



# Medical Indemnity Report

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An analysis of premium and claims trends  
for Australian medical defence organisations and medical indemnity insurers  
from 1995 to 2004 focusing on key specialty groups and large individual losses

Prepared by Insurance Statistics Australia Limited  
On behalf of the MIIAA which comprises

Australasian Medical Insurance Limited (AMIL) and United Medical Protection	Medical Insurance Australia Pty Ltd (MedInsAust) and the Medical Defence Association of South Australia
MDA National Insurance Pty Ltd (MDANI) and MDA National	Professional Indemnity Insurance Company Australia Pty Ltd (PIICA) and the Medical Defence Association of Victoria

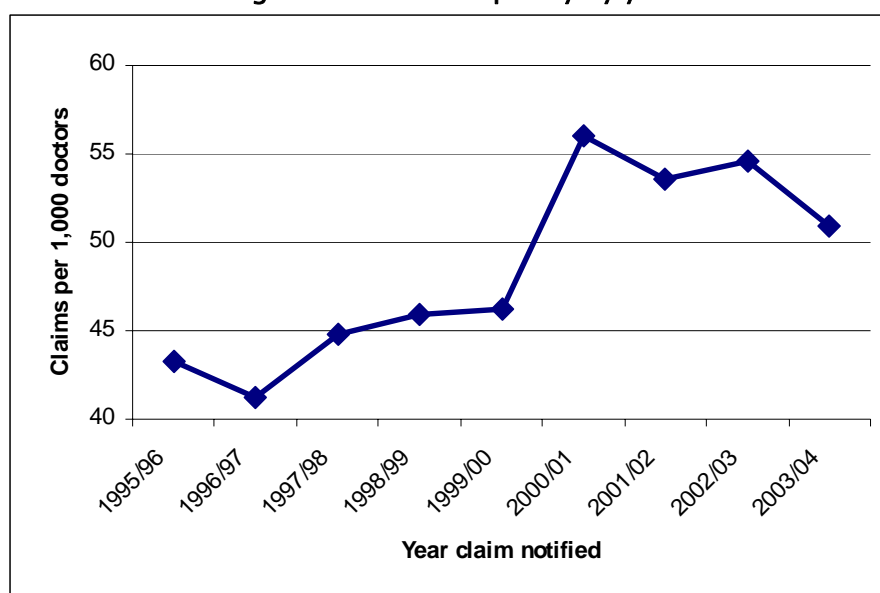
The objective of the data compilation is to help inform the debate in the public and the profession about the emerging trends and issues in medical indemnity.

The data compilation looked at the 12 major speciality groups listed in Table 1 and also at total information for the practitioners covered by MIIAA members.

## 1 Number of claims

The study looked initially at the number of claims per 1,000 practitioners that have been reported each year. A ‘claim’ is generally a matter that is a demand for compensation by a patient against a practitioner. Figure 1 below shows the movement in claims relative to the number of practitioners indemnified or insured by MIIAA members over the last 10 years (for convenience, in this report we have referred to all such practitioners as having being ‘insured’).

Figure 1 – Claim frequency by year



For all practitioners insured by MIIAA members, the claim frequency (or number of claims reported per 1,000 insured practitioners) was between 41 and 47 for the five years 1995/96 to 1999/2000. It jumped 20% to 56 in 2000/01, reflecting the NSW experience that seems to have arisen from the claims ‘spike’ as a result of tort reform. The national frequency has stayed between 50 and 55 since then (incorporating a further claims spike in Victoria in 2002/03). Because we have examined claim numbers relative to year of notification, regardless of whether the underlying policy was written with a ‘claims occurring’ or ‘claims made’ wording, our comparisons over the ten year period are not affected by when individual insurers introduced ‘claims made’ cover.

The claim numbers include MIIAA member estimates of current notifications that will become claims in due course. The various State tort reforms may have begun to reduce claim notifications, although part of this fall may simply represent a (possibly temporary) slowing down of incidents converting to claims while claimants and their advisers come to grips with the new legal environment.

Table 1 below shows the annual claim frequency projected for each of the 12 speciality groups, averaged over the first three year notification years (1995/96 to 1997/98) and the most recent three notification years (2001/02 to 2003/04). The data has been grouped in order to smooth the volatility from year to year

within individual specialty groups caused by small numbers of practitioners in some groups. The resulting percentage change for each specialty is also shown.

**Table 1 - Claim frequency change - specialty groups**

	Claims per 1,000 doctors reported in		
	1995/96	2001/02	Increase
	-1997/98	-2003/04	
General Practitioners (nonprocedural)	26	37	42%
General Practitioners (procedural)	60	91	52%
Physicians (nonprocedural)	21	23	10%
Physicians (procedural)	38	54	42%
General Surgeons	138	155	12%
Cosmetic Surgeons	233	401	72%
Neurosurgeons	397	313	-21%
Orthopaedic Surgeons	252	229	-9%
Obstetricians	225	317	41%
Gynaecologists (no obstetrics)	110	163	48%
Anaesthetists	47	49	4%
Psychiatrists	27	31	15%
All 12 specialty groups	51	61	20%

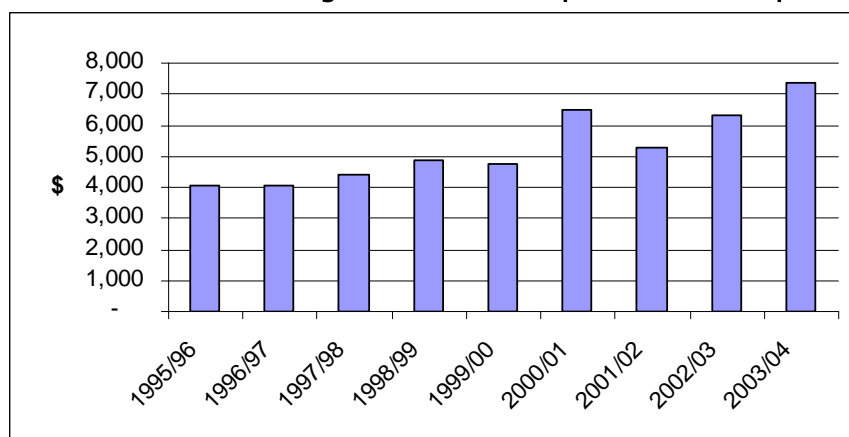
There appear to have been considerable increases in the frequency of claims for some specialty groups, while neurosurgeons and orthopaedic surgeons have shown reductions. The small numbers of practitioners in some groups, and also the ‘grouping’ of some craft groups into the specialties shown mean that these results should be treated with caution.

## 2 Cost of claims

It is not possible to make an accurate measurement of the cost of claims until all claims are finalised, which takes many years.

Based on the actuarial assessments undertaken on behalf of each MIIAA member by their own actuaries, the average undiscounted annual cost per indemnified practitioner of all the claims notified in 1995/96 was about \$4,000, increasing to \$7,300 per practitioner (or 81%) by 2003/04 as shown in Figure 2. This implies a rate of increase in claims costs at around 3% each year in excess of general levels of inflation as represented by average weekly earnings.

**Figure 2 Undiscounted average costs of claims per indemnified practitioner**

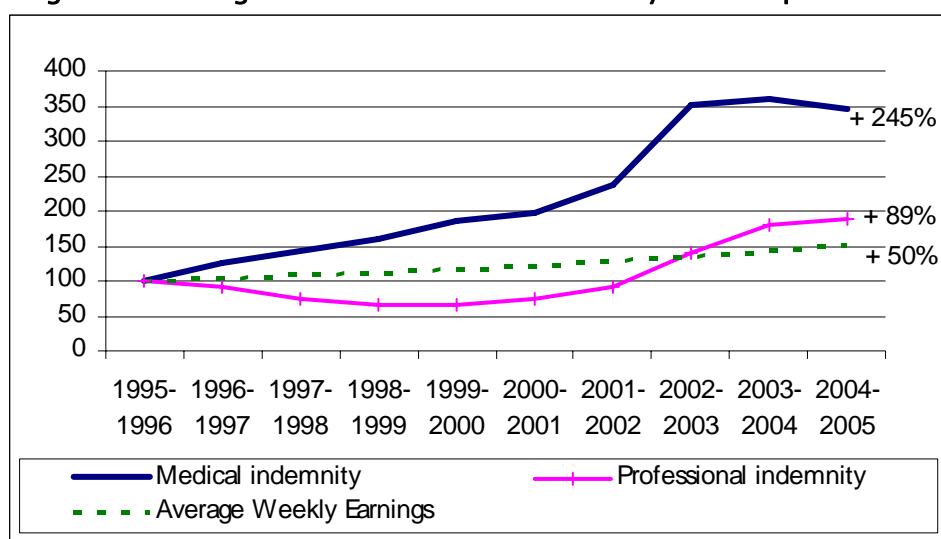


### 3 Subscriptions and premiums paid by practitioners

In this report, the amount received by the medical indemnity group to provide indemnity coverage for practitioners includes subscriptions for indemnity cover formerly paid to the medical indemnity group, any premiums paid to an insurer within the medical indemnity group, membership fees paid to the medical defence organisation and the amount of any call (spread over the period that the call was collected from practitioners). The amounts shown here exclude any GST and stamp duty paid by the practitioner. We have generally referred to these amounts paid as ‘premiums’ for convenience.

Information was collected for 12 speciality groups, representing about 90% of the total premium income of the MIIAA members. Figure 3 below shows the cumulative increase in the average premium paid by practitioners (including calls but before government subsidy) over the last nine years. The movement in 2003/04 excludes one insurer who converted from claims occurring to claims made cover in that year, with an accompanying substantial decrease in premiums. The corresponding movement in professional indemnity premiums (as shown by the JP Morgan / Deloitte general insurance survey 2004) and average weekly earnings for Australia are shown for comparison.

**Figure 3 – Average increases in cost of indemnity cover to practitioners**



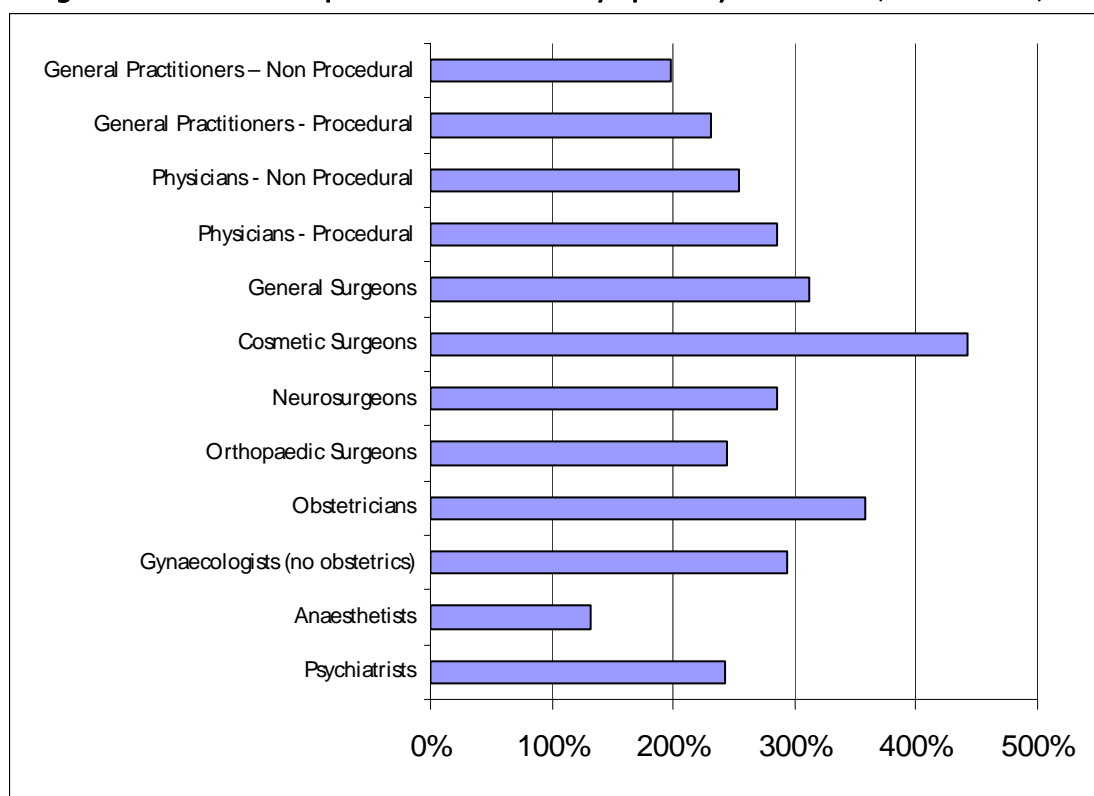
Between 1995/96 and 2004/05, average medical indemnity premiums increased by 245% (averaging 17% p.a.). The largest annual increase was in 2002/03, when the average premium rose nearly 50%. This increase was due to a number of factors including the collapse of HIH and its flow-on effect to medical indemnity providers, the ‘hard’ reinsurance market that occurred in the late 1990’s and the rebuilding of capital and funding of IBNR claims occurring throughout industry. By contrast, Australian average weekly earnings (AWE) increased by 50% (or an average of 4.6% p.a.) over the period.

In 2004/05 there was an average 4% reduction in premiums before allowing for the application of subsidies to some practitioners.

## 4 Premiums for individual specialties

Figure 4 below shows the increase in average premium for each of the 12 speciality groups, cumulative over the nine years between 1995/96 and 2004/05. These amounts are based on typical rates for the various specialties provided by the MIIAA members and may reflect different billing bands or other criteria used for rating purposes.

**Figure 4 – Cumulative premium increases by specialty from 1995/96 to 2004/05**



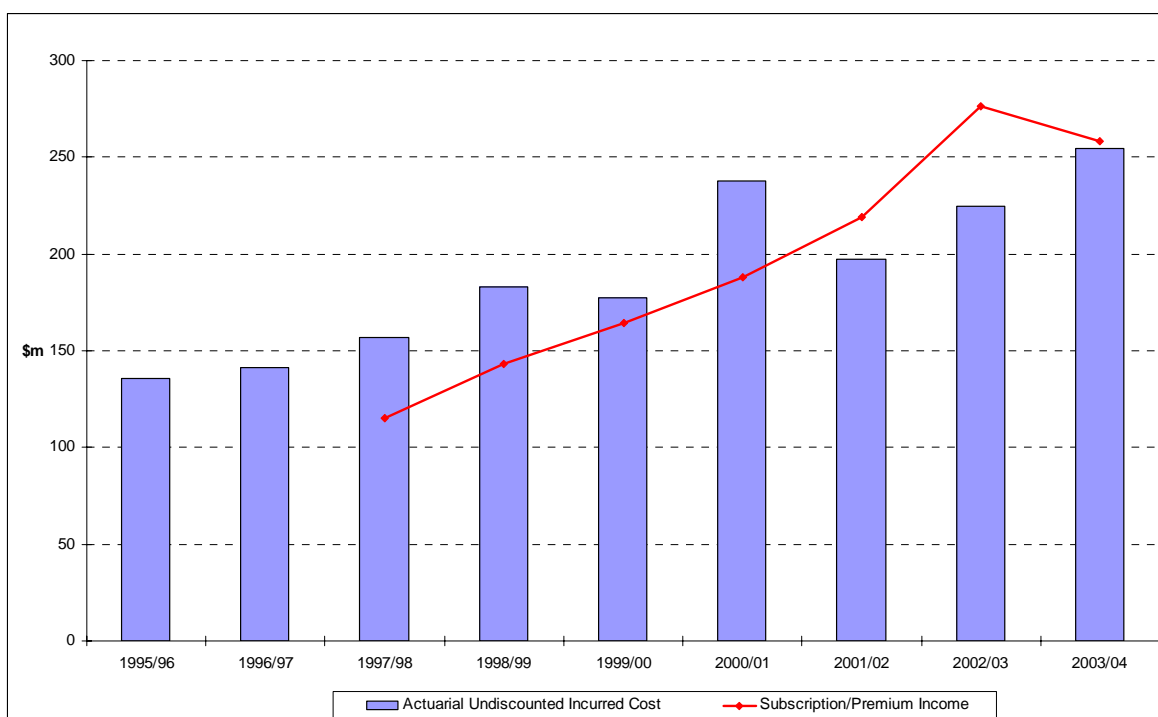
The increases will reflect, in part, the increases in claim frequencies shown in Table 1, the increases in average cost per practitioner reflected in Figure 2 and expectations for future frequency and cost increases. Any reduction in cross-subsidies between different groups of practitioner will also affect the relative rates of premium increase. Obstetricians, general surgeons and cosmetic surgeons have experienced the highest increases – over 300% in the nine years (or an average of more than 20% p.a.).

The other specialty groups included in the study all had increases between 200% and 300% except for anaesthetists where the average cost of indemnity cover rose about 130% over the period (an average of about 14% annum). These figures do not include the effect of government subsidies introduced in recent years, which have partly offset these increases for some classes of practitioner.

## 5 Comparison of claims and premiums

Figure 5 below compares the total premium revenue of the MIIAA members each year with the total undiscounted cost of the claims reported in that year (as measured in the actuarial assessments undertaken by each insurer at 30 June 2004). These figures include all practitioners covered by the MIIAA members, not just the 12 specialty groups focused on above. Note that the effect of future investment earnings on premiums is ignored by such a comparison, but provides a consistent basis for considering relative performance by financial and notification years.

**Figure 5 - Comparison of premium income with actuarial claim cost estimates**



It can be seen that from 1996/97 to 2000/01 premiums were inadequate to meet claims costs, even before consideration of expenses, reinsurance, funding of IBNR, investment return and capital. As a result, the four medical indemnity groups taken together were almost certainly eating into capital rather than building it up.

The financial years 2001/02 and 2002/03 show undiscounted projected claim costs 8% and 20% below the level of premiums respectively, which would be expected to produce a more satisfactory financial outcome after allowing for expenses and investment income. In 2003/04 the gap between undiscounted claims cost and premiums has been virtually eliminated as premium rates fell about 4% while actuarial projections of claim costs continued to increase with inflation.

## 6 Large claims

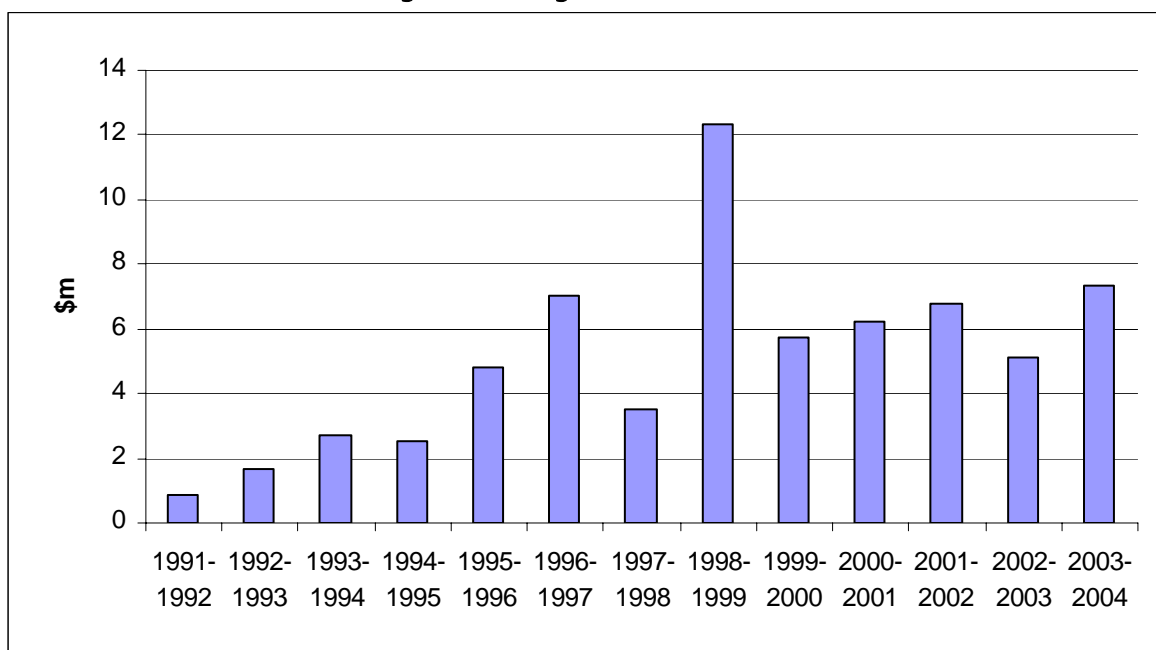
Claims in excess of \$500,000 represented 55% of the total cost of known claims over the nine years to 2003/04, even though they make up only 3% of all reported claims.

Only 1 in 200 claims is greater than \$2m (or 0.5%), but these claims contribute 26% of the total cost of known claims.

The data confirms that obstetrics is the specialty most exposed to large claims. For this specialty group, 1 in 12 claims (8%) is greater than \$500,000 and these claims represent over 90% of the total cost of claims against obstetricians.

Figure 6 shows the cost of the largest claims settled each year (including legal costs).

**Figure 6 – Largest Claims Settled**



The largest settled claim over the last 13 years incurred a cost of \$12m and was made against a procedural GP. The largest claim currently open has a cost estimate of \$17 m and was made against an obstetrician: it is an overseas case that was first notified in 1980. The settlement of a large claim often sets a new ‘precedent’ or standard for claims, resulting in a general increase in the cost of (very) large claims going forward.

## 7 Future directions

The members of the MIIAA have commissioned ISA to collect and collate individual policy and claim data on their behalf, representing an extension of the professional indemnity data collection that APRA now requires all Australian liability insurers to undertake. Extensive coding of existing information is being undertaken by MIIAA members to enable more detailed subdivision of information, while continuing to protect the privacy of both patients and practitioners involved.

This data will allow more extensive investigation of particular specialties beyond those included in this study, as well as permitting correlation of certain quantitative risk factors against claim outcomes. While it will take some years for fully developed data to become available, it is hoped that the existing data can be usefully combined with the new data to enable trends to be compared with earlier years where individual data will not be collected.

## 8 Reliances and Limitations

This report was prepared by ISA for the MIIAA. ISA is an organisation owned by its member insurance companies that collects insurance data from individual companies, compiles it and presents on an aggregate basis in order to protect the confidentiality of individual companies. It should be noted that the data collected for this assignment has not been audited, although reasonableness checks have been performed where possible. As part of this review some anomalies with the data used for preparation of the previous report were identified and corrected.

While the report has been prepared in good faith, neither the MIIAA nor ISA can be held responsible for any errors or for the outcomes of any use to which the information in this report may be put by a reader. Any enquiries about the content of the report should be directed to David Minty of ISA on 02 8252 3347. Requests for copies of the full report should be directed to the MIIAA Project Manager, Ellen Edmonds-Wilson, on 08 8238 4444.