



**Australian Government**

**Department of Health**

## Discussion Paper

First Principles Review of the Indemnity Insurance Fund (IIF)  
and each of the schemes that comprise the IIF

August 2017

## 1. Context and purpose of this Discussion Paper

In line with the recommendations of the Australian National Audit (ANAO)<sup>1</sup>, and as announced on 19 December 2016 in the 2016-17 Mid-Year Economic and Fiscal Outlook (MYEFO), the Department is undertaking a First Principles Review (FPR) of all the Commonwealth funded schemes under the Indemnity Insurance Fund (including the midwife professional indemnity schemes).

Medical indemnity insurance provides financial protection (to the extent set out in the insurance contract) to both medical practitioners and patients in circumstances where a patient sustains an injury (or ‘adverse outcome’) caused by medical misadventure, malpractice, negligence or an otherwise unlawful act. All medical practitioners and midwives are required to hold medical indemnity insurance in order to practice privately, as a condition of their professional registration.

### The Indemnity Insurance Fund

The objectives of the Indemnity Insurance Fund (IIF) are to promote stability in the medical indemnity insurance industry, keep premiums affordable for doctors and ensure availability of affordable professional indemnity insurance for eligible midwives. The IIF is comprised of seven Commonwealth government assistance schemes:

- the Premium Support Scheme (including universal cover arrangements and incorporating the grandfathered Medical Indemnity Subsidy Scheme);
- the High Cost Claims Scheme;
- the Exceptional Claims Scheme;
- the Run-Off Cover Scheme;
- the Incurred-But-Not-Reported Scheme;
- the Midwife Professional Indemnity (Commonwealth Contribution) Scheme; and
- the Midwife Professional Indemnity Run-off Cover Scheme.

Each of these schemes is described in more detail in Chapter 2.

### Terms of Reference

The FPR provides an opportunity to examine whether existing arrangements are ‘fit for purpose’ for all parties or whether changes can be made that better support the ongoing provision of indemnity insurance. Outcomes of the FPR will inform future policy concerning support for professional indemnity insurance for doctors and eligible midwives in private practice and contribute to the development of an appropriate monitoring framework to assist in assessing how the schemes are contributing to affordable access to healthcare.

The terms of reference for the FPR are to:

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<sup>1</sup> Australian National Audit Office (ANAO), *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No.20 2016–17.

- examine to what degree, in the current environment, Commonwealth intervention has been successful in providing:
  - stability of the medical indemnity insurance industry;
  - availability of affordable indemnity insurance for medical practitioners and midwives and by extension, the affordability of healthcare for patients;
  - viability for professions, and patients, where claims have a ‘long-tail’ or high costs;
- assess whether the schemes that comprise the IIF continue to be fit for purpose for all parties, and where improvements might be made; and
- consider the appropriate level of Commonwealth support needed to continue stability, affordability and accessibility of professional indemnity insurance for medical practitioners and eligible midwives.

## Purpose of this Discussion Paper

This Discussion Paper:

- describes the schemes and the rationale for their establishment;
- describes the changes in the operating environment since the schemes were established;
- identifies some of the key issues that have been raised by stakeholders over a number of years relating to the operation of each of the schemes; and
- poses questions to stakeholders about whether the schemes remain fit for purpose and how the schemes might be improved.

Stakeholders’ views will inform the Government’s consideration of the issues, including:

- assessment of the success of the schemes in achieving their aims and providing a safety net for patients;
- assessment of whether the design of the schemes provides for equitable and efficient outcomes;
- consideration of any adjustments required to the schemes to ensure that they:
  - operate efficiently and effectively for insurers, medical practitioners/midwives and Government,
  - minimise market distortions and any unintended impacts,
  - support access to, and quality and safety in the delivery of, health care; and
- assessment of the impacts of any proposed changes to the schemes.

## Your input

The Department invites input into the First Principles Review and this Discussion Paper is designed to outline the review parameters and generate discussion through the inclusion of specific questions asked on each topic. These are prompts and input does not need to be confined to these questions.

In addition, the Department appreciates that stakeholders will vary in their depth of knowledge on the IIF schemes and may not have a specific interest in, or consider themselves qualified to comment on, all of the schemes.

All comments and perspectives are encouraged on whether the schemes continue to be fit for purpose, their strengths and weaknesses, and any suggested improvements. The Department is particularly interested in the views of the medical profession on indemnity insurance in the context of the operation of their practice, and the provision of medical services. Reflections on, or experience with, international professional indemnity insurance arrangements for medical practitioners and/or midwives are also sought.

Submissions received will be made publically available on the Department of Health website unless the originating party specifically requests otherwise.

Respondents should be aware that all submissions may be accessed by a third party through a request under the *Freedom of Information Act 1982*.

Responses should be submitted to the Department no later than **cob 29 September 2017** to:

Post: Ms Kate Medwin  
Director, Medical Indemnity Section  
MDP 951  
Department of Health  
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CANBERRA ACT 2601

or,

Email: [Medical.Indemnity@health.gov.au](mailto:Medical.Indemnity@health.gov.au)

Enquiries regarding the Review or submissions should be directed to:

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## 2. About the indemnity insurance schemes

### What is medical indemnity insurance?

Under national registration arrangements, all registered health professionals must be covered by indemnity insurance. Privately practising health practitioners must purchase their own indemnity insurance. Medical services provided under the public health system are covered by State and Territory professional indemnity arrangements as part of their employment arrangements.

Medical indemnity insurers provide insurance to privately practicing medical practitioners to pay the cost of claims against medical practitioners for medical malpractice proceedings. Insurers also provide a wide range of services including advice on medico legal proceedings, training, disciplinary proceedings and best practice communication and record keeping.

When a medical practitioner applies for insurance and where applicable membership with an insurer, the insurer determines a premium based on a range of potential risk factors, such as the location at which the medical practitioner is practising and the medical practitioner's speciality, claiming history, and private income. The insurer charges the medical practitioner an insurance premium and may also charge a separate membership fee.

When a medical practitioner becomes aware of an adverse event, or when a claim is made against a medical practitioner (usually by a legal practitioner acting on behalf of a patient) the medical practitioner notifies his/her insurer. The insurer advises and defends the medical practitioner throughout the legal process until the claim is finalised.

As the insurer is responsible for the costs of all claims against their members (some of which may be subsidised by the Commonwealth), the value and frequency of claims directly impacts on the amount of premium that insurers charge to members as well as the costs to the Commonwealth.

### What prompted the Commonwealth Government's involvement in medical indemnity insurance?

Prior to 2002, medical defence organisations (MDOs) provided indemnity cover to their members and utilised Australian Prudential Regulation Authority (APRA) regulated insurers to reinsure that cover. Because a MDO had discretion as to whether to pay out on claims made by members, it was not deemed to be conducting insurance business under the *Insurance Act 1973* and MDOs were therefore not authorised and regulated by APRA.

In May 2002, the largest MDO in Australia, United Medical Protection (UMP), was placed into provisional liquidation, which resulted in a potential lack of indemnity cover for many medical practitioners. There was insufficient capacity in the rest of the medical indemnity market to accept UMP members, in the event that UMP could not continue to operate.

At the time that UMP was placed in provisional liquidation there were a number of other events impacting the availability and affordability of insurance. This included the collapse of the HIH group, the destruction of the World Trade Centre and an increasing tendency for courts to award significant damages for claims. These events gave rise to significant uncertainty regarding the outcome of negligence cases, which in turn impacted the

profitability of insurers, resulting in higher premiums and in some cases withdrawal of cover. This pattern was particularly pronounced in the medical indemnity insurance arena.

At the same time, medical practitioners were experiencing significant increases in premiums and fees from MDOs/insurers. In extreme cases, medical practitioners were paying over a third of their incomes for indemnity cover, while others considered leaving the profession or ceasing high-risk procedures like obstetrics. This also had the potential for flow on effects to patients in terms of access to, and the cost of, health care.

Additionally, MDOs did not have sufficient capital in order to make the transition to being medical indemnity insurers authorised and regulated by APRA.

In response to this crisis, the Australian Government's medical indemnity insurance package was announced by the Prime Minister on 23 October 2002.

The reform package included a variety of measures including premium subsidies, government assistance to MDOs/insurers and medical practitioners for high-cost claims, and placing the industry within a new regulatory framework.

Since 2002, there have been some changes to the schemes (including the introduction of two schemes to support midwives) but the broad objectives of the schemes remain - to promote stability of the medical indemnity insurance industry, and support the availability of affordable indemnity insurance for medical practitioners and eligible midwives.

Ultimately, these schemes were designed to support affordable health care and to ensure that patients who make legitimate claims against medical practitioners and midwives are able to be compensated for any loss they have suffered.

**How does each of the schemes within the IIF support medical practitioners and midwives?**

The schemes within the IIF are:

- **Premium Support Scheme (PSS)** – subsidises 60% of indemnity insurance costs for doctors whose premiums exceed 7.5% of their income from private practice. PSS also subsidises 75% of the difference between the higher premiums for rural procedural GPs and premiums for non-procedural GPs. Universal cover arrangements, enabling all medical practitioners to access indemnity insurance, are also currently encompassed under the PSS.
- **High Cost Claims Scheme (HCCS)** – reimburses medical indemnity insurers 50% of the insurance payout over \$300,000 up to the limit of the practitioner's cover, for claims notified on or after 1 January 2004. From 1 July 2018 the threshold increases from \$300,000 to \$500,000.
- **Exceptional Claims Scheme (ECS)** – reimburses medical indemnity insurers for 100% of the cost of private practice claims that are above the limit of their medical indemnity insurance contract limit, typically \$20 million.

- **Run-Off Cover Scheme (ROCS)** – reimburses medical indemnity insurers for 100% of the cost of claims for doctors who have ceased private practice because of retirement, disability, maternity leave, death, or if they stop working as a doctor in Australia. The ongoing costs of the scheme are met by the ROCS Support Payment, a levy on the premium income of medical indemnity insurers.
- **Incurred-But-Not-Reported (IBNR) Scheme** – reimburses medical indemnity insurers for 100% of claims made against doctors arising from incidents that took place on or before 30 June 2002, provided they held incident-occurring based cover with a participating MDO. The IBNR Scheme was established to support the former UMP (now Avant Mutual Group Limited); to continue to provide medical indemnity insurance after it was placed into provisional liquidation in 2002. In practice, Avant is the only participating organisation.
- **Midwife Professional Indemnity (Commonwealth Contribution) Scheme** – under Level 1 of this Scheme, the Commonwealth reimburses the insurer for 80% of claims that exceeds the \$100,000 threshold up to \$2 million. Under Level 2 of this Scheme, the Commonwealth reimburses the insurer for 100% of the cost of the claim above the \$2 million threshold.
- **Midwife Professional Indemnity Run-off Cover Scheme (Midwife ROCS)** – provides secure ongoing insurance for eligible midwives who have ceased private practice because of retirement, disability, maternity leave, death or other reasons, with 100% of the cost of claims reimbursed by the Commonwealth.

Total Commonwealth expenditure under the schemes has been over \$400 million to 30 June 2016.

### What has changed since 2002?

As noted in Chapter 1, one of the purposes of this Review is to consider whether the schemes continue to be fit for purpose in the current environment.

It is therefore important to consider the changes in the environment since 2002 including any factors that may reduce or increase the risks to the sector (and its stability) as well as the factors influencing the availability and affordability of insurance.

Greater legal certainty and decreased claims

Following the provisional liquidation of UMP, substantial reforms were made to ensure medical indemnity insurance was placed on a more sustainable basis as well as changes to the regulatory framework for medical indemnity cover.

Critically, governments in all States and Territories introduced a range of tort law reforms aimed at limiting the extent of damages and improving the availability and affordability of all types of liability insurance including medical indemnity insurance.

To coincide with the tort reforms, APRA also established the National Claims and Policy Database (NCPD) to improve the availability of information on claims and policies.

Within only 5 years, there was evidence of the success of the reforms in limiting liability and the quantum of damages arising from personal injury and death. For example, medical indemnity claims in the 3 years following the 2002 reforms, fell by 36%.

Further, many insurers and policy holders implemented more sophisticated risk management approaches. Government and industry also worked together to introduce measures focused on quality and safety improvement for medical practitioners, such as improving clinical risk management, reducing adverse events and improving patient safety.

#### Strengthened regulatory controls

Since 2002 there have been significant changes to the regulatory arrangements relating to medical indemnity insurers. For example:

- insurers transitioned from offering claims incurred insurance to claims made insurance, which was consistent with changes to reinsurance arrangements;
- medical indemnity cover must be provided via a contract of insurance and discretionary cover is prohibited, meaning medical indemnity insurance can only be offered by insurers authorised and regulated by APRA;
- APRA strengthened its regulation across the entire general insurance industry, including medical indemnity insurers;
- insurers are required to:
  - comply with prudential standards relating to capital, which set minimum requirements relating to the amount and type of capital required to be held, reporting and ongoing capital management; and
  - maintain a sufficient capital buffer to ensure ongoing compliance with the capital requirements;
- the *Insurance Act 1973* sets out the requirements for insurers seeking to exit the industry with guidelines for assigning liability transfers, amalgamations and winding up; and
- the Australian Securities and Investment Commission (ASIC) oversees the administration of product standards and disclosure requirements applying to medical indemnity insurance policies, including the minimum cover limit that an insurer may offer or provide a medical practitioner.

These changes have strengthened the solvency and governance of insurers (increasing their stability) and have supported the availability of affordable insurance to private medical practitioners and privately practicing midwives.

#### Improved data about claims

At the time that the schemes were introduced there was limited data on claims history and the drivers of claim costs, and no national data. For example, it was not clear whether claim costs were driven by large claims in some particular specialties or small claims across all specialties.

Today, there is a 15 year history of claims data. Insurers have stronger data collection systems and there is greater consistency in data collection and reporting across insurers. The improved quality of data better enables insurers to predict future claims costs and set premiums in a manner that provides more certainty (and less fluctuation of premiums) for medical practitioners.

Normalising the market and improving insurer's capital base

As noted in the 2014 National Commission of Audit report, there is strong evidence that suggests that the market has normalised.

The ACCC made similar observations in its reports between 2003 and 2009. For example, in its 2009 report (*Medical Indemnity Insurance – April 2009, Sixth Monitoring Report, page xvi*) the ACCC observed:

*Overall, the ACCC observed a significant change in the medical indemnity industry following the government reforms. The medical indemnity industry had made a transition from providing discretionary medical indemnity cover through MDOs to providing non-discretionary medical indemnity insurance contracts through insurance companies regulated by APRA. The insurers are currently in a much stronger capital position when compared to when they were established, moving away from an objective of raising capital to maintaining capital. The medical indemnity insurers also now actively use actuaries in the premium rating process. As outlined in this report, the ACCC has observed decreases in real premiums as well as improvements in claims experience over the period 2003–04 to 2007–08.*

The National Commission of Audit also noted that major players in the medical indemnity sector have increased profitability.<sup>2</sup>

This is consistent with the more recent findings of APRA, which also reported that each of the four medical indemnity insurers and the two general insurers that offer medical indemnity insurance have positive profitability and net assets. APRA observed that this represents considerable improvements on the negative net asset position in 2002.<sup>3</sup>

The financial reports that the medical indemnity insurers provide to APRA indicate that, for 2015-16, all insurers:

- met and exceeded the prescribed capital amount;
- were profitable; and
- held positive shareholders' equity.

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<sup>2</sup> National Commission of Audit, *Towards Responsible Government - Appendix to the Report of the National Commission of Audit - Volume 2*, [10.16 Medical Indemnity], 2014, [National Commission of Audit Website - Reports - Medical Indemnity](#)

<sup>3</sup> Australian National Audit Office (ANAO), *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No.20 2016–17

There is a potential impact of the National Disability Insurance Scheme, which provides that, when a participant has received compensation in respect of a personal injury that has caused, to any extent, their impairment, from another person or an insurer, a recoverable amount may be payable to the National Disability Insurance Agency.

Affordability of premiums – improvements

While the National Commission of Audit and the ACCC have observed that average premiums have fallen since 2003-04, making them more affordable,<sup>4</sup> the 2016 ANAO report shows that some specialities have experienced change differently over time<sup>5</sup>.

The Government currently has access to data regarding premiums paid by all privately practicing medical practitioners and midwives as submitted by insurers (this does not include individual private income data). From the available data an indicative average gross written premium by specialty can be calculated. Data up to June 2016 indicates that the average gross written premium has declined since 2004, with premiums declining significantly for some specialities with the highest premiums.

While caution must be applied in relying on these data (noting that it relates to both full time and part time medical practitioners), it would suggest that the trajectory of premium increases that existed prior to 2002 (when premiums were increasing annually at an accelerated rate) has since ceased.

### **Questions**

*What other information is relevant to an assessment of the current environment and the success of the schemes in achieving the desired outcomes?*

*Are the current arrangements the most efficient and cost-effective way to support the affordability and availability of insurance? If not, what changes would you suggest and why? Where should Government target its efforts and resources?*

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<sup>4</sup> National Commission of Audit, op.cit.

<sup>5</sup> Australian National Audit Office (ANAO), *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No.20 2016–17, page 28. For example, Figure 2.3 shows a spike from 2011 for ‘All other specialties’ and increases for obstetricians and neurosurgeons in 2013-14.

### 3. Premium Support Scheme and Universal Cover

What is the objective of the PSS?

The Premium Support Scheme (PSS) was introduced on 1 January 2004 to assist eligible medical practitioners with the cost of medical indemnity insurance through payment of premium subsidies.

How does the PSS operate?

Medical practitioners qualify for a premium subsidy under the PSS if they meet one of two criteria:

- their annual gross medical indemnity costs exceed 7.5% of their gross private medical income; or
- they are a procedural general practitioner (GP) practising in a rural or remote area.

Initially the PSS subsidy was 80% of the premium above the 7.5% threshold. A 2009 ACCC report found decreases in real premiums<sup>6</sup>. A decision was taken in the 2011-12 Budget to step down the subsidy. The subsidy reduced to 70% in 2012-13 and 60% from 2013-14 onwards.

The PSS also includes grandfathering arrangements for the Medical Indemnity Subsidy Scheme (MISS) which provided a non-means tested subsidy to high risk specialty groups such as neurosurgeons, obstetricians and procedural GPs. This scheme closed to new applicants in 2004, with existing participants continuing to be eligible for a MISS subsidy if this subsidy is greater than they would have received under the current PSS.

What are the strengths of the PSS?

The key strengths of the PSS are:

- it provides support for medical practitioners whose premiums are in excess of 7.5% of their gross private medical income;
- it provides support for GP's practising in rural and remote areas. No income/premium threshold criteria applies to this subsidy. The subsidy is 75% of the difference between the lowest base premium for a non-procedural GP and a procedural GP in similar circumstances;
- the universal cover arrangements ensure that all practitioners can access indemnity insurance and this does not represent a barrier to them practising; and
- the PSS provides protections for patients because universal cover reduces the risk of medical practitioners being unable to meet the cost of successful claims made by patients (ensuring patients are properly compensated).

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<sup>6</sup>*Medical Indemnity Insurance – April 2009, Sixth Monitoring Report*, page xvi.

***Question***

*Are these the key strengths of the PSS? Are there other benefits of the PSS?*

**What are the issues or challenges with the PSS?**

Decreasing demand

There is decreasing demand for the PSS. Participation in the PSS has steadily declined as premiums have decreased. Department of Human Services statistics show that 4,441 medical practitioners received a premium subsidy in the first year of PSS operation, with participation peaking in 2007-08, with 7,210 medical practitioners participating.

Since then participation has steadily declined with fewer medical practitioners receiving a subsidy each year. In 2015-16, only 1,237 medical practitioners received a PSS subsidy.

Insurers and others have questioned the need for the PSS given its limited application and high cost of administration.

***Questions***

*What role does the PSS play in providing assurance of affordability of medical indemnity premiums?*

*What observations could be made about declining participation in the scheme?*

*Given the increased stability of the medical indemnity insurance market, is there a continuing need for a Government scheme to assist eligible medical practitioners with the cost of medical indemnity insurance?*

*If so, is the PSS appropriate for achieving this purpose?*

*Are there changes that could be made to improve the PSS and best achieve the outcomes sought?*

*If not, is there a suggested alternative approach?*

Access to subsidy

Currently medical practitioners can only access a PSS subsidy if their indemnity insurer has entered into a contract with the Commonwealth.

When the PSS commenced, all Australian medical indemnity insurers entered into the PSS contract with the Commonwealth. The four primary providers of medical indemnity insurance in Australia continue to be signatories. However, in recent years there have been new entrants into the medical indemnity insurance market that have not entered into a PSS contract.

The PSS contract provides both benefits and limitations to signatories. Their members are able to access the premium subsidy and the insurer is paid an administration fee. However, insurers entering into the contract are bound by universal cover requirements (discussed in more detail below) and are required to offer run-off cover at a nominal cost for certain medical practitioners.

### ***Questions***

*Does the PSS offer value for insurers and medical practitioners?*

*What are the key reasons that new entrants to the insurance market have chosen not to contract with the Commonwealth in order to offer the PSS?*

*If the PSS is to be retained, should access to the PSS continue to rely on the insurer having a contract with the Commonwealth or should this scheme be available to any medical practitioners who meet the eligibility criteria regardless of whether or not their insurer has a contractual relationship with the Commonwealth?*

*Are there other changes to the PSS arrangements you would suggest?*

Eligibility for subsidy and level of subsidy

As noted above, the PSS provides support for medical practitioners whose premiums exceed 7.5% of their annual gross private medical income. The level of subsidy paid is 60% of the amount of the premium above the threshold. For GPs practising in rural or remote areas there is no income/premium threshold criteria and the subsidy is 75% of the difference between the lowest base premium for a non-procedural GP and a procedural GP in similar circumstances. Grandfathered MISS recipients qualify solely on the basis of their specialty, with subsidy calculated as a percentage of the difference between their premium and the premium charged to a corresponding medical practitioner.

There are a number of issues associated with these arrangements:

- the Commonwealth does not influence the premiums charged by insurers yet the higher the premiums charged, the greater the Commonwealth's liability to subsidise such premiums;
- the Commonwealth cannot compare the incomes and premiums of those accessing the scheme to those that do not. This means that the Commonwealth has little evidence to determine the appropriate threshold at which subsidy should be paid, or the percentage of the premium that should be subsidised by Government;
- it is unclear whether there continues to be a need for such subsidy to support procedural GPs in rural and remote areas, compared to other locations or specialities. This is because there is limited data regarding the differences in premiums between medical practitioners based on location; and

- there is limited information available to the Commonwealth to determine whether MISS recipients have a greater need for premium subsidy compared to other specialties.

### ***Questions***

*What evidence or other considerations distinguish the medical profession from other professions which incur substantial premiums and do not receive government subsidies?*

*If there continues to be a scheme providing premium assistance, how can this be best structured and targeted to ensure Commonwealth contributions support the area of greatest priority/need?*

*What should be the criteria for subsidy and how should the amount of subsidy be calculated?*

*Is 7.5% of gross private income a reasonable threshold for eligibility to the PSS? What is the evidence for this or a different threshold?*

*Does there continue to be a need for the PSS to subsidise GPs practicing in rural and remote areas? Are there other specialties to which different arrangements for subsidy should apply?*

*Does the differential treatment of MISS practitioners continue to be appropriate?*

### Advance payments

Currently under the PSS, medical practitioners can receive an advance payment of subsidy based on an estimated income. This estimate can be revised by the medical practitioner at any time they consider it may no longer be accurate, resulting in reassessment of eligibility and the amount of the subsidy they receive. After the subject premium year has ended, the medical practitioner is required to make a declaration of actual income which then leads to a further revision of the eligibility, the amount of the subsidy and a further payment to, or from, the medical practitioner.

This approach is resource intensive for insurers, medical practitioners and also for the Department of Human Services.

An alternative to the prospective subsidy would be a single retrospective reimbursement after actual billings by the medical practitioner are known. This would reduce the administrative work required by medical practitioners, insurers and the Department of Human Services as only one assessment of eligibility and subsidy would be required. It would also mean that medical practitioners would only need to apply once a year for subsidy. However, a retrospective rebate would mean that medical practitioners would be required to pay the full premium initially and would not receive financial assistance until after the premium year.

### ***Question***

*If premium subsidies continue to be offered, is it preferable to offer 'advance payment' of a premium subsidy based on an income estimate or should a retrospective payment be made once actual income is known?*

## Universal cover

Medical indemnity insurers who have entered into a PSS contract with the Commonwealth are also required to meet universal cover obligations. Universal cover requires an insurer to make an offer of insurance cover to any medical practitioner whose primary place of practice is the State or Territory in which that insurer is the ‘insurer of last resort’. This guarantees that every medical practitioner can access indemnity insurance.

The insurer of last resort is determined by the market share of these insurers in each State and Territory. Currently the insurers of last resort in each jurisdiction are:

- Avant – New South Wales, Victoria and Queensland;
- MDA National Insurance (MDA) – Western Australia;
- Medical Insurance Australia (MIGA) – South Australia and the Northern Territory; and
- MDA National Insurance (MIPS) – Tasmania and the Australian Capital Territory.

Under the universal cover provisions, insurers are able to impose a range of sanctions or risk limiting conditions of insurance on medical practitioners who they consider to be high risk. These include:

- imposing a financial sanction, such as a deductible or risk surcharge (capped at 100% of the applicable premium);
- excluding certain procedures from cover;
- requiring that the insured medical practitioner be chaperoned or supervised when performing certain procedures; and
- refusing to offer cover or renew cover in certain situations where a medical practitioner has not provided correct or accurate information.

If a dispute arises between an insurer and a medical practitioner in relation to the universal cover arrangements, the matter may be referred to the Financial Ombudsman Service.

Currently only insurers that have entered into a PSS contract are bound by universal cover requirements. Insurers choosing not to enter into a PSS contract can select the practitioners they insure by only offering insurance to specific groups of medical practitioners or medical practitioners they consider to be low risk. Additionally, these insurers are able to further reduce their exposure to risk through access to the HCCS and the ECS, as these schemes are administered under the *Medical Indemnity Act 2002* and supporting legislation rather than through a contract with the Commonwealth.

By contrast, insurers that are part of the PSS are subject to the insurer of last resort arrangements that were agreed when the PSS commenced in 2004. This provides a disadvantage to such insurers relative to those that are not required to be an insurer of last resort under universal cover arrangements.

The key advantage of universal cover is that it means all medical practitioners can secure insurance, enabling them to practice privately. This is particularly valuable for medical practitioners in high risk specialities where the risk of claims is greater (and the quantum of claims also greater) and where insurers may be more reluctant to provide insurance.

However, it also means that there are fewer market-based mechanisms to constrain the practice of medical practitioners with a high claims and complaints history based on inappropriate practice. This is because, regardless of the quality or safety of the practitioner's practices, they are guaranteed insurance through the universal cover insurer of last resort arrangements. Insurers may, however, impose conditions with respect to such practitioners.

Recognising that insurers and medical practitioners may have different views about the value and need for universal cover, the Department is interested in advice from all stakeholders about:

- whether the mechanisms for managing risk that are allowed for as part of the contractual arrangements between the Commonwealth and insurers are adequate or require adjustment;
- other mechanisms that insurers and professional bodies already implement to manage risk and drive safety and quality, particularly with respect to medical practitioners with a high claims history; and
- the role that insurers have in reporting any inappropriate conduct to the Australian Health Practitioner Regulation Agency (AHPRA), noting the inherent disincentives to do so.

### ***Questions***

*Should universal cover continue to be a feature of the medical indemnity insurance in Australia?*

*If so:*

- *should all insurers be subject to universal cover requirements (not just those contracting with the Commonwealth via the PSS)?*
- *are there adequate mechanisms for insurers to limit or monitor the practice of medical practitioners that represent higher risk because of inappropriate practice (i.e. through conditions)?*

*Are the current parameters for universal cover appropriate or should they be changed? For example, currently there is a limitation on the risk surcharge (capped at 100% of the applicable premium). Does this limitation remain appropriate?*

## 4. High Cost Claims Scheme

What is the objective of the HCCS?

One of the reasons the HCCS was established was to assist MDOs (at the time) to raise the capital that they needed to in order to make the transition from MDO to licensed insurer. The HCCS allowed the then MDOs to increase the assets available to pay future claims without needing to significantly increase premiums paid by medical practitioners. It did so by guaranteeing a Commonwealth contribution to the cost of large claims. The HCCS is a form of reinsurance provided free of charge to insurers by the Commonwealth.

Since the establishment of the HCCS, over \$249 million has been paid by the Commonwealth to cover claims against medical practitioners to 30 June 2016.

How does the HCCS operate?

The HCCS pays 50% of the cost of eligible claims over the threshold of \$300,000. Claims are reimbursed by the Commonwealth to the medical indemnity insurer. The threshold increases from \$300,000 to \$500,000 for claims notified from 1 July 2018.

What are the strengths of the scheme?

The HCCS assists in stabilising the market by minimising the impact that large claims may have on the ability of medical indemnity insurers to continue to provide affordable indemnity cover for medical practitioners.

It helps to place downward pressure on premiums by:

- lowering the amount insurers have to pay out; and
- reducing the amount of reinsurance insurers need to purchase to fund large claims.

### ***Questions***

*Are these the key strengths of the HCCS? Are there other benefits of the HCCS?*

What are the issues or challenges with these schemes?

There are four main issues for consideration in relation to this scheme:

- the scope of the scheme (i.e. who the scheme applies to);
- the threshold above which the Commonwealth contributes;
- the level of the Commonwealth's contribution; and
- the costs that should be paid by the Commonwealth (as part of its contribution).

The scope of the scheme

The HCCS covers persons undertaking a medical profession, including medical practitioners and people in a registered health care vocation. This also applies to the Exceptional Claims Scheme.

Of the 996 (approximate) HCCS claims paid to 30 June 2016, approximately 39 claims were paid by the Commonwealth in respect of persons whose specialty code indicated they were health professionals.

Medical indemnity insurers have indicated that the HCCS could better reflect business practices, for example:

- better accommodate medical practitioners who hold their own individual insurance but operate in a company structure; and
- enable the apportioning of claims (where the claim is against more than one medical practitioner or health professional or is across public and private practice or is across Australian and overseas practice).

***Question***

*Does there continue to be a need for Government to subsidise insurers though contributing to the cost of high claims (so as to provide certainty and reduce pressures on claims)?*

*Should the scope of the HCCS be limited to medical practitioners? If not, what is the evidence of the need for these schemes with respect to other registered health care vocations?*

*How could the HCCS better align with the business practices of medical practitioners or otherwise be improved?*

Threshold above which the Commonwealth contributes

The Commonwealth makes a contribution in relation to eligible claims over the threshold of \$300,000. From 1 July 2018, the threshold increases from \$300,000 to \$500,000.

Consideration needs to be given to whether the threshold for eligibility is appropriate.

***Question***

*Is the threshold above which the Commonwealth contributes appropriate?*

*What would be the likely impacts of any changes to the HCCS?*

Costs covered by the HCCS

The definition of claims is sufficiently broad that it could be interpreted to include costs that are not directly attributable to reimbursing the claimant for the impact of the adverse event, for example, the costs of representing members for civil claims, criminal issues and representing medical practitioners in their capacity as directors of a company. Insurers have also sought reimbursement for hotel, food and interest costs for medical negligence claims.

Currently the Department of Human Services reviews claims made by insurers. Insurers have noted that the requirement to submit receipts can be administratively onerous.

The Department welcomes comments about ways in which the administration of the HCCS could be improved while also ensuring that:

- there continues to be transparency and accountability with respect to costs paid;
- all costs claimed are reasonable; and
- that the description of costs paid does not become unnecessarily prescriptive (in terms of what can and cannot be claimed), yet also ensures that inappropriate items are not included in claims.

### ***Questions***

*Is Government involvement in providing this type of reinsurance appropriate, given the availability of commercial insurance and reinsurance?*

*How should claimable costs be defined? What alternative definition would be practical, effective and reasonable?*

*What other issues around claims and eligibility need clarification? Please provide examples and suggestions for inclusion in any future guidance material.*

*What other changes could be made to the HCCS to improve its effectiveness, efficiency and value for money while ensuring it continues to meet the scheme objectives and to reflect current insurance arrangements?*

## 5. Exceptional Claims Scheme

What is the objective of the ECS?

The ECS caps the size of the claims for which insurers will be responsible.

How does the ECS operate?

The ECS pays 100% of the cost of private practice claims that are above \$20 million, either as a single claim or an aggregate of claims that together exceed the threshold. To date, there have been no claims made under the ECS.

What are the strengths of the scheme?

By capping the size of the claims for which insurers will be responsible (because the Commonwealth picks up the cost of any claims above \$20 million), this provides certainty for insurers and reduces the potential impact of occasional very large claims on premiums.

What are the issues or challenges with the scheme?

Since 2002 medical indemnity insurers have strengthened their capital, profitability and overall financial position (including their capacity to pay out rare, high claims such as those covered by the ECS). Consideration needs to be given to whether the ECS should continue and, if so, whether the threshold for eligibility is appropriate.

In considering this question, the Government is also keen to explore the following issues.

### ***Questions***

*What are the benefits of the ECS given the absence of claims made under the scheme?*

*To what extent does the scheme influence the limits of insurance applied by insurers?*

*To what extent does Government involvement in providing this type of insurance provide certainty for the sector?*

*Should the scope of the ECS be limited to medical practitioners? If not, what is the evidence of the need for this scheme with respect to health professionals (and allied health professionals)?*

*Is the ECS best administered by the Commonwealth?*

## 6. Run-off Cover Scheme

What is the objective of the ROCS?

The objective of the ROCS is to ensure that once medical practitioners cease private practice (permanently or temporarily), there continues to be insurance to cover any claims relating to actions taken by the medical practitioner while they were practicing privately (without the need for the medical practitioner to continue to hold medical indemnity insurance after they cease private practice).

As at 30 June 2015, there were approximately 12,019 who became eligible for the ROCS<sup>7</sup>.

How does the ROCS operate?

The ROCS pays 100% of the cost of claims for eligible medical practitioners who have ceased private practice. Insurers are required to provide free run-off cover to eligible medical practitioners under insurance legislation. The Commonwealth pays 5% of the cost of each claim to the insurer as a claim handling fee and there is an annual allowance for ongoing administrative costs.

Insurers make ROCS payments to the Commonwealth as a 5% tax on insurers' premium income. In practice, the cost is met by a loading on practitioners' medical indemnity insurance premiums.

Since the establishment of the ROCS, over \$24 million has been paid by the Commonwealth to cover claims against medical practitioners.

In the event ROCS is wound up, the Commonwealth is liable to pay an amount to each affected medical practitioner, unless there are alternative arrangements in place for providing run-off cover for medical practitioners.

What are the strengths of the scheme?

The key strength of the ROCS is that it guarantees insurance cover for medical practitioners and pays 100% of the cost of claims after they cease medical practice. The ROCS also funds medical indemnity insurers for administering claims and for reporting to the Commonwealth.

What are the issues or challenges with this scheme?

Some of the issues that have been raised by insurers, medical practitioners and others in relation to the ROCS include that:

- the scheme is complex legislatively, making interpretation and understanding by both Government and the sector challenging;
- the scheme may be better managed by insurers rather than by Government;

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<sup>7</sup> *Eleventh report on the costs of the Australian Government's Run-Off Cover Scheme for medical indemnity insurers*, 2014-2015 financial year. Next report due to be tabled late in 2017.

- if there is uncertainty about whether a person has ceased practice (in accordance with the requirements of the ROCS) there are incentives for medical practitioners and insurers to submit a claim via ROCS because the ROCS funds 100% of the costs unlike the other schemes;
- the scheme does not incentivise the settling of claims because there is no barrier to the payment of high claims. The full cost of a claim is met by the ROCS and the fee paid to insurers to manage the claim increases with the size of the claim; and
- the ROCS creates significant administrative burden for insurers and for the Department of Human Services.

Government seeks stakeholder advice on these issues:

### **Questions**

*Does there continue to be a need for the ROCS?*

*If so, is the Commonwealth best placed to manage and administer the ROCS or could it be administered by insurers or others? If the scheme is more appropriately managed by others, how could it be transitioned?*

*Are there any improvements that could be made to the scheme to make it more efficient and effective (regardless of who manages the scheme)?*

*Are the data collection requirements associated with ROCS reasonable and appropriate?*

*Should any changes be made to eligibility or the other requirements for payable claims?*

*Are there any improvements that could be made to clarify which medical practitioners and which claims are eligible for ROCS?*

*Is the ROCS support payment set at an appropriate level? If not, why, and what would be an appropriate level?*

*Does the allowance paid to insurers for ongoing administrative costs continue to be necessary and, if so, is it set at an appropriate level?*

## 7. Incurred But Not Reported Claims Scheme (IBNR)

Why was the scheme established?

The IBNR Scheme was established to allow UMP to continue to provide medical indemnity cover to its existing membership after it collapsed in 2002. While UMP had adequate funds to cover its known claims, there were inadequate reserves for IBNR liabilities.

Accordingly, the government established the IBNR scheme to fund the IBNR liabilities and enable UMP to continue to trade. While this provided benefits to UMP it also supported the sector more broadly because at the time, there was insufficient capacity in the rest of the medical indemnity market to accept UMP's medical practitioner members. In the absence of medical indemnity cover, a number of UMP medical practitioners argued that they would be unable to continue practising.

Government intervention ensured that medical practitioners insured by UMP could continue to practice and that the costs of IBNR claims could be met.

How does the scheme operate?

The IBNR Scheme pays 100% of the cost of claims from the unfunded incurred-but-not-reported liabilities of UMP, now Avant Insurance. A levy (support payment) was collected until 2006-2007.

Since the establishment of the IBNR, over \$102 million has been paid by the Commonwealth to cover liabilities of UMP/Avant to 30 June 2016.

Is there an ongoing need for the IBNR Scheme?

For some time, some insurers have represented to Government that the ongoing existence of the IBNR Scheme provides an unfair advantage to Avant in a highly competitive market and that Avant's balance sheet suggests that ongoing Commonwealth contribution is no longer necessary in order to ensure that IBNR claims can be met. This issue was explored in detail in 2005 as part of a competitive advantage review. The review concluded that some competitive advantage was being received by Avant and a payment back to the Commonwealth was made by Avant to address this.

Further, it is likely that claims will reduce each year for approximately the next 10 years and as such the IBNR scheme will naturally terminate.

### ***Questions***

*Does there continue to be a need for the IBNR?*

*If so, are there any improvements that could be made to make the scheme more efficient and effective?*

## **8. Midwife Professional Indemnity Support Schemes**

How do the Midwife Professional Indemnity Support Schemes operate?

The midwife professional indemnity schemes were introduced in 2010 to support midwives and enable them to practice privately.

Under national registration arrangements, all registered health professionals must hold indemnity insurance. As privately practising midwives represent a small group working in a comparatively high risk field there is apparently little commercial appeal in offering this type of indemnity insurance.

There are two Commonwealth schemes to support indemnity insurance for private midwives: the Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS); and the Midwife Professional Indemnity Run-off Cover Scheme (MPIROC).

The MPIS has two components:

- the Commonwealth has a contract with an insurer to provide affordable professional indemnity insurance to eligible midwives. The cost of the insurance is capped at \$7,500 per annum and is calculated based on the services provided and gross income of the midwife: and
- the Commonwealth subsidises the cost of indemnity claims by paying 80% of the insurance pay out exceeding \$100, 000 up to \$2 million and 100% of the insurance pay out exceeding \$2 million.

MPIROC provides indemnity insurance for midwives who have left private practice. Under MPIROC the Commonwealth pays 100 % of each eligible ROC claim that is notified after an eligible midwife ceases private practice. Like the ROCS for medical practitioners, this scheme is offered through the insurer providing insurance while the midwife is practising and is funded by a levy on the insurer.

What are the strengths of the schemes?

The key strengths of the schemes are:

- it provides support for midwives by capping their premiums. The high subsidisation of claims enables the cost of premiums to be kept affordable for privately practising midwives;
- it guarantees cover for eligible midwives when they leave private practice, in order to fund claims in relation to incidents that occurred while they were practising privately; and
- the schemes provide protections for patients because it reduces the risk of midwives being unable to meet the cost of successful claims made by patients (ensuring patients are properly compensated).

## What are the issues or challenges with these schemes?

The schemes were introduced as a short-term response to market failure, with the view that States and Territories would explore options for a professional indemnity product covering the full spectrum of midwifery services. Although some states (most recently Queensland) have actively investigated midwife professional indemnity options, no resolution or comprehensive indemnity product for private midwives has yet been developed.

The number of midwives holding the Commonwealth subsidised indemnity product is lower than anticipated when the scheme was introduced. It was initially estimated that take-up would reach around 725 nationally by 30 June 2013. As at 30 June 2016, around 200 midwives held the MPIS product. It is understood that the remainder of the 30,285 registered midwives in Australia work in the public sector or under other employment arrangements.

The main issues for consideration are whether there continues to be a need for the MPIS and whether any MPIS is best administered by the Commonwealth or through other arrangements. For example, given the small proportion of midwives covered by Commonwealth arrangements compared to those working in the public sector or under other employment arrangements, there may be advantages in adopting the one approach for all midwives. Further, the scheme has high overhead costs (given the small number of participants) and there may be value in reforming existing arrangements.

In relation to the MPIROC, many of the issues are the same as described in relation to the ROCS.

### **Questions**

*Does there continue to be a need for the Commonwealth midwife indemnity support schemes?*

*Are the current Commonwealth midwife indemnity support schemes the most appropriate way of providing professional indemnity insurance for privately practising midwives? Why?*

*Are there alternative models of providing indemnity insurance for privately practising midwives? If so, what are they and what barriers and/or enablers are there to implementing these models?*

*If the current midwife indemnity support schemes are retained could they be improved, and if so, how?*