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Medical Indemnity – Who’s Got the Perfect Cure?

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Abstract

The paper looks at how medical indemnity is provided in several international jurisdictions, considers the cultural context within which the different approaches evolved, the challenges faced abroad and within Australia, and the transferability of any innovative solutions or successful features from one jurisdiction to another.

Keywords: medical indemnity framework; protection of health professionals; international approaches; transferability.

1 Introduction

Much has happened in the medical indemnity arena over the last decade. In Australia, we have gone through the crisis of increasing litigation, increasing claims costs and premiums, the provisional liquidation of the largest medical indemnity provider and its emergence from provisional liquidation, and a flurry of tort law reform and Government assistance measures. We have now had a few years of relative stability, in terms of claims costs and premiums, with average premiums in fact reducing over each of the past five years [ACCC, 2009].

Does this mean we have now struck the right balance between a system that is cost effective, delivers appropriate redress to the victims of medical accidents, and best serves the medical profession and community at large? Is our system a beacon to the world, or is it a fragile one whose survival is at the mercy of ongoing government subsidies and the continuing effectiveness of tort reforms? What are the attributes of a successful system? And what is our report card now?

To contemplate these questions, we first take a step back and look at what medical indemnity is, how it evolved and what purposes it is meant to serve, who the stakeholders are and what core approaches to the delivery of medical indemnity are taken in modern economies around the world (*Section 2*).

We then focus on Australia and look at the major events framing medical indemnity provision in the present day (*Section 3*).

The medical indemnity crisis was not unique to Australia. Many countries have experienced difficulties at various times since the early 2000’s with escalating claims and costs, and hampered confidence in the healthcare system. We considered that it would be interesting and instructive to look at the issues that have arisen recently in a selection of countries, and the range of ways each has coped with their respective challenges. We look out for any innovative features or solutions in each system and, whilst recognising each nation’s unique social and political circumstances, ponder their effectiveness in an Australian context (*Section 4*).

We then allow ourselves the indulgence of venturing our opinion on what we consider to be the measures of a successful system, and the features of a scheme that best serves the community. What is Australia’s scorecard by these measures? (*Section 5*).

At the very least, it is hoped that our research may help us to consider Australia’s ‘place in the world’ and, from that, be more able to constructively evaluate our own system and policy directions.

2 Features of medical indemnity systems

2.1 What is medical indemnity?

Medical indemnity refers to the system for redress of adverse health care outcomes arising from medical treatment in which standards of care are breached. It provides a framework to be followed for health care professionals and their patients in the event of a breach or perceived breach of a given standard of care, and a system for compensation of injured patients. It is recognised that medical indemnity forms only one part of the complex health care delivery system. Nevertheless, a functional medical indemnity system, or medical liability protection mechanism, is an essential component of any effective health care delivery system in modern economies.

Medical indemnity systems essentially serve three related purposes:

- Covering the liabilities of medical practitioners and health organisations;
- Compensating victims of injuries sustained from medical procedures; and
- Deterring medical malpractice.

The delivery of medical indemnity differs vastly between jurisdictions, in relation to funding practices, levels of coverage, concepts of accountability, burden of proof and claim triggers. Medical liability models have evolved differently in various countries to meet particular needs, and within the context of the wider health and social policy framework of each country. Additionally, each nation’s choice of model and its development are influenced by its unique social history, cultural, economic, legal and political environment.

These differences are evidenced in the array of wordings used in the different countries to describe the medical indemnity compensation system, including compensation for medical “malpractice”, “error/fault”, “negligence”, “misadventure”, “avoidable and adverse events” or simply “treatment injury”. Unfortunately large numbers of people suffer complications from medical treatment and adverse medical outcomes. Only a small percentage of these adverse outcomes are due to negligence, fault or error by the medical practitioners and in most of the countries discussed in this paper this must be proven before compensation is awarded. No-fault systems of compensation have the potential for greatly increased cost.

2.2 Some characteristics of medical indemnity

From an actuarial perspective, it is perhaps appropriate to start by mentioning the *long tail* nature of medical indemnity. Most substantive medical malpractice claims would take several years (potentially more than five years) to settle from occurrence of the injury. Each claim involves several stages from discovery of the malpractice, to filing of the claim, establishing the rights to compensation and financial responsibilities, agreement to settle or go to trial (in tort based jurisdictions), through to actual payment of the claim. This in itself makes the prediction of potential losses and the setting of appropriate premium rates a challenging task. Legislative changes and other government initiatives or interventions over the past decade to meet crises in availability and affordability have added to this complexity.

Medical malpractice is often a highly *emotive* subject. For the injured patient and family, they may feel grief, disappointment, possibly outrage at what they see as a failing on the part of the health care professional involved; this might be exacerbated by the rigours of the claim process and stringent defences mounted by the medical professional or their insurer. For any lawyer on

Medical Indemnity – Who’s Got The Perfect Cure?

the case, their perspective will be to pursue what they see as appropriate compensation for a medical wrong on their client, and a viewpoint may be that aggressive pursuit of medical errors may be a means of motivation for safer health care practices. The medical practitioner concerned, on the other hand, who may have dedicated many years of their life in the care of the sick, may feel emotionally hurt and their professional reputation tarnished by what they see as an honest and forgivable mistake. Insurers, private or public, in vigorously defending a case, will be focusing on cost containment and maintaining the financial sustainability of the system. All of this can provide for a highly explosive environment.

The Hon Justice Michael Kirby, in an address to the Royal College of Physicians, London [Kirby, 2000] summed up the complexities, “As is usually the case, neither side has a monopoly of wisdom. Each side makes valid points. Each party is voicing reasonable perspectives. One lesson that is quickly learned as a judge is that complex problems rarely yield simple solutions ...Strategies that work must be based on sound empirical data, not on intuition, emotion, assumptions or self-serving catch-cries.”

The last point to mention here is that sustainable health care financing has long been a subject of global concern. The medical indemnity landscape has been characterised by a cycle of unsustainable spending growth followed by fervent cost control initiatives over the past half-century. Most recently, a *major medical indemnity crisis* unfolded worldwide in the early 2000’s. In many developed nations including Australia, the United States and several European countries, premium rates for medical malpractice insurance had been rising steadily for some years, resulting in a crisis regarding the availability and affordability of cover. This raised wider concerns over adverse effects on health care quality, patient safety and the sustainability of the overall system.

Any solutions to the crises were made more difficult by divided opinion on the main causes, with suggested factors including:

- Increasing litigiousness of the public, fuelled by media coverage providing greater awareness of the possibility of suing for damages;
- Corporate consolidation of health care resulting in loss of the intimate family-doctor relationship;
- The judicial system, with lawyers being blamed for eagerness to bring malpractice suits with its attendant fees, as well as juries becoming desensitised to increasing quantum of awards;
- Wider publicity and dramatisation of medical errors leading to greater distrust of the medical profession;
- New disease patterns, more expensive technology, and so forth.

Since then, various initiatives have been adopted or at least considered by different nations to deal with the crises, depending on each nation’s unique circumstances, with varying outcomes. We discuss these further in Section 4.

2.3 Who does the system serve?

A well-functioning and effective medical indemnity system would be of interest to:

- **Patients (and their families)** – who are the beneficiaries of the system and who would obviously want to minimise the risk of adverse events, and in such event, receive appropriate compensation for the injury suffered;
- **Health care professionals and establishments** – for whom the maintenance of a robust system is an important contributor to their ability to provide care, including a

Medical Indemnity – Who’s Got The Perfect Cure?

process that ensures their rights are appropriately represented in the event of claim, and also the accessibility to and affordability of cover;

- **Governments (federal, state, regulators)** – representing the broader public interest, and who are responsible for ensuring that resources are applied optimally in the delivery of an efficient and financially sustainable health care system, setting appropriate legislation, and encouraging cooperation between the various stakeholders in achieving these aims. In privately underwritten markets, the government would have responsibility for creating a level playing field between insurers, and ensuring available and affordable coverage for each type of health care professional.

Other stakeholders in the system include insurers (in jurisdictions with private underwriting) and lawyers (primarily in systems with common law).

Whilst we would not expect anyone to argue with the fundamental goals of a medical indemnity system, as articulated in Section 2.1, cost constraints do mean limits have to be imposed around access, distribution and levels of compensation. This provides potential for contention amongst the stakeholders. One challenge in developing a successful medical indemnity framework is in recognition of the different stakeholder concerns and perspectives, providing an appropriate forum for ensuring fair hearing of all viewpoints and finding the right balance between these competing interests.

2.4 Core approaches to medical indemnity around the world

Each society makes decisions in relation to the extent it provides redress to injured patients, and the scheme structure under which it delivers this redress. Whilst the main purposes may be similar, the delivery of medical indemnity differs vastly between jurisdictions in several respects. The core differences in relation to the various approaches to provision of medical indemnity undertaken around the world include:

- Choice between tort liability system or ‘no fault’ scheme;
- Funding sources;
- Coverage, and level of compensation benefits;
- Degree of burden of proof.

We discuss these further below.

Tort-based or no-fault models?

The first fundamental difference in approach relates to whether medical indemnity is provided under a *tort-based compensation model* or a “*no fault*” model. Essentially, a tort-based system relies on the Court process to determine negligence and consequent compensation. “No-fault” compensation schemes on the other hand do not require a determination of negligent practice in order to award compensation, but only the substantially weaker conditions of causation (i.e. the trigger for compensation arises from establishing that an injury resulted from treatment and that it was avoidable). Welfare systems have an even weaker eligibility criteria, providing automatic compensation for an injury.

Countries with a common law system, such as Australia, the US and the UK, have traditionally relied on the tort system to handle negligence cases, including medical malpractice. There is, nevertheless, considerable variation both within and between these countries as their particular set of common law has evolved separately. Schemes based solely on causation exist in several countries, most notably in Nordic European countries (Sweden, Denmark, Norway, Finland) and New Zealand. New Zealand is notable as being the only common law country with a

Medical Indemnity – Who’s Got The Perfect Cure?

comprehensive no-fault scheme. *Hybrid fault/no fault models* also exist in some countries, such as France where a no-fault system is in place for injuries resulting in invalidity of at least 25%, or in Florida and Virginia for neurologically impaired children.

Arguments for a tort system are that:

- It provides a clear process for determining whether the physician provided the expected standard of care, and therefore acts as a deterrent for malpractice;
- Appropriate compensation levels can be determined by the Courts for individual cases;
- It is a socially acceptable means of airing the retributive feelings of injured patients; and
- Costs may be lower than for no-fault systems as a result of its more restrictive coverage, particularly in eliminating more minor cases that may be put off pursuing a claim by the prospect of litigation.

The arguments in favour of no-fault schemes, on the other hand, are that:

- Compensation is more uniformly applied, without a potentially lengthy and stressful legal battle with its uncertain outcomes;
- Consequently the time to receipt of compensation is shorter;
- More funds go directly towards the patient’s care rather than to expensive litigation (court fees, lawyers’ fees, paid expert witnesses) and administration;
- Benefits are mostly provided in the form of ongoing care, rather than as lump sums, with its associated risks of mismanagement and subsequent insufficiency to meet future medical and related costs;
- The criticism against no-fault schemes not providing sufficient deterrence for poor medical practice can be overcome by the establishment of a separate physician accountability framework and deterrence mechanism (separate from the compensation function); and
- In any case, the evidence is not straightforward that the fear of liability alone under the tort system is a sufficient deterrent.

Funding sources

The financing of medical indemnity in different jurisdictions come from a varying combination of public and private sources. These include traditional private insurers, medical defence organisations, mutual companies or provider-owned groups, and government (state/federal). In privately insured markets, premiums would usually be payable by medical practitioners or their health care establishments. Government funding in some jurisdictions may be available (for particular specialties or where premiums exceed a certain threshold) by way of reimbursements or subsidies to premiums (e.g. Premium Support Scheme in Australia). Countries where most health care provision is financed by the state tend to rely less on private insurance, but instead have medical liability provided directly by the state through dedicated funds. Examples of this include the National Health Service Litigation Authority which administers the Clinical Negligence Scheme for Trusts in the UK, or the Accident Compensation Commission in New Zealand. State funds effectively come from general taxes on the working population and so the cost of claims is actually shifted to the whole taxpayer community.

Coverage and compensation levels

Who should pay when a claim is awarded against a doctor? Historically, in an insured market, the answer has been the insurer with whom the doctor had a policy at the time of the incident. This type of policy is known as a “*claims-occurred*” policy. This places a large burden on

Medical Indemnity – Who’s Got The Perfect Cure?

private medical indemnity insurers, since they may face claims that occurred decades in the past against a practitioner with whom they no longer possess a current policy.

As a result, there has been a large push in recent times to change the answer to be whomever the doctor has a policy with at the time of the claim. This so-called “*claims-made*” cover limits the insurers’ exposure. By experience rating their members, insurers can, to some extent, control for incidents that occurred before the policy was enacted, though they typically supply separate cover for incurred but not yet reported (known as IBNR) claims dating from before the practitioner joined the insurer. The practitioner, however, is in a less rosy situation: upon retirement, it is the practitioner who will be sued and who must cover any subsequent costs for incidents that occurred while they were practicing. Clearly, it is not desirable for practitioners to become uninsured after retirement – a large claim is likely to bankrupt them and leave the victim with little or no compensation. Accordingly, cover for these claims must be provided either by the retired doctor purchasing run off cover, or the state providing the run off cover. In Australia, for example, the cost of run off claims are covered by the state, but funded out of levies on the premiums of working practitioners.

In systems with a high administrative overhead, it is undesirable for small claims to be addressed individually as the administrative cost often far outweighs the compensation. Various mechanisms are in place for washing small claims out of the system. These include *deductibles* as well as *minimum levels of injury* before a patient can seek compensation.

There are two broad categories of loss for which a patient may seek compensation – *economic and non-economic losses*. Economic losses are those that have a direct and quantifiable impact on the patients’ economic situation. These include treatment costs as well as loss of future earnings. In contrast, non-economic losses are those that are not directly quantifiable, but still have an impact on the patient’s quality of life. This includes losses related to physical and emotional trauma.

Recently, there has been a large growth in awards for non-economic losses across several countries. One of the most common, and controversial, tort-reform measures seeks to place *caps* on the amount that can be awarded for non-economic loss. Proponents of such caps often argue that excessively large payouts in individual cases threaten the solvency and affordability of the scheme as a whole. Opponents say that such caps are inequitable, as a patient judged to deserve a payment below the cap receives the full amount, whereas one judged to deserve an amount above the cap only receives part of the amount.

Several countries also allow the possibility of suing for punitive damages in cases where malicious intent can be shown. The exercise of this option depends largely upon the litigiousness of the community concerned and the extent of the broader social safety net.

Burden of proof

The criteria that a patient needs to meet when making a claim varies between systems. The three main possibilities are:

1. **Welfare system.** The patient is automatically compensated for the injury.
2. **No-fault system.** The patient needs to show that the injury was caused by the medical treatment.
3. **Negligence based system.** The patient needs to show that the injury was caused by the medical treatment and that the practitioner acted negligently.

The last structure, namely negligence based systems, is the most common. “Negligence” usually coincides with a departure from peer-accepted practice. No-fault systems are comparatively rare, with schemes in existence in New Zealand, Sweden, Norway, Denmark and

Medical Indemnity – Who’s Got The Perfect Cure?

Finland. Pure welfare systems are non-existent within the strict confines of medical indemnity payments, although countries such as Sweden have a comprehensive social welfare program that will compensate a victim for any sustained injury or illness.

Sample of approaches in different countries

The following table sets out a summary of the approaches undertaken in a selection of countries:

Table 1: Selection of international approaches

Country	Legal System	Decision Basis	Fault Based	Funding Source	Features
US	Common	Proven and presumed error	Yes	Mutual companies, captives	Generally occurrence based, caps on non-economic costs in 28 states
UK	Common	Bolam test and balance of probability	Yes	NHSLA, Medical Defence Organisations for private practitioners and Lloyds market for unusual risks	Occurrence basis, compulsory indemnity
Canada	Common	Proven error	Yes	Canadian Medical Protective Association covers 95% of practicing physicians	Occurrence basis, no caps
Sweden	Civil (Scandinavian)	Causation	No	Mutual insurance company of the county councils covers 95% of market	Occurrence basis, cap of \$730,000 per claim
Netherlands	Civil (Roman-Dutch)	Proven error	Yes except for clinical trials.	Hospitals covered by 2 mutuals, individuals by 5 private companies	Claims made basis, individual cap of Eur 1.25m/claim; Eur 2.5m/year
New Zealand	Common	Causation	No	ACC, limited market for tort cover	Occurrence basis

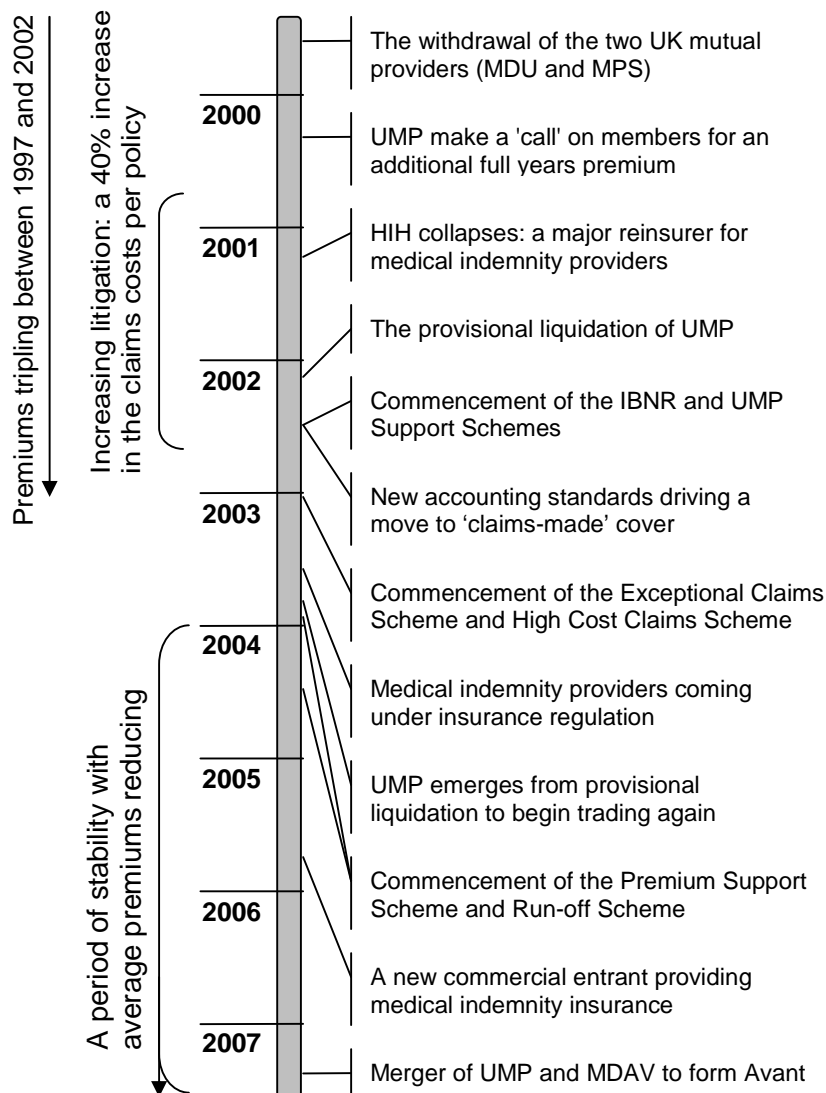
In the following section, we discuss the recent history of the Australian medical indemnity market.

3 Focussing on Australia

3.1 Timeline of significant events

So much has happened in the Australian medical indemnity landscape over the past decade that one can hardly stop to breathe! The following figure provides a timeline of the significant events.

Figure 1: Timeline of significant events in the Australian medical indemnity landscape



3.2 Background

Funding and responsibility for the delivery of health care in Australia is from three main sources:

- The Federal Government;

Medical Indemnity – Who’s Got The Perfect Cure?

- The state and territory governments; and
- The private sector (comprising a combination of health insurers, individuals and compensation schemes).

The responsibility and payment for medical indemnity cover for doctors to a great extent reflects the way delivery of a particular medical service is funded. The Federal Government’s tax-payer funded Medicare system provides payment for medical services provided “privately” by doctors in settings outside the public hospital system. These include private hospitals and doctors’ own surgeries, and within public hospitals when the patient has elected to be a private patient. The Federal Government subsidises private health insurance via premium rebates and tax incentives to take out private health insurance. Roughly 44.6% of Australians hold private hospital insurance, with approximately 40% of all surgery being performed in private hospitals. In the types of health care settings described above, a doctor is responsible for their own medical indemnity cover. As at 30 June 2008 there were five authorised providers of medical indemnity insurance in Australia with total gross premium revenue of \$306m in 2007-2008 [ACCC, 2009].

The states and territories are responsible for the funding and management of public hospitals and employ and contract doctors to work in these institutions. The states and territories now provide medical indemnity cover for their employees and contractors for the treatment of public patients via state administered funds such as the Treasury Managed Fund (TMF), which is a self-insurance scheme owned and underwritten by the NSW Government. TMF has covered visiting medical officers for their treatment of public patients since 2002.

In most states, with the exception of Queensland and the Northern Territory, it is a condition of medical registration that doctors hold approved professional indemnity insurance or can prove that they are an employee of a public health organisation or are covered by another indemnity arrangement (such as TMF cover). The planned system of national registration and accreditation will introduce a consistent approach to this requirement.

3.3 History towards reform

Until the end of the 1990’s most doctors were provided with medical indemnity protection by medical defence organisations (MDOs) which operated as not-for-profit mutuals owned by their members. Although some mutuals had captive insurance vehicles, which issued insurance policies to members, most of the indemnity provided to members was on a claims occurrence discretionary basis, although some claims made cover was offered from 1997.

In common with international [OECD, 2006] and local personal injury claims trends, from the mid-1990’s the medical indemnity industry in Australia was experiencing an increase in the frequency and severity of claims. Between 1995 and 2005, medical indemnity premiums rose by an average of 13% per annum [Attorney-General’s Department, 2006]. A competitive MDO industry culture meant that premiums, although rising, were probably curtailed by competition as by the late 1990’s and 2000, annual premiums were lower than annual claims costs with a decrease in capital across the industry. Throughout the 1990’s and in 2000 certain high-risk medical specialties, especially neurosurgery and obstetrics, had very steep increases in premiums due to MDOs introducing more sophisticated risk rating methods rather than the old mutual model of one rate for all [Attorney-General’s Department, 2006].

Medical Indemnity – Who’s Got The Perfect Cure?

In 2000, the largest provider of medical indemnity cover in Australia, United Medical Protection, advised its members that there would be a call on its members equivalent to a full year’s additional premium [Bain, 2001]. Most of its membership was in NSW and Queensland and its national market share was over 50%.

A perfect storm was brewing. The HIH group of companies, a major reinsurer of United Medical Protection, other MDOs and their insurers, collapsed in March 2001. The NSW State Government introduced tort reform specific to medical indemnity when the Health Care Liability Act 2001 (NSW) was introduced on 5 July 2001. The Act was prospective and the reforms were announced well ahead of its introduction. There was a dramatic increase in the number of claims filed in NSW in the months between announcement of the reforms and the Act’s introduction and the number of high cost claims increased markedly [Medical Indemnity Policy Review Panel, 2005]. The destruction of the World Trade Centre Towers on September 11 2001 and the resultant downturn in financial markets completed the damage to United Medical Protection’s capital and it was placed into provisional liquidation in May 2002 [Medical Indemnity Policy Review Panel, 2005].

The resultant potential supply crisis in the medical indemnity industry coupled with ongoing significant increase in premiums led to the introduction by the Federal Government of a framework of reforms specific to the medical indemnity industry [ACCC, 2009]. The simultaneous liability insurance crisis limiting availability and affordability of insurance, particularly public liability and professional indemnity insurance, meant that wider reforms needed to be introduced. In conjunction with the Federal Government, all state and territory governments reached an accord in November 2002 to introduce tort reform on a consistent basis and as a matter of priority.

3.4 Medical indemnity specific reforms

Funding Schemes

The Federal Government introduced a range of funding schemes between 2002 and 2004 all of which remain operational in 2009 [ACCC, 2009], with a number of reviews having been undertaken over the intervening period.

The reforms included the:

- Exceptional claims scheme (ECS);
- Run-off cover scheme (ROCS);
- IBNR and UMP support schemes;
- High cost claims scheme (HCCS); and
- Premium support scheme (PSS)

Exceptional claims scheme

The ECS was developed to provide protection for medical practitioners against personal liability for private practice claims that exceed their maximum level of insurance cover. Under the ECS, the government assumes liability for all damages payable against a practitioner above the individual’s insurance contract limit in respect of claims notified after 1 January 2003, as long as the practitioner has cover equal to or over a threshold amount. The threshold was set at \$20 million, is subject to review, and no changes have been made since introduction. The scheme can be activated by either a single very large claim or an aggregate of claims that together exceed the threshold. There is no specific

Medical Indemnity – Who’s Got The Perfect Cure?

contribution by the medical profession or medical indemnity insurers towards this scheme. The scheme enables medical indemnity insurers to offer a maximum policy limit of \$20m in the aggregate per year, while the ECS guarantees payment of compensation in the (as yet) unlikely event that annual aggregate claims against a doctor exceed this amount.

Run-off cover scheme (ROCS)

Before 1 July 2003, medical practitioners generally obtained medical indemnity cover on a claims-occurred basis. However, after 1 July 2003 when the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* was introduced, cover has been almost always offered on a claims-made basis. Due to the contractual nature of insurance, doctors who retired would have had to continue to pay annual premiums to a medical indemnity provider to ensure cover. ROCS was introduced in response to medical practitioners’ concerns about their ability to pay for run-off cover when they leave the workforce and are no longer earning an income. Under ROCS, a charge known as the ‘ROCS support payment’ is imposed on medical indemnity providers and subsequently incorporated into each medical practitioner’s annual insurance premium during their working life. Upon leaving the workforce, ROCS will cover the types of claims that a medical practitioner’s last insurance contract covered without further payment. The ROCS support payment in 2009 is currently 5% of the medical indemnity providers’ premium income for a 12-month period, and is subject to review.

High cost claims scheme

The HCCS was introduced by the government to reduce the cost of large claims to insurers and to stabilise medical indemnity premiums. Under this scheme, the government reimburses medical indemnity providers 50% of all claims above a threshold (currently \$300K) up to the practitioner’s limit of insurance. The threshold is subject to review, with a twelve month lead in period to introduction of any new threshold, so that insurers have the opportunity to alter their reinsurance arrangements. HCCS does not extend to incidents that occur outside of Australia or to the treatment of public patients in public hospitals. There is no specific contribution by the medical profession or medical indemnity insurers towards this scheme.

Premium support scheme

Under this scheme, premium subsidies are provided directly to medical indemnity providers and then offset against the medical practitioner’s total premium. The PSS applies to medical practitioners whose gross medical indemnity costs exceed 7.5% of estimated income from private billings. The subsidy is 80% of the amount by which the member’s gross indemnity cost exceeds the base amount. It also covers 75% of the difference between premiums for rural procedural general practitioners and those of non-procedural rural general practitioners, regardless of whether they meet the other PSS criteria. There is no specific contribution by the medical profession or medical indemnity insurers towards this scheme.

IBNR and UMP support schemes

Under the IBNR indemnity scheme, the Australian Government funds IBNR liabilities of participating medical indemnity providers that held unfunded IBNR liabilities at 30 June 2002. All medical indemnity providers’ liabilities were assessed by the Australian Government Actuary and United Medical Protection became the only provider participating in this scheme. To fund payments under the IBNR scheme the Australian Government introduced the IBNR levy (later renamed the UMP support scheme) to

Medical Indemnity – Who’s Got The Perfect Cure?

collect contributions from medical practitioners and other health professionals who were members of medical indemnity providers that participated in the IBNR scheme, with the intention that the IBNR scheme be revenue neutral to the Government. The levy was not well received by the medical profession and the amount of contribution from doctors was amended downwards on several occasions. After United Medical Protection announced significant premium reductions commencing in January 2005, the government also commissioned an independent review of competitive neutrality in the medical indemnity insurance market [Rogers, 2005]. The review found that the specific assistance given to United and its insurer through the IBNR scheme had resulted in a competitive advantage, and legislation was introduced to impose a competitive neutrality payment on United’s insurer. United Medical Protection agreed on a settlement with the Australian Government of \$56 million, and paid this in full in the 2005–06 year. Contributions to the UMP support scheme by medical practitioners were finalised by 2007. The government expects that it will fund around three-quarters of United’s IBNR liability (as at 1 July 2002) as it emerges [ACCC, 2009].

Medical Indemnity regulatory framework

On 1 July 2003, the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 was introduced stipulating that medical indemnity cover must be provided by means of an insurance contract between the doctor and an APRA-authorized insurer. This change extended APRA’s prudential supervision to medical indemnity insurers for the first time. Transitional arrangements were put in place up until 1 July 2008, which allowed the medical indemnity insurers to become fully capitalised under APRA’s minimum standards [ACCC, 2009]. The same legislation introduced specific product standards for insurance products issued to doctors including minimum cover limits and compulsory offers of retroactive and run-off policies for claims-made cover [Medical Indemnity Policy Review Panel, 2005].

3.5 Tort reform

The comprehensive programs of law reform introduced by state and territory governments across Australia since 2002 have reduced the cost and improved availability of all liability classes of insurance. Some of the reforms relate solely to liability of doctors and other health care providers. Although the legislation at State level is varied there is consistency in the principles across jurisdictions [Minter Ellison, 2005]. The reforms are in three categories dealing with:

- Establishing liability;
- Damages for personal injury or a claim for economic loss against a professional;
- Procedural reforms.

Liability reforms

The liability reforms specific to the delivery of health care encompass amendment to the tests of foreseeability, causation and remoteness of damage, and the definition of standard of care for professionals including duty to disclose information and introduction of a modified Bolam principle which will be discussed later. This means that the standard of care is determined by what could reasonably be expected of a person possessing the skill and the relevant circumstances at the date of the alleged negligence; rather than small pockets of opinion to be accepted as the relevant standard. Provisions for apologies have made it possible to apologise, explain and express regret for a medical complication or misadventure without it being taken as an admission of liability.

Damages reforms

Reforms to damages have introduced in the majority of states and territories a threshold before general damages (non-economic loss) can apply, and a cap on general damages. Earnings losses have been capped in all jurisdictions with the maximum award generally based on multiples of average weekly earnings. Payments for gratuitous care are limited to cases where the amount of care is significant and the care is required for a significant period. The discount rate to arrive at present value of compensation for future losses and expenses has been aligned with those used in statutory CTP and workers compensation schemes. Reforms were also introduced to facilitate structured settlements and abolish punitive damages.

Procedural reforms

The reforms attempt to limit the time within which a potential plaintiff can bring an action to court and in general set the limitation period as three years from the date of discoverability of negligence and damage, with 12 year “long stop” or ultimate bar period, with special protection for persons with a disability. The reforms improved pre-litigation procedures, limited legal advertising, and restricted legal costs that could be awarded in small claims.

3.6 Post reform and post scheme environment

The reforms and schemes introduced since 2002 have undoubtedly reduced the costs of provision of medical indemnity insurance with a reduction in real average premium revenue every year from 2003-04 to 2007-08 [ACCC, 2009]. Average premium by specialty (from low to high risk) were all lower in 2008-09 than in 2003-04. Net assets across the industry have steadily risen since 2003-04 and are projected to continue to rise [ACCC, 2009]. By 30 June 2008 all medical indemnity insurers held capital in excess of the target of 150% of minimum capital requirement required by APRA.

The industry has attracted a new commercial entrant since the reforms and, together with the merger of two MDO’s and their insurers, there are now five medical indemnity insurers operating in Australia, giving doctors few issues with availability, choice and price.

The High Cost Claims scheme and Run off Cover scheme remain the most notable measures reducing reinsurance costs and overall risk exposure.

4 International challenges

4.1 A global crisis

The medical indemnity crisis was not restricted to Australia. In the early 2000’s, many countries experienced rapid increases in the size of settlements, particularly for so-called “non-economic losses”, being losses related to intangibles such as pain and suffering. Coupled with increasing claim frequencies in many countries, this led to prohibitively high premiums, the withdrawal of (re)insurers and the refusal of policies with high-risk exposure [OECD, 2006].

This issue was truly global, stretching from America to Europe to Asia. For example:

- In the United States, premiums in several states increased at an annual rate of 30% per annum from 2000. By 2001, obstetricians in Florida were required to pay between US\$143,000 and US\$203,000 [Kessler, Summerton, & Graham, 2006]. In 2002 the St Paul group of companies exited the US market, followed by several other regional insurers. Together, these insurers accounted for approximately 14% of the US market [Sewell, 2004].
- In France, a law was enacted in 2002 introducing a mandatory requirement for insurers to cover medical liability risk without a specified ceiling. In particular, it gave powers to the “*Bureau Central de Tarification*” to assess and set a rate for an insurer in cases where a health care provider has twice been denied coverage. This led to a massive withdrawal of insurers and a rapid increase in premiums of up to 600% [OECD, 2006].
- In Hong Kong, the average premium for private orthopaedic practice rose from \$3,237 in 2002 to \$21,400 in 2007 [Fang, 2007].

Since medical indemnity forms an important part of the health care system in most modern economies, the crisis had wider implications beyond the availability and affordability of medical indemnity cover. It impacted, amongst other things, on the number of practicing physicians in particular specialties, overall health care costs, the general public’s trust in the health care system and providers, and ultimately on patient safety and the quality of health care.

Another point worth mentioning is the speed with which a crisis can unfold. France, for example, was classified in 2000 as the “best healthcare system in the world” by the World Health Organisation [Canadian Medical Protective Association, 2005]. Only a few years later, it faces the crisis of rapidly escalating and unsustainable premiums. There is therefore a need for continued vigilance and review of a system in line with a country’s evolving needs.

4.2 Responses to the crisis

So what initiatives were taken in response to the crisis? Typical responses have focussed on one, or more commonly several, of the following options:

1. Modifying the definition of “negligence”;
2. Reforming the tort system to limit or cap various payments;
3. Rearranging the funding structure;
4. Introducing no-fault schemes or no-fault elements to the overall scheme.

Medical Indemnity – Who’s Got The Perfect Cure?

Whilst useful insights can be garnered from international experiences, it is recognised that the particular approaches taken by a country must take account of its prevailing socio-political, legislative and cultural environments. For example, the solutions appropriate for the US with its largely private sector entrepreneurial history are likely to differ from a country with an extensive social welfare benefit structure such as Sweden. Any direct comparisons of, say, costs or timeframes for compensation between jurisdictions are potentially misleading and should therefore be viewed with care. The following sections consider each of the above policy options in turn, focusing on the experience in OECD countries and, particularly, the UK, USA and New Zealand.

The definition of “negligence”

In dealing with injuries arising from medical procedures, one must distinguish between those injuries that are caused by an accident on the part of the medical provider and those that are caused by negligence. Accidental errors include errors of judgement, where a particular course of treatment is selected that ultimately leads to injury. Without the benefit of hindsight, such decisions may well be perfectly sound at the time. A finding of clinical negligence typically rests on the following conditions:

- The existence of a duty of care between the medical practitioner and the patient;
- A breach of the duty of care;
- The causation of the injury by the breach of duty.

The existence of a duty of care in medical negligence cases is usually clear, so that legal proceedings typically focus on the latter two aspects.

Within Britain and countries that have inherited its common law, such as Australia, the establishment of a breach of the duty of care has historically been guided by the landmark case of *Bolam vs. Friern Hospital Management Committee* (Bolam vs. Friern HMC, 1957). Mr Bolam underwent a course of electro-convulsive therapy at Friern Hospital during which he was not restrained. He flailed about violently during the procedure and suffered several injuries as a result. He subsequently sued the committee, arguing that they were negligent for not issuing relaxants, not restraining him and not adequately warning him of the risks involved. The case was decided in the favour of the Committee, with the following judgement:

“A physician is not negligent if he has acted in accordance with a practice as accepted by a responsible body of medical men skilled in that particular art.”

The above judgement has led to the so-called “Bolam test” of medical negligence. For a negligence finding, this test requires that no group of medical practitioners agree with the particular course of action followed by the physician. In particular, an opinion that is held by only a minority group of physicians is valid. The Bolam test makes it very difficult for negligence to be established, providing a severe disincentive towards litigation and contributing to the lengthy legal proceedings that are characteristic of tort based negligence systems. Sole reliance on the Bolam test also creates the possibility that a treatment is found to be non-negligent because it conforms to an unreasonable minority opinion within the medical community.

Accordingly, the Bolam test has been refined in recent times. In the UK, in the case of *Bolitho vs. City and Hackney Health Authority, 1997* the court maintained that although a particular course of action conformed to the opinion of a body of experts, the court must also be satisfied that the treatment has a sound logical basis. In Australia, the case of *Rogers v. Whitaker, 1992* established that a physician’s duty of disclosure was not

Medical Indemnity – Who’s Got The Perfect Cure?

covered by the Bolam test. This is in keeping with the American notion of “informed consent” whereby a physician has a duty to disclose all information that a reasonable person in the patient’s position would find material to a decision over whether to proceed with the treatment. This was in contrast with the more physician-oriented approach dictated by the Bolam test.

In the wave of tort reform which took place in Australia after 2002 all states but not the Territories, introduced a modified Bolam test (section s5O of the Civil Liability Act 2002) which provided that:

- A professional is not negligent if it is accepted that he/she acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion.
- However this opinion cannot be relied upon if it is considered to be irrational.
- The fact that peer professional opinions may differ does not prevent one or more of them being relied on for the purposes of this section.
- Peer professional opinion does not have to be universally accepted.

Once it has been established that there has been a breach in the duty of care, it still remains to show that this breach caused the injury. In the UK and Australia it is required to show that, on the balance of probabilities, the particular treatment, procedure or lack of action caused or contributed significantly to the injury. Causation is often hotly contended and can be quite hard to establish.

The more complicated the definition of “negligence”, the more complicated the resultant legal proceedings will be, leading to increased trial lengths and legal fees. While reforms to the definition can be considered in isolation, they are typically considered within the broader scope of tort reform, which forms the subject of the next section.

Tort reform

Many countries including Australia, the US and the UK rely on the tort system to handle negligence cases, including medical malpractice. Considerable variation however exists between these countries in their different applications of common law. These differences can have marked effects on claim frequency and severity. For instance, jury trials for civil matters are uncommon within Australia, but occur regularly within the US.

If a common law country experiencing a medical indemnity crisis decides to remain within the framework of tort law, then it must consider legislative reforms that seek to mitigate the underlying issues. To be fair, it may well be the case that the country has experienced a sudden spike in doctor negligence that completely explains the adverse experience (as lawyers might like you to believe!). While it is true that risk mitigation initiatives that decrease the likelihood of genuine negligence must be developed, it is also important that systemic legal reasons for adverse claims experience are ironed out. These reforms aim to increase the predictability of claims and to reduce the total payments and have typically included any or all of the following:

- **Limiting recourse to courts, particularly capping the time between incident and claim.** This aims to reduce the long-tail nature of the claims. For example, Pennsylvania requires a claim to be filed within seven years of the incident, whereas California requires a claim to be filed within three years of the incident or one year of discovery [Sewell, 2004].
- **Caps or bans on contingent legal fees.** In the US, many states have enacted a sliding scale for the maximum amount of contingent fees a lawyer can charge,

Medical Indemnity – Who’s Got The Perfect Cure?

expressed as a percentage of the settlement cost or as an absolute amount. In the UK, contingent fees are banned by law and, instead, lawyers charge an hourly rate. The losing party must cover the legal fees of both parties [Danzon, 2000].

- **Caps on payments for non-economic loss.** This seeks to reduce payments for “pain and suffering” and other non-tangible events. Capping these payments is often controversial, with many complaining about the arbitrary nature of the cap and challenging it on constitutional grounds. In the US, 24 of 51 states have enacted caps on non-economic payments, typically within the range of \$350,000 to \$650,000. There is some evidence to support the assertion that these caps have reduced premiums [Nelson, Morrissey, & Kilgore, 2007] and insurers’ ultimate loss ratios [Viscusi, Baker, & Born, 2009].

Countries also need to be careful that caps on non-economic damages do not just prompt claimants and lawyers to seek punitive damages, which, at least in the US, are typically not capped.

Other major tort reforms deal with the manner in which claims are paid and accounted for. These reforms can have a significant effect on the funding requirements of medical indemnity and we discuss the changes within this broader context in the following section.

Funding structure

In order to curb the long tail nature of claims and limit insurers’ exposure, the medical indemnity crisis this decade has resulted in a large push in recent times to replace “claims-incurred” cover of medical malpractice claims with “claims-made” cover (see Section 2.4 for a discussion of the differences). However, this does not provide a total remedy in that cover is still required for injuries arising from negligent treatment from practitioners no longer in active service at the time of claim. Countries where this switch has been made have therefore had to put in place various means to cope with this, including run-off and retrospective covers.

Next, how should large claims be treated? In Wisconsin, practitioners are only required to purchase cover up to \$1,000,000 per claim and \$3,000,000 in a year. Claims above this amount are covered by the Injured Patients and Families Compensation Fund, which is funded by an annual contribution from health care providers and operates on a claims-occurred basis [Austin, 2009]. As we have seen, Australia has similar measures in place through its High Cost Claims Scheme and Exceptional Claims Scheme.

It is inescapable that certain specialisations will lead to higher claims and, consequently, to higher premiums. For instance, an obstetrician practicing in Quebec faces an annual premium of CA\$25,440 whereas a family practitioner is required to pay only CA\$1,753 [Canadian Medical Protective Association, 2009]. In New Jersey, premiums for specialists practicing in a high-risk area are subsidised by the state, while physicians in West Virginia enjoy an annual tax credit equal to 21% of their adjusted medical liability insurance premiums [Sewell, 2004]. Australia has the Premium Support Scheme, as discussed earlier.

In our discussion thus far, we have assumed that malpractice claims are handled through the legal system and funded from a combination of public and private sources. In the following section, we consider a radically different approach that separates compensation from deterrence and avoids the legal system to as large an extent as possible.

Medical Indemnity – Who’s Got The Perfect Cure?

No-fault schemes

A patient who suffers an injury demonstrably caused by a competently performed standard medical procedure has no recourse to compensation within a system based on a modified Bolam test of negligence. From a physician’s point of view this is a sensible state of affairs, since the onus should not be on the physician to pay for injuries arising from a standard level of care. However, the patient still faces the same medical, opportunity and cost-of-living costs associated with the injury.

If one wishes to award compensation to a patient who has suffered a non-negligent medical injury, then a scheme needs to be designed around causation alone, leaving the issue of breach of care to professional forums. Such a scheme would most likely need to be administered by the state, with funding being provided either directly through a levy on medical practitioners and organisations or indirectly through the general taxation system, although funding through commercial or non-profit organisations remains a possibility.

Schemes based solely on causation, or “no-fault” schemes, exist in several countries, most notably in Nordic European countries and New Zealand. A summary of the key features of several no-fault schemes is provided below.

Table 2: Key features of a selection of ‘no-fault’ schemes

Country	Year no fault introduced	Funding source	Features
Sweden	1975	Mutual insurance company of the county councils covers 95% of market	Occurrence basis, cap of \$730,000 per claim (since 1997).
Denmark	1992	Private insurers and non-insured parties such as the state.	Occurrence basis, only covers claims above DKR 10,000, claims must be made within 5 years.
Finland	1987	Pool of insurers who are part of the Patient Insurance Association, which acts as an insurer of last resort	Occurrence basis, minimum claim size.
New Zealand	1972 (in force since 1974)	Mainly state funding through the Accident Compensation Corporation (ACC).	Occurrence basis.

The benefits of a no-fault compensation system include a simpler claims process, uniformly applied compensation and lower transaction fees than a system that operates through the courts.

The relation between no-fault compensation schemes and tort systems has been somewhat controversial. Idealistically, no-fault schemes should obviate the need for legal recourse. This was the original approach taken in Sweden and New Zealand. However, by enforcing the position that a claim under a no-fault compensation system negates the right to sue, one runs foul of human rights legislation that enshrines the individual’s right to access the courts. In response to European criticism, Sweden abandoned its existing no-fault scheme in favour of the Patient Torts Act (PTA) in 1997, which handles the claim through the country’s legal system [Hershberg-Adelman & Westerlund, 2004]. The PTA requires the plaintiff to establish causation only, so may still be viewed as a no-fault

Medical Indemnity – Who’s Got The Perfect Cure?

scheme. If negligence can be proven, then the patient may file under the general Torts Act. In New Zealand, a claim under the ACC legally substitutes for the right to sue for damages. There is, however, some scope to apply through the courts for punitive damages in cases where malicious intent can be proved and for pain and suffering, through the medical disciplinary boards. However, such claims remain rare and, in the case of malicious intent, can be exceptionally difficult to prove.

The adoption of comprehensive no-fault compensation schemes are considered by tort-based countries on a regular basis. However, this is routinely rejected, primarily due to the prohibitive costs involved in the absence of a comprehensive social welfare-system. This was the finding in the UK of a wide-ranging study by the Chief Medical Officer of the NHS in the UK [NHS, 2003], who concluded:

“Given the disadvantages... the potentially large costs and the practical difficulties in framing an efficient comprehensive no-fault based scheme, not least to conform with the Human Rights requirements, I have rejected a wide ranging no-fault scheme for all types of injury.”

A similar Canadian Report [Canadian Medical Protective Association, 2005] says:

“Even with the application of conservative estimates of compensation levels and the imposition of limitations to only avoidable injuries, the costs associated with the no fault, hybrid no fault/fault and litigation authority models represent a multiple-fold increase over those of the current [Tort] system. In an already stressed health care system, it is not apparent how such significant cost increases could be absorbed or how society would respond to this potential diversion of funds from either direct health care delivery or other national priorities.”

As an alternative to a comprehensive no-fault scheme, countries may choose to adopt no-fault elements for only part of the medical indemnity market. For example, in Florida, the Birth-Related Neurological Injury Compensation Association is a no-fault compensation scheme that covers injuries that leave an infant permanently and substantially mentally and physically impaired. The adoption of such a scheme in Canada was ruled out on cost concerns, as outlined in the above quotation. France has adopted a no fault scheme for injuries resulting in invalidity of at least 25%, which is applicable in those cases where negligence cannot be shown. We are not aware of a similar threshold no fault system existing elsewhere.

4.3 The current international state of play

We now consider a number of different countries in the context of the affordability of their systems both for medical practitioners and the state, efficiency of the systems, the provision of appropriate compensation for injured patients, and the promotion of good medical practice. Again, we point out that comparison of systems in different countries is complicated by different methods of health care provision and financing and specific cultural, historical, social, economic and political circumstances.

USA

Affordability in the USA is influenced heavily by the inflation and magnitude of non-economic damages and punitive damages. The compensation system is therefore generally quite subjective with significant proportions of awards being non-economic. The establishment of no fault systems for birth related neurological injuries in Virginia and Florida [OECD, 2006] improved the affordability of indemnity cover for obstetricians

Medical Indemnity – Who’s Got The Perfect Cure?

and addressed a supply crisis in those states. However the Virginia fund has unfunded liabilities and will need to re-address its funding arrangements if it is to fulfil its obligations. Many medical practitioners retire earlier than they would otherwise because of their high malpractice premiums. There are however subsidies and tax credits for high premiums in some US States [Sewell, 2004].

While the United States has experienced negative trends in claim frequency and severity as a whole, the various states have had markedly different experiences due to vastly different legislative structures and separate sets of common law. As an illustration of the wide variation within the US, the claim frequency and severity for the five largest states is presented in the following table.

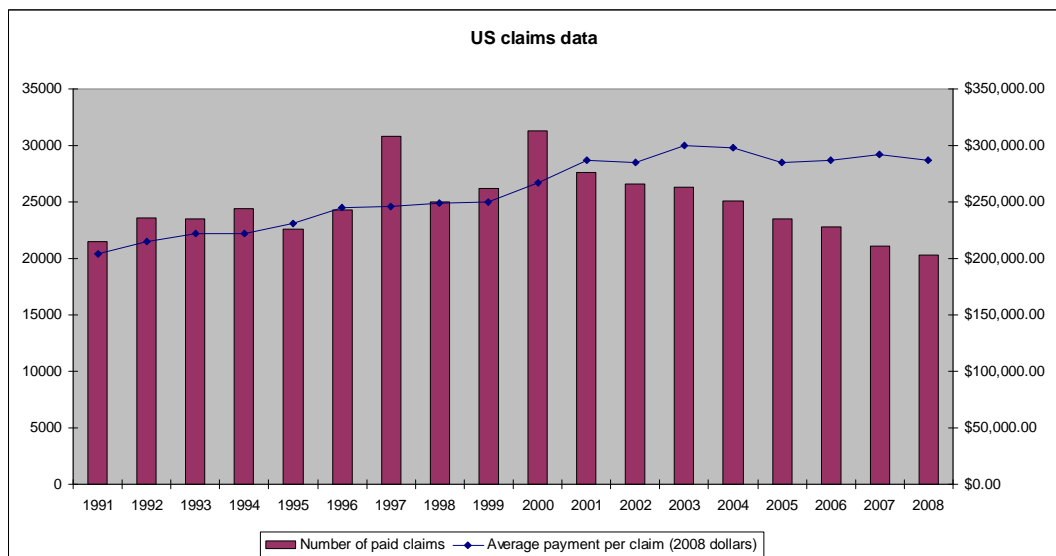
Table 3: US state data

State	Population (millions)	Paid claims per million people (annual average 1991-2008)	Average payment per claim 1991-2008 (2008 dollars, thousands)
California	36.8	68	145
Texas	24.3	57	219
New York	19.5	124	329
Florida	18.3	75	265
Illinois	12.9	62	405

Source: Population [U.S. Census Bureau, 2009], claims [US Health Resources and Service Administration, 2009]

In 2002 the St Paul group of companies exited the US market, followed by several other regional insurers. Together, these insurers accounted for approximately 14% of the US market [Sewell, 2004]. This capped a period of increasing claim frequency and severity and spurred several tort reform measures. Data from [US Health Resources and Service Administration, 2009] indicates that average claim size has remained roughly steady since 2002, with a decreasing number of paid claims leading to an overall decline in the total cost of malpractice claims, as depicted in the following figure.

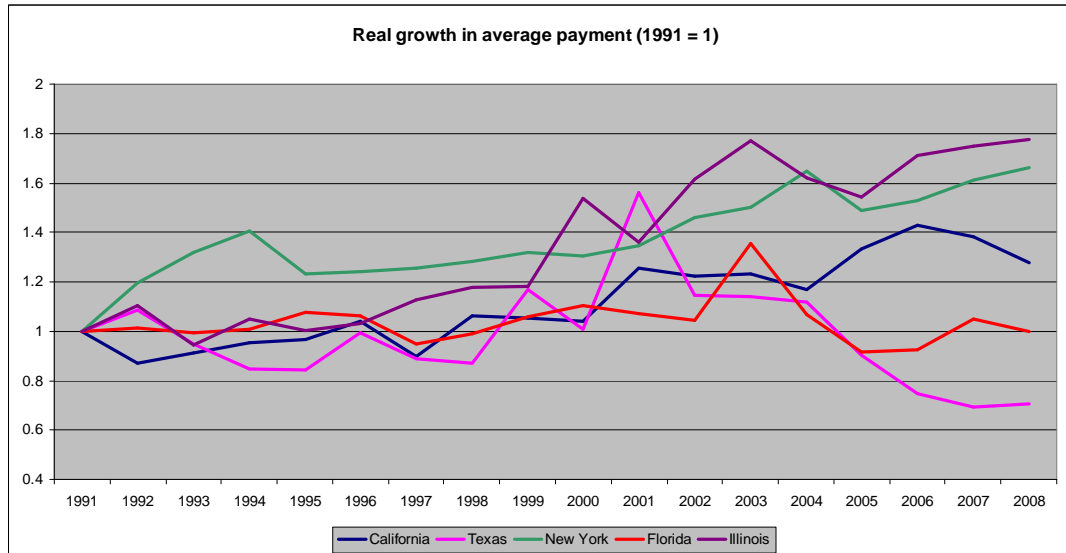
Figure 2: US claim trends



Medical Indemnity – Who’s Got The Perfect Cure?

Of course, one must bear in mind the caveat that overall US performance is not indicative of individual state performance. Indeed, as the following figure illustrates, the average claim payment trends are vastly different across the states, with a real growth of 78% in Illinois over the period 1991-2008, contrasted with a 30% drop in Texas over the same period.

Figure 3: US claim trends by state



Compensation in the US remains largely inequitable and the tort system is seen as something of a lottery. This situation increases conflict between the various stakeholders. Moreover, there is some evidence to suggest that the risk of high-value lawsuits encourages doctors to practice what has been termed “defensive medicine”. That is, it is claimed that doctors order unnecessary tests, procedures and prescriptions purely to mitigate the risk of being sued. One survey puts the incidence of defensive medicine at around 76% of doctors [OECD, 2006].

Canada

In Canada, the vast majority (95%) of doctors are members of one mutual, the Canadian Medical Protective Association (CMPA). While medical liability is covered by a tort-based compensation system, the mutual has lower costs than an insurer and ability to deliver consistent risk management strategies to most doctors in Canada. There are no caps on the occurrence based cover provided by the mutual, with the success of the CMPA lying with its very broad membership base. Some Canadian doctors in higher risk and fee specialties get substantial reimbursement of their CMPA fees from regional governments.

The inefficiencies of the tort-based compensation system are present (although not as magnified) in Canada as the USA. Punitive damages are rarely awarded and in any event are not included in the cover provided to doctors. Promotion of good medical practice is aided by ability of the single indemnity provider to also deliver consistent risk management education to nearly all doctors in Canada.

The CMPA has a goal of avoiding precedents and, as such, often spends more on legal fees than the potential payment. Their near-monopoly on the malpractice market and national reach has led to criticism from trial lawyers. One point of contention is the

Medical Indemnity – Who’s Got The Perfect Cure?

mismatch in resources between the CMPA and plaintiffs and the consequent disincentives towards litigation [International Medical Litigation Consultants, 1998].

UK

Also operating in a common law tort-based system, much delivery of medical indemnity in the UK is provided by government sponsored (non-insured) indemnification for services provided by doctors in public hospitals and clinics, via National Health Service (NHS) Trusts and the NHS Litigation Authority. NHS-employed general practitioners and private medical practitioners are either insured or covered by discretionary indemnity via membership of a medical defence organisation (MDO).

Affordability of these systems has been stretched by rising expenditures on claim payments and the long tail nature of medical indemnity claims. Whilst there has been limited tort reform, tight court procedures and timetables mean that average time to settlement is lower than in the US or Australia. A proposed but yet to be implemented reform, the NHS redress scheme, is aimed to provide swift payments of small claims [Kessler, Summerton, & Graham, 2006].

There are a small number of structured settlements in the UK for personal injury cases each year. Usually the form of a structured settlement is as follows: the defendant's insurer, having agreed a lump sum figure, will arrange to convert part of that sum into a series of periodic payments “structured” to accommodate the claimant’s individual needs. To fund the arrangement, the defendant’s insurer purchases annuities from a life insurer, and assigns the benefit of them to the claimant. Unlike the income that arises from the investment of a lump sum, the regular payments are free of tax in the claimant's hands.

The system in the UK does appear to provide adequate compensation to most injured patients although the conservative tort system has inherent hurdles which would restrict access to compensation for some.

There is no evidence that restriction of certain medical services in the UK is influenced by high medical indemnity premiums. The NHSLA and the MDOs all carry out risk management activities to promote good standards of practice including communication and advice.

Sweden

Health care in Sweden is a public sector responsibility. There are also extensive social security benefits for those that are sick. Medical indemnity compensation is provided on a “no fault” basis under the Patient Torts Act (PTA) introduced in 1997. Under this Act claims are handled under the legal system but only causation needs to be established. Compensation is provided on a “top up” basis as medical costs and long term care costs are covered by the social security system, however there remains a possibility to sue through civil law to obtain higher levels of damages. Payments made under the PTA are capped. The systems means there is prompt redress and cheaper legal costs than in other types of liability claims.

This efficient, affordable system however is promoted by Sweden’s non-litigious culture and comprehensive social services system. Much higher costs would result if this was translated to other jurisdictions without these two important factors. Risk management is promoted and error reporting by practitioners is divorced from the compensation process.

Medical Indemnity – Who’s Got The Perfect Cure?

New Zealand

New Zealand has a unique system administered under the Accident Compensation Corporation (ACC), which administers a compensation scheme covering motor vehicle, workplace, public and medical liability. It is essentially a no fault system, but for medical misadventure the claimant must establish error and fault, or that a “rare and severe” injury has occurred under an accepted treatment. The majority of accepted claims establish “rare and severe” injuries. Average indemnity payments are low with no damages usually payable for non-economic loss.

There is no personal contribution by doctors to the scheme which has led to concerns of lack of personal accountability for bad outcomes. As in any “no fault” scheme there is concern that this could lead to a higher number of claims per capita than would otherwise be the case.

As a general rule, the ACC provides ongoing payments rather than a lump sum, although lump sum payments are available for permanent impairment arising from incidents occurring on or after 1 April 2002.

The scheme is efficient and clearly affordable for doctors. However there are ongoing concerns about affordability to the NZ public, as medical claims costs rose dramatically between 2001 and 2009. The outstanding claims liability for medically related claims rose from NZ\$301m in 2001 [Accident Compensation Corporation, 2001] to NZ\$2,167m in 2009 [Accident Compensation Corporation, 2009]. The present National government has signalled its intention to open up the ACC accounts to private competition.

Despite rapidly rising total claims cost, it is still argued that the ACC provides inadequate compensation, particularly for people who are not in paid employment at the time of the injury and thus unable to claim earnings-related compensation. There is also some community tension over the fact that the ACC only covers treatment-related injuries while excluding all other illnesses, since ACC assistance is usually higher than that received from health and welfare systems [Bismarck & Paterson, 2006].

Netherlands

Like Sweden, the Netherlands has a comprehensive social security system which provides for much of the costs of larger claims being long term care costs. The Netherlands has a tort-based civil system which provides compensation on the basis of proven error; and a no fault insurance scheme for clinical trials.

Insurers offer an individual doctor policy limit of €1.25m per claim. The affordability for doctors compared with other jurisdictions seems to be based on the fact that claims costs are held down by the comprehensive social security available to all citizens despite cause.

5 Measures of a successful system

5.1 In an ideal world...

A medical indemnity scheme needs to balance the interests of patients, doctors, insurers and the broader community. This is a difficult balancing act given the very emotive nature of medical indemnity, as well as cost constraints leading to the potential for contention amongst stakeholders.

The approach adopted by a country, and evaluation of the transferability of any solutions between jurisdictions, must also take account of the particular socio-economic, legal, political and cultural circumstances. What works in a non-litigious country with an encompassing social welfare system like Sweden, for example, is highly unlikely to work in the United States.

Recognising the many differences in approach, we have put forward some universal objectives that we consider a successful system should nevertheless possess, and by which any new scheme features or changes to existing structures should be evaluated, independently of their particular national context:

1. **Appropriate compensation.** There is tension between affordability of a scheme as a whole, and individual compensation. One can trivially ensure affordability by only paying out very low amounts. A successful scheme should appropriately compensate victims. This means both that the amount should be sufficient to cover the victims’ incurred expenses and losses and also that the amount should not be in excess of these needs. To the extent that compensation is restricted, a successful system should ensure that compensation provided is predominately to those with the greatest need. An ideal system would also minimise system transaction costs such as legal expenses.
2. **Timely compensation.** Compensation should be provided as soon as possible after the discovery of the injury. Moreover, payments should be made as they are needed. While minor injuries may warrant individual lump-sum payments, more serious injuries should be compensated via periodic payments for specific needs, such as private nursing care.
3. **Mandatory cover.** Cover should be mandatory for practicing medical professionals.
4. **Available and affordable cover.** Cover should be available for all medical professionals who meet the required standard. The premiums should be affordable for the practitioner.
5. **Accountability and encouragement of good medical practice.** Practitioners should be held accountable for injuries that they cause. Accountability should be separate from compensation and should be dealt with by the relevant profession. The scheme should act to improve the standard of care so as to reduce injuries and claims.
6. **Facility for apology.** It should be possible for the practitioner to apologise without admitting fault.

Medical Indemnity – Who’s Got The Perfect Cure?

7. **Encourage good monitoring.** The system should actively encourage a trusted system of feedback and reporting of errors, so as to help prevent repetitions of the mistake.

5.2 Scorecard for Australia

So how does Australia measure up against these objectives?

Appropriate compensation (7/10)

One of the constraints of a tort based system is that it inevitably will lead to inequities in the amount and distribution of compensation. A medical adverse event does not necessarily lead to a finding of negligence, and many severely injured patients will never receive any redress for loss incurred as a result of their injury as they must be able to prove negligence. Even if there is good evidence this has occurred, a court hearing still provides an unpredictable outcome for the injured.

Medical indemnity insurers pay very detailed attention to liability and causation. From the insurers’ perspective, the tort law reforms enacted throughout the 90’s have removed both the trivial and the extreme spectrum of claims, both in terms of alleged liability and damages. On that view the insurers might consider that the patients that are compensated are firstly the correct ones, and secondly are appropriately compensated while not being over-compensated for ambit heads of damages claims. Punitive or exemplary damages against doctors are virtually unheard of in Australia.

It may be thought from the patient’s perspective that the process for the medically injured seeking compensation is more difficult than before and some injured patients might not be able to find representation. Minor injuries will not meet non-economic loss thresholds. In NSW, a case must be certified by the solicitor to have “reasonable prospects of success” and accompanied by an expert report before it can be initiated. Anecdotally, legal practitioners specializing in plaintiff medical negligence found sustaining practice in this area difficult; there are consequently less players left on this particular field, and they appear more cautious about what cases they take on.

Limits on economic and non-economic awards mean that a sum awarded may eventually run out. The majority of medical negligence cases are settled prior to trial and a plaintiff may be advised, or wish, to accept a sum that proves inadequate to needs in the future.

We have mentioned the long tail nature of medical negligence claims. Particularly in obstetric claims the families of injured people usually fund or provide care for years before initiating a claim. Whether this is due to a slow realisation of the extent of the injury, late discovery of negligence, reaching a stage when other children have started to become independent, or simply exhaustion, it is clear that there is always a long period of past care and lifestyle change which has been occurring for many years and courts can only approximate an “appropriate” level of compensation.

We consider that common law fails the most severely injured claimants. Firstly the long-discussed alternatives of “lump sum” common law compensation, being structured settlements or a long term care scheme, have to date gained little traction in the Australian medical indemnity arena. The 5% net discount rate in determining damages for future care and future loss of earnings is the most penal for the most severely injured plaintiffs.

Medical Indemnity – Who’s Got The Perfect Cure?

Australia is limited in providing “appropriate compensation” to all by its current system and legislation. Other methods of funding the care of the severely disabled could perhaps help “plug the gaps” in Australia’s medical indemnity system.

Timely compensation (6/10)

The table below sets out a comparison of the period between notification and settlement of claims, across Australia, US and UK.

Table 4: Settlement times of malpractice claims across three countries

Country	Australia	United States	United Kingdom
Average period between notification and settlement (years)	6.2	4.7	1.56 (incidents after 1995) 6.18 (incidents before 1995)

Sources: US: [US Health Resources and Service Administration, 2009]. UK: NHS Legal Authority annual report and accounts 2009. Australia: [Insurance Statistics Australia, 2008].

It shows an average period of 6.2 years from notification to settlement in Australia. While some of this might be explained by early notifications by treating doctors, followed by formal claims some years later, this length of time from start of proceedings to completion was not unheard of prior to tort reform. Case management has now been adopted in most courts. In the Supreme Court of NSW, medical negligence cases come into the Professional Negligence List as soon as the proceedings are instituted. Timely preparation of the proceedings for trial is then supervised by the judge in charge of the list. Pre-payments in medical negligence cases are possible but rare.

In terms of whether Australia now demonstrates this feature, we consider timeliness is still not perfect but has improved although will always be limited by the tort system. From a social perspective, as mentioned in the point above, much compensation is far from timely due to the time taken after injury to commence a claim.

Mandatory cover (9/10)

Medical registration in all Australian States and territories is only available to those practitioners who hold medical indemnity insurance with an approved insurer, with the exception of Queensland and the Northern Territory. However, national registration of ten health professions will be introduced in July 2010 and this requirement will apply to all health professions covered under the legislation (chiropractors, dentists, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, and psychologists). There will be a two year exemption until June 2012 from holding indemnity insurance for privately practising midwives who are unable to obtain professional indemnity insurance for attending a homebirth. Homebirths are excluded under the Federal Government’s independent midwives scheme.

For medical practitioners, at least, Australia will soon have a perfect score in this regard.

Available and affordable cover (8/10)

There are five medical indemnity insurers in Australia and there is significant growth in the supply of client doctors as the number of new medical graduates has been rising each year.

Medical Indemnity – Who’s Got The Perfect Cure?

The Government appears committed to providing choice to the Australian public in the way they obtain health care, and is also committed to enhancing the provision of rural health services. Government health policy includes the recent announcement of the Midwives Scheme, which provides both premium support and claims cost support to midwives. This indicates to us that the premium support provided to high premium paying doctors and in particular rural practitioners, is here to stay.

The ACCC has monitored premiums set by all medical indemnity insurers annually over the past six years and has considered premiums to be actuarially and commercially justified. There is regulation in NSW which limits the top end of premiums as obstetricians and neurosurgeons cannot be charged more than 20 times a full time non-procedural GP in NSW. “Insurer of first resort” provisions mean that a selected insurer for each state must offer a policy (albeit under conditions of their own determination) to all medical practitioners who reside in that State who apply regardless of their claims history.

We see no evidence of premiums per se discouraging doctors to train in or practice a particular specialty. Premiums have remained stable since the introduction of Government schemes and tort law reform.

Within the broader international context, the average payment per claim varies widely, with Australia coming in well below the United States and the United Kingdom, as set out in the following table.

Table 5: Average malpractice claim payments across three countries

Country	Australia	United States	United Kingdom
Average paid (AU\$ 2009 PPP, thousands)	89	426	234

Sources: US: [US Health Resources and Service Administration, 2009]. UK: NHS Legal Authority annual report and accounts 2009. Australia: [Insurance Statistics Australia, 2008].

The reasons for variation in claim payments, frequency and settlement time between countries are complex and not very well understood. Contributing factors include the existence of additional compensation from other sources, such as Medicare in Australia, and the attitudes towards punitive damages, which are generally not capped in the US.

Accountability and encouraging good medical practice (7/10)

All medical indemnity insurance companies in Australia offer legal expenses cover as part of their product offering. Usually this covers costs of assistance and representation at complaints bodies, disciplinary hearings including performance assessment, and other investigations into doctors’ practice. It takes significant resources to provide these services, and in most cases the subject incident or incidents precipitating an inquiry or investigation are not the subject of a claim for compensation.

The national registration model includes a provision for mandatory reporting by a medical practitioner when he/she considers his/her peer to be placing the public at risk of harm. Although this has been introduced already in NSW, it does not seem to have precipitated many reports.

In this sense the profession encourages doctors to be accountable and the medical indemnity insurers assist and support when they are requested to do so.

Medical Indemnity – Who’s Got The Perfect Cure?

At Avant Mutual Group, as at other medical defence organisations, the management of insured practitioners who have an above average claim or complaint incidence includes personal risk management visits and education, and in some cases imposition of policy conditions which may encourage a doctor to abandon or amend their practices in relation to a certain procedure.

Risk management education for their members is advertised by all medical indemnity insurers in Australia. Doctors receiving premium support under the Premium Support Scheme are obliged to undertake risk management activities during the period they receive support. The effectiveness of risk management has been poorly addressed in the literature. Assessment is difficult because measuring the number of claims and complaints pre- and post- risk management requires monitoring over many years, and it is difficult to isolate the effect of risk management from the effect of other factors. Nevertheless it seems that the entire medical indemnity industry and the Government are committed to providing this service, and risk management intervention and education is based on best medical practice.

Much has been said that the fear of being sued leads to “defensive” practice by doctors, that is ordering unnecessary tests and investigations for the sole reason to avoid litigation. However there is no conclusive evidence that this is a feature of Australian medical practice.

Facility for apology (9/10)

An open disclosure standard was released by the Australian Council for Safety and Quality in Health Care (now replaced by the Australian Commission on Safety and Quality in Health Care) in 2003. This is a national standard for open communication in public and private hospitals, following an adverse event in health care. The elements of open disclosure in that standard are an apology or expression of regret, a factual explanation of what happened, an explanation of potential consequences and an explanation of what is being done to manage the event and prevent its recurrence.

However, state laws have been inconsistent around protection in the event of open disclosure (including apology) and the Australian Commission on Safety and Quality in Health Care has announced efforts to find a ‘legal clear path’ for Open Disclosure in Australia, with a review of state apology laws, state and federal laws relating to qualified privilege, and any other laws that bear upon the practice of open disclosure or that may affect the status of information conveyed in open disclosures. The reviewer will advise on the changes necessary to implement and achieve a consistent national approach.

Australia is on the way to achieving this element.

Encouraging good monitoring (3/10)

Medical indemnity data is provided to APRA but not for the purposes of feedback and when this is made available it is difficult to interpret largely due to its aggregated nature. In 2008 Insurance Statistics Australia prepared a comprehensive report on premium and claims trends over an 11 year period but the data provided was not from the whole market. The ACCC have prepared six annual reports on the industry focusing on monitoring of premiums.

While there is some reporting, in our view it is still inadequate. There is no national database accessible by insurers in a form that can provide useful learning, so this element is not being achieved in the medical indemnity industry.

5.2 The last word...

In this paper, we have set out the various medical indemnity approaches taken around the world, and in particular, the responses to the crisis of affordability and sustainability over the past decade. This has been undertaken with a particular focus on Australia, with the view that a greater understanding of the international challenges and responses will better inform our own debate and enable us to more constructively evaluate our own system and policy directions.

Transferability of a new innovation or scheme feature from one country to another is very much tied to the unique socio-economic, political, legislative and cultural circumstances of each country. We have nevertheless attempted to put forward a set of universal objectives by which any proposed new feature or changes to the present system should be evaluated, irrespective of national context.

We have attempted to “score” Australia by these measures – our intention in this is not to criticise any shortcomings but simply to see where we currently stand in terms of this universal ideal. Medical indemnity forms only one part, albeit an important one, of the complex health care delivery system. Any proposed solutions to “plug the gaps” therefore need to consider a whole of scheme approach and implications on the broader health care system.

Finally, society’s needs particularly in the complex area of health care provision are constantly evolving. Crises can unfold very quickly as evidenced over the past decade. Whilst we can take some pride from the significant actions taken to curb this crisis in Australia, there is a need for continued vigilance and review, and in constantly striving for a system that meets the universal ideals in this changing environment.

Medical Indemnity – Who’s Got The Perfect Cure?

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Medical Indemnity – Who’s Got The Perfect Cure?

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