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Submission to the Department of Health

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First Principles Review of the Indemnity Insurance Fund

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide comments to the Department of Health (the Department) on its First Principles Review of the Indemnity Insurance Fund (the Review).

ACEM is the not-for-profit organisation responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. The practice of emergency medicine is concerned with the prevention, diagnosis and management of *acute* and *urgent* aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders.[1] As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients.

ACEM supports the Terms of Reference (ToRs) of the Review and welcomes the opportunity to engage with the Department as it works to examine whether existing indemnity insurance arrangements are relevant and 'fit for purpose', if changes to current arrangements are required, and what impact this might have on future policies.

ACEM acknowledges that the proposals put forward by the Department are a first step to informing parameters that should be considered and determined by Government. The paper outlines the rationale behind government intervention in Australia's medical indemnity insurance landscape. However, the paper does not acknowledge that government intervention has historically been reactive, and has not put patients and their families at the heart of policy initiatives.[2] ACEM considers that any change to Commonwealth funded schemes under the Indemnity Insurance Fund must ensure they continue "…to support affordable health care and ensure that patients who make legitimate claims against medical practitioners….are able to be compensated for any loss they have suffered."[3] ACEM strongly believes that patients and their families must be at the heart of any reform measure undertaken as a result of the Review.

ACEM supports the Government's intention to monitor the impact of ceasing these schemes, particularly in rural Australia.[4] The Government has outlined that "…the market is normalising" and that all insurers were in a positive position over 2015-16.[3] However, ACEM contends that caution is required as there are significant internal and external factors that have the capacity to greatly impact Australia's economic capabilities.

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1 Australasian College for Emergency Medicine. Background paper - Policy on standard terminology (P02). Melbourne: ACEM; 2014

2 Wheatland, F 2005. *Medical Indemnity Reform in Australia: "First do no harm".* Medical Malpractice: U.S and International Perspectives. Journal of Law, Medicine and Ethics.

3 Department of Health, 2017. *Discussion Paper: First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF*. Australian Government

4 National Commission of Audit, 2014. Chapter 8.7 – Other selected programs. Australian Government [Internet}. As viewed online 10 October 2017. Available from http://www.ncoa.gov.au/report/phase-one/part-b/8-7-other-selected-programmes.html

Broader market instability exists in the form of housing debt in Australia property markets, which has led to rising social inequalities.[5] Complementing this external factor is the internal health system issue of access block[6]. Access block is the inability to transfer admitted patients in hospital emergency departments to inpatient beds. ACEM considers this as the most significant issue facing EDs in Australia, as it negatively impacts on the provision of safe, timely and quality medical care.[7] Access block is a key indicator of a system in crisis and demonstrates the ongoing challenge for governments in effectively and efficiently utilising resources to address patient and community demand. For example, between 2011-12 and 2015-16 demand for public EDs in Australia continued to rise each year (3.7% on average) to a total of almost 7.5 million ED presentations in 2015-16. Over the same period, public hospital beds increased on average by 1% per year (to a total of 61,000 available beds).[8] However, only 49% of patients admitted from the ED to the hospital were admitted within four hours[9]. [10]

ACEM believes that systemic crisis increases the pressures on staff throughout the broader hospital system, with high workloads demonstrated to impact on the ability of staff to reduce patient neglect.[11] Across all EDs in Australia and New Zealand, Fellows (emergency specialists) and EM trainees have reported that ED overcrowding and access block are key work stressors impacting on their ability to do their job.[12] Furthermore, research suggests that access block and ED overcrowding directly contribute to increased patient mortality in Australia by approximately 20-30%.[13] ACEM contends that if changes are made to indemnity insurance fund arrangements while broader systemic pressures remain, public hospital utilisation will increase, access block will be exacerbated, and there is an increased risk of adverse patient outcomes. Although these risks differ from those experienced pre-2002, similarities exist, and may result in a repeat of the impact upon, and response required by, government.

Members also report that there is increasing confusion among hospital staff, insurance providers and agencies over the indemnity requirements of working as a locum in Tasmania. Short term contracted employees work in public EDs, are employed by hospitals through agencies, and work under the same conditions as full time employees. However, locums are increasingly being told that in order to be contracted they must hold their own indemnity insurance. This is complicated by the refusal of some Medical Defence Organisations to provide cover for locum practitioners working in public hospitals, in the belief that those practitioners should be indemnified by the State (as substantive State employees are). Concerningly, there have also been instances where, upon completion of their contract, locum staff have been asked for proof of their indemnity having worked under the misperception that they were already insured through the agency and/or the hospital. ACEM considers that clarification is

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[5] Clarke, C 2017. *RBA governor says inequality getting worse, contradicting Scott Morrison*. [Internet] Australian Broadcasting Corporation. As viewed online 10 October 2017. Available from http://www.abc.net.au/news/2017-07-26/rba-says-inequality-getting-worse/8746594

[6] Access block is defined by ACEM as "the situation where patients who have been admitted and need a hospital bed are delayed from leaving the Emergency Department because of lack of inpatient bed capacity".

[7] Australasian College for Emergency Medicine. Background Paper – Statement on Access Block (S127). Melbourne: ACEM 2014

[8] Australian Institute of Health and Welfare, 2016. Emergency Department Care 2015-16. Australian Government.

[9] The Australian Institute of Health and Welfare collects data on the time a patient spends from presentation until leaving the ED. ACEM considers that time-based targets for patients in EDs is a useful indicator of the capability of health care systems and provides an insight into the patient's experience of care.

[10] Australian Institute of Health and Welfare, 2017. Hospital resources 2015-16: Australian Hospital Statistics. Table 6.7. Australian Government, Canberra.

[11] Reader T & Gillespie A, 2013. *Patient neglect in healthcare institutions: a systemic review and conceptual model*. BMC Health Service Research: 13:156

[12] Australasian College for Emergency Medicine, 2016. *ACEM Workforce Sustainability Survey Report, November 2016.* Melbourne: ACEM.

[13] Forero R, Hillman K. Access block and overcrowding: a literature review. Sydney: University of New South Wales, 2008.

required as there is an increased risk of locums being unable to fill short-term contract requirements in Tasmanian public hospitals.

In Western Australia, medical services agreements (MSAs) exist between medical practitioners and WA Country Health Service regions. The MSAs include requirements for non-salaried medical practitioner[14] indemnity, which were last updated in 2013.[15] The indemnity ensures that practitioners are covered by the State for all procedures included in the contract. However, it does not cover procedures undertaken in private hospitals.

ACEM notes the importance of the Run-off Cover Scheme (ROCS) that covers medical practitioners who cease private practice. ACEM strongly believes that there is a need for continuation of the ROCS and that it must, regardless of Commonwealth responsibility, continue to include cover for relevant ED staff. ACEM further considers that additional consideration of the questions raised in this paper is required, and calls for a dedicated ROCS component as part of these efforts.

ACEM strongly advocates that every patient has the right to access acute care services and that patients must be supported to make informed choices about their care. Emergency Departments are vital components of hospital infrastructure and must be supported by governments as core elements of health care systems. ACEM considers that while the proposals put forward in this paper do not directly focus on public or private EDs, they have the potential to impact on the financial viability of running a private ED. This is primarily underpinned by potential unexpected consequences that may occur by changing existing indemnity insurance arrangements managed by the Commonwealth. ACEM considers it essential that further consideration is given to these issues, and that the Review also considers Tasmania and Western Australia's approach to ED private contractors in public hospitals.

ACEM looks forward to further developments that are expected to follow this First Principles Review. ACEM considers that a stakeholder workshop would provide an excellent opportunity to engage with the Government on its anticipated next steps.

Thank you for the opportunity to provide feedback to this consultation. Should you require clarification or further information, please do not hesitate to contact the ACEM Policy Officer, Lee Moskwa on [redacted]

Yours sincerely,

Professor Anthony Lawler
President
Australasian College for Emergency Medicine

[14] As defined in the *Terms and Conditions of the Medical Indemnity for Non-Salaried Medical Practitioners*: medical practitioners authorised by the Board to provide medical services but not engaged by way of an employment contract.

[15] Western Australia Country Health Service, 2017. Medical contracting arrangements. [Internet] Government of Western Australia. As viewed online 10 October 2017. Available from http://www.wacountry.health.wa.gov.au/index.php?id=mca