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Medical Indemnity – Protecting Australia's Health

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1 Executive Summary

1.1 Introduction and the provision of medical indemnity insurance

Medical indemnity insurance plays an important role in our society, supporting the effective operation of the healthcare sector. Australia's demand for health services is set to increase over the coming decades. An aging population and an increase in chronic conditions (e.g. diabetes) is driving an ongoing increase in demand for health services. Medical practitioners must hold medical indemnity insurance as a condition of registration. Medical indemnity insurance tends to be provided by either:

1. An APRA-regulated Medical Defence Organisation (MDO) and select insurers covering private practitioners, or
2. State/territory government insurers covering public health services.

While both MDO and state/territory provided cover protect the medical practitioners against claims for negligence, there are key differences in the risks covered and nature of the cover provided. These differences include claims mix, capital requirements, pricing, recoveries and the risk advisory/harm prevention focus.

1.2 What do the numbers tell us about claims cost increases and the case for Civil Liability reform?

We observe significant increases in claims costs year-on-year above economic inflation, population growth and an aging population's increasing healthcare needs. The drivers of the increase include:

- An increase in the propensity to litigate
- Increases in average claim sizes above economic inflation
- Nervous shock claims
- Increases in legal expenses above economic inflation.

We estimate the cost increases due to these factors over an 8 year period from 2017 to 2025 to be 72% for Avant, 14% for MDA National Insurance, 114% for the Victorian Managed Insurance Authority and 78% for the broader state/territory government sector. In our assessment, these numbers provide clear support for calls to review the current Civil Liability settings across Australian jurisdictions.

1.3 Opportunities to work with medical indemnity providers and government to improve patient outcomes

We have identified three key areas to improve the understanding of medical indemnity risks and mitigate claims risk. These are:

1. For state/territory insurers to seek to reduce individual practitioner risk in conjunction with the current focus on system-wide risks.
2. For the private MDO insurers to seek to reduce system-wide risks in conjunction with the current focus on individual practitioner risks.
3. Across all public and private health services, to collect and analyse information on near misses and incidents to support better patient outcomes, ultimately reducing claims.

2 Introduction

Medical indemnity insurance plays an important role in our society, supporting the effective operation of the healthcare sector. Specifically, medical indemnity insurance protects healthcare practitioners (e.g. specialists, doctors, nurses, midwives and dentists) and health services (e.g. hospitals, clinics) against the financial consequences of malpractice claims.

In this paper we:

- Examine the growing demand for health services and what this means for medical indemnity insurers. (Section 2)
- Discuss why a sustainable medical indemnity insurance system is so important for our healthcare system and analyse the different ways medical indemnity insurance cover is provided across public and private sectors. (Sections 3 and 4)
- Assess the financial health of the current market and whether the numbers support the case for Civil Liability law reforms. (Sections 5 and 6)
- Discuss the opportunities to reduce risk across the health sector using data-driven, actionable insights. (Section 7)

3 The growing demand for health services

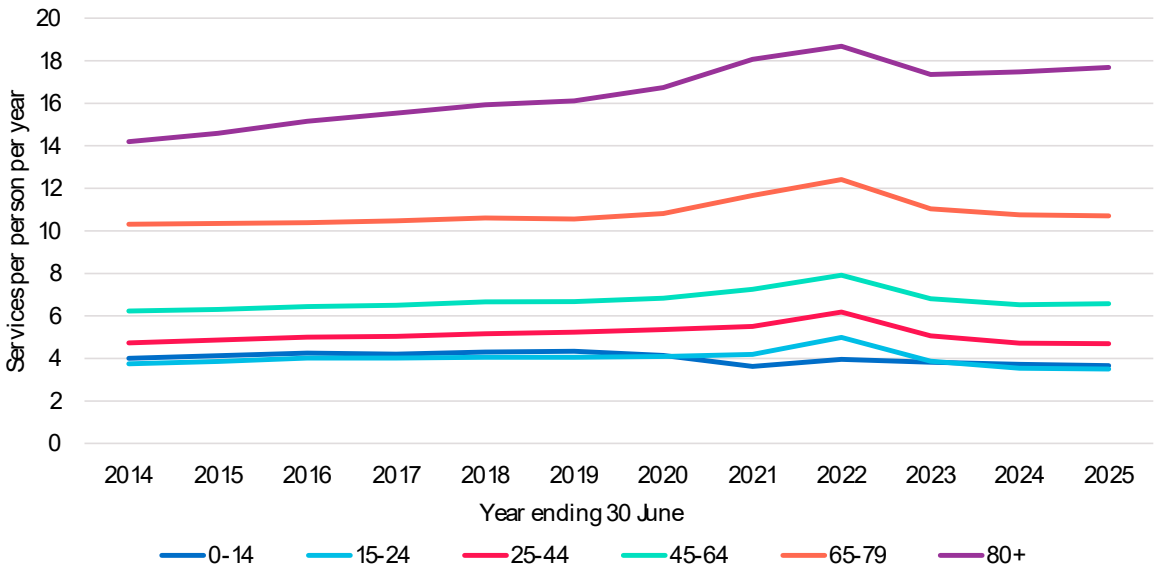
In 2023/24 the Australian Institute of Health and Welfare (AIHW) estimates Australia spent $270.5 billion on healthcare, a 6% increase on 2022/23 levels. This is equal to about $10,000 per person and represents 10.1% of GDP.

Health services are heavily funded by both State and Federal Governments, which collectively contribute around 70% of total healthcare spending. The balance is predominantly met by individuals and private health insurers.

Australia's demand for health services is set to increase over the coming decades. An aging population and an increase in chronic conditions (e.g. diabetes) is driving an increase in demand for health services.

Health services utilisation varies markedly by age cohort. Figure 1 draws from AIHW data showing how the number of GP visits per year varies by age cohort and has changed over time.

Figure 1 – Number of GP services per person per year [1]



In 2025, the average person in the 80+ cohort visited the GP close to 18 times. For the 65-79 year age group, there were 10 visits per year.

Relative to 2014 levels, GP utilisation has:

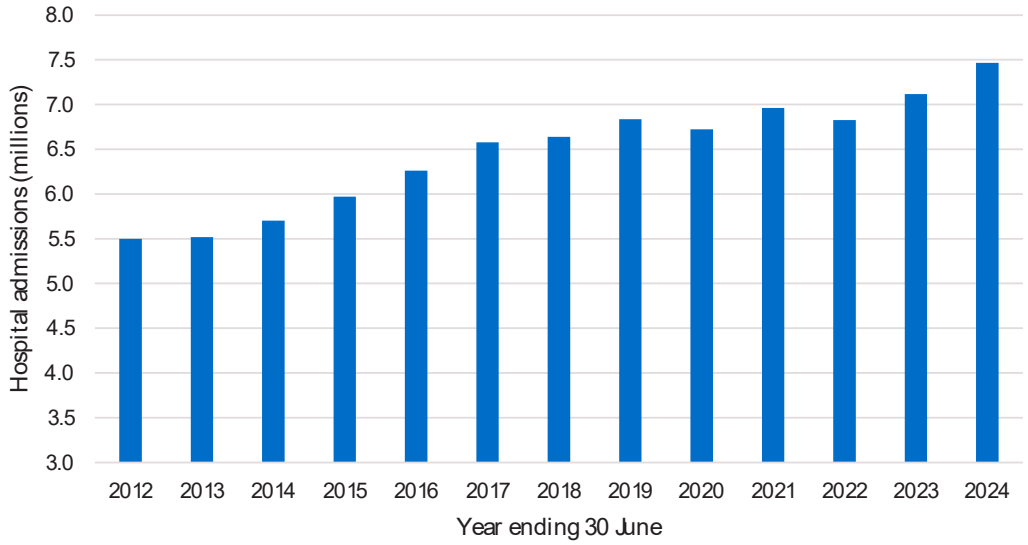
- Increased for the 80+ cohort. This is unsurprising as a higher proportion of people in this category are reaching advanced ages
- Remained relatively stable for most other cohorts.

Note that the COVID-19 vaccinations led to a spike in the number of GP visits across most age cohorts.

[1] Australian Institute of Health and Welfare (2026), *Medicare-subsidised GP, allied health and specialist health care across local areas* [Data set], retrieved April 15, 2026. Compilation of these tables from 2013-14 to 2024-25, accessible at https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-specialist/data

Demand for hospitals, both public and private, has also increased over time. Figure 2 shows hospital admissions in Australia increased by 36% over the last 12 years to June 2024. Over the same period, the population increased by 20%. Hospital admissions increased at close to double population growth.

Figure 2 – Number of hospital admissions across Australia by year[2]



For medical indemnity providers, the increase in demand on the health sector is expected to be accompanied by:

- Changes in the level of risk, particularly as the prevalence of chronic conditions increase and the average patient age increases. This is expected to impact the volume and mix of claims received.
- Increases in mental health related conditions. Anxiety and depression are now common reasons to visit GPs and the number of psychological conditions managed in primary care has increased substantially. Claims against medical practitioners regarding the treatment of mental health conditions are expected to increase.

[2] Australian Institute of Health and Welfare. (2026). *Patient Admissions Data Extract 2011-12 to latest* [Data set]. Australian Institute of Health and Welfare. Retrieved May 13, 2026 from https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

4 Why is a sustainable medical indemnity insurance industry important?

Medical practitioners must hold medical indemnity insurance. The Medical Board of Australia and the Australian Health Practitioner Regulation Agency require professional indemnity insurance that:

- Covers the full scope of practice
- Is adequate for the level of risk
- Includes run-off cover (for claims made after finishing practising where the professional indemnity insurance is claims made).

Ongoing medical indemnity insurance availability and affordability is key to supporting the successful operation of the healthcare sector.

4.1 The laws and regulations impacting medical indemnity insurance

Medical Indemnity insurance is also referred to as medical malpractice insurance. It protects healthcare practitioners (e.g. specialists, doctors, nurses, midwives and dentists) against the financial consequences of malpractice claims and covers damages awards and legal expenses.

Medical indemnity insurance is a low claim frequency and high claim severity insurance class. Delay between the incident giving rise to the claim and settlement of a claim can take over a decade in some cases.

Claims for medical negligence are impacted by a combination of:

- State civil liability acts (e.g. Wrongs Act 1958 in Victoria and the Civil Liability Act 2002 in NSW). These Acts define the standard of care expected of health practitioners, place caps on damages and provide a defence if the practitioner acted in a manner consistent with peer professional opinion. This is an important point as it means not all adverse outcomes are compensable. It is only those cases where the practitioner's actions were inconsistent with peer practice.
- State limitation acts (e.g. Limitation of Actions Act 1958 in Victoria and the Limitations Act 1969 in NSW). The limitation period is generally 3 years from when the injury is discoverable with a long stop of 12 years after the event.
- Health practitioner regulation National Law which impacts standards and disciplinary findings.

The right to claim for medical malpractice is often covered by the same legislation which governs the right to claim public liability personal injury and historical child abuse claims.

While workers compensation and Compulsory Third Party (CTP) insurance across the Australian States and Territories have developed their own standalone statutes and standalone insurance schemes, this has not been the case for medical indemnity insurance where claims are much lower in volume.

5 Who provides medical indemnity insurance?

Medical indemnity insurance tends to be provided by either:

An APRA-regulated Medical Defence Organisation (MDO) and select insurers	These entities cover: ▪ Private practitioners in private hospitals ▪ Private practitioners in public hospitals ▪ Doctors in private practice (e.g. general practitioners, specialists, cosmetic practitioners) ▪ Doctors in training ▪ Allied health professionals (e.g. nurse practitioners, physiotherapists, psychologists, radiographers) ▪ Dentists.
State/territory insurers	State/territory insurers cover public health services. The public health system can often treat the more complex health cases. For example, maternity, emergency medicine and complex surgeries as well as ambulatory services and State-run allied health. 2023/24 Australian Institute of Health and Welfare data shows 92% of emergency admissions are treated in public hospitals.

While both MDO and state/territory provided cover protect the medical practitioners against claims for negligence, there are key differences in the risks covered and nature of the cover provided. The main differences are:

- Claims mix: State/territory backed MI insurance tends to cover higher risk activities. Best practice is to segment the portfolio by level of risk (low, medium and high) to inform analysis. Development patterns tend to be longer for state/territory backed MI insurance on account of the claims incurred cover, rather than claims made, as well as the greater complexity of claims.
- Recoveries: Recoveries from government schemes (for example, the High Cost Claims Scheme) and commercial reinsurance are significant for MDOs and require close analysis. Recoveries can be less significant for state/territory backed insurers, although it is important to consider instances where patients have interacted with both the private and public healthcare systems in the course of treatments.
- APRA regulation and capital: MDOs are required to adhere to APRA's prudential framework which includes holding capital and reinsurance to meet the cost of a 1 in 200 year event. State/territory backed MI insurance often have detailed capital management frameworks and plans, but do not tend to hold reinsurance or capital to such a level and the frameworks tend to be less intricate than the APRA framework.
- Pricing: MDO pricing tends to focus on the characteristics of the individual practitioner. For example, whether a practitioner has had a claim in the past 3 years is a strong predictor of likely future claims experience. State/territory MI pricing is at a site level for hospitals or health service level and does not consider individual practitioners.
- Risk advisory and harm prevention: State/territory focus is at a whole of system level. That is, what initiatives can supplement policy settings to lower risk at a system level. MDOs' risk advisory tends to focus on individuals.

Casestudy: Incentivising Better Patient Safety

In Victoria, VMIA launched the Incentivising Better Patient Safety (IBPS) program in 2018. The progra was designed to provide best practice, evidence-based training to clinicians to reduce the number and cos maternity claims. About 3 out of 4 Australian hospital births occur in a public hospital. Maternity claims represent a sizeable portion of claim costs for State insurers due to large ongoing care costs. Importantly, maternity claims provide a key opportunity to reduce risk in an area where States and Territories support their populations.

Under the IBPS program, eligible health services implement training for their clinicians each year and to meeting attestation criteria, there is a partial refund of maternity-related premiums. Historically, the program has focussed on the recognition of foetal deterioration as well as communication and teamwork to avoid errors and delays and foster timely escalation. In 2025, the program has been expanded to add associated with instrumental births.

Appendix A includes a table summarising the key differences and discusses the two ways states and territories tend to cover their MI risks.

From a practitioner's perspective, the process and engagement with the MDO/state/territory provider is quite different in the event of a claim. Table 1 sets out the process from a practitioner's perspective for a claim covering a complication post operation.

Table 1 – Complication postoperation, from a practitioner's perspective

Stage	Private practice. Private insurance (e.g. Avant)	Public practice. Employer - provided cover (e.g. VMIA)
1. Incident response	▪ Practitioner contacts insurer for immediate advice on what to document and how to approach response. Private practices and practitioners may active incident management responses.	▪ Hospital activates incident management process.
2. Civil claim	▪ Hospital, doctor or both are named as defendant.	▪ State/hospital is usually the named defendant ▪ The practitioner usually serves as a witness.
3. AHPRA complaint	▪ Insurer helps draft formal response, and provides legal support.	▪ Hospital usually has limited involvement outside providing documents.

6 What do the numbers tell us?

In this section we:

- Discuss the premium pool for private MDOs with a focus on market share.
- Show how claims costs have changed by underwriting year for Avant, MDANI, VMIA and the broader state/territory sector. Our focus is to understand whether claims costs have increased faster than economic inflation and population growth which may support the case for Tort Law reform.

Data covering private MI providers and state/territory MI providers is limited. We have based our analysis on a combination of Australian Prudential Regulation Authority (APRA) statistics[3], annual reports, financial statements and request for additional information from state/territory insurers.

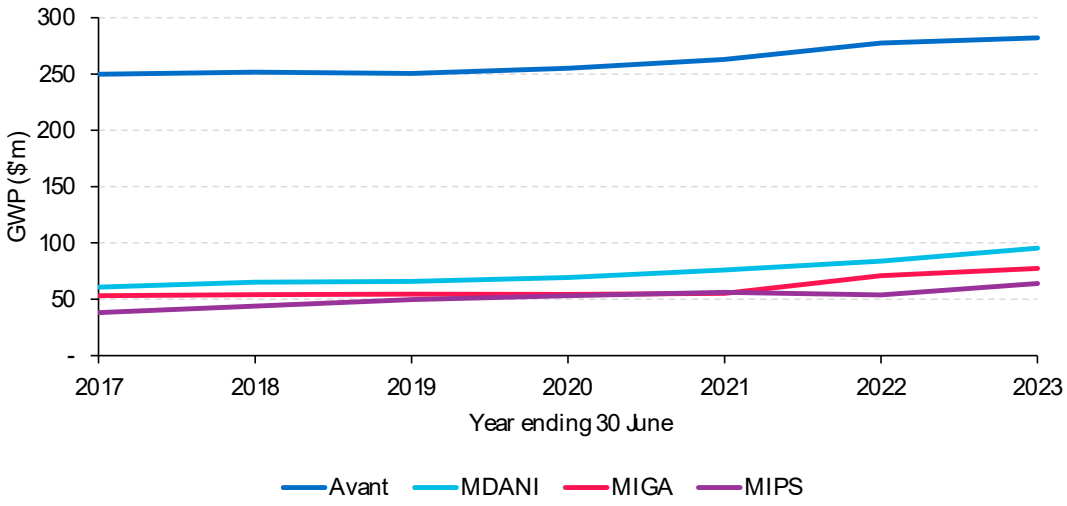
6.1 Gross written premium by private MI provider

Avant, MDA National Insurance (MDANI), Medical Insurance Group Australia (MIGA) and the Medical Indemnity Protection Society (MIPS) are the four largest private sector medical indemnity providers in Australia.

The four largest providers wrote over $520 million in premium in 2023. Since this time, we have observed low single digit premium increases across most of the market.

Figure 3 shows Gross Written Premium (GWP) from 2017 to 2023 by provider.

Figure 3 – Gross Written Premium to 30 June 2023[4]

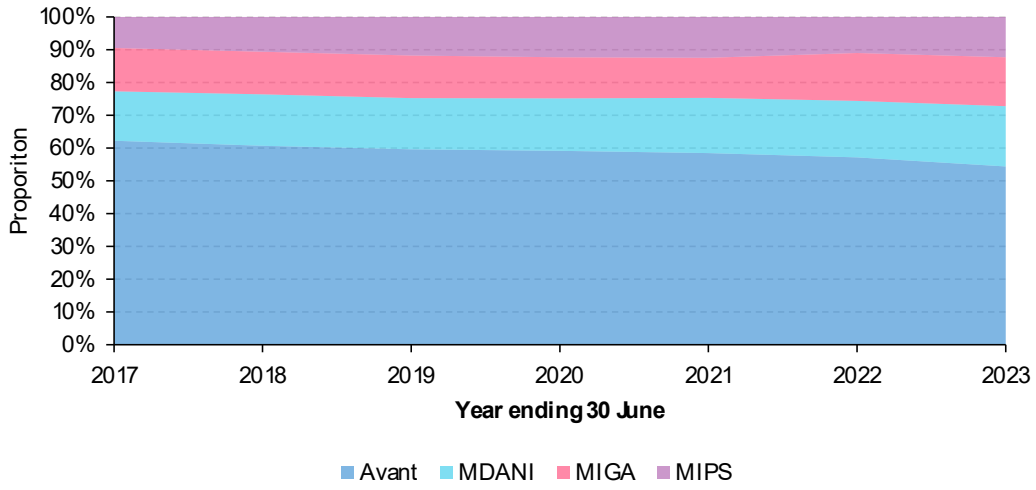


[3] Based on insurance premiums as reported to APRA and excludes fees paid to mutual entities. The conclusions we have outlined in this section may change if the analysis were to consider the sum of insurance premiums and fees paid to mutual entities.

[4] Australian Prudential Regulation Authority. (2023) *Annual general insurance institution level statistics* [Data set]. Australian Prudential Regulation Authority. Retrieved 26 June 2025 from https://www.apra.gov.au/annual-general-insurance-institution-level-statistics.

Figure 4 showsmarket share as measured by GWP.

Figure 4 – Market share measured by GWP[5]



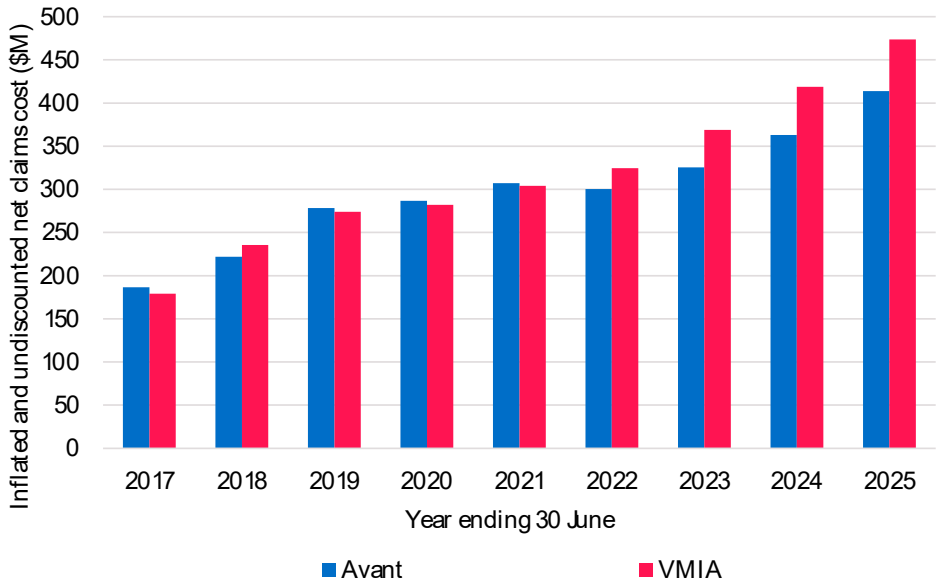
Avant has over 50% of the medical indemnity market. Avant's market share as measured by GWP has reduced from 62% in 2017 to 54% in 2023.

6.2 Estimated ultimate claims costs by financial year for the private and public providers

Figure 5 shows the expected ultimate cost by underwriting year for Avant and the VMIA. Avant and the VMIA are of a similar size as measured by the expected ultimate cost of claims. Note that VMIA covers Victorian experience only while Avant covers all states and territories.

[5] Ibid.

Figure 5 – Estimated ultimate cost of claims (inflated and undiscounted)[6] [7][8]



While costs were similar up to 2021, the VMIA's costs have increased faster than Avant's for 2022 and later years.

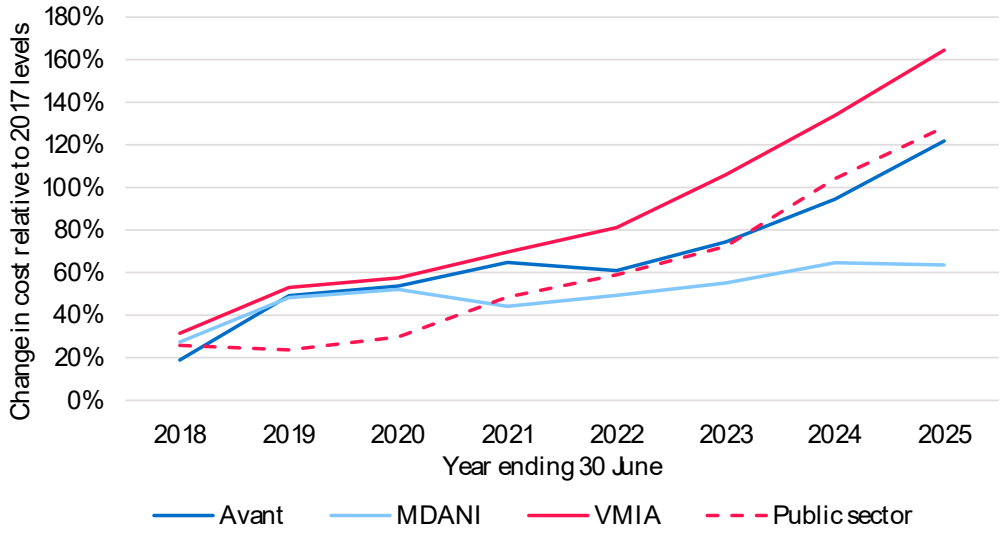
Figure 6 shows the increase in costs relative to 2017 levels for Avant, MDANI, VMIA and the broader public sector index which considers 3 state/territory MI schemes, including the VMIA. We do not have permission to identify these schemes.

[6] Net of reinsurance recoveries.

[7] Data sourced from the 2024/25 Avant/MDANI/VMIA annual reports, as well as anonymised submissions from several state schemes.

[8] The comparison of net claims costs over time is impacted by changes in the High Cost Claims Scheme (HCCS) threshold which applies to MDOs and reinsurance retentions.

Figure 6 – Change in estimated ultimate costs relative to 2017 levels[9] [10]



The key observations are:

- Avant (dark blue line) and MDANI's (light blue line) claims costs are estimated to have increased by 122% and 64%, respectively since 2017. Market share has been relatively stable over this time for the two largest private sector MI providers and is not likely to be a significant contributor to the change in costs.
- The VMIA's estimated ultimate claims costs have increased by 164%, reflecting adverse claims development in Victoria.
- Claims costs for the broader public sector index have increased by 92%, showing strong, but more modest growth in public health services claims cost.

An approximate attribution of the increase in claims costs is:

- Economic inflation: If we assume economic inflation is 3.5% p.a., 32% of the increase in cost is due to economic inflation.
- Population growth: The population has increased by 12% over the 8 years.
- Aging population: If we assume increased utilisation of health services is equal to half the population growth impact, the impact is 6%.

Inflation, population growth and an allowance for the increased utilisation of health services accounts for 50% of the increase. The balance, 72% for Avant, 14% for MDANI, 114% for the VMIA and 78% for the broader public sector index is due to other factors. These other factors include:

- Changes in the propensity to litigate
- Increases in average claim sizes above economic inflation
- Nervous shock claims
- Increases in legal expenses above economic inflation.

These increases in costs often appear as superimposed inflation in actuarial work.

[9] Net of reinsurance recoveries.

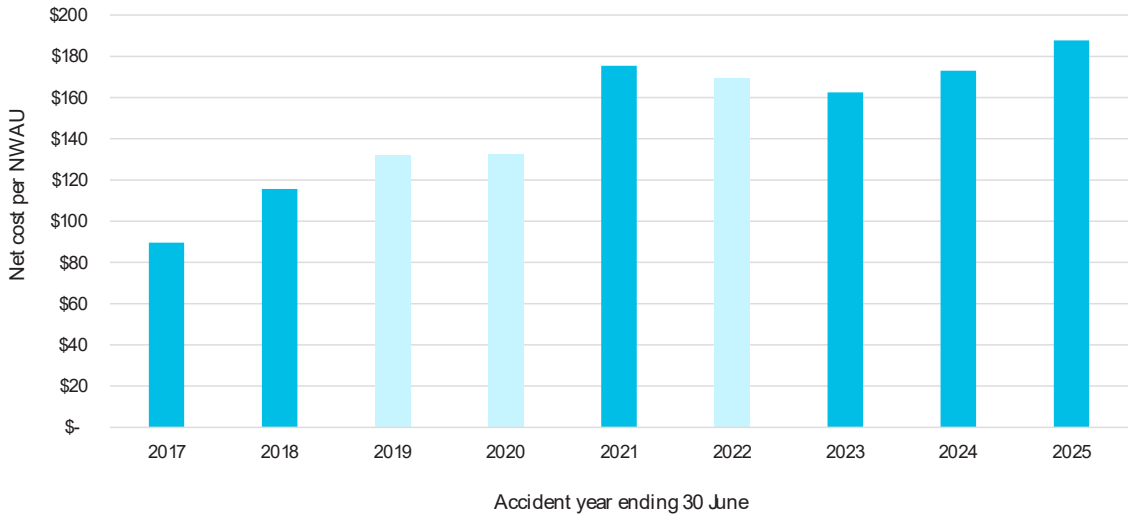
[10] Ibid.

This analysis shows both private and state/territory provided MI insurers are facing similar pressures. Of the insurers analysed, these cost pressures are most pronounced in Victoria.

6.3 Cost per National Weighted Activity Unit in Victoria

The VMIA shows the largest cost increases above inflation. For Medical Indemnity Insurance provided by the VMIA, we have conducted additional analysis which divides estimated ultimate net claims cost by the National Weighted Activity Unit (NWAU). NWAU is a standard measure of hospital activity and complexity in Australia's activity-based funding scheme. This analysis is based on publicly available data.

Figure 7 – Estimated ultimate net claims cost divided by NWAU[11] [12]



Expressing claims costs relative to NWAU normalises for changes in the level of complexity of activity over time.

The key observation to draw from this chart is claims cost per NWAU in 2017 was $90. Over the eight years it has more than doubled to $188.

In our assessment, this conclusion provides support for the calls to review current Civil Liability settings.

[11] The lighter shaded years are those years impacted by stop loss recoveries from Treasury. The gross costs will be higher than the bars shown.

[12] National Health Funding Body (2026) *The Administrator of the National Health Funding Pool Annual Report* retrieved April 3, 2026. Compilation of these reports from 2018-19 to 2024-25, accessible at https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-specialist/data

7 The case for civil liability reform

7.1 But first, what does history tell us?

United Medical Protection Group (UMP) was the largest Medical Defence Organisation in Australia. In 2002, UMP was found to be effectively insolvent and medical practitioners faced the risk of being uninsured. Without medical indemnity insurance cover, medical practitioners are unable to practise.

The crisis was driven by multiple factors:

- Underestimating risk which led to under reserving and charging premiums that were ultimately too low to meet the cost of claims and expenses.
- Increases in litigation, and large damages awards
- The collapse of HIH in 2001 which provided reinsurance coverage to MDOs
- Reinsurance market hardening
- Reduced investment returns.

To address availability and affordability issues, the Commonwealth Government and State and Territory Governments made sweeping changes, including:

1. Tort law reform. While each State and Territory made their own changes to their relevant civil liability Act, the themes were similar and included:
   - Higher thresholds for negligence claims, including that the risk must have been foreseeable, significant and a reasonable person would have taken precautions.
   - For professional indemnity, a professional would not be liable if they acted in a manner widely accepted by their peers.
   - Caps on damages, including loss of earnings, gratuitous care and pain and suffering.
   - Limiting liability for mental harm, including restricting liability to recognised psychiatric illnesses.
2. MDOs were brought under APRA's prudential regime. This led to changes including stronger capital requirements for insurers and an expanded role for the actuary.
3. A number of Commonwealth Government schemes were introduced to help stabilise claims experience and restore confidence in the medical indemnity insurance sector. These included: High-Cost Claims Scheme (Scheme currently funds 50% of the cost of claims above $500,000) and the Run-off Cover Scheme to addresses the coverage gap when a practitioner holding claims-made policies retires but is still exposed to claims risk and the Exceptional Claims Scheme (for claims costs above the $20 million liability cap) and the Premium Support Scheme where part of a doctor's medical indemnity insurance premium is funded by the Commonwealth government where the premium is high relative to the practitioner's income.

7.2 The case for civil liability reform in Australia

The Insurance Council of Australia (ICA) is advocating for changes to civil liability settings. The material increases in estimated ultimate claims costs each year above economic inflation and population growth supports the case for civil liability reform. We analyse these cost increases across the private and public sectors in Section 6.2 and Section 6.3.

The increase in claims costs for medical indemnity insurers is driven by several factors including:

- **An increase in nervous shock claims:** Compared to other classes of personal injury insurance, medical indemnity insurance is particularly exposed to nervous shock claims; that is, a group of claims relating to the same underlying incident

  Nervous shock claims have been increasing in both number and size, particularly in jurisdictions where the definition of a "close relation" is not well-defined and distant relatives are able to make claims. Without civil liability reform to provide tighter legal definitions which are less subject to challenge and interpretation, nervous shock claims will continue to increase as plaintiff lawyers continue to push the boundaries of the current legislative settings.

- **The right to use juries in some states and territories:** Parties can seek to have a civil liability claim heard by a jury in some states and territories. Civil jury trials are available as a right if requested in Victoria. Civil juries are still available in NSW and Queensland with some restrictions. This right originates from the common law system Australia has adopted.

  Juries may focus on the emotional side of cases as litigated by plaintiff lawyers, leading to successively higher settlements which impact future cases.

  Civil liability reform to provide clearer guidelines around when juries should be used, and importantly when they should not, would provide greater clarity around the role of juries in civil liability litigation cases and empower judges to make decisions where the technical area of cases may make it less suitable for cases to be heard before a jury.

- **An increase in complaints/notifications, some of which will become successful negligence claims.** Australian Health Practitioner Regulation Agency (AHPRA) data shows a 19% increase in notifications received in 2024/25 to 13,327 notifications. The increase aligns with AHPRA's proactive approach to raise awareness of the role they play in handling concerns about health practitioners and protecting public safety. The increase in complaints is also thought to reflect the higher expectations society places on healthcare practitioners.

  The increase in notifications to AHPRA follows a few years of increasing representation and damages claim frequency for MDOs. For state/territory insurers, we are seeing an increase in claims notified to state/territory insurers and claims taking longer to settle. The greater settlement delays are putting pressure on claim costs.

- **Increasing legal costs:** Civil Liability reform that considers caps on legal fees, streamlining claims processes to resolve claims faster will help manage these costs.

Available and affordable medical indemnity insurance is key to supporting an effective healthcare sector. We support the ICA's calls to review Civil Liability settings to promote fair outcomes and ongoing industry sustainability.

8 Opportunities to improve patient outcomes and reduce medical indemnity claims

We have identified three immediate opportunities where actuaries can work with medical indemnity providers and government to reduce risk and improve outcomes. These areas are:

1. For the public sector to seek to reduce individual practitioner risk in conjunction with the current focus on system-wide risks.
2. For the private sector to seek to reduce system-wide risks in conjunction with the current focus on individual practitioner risks.
3. To collect and analyse information on near misses and incidents to support better patient outcomes, ultimately reducing claims.

8.1 Reduce individual practitioner risk in the public sector

State and territory governments focus on reducing risk at a whole of system level. For example, the VMIA's Incentivising Better Patient Safety program launched in 2018 focuses on providing training and additional support at a health service level.

Our work with MDOs shows medical practitioners with recent past claims are more likely to have claims in future, all else being equal. This is useful information which can be used to target risk prevention initiatives. For example, consider two surgeons (A and B). Surgeons A and B have the same level of experience, volume of surgeries and training, but different past claims experience. Surgeon A has had no claims in the past 7 years while surgeon B has had 2 claims in the last 7 years. Our analysis shows surgeon B is around three times more likely to have a claim in the next year, relative to surgeon A.

There is an opportunity for states and territories to analyse information at an individual practitioner level. Such analysis will support delivering extra training and support to reduce risk and improve patient outcomes. We are aware that some hospitals and AHPRA already do this, but it tends to be limited and isolated.

A key challenge here is the autonomy afforded to the operations of different hospitals and health services. This might make comparison between health services challenging without co-ordination through the relevant State or Territory Health Department, and a State or Territory Health Department may lack the expertise to assess medical indemnity insurance risks. This is where operating as a data co-ordinator and then working with the State insurer of medical indemnity risks to understand and benchmark incident data at the practitioner level could help to inform and mitigate practitioner-level risks.

8.2 Reduce whole of sector risk in the private sector

MDOs tend to understand risk at an individual practitioner level. What is missing is a whole of system view on risk. A whole of system view of risk would support identifying system-wide opportunities to reduce risk for those operating in private practice.

Combining and analysing de-identified policy and claims information across all MI insurers would help target initiatives to improve outcomes and reduce risk. This could be as an extension to APRA's National Claims and Policies Database (NCPD).

Regulatory bodies, such as APRA and ARHPRA, could play a key role in de-identifying claims data from individual MDOs and providing back insights to assist MDOs in understanding sector-level trends.

8.3 Target initiatives based on near misses and incidents, not just claims

Compared to other classes of personal injury insurance such as workers compensation and Compulsory Third Party (CTP) insurance, medical indemnity insurance claims experience is sparse. This is likely due to the lower exposure to health procedures (i.e. much less time spent in medical care compared to working or driving) and the highly professional nature of the medical profession.

Incidents and near misses, combined with an analysis of claims provides a much richer source of information and if analysed effectively, offers greater potential to reduce risk and improve patient outcomes.

A key challenge is obtaining consistent and reliable information across different health services.

Appendix A MDO and state/territory comparison

	Medical Defence Organisations (e.g. Avant, MIGA)	State or Territory Government (e.g. VMIA, QGIF)
Covers	Individual practitioner and practice level cover	Employer for wrongful acts or omissions of an employee (vicarious liability)
Coverage	▪ Damages ▪ Legal representation ▪ Medico-legal advice. E.g. complaints, disciplinary matters, AHPRA representation.	▪ Damages ▪ Legal representation ▪ Does not cover medico-legal advice
Basis of cover	▪ Claims made. Responds to claims made during the policy, regardless of when the incident occurred.	▪ Usually occurrence basis. i.e. when the incident happened.
Premiums paid by	▪ Practitioners	▪ Public hospitals and health services as a budget expense
Rating factors	▪ Type of practice (e.g. GP procedural) ▪ State (e.g. VIC) ▪ Gross annual billings (e.g. $500K) ▪ Years in private practice (e.g. 15 years) ▪ Sex (e.g. female) ▪ Claims history (e.g. 2 claims in the last 5 years)	▪ For public hospitals, pricing conducted at the site level and aggregated to the hospital level for the premium payer. ▪ Claims history and number and type of services delivered at a site level
Risk advisory / harm prevention / education	Yes. Tends to focus on the individual/medical practice. For example, Avant offers: ▪ Risk mitigation strategies for each specialty informed by Avant's claims experience ▪ Clinical documentation and record-keeping ▪ Patient communication and consent processes.	Yes. Tends to focus on the system/hospital. For example, the VMIA: ▪ Advises public hospitals and other health services on key risk areas and significant claims and premium drivers to identify areas for learning and improvement ▪ Works with public hospitals and health services to define and fund initiatives and programs to reduce the risk of

	Medical Defence Organisations (e.g. Avant, MIGA)	State or Territory Government (e.g. VMIA, QGIF)
		incidents using national and global research on best medical practices ▪ Works across the relevant State or Territory Government agencies who also influence health policy (e.g. Safer Care Victoria) to ensure initiatives are aligned with broader health objectives.
Direct support provided by Government	Yes, including: ▪ High Cost Claims Scheme (funded by Government): Covers 50% of the claims cost above $500K. ▪ Exceptional Claims Scheme: Covers claims that exceed the PI limit (usually $20M). ▪ Run-off Cover Scheme: Covers claims for practitioners who have left private practice. ▪ Premium Support Scheme: Covers part of the medical indemnity premium if the premium exceeds 7.5% of gross private medical income.	Not directly applicable. Premiums are contributed by hospitals and health services and ultimately a capital backing is provided by the relevant State or Territory Government.

Australian states and territories currently retain State/territory run health care risks under two types of models:

- *State insurance captive with limited or no medical indemnity reinsurance:* A statutory authority is empowered to insure the State's assets and risks, including medical indemnity. While backed by the State's balance sheet, the captive is expected to be self-sustaining based on premium contributions. This is the model adopted in Victoria (Victorian Managed Insurance Authority or VMIA), New South Wales (Treasury Managed Fund or TMF under Insurance and Care NSW or icare), Western Australia (Insurance Council of Western Australia or ICWA), South Australia (South Australian Financing Authority or SAFA) and Australian Capital Territory (ACT Insurance Authority or ACTIA).
- *A fund set up by State Treasury which is not separate to the Treasury balance sheet:* Insurance is provided to the State, including for medical indemnity needs, by a fund rather than a separate statutory authority. This is the model adopted in Queensland (Queensland Government Insurance Fund or QGIF), Tasmania (Risk Management Fund or RMF) and the Northern Territory.