CONFIDENTIAL

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Senior Manager, Behavioural Research and Policy Unit
Australian Securities and Investments Commission
Level 5, 100 Market Street
Sydney NSW 2000

By email: IDRdatas@asic.gov.au

Dear Sir/Madam

Addendum Consultation Paper 311 – Internal dispute resolution: Update to RG 165

Thank you for the opportunity to respond to ASIC's Addendum Consultation Paper 311 relating to the IDR data reporting requirements that will apply to Australian financial services licensees.

MDA National

The MDA National Group (MDA National) is made up of MDA National Limited (MDAN) and its wholly owned subsidiary MDA National Insurance Pty Limited (MDANI). MDANI is medical indemnity insurer authorised by the Australian Prudential Regulation Authority and holder of Australian Financial Services Licence No. 238073, which issues professional indemnity insurance and medical practice indemnity policies to the members of MDA National Limited and a number of non-member insureds.

MDAN is an Australian company limited by guarantee. As a not-for-profit, member-owned medical defence organisation its objectives are the support and protection of its member medical practitioners and medical students, and the promotion of good medical practice in Australia.

General position

Given the specialised nature of the medical indemnity insurance product, there being only five medical indemnity providers and reporting requirements required under the *Medical Indemnity Act* 2002 ("MI Act"), we query whether it is necessary or appropriate that medical indemnity is included in the RG271 reporting regime. This review of the reporting requirements raised queries as to whether any effective benefit will be obtained from comparison data within the medical indemnity sphere that may be retrieved in the reporting process.

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Carving out medical indemnity is not unusual. For example, in other circumstances, medical indemnity has been recognised as differing from other retail insurance products as demonstrated by Treasury's agreement to exclude medical indemnity insurance from application of proposed general insurance product design and distribution requirements and more recently from the Unfair Contracts Terms regulation.

As raised in earlier submissions, MDA National is concerned that the proposals do not always take into account, amongst other things, the:

- differences between medical indemnity and other insurance/financial products;
- complexity of, and highly regulated, medical indemnity insurance product;
- sophistication of the purchaser of the medical indemnity product; and
- underlying complexity of issues and length of time needed to manage a medical indemnity claim

which flow into any complaint that may be made. Unlike first party insurance, medical indemnity provides cover to the Insured for liability the Insured has to third parties (ie patients and matters that may arise through the medical regulatory and professional bodies). Consequently, the medical indemnity product has the Insurer and Insured "working together" to assist the Insured address claims or investigations made by a third party. It is often the case, that a complaint's origin is the Insured's frustration and nonacceptance of a regulator or court outcome or the operation of a government scheme relating to premium or coverage which is then taken out on the Insurer but which the Insurer is in no position to change.

Medical indemnity is a highly regulated industry with Medical Defence Organisations (MDOs) and indemnity providers being obliged to offer indemnity cover to all applicants, except in limited circumstances pursuant to the universal cover obligations under the MI Act. The MI Act also has annual reporting requirements regarding complaints associated with refusals of cover and requirements to pay risk surcharges which provides statistics for the areas considered to be meaningful in the medical indemnity context. To meet the meet transparency requirements recommended in the 2016-17 ANAO Report, The Management, Administration and Monitoring of the Indemnity Insurance Fund, this information is made publicly available through the Department of Health.

The small number of complaints and particular circumstances and details of complaints can often mean that there is a chance of a matter being identifiable. In the context of AFCA, requests for non-publication of determinations are common due to this possibility and sensitivities of information.

Specific questions for feedback

While our position is that medical indemnity should be excluded from the RG271 reporting regime, feedback is provided as appropriate to the medical indemnity product and considering some of the factors raised above.

Q1. Data dictionary practicality

MDA National welcomes the reduction from 37 to 23 data elements. However, a high level of reporting remains, particularly in the context of low-level expressions of dissatisfaction. In many instances, time taken to report will be longer than attending to the complaint itself. We query whether this is in the best interests of our Insureds in both time taken away from providing other services to our members and Insureds and increased resourcing costs in preparing the reports and training compared to any benefits obtained from the reported data, if any.

Comment is provided regarding the following numbers in Table 3:

1.1 Number 17:

We query whether this information can be provided directly by AFCA. The date of receipt of the EDR complaint by the Insurer is not necessarily the same date it is received by AFCA.

1.2 Number 18:

We query why "61 Other professional indemnity" is included in the "Product or service category". Pursuant to section 761G of the *Corporations Act 2001* (Cth), and as reflected in the AFCA Rules, the only type of professional indemnity insurance which is considered a retail product is medical indemnity. We refer to page 13 of Section B of RG 271 which states "An IDR process for financial services providers must be able to deal with complaints made by 'retail clients'. The broader definition of 'small business' does not extend to include other professional indemnity.

1.3 Number 19:

The issues in Table 13 fail to recognise the nature of medical indemnity insurance as set out in our general position above. While recognising that the manner of appointment and management of the relationship with a third party such as an external legal adviser may be grounds for complaint, commonly the basis for the complaints received are the services provided by appointed external advisers, regulatory or professional bodies, medical boards, colleges and institutions plus the court system as if the Insurer can do something about it. In such situations where the dissatisfied complainant has taken their complaint to AFCA, AFCA will advise the complainant that these complaints are outside its jurisdiction and need to be taken to the advisers own professional body or the regulator / third parties own complaints mechanism.

For example, perceived 'delays' due to external bodies timeframes are often cause for complaint to the MDO who has no control over the third party timelines. Secondly, as a highly regulated industry which administers government schemes such as the Premium Support Scheme and Run-off Cover Scheme, an MDO is not in a position to change the rules and requirements regarding the operation of such schemes in relation to complaints.

To reflect the interaction of third parties, we suggest that further "complaint issue" categories are included to cover:

- third party providers
- third party processes
- third party timelines
- third party delays
- government regulation.

1.4 Number 21

It is submitted that this element does not reflect other outcome possibilities, for example:

- not being in "favour" of either party; or
- being abandoned or withdrawn.

We also query why the element does not separate out into "1 = In favour of complainant in full", "2 = In favour of the complainant in part" and "3 = in favour of entity". The first recording, as it currently stands, will require further internal amendment to the data to more accurately report the nature of the outcome for internal purposes.

1.5 Number 22

We have concerns about the recording of dollar amounts rather than in ranges for small to medium size financial firms with low numbers of complaints. This granular information is more likely to be:

- identifiable;
- open to abuse by unreasonable / vexatious complainants;
- open to data mining and used against financial firms.

This category also does not take into account payments that may be made on a commercial-in-confidence basis which the Insurer can then not disclose or *ex gratia* payments which in themselves do not reflect any actual loss by the Insured.

1.6 Number 23

To reflect our earlier comment that many complaints are about unrelated third parties which cannot be resolved by us, we suggest that a further code is included which indicates referral to a third party complaint scheme.

We also seek clarification if:

- code 1 is to be used when the outcome is in favour of the entity;
- code 10 is to be used to reflect situations where, in finding for the entity, the outcome provided is an explanation.

If these codes are not to be used for these situations then we submit that an "other" option should be provided where none of the codes in 22 or 23 are applicable, particularly in the context of medical indemnity.

1.7 General comments related to practicality

In general, MDA National notes the current position presented for the recording of all complaints including those resolved within the first five days. However, it continues to have strong concerns regarding the additional burden being placed on front line or claims handling staff particularly in relation to the resolution of straightforward complaints and expressions of dissatisfaction at the time of first contact. For example, attending to 23 datasets of information potentially places an enormous burden on front line staff during busy periods such as annual renewal. It will be counterproductive to time pressures if any expressions of dissatisfaction require the staff member to go off-line to attend to data recording requirements for what may be straightforward complaints or expressions of dissatisfaction where an immediate apology or correction is sufficient to rectify the issue.

Due to the extended nature of medical claims and investigations, claims handling staff are also subject to expressions of frustration from insureds regarding third party time frames. It seems an unnecessary burden to have to attend to a 23 dataset process when the dissatisfaction is not actually about the financial firm or a related party.

Also, not all services that MDA National provides are financial services. A further burden will be placed on front-line staff to differentiate between the complaints that fall under the retail product definition and those that are wholesale products or membership issues. It is submitted that the time and effort required in training and ongoing determination of what must be recorded adds to the cost and time burden on medical indemnity providers.

This increased burden of reporting on staff time and implementing a reporting regime will add to the costs of providing the medical indemnity product. Inevitably, the increased costs will need to be passed onto the Insureds through premium increases which is not in their best interests.

It is further submitted that insufficient guidance is provided regarding ongoing complaints from unreasonable complainants who may contact on an hourly, daily, weekly basis either repeatedly raising the same points or continually bringing up everchanging grievances. These interactions have the potential to be extremely time

consuming and the proposals may further prolong the process and cause confusion and difficulties for frontline and claims staff. Management of such complainants aside, given the long tail nature of many medical indemnity claims, a single complainant may be expressing dissatisfaction for years on a single claim. Continual recording of such complaints is likely to skew the data and provide unrealistic outcomes from a benchmarking perspective.

Q2. Multiple Business Units

Not applicable.

Q3. Multidimensional data

Further to the comments in relation to Number 23 above, the limitation of three issues per complaint is unrealistic in the context of medical indemnity. For example, in a complex claim or in an investigation by a regulator there is potential for the Insured (health practitioner) to be extremely distressed and under threat of losing their livelihood. In these circumstances, Insureds can take this out on the indemnity provider, even though the provider is not the cause of the distress and is supporting the Insured. It can lead to long lists of grievances. Requiring a recording of multiple separate complaints from the one complainant does not give a statistically accurate representation of what is happening. This is also exacerbated by the small number of complaints in general, so one vexatious or extremely aggrieved practitioner can skew the resulting data.

Q4. Reporting frequency

We submit that quarterly reporting provides an additional burden on small to medium size firms who do not have large or single focused complaints teams. While not immediately quantifiable, all reporting requires staffing allocation. Medical indemnity provides already have annual reporting requirements for complaints under the MI Act aside from other multiple reporting requirements required under the medical indemnity regime. If required to report, our preference is to provide annual reporting.

Q5. Additional data elements

We submit that reporting on vulnerabilities would not be feasible for providers given the Insureds are medical health practitioners, the small number of complaints and possibility of recognition (even if only by the complainant themselves). Noting the extreme sensitivities surrounding any vulnerability and thresholds around reporting health impairment under the Health Practitioner Regulation National Law, a financial entity should not be making such decisions and publicly reporting such information about health practitioners. At the very least, it can create further unnecessary tension with the complainant and risk creating a further dispute. `

In general, we query the necessity for reporting the method of communication used to make a complaint. If complaint channels are to be reported then further clarification is required for the forms already suggested on page 5. For example, does “in person” include phone, email and letter?

Q6. & 7. Contextualising data and Benchmarking

As the nature of medical indemnity insurance is different from other financial products, including other general insurance products, it is not meaningfully comparable to these other products. Further, given the small number of providers and variance in size of the entities within the medical indemnity product, we query the statistical significance and relevance of any data that is provided.

In summary

While recognising the importance of providing and maintaining an appropriate complaints regime, MDA National submits that medical indemnity insurance should be excluded from the proposed RG 271 IDR data reporting requirements.

The highly regulated nature of this product already provides for a sufficiently meaningful and transparent complaints reporting process through the MI Act and through the AFCA reporting regime which enables regulators to respond to any perceived irregularities or deficiencies should they arise.

The increased reporting requirements under RG 271 will lead to the increased costs being passed on to the insureds, without any other potential benefits gained from the reporting outcomes in the context of medical indemnity.

MDA National welcomes any further opportunity to discuss issues arising from these comments particularly as it applies to the medical indemnity sector or to provide further information that may assist. Tricia Shandley-Jones can be contacted on [redacted]

Yours sincerely

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