Thank you for the opportunity to provide a submission. Established in 1925, MDA National is one of Australia's leading providers of medical defence and medico-legal advocacy services. With over 22,000 Members it works in close partnership with the medical profession on a wide range of issues that impact on medical practice. In addition to its advocacy and advisory services, MDA National's insurance subsidiary (MDA National Insurance) offers insurance policies to MDA National's members that provide cover for the cost of investigations of professional misconduct and claims for compensation by third parties. The MDA National insurance policy provides doctors with $20 million of civil liabilities cover as well as a range of other professional risks covers.

Patients who are injured as a result of medical negligence form a very small subset of the estimated 600,000 people with severe or profound disabilities. However, there are a number of issues in the provision of medical indemnity insurance that are unique. We believe it is important that the Productivity Commission has a good understanding of these issues so that the implementation of a National Disability Long Term Care and Support Scheme (NDC&SS) does not have unintended adverse outcomes for medical indemnity insurers, doctors and their patients.

In particular, MDA National is concerned that the introduction of a NDC&SS should not result in an increase in medical indemnity insurance premiums for doctors. Depending on the interaction of the NDC&SS with medical indemnity insurance, there is a risk that the NDC&SS will increase medical indemnity insurance premiums for our doctor members. The cost of premiums will need to be passed on to patients and the community. Following the introduction of tort reform in 2002/2003, the medical indemnity insurance industry has stabilised and the premiums for our doctor members have become more affordable. This has encouraged the provision of medical services, and minimised the withdrawal of services in certain areas of clinical practice, to the benefit of patients and the community.

Existing Government Support Schemes

There are a number of existing Government support schemes for medical indemnity insurance which were introduced to support the provision of affordable insurance cover for doctors. The Government support schemes are –

- The Exceptional Claims Scheme (ECS) which provides cover for any claim or claims in the aggregate in excess of $20 million;
- The High Cost Claims Scheme (HCCS) providing cover for 50% of the cost of claims over $300,000;
- The Run-off Cover Scheme (ROCS) which covers the cost of claims arising from retired doctors;
- The Premium Support Scheme (PSS) which rebates 80% of the cost of medical indemnity insurance to doctors once the cost exceeds 7.5% of gross private medical income.

The first three schemes have a direct impact on medical indemnity insurers. The ECS and HCCS reduce the cost of large claims and have a significant impact on reinsurance needs. The introduction of these schemes resulted in a significant reduction in medical indemnity premiums for doctors particularly those (such as obstetricians) with an exposure to very large claims. Overall MDA National estimates that these schemes result in around a 10% to 15% reduction in medical indemnity premiums for our members.

ROCS provides certainty of cover for claims after a doctor retires which is important since medical indemnity is provided on a claims made basis and claims (particularly obstetric matters) can be notified many years after the incident giving rise to the claim has occurred. ROCS is funded through a levy on medical indemnity premiums (currently 5%).

The PSS is a direct subsidy of medical indemnity costs to doctors to maintain affordability of premiums. Given the current level of medical indemnity premiums, the PSS is most likely to apply to obstetricians and some part-time doctors where billings are relatively low compared with the medical indemnity premium.

MDA National is concerned that a blanket removal of these existing schemes following the implementation of the NDC&SS may increase the cost of medical indemnity insurance for doctors. Our preliminary analysis suggests, for example, that the direct financial benefit of the NDC&SS in terms of reduction in medical indemnity claims costs is likely to be less than the financial benefit currently provided by the HCCS.

Furthermore, since the HCCS applies on a claim made basis, while it is suggested that the NDC&SS would be implemented on an incidence basis, then replacement of HCCS with the NDC&SS would result in some claims not being covered by either scheme for a period of time.

MDA National therefore submits that the decision to remove or modify any of the existing Government support schemes should only occur once the impact of the NDC&SS is actually understood. We submit that in the transition phase the existing schemes should be maintained and should apply after the NDC&SS. In particular, we submit that the HCCS should be maintained although it may be possible to increase the threshold at which the HCCS applies from $300,000.

Boundary Issues

It is critical that there is certainty regarding who is covered by the NDC&SS and what they are covered for. Without this certainty it will be difficult for medical indemnity insurers to establish insurance prices and it is unlikely that the full benefit of the NDC&SS (for example, in terms of reductions in reinsurance costs) will be realised in the short term.

Decisions on inclusion in the NDC&SS should be clear and irrevocable. Specific boundaries will need to exist with respect to injured infants where the extent of the injury and ongoing care requirements may not be apparent for a number of years. In some cases it may be some time before a proper determination can be made regarding eligibility for the NDC&SS and this will result in a potential lengthy period of uncertainty about what is covered by insurance.

For eligible persons, all costs associated with care must be “carved out” of the insurance system and there must be no ability for a claimant to “top up” care benefits with an additional insurance lump sum relating to care.

MDA National is concerned that the care benefits available under the NDC&SS will not be considered to be on a "full restitution" basis which is the standard for a common law lump sum. This provides an incentive for those people covered by insurance to look to increase care benefits through tort-based compensation. The possibility of leakage of care benefits back to the insurance system is another reason why MDA National believes that it is important that the existing Government support schemes are not wound back immediately.

Funding

We understand that the Productivity Commission is considering a range of options for funding the NDC&SS. MDA National submits that the NDC&SS should be funded by a broad based tax or levy (such as through an addition to the Medicare levy).

MDA National submits that it would be inappropriate and impractical to fund the NDC&SS through a levy on insurance premiums, particularly medical indemnity insurance premiums.

From a practical perspective, for example, how would the NDC&SS distinguish between –

- Compensable and non-compensable cases;
- Private versus public matters;
- Doctor versus hospital matters;
- For private doctor matters between different specialty groups or jurisdictions.

Inevitably the levy on medical indemnity insurance premiums would be approximate in nature and likely to lead to doctors having to fund the cost of care for cases which they did not contribute to causing. Even if at an overall level a levy on medical indemnity premiums did not increase insurance costs then it is highly likely that it will do so at a specialty group level with premiums for some groups increasing while premiums for other groups decrease. This is likely to have medical workforce implications and may result in the withdrawal of medical services in certain areas of practice, such as obstetrics.

MDA National therefore submits that funding the NDC&SS through a levy on medical indemnity premiums would be inequitable and may well result in higher insurance premiums for doctors, which would then need to be passed on to patients.

No-Fault Extension

MDA National does not support a no-fault medical injury insurance scheme. We do not believe that it is feasible to extend to a no-fault system without a significant increase in claims costs and therefore premiums payable by our doctor members. Furthermore, the introduction of a no-fault insurance scheme funded through premiums would be inequitable since doctors would be paying to cover benefits for people who are injured, but not as a result of negligence or fault.

Unlike some other forms of insurance (especially CTP where there are established no-fault schemes) the cost of extending cover to a no-fault basis is large relative to the pool of premium payers. Across Australia we estimate that there are around 35,000 doctors paying for full indemnity cover. This number is much lower than the total medical indemnity policyholders since many of these are students, interns, trainees and employer-indemnified doctors who pay a modest or sometimes nil premium for advisory and other services. Extending the current cover to a no-fault basis would place a significant financial burden on the small pool of premium payers.

We understand there is a view that reductions in legal costs from the introduction of NDC&SS will support the extension of benefits on a no-fault basis. MDA National does not support this view. MDA National estimates that there are 5 to 10 catastrophic medical indemnity insurance claims every year from the private doctor market which are likely to be eligible for the NDC&SS. These claims have defendant legal costs of up to $500,000 each with plaintiff legal costs of a similar amount, giving total legal costs of $2.5 million to $5 million per annum. Medical indemnity claimants will still have an entitlement to a significant lump sum for general damages and economic loss under the insurance system and there will be legal costs involved in –

- establishing causation and negligence;
- determining quantum.

While the NDC&SS will mean that issues of quantum may be simplified, the causation and negligence issues will remain as complex as currently. As a medical defence organisation, MDA National is committed to defend the reputation of its members and will continue to operate in this manner where a claim against a member is defensible. Therefore, while we agree that there may be some reduction in legal costs as a result of introduction of the NDC&SS, our data does not support a view that these savings will be sufficiently material to fund an extension of cover to no-fault cases.

Furthermore, it should be noted that in New Zealand (where a no fault insurance system has operated for a number of years) for injuries and accidents involving health care professionals, the concept of fault was reintroduced in 1992. These provisions were intended to address the public perception that the loss of the right to sue had left a gap in medical accountability. Removal of a patient's right to sue, denies the injured patient the right to bring a legal action which may be seen as condoning a wrong. Thus, medical negligence claims are seen as an important part of medical accountability to the community.

Transition and Implementation

The NDC&SS envisages a start-up to include new incidents only. As highlighted earlier because medical indemnity insurance is provided and priced on a claims reported basis, the insurance cover will continue to pick up care costs for catastrophically injured people for some time after the introduction of the NDC&SS. Therefore the immediate reductions in medical indemnity premiums following introduction of the NDC&SS will not be as large as may be anticipated.

Integration with Existing Insurance Systems

MDA National understands that the implementation of a NDC&SS to cover the care needs of profoundly and severely disabled people is a significant endeavour. Of the 600,000 people identified as being profoundly or severely disabled only a handful (less than 10,000) are currently covered by insurance. Medical indemnity insurance probably represents less than 10% of those covered by insurance with almost all of these cases being infants suffering a severe brain or physical injury at birth.

We understand that quite rightly much of the focus of the Productivity Commission is how to provide and fund care for those people who currently have inadequate resources and funding to meet their needs. Integrating existing insurance systems with the NDC&SS adds a significant further layer of complexity possibly for little marginal gain given that those people covered by insurance already receive resources to meet their future care needs on a "full restitution basis" and these benefits are funded in advance through insurance premiums. We believe that the integration issues are even

more complex for medical indemnity insurance compared to some other forms of insurance (such as CTP) for the reasons given previously.

In this context MDA National submits that rather than attempting to ***integrate*** medical indemnity insurance with the NDC&SS, that medical indemnity insurance should continue to operate as it currently does ***in parallel with*** the NDC&SS. Under this approach –

- all people severely and profoundly injured as a result of a medical procedure would be entitled to NDC&SS care benefits immediately and for life;
- people would retain the ability to pursue a common law claim for care where negligence exists;
- if successful, the NDC&SS would be reimbursed for care provided to the date of settlement.

Such a system would be similar to the way in which many workers' compensation schemes operate where all injured workers are entitled to statutory benefits regardless of fault and, in addition, can pursue a common law claim where negligence exists.

The benefits of this proposed approach are that it –

- retains the existing funding source for care for people who are currently covered by medical indemnity insurance;
- retains the current basis of "full restitution" for care entitlements;
- is relatively straightforward to implement.

Because the NDC&SS will be running in parallel with the insurance scheme then insurance claimants will have the benefit of early intervention and provision of care through the NDC&SS. Therefore this proposed approach maintains the benefits of early rehabilitation envisaged under the NDC&SS.

The main objections to this proposal will probably be –

- it does not achieve the legal costs savings envisaged;
- it results in different levels of compensation for care depending on the circumstances of the disability;
- lump sum compensation for care is seen as undesirable.

Dealing with each of these potential objections separately: As noted previously, in MDA National's view, the level of legal costs savings for medical indemnity from the introduction of the NDC&SS are not particularly material. Moreover, the benefits of early intervention and universal provision of care will be the same under a parallel or integrated insurance system.

While MDA National appreciates the philosophy of care levels being based on needs rather than the circumstances of disability, it is a fact that under the tort system the level of care being compensated for those currently covered by insurance is intended to be on a "full restitution" basis. This may well be a higher standard of care than what can be afforded under the NDC&SS. MDA National supports a full restitution basis where negligence has caused a person's disability.

MDA National understands the concern about lump sums as an appropriate form of compensation for care over the lifetime of a severely disabled person. However we suggest that this concern could be dealt with in other less complex ways than integration of the insurance system with the NDC&SS. One possibility would be by appointment of a trustee to oversee the management of funds, ensuring appropriate payments for care costs over the lifetime of the injured person. Alternatively, in the short term at least, the Productivity Commission may decide that the downside of lump sum

compensation for care is a less pressing issue than the provision of an adequate standard of care for people with severe disabilities who are not covered by insurance.

The retention of the current medical indemnity insurance arrangements will mean that those who are responsible for medical injury will continue to be financially responsible. This provides a continued incentive for the implementation of quality and risk management strategies to minimise the possibility of adverse events which result in harm to patients.

MDA National submits that the current medical indemnity insurance arrangements for medical injuries are appropriate when operating in parallel with the NDC&SS.

Conclusion

In conclusion, MDA National reiterates the following key points –

- the existing Government support schemes should be maintained especially during the NDC&SS transition, otherwise medical indemnity insurance premiums will increase;
- clear and irrevocable eligibility for NDC&SS and complete carve out of care benefits from the insurance system is required to enable insurers to incorporate any benefit from the NDC&SS into premiums;
- the NDC&SS should not be funded through a levy on medical indemnity insurance premiums as this is likely to be inequitable and will result in premium increases for at least some doctors, which is likely to result in the withdrawal of services in certain areas of medical practice, such as obstetrics;
- extending medical indemnity insurance to a no-fault basis would lead to significant premium increases for doctors. MDA National estimates only modest legal costs savings from the introduction of NDC&SS to offset a no-fault extension;
- allowing the current insurance system to operate in parallel with the NDC&SS rather than attempting to integrate the two systems would resolve a number of complex implementation issues and enable the Productivity Commission to focus on the funding and provision of care for those people who currently have no insurance cover and inadequate resources to cover their care needs.