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Ms Kate Medwin
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Dear Ms Medwin,

Medical Indemnity Protection Society Ltd (MIPS) Response to First Principles Review of Indemnity Insurance Fund

Thank you for the opportunity to provide input into the First Principles Review.

Medical Indemnity Protection Society Ltd is an Australian Medical Defence Organisation (MDO) with over 50,000 members. MIPS members are provided a range of membership benefits including medical indemnity insurance. This insurance is provided to MIPS membership by MIPS Insurance Pty Ltd - MIPS wholly owned Australian Prudential Regulation Authority (APRA) regulated insurance subsidiary. All assets of the MIPS Group ultimately belong to MIPS members.

The First Principles Discussion Paper poses questions in respect of the various schemes that have been implemented to assist with the availability and affordability of indemnity cover for health professionals and in particular, medical practitioners.

Through the Indemnity Insurance Fund, the community has benefitted from wider access to a broader range of less expensive than otherwise healthcare. It is important therefore to ensure that any changes to the Indemnity Insurance Fund further enhance that positive impact on the broader community.

Executive Summary

In our response MIPS articulates that;

- The Government Medical Indemnity Schemes play an important ongoing role in ensuring the affordability and availability of health care in the community
- The High Cost Claims Scheme (HCCS) currently appears to fund approximately 25% of the cost of claims and anticipated HCCS recoveries form over 30% of the assets held against claims liabilities of medical indemnity insurers.
- Medical indemnity providers are in effect conduits of Government funding to health care in the community. Any changes in insurer's input costs will ultimately be passed on to insureds. In the case of medical indemnity changes in costs are passed on to the healthcare practitioners. Increased costs to health practitioners will in turn affect the availability and affordability of healthcare in the community. The effect on healthcare availability and affordability will most impact those most reliant on available and affordable health care being principally the young, the old and those with chronic health issues.

- Government Scheme sourced funding is an efficient source of funding medical indemnity insurance compared with funding via insurance premium. Any reduction in efficient Government funding will cause a higher pricing impact. That is because each dollar reduction in Government funding requires a higher amount of premium to replace that reduction in government funding because of the effect of various government imposed transaction costs consisting of taxes, duties and levies and a need to fund a higher than otherwise APRA capital requirement buffer.

- MIPS does not support any reduction in the total amount of Government support provided under the medical indemnity schemes because of the adverse impact that is likely to have on the community.

- MIPS is confident that with appropriate modification the current medical indemnity schemes funding can be deployed more effectively to better align with the objective of ensuring equitable access to affordable health care for the community.

- The Premium Support Scheme (PSS) is the most important of the government schemes in that regard. We believe that the PSS can be improved so that it is even more effective in ensuring equitable access of the community to affordable health care.

- The Run-Off Cover Scheme (ROCS) should be extended to include periods of non-discretionary cessation of practice arising from significant un-expected health events that do not currently qualify under ROCS. These additional qualifying events should also include those that lead to loss of Australian Healthcare Practitioners' Regulation Agency (AHPRA) registration.

- The government requirement for Universal Cover and its current framework of application materially increases risk of harm to the community.

- Noting the safety net of the National Disability Insurance Scheme, healthcare practitioners should now be permitted to participate in professional standards schemes that appropriately limit civil liability. Extension of professional standards schemes to healthcare practitioners would bring health professionals in line with many other professions and is expected to significantly reduce or perhaps even remove the ongoing need for government Indemnity Insurance Scheme funding.

Need for an expanded scope

We also believe that a First Principles review should provide an opportunity to consider more fundamental changes such as rationalisation of the various patchwork of medical indemnity legislation that was created in a reactive manner early last decade.

The medical indemnity legislation appears to have done its job in response to the perceived crisis however as it was created sequentially in a reactive manner we are concerned that it is not well suited to meeting the needs of stakeholders going forward.

In our view the administration heavy, prescriptive and complex approach to the medical indemnity schemes severely limits efficiency and discourages competition.

Arguably if the Australian Health Practitioner Regulation Agency (AHPRA) had been in operation at the time of the perceived crisis then much of the raft of medical indemnity legislation that was created would not have been required.

That is because the subsequently established AHPRA sets the indemnity requirements for registration of health practitioners.

By requiring indemnity to be provided by APRA authorised insurers and setting insurance requirements (including run-off cover and cover limits etc) as a condition of health care practitioners' registration to practise, AHPRA can make unnecessary much of the earlier medical indemnity legislation and better meet the needs of the community going forward.

As well as providing greater clarity such an approach would increase the flexibility of AHPRA to respond in a timely manner and to set indemnity requirements for health professionals that it believes will best serve the community.

Unfortunately, the current inflexible medical indemnity legislation impedes AHPRA applying a preferred general overarching framework. The medical indemnity legislation constrains AHPRA's preferred approach to indemnity requirements for registration in respect of medical practitioners.

A more fundamental review of the medical indemnity schemes would also help government's expressed desire to significantly reduce red-tape, reduce that as a barrier of entry to competition and help to enable AHPRA and other stakeholders to address rapidly changing indemnity needs of stakeholders going forward.

We would welcome the opportunity to discuss this further with Government in addition to our attached responses to the questions posed in the discussion paper.

MIPS authorises our submission to be made publicly available on the Department of Health website if required by the Department of Health.

Yours faithfully,

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Managing Director - MIPS

MIPS - Medical Indemnity Protection Society Limited
is a Doctors for Doctors, "not for profit" organisation that provides membership benefits to over 50,000 members.

Encl. *Response to discussion paper questions*

Response to Discussion Paper Questions

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

It appears that there may be some deterioration in both certainty of legal outcomes; settlement and claims amounts; and claims frequency since the National Commission of Audit report.

Medical indemnity insurers have commented on the increased numbers of claims in recent times for example those associated with college training disputes and Australian Health Practitioners Regulation Agency (AHPRA) matters.

Sources of updated data to be referenced include Australian Prudential Regulation Authority (APRA) with its now expanded and more granular National Claims and Policy data and also AHPRA annual statistics.

For example, in the 15/16 AHPRA Annual Report the Medical Board's report contains the statement;

'This year, 5,371 notifications were received nationally about medical practitioners (including the HPCA in NSW). This represents an increase of 18.3% from the previous year….'

Although this was attributed mostly to a change in Queensland processes it might also indicate a worsening trend.

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?

In general terms insurers are conduits that pass on to their insureds through the premiums they charge any changes in their input costs.

Insurers must maintain additional surplus capital and if more than adequately capitalised may choose to act as capacitors to absorb some and/or slow the passing on of increased input costs. However, those increased costs must ultimately be passed on to insureds and in the case of medical indemnity insurance that means passing on those costs to health care consumers.

For Medical Indemnity insurance those consumers are health care recipients. Increased indemnity costs have an adverse impact on the affordability and availability of healthcare services.

In its purest form, direct Government funding is the most efficient mechanism for funding equitable, affordable and available health care. For the reasons outlined above that government funding should also include funding of affordable and available medical indemnity insurance.

For example, the High Cost Claims Scheme (HCCS) reduces or removes cost inflators such as Stamp Duty, Taxes, capital charges and transaction costs associated with funding that but for the HCCS, would otherwise need to be obtained through premium income.

Unfortunately, the current Government schemes arrangements are complex and not as efficient or targeted as they might be. This is because the various schemes were developed - sometimes independently of each other and primarily in a reactionary manner - over a relatively short period of time when there was a perception of significant crisis.

MIPS suggests that the Government Schemes could be greatly simplified to achieve a better outcome for stakeholders.

At its most reduced and extreme MIPS believes that if there is a decision to rationalise some schemes then there should be transfer of that funding to an expanded and better targeted Premium Support Scheme (PSS). That increased PSS funding support (being all the funding that would otherwise have to be allocated for now ceased or reduced schemes as if they were ongoing) would help avoid adverse effects on the affordability and availability of healthcare to the community.

If this transfer of funding occurred it could help ensure adequate and appropriate support for health practitioners and provide a better methodology for achieving the goal of providing the community with equitable, affordable, readily available, high quality health care.

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

An important feature of the Premium Support Scheme (PSS) is that it can help to ensure access by consumers, especially remote, disadvantaged and/or lower income groups, to a wider range of more affordable health care.

That is because the PSS can reduce a significant cost of practise for those practitioners whose lower than average income may be a reflection of;

* low patient population numbers in remote or isolated areas and/or

* where there is a larger proportion of the population who are disadvantaged/lower income or welfare recipients and/or

* those with healthcare affordability issues associated with chronic health problems.

The PSS also helps ensure equity of access and care for the community in respect of a wider range of clinical skills and specialities than otherwise. That is particularly so for essential but higher clinical risk craft groups.

The PSS also helps to ensure consumers can have choice of provider.

It is our long-expressed view that not enough focus has been placed on ensuring the PSS is aligned with social health equity objectives. Unfortunately, the PSS was more narrowly framed as a benefit to medical practitioners (a cost to health care) rather than an important mechanism to ensure that equitable, affordable, high quality health care is available to all communities.

MIPS also confirms its previous position that the PSS is the most important of the Government schemes for the reasons outlined above.

The PSS also provides a vital safety net in respect of consequences - whether foreseen or not foreseen - arising from changes in the other Government schemes or other significant system shocks that can include changes in law and judicial interpretation.

Our view is that the PSS should be further developed and strengthened and better aligned with social utility. For example, the potentially very significant but possibly uncertain effects on the costs of medical indemnity insurance, particularly for some practise craft groups, (and the flow-on effects on the cost and availability of health care to consumers) that would arise from a decision to further reduce or cease the High Cost Claims Scheme can be ameliorated through a revised PSS.

We suggest that consideration also be given to changing the name of the scheme to better reflect the important contribution it should make to the community and to help clarify that the PSS is a benefit to the eligible practitioner in meeting their Australian Health Practitioner Regulation Agency medical indemnity requirements.

It is important to recognise that the PSS is ultimately not a benefit to the insurer. That is because insurers must charge what they need to for the risk they offer to accept - being the health services that the practitioner provides - whereas the PSS can help some practitioners with meeting the cost of that cover.

The purpose of PSS would be clearer to stakeholders if the name was changed to better reflect that important social utility. Perhaps the name Healthcare Indemnity Support Scheme might better frame the purpose and the role of the scheme in the community.

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

See previous.

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

The decrease in numbers of PSS recipients belies the significant role the PSS plays - particularly for some practitioners and their communities - and the safety net that it provides against unexpected adverse indemnity cost developments.

There are a number of factors associated with the fall in numbers of PSS recipients over time.

A significant factor has been the reduction of PSS rebate percentage dropping from 80% of amounts in excess of 7.5% of billings to 60% of amounts in excess of 7.5% of billings.

This drop has further reduced the benefit for some who were receiving relatively modest rebates. Quite simply the time cost, uncertainty and complexity of the current PSS processes are a significant deterrent to any otherwise eligible practitioner. As a result some that are eligible will choose not to participate.

Currently each change in category/billings/practise jurisdiction/retroactive cover date etc triggers an adjustment to both premium and the PSS amount for those who have opted in. Each change will result in either an additional amount of PSS benefit or requirement to repay some of the PSS previously advanced.

The current process also means that no matter how many interim adjustments are made during the year that there is an almost universal expectation of all stakeholders that the final determination will result in a final adjustment leading either to additional PSS payment or very frequently repayment of the PSS advanced either in part or in full.

The current process can create significant timing delays for final determination for each PSS year.

It is therefore possible for a practitioner that was advanced PSS to find that they are ineligible at final determination of the earlier PSS year. Some practitioners may also find that they then have more than a year of PSS to refund and some of those in turn may have very significant amounts required to be repaid.

Subsequent necessity for amendments of prior year tax returns etc. may further complicate the process.

Following the legislated requirement for medical indemnity cover to be provided only under contract of insurance, early in the life of the PSS scheme, most medical indemnity insurers were including large solvency loadings into their premium pricing. This materially increased premium pricing and therefore PSS participation.

In addition, the Australian Prudential Regulation Authority (APRA) previously required a higher capital adequacy for medical indemnity insurers compared to non-medical indemnity general insurance insurers. This again meant higher premium pricing than otherwise and higher PSS participation at that time.

The need to rapidly amass capital meant higher premiums than otherwise which then led to higher than otherwise PSS participation measured by number of participants and by total PSS amount paid.

The need for inclusion of significant solvency loadings into medical indemnity insurer’s premium has now greatly diminished so that there has been a relative reduction in

premiums and less pressure on premium increases. That combined with health practitioner income growth over time has resulted in reduced eligibility for PSS participation by number and amount paid than would otherwise have resulted.

Many insurers have also introduced additional billing bands in their membership categories and adjusted premiums accordingly resulting in fewer practitioners than previously now eligible for PSS.

However, for some risk categories there may still be a single premium rate no matter what the individual practitioner billings are. That is because the risk for that group is not as sensitive to the exposure rating proxy of billings and also where the average claim size for that craft group is equivalent to many practitioner lifetimes of insurance premium. For such groups, the PSS has a significant role to play.

The $300,000 HCCS threshold has been in place for many years. Because this threshold has not been indexed for inflation this has had a significant role in mitigating premium increases that would otherwise have led to greater PSS participation.

It is important to note that all else being equal any reduction in HCCS assistance such as the increase of the $300,000 HCCS threshold to $500,000 from 1 July 2018 should increase PSS participation as the increased costs to the insurer are passed on to practitioners.

Over time there have also been significant improvements in the efficiency of insurers. One area of efficiency has been funding of non-insurance services provided to members (such as risk education, clinico-legal advice, employment issues etc) using mutual subscription income. This has resulted in lower than otherwise total indemnity costs for PSS purposes (and thereby lowering the numbers of those practitioners otherwise eligible for PSS as well as the PSS amounts otherwise paid).

The use of traditional MDO non-premium income has therefore further helped to achieve lower costs and greater availability of health services in the community.

Movement of practitioners from lower to higher income areas of practice and geographic location will usually mean an increase in billings and a reduction in PSS eligibility.

The Department of Health will have access to demographic data and analysis of population to health care provider ratios for different geographic locations to compare changes over time.

A decreased ratio of practitioners to patients in remote/rural and/or more disadvantaged areas compared with more advantaged areas of major cities over time may help shed further light on the relative contribution of this factor on the decreased number of PSS participants.

Ineffective policy to ensure that remote/rural and/or disadvantaged areas have equitable access to affordable health care will also reduce PSS participation.

The improved economic climate post Global Financial Crisis and subsequent repair of retirement savings may also mean that mature practitioners who might have previously maintained ongoing but limited practise rather than retiring; and others working part-time (for reasons of maternity or paternity) who were therefore perhaps more likely to receive PSS; now no longer need to do so.

These factors combined with the effect of the non-indexed HCCS has resulted in a relatively flat total premium pool for the Medical Indemnity sector over many years despite significant growth in number of registered practitioners and on-going cost shifting from public to private sector.

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?

It is MIPS view that the PSS is the most important of the Government schemes but that the focus of the PSS needs to be recast to ensure that it is an effective and transparent means to ensure government health policy and in particular Community healthcare equity is achieved.

As previously stated the PSS also provides an important safety-net in respect of expected as well as unexpected system pricing shocks such as might occur from changes in medical indemnity schemes.

If the government is considering any changes to the MI schemes then the PSS should be strengthened to help reduce the adverse impact on health care availability and affordability.

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

The PSS in its current form is not appropriate.

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?

Yes. The PSS should be better aligned to the purpose of achieving equity in the community in respect of health care availability and affordability.

Please see MIPS response to the question '*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?*' provided further on in this response.

Does the PSS offer value for insurers and medical practitioners?

As previously outlined, in general terms insurers are conduits that pass on to their insureds - through the premiums they charge - the insurer's input costs and any changes in those input costs.

In that respect, the PSS offers no value to insurers because it does not change the premium that an insurer must charge i.e. there is no net benefit to insurers from the presence of the PSS.

The PSS does however provide a benefit to eligible medical practitioners and through them their patients in respect of availability and affordability of health services. This is commented on elsewhere in our responses.

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?

Our comments in respect of the decrease in PSS participation over time have been articulated earlier.

In general terms, Medical Defence Organisations and their insurance subsidiaries are focussed on assisting their members in the service of their health communities. Although prudently run MDO's take an equitable approach to members and do not differentiate their focus based on amount of premium charged nor do they exclude craft groups.

There have been no new MDO entrants following the introduction of the medical indemnity legislation. During that time, the number of MDO insurers has decreased from 7 to 4 and their number would have decreased to 3 but for one organisation's members voting to block their merger.

One post legislation commercial entrant entered and then was subsequently sold to an incumbent MDO (and absorbed). More recently another commercial entrant has entered the sector.

For-profit/commercial insurers and their intermediaries are likely to receive a better return (being often based on a % of premium) for their time/efforts by signing up higher than average premium health practitioners that are also relatively higher income earning.

To ensure higher profits and/or greater stability in financial results there may also be a reluctance of some commercial insurers to insure some higher clinical risk practitioners.

As a result of these factors the practitioners that commercial insurers are attracted to (and therefore make themselves more attractive for) are less likely to be eligible for the PSS.

Commercial new medical indemnity insurer entrants also appear to price significantly below current incumbents. This may be due to lack of historical claims data and/or an attempt to gain early growth in share of market. Even though not sustainable over the longer term, unless subsidised by other business income, this initial lower pricing further reduces the need for PSS.

Additionally, the PSS process is complex and inefficient and creates a credit risk for insurers. The credit risk arises because insurers are required to repay government any downwards adjustments of PSS advanced and then attempt to recover those repayments from practitioners who may or may not still be insured with them.

Although a PSS administration fee is paid it is likely that the primary driver of MDO insurers participation is to provide a service to their members. For other non-MDO insurers, the complexity and compliance risks may reasonably be considered as not worth the trouble.

A very significant problem with the PSS administration contract between government and insurer that is required for insured practitioners to access PSS is the Universal Cover requirement that is imbedded in that contract.

Colloquially known as ‘the insurer of last resort’ requirement the contractual obligation to provide Universal Cover to those practitioners who would be otherwise uninsurable is out of step with current community expectations and creates an increased risk of otherwise avoidable harm to the community.

MDO’s may feel that they have little choice because the Universal Cover obligation is tied to the PSS contract which they must sign in order for their members to access PSS benefits. As discussed previously those PSS benefits assist in the availability and affordability of health care to patients.

Commercial insurers on the other hand are more likely to look at the greatly increased risk attaching to those practitioners required to be accepted under the Universal Cover provisions. This risk is further heightened because of the significant Universal Cover restrictions under the contract in respect of measures that might normally be applied by insurers to modify risk (to the community and therefore the insurer). The complex, expensive and time-consuming requirements of meeting the contract requirement for offering actuarially justifiable Universal Cover terms is a further significant disincentive.

Under Universal Cover there are also requirements that the measures usually undertaken to reduce risk such as excesses/loadings/risk education/practise restrictions etc are all actuarially justifiable terms and conditions. These in turn are all then subject to Financial Ombudsman Scheme appeal.

As a consequence of Universal Cover other medical practitioners must pay more than they would otherwise to subsidise any shortfall in funding arising from the Universal Cover restraints. This in turn makes pricing for non-Universal Cover insureds less competitive.

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?

The PSS should be available to any practitioner regardless of the insurer they choose and must not be tied to Universal Cover.

For that to occur there needs to be changes to the current PSS process.

MIPS recommends that these changes include;

- A single final eligibility/determination process
- Management of the PSS through a government agency – ideally as part of each practitioner's income tax process

A move to a final (once only) PSS eligibility/determination process would;

- remove significant uncertainty for stakeholders. The current process means significant delays so that it is possible for a practitioner to find that they have more than one year of advanced PSS to refund. That in turn creates a credit risk for Medical Indemnity insurers. This credit risk must in turn be managed by credit/debt management processes and often the need to hold additional capital.
- remove complexity. Currently each change in category/billings/practise jurisdiction and retroactive cover date etc triggers an adjustment to both premium and the PSS benefit for those who have opted in and are eligible.
- not significantly affect upfront insurance affordability. That is because most insurers offer instalment payments (MIPS for instance offers interest and administration fee free membership subscription instalment payments). Other insurers may offer premium funding. It is also important to remember that Financial Services Licence holders must consider financial hardship issues.

Use of a single government agency (perhaps the ATO to administer the PSS via Income Tax Return process similar to HECS/HELP schemes) seems the most efficient and transparent approach going forward.

Using a single determination approach means a single submission by a practitioner with declarations in respect of income from all medical practice; cost of medical indemnity and then application of the appropriate rebate. These are all elements that already need to be considered as part of each practitioner's annual tax return.

Improved alignment of PSS with social utility to assist less affluent groups in the community to access affordable healthcare might be better achieved if Medicare billings were used to determine the final amount of PSS entitlement. For example, those eligible for PSS who had a higher proportion of their total billings from Medicare receipts might be provided a higher PSS benefit for the same indemnity costs paid compared with than those billing the same amount but with lower Medicare receipts

Weightings/loadings for some geographic locations could also be applied to help support an appropriate mix of craft groups for the communities of those areas noting Medicare billings are associated with a location specific healthcare provider identifier.

If PSS administration of a final once only approach was achieved via an ATO process then scheme audit would form part of normal ATO oversight.

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

In general terms, the PSS currently operates on a flat rate basis in respect of indemnity amounts greater than 7.5% of private practise income. There is no differential approach in respect of low income practitioners - where that may reflect providing services to disadvantaged low income communities - compared with higher income practitioners who may or may not be involved in higher risk clinical activities.

For example PSS support for a practitioner with $100,000 in billings per annum from providing services in remote areas or to disadvantaged low income communities who is paying $5,000 in indemnity cost per annum should not be compared for PSS purely on % terms with a higher craft risk practitioner providing services, perhaps including significant amounts of elective or discretionary health services, to urban high income groups and earning $1,000,000 per annum who is paying $100,000 per annum for indemnity.

Although the second practitioner is paying twenty times the indemnity cost of the first practitioner the second practitioner's total income net of indemnity costs is $900,000 while for the first practitioner it is $95,000. In addition, the practitioner earning $1,000,000 may receive premium support while the first does not.

As previously proposed we believe a better use of tax-payer funded PSS is to align the indemnity cost support with social utility to help achieve equity in the community in respect of health care availability and affordability.

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

As previously discussed the current government schemes help to ensure more of the community and particularly those in disadvantaged, low income or remote areas and with chronic disease will have access to a wider range of more affordable health care.

That is because tax payer funding of indemnity costs is more efficient than funding through charges for health care services. When appropriately applied to health care, government funding improves the cost efficiency and availability of health services to the community.

Health care provision is an important responsibility of Governments and is significantly funded by them. Other professions are not.

Health care is often not a discretionary purchase especially for those with urgent medical conditions and chronic disease. Many other professional services are discretionary or less urgent and therefore able to be budgeted for.

Most importantly most non-healthcare professionals have access to Professional Standards Schemes that in effect cap their professional liability exposures and so are better able to fund their indemnity costs. Appendix 1 shows the current list of Professional Standards Schemes participants.

The Professional Standards Council website states; '*Professional Standards Schemes limit association members' civil liability. This means that, if any of your participating members are sued by a client, a monetary ceiling will generally apply to the amount of damages that can be awarded. This is intended to in turn make it easier for your members to get the professional indemnity insurance they need to stay in business.'*

If healthcare practitioners had similar access to a Professional Standards Scheme it is likely that there would not have been a medical indemnity crisis and initial government intervention and ongoing support would not be required.

This differential approach between professions is inequitable and irrational for example when a catastrophically injured medical accident patient's claim fails because of the negligence of their legal advisor the potential monetary damages available to that claimant are significantly different to that which otherwise would have been available.

Appendix 1 shows the various State legal practitioner bodies that are Professional Standards Scheme members.

Now that the National Disability Insurance Scheme is in place it seems sensible for health care practitioners to be permitted to participate in Professional Standards Schemes. When that occurs, there would be a significant reduction in the use/need of government MI schemes.

However at its most objective, if the Government believes that it can achieve better health outcomes (using metrics such as improved access, affordability and outcomes) by cessation of the Government schemes and redeployment of those funds in some other way then it is in the best interests of the community to do so.

In addition, it is important to that the Government Schemes target affordability of indemnity (being a significant input to healthcare availability and affordability for patients) in private sector health care whereas those health professionals employed by entities or the public sector are indemnified by their employer.

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?

As previously stated the PSS should be available to any practitioner regardless of the insurer they choose and should not be tied to a Universal Cover obligation.

Better alignment of PSS with social utility might be achieved if Medicare billings were used to determine the final amount of entitlement. That would mean that those who had a higher proportion of their total billings from Medicare receipts would be entitled to a higher PSS benefit for the same indemnity costs paid compared to those billing the same amount but with lower Medicare receipts

A weighting/loading for some geographic locations could also be applied to help support an appropriate mix of available craft groups in those areas noting the Medicare billings are associated with location specific healthcare provider identifiers.

If that could be achieved via an ATO process (similar to HELP/HECS schemes) then scheme audit would form part of normal ATO oversight.

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

Please see previous comments

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?

The 7.5% threshold cannot be considered in isolation. For example, it also needs to be considered alongside the % of PSS benefit applicable.

The 7.5% of gross private income threshold may not currently be appropriate (if declining participation numbers are considered as illustrating decreasing benefit) however reconsideration should occur when decisions have been made in respect of all the government schemes.

For example, MIPS suggests increasing the PSS subsidy to 100% of the premium above that 7.5% threshold and following adoption of factors to better align the PSS with government health policy settings (such as applying % of Medicare billings of total billings and/or location loadings) the threshold % and % of PSS applicable should then be reconsidered to ensure they are appropriately calibrated to achieve healthcare policy aims.

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

A transparent and equitable approach should be applied across all craft groups in respect of potential eligibility. However, the actual PSS paid should be determined by Medicare billing/geographic location and other factors to better align the PSS with government health policy settings to help achieve equitable and affordable health care for the community.

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

Fifteen years on there should no longer be any difference between the approach taken to medical practitioners conducting the same practice in the same location all else being equal in respect of PSS eligibility.

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?

As previously stated we believe that a retrospective payment is fairer and has the additional advantage of preventing scenarios where recipients may have to repay large amounts of subsidy previously advanced, sometimes in respect of multiple years as can occur, as a result of the current final determination process.

As previously stated we do not anticipate that this would significantly affect upfront indemnity affordability. That is because most insurers offer instalment payments (MIPS for instance offers interest and administration fee free membership subscription instalment payments) or premium funding.

In addition, as Financial Services Licence holders, financial hardship issues must be considered by medical indemnity insurers.

Even if those affordability mitigants were not available practitioners entering private practice where there is uncertainty of income can choose a reasonable starting point for billing expectations and advise their insurer of changes in those expectations over the course of the insurance year.

That approach means that there is a shorter period of being without the full benefit of PSS if ultimately eligible.

Going forward those with stable practise and cash flows are less likely to be significantly inconvenienced by a retrospective approach.

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

No. Universal Cover does not meet current community expectations. Universal Cover does increase the likelihood of harm to patients by otherwise uninsurable practitioners.

At its worst, the benefit to the community of Universal Cover is to help ensure that it is more likely, although no means certain, that monetary compensation will be available in the anticipated and perhaps near certain likelihood of patient harm by a practitioner who but for Universal Cover would be uninsurable.

MIPS view is that monetary compensation is not a substitute for first instance avoidance of patient harm.

MIPS believes that we should do all we can to help members avoid situations where there is a high likelihood that there will be outcomes that will lead to significant adverse professional and personal consequences for them.

MDO's provide their members with risk management programmes, mentoring, support and other initiatives to help reduce a member's risk (to themselves, the community and the

MDO membership as a whole). The requirement of Universal Cover and the constraints of the framework that must be complied with significantly impede that approach.

Following a 'but for Universal Cover' otherwise preventable death or catastrophic injury (or series of deaths and injuries) it is likely that the public/coroner/media or others will be highly critical that the Government had required an insurer to insure a doctor that the insurer would not otherwise have insured ie in effect a situation where but for the Universal Cover requirement the outcome would not have occurred.

Such a situation might also reflect that the Universal Cover severely constrains the ability of the insurer to limit the anticipated risk to the community. That is because the Government contract significantly limits the ability of the insurer to apply risk mitigation measures.

Universal Cover ensures insurance is available to practitioners that have been refused insurance by all insurers. It should be remembered that insurers who are not the Universal Cover insurer for the jurisdiction of the applicant are not constrained by the Universal Cover framework in their ability to price the risk and/or apply risk mitigation measures so a refusal to make any offer of insurance terms reflects the unacceptable nature of the risk of those individuals that are then ultimately required to be made an offer of insurance under Universal Cover.

Through their normal operations Medical Indemnity insurers can gain early insights into practitioners who are an abnormal risk compared to others of their craft group. This information can come from near misses as well as incident reports, complaints that do not go to health ombudsmen/AHPRA, non-litigated claims and claims that even though litigated do not come to AHPRA attention.

AHPRA can only consider risks to the community when it has an awareness of matters that indicate a dangerous pattern of practise. Unfortunately, AHPRA awareness may only occur after significant patient harm has occurred.

Under the current Universal Cover requirements those medical indemnity providers who contract with Government are very constrained in their ability to protect the public (and also the practitioner from themselves).

The limited risk modifying measures that are permissible are further restricted under the Government's contract and are also able to be disputed as outcomes and offers are subject to Financial Ombudsman Review under Universal cover.

Under the contract the limits to financial and non-financial measures of risk modification must all be actuarially justifiable in respect of the individual indemnified under Universal Cover. The Universal Cover restrictions on loadings etc also ultimately means that insurers have to charge other insureds more than they would otherwise to fund the gap between what is permitted to be charged and what needs to be charged for the risk.

Those costs must then be passed on to the community through higher than otherwise healthcare costs.

We believe that most health practitioners would not support the principle of having to pay more for their indemnity to cover the claims costs of Universal Cover practitioners that would be deemed uninsurable because of their risk but for the Universal Cover requirement.

We also anticipate that most patients would prefer not to pay more for their health services than otherwise particularly if that was triggered by the higher indemnity costs of their health service provider following cross-subsidisation of Universal Cover practitioners because those practitioners were more likely to cause harm to the community.

Health practitioners with abnormal risk profiles and the patients they treat are better protected in environments where there is appropriate oversight, collegiate support, training and systems.

Unfortunately, Universal Cover can enable higher risk practitioners to practise outside of such protective frameworks.

Because of the high likelihood of patient harm those supporting the principle of Universal Cover must be prepared to publicly justify their stance to those who have suffered harm where that harm could have been avoided but for the Universal Cover requirement.

There has previously been put forward a concern that without Universal Cover some craft groups would not be able to access or afford indemnity.

In effect, the current Universal Cover framework mixes those in high risk craft groups that have a normal risk profile for that craft with those whose risk profile is many times worse than those in their particular craft group.

Any issue of affordability in respect of high risk craft groups is currently and should continue to be addressed through the Premium Support Scheme noting that currently some higher risk craft groups already have access to more generous non-standard PSS terms.

As long as insurers are able to underwrite and price appropriately for risk then cover will be available. Universal cover is not an appropriate methodology for ensuring availability of affordable cover – PSS is.

Doctors like other professionals may also make a rational decision to remain or become employees.

When that happens the employer normally provides indemnity for their employees ongoing practise.

As an employee those professionals will also usually practice in an environment where there is more oversight, support and training.

If so:

- should all insurers be subject to universal cover requirements (not just those contracting with the Commonwealth via the PSS)?

As previously stated we do not believe that there is any benefit to the community through the mechanism of Universal Cover. In our view, Universal Cover significantly increases risks for all stakeholders and is out of step with wider community expectations.

- 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)?

As previously stated the Government's Universal Cover constraints to normal risk mitigation measures significantly limits insurers ability to modify the risk to the public and adequately price any acceptable residual risk.

It also means higher than otherwise costs for other medical practitioners and their patients.

The core problem however is that under Universal Cover no practitioner can be refused an offer of insurance ie Universal Cover means that there is no such thing as an uninsurable medical practitioner in private medical practice.

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?

Please see previous responses. Any capping of any risk modifying mechanism such as currently required under the Government contract increases the risk to patients and the cost to other practitioners.

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

The HCCS was initially put forward as a reinsurance cost mitigant. Unfortunately, the HCCS was designed and applied in a mismatched way as eligibility is determined by the cost of the proportion of a claim relating to each individual practitioner rather than relating to the total claim payment by the insurer in respect of a claim.

Adverse medical indemnity events often involve a number of parties that may or may not be insured by the same insurer. Under the HCCS mechanism the threshold (currently $300,000) applies to each practitioner's claim not $300,000 in total for the insurer for their exposure to a claim arising from a plaintiff.

As a result, there has always been a mismatch between per event reinsurance and the operation of the HCCS which is at odds with its stated initial policy intent.

As previously stated, in general terms, insurers are conduits that pass on to their insureds through the premiums they charge any changes in their input costs. Insurers may maintain additional capital and if more than adequately capitalised may choose to act as capacitors to absorb some and/or slow the passing on of increased costs. However ultimately those increased costs must be passed on to insureds and in the case of medical indemnity insurance then on to health care consumers.

For Medical Indemnity insurance those consumers are health care recipients and increased costs have an impact on the affordability and availability of healthcare services.

In its purest form, direct Government funding is the most efficient mechanism for funding affordable and available health care. That also includes funding of affordable and available medical indemnity insurance.

The HCCS reduces associated cost inflators such as Stamp Duty, Taxes, capital charges and transaction costs associated with funding that would otherwise need to be gathered through premium. For those reasons, the HCCS is a very efficient funding input by government into the healthcare system.

The several years of reviews by the ACCC confirmed the HCCS benefits were being passed on to healthcare practitioners through lower than otherwise premiums.

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)?

The HCCS was intended to reduce the reinsurance costs of insurers. Those savings have in turn been passed on to their insureds. Removal or significant reduction of HCCS benefit will have a profound adverse effect on medical indemnity pricing. That in turn will have an adverse effect on the availability and affordability of healthcare services in the community.

For example, the HCCS may provide funding for 25% or more of total claims liabilities each year. However, it is usual for larger more complex claims (which will have a higher proportion of HCCS recoveries) to take longer to finalise than smaller claims. For most medical indemnity insurers HCCS recoveries form more than 30% of the value of their claim reserves.

The funding provided by the HCCS is therefore of material importance. However, if the objective of Government is to ensure the affordability and availability of a range of necessary health care services to the whole community then MIPS view is that the PSS can be developed into a more effective tool than the current HCCS.

For example, the benefits of the HCCS are more likely to be triggered by claims relating to higher risk craft groups and clinical practice while lower risk craft groups and clinical practice receive less benefit and perhaps even no benefit (as the HCCS threshold is $300,000 per claim per practitioner which will move to $500,000 from 30 June 2018).

Through the operation of the HCCS the Government, may be significantly subsidising discretionary higher risk practise but providing relatively little benefit to craft groups involved

in lower risk and lower remunerated acute community care, disease prevention and health promotion and maintenance.

Insurers may also choose to vary the benefit of HCCS support from the groups or in proportions other than those that generated the HCCS recoveries. For example, there may be less incentive to pass on to higher risk craft groups all the possible reduction in indemnity costs arising from HCCS protection and recoveries where those groups also enjoy a preferential PSS treatment.

For many years MIPS has recommended that government funding should support a more focussed and aligned PSS to ensure that government policy and tax-payer funding could be more precisely targeted to better ensure access and affordability of necessary health care for the whole community.

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?

As previously stated MIPS recommends that any reduction in HCCS funding be re-directed to improved and re-focussed PSS.

That will allow government to better align tax payer funds with health objectives which may require inclusion of both medical practitioners and others.

As previously stated the effects of any removal or reduction of indemnity funding support by government must be passed on to practitioners which will have an impact on patients.

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

The HCCS can be better aligned to its original purpose in respect of reinsurance if it was changed to per event per insurer. That would mean that whether one or many practitioners were involved in the same adverse event if they were insured by the same insurer then a single HCCS deductible/threshold would apply to the event. This would improve certainty for insurers, reinsurers and government in respect of reserving for claims and help streamline processing of claims.

Is the threshold above which the Commonwealth contributes appropriate?

For the reasons previously outlined if the HCCS is to continue on a per practitioner basis then a more equitable and fairer approach to benefit more practitioners and therefore more patients would be to ensure a very low (if any) deductible (threshold) up to a modest cap (eg $2m).

More practitioners and therefore patients will benefit from such an approach (even if the total HCCS cost remains the same) compared to current approach and particularly if a decision is made to raise the HCCS threshold significantly.

That is because as the threshold increases lower risk craft groups and therefore their patients will receive less total benefit.

An analogy would be if a HCCS was applied to motor vehicle insurance. Those that drove modest hatchbacks would receive no benefit in respect of claims and therefore no benefit to their insurance premiums whereas those that drove expensive luxury cars more aggressively would be more likely to benefit and perhaps those who would be considered uninsurable but had to be insured under a Universal Cover type arrangement would benefit most of all!

The current HCCS protection of amounts above $2m could be replaced, should an insurer wish to do so, through normal excess of loss reinsurance that is widely available in the market. The impact of additional costs for such reinsurance should be met through appropriately calibrated PSS which has been discussed elsewhere in this submission.

The current soft reinsurance market and high levels of available reinsurance capital means the cost of such insurance is more reasonable than when the HCCS was initially established.

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

As previously advised any reduction of government funding into the system must be passed on by insurers and then subsequently passed on by practitioners to their patients.

For some craft groups and including both non-discretionary and discretionary health care, the impacts of changes on cost of cover could be very significant depending on whether the change is to the HCCS threshold, implementing a cap or changing the percentage of HCCS rebate and any combination of these.

For lower to medium craft risk practitioners (the majority of medical practitioners and numbers of patients seeking care) an increase to the threshold may have a greater adverse effect than a change to the percentage of rebate or a cap.

For the highest craft risk practitioners, a HCCS cap and change to percentage may have the greatest adverse effect rather than a change in threshold.

It is for such reasons that we believe that a revised PSS is the only mechanism that will be flexible enough to manage any pricing and insurance availability shocks to practitioners over time while allowing more precise alignment of government funding with availability and affordability of health care.

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

See previous comments. There is arguably no need for government support to be provided by the HCCS if the funding that would otherwise be provided by the HCCS is re-allocated to better targeted and calibrated PSS to assist in ensuring available and affordable healthcare.

In the absence of market failure government does not need to take on the role of services that are otherwise available.

In recent times, there has been significant surplus reinsurance capacity. The HCCS provides very efficient reinsurance like capital that is AAA rated but any significant additional frictional costs arising from replacement of HCCS by reinsurance which would be passed on to practitioners could be mitigated by an appropriately calibrated PSS.

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

Uncertainties in respect of the current operation of the HCCS and the per practitioner rather than per insured event approach all reduce the effectiveness of the HCCS and create additional risks for the insurer.

Any definition must be clear to be workable.

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

No comments.

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?

No further comments.

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

The benefits of the Exceptional Claims Scheme (ECS) apply to individual practitioners and provide them with confidence that there is no limit to the dollar amount of the cover that they have when practising.

The ECS would not be required if health practitioners like other professionals were permitted to establish Professional Standards Schemes. That is because the Professional Standards Schemes achieve the equivalent of the ECS ie provide certainty that professionals will not be exposed to insured claims for amounts over the cover limit albeit those limits under the Professional Standards Schemes are much lower than the ECS.

That there have not been any claims under the ECS is purely a reflection that many large claims often involve multiple defendants so that although claims can exceed $20m that to date no such catastrophic claim has been triggered entirely by the negligence of a single practitioner in private practice.

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

The ECS provides a ceiling for cover limits of insurers. Without that there would be greater uncertainty for all stakeholders. For example, each practitioner would need to consider how much cover is adequate.

It would also create uncertainty for insurers and reinsurers as well as their actuaries and APRA.

All else being equal, wherever there is uncertainty, costs will be higher than otherwise; the risk transfer process will be less efficient and those higher costs must be passed on – in this case to those seeking healthcare.

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

Through the ECS the Government is in effect providing what cannot be obtained by practitioners anywhere else – uncapped AAA rated security for practitioners, their patients who have adverse medical outcomes and the utility that in turn provides the wider community.

As previously stated the ECS provides greater certainty for stakeholders which benefits health practitioners and their patients.

All else being equal, wherever there is uncertainty, costs will be higher than otherwise; the risk transfer process is less efficient and those higher costs must be passed on – in this case to those seeking healthcare

The ECS offers protection for practitioners against potential financial ruin. It is important to note however, that this is a somewhat simplistic view because it ignores the effects of potential accumulations of sub-limits, deductibles, exclusions etc that apply to insurance policies and that can also aggregate to result in potentially financially ruinous non-insured out of pockets for individual practitioners.

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)?

The ECS is a policy decision for government. Medical Practitioners are more likely than many other AHPRA registered health practitioners to be involved in high value claims more regularly.

However, if there is evidence that other health practitioners are similarly exposed then it would seem appropriate that the ECS should be extended to those groups to protect them and the community.

The ECS is unlikely to be required under an appropriate Professional Standards Scheme.

Is the ECS best administered by the Commonwealth?

Yes. There is a potential moral hazard if insurers both managed ECS claims and administered them. It would be possible however for the Government to transfer the process management to a contracted manager (see ROCS comments).

Does there continue to be a need for the ROCS?

Under claims-made insurance and noting AHPRA indemnity requirements there is a need to hold run-off cover during periods of cessation of practice and after complete cessation of practice.

Run-off cover is in the best interests of the practitioner and of the community.

Arguably there is less need now for ROCS than when the scheme was initially established.

That is because many practitioners would now qualify for minimal cost run-off cover from their insurer on complete cessation of practice.

MIPS has previously proposed that ROCS should be extended to cover unanticipated breaks in practice arising from health issues (such as heart attacks, strokes, diagnosis and treatment of cancer etc) perhaps being triggered after 3 months in situations where the practitioner is unable to practise but has hopes/intentions of returning to practise and so cannot declare that they are totally ceasing practise.

Entry into ROCS would also benefit all stakeholders in respect of the consequences of AHPRA show cause, cessation or disqualification periods including health related triggers.

Currently some of those who qualify for ROCS qualify for reasons that are anticipated and planned for and arguably where alternative run-off arrangements to ROCS could be made.

For example, ROCS is accessible for reasons of maternity (but not paternity) however ROCS does not apply to periods of cessation of practice arising from unexpected significant health events where run-off cover must be maintained during those periods of no practise income and perhaps ongoing practice expenses and other financial commitments.

We recommend that ROCS be extended to include un-anticipated periods of non-discretionary cessation of practice perhaps applying after a qualifying period of three months in situations where there may be a desire on the part of the practitioner to return to practise but that the ability to return to practise is uncertain. This should also include cessation of practice due to AHPRA decisions arising from health-related triggers.

The need for and cost of ROCS would be reduced from otherwise if all courts firmly applied their jurisdiction's claims lodgement limitations.

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?

ROCS funds are best overseen by the Commonwealth. Much of the current strength of medical indemnity insurers has been achieved because they are no longer exposed to the accumulated and uncertain risk of incurred but not yet reported (IBNR) claims liabilities.

Most of the funding issues that led to the industry crisis related to unfunded IBNR liabilities. Extreme funding measures such as calls on membership and establishment of various government schemes (IBNR scheme, UMP Support Scheme etc) had to be implemented to help back-fund this shortfall.

Handing back ROCS funding and the associate IBNR liabilities to insurers to manage going forward, even if that was allowable, could over time lead to a similar situation of IBNR shortfall arising.

APRA may also reasonably form a view that because of the long-tail nature of medical malpractice insurance and the problems with managing reserves for those claims that such IBNR cover would not be permitted or only permitted if there was very significant additional capital held by insurers and much greater oversight by APRA. This in turn would lead to further increases in premium pricing than otherwise.

As an alternative, the Commonwealth could seek tenders from experienced parties such as large insurance brokers in respect of ongoing management of the scheme. Large brokers have the skills and resources to ensure that - claims are eligible under the relevant policy; payments are processed appropriately and also ensure that claims are managed appropriately by insurers.

As the ROCS funds are accounted for on a per contributing practitioner basis it would be inappropriate to transfer those funds to insurers without the express permission of each contributor.

However, our understanding is that those sums are permitted to be handed back to the individual practitioners to whom the sums applied and who are not yet in ROCS.

If that occurred it would be very important to ensure that practitioners who were handed back their ROCS contribution understood that they needed to ensure that they maintained appropriate run-off arrangements when they ceased practice as they would not be entitled to ROCS under grandfathering provisions.

The claims for those who are already in ROCS could be administered by a contracted insurance broker.

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

As previously discussed we believe that the scheme should be expanded to include extended but not permanent hiatus in practise arising from unexpected health events including AHPRA instigated cessation of practice.

MIPS has also previously recommended inclusion of dental practitioners in the scheme to ensure that they are not reliant on 3rd party run-off cover arrangements that the individual practitioners may not be party to going forward. This would allow these practitioners to have confidence that they clearly met AHPRA's ongoing indemnity requirements on cessation of practise.

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

No suggestions or comments.

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

No additional comments or suggestions.

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

Insurers do not have visibility of the insurance arrangements that practitioners may previously have had or currently have with other insurers or whether there has been any return to practise following receipt of advice of cessation of practice/eligibility for ROCS.

As a result, there can be significant uncertainty as to whether the practitioner is ultimately eligible for ROCS and whether the nature of a claim notified to an insurer ultimately qualifies for ROCS.

Further confusion arises from public hospital indemnified practitioners who have previously qualified for ROCS (as they no longer work in private practice) who provide care in privatised public hospital outpatients or clinics (sometimes without knowing they are doing so).

This in turn may result in patients being 'billed' (often Medicare bulk-billed) in the doctor's name but where the practitioner receives no financial benefit from that service.

Unfortunately, such practise creates issues in respect of the employed doctor's eligibility for ROCS in respect of cover for previous non-employer indemnified private practise.

The Government is the only stakeholder who has full data visibility of the practice category/ROCS levy contributions and practice undertaken and so should retain that control and oversight albeit possibly through an external contracted service provider.

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

Currently the level appears too high for the current range of entitlement triggers and the Australian Government Actuary report seems to indicate considerable surplus accumulated reserves.

MIPS actuary advised at the establishment of the scheme that a levy % of approximately 2.5 -3% would be appropriate.

That said the current % could be kept until the effect of extension of the ROCS scheme to include unexpected but possibly non-permanent cessation of practice due to health or AHPRA events is fully understood.

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

If administration was outsourced to an insurance broker the scheme could be changed to an assessment at the time of reporting a claim of whether the matter being reported was covered under ROCS.

At that time, the outsourced service provider could undertake the work required in respect of determining eligibility including declarations by the practitioner, checking with government regarding ROCS contributions and recency of any private practice and with previous insurers in respect of prior insurance covers.

Does there continue to be a need for the IBNR?

There is no longer any requirement for an IBNR scheme. That said if there was a desire to hand control and operation of ROCS to insurers and that was permitted then the IBNR scheme should be kept in place. That is because it might help provide APRA with comfort and perhaps provide insurers with potential mitigation of the increased capital charges that APRA is likely to apply if control and operation was handed to them.

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

No comment

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

No comment.

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

No comment

Are there alternative models of providing indemnity insurance for privately practising midwives?

No comment

If so, what are they and what barriers and/or enablers are there to implementing these models?

No comment

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

No comment

APPENDIX 1 Professional Standards Schemes

Association of Taxation and Management Accountants (ATMA)	2013-2017	N/A
Australian Computer Society (ACS)	2016-2017	2010-2016**
Australian Property Institute Valuers Limited (APIV)	2016-2021	2010-2016** 2010-2015*
Bar Association of Queensland	2013-2018	
Chartered Accountants Australia and New Zealand (CA ANZ) *Formerly known as Institute of Chartered Accountants in Australia (ICAA)*	2014-2019 (ACT)*** 2014-2019 (NSW)*** 2014-2019 (NT)*** 2014-2019 (QLD)*** 2014-2019 (SA)*** 2014-2019 (VIC and TAS)*** 2014-2019 (WA)***	2013-2014 (ACT) 2013-2014 (NSW) 2013-2014 (NT) 2013-2014 (QLD) 2013-2014 (SA) 2013-2014 (VIC) 2013-2014 (WA) 2008-2013 (ACT) 2008-2013 (QLD) 2008-2013 (SA) 2008-2013 (VIC) 2007-2012 (WA) 2007-2012 (NSW) 2007-2012 (NT) 2001-2006 (NSW) 1997-2001 (NSW)
College of Investigative and Remedial Consulting Engineers of Australia (CIRCEA)	2013-2018	2000-2006** 1996-2000

Institute of Public Accountants (IPA)	2013-2017	
Law Institute of Victoria	2016-2021	2010-2016**
Law Society of NSW	2012-2017	2006-2011 2000-2006** 1996-2000
Law Society of South Australia	2017-2021	2012-2017**
Law Society of Western Australia	2014-2019	
New South Wales Bar Association (NSW Bar)	2015-2020	2010-2015 2005-2010
Professional Surveyors Occupational Association (PSOA)	2013-2018	2007-2013** 2001-2007**
Queensland Law Society	2016-2021	2010-2016**
Royal Institution of Chartered Surveyors Valuers (RICSV)	2016-2020	
South Australian Bar Association (SA Bar)	2017-2021	2012-2017**
Victorian Bar Association	2014-2019	2008-2014**
Western Australian Bar Association (WABA)	2014-2019	

* This scheme was amended. The updated version appears under Current schemes.
** This scheme was extended beyond its original five-year term.
*** This Scheme commenced on 8 October 2014.