Productivity Commission inquiry into a long term disability care and support scheme

Avant Mutual Group submission

Background

Avant Mutual Group Limited (Avant) is Australia's largest medical defence organisation (MDO). Through our licensed insurance subsidiary, Avant Insurance Limited, we provide indemnity insurance and support to more than 50,000 members.

Avant is a mutual, not-for-profit organisation and operates nationally with offices in New South Wales, Victoria, Queensland, Tasmania, South Australia and Western Australia. Avant provides insurance cover for over 60 per cent of insured doctors and also on behalf of a large number of allied health professionals.

Avant offers professional indemnity insurance to health care practitioners, medical students and allied health professionals. Among other things, Avant also provides:

- Medico-legal and risk management advisory services;
- Support, advice and legal representation in the event of a claim or complaint; and
- Education, research and training programs in collaboration with medical associations, colleges and training providers.

Avant has a unique capability to understand the medical indemnity landscape and access data which can be analysed and directed toward solving problems and reducing clinical risk. By drawing on this knowledge we hope to be able to inform and assist the Commission to reach appropriate recommendations from the inquiry.

We have set our submission out under the following headings:

1. Summary and recommendations.
2. The medical indemnity environment.
3. Issues discussion.

We look forward to discussing any of the points raised in this submission.

1. Summary and recommendations

Avant supports the objective of a national long term care and support scheme for Australians with profound or severe disabilities.

In the absence of any detailed scheme design, our comments are limited to a high level analysis and discussion of the key issues as they relate to medical indemnity insurance. As such, we will need to undertake further review and analysis once the Commission's thinking becomes clearer. That may result in refining or changing our position on some issues.

Our recommendations to the Commission, at this stage, are as follows:

- Access to any scheme should be fair and the rationale driving assessment criteria easily understood by stakeholders including both prospective beneficiaries under the scheme and insurance companies who would continue to underwrite risks residing outside the scheme.

- The initial threshold for scheme access should be high enough to allow relaxation of the eligibility criteria, should this be warranted in the future, as the scheme becomes more established.

- Participation should be compulsory in the sense that there should be no other source of compensation for long term care needs (be it litigation or other government schemes). It is in our view essential for the management of insurable risk that the interaction of a future scheme with civil litigation is unambiguous and stable over time.

- Timely assessment of disability and early access to care and support resources is essential and in the best interests of the people with long term care needs. It is our experience that in major civil claims litigation the most significant head of damage is future care costs. By eliminating this head of damage we would expect major civil claims litigation to be resolved more quickly, less expensively and with less stress for those involved. Notably, speedy resolution will deliver more immediate support to severely or profoundly disabled Australians than waiting until their claim for compensation is finally resolved which may take some years.

- Funding of future care costs associated with all adverse medical outcomes that result in severe and profound disability should be broad-based and federally funded. A new scheme should not increase the existing insurance cost for Australia's doctors and allied health professionals.

  Through the operation of various government support schemes, the Medicare system and "user pays" principle of existing health care, funding is already diversified and passed on to users of those services. In the event our insureds were required to partly fund such a scheme, any increase in medical indemnity premiums would either be absorbed by our insureds or, more likely, passed on to patients which would adversely impact high users of those services, with no nexus between the "user payer" and the ultimate scheme recipients. Indeed, one might expect pressure on Medicare rebates to meet any increase in premiums leading to a funding "round robin".

- All future care costs related to severe and profound disabilities as a result of adverse medical events should be fully included in a no fault scheme. The right to pursue compensation through civil litigation for other damages should remain.

  A scheme that provides immediate and ongoing support, as opposed to lump sum compensation payments, is more likely to focus on the immediate medical, social and personal needs of the disabled. This is particularly so given the considerable uncertainty involved in determining future care costs during consideration of heads of damage.

- If the right to sue for future care costs remains, the potential for "double recovery" would need to be carefully addressed.

- Transitional arrangements need to be carefully considered to avoid any unintended impact on the stability of the current medical indemnity insurance environment and other schemes impacted by the new scheme.

- The Federal Government already provides medical indemnity support (and hence support of patients with long term disabilities) through various existing schemes and indirectly through Medicare funding of health costs (which finance indemnity premiums). In our view, these existing medical indemnity schemes should be maintained. Inclusion of long term care costs in a future scheme should reduce the demand on, and therefore the cost of, these schemes.

2. The Medical Indemnity Environment

2.1 Key providers

The private medical indemnity environment in respect of medical practitioners and allied health professionals in Australia is dominated by licensed insurance subsidiaries of mutual organisations. The participants are:

- Avant
- MDA National
- MIGA
- MIPS
- Invivo (backed by QBE)

Avant insures over 60% of insured doctors in Australia.

2.2 Current professional indemnity policy inclusions

In addition to civil liability coverage, most policies also cover legal expenses in relation to commissions, enquiries, inquests, complaints etc.

2.3 Current funding

2.3.1 Medical indemnity premiums

Insurance premiums continue to be the primary funding mechanism of medical indemnity insurance. For 2010, industry wide gross written premiums in relation to practitioner policies will be approximately $300m. The majority of these premiums are effectively attributable to civil liability coverage.

Premium costs are passed on to patients of health providers via service charges with the users of inherently high risk services, such as obstetrics and neurosurgery, paying a proportionally higher price. As such, it represents a narrow funding source with high frequency users of services effectively paying a higher share of funding cost.

Arguably, the Medicare system, as a major funding source of service charges, is also a significant contributor to existing health care insurance premium funding. Decreases in future insurance premiums should, over time, lead to less pressure to increase health service costs and Medicare expenditure.

2.3.2 Government support schemes

As a result of the indemnity crisis of 2000-2002, a number of government schemes were introduced, together with tort law reform and increased prudential regulation, to bring stability to the market and make premiums affordable.

Key schemes include:

- **The High Cost Claims Scheme (HCCS)** - The Government meets 50% of the claim cost over a threshold (currently $300,000) up to the limit of the practitioner's cover (generally $20m), for claims notified on or after 1 January 2003. Claims funded include those in respect of severe and profound disability.

- **The Run-Off Cover Scheme (ROCS)** - Provides run-off cover for eligible medical practitioners who cease medical practice (retirement at age 65 years or older, cessation of private practice for three years, death, permanent disability or maternity leave). ROCS operates after HCCS scheme payments. Funded by a 5% levy on medical indemnity insurer's gross premiums.

- **The Exceptional Claims Scheme (ECS)** - A programme where the Commonwealth pays 100% of claims against a practitioner exceeding $20 million. No claims have been made under this scheme to date.

For the purposes of this submission, the HCCS is most relevant as it would potentially be impacted to the greatest extent by the introduction of a long term care scheme which dealt with future care costs.

The following approximate payments were made by the Commonwealth, attributable to these schemes, in 2008/09. These payments simply depict annual expenditure and are not necessarily reflective of the future scheme liabilities. For example, HCCS payments are expected to rise over the next several years as the portfolio of historical claims matures.

- HCCS Claim Payments – $19.5m[1]

- ROCS Claims Payments 2008/09 - $1.6m[2]

- ECS - Nil

The Commonwealth received substantial contributions from industry insureds during 2008/09 via ROCS Levies ($13.8m[3]) and substantial GST and corporate tax revenue.

2.4 Claim numbers and costs

MDOs, through payment of claims in respect to adverse medical outcomes, contribute to the care of a relatively small number of people with severe and profound disabilities as severe and profound disability claims represent only a very small number of private practice medical indemnity insurance claims.

---

[1] Medicare Australia Annual Report 2008/09

[2] As at 30 June 2009 the Government Actuary estimated that the ROCS scheme had a notional surplus of around $50m.

[3] Report on the costs of the Australian Government's ROCS for medical indemnity insurers by the Australian Government Actuary 2008-09.

We estimate that the plaintiffs in approximately 5 to 10 claims settled annually by private medical indemnity insurers would likely be eligible for inclusion in a long term care scheme as a result of having a severe and profound disability, depending on what eligibility criteria are established. The majority of these cases relate to infants suffering injury at birth. The quantum of these claims is typically large, representing around 40% of total settlement payments annually.

We have included, as attachment A, an example of the heads of damage in a typical claim involving serious or profound disability. We have also included the legal expenses typically incurred by the plaintiff and the insurer. Plaintiffs in these claims would, on most definitions of how the scheme might operate, be likely to be eligible for assistance through a future long term care scheme.

Therefore, whilst a scheme that includes incidents arising from adverse medical outcomes will impact the medical indemnity industry, the number of cases per annum is unlikely to be significant.

3. Issues discussion

3.1 Eligibility and the right to pursue civil litigation

To provide certainty for industry and avoid any unintended consequences for eligible scheme participants, we believe that participation in the scheme should be compulsory and that those supported and compensated by the scheme should not also have the right to pursue a civil claim for future care costs. The right to pursue a civil claim in respect to other classes of compensable damages should however remain.

Determination of the compensable amount associated with future care costs is, in our experience, a major contributor to the length of time taken to finalise many civil claims. If the need for long term care quantification is removed we would expect that claims affected could be finalised more quickly. The benefits to the disabled would include immediate access to appropriate support and services through the scheme and, where relevant, quicker access to any funds awarded as damages payments.

A clear definition of "future care" costs types will be required to ensure clarity in the event of civil litigation compensation determination. The heads of damage assessment example in attachment A provides an example of the range of compensable items that would need to be considered when defining long term care costs.

The interaction of the proposed scheme with the civil litigation process will need to be assessed when more details of the proposed scheme are known. This is to ensure the scheme and civil litigation operate effectively together to enable early therapeutic interventions for the best outcome for individuals. This interaction should seek to avoid any perverse outcomes such as the incentive not to take up opportunities for early care and support under the scheme for fear of jeopardising any actual or potential civil claim.

Clear criteria regarding civil litigation and the extent of damages which can be claimed would need to be developed. In our experience, typically 50% or more of the damages paid in large disability claims relates to future care costs. Refer attachment A for a typical example, which may assist the Commission in understanding the extent of future care costs compared with other heads of damage involving profound or catastrophic injury. If the ability to pursue civil litigation for future care costs is restricted, it is expected that future medical

indemnity premiums would decrease should the experience of the scheme over time or other considerations warrant this.

The initial threshold for access to a future scheme should be high enough to allow future relaxation of the eligibility criteria without causing funding stress as it is inevitably easier to move the threshold down than up.

Implementation of a no fault scheme would, in our view, also result in less value leakage via legal and administration costs and therefore a more efficient arrangement for those affected overall. For large claims these costs can be substantial as shown in attachment A.

3.2 Deterrent effect of insurance

Insurance can also have a deterrent effect on undesirable behaviour provided the cost is correctly assessed commensurate with the underlying risks involved. However, in respect to the medical profession, a major arbitrator of poor practice is the involvement of professional associations and Medical Boards in setting standards and investigating patient complaints. Sanctions imposed via these processes can include restrictions on services and removal of authority to practice. The existence of "insurer of last resort" provisions in legislation also blunts the impact of insurer risk assessment on undesirable insured behaviours.

Consideration should be given to the potential impact on insured behaviours and interaction with medical industry regulatory bodies.

3.3 Funding options for the scheme

Funding of future care costs associated with all adverse medical outcomes that result in severe and profound disability should, in our view, be broad based and provided federally.

The costs of adverse medical related outcomes in the public health system are currently funded through various state Government revenue streams. However, for ease of design and administration of the scheme, access to funding for compensation, including future care costs, should, in our view, come from one source. As the scheme is intended to operate nationally it is our view that costs should be funded by the Commonwealth. The most equitable and administratively convenient source would be from consolidated revenue.

Through the operation of the HCCS, severe and profound disability claims, which result from adverse medical outcomes are already partly funded from general federal government revenue. Redirection of funds, in respect of future care costs, to a long term care scheme would help offset the scheme cost to Government though the amounts, as noted previously, are not large when compared to the overall funding effort outlined by the Commission in the issues paper.

Medical indemnity premiums should, all other things being equal, reduce for some categories of medical practitioners if future care costs are funded through the scheme rather than by compensation via a civil litigation process. Any reduction in premiums should ultimately be passed on to patients as a consequence of less pressure on practitioners to increase their charges.

3.4 Cost savings - existing medical indemnity schemes

In our view, the current medical indemnity insurance schemes should be maintained, as medical indemnity premiums should reduce for some categories of medical practitioners if disability care and support services are provided through the scheme as opposed to being funded through compensation. Moreover, for certain categories of medical practitioners, there should be less reliance on premium subsidies provided by the Federal Government under the PSS.

The introduction of a scheme will inevitably provide the Commonwealth with savings from the obligations it has under the HCCS as the 50% contribution to claims over $300,000 will be significantly reduced over time.

The impact of a long term care scheme on the existing government schemes will need to be carefully assessed. From an insurance perspective we will also need to carefully analyse and implement appropriate premium adjustments over time.

3.5 Transition arrangements

Appropriate transitional arrangements in respect to the establishment of the scheme and the management of existing claims will need to be considered if changes to civil litigation rights occur.

3.6 Potential for adverse potential outcomes if civil litigation rights remain for future care costs

If civil litigation rights remain in their current form, care needs to be exercised to ensure that there is no double recovery in respect to immediately provided care and subsequent lump sum compensation payments from private medical indemnity insurance settlement. The availability of a potential future settlement, via insurance, may also generate poor care outcomes for individuals in the short to medium term as they pursue these future benefits. This is particularly the case where lump sum settlements include a substantial amount of "wants" versus "needs" that will be covered by a long term care scheme.

If civil litigation to pursue future care costs remains an option, the outcome may be at odds with the objective of providing appropriate and timely care, support and services for affected individuals.

3.7 Aged based criteria

Some questions would need to be explored in due course around the age criteria for cover under the scheme. For example:

- How will cases be treated if the incident giving rise to the disability occurred prior to age 65 but the physical effects occurred after?

- Will patients still have access to civil litigation for adverse medical outcomes due to negligence if they are older than the maximum age?

We welcome the opportunity to discuss any of the issues and recommendations raised in this submission with the Commission as it develops its thinking and works towards its final recommendations.

Attachment A

TYPICAL CLAIM INVOLVING SEVERE OR PROFOUND DISABILITY

Nature of injury:	Spastic quadriplegia/cerebral palsy at birth
Patient's age when claim commenced:	11 years
Patient's age when claim concluded:	14 years
Predicted life expectancy:	To age 66 to 76
Gender:	Female
Likely earnings:	Average weekly earnings with time out for raising a family

Head of damage	**Low**	**High**
Non economic loss (maximum available under the *Civil Liability Act)*	$473,500	$473,500
Losses to date of hearing		
Past out of pocket expenses (treatment costs, medication, house modifications, purchase of modified vehicle)	$80,000	$100,000
Interest for 14 years	$15,000	$30,000
Value of past gratuitous care provided by family (at weekly rates capped by the *Civil Liability Act*)	$400,000	$500,000
Anticipated future costs		
Future care	$4,500,000	$6,000,000
Future costs of being accompanied by a carer on holiday	$200,000	$375,000
Future medical expenses	$150,000	$175,000
Future aids and equipment	$150,000	$300,000
Future computers & assistive technology	$350,000	$500,000
Future motor vehicle expenses	$125,000	$145,000
Future housing costs	$400,000	$825,000
Loss of future earning capacity	$400,000	$600,000
Costs of managing funds for remainder of patient's life		
Predicted trustee company charges	$1,000,000	$1,500,000
Sub-total	$8,243,500	$11,523,500
Estimated legal costs (patient only)	$625,000	$800,000
Total	$8,868,500	$12,323,500