GEORGIA

Financial Inclusion and Accountability Project (P169543)

Medical Malpractice Liability Insurance in Georgia

Overview and Policy Recommendations

October 2021

Contents

Figures

Tables

Executive Summary

Medical malpractice liability insurance (MMLI) is a special type of professional liability insurance. MMLI provides insurance coverage for healthcare professionals and medical service providers against legal liability to third parties for damages caused by their negligence in the course of conducting medical services. Patients, the healthcare system, and the insurance industry would greatly benefit from the development of MMLI in Georgia. Adequate coverage of medical practitioners and health providers' liability, fair compensation of patients that suffered as a result of medical malpractice, as well as deterrence of medical malpractice is of utmost importance for improving the quality and safety of the Georgian health care system, its smooth functioning and long-term sustainability.

Many countries made coverage for medical malpractice liability mandatory by law to ensure that physicians and medical providers remain solvent in case of major claims. MMLI in a mandatory form exists in many European countries, such as Austria, Czech Republic, Denmark, France, Finland, Hungary, Iceland, Macedonia, Poland, Slovak Republic, Slovenia, Spain, Sweden, and Turkey. International experience shows that introduction of compulsory insurance ensures adequate indemnification of victims, greater affordability and accessibility of malpractice insurance, and better risk management practices by insurers.

This report reviews the current state of MMLI in Georgia and identifies market and regulatory challenges to its growth and future development. As this market segment is almost non-existent in Georgia, the report relies heavily on international best practice and standards, which are then used as a basis for policy recommendations for key decision-makers such as the Insurance State Supervision Service of Georgia (ISSSG), the Georgian Insurance Association (GIA), the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs (MOLHSA), the Agency for Regulation of Medical and Pharmaceutical Activities (ARMPA), and the Union of Georgian Medical Association (UGMA).

The insurance market in Georgia is a small emerging market with a low insurance culture and product penetration. Georgia has only a few compulsory professional liability insurance products, such as the liability insurance for notaries, auditors, and insurance brokers, and owners of facilities or places where the general public is present in mass numbers. The international experience has proven that compulsory forms of liability insurance are the most essential driving factors for market growth.

Non-compulsory medical malpractice liability insurance products are currently available in Georgia. However, only seven out of eighteen insurance companies operating in the market offer such products and the share of the premiums from this line of business accounts for less than 0.5 percent of total gross premium written in the market. Despite its small size this line of business is highly profitable as insurance companies are faced with very few claims - Georgia has a relatively non-litigious environment, low claims awareness and low insured limits.

Based on the specificity of the Georgian healthcare system, the level of development of the national insurance market, and international experience in MMLI, the report summarizes the main challenges faced by the local insurers in developing this line of business and provides policy recommendations.

First, the report recommends prescribing compulsory medical liability insurance for all medical providers (i.e., individuals and medical service business entities) in the Law on Medical Practice. This reform must be accompanied by the issuance of special ordinances by the Ministry of Health related

to the minimum required limits of insurance coverage based on the type of medical specialization, standards and detailed criteria for assessing amounts of economic and non-economic damages, and introducing caps on legal awards.

Second, the report recommends introducing a standard policy form with the same common general terms and conditions for greater consumer protection and building trust among patients receiving medical services. The report suggests that ISSSG, GIA, ARMPA and UGMA approve a standard insurance policy form that can be used by all insurance market players. Common ratemaking should also be applied which will ensure fair premium rates for this compulsory class of business.

Third, the report recommends that premium rates should be set separately for providers of hospital care and individual physicians. Pricing should be done according to the physician's specialty, geographic location, number of hours worked, and other factors. Experiments with detailed individual experience rating have not worked well because physicians' claims experience is too variable over short time periods, making it difficult to produce an actuarially stable estimate of their risk. For rate-making purposes, GIA should carry out an actuarial review of technical rates in the market with the view of proposing a market-wide tariff for a compulsory MMLI policy. This report provides indicative suggestions on the premium tariff, level of deductible, discounts, and tariff system for variable sums insured.

The report also reviews the current medical risk management processes adopted by providers of hospital care. The development of quality risk management processes in medical institutions can greatly reduce occurrence of professional liability claims. Therefore, requirements for physicians to immerse themselves in medical malpractice prevention and risk management techniques should be introduced along with the appropriate standards of duty of care as part of their licensing obligations. Eligibility for government premium subsidies or lower insurance premium rates should be linked to doctors' proactive day to day practicing of risk management activities.

The World Bank stands ready to support the implementation of the report recommendations. As a next step, technical assistance can be provided in the following areas: (i) preparing the regulatory framework for introducing compulsory medical malpractice liability insurance, (ii) organizing workshops for stakeholders on the standard insurance policy form, ratemaking, claims settlement best practice and medical risk management. The workshops will also review experience of other countries which authorities might find useful as they discuss potential introduction of compulsory MMLI product in Georgia.

Acronyms

AO	Adjusting and Other
ARMPA	Agency for Regulation of Medical and Pharmaceutical Activities
CMPA	Canadian Medical Protective Association
DCC	Defense and Cost Containment
GIA	Georgian Insurance Association
GWP	Gross Written Premium
IBNR	Incurred But Not Reported
ISSSG	Insurance State Supervision Service of Georgia
JUA	Joint Underwriting Association
LAE	Loss Adjustment Expenses
MMLI	Medical Malpractice Liability Insurance
MPLI	Medical Professional Liability Insurance
MDO	Medical Defense Organization
MDU	Medical Defense Union
NHF	National Health Fund
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
PCI	Patient Compensation Insurance
PLI	Professional liability insurance
PTA	Patient Tort Act
RBNS	Reported but not Settled
SERP	Supplemental Extended Reporting Period
UGMA	Union of Georgian Medical Association

1. Introduction[1]

This Medical Malpractice Liability Insurance Report reviews the current state of professional liability insurance for the non-life insurance market in Georgia, and identifies market and regulatory challenges to its growth and future development. Because this market segment is almost non-existent in Georgia, this report relies heavily on international best practices and standards, which are then used as a basis for policy recommendations to key decision makers in the Government of Georgia, the Insurance State Supervision Service of Georgia (ISSSG), the Georgian Insurance Association (GIA), the Agency for Regulation of Medical and Pharmaceutical Activities (ARMPA), and the Union of Georgian Medical Association (UGMA).

This report is based on online information of the Georgian insurance sector and includes relevant laws, regulations, and market statistics. Most of the information was acquired from the website of the insurance sector regulator, ISSSG. Information was also acquired through online conference meetings with ISSSG representatives.

In order to provide a better insight into current medical malpractice liability insurance (MMLI) in Georgia, a survey, as well as online meetings, were conducted with respective representatives from insurance companies to discuss their MMLI business practices, views on Georgia's regulatory framework, and potential challenges in providing medical malpractice insurance.

As MMLI is meant to provide financial protection to medical providers, UGMA and medical providers also provided feedback through an online meeting. In order to gain a better insight into the liability exposure of medical providers, a second survey was also conducted.

Complementary data was provided by World Bank reports, the World Health Organization, and information from the European Hospital and Healthcare Federation and the Organization for Economic Co-operation and Development, as well as other available sources.

1.1. Market Overview

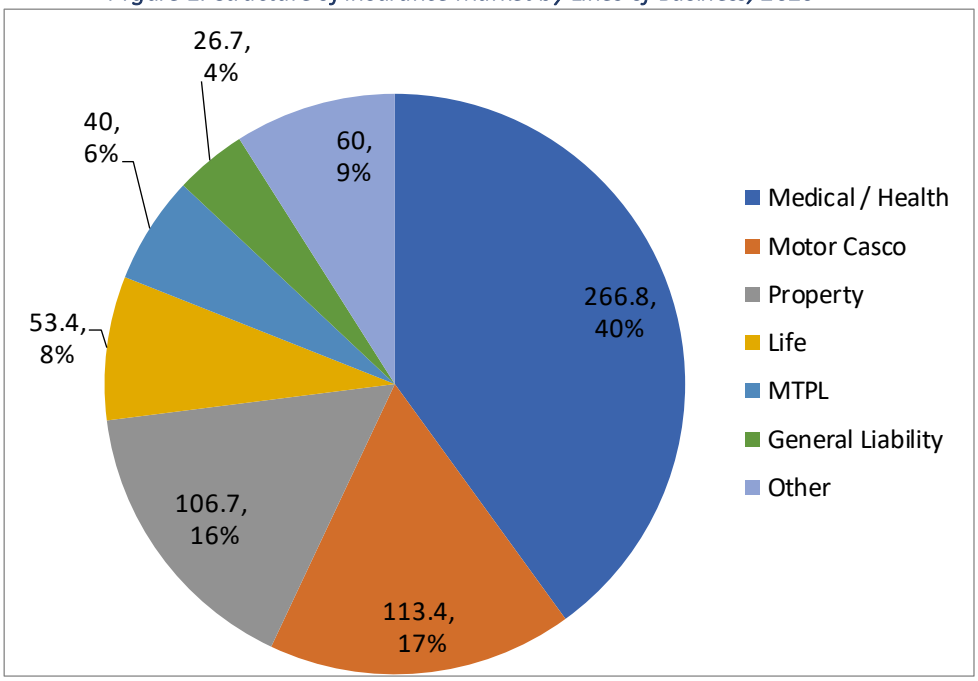
Georgia's insurance market is considered to be a small to medium-sized emerging market with insurance penetration rate of 1.35% and a density rate of USD 40.[2] As in some other post-Soviet economies, insurance culture and product penetration remain quite low, especially in the consumer segment. Moreover, Georgia has only a small number of compulsory insurances. For example, motor third party liability is not compulsory other than for foreign-registered vehicles entering Georgia.

In 2020, total gross written premiums (GWP) amounted to GEL 667 million (USD 196.59 million) with 40% in private health insurance, 17% in casco insurance, and 16% in property insurance (Figure 1). Life insurance is underdeveloped with a market share of 8%.

[1] This report was prepared by the World Bank external consultant Klime Poposki under the guidance of Eugene Gurenko (Lead Financial Sector Specialist) and Natalia Tsivadze (Financial Sector Specialist) as part of the Financial Inclusion and Accountability project implemented by the World Bank in partnership with the European Union.

[2] Data is from December 31, 2020 and taken from ISSSG (written insurance premiums), a survey filled by the insurance companies (medical malpractice insurance data), the National Bank of Georgia (data on GDP, population and annual exchange rate) and an AXCO report on Georgian Non-Life Insurance.

Figure 1: Structure of Insurance Market by Lines of Business, 2020



As of 31 December 2020, there were eighteen insurance companies operating in the market registered as composite insurers, all of which wrote non-life business. Five of the insurers also wrote reinsurance business. Moreover, there were twenty-four insurance brokers in the broker register.

This principle of professional liability (civil liability) is articulated in the Georgian Civil Code[3]: "Any person has a duty to obey the rules of conduct imposed by the law or local habits and refrain from any action or inaction which might prejudice the legitimate rights and interests of other people. Any competent person who breaches this duty shall be held liable for all the incurred damages and must redress them fully." The concept of claiming from a third party for bodily injury or loss or property damage is still not widely understood or practiced in Georgia because of the limited offer of liability insurance products, a very few compulsory forms of liability insurance, and the fact that many people still wish to settle matters privately, without involving state institutions.

In general, only the insured has a right to file a claim covered under an insurance contract directly against the insurer. However, in the case of third-party liability insurance, a prospective third-party claimant who has suffered a loss as a result of the actions and/or omissions of the insured, which are covered by the liability policy, has the right to step into the position of the insured under the insurance contract and file a claim directly against the insurer (so-called actio directa). The Georgian law does not explicitly regulate insurance policy triggers. Usually, the policy is triggered by the occurrence of the insured event. However, the law does not limit parties' rights to agree on other policy triggers as long as it is in compliance with Georgian law.

According to an AXCO market research report, since 1991, the Georgian liability insurance market has developed slowly but has been profitable. There is evidence that a broader range of businesses are buying general third party coverage, as well as some of the sub-classes such as product liability, professional indemnity, director and officer liability, pollution and environmental liability, and other types such as cargo carrier and freight forwarder liability, and terminal operator liability. Gross written

[3] Law No 786- IIs (Civil Code of Georgia).

premiums for general third-party liability amounted to GEL 26.68 million (USD 7.87 million). The class remains small, however, accounting for just 4% of total gross written premiums.

Special legislation has been enacted for compulsory general third-party liability insurance for notaries, auditors, and insurance brokers, as well as liability insurance for owners of facilities or places where the general public is present in mass numbers.

Based on survey data collected from insurance companies, seven insurers offer medical malpractice liability insurance.[4] The MMLI premiums in the non-life insurance market are insignificant (less than 0.5%) and accounts for only 3% in the general third-party liability line of business.

As shown in Figure 2, MMLI in Georgia is fairly undeveloped judging both by gross written premiums and the number of policies sold. However, although the market is not increasing, it remains stable. The gross written premium and number of policies sold in 2020 is at the same level as in 2016.

Figure 2: Gross Written Premiums (in GEL) and Number of Policies for MMLI, 2016-2020

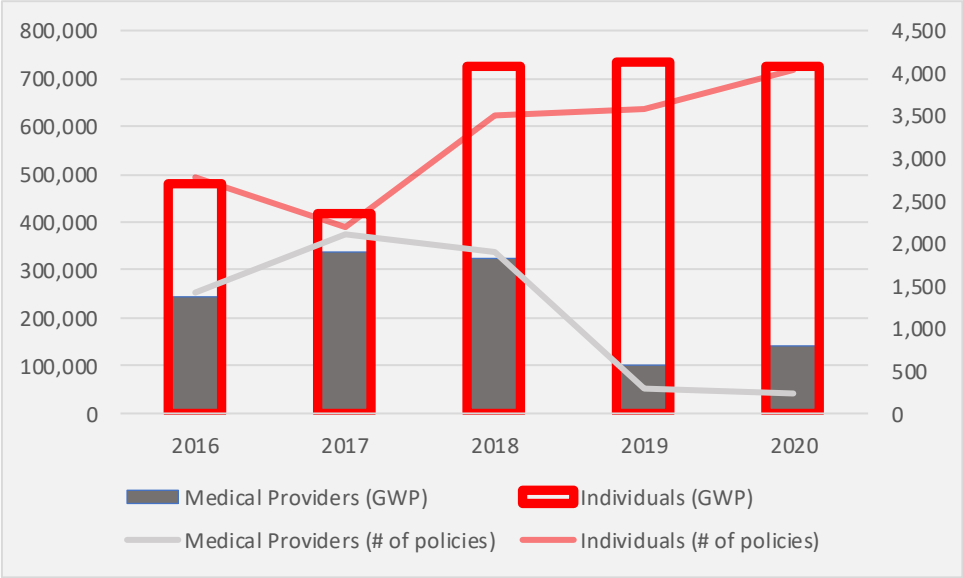
International experience shows that buyers of medical malpractice liability insurance typically fall into two categories:

- Medical providers, e.g. hospitals and other medical organizations such as clinics, nursing homes, laboratories, managed care organizations, and visiting nurse associations.
- Individuals, e.g. physicians, dentists, nurses, therapists, optometrists, emergency medical technicians, veterinarians and others.

Survey data show that of medical providers, mainly hospitals and dental clinics purchase MMLI. On the individual level, mainly physicians, dentists, and therapists purchase MMLI. Medical providers are only a small share of total sales, while individuals account for the largest part of GWP and policies sold (Figure 3). Based on survey findings and interviews with insurers and medical providers, the differences in MMLI market demand are due to reliance on self-insurance, low numbers of court cases against hospitals, and lack of effective risk management processes for liability risk exposure among institutional medical service providers.

[4] Of these seven insurers, only four fully participated in the market survey.

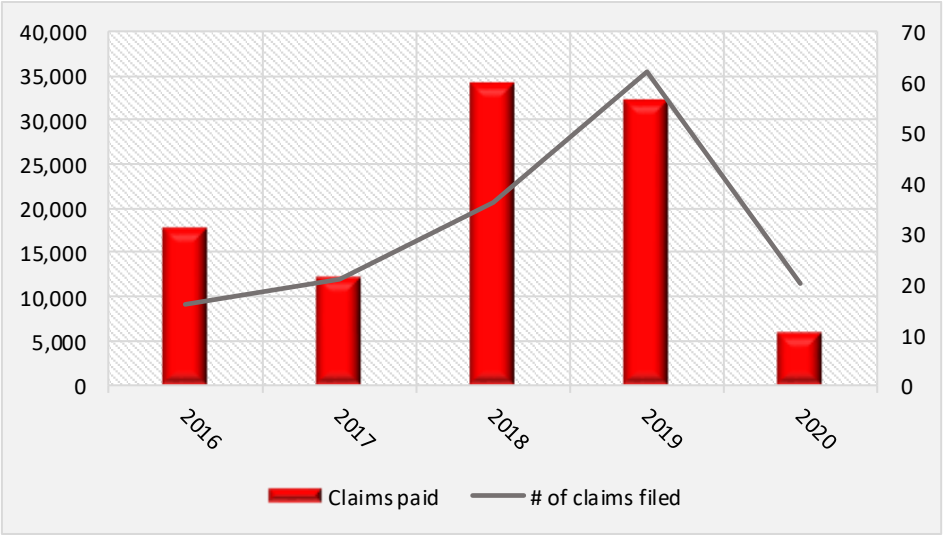
Figure 3: Gross Written Premium (in GEL) and Number of Policies for MMLI, 2016-2020



Georgia has a relatively non-litigious environment and claims awareness is low. Legal defense costs are typically included within the limit of indemnity and are not specified/payable in addition to other costs.

In terms of loss experience, there have been no notable losses on the few risks written, although some frequency claims have occurred on medical malpractice. According to market sources, loss experience is positive with very few claims incurred and paid (Figure 4). The small number of claims and low insured limits all but guarantee high profit margins.

Figure 4: Claims Paid (in GEL) and Number of Claims Filed



The average compensation paid per insurance policy is GEL 1.248 (USD 368) and the largest amount of claims ever paid was GEL 7.200 (USD 2121). It is worth noting that non-pecuniary damage is not covered due to a standard exclusion in the policy forms of MMLI products.

1.2. Distribution Channels

There are no officially published statistics on the breakdown of premiums written by various distribution channels. Based on the last AXCO report, a tentative profile of the split of total non-life

market premiums by distribution channel shows that direct sales accounted for 70% of GWP, followed by bancassurance with 18%.[5]

Under current legislation, licensing is not required for insurance agents and brokers in Georgia. However, to commence business activities, insurance brokers are obliged to apply and register with the ISSSG. Third party agents such as retailers, car dealers and travel agents are also used for distribution. Bancassurance is also important for life, property, and motor insurance.

The sales methods of insurance products in Georgia have been changing slowly. MMLI data received from insurance companies imply that 53% of premiums are written through direct channels, 26% by brokers, and 21% via agents.

Based on a market survey, the average agent commission ranges from 12-13%. In the case of direct sales made by company agents, insurers also pay some fixed remuneration in addition to the commission.

1.3. Medical Malpractice Liability Insurance Products

The MMLI market is mainly driven by individual health workers. On average, sums insured are very low and are in the range of GEL 5.000 (USD 1.500) to GEL 150.000 (USD 45.000). The sums insured are variable depending on the client's request, the product package, and the company's underwriting standards and retention capacity.

Reinsurance is not widely used as a risk transfer mechanism, nor to increase underwriting capacity. This is due to limited insurance sums, low claims pattern history with only a few claims cases, and a small amount of compensation. The overall risk exposure to this product does not have much effect on an insurer's capital requirements.

Policy durations are mainly one year. Rates and deductibles are in line with international norms and program terms.

Parameters used for pricing fall into two categories. For medical providers, revenue, number of patients, number of beds, and number and structure of medical personnel are taken into account. For individuals, professional experience and loss history are included in pricing parameters. In both cases, sum insured is also a price factor. Medical area of specialization is not a rating factor with the exception of one insurer, which applies three levels of grades upon the level of riskiness - high, medium and low.

The main underwriting considerations are the insured's profile, past loss experience, and limit of liability. Deductibles are applied with an average range of 0 to 5%, with one insurer applying a 10% deductible on certain risks.

For exclusions in general terms and conditions, all four insurance companies have provisioned the international standard exception clause such as asbestos, assumed liability, clinical trials, contagious diseases, deregistered practitioners, dishonest or reckless acts, employer's liability, fines penalties and damages, insolvency, jurisdiction and territorial limits, medicines, narcotics, occupier's liability, prior claims or circumstances, radioactivity, related entities, rights of recovery, sexual misconduct, terrorism, and war. Additionally, two insurers have additional exceptions to include plastic surgery and telemedicine.

[5] Direct includes own sales employees, tied agents, and other direct channels.

With the exception of one insurer that offers occurrence-based policies, medical malpractice coverage is usually provided on a claims-made basis and usually includes a local jurisdictional clause. Both provide for extended reporting periods, which extend the amount of time one can report a claim after a policy cancellation, and retroactive dates, a specific date on which the policy coverage begins, are typically included in policy provisions, with the length of time varying for each company. However, the duration of the extended reporting period and the retroactive date is shorter compared to best international practices. In Georgia, when the client requires extended reporting periods, six months or a year are given. This is another constraint that limits the appeal of MMLI in Georgia.

1.4. Regulatory Framework on Professional Medical Liability

The legal standard definition of liability can be found in the Civil Code of Georgia as was mentioned in Section 1.1. Any competent person who breaches his duty shall be held liable for all incurred damages and must redress them fully. The person who injures another through an illicit act done with fault must redress any such damage. Offensive professional liability is a sanction specific to Civil Law, applicable to any act resulting in injuries or damage. Strictly speaking, it is a civil sanction without acting as a punishment.

In addition to the Civil Code, the legal basis for medical liability is also grounded in Georgia's Law on Medical Practice, which regulates the medical profession.[6] In *Chapter X Professional Liabilities of Independent Medical Practitioners*, Article 73 says, "an independent medical practitioner shall have professional liability determined by the legislation of Georgia for violation of medical standards and ethical norms related to the examination, care and treatment of a patient." In Article 97, there is also a provision on professional liability insurance, which states that "an independent medical practitioner shall have the right to professional liability insurance for property or non-property losses inflicted to a patient as a result of professional errors."

In the Georgian healthcare system, the quality assurance of medical providers, including individual health workers, is monitored by ARMPA under the authority of the Ministry of Health. ARMPA is also in charge of the licensing and certification of medical doctors. In Chapter III, the legal requirements for medical education are described in the *Law on Medical Practice*, which includes the physician's professional qualifications and continuous professional development. To receive a license to act as a medical doctor, Georgia requires doctors to graduate from the Postgraduate Medical Education/Residency Program and pass the State Certification Exam.

In the past, medical malpractice liabilities were not a relevant risk exposure for medical providers due to the low financial liability arising out of a patient's passive behavior and no liability insurance. Furthermore, the Civil Code provision on liability due to medical malpractice does not impose sanctions on the doctor or the pharmacist (i.e., limiting or denying their rights, social censure, or obligation to perform mandatory services). Instead, it focuses on the injured patient's rights of receiving redress and indemnification for the damage or injury caused through a faulty medical act. This does not mean that medical personnel are exempt from any criminal or administrative liability or disciplinary sanctions. However, incurring any such liability is not considered malpractice but a method for sanctioning a physician, pharmacist, or nurse.

[6] https://matsne.gov.ge/en/document/download/15334/14/en/pdf

1.5. Liability Risk Management by Healthcare Providers in Georgia

To gain a better insight into the liability exposure of medical providers, we carried out a survey consisting of 18 questions. With the support of ISSSG, the questionnaires were distributed to the largest medical providers. The main survey findings are as follows:

- Based on hospital records, it is common for patients to initiate a malpractice lawsuit in the case of medical malpractice. Very rarely do patients directly claim compensation against the hospital and/or health workers. There were a few cases where the patient filed an administrative complaint without any financial compensation.
- According to the LEPL State Regulation Agency for Medical and Pharmaceutical Activities, 200 – 250 complaints related to the quality of medical services are, on average, registered annually across the country. However, there are no statistics on cases of malpractice (the administrative body only registers complaints from the medical service quality perspective). Only in rare cases is the issue of a doctor's professional liability raised.
- On average, hospitals receive less than ten complaints per year directly from the patients about the quality of medical services. Only three out of nine hospitals surveyed declared that they have experience in medical malpractice lawsuits, with less than five court cases.
- The effective legislation does not provide a maximum limit on the size of financial compensation awarded by the court to a victim of medical malpractice. Survey results show that the maximum amount of court awarded compensation for moral damages frequently did not exceed GEL 20.000 (USD 5.900), while the highest compensation for moral damages resulting from death of a close relative due to medical malpractice equaled GEL 50.000 (USD 14.700).
- There is no time limit defined for filing information related to medical malpractice. However, a rule exists on the timeframes for storage of medical documents. Specifically, outpatient documents are kept for 5 years, while inpatient ones are kept for 15 years.
- A review of a health worker's liability is based on an evaluation of his/her compliance with guidelines recognized by national or authoritative organizations and high credibility evidence. If the doctor complies with these requirements, he/ she cannot be held liable (inter alia professionally).
- Cases of health workers liability and associated penalties are not regulated by current legislation. The Code of Administrative Offences only imposes a penalty for pursuing illegal medical activity. In addition, a hospital can impose monetary penalties on health workers in the case of malpractice based on the Civil Code provision of the subrogation right. However, insurers cannot claim subrogation from health workers.
- In Georgia, there is a no-fault compensation system for the National Healthcare System. Therefore, the only compensation system that exists is medical malpractice liability insurance. Hence, the primary buyers of such products are individual health workers. The insurance risk premium for a one-year contract is typically USD 100 on average.

2. International Experience on Medical Professional Liability and Insurance Coverage

Most European medical laws state that medical personnel are civilly liable for any damages incurred by error to include negligent or imprudent behavior, or insufficient medical knowledge in exercising one's profession through individual deeds during intervention, diagnostic, or treatment procedures.

There are several types of legal liability for medical personnel such as civil (contractual or delictual), criminal, administrative, and disciplinary liability. Malpractice is professional misconduct, which occurs while rendering a medical or pharmaceutical service and results in injury to a patient, thus resulting in the civil liability of medical personnel and/or of the provider of medical, sanitary and pharmaceutical products and services.

It is everyone's duty to obey the rules of conduct imposed by the law or local habits and to refrain from any action or inaction which might prejudice the rights and interests of other people. Any competent person who breaches this duty shall be held liable for all incurred damages and must redress them fully.

If misconduct occurs at the ethical level of medical practice, it results in a failure to obey the ethical principles applicable to medical activities. The ethical courts (the disciplinary bodies) are to decide what a doctor or a pharmacist should have done. Medical ethics and medical law have a complex relationship. Medical ethics state what medical personnel should do, while the medical law states what they are required to do. Therefore, a failure to obey medical ethics could also result in legal or civil liability.

Medical malpractice policies generally cover economic damages and/or non-economic awards in case of lawsuits, but they generally do not cover punitive and exemplary damages. These generally include legal fees incurred in the process of defending and settling malpractice suits, including attorney fees, court costs, arbitration and settlement costs. Lastly, most insurance policies put a limit on the amount of indemnity they pay, meaning that very high monetary awards are partly financed directly by health care providers. Some policy contracts also provide for deductibles.

2.1. Individual vs. Institutional Liability

From a civil point of view, medical personnel are liable for any damage or injury incurred by a patient due to a breach of duty or care in the medical personnel's scientific, professional, or ethical activities. If they breach legal regulations applicable to medical practice, they are also considered legally liable e.g., regarding confidentiality informed consent, obligation of granting medical assistance, patient discrimination, and/or doctor's limitation of their own specialization.

There are also situations when the medical institution is also liable. These situations should be well defined by the legal framework, according to which medical unit is responsible when the patient suffered injury/damage due to:

- Nosocomial infections, except when an external cause appeared which was not under the institution's control;
- Known malfunctions of abused medical machinery and appliances which were not repaired;
- Using sanitary materials, medical devices, drugs, and sanitary substances after their expiry or validity date;
- Accepting medical equipment and devices, sanitary materials, drugs and sanitary substances from suppliers, without insurance as required by law, as well as subcontracting medical or nonmedical services from providers without professional liability insurance in the medical field;
- Failure to observe the internal regulations of the sanitary unit.

The medical provider will be liable for ensuring the working conditions for medical doctors and the conditions for granting medical assistance to patients.

2.2. Loss Exposure

To prevail in a medical malpractice claim against a physician, under the 'preponderance of evidence' standard, the injured party (i.e., the patient or patient's family) must demonstrate that it was more likely than not that the following four elements were present:

- The physician had a duty to the patient;
- The physician was negligent in his or her execution of the duty, (i.e., by breaching the standard of care);
- The physician's negligent action was the proximate cause of the patient's injuries; and
- The patient's injury resulted in damages, whether economic or other.

A breach of a physician's duty to a patient can take many forms. For example, injuries may result from misdiagnosis, errors in the choice or technical execution of procedures, improper administration of medications, failure to follow up appropriately with a patient, and failure to obtain adequate informed consent. The standard of care requirement means that the finder of fact, typically the jury, must hear testimony from both sides about what the standard of care is and then evaluate that information to decide if the physician breached it, i.e., whether a reasonably prudent physician confronted with similar circumstances would have acted as the defendant physician did.

The three social goals of malpractice litigation are, first, to deter unsafe practices; second, to compensate persons injured through negligence; and third, to exact corrective justice. Thus, it is reasonable to expect that medical malpractice can serve as a deterrent to the improper practice of medicine and, either through a negotiated settlement or trial, can compensate patients who are victims of physician negligence.

2.3. Common Allegations against Physicians

Professional liability claims against medical professionals are often based on allegations of surgical error, improper diagnoses, improper tests, lack of informed consent, and improper administration of anesthetics and drugs. An explanation of each is provided below.

Surgical Error - A surgeon who performs an operation has the duty to exercise reasonable care, skill, and diligence that prudent surgeons in similar situations usually exercise. For example, failure to remove instruments, surgical sponges, or other foreign substances from the patient's body before the incision has been closed has been held to be negligence on the part of the operating surgeon.

Improper Diagnosis - One of the fundamental duties of a physician is to make a skilled and careful diagnosis of ailments. If a physician fails to bring the proper degree of skill or care to a diagnosis, the physician may be held liable to the patient for any resulting damage. However, a mistake in diagnosis caused by an error in judgment is not actionable if the physician has used the proper degree of skill and care. In other words, liability is not imposed on a physician for making an error in judgment, except when the error results from a failure to comply with a recognized standard of medical care that is exercised by prudent physicians in the same specialty under similar circumstances.

Improper Tests - Physicians have a duty to employ the proper tests and evaluations to determine the condition of a patient about to undergo a proposed treatment or operation. Whether the failure to make such tests or examinations constitutes a lack of due and reasonable care and skill depends on whether the standards of skill and care require such a test or an examination in a particular case.

Lack of Informed Consent - The informed consent doctrine is a direct expression of the fundamental principle of the inviolability of personal liberty and reflects the patient's right to accept or refuse any

treatment after having received all necessary information about the medical procedure and its possible consequences. Physician is generally required to disclose information to the patient on the following topics:

- the nature of the patient's condition or problem;
- the nature or purpose of the procedure or treatment that the physician is proposing;
- the risks associated with the proposed procedure or treatment;
- the anticipated benefits (results) of the proposed procedure or treatment; and
- alternative procedures or treatments and the risks associated with them.

Failure to disclose in advance any known significant risks of a particular procedure or treatment may render the physician or surgeon liable. Physicians and surgeons are not, however, expected to disclose every conceivable risk because excessive disclosure might do patients more harm than good.

Use and Administration of Anesthetics or Drugs - The duty and liability of a physician in administering an anesthetic or a drug to a patient are substantially the same as those which govern the general treatment of patients. Specifically, physicians are bound to exercise the same degree of care and skill that prudent physicians of similar skill and training usually exercise under similar circumstances. In most cases involving the question of negligence, physicians have been held liable for injuries to patients resulting from the administration of the wrong drug or medicine. Related actions include the failure to properly sterilize instruments or operative fields, breaking hypodermic needles, the use of harmful drugs instead of the proper ones, the improper use of spinal injections, and the death or injury of a patient under excessive or improper anesthesia.

Other Allegations - Many other allegations can be made against medical professionals. For just a few possible examples, an injured patient's liability claim might be based on the following:

- A surgeon's failure to continue care after the patient leaves the operating room;
- Negligent treatment of an organ donor or donee in connection with organ transplants;
- Improper treatment of fractures or dislocations caused by the improper application of a cast or a splint or other treatment;
- Transfusions of the wrong type of blood or blood contaminated with serum hepatitis or the human immunodeficiency virus (HIV);
- Improper implantation or insertion of a prosthetic device.

2.5. Loss Control

Loss control includes all of the measures that can reduce or eliminate hazards. Continuing education is one of the most effective means to control liability losses. Courts often perceive the failure to make reasonable continuing education efforts as evidence of professional negligence. Indeed, the common law duty to stay current in one's field has been supplemented and underscored by such modern developments as (1) the universal recognition of continuing education as an ethical obligation of all professionals, and (2) the trend toward mandatory continuing education as a condition of periodic relicensing or recertification of professionals. Regardless of whether a medical professional is required to complete formalized programs of continuing education, every medical professional who is named as a defendant in a negligence action can expect to be questioned about what he or she has done to stay abreast of the latest techniques and knowledge in the field.

Some medical professionals practice "defensive medicine" by requiring extensive diagnostic tests before rendering opinions or performing services. Some of these tests may be medically unnecessary and thus contribute to the spiraling costs of healthcare. Some of these unnecessary tests, however,

are legally necessary to prevent and control medical professional liability claims. Defensive medicine is medical practice performed primarily to limit future risk of a successful lawsuit against the physician and only secondarily to adhere to the medical standard of care. Defensive medicine can lead to a broad set of consequences (Studdert DM, Mello MM, Sage, 2005) such as providing care that is unproductive, not cost effective, may lead to a decrease in beneficial care, and could even be harmful. Additionally, defensive medicine can inflict moral harm on the physician and damage the patient-physician relationship. Defensive medicine is ethically problematic because it moves the focus of medical care away from the best interests of the patient toward the best interests of the physician.

A summary of measures that physicians can use to prevent professional liability claims is presented in Annex 1 of this report.

2.6. System of Compensation for Medical Malpractice Liability

Solutions for challenges to medical malpractice coverage involve a complex mix of options. Different options involving partnerships between the main players of a medical malpractice compensation system (i.e. healthcare providers, patients, insurers/reinsurers, and governments) exist and should take into account the needs, particularities, and preferences of concerned jurisdictions, notably the healthcare system, size of the insurance market, litigation culture, patient's expectations, and the overall expected scope of state intervention and regulation.

The difference in the treatment of medical liability is also due to the difference in the provision and financing of healthcare. Countries where the government finances most healthcare providers tend to rely less on the private insurance market to cover medical liability. In these cases, the government often finances medical liability through dedicated funds. On the contrary, in countries where private practices of healthcare are more widely developed, the private market plays a greater role in the compensation of injured victims.

The following are types of compensation mechanisms for medical injuries to include medical malpractice liability insurance:

- Risk mitigation[7];
- No-fault compensation systems;
- Alternative and/or complementary private sources of financing;
- Mixed private – public compensation mechanisms: compulsory insurance and pools;
- Guarantee funds;
- Sharing medical malpractice liability between public and private actors;
- First direct insurance; and
- Medical malpractice liability insurance.

2.6.1. Risk Mitigation

In many countries, in order to prevent the occurrence of adverse events, risk mitigation is used to improve the medical sector, particularly in hospitals, physician practices, and high-risk specialties. Risk management programs are generally aimed at identifying risks, assessing the impact of these risks, and seeking solutions to better handle them, as well as related claims.

Many countries have established monitoring and supervisory bodies to evaluate medical risk and improve the systematic reporting of medical errors. For instance, in France, a project named

[7] Risk mitigation is not a traditional system for compensation. However, risk mitigation programs are generally aimed at better-identifying risks, seeking solutions to handle the risks better, and above all, improving the insurability of the risks.

"Resisrisq" focuses on ways to improve the assessment and management of medical risks in order to mitigate the rise of premiums. In the United Kingdom, to address the rising costs of compensation principally related to obstetrics claims, the Chief Medical Officer led a working group, which made recommendations to reform clinical negligence procedures.

Overall, since one of the drivers of increased claims frequency is excessive patient expectation, which is typically coupled with a general distrust in the healthcare system, medical practitioners and health service providers should consider putting more effort in building a better trust relationship with their patients. This generally requires enhancing the quality and level of medical information provided to patients through better communication of treatments and possible outcomes, as well as formalizing the informed consent of patients.

2.6.2. No-Fault Compensatory Regimes

In a no-fault system of compensation, a court's assessment of a healthcare provider's liability is not a pre-condition for granting indemnification to the injured patient. Rather, the trigger to compensate is generally based on the injury itself or the fact that it could have been avoided. These systems may be privately financed through commercial and not-for-profit insurance entities (e.g., in Denmark and Finland) or publicly financed (e.g., in Sweden and New Zealand).

In Finland, the system is funded through a consortium of private insurers to cover compensation in certain circumstances. The Patient Insurance Center is a pool of insurers working as a guarantee fund. It was created in 1987 to ensure a broad compensation of damages arising from medical misadventure on a no-fault basis and to preserve the solvency of insurers. The Financial Supervisory Authority of Finland regulates the Patient Insurance Center. Moreover, under this scheme, premiums rates and contract clauses for 'patient insurance' policies are disclosed to and regulated by the Financial Supervisory Authority.

In Sweden, the system is based on voluntary contracts between medical providers and a consortium of insurers. One of the main features of this scheme is the decoupling of compensation and deterrence. Patient compensation is provided by Patient Compensation Insurance (PCI), while the discipline of medical providers is handled by the Medical Responsibility Board. The Swedish system is based on the principle of avoidance. Typically, adjudicators investigate whether 1) an injury resulted from treatment; 2) the treatment in question was medically justified, and 3) the outcome was unavoidable. If the answer to the first query was yes, and the answer to either the second or third queries was no, the claimant receives compensation.

In 1997, this system was made compulsory for all healthcare providers with the adoption of the Patients' Injuries Act. Patients have the possibility to take their liability claims to court even though the system remains a no-fault one. It compensates for injuries that could have been avoided and that have been caused by healthcare practitioners, including conditions that are the results of the diagnosis and treatment of disease (also involving transmission of infections, accidents, defective medical devices and pharmaceuticals), as well as medical research. Under the Patient Tort Act (PTA), claims must be filed within three years from the time the patient recognizes the injury and within ten years from the time of injury. The PTA criteria for calculation of compensation are particularly detailed and compensation is provided only for necessary expenses, not so called 'comfort' expenses. Compensation may also include damages for loss of future income when an injury leads to permanent harm, as well as compensation for acute and permanent pain and suffering, depending on the length of hospitalization or sick leave.

2.6.3. Alternative and/or Complementary Private Source of Financing

In some countries, for historical and cultural reasons as well as owing to the particularities of the market, medical malpractice compensation is dominated by one or several non-profit associations of physicians or medical defense organizations devoted to the coverage of medical liability for their members.

These structures may be reinsured through insurance captives or reinsurers. In some cases, self-insurance mechanisms, risk retention groups, or trusts have also emerged to provide coverage to individual establishments and consortia of establishments, as well as physicians. These diverse initiatives have resulted in wide variations to legal structures, type and scope of coverage, and regulations.

For example, in Canada, the Canadian Medical Protective Association (CMPA) is a not-for-profit medical mutual defense association that provides education, advice, legal defense, and indemnification to approximately 95% of practicing physicians in Canada. The CMPA model is built on a discretionary occurrence-based assistance.

The scheme is financed through a fully funded mechanism and is actuarially sound. Fees are calculated according to an actuarial risk assessment based on a physician's specialty and region of practice. These fees are modulated using experienced funding adjustments based on investment gains and losses. Reserves are accumulated to cope with future liabilities that are determined by using past data and current trends. The CMPA's protection includes no limit on damages paid to patients and, rather than denying help, has extended assistance to members. In addition, the CMPA has supported efforts to improve patient safety and medical risk management in the overall health system.

Another example can be seen in the United Kingdom. In the UK, since the 1990s, the state has directly indemnified doctors working in the National Health Service (NHS) in a non-insured state funded scheme. Compensation is based on the claimant establishing clinical negligence and associated financial loss. Outside this scheme, NHS general practitioners, hospitals, and doctors in private practice, are mainly covered by three Medical Defense Organisations (MDOs). The Medical Defence Union, which provides 8% of claims payments, offers indemnity on an insured basis backed up by a discretionary fund for claims and other medico-legal matters that fall outside the terms of the policy, while the other two MDOs, Medical Protection Society and the Medical and Dental Defence Union of Scotland, only offer indemnity on a discretionary basis. In addition, there is a small number of insurance companies that offer professional indemnity insurance to doctors.

2.6.4. Mixed Private/Public Compensation Mechanisms: Compulsory Insurance and Pools

In many countries, in order to ensure that physicians and hospitals remain solvent in the case of major claims, insurance coverage for medical malpractice liability is mandatory by law or through medical deontology or good practices codes. Usually, this requirement mainly applies to individual physicians and to physicians practicing in hospitals but not necessarily to establishments. Moreover, this obligation has sometimes been associated with a legal requirement mandating insurers cover medical liability risk without specified ceilings.

In some countries, pools have been established. For example, since 2002 in France, if insurance coverage has been denied twice by market carriers for a particular healthcare provider, the latter can refer to the Bureau Central de Tarification, which will assess and set a rate for the insurer. In the aftermath of this 2002 law, massive withdrawal of insurers and huge premium increases (sometimes reaching 600% and threatening the coverage of around 700 private establishments) also fostered the

creation of a temporary pool of insurers. This pool, named the Groupement Temporaire des Assureurs Médicaux (GTAM), brought together 19 insurance companies and 3 reinsurers.

In the United States, in order to respond to previous medical malpractice crises, many states introduced Joint Underwriting Associations (JUAs) to provide a 'market of last resort' for health providers that could not obtain primary coverage at an affordable rate. These systems, which work as state sponsored pools, are aimed at spreading the risk of coverage across all members participating in the plan, thus decreasing the risk to one company.

2.6.5. Guarantee Funds

Another option to enhance insurability of medical malpractice while maintaining a market-based healthcare system is the introduction of guarantee funds in order to assess and cover high-level claims or limit the long-term nature of medical risk.

In Australia, there is a scheme to fund 'incurred but not reported' (IBNR) liabilities. The IBNR indemnity scheme meets certain unfunded claims of eligible medical indemnity providers. This scheme is financed by member contributions. Another example is in Finland where within the no-fault compensation framework, the Patient Insurance Center also works as a guarantee to cope with insurers' insolvency.

2.6.6. Sharing Medical Malpractice Liability between Public and Private Actors

In some countries, limited no-fault indemnification schemes directly financed by social security have also been established to cover specific healthcare providers (e.g., public healthcare establishments) or very low injury/claims.

In cases of serious injuries, public funds or social security systems may also finance risk. For instance, in France, the Act on Medical Liability insurance introduces a new financial sharing of medical liability between insurers and the government through the Office National d'Indemnisation des Accidents Médicaux, des Affections Iatrogènes et des Infections Noscomiales (ONIAM). For disability over 25% due to nosocomial infection, this regulation provides that ONIAM will fund damages even if the error was avoidable. However, if it can be proved that the injury was caused by a negligent act (notably if the healthcare provider did not comply with medical standard practices), the ONIAM may sue the concerned healthcare provider.

In the United States, a program in Virginia was created as an insurance alternative to the state tort system in order to provide lifetime care for babies who are born with serious birth-related neurological injuries, provided that the concerned doctor or hospital participates in the program. The fund has four sources of revenue coming from participating physicians and hospitals, nonparticipating physicians, and liability insurers. This program is thought to compare favorably with the tort system by offering more benefits to injured children and their parents, as well as resulting in lower rates for malpractice insurance.

2.6.7. First Party Insurance

First party insurance for victims of medical malpractice compensates injured victims without any reference to a practitioner's negligence or responsibility. These insurance policies are aimed at protecting the whole family against all types of personal injuries occurring in private life, including medical malpractice. Although this type of contract might improve the coverage and compensation of medical adverse events in the future, the current volume of contracts and demand are not sufficient to produce an observable impact. Moreover, apart from being unfair to patients unable to afford this type of coverage, this option does not address the medical liability issue. Insurers that cover injured

patients will most likely turn to medical providers to seek reimbursement for these compensations through litigation.

This type of contract does not deal with medical-risk mitigation aspects. However, if developed more widely, they could possibly replace current medical malpractice liability policies with complementary and tailored risk-management mechanisms and policies. In some very specific circumstances, first direct insurance can constitute a relevant alternative. For example, in 1999, the Netherlands introduced compulsory direct insurance to provide minimum coverage to victims who participate in medical research projects (though causality still needs to be proven). It should be noted, however, that in the case of loss exceeding the maximum coverage provided by the first party insurance, the injured party can still file a liability claim.

Similarly, in Germany, all persons taking part in clinical trials must be covered by personal accident insurance provided by the testing institution, which is required by law (the requested cap is €500 000). This coverage only indemnifies economic losses.

2.6.8. Medical Malpractice Liability Insurance

Medical malpractice insurance is a special type of professional indemnity insurance. In some countries, professional indemnity insurance may also be called Errors and Omissions Insurance. Medical malpractice insurance provides insurance to healthcare professionals and healthcare facility operators for legal liability to a third party and for losses caused by negligence in the conduct of their professional business.

A healthcare practitioner or facility will always have the primary responsibility to indemnify negligent conduct causing injury to a third party. If, for example, the third party obtains a judgment against the healthcare practitioner, a medical malpractice policy will assist the healthcare practitioner in whole or in part, discharging the judgment debt to a third party. It should be noted, however, whether the court determines a claim is payable to the harmed person is a separate issue to whether a healthcare practitioner's insurance will pay out (which is determined by the insurer – although if the insurer refuses to pay, this may also become a matter for a court to decide).

A contract of insurance is a contingent liability. The contract of insurance is a legally enforceable obligation to pay the specified benefit upon the occurrence of events referred to in the policy, but which may be subject to limits of indemnity and exclusions. Therefore, the insurer has an obligation to pay the claim if a covered, insured event happens, and can only escape liability to the extent of its limit of indemnity (the maximum amount that the policy will pay) or if an exclusion applies.

2.7. Case Studies on Medical Malpractice Liability Insurance

2.7.1. Austria

Since 2010 in Austria, all practicing doctors are required to take out liability insurance with a minimum coverage of EUR 2 million. Most insurers offer policies with such coverage. Premiums are calculated according to the area of expertise (e.g., plastic surgeons, gynecologists, radiologists, and anesthetists are the most expensive), as well as professional status (e.g., trainee, general practitioner, or specialist).

Importantly, upon request from the Austrian Medical Chamber, the Austrian Insurance Association adopted a standard insurance policy form for medical liability insurance. This framework agreement is used as a base in drafting insurable policy terms and conditions, which are accepted by medical

providers (Annex 3).[8] All doctors are mandatory members of a medical chamber in their respective province, called the Landesärztekammer. These provincial institutions jointly constitute the Austrian Medical Chamber or the Österreichische Ärztekammer. Dentists are also united in the Austrian Dentists Chamber, the Österreichische Zahnärztekammer. These chambers are established by statute under public law and represent their members' interests. They are, inter alia, in charge of organizing training, as well as disciplinary matters.

In Austria, all patients are to be treated on the basis of a contract with a doctor or a hospital. This is not only true for patients who pay out of pocket, but also for the vast majority of patients whose treatment is directly paid for by a social health insurance provider. A contractual relationship between a patient and a hospital can fall under a broad range of situations, from an 'all-inclusive' contract covering all services connected with the patient's stay at the hospital (including medical treatment) to 'lodging' contracts where the patient merely rents the room and the medical facilities, which are then used by one or more internal or external medical professionals that the patient hires separately.

The Austrian Civil Code's tort law section applies equally to contractual liability, as the concept of liability encompasses both for a compensation claim, which is also expressed by the core rule of tort law: Everyone is entitled to claim compensation for a loss from the person whose fault has caused it. The loss may have been caused by a breach of a contractual obligation or irrespective of any contract.

The doctrine of informed consent is of utmost importance for medical malpractice claims in Austria, as it traditionally seems to have served as a buffer for those cases filed against healthcare providers where the deviation from medical standards cannot be established. The contract for medical treatment requires doctors or hospitals to inform the patient not only about the diagnosis and recommended therapy, but also about all possible risks of treatment and to offer adequate and proper medical care.

2.7.2. Poland

Since 2007, medical liability insurance has been obligatory in Poland for all healthcare providers (whether public or private hospitals, doctors, or other members of medical staff) that render medical services under National Health Fund contracts.[9] Liability insurance is also compulsory for independent contractors who render healthcare in hospitals. In each of these cases, liability insurance is required to enter into a contract to perform treatment and, consequently, to become a participant of the health insurance scheme.

The scope and conditions of both kinds of insurance are regulated in a detailed manner in the Ordinances of the Minister of Finance. According to its provisions, the insurance covers all injuries due to the faulty acts and omissions of an insured doctor, provided the damage is caused in the course of treatment and within the doctor's vocational duties. There is no possibility for an insurance company to limit its duty to pay indemnities in the insurance contract. Minimum insurance sums have been established with respect to the types of medical specialization. The minimum insurance sums are as follows:

[8] Framework Agreement between the Austrian Medical Chamber (AMC) and the Association of Insurance Companies (AIC) on the contractual terms and conditions regarding professional liability in accordance with § 117b, paragraph 1, item 22a of the Law on Medical Activity.

[9] See the Ordinance of 28 December 2007 concerning compulsory liability insurance of healthcare providers, Journal of Laws 2008, No. 3, item 10.

- The PLN equivalence of 100,000 EUR for doctors who specialize in oncology and clinical oncology, anesthesiology, gynecology and obstetrics, intensive care, urology, neurology, laryngology and otolaryngology, emergency medicine, ophthalmology;
- The PLN equivalence of 50,000 EUR for dentists and dental surgeons; and
- The equivalent of 25,000 EUR for remaining doctors.

In all fields of medical malpractice, civil liability is based on fault. Fault is a necessary premise of a doctor's or hospital's liability for acts and omissions which cause the damage. If fault is committed by a member of the medical staff (in particular, a doctor), it may constitute a prerequisite of that hospital's vicarious liability, even when it objectively appears as anonymous fault.

Fault usually consists of negligence, which is defined as a failure to work with due care and diligence while treating a patient. The doctor's conduct is negligent if, according to the current state of medical knowledge, a doctor has not exercised due care required by the profession. Apart from negligence, fault may involve any kind of carelessness, lack of skill, inadequate attentiveness, imprudence, or insufficient knowledge.

The general rule is that a patient is burdened with proving damages, fault, and a causal connection between the faulty conduct and damages. However, in the field of medical malpractice, these strict requirements have been lowered by case law in order to be more convenient for a claimant. Otherwise, it would be too difficult to establish negligence and to explain whether the damage resulted from the doctor's wrongdoing or whether the issue was only the progression of the patient's initial disease.

3. Conclusions, Considerations, and Policy Recommendations

Medical malpractice liability insurance is one of the most important vehicles for financial protection of medical providers. MMLI protects medical providers from adverse financial impacts due to medical or pharmaceutical services that injure a patient and result in the civil liability of medical personnel and/or provider.

In its current form, the medical malpractice liability insurance sector in Georgia is in a nascent state of development and has an excellent development potential. Very few insurance carriers offer MMLI products with relatively small sums insured and a low-risk premium. Georgia has relatively low litigation environment and low claims awareness. Therefore, there have been no notable losses from the few risks written, although some frequent claims have occurred due to medical malpractice. Without creating too much risk exposure for the insurers, this line of business generates stable premium income, a good underwriting profit, and can allow insurers to gradually build an expertise in this relatively new line of insurance business.

A favorable regulatory environment and non-litigious society are good starting points for the development of medical malpractice insurance. The legal basis for medical liability can be found in Georgia's *Law on Medical Practice and Civil Code*. It is notable that a very small number of malpractice lawsuits have been recorded. However, based on survey results, health providers expect that there will be a record inflation of lawsuits and greater liability exposure in the future, accompanied by a more adverse role of litigation lawyers, and a higher claims awareness of patients.

3.1. Main Considerations Specifically Related to Insurance

3.1.1. Ratemaking for Medical Malpractice Professional Liability Insurance

The basic building block for medical malpractice rates consists of the loss costs, or pure premium, plus the expenses of the insurer, and a factor for profit and contingencies. Insurers use historic loss and expense information to forecast and adjust current rates to those needed for a future period.

Proper actuarial procedures should be employed to derive rates that protect the insurance system's financial soundness and promote equity and availability of coverage for insurance consumers. In addition, actuaries must comply with standards of practice. These standards address a variety of issues, including risk classification, trending procedures, data quality, expense provisions, treatment of provisions for profit and contingencies, and documentation and disclosure.

At the heart of medical malpractice ratemaking is the problem of time lag between the date of an incident of negligence and the date a claim is finally paid. The average time from occurrence to payment is four to five years, with many claims taking much longer (Nordman E., Cermak D., McDaniel K., 2004). This long timeframe means that insurers have a lot of uncertainty about what their liability ultimately will be. The difficulty of estimating liability for claims that have not yet been brought or resolved makes it harder for insurers to set premiums accurately. Thus, the ratemaking actuary must strike a balance between data from older years with claim amounts close to their ultimate values, and data from more recent years where that is not the case.

Rather than using experience ratings, premiums for malpractice insurance vary with the provider's degree of risk. Medical professional liability insurance does not work like auto insurance, which is generally experience rated. When a motorist has a claim, his insurance premiums go up. Physician malpractice premiums, by contrast, are usually set according to the physician's specialty and geographic location, although some insurers also consider number of hours worked, as well as types and setting of work within the specialty. Experiments with individual experience rating of physicians have not worked because their claims experience is too variable over short time periods, making it difficult to produce an actuarially stable estimate of their risk. In contrast, for hospitals, because of their more stable claims experience, experience rating is more reliable than for physicians.

Premium rating of physicians is typically based on the insurance classification method of grouping insured parties based on factors, which theoretically ensure that members of the same classification share similar risks. Premiums are then determined based on an averaging of the past statistical experience of the classification group. It is this rate-making approach which predominates among carriers of medical malpractice insurance. For example, an insurance company might employ a multi-tier classification scheme ranging from Class 1 physicians who perform no surgical or invasive procedures, to Class 8 neurosurgeons. While the number of classification groups may vary among carriers, the basic methodology is the same. Generally, the greater the risk associated with the procedures performed by a specialty group, the higher will be the group's rank and premium payments. However, the premium will frequently be further adjusted based on the geographic region (e.g., urban versus rural) in which the physician practices. Therefore, in this system, losses are distributed across a group whose members share similar risks. Of course, perfect "homogeneity ' within a class is not completely possible since there must be enough class members to generate valid statistical inferences.

Importantly, for rate-making purposes, the Insurance Association of Georgia should carry out an actuarial review of technical rates with the view of proposing a market-wide tariff for a compulsory MMLI policy.

3.1.2. Risk Segmentation

Risk segmentation and adverse selection in the healthcare field are particularly problematic because information to judge the quality of a provider and to estimate his or her risk of a malpractice claim is rare. It can be very difficult to distinguish between a physician with poor skills and one with high skills who takes on sicker patients and more difficult cases. Both may have poor patient outcomes but without a careful examination of the incoming patient population, which is rarely practicable to undertake, an insurer is likely to charge both physicians similar rates.

Risk segmentation in medical malpractice insurance is generally based on geographic area and specialty type, but relatively little is based on some measure of provider quality or on malpractice claims history.

3.1.3. Claims

The claim amounts that medical malpractice insurers pay are generally determined by civil law, tort law, and court experience. The compensatory damages are often separated into two types:

- Economic damages are generally intended to redress direct economic loss, such as lost wages and costs for medical care;
- Non-economic damages are not tied to direct out-of-pocket expenses and include damages due to pain and suffering.

Another primary type of damage is punitive damages. Punitive damages are non-compensatory damages that are intended to punish a defendant for poor conduct.

Economic damages generally have the greatest impact on medical malpractice claims through the medical cost component. As a result, medical costs tend to account for a higher percentage of medical malpractice claims than most other types of insurance claims. Medical costs have also grown faster than the general rate of inflation, which implies that the rates for medical malpractice insurance will rise faster than most other types of insurance.

Non-economic and punitive damages are more subjective and difficult to quantify than economic damages. Different juries in the same city have come to different conclusions as to the monetary value of a plaintiff's pain and suffering or the amount of punitive damages warranted to punish willful misconduct. Jury awards are even more variable when comparisons are made involving different parts of the country. This unpredictability reduces the accuracy of estimating expected losses that are at the heart of insurance pricing.

These kinds of damages constitute an effort to compensate a plaintiff with money for what is in reality non-monetary considerations. The different experiences on which these awards are set, however, are entirely subjective and without any standards. Therefore, unless a government has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status. Also, legal fees incurred while defending and settling malpractice suits, including attorney fees, court costs, arbitration and settlement costs should be covered.

3.1.4. Technical provisions

Loss reserve is a provision for an insurer's liability for claims and is comprised of five elements:

- Case reserves assigned to specific claims (RBNS);
- Provision for future development on known claims;
- Provision for claims that re-open after they have been closed;

- Provision for claims that have occurred but have not yet been reported to the insurer; and
- Provision for claims that have been reported to the insurer but have not yet been recorded.[10]

A lengthy claims settlement characterizes the medical liability insurance line of business. Thus, it is critical for the actuary to make the best estimate possible of the ultimate settlement value of all losses that the insurer faces.

One of the key elements in medical liability claims is loss development. As the amount paid for a claim arising from a given year grows, estimates of future reserves will be adjusted. Actuarial standard of practice regarding property and casualty loss, as well as loss adjustment expense reserves, states (Research AAJ, 2012) "Actuarial estimates are inherently uncertain because they are dependent on future contingent events. Moreover, loss and loss adjustment expense reserve estimates are generally derived from analyses of historical data, and future events or conditions often differ from the past. Even when appropriate actuarial techniques and assumptions indicate that the stated reserve amount is reasonable, the actual amount necessary to settle the unpaid claims can be significantly different from the stated reserve amount."

With each annual financial statement, insurers provide their best estimates of the final cost for claims in a given year. As prior years mature, estimates for previous years get closer to a final figure. The adjustment to estimates for prior years impacts an insurer's income statement in the year of the adjustment. This process also impacts ratemaking. When using five to ten years of data to determine future rates, the ratemaking actuary must use estimates of the ultimate cost for those years. When reserves in the financial statement are increased or decreased for a prior year, those changes impact the data used to estimate the full cost of claims to be covered in the future. This is equally true for estimates of losses and for estimates of loss adjustment expenses.

3.1.5. Occurrence-Based and Claims-Made Types of Medical Malpractice Insurance

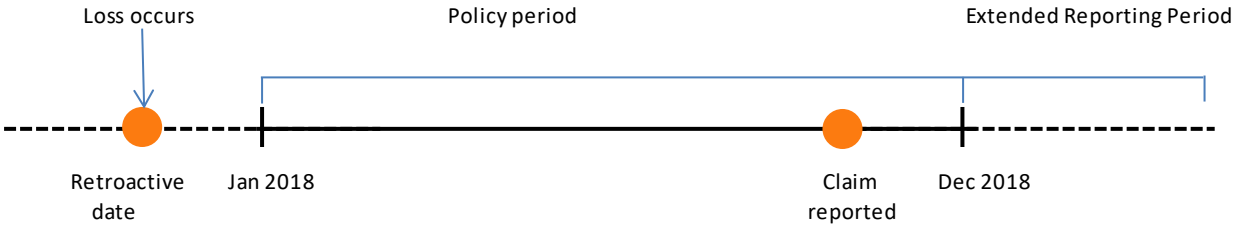
There are two basic forms of business insurance coverage – claims-made form and occurrence form. The only difference between a claims-made and occurrence policy is how coverage is activated.

The claims-made form covers incidents that are reported during the active policy period - or an extended reporting period - and occur after a policy's retroactive start date. A retroactive date is the specific date a policy's coverage begins. This is generally the policy's effective date or a past date agreed on by the insured. If an incident occurs before the retroactive date, it won't be covered. Also known as tail coverage, an extended reporting period is a provision on a policy that extends the amount of time you can report a claim after a policy's cancellation. Most policies typically include tail coverage, and the length of time varies depending on the insurer. An endorsement may be added to the policy to lengthen the extended reporting period indefinitely and is commonly known as a supplemental extended reporting period (SERP). A loss must occur between the retroactive date and the end of the policy period for coverage to apply.

For example, a hospital purchases a medical malpractice liability policy on a claims-made basis. The policy is effective from January 1, 2018, through December 31, 2018 and has a retroactive date of October 1, 2015. A claim is reported during the policy period for a loss that occurred on November 10, 2017. Since the incident was reported during the policy period and occurred after the retroactive date, the claim is covered. Claims-made coverage wouldn't apply had the loss occurred prior to October 1, 2015.

[10] It should be noted that the last four elements are combined into what is generally defined as IBNR losses.

Figure 5: Claims-Made Example



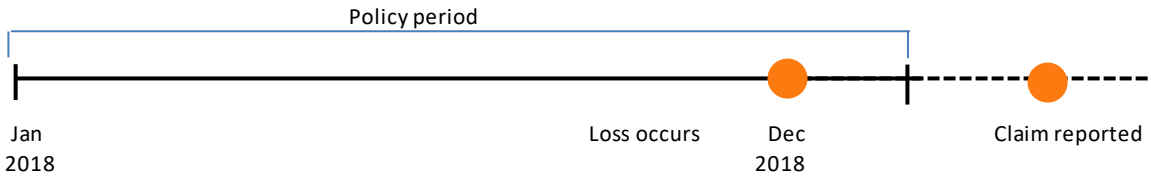
Since the claim was reported during the policy period and the loss occurred after the retroactive date, it would be covered under a claims-made policy. If a claim is reported after the policy's expiration, it must fall within the extended reporting period listed on the policy's declarations page for coverage to apply.

If the retroactive date is the beginning of the policy period, the policy is relatively inexpensive and is called "first-year" claims-made. However, as the number of years from the retroactive date increases, the policy "matures," and the premiums increase each year using "step factors" until reaching the mature level, which is about five to eight years after the policy's retroactive date. Once the mature level is reached, the premium approaches the occurrence premium.

If the insured cancels the medical liability insurance, for example, in case of medical professionals retiring or changing professions, it should be considered as purchasing a run-off policy. This covers any new claims that are brought against the insured after his professional indemnity insurance has expired. If medical professionals are changing insurer, a run-off policy will protect them against new claims for incidents that occurred when they were with the previous insurer. Alternatively, a new insurer may agree to cover claims relating to prior incidents.

Occurrence-based policy protects against claims while the policy is in force no matter when they are reported, even if the claim occurs years after the end of insurance. A significant benefit of occurrence-based insurance is the protection against claims for incidents that occurred during the life of the policy, incidents that the healthcare practitioner was unaware of and therefore, could not have notified their insurer of.

Figure 6: Occurrence Example



Since the incident occurs within the policy period, it will still be covered under an occurrence policy even though it was reported after the policy's expiration date. An occurrence policy is typically more expensive than claims-made policy because there is not a limit on the time a claim must be reported.

3.1.6. Insurance Policy Provisions

A typical medical professional liability policy includes two insuring agreements, both individual coverage and organization coverage. The individual insuring agreement typically covers sums that the individual professional becomes legally obligated to pay because of the following:

- Professional acts or omissions committed by the insured medical professional;
- Professional acts or omissions committed by the medical professional's employees or other persons under his supervision (such as anesthesiologists, nurses, midwives, laboratory assistants) and for which the insured professional incurs vicarious liability; and
- The liability arising out the professional's service on a formal accreditation board or any similar committee. This aspect of individual liability coverage corresponds to the common practice of physicians serving on hospital committees whose purpose is to consider other physician's requests for staff privileges at the hospital. If the committee denies staff privileges to a physician, that physician might sue the committee members for damages.

Although the individual insurance agreement protects the insured physician against vicarious liability for professional acts or omissions of employees and others, the policy usually does not provide any coverage for the subordinate professional[11] . Although coverage for such individuals can be added by endorsement to the physician's policy, the coverage can also be provided under a separate policy covering the nurse or other professional employee. The separate policy approach is often preferred because it provides a separate limit of liability. Thus, in a claim made against both the physician and his or her employee, both parties will not have to share the same limit of insurance for the claim.

The organization insurance agreement covers the insured's professional partnership, association, or corporation (health care provider) for damages resulting from professional acts or omissions committed by anyone for whose acts or omissions the organization is legally liable. For example, one of the insured's patients might sue both the insured and the professional corporation at which the insured practices medicine. The individual insurance agreement would cover the medical professional, and the organization insurance agreement would cover the corporation. The health care provider can bear liability for a failure to provide patients with a "safe hospital stay", be responsible for injuries which result from the use of faulty and defective medical equipment, be responsible for the damage caused by an unjustified refusal to admit a patient to the hospital and the delay in rendering necessary medical care (only if, by means of immediate help, the injury could have been avoided) as well as for injuries resulting from lack of a sufficient number of properly qualified doctors (anesthesiologist, surgeons, etc.) and other members of medical personnel (nurses, midwives, laboratory assistants, etc.). An improper organization of a hospital may consist of "technical" faults and mistakes that cause the damage.

Exclusions that might be found in a medical professional liability policy are:

- *High-Risk Medical Procedures* - Some policies exclude surgical procedures or other treatments that are more likely than others to result in severe liability losses. If a physician specializes in such procedures or treatments, he or she can usually have the applicable exclusion(s) removed from the policy for an additional premium;
- *Criminal Acts* - Most policies exclude criminal acts committed by the insured, although some policies agree to defend the insured against allegations of criminal acts;
- *Sexual Misconduct* - Many medical professional liability policies agree to defend their insureds against allegations of sexual misconduct but exclude any damages payable if the insured is found to have committed sexual misconduct. Some policies exclude both defense costs and damages for sexual abuse or misconduct;

[11] Doctor who runs his individual private practice and employs medical staff such as assistants, subcontractors, or subordinates is liable for the misconduct of the members of that staff, regardless of whether the resulting damage is caused by his own fault.

- *Proprietary Activities* - Medical professional liability policies often contain an exclusion eliminating coverage for the insured's activities as a proprietor, administrator, officer, stockholder, or member of the board of trustees of any hospital, clinic with bed and board facilities, nursing home, laboratory, or other business enterprise. Coverage for such activities is not contemplated in the rates for medical professional liability policies. Such activities can be covered under a separate hospital professional liability policy or in some cases by endorsement to the medical professional liability policy; and
- *Other Exclusions* - A medical professional liability policy might also exclude any of the following:
  - Punitive damages
  - Pollution (as might result from hazardous waste generated by a physician's practice)
  - Discrimination (as might occur if a physician refuses to treat a particular patient)
  - Contractual liability (as might occur if the insured agrees to hold a substitute doctor harmless).

3.1.7. Other Provisions

Medical liability policies are usually subject to two limits of insurance. One limit applies to each medical incident (or, in some cases, to each person). The other limit is an annual aggregate limit. The annual aggregate limit is usually set at two or three times the per incident limit.

3.2. Policy Recommendations

3.2.1. Role of Government

The role of government in dealing with medical malpractice mainly involves establishing a level playing field for insurance entities and providing incentives to enhance market capacity, while making sure that sufficient and affordable coverage is available for all types of healthcare professionals.

Based on the specificity of the healthcare system in Georgia, the level of development of the national insurance market and international experiences in the field of medical malpractice liability insurance, this project's main policy recommendations to the government are as follows:[12]

- Compulsory medical liability insurance for medical providers (i.e., individuals and medical entities) should be introduced to ensure that patients are able to seek redress from a liable party;
- Compulsory medical liability insurance could be prescribed in the Law on Medical Practice;
- Medical liability insurance is compulsory for all healthcare providers and individual medical professionals;
- Scope of coverage and insurance conditions should be spelled out in separate Ordinances by the Ministry of Health such as;
  - Minimum insurance sums should be established based on the type of medical specialization. The proposed minimum insurance sums are summarized in Annex 4;
  - Setting standards and detailed criteria to assess amounts of economic damages (e.g., fixed discount rates for the calculation of loss of earnings and impairment of quality of life; establishment of harmonized disability rates) and in particular non-economic damages (e.g., extent of the error);
- Introducing caps on a relative or absolute basis for economic and non-economic damages; Insurance should cover all injuries inflicted on patients due to the faulty professional acts and

[12] Government institutions will require joint actions from the Ministry of Health, the Agency for Regulation of Medical and Pharmaceutical Activities, and the Insurance State Supervision Service of Georgia.

omissions of an insured doctor, provided that the damage is caused in the course of treatment and within the doctor's vocational duties. There should be no possibility for an insurance company to limit its obligation to pay indemnities under the insurance contract;

- The government may also wish to consider providing subsidies on a temporary basis to cover a part of insurance premiums, directly or indirectly, to ensure that all government healthcare providers (institutions or individual practitioners) can afford medical liability insurance premiums;
- Allowing the use of the right of subrogation by the insurer.

3.2.2. Insurance sector

To grow the MMLI market further, cooperation between medical providers and insurers must be strengthened.[13] Specifically:

- The introduction of a standard policy form with same standard general terms and conditions accepted and approved by the Insurance State Supervision Service, Georgian Insurance Association, the Agency for Regulation of Medical and Pharmaceutical Activities and the Union of Georgian Medical Association;
- The introduction of a claims-made basis trigger should be considered as a preferred option;
- Insurers should seek to distinguish between coverage for physicians and medical entities;
- For rate-making purposes, the Insurance Association should carry out an actuarial review of technical rates with the view of proposing a market-wide tariff for a compulsory MMLI policy. Annex 4 provides suggestions on the premium tariff, level of deductible, discounts, and tariff system for variable sums insured;[14]
- The Insurance Association should develop a standard experience-rated policy;
- There should be a better and systematic data collection for medical errors; and
- Specific agreements must be reached between physicians/medical entities and insurers (e.g., compliance with good medical practices relative to duty of care and risk-management processes in exchange for lower premium rates).

3.3.3. Medical Providers Risk Management

Medical risk management processes should be considered and implemented to improve patients' safety. They should particularly be aimed at enhancing reporting mechanisms, identifying risks, appropriately assessing their impact, and seeking solutions to better handle risk. The following are recommended risk management actions:

- The development of a risk management approach and quality process within medical institutions. In Annex 1 of this Report, a summary of measures that medical providers can use to prevent professional liability claims is presented;
- The introduction of requirements for physicians to study medical malpractice prevention and risk management, as well as to comply with appropriate standards of duty of care as part of their licensing obligations;
- The development of tailored practice standards (according to the area of specialty) taking into account the analysis of past errors and/or adverse consequences;

[13] An example of a medical liability insurance policy model is attached in Annex 2 of this report.

[14] Annex 4 provides an indicative premium tariff, level of deductible, discounts and tariff system for variable sums insured based on international experience. In this case, two national insurance markets were used as benchmarks, Slovenia and the Republic of North Macedonia. Both countries have mandatory MMPI imposed by their domestic health protection regulation, risk-based rates, on average similar sums insured, and importantly, as a common characteristic, same insurance undertakings active in both countries.

- In order to receive a subsidy or lower insurance premiums, the participation of doctors in safety and quality activities and/or risk management activities;
- The establishment of specific requirements related to the disclosure of information to the patient (e.g., on the disease, possible treatments and their likely consequences) as well as the development of a more systematic and formal regulation of patient's informed consent; and
- The use of appropriate technological medical devices and electronic book-keeping of patient's medical data.

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Annex 1: Summary of Loss Control Measures for Physicians[15]

1. Know the Patient

Physicians should look for red flags that can alert them to the possibility that the patient is the type who could initiate litigation later. The patient might cause problems if he or she:

- ❖ Does not complete a thorough medical history
- ❖ Is mentally incompetent
- ❖ Complains about other physicians
- ❖ Says the physician is the only one who "understands" him or her
- ❖ Misses appointments without good reason
- ❖ Lies to the physician or the physician's staff
- ❖ Acts contrary to the physician's advice
- ❖ Has a history of filing medical professional liability suits
- ❖ Continually avoids financial responsibility
- ❖ Asks for a guarantee of results

2. Maintain Communication and Exercise Courtesy

Physicians and their staff should:

- ❖ Return patients' phone calls promptly
- ❖ Listen to their patients' concerns about both their cases and their personal lives
- ❖ Communicate with patients' family members
- ❖ Avoid making careless or indiscreet remarks
- ❖ Never lose their temper with patients
- ❖ Never ignore patients
- ❖ Never criticize the work of other physicians
- ❖ Keep their waiting rooms tidy

3. Keep Thorough Records

To help in a medical professional liability defense, every patient's medical records should contain the following:

- ❖ The patient's medical history, including the patient's own medical history form
- ❖ Personal information about the patient
- ❖ The date, time, and place of every meeting and every medical treatment
- ❖ Results of every examination and test
- ❖ Every diagnosis and reasons for the diagnosis
- ❖ Prognosis and treatment plan, and follow-up instructions
- ❖ Informed consent forms

[15] "Ten Procedures for Avoiding Medical Malpractice", published by the St. Paul Fire and Marine Insurance

- ❖ Names of prescription medicines used before, during, and after treatment, with copies of prescription forms
- ❖ Results of medications and treatments
- ❖ Information about drug or other allergies
- ❖ Photographs of the patient taken during the tenure of treatment
- ❖ Information about missed appointments, refused medications and treatments, medical complications, noncompliance or lying, and any unusual occurrences

4. **Avoid Even the Appearance of Negligence**
   Physicians must be especially careful when discharging patients from treatment. They should avoid making statements like "the patient has no medical problems," because every patient will eventually develop some kind of medical problem. They should also avoid saying that they're discharging patients "for financial reasons"; juries are notoriously unsympathetic towards physicians who refuse to see poverty-stricken patients.
5. **Diagnose and Test Thoroughly**
   Physicians should adequately document the diagnoses, particularly negative diagnoses. Diagnoses are often missed because the physician didn't conduct a thorough diagnosis or order enough tests; sometimes the failure to test is a more significant problem than the failure to diagnose. Other diagnosis-related problems can occur when a physician fails to discover or test for drug or food allergies or other conditions that may affect the course of treatment.
6. **Keep Informed About Informed Consent.** Proper informed consent documentation contains three elements that a physician should obtain before performing medical treatment. Those three elements can be remembered by the acronym "BAR":

   - ❖ B is for background—Everything the physician knows about the patient on which the diagnosis is based, including the patient's symptoms and medical history and the physician's recommended
   - ❖ A is for alternatives—The physician must explain what he or she expects will happen if the patient declines to have a treatment or procedure and describe any safe alternatives to the treatment or procedure.
   - ❖ R is for risks—The patient must clearly understand the risks and possible outcomes, even if they are remote, of the treatment or procedure.

7. **Know What's Happening at the Hospital**
   Physicians must be careful when referring patients to the emergency room; if something were to go wrong, they could be found jointly liable for abandonment or an emergency room physician's missed diagnosis. In addition, physicians are responsible for potentially harmful conditions in a hospital if they notice them and fail to take remedial action. Most hospitals also require that discharge orders be made by the patient's physician, so physicians shouldn't delegate that responsibility to anyone else.

8. **Don't Take On Too Much Work**

   When physicians spread themselves too thin, they can adversely affect their relationships with patients by causing the patients to think that they don't care enough to spend sufficient time with them. In addition, physicians shouldn't handle cases outside of their own areas of training and expertise; rather, they should refer patients to qualified specialists for treatment. Physicians must remember, though, that even when they refer a patient to another physician for treatment, they still have responsibility, and thus liability, to the patient.

9. **Monitor Partners and Staff**

   Careless comments by office assistants can lead to lawsuits, especially if the comments pertain to a patient's finances, sexual matters, emotional problems, pregnancies, and abortions. Nurses and other staff members who aren't licensed physicians should refrain from diagnosing illnesses and treating patients. When physicians share space, staff, and expenses, they also share liability, and assets of the partnership could be liquidated to cover damages resulting from the negligence of any past or present partner.

10. **Prevention Is the Best Defense**

    More and more doctors are practicing "defensive medicine," in which every patient is appraised as a potential litigant. The goal of these physicians is to prevent the mistakes that can later lead to a medical professional liability suit.

Annex 2: Insurance Policy Form

Part A - *Instructions to the Applicant*

A. This form is intended for individual healthcare practitioners. This includes, but is not limited to, physicians, surgeons, dentists, pharmacists, physician assistants, nurses and other allied health and therapeutic care practitioners.

B. You must answer all the questions in this form. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.

C. If you are a new practice, use the projected figures from your business plan.

D. If you have any questions concerning this proposal, please contact your insurance broker or adviser to discuss.

Application for Insurance Cover

Period of Insurance	From DD / MM / YYYY	To DD / MM / YYYY
Limit of Liability Required	Option 1 SGD _____	Option 2 SGD _____
Excess / Deductible Requested	Option 1 SGD _____	Option 2 SGD _____
Retroactive Date	DD / MM / YYYY	

Are you requesting cover for Cyber and Privacy Infringement Liability? ☐Yes ☐No

1. Details of Applicant

Name:
_____ Date of Birth: DD / MM / YYYY Gender: ☐Male ☐Female

1.1. Primary practice address
_____
_____
_____ Postal Code_____

1.2. Are you duly licensed to practice at the address(es) specified? ☐Yes ☐No

1.3. Contact phone number _____

1.4. Email Address
_____

1.5. Please indicate your qualifications.

Institution	Degree or Qualification	Year Obtained

1.6 Please provide the details of your registration below:

a) Licensing / Registration Body: _____

b) Registration Number: _____

c) Registration Date: _____

d) Registration Type: _____

e) Date of first Registration: _____

1.7 Other Registration Details (where applicable).

_____

1.8 Please list any medical societies & associations you are a member of.

_____

Have you ever had any of the above declared in questions 1.6, 1.7 and 1.8 refused, suspended, withdrawn or had conditions imposed at any time? ☐Yes ☐No

If **Yes**, please provide details on a separate sheet, noting the Section number.

2. Details of Healthcare Services

2.1 Please indicate your classification and volume of work performed below:

Specialization	%	Specialization	%
Doctor			
Anesthesiology		General Practitioner	
Cardiology		Ophthalmology (including LASIK & laser)	
Dermatology		Pediatrics (no surgery)	
Dentist – Cosmetic Dentistry		Psychiatry	
Dentist - Employer Indemnified		Radiology	
Dentist – Endodontist / Periodontist / Prosthodontist		Other (please specify):	
Dentist – General Dentistry			
Gastroenterology		**Total**	**100%**
Surgeon			
Bariatric Surgery		Oncology	
Cardiothoracic Surgery		Oral Maxillofacial Surgery	
Ear / Nose / Throat		Orthopedic Surgery	
General Surgery		Pediatric Surgery	

Gynaecology		Plastic Surgery (elective / cosmetic)	
Hand Surgery		Plastic Surgery (reconstructive)	
Neurosurgery		Other (please specify):	
Obstetrics / maternity		**Total**	**100%**
Allied Health & Ancillary Staff			
Counsellor		Optometrist	
Chinese Medicine Practitioner		Osteopath	
Chiropractor		Pharmacist	
Dental Assistants - Therapist, Hygienist, Technician		Physiotherapist	
Diagnostic Radiographer		Podiatrist	
Healthcare Assistant / Worker		Psychologist	
Massage Therapist		Therapist Aide	
Midwife		Other (please specify):	
Nurse			
Occupational Therapist		**Total**	**100%**

2.2 Please provide details of your income and patient numbers:

Year	Income	Number of Patients
Current year (est.)	SGD	
Past year	year SGD	

2.3 Do you provide healthcare services in your host country only? ☐Yes ☐No

If **No**, please provide the breakdown of overseas services below:

Year	Country	Income	Number of Patients
Current year (est		SGD	
Past year		SGD	

3. Risk Management

3.1. Do you maintain accurate and descriptive records of all medical services rendered, and equipment used in procedure? ☐
Yes ☐No

3.2. Is informed consent obtained from each patient and documented in their medical record?

☐Yes ☐No

If **No**, how often is informed consent obtained?

_____

3.3. Do you have facilities for sterilization of instruments in accordance with relevant guidelines/standards applying to your industry? ☐Yes ☐No

3.4. Do you have a written procedure for the reporting of incidents and adverse events? ☐Yes ☐No

4. Insurance History

4.1. Do you currently have medical malpractice? ☐Yes ☐No

If **Yes**, please provide details.

Period of Insurance	Insurer	Policy Limit (SGD)	Excess (SGD)	Retroactive Date

4.2. Have you ever had any application for medical malpractice insurance refused, or had any medical malpractice insurance coverage rescinded or cancelled? ☐Yes ☐No

If **Yes**, please provide brief details on a separate sheet, noting the Section number.

5. Claims Experience

5.1. Have any claims ever been made, or lawsuits been brought against you? ☐Yes ☐No

5.2. Are you aware of any errors, omissions, offences, circumstances or allegations which might result in a claim being made against you? ☐Yes ☐No

5.3. Have you ever been the subject of disciplinary action or investigation by any authority or regulator or professional body? ☐Yes ☐No

5.4. Have you ever been the subject of a criminal investigation or had criminal charges brought against you? For the purposes of this question, please disregard traffic or minor motor vehicle licensing offences. ☐Yes ☐No

If you answered **Yes** to any of the questions in this section, please provide full details and the status of each claim, lawsuit, allegation or matter, including:

• the date of the claim, suit or allegation • the date you notified your previous insurers

• the name of the claimant(s) and the establishment(s) • the allegations made against you

• the amount claimed by the claimant(s) • whether the status is outstanding or finalized

• the amounts paid for claims and defense costs to date

_____

_____

_____

_____

Signature _____

Name of Signatory _____

Date_____

Part B – Policy form and wording **"MEDICAL LIABILITY INSURANCE POLICY"**

TABLE OF CONTENTS:

1. SECTION 1 - INSURING CLAUSES

1.22 Retroactive Date

1.23 Increased Aggregate Limit of Liability (Optional)

2. SECTION 2 - LIMITS OF LIABILITY

2.1 Limit of Liability

2.2 Deductible

2.3 Claims Aggregation

3. SECTION 3 – EXCLUSIONS

3.1 Asbestos

3.2 Assumed Liability

3.3 Clinical Trials

3.4 Contagious Diseases

3.5 Deregistered Practitioners

3.6 Dishonest or Reckless Acts

3.7 Employer's Liability

3.8 Fines Penalties and Damages

3.9 Insolvency

3.10 Jurisdiction and Territorial Limits

3.11 Medicines

3.12 Narcotics

3.13 Occupier's Liability

3.14 Prior Claims or Circumstances

3.15 Radioactivity

3.16 Related Entities

3.17 Rights of Recovery

3.18 Sexual Misconduct

3.19 Terrorism

3.20 War

4. SECTION 4 — GENERAL CONDITIONS

4.1 Alteration to the Insured's Medical Business

4.2 Assignment of Interest

4.3 Policy Construction, Interpretation and Notices

4.4 Severability and Non-Imputation

Annex 3: Framework Agreement

Framework Agreement between the Austrian Medical Chamber (AMC) and the Association of Insurance Companies (AIC) on the contractual terms and conditions regarding professional liability in accordance with § 117b, paragraph 1, item 22a of the Law on Medical Activity

General liability insurance conditions apply if no special regulations are adopted in the Additional general liability insurance conditions. Within the meaning of §52d of the Law on Medical Activity, Chapter B item 9 of the Additional general liability insurance conditions from the non-mandatory standard conditions reads as follows

Physicians within the meaning of **§ 52d of the Law on Medical Activity**

Unless otherwise agreed, the following shall apply:

1. Chapter A of the Additional general liability insurance conditions (General liability insurance conditions).

2. Insurance protection encompasses any individual activity of a physician who, pursuant to § 3 of the Law on Medical Activity, has the right to perform individual profession, regardless of whether this refers to general practitioner, specialist or licensed physician with his/her own medical institute, as well as institutions of independent professional group in legal form of open society (OS) or limited liability company (LLC). Liability insurance encompasses group practice activity, as well as all subsidiaries. Insurance protection encompasses medical activity within and outside the company (second medical institute).

   Physician who, pursuant to § 37 of the Law on Medical Activity, is authorized to perform temporary cross border activity with professional or official headquarters in another country - EEA contracting party or in the Swiss Federation must conclude professional liability insurance in order to be able to commence with work in Austria. The physician working in accordance with § 37 of the Law on Medical Activity must submit a proof of the professional liability insurance to the Austrian Medical Chamber according to the requirements referred to in § 52d of the Law on Medical Activity via the medical chamber of the respective federation wherein such services should be performed.

3. Personal liability for damage compensation to the representative (e.g. permanent representation agreed with social and health insurance company, representation in the event of annual leave, sick leave or professional development) is also included in the insurance, unless there is other insurance protection. The policy holder is obliged to provide notification (state the name and area of expertise of the representative or representatives) if being represented for a period longer than six months, in order to ensure transparency to the insurer. The failure to submit such notification is not deemed as violation of the obligation.

   Insurance protection encompasses dependent performance of medical activity in an institution

recognized as educational institution, within the lecturing practices or group lecturing practices under the guidance and supervision of physicians – lecturers.
Insurance protection should apply to other medical and non-medical staff employed in the medical institute and in the group practice (members of other health-related professions) and students throughout their education as medical practitioners (residents).

4. Insurance also applies to the operation and existence of home care pharmacy within the meaning of Law on Pharmacies.

5. Contrary to Article 1, item 2 of the General insurance liability conditions (bodily injury, material damage and property damage), insurance also covers liabilities for compensation of property damage up to the agreed legal amount of the insurance. Judicial activity as a forensic scientist in accordance with § 2a of the Law on Forensic Science and Interpretation is not included in the professional liability insurance in accordance with § 52d of the Law on Medical Activity.

6. Contrary to Article 3 of the General liability insurance conditions, insurance protection covers insurance cases occurring globally, provided that the medical treatment that caused such damage was done in Austria. The limitation referred to in Article 3, item 1, second sentence of the General liability insurance conditions applies, whereby claims for damage compensation, deriving from damage which according to the American, Canadian or Australian law – in any area under competence of the courts, are not insured i.e. they are realized by means of filing a complaint.

7. Contrary to Article 2 of the General liability insurance conditions, the liability for damage compensation to physicians for first aid services are co-insured globally, same as the actions within organized rescue missions, as well as persons for medical care within association.

   The limitation referred to in Article 3, item 1, second sentence of the General liability insurance conditions does not apply.

8. Additional coverage upon the completion of the medical activity

a) Damage occurrence principle
   Partially modified Article 4, item 1, paragraph 1 of the General liability insurance conditions specifies that the insurance protection refers to insurance cases after the completion of the respective insurance agreement, provided that the provisioning or non-provisioning of medical treatment that caused the damage occurred within the regular insurance.

   However, such insurance protection exists only if there is no other insurance protection deriving from any subsequent agreement, since the insured medical activity was permanently or temporarily terminated when the agreement ended.

   In such case, the insurance protection exists for the entire additional coverage within and in accordance with the contractual provisions that applied at the time of provided or non-provided medical treatment that caused the damage.

b) Occurrence/determination principle

If the insurance cases with the distribution referred to in Article 4, item 3 of the General liability insurance conditions occur in a period not covered by insurance protection due to permanent or temporary termination of insured medical activity, such insurance cases will be covered with the last insurance agreement that existed prior to the termination of the professional activity. With the modification of Article 5.2. of the General liability insurance conditions, the insurer pays the total insured amount specified in the insurance statement for all insurance cases that occurred in line with these provisions at least three times, and at least five times with regards to the group medical practices within LLC legal form.

c) Violation principle – coverage of property damage

Contrary to Chapter B, 3.1., item 4 of the Additional general liability insurance conditions, insurance protection exists if the violation is done while the insurance coverage was effective.

If the damage is caused by the failure to take an action, in case of doubt it will be deemed that the violation was done on the day of failing to take an action in order to avoid the occurrence of damage.

With the modification of Chapter B, row 9, item 3 of the Additional general liability insurance conditions, the insurance covers compensation of damage deriving from property damage up to the maximum legal amount for liability.

9. Damage compensation liabilities pursuant to the Law on Official Duty Liability:

Contrary to Article 7, item 3 of the General liability insurance conditions, the insurance also covers damage compensation liability pursuant to the Law on Official Duty Liability (Federal Law Gazette no. 20/1949) in its respective valid version i.e., for example, medical practice in schools, services, municipalities, areas, districts and parishes.

10. The insurers are obliged to inform the Austrian Medical Chamber (via the medical chamber in the area of expertise of the physician who freely performs his/her medical activity or in the area of expertise of the group practice), without previous request and within 14 days for conclusion and completion of the insurance agreement in electronic form.

11. The physicians and group practices recorded in the list of physicians (regardless of the type of professional activity) on the day of entering into force of § 52d of the Law on Medical Activity (19.08.2010) by means of insurance must enclose a proof of professional liability insurance for free medical activity within one year at the latest as of the date of entering into force of the Federal Law, Federal Law Gazette I no. 61/2010 (19.08.2011).

The same applies to physicians who were authorized to perform medical service in other EEA countries (regardless of the type of service) by 19 August 2010.The existing liability insurances can be prolonged, provided that they meet the legal requirements referred to in § 52d of the Law on Medical Activity and this Agreement - by means of concluding additional agreement.

Annex 4: Tariff of Premiums for Medical Malpractice Liability Insurance

Tariff group – healthcare workers

The insurance contract under this tariff group is concluded in accordance with the General Conditions for professional liability insurance and the Special Conditions for professional liability insurance of healthcare workers.

Deductible

The deductible is 10% of the claim or a minimum of USD 500.

Table of premiums

The insurance premium is calculated for each healthcare worker individually to include trainees and/or interns who perform a medical specialist activity.

Table 1: Premiums for Healthcare Workers by Specialization – Insurance Sum USD 100,000

Area of Specialization	***Premium per Healthcare Worker (in USD)***
General Medicine, Occupational Medicine, Sports Medicine, Gastroenterology, Hematology, Public Health, Clinical Genetics, Clinical Microbiology, Family Health, Nephrology, Neurology, Nuclear Medicine, Pathology, Radiology, Rheumatology, Rheumatology	USD 100
Jaw and tooth orthopedics, Dermatovenereology, Physical and Rehabilitation Medicine, Infectious Diseases, Internal Medicine Oncology, Radiotherapy Oncology, Child Psychiatry, Pediatric Neurology, Pediatric and Preventive Dentistry, Periodontology, Pediatrics, Pneumatology, Psychiatry, Dental Prosthetics	USD 150
Abdominal Surgery, Anesthesiology, Resuscitation, Perioperative Intensive Care, Gynecology and Obstetrics, Intensive Care, Internal Medicine, Cardiovascular Surgery, Maxillofacial Surgery, Neurosurgery, Ophthalmology, Orthopedic Surgery, Oral Surgery, Otorhinolaryngology, Plastic, Reconstructive and Esthetic Surgery, General Surgery, Thoracic Surgery, Traumatology, Emergency Medicine, Urology	USD 200

Note: For sum insured over USD 100,000, the premium is determined by the Underwriting Unit

Insurance can also be contracted on lower sums insured, with a discount on the basic premium:

Table 2: Lower Sum Insured and Discounts

Lower sum insured	***Discount on the basic premium in %***
USD 50,000	30%
USD 75,000	20%

Table 3: Insurance Premiums for Healthcare Workers with Different Sum Insured

No. of healthcare workers	***Coverage of USD 3,000 and deductible USD 325***	***Coverage of USD 5,000 and deductible USD 500***	***Coverage of USD 10,000 and deductible USD 1.125***
1	30	45	80
to 2	40	64	83
to 4	50	80	104
to 8	100	160	208
to 10	135	216	281
to 12	170	272	354
to 14	210	336	437
to 16	244	392	510
to 18	280	448	582
to 20	325	520	675
to 50	500	800	1040
Add-on in the case of high claims ratio – up to 300%			