

## LOOKING FORWARD

The last few months has been a period of substantial change and success for the Association.

Dr Andrew Miller's overview article explains the changes to the legal status of the Association and to its Governance structures.

These changes demonstrate the continuing process of industry maturity and are a further recognition that the Association represents both the interests of insurers and the medical profession.

The Association has recently published its third annual study of premium and claim trends. This study provides the only source of consolidated 'private' sector medical indemnity premium and claims information in Australia. It provides a useful macro level perspective which indicates that:

- The growth in claims costs has begun to level out;
- As a result, insurers have been able to stabilise premiums and this, combined with the Federal Governments premium support scheme, should be easing pressure on affordability; and
- The industry is now managing its capital, with premiums exceeding claim costs by appropriate margins.

While the study has been well received over the past three years, medical colleges and practitioners and other key stakeholders have rightly been looking for a more detailed analysis.

It is with pleasure that the Association announces the Australian landmark completion of a detailed policy and claims data specification. The data and analysis that

will ultimately be provided by the MIIAA will allow the industry to meet reporting obligations to APRA, the HIC and to the medical community.

Most importantly, this data will provide more information of direct relevance to informing the design and implementation of risk management activities in the interest of the community, patients and the medical profession.



Recognising the importance and urgency of unlocking the answers embedded in the industry's claims data, the industry is committed to retrospective coding. The first report will be released in approximately twelve months.

## FROM THE CHAIRMAN

As the incoming Chairman of MIIAA I firstly want to acknowledge the extraordinary contribution that Mandy Anderson has made in her role as my predecessor. Mandy responded, with the support of her fellow MII CEOs, to the medical indemnity issues that arose in the last few years which threatened doctor control and choice in their indemnity arrangements. She has sacrificed countless hours of her time to identify the issues, seek a solution and get her colleagues and the decision makers around the table to make the necessary changes. She has been an inspiration with her ability to cut through the talk to find out precisely what needs to be decided, by whom and when, and what the consequences will be. I am sure all of us have learnt from her persistence, patience and ability to keep the agenda moving forward, whatever the obstacles. Of course she remains involved with MIIAA as a Board member and her expertise will continue to be vital to our operations. Mandy has enjoyed the support of Dr Jill Maxwell and the Medical Insurance Australia Group who should also be acknowledged for their particular contribution to the good of the industry and profession.

Secondly I acknowledge the contribution and support of the other three CEOs, Mark Valena from MDAV, Mike McLeod from UNITED/AMIL and Peter Forbes from MDA National. In particular Mark Valena, as the previous Deputy Chair, has given Mandy Anderson enormous support and backup. In addition to the considerable efforts of all CEOs, they have provided resources in the form of staff and intellectual property to the various committees that have done the hard work on industry reforms. They have worked together extremely well, despite their competitive businesses, to achieve much for the common good of doctors and their patients.

All of this would not have been possible without the desire of the governing bodies of each MDO and MII to be involved, in particular the Presidents and Chairs: Dr Jonathan Burdon (MDAV), Dr Stuart Boland (UNITED), Ms Merran Kelsall (PIICA), Mr Malcolm Irving (AMIL), and Mr Graham Reynolds (MDANI).



In addition, the work of Ms Ellen Edmonds-Wilson, our tireless Project Manager, should be noted. Ellen has, with good grace and patience, dealt with volumes of email and paperwork and chaired our meetings when required. She has kept the administrative cogs turning in close consultation with Mandy.

As the indemnity industry has settled we have had time to consider the future structure of our industry group. The efficacy of working together, where appropriate, on industry issues has been impressed upon us all. Thus we have set aside our competitive differences and committed to a new formal structure for our association. We are currently finalising the rules for the incorporation of the MIIAA. The Board of the new entity will consist of nominees from each of the MIIs and each of the MDOs. In acknowledging the doctor ownership of our capital, and the need to always remain doctor focused, it has been agreed that the Chairman will be a medical practitioner.

The new Board will be appointing an independent Chief Executive Officer who will implement the strategy set by the Board and be our public face and spokesperson, while coordinating the work of our various committees.

I look forward to working with all the Board and the other office bearers, Dr Burdon, Deputy Chairman and Mr Irving, Treasurer, to achieve our aims. We are excited and proud to be entering this new phase of our Association and we look forward to enabling and encouraging excellence in indemnity for all Australian doctors and their patients.

**Dr Andrew Miller - Chairman**

## RUN-OFF COVER SCHEME – HAS IT BECOME TOO COMPLICATED?

In May 2004, the Australian Government announced the introduction of the Run-off Cover Indemnity Scheme (ROCS). Since then, the Government, in consultation with medical indemnity insurers has been working to finalise the detail of the scheme. So what does the scheme look like and what will it all mean for doctors and insurers?

In theory the scheme is quite straight forward. A doctor retires, contacts his/her final medical indemnity insurer and is issued with confirmation of ROCS indemnity. However in practice, the scheme has emerged with a level of sophistication resulting from pressures to meet competing needs of affordability, breadth/confidence of cover, equity and operational efficiency.

Insurers increasingly recommend that doctors take the time to understand the scheme and consider their own circumstances and assess the adequacy of cover provided.

### So how does the scheme work?

Coverage under the scheme is a statutory entitlement of the doctor. Therefore, in the event a doctor is eligible but does not receive confirmation from an insurer, coverage is still assured.

Indemnity under the scheme is provided by the insurer, with the cost of eligible claims reimbursed to the insurer from the Federal Government. This guarantees that insurers are accountable and provide the normal types of disclosures that apply to financial products to the individual doctor.

The scheme provides cover in respect of periods of claims made insurance as well as periods of claims-incurred discretionary indemnity by an MDO.



Coverage under the scheme needs to mirror both the cover provided through the doctor's final indemnity policy and also the 'discretionary' rules applicable to periods of claims-incurred membership of an MDO.

Finally, the scheme shows traits of both claims-made and claims-incurred cover. Similar to claims-made cover, under the scheme, cover remains in place only as long as the doctor remains eligible. In the event a doctor returns to work, after being eligible for ROCS, in order to remain covered for prior periods of work, the doctor will need to obtain separate cover. In keeping with a claims-incurred style of cover, a doctor must have had cover in place at the time of the incident (with limited exceptions) for ROCS cover to respond. At present, a doctor must have rectified any gaps in cover within 12 months of the start of a membership or insurance period in order for ROCS to respond.

### How is the scheme funded?

The scheme is funded by a charge on Medical Indemnity Insurers. Insurers collect funds via premium income with each doctor being notified on the renewal or application quotation of the amount that is being contributed on their behalf.

### What are the eligibility criteria?

The key entry points of the scheme include death, disablement and retirement (65 years or over), as well as maternity leave. In these situations, doctors will have immediate entry into the scheme. The scheme also has a delayed entry feature for those doctors who have ceased medical practice (or private medical practice) but are under 65 years of age. These doctors will gain entry into the scheme 3 years after they ceased practice, unless they become eligible under another criteria (e.g. turn 65 or become disabled). Delayed entry may also apply where a





doctor ceases private medical practice but continues to practise in the public hospital system. Eligibility for ROCS is sustained if the only services a doctor provides are gratuitous services (as defined). The scheme entertains the prospect that those providing only gratuitous services can enter ROCS a second time after they cease providing gratuitous services, (the first entry point being when they retired).

The scheme also caters for internationally qualified doctors who practice in Australia on a temporary basis (on a visa 422 or 457). Upon ceasing practice in Australia and leaving the country, they enter the scheme.

So generally, doctors can become eligible in one of 3 ways:

1. cease all medical practice; or
2. cease private medical practice; (allows a doctor to continue practising only in the public system); or
3. cease providing gratuitous services

## What types of claims does ROCS cover?

1. ROCS indemnity extends to periods of claims-made membership/insurance and claim-incurred periods of membership with an MDO.

2. The doctor must have had cover at the time of the incident for the scheme to respond. This is important for those who have (or had) gaps in cover. Doctors may have gaps if they:
  - a. spent time overseas or had a career break;
  - b. changed insurers;
  - c. believed wrongly that indemnity was being provided by or through a public hospital;
  - d. purchased retroactive cover for a gap in cover, (that gap period may never be covered by ROCS indemnity). Special provisions apply
3. A doctor who retires (or otherwise becomes eligible) but continues to provide occasional gratuitous services will have ROCS indemnity for all prior work, as covered by the policy or as covered by the MDO. ROCS will not cover claims arising from any work (including gratuitous services) provided after entry into the scheme.

The charting of this scheme has been a long and complex process. However the implementation is likely to affect every aspect of an insurers operation, including the less seen areas of reinsurance, finance, data coding, claims reporting and systems development. One important consideration though is how the detail of the scheme is to be conveyed to doctors.

Final thoughts must be given to those who will use the scheme. Doctors are encouraged to have a thorough knowledge of the scheme, its benefits, terms and limitations. For most, ROCS will provide great comfort and security in retirement. For a few, extra cover may be needed to cover some gaps. For all, it will pay to do a little homework and be on alert before setting the mainsail. ROCS isn't designed to cover absolutely everything.

**Luke Thomson - MDA National Member of the MIIAA Technical Committee**

## LONG TERM CARE FOR THE SEVERELY DISABLED

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The stakes have been raised in respect to the issue of long-term care with the New South Wales Premier Bob Carr announcing at the Labor Party Conference on 7 June 2005 that the New South Wales Government will introduce a no fault long-term care scheme for persons injured in motor accidents.

The Medical Indemnity Policy Review Panel on 10 December 2003 advocated this position urging:

“The ministerial meetings on insurance to develop a scheme for the long-term care of the catastrophically injured”. (R10)

In the case of *Simpson v Diamond* the Supreme Court of New South Wales set a new benchmark for damages for the catastrophically injured by awarding \$14.2million, reduced on appeal to \$11million, of which \$4.9million was for future attendant care.

The experience of medical defence organisations is that there are relatively few successful claims for damages for the catastrophically injured. Many are left without compensation, as they are not able to establish negligence.

The New South Wales Court of Appeal delivered a decision highlighting this on 21 June 2005 involving a claim by Kristy Bruce. The case, which was heard over two months by Justice Grove, revolved around an assessment to the term of the pregnancy and what the doctor knew or ought to have known about it. Kristy Bruce is severely disabled and it is considered that society should ensure there are appropriate resources available for her proper care.

Justice of Appeal, Santow JA, in agreeing with the judgment of Bryson JA, stated:

“The meticulous reasons of Grove J are now on appeal of Bryson JA demonstrate why this appeal could not succeed. It is not to diminish the tragic outcome for the appellant, to whose care her mother has been devoted, to acknowledge that the respondent’s impeccable management of the confinement was, on the evidence, no way responsible for what occurred”.

Is it equitable that one child born with cerebral palsy acquires the cost of “Rolls Royce” future care and another must make do with the bare minimum, pending on the outcome of the legal lottery relating to an assessment about compliance with foetal heart monitoring protocols?

“For every Calandre Simpson each year hundreds of children are born in Australia who will suffer life long disabilities where fault is not an issue and hence



## Long Term Care for the Severely Disabled

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compensation is not an option. All Australians who have the need for care, medical services, income support and the like should have those needs met by the community”.

The cost of long term care is usually the largest contributor to the overall cost of a large claim. The main driver of this cost is generally life expectancy and therefore long term care costs are most significant where they relate to injuries suffered by babies, particularly at birth.

Based on data compiled for the MIIAA, claims with an overall cost in excess of \$2m, where care is a critical factor, make up 0.5% of claims, but 26% of known cost of all claims. Claims in excess of \$500,000 represent 3% of reported claims by number and 55% by cost. The specialty group that is most exposed to these claims is Obstetrics. 8% of their claims exceed \$500,000 (being nearly 3 times the industry average) and large claims represent 90% of the total cost of claims against Obstetricians (64% greater than industry average).

These figures represent the total claims cost and do not quantify the component which relates to long term care costs. Therefore they do not predict the savings possible through implementation of a long term care scheme.

The establishment of a long term care scheme to assist in the area of adverse medical outcomes, particularly in obstetric cases, may be appropriate, especially when it is considered that most injuries do not arise for a compensable incident.

Dialogue and research will continue within the industry to determine the likely impact and possible benefits of such a scheme and MIIAA will advise its agreed position on the matter in future editions of the newsletter.

**Allan Hunter and Allan Tattersall**  
**MIIAA Claims Committee**

