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ATB2010\MIPS\SUB TO PROD COMM 10908-2
16 August, 2010.

Disability Care and Support Inquiry,
Productivity Commission,
GPO Box 1428,
CANBERRA. ACT. 2601

Re: DISABILITY LONG TERM CARE & SUPPORT SCHEME

The Medical Indemnity Protection Society Ltd. (MIPS) welcomes the opportunity to contribute to the Disability Care and Support Scheme discussion.

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 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.

MIPS is a membership organisation, however its objectives are perfectly aligned with minimising risk to the public and therefore distress to our members. MIPS is extensively involved in clinical risk management for that reason.

In blunt economic terms less harm to the public means lower indemnity and other treatment costs which in turn means less pressure on patient fees and/or less diversion of heath funding from health and treatment initiatives.

In accordance with MIPS' philosophy as a not for profit, membership organisation MIPS believes that equity is an important and fundamental right of the community.

MIPS therefore supports initiatives to help ensure that those who do not have a compensable cause for their disability are not materially disadvantaged.

MIPS also supports funding of such initiatives through fair, efficient, transparent, prudent and sustainable broad-based mechanisms.

MIPS, in its submission, comments mainly on broad funding principles with reference to the current funding of catastrophic/long-term care claims relating to private medical practice.

We believe there is considerable scope for greater efficiency in that funding process to the greater benefit of the community.

MIPS notes that only a few years ago there was a significant indemnity crisis profoundly affecting the community that led to major tort reform.

That tort reform also triggered a claims spike which placed further stress on stakeholders. MIPS is therefore keen to see that any initiatives are considered carefully to ensure that they do not inadvertently cause or help cause another indemnity crisis.

The major impediment at this time to discussion, (other than at a very high and broad level), of issues relating to a potential Disability Long-term Care & Support Scheme is that the scale, and therefore the potential funding requirements of such a scheme, are currently unclear.

Defining who will be able to access the scheme and the benefits available under the scheme will of course define the resources required.

Setting any threshold for access to scheme benefits will be a very difficult task. If a threshold/minimum requirement is set it will be the subject of gaming. Assessment of access to any scheme therefore needs to be objective, impartial and transparent to ensure fairness and equity.

Such access should also be seen to be fair and the philosophy behind it easily understood by stakeholders. Ideally access to benefits should occur immediately upon the event to ensure the best possible outcome, that is while there is the greatest opportunity to both mitigate the ultimate level of disablement and minimise distress.

The mechanisms required to ensure timeliness of decisions regarding scheme eligibility will provide a particular challenge.

The use of comprehensive, tried and tested, standard diagnostic classifications that are already in widespread use such as the International Classification of Diseases (ICD-10) and Gross Motor Function Classification Scheme should facilitate that process.

In many ways setting a high threshold to entry to a scheme so that only those who are the most severely disabled and presumably most in need may be easier to implement in the first instance. The lessons learned from that group may also help in implementing any subsequent wider roll-out while ensuring that funding requirements and mechanisms for obtaining funding are well understood.

In general terms the current "trigger" for access to care and support funding in relation to health care incidents is a finding of fault (negligence) that has caused the injury.

That trigger generally requires an arguably inefficient and time consuming process that dissipates resources which in our view could be better applied to outcomes rather than process.

As well as the quantifiable financial costs and the potentially quantifiable opportunity costs (time spent by patients and practitioners in relation to the matter that could otherwise be spent helping to improve productivity), there are very significant emotional costs associated with an adversarial process.

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

In this submission MIPS will confine itself to very broad and high level comments in relation to its primary area of expertise being medical indemnity for medical and dental practitioners.

The Commission will be aware that adverse health care events can occasionally result in permanent patient disability. In our experience such events cause significant distress to all involved.

Although all health care professionals can potentially be causally involved in events that result in permanent patient disablement through act or omission (including through delay in diagnosis and/or definitive treatment), medical practitioners, and in particular some clinical sub-groups such as Obstetricians, are particularly exposed to relatively infrequent but potentially devastating adverse clinical events.

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.

At its broadest, such claims for compensation are primarily concerned with quantification of the loss arising from negligence that led to the adverse outcome and such considerations, usually in an adversarial setting, do not easily lend themselves to a comprehensive and holistic approach to reparation.

Health care practitioners in private practice must fund the costs of representation in the various fora as well as the cost of compensation (or cost of indemnification against that cost), through income from the health services they provide.

It is to be expected that all else being equal a higher percentage of that "funding" burden will consequentially be borne by those who are more frequent users of health services being the sickest, youngest and oldest.

Through Medicare, the Commonwealth is a major contributor to that funding. Other major contributors to private health funding are Private Health insurers and patients themselves.

For events related to care in public hospitals and public organisations it is the State that must fund those costs through various revenue streams.

The common theme is that as such funds for the various fora, required assessment process and compensation come from the available pool of private practice funding, there is a direct relationship between ensuring affordable access to health services and payment of compensation/support.

Any increased compensation or support funding demands in the absence of efficiency reforms, will have an adverse effect on patients' ability to access health services unless the total available health care funding pool is also increased.

The challenge, therefore, is to improve the efficiency and effectiveness of current sources of funding of care and support so as not to adversely impact on the costs of providing health care. In that way we help avoid the flow-on effect of reducing patients' ability to access health services because of increased cost.

Most health care practitioners are required to hold appropriate medical indemnity insurance cover in order to be registered to lawfully practice. Through this mechanism the financial risk to a private practice health practitioner of not being able to meet compensation claims is mitigated, however the source of funding to purchase such cover is no different to funding of compensation claims not covered by insurance.

Several years ago the Commonwealth introduced initiatives that help the affordability of medical indemnity insurance. In general terms the schemes are:

- The *High Cost Claims Scheme* - a programme where the Commonwealth pays 50% of the amount of a claim against a health practitioner that exceeds a threshold amount – currently $300,000;
- The *Exceptional Claims Scheme* – a programme where the Commonwealth pays 100% of claims against a practitioner exceeding $20 million;
- The *Premium Support Scheme* – where the Commonwealth contributes 80% of the amount that the gross indemnity cost to a medical practitioner exceeds 7.5% of their income;
- The *Run-Off Cover Scheme (ROCS)* – funded by a levy on medical indemnity insurer's premium to provide run-off cover for eligible medical practitioners who cease practice, at no cost to those practitioners.

The High Cost Claim Scheme applies in the first instance to claims under the Run-off cover scheme.

For most significant adverse events the major component of compensation cost relates to "future care costs". Those costs include the ongoing costs associated with assistance with daily living and additional treatment, support and other interventions.

There is considerable uncertainty in relation to calculation of such costs dependent as the calculations are on parameters that include life expectancy and future needs. For those reasons there is often a significant delay between the adverse event and compensation being paid (if negligence is accepted or proved). Such delays are not in the interests of the injured individual and usually increase the transaction costs associated with legal advisers, expert opinions and legal process.

Schemes that reimburse costs of care as they are incurred, rather than a lump sum, are more likely to focus on social, personal and domestic activities of daily living issues.

Such costs can be assessed and then extrapolated over the expected term of the claim.

In respect of long-term care and support provision a significant issue that must be managed is that of any change in objective needs versus subjective wants. That potential dissonance between needs and wants can be compounded by perceptions of lack of equity, particularly if there is a view, perhaps introduced and encouraged by well meaning individuals or groups, that an individual is receiving less favourable treatment than another.

Management of such expectations to try to align expectations with needs is often difficult and time consuming.

Under its current initiatives, as outlined above, significant funding of future care costs for events arising from private medical practice is already being undertaken by the Commonwealth, particularly through the High Cost Claims Scheme.

In effect through the action of the Premium Support Scheme the Commonwealth also helps to fund the costs not met by the High Cost Claims Scheme that must be passed on in medical indemnity premiums.

The Premium Support Scheme also offers additional indemnity cost protections for those involved in higher risk clinical practice.

If Medicare payments to health practitioners (that contribute to a practitioner's total income out of which practitioners are required to pay their medical indemnity insurance premium) are also considered, it can be seen that ultimately the Commonwealth currently underwrites the majority of funding required for the current, arguably inefficient, process for providing future care costs and support to qualifying patients.

We believe funding of compensation in relation to health care events is less efficient than it could be because of:

- the usual adversarial nature of the process for determining fair compensation resulting in the majority of funds being expended in process and other parties not compensation of the patient; and
- the means of funding of those costs.

It is our view that there is considerable scope within existing funding for appropriate long-term care costs of patients who become significantly disabled if more efficient processes for determining access to resources and funding of those resources are implemented.

Such initiatives would mean access to a bigger net funding pool, even in the absence of an increase in health care funding over current funding.

It is noted that in relation to the majority of States and Territories there has been agreement in principle to work towards the Commonwealth assuming responsibility for public hospitals.

In our view it is therefore even more pressing that a fair, equitable and universal means of providing long-term care and support for the significantly disabled be introduced.

Recommendations

- Early provision of information in relation to the scope, scale and nature of the potential disability long-term care and support scheme to allow stakeholders time to consider the proposals and provide comment, and work with, the Productivity Commission
- Entry to any disability long-term care and support scheme needs to have clear and timely triggers and not reliant on a presumption/finding of negligence
- Entitlement to and types of benefits provided under any long-term care and support scheme need to be clearly articulated
- Future care and medical costs relating to significant adverse medical events should be funded 100% by the Commonwealth noting:
    - There can be significant savings from the current High Cost Claims Scheme from process savings and from reduced (from otherwise) premium support scheme payments (because of the reduction in premium required due to reduced risk required to be funded).
    - The Commonwealth through its Medicare payments is contributing to health care practitioners' funding of their indemnity arrangements.
    - In the absence of direct Commonwealth funding any increased costs of indemnity arrangements are likely to be passed on by health professionals and will therefore lead to pressure on Medicare payments, health insurance and increased direct patient contributions.
    - The Commonwealth is intending to take over responsibility for public hospitals.
    - Such a funding approach will be more efficient and transparent than the current process.
    - The Commonwealth through Medicare, Carers' Allowances, Pensions, etc. already underwrites the majority of care and support for non-compensable matters.
- Introduction of a compensation scheme for funding care and support costs for patients injured by medical misadventure that does not require a presumption/finding of negligence, noting:
    - A number of fora are available to consider issues arising from the provision of health care including the potential for serious sanctions being imposed on health care practitioners, such as public exposure, censure and loss of ability to practice via health registration boards processes;

- the availability of such fora means that there is negligible moral hazard in introducing a compensation scheme for funding care and support costs for patients injured by medical misadventure that does not require a presumption/finding of negligence.

- Any initiatives should not undo the hard work of tort reform by inadvertently helping to create a new indemnity crisis.

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

Yours sincerely,

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MIPS - The Medical Indemnity Protection Society Limited
is a Doctors for Doctors, "not for profit" organisation that provides membership benefits to over 30,000 members.