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Medical Indemnity Agreement (Financial
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Bill 2002

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I N F O R M A T I O N A N D R E S E A R C H S E R V I C E S

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Medical Indemnity Agreement (Financial Assistance-
Binding Commonwealth Obligations) Bill 2002

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Medical Indemnity Agreement (Financial Assistance-Binding Commonwealth Obligations) Bill 2002

Date Introduced: 26 June 2002

House: House of Representatives

Portfolio: Revenue and Assistant Treasurer

Commencement: Royal Assent

Purpose

To provide a legislative basis for the payment of Commonwealth obligations made under a Medical Indemnity Agreement.

Background

Insurance markets

While this Bill is confined to the agreement to provide assistance to United Medical Protection Limited (UMP) and its wholly-owned subsidiary Australasian Medical Protection Limited (AMIL), a few brief comments regarding the general public and professional liability insurance markets are necessary to place the medical industry in context.

The first major shock to the Australian insurance and reinsurance markets came when HIH Insurance filed for voluntary liquidation on 15 March 2001, although there had been pressure for premium increases prior to the demise of HIH. While the reasons for HIH going into voluntary liquidation are currently being examined by a Royal Commission, significant reasons for an \$800 million interim half-year loss have been reported as overseas losses, the acquisition of FAI Insurance and unprofitable premium rates.¹ The second major shock to the insurance markets occurred on September 11 2001 when the World Trade Centre towers were destroyed. This was/is the largest insurance event in history and not only stretched the industry's resources but also led to a recalculation of the risk/reward position which resulted in increased premiums.

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A recent industry survey by Deloitte Touche Tohmatsu and JP Morgan (the survey) found that: ‘In our view, the industry’s resolve to improve its risk/reward position has been the greatest driver of the increase in premium rates.’² It was also noted that the industry has only made an insurance profit in 3 of the past 7 years even though the industry was profitable for each of the years due to income from other sources, such as investments.³

The survey also reveals that while domestic insurance (vehicle and household) have increased at a steady rate since 1993 and that statutory insurance (compulsory third party-CTP- and workers’ compensation) have, on average, increased substantially in this period, commercial insurance, including professional indemnity, on average fell in at least 4 of the 9 years under consideration since 1994 (including an estimate for June 2002 increases). For example, professional indemnity insurance, which applies to the medical profession as well as other groups, increased by 6% in 1994, fell by 2%, 9%, 18% and 12% in the years 1995 to 1998, and increased by 2%, 12% and 23% in the years 1999 to 2001. They are estimated to rise by an average 20% in June 2002.⁴ The same pattern is evident in liability insurance.

Another way of looking at current insurance premiums is on an inflation adjusted basis. If 1993 premiums for all classes are taken to be \$100, the following average rates apply for the rates after the estimated June 2002 increases:

Domestic: Motor	\$132
Household	\$114
Commercial: Property	\$69
Motor:	\$89
Liability	\$90
Professional Indemnity	\$85
Statutory: CTP	\$229
Workers’ compensation	\$144 ⁵

What is apparent from these figures is that commercial insurance received very favourable treatment during the late 1990s when there was oversupply and fierce competition for commercial insurance. Even substantial increases since 2000, including the estimate for 2002, will leave average commercial premiums below the real level paid in 1993. While there are cases where premium increases have been substantially above the average, it is perhaps surprising that average commercial premiums have not increased more over recent years rather than the fact that they have increased by the extent that they have.⁶

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UMP/AMIL Difficulties

Prior to its demise, UMP/AMIL was the largest medical insurer in Australia with coverage of approximately 60% of medical practitioners nationally and 90% in NSW and Queensland.⁷ A brief history of UMP/AMIL shows that:

- UMP was created from the NSW Medical Defence Union in 1997 and pursued an aggressive market growth strategy.
- On 24 November 2000 UMP announced at its annual general meeting that it would call on members to contribute an extra years subscription, spread over 5 years (estimated to total \$75 million⁸), and that premiums would increase by 8%.⁹
- Following HIH Insurance seeking voluntary liquidation in March 2001, the Chief Executive of UMP is reported to have stated that ‘UMP has applied a “worst case scenario” to its current balance sheet and had found that it continued to exceed the industry regulator’s (APRA) solvency requirements.’¹⁰
- In June 2001 UMP announced that it had written off \$30 million due to the collapse of HIH, with the figure being based on a return of 46c in the dollar. At this level of return UMP was confident that it could continue to satisfy APRA’s requirements. However, it was also reported that no calculation had been made if there was no return from HIH in which case the loss would be \$56 million.¹¹
- In November 2001 it was reported that UMP had not recorded approximately \$455 million of incurred but not reported (IBNR) claims which it expected to pay over the next 20 years. Reportedly the IBNR claims were not included as UMP would have a discretion as to whether to pay them and legal liability would not arise until that discretion was exercised.¹²
- On 12 December 2001 UMP is reported to have announced substantial premium increases with average increases of 52%. The increases were higher for some specialists, such as obstetricians and neurosurgeons (increases are reported to have ranged from 36% to 123%). The increases were justified by increased reinsurance costs and some recent very high payments.¹³
- APRA announced on 27 February 2002 that after appointing an Inspector to AMIL it was directing AMIL to raise additional capital by 30 June 2002 to ensure that it met the minimum capital requirements under the *Insurance Act 1973*.¹⁴ Reportedly AMIL’s capital had fallen from \$118 million on 30 June 2001 to \$38 million at the end of the year and APRA directed that this be raised to \$68 million by 30 June 2002.¹⁵
- On 28 March 2002 the Ministers for Health and Aging and for Revenue and the Assistant Treasurer jointly announced that the Government would provide a short-term guarantee of up to \$35 million to enable AMIL to meet its capital requirements on 30

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June 2002. The announcement followed a meeting with representatives of AMIL on 26 March 2002.

- In April 2002 UMP sought further government assistance, including assistance to enable the directors to get personal liability insurance. Reports of the assistance requested ranged from \$12 million for the Directors insurance, to \$100 million to enable new capital requirements to be met, and to \$350 million to enable AMIL to continue to provide insurance cover.¹⁶ It was reported that in a letter to UMP the Prime Minister stated: ‘...in light of the continued deterioration in the Group’s financial position, the government has decided that it would be inappropriate to provide the assistance you have sought.’ The Prime Minister also noted that should UMP and AMIL go into provisional liquidation the government would work urgently with the liquidator to ensure members were covered while a long-term solution was developed.¹⁷
- On 29 April 2002 UMP/AMIL announced that it would seek to have a court appoint a provisional liquidator to the group. The provisional liquidator was actually appointed on 3 May 2002 and indicated that the priorities would be to determine whether the companies were solvent and had the ability to continue trading. The provisional liquidator also stated:

My primary responsibility is to produce the best possible result for creditors of the companies, who include people with existing future claims against members of UMP, as well as the companies’ employees and trade creditors.¹⁸

Government Response

The Minister for Revenue and the Assistant Treasurer had already indicated on 29 April 2002 that the government would work with the provisional liquidator to prevent any disruption of medical services and to ensure that doctors are protected between ‘now and 30 June 2002’. It was also indicated that the period could be used to enable medical practitioners to seek alternative coverage.¹⁹ The Minister subsequently announced that following a meeting with the Australian Medical Association (AMA) the government would:

- immediately confirm with the provisional liquidator that the government would guarantee claims arising from any medical procedure provided between 29 April and 30 June 2002 by doctors currently covered by UMP/AMIL
- legislate by 30 June to give effect to the guarantee, and
- would work with the provisional liquidator to determine the extent of long-term claims, assets and liabilities of UMP/AMIL and whether it is a viable long-term concern.²⁰

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However, the governments initial reaction did not satisfy all groups. In relation to doctors insured with UMP, the AMA stated that:

- if UMP goes into liquidation there is currently no guarantee that all existing claims, past claims not yet reported and claims that may arise between today [30 April] and 30 June 2002 will be fully covered
- the government's purported guarantee to cover claims arising between 29 April and 30 June 2002 has no legal force as no government can bind a future government, and
- the government is indicating that it may pass legislation to protect UMP doctors for the 29 April – 30 June period and, while this could be repealed by a future government, a clear Act of Parliament would be a much stronger guarantee than a press release.²¹

The AMAs concerns about the nature of the government's guarantee led to some medical practitioners deferring patient treatment and cancelling operations due to uncertainty about their insurance coverage. The Minister for Revenue and the Assistant Treasurer subsequently wrote to doctors and doctors groups to explain the government's position but this did not satisfy all groups and disruptions continued. Subsequently, carriage of the matter was transferred to the Minister for Health and Ageing who announced on 1 May that she was writing to doctors to explain why they should have complete faith in the government's guarantees for coverage for the period 29 April to 30 June 2002. The Minister's Statement also stated that the Royal Australian College of GPs and the AMA had accepted the guarantees and recommended to their members to return to normal practices.²² Patient treatment largely returned to normal following this action.

The next step was for the provisional liquidator to seek court approval for the government guarantee which would enable payments to be made by AMIL. However, on 24 May 2002 the judge hearing the matter found a flaw in the proposed arrangements under which some unsecured creditors would be disadvantaged compared to others. The matter was finally resolved when the NSW Supreme Court gave approval for the arrangements on 11 June 2002, including their extension to 31 December 2002 (see below).

Meanwhile, on 31 May 2002 the Prime Minister announced further details of the arrangements to provide assistance to UMP/AMIL and potentially other insurers. Major features of the Prime Minister's announcement were:

- For UMP/AMIL the guarantee to cover payments for claims finalised and incidents occurring between 29 April and 30 June 2002 would be extended to 31 December 2002 for claims made under an existing or renewed policy.
- For IBNR (incurred but not reported), the government will assume responsibility for claims for which there is no adequate provisioning and will recoup the funds paid through a levy on members of Medical Defence Organisations (MDO) which have not fully provided IBNRs:

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- the levy will be spread over an extended period, at least 5 years, to spread payments and make them affordable
 - members of MDOs will be required to contribute to the extent of the unprovided for IBNRs of their MDO, and
 - the scheme will also be used to fund the extension of the guarantee given to UMP/AMIL noted above.
- The Prime Minister also outlined a longer term strategy to assist in making medical insurance a viable commercial product. Major elements were envisaged to be:
 - the removal of NSW legislation provisions which provide a cap on premiums for higher risk specialists
 - developing arrangements, including possible direct government assistance, to assist the payment of premiums for higher risk specialists
 - working with the States to provide greater certainty in the size of likely claims, including tort law reform, encouraging structured settlements, improved claims management and better risk assessment, and
 - bringing the insurance business of MDOs into the prudential framework for general insurers.

It was envisaged that the measures would be in place by 31 December 2002 following consultation with States and Territories, medical practitioners and the AMA, commercial insurers and MDOs.²³

The Prime Minister's proposals were subject to some criticism. The AMA has been critical of the proposal to impose the levy on members of MDOs (ie medical practitioners), with the President of the AMA reported as stating that doctors would not be prepared to pay the levy unless there were substantial reforms in place.²⁴ In an address to the National Press Club the President of the AMA sought urgent responses from the government regarding a number of matters, including:

- national reform of the laws of negligence 'with as a minimum the return of the Bolam test (ie where the 'standard of reasonable care' for purposes of negligence is set by the medical profession rather than the courts)
- consistent tort law reform in all States and Territories
- a national Statute of Limitations of 3 years for adults and 6 years for minors (currently the period can run for a maximum of 21 years)
- removing Medicare benefits and hospital costs from awards, and

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- a community-funded national care and rehabilitation scheme. Such a scheme would be government funded, provide services for long-term care of severely injured people and contain an impairment threshold, with claims below the threshold being dealt with through an non-adversarial mechanism.

In addition, the President of the AMA argued that the proposed levy should be postponed until tort law reform was introduced in every State and Territory and the national care and rehabilitation scheme was introduced. The President of the AMA also stated:

As a community we need to put an end to the notion that patients have the basic right to sue their doctors. That does not appear in any human rights charter.²⁵

It may be noted that the common law of negligence is not based on any human rights charter but applies equally to all circumstances.

The proposal to change the laws of negligence in the medical and public liability areas has been criticised by leading lawyer groups. The Law Council of Australia (LCA) has commented that the problems with medical insurance are not problems with the legal system but with the insurance industry. LCA identified problems with the insurance market as having arisen from:

- losses of international insurers following national disasters, including that of 11 September 2001
- declining investment returns for insurance companies
- the collapse of HIH Insurance
- poor premium pricing in previous periods, and
- financial strictures imposed by new APRA prudential standards.

The LCA also suggested a number of insurance reforms, including:

- the creation of buying groups and pools
- temporary government support in extreme cases, such as UMP or not for profit insurance, and
- relaxing or moderating the impact of new APRA standards.²⁶

In direct response to claims by the AMA, the LCA stated that:

The AMA should stick to the facts. The AMA shouldn't try to win political points by frightening people. The problems with medical insurance for doctors has resulted largely from the management of the doctor's own insurance scheme, rather than from the injured patients suing doctors.

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Dr Phelps [the President of the AMA] and the doctors' lobby consistently misrepresents the way in which the legal system deals with cases of medical negligence. The reality is that courts are very loath to interfere with the judgement that doctors exercise in treating patients. They only do so where there is clear evidence that a doctor has failed to meet proper professional standards or has not properly informed their patients of the consequences of a particular course of treatment.²⁷

Main Provisions

Clause 3 contains definitions of:

- **Insolvency representative:** this covers a wide range of positions which may be involved in insolvency administration, including liquidators or provisional liquidators, a receiver, an administrator or a trustee administering an arrangement between a company and another person.
- **Medical Indemnity Agreement:** an agreement between the Commonwealth, UMP, AMIL and an insolvency representative of those companies, and includes an amended agreement between the parties.

The Commonwealth will be obliged to pay to AMIL and/or UMP or their insolvency representative amounts required to be paid under a Medical Indemnity Agreement. The Commonwealth will also be obliged to make payments to any other person as required under a medical Indemnity Agreement (**clause 4**).

Clause 5 will appropriate the funds needed for payments under clause 4.

If a payment is made during a financial year the Minister is to have a report on the payment/s prepared and this report must be tabled in each House of Parliament within 15 sitting days of the completion of the report (**clause 6**).

A copy of a Medical Indemnity Agreement is to be tabled in each House of Parliament within 15 sitting days of the later of the Bill receiving Royal Assent and the agreement entering into force. Similarly, any amendment to such an agreement must also be tabled (**clause 7**).

Clause 8 makes it clear that a Medical Indemnity Agreement may contain provisions relating to matters other than indemnities.

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Concluding Comments

Although rarely directly mentioned, much of the discussion regarding medical indemnity insurance is the question of who should pay when a person is injured through a doctors negligence. Proposals for government funded schemes to provide long term care and restrictions on the ability to sue doctors seek to transfer the cost from doctors and their insurance companies to the government and injured patients. However, if higher indemnity insurance costs are passed on to patients, as they are likely to be, then the wider community will bear the additional cost as may the government if the Medicare rebate is increased to cover the additional cost and help preserve bulk billing. Similarly, the wider community will bear the cost if medical services, especially highly specialised services, are restricted in their availability due to high insurance premiums. While the wider community and governments would appear to be in the best position to bear part of the additional costs as the impact would be widely spread and have a relatively small financial impact on each individual, the transfer of the cost to individuals by restricting the right of injured people to sue or by restricting the availability of some services would involve a small number of people bearing a significant individual cost.

An interesting aspect of the Bill is that a Medical Indemnity Agreement need not be tabled until after the Bill has been passed and received the Royal Assent. While a final agreement between the Commonwealth and UMP/AMIL may not yet be in place (though it may have been finalised) the agreement endorsed by the NSW Supreme Court is in place and it would seem reasonable that this agreement be tabled prior to debate on the Bill so that some idea of the final guarantees given by the government can be ascertained.

Endnotes

- 1 *Australian Financial Review*, 17 and 30 March 2001.
- 2 Deloitte Touche Tohmatsu and JP Morgan, *2002 Interim Insurance Survey*, Executive Summary.
- 3 *ibid.*
- 4 *ibid.*
- 5 *ibid.*
- 6 In relation to the use of average premium increases the executive summary to the survey comments: 'While massive premium increases have become the focus of the media and politicians, it is more relevant to examine the average change in premium rates.'
- 7 *Joint Media Release*, Ministers for Health and Aging and for Revenue and Assistant Treasurer, *Australian Financial Review*, 30 April 2002.
- 8 *The Canberra Times*, 24 June 2002.

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- 9 *The Sydney Morning Herald*, 28 November 2000.
- 10 *The Australian Financial Review*, 27 April 2001.
- 11 *The Australian Financial Review*, 22 June 2001.
- 12 *The Australian Financial Review*, 1 November 2001.
- 13 *The Australian*, 13 December 2001.
- 14 Australian Prudential Regulatory Authority, *Media Release*, 27 February 2002.
- 15 *The Australian Financial Review*, 28 February 2002.
- 16 See *The Australian Financial Review*, 23 April 2002 and *The Australian* 24 April 2002.
- 17 *The Sydney Morning Herald*, 24 April 2002.
- 18 United medical Protection, *Media Release*, 3 May 2002.
- 19 Minister for Revenue and the Assistant Treasurer, *Press Release*, 29 April 2002.
- 20 Minister for Revenue and the Assistant Treasurer, *Press Release*, 30 April 2002.
- 21 AMA, *Daily Update from Secretary General*, 30 April 2002.
- 22 Minister for Health and Aging, *Statement*, 1 May 2002.
- 23 Prime Minister, *Medical Indemnity Insurance*, 31 May 2002.
- 24 *The Australian Financial Review*, 15 June 2002.
- 25 AMA, *Media Release*, 17 July 2002
- 26 Law Council of Australia, *Media Release*, 8 August 2002.
- 27 Law Council of Australia, 2 August 2002.

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