, however this is not consistent across the country. If the exemption for volunteer health professionals continues, are there volunteer medical practitioners who will be exposed for lack of adequate cover, and if so will they be required to purchase personal insurance for 'top up"? The discussion paper does not address this issue.

Question 2
Are the circumstances of volunteer organisations sufficiently different to warrant special treatment under the Act?

See the answer to question 20.

Additional changes to regulations

Question 22
Treasury would appreciate views of the possible additional changes to regulations discussed and any alternative approaches.

As stated above the AMA is opposed to limiting the requirement for prudential supervision of insurance; prudential supervision of insurers should apply in relation to all health care providers. Accordingly the AMA does not support an exemption for oral and maxillo-facial surgeons merely because they are registered as dental practitioners.

Additional changes to the Act

Question 23
Treasury invites comment on whether there are any other issues with the Act not addressed by this paper. If there are additional issues, what would be possible solutions?

One issue that has arisen concerns the Premium Support Scheme. Generally this scheme appears to be working well however the threshold for the subsidy, that is, insurance costs being 7.5% of gross income, is proving to be too high a threshold for lower earners, such as part time General Practitioners. This arises because GP's employment contracts allow their employers to recoup a high percentage of the fees earned, hence leaving the employed GP with low earnings and a relatively higher premium that does not attract the PSS. The AMA welcomes the opportunity to consider a mechanism to enable GPs and other groups of practitioners to access the PSS where the burden of insurance costs is disproportionate to their income and risk.

Another issue that needs to addressed concerns Overseas Trained Doctors/International Medical Graduates who return for a second period of employment some years after initial period of residence in Australia. Perhaps a loading on their premium at first presentation to contribute to their ROCS liability, and a subsequent additional loading relative to the number of years that have elapsed since their last visit on their return should be considered as they move out of ROCS relative to their first visit while they remain in Australia for their second or subsequent visit.