AUSTRALIAN HEALTH CARE SUMMIT 2003

MEDICAL INDEMNITY

Kingsley Faulkner

Immediate Past President RACS

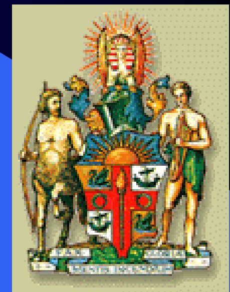
Medical indemnity

Urgency:

I Immediate – insolvency crisis

II Medium term – unfunded IBNR

III Long term - options



Medical indemnity

Immediate – Insolvency crisis

Reasons

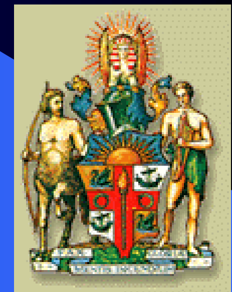
- Litigation ↑
- Judicial ↑
- Adverse events
- Regulation (lack)
- Competition
- Premiums
- HIH collapse etc

Affecting

UMP
30,000 (60%)

Response

(a) UMP call – Dec 2000
(b) Fed govt guarantee
    29 Apr – 30 June
    1 July – 31 Dec 2002
    Claims notified
    before 29 Apr
    properly payable



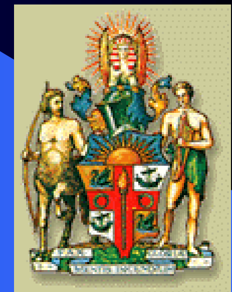
Medical indemnity

Medium term – Unfunded IBNR

Reasons
- No regulation
- Competition
- Litigation ↑
- Payout quantity ↑
- HIH collapse etc
- Premiums too low

Affecting
UMP
?Other MDOs

Response
Fed govt levy based on:
- Medicare income
- MDO risk based categories
- Other mechanism

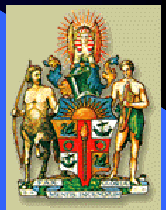


RACS proposal

Preamble

Crisis:

- Solvency - accounting standards
  - APRA
- Reinsurers
- Premium levels/levies
- Responses - resignations
  - retirements
  - industrial action
- Healthcare provision



Impact of rising medical indemnity costs

	No of fellows	%
Retirement in last 3 yrs		5.8%
Planning to retire early		3.3%
If no, planning early retirement		60.0%
Plan to cease pvt practice		11.6%

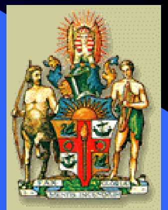
Axis: 0, 200, 400, 600, 800 — No of fellows

(n=1128)

Potential long term solutions

Reforms:

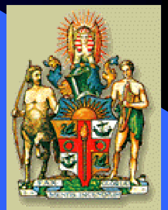
- Legislative - judicial
  - legal
- Societal
- Medical
- Insurance



Medical indemnity

Legislative reforms:

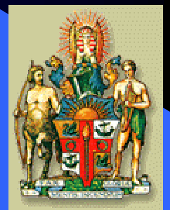
- Tort law
- Statute of limitations
- Long term care
- Structured settlements



Medical indemnity

Judicial reforms:

- Definition of medical negligence
- Bolam principle
- Post Rogers vs Whitaker
- Judge vs jury system
- Expert medical witnesses
- Tribunals vs courts



Medical indemnity

Public expectations:

- Medical advances
- Information/explanation
- Consent
- Open disclosure
- Uncomplicated outcomes

Medical indemnity

Societal expectations:

Eg. Breast cancer

Diagnosis	**- mammography**
	- FNAC
Treatment	**- Surgery**
	- Sentinel node
	- Chemotherapy
	- Radio-therapy

Patient factors

Medical indemnity

Medical performance:

Available knowledge

Technological advances

Training - Cognitive

- Technical
- Personal

Continuing Professional Development

Expertise / competence

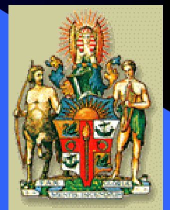
Medical reforms

Risk management:

- Communication skills
  - general
  - 45 second rule
  - informed consent
  - open disclosure

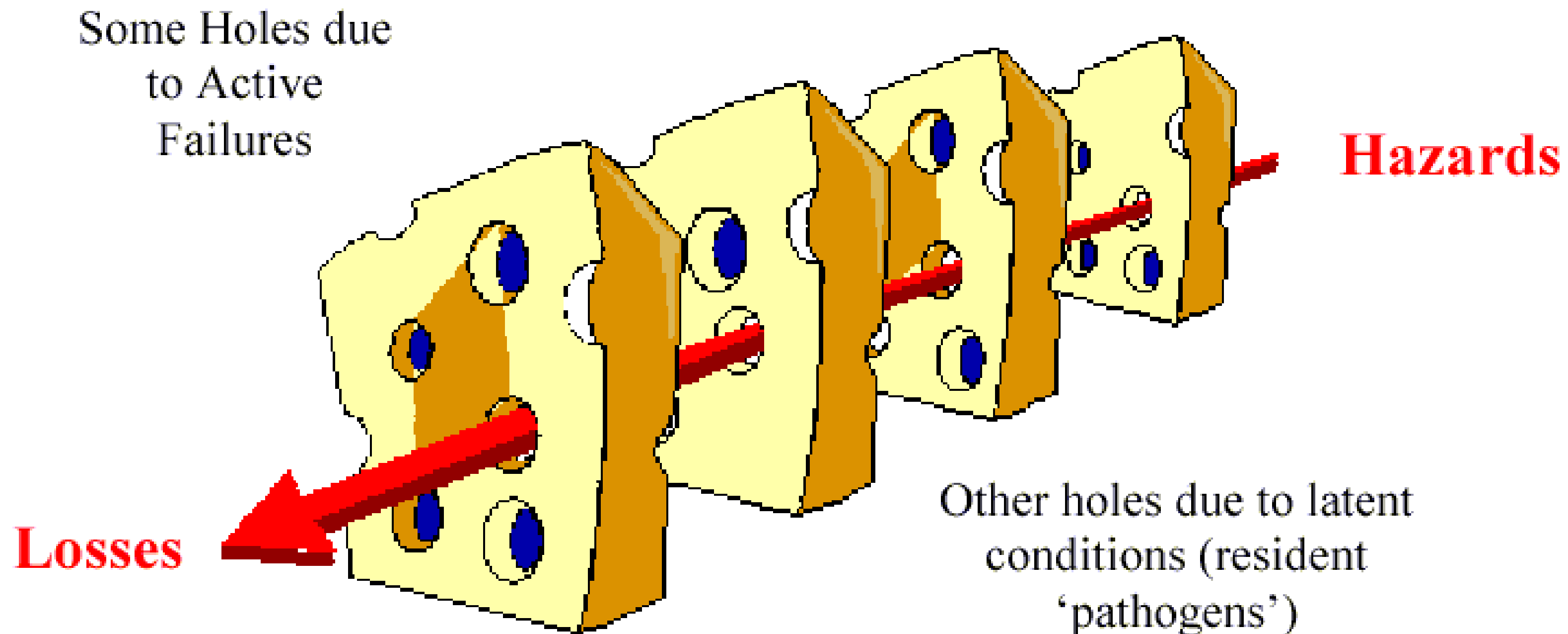
B. CPD
- audit/peer review
- palm pilot

C. ↓adverse events

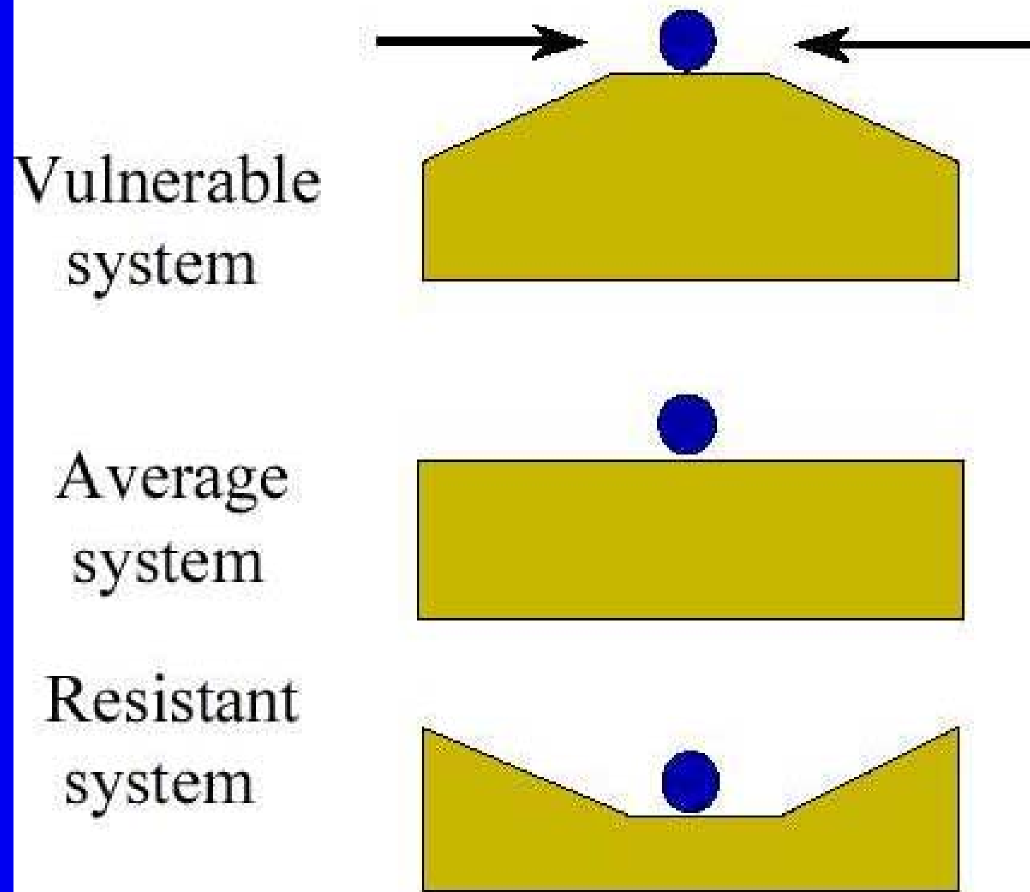


Medical error research

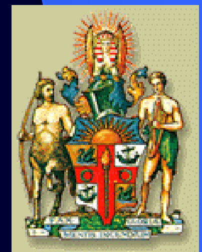
Swiss Cheese model of accident causation

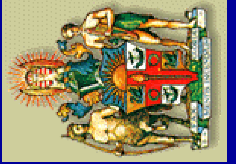


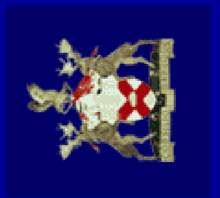
Medical error research



(Prof J Reason, 2000)



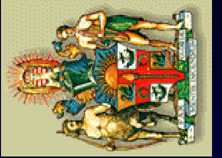


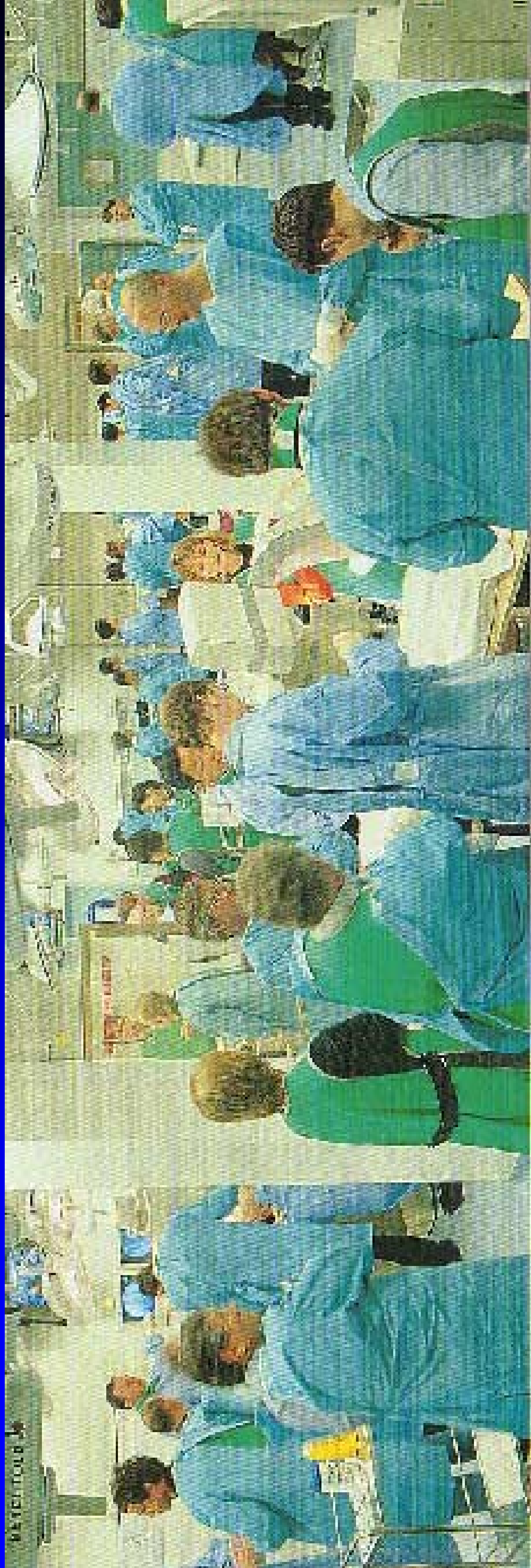


Australian Council for Safety and Quality in Healthcare (ACSQH)

Focus 2002:

- National standards for open disclosure
- Medication safety
- Infection control
- Learning from adverse events – coordinated national approach





MDAWA premiums

RACS indicative rate 2002/03

GP non-proc indicative rate 2002/3

Gen Surg

Lap chole m'care schedule

GP non-proc

$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$-

85/86 86/87 93/94 94/95 95/96 96/97 97/98 98/99 99/00 00/01 01/02 02/03 2003/4

Year

MDAWA - Number of claims reported 1992 - 1997

Source: MDAWA

MDAWA - Cost of claims reported 1992 - 1997

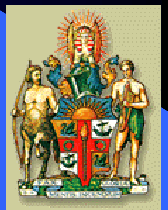
Category	Share
GP	19%
Gen surg	8%
Plastic surg	2%
Orthopaedic surg	6%
Anaesthetics	13%
Other surg	5%
Others	9%
O & G	38%

Source: MDAWA

Medical indemnity

Australian scene – mega claims

c 1997	Lipovac vs Black	$7.6M (2 fold ↑)
2001	Calandre Simpson case (NSW)	$15M (2 fold ↑)



Mega awards in US states without caps

millions of dollars

100
80
60
40
20
0

Arizona
Kentucky
Mississippi
Nevada
Nth Carolina
Pennsylvania
Washington

Source: ASPE Review of Media Reports

Premium growth: California vs US premiums 1976 – 2000 (billions of dollars)

6.5
6.0
5.5
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0

76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

Increase of 505% Since 1976

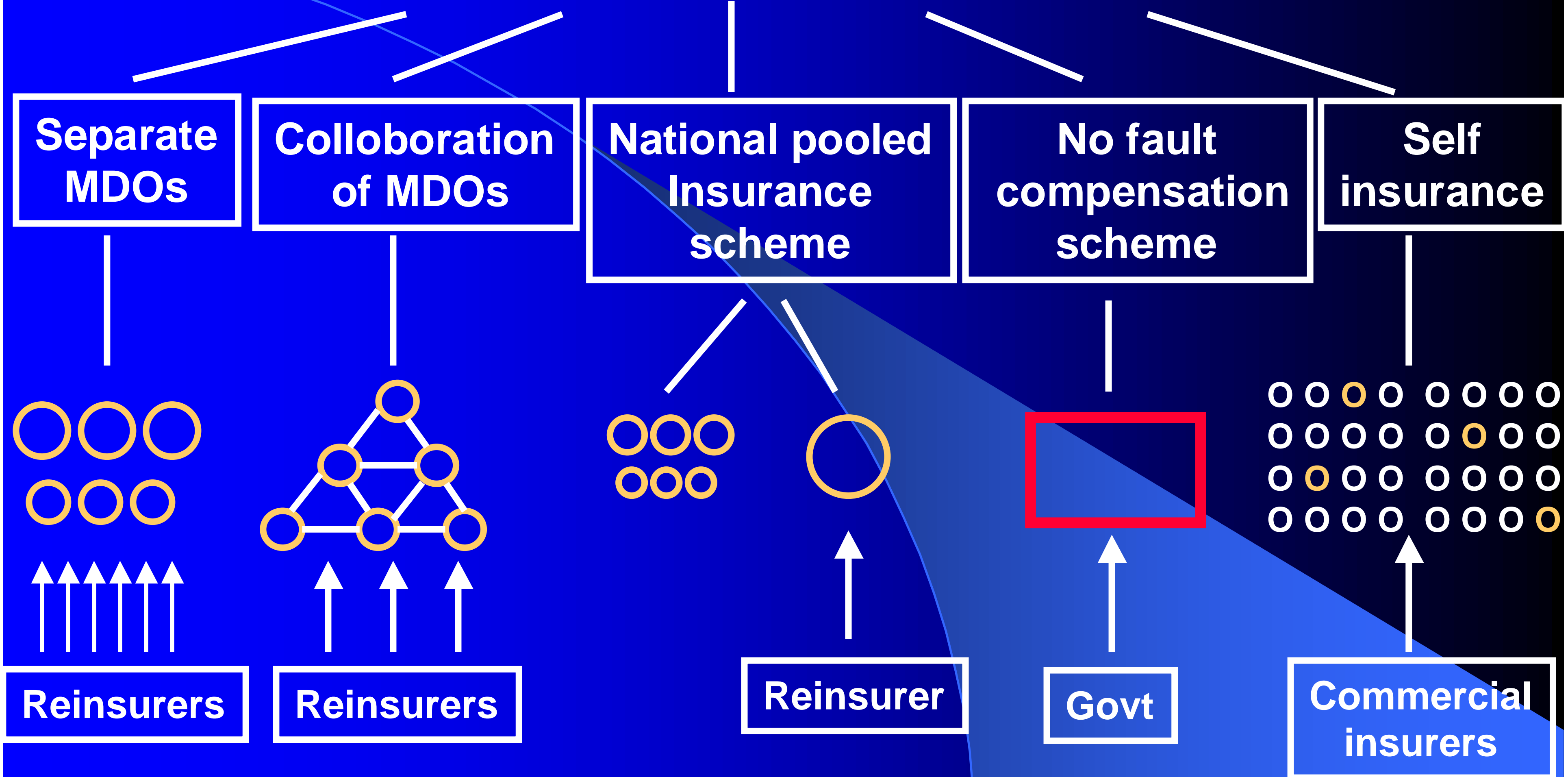
Rest of U.S.
California

Increase of 167% Since 1976

Source: NAIC Profitability Study

Medical indemnity

Long term – Insurance models



National insurance (or reinsurance) pool

Indicative models

Non Proc GP	General Surgeon	Neurosurgeon	Total
$3,000	$21,000	$30,000	$319.2 m
$4,000	$28,000	$40,000	$425.6m
$5,000	$35,000	$50,000	$532m

Premium levels

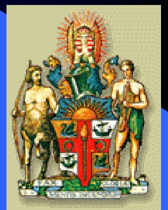
RACS indicative scale variations based upon:

- **MDO unfunded IBNR**
- **State of origin**
- **Specialty (±subspecialty)**
- **Individual risk/record**

$5000 - $50,000 range = $530M p.a.

Medical indemnity – Federal govt initiatives

- Jurisdictional working party
- Legal process reform group
- PM's task force
- Medical, legal & insurance fora
- Treasury proposals – levy etc



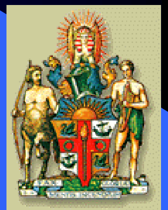
Medical Indemnity

Legal process reform group

Chair Prof Marcia Neave AO
inc Ms Fiona Tito

A) Scope: Open disclosure
Dispute management
Early notification disclosure
Settlement of claims
Legal cost incentives
Sustainable cost measures
Statute of limitations

Also quantifying impact of reforms



Medical Indemnity

Legal process reform group

B) Scope: (*cont'd*)

Accreditation of legal specialists

Expert evidence

Legal standards

Definition of negligence

Good Samaritan legislation

National approach – desirable or not?

Medical indemnity

IPP recommendations

Definition of medical negligence

Modified Bolam

Case management

Expert witness

Medical Indemnity Jurisdictional Working Party

Settlement

Life long care costs	Punitive/ exemplary damages	Non-economic loss	Lost income
To follow	Prohibition of damages	Caps on amounts paid	Caps on amounts paid

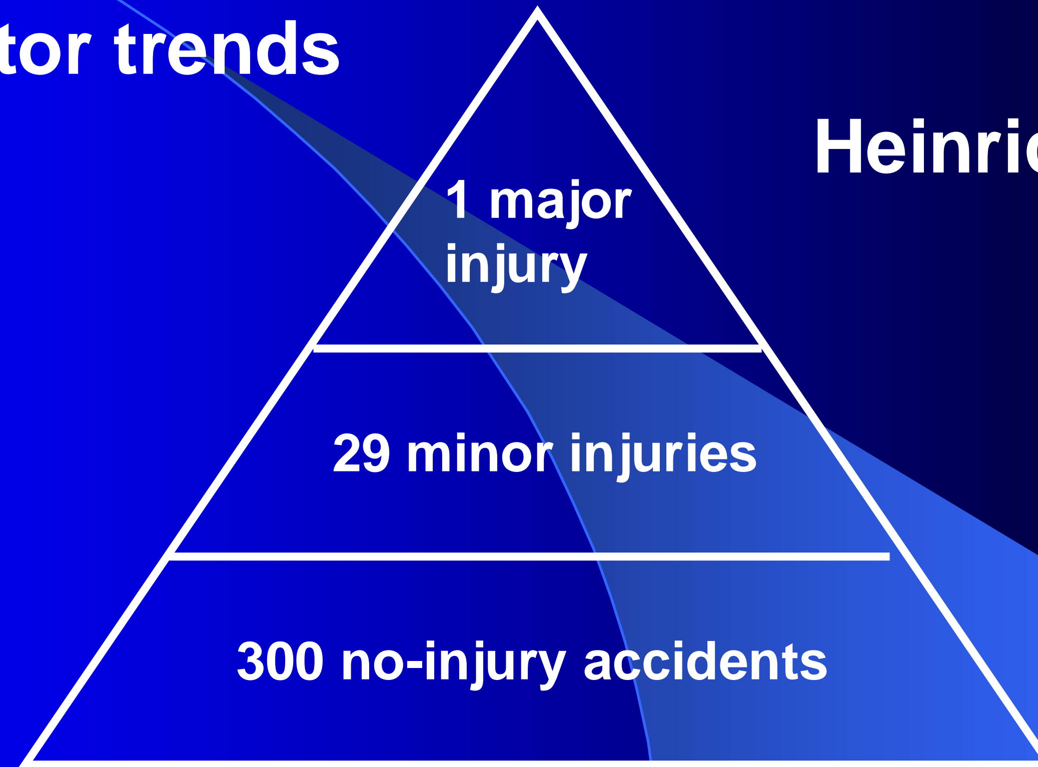
Life long care costs

Reduced by:

- Structured settlements
- ↓money for free services
- Caps on amounts paid
- ↑Discount rate
- Direct care provision

National aggregated medical litigation database

- Great need
- Currently being developed
- Monitor trends

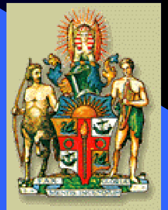


Heinrich ratio

Australian Prudential Regulation Authority

Standards

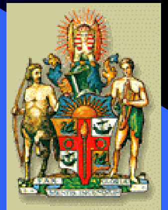
- Insurance
- Accounting



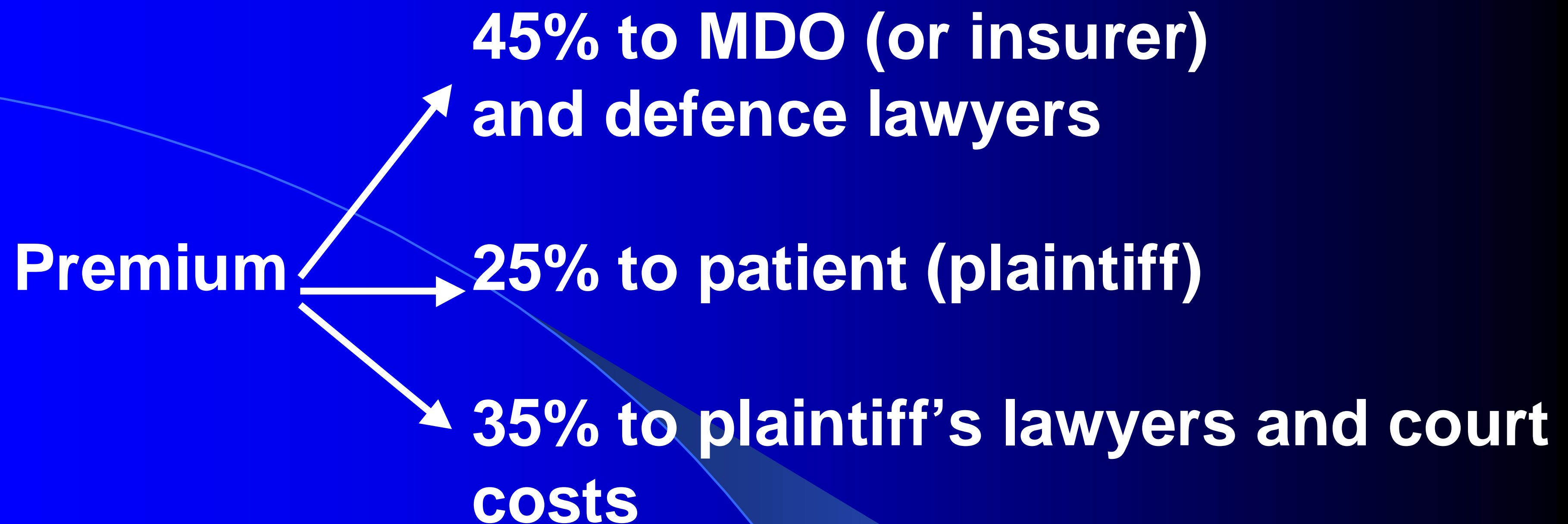
Medical indemnity insurance

Standards need to be established in areas of:

- Capital adequacy
- Valuation of claims made
- Estimated valuations of IBNR
- Risk management practices
- Reinsurance protection
- Premium setting
- Nature of coverage



Medical indemnity costs – outgoings



Premium

45% to MDO (or insurer) and defence lawyers

25% to patient (plaintiff)

35% to plaintiff's lawyers and court costs

Successful plaintiffs would receive a higher % of their claim

Commonwealth government initiatives (Oct 2002)

- Direct financial support for groups of doctors
- Scheme to meet 50% of claims > $2 million
- Guaranteed funding of IBNRs for MDOs – not fully funded (to 31 Dec 2003)
- Enhanced risk management approaches

Commonwealth government initiatives (cont'd)

Direct financial support of doctors

50% of difference (premiums and levy-where applicable)

A. Obstetrician cf Gynaecologists

B. Procedural GP cf Non procedural GP

C. Neurosurgeons cf General surgeons
(for neurosurgeons 80% subsidy on that portion of their premium and levy which exceeds $50,000 pa)

Costing of Commonwealth government initiatives

Conservative	$40 – 50 million pa
Possible	$120 million pa

Excluding possible long term care costs scheme

Federal government proposals

IBRN Levy

UMP members (as of June 2002)

Rate - 50% of 2000 premium

- estimated 10 years

4 out of 5 <$1500 per annum

12 months deferment option

Federal government proposals

IBRN Levy (estimates)

Non procedural GP $970 pa

Procedural GP $2300 pa ($3700 pa)

Obstetricians $8100 pa ($11800 pa)

Neurosurgeons $9700 pa ($15700 pa)

General Surgeons $7500 pa

(from 15 Aug 2003)

Medical indemnity

Federal government IBNR proposals

Exemptions:

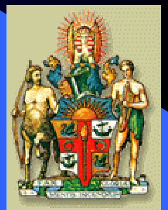
Doctors who are:

- In other MDO (2003/04 at least)
- Retiring > 5 years (<$5000 pa)
- Purchased retroactive cover <1 July 2003
- Entire liabilities covered state/territory
- Left private practice, 1 May 2002 – for FT salary

Medical indemnity

Federal government blue sky scheme

- Payments > $20 million
- Exceeding insurance contract ceiling
- Repayable by MDO (Insurer)



Medical indemnity

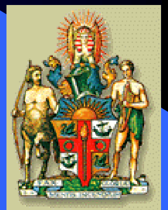
Financial benefits for governments
(of new medical indemnity insurance arrangement)

Federal

- Company tax on insurance company profit
- Profits required to meet solvency requirements

State

- Stamp duty on policies
- Estimated $20 million nationally



Medical indemnity

Financial government subsidies
(as at Aug 2003)

Costs	Annually
High cost claims scheme	$19 million
Subsidies to obstetricians, neurosurgeons, GP proceduralists	$38 million
IBNR exemptions eg retirees	$12 million
	$69 million

Compliance costs
New medical indemnity insurance scheme

Financial services reform act (FSR)
- Medical indemnity classified as retail
- $2 – 3 million pa costs

ARPA
- quarterly monitoring
- additional $1.5 - $2.5 million pa

Insurance
- directors and officers insurance
- est $5 million pa

ACCC – monitoring $½ - $ 1million pa

Medical indemnity

Affordability:

General surgeon UMP/NSW 2003 / 04

Annual premium	**$60,000**
Call	**$ 6,000**
Levy installments	**$ 8,500**
	$74,500

Medical indemnity

Affordability:

Subgroups

eg. Establishing practice
- patient profile

Part-time practice
- Pro-bono service
- Female surgeons
- Teaching/research

Rural surgeons

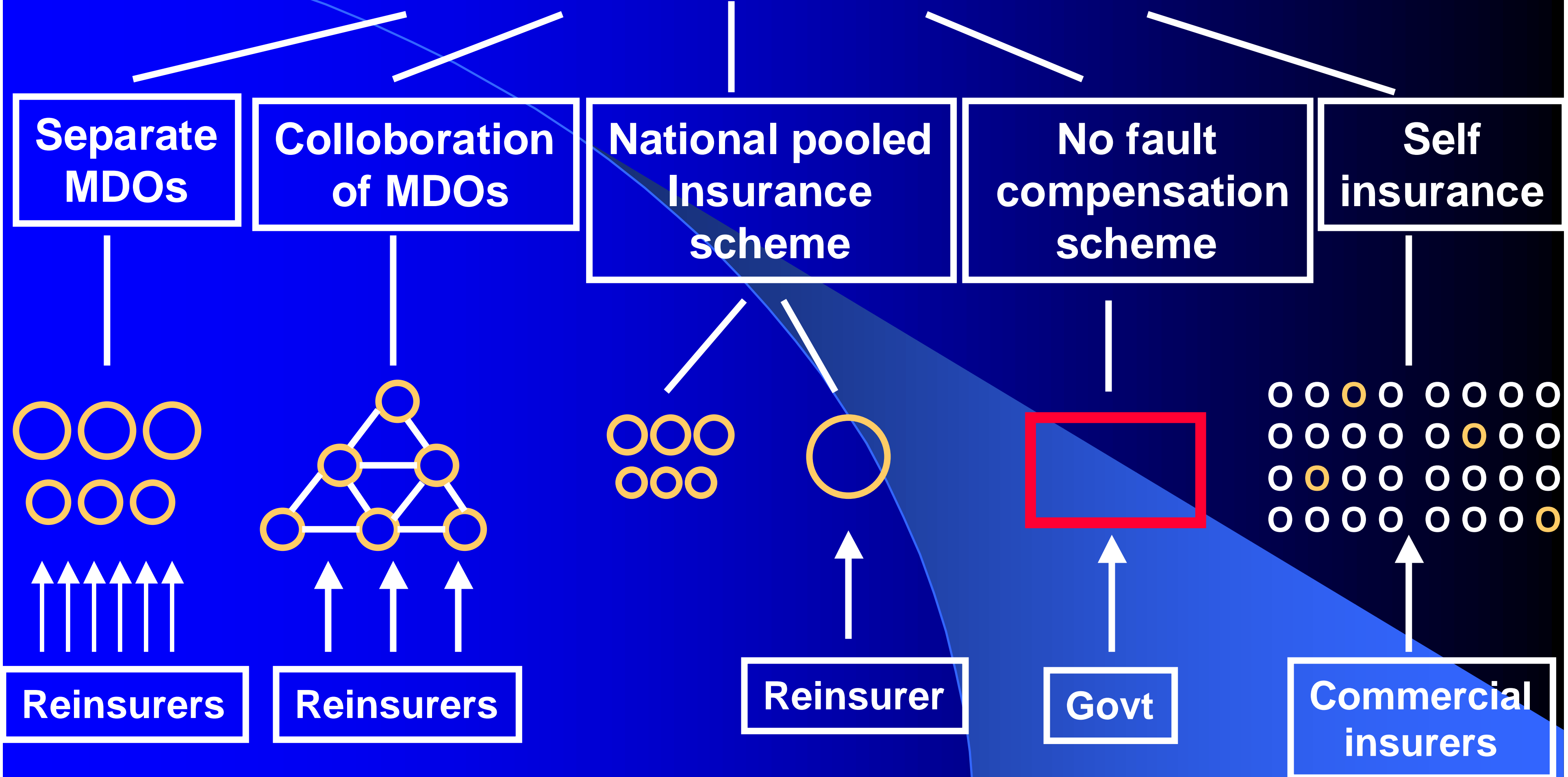
Australian Medical Defence Organisations

From 1 July 2003 only medical indemnity insurers can provide medical indemnity

Insurer	MDOs	Insured (est)
AMIL	UMP	22,000
MICWA	MDAWA/MDA National	7,500
PIICA	MDAV	7,900
HPIA	MIPS/QDM/MPST	10,000
MIA	MDASA	5,000
5	8	52,400

Medical indemnity

Long term – Insurance models



Medical indemnity

Alternative proposal

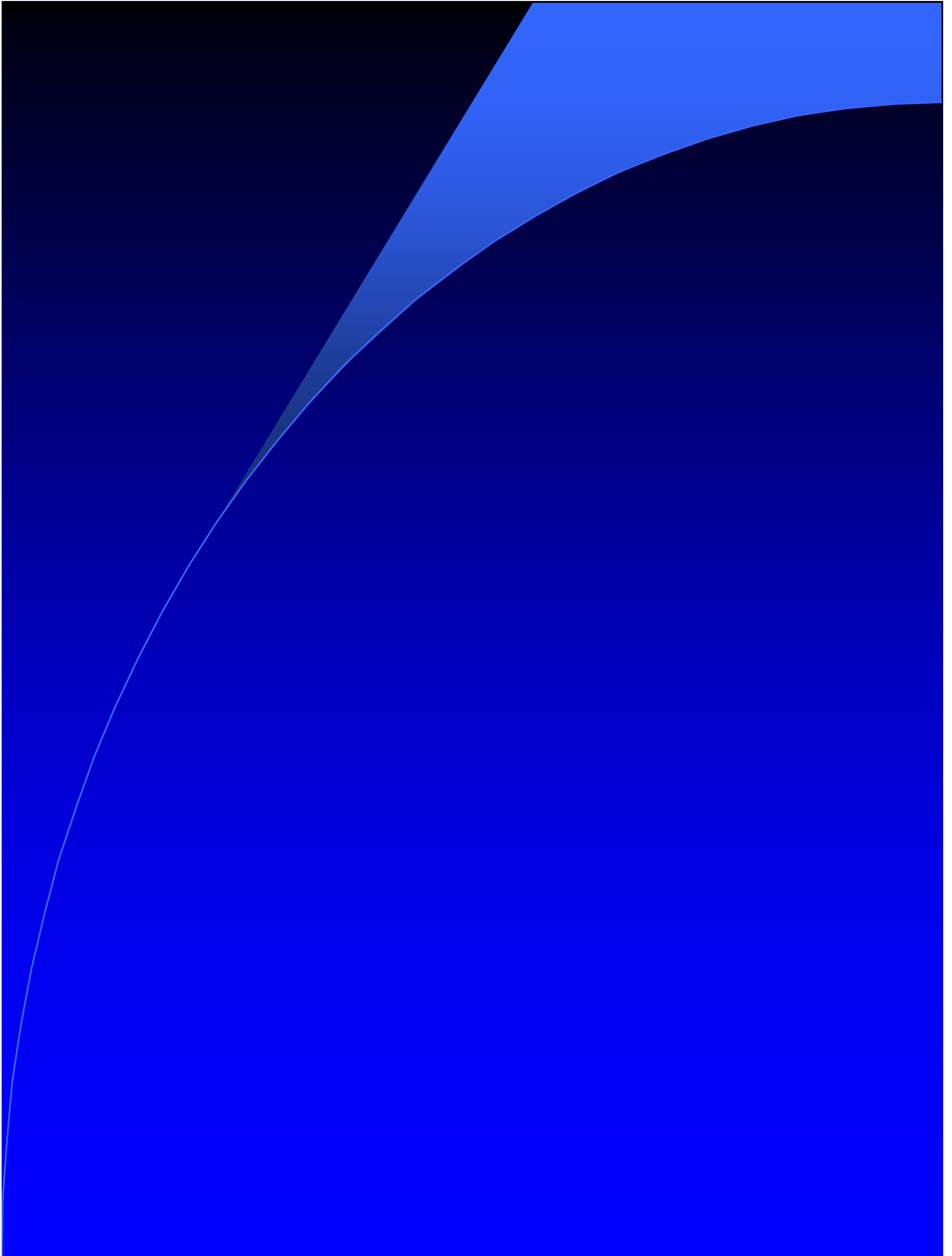
Up to $500,000 funded by: - Medical profession existing MDO
or restructured MDO as agents for National insurer
- Commercial model
- Statuary pool

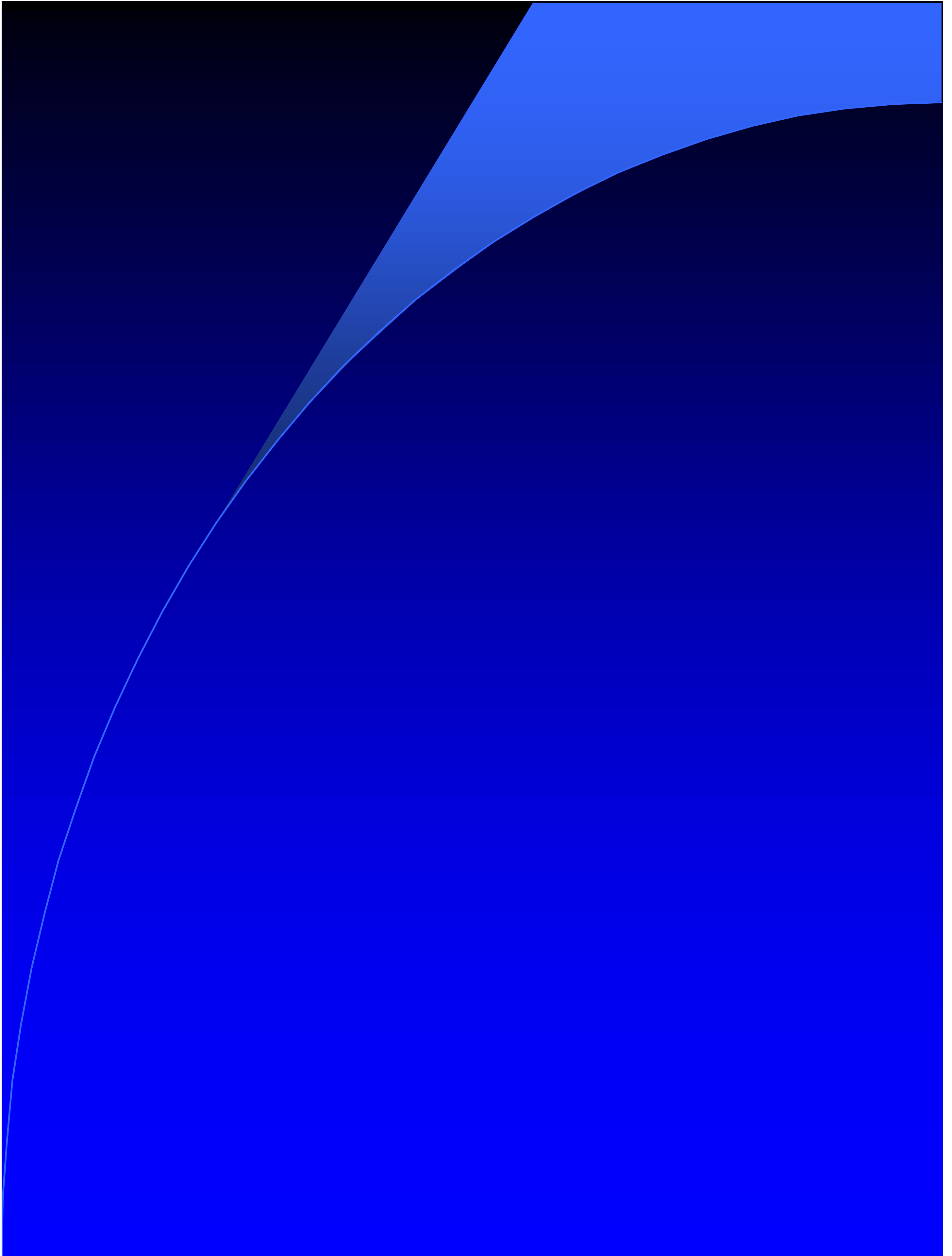
>$500,000 - Federal govt ie. Variation of long term care plan

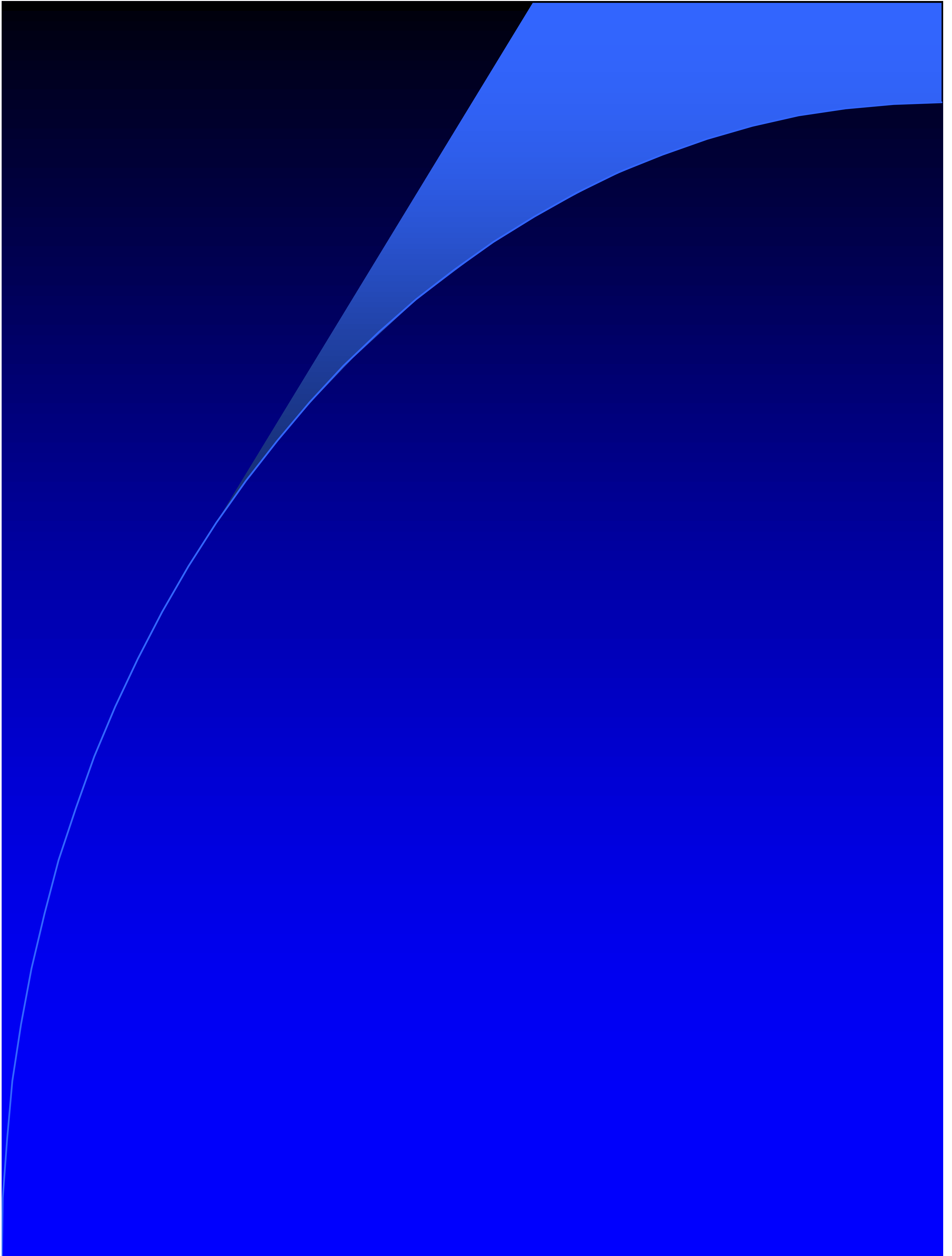
Medical indemnity

$500,000 ceiling model

- Participating doctors involved in
- Continuing Professional Development
- Risk Management Courses







Australian Council for Safety and Quality in Healthcare (ACSQH)

Key priority areas:

- Supporting healthcare workers – to practice safely
- Data collection/information feedback
- Consumer involvement
- Redesign systems → culture of safety
- Build awareness/understanding of health care safety

Australian Council for Safety and Quality in Healthcare (ACSQH)

Vision of success:

- Consumer centred
- Open, honest communication
- Accountable
- Supports multidisciplinary approach
- Culture of learning for improvement
- Constantly strive to: maximise safety
eliminate error
improve system design

Medical indemnity costs – outgoings

1	Care of catastrophically injured	25%
2	Administrative costs MDO	15%
	Legal costs MDO	<u>30%</u>
	Total MDO	45%

- Legal costs to plaintiff
- Reinsurance costs
- Plaintiff's receipts (including long term receipts)

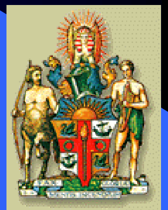
30 – 35 cases p.a. → $80M p.a.

Medical indemnity costs – outgoings

After deducting MDO administration of like expenses (ie looking only at claims expenses)

50 – 60% paid out as compensation (? How much to plaintiff)

40 – 50% represent legal and other costs of managing the claims



Potential reforms to reduce MI costs

- Govt care of the catastrophically injured
  potential savings to MI=25%
- Tort law reform – structured settlements
- Statute of limitations
  Tribunal > adversarial
  Definition of negligence
  Reinstatement of Bolam principle
  Use of experts (2 independent witnesses)
  Caps to large payouts
  (especially non-economic loss)

RACGP Position

Nationally coordinated approach

- Medical indemnity insurance mandatory – index rebates
- Reforming Tort Law and Tort Law administration
- Enhancing safety & quality measures and risk management
- Strengthen prudential regulation
- Restructure premium setting
- Ameliorate negative impacts on doctors/staff

CONCEPT OF A GP SPECIFIC AND RACGP BADGED INDEMNITY SCHEME