MDA National
Support Protect Promote

13 October 2017

Ms Kate Medwin
Director, Medical Indemnity Section
Australian Government Department of Health

By email at: Medical.indemnity@health.gov.au

Dear Ms Medwin,

Re: First Principles Review of the Indemnity Insurance Fund

MDA National Limited and MDA National Insurance Pty Ltd thank the Department for an opportunity to comment upon the matters outlined in the Discussion Paper dated August 2017. Our comments are included in the following three pages.

If you have any questions or would like any further information please contact me at

Yours sincerely

Dianne Browning
Company Secretary & General Counsel

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The MDA National Group is made up of MDA National Limited ABN 67 055 801 771 and MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417 AFS Licence No. 238073.

1. Summary

The Federal Government introduced an Indemnity Insurance Fund (IIF) in the early 2000's, thanks to which a number of schemes (the Schemes) were put in place to stabilise a medical indemnity sector which was undercapitalised and in crisis in NSW. The Schemes have been successful. Medical Practitioners, while practising, now enjoy choice of insurer in a healthy and competitive industry and long term protection after ceasing practice.

While financial stability of the sector was the immediate goal of the IIF, the underlying purpose was, and in our view, remains affordable indemnity insurance for doctors which flows to more affordable care and financial protection for doctors and ultimately patients.

As part of the current review, the Schemes under the IIF are all being reviewed.

While the legislation and administration around the Schemes is complex, sometimes uncertain, and in some cases not operating in a competitively neutral manner and we look forward to the review in those regards, the Schemes themselves have provided and continue to provide valuable support to the medical profession and the community. Removal or significant reduction of Scheme support will inevitably lead to premium increases in the short term. The medical claims environment in Australia has been relatively stable over recent years. This, together with the support of the Schemes, has enabled insurers to limit the level of premium increases and to build capital buffers to cover claims. This has enabled them to become the healthy organisations they are which support medical practitioners to support the community with the practice of medicine. A change in that environment, if coupled with reduction of government support, could, in the longer term, risk the stability which has been so hard won.

We submit that any changes to MII legislation and the Schemes should be directed at reducing complexity, increasing administrative efficiency, improving competitive neutrality and focused mainly on community outcomes.

2. Premium Support Scheme (PSS)

MDA National supports the PSS being retained at its current level. While its usage has diminished it remains important in managing cost for those practitioners operating in high risk specialties and for low income practitioners, particularly outside metropolitan areas.

We also submit that the PSS should be accessible to all eligible practitioners regardless of whether their insurer has entered into a contractual arrangement with the Department or not. Tying the PSS to universal cover obligations creates a disincentive for some insurers to participate. This not only effectively reduces the availability of the Scheme but has an illogical impact on the competitive landscape i.e. those insurers who work with the Department to administer the Scheme for the benefit of eligible practitioners are subject to additional quasi-regulation, including by way of universal cover obligations, which may result in increased cost for other insureds. Insurers who choose not to participate are not able to offer access to their eligible insureds but retain greater underwriting freedom to price for, and to refuse, risk.

This anomaly arises when implementation of the scheme relies on voluntary entry into services contracts. As part of this general review we recommend close consideration of whether access to the PSS may better be implemented through legislation, consistent with other Schemes, to ensure all eligible practitioners may both access the Scheme and retain freedom of choice in their selection of insurer.

From an administrative perspective the advance nature of payment of the PSS based on an estimation of income is burdensome and involves double handling following receipt of the actual data. We would welcome simplification of the PSS payment method.

3. PSS ancillary obligations and universal cover

Entry into a services contract with the Department enables access to the PSS but imposes a number of obligations on participating insurers. While undertaken by insurers individually by way of contract these obligations are inextricably linked to the IIF and the medical indemnity suite of reforms as a whole. We refer to our earlier comment on the anomaly this creates both for practitioners and for insurers.

Universal cover obligations are designed to ensure individual registered medical practitioners are able to obtain indemnity cover. The obligations operate to require insurers to make offers of insurance, even when normal underwriting criteria would militate against this. The requirement to make an offer of insurance appears to operate even when a former insurance contract has been terminated appropriately under the Insurance Contracts Act. Undertaking risk in such a circumstance appears justified only in the case where it is necessary to fulfil important public policy.

The circumstances which indicate that a practitioner poses an extreme risk to insurers may in some cases, in our experience, also indicate a high risk to patient safety and the community. Universal cover, in its current form, sometimes serves to mask that risk as it limits the role of insurance in providing a risk signal to the insured and community more broadly.

We support the Government conducting a comprehensive policy review but submit that it not only considers the benefits of ensuring access to practitioners in inherently high risk specialties but whether the public policy objective is served by the unintended but associated risk to patient safety which may be a consequence of the universal cover requirement in its current form.

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

We support the continuation of the HCCS and ECS. These play a role in minimising the impact that large claims may have on the ability of insurers to continue to provide affordable cover. Significant reductions in the HCCS are likely to have more impact on premiums for practitioners in inherently high risk specialties for example obstetrics.

While large commercial insurers participate in the industry, the majority of providers of indemnity cover to individual medical practitioners in Australia are practitioner-owned mutuals. This structure is particularly successful where a deep understanding of medical practice is crucial to effective claims and risk management. The structure however also limits size and access to capital. The current claims environment is relatively stable. While all providers are well capitalised, in the circumstance

of a significant adverse movement in the claims environment or of a cluster of high value claims the Schemes will be extremely important in supporting financial stability in the industry.

From an administrative perspective the HCCS recovery process is extremely complex and unnecessarily time consuming. The documentation and level of detail required by the Department of Human Services is often impractical and may result in lengthy delays in payments. Minor clerical errors with no impact on the amount recovered can, in our experience, result in significant delays in processing. We support amendment to the Medical Indemnity Act to enable a process which is simpler and more effective for both the insurer and the government.

5. Run-Off Cover Scheme (ROCS)

We support the retention of the ROCS but submit that it is timely that the government consider the level of the ROCS levy and the level of sufficiency required to fund future liabilities.

We together with other industry participants will be happy to assist with any endeavour to provide sufficient data to forecast future liabilities, so that the levies on insurers can be better aligned with the current and future costs of the Scheme.

From an administrative perspective ROCS could be simplified and provide greater clarity for scheme administration. Elements of the ROCS are contained in both the Medical Indemnity Act and Medical Indemnity (Prudential Supervision and Product Standards) Act. Consideration should be given to combining these two Acts.