

Medical Insurers Contribute to Quality and Safety in Health Care

The medical indemnity industry continues to underpin private medicine in Australia by providing affordable and accessible insurance for medical practitioners; for the benefit of their patients. The industry is well capitalised and efficiently run, with support from the Commonwealth through the High Cost Claims Scheme, Premium Support Scheme and Exceptional Claims Scheme.

Medical insurers are actively involved in promoting risk management and improvements in medical practice with all participants competing to provide their insured professionals with meaningful opportunities to improve quality and safety. There are also some initiatives on which it makes sense for insurers to cooperate and share expertise for the public good. One such project was the financial support from Avant, MDA National and MIGA to the Royal Australian College of Surgeons to develop a program to measure and improve Non-Surgical Competencies for Surgeons. This ground breaking project has been enthusiastically received by the medical profession.

Most insurers also contribute data on claims to the Medical Indemnity National Collection (MINC) Database, a project set up in 2002 by Australian Health Ministers' Advisory Council through the Australian Institute for Health and Welfare (http://www.aihw.gov.au/safequalityhealth/minc_stats.cfm). This initiative began with national public sector data from 2003 and has developed to include national private sector data as well from 2005. The most recent published report for the year to June 2007 managed to include data from 93% of claims within the scope of the report.

"Cause of loss" - the specifics of which are of most interest to the medical profession from a clinical point of view - can be difficult to derive from medical negligence

data. The adversarial nature of the negligence system means that the cause of loss is many times the contested issue between the parties. The collected information can be used however to confirm generally that emerging information from clinical adverse events monitoring fits with the medicolegal experience. We now know for instance that General surgery, Obstetrics and Accident and Emergency contexts make up for about half of all claims (in the 2007 MINC report) so this helps Risk Management providers to focus in on these groups to understand better the reasons for this.

Trends in claims numbers, costs and duration are also of great interest to insurers and the actuaries and other professionals who model likely claims costs. These models will have a real impact on reserving and thus the affordability of premiums for the medical profession and the community. For instance the fact that "total claim size including legal costs was less than \$100,000 for approximately 83% of finalised claims, and in excess of \$500,000 for roughly 4% of finalised claims" is very useful information not only for insurers but policy makers and medical professionals as well.

The challenges of providing meaningful analysis of this sort of data are complex but with commitment and refinement hopefully the information will become as useful and influential as the long term US based series, such as the American Society of Anesthesiologists' Closed Claims series, operating since 1985 (<http://depts.washington.edu/asaccp/ASA/index.shtml>), or the Department of Veterans Affairs Patient Safety Program, incorporating root cause analysis of adverse events, which began in 1998 (<http://www.ncbi.nlm.nih.gov/pubmed/12369156>).

The commitment of MIIAA and its members to think about the data the industry has been collecting and to attempt through risk management to improve the environment for medical professionals and patients will continue.

We hope to promote these aims through

the MIAA Forum in Canberra on 17 September 2010 and the International Section meeting of the Physician Insurers Association of America in October 2011 in Melbourne. If these ideas impact on your area of expertise, please come along to interact and contribute your views.

Dr Andrew Miller
MIAA Chairman

National Registration and Accreditation Scheme for the Health Professions: What do you need to know?

Since 2008 there has been much effort expended in establishing the National Registration and Accreditation Scheme for the Health Professions. So much has happened, that the MIAA felt it was timely to provide an update on where we have come in the period since March 2008. You will have been reading summaries of the MIAA submissions on the Scheme, but the article below provides an up to date review of the current status of the Scheme.

Background

On 26 March 2008, the Council of Australian Governments signed an Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions ("the Scheme"). The new Scheme is scheduled to be introduced on 1 July 2010. The ten health professions to be covered by the Scheme are:

- Chiropractors
- Dental care practitioners
- Medical practitioners
- Nurses and midwives
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists.

The protection of the public is the key objective of the Scheme. The Scheme is intended to:

- Provide greater safeguards for the public;
- Allow health professionals to move around the

country more easily;

- Reduce the regulatory burden on health professionals;
- Promote a more flexible, responsive and sustainable health workforce; and
- Establish a national register for each health profession to ensure that a professional who has been banned from practising in one jurisdiction would be unable to practise in other Australian jurisdictions.

Current Status of the Scheme

A staged approach is being taken to establishing the legislative basis for the Scheme. The Health Practitioner Regulation National Law 2009 Bill ("Bill B") was introduced into the Queensland Parliament on 6 October 2009. This legislation includes the Scheme's arrangements for:

- Registration;
- Accreditation;
- Complaints, conduct, health and performance; and
- Privacy and information-sharing.

The other States and Territories agreed to introduce adopting or corresponding legislation (known as "Bill C") into their parliaments to implement the Scheme so that it is fully operational by 1 July 2010. The following table indicates which jurisdictions have passed their respective enabling legislation:

STATE	BILL	STATUS
ACT	<i>Health Practitioner Regulation National Law Act 2010</i>	Statute
NSW	<i>Health Practitioner Regulation Act 2009</i>	Statute
NT	<i>Health Practitioner Regulation (National Uniform Legislation) Act 2010</i>	Statute
QLD	<i>Health Practitioner Regulation National Law Act 2009</i>	Statute
SA	Consultative submissions no longer being received. Bill not yet introduced to Parliament.	
TAS	Health Practitioner Regulation National Law (Tasmania) Bill 2009	Passed by House of Assembly on 17 November 2009 – Government in transition
VIC	<i>Health Practitioner Regulation National Law (Victoria) Act 2009</i>	Statute
WA	Consultative submissions still being received. Bill not yet introduced to Parliament.	

New Features of the Scheme

Mandatory reporting of colleagues will be introduced across all of the health professions included in the Scheme. The Scheme imposes on all registered health practitioners, and

employers of health practitioners, a legal obligation to report to the Australian Health Practitioner Regulation Agency (the National Agency) any registered health practitioner who has behaved in a way that constitutes 'notifiable conduct'. The National Agency will then refer the notification to the relevant Board.

'Notifiable conduct' means the practitioner has:

- (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
- (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
- (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
- (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Exemptions to the requirement to report colleagues are provided to practitioners who are:

- employed or otherwise engaged by a professional indemnity insurer;
- lawyers providing legal services in respect of the notifiable conduct;
- a member of a quality assurance committee, council or other body approved or authorised under an Act, and unable to disclose the information because the Act prohibits disclosure.

Registration arrangements will include:

- Compulsory professional indemnity insurance
 - Criminal history and identity checks
 - Compulsory continuing professional development.
- Complaints arrangements

Bill B contains provisions for disciplinary, health and performance pathways. However, some states and territories, such as NSW, will retain their existing complaints management provisions

The new Medical Board of Australia will be based in Melbourne. The State and Territory Medical Boards will be retained as committees of the National Board.

Next Steps

On the 1st of July 2010 it is essential that all medical practitioners carefully check that they are registered with the appropriate conditions or undertakings, if applicable. The medical practitioner should also check that they are on the appropriate Specialist Register.

The annual renewal date for all Australian medical practitioners will be 30 September.

The MIIAA will continue to monitor and have input into the development of the Scheme to ensure that the interests of the medical profession and our members, are protected. If there are any concerns arising out of the scheme, MIIAA recommends members contact their medical defence organisation for further individual assistance. More information about the Scheme is available at the Australian Health Practitioner Regulation Agency website <http://www.ahpra.gov.au/index.php>.

Dr Sara Bird, Manager, Medico-Legal and Advisory Services - MDA National and Nicholas Regener, Paralegal - Avant.

Proposed Regulations for the Healthcare Identifiers Service

In April 2010 the Healthcare Identifiers Regulations 2010 were released for comment. The MIIAA prepared a submission on the Regulations. The submission focused on two areas, Regulation 10, which covered the maintenance of records, and the penalties imposed by the Regulations.

Regulation 10

The MIIAA submitted that Regulation 10 particularly ss(8) maintaining records of authorized persons and 11(1) imposed unnecessary impositions and additional administrative burdens on medical practices which potentially may detract from delivery of healthcare to patients. The submission suggested that this could have further medico legal implications for the medical practitioners. The MIIAA believes that the burden would be exceptionally onerous for general practitioners who have a large number of patients. The MIIAA submitted that by imposing an obligation on practices to keep records and logs, the legislation added a further burden on medical practices.

The MIAA also submitted that guidelines and record keeping templates should be provided to assist medical practices to deal with the administrative requirement imposed by the Regulations.

Penalties

The MIAA submitted that the imposition of penalties is not warranted. The MIAA believes that in the event of a breach of the draft Bill or draft Regulations penalties should not be imposed and they are not warranted. The MIAA submitted that any breach of the draft Bill or draft Regulations should be assessed by the Privacy Commissioner as stated in draft Regulation 10 (8) Note 2.

The MIAA submitted that penalising Healthcare Provider Operators for failing to ensure their staff are aware of their obligations pursuant to the draft Bill and draft Regulations was unnecessary and this issue could be dealt with in a positive manner by support, education and the use of guidelines and information sheets (similar to the information sheets provided by the Privacy Commissioner).

The MIAA continues to monitor the move toward electronic records and the national e-health agenda. We are delighted that Dr Mukesh Haikerwal has agreed to speak at the 4th Medical Indemnity Forum on 17 September, representing NEHTA and providing Forum delegates with an update on initiatives at NEHTA.

Ellen Edmonds-Wilson
MIAA CEO

4th Medical Indemnity Forum 17 September 2010 – Canberra Contemporary Issues in Health

The 4th Medical Indemnity Forum is being held at the Hotel Realm in Canberra on 17 September 2010. The programme for the Forum is to be released shortly, but the confirmed topics and speakers at the time of publishing this newsletter are:

Contemporary issues in Health

- Dr Joanna Flynn - Chair of the Medical Board of

Australia

- Veronica Hancock – Assistant Secretary, Hospital Development, Indemnity and Dental Branch, Acute Care Division, Department of Health and Ageing
- Dr Mukesh Haikerwal – National Clinical Lead, NEHTA

When to settle and for how much

- Bill Madden – Slater and Gordon Lawyers, National Practice Group Leader – Medical Law
- Alison Biscoe – Avant Law National Director
- Jeremy Gormly SC - Barrister
- A/Prof Julian Rait – President, MDA National

Open disclosure – an opportunity lost

- John Arranga - Avant Law Victorian State Manager
- Graham Bedford – Manager, Open Disclosure Programme, Australian Commission on Safety and Quality in Health Care
- Heather Martin – Manager, Risk Management Services, MDA National

Full programme details are available at the MIAA website: www.miaa.com.au. Registration will also be done online via the MIAA website.

The Forum has in the past been well attended, with a range of stakeholders attending. If you require any information on the Forum please contact us either at 08 8423 4437 or admin@miaa.com.au