

First Principles Review of the Medical Indemnity Insurance Fund

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mpconsulting ™

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Executive Summary

In May 2002, the largest Medical Defence Organisation (MDO) in Australia was placed into provisional liquidation, which resulted in a potential lack of indemnity cover for many medical practitioners. At this time, insurers were also experiencing increased claims costs, uncertainty about the way courts were determining negligence cases (increasing the risk in setting premiums), reduced profitability and a fall in investment returns. As a result, medical practitioners were also experiencing significant increases in premiums (with some reportedly paying over a third of their incomes for indemnity cover), while others considered leaving the profession or ceasing high-risk procedures. If the MDO had gone into liquidation, it was estimated that approximately 60% of Australia's medical practitioners would have been without medical indemnity cover and patients may not have been able to obtain redress for medical negligence.¹

Against this backdrop, the Australian Government announced in October 2002, a range of measures including premium subsidies, government assistance for high-cost claims and improved regulation of the medical indemnity industry. In announcing the measures, the Prime Minister and the Assistant Treasurer stated that the arrangements would be monitored and that "in the long term hopefully these subsidies can be phased out".²

Since 2002, the Australian Government has expended over \$400 million to 30 June 2016 on the schemes³. Expenditure for the 2016-2017 financial year was \$62.1 million, across seven discrete schemes, all of which form part of what is now known as the Indemnity Insurance Fund (IIF).⁴

Collectively the schemes comprising the IIF are designed to subsidise those privately practising medical practitioners with high premiums compared to their income (or practising as procedural general practitioners (GPs) in rural and remote areas) and to meet part or all of the claims costs associated with high or exceptional claims, or claims made when a privately practising medical practitioner or midwife has ceased practice.

Consistent with the Terms of Reference, the purpose of this First Principles Review (FPR) is to answer three questions:

1. To what degree has Commonwealth intervention been successful in providing stability to the medical indemnity insurance industry, availability of affordable indemnity insurance, and viability for professions, and patients, particularly in relation to high cost claims?
2. What is the appropriate level of Commonwealth support needed to continue stability, affordability and accessibility of indemnity insurance for medical practitioners and eligible midwives?
3. Are the seven schemes that collectively comprise the IIF fit for purpose or might improvements be made?

¹ Explanatory Memorandum, *Medical Indemnity Competitive Advantage Payment Bill 2005*, p. 1.

² Parliament House, 23 October 2002, *Transcript of press conference: new medical indemnity insurance*, Canberra.

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

⁴ Commonwealth expenditure is reported separately for each medical indemnity scheme: PSS, HCCS, ECS, ROCS, IBNR, MPIS, MPROC expenditure in Department of Human Services Annual Report 2016-17 p. 57-59.

To what degree has Commonwealth intervention been successful in providing stability of the industry and availability and affordability of medical indemnity insurance (and in turn viability for professions and patients)?

At the time that the reforms were announced in 2002, the then Prime Minister acknowledged that Commonwealth intervention was one part of the solution only and urged State and Territory governments to implement tort law reform in order to address some of the underlying issues that were driving increased premiums.

From 2002, a range of structural changes and reforms were implemented – some driven by the Commonwealth, some by State and Territory governments, some by the insurance industry and some by medical practitioners and their respective professional bodies.

Given this collective and ongoing effort, it is not possible (nor meaningful) to disaggregate the impact of the Commonwealth intervention alone. What is relevant to this Review is documenting the key changes that have occurred since 2002, the impact of these changes and whether, in the context of the current environment, there continues to be a need for the various schemes that comprise the IIF. Some of the key changes since 2002 include the following:

- structural reforms have strengthened the sector and reduced the uncertainty surrounding medical indemnity. This has included tort law reforms and significant changes to the regulatory arrangements relating to medical indemnity insurers, which have strengthened the solvency and governance of insurers (increasing their stability)
 - Medical indemnity insurers consistently exceed minimum capital requirements (having held more than twice the minimum level of required capital for the majority of the last 10 years).
 - The average net profitability of medical indemnity insurers over the five years to 30 June 2016 was 18% of gross earned premium (contrasting the general insurance industry, which has achieved an average result of 10% over the same period).⁵
- the affordability of premiums has improved and the real cost of premiums has generally fallen in absolute terms, and
- there is improved availability of insurance, with active and stable insurers underwriting in each area of medical specialty and a new entrant to the market.

At a high level, it is reasonable to conclude that the range of reforms implemented since 2002 (including the Commonwealth interventions) have improved the stability and profitability of the medical indemnity insurance industry and, in turn, improved the availability and affordability of insurance premiums. As recommended in this Report, improved monitoring of the schemes would better enable assessment of how the IIF is performing against its objectives and better discern the likely impact of any future changes to the schemes.

The Terms of Reference for the Review require consideration of the extent to which the schemes have been successful in supporting viability for professions and patients. The Review has not been able to reach a conclusion on this given the wide range of factors influencing the viability of medical professions and also costs to patients. The advice of stakeholders is noted – that any changes to the schemes that drive up the cost of premiums, risk increasing out-of-pocket costs for patients. As

⁵ Australian Prudential Regulation Authority, *General Insurance Institution-level Statistics*, as analysed by Australian Government Actuary.

noted above, improved monitoring of the schemes will enable better assessment of the impact of any changes into the future.

What is the appropriate level of Commonwealth support needed through the IIF to continue stability, affordability and accessibility of indemnity insurance for privately practising medical practitioners and eligible midwives?

In the absence of comprehensive monitoring data, it is difficult to determine the appropriate level of Commonwealth support necessary to maintain stability and affordability.

On the one hand, it could be argued that the stability and strength of the sector (and the normalisation of the market) reduces the need for the schemes. This was the conclusion drawn by the National Commission of Audit, which recommended in 2014 that the Commonwealth could scale back its subsidies.⁶

It could also be argued that:

- the schemes provide a safety net should there be sudden changes in the frequency and number of claims and the damages awarded. Stakeholders suggest that there is some evidence that the claims environment could worsen in Australia over the coming years
- medical indemnity insurance differs to other types of insurance as there can be many years before a claim is made. This makes prediction of potential loss and the setting of premium rates more challenging than in other sectors (warranting continued Government intervention in this sector), and
- for each of the schemes there are specific reasons for continuance. For example:
 - **the Premium Support Scheme (PSS)** subsidises the premiums of less than 2% of privately practising medical practitioners. While the low level of participation may warrant reconsideration of the need for the PSS, approximately 35% of eligible PSS participants are rural and remote practitioners. Removal of subsidy for this group would run counter to broader Government policies that seek to incentivise practice in rural and remote locations.
 - **the High Cost Claims Scheme (HCCS)** was established to, amongst other things, assist MDOs to raise capital. As the capital position of insurers has improved considerably, it could be argued that the need for the HCCS is reduced. However, the scheme also reduces year-to-year volatility (by reducing the impact of high cost claims) which is critical for premium stability. Rather than withdrawing the scheme entirely, a more prudent approach would be to steadily reduce the Commonwealth's contribution. Government has already announced changes, to scale back the HCCS, with effect from 1 July 2018. Following monitoring of the impact of these changes, further consideration could be given to the introduction of a levy to enable the Commonwealth to gradually reduce its costs without increasing the volatility of insurers.
 - **the Exceptional Claims Scheme (ECS)** is designed to provide protection to the public where claims exceed the upper limit of the insurance industry's capacity (\$20 million). While the scheme has not been activated, the Australian Government Actuary has advised that the capacity of insurers and reinsurers has not recently been evaluated. Before making any changes to the ECS, it would be desirable to explore the cost implication if insurers were to

⁶ National Commission of Audit, 2014, *Towards Responsible Government - Appendix to the Report of the National Commission of Audit - Volume 2*, [10.16 Medical Indemnity].

- offer higher levels of cover, as well as the capacity of the sector to cover exceptional claims (also proposed to be addressed through the recommended monitoring framework).
- **the Run-Off Cover schemes** (for both medical practitioners and midwives) (ROCS and MPIROC) involve participants paying a levy to government in return for the Government assuming liability for claims arising after practitioners/eligible midwives cease private practice. Given funding for the schemes is via a levy (and the schemes include a legislated responsibility for government to repay the levies and interest if the schemes are wound up), any decision to wind up the schemes would result in an immediate cost to Government and likely cause significant disruption to the insurance market. In a tight fiscal environment, and in circumstances where the liabilities of the scheme are intended to be covered by a levy, there are few arguments for fundamentally changing the schemes at this time.
 - **the Incurred-But-Not-Reported (IBNR) Scheme** reimburses the full costs of claims that were incurred prior to 30 June 2002 to UMP/Avant, along with claims handling fees. It is recommended the scheme be maintained as it largely serves an historic purpose, delivering on commitments made by the Government in 2002 and re-negotiated in 2005/2006. The IBNR scheme is expected to naturally terminate in the next 10 years.
 - **the Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS)** subsidises the cost of indemnity claims against eligible midwives by paying 80% of the claim between \$100,000 and \$2 million and 100% of the claim for claims exceeding \$2 million. The scheme has not to-date been triggered. Subject to further consultation and testing of the insurance market for midwives, the scheme could be removed (if no longer necessary) or expanded to cover any insurer of midwives (should need be established).

On balance, there is merit in continuing the schemes, including for the reasons detailed above (and expanded in the body of this Report). Continuance of the schemes is also strongly supported by stakeholders who emphasise the contribution the schemes have made to stabilising the industry and supporting the affordability of premiums.

Are the seven schemes that collectively comprise the IIF fit for purpose or might improvements be made?

Overall, the schemes largely remain fit for purpose. Should Government accept the rationale offered in this Report regarding the continuance of the schemes, some changes are proposed to the HCCS, ECS and ROCS/MPIROC to improve efficiency and effectiveness. No changes are recommended to the IBNR. Changes are proposed to:

- the PSS and universal cover (which is currently tied to the PSS). In summary, these include:
 - removing the complex contractual arrangements between the Commonwealth and insurers and instead including key matters in delegated legislation
 - enabling all eligible medical practitioners to access the PSS (rather than only those insured by a contracted insurer)
 - enabling medical practitioners to make claims for PSS subsidy directly to the Department of Human Services (DHS). This removes the need: for insurers to act as an intermediary; for medical practitioners to liaise with the insurer in relation to the PSS; and for an administration fee to be paid by the Commonwealth to insurers to administer the PSS (approximately \$1.4 million annually)
 - adjusting Medical Indemnity Subsidy Scheme (MISS) grandparenting arrangements, so that all practitioners receiving PSS subsidy (other than rural and remote procedural GPs) must

- meet the income related eligibility criteria (such that premiums are in excess of 7.5% of their income from private practice)
- updating the way that rural and remote areas are determined (for the purposes of the PSS) by reference to the Modified Monash Model (MMM), delivering on the Government’s 2014 commitment to progressively introduce the model to more effectively target health workforce programs, and
- replacing State-based insurer of last resort arrangements with a requirement that each medical indemnity insurer must offer medical indemnity cover to any medical practitioner who seeks it from the insurer.
- the ROCS and MPIROC to enable medical practitioners and midwives who permanently retire from practice before the age of 65 to access the scheme without waiting three years (noting that the impacts of this should be modelled by the Australian Government Actuary prior to implementation), and
- the ECS and HCCS to clarify the intent of the schemes (consistent with the objects of the legislation) such that the schemes apply to claims arising from the practice of medical practitioners and not all health professionals.

The detailed rationale for each of these proposed changes (along with likely impacts) is included in the body of this Report. Any costs/savings associated with the recommended reforms would need to be modelled by the Department in the context of a comprehensive reform package.

In addition to the changes recommended in relation to individual schemes, it is also recommended that Government:

- improve its IT and administrative systems to reduce reliance on manual handling of claims and enable online claiming and payments which will reduce regulatory burden and cost to insurers, medical practitioners and Government, and
- enhance its monitoring capacity to enable better analysis of the stability of the sector and the affordability of premiums so that the ongoing need for, and level of, support can more accurately be determined in the future.

Subject to the implementation of an improved monitoring framework, the Government could consider scaling back its contribution further from 2021. Consideration could be given to three specific measures:

- restricting eligibility for the PSS such that medical practitioners earning over a certain income in annual private billings (for example, \$500,000) would not be eligible for the PSS
- whether there is an ongoing need to cap premiums paid by privately practising midwives and to subsidise the cost of high claims (noting the absence of any high claims to date and the potential for other insurers to enter the market), and
- introducing a levy in association with the HCCS such that the Commonwealth’s contribution is steadily reduced, without increasing volatility to insurers and without disproportionately impacting smaller insurers and new entrants.

The rationale for considering changes in each of these areas is discussed in the body of this Report, along with the reasons why a final position on these matters would best be informed by further monitoring and stakeholder consultation.

Chapter 1 - Context and purpose of this Review

About the Indemnity Insurance Fund

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

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

- **Premium Support Scheme (PSS)** - subsidises 60% of indemnity insurance costs for doctors whose premiums exceed 7.5% of their income from private practice. PSS also subsidises 75% of the difference between the higher premiums for rural procedural general practitioners (GPs) and premiums for non-procedural GPs. The PSS also includes grandparenting arrangements for MISS, which provided non-means tested subsidies to specific specialties. Universal cover arrangements enabling all eligible medical practitioners to access indemnity insurance are also currently encompassed under the PSS.
- **High Cost Claims Scheme (HCCS)** - reimburses medical indemnity insurers 50% of the insurance payout over \$300,000 up to the limit of the practitioner's cover for claims notified on or after 1 January 2004. From 1 July 2018, the threshold increases from \$300,000 to \$500,000.
- **Exceptional Claims Scheme (ECS)** - reimburses medical indemnity insurers for 100% of the cost of private practice claims that are above the limit of their medical indemnity insurance contract limit, which is typically \$20 million.
- **Run-Off Cover Scheme (ROCS)** - reimburses medical indemnity insurers for 100% of the cost of claims for doctors (plus a 5% claims handling fee) who have ceased private practice because of retirement, disability, maternity leave, death or if they stop working as a doctor in Australia. The ongoing costs of the scheme are met by the ROCS Support Payment, a levy on the premium income of medical indemnity insurers.
- **Incurred-But-Not-Reported (IBNR) Scheme** - reimburses medical indemnity insurers for 100% of claims made against doctors (plus a 5% claims handling fee) arising from incidents that took place on or before 30 June 2002, provided they held incident-occurring based cover with a participating MDO. The IBNR Scheme was established to support UMP (now a subsidiary of the Avant Mutual Group Limited) to continue to provide medical indemnity insurance after it was placed into provisional liquidation in 2002. In practice, Avant is the only participating organisation.
- **Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS)** - under Level 1 of this Scheme, the Commonwealth reimburses the insurer for 80% of claims that exceed the \$100,000 threshold up to \$2 million. Under Level 2 of this Scheme, the Commonwealth reimburses the insurer for 100% of the cost of the claim above the \$2 million threshold.
- **Midwife Professional Indemnity Run-off Cover Scheme (MPIROC)** - provides secure ongoing insurance for eligible midwives who have ceased private practice because of retirement,

disability, maternity leave, death or other reasons, with 100% of the cost of claims reimbursed by the Commonwealth (funded via a levy on premium income).

Since 2002, the total Commonwealth expenditure under the schemes has been over \$400 million to 30 June 2016.⁷

Objectives of the Review

In line with the recommendations of the Australian National Audit Office (ANAO)⁸ and as announced on 19 December 2016 in the 2016-17 Mid-Year Economic and Fiscal Outlook (MYEFO), the Department of Health commissioned a FPR of the Commonwealth funded schemes under the IIF.

The terms of reference for the FPR are to:

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

Relationship to other reviews

ANAO performance audit

In 2016, the ANAO conducted a performance audit of the IIF. In its report, *“The Management, Administration and Monitoring of the Indemnity Insurance Fund”*, the ANAO noted the significant improvement in the financial strength and stability of the medical indemnity insurance market since the first of the IIF schemes were introduced in 2002 and recommended that the Department of Health conduct a FPR of the IIF.

Thematic Review

In parallel with the FPR, mpconsulting conducted a Thematic Review of the Commonwealth’s medical and midwife indemnity legislation. The purpose of this review was to consider relevant indemnity legislation with a view to simplifying and streamlining the legislation, with a particular focus on deregulation.

⁷ Australian National Audit Office (ANAO), 2016–17, *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No.20.

⁸ *ibid*

The Thematic Review involved a review of 17 legislative instruments that support the IIF and identified opportunities to:

- remove redundant or inoperable legislation
- consolidate multiple instruments into single instruments wherever possible
- ensure the instruments are consistent with the broader legal and policy context and with the clearer laws principles, and
- simplify the legislation wherever possible.

Subject to Government's consideration of, and response to, the FPR, it is proposed that a single, comprehensive legislative package would be implemented and that changes would be accompanied with detailed explanatory and education materials for the sector.

Conduct of the Review

Call for submissions

To inform the Review of the IIF, the Department invited stakeholders to make written submissions. The Department requested feedback in relation to:

- each of the schemes that form the IIF
- the benefits and limitations of the schemes
- whether the schemes are achieving their objectives, and
- any necessary adjustments to the schemes.

Stakeholders had six weeks in which to provide written submissions. Of the 29 written submissions received from insurers, medical practitioners, midwives, the Australian Commission on Safety and Quality in Health Care, peak bodies and others, 22 have been made publicly available on the Department's website. Public submissions can be accessed at: [Submissions to First Principles Review Discussion Paper](#)

Consultations

The Review of the IIF was conducted over a period of six months and involved consultation with a range of stakeholders. Consultations were conducted by face-to-face meetings, workshops and teleconferences with insurers, the Insurance Council of Australia, the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and the Australian Medical Association.

Consultations were also undertaken with:

- the Chief Nursing and Midwifery Officer for the Australian Government
- the Australian Government Actuary
- the Treasury, and
- DHS.

Document review

The documents reviewed are detailed in the bibliography to this Report and include:

- submissions received from insurers, medical practitioners, peak bodies and others
- summary documents, diagrams, data, meeting notes, reports and emails provided by the Department
- IIF fact sheets and guidelines and data produced by the Department and DHS
- media articles, reports and position papers relating to various aspects of the IIF
- Australian Government publications including reports prepared by the Australian Institute of Health and Welfare, the Australian Competition and Consumer Commission (ACCC) and the Australian Government Actuary, and
- ANAO reports and better practice guides.

Chapter 2 – Medical indemnity and the IIF

What is medical indemnity insurance?

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

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

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

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

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

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

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

At the time that UMP was placed into provisional liquidation, there were a number of other events impacting the availability and affordability of insurance. This included the collapse of the HIH group, the destruction of the World Trade Centre and an increasing tendency for courts to award significant damages. The exit of the HIH group from the market reduced the supply of medical indemnity reinsurance, increasing costs to insurers. The attack on the World Trade Centre also had an adverse impact on the reinsurance market, reducing the profitability of insurers, resulting in higher premiums and, in some cases, withdrawal of cover. This pattern was particularly pronounced in the medical indemnity insurance arena.

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

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

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

The reform package included a variety of measures including premium subsidies, government assistance to MDOs/insurers and medical practitioners for high-cost claims and placing the industry within a new regulatory framework. The Prime Minister announced that the ACCC would monitor medical indemnity premiums to assess whether they are actuarially and commercially justified.

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

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

Summary of the schemes – expenditure and reach

The following table summarises the Commonwealth's expenditure under each of the schemes as well as the beneficiaries of such expenditure.⁹ This also shows the reach of the various schemes.

⁹ Commonwealth expenditure 2015-16 is reported separately for each medical indemnity scheme: PSS, HCCS, ECS, ROCS, IBNR, MPIS, MPROC expenditure in *Department of Human Services Annual Report 2016-17*, p. 57-59. Figures are provided for the 2015-16 financial year, for consistency with the most recent report of the Australian Government Actuary, *Twelfth report on the cost of the Australian Government's Run-off Cover Scheme for medical indemnity insurers*.

Scheme	Components	Commonwealth expenditure 2015-16	Details re subsidies, fees, claims and beneficiaries
PSS	Subsidy	\$8 million	<ul style="list-style-type: none"> 1,237 medical practitioners subsidised. This represents less than 2% of privately practising practitioners (approx. 80,000) Average subsidy ranging from approx \$560 for non-procedural GPs to \$13,500 for obstetricians¹⁰ Commonwealth expenditure is taxpayer funded
	Administration fee	\$1.4 million	<ul style="list-style-type: none"> Paid to the four insurers who offer PSS, based on a formula Commonwealth expenditure is taxpayer funded
HCCS	Claims	\$49.9 million	<ul style="list-style-type: none"> 258 payments for medical practitioners: <ul style="list-style-type: none"> Commonwealth payments ranging approx \$8 to \$3.959 million (noting insurers may receive multiple payments in respect of a claim) Seven claims for health professionals: <ul style="list-style-type: none"> Commonwealth contribution ranging from \$17,908 to \$687,051¹¹ Commonwealth expenditure is taxpayer funded
ECS	Claims	\$0	<ul style="list-style-type: none"> No claims
ROCS	Claims	\$2.6 million	<ul style="list-style-type: none"> 82,472 contributing doctors as at 30 June 2016 14,034 eligible practitioners as at 30 June 2016 \$15.6 million recovered via levy in 2015-2016¹² Total ROCS levies and interest accumulated as at 30 June 2016 – \$284 million Commonwealth expenditure is funded via a levy
	Administration fee	\$1.6 million	<ul style="list-style-type: none"> Paid to insurers
IBNR	Claims	\$5.9 million	<ul style="list-style-type: none"> Payments made to Avant in respect of claims arising from before 2002 Commonwealth expenditure is taxpayer funded
MPIS	Claims	\$0	<ul style="list-style-type: none"> No claims (administration fee of \$235,000 paid under contract)
MPIROC	Claims	\$0	<ul style="list-style-type: none"> No payments have been incurred 182 contributing midwives as at 30 June 2016 Approx \$32,000 recovered via levy in 2015-2016¹³ Total ROCS levies and interest accumulated as at 30 June 2016 – \$111,000¹⁴
Total		\$69.4 million	

¹⁰ PSS average subsidy ranges are approximate as they are subject to amendment because insurers provide data to DHS in subsequent financial years.

¹¹ DHS HCCS expenditure data. Figures shown are for the 2016 calendar year. Some claims comprise more than one payment by DHS to the insurer. Lowest payments are the lowest 'initial payment' made to the insurer towards a claim.

¹² Department of Health, 2016, *Department of Health Annual Report 2015-16*, p. 349.

¹³ Australian Government Actuary, 2017, *Sixth report on the costs of the Australian Government's Run-off Cover Scheme for midwife professional indemnity insurers*, p. 14.

¹⁴ Ibid, p. 15.

Chapter 3 – What has been the impact of the schemes?

Has Commonwealth intervention been successful in establishing stability of the industry, availability and affordability of medical indemnity insurance?

At the time the reforms were announced in 2002, the then Prime Minister acknowledged that Commonwealth intervention was one part of the solution only and urged State and Territory Governments to implement tort law reform in order to address some of the underlying issues that were driving increased premiums.

From 2002, a range of structural changes and reforms were implemented – some driven by the Australian Government, some by State and Territory governments, some by the insurance industry and some by medical practitioners and their respective professional bodies.

Given this collective and ongoing effort, it is not possible (nor meaningful) to disaggregate the impact of the Commonwealth intervention alone. What is relevant to this Review is documenting the key changes that have occurred since 2002 and the impact of these changes on industry stability and insurance availability and affordability.

Based on the changes documented below it is reasonable to conclude that the range of reforms implemented since 2002 (including the Commonwealth interventions) have improved the stability and profitability of the medical indemnity insurance industry and in turn improved the availability and affordability of premiums.

As recommended in this Report, improved monitoring of the schemes would better enable more detailed assessment of how the IIF specifically is performing against its objectives.

What has changed since 2002?

The following table summarises the key changes, with further information provided below.

	Medical indemnity insurance environment before 2002 (pre-reforms)	Medical indemnity insurance environment today (post reforms)
Regulation of insurers	Indemnity protection provided by medical defence organisations	Medical indemnity insurance can only be offered by insurers authorised and regulated by APRA.
Availability of insurance	Five MDOs/insurers	Six insurers in total: <ul style="list-style-type: none"> • Two recent entrants to the market • Four are specialist insurers only offering medical indemnity insurance.
Insurance products	Indemnity provided as a bundled product to medical practitioners	Cover is provided through an insurance policy subject to terms and conditions.
	Cover is discretionary	The Australian Securities and Investment Commission (ASIC) oversees the administration of product standards and disclosure requirements applying to medical indemnity insurance policies.
	MDOs offering both claims-incurred cover and claims-made cover	Insurers offering claims-made cover only.

	Medical indemnity insurance environment before 2002 (pre-reforms)	Medical indemnity insurance environment today (post reforms)
Premium affordability	Average gross written premium in 2004 in excess of \$6,000	<p>Average premium approximately \$3,900¹⁵ in 2015-16.</p> <p>Average premiums have reduced since their peak in the early 2002 and have remained flat in nominal terms in recent years.</p> <p>Decline in number of practitioners accessing the PSS (suggesting improved affordability).</p> <p>Unable to measure premium as percentage of private income (data not collected).</p>
Insurer stability including capital	No regulation of minimum prudential requirements	APRA regulation and monitoring of insurer prudential position.
	Ratio of insurer capital to prudential capital requirement not known	Specialist insurers consistently exceeding minimum capital requirements having held more than twice the minimum level of regulated capital for the majority of the last 10 years.
	No prudential requirements	APRA regulation and monitoring of prudential standards.
Insurer profitability	Not known	Average net profit of 18% of gross earned premium over the last five years to 30 June 2016 (compared to general insurance industry average of 10% over the same period).
		Some insurers allocating excess funds to dividends offering renewal bonuses and free additional insurance (indicating confidence in their capital positions).

Tort reform

From 2002, governments in all States and Territories introduced a range of tort law reforms aimed at limiting the extent of damages and improving the availability and affordability of all types of liability insurance including medical indemnity insurance.

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

Within only five years, there was evidence of the success of the reforms in limiting liability and the quantum of damages arising from personal injury and death. For example, medical indemnity claims in the three years following the 2002 reforms fell by 36%.¹⁶

¹⁵ Advice from Australian Government Actuary, based on Run-off Cover Scheme data, excluding tax.

¹⁶ Attorney-General's Department, December 2006, *Improvements in liability insurance following tort law reform in Australia*, CanPrint Communications

Strengthened regulation of insurers

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

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

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

Improved risk management

Many insurers and policy holders have implemented more sophisticated risk management approaches. For example, different insurers offer a range of supports for medical practitioners to minimise the likelihood of claims. This includes: risk management education, clinical practice review, submission of action plans, practice reviews, self-directed learning and health assessments.

Government and industry also worked together to introduce measures focused on quality and safety improvement for medical practitioners, such as improving clinical risk management, reducing adverse events and improving patient safety.

In addition, there have been changes in the regulation of medical practitioners which has also contributed to improvements in clinical risk management and quality assurance. These changes have included:

- the establishment of the Australian Health Practitioner Regulation Agency (AHPRA) in 2009, which administers the National Registration and Accreditation Scheme, and
- the establishment of the Australian Commission on Safety and Quality in Health Care under the *National Health Reform Act 2011*.

All of these changes have been aimed at reducing the risk of harm to patients, which in turn reduces claims and medical indemnity premiums for practitioners.

Improved data about claims enabling greater predictability

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

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

Improved insurer capital and profitability

Capital

APRA has recently reported that each of the four medical indemnity insurers and the two general insurers that offer medical indemnity insurance have positive profitability and net assets. APRA observed that this represents considerable improvements on the negative net asset position in 2002.¹⁷

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

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

The Australian Government Actuary has advised that medical indemnity insurers have consistently exceeded minimum capital requirements, having held more than twice the minimum level of required capital for the majority of the last 10 years.

Profitability

The Australian Government Actuary has advised that:

- each of the four medical indemnity insurers and the two general insurers that offer medical indemnity insurance have positive profitability and net assets, and

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

- average net profitability of the specialist insurers over the five years to 30 June 2016 was 18% of gross earned premium (contrasting the general insurance industry, which has achieved an average result of 10% over the same period).

Further indications of profitability include:

- the allocation of dividends and renewal bonuses by some insurers suggesting a level of confidence in the capital position of the organisations, and
- the offer of free additional insurance and insurance like benefits by some insurers (such as practice entity protection, personal accident cover and discretionary cover for non-health care related legal costs).

Improved affordability of premiums

Gross average premium

While the National Commission of Audit and the ACCC have observed that average premiums have fallen since 2003-04, making them more affordable,¹⁸ the 2016 ANAO Report shows that some specialities have experienced change differently over time.¹⁹

The Australian Government Actuary has also advised that:

- data up to June 2016 indicates that the average gross written premium has declined since 2003, with premiums declining significantly for some specialties with the highest premiums, and
- while caution must be applied in relying on this data (noting that it relates to both full time and part time medical practitioners), it would suggest that the trajectory of premium increases that existed prior to 2002 (when premiums were increasing annually at an accelerated rate) has since softened.²⁰

Affordability

Data illustrating medical professionals' private medical practice incomes are not currently available to Government and as such, the effect of the apparent improvement in affordability against the income that is generated cannot be measured.²¹ However, the decline in PSS participants suggests that there has been a decline in the average premium relative to private billings income.

While there are approximately 80,000 registered medical practitioners working in private practice who are potentially eligible to benefit from a premium subsidy via the PSS (if his/her gross indemnity cost exceeds 7.5% of his/her income or the medical practitioner is working as a procedural GP in a rural or remote area), in 2015-16, there were only 1,237 medical practitioners

¹⁸ National Commission of Audit, op.cit.

¹⁹ Australian National Audit Office, 2016–17, *The Management, Administration and Monitoring of the Indemnity Insurance Fund*, ANAO Report No. 20, p. 28. For example, Figure 2.3 shows a spike from 2011 for 'All other specialties' and increases for obstetricians and neurosurgeons in 2013-14.

²⁰ Advice from Australian Government Actuary, based on Australian Prudential Regulation Authority National Claims and Policies Database.

²¹ Advice from Australian Government Actuary.

who sought a subsidy under the PSS scheme.²² This represents less than 2% of medical practitioners accessing the PSS.

Other measures supporting affordability

In addition to Australian Government subsidies, the governments in some States also provide assistance for higher risk specialties, particularly in rural areas. For example, in South Australia, the State Government supports rural obstetric GPs to the extent that their premiums are capped at the equivalent to that of a non-procedural GP. This is specifically designed to ensure that obstetrics in rural areas continues.

Some States have also introduced regulation capping the premiums that may be charged for some specialties. For example, in New South Wales the *Health Care Liability Act 2001* provides that premiums charged by insurers for high risk specialties may not exceed certain multiples of the base premium for GPs.

²² Department of Human Services, 2016, *Annual Report 2015-16*, p. 58.

Chapter 4 – Is there an ongoing need for the schemes and do they remain fit for purpose?

Ongoing need

The Terms of Reference for the Review require consideration of the appropriate level of Commonwealth support needed for continued stability, affordability and accessibility of indemnity insurance for medical practitioners and eligible midwives.

Given the strength of the sector in terms of its stability, capital reserves and profitability (detailed in the previous Chapter), there are limited arguments for expanding the level of support provided by the Commonwealth to insurers via the schemes that pay claims (ECS, HCCS and ROCS).

Likewise, removing the schemes entirely is not prudent given the potential significant impact on stability, premium affordability and claims volatility. All stakeholders making submissions to this Review supported the continuation of the schemes and emphasised the valuable role they play in providing a safety net should there be sudden changes in the frequency and amounts of claims, and the damages awarded.

The question that then remains is: should the Commonwealth's current level of support be reduced?

Various bodies have suggested that the evidence of the market normalising reduces the need for the schemes, including the National Commission of Audit who concluded in 2014 that the evidence of the market normalising, warranted the Commonwealth scaling back its subsidies for medical indemnity insurance by ceasing the PSS and the HCCS (with the need to consider grandparenting provisions) accompanied by monitoring of the impact of these changes.

Others, including the majority of stakeholders making submissions to this Review, have suggested that despite the improvements in the environment the current levels of support should be continued because of the future uncertainty and the speed at which the medical indemnity environment can change, with immediate and direct impacts on insurers and medical practitioners.

It was variously submitted by stakeholders that:

- there are a number of factors that make medical indemnity insurance difficult for an insurer to underwrite. For example, medical indemnity insurance differs to many other types of insurance as there can be many years before a claim is made, making prediction of potential losses and the setting of premium rates more challenging than in many other sectors
- the ability for the Chief Executive Officer (CEO) of the National Disability Insurance Agency (NDIA) to require a participant or prospective participant to take action to claim or obtain compensation could mean a significant increase in claims with unknown impact
- there appears to be a deterioration in both certainty and legal outcomes, settlement and claims amounts and claims frequency since the National Commission of Audit Report

- there has been an increase in notifications to AHPRA about medical practitioners. For example, in the last year notifications increased by 3.9% from 2015-16 to 2016-17. Stakeholders suggested that this may indicate a worsening trend, and
- international trends suggest a worsening of the insurance environment. Stakeholders noted that both the USA and the UK are experiencing deteriorations in the costs of medical indemnity claims.
 - For example, in the US the industry claims that costs have increased by 15% over three years to 2016, partially due to increases in large claim costs, with a material growth in the costs of claims above \$1 million. Underwriting profitability has also decreased. In the UK, the NHS has also experienced a 72% increase in the claims costs over the last five years to 2016.²³

Some of the points made above could not be verified through this Review, including whether increases in AHPRA notifications are likely to have any impact on claims, and also whether NDIA actions are likely to impact the market (noting that the Department of Social Services has advised that to date the NDIA has not requested a participant to take action to obtain compensation).

Despite this, we acknowledge the concerns expressed by insurers and the potential (but not known) impacts on the indemnity insurance market. We also note that a number of stakeholders suggested that any changes in insurers' costs will be passed on to medical practitioners and will in turn impact the availability and affordability of health care.

We also consider that the arguments for retaining or reducing the current level of Commonwealth support varies for each of the schemes. This is discussed in more detail in Chapters 5 to 13, which deal with each of the schemes in turn.

Fitness for purpose

Overall, the schemes largely remain fit for purpose and should Government accept the rationale offered in this Report regarding the continuance of the schemes, some changes are proposed in relation to the ECS, HCCS (noting that some changes have already been announced with effect from 1 July 2018), ROCS and MPIROC, and no changes are recommended to the IBNR.

The main changes that are proposed relate to:

- the PSS and universal cover (which is currently tied to the PSS). In summary, these include:
 - removing the complex contractual arrangements between the Commonwealth and insurers and instead including key matters in delegated legislation
 - enabling all eligible medical practitioners to access the PSS (rather than only those insured by a contracted insurer)
 - enabling medical practitioners to make claims for PSS subsidy directly to DHS. This removes the need: for insurers to act as an intermediary; for medical practitioners to liaise with the insurer in relation to the PSS; and for an administration fee to be paid by the Commonwealth to insurers to administer the PSS (approximately \$1.4 million annually)
 - adjusting the MISS grandparenting arrangements such that all practitioners receiving the PSS subsidy (other than rural and remote procedural GPs) must meet the income related

²³ MIGA, 13 October 2017, *Submission to the First Principles Review*, p. 3.

- eligibility criteria (such that premiums are in excess of 7.5% of their income from private practice)
- consistent with Government policy announced in 2014, adjust the way that rural and remote practitioners are identified by reference to the MMM
 - replacing State-based insurer of last resort arrangements with a requirement that each medical indemnity insurer must offer medical indemnity cover to any medical practitioner who seeks it from the insurer, and
 - enable insurers to charge a loading in circumstances where the insured's claims history and particular personal circumstances (such as substance misuse) distinguish them from other medical practitioners practising in the same location and speciality.
- the ROCS removing the differential charging for run-off cover for medical practitioners based on the years of continuous cover (noting that the limit on the amount that may be charged currently does not apply to insurers that do not contract with the Commonwealth)
 - the ROCS to enable medical practitioners who permanently retire from practice before the age of 65 to access the scheme without waiting three years (noting that the impacts of this should first be modelled by the Australian Government Actuary prior to implementation). This would also enable the removal of PSS contract terms that cap the cost of run-off cover for those retiring early, but only for practitioners insured by a contracted insurer and with continuous cover of at least 10 years
 - the ECS and HCCS to clarify the intent of the schemes (consistent with the objects of the legislation) such that the schemes apply to claims arising from the practice of medical practitioners and not all health professionals, and
 - administrative arrangements such that improvements are made to:
 - IT systems
 - communication and engagement with the sector
 - data collection, and
 - monitoring and reporting.

Further, if Government is seeking to gradually reduce the level of Commonwealth support (and achieve cost savings), further changes could be considered following the implementation of the monitoring framework and taking into account the outcomes of further consultation.

Consideration could be given to three specific measures:

- restricting eligibility for the PSS such that medical practitioners earning over a certain income in annual private billings (for example, \$500,000) would not be eligible for the PSS
- reconsidering the need to cap premiums paid by privately practising midwives and to subsidise the cost of high claims (noting the absence of any high claims to date and the potential for other insurers to enter the market), and
- introducing a levy in association with the HCCS such that the Commonwealth's contribution is steadily reduced, without increasing volatility to insurers and without disproportionately impacting smaller insurers and new entrants.

The following Chapters describe the issues and proposed changes to each of the schemes.

Chapter 5 – PSS

Context

The PSS assists eligible medical practitioners with the cost of medical indemnity insurance through payment of premium subsidies. Medical practitioners qualify for a premium subsidy under the PSS if they meet one of two criteria:

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

The PSS also includes grandparenting arrangements for MISS, which provided a non-means tested subsidy to specific specialties.

Ongoing need, and support, for the PSS

Participation in the PSS has steadily declined. DHS statistics show that 4,441 medical practitioners received a premium subsidy in the first year of PSS operation, with participation peaking in 2007-08 with 7,210 medical practitioners participating.²⁴

Since then participation has steadily declined with fewer medical practitioners receiving a subsidy each year. In 2015-16, only 1,237 medical practitioners received a PSS subsidy. This represents less than 2% of privately practising medical practitioners.

Two of the six medical indemnity insurers have also chosen not to participate in the PSS given its limited application and high cost of administration.

Despite the small reach of the scheme, the cost to the Commonwealth is reasonably high with the total amount of subsidy paid by the Commonwealth in 2015-16 being \$8 million with the average subsidy paid ranging from approximately \$560 for non-procedural GPs to \$13,500 for obstetricians.²⁵

Given the relatively small (and declining) number of medical practitioners accessing the scheme it could be argued that removal of the PSS (including for grandparented MISS participants) would have limited impact on medical practitioners overall.

However, for those accessing the scheme the impact is likely to be significant for a few (particularly those receiving subsidy in excess of \$5,000 per year).

²⁴ Australian Health Insurance Commission, 2005, *Health Insurance Commission Annual Report 2004-2005*, p. 16 and Medicare Australia, 2005, *Annual Report 2007-08*, p. 54.

²⁵ PSS average subsidy ranges are approximate as they are subject to amendment because insurers provide data to DHS in the financial year subsequent to the year in which the medical practitioner was eligible for PSS subsidy.

Further, the impact of removing the scheme would be experienced disproportionately by rural and remote practitioners. Of the GPs accessing the PSS in 2015-2016, approximately 70% were practising in rural and remote locations.

Removal of subsidy for this group would also run counter to broader Government policy that seeks to incentivise medical practitioners to practice in rural and remote locations.

While the continuation of the scheme is recommended, some changes could be made to improve monitoring to better enable assessment of the affordability of premiums (as discussed in Chapter 12) and to strengthen the eligibility criteria to better reflect Government priorities. A number of specific changes are recommended, as described below.

Issues and proposed treatments

PSS contract

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

When the PSS commenced, all Australian medical indemnity insurers entered into the PSS contract with the Commonwealth. Four providers of medical indemnity insurance in Australia continue to be signatories. However, in recent years there have been others providing insurance to medical practitioners that have not entered into a PSS contract (Berkshire Hathaway Specialty Insurance and Guild Insurance).

The PSS contract provides benefits to contracted insurers, and also carries obligations. One of the key benefits is that medical practitioners insured by contracted insurers are able to access the PSS and the insurer is paid an administration fee for assisting in the administration of the subsidy (\$1.4 million in 2015-16 across the four contacted insurers).

Obligations imposed via the contract also include universal cover requirements (discussed in the following Chapter) and a requirement for insurers to offer run-off cover at a nominal cost for certain medical practitioners.

The contracts are also dated, include unnecessary reporting requirements and duplicate matters that are addressed in legislation describing the PSS.

In order to streamline the operation of the PSS, remove unnecessary burden and enable all eligible medical practitioners to access the PSS (if they wish), it is proposed that all matters relating to the PSS be consolidated in delegated legislation (rather than being spread across contracts and legislation).

As discussed in Chapters 6 and 8 of this Report, it is also proposed that there be changes to the universal cover and run-off cover arrangements such that a contract between the Commonwealth and insurers is no longer necessary.

PSS subsidy payment arrangements

Currently under the PSS, contracted insurers must invite medical practitioners to participate in the PSS prior to the commencement of each policy period. Practitioners may opt in by giving notice each year to their insurer.

Each insurer sends relevant information to DHS (including the anticipated income of the medical practitioner for the subject year), DHS assesses the eligibility of the medical practitioner and calculates the relevant amount of subsidy. DHS makes payment to the insurer for all eligible applications for PSS. The subsidy is passed on to the medical practitioner via a reduced premium. In some cases, the insurer anticipates the payment of the subsidy and offers a reduced premium to the practitioner in advance of acceptance of the claim and payment by DHS.

Medical practitioners must give statutory declarations stating actual gross private income to insurers within 12 months of the end of the premium period and insurers submit relevant data to DHS. If there are any adjustments to subsidy (based on actual income compared to estimated income) insurers return any overpaid PSS subsidy to DHS. If a medical practitioner fails to submit a statutory declaration, the insurer must return the advance subsidy to DHS within 15 months and must seek reimbursement from the medical practitioner.

The current approach:

- is resource intensive for insurers, medical practitioners and also for DHS. In particular, the advance nature of the payment based on provisional or estimated information causes complexities and administrative burden when it comes to recalculation following receipt of the actual data, particularly when payments (and recoveries) are made through the insurer rather than directly to the medical practitioner
- imposes an unnecessary burden on medical practitioners through the requirement for statutory declarations
- can place the insurer in the position of needing to recover from the medical practitioner (if there has been overpayment of subsidy or the practitioner is deemed ineligible by DHS). This can be challenging for insurers including when the medical practitioner changes insurers, and
- provides the medical practitioner with limited visibility of the Government's contribution. Some insurers have advised that they do not separately itemise the subsidy reduction on the statement of premium provided to the medical practitioner.

An alternative to the current approach is for medical practitioners to make claims for subsidy directly to DHS. DHS could continue to pay the subsidy based on the estimated income for the relevant year but make any adjustments to the subsidy in the following year, based on a statement of actual income for the previous year.

In the event that a medical practitioner becomes ineligible for the PSS subsidy (because of changes to their income or because they change their practice or stop practising), DHS could recover any over-payment in the previous year via its usual, well-established recovery mechanisms (with which many medical practitioners are already familiar).

This proposed new approach:

- reduces the administrative burden on medical practitioners because rather than needing to engage with the insurer in order to claim the PSS they can engage directly with DHS. An improved online claiming and payments system (as recommended in Chapter 12 of this Report) would also reduce the administrative impost. An online system should also minimise the risk of delays in payments to eligible medical practitioners
- removes the need for insurers to be involved in the administration of the PSS, and
- reduces overall costs to Government because Government would no longer need to pay an administration fee to the insurers to administer the PSS. While there would be establishment costs associated with an online claiming and payment system, the ongoing costs to Government are likely to be lower than the current annual costs.
 - Based on advice from the Australian Government Actuary, the administration fee currently represents approximately 20% of the value of the subsidy paid under the PSS. Further, the average administration fee paid per participant in the PSS varies between insurers and ranges from just over \$700 to over \$2,000 per participant.
 - It is expected that online claiming and payment directly through DHS would cost significantly less than this per participant.

As for the other changes recommended by this Review, consideration will also need to be given to transitional arrangements (to minimise disruption of payments to PSS participants during the transition period). Implementation of the changes should also be accompanied by education materials for practitioners and insurers to ensure that eligible practitioners are aware of the opportunity to apply for the PSS and how to apply through DHS.

Grandparenting arrangements

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

Due to these grandparenting arrangements, a number of PSS participants do not meet the income related eligibility criteria which require participants' premiums to be in excess of 7.5% of their private income in order to access the scheme. There are, for example, some practitioners accessing the scheme whose premiums represent less than 5% of their private income.²⁶ While this arrangement was originally put in place to ease the transition from the MISS to the PSS, it now represents a distortion of the policy intent, which is to offer subsidy for those with particularly high premiums as a percentage of their private income.

It is therefore proposed that the MISS grandparenting arrangements be reviewed such that MISS participants are subject to the same eligibility criteria as all other PSS participants.

It is not known precisely how many medical practitioners will be impacted by this change because the Department does not hold information about the private income of all of participants (only

²⁶ Advice from Australian Government Actuary.

some). However, as the total number of MISS participants is around 180, the total number affected by the reform is likely to be less than 100 (and could be significantly less).

In addition to better reflecting Government policy, alignment of the eligibility requirements for MISS participants (with the eligibility requirements for all other PSS participants) will also significantly reduce legislative and administrative complexity.

This change will not impact procedural GPs practising in a rural or remote location because under the PSS there is no requirement for their gross medical indemnity costs to exceed 7.5% of their gross private medical income in order for them to claim the PSS subsidy.

Rural and remote classification

The delegated legislation that describes the PSS (the *Premium Support Scheme 2004*) extends eligibility for the PSS to procedural GPs practising in a rural or remote area.

A rural or remote area is defined by reference to the *Rural, Remote and Metropolitan Areas Classification* as in force on 1 January 2001, setting out certain categories of areas in Australia by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994.

It is recommended that as part of the package of amendments to be developed to implement any agreed recommendations from this Review or the Thematic Review, the opportunity be taken to update the way that rural and remote areas are determined by reference to the MMM. This would deliver on the Government's commitment (reflected in a statement on 31 October 2014 by the then Assistant Minister for Health) that the MMM would be progressively introduced to more effectively target a range of health workforce programs.

It is proposed that the Department model the impact of this change prior to its implementation to determine the need for any transitional arrangements.

Matters for further consideration in the future

Eligibility based on private income

As noted above, the PSS currently subsidises medical practitioners on a flat rate basis for premiums that exceed 7.5% of the practitioner's private practice income, regardless of how high that income is. This means that there is no differential approach in respect of low income practitioners (even 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 who earns \$100,000 in private practice income per year and is paying \$5,000 in premiums per year is determined at the same percentage as for the practitioner who is earning \$1,000,000 per year and paying \$100,000 per year in indemnity premiums. While the second practitioner is paying twenty times the indemnity cost of the first practitioner, there is a significant difference in earnings post indemnity costs (i.e. \$95,000 versus \$900,000).

While a sliding scale to determine varying subsidies based on private practice income may provide a more equitable outcome in terms of PSS entitlement, implementation of such a formula poses challenges to be considered relative to the small numbers of practitioners accessing the PSS.

Another option is to provide for an income threshold over which a practitioner is no longer eligible for the PSS (noting that the current arrangements supporting rural and remote practitioners are proposed to continue). For example, a participant could become ineligible for the PSS if their private income exceeds \$500,000 per annum (an income that well exceeds average private income earnings across most specialties).

The Department does not have access to comprehensive data to enable a full assessment of the likely impact of this approach (including because income data is not submitted for all PSS recipients including grandparented MISS participants).

Further, stakeholders advised against such a change noting that if there are sudden changes in the insurance market, those subject to the most significant premium increases may not be able to access the PSS based on their income (reducing the effectiveness of the PSS as a shock absorber).

If the Government accepts the recommendations in this Report (that all eligible medical practitioners be able to access the PSS, that applications for subsidy be made directly to DHS by medical practitioners, and that MISS participants be subject to the same eligibility requirements as other PSS recipients), this will ensure the Department has a much clearer picture of the true need for the PSS and the income levels of those accessing the PSS.

With this information, Government will be better placed to make decisions regarding the need for the PSS and any scaling back of the PSS based on the gross private income of the medical practitioners.

Chapter 6 - Universal cover

Context

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

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

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

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

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

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

It is estimated that fewer than 120 medical practitioners across Australia are insured under universal cover arrangements. This represents less than 0.2% of the total number of privately practising medical practitioners.

Issues

There are four main problems with the current universal cover arrangements:

1. **Application** - Only insurers that have entered into a PSS contract are bound by universal cover requirements.
 - If, as recommended by this Review, PSS contracts are not continued (such that all eligible medical practitioners can access the PSS), consideration needs to be given to how the universal cover obligations should apply.

2. **Distribution of obligations** - The universal cover obligations are currently not evenly distributed between insurers nor based on market share. This means that amongst insurers who have entered PSS contracts with the Commonwealth, some insurers cover a disproportionate number of medical practitioners via universal cover obligations relative to others. Further, if a new insurer were to enter the PSS (or an existing insurer exit) there is no formula or method for re-distributing the universal cover obligations between either a larger or smaller pool of insurers.
 - If universal cover obligations are to continue (including in the absence of a PSS contract) consideration needs to be given to how to more equitably distribute the universal cover obligations.
3. **Public safety** - There are limited market-based mechanisms to constrain the practice of medical practitioners with a high claims history based on inappropriate practice. This is because, regardless of the quality or safety of the practitioner's practices, they are guaranteed insurance through the universal cover arrangements.
 - Insurers have advised that some of the medical practitioners insured via universal cover obligations represent increased risk not because of the specialty within which they practice (or the particular cohort of patients), but because of the personal circumstances of the medical practitioner including substance abuse, mental illness or cognitive decline.
 - Insurers do not notify AHPRA/medical and other boards when they become aware of these practitioner-specific risks because of confidentiality obligations, conflict of interest (in the event that an insurer needs to defend a claim) and because disclosure could also result in practitioners not seeking early advice or providing early reports of incidents which in turn will create missed opportunities for harm reduction and mitigation.
4. **Pricing and cost burden** - For some medical practitioners who are utilising the universal cover arrangements and have a long claims history, the gross premium (including the maximum risk surcharge of 100% that is able to be charged by the insurer) does not cover the real cost of insuring the medical practitioner. With universal cover arrangements, the real cost of insurance is not fully borne by the person generating the risk (as would be the case under normal market conditions). The cost is instead spread across all medical practitioners through cross subsidisation. Government may also absorb some of this cost if the practitioner is claiming subsidy under the PSS.

In summary, while the universal cover arrangements guarantee insurance for medical practitioners, universal cover creates risk:

- for the practitioner (who is not exposed to the full set of risk signals because they are able to secure insurance and continue practising, unlike other health professionals)
- for the insurer and the insurer's membership as a whole (reputational as well as financial risk as members have to pay more to cover the cost of claims from practitioners who might otherwise not be practising)
- for the community (potential increased risk of harm from practitioners who might otherwise not be practising), and
- for all stakeholders (reputational risk and adverse public comment likely in the event that a practitioner – who was known to be an uninsurable risk – was able to cause the harm because the insurer was compelled to provide insurance due to a contract with the Commonwealth).

Proposed treatments

The issue of universal cover is contentious with different insurers expressing varying views about its value and the necessity (or otherwise) for change, and with professional bodies also expressing strong views about the value of universal cover.

Noting the polarised stakeholder views and that changes to universal cover are likely to favour some insurers over others, it may seem appealing to retain the status quo. However, this is not possible. This is because retention of existing arrangements depends on all existing insurers continuing to contract with the Commonwealth and for the universal cover obligations to be distributed as they are currently. Some insurers have advised that they do not wish to continue to contract in the future if the universal cover provisions remain and the new entrant to the market is also choosing not to contract. This means that the universal cover arrangements necessarily need to change.

Through discussion papers and workshops conducted as part of this Review, a range of options have been explored with stakeholders, including removing universal cover obligations entirely.

While removal of universal cover (such that medical practitioners are not guaranteed insurance) would align the position of medical practitioners with that of all other health professionals, stakeholders have generally not supported this approach at this time.

Options to address the issues have been explored with the objective of improving existing universal cover obligations such that:

- the obligations are not dependent on insurers contracting with the Commonwealth (which currently creates a barrier for new entrants to the insurance market)
- premiums can more appropriately be priced for those practitioners who represent increased risk relative to their peers practising the same craft
- all insurers are subject to the same responsibilities relating to universal cover, and
- the inherent risk created by universal cover obligations is minimised.

On balance the recommended option is to:

- transition universal cover arrangements to legislation such that they apply to all medical indemnity insurers and continue to guarantee insurance for all privately practising medical practitioners
- reset universal cover arrangements such that each medical indemnity insurer must offer medical indemnity cover to any privately practising medical practitioner who seeks it from the insurer
- enable a more appropriate loading to be applied where a medical practitioner's claims history and particular personal circumstances represent increased risk (refer further detail below)
- enable insurers to be able to refuse cover in certain circumstances including where the medical practitioner provides false or misleading information or demonstrates abusive or threatening behaviour towards the insurer's representatives, and
- continue to enable medical practitioners to apply to the Financial Ombudsman Service in circumstances where they consider they should not have been charged a loading (or are otherwise dissatisfied with the offer of insurance).

It is proposed that the detail surrounding the circumstances in which a loading may be applied (and the value of the loading) be developed in consultation with stakeholders and the Australian Government Actuary, consistent with the following principles:

- that the loading is only able to be applied where the insured's individual claims history and individual circumstances warrant the imposition of a loading
- that a loading cannot be applied where the insured represents no greater risk than that of the class of practitioners to which the insured belongs (based on type of practice, location etc.)
- that where a loading is imposed, the insurer also implements risk management conditions such that the practitioner has an opportunity to address the source of concern and return to standard pricing
- that where a practitioner is eligible for the PSS, the subsidy applies in relation to the standard premium for a practitioner of the same specialty and risk profile and not also to the loading. This would reinforce the policy messaging that the PSS is intended to apply to subsidise premiums relating to 'normal' medical risks but not risk arising from the individual circumstances of the practitioners relating to poor practice, and
- that Government monitor the application of the policy to ensure that the changes to universal cover do not result in any increased pricing more generally, or in an expanded class of practitioners, subject to higher premiums.

The advantages of this approach are that it:

- maintains universal cover but enables the obligations to extend to all medical indemnity insurers
- provides a stronger pricing signal to practitioners that, due to personal circumstances, they represent a greater risk (providing them with an additional incentive to address their circumstances), and
- enables insurers to better price the risk (through a loading), such that other medical practitioners are not cross-subsidising the highest risk practitioners to the same extent as they are currently.

The main disadvantage of this approach is that some of the risks to the insured, the public and the insurer (relating to otherwise uninsurable practitioners being able to continue practising) remain. There are, however, other reforms underway (or being developed) to address poor practice. These include:

- the announcement by the Medical Board of Australia in November 2017 of the *Professional Performance Framework* which is designed to ensure all registered medical practitioners in Australia practice competently and ethically and provide safe care to patients during their working lives, and
- the ongoing work of the Australian Commission on Safety and Quality in Health Care.

Chapter 7 – HCCS

Context

The HCCS was designed to enable then MDOs (now medical indemnity insurers) to increase the assets available to pay future claims without needing to significantly increase premiums paid by medical practitioners. It did so by guaranteeing a Commonwealth contribution to the cost of large claims. The HCCS was designed to reduce the level of assets MDOs were required to hold to meet costs of claims, to increase stability by reducing claims volatility and to reduce the cost of reinsurance. In turn, this reduced the need for insurers to significantly increase premiums.

Since the establishment of the HCCS, over \$249 million has been paid by the Commonwealth to cover claims against medical practitioners to 30 June 2016.²⁷

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

Ongoing need, and support, for the HCCS

Since the establishment of the scheme the capital position of insurers has changed considerably, with all insurers holding capital reserves in excess of the mandated minimum. Further, the capacity of the sector to meet high cost claims has improved (with improved sector profitability overall). These factors suggest that the need for the scheme is reduced.

However, the HCCS also:

- assists in stabilising the market by minimising the impact that large claims may have on the ability of medical indemnity insurers to continue to provide affordable indemnity cover for medical practitioners
- helps to place downward pressure on premiums by:
 - lowering the amount insurers have to pay out – since 2002 the scheme has contributed approximately 14% of the cost of all claims paid (according to industry data), and
 - reducing the amount of reinsurance insurers need to purchase to fund large claims.
- reduces year-to-year volatility of claims costs. The Australian Government Actuary has noted that:
 - the cost of medical negligence claims is highly variable since the claims relate to bodily injury. While most claims are finalised for less than \$100,000, a small number of claims are large (perhaps 5% of claims cost more than \$500,000). These large claims have a significant impact on the overall cost of medical indemnity insurance. At least 40% of the cost of all medical indemnity claims relates to claims which are larger than \$500,000²⁸, and

²⁷ Department of Human Services data provided to Department of Health.

²⁸ Australian Government Actuary, 2017, *Twelfth report on the costs of the Australian Government's ROCS for medical indemnity insurers 2015-16*, p. 4.

- much of the cost is likely to relate to a small minority of claims, which further adds to uncertainty (because it is difficult to know how much premium to charge and how much money to hold in reserves to pay claims).²⁹

Given these factors, the potential impact of removing the scheme on stability, premium affordability and volatility cannot be known (particularly when the operating environment is changing).

Rather than withdrawing the scheme entirely, a more prudent approach would be to steadily reduce the Commonwealth's contribution and to monitor the impact.

Government has already announced that the threshold over which the Commonwealth will pay 50% of the cost of eligible claims will increase from \$300,000 to \$500,000 for claims notified from 1 July 2018. It is therefore recommended that this change proceed as planned, with the impact monitored, prior to any further changes being made to the level of support provided under the HCCS.

If improved monitoring establishes that the need for the schemes is reduced, Government could consider scaling back its contribution to the high cost of claims in the future by introducing a levy to assist in funding the HCCS (similar to the ROCS levy). A levy would steadily reduce the Commonwealth's exposure, without increasing volatility to insurers or disproportionately impacting smaller insurers and new entrants.

Issues and proposed treatments

Application of the HCCS to health professionals

The *Medical Indemnity Act 2002* establishes the various schemes that form the IIF including the HCCS. The objects of that Act (set out in section 3) include:

- to contribute towards the availability of medical services in Australia by providing Commonwealth assistance to support access by medical practitioners to arrangements that indemnify them for claims arising in relation to their practice of their medical professions, and
- that the Commonwealth provide assistance by meeting part of the costs of large settlements or awards paid by organisations that indemnify medical practitioners.

Press statements and explanatory materials from the time the scheme was introduced focus on the HCCS being available in relation to high cost claims made against medical practitioners (discussed in more detail below).

Despite this, the relevant provision in the *Medical Indemnity Act 2002* that describes eligible claims for the purposes of the HCCS (section 30) defines an eligible claim as one that relates to 'an incident that occurs or occurred (or a series of related incidents that occur or occurred) in the course of, or in connection with, the practice by the practitioner of a medical profession, other than practice as an eligible midwife'.

²⁹ Australian Government Actuary, 2017, *Twelfth report on the costs of the Australian Government's ROCS for medical indemnity insurers*, p. 4.

The wording of the eligibility criteria (focusing on ‘practitioners of a medical profession’ rather than ‘a medical practitioner’) has meant that claims have successfully been made under the HCCS for health professionals, including allied health professionals and dentists.

Of the 1,160 (approximate) HCCS claims paid since the inception of the scheme, approximately 50 claims have been paid by the Commonwealth in respect of persons whose specialty code indicated they were health professionals, rather than medical practitioners.

Based on the National Health Workforce Dataset, as at 2016, there are over 538,000 registered allied health professionals (including nurses). Of these, it is estimated that there are over 70,000 privately practising (and over 56,000 practising in a private hospital).

To date, only medical indemnity insurers, including Guild Insurance, have made claims under the HCCS in respect of health professionals. It is not known whether other general insurers have had claims that may have been eligible or whether they are aware of the potential availability of the HCCS in respect of health professionals.

If the scheme is available to all insurers in respect of all health professionals, then the scope of the scheme (and potential liability of the Commonwealth) may be greater than intended.

Based on the information available to the Review, it would appear that the availability of the HCCS (and the ECS) to general insurers of all health professionals (rather than only medical indemnity insurers of medical practitioners) was unintended. This conclusion is informed by the following³⁰:

- a review of the reports that informed Government decisions at the time, the explanatory statements to the legislation and press releases at the time, all focus on the IIF (including the HCCS and ECS) applying to doctors rather than health professionals more broadly
- a 2003 report to the Prime Minister³¹ (that informed further changes to the HCCS and other aspects of the IIF in 2003) expressly details the impetus for the reforms commencing in 2002 (affordability of premiums for doctors) and proposals for addressing the problems – all relating to insurance of doctors
- a review of the Medical Indemnity Amendment Bill 2004 and the accompanying explanatory memorandum and regulation impact statement: state that the objectives of government relate to enabling doctors to remain in practice; state that the proposed actions apply to doctors; include costings based on the schemes applying to doctors; and include an impact analysis which focuses on doctors rather than health professionals more broadly, and
- the advice of Departmental officers who have examined relevant government documents and confirmed the policy intent that the HCCS be available to medical indemnity insurers in respect of claims made by doctors.

Given the intent of the HCCS, it is recommended that the wording of the relevant provisions be amended, such that the HCCS only enables eligible claims to be made by medical indemnity insurers in respect of medical practitioners.

³⁰ Note that the following section refers to medical practitioners as doctors because this was the language used in the historical documents that are referenced.

³¹ Medical Indemnity Policy Review Panel, 10 December 2003, *Affordable, Secure and Fair: Report to the Prime Minister*

It is recognised that this will have an impact, particularly on Guild Insurance, who has made the majority of claims in respect of health professionals. Guild Insurance has also advised that changes to the legislation (to clarify its intent, such that the schemes apply only to eligible claims in respect of medical practitioners) may result in increased premiums for health professionals.

The likely impact of these changes is difficult to discern. While stakeholders were provided an opportunity to comment on whether the HCCS and ECS should be limited in this way and to provide evidence of the need for the schemes with respect to health professionals (via a Discussion Paper that was made publicly available in August 2017), submissions on this point were limited and no evidence was received about the likely impact should the HCCS and ECS be limited to medical practitioners. Further, as the IIF has focused on medical practitioners rather than health professionals, only medical indemnity insurers have been required to routinely submit data. Analysis by the Australian Government Actuary has also focused on medical indemnity insurers rather than general insurers.

Should Government agree to limit the availability of the HCCS to medical indemnity insurers of medical practitioners (as originally intended), it is recommended that the Department work closely with all stakeholders (including general insurers and health profession bodies) to develop transitional arrangements to enable the processing of current claims and to ensure no retrospective application of the changes.

Improving the claims process

Currently the claims process for HCCS is largely manual and both DHS and insurers have described inefficiencies in terms of the IT interface, the processing of claims, the making of payments and reporting. As discussed in Chapter 12 of this Report, it is recommended that changes be made to the administrative processes that support the HCCS including through the implementation of a fit-for-purpose IT system.

As noted previously, there are often multiple payments per claim and some payments are very small (less than \$100). This creates work for all parties involved and may be avoided.

Enhanced IT systems would also allow better quality data to be collected for analysis and monitoring of the scheme.

Clarifying some claiming criteria

Stakeholders have described a lack of certainty regarding the application of the HCCS in circumstances where, for example:

- treatment is provided across public and private settings
- there are multiple defendants, and
- the practitioner is based overseas and provided the service from overseas.

As part of this Review, the Department has documented each of the issues raised by insurers, relating to interpretation and application of the legislation.

Where the underlying problem is uncertainty or lack of clarity in the law itself, it is proposed that this be addressed through amendments to the legislation to be made at the same time other recommendations from this Review (and the Thematic Review) are being implemented. For example, an avoidance of doubt provision could be included in the legislation expressly noting that the HCCS does not apply to claims arising from advice provided by medical practitioners practising overseas.

In other cases (where the law is clear but interpretive guidance is needed) it is recommended that the Department enhance communication directly with the sector regarding its policy intent and interpretation of the eligibility criteria. This could be achieved through a regular newsletter (discussed in more detail in Chapter 12 of this Report).

Chapter 8 – ROCS

Context

The objective of the ROCS is to ensure that once medical practitioners cease private practice (permanently or, in some limited cases, temporarily), there continues to be insurance to cover any claims relating to actions taken by the medical practitioner while they were practising privately (without the need for the medical practitioner to continue to hold medical indemnity insurance after they cease private practice). Under the ROCS the Commonwealth is essentially acting as reinsurer for claims arising after medical practitioners cease private practice.

The ROCS comprises the following key elements:

- a legislative obligation on insurers to provide run-off cover to particular groups of medical practitioners who have ceased private practice
- provision for the Commonwealth to make payments to insurers:
 - to reimburse 100% of the costs of eligible run-off claims
 - to make other payments to insurers to offset the relevant costs of administering ROCS. The Commonwealth pays 5% of the cost of each claim to the insurer as a claim handling fee and there is an annual allowance for ongoing administrative costs
- provision for insurers to make payments to the Commonwealth to ensure that the scheme is largely cost-neutral to taxpayers. These payments (ROC support payments) are by way of a 5% levy on insurers' premium income, funded by a loading on practitioners' medical indemnity insurance premiums, and
- in the event ROCS is wound up, the Commonwealth is liable to pay an amount to each affected medical practitioner, unless there are alternative arrangements in place for providing run-off cover for medical practitioners.

As at 30 June 2016:

- there were approximately 14,034 ROCS eligible practitioners
- the number of practitioners contributing to ROCS was 82,472
- the total amount of ROCS levies and interest accumulated by the Commonwealth was approximately \$280 million, and
- over \$27 million has been paid by the Commonwealth to cover claims against medical practitioners since the establishment of the ROCS (to 30 June 2017), with claims over each of the past three years being: \$5.6 million in 2014-15, \$2.6 million in 2015-16 and \$2.9 million in 2016-17.

Ongoing need, and support, for the ROCS

Given funding for the scheme is via a levy (and the scheme includes a legislated responsibility for the Commonwealth to repay the levy and interest if the scheme is wound up), any decision to wind up the scheme would result in an immediate cost to Government and is likely to cause significant disruption.

In a tight fiscal environment, and in circumstances where the liabilities of the scheme are intended to be covered by a levy, there are few arguments for fundamentally changing this scheme.

Issues and proposed treatments

The appropriateness of the levy

During consultations to inform this Review, stakeholders queried the levy (which is currently 5%) and whether it could be decreased. The Australian Government Actuary has advised that:

- an important financial dynamic of the ROCS is the timing mismatch between the payment of ROC support payments and the emergence, payment and reimbursement of medical indemnity claims of eligible medical practitioners who are no longer in private practice
- ROCS applies to eligible medical indemnity claims that are first notified to the insurers or MDOs on or after 1 July 2004. The first ROC support payments were received on 30 June 2005
- as there is often a lag between medical incident and payment, most of the payments in relation to incidents already incurred have not been made. The discounted value of all future payments in relation to these incidents is estimated to be \$62 million at June 2016
- it is likely to take until about the mid 2020s to reach maturity when income from ROC support payments and expenditure on ROC indemnity payments are of a similar order of size, and
- to preserve the financial integrity of the ROCS, a system of notional accounting is maintained and reported.

Based on the advice of the Australian Government Actuary, no changes to the levy are recommended at this time. However, as discussed in Chapter 12 of this Report improved data collection and monitoring would enable deeper analysis of the Commonwealth exposure and future liabilities.

Application of ROCS to practitioners permanently retiring before age 65

Under the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* and related Regulations, an insurer must offer run-off cover to a medical practitioner who retires when they are under 65, on the same terms and conditions as their last cover (other than terms as to price).

In addition, the PSS contract provides that such cover must be offered to medical practitioners, that have held cover with the insurer (or the associated MDO) for 10 or more continuous years, for \$50 or less.

After three years of not engaging in private medical practice, the practitioner becomes eligible for ROCS and is no longer charged for run-off cover.

Under the current arrangements, the PSS-specific requirement (that caps the cost of run-off cover for three years) does not apply to insurers who have not entered a PSS contract. Nor does the requirement apply to practitioners with less than 10 years continuous cover.

The effect of this is that there is differential treatment of practitioners based on how old they are when they permanently retire and also based on the period of time for which they hold cover

before they retire. This differential treatment is relevant only for three years because if a person has not engaged in private medical practice for three years, they become eligible for ROCS (regardless of their age or number of years they have held cover).

If Government accepts the recommendation to cease PSS contracts, the contractual provisions relating to capping the price of run-off cover (for medical practitioners who have retired before the age of 65 and had continuous cover for 10 years or more) will cease.

Rather than replicating these requirements in law (and maintaining differential treatment of practitioners based on the age at which they permanently retire and their period of continuous cover) it is proposed that the ROCS eligibility requirements be amended such that practitioners who have retired permanently from private medical practice (regardless of their age) are eligible for ROCS, without needing to wait 3 years.

While this would increase overall ROCS liability it would also mean that all permanently retiring practitioners would be treated in the same way – ensuring protections for patients making claims against doctors after they permanently retire (but in relation to events that occurred while they were practising). It would also incentivise practitioners to retire if, regardless of their age, they are not able to practice including because of physical or cognitive decline.

Given the impact on overall ROCS liability, it is recommended that the impacts of this proposal be modelled by the Australian Government Actuary (and discussed further with the sector) prior to implementation. Consideration could also be given to any necessary transitional arrangements as well as ways to ensure that the changes only apply to practitioners permanently retiring (rather than those taking a break from practice and returning to practice).

Clarifying some claiming criteria

As for the HCCS, stakeholders have described a lack of certainty regarding the application of the ROCS in certain circumstances. It is proposed that where the underlying problem is uncertainty or lack of clarity in the law itself, this be addressed through amendments to the legislation. Otherwise the issues may be addressed by the Department offering policy clarity via a regular newsletter.

Chapter 9 – ECS

Context

The ECS caps the size of the claims for which insurers will be responsible. The ECS pays 100% of the cost of private practice claims that are above the limit of a medical practitioner's insurance contract (generally \$20 million), either as a single claim or an approved aggregate of claims that together exceed the threshold.

To date, there have been no claims made under the ECS.

Ongoing need, and support, for the ECS

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

While the scheme has not yet been called upon, the effect of the scheme is to provide protection to the public where claims exceed the upper limit of the insurance industry's capacity. The Australian Government Actuary has advised that the capacity of insurers and reinsurers has not recently been evaluated and as such the impact of any changes to the scheme (including the limit of \$20 million) cannot be determined.

It is recommended that the ECS be maintained as is, until such time as an evaluation of insurer/reinsurer capacity has been undertaken. This is discussed in more detail in Chapter 12 of this Report.

Issues and proposed treatments

Application of the ECS to health professionals

As for the HCCS, the ECS covers not just medical practitioners but also a broader class of health professionals.

Should Government agree to restrict HCCS eligibility to medical indemnity insurers in respect of claims arising from practice by medical practitioners, it is recommended that the same change be made in relation to the ECS.

Chapter 10 – IBNR Scheme

Context

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

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

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

The IBNR Scheme reimburses the full costs of claims that were incurred prior to 30 June 2002 by UMP (now a subsidiary of Avant), along with claims handling fees of 5% of the total claims costs.

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

As at 30 June 2017, the estimated outstanding liability of the scheme was \$26 million³². It is likely that claims will reduce each year for approximately the next 10 years and that the IBNR scheme will naturally terminate.

Ongoing need, and support, for the IBNR Scheme

Some insurers have represented to Government that the ongoing existence of the IBNR Scheme provides an unfair advantage to Avant in a highly competitive market and that Avant's balance sheet suggests that ongoing Commonwealth contribution is no longer necessary in order to ensure that IBNR claims can be met.

This issue was explored in detail in 2005 as part of the *Review of Competitive Neutrality in the Medical Indemnity Insurance Market*. As recommended by that Review, the Government required a competitive advantage payment to be made by Avant/UMP. The payment was designed to neutralise any competitive advantage Avant/UMP had, relative to other insurers, as a result of Government financial assistance under the IBNR scheme.

At that time, the Government considered the amount of the payment, it also considered the value of the IBNR liability and estimated it to be \$253 million at 30 June 2004.

³² Advice of the Australian Government Actuary.

In the absence of evidence to suggest that the Commonwealth's liability is likely to exceed this amount, it is not considered appropriate to revisit the need for a further competitive advantage payment to be made. Continuance of the scheme:

- ensures that claims incurred prior to 30 June 2002 can continue to be met (to the benefit of affected patients)
- delivers on Government's commitment made in 2002 and redefined in 2005 when a competitive advantage payment was made by Avant/UMP taking into account forward estimates of IBNR liability and the impact on the broader insurance market of the scheme, and
- continues to provide certainty for Avant/UMP noting the potentially destabilising effect of dramatic or immediate changes in Government policy (including, for example, the withdrawal of ongoing support for the IBNR scheme).

Issues and proposed treatments

No changes to the IBNR scheme are proposed.

With improvements to online claims and payment processes (as recommended in Chapter 12 of this Report) there are likely to be improvements to the administration of the IBNR. With such improvements, the cost to Avant/UMP of administering the scheme is also likely to decrease.

Following implementation of the DHS administrative changes (which will reduce the administrative burden associated with claiming), consideration could then be given to reducing the administrative fee paid to Avant/UMP (currently 5% of claims value).

Chapter 11 – MPIROC and MPIS

Context

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

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

There are two Commonwealth schemes to support indemnity insurance for privately practising midwives: the MPIS and the MPIROC. The schemes are offered by the one insurer (MIGA) who has a contract with the Commonwealth to deliver the schemes.

Under the MPIS the Commonwealth subsidises the cost of indemnity claims by paying 80% of the insurance pay out for those between \$100,000 and \$2 million and 100% of the insurance pay out for those exceeding \$2 million. Claims under \$100,000 are paid entirely by the insurer.

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

The contract with the insurer also requires the provision of affordable professional indemnity insurance to eligible midwives. The cost of the insurance is capped at \$7,500 per annum (as required by the Commonwealth) and is calculated based on the services provided and gross income of the midwife as follows.

Gross Income Band	Annual premium – Cover Option A (if providing Intrapartum Care)	Annual premium – Cover Option B (if not providing Intrapartum Care)
\$90,000 or more	\$7,500	\$3,400
\$70,000 - 89,999	\$6,500	\$3,000
\$50,000 - 69,999	\$5,000	\$2,250
\$25,000 - 49,999	\$3,375	\$1,530
Less than \$25,000	\$2,400	\$1,350

Ongoing need, and support, for the MPIROC and MPIS

The schemes were originally introduced to:

- expand the care options available to women, by subsidising premiums for privately practising midwives (to improve affordability for patients) and ensure protections for patients in the event that harm was caused and a successful claim was made, and

- as a short-term response, with the view that States and Territories would explore options for a professional indemnity product covering the full spectrum of midwifery services.

There is limited evidence that these objectives have been achieved.

- The available evidence does not support that private care options have expanded for women to the extent envisaged.
 - The number of midwives holding the Commonwealth subsidised indemnity product is lower than anticipated when the scheme was introduced. It was initially estimated that take-up would reach around 725 nationally³³. As at 30 June 2017, there were 183 policy holders accessing the MPIS.
 - Midwives insured by MIGA (and accessing the schemes) are not insured for homebirths. Of the 183 policy holders, 118 are insured to provide intrapartum care.³⁴ The remaining 65 policy holders do not provide intrapartum care but can provide antenatal and postnatal care.
 - While the majority of jurisdictions have policy frameworks that support privately practising midwives to access public hospitals, we understand that Queensland is the only state to have midwives credentialed to admit their clients and provide inpatient birth care in hospital.
- While there is the perception that privately provided midwifery services are high risk, the need for the scheme (in order to subsidise the high cost of claims) is not borne out by the limited evidence available to inform this Review.
 - Between 2010 and 2017 there have only been two claims made against midwives insured by MIGA (one in 2011-12 and one in 2016-17).³⁵ Neither of these reached the \$100,000 threshold for a claim to be made under the MPIS. Combined, the claims costs amounted to \$73,675 (with an incurred cost to MIGA of \$148,412).
 - Over the same period (2010-2017) there have been 15 legal expense only matters (not reaching the threshold) and 95 incidents reported to MIGA which have not yet led to a claim.³⁶
 - No payments have been incurred under the MPIS or MPIROC, since the inception of the schemes.
- The need for the scheme, in order to subsidise the high cost of premiums, is not well-established by the data.
 - As noted previously, the contract between the Commonwealth and the insurer caps the premiums paid by privately practising midwives at between \$1,350 and \$7,500 based on income.
 - The average premium has reduced from around \$3,500 in 2010-11 to \$2,300 in 2016-17.
- The exploration of alternative options for a professional indemnity product for midwives is not well progressed for the full spectrum of midwifery services.

³³ Department of Health, August 2017, *Discussion Paper – First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF*, p. 24.

³⁴ Information provided by MIGA to the Department of Health, February 2018.

³⁵ *ibid*

³⁶ *ibid*

- No resolution or comprehensive indemnity product for private midwives has yet been developed.
- The extent to which the schemes represent value for money for the Commonwealth is difficult to discern.
 - There is only one insurer that has contracted with the Commonwealth to offer the schemes.
 - The Commonwealth pays an administration fee to MIGA to offer the MPIS and MPIROC (\$235,000 for 2017-18). This fee is intended to cover the cost of administering the schemes for all midwives and MIGA's internal costs in managing claims and providing advisory and related services.

Issues and proposed treatments

As for the ROCS, funding for the MPIROC is via a levy and the cost to the Commonwealth of maintaining the scheme is therefore minimal.

Likewise, the overall cost to the Commonwealth of maintaining the MPIS is also minimal because there have been no eligible claims and the only ongoing liability to the Commonwealth is the administration fee paid to the one insurer that has contracted with the Commonwealth.

For these schemes, the more relevant question is whether the schemes continue to be necessary and whether in the absence of the schemes there would be an insurance market for privately practising midwives that offers premiums at an affordable price.

In relation to these schemes it is proposed that, over the next two years, further consultation be undertaken with the insurance industry and midwives (along with detailed examination of the sector and the information provided by the insurers) such that an informed decision can be made regarding the ongoing need for the schemes.

Based on the monitoring and exploration of the market, a decision can be made about whether the schemes be disbanded or, if there is an ongoing need for the schemes, expanding the schemes to cover all insurers of midwives (rather than legislatively restricting their availability to one contracted insurer).

In the interim it is not proposed that any changes be made to the scope of the schemes.

It is however recommended that any changes that are made to ROCS for medical practitioners, also be made in respect of MPIROC (where relevant). For example, any changes made to clarify eligibility and changes to enable MPIROC to apply to midwives permanently retiring before age 65.

Chapter 12 – Future administration, monitoring and reporting

Context

In addition to the changes recommended in relation to each of the individual schemes, it is also recommended that changes be made to the system of administration, monitoring and reporting to:

- improve efficiency
- increase transparency
- better enable monitoring
- enable ongoing engagement with the sector to inform improvement to the administration of the scheme and future policy directions, and
- reduce unnecessary burden on insurers and medical practitioners.

Administration

Communication and engagement

Both prior to and over the course of the Review stakeholders have sought clarity on the operation of the various schemes including eligibility requirements. For example, stakeholders have sought advice on:

- the application of the HCCS in circumstances where:
 - treatment is provided across public and private settings
 - there are multiple defendants
 - the practitioner is based overseas and provided the service from overseas, and
- the treatment of ROCS claims when a person returns to work after expecting to be permanently retired.

Stakeholders also emphasised the value of ongoing engagement with the Department and DHS including to:

- support the effective administration of the schemes
- quickly resolve issues that may be impacting more than one insurer
- contribute to the policy development process, and
- share information about the insurance environment.

In its audit of 2016, the ANAO identified that the Department did not have an overarching communication or engagement strategy to support the administration and monitoring of the IIF schemes.

Since then the Department has developed a strategy but has advised that this will be reviewed and updated in line with the outcomes of the Review and taking into account any reform package agreed by Government.

As has been acknowledged by the Department, strong and ongoing communication with stakeholders will be critical as any reforms are developed and implemented.

IT systems

Currently the IIF system of administration relies heavily on manual applications by insurers and manual assessments by DHS. Data systems have limited capacity to send data extracts to relevant agencies and to use data to inform effective monitoring of the schemes.

Should Government agree to the continuation of the schemes as recommended, it would be highly desirable for system changes to be made to reduce regulatory burden, improve efficiency, enable more timely payments to be made, improve data quality and consistency, and enable more effective monitoring and reporting.

Features of any new system could include:

- a web-based interface for insurers to engage with DHS on all schemes
- a single online application for all medical indemnity schemes including relevant authentication/security measures
- capacity to accommodate large files and receive data uploads
- automated determination of over/underpayments made under the PSS
- automated reminders to insurers regarding payment timelines
- capacity to link a unique practitioner and/or insurer ID to claims (such an identifier may be consistent with that used by APRA)
- capacity to send data extracts from DHS to relevant agencies such as the Department of Health, the Australian Government Actuary and APRA, and
- regular and consistent reporting.

This recommendation is also consistent with that made by the ANAO in 2016 that the Department establish suitable controls to improve data integrity.

Monitoring and reporting

Much of the data referenced in this report has been provided by the Australian Government Actuary.

To inform this advice, the Australian Government Actuary has relied on data sources including data collected through existing mechanisms (facilitated by the administration of the IIF), financial reporting for the IIF, APRA monitoring of regulated insurers, the National Claims and Policies Database (NCPD) and published annual reports of medical indemnity insurers.

While the data enables high level and generalised statements to be made about medical indemnity insurance and the IIF, it does not enable detailed consideration of the impacts if the schemes were withdrawn entirely or scaled back significantly. Nor does the data enable more sensitive measurement of, for example, the adequacy of the ROCS levy, whether Government subsidies to insurers are being passed on to medical practitioners by way of more affordable premiums and

whether alternative funding mechanisms are available and might be effective to reduce the cost of the HCCS to government whilst continuing to support industry stability.

In order to address this, it is recommended that the Department extend the monitoring of the IIF beyond the existing financial monitoring to monitor the performance of the IIF against its objectives and to monitor the Commonwealth's current liabilities and ongoing exposure to risk. This would improve transparency and establish a strong basis for assessing future refinements of (or other changes to) the schemes.

This is consistent with the 2016 recommendations of the ANAO that the Department develop and implement a fit-for-purpose monitoring and reporting arrangement for the IIF, medical indemnity legislation, and related schemes that provides the relevant Minister with timely, robust analysis of the IIF's performance and risks to Government (ANAO recommendation 2).

As part of any new monitoring framework:

- consideration could be given to addressing the range of data inconsistencies and to enable consistent reporting to be applied across all APRA, NCPD and IIF data. For example, by establishing a standard data dictionary that could be developed, in conjunction with insurers and APRA
- the scope of data that is currently collected could also be reviewed with the objective of supplementing and streamlining existing data collection processes. This would be completed in consultation with APRA, insurers and the Australian Government Actuary, and
- consideration should be given to a single reporting mechanism such that instead of the Australian Government Actuary providing discrete reports for different schemes there could be one consolidated report relating to the operation of the IIF.

Chapter 13 – Summary of recommendations and next steps

Should the Government wish to continue its current contribution to medical indemnity, a number of changes could be made to the schemes to improve efficiency, better target the schemes, increase transparency, better enable monitoring and reduce unnecessary burden on insurers and medical practitioners.

These proposed changes are included in the table at Attachment A.

If Government is seeking to gradually reduce the level of Commonwealth support (and achieve cost savings), further changes could be considered following the implementation of the monitoring framework and taking into account the outcomes of further consultation. Consideration could be given to:

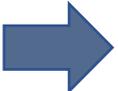
- restricting eligibility for the PSS such that medical practitioners earning over a certain income in annual private billings (for example, \$500,000) would not be eligible for the PSS
- whether there is an ongoing need to cap premiums paid by privately practising midwives and to subsidise the cost of high claims (noting the absence of any high claims to date and the potential for other insurers to enter the market), and
- introducing a levy in association with the HCCS such that the Commonwealth's contribution is steadily reduced, without increasing volatility to insurers and without disproportionately impacting smaller insurers and new entrants.

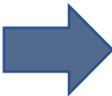
Should Government agree to the Review recommendations, it is proposed that:

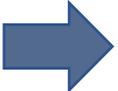
- the Department work closely with the sector to co-design the implementation detail. The Department could convene a regular meeting of key stakeholders (for example, every three months) to discuss implementation options for the reforms, review progress on the reforms and consider any changes needed to legislation and/or contracts (noting standard Government constraints relating to sharing of information subject to Government/Parliamentary consideration), and
- the changes arising from the Thematic Review progress as part of the reforms recommended by this First Principles Review

As legislation will require amendment (and an IT system will require development), a 12 to 24 month timeframe for some reform elements would be realistic. A reform package could commence from mid-2019, with some phasing-in of changes depending on the Government's preferred reform package.

Attachment A – Summary of Review recommendations

Scheme	Existing		Reform
Across all schemes	Minimal monitoring capacity. Limited capture and use of data.		1. Co-design and implementation of a monitoring framework to enable more effective and transparent monitoring and reporting.
	Manual processes and limited IT interface.		2. Comprehensive IT system changes to enable online claiming, payments and data management.
	Opportunities for improving communication around eligibility and claims requirements.		3. Enhanced communication with insurers and other stakeholders to clarify eligibility and claims requirements. Where lack of clarity arises from the law itself, amend the legislation to clarify and reflect policy intent.
PSS	PSS described in legislation and contracts. Contracts dated and unnecessarily prescriptive. Only eligible practitioners insured by contracted insurers can access the PSS.		4. Discontinue contracts for PSS and legislate necessary requirements (noting that unnecessary reporting can be reduced). Enables all eligible medical practitioners to access the PSS.
	PSS subsidy paid monthly to insurer based on fee estimates of private income with adjustments made and multiple touchpoints with DHS. Where income is underestimated and subsidy overpaid, DHS reduce payments to insurers but insurers must recover from medical practitioners. Medical practitioners have limited visibility of Government support.		5. DHS pays the PSS subsidy directly to eligible medical practitioners via a single annual reimbursement based on estimate of income. Where income over or under estimated, adjustments made in the following year.
	Insurers receive a monthly administration fee for administering the PSS (costing \$1.4 million in 2015-16).		6. By DHS paying the PSS subsidy directly to medical practitioners, this removes the need to pay insurers an administration fee (and further reduces the need for a PSS contract).

Scheme	Existing		Reform
	Some grandparented participants (who previously participated in the MISS – a scheme closed in 2004) are eligible for PSS (or to a higher subsidy) regardless of the value of their premium relative to income. This creates inequity between different classes of medical practitioners.		7. MISS participants subject to same eligibility requirements and PSS subsidy as other PSS participants.
	Rural and remote practitioners eligible for PSS regardless of income but definition of rural/remote is from 1994.		8. Retain existing eligibility requirements for rural and remote practitioners but amend definitions of rural/remote to reference the Modified Monash Model (reflecting Government policy announced in 2014).
<i>Universal cover</i>	Universal cover obligations are described in PSS contracts so only apply to insurers who have contracted with the Commonwealth and offer PSS.		9. De-link universal cover obligations from PSS and create universal cover obligations in legislation.
	Obligations have been allocated to insurers based on distributing responsibility for States/Territories. No capacity to re-distribute universal cover obligations for new or existing insurers, and uneven distribution of obligations.		10. Reset universal cover obligations by replacing State-based insurer of last resort arrangements with a requirement that each medical indemnity insurer must offer medical indemnity cover to any medical practitioner who seeks it.
	Insurers able to charge a 100% risk surcharge to reflect the prior claims history or other particular circumstances of that practitioner.		11. Where the claims history or particular circumstances of the medical practitioner increase the risk to the insurer, the insurer may charge a loading/surcharge. Its value (and circumstances in which it may be applied) should be developed with stakeholders in accordance with principles identified by this Review. Legislation should expressly prohibit the charging of the loading/surcharge where the risk is consistent with that of the class of practitioners as a whole. Where the medical practitioner is dissatisfied with the premium charged by the insurer they may seek review by FOS.

Scheme	Existing		Reform
HCCS	Pays 50% of the cost of eligible claims over the threshold.		<i>No changes recommended.</i>
	As a result of previous Government decisions, the threshold for HCCS will increase from \$300,000 to \$500,000 from 1 July 2018.		<i>No further changes recommended (continue with previously announced change from 1 July 2018 and monitor impact).</i>
	While the objects of the legislation refer to support for medical practitioners, the wording of the HCCS provisions has meant that claims have been made by insurers of health professionals.		12. Clarify the eligibility criteria for the HCCS such that the scheme only enables claims by medical insurers in respect of medical practitioners (consistent with the original intent of the HCCS).
	Uncertainty regarding some circumstances in which Commonwealth will pay claims and evidential requirements.		13. Clarify eligibility and claims requirements.
ECS	Pays 100% of the cost of private practice claims that are above \$20 million.		<i>No changes recommended (no claims have been made under the ECS to date).</i>
	As for the HCCS, the wording of the ECS provisions means that claims could be made by insurers of health professionals.		14. Clarify the eligibility criteria for the ECS such that the scheme only enables claims by medical indemnity insurers in respect of medical practitioners (consistent with the original intent of the ECS).
ROCS	Costs of the ROCS are recovered from medical practitioners via a levy which is collected by insurers. Some have argued that the levy should be lowered as the Commonwealth is recovering in excess of the cost of the ROCS.		15. Retain levy at current level but improve monitoring to enable re-assessment of the appropriateness of the levy in five years.
	Practitioners over 65 who permanently retire can access ROCS. Those under 65 must cease practice for three years before accessing ROCS. If their insurer has contracted with the Commonwealth for the PSS, the insurer must offer run-off cover at \$50 per year for the three years until they		16. Enable access to ROCS for practitioners permanently retiring before age 65. This would also remove the need for PSS-specific differential charging for run-off cover for such practitioners who have had continuous cover with the insurer for 10 years.

Scheme	Existing		Reform
	<p>become eligible for ROCS. The requirement to cap the cost of cover does not apply to insurers who have not entered a PSS contract.</p>		
	<p>Uncertainty regarding some circumstances in which Commonwealth will pay claims and evidential requirements.</p>		<p>17. Clarify eligibility and claims requirements.</p>
<p><i>IBNR</i></p>	<p>Historical scheme, naturally terminating within 10 years.</p>		<p><i>No changes recommended.</i></p>
<p><i>MPIS and MPIROC</i></p>	<p>The schemes subsidise the premiums and high cost claims of eligible privately practising midwives. The absence of reliable data (and a single provider of the schemes) means that proper assessment of value to the Commonwealth and midwives (and the need for the schemes) is not possible.</p>		<p>18. Undertake further consultation and monitoring to assess the capacity of the market to insure midwives at an affordable price. Based on outcomes, the scheme could be disbanded or if there is an ongoing need for the scheme, expanded to apply to all insurers of midwives (rather than legislatively restricting scheme availability to one contracted insurer).</p>
	<p>Uncertainty regarding some circumstances in which Commonwealth will pay claims and evidential requirements.</p> <p>Midwives permanently retiring before 65 must cease practice for three years before accessing the ROCS.</p>		<p>19. Changes to:</p> <ul style="list-style-type: none"> • ensure alignment with proposed changes to ROCS, by enabling access to the MPIROC for midwives permanently retiring before age 65 • clarify eligibility and claims requirements, and • simplify evidential requirements to support a claim.

Bibliography

Legislation

Act	Instrument
Medical Indemnity Act 2002	<i>Medical Indemnity (IBNR Claims) Protocol 2006</i>
	<i>Medical Indemnity (Unfunded IBNR factor - United Medical Protection Limited) Determination 2003</i>
	<i>Medical Indemnity (Non-participating MDOs) Determination 2003</i>
	<i>Medical Indemnity (UMP support payment exemption) Regulations 2006</i>
	<i>Premium Support Scheme 2004</i>
	<i>Premium Support (Medical Indemnity Provider) Scheme 2006</i>
	<i>Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006</i>
	<i>Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006 (No.2)</i>
Medical Indemnity (Prudential Supervision and Product Standards) Act 2003	<i>Medical Indemnity (Prudential Supervision and Product Standards - Notice of Provision of Run-off Cover) Determination 2007</i>
	<i>Medical Indemnity (Prudential Supervision and Product Standards - Terms and Conditions for Run-off Cover) Determination 2004</i>
	<i>Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003</i>
Medical Indemnity (Run-off Cover Support Payment) Act 2004	<i>Medical Indemnity (Run-off Cover Support Payment) Regulations 2008</i>
Medical Indemnity (UMP Support Payment) Act 2002	<i>Medical Indemnity (UMP Support Payment) Regulations 2004</i>
Medical indemnity (Competitive Advantage Payment) Act 2005	<i>Medical Indemnity (Competitive Advantage Payment) Regulations 2005</i>
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010	<i>Midwife Professional Indemnity (Commonwealth Contribution) Scheme Rules 2010</i>
Midwife Professional Indemnity (Run-off Cover Support Payment) Acts 2010	<i>Midwife Professional Indemnity (Run-off Cover Support Payment) Rules 2010</i>
Medical Indemnity Agreement (Financial Assistance—Binding Commonwealth Obligations) Act 2002	<i>No instruments</i>

Reports and additional resources

Advice from Australian Government Actuary

Advice received from insurers, medical practitioners, peak bodies and others

Attorney-General's Department, December 2006, *Improvements in liability insurance following tort law reform in Australia*, CanPrint Communications

Australian Government Actuary, 2017, *Sixth report on the costs of the Australian Government's Run-off Cover Scheme for midwife professional indemnity insurers*

Australian Government Actuary, 2017, *Twelfth report on the costs of the Australian Government's ROCS for medical indemnity insurers 2015-16*

Australian Health Insurance Commission, 2005, *Health Insurance Commission Annual Report 2004-2005*

Australian Institute of Health and Welfare, 2014, *Australia's medical indemnity claims 2012-13*

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

Australian Prudential Regulation Authority, *General Insurance Institution-level Statistics*, as analysed by Australian Government Actuary

Centre for International Economics, 2017, *Impact analysis of the Premium Support Scheme prepared for the Department of Health*

Contracts between the Department of Health, the Department of Human Services and insurers

Confidential information provided by insurers and others

Department of Health Annual Report 2015-16

Department of Health, August 2017, *Discussion Paper – First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF*

Department of Human Services Annual Report 2016-17

Explanatory Statements for Bills establishing and reforming the IIF

Medical Indemnity Policy Review Panel, 10 December 2003, *Affordable, Secure and Fair: Report to the Prime Minister*

Medical Indemnity Policy Review Panel, 2007, *Achieving stability and premium affordability in the Australian medical indemnity marketplace*

Medicare Australia Annual Report 2007-08

MIGA, 1 July 2017, Insurance for Eligible Midwives in Private Practice Combined Financial Services Guide and Product Disclosure Statement

MIGA, 1 July 2017, Insurance for Eligible Midwives in Private Practice Professional Indemnity Insurance Policy

National Commission of Audit, 2014, Towards Responsible Government - Appendix to the Report of the National Commission of Audit - Volume 2

National Health Workforce Dataset, Health Professionals 2016

Nursing and Midwifery Board of Australia, April 2016, Guidelines for professional indemnity insurance arrangements for midwives

Parliament House, 23 October 2002, Transcript of press conference: new medical indemnity insurance

Press releases relating to the establishment and reform of the IIF

Submissions received from stakeholders

Summary documents, diagrams, data, reports and emails provided by the Department