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Department of Health

RANZCOG Feedback on the Discussion Paper: First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF

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The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) welcome the opportunity to provide feedback on the *Discussion Paper: First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF.*

The following submission provides RANZCOG's view on the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF.

Discussion

The medical indemnity schemes were introduced following the 'indemnity crisis' of the early 2000s, during which private maternity services in Australia were almost extinguished. Since that era, the schemes have underpinned confidence in indemnity cover for Australians and thus have served the Australian community well.

Obstetricians have been able to access medical indemnity cover and this has stabilised premiums which, in turn, have both maintained patient access and ensured ongoing support to patient's rights under common law. The medical indemnity schemes have brought stability to a system that was in crisis.

In view of the historical volatility of medical indemnity, both in Australia and abroad, continuing uncertainty and volatility remains a risk to healthcare in Australia. For this reason, **the schemes must be retained**; introducing uncertainty over indemnity cover has the potential for severe adverse consequences and it is not clear how the system would respond in the event of another crisis. The schemes provide confidence that patients will compensated in the event of medical negligence. **The schemes represent good value for money and RANZCOG strongly supports their continuation**.

Premium Support Scheme (PSS)

Questions

Are these the key strengths of the PSS? Are there other benefits of the PSS?

What role does the PSS play in providing assurance of affordability of medical indemnity premiums?

What observations could be made about declining participation in the scheme?

Given the increased stability of the medical indemnity insurance market, is there a continuing need for a Government scheme to assist eligible medical practitioners with the cost of medical indemnity insurance?

If so, is the PSS appropriate for achieving this purpose?

Are there changes that could be made to improve the PSS and best achieve the outcomes sought?

If not, is there a suggested alternative approach?

Does the PSS offer value for insurers and medical practitioners?

What are the key reasons that new entrants to the insurance market have chosen not to contract with the Commonwealth in order to offer the PSS?

If the PSS is to be retained, should access to the PSS continue to rely on the insurer having a contract with the Commonwealth or should this scheme be available to any medical practitioners who meet the eligibility criteria regardless of whether or not their insurer has a contractual relationship with the What evidence or other considerations distinguish the medical profession from other professions which incur substantial premiums and do not receive government subsidies?

If there continues to be a scheme providing premium assistance, how can this be best structured and targeted to ensure Commonwealth contributions support the area of greatest priority/need?

What should be the criteria for subsidy and how should the amount of subsidy be calculated?

Is 7.5% of gross private income a reasonable threshold for eligibility to the PSS? What is the evidence for this or a different threshold?

Does there continue to be a need for the PSS to subsidise GPs practicing in rural and remote areas? Are there other specialities to which different arrangements for subsidy should apply?

Does the differential treatment of MISS practitioners continue to be appropriate? Commonwealth?

Are there other changes to the PSS arrangements you would suggest?

If premium subsidies continue to be offered, is it preferable to offer 'advance payment' of a premium subsidy based on an income estimate or should a retrospective payment be made once actual income is known?

RANZCOG response

The PSS provides stabilisation of obstetrician/gynaecologist annual premiums, an important protection against shocks and changes that could affect the overall system of indemnity. The PSS is highly valuable to obstetricians in particular, and for those in rural and remote areas. It addresses concerns that high medical indemnity premiums for some areas of medicine could be a disincentive for doctors to practice.

Universal Cover

Questions

Should universal cover continue to be a feature of the medical indemnity insurance in Australia?

If so:

- *should all insurers be subject to universal cover requirements (not just those contracting with the Commonwealth via the PSS)?*
- *are there adequate mechanisms for insurers to limit or monitor the practice of medical practitioners that represent higher risk because of inappropriate practice (i.e. through conditions)?*

Are the current parameters for universal cover appropriate or should they be changed? For example, currently there is a limitation on the risk surcharge (capped at 100% of the applicable premium). Does this limitation remain appropriate?

RANZCOG response

A fundamental aspect of current medical indemnity arrangements is the concept of 'Universal Cover,' giving all Australian doctors access to medical indemnity coverage. Without this, barriers would exist for some doctors, negatively affecting their ability to be able to practice. RANZCOG supports medical regulators and professional standards bodies in determining which doctors can practice, not medical indemnity providers.

High Cost Claims Scheme Questions

Questions

Are these the key strengths of the HCCS? Are there other benefits of the HCCS?

Does there continue to be a need for Government to subsidise insurers though contributing to the cost of high claims (so as to provide certainty and reduce pressures on claims)?

Should the scope of the HCCS be limited to medical practitioners? If not, what is the evidence of the need for these schemes with respect to other registered health care vocations?

How could the HCCS better align with the business practices of medical practitioners or otherwise be improved?

Is the threshold above which the Commonwealth contributes appropriate?

What would be the likely impacts of any changes to the HCCS? Is Government involvement in providing this type of reinsurance appropriate, given the availability of commercial insurance and reinsurance?

How should claimable costs be defined? What alternative definition would be practical, effective and reasonable?

What other issues around claims and eligibility need clarification? Please provide examples and suggestions for inclusion in any future guidance material.

What other changes could be made to the HCCS to improve its effectiveness, efficiency and value for money while ensuring it continues to meet the scheme objectives and to reflect current insurance arrangements?

RANZCOG response

The High Cost Claims Scheme (HCCS) is a fundamental component of the current arrangements, and is a key element in the stable medical indemnity environment. Through the HCCS, the Government shares an element of risk above a threshold with the private sector. Changes to the scheme will directly and adversely impact doctors' premiums – increases in cost will inevitably be passed on to patients. This increases out-of-pocket costs for patients, and as a flow-on will have a direct negative effect on the long-term stability of the sector and the provision of health care.

The recent changes announced by the Government increasing the threshold of the HCCS from $300,000 to $500,000 will increase premiums by about 5% and this will be passed on to patients. The impact will be very uneven, with higher risk specialties such as obstetrics bearing even higher premium increases.

The HCCS is effectively a form of reinsurance. The Government can provide this more efficiently than the global reinsurance market since it does not need to hold backing risk capital or generate profits on the scheme. Thus the HCCS (together with the Exceptional Claims Scheme – see below) is a Governmental initiative that provides overall net benefits to patients and doctors significantly beyond what could be realised under any other system.

Exceptional Claims Scheme (ECS)

Questions

What are the benefits of the ECS given the absence of claims made under the scheme?

To what extent does the scheme influence the limits of insurance applied by insurers?

To what extent does Government involvement in providing this type of insurance provide certainty for the sector?

Should the scope of the ECS be limited to medical practitioners? If not, what is the evidence of the need for this scheme with respect to health professionals (and allied health professionals)?

Is the ECS best administered by the Commonwealth?

RANZCOG response

The Exceptional Claims Scheme (ECS) must be retained - it is one of the key foundations of the medical indemnity system in Australia, providing certainty to doctors and patients that for exceptionally large claims they will not be faced with the prospect of policy limits being exhausted. The ECS provides stability and security to medical indemnity insurers and to the wider health system. If the ECS were to be withdrawn, it is not clear that the private insurance and reinsurance markets would be able to provide such unlimited protection on a reliable, stable and sustainable basis.

Run-off Cover Scheme

Questions

Does there continue to be a need for the ROCS?

If so, is the Commonwealth best placed to manage and administer the ROCS or could it be administered by insurers or others? If the scheme is more appropriately managed by others, how could it be transitioned?

Are there any improvements that could be made to the scheme to make it more efficient and effective (regardless of who manages the scheme)?

Are the data collection requirements associated with ROCS reasonable and appropriate?

Should any changes be made to eligibility or the other requirements for payable claims?

Are there any improvements that could be made to clarify which medical practitioners and which claims are eligible for ROCS?

Is the ROCS support payment set at an appropriate level? If not, why, and what would be an appropriate level?

Does the allowance paid to insurers for ongoing administrative costs continue to be necessary and, if so, is it set at an appropriate level?

RANZCOG response

RANZCOG supports the Run-Off Cover Scheme (ROCS) since it provides protection to doctors and patient. All doctors should be required to secure run-off cover whenever they cease practice.

Incurred But Not Reported Claims Scheme (IBNR) Scheme

Questions

Does there continue to be a need for the IBNR?

If so, are there are any improvements that could be made to make the scheme more efficient and effective?

RANZCOG response

The IBNR scheme acts as reinsurance for unfunded claims arising before the indemnity industry change to claims-made cover (from 2003). The IBNR scheme is still theoretically active and could be triggered if another medical indemnity insurer were to have unfunded claims from the pre-claims-made period. Although unlikely, the scheme is still a valuable protection mechanism against a major systemic shock, and should be retained until all pre-claims-made medical indemnity liabilities have fully run off.

Midwife Professional Indemnity Support Schemes

The area of Midwife Professional Indemnity Support Schemes is out of scope for RANZCOG.