ATB2011\SUB PC DISABILITY SUPPORT 29042011
29 April 2011

MIPS

Medical Indemnity
Protection Society Ltd
ABN 64 007 067 281

PO Box 25
Carlton South, Vic, 3053
Email: info@mips.com.au
www.mips.com.au

Membership
Freecall: 1800 061 113
Freefax: 1800 061 116

Medico-Legal
Freecall: 1800 021 223
Freefax: 1800 185 186

Inquiry into Disability Care & Support,
Productivity Commission,
GPO Box 1428,
CANBERRA CITY. ACT. 2601

Attention: Roberta Bausch
Fax: (02) 6240 3377
Email: disability-support@pc.gov.au

SUBMISSION IN RESPONSE TO THE PRODUCTIVITY COMMISSION DRAFT DISABILITY AND SUPPORT REPORT

MIPS welcomes the opportunity to provide further comment particularly in relation to the Productivity Commission's proposed National Injury Insurance Scheme (NIIS).

The Medical Indemnity Protection Society Ltd. (MIPS) is a "not for profit" discretionary mutual and parent company of the MIPS Group that includes a wholly-owned subsidiary **MIPS Insurance Pty. Ltd.,** an APRA regulated general insurer providing medical indemnity insurance to MIPS members.

MIPS' Constitution requires it to promote honourable and discourage irregular practice and to consider, originate, promote and support, or oppose legislative or other measures affecting Members.

MIPS is a membership organisation and has some 20,000 registered health professionals and over 10,000 health student members.

MIPS' principal activity is to provide medical indemnity cover for its members who are mainly medical and dental practitioners. It is a MIPS requirement that members hold appropriate recognised qualifications, training and experience for the health services they provide.

The Draft Productivity Commission Report (Report) outlines the establishment of both a National Disability Insurance Scheme (NDIS) and a National Injury Insurance Scheme (NIIS).

The following key features of the proposed NIIS are extracted from the Report:

- *'....primarily funded from insurance premiums ....'*
- *'structured as a federation of separate, state-based schemes'*
- *'financing of claims would be jurisdictionally based.*
- *'no-fault insurance for catastrophic injury would mean that common law actions for damages associated with lifetime care and support would be extinguished' and 'would include cases where medical error was not necessarily the cause of injury, but where the particular injury resulting from that treatment is not a usual or expected consequence of that treatment.'*

.../2.

The two areas the Commission seeks feedback in relation to Medical Accidents are:

- *...practical interim funding arrangements for funding catastrophic medical accidents covered under the NIIS; and*
- *...an appropriate criterion for determining coverage of medical accidents under the NIIS.*

Summary of MIPS Recommendations

- MIPS restates its earlier recommendation for the Commonwealth to fund medical accidents for reasons of process efficiency, transparency and to allow ongoing alignment of social policy with health resource allocation.
- MIPS notes that re-allocation of funding from the High Cost Claims Scheme (HCCS) to the NIIS is in keeping with the previous point and can be achieved with 12 months' notice.
- Maintaining the Premium Support Scheme is necessary to ensure that medical practitioners are protected from concerns of unacceptable increases in indemnity funding costs that might arise from removal of the HCCS (if not balanced by the transfer to the NIIS of 100% of the lifetime care liabilities).
- MIPS anticipates that additional NIIS funding for medical accidents is likely to be required due to inclusion of no-fault matters. MIPS believes that additional funding could be substantially met through removal of the adversarial/frictional costs of legal process.
- If further NIIS funding for medical accidents is required, broad-based non-insurance premium sources should be utilised to avoid, or at least minimise, the inefficient use of healthcare dollars that occurs when funding occurs via medical indemnity insurance premiums.
- To ensure community equity there should be no difference in qualifying criteria for the NIIS between medical or other accident types.

MIPS Response to the draft Productivity Commission National Injury Scheme Report

Need for process efficiencies not just new sources of funding

In our previous submission MIPS observed that the current legal framework requires an injured patient to allege and prove a health professional negligent in order to fund ongoing care and support in respect of an adverse clinical outcome. This process is inefficient and uncertain for all stakeholders.

As stated, MIPS' view is that a clearer and more cost and time efficient trigger than "negligence" is needed to determine timely access to benefits under any disability long-term care and support scheme.

We also commented that in our view the adversarial approach required to prosecute negligence is also a grossly inefficient use of "healthcare dollars". In MIPS Insurance recent experience approximately 60% of the costs of medical indemnity claims relate to the legal fees of the parties.

Although the quantum of legal costs is usually larger, for catastrophic claims, the percentage of total costs relating to legal costs is lower because of the much larger compensation component (especially lifetime care) of these claims.

.../3.

For MIPS Insurance approximately 1/3 of the cost of the six largest finalised claims to date relates to legal fees of the parties.

In our view the sustainable delivery of high quality healthcare to an ageing population must require:

- closer and more transparent alignment of health funding with social policy; and
- achieving greater efficiencies in all aspects of healthcare funding.

In its previous submission, MIPS proposed that future care and medical costs relating to significant adverse events should be funded 100% by the Commonwealth. We proposed that:

- the resultant savings to the Commonwealth from the various medical indemnity insurance support arrangements, such as the High Cost Claims Scheme and Premium Support Scheme, could then be redirected to fund lifetime care costs;
- the Commonwealth through Medicare (also Department of Veterans Affairs, etc.) is, in effect, funding most of medical practitioners' indemnity costs. We note that due to the highly competitive nature of the medical indemnity sector reduction of indemnity costs would be passed on and would help ease pressure on health cost increases;
- conversely, that any increased costs of indemnity arrangements are likely to be passed on to patients by health professionals and will therefore lead to pressure on Medicare payments, health insurance policyholders and higher direct patient contributions; and
- the Commonwealth through Medicare, Carers' allowances, Pensions, etc. already funds the majority of care and support for non-compensable matters.

In blunt terms, we believe that without addressing process inefficiencies that funding the increased medical accident compensation costs required to be funded under the NIIS arising from the introduction of a no-fault approach is not sustainable, will limit future scheme initiatives and adversely impact health care services.

MIPS is concerned that without addressing current medical accident compensation inefficiencies that the objectives of the NDIS and NIIS will not be achieved. That is, these important initiatives will either not be able to be implemented at all or subject to further delay and/or compromised in their delivery.

The proposals put forward by the Productivity Commission in respect of the care and support for catastrophic medical injury go significantly towards reducing the current "lottery" whereby equally catastrophically injured patients may end up with access to very different levels of resources.

However, the approach proposed by the Commission will not generate the compensation process savings required to meet the additional need generated under a no fault scheme.

That is because the no-fault proposals will "... *include cases where medical error was not necessarily the cause of injury, but where the particular injury resulting from that treatment is not a usual or expected consequence of that treatment*".

The definition of "usual" has not been given, however if "usual" is considered equivalent to normal or habitual and if "expected" is defined from a patient's perspective, then it is likely that the annual number of additional patients entitled to lifetime care and support will be significantly higher than would normally qualify (and be funded for) currently under a fault based system.

.../4.

Under the NIIS proposals process savings will not be sufficient to fund that increased need. That is because the anticipated process cost savings appear to be only the costs associated with plaintiffs and defendants no longer needing to meet the cost of:

- obtaining expert opinions in relation to life expectancy/care requirements; and
- the cost of legal process usually associated with negotiation of those issues.

Other elements of compensation (for example general damages, economic loss, etc.) will require, as it does now, for negligence to be found. The healthcare dollars required to fund the costs of that adversarial process prevent their use to fund the NIIS.

As outlined above, under the proposals as currently framed, the only apparent savings compared with costs otherwise incurred will be the marginal process savings relating to lifetime care.

On that basis we anticipate an average saving of up to ten thousand dollars per catastrophic claim. This appears significantly less than that anticipated in the Draft Report – "... *no-fault lifetime care of catastrophic medical accidents under the NIIS (and the associated removal of the head of damage for future care costs), will remove a proportion of the frictional costs associated with determining the quantum of damages in medical negligence claims. The extent of such saving is not certain, but it is reasonable to assume that the litigation process should be significantly more straightforward ... Even so, moving to a no-fault cover for catastrophic medical accidents is unlikely to come at zero cost, as the savings in legal process and disputes many not be sufficient to fully meet the increase in coverage. This may place some pressure on medical indemnity premiums if arrangements for funding the larger number of claims were drawn solely from such insurance.*"

In summary, retaining elements of the current fault-based components for compensation components other than lifetime care:

- denies the majority of process and cost efficiencies that could be otherwise redirected to help fund the costs of the NIIS (and the additional costs that will arise under a no-fault scheme);
- perpetuates significant elements of an inequitable two-tier approach i.e. those claimants that can access the other (than lifetime care) elements of compensation by showing negligence and those who cannot; and
- seems to sit uneasily with the underlying no-fault theme that forms a philosophical core for the entire Productivity Commission report.

MIPS suggests that it would seem sensible and timely while attending to the legislative changes required to introduce a no-fault legal framework for lifetime care and support to also remove other "frictional costs" and replace them with clearly defined, quantified and codified entitlements for all heads of compensation relating to catastrophic injury.

Such an approach would replace the uncertainty of fault triggered access to compensation and allow the funds (sourced from healthcare dollars), that otherwise would be inefficiently collected via insurance premium and then arguably wasted in adversarial process costs, to be available for funding the NIIS.

Such an initiative seems more in keeping with the underlying theme of community equity and will enable close alignment of social policy initiatives with health funding. It should also be expected to help simplify NIIS funding modelling.

.../5.

Equity

In response to MIPS earlier submission regarding funding of a National Disability Insurance Scheme by the Federal Government the Productivity Commission Draft Report states '*It is not clear how full taxpayer funding, the continued availability of measures to support the affordability of premiums (even if less use is made of them) and reduced premiums for practitioners represents an equitable outcome*'

Elsewhere in this submission we put forward proposals to deal with issues of funding equity and efficiency that now arise in meeting the funding challenge from the additional subsequently proposed National Injury Insurance Scheme (NIIS).

We anticipate that the NIIS proposals will lead to a greatly increased funding need because of the inclusion of the greater number of 'non-negligent' compared with 'negligent' adverse outcomes. Putting to one side the inefficiency associated with collection of funding via insurance premiums discussed elsewhere in this submission it would be inequitable to expect health professionals to fund the large increase in lifetime care costs arising from inclusion of non-negligent adverse outcomes while forced to continue to fund the wasteful adversarial process associated with other than lifetime care compensation for catastrophic medical injuries.

Based on MIPS experience to date if the High Cost Claims Scheme (HCCS) ceases the HCCS funding foregone, (in general terms 50 cents in the dollar for claims over $300,000) will be significantly greater than the lifetime care costs transferred to the NIIS.

In general terms the Premium Support Scheme operates to help to fund that part of any increased premium that exceeds 7.5% of a medical practitioners gross indemnity costs. An increase in total indemnity costs required to be funded by an insurer (as could arise if the redirection of the HCCS to the NIIS was not balanced by the transfer of 100% of the lifetime care costs) might lead to higher overall medical indemnity costs and therefore higher PSS funding contributions.

However it should be noted that indemnity costs and therefore PSS funding will be significantly higher again if a similar amount of NIIS funding was required to be raised via a levy on medical indemnity insurance premiums.

Although a simplistic view of funding cause and effect may be preferred reality is more complex.

The following examines what would happen in the event that the introduction of the NIIS reduced the total amount of premium that insurers needed to collect.

- Medical indemnity insurance is very competitive. In recent years most competition has been price based. Decreased risk to insurers (from liabilities being indemnified elsewhere such as the NIIS) will be passed on in premium pricing to healthcare practitioners by insurers who are all seeking to grow, or at least retain, their market share.
- It should be noted that medical indemnity insurers pay income tax on any profits and most are owned by not for profit mutuals who are not required to pay dividends to shareholders
- All else being equal reduced medical indemnity insurance premiums will lead to savings in tax deductible business expenditure which in turn will lead to higher tax revenue amounts being collected from health professionals (many of whom fall into the highest tax bracket) i.e. general tax revenue will be expected to increase if premium costs are decreased.
- There will be decreased pressure on the costs of medical services compared with otherwise from decreased indemnity costs. The general revenue that would otherwise be used to fund Medicare for those otherwise increased costs could then be properly applied to help fund the NIIS.

.../6.

- Savings to patients from reduced or stabilised healthcare costs (such as co-payments, health insurance fund costs, Medicare safety net etc) will also lead to increased Commonwealth revenue (GST, tax receipts from other product and service providers, safety net savings) compared with otherwise.
- There are also likely to be other savings arising from the reduction of the number of healthcare services necessarily provided by health professionals to fund indemnity costs.

Although there may be timing differences there will be no ongoing advantage or windfall to medical indemnity insurers from no longer having to fund lifetime care costs.

State based schemes

The Commission has proposed that the NIIS be "structured as a federation of separate, state-based schemes".

Workers compensation, motor vehicle compulsory third party and public healthcare insurance may be underwritten by State schemes, such as Workcover, TAC and Victorian Managed Insurance Authority in Victoria, however private healthcare practice medical indemnity insurers are no longer State or Territory based.

Most, if not all, medical indemnity insurers have medical practitioner policyholders in every State and Territory with significant numbers of policyholders practising in more than one State and/or moving from State to State to practise.

It is uncertain how the Commission's jurisdictional funding preference might be fairly, efficiently and effectively translated to the current medical indemnity insurance market structure through medical indemnity insurance providers.

State and Territory funding affordability

Under the NIIS proposal funding is to be State based.

It would therefore seem sensible for States and Territories while implementing the necessary legal framework for lifetime care to take the opportunity to maximise the benefits of such reform through extension to non-lifetime care areas of compensation for medical accidents.

Only in this way will governments be able to ensure that they will be able to fund the scheme proposals without adversely affecting healthcare funding and services and/or significantly increasing revenue from other sources and/or implementing funding cuts in other areas.

Primarily funded by insurance premiums

The Commission has stated that the NIIS will be "... *primarily funded from insurance premiums* ...".

The no-fault approach under the NIIS will, as previously flagged, mean that there will be a significant increase in funding requirements compared with the current fault based system for medical accidents. These additional costs should not be funded through the fault based system.

.../7.

As stated previously MIPS is concerned because funding via insurance premiums is inefficient.

Over time the Insurance Council of Australia has provided compelling argument and submissions in relation to the inefficiency and untoward consequences of collecting revenue via insurance premiums - the most recent in relation to the Victorian Bushfires Royal Commission. We note that the Commission's recommendation (64) is that the Fire Services Levy be abolished and replaced with a property based levy.

Funding via insurance premiums is inefficient because any funding amount obtained through taxes or levies on insurance premium is further inflated by other existing taxes so that the gross amount that has to be charged as premium is significantly greater than the additional net amount sought.

As previously stated, inefficiency must be avoided where healthcare monies are involved to ensure that scheme funding is maximised and adverse impacts on health care funding and access to health care are minimised.

Similar to the decision by the Victorian Bushfires Royal Commission in relation to the Fire Services Levy it would seem preferable to implement broad-based community methods of funding of the additional costs of the NIIS.

Such an approach is especially appropriate when the majority of lifetime care costs for medical injury under the NIIS will relate to non-negligent injuries.

Medical claims differ from non-medical events that might be included in the NIIS because it is very common for a number of parties to be involved in any adverse medical outcome. The parties involved in medical accidents can include organisations of various sizes both State and private, employees of those organisations, contractors, private healthcare practitioners, etc.

Although some types of health care practitioners may be more frequently involved than others, any health professional can potentially be involved in catastrophic medical injuries. Catastrophic medical injuries can be caused by acts and/or omissions – they do not always relate to an intervention or procedure. Adverse outcomes commonly relate to delays in acting.

Due to the changing involvement of health care practitioners (for example collaborative care arrangements) there will be increasing likelihood of involvement of different and multiple health practitioners and organisations in medical accidents.

Some of the insurers of healthcare organisations and healthcare professionals are more identifiable than others, for example health practitioners insured by specialist monoline medical indemnity insurers compared with insurers of corporate bodies that also cover the health professionals those corporate bodies employ.

It would be inequitable to look to narrower sources for funding of the NIIS purely on the basis that those sources were more easily identified. Fair, appropriate, broader based, funding alternatives more in keeping with the move to a "no-fault" scheme should be implemented.

We are also concerned that a narrow, more limited funding approach, for example, directed at medical indemnity insurers, might create unintended financial incentives for health professionals to restructure their current insurance arrangements. That in turn would further limit the available NIIS funding pool going forward and/or create inequitable additional funding burdens for the reduced but identifiable funding group.

It is also important to ensure that NIIS funding mechanisms do not lead to an aversion to either the provision of necessary but higher risk procedures and treatments or routine treatments involving higher risk patients. That is more likely to occur in the absence of a broad based funding approach.

.../8.

As stated elsewhere all else being equal, the inclusion of patients in the NIIS under the no-fault approach who currently are not entitled to compensation means that additional funding must be found.

To ensure that maximum NIIS benefits can be provided (without adversely affecting access to health care) funding must be collected in a fair, equitable, efficient and sustainable manner.

The Productivity Commission will be aware that health professionals' income derives from "health dollars" – money that enters the health system in a number of ways. We have previously referred to those sources that include:

- Medicare payments (partially funded by the Medicare levy);
- Other Federal Government schemes (special funds such as Veterans, Pharmaceutical Benefits Schemes, etc.);
- State Government revenue;
- Private health funds and other insurers (workers, motor, life, etc.);
- Employers;
- Patient co-payments.

In its earlier submission MIPS also listed those federal initiatives such as the High Cost Claims Scheme, Exceptional Claims Scheme and Premium Support Scheme that decrease medical indemnity costs. But for those initiatives, patients would have to pay more for health services so that health practitioners could in turn meet their higher medical indemnity costs.

It is important to note that it is the sickest (especially those with chronic health problems), the disabled, oldest and those with young children who are more likely to bear the lion's share of additional health costs or any failure to maximise healthcare or compensation efficiency.

Any loss of efficiency or increased overall operating costs in delivering healthcare will add to the financial burden of patients and disproportionately affect those in society previously listed, who arguably may be least able to meet such increases. That in turn will put further pressure on public health resources as the community tries to minimise it's "out of pockets".

Quite simply, although the Productivity Commission's current proposals will assist more of those who are catastrophically injured (by removing the requirement for fault), they must necessarily lead to increased medical costs (particularly affecting those who arguably are least able to afford them and have least discretion to avoid them), unless alternative sources of funding and process savings are found.

High Cost Claims Scheme and the NIIS

The High Cost Claims Scheme (HCCS) is a Federal Government scheme that currently reimburses insurers 50% of the amount of a health care practitioner's medical indemnity claim paid that exceeds $300,000. The HCCS initiative was introduced to help insurers with their reinsurance costs and therefore improve the affordability of healthcare practitioner medical indemnity premiums while the industry stabilised.

The explanatory note to 2004 legislation amendments included:

"The intention of the High Cost Claims Scheme is to reduce the need for medical indemnity insurers to purchase reinsurance cover for claims over a threshold ($2 million or whatever is specified in regulations) by providing for the Government to meet a proportion (50% or whatever is specified in Regulations) of payments in respect of these claims. Regulations have been made reducing the threshold to $300,000 from 1 January 2004."

.../9.

Under the legislation any change in Regulations for high cost claims threshold or reduction of high cost claims percentage requires 12 months' notice.

As the High Cost Claims Scheme (HCCS) funding is direct from Government it does not attract the additional taxes that funding via insurance premium does, and is therefore an efficient means of funding initiatives.

MIPS understands that over recent years medical indemnity reinsurance has been readily available to all insurers. The transfer of the lifetime care elements of catastrophic claims to the NIIS should further enhance availability of reinsurance and at the same time significantly moderate the volatility of claims and reinsurance costs as the more significant future care cost elements associated with the infrequent but high value catastrophic claims would fall to the NIIS.

Going forward MIPS suggests HCCS funding should be used to more efficiently and directly fund catastrophic claims via the NIIS rather than through the less efficient conduit of medical indemnity insurers. Such a redeployment of HCCS funding can be achieved in the timeframe proposed under the NIIS.

The removal of the HCCS will not cause an increase in total indemnity costs (that include reinsurance costs) if the savings from moving the lifetime care costs from insurers to NIIS are equal to or exceed the HCCS recoveries forgone.

Continuation of the Premium Support Scheme would however be of assistance in providing comfort in relation to such a change and helping to ensure that medical practitioners would be protected if costs were increased.

The Federal Government introduced the Premium Support Scheme (PSS) to assist medical practitioners with their individual gross indemnity costs. The assistance provided under the PSS may vary between groups of practitioners according to their specific PSS entitlement structure, however in general terms, meets 80 cents in the dollar for gross indemnity costs that exceed 7.5% of their gross income from private billings.

Financial Stability of the Medical Indemnity Insurance Industry

The financial statements and 30 June 2010 annual reports of medical indemnity insurers show that the industry is in a healthy position and reflect the considerable efforts of stakeholders including significant government support over time.

To address any concerns in relation to redeploying HCCS funding the Premium Support Scheme should remain in place. The PSS will moderate any potential adverse impact in indemnity costs for medical practitioners (noting that medical practitioner indemnity costs are on average much higher than other health professionals).

It may, however, be necessary to monitor the costs of indemnity for medical practitioners and other healthcare practitioners to ensure that the premium support scheme is closely aligned with social policy, especially healthcare delivery.

Lifetime care costs are by far the greatest contributor to catastrophic claim costs so transfer of those lifetime care costs to the NIIS will result in a much lower average catastrophic claims cost than otherwise.

Although HCCS savings could be generated by raising the HCCS threshold, we are concerned that such an approach would create untoward effects.

MIPS' concern is that although raising the HCCS threshold would reduce the HCCS payments (and those HCCS savings could then be redirected to the NIIS), there would be some unintended distortions. Because the reduction in HCCS recoveries generated from such an approach would relate in the main to non-catastrophic claims, those HCCS savings would be significantly misaligned with the savings created by the transfer of lifetime care liabilities to the NIIS that arise from catastrophic claims.

.../10.

Some groups of healthcare professionals such as General Medical Practitioners have lower average claims sizes and are less likely to generate catastrophic claims. Those groups will, on the current HCCS threshold, obtain some premium pricing benefit from the HCCS. An increase in the HCCS threshold would be expected to adversely affect the premiums paid by such groups. They would be paying more to fund the loss of HCCS recoveries, while groups more likely to generate catastrophic claims could be paying significantly less. That is because 100% of the lifetime care costs for higher risk group claims will have been transferred to the NIIS in exchange for losing the current 50% HCCS recovery for the amount of those costs relating to the difference between the old and new HCCS thresholds.

In summary, although health professional groups with higher average claims would also lose access to some HCCS recoveries if the HCCS threshold was raised, they would be expected to benefit significantly from the lifetime care costs of claims being transferred to the NIIS. In contrast, those types of health professionals less likely to generate catastrophic claims are likely to be comparatively worse off (than those who are more likely to generate such claims). Such an approach would be illogical and inequitable and likely to be considered as such by the groups adversely affected.

Other potential NIIS funding sources for medical accidents

As previously noted, funding is best achieved if broad based and efficient.

Because of the need for sustainable efficient sources of NIIS funding that do not adversely affect health care costs or health service access, and with an eye to possible expansion of the NIIS scheme in future years, it is important to consider practical new sources of funding.

As the Commission has proposed State based NIIS funding it is important that alternative broad state-based taxes should be considered, such as payroll tax.

Federal funding mechanisms such as increasing the Medicare levy or GST should also be considered.

An ancillary funding source might be to increase healthcare facility licensing fees while an additional approach for funding medical accident NIIS claims may be through funding as a part of healthcare regulation.

Funding as a part of healthcare regulation

The Australian Health Professionals Regulation Authority (AHPRA) supports the 10 national health boards that are responsible for regulating 10 groups of the health professions. The primary role of the Boards is to protect the public and to do that, they set standards and requirements that registered health practitioners must meet.

AHPRA has offices in each State and Territory and at the time of writing AHPRA stated that "more than 525,000 health practitioners have transferred to the National Registers".

Noting the:

- role of AHPRA in protecting the public (including requiring health practitioners to hold appropriate professional indemnity to meet patients' claims);
- increased involvement of multi-disciplinary teams/collaborative care in patient treatment;
- proposed extension of lifetime care under the NIIS to those who suffer medical injury where there has been no negligence (and therefore no health practitioner is to blame), where injury is not usual or expected;

.../11.

- the centralised mechanism for invoicing and payment collection by AHPRA;
- the recognised inefficiencies, reduced transparency and narrow collection base of collecting additional funding via medical indemnity insurance premiums; and
- additional health practitioner groups that will be brought into the regulatory framework

it seems reasonable to consider the NIIS funding for medical accidents that might be collected via a relatively modest annual levy on health professionals collected via AHPRA.

For example although funding might vary per registrant - using current registrant numbers, an average levy of $100 per registrant would generate approximately $52m. By contrast, collection of a similar net funding amount via medical practitioners' insurance premiums would require collecting approximately $62m (due to the effect of 5% ROCS levy, 10% GST and using an average stamp duty of 7.5%). That would mean an extra $1,000 per annum on average to be paid by medical practitioners to achieve the same net funding result.

Protection of the public not reliant on insurance

In MIPS' previous submission we stated:

"The Productivity Commission will be aware that issues arising from health events may be addressed in a number of ways in several fora and include potential registration sanctions (up to and including loss of legal entitlement to practice), in addition to claims for compensation."

The most powerful modifiers of risk behaviour in health professionals are not insurance related. That is because for most health professionals there is little or no financial impact arising from a professional indemnity claim, as the costs are usually met in full by their insurer.

In addition an increase in insurance costs arising from adverse claims experience may be substantially moderated via initiatives implemented to assist medical practitioners with their indemnity costs, including the Premium Support Scheme and mechanisms to limit the multiple of premium (compared with average for a craft group) and front-end deductible/excess that might be imposed.

In contrast, although process costs might be met by an insurer, matters before the Australian Health Practitioner Regulation Authority (AHPRA) Boards can greatly modify a healthcare practitioner's professional behaviour. That is because AHPRA can significantly limit a health practitioner's ability to practice in many ways up to and including deregistration in response to professional practice concerns.

The financial and reputational impacts from AHPRA determinations are therefore far greater, and there is greater opportunity for more timely action by AHPRA to reduce risk to patients.

This in turn means a more proactive response to clinical risk minimisation by individual practitioners. State health complaint organisations also assist the oversight framework to deal with concerns relating to the provision of healthcare that in the main do not relate to negligence.

Coverage of medical accidents

On the basis of equity and to prevent potential issues arising from jurisdictional arbitrage that could arise if there were differences between work/motor/medical NIIS claims (as all claimants are likely to receive medical treatment proximate upon their injury), it is recommended that the same definition of catastrophic injury apply across all NIIS claims.

.../12.

Relying on the terms "usual" and "expected" for determining entry into the NIIS, unless clearly defined, will create significant uncertainty and associated process inefficiencies as the issue is debated. We believe it would be much clearer and fairer for all stakeholders to avoid the use of such terms and rely on an objective measure of loss of function.

In that way patients who did not meet that objective measure of loss of function prior to treatment, but did so after receiving treatment, would qualify under a no-fault medical accident scheme.

I am happy to discuss further any of the points raised in this correspondence.

Regards,

DR. TROY BROWNING
MB BS, MBA, Grad. Dip. Ins., ANZIIF (Fellow) CIP, AFAIM, GAICD
Managing Director - MIPS
Chief Executive Officer – MIPS Insurance