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Medical and Midwife Indemnity Legislation Amendment Bill 2019

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Date introduced: 18 September 2019

House: House of Representatives

Portfolio: Health

Commencement: Schedules 1 to 5 commence on 1 July 2020. Schedule 6 commences immediately after schedules 1–5. All other sections commence on Royal Assent.

Links: The links to the Bill, its Explanatory Memorandum and second reading speech can be found on the Bill's home page, or through the Australian Parliament website.

When Bills have been passed and have received Royal Assent, they become Acts, which can be found at the Federal Register of Legislation website.

All hyperlinks in this Bills Digest are correct as at November 2019.

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Glossary

AMA	Australian Medical Association
AMIL	Australian Medical Protection Limited
ANAO	Australian National Audit Office
APRA	Australian Prudential Regulation Authority
Avant	Avant Mutual Group Limited
CEM	Chief Executive Medicare
Competitive Advantage Payment Act	*Medical Indemnity (Competitive Advantage Payment) Act 2005*
ECS	Exceptional Claims Scheme
FPR	First Principles Review
HCCS	High Cost Claims Scheme
IBNR	Incurred But Not Reported
IIF	Indemnity Insurance Fund
MDO	Medical Defence Organisation
MI Act	*Medical Indemnity Act 2002*
MI(PS&PS) Act	*Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*
MPICCS Act	*Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*
MPIS	Midwife Professional Indemnity (Commonwealth Contribution) Scheme
National Law	*Health Practitioner Regulation National Law Act 2009*
PSS	Premium Support Scheme
ROCS	Run-off Cover Schemes
UMP	United Medical Protection
UMP Support Payment Act	*Medical Indemnity (UMP Support Payment) Act 2002*

Purpose of the Bill

The purpose of the Medical and Midwife Indemnity Legislation Amendment Bill 2019 (the Bill) is to amend the *Medical Indemnity Act 2002* (*MI Act*), *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* *(MI(PS&PS) Act)* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* (*MPICCS Act*) to:

- simplify the current legislative structure underpinning the Government's support for medical indemnity insurance
- repeal redundant legislation
- remove the existing contract requirements for the Premium Support Scheme (PSS) and incorporate the necessary requirements in legislation
- require all medical indemnity insurers to provide universal cover to medical practitioners
- maintain support for high cost claims and exceptional claims made against allied health professionals and enable exceptional cost claims to be made, which is provided for in a separate scheme to medical practitioners
- support high cost claims and exceptional cost claims made against private sector employee midwives not covered under the Midwife Professional Indemnity Scheme (MPIS)
- clarify eligibility for the Run-off Cover Scheme (ROCS) and permit access for medical practitioners and eligible midwives retiring before the age of 65
- cause an actuarial assessment to report on the stability and affordability of Australia's medical indemnity market, with the report to be laid before each House of Parliament and
- streamline reporting obligations and improve the capacity for monitoring and information sharing.[1]

These amendments are designed to support the long-term stability and affordability of medical indemnity premiums for medical practitioners.

Structure of the Bill

The Bill contains six Schedules:

- Schedule 1 removes redundant legislation by repealing the *Medical Indemnity (Competitive Advantage Payment) Act 2005* (*Competitive Advantage Payment Act*) and the *Medical Indemnity (UMP Support Payment) Act 2002* (*UMP Support Payment Act*) and making associated consequential amendments to other legislation that refer to those Acts
- Schedule 2 clarifies eligibility under existing claim schemes:
  - Part 1 provides clarity for the claiming criteria under the High Cost Claims Scheme (HCCS) relating to aggregation of claims (where the claim/s is/are against the same medical practitioner or in relation to the same incident or series of incidents)
  - Part 2 amends relevant provisions in the *MI Act* to clarify that the HCCS and the Exceptional Claims Scheme (ECS) are only intended to apply to medical practitioners (as distinct from allied health professionals)
  - Part 3 will allow greater access to the ROCS for medical practitioners and eligible midwives who permanently retire before the age of 65 by removing the current age restriction
  - Part 4 provides that medical and midwife indemnity claims will only relate to incidents that have occurred in connection with a health service

1. Explanatory Memorandum, Medical and Midwife Indemnity Legislation Amendment Bill 2019, pp. 1–2.

- Schedule 3 deals with administrative changes intended to streamline and/or clarify the operation of the legislation, including more efficient information sharing, the use of computerised decision-making by the Chief Executive Medicare (CEM) and an actuarial evaluation of the affordability and stability of the medical indemnity market by February 2021
- Schedule 4 provides for the restructure and consolidation of delegated legislation and creates the power of the Minister to make rules required or permitted by the *MI Act*, or necessary or convenient for carrying out or giving effect to that Act
- Schedule 5 sets out the requirements for universal cover and
- Schedule 6 creates high cost claim and exceptional claims schemes for allied health professionals, including private sector midwives.

Background

Medical indemnity insurance provides financial protection 'to both medical practitioners and patients in circumstances where a patient sustains an injury (or adverse outcome) caused by medical misadventure, malpractice, negligence or an otherwise unlawful act'.[2] In Australia, it is compulsory for all registered health professionals to hold medical indemnity insurance under the *Health Practitioner Regulation National Law Act 2009* (*National Law*).[3] Subsection 129(1) of the *National Law* provides:

> A registered health practitioner must not practise the health profession in which the practitioner is registered unless appropriate professional indemnity insurance arrangements are in force in relation to the practitioner's practice of the profession.

Currently an exemption from this requirement applies under section 284 of the *National Law* for privately practicing midwives who provide intrapartum services (labour and delivery) for women having homebirths. This exemption applies until 31 December 2019.[4]

Government support for medical indemnity

Prior to 2002, medical indemnity insurance was traditionally provided by medical defence organisations (MDOs), not-for-profit mutual organisations that offered discretionary indemnity cover as a benefit to members in return for an annual subscription.[5] In May 2002, the largest MDO in Australia, United Medical Protection (UMP) and its wholly owned subsidiary Australian Medical Protection Limited (AMIL), was placed into provisional liquidation. It was estimated that the collapse of UMP would leave up to 60 per cent of medical practitioners in Australia without professional indemnity cover.[6]

At the same time, insurers were experiencing pressure due to increased claim costs, a fall in investment returns and for some MDOs, a failure to make sufficient provisions for 'incurred but not reported claims' (claims that may occur many years in the future). Further, medical

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2. MP Consulting, *First principles review of the Medical Indemnity Insurance Fund*, report prepared for the Department of Health (DoH), April 2018, p. 9.
3. In 2008, the Council of Australia Governments (COAG) agreed to establish a single national scheme for registered health practitioners, the National Registration and Accreditation Scheme (NRAS). The NRAS 'ensures that all regulated health professionals are registered against consistent, high quality, national professional standards and can practise across state and territory boarders [sic] without having to re-register in each jurisdiction'. The NRAS has been in operation since 2010 and currently covers 15 health professions practicing under protected titles. The NRAS is administered by the Australian Health Practitioner Regulation Agency (AHPRA).
4. Australian College of Midwives (ACM), 'Insurance exemption for private midwives', ACM website.
5. Explanatory Memorandum, Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002, p. 4.
6. S Dudley, *Medical Indemnity Bill 2002*, Bills digest, 71, 2002–03, Parliamentary Library, Canberra, 3 December 2002, p. 2.

practitioners were facing increased premium costs (as high as one third of their incomes) and considering leaving the profession or ceasing high-risk procedures. [7]

As a result of these issues, between 2002 and 2010, the Australian Government implemented a range of financial and regulatory measures designed to support the medical indemnity insurance industry, including: premium subsidies; government assistance for high-cost claims; and placing providers of medical indemnity insurance under the regulatory supervision of the Australian Prudential Regulatory Authority (APRA). These measures were underpinned by tort law reform at the state and territory level.[8]

Indemnity Insurance Fund

During the period 2003–10, seven discrete schemes to provide medical and professional indemnity support for medical practitioners and midwives were established (see Table 1). In 2011, these schemes were consolidated under the Indemnity Insurance Fund (IIF), which is administered by the Department of Health. The primary objective of the IIF is to streamline the administration of the seven schemes with the following priorities:

- promote stability of the medical indemnity insurance market
- keep premiums affordable for doctors in private practice and
- ensure availability of professional indemnity insurance for eligible midwives.[9]

Table 1: schemes within the Indemnity Insurance Fund

Scheme	Purpose and key features
Premium support scheme (PSS)[a]	The PSS assists eligible doctors with the costs of their medical indemnity insurance through reductions in the level of premiums charged to them by their medical indemnity insurer. The PSS currently subsidises 60% of indemnity costs for doctors whose premiums exceed 7.5% of their income from private practice. The applicable subsidies under the PSS have decreased since its introduction. Previous subsidies were: • 80% from 2004 to 1 July 2012 and • 70% from 1 July 2012 to before 1 July 2013. Procedural GPs working in rural areas (Rural, Remote and Metropolitan Areas 3-7[b]) are eligible for PSS regardless of whether they meet other PSS eligibility criteria. The PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances.

7. MP Consulting, *First principles review of the Medical Indemnity Insurance Fund*, op. cit., p. 4.
8. Australian National Audit Office (ANAO), *The management, administration and monitoring of the Indemnity Insurance Fund*, DoH and Department of Human Services, Audit report, 20, 2016–17, ANAO, Barton, ACT, 2016, p. 16.
9. DoH, 'The Indemnity Insurance Fund schemes', DoH website, last updated 31 January 2017.

Scheme	Purpose and key features
Run-off Cover Scheme (ROCS)[c]	The ROCS is designed to provide secure ongoing insurance for doctors who have ceased private practice because of retirement (after the age of 65), disability, maternity leave, death, or if they discontinue working as a doctor in Australia. The Australian Government pays 100% of the costs of valid claims (including the costs of managing claims) made against eligible doctors. The ongoing costs of the scheme are met by the ROCS Support Payment, a levy on the premium income of medical indemnity insurers. Currently a private medical practitioner who leaves the workforce for a reason other than those outlined above, or who retires before the age of 65, will not be eligible for ROCS for a period of three years. As such, those practitioners must purchase run-off cover from their medical indemnity insurer for the three year period if they wish to remain insured. This Bill seeks to permit access to ROCS for medical practitioners and eligible midwives retiring before the age of 65.
High Cost Claims Scheme (HCCS)[d]	The HCCS is intended to place downward pressure on premiums, particularly for doctors in high risk areas, by lowering the amount that insurers pay out and reducing the amount of reinsurance medical indemnity insurers need to buy to fund large claims. Under the HCCS, the Australian Government will reimburse medical indemnity insurers 50% of the insurance payout over $300,000 up to the limit of the practitioner's cover, for claims notified on or after 1 January 2004. From 1 July 2018, the threshold for claims under the HCCS was amended from $300,000 to $500,000. The new threshold will be applied to claims notified to insurers on or after 1 July 2018.
Exceptional Claims Scheme (ECS)[e]	The ECS covers health practitioners for 100% of the cost of private practice claims that are above the limit of their medical indemnity insurance (generally $20 million), so that they are not personally liable for exceptionally high claims. These claims can be either a single very large claim or an aggregate of claims related to an incident that together exceed a threshold for a contract's limit. Health practitioners are not required to make a contribution towards the ECS. It is fully funded by the Government.

Scheme	Purpose and key features
Incurred But Not Reported (IBNR) Indemnity Scheme[f]	The IBNR Indemnity Scheme covers unfunded medical insurers' liabilities that were incurred but not reported as at 30 June 2002. The Government covers 100% of claims. At present, only one insurer, United Medical Protection Limited (now known as Avant Insurance Limited) participates in the IBNR Scheme.
Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS)[g]	The MPIS provides financial assistance to eligible insurers who provide indemnity to eligible midwives. The MPIS was introduced in 2010 to address concerns that privately practicing midwives were unable to access professional indemnity insurance cover from commercial insurers (see further information below). Payment rates: • under the MPIS, the insurer pays the first $100,000 for each claim • Level 1 Commonwealth contribution payments – for each claim over $100,000, the Government will pay, via the insurer, 80% of the cost that exceeds the threshold, up to a ceiling of $2 million • Level 2 Commonwealth contribution payments – for each claim that exceeds $2 million, the Government will pay, via the insurer, at the Level 1 rate for the first $2 million, plus 100% of the cost of the claim above the threshold. There is currently only one provider of professional indemnity insurance for privately practising midwives.
Midwife Professional Indemnity Run-off Cover Scheme (Midwife ROCS)[g]	The Midwife ROCS provides secure ongoing insurance for eligible midwives who have ceased private practice because of retirement, disability, maternity leave, death or other reasons, with 100% of costs covered by the Commonwealth.

Notes: (a) Further information on the PSS, including eligibility criteria can be found at Department of Health (DoH), ' Premium Support Scheme (PSS) – frequently asked questions', DoH website, last updated 1 March 2017; (b) The Rural, Remote and Metropolitan Area (RRMA) classification divides Australia into three zones and seven classes: metropolitan zone (RRMA 1 and 2), rural zone (RRMA 3 to 5) and remote zone (RRMA 6 and 7); (c) Further information on the ROCS, including eligibility criteria can be found at DoH, 'Coverage - doctors', DoH website, last updated 4 April 2018; (d) Further information on the HCCS, can be found at Department of Human Services (DHS), 'High Cost Claim Indemnity Scheme', DHS website, last updated 22 February 2019; (e) Further information on the ECS, can be found at DoH, 'Exceptional Claims Scheme (ECS) – frequently asked questions', DoH website, last updated 31 January 2017; (f) Further information on the IBNR Indemnity Scheme, can be found at DHS, 'Incurred But Not Reported Indemnity Scheme', DHS website, last updated 22 February 2019; (g) Further information on the MIPS, can be found at DHS, 'Midwife Professional Indemnity Scheme', DHS website, last updated 20 September 2019.

Source: DoH, 'The Indemnity Insurance Fund Schemes', op. cit.; Australian National Audit Office (ANAO), The management, administration and monitoring of the Indemnity Insurance Fund, DoH and DHS, Audit report, 20, 2016–17, ANAO, Barton, ACT, 2016, p. 17.

Midwife indemnity insurance

Before 2009–10

Before 2010, there was no obligation for nurses or midwives to have professional indemnity insurance as a condition of their registration to practice. At this time, insurance arrangements for midwives varied. Midwives employed with the public and private sectors were generally

indemnified under the employer's insurance policies and, prior to 2001 privately practicing midwives were able to access indemnity insurance through membership of industrial and professional organisations, such as the Australian Nursing Federation. In 2000–01 professional indemnity insurance coverage was withdrawn from privately practicing midwives. This was perceived to be in response to the medical indemnity crisis of the late 1990s.[10] As such, privately practicing midwives were unable to access indemnity insurance as there were no insurers willing to offer suitable products for the full range of maternity services.[11]

The lack of professional indemnity insurance for privately practicing midwives was raised as a concern during a 2008 review into maternity services, which found that the lack of insurance created a barrier to implementing new models of maternity care. The report further noted that the planned introduction of the health profession's National Registration and Accreditation Scheme in 2010 would pose problems for privately practicing midwives who could not obtain the cover required for registration under state and territory laws.[12] It recommended:

> … while a risk profile for midwife professional indemnity insurance premiums is being developed, consideration be given to Commonwealth support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives operating in collaborative team-based models. Consideration would include both period and quantum of funding.[13]

After 2009–10

In response to the review, the Government announced a $120.5 million package of maternity measures in the 2009–10 Budget aimed at giving access to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme benefits for services provided by eligible midwives and providing government-supported professional indemnity insurance.[14] The Government subsequently introduced and passed legislation which created a framework for the Commonwealth's involvement in an indemnity scheme for midwives. Relevant legislation includes:

- *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*
- *Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2010* and
- *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010*.

As noted previously, under an exemption in the *National Law*, privately practicing midwives who provide intrapartum services (labour and delivery) for women having homebirths are not required to hold professional indemnity insurance, as there is currently no indemnity insurance product available. This exemption applies until 31 December 2019.[15]

MIGA is currently the only provider of professional indemnity insurance for privately practising midwives in Australia.[16]

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10. K Forrester, 'Nurses, midwives and the requirement for "appropriate" professional indemnity insurance', *Journal of Law and Medicine*, 19(4), 1 June 2010, p. 679; R Bryant, *Improving maternity services in Australia: the report of the Maternity Services Review*, report prepared for the Department of Health and Ageing, [Canberra], February 2009; pp. 53–54.
11. Bryant, *Improving maternity services in Australia: the report of the Maternity Services Review*, op. cit., pp. 54–55.
12. Ibid., p. 55.
13. Ibid., p. 55 (recommendation 18).
14. P Pyburne, K Magarey and R Jolly, *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009*, Bills digest, 12, 2009–10, Parliamentary Library, Canberra, 12 August 2009, pp. 3–7.
15. ACM, 'Insurance exemption for private midwives', ACM website.
16. MIGA, 'Insuring with us: protection tailored to midwifery practice', MIGA website.

Recent reviews

In February 2014, the National Commission of Audit recommended that the Commonwealth scale back its subsidies for medical indemnity insurance. It reported that there was evidence that the market was normalising, with premiums becoming more affordable and net assets and profits for insurers increasing.[17] At the time the Government announced that reforms to medical indemnity would be considered following the 2014–15 Budget.[18]

Australian National Audit Office

The Australian National Audit Office (ANAO) conducted a performance audit of the IIF in 2016. The report made a number of recommendations which were accepted by the Department of Health:

> Recommendation No. 1: The Department of Health should conduct a 'first principles review' of the Indemnity Insurance Fund and related schemes prior to the 2017–18 Budget.
>
> Health's response: Agreed with qualification.
>
> Recommendation No. 2: Subject to the outcome of this 'first principles review', the Department of Health should develop and implement a fit-for-purpose monitoring and reporting arrangement for the Indemnity Insurance Fund, legislation, and related schemes that provides its Minister with timely, robust analysis of the Indemnity Insurance Fund's performance and risks to government.
>
> Health's response: Agreed.
>
> Recommendation No. 3: That the Department of Health establish suitable governance and stakeholder engagement arrangements, including risk management plans, to support its and other shared responsibilities for the administration of the Indemnity Insurance Fund and related schemes.
>
> Health's response: Agreed.
>
> Recommendation No. 4: That the departments of Health and Human Services review their Indemnity Insurance Fund administrative arrangements to:
>
> (a) establish a suitable set of public and internal key performance indicators that allow for relevant, reliable and complete reporting of the Indemnity Insurance Fund schemes' performance;
>
> (b) ensure that public guidance materials are accurate, consistent and current;
>
> (c) establish suitable controls to improve data integrity, including monitoring and reporting of any relevant matters under the bilateral programme agreement; and
>
> (d) consult with relevant insurers and the Australian Government Actuary to improve the relevancy, consistency and accuracy of data used to inform projections of the Commonwealth's risks.
>
> Health's response: Agreed.
>
> Human Services' response: Agreed.[19]

17. ANAO, The management, administration and monitoring of the Indemnity Insurance Fund, op. cit., p. 7.
18. J Hockey (Treasurer) and M Cormann (Minister for Finance), *Budget 2014: our response to the National Commission of Audit Report*, joint media release, 13 May 2014.
19. ANAO, The management, administration and monitoring of the Indemnity Insurance Fund, op. cit., pp. 10–11.

First Principles Review

In the 2016–17 Mid-Year Economic and Fiscal Outlook (MYEFO) the Government announced that it would achieve savings of $35.9 million over three years from 2017–18 by raising the eligibility threshold for claims under the HCCS from $0.3 million to $0.5 million from 1 July 2018. At the same time, the Government provided $0.2 million to conduct a review of the IIF and associated schemes.[20] Two reviews were conducted by the Department of Health:

- the *First Principles Review* (FPR) of the IIF and
- a thematic review of the medical indemnity legislation.

The FPR of the IIF sought to answer three questions:

- To what degree has Commonwealth intervention been successful in providing stability to the medical indemnity insurance industry, availability of affordable indemnity insurance, and viability for professions, and patients, particularly in relation to high cost claims?
- What is the appropriate level of Commonwealth support needed to continue stability, affordability and accessibility of indemnity insurance for medical practitioners and eligible midwives?
- Are the seven schemes that collectively comprise the IIF fit for purpose or might improvements be made?[21]

The report made a number of recommendations aimed at improving efficiency, targeting and transparency of the IIF. This Bill puts in place the legislative framework to implement a number of these recommendations. The complete list of recommendations can be found at **Appendix A** of this Bills Digest.

Thematic Review

The *Thematic Review of Commonwealth Medical and Midwife Indemnity Legislation* examined 17 legislative instruments supporting the IIF. The review focussed on identifying opportunities to:

- consolidate instruments wherever possible
- remove redundant or inoperable legislation
- ensure the instruments are consistent with the broader legal and policy context and with the clearer laws principles and
- simplify the legislation wherever possible.[22]

A summary of the key findings of the review can be found at **Appendix B** of this Bills Digest.

Committee consideration

Senate Selection of Bill Committee

In its report on 17 October 2019, the Senate Selection of Bills Committee recommended that the Bill not be referred to a committee for inquiry.[23]

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20. S Morrison (Treasurer) and M Cormann (Minister for Finance), *Mid-year economic and fiscal outlook – 2016–17*, p. 171.
21. MP Consulting, *First principles review of the Medical Indemnity Insurance Fund*, op. cit., p. 4.
22. MP Consulting, *Thematic review of Commonwealth medical and midwife indemnity legislation*, report prepared for the DoH, February 2018, p. 4.
23. Senate Standing Committee for Selection of Bills, *Report*, 7, 2019, The Senate, Canberra, 17 October 2019, p. 3.

Senate Standing Committee for the Scrutiny of Bills

In its report on 16 October 2019, the Senate Standing Committee for the Scrutiny of Bills (the Committee) raised three concerns relating to the Bill about which it requested further Ministerial advice.

Computerised decision-making

The Committee noted:

> Items 15 and 26 of Schedule 3 to the bill seek, respectively, to insert sections 76A into the *Medical Indemnity Act 2002* (Indemnity Act) and section 87A into the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010 (MPI) Scheme Act)* [that would allow the Chief Executive Medicare] to arrange for the use of computer programs for any purpose for which the CEM may or must take administrative action.[24]

The Committee questioned whether this was 'necessary and appropriate' and whether consideration had been given to requiring that certain administrative actions (for example, complex or discretionary decisions) be taken by a person rather than by a computer.[25]

Reversal of evidential burden of proof

The Committee noted:

> Subsection 77(2) of the Indemnity Act and subsection 88(2) of the MPI Scheme Act provide that a person commits an offence if they copy, record, disclose or produce protected information or a protected document to another person, where the first person is not performing or exercising duties, powers or functions under specified legislation. The offence is punishable by two years' imprisonment.
>
> Items 18 and 29 of Schedule 3 to the bill seek, respectively, to insert subsections 77(2A) and (2B) into the Indemnity Act, and subsections 88(2A) and (2B) into the MPI Scheme Act. The new provisions would provide that, despite subsections 77(2) and 88(2), certain listed persons may copy, record, or disclose protected information or a protected document, for the purposes of monitoring, assessing or reviewing the operation of the medical indemnity legislation. In this respect, they would create offence-specific defences to the offences in subsections 77(2) and 88(2). The defences reverse the evidential burden of proof.[26]

The Committee requested the Minister's advice as to whether the proposed reversal of the evidential burden of proof was necessary and appropriate.[27]

Broad delegation of legislative power

The Committee also noted that Schedule 6, item 26, proposed paragraphs 34ZZG(2)(b) and 34ZZZD(2)(b), and proposed subsections 34ZZZF(1) and (2) allow regulations to modify and exempt matters from the operation of the primary legislation and questioned whether it would be appropriate to amend the Bill to insert high-level guidance concerning the making of regulations:

> Item 26 of Schedule 6 to the bill seeks to insert new Divisions 2C and 2D into the Indemnity Act, to provide for the operation of the allied health high cost claim indemnity scheme and the allied health exceptional claims indemnity scheme.

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24. Senate Standing Committee for the Scrutiny of Bills, *Scrutiny digest*, 7, 2019, 16 October 2019, pp. 33–34.
25. Ibid., pp. 34–35.
26. Ibid., p. 35.
27. Ibid., p. 36.

Proposed paragraphs 34ZZG(2)(b) and 34ZZZD(2)(b) seek to allow regulations to provide, respectively, that Divisions 2C and 2D apply, with specified modifications, to certain liabilities associated with costs which have been paid.

Additionally, proposed subsection 34ZZZF(1) seeks to allow the regulations to provide that Division 2D applies, with specified modifications, in relation to a specified class of claims, a specified class of contracts of insurance, or a specified class of situations in which a liability is wholly or partly covered by more than one contract of insurance. Proposed subsection 34ZZZF(2) further seeks to allow the regulations to provide that Division 2D does not apply, or applies with specified modifications, in relation to a specified class of liabilities or payments.

Provisions enabling delegated legislation to modify the operation of primary legislation are akin to Henry VIII clauses, which authorise delegated legislation to make substantive amendments to primary legislation (generally the parent Act). The committee has significant scrutiny concerns with Henry VIII-type clauses, as such clauses impact parliamentary oversight and may subvert the appropriate division of powers between the Parliament and the executive. The committee will also have concerns about provisions that enable delegated legislation to create exemptions from primary legislation, as these provisions may have the effect of limiting, or in some cases removing, parliamentary scrutiny.

In light of these matters, the committee expects a sound justification in the explanatory materials for any provision that allows delegated legislation to modify, or to exempt matters from, the operation of primary legislation. The committee notes that, in this instance, no such justification is provided in the explanatory memorandum.

The committee requests the minister's advice as to:

- why it is proposed to allow regulations to modify and exempt matters from the operation of the primary legislation; and

- whether it would be appropriate to amend the bill to insert at least high-level guidance concerning the making of such regulations.[28]

At the time of writing the Ministerial response had been received but not published.[29]

Policy position of non-government parties/independents

Australian Labor Party

The Australian Labor Party (Labor) is broadly supportive of the Bill, but has raised concerns regarding two main issues: the continued lack of insurance coverage options for private midwives providing intrapartum services (labour and delivery) for women having homebirths and the continuation of a single insurance provider for midwives, limiting individual choice.[30]

28. Ibid., p. 37.
29. Senate Standing Committee for the Scrutiny of Bills, *Ministerial responses*, The Senate, Canberra, as at 13 November 2019.
30. S Templeman, 'Second reading speech: Medical and Midwife Indemnity Legislation Amendment Bill 2019', House of Representatives, *Debates*, (proof), 16 October 2019, p. 14; G Kearney, 'Second reading speech: Medical and Midwife Indemnity Legislation Amendment Bill 2019', House of Representatives, *Debates*, (proof), 16 October 2019, p. 20.

Independents

The Member for Indi, Dr Helen Haines MP, supports the Bill but also considered that the inclusion of insurance options for private midwives providing intrapartum services for homebirths would be beneficial.[31]

Position of major interest groups

Australian Medical Association

The Australian Medical Association (AMA) is strongly supportive of the Bill, noting its continued advocacy in the space since 2002:[32]

> The *Medical and Midwife Indemnity Legislation Amendment Bill 2019* will ensure the AMA's hard-won medical indemnity reforms of 2002 will continue to provide confidence for doctors, their patients, and insurers.
>
> …
>
> The ability of doctors to continue to practise medicine securely into the future has been strengthened.
>
> The AMA played a critical role steering two indemnity reviews over the past two years.
>
> AMA President Dr Tony Bartone said bringing the reviews to their conclusions was both challenging and rewarding.
>
> "The AMA has fought hard to maintain the stability of our medical indemnity system and preserve the underwriting from the Commonwealth, which we achieved well over a decade ago," Dr Bartone said.
>
> "In 2016, there was a sudden and substantial cut to medical indemnity schemes, followed by the announcement of the two reviews.
>
> "Concerned about the Government's ongoing commitment to these schemes, the AMA advocated forcefully at each and every consultation, meeting, roundtable, and re-draft of the schemes.
>
> "On behalf of the entire profession, we have worked with indemnity insurers, other peak groups, the Department of Health, the Minister's office, and the Australian Financial Complaints Authority, to name but a few."
>
> …
>
> "This should ensure that the premium stability we have enjoyed continues."[33]

Financial implications

The Explanatory Memorandum states that the legislative changes have nil financial impact.[34]

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31. H Haines, 'Second reading speech: Medical and Midwife Indemnity Legislation Amendment Bill 2019', House of Representatives, *Debates*, (proof), 16 October 2019, p. 18
32. Australian Medical Association (AMA), 'Medical indemnity reform wins', AMA website.
33. Ibid.
34. Explanatory Memorandum, Medical and Midwife Indemnity Legislation Amendment Bill 2019, p. 2.

Statement of Compatibility with Human Rights

As required under Part 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth), the Government has assessed the Bill's compatibility with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of that Act. The Government considers that the Bill is compatible.[35]

Parliamentary Joint Committee on Human Rights

At the time of writing, the Parliamentary Joint Committee on Human Rights has not commented on the Bill.

Schedule 1—Competitive advantage payment and UMP support payment

Part 1 – Repeals

Items 1 and 2 repeal the *Competitive Advantage Payment Act* and the *UMP Support Payment Act* respectively. Both Acts are being repealed as they are considered redundant.

The *Competitive Advantage Payment Act* provides for an annual tax (competitive advantage payment) to be imposed on a MDO participating in the Incurred But Not Reported (IBNR) Indemnity Scheme.[36] The annual tax is imposed to neutralise any competitive advantage the MDO may have due to its participation in the IBNR Indemnity Scheme.

Avant Mutual Group Limited (Avant) and its predecessor UMP was the only MDO subject to the competitive advantage payment. According to the Explanatory Memorandum, in 2006, the only MDO (UMP, now Avant) entered into a deed of agreement with the Commonwealth, to pay a lump sum in order 'to redress the competitive advantage received by the insurer through participation in the IBNR Indemnity Scheme'.[37] The effect of this arrangement means that under section 25A of the Medical Indemnity Regulations 2003, the MDO is exempt from having to make the annual competitive advantage payment. This has therefore rendered the *Competitive Advantage Payment Act* redundant.

The Explanatory Memorandum states:

> The Medical Indemnity (UMP Support Payment) Regulations 2002 (established under the *Medical Indemnity (UMP Support Payment) Act 2002*) declare that the financial year starting on 1 July 2006 is the last contribution year for UMP (now Avant). As UMP support payment is no longer payable, the legislation and regulations are redundant.[38]

Part 2 – Amendments

Part 2 of Schedule 1 to the Bill amends a number of statutes which are affected by the repeal of the two pieces of legislation in Part 1 of Schedule 1 by, among other things, removing reference to

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35. The Statement of Compatibility with Human Rights can be found at pages 3–6 of the Explanatory Memorandum to the Bill.
36. M Bracken, Major changes to Medical Indemnity Support Schemes: implications for medical indemnity insurers, doctors and allied health professionals , *Insights*, Colin, Biggers & Paisley Lawyers, 27 September 2019.
    The IBNR Indemnity Scheme funds the IBNR liabilities of MDOs where they don't have enough reserves to cover their liabilities. IBNR is a type of reserve account used in the insurance industry as the provision of funds for claims and/or events that have transpired, but have not yet been reported to an insurance company. An insurer knows neither how many of these losses have occurred, nor the severity of each loss, thus the IBNR figure is an estimate which is tested using actuarial and statistical techniques. Source: J Kagan, ed., 'Incurred But Not Reported (IBNR)', Investopedia website, last updated 25 June 2019.
37. Explanatory Memorandum, op. cit., p. 8.
38. Ibid., p. 9.

the *Competitive Advantage Payment Act* and the *UMP Support Payment Act*. Amendments are also made as a consequence of changes to the run-off cover in Part 3 of Schedule 2 to the Bill which is discussed below. Other amendments include changes to the objects of the *MI Act*, and also to the IBNR annual assessment and reporting requirements, shifting from a contribution year to a financial year.

Medical Indemnity Act 2002

Items 8–52 in Part 2 of Schedule 1 to the Bill amend the *MI Act*. Existing section 3 of the *MI Act* outlines the objects of the Act.

Item 8 inserts a new subheading 'Availability of medical services' in the Objects provision, just above subsection 3(1), which refers to the object of contributing towards the availability of medical services in Australia.

Existing subsection 3(4) states that an object of the *MI Act* is to allow the Commonwealth:

- to recover the costs of providing the assistance referred to in paragraph (2)(c)[39] by requiring payments from persons who were members of relevant organisations on 30 June 2000
- to recover the costs of providing the assistance referred to in paragraph (2)(ab)[40] by requiring payments from medical indemnity insurers and
- to require a payment from medical indemnity insurers to ensure that the assistance referred to in paragraph (2)(c) does not give a competitive advantage to the organisations that receive that assistance.

Item 9 repeals and replaces subsection 3(4) to re-shape the currently stated object to provide that it is 'to allow the Commonwealth to recover costs of providing the assistance referred to in paragraph (2)(ab) by requiring payments from medical indemnity insurers'.

Item 21 in Part 2 of Schedule 1 to the Bill inserts **proposed Subdivision G—IBNR exposure** into Division 1 of Part 2 of the *MI Act*. Within new Subdivision G, **proposed section 27C** sets out the process for annually reassessing IBNR exposure. The IBNR Indemnity Scheme funds the IBNR liabilities of MDOs where they do not have enough reserves to cover their liabilities. 'IBNR is a type of reserve account used in the insurance industry as the provision of funds for claims and/or events that have transpired, but have not yet been reported to an insurance company.'[41] An insurer knows neither how many of these losses have occurred, nor the severity of each loss, thus the IBNR figure is an estimate which is tested using actuarial and statistical techniques.[42]

Report by the Actuary

Proposed subsection 27C(1) of the *MI Act* provides that for each financial year, the Actuary[43] must give the Minister for Health a written report that:

- states the Actuary's assessment of the participating MDO's IBNR exposure as at the end of the financial year and

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39. Paragraph 3(2)(c) of the *MI Act* deals with meeting the cost associated with certain IBNR liabilities of organisations that indemnify medical practitioners to the extent to which those organisations had not made adequate provision for those liabilities as at 30 June 2002.
40. Paragraph 3(2)(ab) of the *MI Act* deals with meeting the amounts payable in relation to certain claims (notified on or after 1 July 2004) against medical practitioners who are no longer in private medical practice.
41. J Kagan, ed., 'Incurred But Not Reported (IBNR)', op. cit.
42. Ibid.; Explanatory Memorandum, op. cit., p. 13.
43. *MI Act*, subsection 4(1) defines the term ***Actuary*** as the Australian Government Actuary.

- sets out the reasons for the assessment.

In preparing the report, the Actuary must take into account any information that the CEM gives the Actuary in relation to the participating MDO, which has been given by the MDO for the purposes of preparing the report for the Minister for Health.

Chief Executive Medicare's information gathering powers

Proposed subsection 27C(3) of the *MI Act* provides that if the CEM believes on reasonable grounds that the participating MDO is capable of giving information that is relevant to assessing the participating MDO's IBNR exposure as at the end of a financial year, the CEM may request the participating MDO to give him, or her, the information. Without limiting the type of information that may be requested, by way of example it may include financial statements, and a report prepared by a suitably qualified actuary assessing the participating MDO's IBNR exposure as at the end of a financial year.[44]

Currently section 45 of the *MI Act* provides that a failure to provide information under specified provisions gives rise to an offence of strict liability.[45] **Item 27** of Part 2 of Schedule 1 to the Bill amends subsection 45(1) so that the failure to comply with a request for information under **proposed subsection 27C(3)** is an offence under the *MI Act*.[46]

Schedule 2—Indemnity scheme payments

Part 1 – Aggregation of claims for high cost claim indemnity schemes

The provisions in Part 1 of Schedule 2 to the Bill amend the *MI Act*.

The *MI Act* aims to contribute towards the availability of medical services in Australia, by providing Commonwealth assistance to support access by medical practitioners to affordable arrangements that indemnify them for claims arising in relation to their practice of their medical professions.[47] It seeks to maintain the affordability of medical indemnity insurance premiums.

The Explanatory Memorandum states that amendments proposed under this part are aimed at providing greater 'clarity around the claiming criteria under the High Cost Claim Scheme (HCCS) when claims [or a claim] have more than one defendant'.[48] The amendments will also apply to the new Allied Health High Costs Claim Scheme (AHHCCS) (see Schedule 6).

Item 1 amends **subsection 4(1)** of the *MI Act* to insert a reference to the definition of ***eligible related claims***.

Item 2 repeals and replaces section 8A to set out the criteria for ***eligible related claims*** in relation to a high cost claim indemnity or allied health high cost claim indemnity. A claim or claims will be eligible related claims for the purposes of aggregation, where the claim is against the same medical practitioner, in relation to the same incident, or series of incidents, and either:

- all the claims are part of the same class action or representative proceeding or

44. *MI Act,* **proposed subsection 27C(4)**, inserted by **item 21** in Part 2 of Schedule 1 to the Bill.
45. The imposition of strict liability means that a fault element does not need to be satisfied. The offence will not criminalise honest errors and a person cannot be held liable if he, or she, had an honest and reasonable belief that they were complying with relevant obligations. See section 6.1 of the *Criminal Code Act 1995*.
46. *MI Act,* **proposed paragraph 45(1)(b)**, inserted by **item 27** in Part 2 of Schedule 1 to the Bill.
47. *MI Act*, subsection 3(1).
48. Explanatory Memorandum, op. cit., p. 18.

  - the incident, or series of incidents, occurred in connection with a pregnancy or birth of a child or children (that is, in respect of a single birth event)[49] and
- the application is the only application for a high cost claim indemnity or allied health high cost claim indemnity that has been made in relation to any of the claims and
- none of the claims are eligible related claims in relation to another claim for which an application for a high cost claim indemnity or allied health high cost claim indemnity has been made.

The Explanatory Memorandum states:

> The policy intent is that the aggregation of claims can only apply in respect of the same individual practitioner. A single high cost claim threshold cannot be applied across multiple practitioners in relation to the same event.[50]

Section 30 of the *MI Act* sets out the circumstances in which high cost claim indemnity is payable.

Item 3 of Part 1 in Schedule 2 to the Bill repeals and replaces subparagraphs 30(1)(d) to (f) which provide for a new payability rule.

In addition to the existing criteria for payment of a high cost claim indemnity to a MDO or insurer, the amendment also requires that:

- the MDO or insurer is first notified of the incident, claim or eligible related claim between 1 January 2003 and the date specified in the rules as the termination date for the high cost claim indemnity scheme[51]
- the MDO or insurer has a qualifying payment in relation to the claim, or qualifying payments in relation to the claim, or the claim and one or more eligible related claims[52] and
- the amount of the qualifying payment, or the sum of the amounts of the qualifying payments, exceeds what was the high cost claim threshold at the earliest of the following times:
  - when the MDO or insurer was first notified of the incident
  - when the MDO or insurer was first notified of the claim or
  - when the MDO or insurer was first notified of an eligible related claim.[53]

Subsection 31(1) of the *MI Act* sets out the circumstances in which aggregating amounts for eligible claims are paid or payable by a MDO and insurer. Currently, the section applies if a MDO pays, or is liable to pay, an amount in relation to a claim, and an insurer pays or is liable to pay 'an amount in relation to the *same claim* (the insurer amount)', and the other limbs of that section are satisfied. [Emphasis added]

Item 6 amends paragraph 31(1)(b) by removing the reference to 'an amount in relation to the *same claim* (the insurer amount)'. This is substituted with a reference to 'an amount (the insurer amount) in relation to the same claim *or an eligible related claim*'. [Emphasis added]

Item 9 inserts **proposed subparagraph 31(2)(a)(iii)** into the *MI Act* which deems the MDO to have received notification of the incident, claim or eligible related claim when the insurer was first notified. The Explanatory Memorandum clarifies that if the MDO was first notified (before the

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49. Ibid., p. 19.
50. Ibid.
51. *MI Act*, **proposed paragraph 30(1)(d)**. The Explanatory Memorandum (at page 20) states that no change has been made to the basic payability rule with respect to the time for first notification of the claim or the incident.
52. *MI Act*, **proposed paragraph 30(1)(e)**.
53. *MI Act*, **proposed paragraph 30(1)(f)**.

insurer), then that time will be the relevant time of notification for the purposes of satisfying proposed **paragraphs 30(1)(d) and (f)** in relation to payability and timing.[54]

Item 10 provides that the amendments made by this Part of the Bill apply in relation to any application for an indemnity scheme payment made on or after Schedule 2 commences (whether in relation to a claim made before or after that commencement).

Part 2—Medical Professions

Medical Indemnity Act 2002

Part 2 of Schedule 2 to the Bill makes amendments to the *MI Act* which clarify the eligibility of medical practitioners, as distinct from allied health professionals, in relation to the HCCS and the ECS.[55]

Items 12 to 15 make necessary amendments to relevant provisions of the *MI Act* by removing reference to individuals who fall under the rubric of allied health professionals. This is done to clarify that the HCCS and ECS only have application in relation to medical practitioners.

Item 16 contains an application provision specifying that despite the amendments made under this Part, those sections will continue to apply in respect of a claim if that claim relates to an incident that occurred prior to 1 July 2020, or a series of incidents, at least one of which occurred before 1 July 2020, in the course of or in connection with, the practice by a practitioner of a medical profession (other than practice as an eligible midwife or medical practitioner). Thus those who were eligible for the HCCS and ECS prior to 1 July 2020 will continue to have their claims assessed under the HCCS or ECS.

Part 3—Run-off cover on retirement

Run-off Cover is a niche class of insurance held within a Professional Indemnity Insurance policy which provides liability cover for work done by a person or business in the past, prior to adopting the run-off cover. This type of cover is provided by an insurer when a particular person retires or when a business is sold.[56] The ROCS 'is a scheme designed to provide secure insurance for doctors who have left private practice'.[57]

Medical practitioners

Currently, if a medical practitioner retires before the age of 65, an insurer must offer them run-off cover on the same terms and conditions as their last cover[58] (other than terms as to price).[59] After three years of not engaging in private medical practice, the practitioner becomes eligible for ROCS and is no longer charged for run-off cover.

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54. Explanatory Memorandum, op. cit., p. 21.
55. Ibid., p. 22.
56. D Gribble, 'Guide to run-off insurance', Finder website, n.d.
57. DoH, 'Run Off-Cover Scheme (ROCS) - frequently asked questions', DHS website, last updated 19 January 2017.
58. 'Last cover' refers to the cover a practitioner had prior to a period in ROCS. It will usually correspond to a medical indemnity contract of insurance which was in place immediately prior to leaving private practice. DoH, 'Run Off-Cover Scheme (ROCS) - frequently asked questions', op. cit.
59. Experien Insurance Services (EIS), 'Run Off Cover (ROC) and The Run Off Cover Scheme (ROCS) for doctors' professional indemnity insurance', *EIS blog*, 9 April 2019.

Thus, in the interim three year period, insurers can charge a nominal amount for run-off cover offered to medical practitioners who permanently retire from private medical practice under the age of 65.

Midwives

A parallel scheme with the same three year waiting period applies to midwives who permanently retire from private practice before the age of 65.[60]

Effect of Amendments

The amendments proposed by this Part of the Bill will have the effect that on expiry of the medical practitioner's or midwife's insurance contract, an insurer will not be able to charge a premium for the run-off cover despite a medical practitioner or midwife retiring before the age of 65.[61]

The Bill amends the ROCS eligibility requirements to provide that medical practitioners and midwives who have retired permanently from private medical practice (regardless of their age) are eligible for the ROCS, without requiring them to wait three years.

Age Discrimination Act 2004 (Cth)

Subsection 39(1A) of the *Age Discrimination Act* provides that anything done in direct compliance with a provision of an Act listed in the table contained in Schedule 2 of the *Age Discrimination Act* is not unlawful. This is because the statutes listed in that table are those for which an exemption is provided by subsection 39(1A). Currently, items 6 and 7 of the table are the *MI(PS&PS) Act* (Part 3) and the Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003 (Part 3), respectively.

Item 17 repeals table items 6 and 7 from Schedule 2 of the *Age Discrimination Act*, thus removing the age discrimination exemption in relation to run-off cover for medical practitioners and midwives.

Medical Indemnity Act 2002

Section 34ZB of the *MI Act* sets out the eligibility criteria for run-off claims. One of the eligibility criteria in existing paragraph 34ZB(2)(a) is that the person against whom the claim is made is aged 65 years or over and has retired permanently from private medical practice.

Item 19 amends paragraph 34ZB(2)(a) by removing the 'aged 65 years or over' requirement, and simply requiring that the person has retired permanently from private medical practice regardless of age.

Item 20 contains transitional provisions specifying that the amendments made to the *Age Discrimination Act* made by this Part apply in relation to anything done after the commencement of **subitem 20(1)**. **Subitem 20(2)** provides that the amendments to subsection 34ZB(2) of the *MI Act* made by this Part apply in relation to:

- any claim made after the commencement of this item against a person who has retired permanently from private medical practice and

60. Explanatory Memorandum, op. cit., p. 23.
61. *MPICCS Act,* paragraph 31(2)(a), amended by **item 21** of Part 3 in Schedule 2 to the Bill.

- any requirement under Division 2A of Part 3 of the *MI(PS&PS) Act* to provide medical indemnity cover after the commencement of this item for a person who has retired permanently from private medical practice

whether the person retired before or after the commencement of this item.

However, if before **item 20** commences:

- a person less than 65 years has permanently retired from medical practice and
- they have accepted an offer to provide medical indemnity cover because of a particular event prescribed by the regulations, or they have accepted an offer to renew because of those circumstances, and that cover has not expired

that person cannot enjoy relief from premium for that indemnity until that cover expires.

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010

Paragraph 31(2)(a) of the *MPICCS Act* sets out the eligibility criteria for run-off claims. One of the eligibility criteria in existing paragraph 31(2)(a) is that the person against whom the claim is made is aged 65 years or over and has retired permanently from private practice as an eligible midwife.

Item 21 amends paragraph 31(2)(a) of the *MPICCS Act* by removing the 'aged 65 years or over' criterion, and simply requiring that the person has retired permanently from private practice as an eligible midwife, regardless of age. This amendment enables them to access the ROCS without paying a premium for the run-off cover.

Item 22 contains an application provision specifying that midwives who have permanently retired from private practice under the age of 65 before or after the commencement of item 21, will be entitled to access the ROCS in relation to claims made after the commencement of amendments in item 21.

Part 4—Health service incidents

Medical Indemnity Act 2002

The proposed amendments in this Part are intended to provide clarification about the purpose and scope of the IIF. The Explanatory Memorandum states that 'payments will only be made if the claim relates to the provision of a health service (for example rather than a workplace or occupier's liability issue)'.[62] Two amendments are made to the definitions subsection 4(1) of the *MI Act* to ensure the payment of claims clearly align with this intent.

Item 23 inserts a definition of ***health service*** into subsection 4(1) of the *MI Act* to more clearly delimit it to its practical professional meaning. The proposed definition of health service is 'any service, care, treatment, advice or goods provided in respect of the physical or mental health of a person'.

Item 24 repeals the existing definition of ***incident*** in subsection 4(1) of the *MI Act* and substitutes it with a new definition so that ***incident*** will mean 'any incident (including any act, omission or circumstance) that occurs, or that is claimed to have occurred, in the course of, or in connection with, the provision of a health service'.

62. Explanatory Memorandum, op. cit., p. 24.

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010

Amendments proposed to the definitions section of the *MPICCS Act* by **items 25 and 26**, mirror the amendments made by **items 23 and 24** in this Part. Correspondingly, the intent of the amendments is to ensure that 'payments will only be made if the claim relates to the provision of a health service (for example rather than a workplace or occupier's liability issue)'.[63]

Item 27 of Part 4 in Schedule 2 to the Bill contains an application provision stating that the amendments made by this part apply in relation to an incident that occurs or is claimed to have occurred after the commencement of this Part.

Schedule 3—Administration

The Explanatory Memorandum states that the amendments proposed in this Schedule 'deal with administrative changes that streamline and/or clarify the operation of the legislation'.[64]

The Explanatory Memorandum provides a good summary of the key changes as follows:

- insert subsection headings to improve readability
- enable the Chief Executive Medicare to treat an application as having been withdrawn if further information requested is not provided by the date specified (**items 4** and **11**)
- streamline the process for annual reporting on the ROCS to enable the Secretary to publish the Actuary's report on the Department of Health's website (**items 5-7** and **22-24**)
- enable more efficient information sharing between relevant agencies by specifying the circumstances in which it will not be an offence to share protected information and documents where it is for the purposes of monitoring, assessing or reviewing operation of the medical indemnity legislation (**items 18** and **29**). Specifically, it will not be an offence for the Secretary of the Department, the Chief Executive Medicare, the Actuary, Australian Prudential Regulation Authority or Australian Securities and Investments Commission to share information where it is for the purposes of the medical indemnity legislation or the midwife professional indemnity legislation, in particular to monitor and report to Parliament on the effectiveness of Government financial support for the medical indemnity sector
- confirm that the Chief Executive Medicare may use a computer program to make decisions etc. under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* (**items 15 and 26**)
- confirm the Secretary's ability to delegate powers and functions under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* to persons prescribed in those Acts (**items 15** and **26**).[65]

In 2016, the ANAO released its report on *The Management, Administration and Monitoring of the Indemnity Insurance Fund*.[66] In its report the ANAO made a number of observations and recommendations. Among its findings was:

> The Department of Health does not have fit-for-purpose monitoring and reporting arrangements in place to assess the impact of the measures—including regulatory and other legal reforms on the stability

63. Ibid., p. 24.
64. Ibid., p. 25.
65. Ibid.
66. ANAO, *The management, administration and monitoring of the Indemnity Insurance Fund*, op. cit.

> of the indemnity insurance market, the affordability of premiums or importantly, the government's exposure to risk.[67]

In response to these findings, particular amendments are proposed in Schedule 3 to the Bill which make provision for 'an evaluation of the affordability and stability of the medical indemnity market'.[68] The Explanatory Memorandum states:

> The intent of these provisions is to evaluate and report to Parliament on the effectiveness of the Government's support for medical indemnity insurance and whether objectives are being achieved.[69]

Item 14 inserts at the end of Part 2 of the *MI Act*, **proposed Division 8—Monitoring**. Under this Division, **proposed section 50** outlines the circumstances under which a medical indemnity insurer may be required to provide information to the Secretary about any of the following matters:

- premium costs of medical indemnity cover provided by contracts of insurance with the insurer[70]
- the income of medical practitioners, or persons who practise an allied health profession, for whom contracts of insurance with the insurer provide medical indemnity cover[71]
- the profitability of the insurer[72]
- the insurer's reinsurance arrangements and costs.[73]

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010

Item 25 inserts at the end of Part 4 of Chapter 2 of the *MPICCS Act*, **proposed Division 9—Monitoring**. Under this Division, **proposed section 71A** outlines the circumstances under which an eligible insurer may be required to provide information to the Secretary about any of the following matters:

- premium costs for midwife professional indemnity cover provided by contracts of insurance with the insurer[74]
- the income of eligible midwives for whom contracts of insurance with the insurer provide midwife professional indemnity cover[75]
- the profitability of the insurer[76]
- the insurer's reinsurance arrangements and costs.[77]

67. Ibid., p. 8.
68. Explanatory Memorandum, op. cit., p. 26.
69. Ibid.
70. *MI Act*, **proposed paragraph 50(a)**.
71. *MI Act*, **proposed paragraph 50(b)**.
72. *MI Act*, **proposed paragraph 50(c)**.
73. *MI Act*, **proposed paragraph 50(d)**.
74. *MPICCS Act*, **proposed paragraph 71(a)**.
75. *MPICCS Act*, **proposed paragraph 71(b)**.
76. *MPICCS Act*, **proposed paragraph 71(c)**.
77. *MPICCS Act*, **proposed paragraph 71(d)**.

Schedule 4—Instruments

Part 1—Amendments

Medical Indemnity Act 2002

The amendments in Part 1 of Schedule 4 to the Bill are mainly 'minor and machinery in nature'.[78] For example, there are amendments to remove redundant references, but also to insert new and necessary definitions.

Item 6 repeals the existing definition of ***participating MDO*** and substitutes it with a new definition such that ***participating MDO*** means UMP. This is to provide clarity that there is only one participating MDO.[79]

As already mentioned, the thematic review of Commonwealth medical and midwife indemnity legislation identified opportunities to, and recommended the consolidation and streamlining of multiple instruments, simplifying the law and ensuring the instruments are properly aligned with the broader legal and policy context. The amendments in this Part of the Bill enable these changes to occur, reducing 'the number of separate legislative instruments used for the purpose of regulating the Government's support for medical indemnity'.[80]

Of note is that all matters prescribed under the powers in the *MI Act* will be consolidated into one of two instruments: the Medical Indemnity Rules or Medical Indemnity Regulations.

Minister's Rule Making power

Item 138 in Part 1 of Schedule 4 to the Bill inserts **proposed section 80** at the end of the Part 4 of the *MI Act* titled '**rules**'.

Proposed subsection 80(1) empowers the Minister to make rules by legislative instrument prescribing matters:

- required or permitted by the *MI Act* to be prescribed by the rules or
- necessary or convenient to be prescribed for carrying out or giving effect to the *MI Act*.

Proposed subsection 80(2) of the *MI Act* states that these rules may not do any of the following:

- create an offence or civil penalty
- provide powers of arrest, detention, search or seizure
- impose taxes
- set an amount to be appropriated from the Consolidated Revenue Fund under an appropriation in the *MI Act*
- directly amend the text of the Act.

Rules that are inconsistent with the regulations will have no effect to the extent of the inconsistency. Rules are taken as being consistent with the regulations, where they are capable of operating concurrently with the regulations (**proposed subsection 80(3)**).

78. Explanatory Memorandum, op. cit., p. 34.
79. Ibid., p. 37.
80. Ibid., p. 35.

Records to be retained for a certain period

Section 40 of the *MI Act* imposes particular record keeping requirements on participating MDOs.

Item 122 repeals subsections 40(2) to (4), replacing them with **proposed subsections 40(2) to (3)**.

Proposed subsection 40(2) of the *MI Act* states that records must be retained for a period of five years (or any other period specified in the rules) starting on the day on which the records were created. Failure to do so gives rise to an offence of strict liability under section 47 of the Act.

Proposed section 40(3) provides that rules made for the purposes of paragraph 40(1)(e)[81] must not commence earlier than 14 days after the day on which the rules are registered on the Federal Register of Legislation.

Requirements for the terms of medical cover

Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

Section 26A of the *MI(PS&PS) Act* deals with the provision of run-off cover to certain medical practitioners. Subsection 26A(4) provides that this medical indemnity cover must meet the requirements of the subsection. Existing paragraph 26A(4)(d) requires that the cover is provided on such terms and conditions (if any) determined, by legislative instrument, by the Minister administering the *MI Act*.

Item 141 repeals paragraph 26A(4)(d), substituting it with a new paragraph 26A(4)(d) which states that medical indemnity cover meets the requirements of the subsection if it is provided on the terms and conditions on which the last medical indemnity cover provided for the practitioner was provided, to the extent they are relevant to the provision of medical indemnity cover.

Part 2—Application and Transitional

'Part 2 of Schedule 4 specifies when the various changes made by Part 1 of Schedule 4 to the Bill will take effect.'[82] The Explanatory Memorandum provides a good high level explanation of these in relation to the various proposed changes.[83]

Schedule 5—Universal cover

Medical Indemnity Act 2002

Item 1 inserts a **proposed subsection 3(3A)** into the 'objects' section of the *MI Act* adding:

> The Act also supports access by medical practitioners to arrangements that indemnify them for claims arising in relation to their practice of their medical professions by limiting when medical indemnity insurers can refuse to provide medical indemnity cover.

Item 2 inserts new key definitions for the Australian Financial Complaints Authority (AFCA), *Health Practitioner Regulation National Law*, private medical practice, professional indemnity cover, and risk surcharge. The need for these definitions arises so as to facilitate the integration of universal cover into the *MI Act*.

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81. Paragraph 40(1)(e) of the *MI Act* deals with other matters in relation to the records to be kept by a participating MDO, which are currently determined by the Chief Executive Medicare, but will be specified in the rules as a result of the amendment proposed by **item 121** of **Schedule 4** to the Bill.
82. Explanatory Memorandum, op. cit., p. 35.
83. Ibid., pp. 51-53.

Private medical practice means practice as a medical practitioner other than:

- practice consisting of treatment of public patients in a public hospital
- practice for which the Commonwealth, a state or a territory, a local governing body, or an authority established under a law of the Commonwealth, a state or a territory, indemnifies medical practitioners from liability relating to compensation claims
- practice conducted wholly outside both Australia and the external Territories or
- practice of a kind specified in the rules.

A contract of insurance with a medical practitioner provides ***professional indemnity cover*** if it provides medical indemnity cover for the practitioner in relation to the practitioner's private medical practice.

Item 4 inserts **proposed Part 2A—Universal cover obligation** comprising three new Divisions into the *MI Act*.

This Part imposes an obligation on medical indemnity insurers to provide medical indemnity cover for medical practitioners in relation to private medical practice (subject to limited exceptions). It specifies the circumstances in which a medical indemnity insurer may require a medical practitioner to pay a risk surcharge, and it imposes record keeping requirements on medical indemnity insurers in relation to the obligation to provide universal medical indemnity cover.

Within new Part 2A, **proposed section 52** states that a medical indemnity insurer is not required to comply with Division 2 (Requirements in relation to providing professional indemnity cover) other than for the purposes of the AFCA scheme.[84]

The Explanatory Memorandum states:

> Universal cover obligations will be managed under existing AFCA arrangements whereby a practitioner can make a complaint to AFCA about a potential breach of this Division.[85]

Universal cover obligation

Proposed section 52A provides that a medical indemnity insurer must not refuse to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover unless one of the following circumstances applies:

- in relation to a medical professional indemnity insurance contract between the practitioner and the insurer, the practitioner:
  - failed to comply with the duty of the utmost good faith or the duty of disclosure (within the meaning of the *Insurance Contracts Act 1984*)
  - made a misrepresentation to the insurer during the negotiations for the contract but before it was entered into
  - failed to comply with a provision of the contract, including a provision with respect to payment of the premium or
  - made a fraudulent claim under the contract
- the practitioner places the public at risk of substantial harm in the practitioner's private medical practice because the practitioner has an impairment (within the meaning of the *Health Practitioner Regulation National Law*)

84. The AFCA scheme is the external dispute resolution scheme for financial products authorised by the Minister under Part 7.10A of the *Corporations Act 2001*.
85. Explanatory Memorandum, op. cit., p. 57.

- the practitioner poses an unreasonable risk of harm to members of the insurer's staff because of persistent threatening or abusive behaviour towards members of the insurer's staff
- the practitioner has persistently failed to comply with reasonable risk management requirements of the insurer or
- additional circumstances in which cover may be refused may also be specified in the rules. [86]

These rules made will be a legislative instrument, and thus subject to Parliamentary scrutiny.

Medical indemnity insurer to notify of refusal to indemnify

Proposed section 52B requires a medical indemnity insurer to notify a medical practitioner in writing in relation to a decision to refuse to enter into a contract for insurance. This notice in writing must comply with any requirement specified in the rules.

Risk surcharge requirements

Proposed subsection 52C(1) of the *MI Act* enables a medical indemnity insurer to require that a medical practitioner, pays a ***risk surcharge*** as part of the amount payable for professional indemnity cover provided by a contract of insurance with the practitioner. This risk surcharge is to reflect the fact that if the practitioner engages, or has engaged, in conduct that deviates from good medical practice, the practitioner's private medical practice is likely to pose a higher risk to patients than similar practices.[87] Additional circumstances for the imposition of this surcharge are to be specified in the rules.[88]

The imposition of the risk surcharge is subject to parameters contained in **proposed subsections 52C(2) and 52C(3)**. **Proposed subsection 52C(2)** provides that the private medical practice of another medical practitioner (the ***comparison practitioner)*** is a similar practice if the insurer reasonably considers that the practitioner and the comparison practitioner have similar practice profiles for the purposes of calculating premiums for professional indemnity cover, except that the comparison practitioner does not engage, and has not engaged, in conduct that deviates from good medical practice. **Proposed subsection 52C(3)** states the risk surcharge must not exceed the amount articulated in the rules.

Proposed subsection 52D(1) of the *MI Act* provides that an indemnity insurer may be required to offer interim cover to a medical practitioner until complaint to AFCA is **finalised**, where that complaint relates to a refusal by the insurer to enter into a subsequent contract of insurance with a practitioner who has an existing contract for professional indemnity cover with that insurer.

Proposed subsection 52D(4) specifies that a complaint is ***finalised*** when any of the following circumstances are applied:

- the complaint is resolved by agreement between the insurer and the practitioner
- the complaint is withdrawn
- AFCA closes the complaint or
- the complaint otherwise ceases to be dealt with by AFCA.

Proposed subsection 52D(2) of the *MI Act* provides that the interim offer must comply with any requirements specified in the rules.

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86. *MI Act*, **proposed paragraph 52A(f)**.
87. *MI Act*, **proposed paragraph 52C(1)(a)**.
88. *MI Act*, **proposed paragraph 52C(1)(b)**.

Records, reporting and information

New Division 3—records, reporting and information sets out record keeping requirements and the consequences of a failure to keep records as required. It also imposes annual reporting requirements on the medical indemnity insurer in relation to specific matters, and it empowers the Secretary of the Department of Health (the Secretary) to request particular information, and imposes a penalty for a failure to comply with such a request.

Proposed subsection 53(1) provides that the rules may require a medical indemnity insurer to keep records relating to the following:

- a refusal to enter into a contract or insurance with a medical practitioner to provide professional indemnity cover
- a requirement by the insurer that a medical practitioner pay a risk surcharge.

The subsection contains a note stating that a failure to retain the records is an offence under **proposed section 53A**.The offence is an offence of strict liability.[89]

Medical indemnity insurer must report annually

Proposed subsection 53B(1) of the *MI Act* provides that if, in a financial year, a medical indemnity insurer refuses to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover, the insurer must notify the Secretary within two months after the end of the financial year of:

- the number of times in the financial year the insurer refused to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover and
- any other matter that relates to the insurer's obligations under Division 2 of new Part 2A and that is specified in the rules.

The subsection contains a note stating that a failure to notify the Secretary is an offence under **proposed section 53C**. The offence is an offence of strict liability.[90]

Secretary may request information

Proposed subsection 53D(1) provides that the Secretary may request a medical indemnity insurer to give the Secretary the following information, in the form requested by the Secretary:

- the number of times in a period the insurer refused to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover
- the number of times in a period the insurer required a medical practitioner to pay a risk surcharge
- other information that relates to the insurer's obligations under Division 2 of new Part 2A and that is specified in the rules.

Proposed subsection 53D(2) sets out the manner and form requirements in relation to the Secretary's request for information:

- must be made in writing
- may require the information to be verified by statutory declaration

89. *MI Act*, **proposed subsections 53A(2) and (3)**.
90. *MI Act*, **proposed subsections 53C(2) and (3)**.

- must specify the day on or before which the information must be given (at least 28 days after the day on which the request is made)
- must contain a statement to the effect that a failure to comply with the request is an offence.

Schedule 6—Allied health professionals

The Explanatory Memorandum states:

> In the 2018-19 MYEFO, the Government decided to continue to provide support for insurers currently providing professional indemnity insurance to registered privately practising allied health professionals, and that these schemes would be independent to schemes available to medical practitioners.[91]

The provisions in Schedule 6 establish high cost claim and exceptional claims schemes in new Divisions of Part 2 of the *MI Act* specifically tailored for access by allied health professionals (rather than medical practitioners). The makeup of these schemes significantly reflects 'the provisions in the existing HCCS and ECS as they apply to medical practitioners'.[92]

The Explanatory Memorandum further states:

> It is Government's intent that the new allied health schemes will initially only be accessed by those medical indemnity insurers that are currently providing medical indemnity cover for both medical practitioners and for persons who practise an allied health profession. The rules are therefore intended to prescribe those medical indemnity insurers that currently access the HCCS.[93]

Medical Indemnity Act 2002

Item 1 inserts at the end section 3 (the Objects provision in the *MI Act*), another objective of the Act, which is:

> … to contribute towards the availability of certain health services in Australia by providing Commonwealth assistance to support access by persons who practise allied health professions to arrangements that indemnify them for claims arising in relation to their practices.[94]

Proposed subsection 3(6) of the *MI Act* states that the Commonwealth provides that assistance under the *MI Act* by:

a) meeting part of the costs of large settlements or awards paid by organisations that indemnify persons who practise allied health professions and

b) meeting the amounts by which settlements and awards exceed insurance contract limits, if those contract limits meet the Commonwealth's threshold requirements.

Item 2 inserts new definitions relevant to the new schemes in subsection 4(1) of the *MI Act*. For example, allied health exceptional claims indemnity, allied health high cost claim indemnity, allied health high cost claim threshold, and allied health profession. The inclusion of these new definitions is necessary in order to integrate the AHHCCS and the allied health exceptional claims scheme (AHECS) into the medical indemnity legislation.

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91. Explanatory Memorandum, op cit., p. 66.
92. Ibid.
93. Ibid., p. 67.
94. *MI Act*, **proposed subsection 3(5)**.

Allied health high cost claim indemnity scheme

Item 26 inserts **Division 2C—Allied health high cost claim indemnity scheme** into Part 2 of the *MI Act*.

Within new Division 2C, **proposed subsection 34ZY(1)** sets out a **Guide to the Allied Health high Cost Claim Indemnity provisions**.

Proposed subsection 34ZY(1) states that Division 2C provides that an allied health high cost claim indemnity may be paid to an eligible MDO or eligible insurer that pays, or is liable to pay, more than a particular amount (referred to as the ***allied health high cost claim threshold***[95]) in relation to a claim against a person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of an allied health profession.

Proposed subsection 34ZY(2) provides for the making of regulations and rules to deal with other matters or incidents relating to incidents covered by the allied health high cost claim indemnity scheme.

Proposed subsection 34ZY(3) of the *MI Act* provides a useful table (see below) in relation to where to find the provisions on various key issues in relation to the scheme, eligibility of MDOs and insurers, claim threshold, the amount of the AHHCC indemnity etc.

Guide to the allied health high cost claim indemnity provisions

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
1	which MDOs and insurers are eligible?	section 34ZZ
2	what is the allied health high cost claim threshold?	section 34ZZA
3	what conditions must be satisfied for an MDO or insurer to get the allied health high cost claim indemnity?	sections 34ZZB to 34ZZD
4	what happens if the incidents occurred during treatment of a public patient in a public hospital?	paragraph 34ZZD(a) and section 34ZZE
5	how much is the allied health high cost claim indemnity?	section 34ZZF
6	what regulations can deal with	section 34ZZG
7	how do MDOs and insurers apply for the allied health high cost claim indemnity?	section 36
8	when will the allied health high cost claim indemnity be paid?	section 37
9	what information has to be provided to the Chief Executive Medicare about allied health high cost indemnity matters?	section 38

95. The ***allied health high cost claim threshold*** is defined at proposed subsection 34ZZA(1) as $2 million, or another amount specified in the rules.

10	what records must MDOs and insurers keep?	section 39
11	how are overpayments of allied health high cost claim indemnity recovered?	sections 41 and 42

According to the Minister for Health, Greg Hunt, 'the allied health schemes will mirror the existing high cost claims and exceptional claims schemes'.[96]

96. G Hunt, 'Second reading speech: Medical and Midwife Indemnity Legislation Amendment Bill 2019', House of Representatives, *Debates*, 18 September 2019, p. 3356.

Appendix A: Recommendations from the First Principles Review (FPR) of the Indemnity Insurance Fund (IIF)

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

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

Scheme	Existing		Reform
HCCS	Pays 50% of the cost of eligible claims over the threshold.		*No changes recommended.*
	As a result of previous Government decisions, the threshold for HCCS will increase from $300,000 to $500,000 from 1 July 2018.		*No further changes recommended (continue with previously announced change from 1 July 2018 and monitor impact).*
	While the objects of the legislation refer to support for medical practitioners, the wording of the HCCS provisions has meant that claims have been made by insurers of health professionals.		12. Clarify the eligibility criteria for the HCCS such that the scheme only enables claims by medical insurers in respect of medical practitioners (consistent with the original intent of the HCCS).
	Uncertainty regarding some circumstances in which Commonwealth will pay claims and evidential requirements.		13. Clarify eligibility and claims requirements.
ECS	Pays 100% of the cost of private practice claims that are above $20 million.		*No changes recommended (no claims have been made under the ECS to date).*
	As for the HCCS, the wording of the ECS provisions means that claims could be made by insurers of health professionals.		14. Clarify the eligibility criteria for the ECS such that the scheme only enables claims by medical indemnity insurers in respect of medical practitioners (consistent with the original intent of the ECS).
ROCS	Costs of the ROCS are recovered from medical practitioners via a levy which is collected by insurers. Some have argued that the levy should be lowered as the Commonwealth is recovering in excess of the cost of the ROCS.		15. Retain levy at current level but improve monitoring to enable re-assessment of the appropriateness of the levy in five years.
	Practitioners over 65 who permanently retire can access ROCS. Those under 65 must cease practice for three years before accessing ROCS. If their insurer has contracted with the Commonwealth for the PSS, the insurer must offer run-off cover at $50 per year for the three years until they		16. Enable access to ROCS for practitioners permanently retiring before age 65. This would also remove the need for PSS-specific differential charging for run-off cover for such practitioners who have had continuous cover with the insurer for 10 years.
	become eligible for ROCS. The requirement to cap the cost of cover does not apply to insurers who have not entered a PSS contract.		
	Uncertainty regarding some circumstances in which Commonwealth will pay claims and evidential requirements.		17. Clarify eligibility and claims requirements.
IBNR	Historical scheme, naturally terminating within 10 years.		*No changes recommended.*
MPIS and MPIROC	The schemes subsidise the premiums and high cost claims of eligible privately practising midwives. The absence of reliable data (and a single provider of the schemes) means that proper assessment of value to the Commonwealth and midwives (and the need for the schemes) is not possible.		18. Undertake further consultation and monitoring to assess the capacity of the market to insure midwives at an affordable price. Based on outcomes, the scheme could be disbanded or if there is an ongoing need for the scheme, expanded to apply to all insurers of midwives (rather than legislatively restricting scheme availability to one contracted insurer).
	Uncertainty regarding some circumstances in which Commonwealth will pay claims and evidential requirements. Midwives permanently retiring before 65 must cease practice for three years before accessing the ROCS.		19. Changes to: • ensure alignment with proposed changes to ROCS, by enabling access to the MPIROC for midwives permanently retiring before age 65 • clarify eligibility and claims requirements, and • simplify evidential requirements to support a claim.

Source: MP Consulting, *First principles review of the Medical Indemnity Insurance Fund*, report prepared for the DoH, April 2018, pp. 53–56.

Appendix B: Recommendations from the Thematic Review of Commonwealth Medical and Midwife Indemnity Legislation

Summary of key findings of the Thematic Review

Question	Finding
Do the objectives of the legislation remain relevant?	Yes. The legislation achieves the current policy objectives of Government by enabling the payment of subsidies and reimbursements and recovering certain costs from industry via certain levies. Separate matters for consideration by Government are: • whether Government intervention continues to be necessary in order to support the stability of the medical indemnity insurance industry and the availability of affordable indemnity insurance for medical practitioners and midwives, and • whether the way that government is subsiding/reimbursing is the most effective and efficient use of limited resources or whether alternative approaches are appropriate for achieving Government's objectives. These matters are being considered through the First Principles Review.
Should any of the Instruments (or enabling Acts) be repealed or allowed to sunset?	The following Acts and instruments (or provisions within) are no longer operable and can be repealed: • *Medical Indemnity (UMP Support Payment) Act 2002* • *Medical Indemnity (UMP Support Payment) Regulations 2004* • *Medical Indemnity (UMP support payment exemption) Regulations 2006* • *Medical Indemnity (Competitive Advantage Payment) Act 2005* • *Medical Indemnity (Competitive Advantage Payment) Regulations 2005* • Division 1 and Division 2A of Part 3 of the *Medical Indemnity Act 2002* (and related amendments) • Division 3.1 and 3.1A of Part 3 of *the Medical Indemnity Regulations 2003* • *Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006* • *Premium Support (Medical Indemnity Provider) Scheme 2006* It is proposed that the following instruments be repealed and remade in one consolidated instrument under the *Medical Indemnity Act 2002*: • *Premium Support Scheme 2004* • *Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006 (No.2)* • *Medical Indemnity (IBNR Claims) Protocol 2006*

Question	Finding
	It is proposed that the following instruments be repealed and remade (with minor consequential amendments if required): • *Medical Indemnity Regulations 2003* • *Medical Indemnity (Prudential Supervision and Product Standards - Notice of Provision of Run-off Cover) Determination 2007* • *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Rules 2010* • *Midwife Professional Indemnity (Run-off Cover Support Payment) Rules 2010* • *Medical Indemnity (Run-off Cover Support Payment) Regulations 2008* • *Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003* (these changes may be progressed within a separate legislation package administered by the Treasury). It is proposed that the following instruments be repealed, but only after amendments have been made to the enabling Acts: • *Medical Indemnity (Unfunded IBNR factor – United Medical Protection Limited) Determination 2003.* The *Medical Indemnity Act 2002* would require amendment first, noting that the Act currently prevents repeal of the instrument • *Medical Indemnity (Prudential Supervision and Product Standards - Terms and Conditions for Run-off Cover) Determination 2004.* The *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* would first require amendment to incorporate the few matters currently in the Determination. • *Medical Indemnity (Non-participating MDOs) Determination 2003.* The *Medical Indemnity Act 2002* would first require amendment to refer to Avant as the only participating MDO.
What is the regulatory impact of the instruments? Is there opportunity for deregulation?	Many of the instruments are declaratory only and as such there is no opportunity for deregulation, or to reduce compliance costs. However, for the more substantive instruments, it is proposed that: • all redundant provisions be repealed (to clarify the legislation and reduce costs to insurers, medical practitioners and eligible midwives having to navigate complex legislation), and • wherever possible instruments that require information to be reported to Government be amended to minimise the information reported to that which is absolutely necessary to enable Government to effectively and efficiently manage the relevant scheme. As part of the First Principles Review, Government is separately considering other changes that may be desirable to improve the operation of the schemes.
Are the instruments consistent with broader legal and policy context?	Yes. In summary: • the legislation does not engage any of the human rights and freedoms recognised in the seven core international human rights treaties which Australia has ratified • none of the instruments pose any international or constitutional law issues

Question	Finding
	• to the extent that criminal offences are created in the legislation, these are consistent with the *Attorney Generals' Guide to Framing Commonwealth Offences* and the penalties attached to such offences have been benchmarked against like offences in other Commonwealth laws and found to be appropriate • in relation to administrative law, two instruments create review rights to the Administrative Appeals Tribunal (AAT). To date, no applications have been made for review of decisions made under these instruments. The legislation does not exclude the jurisdictions of the Federal Court under the *Administrative Decisions Judicial Review Act 1997*, and • in relation to privacy law, a number of the instruments require submission of information (by insurers or practitioners) to the Department of Human Services (DHS). Some of the information provided to DHS, the Department and other government agencies is personal and/or confidential information protected under the *Privacy Act 1988* and the Australian Privacy Principles (APP). While the instruments do not expressly refer to the *Privacy Act 1988* or the APP, government departments and agencies are subject to such legislation and, therefore, deal with all information in accordance with relevant requirements.
Do the instruments comply with the clearer laws principles? What can be done to make it simpler, clearer or easier to read?	The clearer laws principles require that, amongst other things, the laws are no more complex than necessary to give effect to the policy, and that people affected by the laws can understand the laws and how they apply to them. While each of the individual instruments is reasonably clear, the fact that there are 17 separate instruments dealing with essentially one subject matter (subsidies and payments relating to medical indemnity for medical practitioners and eligible midwives) has the effect of making the law difficult to navigate. This adversely impacts those in government administering the law, and stakeholders. A key recommendation of this Thematic Review is that the opportunity be taken to repeal all redundant instruments/provisions and to consolidate the instruments such that they are clearer and more user-friendly.
What was the advice of stakeholders in relation to the instruments.	Most stakeholders did not make comments on individual instruments but expressed support for repealing redundant legislation, consolidating instruments and any other measures designed to support ease of use for stakeholders. Through the submissions on the Thematic Review a number of stakeholders also raised broader matters of policy, and suggested a number of changes to the schemes. These broader policy issues and stakeholder suggestions will be examined as part of the First Principles Review which is occurring in parallel with this Thematic Review.

Source: MP Consulting, *Thematic review of Commonwealth medical and midwife indemnity legislation*, report prepared for the DoH, February 2018, pp. 5–7.

Members, Senators and Parliamentary staff can obtain further information from the Parliamentary Library on (02) 6277 2500.