Australian Health Ministers' Advisory Council's Medical Indemnity Jurisdictional Working Party and Consultative Forum

This report is a summary of the work of the Australian Health Ministers' Advisory Council's Medical Indemnity Jurisdictional Working Party and Consultative Forum, and an outline of future work including the broader consultation on the discussion papers that are being prepared.

Following the Australian Health Ministers' Advisory Council (AHMAC) meeting in February 2001, the Medical Indemnity Jurisdictional Working Party, and Consultative Forum, were established, each with its with own terms of reference and membership.

Ministers recently agreed that medical indemnity issues raised by midwives be referred to the Jurisdictional Working Party, that the consultative forum be further strengthened, and that the Jurisdictional Working Party's terms of reference be amended to include "assessment of the need for a national regulatory regime for medical indemnity insurance."

Members of the Working Party and the Consultative Forum have met with each other and other relevant individuals and organisations.

Sub-committees of the Working Party and the Forum are assisting the Working Party's consultant, Fiona Tito, in the preparation of discussion papers. In addition to these, a paper being finalised that looks at the overall cost drivers for medical indemnity premiums, to identify all areas where reforms are likely to reduce or contain costs.

Penny Gregory is the Chief Executive of the ACT Department of Health, Housing and Community Care, and Chair of the AHMAC Working Party on Medical Indemnity.
PHONE 02 6205 0825 **EMAIL** penny.gregory@act.gov.au

The discussions so far and papers have gone some way toward developing practical solutions to the problems identified. However, the Working Party and Consultative Forum have noted the complexity of the work required and strongly supported the need for further consultations with relevant stakeholders before any policy directions were concluded.

A consultation was planned for 12 September 2001 to focus on the issue of National Standards and Regulation for the Medical Defence Industry, with representatives of the medical defence and insurance industry, Australian Prudential Regulation Authority, Australian Medical Association, Institute of Actuaries, Committee of Presidents of Medical Colleges, and consumer and government representatives. The roundtable consultations have now been completed with participation from 60 industry, consumer and government representatives. Discussions at the roundtable were extremely constructive and a summary of outputs is being prepared. The roundtable was generally supportive of national standards and prudential regulation of the industry and it explored options for price and product regulations. The next steps on this issue will involve government agencies outside the health portfolio.

Further consultations are planned for the New Year. The following is a summary of considerations in each of the areas the Working Group is looking at:

Reference 1 - Sustainable Solutions to Long Term Care Costs in Health Care Litigation

Structured settlements: The tax treatment of structured settlements remains an important issue, with work progressing on a number of fronts. Currently the tax treatment of these vis-à-vis lump sum payments actively discourages their use.

State Governments, other Commonwealth agencies adversely affected such as those administering social security, health and disability services, and many other interested groups have been lobbying the Commonwealth Government for some time to have the relevant tax laws changed, as has already occurred in the United Kingdom, Canada, and the United States of America.

The Structured Settlements Group recently met with the Assistant Treasurer who confirmed Commonwealth Government support for amending the taxation law to encourage structured settlements. While it is recognised that this may not produce significant cost savings, partly because its use will be optional, there is strong evidence that such periodic income streams provide benefits in a manner more appropriate to the needs of people with high levels of disability and a long term inability to work.

The Working Party and Consultative Forum will continue to support this work without duplicating it.

Care provision option: The payment of lump sum damages to future care costs to people with high levels of disabilities raises many problems, including:

- Significant delays in obtaining necessary assistance while waiting for the case to conclude, particularly in medical negligence litigation;
- Problems of over and under compensation because of the need to estimate life expectancy;
- Investment problems;
- Service availability issues; and
- Cost recovery issues for mainstream disability services.

There are also broader social policy issues about the different levels of assistance available for people with similar needs, but who come through different systems (and the significant diversion of costs to the legal profession with the tort system). There is also an awareness of the growing size of this issue. As medicine is better able to treat people with serious traumatic injury and complications from severe disability, this leads to more people surviving and longer life expectancies for people who do.

The Working Party and Consultative Forum have been looking at options which involve direct care provision for all people who have severe disabilities arising from their health care, as well as how this fits into broader arrangements for those who have severe disabilities whatever the cause. This has included looking at the Tasmanian Motor Accident Insurance Board's experience, as well as that of the Motor Accidents Authority in NSW, where specific brain injury arrangements are in place and the Victorian and Northern Territory No-Fault Motor Motor Vehicle Scheme arrangements. The work will also examine developments in broader disability service provision, including looking at care packaging and brokerage arrangements being used in aged care and disability services. It will also consider the issue of determining what is "reasonable and necessary" assistance, and how to ensure that services that people need are actually available when needed.

Reference 2 - A National Database on Health Care Litigation

There is an acceptance that there is a need for a national data collection that will assist both the MDO industry, policy-makers, governments and others to really understand what is happening in the medical indemnity area. A two-stage approach to developing this collection is being developed at the moment.

In the immediate term, a set of key definitions will be developed and desirable data items outlined. The sort of information, which this initial collection would seek, could include:

- Numbers of open claims by year of incident;
- Proportion of incidents which turn into claims;
- Number of new claims commenced each year, by year of incident;
- Amounts paid out each year in various cost ranges;
- Amounts paid out by year of incident or by year the claim commenced; and

- Claims made by type of specialty and estimated liability.

To control for other variables, some other data might be required which could be obtained from other sources, e.g. hospital separation numbers, the number of Medicare services provided by doctor type, number of doctors in different speciality groups. Availability of this and the applicability of the data definitions will be tested with agencies with responsibility for the collection of State and Territory Health Department health professional indemnity data and with MDOs in each jurisdiction.

The Australian Institute of Health and Welfare is undertaking a data collection, analysis and reporting project on behalf of the Department of Health and Aged Care and specialist obstetrician and gynaecologist groups. The survey is de facto testing the feasibility of establishing a medical negligence database as proposed by the Working Party. Working Party members are also looking at whether the public sector's databases will be able to provide this first tier of information. Results thus far indicate that the collection of this information may need to be implemented in a gradual manner.

NSW has enacted legislation covering limitations on damages, industry standards on claim handling, and mandating data collection. The regulatory framework is currently being prepared. Given the NSW legislation covers data provision, the AHMAC group is working co-operatively with that process as well.

The second stage of the data collection process involves a national data collection on adverse events and patient harm. This is being developed by the Australian Council for Quality and Safety in Health Care. The Working Party has undertaken to work with the Council to ensure that any data collection processes set up in Stage 1 will complement the Stage 2 initiatives.

Reference 3 and 5 – National Standards for the Medical Defence Industry

The medical indemnity providers in Australia have provided discretionary indemnity cover for doctors for many years. Over the last two decades, the environment in which they have been operating has changed considerably. Of late, there have been concerns raised about the need for consistent standards within the industry, so that doctors, consumers and policy makers can look with some confidence and consistency across the industry. Questions about the possible role of insurance, the benefits and downsides of claims made and claims-incurred cover, the benefits and downsides of insurance-based cover and discretionary cover have all been raised.

The Working Party and Forum have been looking at these issues and how best to address the range of public interests at stake in the area. Our newest term of reference, relating to a national regulatory framework for the medical defence organisations (MDOs), is being looked at as part of this work. Other collateral issues, such as compulsory cover and/or cover by vicarious liability are also being considered. The September 12 roundtable was held with those parties with an interest in professional indemnity products for the medical profession.

Reference 4 - Reduction in Legal and Administrative Costs associated with Health Care Litigation

Some reform options that have been raised include:

- Improving the use and availability of expert evidence;
- Looking at ways of determining early the issues in dispute, and encouraging early settlement of cases through pre-litigation notification and cost penalties if reasonable offers of settlement are rejected.
- Using conciliation and other alternative dispute resolution processes either through the court system or through independent health complaints mechanisms;
- Using more inquisitorial and informal processes, as used by some Tribunals;
- Simplifying proof of liability and reducing the occasions where causation has to be proved, e.g. "accelerated compensable events", strict liability in some situations; and
- No-fault options.

Many of these are outside the control of the health system, and some are reforms that might need to be applied more generally, e.g. through court reform processes applying to all cases. The AHMAC group is looking to categorise and determine which of these are of particular relevance to the health arena or which can be undertaken by the health department or others in the health sphere; and which ones need to be referred elsewhere for action or policy development e.g. the Standing Committee of Attorneys General. PL