

# 1. INTRODUCTION

1.1 This report has been prepared to comply with certain requirements of the *Medical Indemnity Act 2002* (Medical Indemnity Act). Section 34ZW of the Medical Indemnity Act provides for a report on aspects of the Run-Off Cover Scheme (the Scheme) to be tabled each year in Parliament. The report is required to contain a statement of the:

- number of persons eligible for membership of the Scheme;
- total Run-Off Cover indemnity payments (ROC indemnity payments) paid by the Commonwealth during the financial year, including claims handling and administration expenses;
- total Run-Off Cover support payments (ROC support payments) paid to the Commonwealth during the financial year; and
- projected liabilities of the Scheme in future financial years.

1.2 This is the seventh report that has been prepared under section 34ZW of the Medical Indemnity Act. It relates to financial year 2010-11. The sixth report was tabled in Parliament on 21 June 2011.

# 2. BACKGROUND

## 2.1 Medical indemnity insurance

2.1.1 Medical indemnity insurance is a form of professional indemnity insurance. It covers practitioners for their professional negligence.<sup>1</sup>

2.1.2 Doctors who undertake private medical practice in Australia generally purchase medical indemnity insurance from private sector underwriters.<sup>2</sup> This report considers the five private sector underwriters operating in Australia during 2010-11. Figure 1 below illustrates the market shares of the five private underwriters calculated on the basis of premium data provided by them.

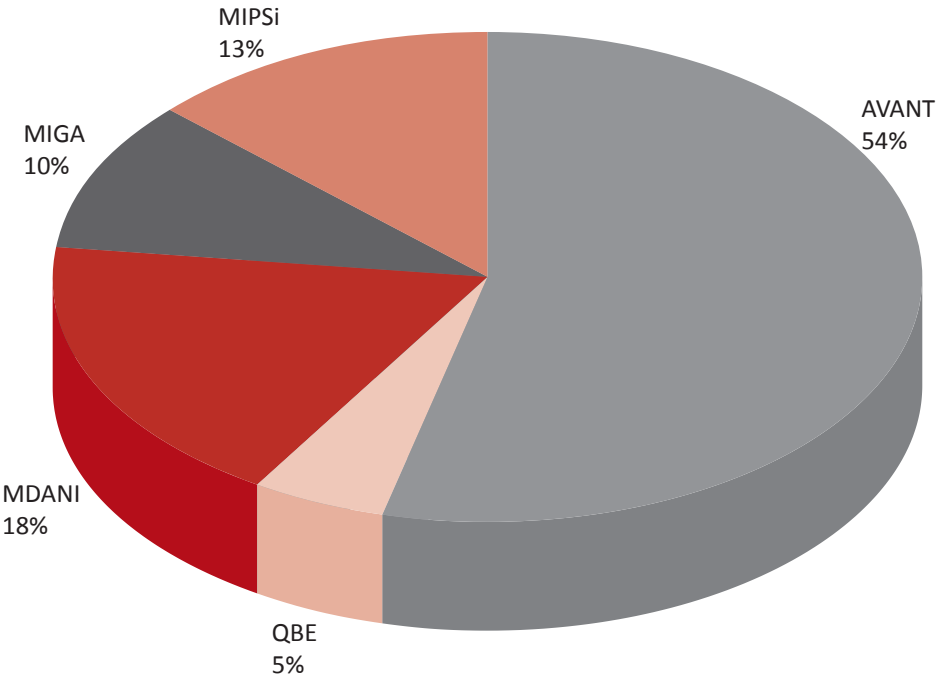
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1 Medical indemnity insurance can also cover other costs such as those associated with appearing at coronial inquiries.

2 On the other hand, many employed practitioners such as doctors practising solely in a public hospital will be indemnified by their employer against negligence.

2.1.3 The five private underwriters operating in Australia during 2010-11 were Avant Mutual Group Limited (Avant), MIPS Insurance (MIPSi), MDA National Insurance (MDANI), Medical Insurance Group Australia (MIGA), and QBE Insurance (Australia) Ltd (QBE).

**Figure 1: Market share of medical indemnity insurers**



2.1.4 Note that the owners of Australasian Medical Insurance Limited (AMIL) and Professional Indemnity Insurance Company Australia (PIICA) — United Medical Protection and Medical Defence Association of Victoria — merged on 1 July 2007 to become Avant Mutual Group Limited. Avant Insurance Limited succeeded AMIL as the provider of medical indemnity insurance to Avant members.

2.1.5 Medical negligence claims are initiated by, or on behalf of, patients against doctors. Roughly 2,000 claims of negligence might be expected each year in relation to private medical practice in Australia. However, there can be substantial variation from one year to the next. It is difficult to project the number of medical indemnity claims with any precision. A significant number of claims will be successfully defended.

2.1.6 The cost of medical negligence claims is highly variable since the claims relate to bodily injury. The cost of a medical negligence claim to the insurer is made up of damages which are payable to the plaintiff, any of the plaintiff's legal costs which the insurer is obliged to pay, and the insurer's own costs of defending and managing the claim. While most claims are finalised for less than \$100,000, a small number of claims are large. Perhaps 5 per cent 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 per cent of the cost of all medical indemnity claims relates to claims which are larger than \$500,000.

2.1.7 The medical indemnity claim process can be long. Years can elapse between the date of a negligent medical incident and the date that legal action against the practitioner is initiated. It is not unusual for claims to take a number of years to finalise after they have been initiated. It is common for the whole process to take more than five years for a single claim. The cost of a claim depends significantly on economic and judicial conditions prevailing at the time the claim is finalised (paid), rather than at the time of the medical incident or the time that the claim is made.

2.1.8 All of these factors make medical indemnity insurance difficult for an insurer to underwrite. It is hard to forecast claim numbers and claim sizes reliably. Moreover, much of the cost is likely to relate to a small minority of the claims, which adds further uncertainty. As a result, it is difficult to know how much premium to charge and how much money to hold in reserve to pay claims. For these reasons a robust private market in medical indemnity insurance requires professional and disciplined underwriting and management.

## **2.2 Brief history of private medical indemnity insurance in Australia — the lead-up to the Run-Off Cover Scheme**

2.2.1 Historically, medical indemnity cover was provided to Australian doctors in private practice by medical defence organisations (MDOs). MDOs were not licensed insurers and were therefore not subject to prudential regulation.

2.2.2 Medical indemnity cover was originally provided to practitioners on a so-called 'claims-occurring' basis. Practitioners were protected against claims that might be made in relation to the medicine that they had practised while members of the MDO. Thus, practitioners who had claims made against them after retirement could seek assistance from their MDO provided that they had been members at the time of the medical incident. Medical indemnity is difficult to underwrite on a 'claims-occurring' basis, partly due to the often long delay between the date of medical incident and the time at which a claim is initiated.

2.2.3 During the 1990s most MDOs came under financial pressure as a result of increasing levels of claim payments and were forced to make calls on their members for additional funds.

2.2.4 At the same time, most MDOs progressively changed the basis of their cover from 'claims-occurring' to 'claims-made'. In simple terms, claims-made cover provided protection for the practitioner against claims that were made during the period of membership. Thus, in order to continue to be covered against claims that might emerge in relation to past medical practice, a doctor had to continue his

MDO membership. Professional indemnity insurance is generally provided on a 'claims-made' basis.

2.2.5 In 2002, Australia's largest MDO, United Medical Protection, was placed in provisional liquidation. Following this, steps were taken to stabilise the medical indemnity industry.

2.2.6 Since 1 July 2003, medical indemnity insurance has been required to be provided to Australian practitioners by insurers licensed under the *Insurance Act 1973* and prudentially supervised by APRA.

2.2.7 This has ensured a more disciplined approach to underwriting and has reduced the risk of failure of a medical indemnity provider.

2.2.8 Consistent with more disciplined underwriting, all medical indemnity insurance is now provided on a 'claims-made' basis. Consequently, doctors have to maintain insurance in order to remain covered against claims that might emerge, even if they are no longer practising. This form of insurance cover is known as run-off cover. Put simply, run-off cover provides insurance protection for doctors who have ceased medical practice. The potential delay between a medical incident and a claim highlights the need for doctors to maintain run-off cover after ceasing practice.

2.2.9 For some doctors the annual cost of medical indemnity insurance runs into the tens of thousands of dollars. In order to address problems associated with the cost of run-off cover, including the potential threat to the provision of medical services, a scheme was established which requires medical indemnity insurers to provide free run-off cover to certain groups of doctors who have ceased private practice. The Scheme was intended to be largely cost neutral to taxpayers whilst not threatening the viability of the insurance companies. This scheme is known as the Run-Off Cover Scheme.

## **2.3 What is the Run-Off Cover Scheme?**

2.3.1 The Scheme facilitates the provision of free medical indemnity insurance cover to particular groups of doctors who have ceased private medical practice.

2.3.2 The rules for the Scheme appear in the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (PSPS Act), the *Medical Indemnity (Run-off Cover Support Payment) Act 2004* (MI ROCSPA) and the *Medical Indemnity Act 2002*. The principal elements of the Scheme are as follows:

- The PSPS Act imposes an obligation on insurers to provide free run-off cover to particular groups of doctors who have ceased private practice.

- The Medical Indemnity Act provides for the Commonwealth to make payments to the insurers to reimburse the costs of eligible run-off claims. These payments are known as ROC indemnity payments.
- The Medical Indemnity Act provides for the Commonwealth to make other payments to insurers to offset the relevant costs of administering the Scheme that are incurred by insurers.
- The Medical Indemnity Act also provides for the insurers to make payments to the Commonwealth to ensure that the Scheme is largely cost-neutral to taxpayers. These payments are levied as a tax on insurers' premium income. In practice, the cost is met by a loading on practitioners' medical indemnity insurance premiums. These payments are known as ROC support payments. The MI ROCSPA sets out the rules for calculating ROC support payments.

2.3.3 The Scheme provides for ROC support payments to be made by medical indemnity insurers to the Commonwealth and for ROC indemnity payments to be made by the Commonwealth to medical indemnity insurers (MIs) and MDOs. Ancillary arrangements provide for payments to cover other costs such as administrative costs.

2.3.4 Amendments to the primary legislation were passed late in 2006 which simplified the administration of the Scheme. Protocols governing certain administration payments to insurers are now in place.

2.3.5 An important financial dynamic of the Scheme is the timing mismatch between the payment of ROC support payments by MIs and the emergence, payment and reimbursement of medical indemnity claims of eligible doctors who are no longer in private practice. The first ROC support payments were received on 30 June 2005. The Scheme applies to eligible medical indemnity claims that are first notified to the MIs or MDOs on or after 1 July 2004. As a result of inherent delays in the medical claims process, it is to be expected that the level of ROC support payments will be substantially greater than the level of ROC indemnity payments for a number of years. That is, in a cashflow sense, the Scheme is at a reasonably immature stage. It will probably take about 20 years to reach maturity when income from ROC support payments and expenditure on ROC indemnity payments are of a similar order of size. To preserve the financial integrity of the Scheme, a system of notional accounting is maintained and reported on in section 4 of this report.