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Dear Ms Medwin

First Principles Review of the Indemnity Insurance Fund

The Insurance Council of Australia (the Insurance Council) welcomes the opportunity to comment on the Department of Health's (the Department) First Principles Review (the Review) of the Indemnity Insurance Fund (IIF). Since their origin as part of the response to the crisis in medical indemnity insurance early in the century, the schemes within the IIF have been critical in maintaining a stable medical indemnity market and continue to contribute to affordable and secure cover for medical practitioners. The Review provides a timely opportunity to reaffirm the ongoing need for the IIF, and to ensure that the policy settings are appropriate for more normalised market conditions.

The Insurance Council's members include the five medical indemnity insurers (MIIs) that provide cover to privately practicing medical practitioners. The Insurance Council's members also include general insurers that provide medical indemnity to professionals practicing in the private health sector, such as hospital and ancillary staff and, and allied health professionals. For these general insurer members, their interest in the Review are limited to the schemes where eligibility is broader, including the High Cost Claims Scheme (HCCS) and Exceptional Claims Scheme (ECS).

The Insurance Council's submission comments on the schemes that have an impact industry-wide. Our submission does not comment on schemes that are currently accessed by single insurers, including the Incurred-But-Not Reported Scheme (IBNR), Midwife Professional Indemnity (Commonwealth Contribution) Scheme and Midwife Professional Indemnity Run-Off Cover Scheme (Midwife ROCS).

Our submission addresses the objectives of the IIF and the important role it plays as a safety mechanism to support market stability. The submission then outlines the key policy and administrative issues in relation to the Premium Support Scheme (PSS); HCCS; ECS; and Run-Off Cover Scheme (ROCS).

1. Executive Summary

As noted in the Discussion Paper, the seven schemes that comprise the IIF were introduced as a package of reforms with two broad objectives to:

- promote stability of the medical indemnity industry; and
- support the availability of affordable indemnity insurance for medical practitioners and midwives.

The position of the Insurance Council is that:

- the continuation of the IIF is important in supporting the availability of affordable indemnity insurance and facilitating access to affordable health care for the community;
- access to and administration of the schemes, including obligations imposed on insurers, should apply in a competitively neutral manner and should not impede competition;
- the IIF should support quality and safety of healthcare, and should not diminish the role of insurance in signalling and discouraging risky behaviour;
- the objectives of the IIF, and each individual scheme, should be more clearly articulated and understood;
- the legislative framework underpinning the IIF should be simpler, contributing to scheme efficiency and enabling consistent interpretation.

While the industry's view is that the IIF schemes continue to play a critical role and should be maintained, adjustments to current arrangements to better meet these considerations would improve scheme efficiency and better align scheme objectives with current administrative practice.

In relation to the legislative framework underpinning the various schemes, the Insurance Council is aware that the Department is concurrently undertaking a thematic review to reduce unnecessary red-tape. The patchwork of complex and prescriptive medical indemnity legislation was introduced to stabilise and substantially reform the industry following the market crisis in 2002. Since then, the medical indemnity industry has become part of the robust financial services regulatory regime, and medical practitioners are required to obtain indemnity insurance as stipulated by the Australian Health Practitioner Regulation Agency (AHPRA). To better reflect the current regulatory landscape, the medical indemnity legislation can be substantially streamlined and simplified. Our submission identifies examples relevant to the specific schemes.

2. Current Market Conditions and Role of the IIF

The Discussion Paper outlines a number of sources evidencing the normalisation of the medical indemnity market since 2002. Reviews by the National Commission of Audit¹, Australian National Audit Office² (ANAO) and Australian Competition and Consumer Commission³ (ACCC) have all concluded that the schemes have worked as intended to improve the stability of the medical indemnity market and the general affordability of indemnity insurance. The most recent analysis by the ANAO suggests that premiums, in absolute terms and in proportion to income, have fallen or been flat since the early 2000s. The ANAO concludes that premium levels are generally affordable for most medical practitioners, although there has been some recent increases to the rate of premiums in proportion to income for neurosurgery and obstetrics specialties.

The National Claims and Policies Database (NCPD) compiled by the Australian Prudential Regulation Authority (APRA) provides insights into medical indemnity premiums and claims trends compared with other professional indemnity classes. The data (see Table 1) shows that while medical indemnity and Directors' and Officers' (D&O) liability are comparable with regards to the premiums written (as a proportion of the number of risks written and claims reported), the value of claims incurred for medical indemnity is 1.78 times greater. Even taking into account the impact of HCCS recoveries on reducing claims costs for insurers, the claims costs ratio is still elevated for medical indemnity. While we do not have access to HCCS recoveries data for 2016, in 2015 the ratio of medical indemnity to D&O claims incurred (factoring in the impact of HCCS reported incurred costs⁴) was 1.31 compared to a written premium ratio of 1.17.

This suggests that the medical indemnity premiums are not fully reflective of the claims experience. While an imperfect measure, the disparity in the ratio of medical indemnity to D&O claims incurred provides an indication of the magnitude of the impact of the schemes in reducing medical indemnity premiums.

Table 1: Medical indemnity policy and claims data compared with D&O liability

Policy & Claims metrics	Medical indemnity/ malpractice	D&O liability	Ratio of medical indemnity to D&O
No. of risks written	203,207	152,350	1.33
No. of claims reported	4,809	3,585	1.34
Gross written premium	354,894,000	265,597,000	1.34
Gross claims incurred	304,115,000	170,723,000	1.78

Source: APRA, National Claims and Policies Database, policy and claims data for 2016 calendar year.

¹ National Commission of Audit (2014), *Towards Responsible Government*, Appendix to the Report of the National Commission of Audit – Volume 2.

² Australian National Audit Office (2016), *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No. 20 2016 – 17.

³ Australian Competition and Consumer Commission (2009), *Medical Indemnity Insurance*, Sixth Monitoring Report.

⁴ Australian National Audit Office (2016), *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No. 20 2016 – 17.

Any significant reduction in the IIF will have a corresponding impact on insurance premiums, which may also have an asymmetric effect by impacting some craft groups more than others.

While the IIF, and in particular the PSS, plays an important role in supporting affordable premiums, it also plays a critical role in maintaining the stability of the medical indemnity market. Key characteristics of the medical indemnity market set it apart from other general insurance and professional indemnity markets which makes it more difficult to predict the likelihood and magnitude of the next turn in the claims environment.

Medical indemnity insurance is long tail in nature, with most claims taking several years to settle, from the discovery of the malpractice, to lodgement of the claim, establishing the rights to compensation and finally the payment of the claim. Determining compensation for medical indemnity claims is more complex than other professional indemnity claims. In addition to economic loss, medical practitioners may also be sued for general pain and suffering, medical costs, attendant care costs and legal costs.

The uncertainty in predicting the number of long tail claims likely to be made in a certain year is also exacerbated by the significant impact a small minority of claims have on overall claim costs; it is estimated that 5% of claims account for 40% of all claims costs⁵. This all makes the forecasting of claim numbers and sizes challenging; as found by the Australian Government Actuary in claims forecasting for the purposes of the ROCS⁶.

The experience of cyclical volatility in global medical indemnity markets over the past 50 years has been well documented⁷. These global experiences, as well as the market crisis experienced in Australia in the early 2000s, shows that a turn in the claims environment can unfold quickly and can have substantial detrimental impacts on:

- the number of practicing physicians in particular specialties;
- overall health care costs;
- the general public's trust in the health care system and providers; and
- patient safety and quality of health care.

While the market has normalised substantially since the schemes and various reforms were implemented, the IIF continues to play a valuable role as a safeguard against the next turn in the claims environment. This role is invaluable in a market characterised by small mono-line insurers, where even single exceptionally large claims could have substantial destabilising effects. The advantage of the IIF is that its size and cost will automatically adjust according to need; the cost of maintaining schemes with limited participation is negligible compared to the value provided as a safety net.

⁵ Australian Government Actuary (2016), *Eleventh report on the costs of the Australian Government's Run-Off Cover Scheme for medical indemnity insurers*, 2014 – 15 financial year.

⁶ Ibid.

⁷ Toh, W.L et. al. (2009), *Medical Indemnity – Who's Got the Perfect Cure?*, Presented to the Institute of Actuaries of Australia 12th Accident Compensation Seminar, 22 – 24 November 2009, Melbourne.

3. Premium Support Scheme (PSS)

3.1. Need for PSS

The industry supports the continuation of the PSS, which plays an important role in mitigating the potential for high medical indemnity premiums to discourage doctors from practising in some areas of medicine. The PSS is of particular value to those practising obstetrics and those in rural and remote areas and helps facilitate access to health services in communities where, but for the PSS, socioeconomic factors would limit the commercial viability and therefore availability of medical practitioner care. The PSS also plays a role in mitigating the costs of participating in the workforce for part-time, particularly female, medical practitioners.

The Discussion Paper queries whether, given the declining rates of participation in the PSS, there is a continuing need for Government assistance. We note that participation in the PSS is also impacted by the other IIF schemes, particularly the HCCS. We expect that any scaling back of the HCCS will likely be reflected in an increase in the number of medical practitioners that would become eligible for the PSS.

As noted earlier, the IIF plays an important role as a safety mechanism; this is particularly the case for the PSS in view of the reforms being implemented through the National Disability Insurance Scheme (NDIS). Given the infancy of the NDIS, it is not yet clear whether it will lessen or magnify the costs of indemnity. The PSS will play an important role in helping to manage any pricing shocks or unexpected outcomes which would reduce the affordability and availability of health services to communities.

3.2. Access to the scheme

A key issue for participants in the PSS is its implementation through services contracts between individual insurers and the Department. Implementation through voluntary contractual arrangements means that insureds can only access the scheme if their insurer is a signatory to a contract with the Department, even if they otherwise meet the eligibility criteria.

Scheme implementation through legislation may enable the scheme to better meet its objective of supporting affordable premiums for *all* eligible medical practitioners. We acknowledge that the Services Contract between participating MIIs and the Department gives more flexibility to adjust to changed circumstances, given it is easier, in theory at least, to amend a contract rather than legislation. However, the industry would be keen to explore options that would result in more equitable access for insureds, but which would also retain the existing flexibility provided to participants.

3.3. Scheme obligations and universal cover

As noted in the Discussion Paper, the Services Contract enables access to the PSS but imposes a number of obligations on participating insurers. While these obligations are contained in the PSS Services Contract, participating insurers believe that these obligations were adopted within the context of a broader regime of benefits being provided through the IIF as a whole. The ability of all insurers, not just those party to the PSS Services Contract, to access IIF benefits creates a mismatch between the obligations and benefits of the

schemes. Insurers which are signatories to the Services Contract have conditions imposed on them in terms of underwriting and pricing that do not apply to insurers which are not. Against this background, it can be seen as a matter of commercial judgement whether an insurer decides to undertake Services Contract obligations in order to access the PSS. The question then comes up whether this is a sustainable basis for policy making. With the Services Contracts with four participating MIIIs to expire on 30 June 2018, any non-renewal of contracts could further widen the coverage gap of these obligations.

The key obligation imposed is the requirement to provide universal cover. However, there are also other obligations, such as that insurers must provide effectively free run-off cover to certain insureds and to have any conditions, including the premium charged, imposed on universal covered insureds subject to Financial Ombudsman Service (FOS) adjudication.

The Review provides a timely opportunity to reconsider whether the PSS obligations are effectively serving their intended purpose. The obligations were introduced within the very specific context of a government support scheme to ensure wide access to insurance for medical practitioners. There was no rigorous assessment of the broader implications, for example, under the universal cover requirements for cover to be offered regardless of the risk posed by a practitioner.

In undertaking this assessment now, the Government should consider the implications for a robust, competitive market such as whether the obligations act as a barrier to market entry or impact the viability of new market entrants. If it is assessed that the obligations fulfil an important policy objective, and satisfy a cost/benefit analysis, then they should be applied in a way that has no adverse effect on competition.

As the Department will be aware, the industry has identified some challenges with the universal cover requirements where cover is required to be offered to certain practitioners who have been assessed as an extreme or uninsurable risk. These challenges were outlined in the Insurance Council's submission to the Department dated 26 May 2017.

Universal cover, as it is currently implemented, limits the valuable role that insurance plays in providing a risk signal to the insured and community more broadly. Insurance essentially transfers "insurable risk" from insured to insurer. "Uninsurable" risks are those with a high statistical probability of occurring, or are significantly within the control of the insured. These are generally not insured and can send a signal to the market that behaviour needs to be modified or the activity needs to cease altogether. Notwithstanding the risk limiting conditions of insurance enabled by the Services Contract, insurers' experience is that they are at times insufficiently enabled to manage higher risk practitioners, with serious implications for patient safety.

The policy decision to mandate universal cover did not balance the associated benefits against the unintended impacts on the safety of patients. It also did not consider whether it is equitable for lower risk practitioners within the same craft group, or practitioners between craft groups, to cross subsidise higher risk practitioners. Mandating universal cover dampens risk signals which might otherwise influence the safety of medical practice, and essentially requires the costs of providing cover to higher risk practitioners to be met by all other practitioners and funders in the system.

On the other hand, we acknowledge that universal cover ensures accessibility of insurance, particularly to practitioners in higher risk craft groups. Removing universal cover could result in gaps in the market if all insurers were to limit their coverage to certain groups. There would also be implications for the prudential strength of the medical indemnity market if specific risks were to be concentrated in fewer insurers.

While the MIIIs differ in their views around whether universal cover should be retained, the industry is supportive of the Government conducting a comprehensive policy review that considers all of the associated benefits and risks of mandating universal cover. If the Government decides that universal cover should be retained, the existing requirements should be adjusted to ensure that any impact on the community safety is minimised.

Importantly, requirements around minimum cover, clinical risk mitigants and premium pricing need to be carefully calibrated to enable some form of effective risk signalling in the market for medical indemnity insurance.

3.4. PSS payment method

The Insurance Council had previously raised with the Department the feasibility of moving from the current advanced PSS payment to a single reimbursement in arrears. The advance nature of payment based on provisional or estimated information causes complexities and an administrative burden when it comes to recalculation following receipt of the actual data. While insurers can see the benefits of a less complex in-arrears payment method, such a change will require substantial investments in systems. There will also be an impact on medical practitioners in the short-term while the system is in transition. The industry would be keen to work with the Department, and other relevant stakeholders, to explore options to simplify the PSS payment method.

4. High Cost Claims Scheme (HCCS) & Exceptional Claims Scheme (ECS)

The industry supports the continuation of the HCCS and ECS, which play an invaluable role in minimising the impact that large claims may have on the ability of insurers to continue to provide affordable cover. Significant reductions in the HCCS will have a greater impact on higher risk practitioners, for example those in obstetrics and neurosurgery.

Unlike the other schemes where access is limited to medical practitioner insureds and insurers, including the PSS and ROCS, the HCCS and ECS have broader eligibility criteria and access is open to people in a registered health care vocation. If the HCCS fulfils the same objective for other registered health care vocations, in addition to medical practitioners, then insurers should be able to continue to access the scheme in providing cover for these health professionals.

While the industry's view is that the HCCS is effective in reducing the impact of large claims, and potential large claims, greater legislative clarity would enhance the operational efficiency of the scheme. Key aspects of the scheme, including determining whether particular matters fall within the scheme's scope, are open to interpretation and there is a lack of guidance to assist scheme participants. The following examples are areas where greater clarity would enhance scheme efficiency:

- **Public treatment** – How the HCCS applies when a claim arises partly from private medical services and partly as a public patient in a public hospital could be clearer. Guidance could be provided to show how an insurer should calculate the HCCS contribution to a claim that relates partly to public treatment and partly to private treatment where there is no court decision or settlement terms that determine that apportionment.
- **Multiple defendants** – Where a HCCS claim may be made against both an individual and a practice company, the legislation is not clear as to whether a single application will suffice. The legislation (or a protocol) could make clear whether this requires two applications or one and how apportionment works in these cases.
- **Apportionment** – Members have observed in cases that involve multiple defendants that the Department has required insurers to obtain retrospective advice from counsel on apportionment. Such agreements on apportionment have been negotiated and agreed in good faith between Defendants with the benefit of intimate knowledge of the strengths and weaknesses of their defences. The process of assessing this after the fact is impractical and not necessarily accurate. If the Department requires this, then it should be included in any protocol so it may be obtained prospectively (noting this will add to the cost recovery).
- **Overseas practice** – It is unclear how the HCCS would apply where practitioners are overseas but providing services into Australia.

The scope of cover under the HCCS and ESC should be amended to ensure it is clear that the policy coverage follows the terms and conditions of the policy issued by the MIIIs and general insurers, in the same way that their reinsurance follows form. There is some confusion around this point resulting in uncertainty and potential gaps in cover for MIIIs.

The HCCS (and also ROCS) recovery process is also extremely onerous. The documentation required is significant and the level of detail required by the Department of Human Services (DHS) is often impractical, often resulting in lengthy delays in payments. For example, the DHS has rejected a recovery application where the insurer claimed 1 cent less than the sum of the invoices they supplied. The *Medical Indemnity Act 2002* (the MI Act) should be amended so that it reflects a commercial arrangement where the evidence required to support a claim is practical and pragmatic.

5. Run-Off Cover Scheme (ROCS)

An effective ROCS, in providing cover to medical practitioners who have ceased practice, is an essential component to any claims made system. While the industry is of the view that the ROCS is working effectively, greater transparency around how the size of the ROCS levy is determined would be beneficial. Feedback from members is that the current 5 per cent levy on premium income is too high.

Each year, the Australian Government Actuary (AGA) is required to table a report in Parliament detailing usage and projected liabilities of the ROCS. In its 2014-15 report, the AGA acknowledged that there is a mismatch between the level of ROC support payments levied on insurers and the level of ROC indemnity payments; it suggested this is necessary

to manage the long-tail nature of medical indemnity⁸. The AGA also indicated that its ability to reliably forecast future liabilities is impacted by the lack of data in a form which is directly amenable to ROCS analysis. The industry is keen to work with the AGA to ensure that there is available data to enable it to forecast future liabilities, such that the levies on insurers can be better aligned with the current and future costs of the scheme.

Similar to the HCCS, the legislation underpinning ROCS could be simplified and provide greater clarity for scheme administration. Elements of the ROCS are contained in both the MI Act and *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*. Consideration should be given to combining these two Acts. Examples of clarity required in scheme administration include:

- **Ceasing practice** – Ambiguous wording in the MI Act around permanently ceasing practice due to disability should be clarified. For example, at the time of the claim, the applicant must ‘permanently’ have ceased practice due to an injury that is ‘likely to be permanent’ but if the applicant recovers and is able to return to work then there is no policy reason why they should not have been eligible for ROCS while disabled.
- **Overseas practice** – Ambiguities arise where medical practitioners cease practising in Australia and move overseas for a number of years and then return to Australia to practise. In these circumstances, it is unclear whether ROCS applies to the medical practitioner’s prior Australian practice.

If you have any questions or comments in relation to our submission, please contact John Anning, General Manager Policy, Regulation Directorate, [REDACTED]

Yours sincerely



Robert Whelan
Executive Director and CEO

⁸ Australian Government Actuary (2016), *Eleventh report on the costs of the Australian Government's Run-Off Cover Scheme for medical indemnity insurers, 2014 – 15 financial year*.