

AFFORDABLE AND SECURE IN 2007

During 2006 Tony Abbott, Minister for Health and Ageing chaired the Medical Indemnity Policy Review Panel. The report from the Panel was released on 22 February 2006.

The Panel included independent actuarial advisors, representatives of the Australian Medical Association, the Council of Procedural Specialists, rural doctors and medical indemnity insurers.

In summary, the Panel found that the package of measures introduced to provide stability in medical indemnity had been successful. It recommended that the current package of reforms should be maintained.

Medical indemnity coverage was previously provided as discretionary cover by medical defence organisations (MDO). In the two years since the major reforms were instituted premiums have fallen, with some specialties experiencing a significant drop in the cost of medical indemnity insurance. The threshold for the HCCS is currently set at \$0.3m. This threshold is a reduction from the original \$2m and then \$0.5m thresholds set previously. The impact of this threshold was identified by the Panel as requiring ongoing monitoring to ensure that it continues to provide stability in the medical indemnity industry.

The Premium Support Scheme (PSS) has had an impact for those doctors whose premiums exceed 7.5 per cent of their gross private medical income. The report indicated that overall 5460 doctors have accessed the scheme whereby they pay only 20 per cent of the cost of medical indemnity insurance above the 7.5 percentage threshold, with the Federal Government paying the difference. As a consequence of the improved affordability of medical indemnity insurance, fewer doctors are now accessing the PSS, which reflects that fewer doctors are paying in excess of 7.5 per cent of their gross medical income on medical indemnity insurance.

The report recognised that medical indemnity is a long-term business, and that changes may take some time to



have their full impact. Accordingly, it strongly recommended that no changes be made which may affect the environment in which medical indemnity insurers operate. The framework in which insurers operate must be stable for a period, to allow for a full assessment of the measures instituted to be evaluated. The application of tort law reform is in its relative infancy in its application to medical indemnity insurance, and as such the Panel recommended that the recent reforms should not be wound back. The MIIAA supports this view and notes that tort law reforms are beginning to have an impact, but that the reforms need to be safeguarded. Consistency across the states and territories was encouraged by the Panel, and this

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EMPLOYED DOCTORS – ARE THEY COVERED?

In 2006 the Department of Treasury released a discussion paper on aspects of the *Medical Indemnity (Product Supervision and Prudential Regulation) Act 2003* (Cth.) The Act imposes product standards for medical indemnity insurance.

As we have reported in previous editions of the MIIAA newsletter, there have been ongoing discussions between Treasury and stakeholders on the various proposals being canvassed.

Most recently, Treasury has been seeking advice on the issues surrounding medical indemnity cover for doctors directly employed by private hospitals. A copy of the MIIAA submission can be accessed at <http://www.miaa.com.au/submissions.php>

The MIIAA is concerned that any change exempting medical practitioners from the product standards for insurance arrangements has the potential to destabilise the medical indemnity industry. Medical indemnity insurers operate with relatively small numbers of insureds in single line businesses. The loss of significant numbers of insureds could impact dramatically on the stability of the industry.

Similarly, patients treated in private hospitals are potentially exposed to inadequate protection in the event that hospital ceases operating, or retroactive cover is not purchased to cover prior events by a new owner.

MIIAA believes that the issue presently impacts on a small number of doctors, as most doctors prefer to maintain private medical indemnity cover within the individual product standards, which may be subsidised or paid for by a corporate employer. The definition of 'employee' has not been clarified, and remains at the heart of the discussions with Treasury.

Any solution, other than requiring that all doctors practising in Australia have their own individual policy, with the exception of Government employed / contracted doctors, has the potential to destabilise the industry and expose patients to inadequate protection.

We believe that presently more often employers require doctors to obtain their own insurance and arrange cover for the business on the basis that the doctor contractually indemnifies the employer for claims arising from his/her acts and omissions. Doctors who obtain their own insurance have insurance complying with the individual product standards.



In approaching the question of employer insurance arrangements a distinction should be drawn between the independent entity and the doctor-controlled entity.

A doctor-controlled entity effectively involves medical practitioners providing direct medical services to the patients. Doctors practising within those entities should be required to obtain individual cover that meets products standards.

Independent entities can be distinguished from doctor-controlled entities as they are either operated on a not for profit basis or on a commercial basis, and are controlled by boards of directors acting in the overall interest of the entity. Independent entities should not be required to meet product standards existing for individual medical practitioners.

The MIIAA believes that individual standards are not appropriate for an independent entity. However, an independent entity employer should be required to obtain indemnity insurance from a regulated insurer, with different product standards applying to that entity, including:

1. Insurance cover for all employees
 2. Run-off and retroactive cover
- and that a successor business should be responsible for arranging retro cover.

Submissions to the Treasury review from those organisations representing the specific interests of doctors were extremely critical of the effect of the potential impact of the changes proposed. The AMA submission in particular was concerned that patients, doctors and medical indemnity providers would be detrimentally affected if the Treasury proposals were adopted.

We will continue to provide information on the development of the Treasury proposals in future editions of the newsletter.

Ellen Edmonds-Wilson
MIIAA CEO

RISK MANAGEMENT IN CLINICAL PRACTICE

Risk management in clinical practice is now receiving significant attention by the medical profession. Doctors were always aware of the risks associated with medical and surgical treatment but the elevation of risk management activities into every doctor's consciousness and their acceptance as part of everyday activity in medical practice was prompted by the medical defence organisations (MDOs) and the so-called 'medical indemnity crisis'. As part of the solution to the 'crisis' and as a claims containment strategy, the MDOs took a leaf from the book from which that most other industries had been reading for decades. To the latter risk management was nothing new but its concepts needed to be adapted and expanded into the sphere of everyday medical practice. The introduction of these strategies was not always welcome, with many doctors being openly hostile. One doctor put it that 'it is a myth that risk management can protect us'. Others said 'there is no proof'. There is some evidence from the USA and Europe to counter this position in certain risk categories. However, despite the lack of overwhelming evidence on either side of the equation, intuitively, good risk management strategies should lead to better healthcare for patients. This should be the outcome the profession is seeking. If there is a consequential reduction in claims and, therefore, premium costs then, there is also a positive outcome for individual doctors. Australian MDOs and their subsidiary insurers agree and believe that risk management has an important part to play in the delivery of healthcare services and they are encouraging their insured members to adopt systematic risk management strategies.

In Australia, risk management had not been completely ignored over the years and, it is fair to say that, in the early to mid 1990s, some far seeing individuals, groups and hospitals committed themselves to a more systematic approach to this subject, e.g. the Australian Quality and Safety in Health Care Committee. The 'medical indemnity crisis', however, acted as the catalyst which prompted enormous activity and the application of a more systematic and aggressive approach to the management of risk across the broader profession.



Put simply risk management has two aims - to ensure better outcomes for more patients and to attempt to reduce the number of negligence claims and their costs. Managing risk is about minimisation of adverse events and unwanted outcomes and not about elimination. The latter can only be possible if all activity ceases. Generally speaking, risk management is largely about communication. All aspects of communication are involved – verbal (instructions, advice, informed consent, explanation and education, just to name a few), non-verbal (a smile, a welcome greeting, touching), written (clinical notes, prescriptions, reports, referrals), handover (end of shift, locums, to nurses and other health professionals), e-health, privacy etc. It is not rocket science. Most strategies are simple, easy to follow and are not time consuming. Guidelines, protocols, care pathways and explanatory materials, among many others, are useful risk management tools as the evidence shows that a claim is less likely to be successful if these have been used and followed.

International experience tells us that these programs are successful and they are in no doubt about their effect. In Australia, some similar results have been published. United Medical Protection released the results of their intervention program for 48 of their 'high risk' members who had accounted for 281 claims over a ten year period costing \$15million (annual average cost \$1.36million). After intervention the annual average cost was significantly reduced at \$24,000. The Medical Defence Association of Victoria, in its 2006 Annual Report, also reported a reduction in claims in those of its members who participated in their RISQ and SMaRTE programs. However, the numbers are small and the reduction occurred during a period of significant tort reform. These are early but very encouraging figures.

This early Australian data should make doctors more comfortable about the success of these programs and encourage support for them. In conjunction with tort reform, risk management is effective in reducing claims numbers and costs in medical negligence and continued activity in this area will see further changes in the future as the effect of these programs becomes clearer.

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MIIAA Chairman

MIAA BOARD ON THE ROAD

The MIAA Board met in Canberra in March 2007. The quarterly meetings of the Board rotate around Australia, with previous meetings having been held in Melbourne, Sydney and Adelaide. The rotation of the venue for the meetings provides an opportunity for the Board to meet with key stakeholders in each State. In 2006 the Board met with representatives of APRA and discussed important issues surrounding the regulation of medical indemnity insurers, as well as obtaining information from them on the development of the National Claims and Policies database.

The March meeting in Canberra provided an excellent opportunity to invite key people from the AMA, Health and Treasury to meet with Board members and discuss a broad range of issues. The Treasury Review of the arrangements for employed doctors was the focus of a large part of the round table discussions. The shared concerns of the AMA and MIAA were able to be discussed with Treasury and Health representatives, and an update on the progress of the Review was provided. The Medical Indemnity Policy Review Panel report which was released shortly before the meeting also provided important areas of discussion.

Further such meetings will be held with the MIAA Board when it meets in Melbourne in June 2007.

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recommendation is supported by the MIAA.

It is very important that the affordability of insurance is maintained for the medical profession, and that the medical indemnity industry operates in a stable environment. The report notes that as the Treasury continues to review coverage of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth). It also needs to consider the impact any changes may have on the government's medical indemnity package in terms of adequacy and security of cover for doctors, security for the community and the long-term viability of the medical indemnity industry.

Medical indemnity insurers have worked closely with the Government and profession to ensure that cover is

MEMBERSHIP CRITERIA CHANGED IN MARCH 2007

A Special General Meeting of the MIAA was held in March 2007 to consider the membership criteria of the Association. Since the formation of the MIAA the medical indemnity landscape has changed considerably, and the MIAA Board wished to ensure that the membership criteria were inclusive so that new industry entrants could participate to the fullest possible extent in industry activities.

The Special General Meeting voted in favour of changing the rules to largely reflect the membership criteria for our sister American organisation – the Physicians Insurers Association of America. The changes have introduced a new category of membership – Provisional Membership – for those organisations who are new entrants to the industry. Provisional membership is retained for three (3) years and until such time as the new entrant has obtained 2.5 per cent of market share and not less than 1,000 insureds. Provisional members participate in Board meetings and all other industry activities.



affordable and accessible for medical practitioners. The industry has appreciated the opportunity to participate in the review process and to provide information to the Panel on issues as they arose. Insurers will continue to work with stakeholders to maintain the stability of the industry and to ensure that doctors can practice into the future.

Dr Jonathan Burdon and Ellen Edmonds-Wilson