Avant
By doctors for doctors

Issue 23 | November 2024

Connect

Dr Matthew Lennon
Psychiatry registrar and researcher, Avant Grant recipient

The future of healthcare

How AI tools and other data-driven technologies are changing the practice of medicine

Hypertension and dementia connection

Big data helps establish a relationship

AI scribes during physical examinations

Benefits for doctors and patients

Locum cover led to Medicare audit

Government department data sharing picks up billings when doctor overseas

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Dr Tom Wang
General practitioner

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Supporting doctors as they navigate the future of healthcare

It's now two years since ChatGPT launched and the world woke up to the potential of, and concerns about, the latest generation of artificial intelligence (AI)-powered technology.

In the medical world we've always been at the forefront of harnessing the power of new technologies, and many doctors would not have been surprised at how responsive and sophisticated the new AI-generative tools are proving. We are also more naturally inclined to be wary of trusting the hype, being all too aware that if something goes wrong it could have serious implications.

In this 'Future of healthcare' edition of *Connect*, we look at some of the ways AI and other data-driven technologies are impacting on doctors' lives.

As I've said before, digital tools will never replace doctors, but doctors who use digital tools will likely replace doctors who don't.

One positive is the potential of tools, such as AI scribes, to lighten workloads by assisting with the more tedious parts of our jobs. Having the details of a consultation captured not only frees up doctors to focus on engaging with patients but can also reduce misunderstandings during physical examinations.

Another beneficial development is the establishment of big databanks holding genetic data, information on individual lifestyles and longitudinal health history for large numbers of people. The connection between untreated hypertension and dementia is just one example of the sort of discovery interrogating this data can establish. We spoke to Dr Matthew Lennon, who has recently been supported through an Avant grant, about his work in this area.

Funding doctors like Dr Lennon, to pursue research and quality improvement projects is one way Avant contributes towards future improvements in the health system.

Technology also has its downsides, with cyber crime a growing concern among doctors. Avant has recently assisted a number of practices and individual practitioners who found themselves in the highly stressful situation of realising their data has been hacked. One of our case studies describes a range of cyber incidents and how our Risk Advisory Service was able to help the practices impacted set up more rigorous systems to limit the likelihood of it happening again.

Providing advice and education on the risks of new technologies is a key part of our support for members.

The protection of our members in medico-legal matters, both current and emerging, will always be a primary concern. This is why we are working hard to ensure the regulatory environment keeps up with the latest developments around AI tools and access to patient data. In this edition, you can read about our advocacy activities with government bodies on proposals to regulate AI. Our aim is to minimise the medico-legal risks for members and support effective public policy development on AI in healthcare.

In our featured cases, we draw from the experiences of our members who found themselves in situations where they needed our support.

We have summarised these cases and highlighted some key lessons for doctors with guidance on how to avoid similar issues.

Our commitment to supporting members and the sustainability of the Australian healthcare system extends to the arrangements we make with private hospitals. Read about our position and how we are focused on strong partnerships and continued delivery of high-quality care.

Thinking about the future isn't always about focusing on your professional life. Avant is also here to support members with planning for the years ahead in their personal lives.

Whether you want to maximise the investment you have made in your business as you plan ahead for retirement, or are looking for information to help you decide between paying down a mortgage or making additional contributions to superannuation, we have expertise that can guide you.

I trust you will find the range of articles included in this edition provide a good demonstration of how Avant is by your side more than ever before.

Best regards,

Steve Hambleton

Dr Steve Hambleton AM
Chair, Avant Mutual

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Connect with us

We'd love to hear what you think of *Connect*, or what you'd like to see more of – email editor@avant.org.au.

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Acknowledgement of Country

In the spirit of reconciliation, Avant acknowledges the Traditional Custodians of Country throughout Australia, and their connections to land, sea and community. As a national organisation, we pay our respects to Elders past and present, of the lands on which we gather and work, and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Big data reveals connection between hypertension and dementia

The link between hypertension and heart disease or stroke is well understood by doctors and many of their patients. But it's less commonly known that high blood pressure is a significant risk factor for dementia, including Alzheimer's disease.

Investigating this relationship has become a priority for Dr Matthew Lennon, a psychiatry registrar working with the research team at UNSW's Centre for Healthy Brain Ageing.

Dr Lennon's hope is that increased awareness of the dementia risk of poorly controlled hypertension will provide doctors and patients with additional motivation to diagnose, monitor and more effectively manage high blood pressure.

Dr Lennon and colleagues published a meta-analysis in 2019 that shone new light on the relationship between mid-life hypertension and Alzheimer's disease (AD). They found the risk of AD increased by 18% and 25% respectively in people with stage 1 (≥140 mmHg SBP) and stage 2 (≥160 mmHg SBP) hypertension.

Key dementia risk factor is treatable

More recently, Dr Lennon used a large, international consortium of datasets, including more than 43,000 participants, to further investigate the effect of blood pressure and antihypertensives on dementia risk in late life.[1]

The size of the data is important. As Dr Lennon explains, "Big data allows us to drill down and identify how risk factors may differ between people of different ages, sexes and racial groups. This more basic demographic data, in combination with our increasingly available large genetic datasets, allow us to be more precise in stratifying an individual's risk of dementia, and thus be more targeted in monitoring and treatment."

In a separate study, Dr Lennon used one of the largest genetic datasets in the world, the UK Biobank, which has more than 500,000 participants, to explore how the genetic risk for high or low blood pressure affects cognition.

These studies supported earlier findings by showing that individuals with untreated hypertension had a greater risk of both dementia (+42%) and AD (+36%) compared to those without a previous diagnosis of hypertension. Furthermore, individuals whose hypertension was effectively treated had a substantially lower risk than those who were left untreated.

Dr Lennon highlights, "It was particularly interesting to establish that the higher risk of either dementia or AD in people with untreated hypertension remained similar for individuals in their 70s and even 80s. This really does show it's outdated to believe treating high blood pressure is less important in old age."

Opportunity for an impactful public health campaign

High blood pressure is the leading factor for preventable deaths in Australia, and is becoming more prevalent as the population ages. Historically, hypertension has been underdiagnosed and undertreated, with blood pressure control rates in Australia currently at only 32%. While guidelines for effective management are well established, compliance is poor.

Dr Lennon is hopeful that generating public awareness about this less-known risk of hypertension may change the way people think about, monitor and treat high blood pressure.

He is encouraged by a recent cross-sectional survey of Australians attending an outpatient clinic, which found dementia was the second most feared disease (after cancer).[2] For 29.3% of respondents this was their primary worry, four times the percentage who replied with "coronary heart disease". As people age, their fear of getting dementia increases and, for over 65s, it is the most feared health condition. ●

"

It's increasingly recognised that even in older patients, it's important to keep to a target 120/80 mmHg.

Reducing blood pressure is effective for stroke prevention and heart attack. But for many people, knowing it is protective for dementia will be a greater motivator to manage this often silent but deadly disease.

Dr Matthew Lennon received funding towards his research work through Avant's Early Career Research Program.

Avant Foundation
Find out more about our grant programs

[1] *A new focus on hypertension and dementia,* Medical Journal of Australia, InSight+
[2] *Dementia is the second most feared condition among Australian health service consumers: results of a cross-sectional survey,* BMC Public Health

Tanya has had a rewarding career in medicine. We're sure there's even more to come.

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Dr Tanya Gray
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Supporting safe and responsible AI use in healthcare

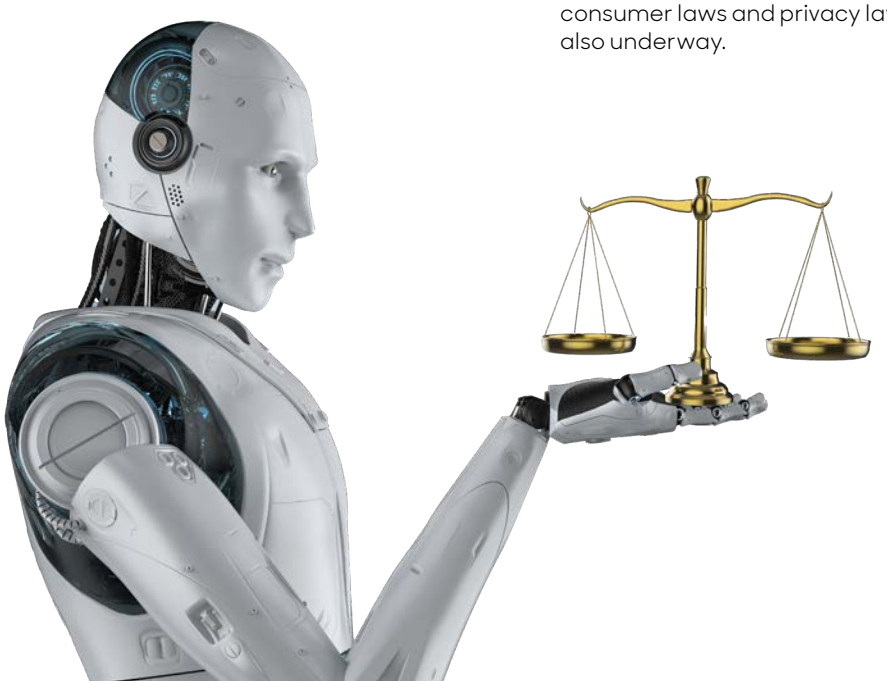
Georgie Haysom
BSc, LLB (Hons), LLM (Bioethics), GAICD, GCPsyBM
General Manager, Advocacy, Education and Research, Avant

With artificial intelligence (AI) technology progressing rapidly, it seems that just about every day we hear of a new advance in how it is being used. In healthcare, while AI has many potential benefits, it can also create medico-legal risk.

Listening to our members

Over the past 18 months we have received an increasing number of requests from members for advice about the potential medico-legal risks associated with using AI, including general purpose AI such as ChatGPT and AI scribes for clinical notetaking. A recent survey of 600 members showed three in four respondents had a fair to poor knowledge of AI overall. And while only a small number (around 10%) were using AI, around 40% of respondents indicated they were likely to use an AI scribe in the future.

For AI scribes, assessing their quality, safety and performance isn't simple. Members have told us they want some reassurance and guidance about which AI scribes are safe to use. However, AI scribes are currently not subject to any regulatory oversight.



Responsibility currently a grey area

Another area of concern is the uncertainty about who is legally responsible if a patient is harmed by the use of AI. The complexity of AI algorithms and machine learning makes it hard to trace the decision-making process, and this creates difficulties in determining who is accountable for errors or adverse outcomes.

Broad indemnity clauses in some AI provider contracts could unfairly shift responsibility onto the doctors using the AI tool, when they are not responsible for controlling the risk.

Evolving regulatory environment

As AI continues to progress, it is only natural that regulatory frameworks will evolve alongside the technology to support opportunities for innovation and respond to the distinct risks. The Australian Government has proposed mandatory guardrails for AI systems in high-risk settings, including healthcare. These would require developers and deployers of AI to take steps to ensure their products are safe.

At the same time, health laws are being reviewed, with proposals to clarify and strengthen legislation and regulation for AI in healthcare settings. Complementary reviews of consumer laws and privacy laws are also underway.

Avant's position and advocacy

We believe mandatory minimum standards are required for AI tools used in healthcare that fall outside the Therapeutic Goods Administration's regulatory framework. These should cover a range of issues including privacy and security, risks management and insurance. These standards should include any AI tools that suggest clinical findings and make recommendations that if inaccurate, or not acted upon, could cause adverse patient outcomes.

Legislative and regulatory obligations should be placed on the entities across the AI supply chain and throughout the AI lifecycle that can most effectively prevent harm before people interact with the AI tool. Where harm does occur, there needs to be mechanisms for appropriately determining liability and obtaining redress. It is not appropriate that healthcare professionals bear the sole liability, particularly where they do not control the risk.

Ongoing consultation will be essential to ensure the appropriate regulation of AI in healthcare and should involve all relevant stakeholders, including insurers.

Avant is actively engaging with government about these proposals to minimise the medico-legal risks for members and support effective public policy development on AI in healthcare. We have made submissions to the various consultations.

Our focus is on advocating for clear frameworks and guidelines to address the complexities of AI in healthcare and manage the medico-legal risks. We want to ensure that responsibility and liability are clear and properly managed. Both doctors and patients need to be adequately protected in the case of patient harm. ●

Learn more
See submissions to consultations on AI and digital health

How AI could make your job easier

Tracy Pickett
BA, LLB
Legal and Policy Adviser, Avant

As the healthcare system faces increasing workloads and staff shortages, artificial intelligence (AI) is showing enormous potential to handle the more tedious and time-consuming aspects of many doctors' roles.

This extends beyond assistance in healthcare data collection, with recent advancements demonstrating AI's promise as a diagnostic adjunct across many clinical specialties.

The role of AI in clinical practice

You may already use medical documentation tools, or AI scribes, to save time in your practice.

These scribes are useful to record patient consultations and write a summary. But as a relatively new technology, there are risks of the scribe creating inaccurate records of a consultation.

In our recent webinar on AI, Prof Farah Magrabi, of Biomedical and Health Informatics at Macquarie University's Australian Institute of Health Innovation, gives the example of a doctor talking about issues with a patient's hands, mouth and feet and the AI scribe recording that they had hand, foot and mouth disease!

According to Prof Magrabi, the clinical use of AI in healthcare falls broadly into three main groups:

- Providing information to clinicians to support their decisions.
- Assisting humans to make decisions. For example, AI can look at ECG signals and detect abnormal cardiac rhythms, making it a second pair of eyes for a clinician.
- Providing decisions. This feature is useful for screening services where specialists aren't available. For example, AI can be trained to look at images of a retina and detect diabetic retinopathy.

Like most tech solutions, AI's output accuracy relies on the quality of data a user inputs. Prof Magrabi cited US FDA data on six years' worth of reported safety events, showing 82% resulted from poor data being fed into AI systems. She reminds doctors not to use AI-generated output as the primary interpretation: "Responsibility for final decisions rests with clinicians. It's about knowing what the AI is doing and accordingly adapting their practice to use it safely."

Potential for improved diagnosis and disease risk prediction

Radiology is one specialty where AI is proving to be accurate, and useful in relieving demands on radiologists to interpret medical imaging. Speaking in the same Avant webinar, Prof Paul Parizel, the inaugural David Hartley Chair of Radiology, University of Western Australia, said, "AI can increase diagnostic accuracy and lower the rate of misdiagnosis. [It] can detect up to 25% more fractures than a trained radiologist or ED physician. AI can quantify abnormalities, allowing us to monitor treatment response in patients with chronic diseases, for example, in multiple sclerosis and oncology."

For radiologists themselves, Prof Parizel said AI has the potential to "improve the quality and speed of service delivery to patients. AI will change the content of our jobs and define new roles. Medical imaging technologists will become empowered, with AI offering opportunities for greater autonomy and self-definition of the profession."

Beyond aiding specialists to diagnose disease, studies show AI may predict disease risk. Recent research has demonstrated that an AI-driven eye scan could potentially predict cardiovascular and Parkinson's disease risk.

> What they found was … clinicians were staying back less at the end of the day to complete their documentation. Patients also reported that they observed doctors spent less time on the computer and more time talking to them, compared to past visits.
>
> **Prof Farah Magrabi**
> Biomedical and Health Informatics
> Macquarie University's Australian Institute of Health Innovation

Improving the patient experience

For patients, the improved efficiencies AI can support in hospital systems can decrease processing time in emergency departments and free up hospital beds. And the potential to analyse vast amounts of data and identify patterns, augments a clinician's ability to make treatment decisions, so that patients receive more targeted, personalised medicine.

With AI performing more administrative tasks, doctors are freed up to engage better with patients during a consultation. Prof Magrabi cited a recent 10-week study of 10,000 physicians and staff in a large health system in California.

"What they found was … clinicians were staying back less at the end of the day to complete their documentation. Patients also reported that they observed doctors spent less time on the computer and more time talking to them, compared to past visits," she said.

Cost savings and consumer demand

Automating administrative tasks using AI can significantly improve the efficiency and accuracy of healthcare and hospital operations, including logistics and resource management, patient flow and scheduling optimisation, and billing and invoicing.

This was quantified in a 2024 Productivity Commission research paper that found "better integrating digital technology into everyday practice could save more than $5 billion a year and ease pressures on our healthcare system."

Prof Magrabi said, "Our consumers want and expect us to use AI in healthcare". She cited the outcome of a University of Wollongong citizens' jury on Artificial Intelligence in Health: "Australians welcome the clinical application of AI and expect strong governance to be in place."

Watch our webinar
AI's expanding horizon in healthcare

Unexpected benefit of using AI scribes

Dr Victoria Phan
BMed, MD, MClinUS, DCH, FPAA Cert
Risk Adviser, Avant

If you are not already using an artificial intelligence (AI) scribe, it's possible you are thinking about it, or planning to use one in the future, as our recent member survey found.

AI scribes 'listen' to your consultation and process the audio into a structured clinical note. Because you do not need to write or type during the consultation, you can direct more attention to the patient. As well as taking away some of the documentation burden for you, this offers benefits for patients as you are able focus on them more while you listen to their history and discuss their condition, treatment and management.

But if you need to carry out a physical examination, this will not automatically be picked up by the AI scribe.
So how do you convey the relevant information to ensure it's captured in the clinical note?

Capturing the physical examination

Your patient should already be aware that you are using an AI scribe and should have consented to its use at the start of the consultation.

You will need to consider your consultation style to best capture the physical examination. Members who have started using AI scribes, have told us the most effective way of capturing the physical examination is to say what you are doing, both before and during the examination.

Some doctors will adjust their consultation style by verbalising and 'dictating' their examination findings out loud so it can be captured by the AI scribe and as a memory aid. However, you will need to be mindful of your use of medical jargon in front of the patient, as this may trigger further questions from them.

Alternatively, consider using your usual approach for conducting the physical examination using plain language. That is, you might explain your examination findings as you are examining the patient (much like an OSCE) or explain to the patient your examination findings after you have completed the physical examination.

The AI scribe may be able to interpret your examination findings and record it under 'objective findings' or 'examination' as a basis for your clinical note.

It is imperative you review and edit the clinical note afterwards to ensure your record accurately represents the full examination, including any positive and negative findings as well as non-verbal cues noted.

Improved patient engagement

The process of verbalising the examination for the AI scribe can improve communication and patient understanding. It provides an opportunity for patients to engage with you during the examination and prompts them to ask questions.

If you verbalise your examination out loud as you go using medical jargon, make sure you manage your patient expectations and avoid unduly worrying them by adequately explaining what this terminology means. It may also help the patient if you explain why you have verbalised certain relevant positives and negatives as part of your diagnostic thought process.

One of the unexpected benefits of using an AI-scribe is that describing to the patient what you are doing, and why, can reduce the risk of unintended confusion or miscommunication. This is a common source of patient complaints, particularly when an intimate examination is needed.

Documentation responsibilities

You are responsible for the accuracy of the final clinical note, so always review the note and make any corrections or additions before saving it to the patient's medical record.

As with all medical records, clinical notes produced with the assistance of an AI scribe must meet the requirements of the Medical Board's code of conduct, the Medical Benefits Schedule, Health Insurance Act and Health Insurance Regulations.

Information or aspects that may be omitted from the AI-generated note include non-verbal cues from the patient, or the results of a mental state examination. Information may also be missed, incorrectly categorised or misheard (such as names of referring doctors, medications or unusual symptoms).

Or there may be areas of sensitivity for your patient that you choose not to verbalise. An example might be a patient with an eating disorder and not highlighting their weight or BMI calculation. You may also wish to document other aspects not picked up by the AI-scribe, including trends in vital signs, such as blood pressure.

You should have a process to ensure this information is added to the final clinical note.

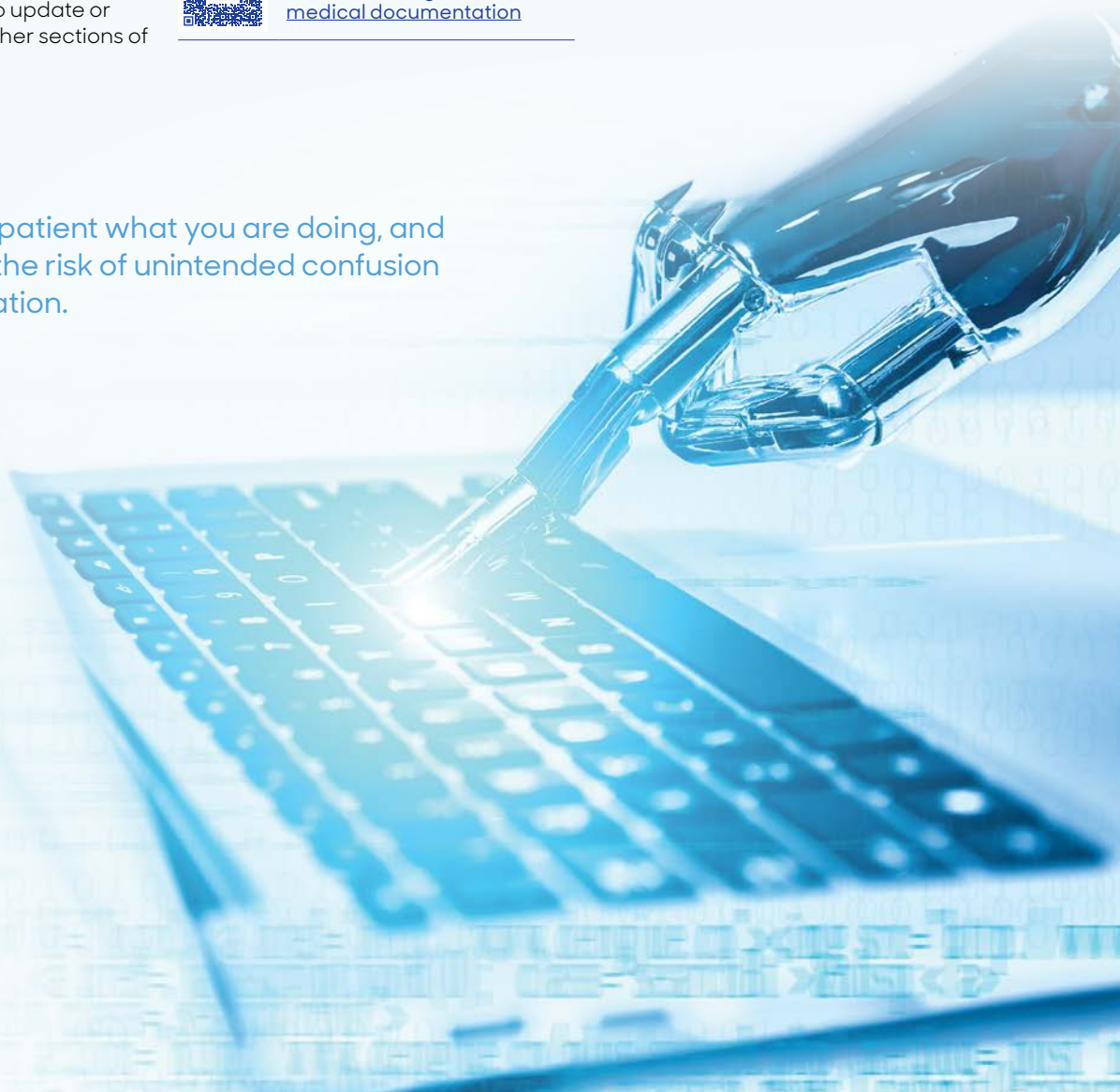
As well as checking the accuracy of the AI-generated note for a consultation, new information gathered, such as a chronic health condition, allergies, social and family history should be used to update or amend information in other sections of the patient's record. ●

Key lessons

- As the technology and integration of AI scribes improves, it promises to ease the administrative burden for doctors and improve the quality of communication and documentation.
- Using an AI scribe can support clear communication with patients and may be a good way of explaining what you are doing in an examination, and why, to avoid misunderstandings.
- Remember though, an AI scribe is just a tool and you are responsible for its safe and effective use. So always check the generated clinical note to ensure it is accurate and complete.

Factsheet
Artificial Intelligence for medical documentation

> Describing to the patient what you are doing, and why, can reduce the risk of unintended confusion or miscommunication.



Urgent Care Clinics: who's responsible for follow-up care?

Kate Gillman
BA, LLB
Head of Medico-legal Advisory Service, Avant

Medicare Urgent Care Clinics (UCC) have been commissioned by governments across the country to reduce the pressure on emergency departments.

The clinics are designed to treat urgent conditions that do not require an emergency department. The intention is that this will be episodic care with follow-up care provided by the patient's regular GP.

However, where a patient does not have a regular GP, who is required to provide follow-up care?

Is a UCC to be assessed against the standards of a general practice or an emergency department?

Operational guidance

According to Medicare's *Operational Guidance for Urgent Care Clinics*, UCCs should not conduct follow-up care. Patients should be referred to their usual GP for follow-up and the UCC doctor should facilitate this by booking an appointment for the patient with their GP.

Every patient is to be given a discharge summary and a copy uploaded to My Health Record and sent to their usual GP electronically, within 24 hours.

Test results need to be reviewed and actioned within 24 hours by a clinician. Patients must be notified of abnormal test results within an appropriate time frame by a UCC doctor, and advised to follow up with their usual GP, who will also be copied into all diagnostic test requests and other referrals.

Continued treatment by UCC

If patients can't see their usual GP within an appropriate timeframe, including follow-up of diagnostic test results, the UCC operational guidance states that:

- Follow-up can be undertaken by the UCC doctor until the condition can be transferred back to the GP.
- The UCC doctor can also follow up where the GP may not have the capability to provide the necessary follow-up care.

Regular GP to follow up

Underpinning the UCC model is an assumption that the patient has a regular GP. In many cases they don't. Where the UCC is co-located with a GP practice, it may be possible to offer an appointment with one of the GPs in the practice.

However, who is responsible for follow-up if there isn't a co-located GP practice, or the co-located GP practice doesn't have capacity to take on new patients, and the UCC doctors aren't able to continue to provide the follow-up care?

As many UCCs are co-located with GP practices and staffed by GPs, doctors are likely to be assessed against the standard of care expected for a GP providing an urgent care service (treating acute injuries and illnesses within their scope of practice). The RACGP standards state that GPs are obligated to ensure results from all tests are recorded and patients are followed up appropriately.

While it is not intended that UCC doctors provide ongoing follow-up care, it may be necessary for them to continue to provide treatment until the patient can be effectively handed over to another doctor. This decision, and how long you provide care, will need to be made on a case-by-case basis, considering the clinical urgency.

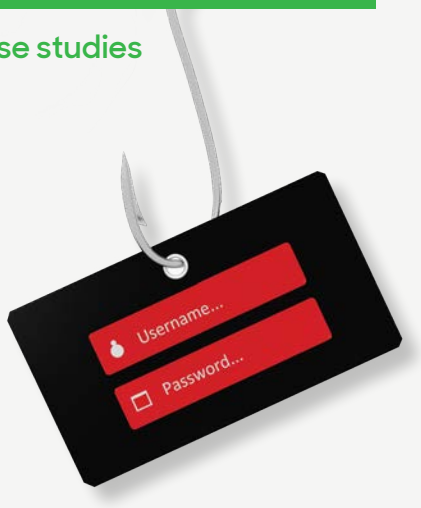
The AMA's position is that a health service will support patients to locate a GP, although it is not the role of a health service to allocate a patient to a GP practice.

These issues need to be factored into the role of a UCC doctor and the operational model for UCCs.

A GP practice co-located with the UCC is not obliged to take on new patients from the UCC. If the UCC doctors do not have the capacity to continue to provide ongoing GP care, either in their UCC capacity or co-located GP practice role, this should be explained to the patient with the advice that they see their old GP or locate a new one. This should be confirmed in a letter to the patient with a copy of the discharge summary to be given to their doctor.

The bottom line is, don't abandon responsibility for the care of the patient. Direct patients to their regular GPs for follow-up and have processes to manage situations where patients requiring follow-up care do not have a regular GP. ●

Cyber security incidents – are you ready?



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Grad Certificate in Emerging Technologies & Law
Claims Manager, Professional Conduct, Avant

Any practice still operating without a cyber security framework is exposing their business to risks that could be very costly. Last year, the highest number of data breach notifications reported to the Office of the Australian Information Commissioner (OAIC) came from the Health Service Providers sector.

The reality is that the risk of a cyber attack is not a question of 'if' but 'when'. Ignoring the problem and hoping for the best, is not an option. As these Avant cases show, cyber incidents and breaches of your sensitive information can occur in many ways.

Case 1: Data phishing

A medical practice received a phishing email disguised as a message from an existing patient, prompting staff to download a file via a malicious link.

After the login credentials of affected staff failed, they contacted their IT provider, who quickly disabled the impacted accounts. Luckily, the hacked accounts did not have administration rights and weren't linked to the practice's software, so only the mailbox contents were exposed. However, these did include referral letters and personal information such as drivers' licence details and Medicare numbers, and 500 patients' details were compromised.

Case 2: Medicare fraud

A member's laptop, which they used to process Medicare claims through a secure payment platform, was stolen.

Despite password protection on both the laptop and payment processing platform, cyber criminals were able to access patient information. They then updated the doctor's bank account details to defraud Medicare.

Case 3: Email hacked

A member working from shared rooms did not realise when he first set up his MS Office account that he had permitted global administrative rights to his Office email.

This meant that hackers were able to gain unlimited access to his system, including full access to the email inbox containing sensitive patient information, resulting in nearly 4000 spam emails being sent to patients.

Avant's assistance

For those who held a Practice Medical Indemnity Policy, the complimentary cyber cover provided by Avant to eligible practices*, helped them to recover the significant costs these incidents incurred. Cyber cover includes business interruption expenses, IT provider costs to recover or restore damaged data files, conducting forensic investigations (to assess the scale of an incident and identify those impacted), and regulatory defence, fines and penalties.

Avant was also able to assist with reporting obligations to the OAIC, notifications to impacted patients and recommend remedial actions, including implementing cyber security frameworks. ●

Key lessons

No practice or individual is immune from a cyber incident. Acknowledging this inevitability, and taking proactive measures, mitigates risks and equips you to better handle such an incident.

Your practice's first defence should be a strong cyber security and privacy framework, along with staff training in these areas.

While Avant can assist members with reporting obligations, if you experience a significant event without cyber insurance, it's likely you will have to deal with it on your own and at a considerable cost.

Resource
Cyber security checklist

Strong first line of defence is essential

Gail Wang
Risk Adviser, Member Advisory Services

While cyber insurance may cover direct costs due to a cyber event, it is harder to recover your reputation or be compensated for the stress arising from such a disruption.

Avant's Risk Advisory Service was able to help these members review and set up improved processes and procedures, including privacy protocols, that would help reduce the risk of such an incident occurring again. This included:

- Implementing cyber security and privacy awareness frameworks, and ensuring staff receive ongoing training.
- Setting out the reasonable steps taken to protect patients' sensitive information from misuse, interference, loss, and unauthorised access, modification, or disclosure. This is a requirement of the Australian Privacy Principles that, if breached, can lead to regulatory actions and penalties.
- Introducing multi-factor authentication systems to reduce the likelihood of unauthorised access.

As well as giving advice on issues that have already occurred, our Risk Advisory Service provides complimentary personalised risk assessments for doctors and practice policyholder members.

The cases featured in this article are based on real cases. Certain information has been de-identified to preserve privacy and confidentiality.
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*Avant Cyber Insurance cover is available to eligible Avant Practice Medical Indemnity Policy holders up to the cessation of their policy and is provided under a Group Policy between Liberty Mutual Insurance Company ABN 61 086 083 605 (Liberty) and Avant Insurance.

Reprimanded for 'shortcuts and skipping steps' when issuing medical certificates

Ruanne Brell
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Senior Legal Adviser, Advocacy, Education and Research, Avant

Patients and practice workloads can put pressure on doctors to quickly issue a medical certificate. However, these are legal documents and come with professional and legal responsibilities.

Taking shortcuts to assist a patient or save time can call doctors' professional integrity into question.

This case involved a rural general practitioner and several concerns raised by the Medical Board about medical certificates he issued for six patients.

These concerns related to both his medical records and the certificates themselves.

Medical records

The board alleged that the doctor had issued medical certificates for patients after a consultation without documenting:

- that he had issued a certificate
- any contemporaneous examination of the patient
- the clinical reason(s) for the certificate.

The tribunal agreed and the doctor accepted that this conduct was below the standard expected.

Medical certificates

The board also alleged the doctor 's certificates did not satisfy the expected standard because:

- some related to absences significantly prior to the date of the certificate
- other certificates were undated
- one certificate was for extended absence for stress where the doctor ought to have considered issuing a WorkCover certificate
- another certificate was for a period of six months where there were no arrangements for regular review of the patient.

The concerns related only to the form of the certificates and procedures for issuing certificates. There was no suggestion any of the certificates were fraudulent or deceptive. The board accepted that all were for genuine absences and in all cases the doctor knew the patient's circumstances and medical history.

The tribunal agreed the medical certificates were issued legitimately but concluded the concern lay in the shortcuts taken by the doctor, particularly in relation to inadequate record keeping underpinning the certificates.

The tribunal found, and the doctor accepted, that this conduct was below standard and constituted professional misconduct.

Medical statement

There was a separate allegation that the doctor did not satisfy the expected standard when issuing a 'medical statement' to a patient, detailing the patient advised they'd been unwell and unfit to attend work on certain dates. The tribunal did not accept these actions were below the accepted standard.

The tribunal acknowledged the doctor had not certified this information but rather he simply stated what the patient had told him and made it clear in the document. Whether or not it would be accepted by an employer was another matter, but the document was not misleading and writing it was not unprofessional conduct.

Professional boundaries - treating those close to you

The board also alleged in one case the doctor had written a certificate for a close friend or family member and allowed them to complete the dates of absence in the certificate.

The tribunal noted the doctor had countersigned the dates added and accepted his explanation that the patient had been uncertain of the dates at the consultation and had needed to check these. The tribunal commented that this situation illustrated the risks for doctors in treating those close to them. While this conduct was below standard, it could not be characterised as fraudulent or misleading.

The independent expert, also a rural practitioner, noted that when practising in a small community, "It is even more important that we are aware of ethical responsibilities, and how we must be extra vigilant around maintaining the professional boundaries when we see [members of our community] as medical practitioners, rather than out socially in the community. Sadly, I think the lines have become very blurred in this situation..."

Outcome

The tribunal noted that doctors have serious professional and ethical obligations when writing medical certificates. It reiterated their legal status, the important and trusted role doctors have when issuing them, and confirmed employers and others should be able to rely on them.

The doctor accepted his conduct could constitute professional misconduct. He agreed his actions were inadequate. Prior to the tribunal hearing, he had undertaken one-on-one education and made substantial changes to his practice.

The tribunal noted there was no suggestion of fraud or dishonesty. The doctor had cooperated with the investigation and demonstrated candour and understanding throughout. It also acknowledged he was providing an important role in the healthcare of his community and that in all circumstances, suspension would be disproportionate.

The tribunal specifically recognised the pressures facing many rural and remote practitioners and their critical importance to the communities they care for, especially when already experiencing shortages. However, it noted this does not exempt them from the same professional and ethical obligations as those in metropolitan settings and in fact makes it even more important they remain practising and do not "blur the lines, take shortcuts, or otherwise put their professional obligations last and their registration in jeopardy."

The doctor consented to orders that he be reprimanded and subject to three-monthly practice audits for at least two years. ●

Medico-legal Advisory Service

Key lessons

When issuing medical certificates, always ensure these are based on your clinical assessment, supported by appropriate history and examination findings. Even if you're assessing the patient via a telehealth consultation (for example, because the patient is infectious), it is still important to gather information from the patient and ensure you are satisfied it is appropriate to provide a medical certificate.

Always document the results of your examination and the reasons for issuing a certificate in your notes for the consultation. Keep a copy of any certificate you issue in the patient's records.

Never provide a certificate with blank dates or allow anyone else to complete parts of the certificate.

A medical certificate must always clearly show the date it was written.

You can provide a certificate for an illness that began prior to the consultation, as long as you are confident the certificate is warranted. Never backdate a certificate or suggest you examined the patient on a different day.

Be cautious about issuing certificates for long periods. Consider whether it is more appropriate to write a certificate for a shorter period and review the patient's situation if the incapacity or illness persists.

Wherever possible avoid treating or providing medical certificates to anyone with whom you have a close personal relationship.

The case discussed in this publication is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

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Successfully transitioning out of your practice

Dr David Williams
MBBS, PhD, FRACP, GAICD
General Manager, Avant Practice Solutions

Over the course of your professional life, you'll have put your heart and soul into your medical practice. But inevitably, the time comes when thoughts turn to moving on. Planning ahead can make all the difference between simply walking away, or being able to command an attractive sale price.

Like many doctors, your practice is likely to be something you've spent many years building up and should be a significant asset. Getting the best return on this investment means thinking about the things a potential buyer will value.

Understand what you're selling

You need to separate your 'practice management business' from your personal professional duties, as this is what you will be selling. This business will be most valuable to new owners if you focus on deliberate planning to reduce legacy problems. Strategically updating software, improving equipment, reducing organisational challenges, optimising staff levels, minimising costs and setting out a reliable business plan outlining growth, can help to create demand and increase the value you can receive for your practice.

Making your practice attractive to buyers

To enhance the emotional buy-in of prospective purchasers, you should consider the first impression the practice creates. Do you need to update the website and branding used on stationery and other materials, or refresh the physical presentation of your reception area and consulting rooms?

Doctors who are interested in buying your practice usually need to secure funding. There are several steps you can take to make the business more attractive to their lender.

- Having up-to-date financial records is essential, and also acts as a good sign for buyers that the practice is well run. Lenders typically want to see at least two years' worth of financial reports.
- Investing in new equipment means one less additional expense the new owner will need to factor into their financial plan.
- Setting up 'gold standard' operational efficiency through practice systems, staff procedures and reporting provides reassurance that the business will continue to be viable after you have left.

Consider too, whether you are prepared to stay in the business to support a smooth handover. Agreeing to stay on for a specified period can increase the number of buyers interested in your practice.

Regulatory and legal considerations

Transitioning out of a practice brings a raft of regulatory requirements, especially around patient records and employee entitlements. These still need to be followed even if you're not selling and are simply walking away.

Firstly, tell patients you are signing off. The requirements around this vary by state, though as a rule, it is worth notifying patients in writing, as well as during consultations.

There are then legal requirements around patient records, such as transferring records to a patient's new doctor or ensuring they are securely stored, as they could be needed in the future. You also need to notify bodies such as your insurers, Medicare and hospitals you have practised at. And let referring doctors know what is happening to your patients.

It's also worth checking your run-off indemnity insurance cover. Even if you have retired, you need to have protection against claims of professional negligence relating to when you were practising.

With so much to consider, you might want to engage a legal expert who can offer advice specific to medical practice.

Plan now to protect tomorrow

While retirement is a natural stage in any professional's life, it can also be a reminder to get things organised that you've put on the back burner during your busy working years.

This includes the need to have an up-to-date will, as well as thinking about appointing a Power of Attorney and an Advance Health Directive to set out your healthcare preferences.

Transitioning out of a much-loved and successful medical career marks the end of an era for many doctors. It's also an exciting time and, with appropriate planning, it can form the foundation of an equally rewarding retirement. ●

> "I was seeking advice on succession planning and what retirement might look like. It's been really helpful to look at everything together: legal, accounting, marketing and financial, particularly understanding the implications around super. I so wish I'd heard all of this 20 years ago.
>
> Avant Growth Academy attendee
> Karen Douglas, GP, NSW

Watch our webinar
Transitioning out of your practice

Locum cover led to Medicare audit

Dr Kelly Nickels
MBBS, MHlth&MedLaw
Claims Team Manager, Professional Conduct, Avant

For many doctors, concern about who will look after their patients if they go away is a major barrier to taking time off.

If you arrange for a locum to ensure continuity of care for your patients, it's important to be clear on the billing arrangements.

Recently we were contacted by one of our members who found himself the subject of a time-consuming and costly Medicare compliance audit.

The specialist physician had done the right thing for his patients by arranging a locum consultant of the same specialty to provide cover while on holiday overseas. What he and his locum hadn't realised was that, although his colleague was only covering for a few weeks, all billing of his patients seen by the locum needed to go through a new provider number specific to the locum for the practice location. Instead, the practice manager had submitted claims to Medicare using our member's provider number.

Government departments sharing data

The issue came to light through a data-sharing arrangement between the Department of Health and Aged Care and the Department of Home Affairs. This picked up that MBS claims had been made to Medicare under our member's provider number, when passport office records showed he was overseas.

As data sharing between government departments increases, we're seeing a growing number of members contacting us concerned that they have unknowingly done the wrong thing and their billings are now being audited by Medicare.

In this case, the member was invited to voluntarily repay the MBS services billed, before a debt and administrative penalty was found against him. Despite the good care his patients received from the locum, all the Medicare payments had to be refunded. We were able to support him to make sure no further penalties were applied.

Only bill for services you provide

Members are reminded that the rules around MBS billing are clear. Locum arrangements are designed such that the locum takes over the care of your patients and personally bills for the services provided. One practitioner's consultation cannot be billed under another practitioner's provider number, even when providing short-term locum cover.

You cannot bill Medicare when you (or your patient) are out of Australia.

In summary

Practitioners utilising a locum to cover when going on leave should ensure their locum has arranged a provider number or made arrangements with the department before they leave.

They should also ensure staff and the locum are aware not to use their provider number. ●

Resource
Medicare FAQs

> One practitioner's consultation cannot be billed under another practitioner's provider number, even when providing short-term locum cover.

Data matching laws

Data matching laws passed in late 2019 gave the Department of Health and Aged Care power to match data across various agencies, one of which is Home Affairs. The intention of matching to this particular dataset was provided as a practical example of what can be identified in the Data Matching Notice issued by the department:

"Matching the dates of MBS claims made by a health provider, to Home Affairs records can help determine if a health provider or patient was outside of Australia at the time of the MBS service. This will assist in identifying instances where a health provider may have fraudulently claimed Medicare benefits for services which were not validly provided."

Provider numbers for locums[1]

Situation	Requirement
Placement at a particular practice will be for two weeks or more.	Locum should apply to Services Australia for a provider number for that location.
Placement at a particular practice will be for less than two weeks at one time, but is expected to occur on a regular basis.	Locum should apply to Services Australia for a provider number for that location.
Placement at a particular practice will be for less than two weeks and is not anticipated to recur.	Locum should contact Services Australia to discuss options. (They may be permitted to use one of their other provider numbers.)
Relieving a specialist but does not hold specialist registration.	Locum cannot claim Medicare benefits at the specialist rates.

[1]MBS Online, Medical Benefits Schedule General Explanatory Note GN.2.6

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Navigating estate planning: 6 tips for medical practitioners

Jennifer Jackson
LLB
Partner, Head of Estate Planning & Probate, Avant Law

Looking after your own affairs is easily put off when you're busy looking after patients. Too often we see the consequences of not having a good estate plan. Whether you're an individual practitioner or a practice owner, proper estate planning makes sure that when you're not able to make the decisions yourself, your wishes are followed. These six tips will make it easier for those needing to fulfil your wishes.

1

Determine what assets and liabilities are covered by your will

How your assets and liabilities are owned is at the core of your estate plan and should be clearly understood at the outset. People often assume their will deals with all of their assets and are surprised to hear that superannuation and assets held in trusts are governed by separate estate planning documents. It's essential to properly structure all your assets and liabilities and ensure your estate planning is prepared accordingly. Additionally, this will minimise the chance of potential future disputes amongst beneficiaries.

2

Determine what your beneficiaries will receive

After you have identified your assets, deciding who you wish to inherit what is crucial.

Often people have specific intentions for certain assets, for example, you may choose to pass on the family home, specific financial investments and personal valuables to different beneficiaries. Alternatively, you may wish to simply divide your estate into equal or particular proportions.

3

Business succession planning for your medical practice

A medical practice is no different from any other business or asset, whether you own your own practice or a share of it. Business succession planning is essential to safeguard your financial interest in the business and support your employees and patients. There are different pathways to consider in the event of you losing capacity, or your death. These include identifying a successor to run or own the practice so it continues to run with minimal disruption, or instructing for it to be sold and how the proceeds are dealt with.

4

Select someone to be responsible for carrying out your wishes

Giving responsibility to someone to carry out your wishes differs vastly from deciding who your beneficiaries will be. When choosing the right person to execute your will it is important to remember they will be responsible for managing your estate, carrying out your wishes and ensuring your beneficiaries receive their inheritance.

Your executor should be organised, reliable, trustworthy, and capable of handling legal and financial matters (or seeking the appropriate support). If you have children, your executor may also need to manage their inheritance until they come of age.

5

Plan for the care of minor children

Safeguarding children of any age is essential when preparing your will. When considering the care of minor children, your estate plan should specify who you want to make decisions about where they live, go to school and their day-to-day care. While these critical decisions can be overwhelming, making them ahead of time will ensure your children's futures are secured.

6

Protect your beneficiaries from their own vulnerabilities

Estate planning doesn't stop at distributing your assets to your beneficiaries. You may have concerns about your beneficiaries mismanaging their inheritance, being vulnerable to exploitation or unable to handle the financial responsibility. As well as age, these concerns can be around addiction, gambling, intellectual disability or mental health issues, and may require additional measures to ensure they are protected, and your legacy is secured.

Download
Avant Law Estate Planning checklist

Mortgage vs super: which is a better place for doctors' money?

Jacqui Lombard
Head of Residential Lending, Avant Finance

Medical professionals are often asset-rich while carrying substantial debt. This is partly a reflection that banks are comfortable lending to doctors, who tend to be high income earners.

Nonetheless, over the past two years we have seen a string of Reserve Bank rate hikes, and for many medical professionals this has driven loan repayments higher. This can be particularly challenging when personal debt is high.

As a result, home owners often want to know whether it makes better financial sense to use spare cash to pay down a mortgage or make additional contributions to superannuation.

There is no one-size-fits-all answer, but we spoke to Matthew Holden, Managing Partner at chartered accountants and advisory firm Brentnalls SA, and he provided a number of points for medical professionals to think about.

Using after-tax and before-tax money

First, let's consider the basics.

Additional home loan repayments are made from your income after you have paid the top rate of tax (for your income bracket). The major benefit of doing this comes from reducing the interest you are paying due to having a smaller mortgage.

By contrast, additional super contributions can be from your income before it is taxed. These payments do get taxed, but at a much lower rate, and the extra funds in your super will be earning interest.

The tax factor is worth a closer look.

"Although instinct might suggest that paying down your home loan debt should be a first priority, often it is the case that maximising your concessional (i.e. tax deductible) contributions to super instead will provide a greater return in the long term," says Matthew.

"Doctors are in a sweet spot because, as high income earners, they are often on a high marginal tax rate. This leaves them well-placed to take advantage of the tax breaks available by making additional super contributions."

By way of explanation, most workers can add to their super through salary sacrifice or by making additional contributions from their own pocket. Salary sacrifice means opting to have part of your before-tax salary paid to super instead of receiving the money as regular pay.

Just like employer-paid super contributions, salary sacrifice or other additional contributions are taxed at just 15%, which is likely to be a lot lower than a doctor's marginal tax rate.

See the boxed text for an illustration of how this works.

Dr A, a senior registrar, earns $180,000 annually. Dr A's marginal tax rate is 39% (including Medicare Levy).

For every $1 of additional salary she earns, 39 cents goes to tax/Medicare, leaving her with 61 cents in her pocket to pay more off her mortgage.

However, for every $1 Dr A adds to super, only 15 cents goes to tax, leaving 85 cents invested in her super fund account.

In this way, Dr A is 24 cents, or about 39%, better off for every dollar she invests in super rather than taking the money and putting it against her mortgage (or spending it!).

Note:
Once Dr A earns over $190,000 her marginal tax rate will go up to 47c (including Medicare levy) and the difference between adding to her super and paying into her mortgage will be higher.

Correct as at October 2024

There are a few catches

As Matthew points out, when personal earnings exceed $250,000 annually an additional 15% tax applies to super contributions.

In addition, annual caps apply that limit before-tax super contributions. Since 1 July 2024, up to $30,000 can be added to super each financial year in pre-tax (concessional) contributions. This limit includes employer contributions plus salary sacrifice contributions along with additional personal contributions.

However, those with less than $500,000 in super savings at 30 June of the previous financial year may also be able to claim a tax deduction for any unused ('carry forward') super limits from the previous five years. For example, an unused super cap from 2019–20 must be used by the end of 2024–25, or it will expire.

The upshot is that if you qualify, it is possible to get a tax break for reasonably substantial super contributions.

What to weigh up

Superannuation is a very long-term investment, and this is a plus for compounding returns. "The earlier you start, the greater the impact of compounding," says Matthew.

Nonetheless, he cautions, "You need to balance the merits of compounding and the potential tax savings of adding to super with the fact that superannuation can't normally be touched for many years. With the rising cost of living and significant expenses still to come, such as housing, travel, children's education etc, care must be taken to ensure contributions to super do not leave you unable to achieve your financial goals pre-retirement."

On the flipside, Matthew notes that an outstanding mortgage can impact your borrowing capacity. So paying down your home loan means you will be viewed more favourably if you need funding for other purposes.

Fortunately, the two options – pay more off your mortgage or add to super – are not mutually exclusive. It may pay to take a balanced approach and take advantage of the concessional super contribution limits available to you, and utilise any excess savings towards loan repayments (or deposited in an offset account).

However, as we noted earlier, there is no single approach that is right for everyone. It's a good idea to seek tailored advice around the strategy that works best for you. ●

Surgeon pulled up for poor communication

Anna Gornall
LLB (Hons)
Senior Associate, Professional Conduct, Avant Law

As a medical specialist, it's common for you to see many patients requiring the same treatment. This may mean you sometimes forget that, while you're very familiar with the possible adverse events relating to treatment, your patients are not and are often overwhelmed by the situation they find themselves in.

Background to the case

In this case, a patient was referred to a urologist for management of prostate cancer.

The urologist recommended neoadjuvant hormone therapy and radiation therapy as an appropriate treatment given the patient's age. Following the treatment, the patient developed significant urinary tract symptoms and night-time urination. These are recognised side effects of the treatment, of which the surgeon believes he informed the patient. To alleviate the patient's significant urinary symptoms, a steam prostatectomy was performed. This resulted in bladder spasms and pain for which trans-urethral resection of the prostate was recommended.

Patient unhappy with treatment outcome

Unfortunately, the treatment resulted in incontinence and pain post-operatively. Again, these are recognised complications of which the patient was advised. Understandably, the patient was very unhappy with the outcome.

The patient made a notification to Ahpra alleging the clinical treatment provided to him by the urologist was inappropriate. In addition, he claimed the urologist did not adequately explain the risks associated with the procedures he performed, and was rude, dismissive and lacked empathy in his communications.

Management appropriate, but communication was not

Ultimately, the Medical Board accepted that the management recommended by the urologist was reasonable. However, it was determined the clinical records did not assure the board that appropriate informed consent was sought from the patient, or that the urologist communicated with the patient in an effective and empathetic manner.

Regulatory action proposed

The board proposed regulatory action in the form of one-on-one education around communicating with patients and informed consent.

Avant assisted the urologist in proactive completion of education, including one-on-one mentoring.

Ultimately, no further action was taken. ●

This case is a reminder that as a medical practitioner, it is essential to maintain good medical records, especially to capture your discussions around consent, as well as risk and complications of the proposed treatment. Our Risk Advisory Service can assist in creating a comprehensive consent form.

If a patient attends to discuss their concerns, it is also worth noting in the records what those concerns were and that they were addressed appropriately and with empathy.

Article
Connecting with patients

The case discussed in this publication is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

Doctor-patient communication a common issue

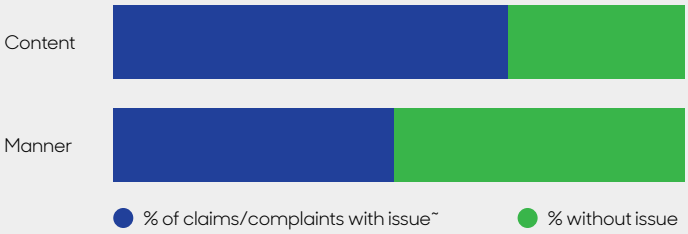
The complaint notification to Ahpra in this case could likely have been avoided if the doctor had communicated better with his patient.

This is a common issue, with our analysis showing 4 in 10 complaints and compensation claims involved doctor-patient communication as either a primary or secondary allegation. The content of the communication (or lack thereof) was the most common concern raised, followed by the manner of communication.

Key points

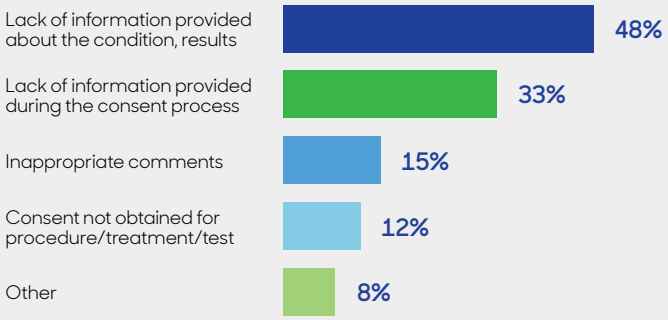
- Content and manner were the two main issues in claims and complaints about doctor-patient communication.
- Lack of information provided was the most common allegation about the content communicated.
- Inappropriate manner of communication and lack of empathy were the key allegations regarding manner of communication.
- Perception of lack of care or consideration for the patient underlies many allegations about the manner of communication.
- One in five communication-related allegations was assessed not to meet the standard of care.

Complaints involving communication issues



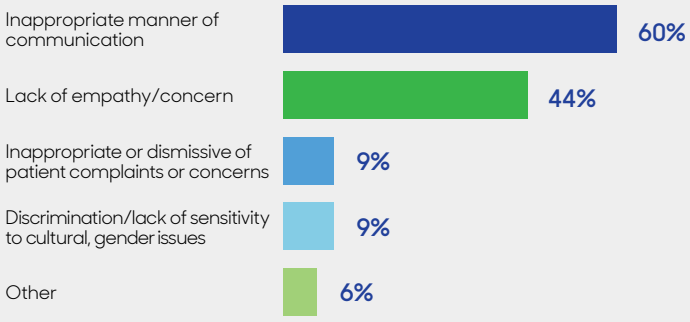
~Some cases had more than one issue.

Content issues



(% of total claims and complaints involving allegations about the content communicated. Some cases had more than one issue.)

Manner issues



(% of total claims and complaints involving allegations about the manner of communication. Some cases had more than one issue.)

Data source: claims and complaints involving communication issues closed 2017-18 to 2021-22

Pulling together in private hospital funding

Peter Aroney
BComm, ACA
Chief Executive Officer, Doctors' Health Fund

Australia's healthcare system, with its unique blend of public and private services, is admired globally.

This success depends on strong partnerships. Private hospitals provide essential care, doctors and healthcare professionals deliver expert treatment, health insurers facilitate funding through affordable coverage, and the government provides regulation and support.

Maintaining the balance between the needs of these stakeholders has challenges, but it has been preserved through a shared commitment to prioritising patient care. However, the recent, often heated debate on private hospital funding, risks disrupting this balance.

Discussions over cost agreements are a standard part of the healthcare landscape. Typically, these negotiations occur privately, in good faith, and lead to a fair outcome for all parties involved. Our fund maintains long-standing and ongoing contracts with over 500 private hospitals nationally, with contract terminations rarely occurring.

At their core is a shared goal: ensuring patients receive the best possible care while maintaining access and affordable premiums, through collaboration and co-operation.

Unfortunately, in recent months, this spirit of co-operation has been overshadowed by public comments that insurers are squeezing private hospital operators to boost profits. These claims miss a critical point: around 5.2 million Australians are covered by health funds that are mutuals or part of mutuals, like ours.

Our goal is not to maximise profits for shareholders, but to keep premiums affordable and improve services for our members. This requires a delicate balancing act, especially when factoring in external pressures like claims inflation driven by an ageing population and rising procedural costs. For our fund, hospital and medical claims inflation has averaged 5.9% compounded over the three years to 30 June 2024. Additionally, we returned more than $20 million to members, reflecting the surplus funds arising from delayed claims during the COVID-19 period. These funds are actuarially assessed and overseen by the ACCC.

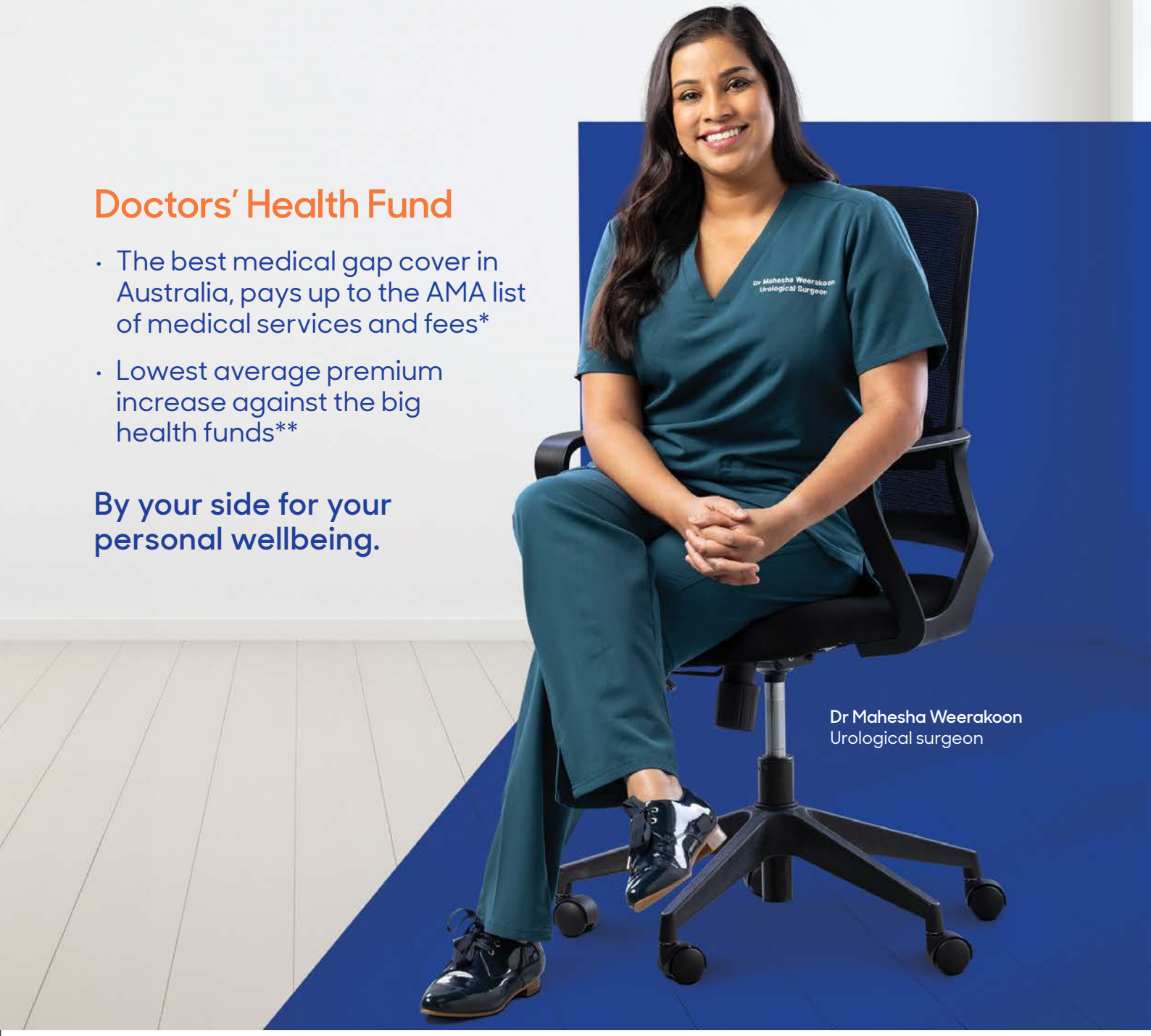
Doctors working in private hospitals recognise the critical role of appropriate investment and sound hospital administration in maintaining high standards of care. While we are dedicated to ensuring our funding supports this, we must also protect our members from unaffordable premiums, especially if those premiums are funding services patients are using less frequently.

The dynamics of private hospital care are evolving, with a shift in the service mix. Doctors are increasingly choosing day surgeries and shorter admissions, meaning patients spend less time in hospitals or receive out-of-hospital care when appropriate. These efficiencies will ultimately benefit patients and enable more effective use of resources.

It is essential that all parties recognise our symbiotic relationship, where each of our successes contributes to our shared goals. Public disputes only serve to harm the very people we are all here to support. Instead, our intent should focus on innovative care models, improving hospital and insurance efficiencies, and most importantly, listening to the 'voice of the patient'.

We will always conduct negotiations with our private hospital partners in good faith and are committed to supporting their sustainability and continued delivery of high-quality care. It's in everyone's best interest that we reach a satisfactory resolution. ●

Mahesha spends all her time looking after other people's health. So we look after hers.



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