NASOG
National Association of Specialist Obstetricians and Gynaecologists

Ms Kate Medwin
Director
Medical Indemnity Section
MDP 951
Department of Health
GPO Box 9848
Canberra ACT 2601

Dear Ms Medwin,

Re: Response to Discussion Paper: First Principles Review of the Indemnity Insurance Fund (IIF) and Associated Schemes

I am writing in response to the invitation to provide input into the above matter. I note the discussion paper released by the Department of Health is extensive in nature. As a voice representing the interests of obstetricians and gynaecologists, our response is focussed solely in the context of conducting practice.

While I acknowledge the importance of written consultations, as a representative of a craft group that stands to be the most affected by changes to the schemes, NASOG would welcome the opportunity to actively engage in any formal committee or group that may be established under this review.

About NASOG

NASOG is a not-for-profit professional association representing specialist obstetricians and gynaecologists, the leading providers of specialist women's health services in Australia. We work closely with other specialists, midwives, GPs, nurses, physiotherapists and other health professionals to provide comprehensive care for all aspects of women's health. Our patients are a particularly vulnerable group, and we are committed to serving them through being an active voice for our members.

Background & Key Considerations

Disappointingly, in the 2016-17 Mid-Year Economic and Fiscal Outlook (MYEFO), significant cuts were made to the IIF schemes which are critical pillars that enable doctors to practice privately without the fear of cost prohibitive Indemnity Insurance. We urge the government to proceed with caution regarding this review, for reasons we outline in this submission.

As the department is aware, the schemes were established in the early 2000s as a result of disruption and complete market failure caused by a number of significant events. This included the largest medical defence organisation (MDO), United Medical Protection (UMP), being placed into provisional liquidation, and the collapse of the HIH Group. These events meant the market could not adequately supply indemnity insurance to medical practitioners at affordable premiums.

Rapid escalation of potential payouts and liabilities and the 18 + 7-year period of liability, meant premiums were rising at rate that threatened the viability of private obstetric practice. Forward premium estimations far exceeded obstetric incomes and many feared the specialty would be “uninsurable”. Applications to train in the specialty plunged below available places, in stark contrast to today’s competitive environment.

Without government intervention, many doctors simply would have been forced to cease practice. This would have been disastrous for Australia’s healthcare system, and I applaud the Howard Government who at the time recognised this, and took appropriate action.

During the ‘medical indemnity crisis’, this matter was a key priority for NASOG, and our organisation worked closely with senior levels of government (including the Prime Minister), and other stakeholders, to identify solutions that would work for doctors and patients. As a craft group whose work is categorised as ‘high risk’, our members, especially those who primarily practise private obstetrics, stand to be the most affected by this review of the IIF and associated schemes. More importantly, if our members are negatively affected, then so too will the patients they provide specialist level care to; women and young families. Affordable indemnity directly correlates to affordable care. Any change to the schemes that would result in increased premiums will increase cost of care delivery to patients. With the Medicare freeze, falling rates and utilisation of private health insurance and cost of living rises, obstetricians can no longer absorb the rising costs of delivering health services.

While we recognise the efforts of the then government to intervene and stabilise what was a very dire situation, restoring a system whereby doctors could continue to practice privately, cost of indemnity insurance has continued to remain a core issue for our membership. An objective of the schemes is to ensure indemnity insurance remained affordable. However, NASOG is aware that many obstetricians and gynaecologists chose to retire, often

prematurely, rather than practice in an environment of such fiscal uncertainty and we would certainly not like to see this pattern repeated. Medical indemnity costs, for many, are the second largest practice expense after staff wages.

For specialists who lived through the crisis, it is fair to say it took its toll mentally due to the level of uncertainty, stress and anxiety involved. At the height of the crisis, many doctors were forced to consider whether they would even continue to practice, and some simply chose to close their practice, or leave the profession all together. The threat to private obstetrics practice was very real indeed. Since the announcement of this review, many in the specialty feel a sense of deja vu. Given this, NASOG seeks the department's assurance that this review, and/or its potential outcomes, will not reflect the crisis of the early 2000s.

The department would be aware that running a private medical practice, has, by its nature, the same economic demands as any other business. The costs to run a practice have increased year-on-year, eg. wages, utilities, rent, etc. In addition to rising costs, practices have faced a range of other economic factors affecting practice. These include the Medicare freeze, inadequate indexation, rising costs of private health insurance and increased constraints placed on doctors by health funds, eg. gap cover scheme terms and conditions. The pressure on practices as businesses is substantial, as we endeavour to absorb increased costs into the business so the impact on patient out-of-pocket costs is reduced. An accessible and affordable private system alleviates pressure, as it should, on the public system, therefore creating savings for tax payers. Maintaining a viable and sustainable private system is essential to the survival of the public system, and broader healthcare system. Without it, the public system would simply not function, and patient outcomes would deteriorate.

As stated, this review brings with it a new level of uncertainty for doctors. Following the crisis, and with high practice costs continuing, long working hours, family disruption and fear of litigation (long after ceasing practice), many specialists made the decision to cease obstetrics and practise gynaecology only. There is evidence that private obstetrics is in decline, and private obstetrics practice in particular is no longer an attractive proposition for trainees. This comes at a challenging time for private practice, particularly given the range of policy matters impacting private practice including the MBS review and private health insurance affordability. With this in mind, and a public system that is increasingly over-

burdened for a range of reasons, we urge government to carefully consider all matters broadly connected with this policy area, not just the schemes themselves. Critical to this review is consideration of the total practice environment leading to fully informed decision-making.

Scheme Specific Observations

Premium Support Scheme (PSS)

Table 2.2 from the Australian National Audit Office's (ANAO) report of 2016-17[1] shows the PSS provides significant support for obstetricians. While the difference in premium as a percent of income pre and post subsidy is 2%, removing the subsidy or reducing it would have substantial impact for our members, and this would result in impact on their patients. Our members cannot continue to absorb growing costs to practice based on policy changes by government. It simply becomes a question of viability, and more importantly willingness to continue to practice for the level of demand their role requires.

Table 2.2: Participation levels and impact of the Premium Support Scheme, 2013–14[(a)]

Specialty	Doctors in PSS	PSS cost per doctor	Private income	Premium set by insurers, prior to PSS subsidy		Premium, including PSS subsidy	
		$ 000	$ 000	$ 000	Per cent of income [(b)]	$ 000	Per cent of income
GP with obstetrics	177	8	383	15	4	7	2
GP procedural	531	3	309	8	3	5	2
Obstetrician[(c)]	293	15	695	56	8	41	6
Neurosurgeons	45	11	878	47	5	36	4
Other specialities[(d)]	551	2	85	10	12	7	9

Note a: Data for 2013–14 used, as income data for 2014–15 was incomplete.

Note b: Significant proportions of these speciality groups continue to receive PSS subsidies due to MISS grandfathering arrangements.

Note c: Includes gynaecology.

Note d: Weighted average across all other specialities.

Source: ANAO analysis on Human Services' PSS data.

High Cost Claims Scheme (HCCS)

Obstetrics, as an area of practice, is particularly vulnerable to high cost claims. It should be noted that claims arising from obstetrics can take a considerable length of time, many years after the management and delivery of care has occurred with the statute of limitations

[1] ANAO Report No.20 2016-17, The Management, Administration and Monitoring of the Indemnity Insurance Fund, p. 38.

starting 18 years after the birth of a child. This needs to be forefront of mind when analysing data, and subsequent trends.

The decision to increase the HCCS claims threshold from $300k to $500k will increase premiums[2,3], and therefore impact patients. We condemn this decision, particularly given it was made prior to the commencement of this review, and call upon government to reconsider this.

Exceptional Claims Scheme (ECS)
While there have been no claims to date since the ECS was established, the scheme provides a high level of certainty to insurers, and this certainty would no doubt be factored into insurers business planning. This certainty would be taken into consideration in terms of insurers assessing risk levels, and mitigations of risk. Without this level of certainty, risk profiles would change, therefore increasing premiums. Terms and conditions of policies may also be negatively impacted, thereby making it difficult for doctors to practice with a level of certainty. It is not only cost of premiums that is important, but also the policies insurers provide and what the terms and conditions are of those policies.

Run-off Cover Scheme (ROCS)
It would not be reasonable to expect doctors to continue medical indemnity coverage after they cease practice and into retirement in the absence of this scheme. Specialists train for more than 12 years in order to qualify to practice. This means they are over 30 years of age when starting their specialist career and earning income as a specialist. The Specialty Training Timeline diagram from the Department of Health's Australia's Future Health Workforce – Doctors Report of 2014 depicts the investment an individual makes in specialist training emphasising the point regarding length of time income is earnt as a specialist.[4] This should be considered along with total costs to train and practice. A specialist's working life is therefore approximately 20-30 years based on a retirement age of 70. For them to incur ongoing professional costs of practice after ceasing practice into retirement is not acceptable.

Not having the ROCS (and other schemes) would be a deterrent to those entering the profession, and would have consequences for the medical workforce into the future.

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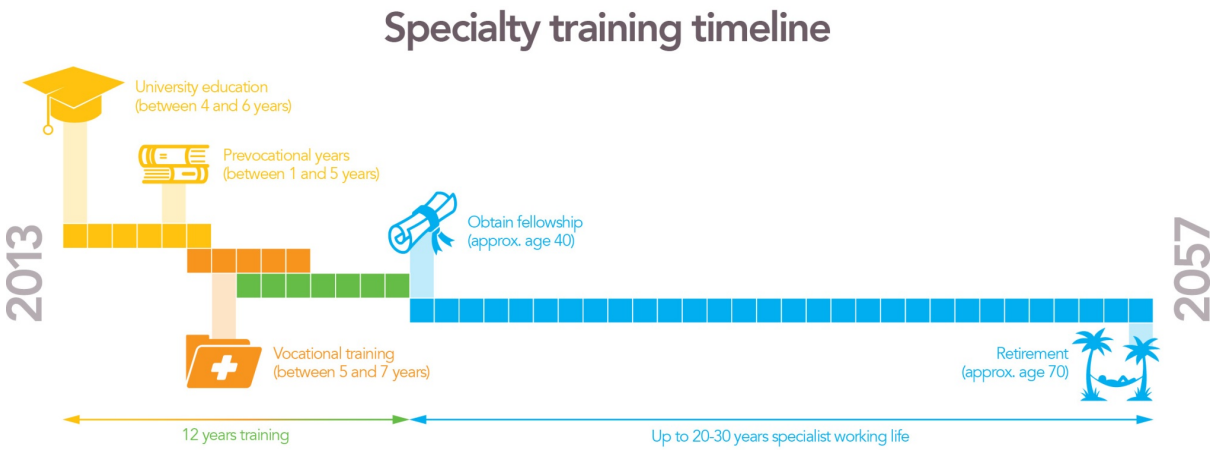
[2] MDA National. Available from: www.mdanational.com.au/Miscellaneous/High-Cost-Claims-Scheme.
[3] Avant Media, Dec 2016. *MYEFO means higher medical indemnity for doctors*. Available from: www.avant.org.au/news/higher-medical-indemnity-premiums-for-doctors/.
[4] Department of Health, Aug 2014. Australia's Future Health Workforce – Doctors Report. Available from: www.health.gov.au/internet/main/publishing.nsf/Content/F3F2910B39DF55FDCA257D94007862F9/$File/AFHW%20-%20Doctors%20report.pdf.



The age demographic of the medical workforce is well documented. And with a large number of doctors predicted to retire from 2025[4], the ROCS will be needed even more.

Incurred But Not Reported Claims Scheme (IBNR)
Given this scheme was established to support UMP to cover a specific set of claims unknown at the time for members of UMP, it is logical that this scheme has a naturally limited life with time progression. It would therefore be prudent to allow the scheme to run its course of natural life, thereby providing protection for remaining previous UMP members.

Summary
NASOG does not support the unravelling of the IIF and associated schemes that restored essential stability to a sector that was in crisis in the early 2000s. On behalf of all those within our specialty, I call on government to proceed with careful consideration of all matters in practice, not just the policy framework itself. A system which covers new specialists, those in established practice and those approaching retirement with a fair and equitable level of underwriting is required.

Thank you for the opportunity to input into the early stages of this review.

Yours sincerely

Dr Gary Swift
President

13 October 17