Medical Indemnity Industry Association of Australia
Submission

Treasury Discussion Paper – November 2005

Coverage of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

General overview

This Paper is submitted by the Medical Indemnity Industry Association of Australia (MIIAA) and we welcome this opportunity to contribute to Treasury's review of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003.

Within this Paper, we have provided our views on the major issues raised by Treasury in the Discussion Paper in relation to medical indemnity insurance and:

- Prudential supervision of insurers of health care professionals
- Product standards for employed medical practitioners
- Minimum contract cover amounts
- Linking access to government subsidies with the product standards
- Training institutions, clinical trials and volunteer health care professionals.

As a general observation, it appears that many of the potential options raised in the Treasury Paper are at odds with the thrust of government policy on medical indemnity over the last 4 years.

The Federal Government introduced prudential regulation and minimum product standards for medical indemnity insurance with the objective of providing consumers and patients with security and to ensure their capacity to pursue and obtain damages should a claim of medical malpractice be proven.

Whilst the Discussion Paper identifies there are certain segments of the market where it is suggested that complying with the requirements introduces complexities (mainly in terms of affordability), in principle we do not see this as a compelling reason to support reverting to a non-regulated indemnity structure for those groups.

We do not believe Government should introduce different and inconsistent standards within the market, which are at odds with its stated policy objectives.

In our view, the consequences of the proposals to reduce or eliminate the stated policy objectives for certain components of the health care profession are principally:

- Reduced consumer protection

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

General Overview cont…

- Introduction of an uneven playing field in the insurance market, with the potential for destabilisation of the industry
- A reduction in the long term strength of the healthcare indemnity industry, which is dependent on sound prudential regulation.

Our views on each of the issues raised in the Discussion Paper and background information are outlined in detail in this Paper.

We would be pleased to respond to any queries Treasury may have in relation to this Paper and to be part of a broader discussion on the options being canvassed and their impact on not just the medical indemnity industry but also the medical profession. We would also welcome the opportunity to work through a more comprehensive exploration of possible options and solutions with Treasury.

1. Prudential supervision of insurers of health care professionals

(Paragraphs 47 to 55)

Treasury proposal

- We understand that Treasury is considering removing the requirement for prudential supervision of insurance for health care professionals, other than for medical practitioners
- This would mean that health care professionals (other than medical practitioners) could effect their insurance (or indemnity) through arrangements that are not prudentially supervised by APRA eg via an offshore captive or a mutual.

MIIAA position

It is the view of the members of the MIIAA that:

- If prudential regulation is required for medical indemnity insurance then it should apply to all health care professionals, not just medical practitioners i.e. it either applies to all or is removed for all
- The Government's stated policy objective for introducing the requirement in the first instance would be weakened if the proposed outcomes were implemented, with the potential for 'insurer' collapse increased and patients potentially being exposed to uninsured compensation claims for health care treatment

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

1. Prudential supervision of insurers of health care professionals cont…

MIIAA position (cont)

- If prudential regulation of insurance for health care professionals other than medical practitioners is not required, then this will distort market competition. A level playing field is vital to the insurance industry – prudentially regulated insurers operate at a cost disadvantage to unregulated entities. In addition, insurers of medical practitioners may be unduly exposed to increased claims activity, as they could become insurers of last resort (or the only available insurer)

- A partial solution to some of the issues raised in the Treasury Paper could be for the Government to review the definition of health care professional, to ensure it is only capturing those professionals who are providing health care services.

Background

- We understand the Government's stated policy intent for the extensive legislative framework introduced over the past four years is that regulation of insurance for health care professionals was necessary for the community to be satisfied with the ability of such professionals to pay claims as and when they are due

- We believe there must be consistency in the Government's policy objective as applied across all health care professionals i.e. we are not aware of any valid argument as to why a different set of standards should be applied to a subset of this group i.e. medical practitioners

- The fact that the size and frequency of claims for some sub groups varies does not seem to be a valid reason for changing the current structure i.e. a midwife has the potential to be exposed to claims of equal size as an obstetrician. Equally, the risk profile varies considerably between different types of medical practitioners

- As health care professionals are often employed by medical practitioners, or entities they own, it does not make sense for one set of product standards to apply to medical practitioners, that are robust, providing sustainability and security, and yet another set of product standards might apply for health care professionals that are less robust

- We do not accept the arguments raised to justify the removal of prudential supervision on the basis of access to insurance and affordability are valid. Affordability issues are not per-se a function of how cover is provided but reflect the underlying claims experience and the premium that is therefore required to meet those claim obligations (and at least in the case of regulated

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

1. Prudential supervision of insurers of health care professionals cont…

Background (cont)

insurers provide a buffer for uncertainties). Affordability issues need to be dealt with by addressing the underling costs of the relevant risks

- We question how much of an issue this has been i.e. how many individuals in these groups have not been able to obtain cover? We are not aware of any, other than the well publicised issues with midwives and those groups who have already been exempted (on the basis they were inadvertently captured by the heath care definition in the first instance).
- Requiring only some health care professionals who are part of a health care team to have regulated insurance would leave those with appropriate insurance exposed to claims from patients who have no right of claim against others involved in the incident eg obstetricians working as part of a health care team with midwives, etc. There is a major risk that those with the better level of insurance cover will be liable for a greater proportion of any claim, based on their insurer's ability to pay rather than their true liability
- We acknowledge that the medical indemnity legislation introduces some inconsistency given that it is not compulsory for many health care professionals to have insurance (therefore it could be argued it is illogical to require regulated insurance only where it is compulsory or voluntarily effected) however this argument applies equally to medical practitioners . Not all states in Australia yet require medical practitioners to have insurance as a matter of law.

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

2. Product standards for employed medical practitioners

(Paragraphs 56 to 99)

Treasury proposal

We understand that Treasury is considering that the product standards for medical practitioners should not apply to employed doctors.

MIIAA position

It is the view of the members of the MIIAA that:

- There should be product standards for all medical practitioners as there is no valid reason to substantiate why standards should apply to one subset of medical practitioners only
- Removing product standards for employed doctors may result in an outcome where a significant number of doctors no longer have insurance which meets the Federal Government's policy objective of access by patients to rights of compensation (because the majority of doctors are employed)
- There may be a case to argue for a different set of product standards for employed doctors eg a different minimum level of cover to apply, which may be aggregated across the employer and all their employees. That is the application of the product standards to the employing entity and their insurer rather than the individual practitioner
- Removing product standards for employed doctors may introduce complexities and uncertainties for the profession.

Background

Consistency in policy objective

- We are not clear on the rationale for the policy position being different for employed doctors versus those running their own practice. The potential for uninsured or inadequately indemnified claims is equal between the two groups
- The Le Fevre Hospital incident (date of incident 15 Dec 1989 - ref SCGRG 92/0833 Judg no 4899) is a good example of this
    - This was a case of a brain damaged baby, where the hospital and midwife conceded negligence, judgment was awarded at $4.9m and the hospital's insurance was inadequate (the policy limit was <u>$2m in total</u>). The hospital was made bankrupt and even after the sale of the

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

2. Product standards for employed medical practitioners cont…

Background (cont)

property and its equipment and furniture there were insufficient funds to satisfy the award

- The patient was not fully compensated and the community lost access to a valuable local hospital. The case highlights the risk of unregulated insurance and inadequacy of policy limits *(Note: we are not suggesting in this case the insurer was unregulated, but highlighting that in the future it could be, with similar implications)*. Whilst the midwife was responsible in this instance, in a future case it could equally be an employed obstetrician

- Allowing a private hospital's insurance to be extended to employed medical practitioners with no control over minimum policy limits or regulation of the insurance could result in a similar problem in the future

- The reasons for introducing a different set of rules for employed medical practitioners appear at odds with the Federal Government's stated policy objective of access to secure compensation, unless a different set of product standards is introduced for these entities, that still provides the required level of security

- We are not aware of how much of an issue this really is and how difficult it has been for entities to access the required insurance. It would be useful, for example, to understand how many entities have accessed the current exemptions and how many of those that could have but didn't and why

- Cover for large groups of employed medical practitioners is not unavailable (as suggested in Para 70) – it is available from any one of the medical indemnity insurers that are members of the MIIAA, who have no difficulty in offering the required cover

- We acknowledge, however, that the employing entity may consider it unaffordable. Purchasing insurance on a per claim limit per doctor will always be more expensive than effecting it as an aggregate limit across an entity, irrespective of who the insurer is and what level of discount is applied to reflect the risk profile. The argument outlined in paragraph 68 could equally apply to a group of medical practitioners working in a group practice but operating independently i.e. there are similar justifications for having a lower overall group limit

- We understand there may be issues of affordability for entities, but do not understand how these are at a level of importance that would warrant the stated policy objective being removed and introducing different standards for sub-groups of medical practitioners (and therefore patients)

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

2. Product standards for employed medical practitioners cont…

Background (cont)

- As an alternative, we propose that the Government consider the introduction of a different set of product standards for employing entities.

Vicarious liability issues

- The complications of subrogation and vicarious liability are ones which we recognise, however, they are issues which all insurers manage on a day to day basis and are not insurmountable where different parties to an incident have separate insurance cover

- For example, similar issues arise where there are claims involving the public sector where doctors are separately insured. These have existed for many years and we are not aware they have raised problems which cannot be dealt with.

Interests of employed doctors

- We believe that the interests of employed doctors need to be carefully considered and that any change where they no longer have access to their own insurance would need to ensure that the following are addressed:

  - Would they feel their level of protection from their employer would be adequate?
  - How would doctors and patients be protected where corporate/business failures occur?
  - What is the likelihood of them being sued in their own right and not being adequately covered?
  - What exposure would this leave for doctors and patients?
  - How do they protect themselves for run-off?
  - How do they cover their retro exposure?

Doctors who change their arrangements

- An additional complexity would arise from doctors who change their arrangements

- We are not clear on how the Government would deal with doctors who move in and out of employed arrangements or who work privately in their own practice and as an employee of a corporate practice at the same time, as many doctors currently do

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

2. Product standards for employed medical practitioners cont…

Background (cont)

Definition of "employed doctor"

- A significant number of doctors are employed via their own company. We are not clear what is the policy intent about who is and who is not deemed to be employed. Even in very small practices a doctor may be employed by a practice company which they own either solely or jointly with other doctors

- The definition of employed medical practitioner would need to ensure that the Government avoids giving an incentive to practitioners to alter their practice structure to obtain access to an exemption, that ultimately has the potential to seriously damage security for consumers/patients.

Retroactive cover

- We are not clear how the interests of employed doctors would be protected in circumstances where their employee's insurer is not required to offer retroactive cover for prior practice.

Run-off cover

- We are concerned with the complications that would arise if ROCS is offered to employed doctors buying a non-complying product

- ROCS is already very complicated for both doctors and insurers

- The options canvassed in the Paper to extend it to employed doctors insured via non-complying products would introduce further complexities, such as:

    - How would the level of cover be decided where there is an aggregate policy
    - What limit applies if the entity has already eroded its cover with actual claims or circumstances
    - How would the contract be issued and in what form
    - How would the levy be calculated
    - Who would pay any excess?

- Conversely, if ROCS is not extended to this group, we do not see that employed doctors would receive appropriate certainty about access to guaranteed run-off cover in retirement etc.

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

3. Minimum contract cover amount

(Paragraphs 59 to 63)

Treasury proposal

We understand that Treasury is considering the removal of the requirement for a minimum level of cover of $5m for medical indemnity insurance for medical practitioners.

MIIAA position

We do not believe the minimum limit should be removed as to do so is in conflict with the stated policy intent of ensuring that medical practitioners have in place an appropriate level of insurance cover. Minimum levels of cover serve as an important mechanism for consumer protection.

The fact that insurers offer and doctors are insured for limits of $20m (to ensure access to the Exceptional Claims Scheme), does not appear to be a valid reason for reducing or removing the requirement.

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

4. Linking access to government subsidies with the product standards

(Paragraphs 79 to 82)

Treasury proposal

The Treasury Paper queries whether the Government should allow access to various Federal Government benefits for medical indemnity insurance that does not comply with the product standards.

The Government has previously advised that it is intended that access to legislated benefits such as ROCS, PSS, HCCS and ECS is restricted to complying insurance products

MIIAA position

It is the view of the members of the MIIAA that:

- Access to Federal Government benefits should be limited to regulated contracts of insurance that meet legislated product standards

  This appears an appropriate trade off for ensuring that the Government's policy objectives are met i.e. doctors have the benefit of the medical indemnity package if they in turn are insured via arrangements that deliver sustainability and security.

- Allowing access to these benefits for insurers that do not comply with the legislation will introduce significant instability in the medical indemnity market for insurers that are obligated to offer a complying product and abide by the requirements of the HIC Contract

- The Government could be exposed to increased liability if it were to extend these assistance measures across the board

- It is difficult to see how some of the current Government assistance programs, e.g. premium support, could be made to work in practice – for example, where a medical indemnity premium is paid for a hospital and all its employees, rather than for an individual doctor

- Given the Government introduced the minimum policy standards to protect the rights of consumers to be able to seek appropriate compensation in the event of medical negligence, it would seem counter-intuitive to offer assistance for non-complying products.

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

5. Training institutions and volunteer health care professionals

(Paragraphs 100 to 108 and 113 to 119)

Treasury proposal

We understand that Treasury is questioning whether the current temporary exemptions should continue and be made permanent.

MIIAA position

The MIIAA supports the current exemptions for these groups, given that these individuals offer services which are often provided as part of a public sector setting (the insurance for which is in any event exempt as per Reg 4(f)) and the acknowledged difficulties in arranging such insurance and affordability of complying insurance.

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

6. Insurance for clinical trials

(Paragraphs 109 to 112)

Treasury proposal

We understand that Treasury is questioning whether the current temporary exemptions for clinical trials by training institutions should continue and whether it should be extended to all insurance for clinical trials (i.e. not just for training institutions).

MIIAA position

It is the view of the members of the MIIAA that:

- The temporary exemption for insurance for training institutions for clinical trials should continue and be made permanent, but only for public institutions, on the basis that these organisations are in any event exempt via Reg 4 (f) and for other reasons outlined in this Paper
- The exemption should not be extended or continue for insurance for health care professionals and medical practitioners involved in other forms of clinical trials
- If an exemption is granted for all clinical trials, then there should be consistency in the application of the Government's policy objectives and the exemption should also apply to medical practitioners.

Background

- We believe that there should be consistent application of the Government policy objective to the treatment of clinical trials (other than those through the public system)
- This is in line with our views raised in Sections 1 and 2 of this Paper. Where health care treatment is provided to the public it should be supported by APRA regulated insurance, and in the case of medical practitioners, by insurance which complies with the product standards. There appears to be no justifiable reason to take a different point of view on this
- We do not agree with the statements in Para 110 of the Discussion Paper in relation to the availability of insurance for clinical trails. In our experience clinical trial insurance is available, we have seen considerable evidence of it being effected
- In our experience the cover is often part of global insurance arrangements and the insurer is sometimes not a regulated entity e.g. it may be an offshore captive

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA

6. Insurance for clinical trials cont…

Background (cont)

- In terms of the scope of the cover where clinical trials insurance is arranged, in our experience the sponsor companies generally extend an indemnity to third parties working on the trial e.g. doctors, nurses etc

- The indemnities provided to medical practitioners are usually very narrow in the sense that the doctor is only entitled to an indemnity for claims arising out of the failure of the trial provided the doctor operated strictly within the trial protocol

- There are two issues here:

  - The trial protocol itself might be faulty in which cases the sponsor is legally liable for the outcomes and the participating doctors and others are indemnified because they followed the protocol

  - Medical practitioners and other health care professionals are generally not indemnified for their negligence. If they are liable to a third party patient and the liability arises from something outside the protocol there is no indemnity and they must have their own insurance

- Generally the MIIAA members will offer cover (often by policy extension) to their insured doctors who are involved in clinical trials and generally this will indemnify them for liability they incur which arises where there is an allegation of negligence where the doctor may have operated outside of the protocol of the trial. The specific details and nature and scope of cover offered and the types of clinical trials that can be covered vary across the industry depending on individual underwriting requirements which are largely driven by reinsurance arrangements.

© MIIAA Strictly Private and Confidential – Not for circulation nor for public release without prior approval of the MIIAA