



Medical Indemnity Report

**An analysis of premium and claim trends
for medical indemnity insurance in Australia
from 1995 to 2005**

**Prepared by Insurance Statistics Australia Limited
on behalf of the MIIAA**

The MIIAA comprises:

Australasian Medical Insurance Limited and United Medical Protection	MDA National Insurance Pty Ltd and MDA National
Medical Insurance Australia Pty Ltd and the Medical Defence Association of South Australia (together, Medical Insurance Group Australia)	Professional Indemnity Insurance Company Australia Pty Ltd and the Medical Defence Association of Victoria

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Insurance Statistics Australia Limited (ISA) has compiled information on behalf of the Medical Indemnity Industry Association of Australia (MIIAA), an industry organisation whose members provide medical indemnity insurance cover to eighty-three percent of the medical practitioners privately insured in Australia at 30 June 2005.

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The objective of this report and the analysis undertaken is to help inform the debate in the public and in the profession about the emerging trends and issues in medical indemnity.

The analysis examined the 12 major speciality groups listed in Table 1 and also total information for the practitioners covered by MIIAA members.

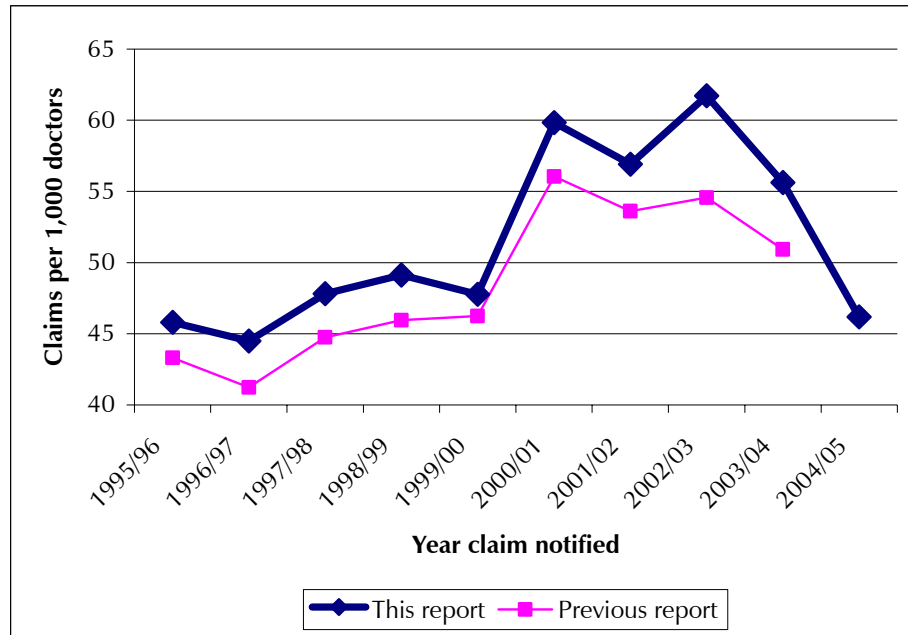
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1 Number of claims

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, not simply an incident that has been notified to an MIIAA member. Figure 1 below shows the movement in the estimated number of claims in respect of incidents that have been notified in each financial year 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' and to all MIIAA members as 'insurers').

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 44 and 49 for the five years 1995/96 to 1999/2000. It jumped 25% to 60 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 stayed between 56 and 62 (incorporating a further claims spike in Victoria in 2002/03), before falling to 46 in 2004/05. 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, unless the change in policy conditions or the legal environment altered the reporting behaviour of practitioners or claimants.

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. However, there was an upward revision of estimated claim numbers by one MIIAA member in the data supplied for this report, producing most of the shift in the absolute level of the expected claim frequency compared to last year shown in Figure 1.

Table 1 shows the annual claim frequency projected for each of the 12 speciality groups, averaged over the first three notification years (1995/96 to 1997/98) and the most recent three notification years (2002/03 to 2004/05). 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	2002/03	Change
	-1997/98	-2004/05	
Anaesthetists	61	50	-18%
Cosmetic Surgeons	244	276	13%
General Practitioners (nonprocedural)	27	37	37%
General Practitioners (procedural)	63	75	19%
General Surgeons	160	171	7%
Gynaecologists (no obstetrics)	128	158	23%
Neurosurgeons	426	252	-41%
Obstetricians	233	304	30%
Orthopaedic Surgeons	264	213	-19%
Physicians (nonprocedural)	23	20	-13%
Physicians (procedural)	40	55	38%
Psychiatrists	33	35	6%
All 12 specialty groups above	56	61	9%
All other indemnity members	20	33	65%
All indemnity members	46	54	17%

There appear to have been considerable increases in the frequency of claims for some specialty groups, while neurosurgeons, orthopaedic surgeons and anaesthetists have shown reductions. The small numbers of practitioners in some groups, and also the ‘grouping’ of some craft groups into the specialties shown, means that these results (and others later in this report) need to be interpreted with caution.

2 Cost of claims

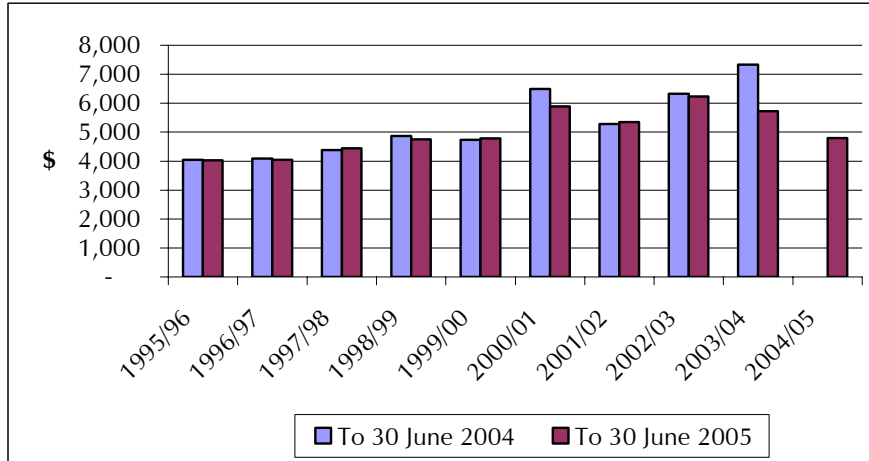
It is not possible to make an accurate measurement of the cost of claims until all claims are finalised, which takes many years. Until that time, the ultimate cost of claims can only be estimated, and changes of views by individual insurers (or their actuaries) can have a significant impact on the assessed value of claims.

Based on the actuarial assessments undertaken on behalf of each MIIAA member by their own actuaries to June 2004, 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, the left-hand set of columns shown in Figure 2.

With the data supplied to June 2005, one insurer had maintained its assessment of ultimate undiscounted costs for prior years at the same level as it reported last year (and as it had done in the previous report as well). Two insurers made minor changes to their assessment of prior years, while one insurer significantly reduced its assessment of ultimate claim costs, particularly for more recent notification years. As a consequence, the projected average undiscounted cost per member has reduced from a peak of \$6,200 in 2002/03 to \$4,800 in 2004/05. This is an increase of only 42% over the ten years and implies a drop in real terms in the average cost per member since 1995/96 of around 1% per annum. This is counter to the assessment last year which implied 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

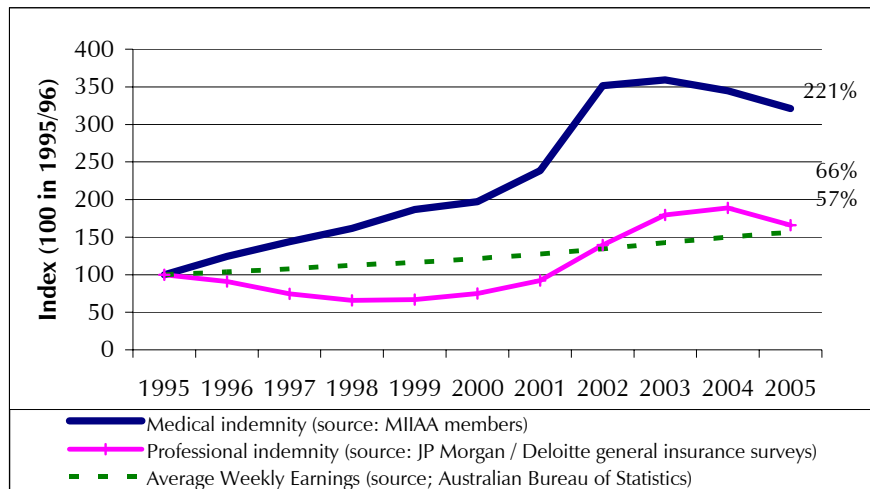


3 Subscriptions and premiums paid by practitioners

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). We have generally referred to these amounts paid by practitioners as ‘premiums’ for convenience. The amounts shown here exclude levies for the Run-Off Cover Scheme (ROCS), the UMP Support Payments Scheme (UMPSPS), GST and stamp duty paid by the practitioner.

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 ten years. The movement in 2003 excludes one insurer which 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 2005) and average weekly earnings for Australia (from the Australian Bureau of Statistics) are shown for comparison.

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



Between 1995 and 2005, average medical indemnity premiums increased by 221% (averaging 13% p.a.). The largest annual increase was in 2002, when the average premium rose nearly 50%, and medical indemnity premium rates peaked the following year. 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 57% (or an average of 4.6% p.a.) over the period.

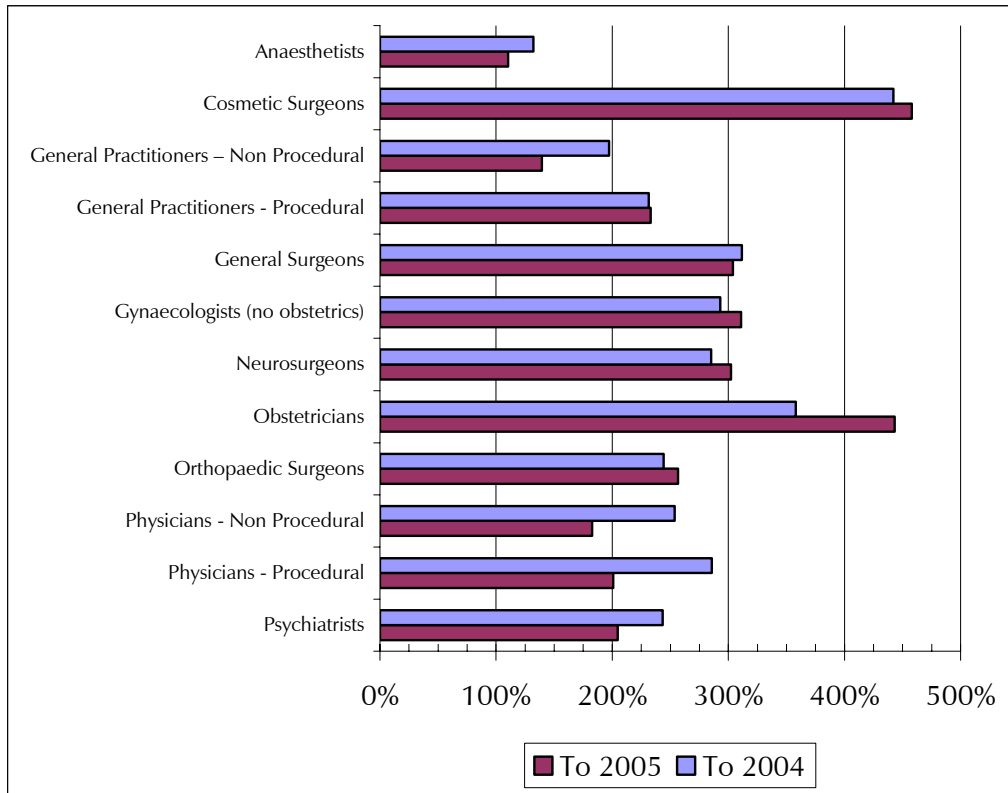
In the two policy years since 2003, medical indemnity rates have reduced by around 11% on average before allowing for the application of subsidies to some practitioners.

4 Premiums for individual specialties

Figure 4 shows the change in average premium for each of the 12 speciality groups, cumulative over the ten years between 1995 and 2005. For policy years to 2004, these figures were based on the ‘typical rate’ for each specialty as assessed by each MIIAA member and may reflect different billing bands or other criteria used for rating purposes. The cumulative position shown in last year’s report is included for comparison.

It should be noted that for the latest year the change in premiums has been calculated relative to the average movement in premiums charged to all policyholders in the given specialty between 2004 and 2005 using the individual policy data supplied to ISA for the MIIAA database. This change in approach has also affected the number of members classified, particularly as “physicians”, “general surgeons” and “cosmetic surgeons”. Thus, there may be a break in the series for the latest year, which may be more pronounced for some specialty groups than others.

Figure 4 – Cumulative premium increases by specialty since 1995



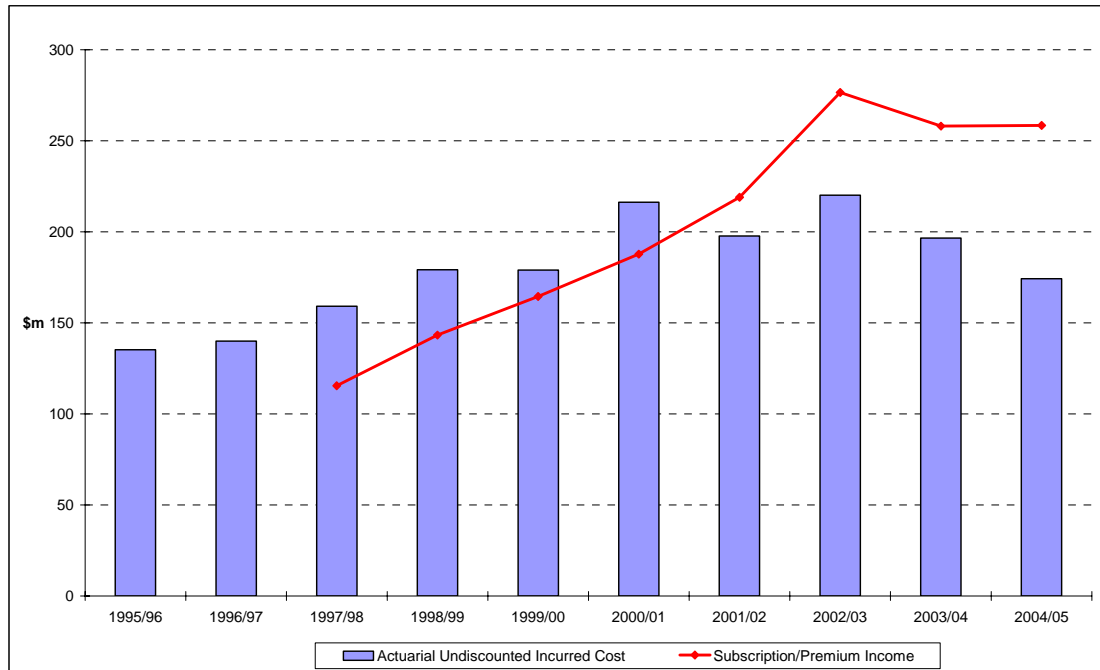
The increases will reflect, in part, the changes in claim frequencies shown in Table 1, the changes in average cost per practitioner reflected in Figure 2 and expectations for future frequency and cost increases. Any reduction in cross-subsidies between different groups of practitioner will also affect the relative rates of premium increase. Cosmetic surgeons and obstetricians have experienced the highest increases – over 400% in the ten years (or an average of more than 18% p.a.). Non-procedural GPs and physicians appear to have received significant reductions in rates in the most recent renewal year.

The other specialty groups included in the study all had increases around 200% to 300% except for anaesthetists where the average cost of indemnity cover rose about 110% over the period. These figures do not include the effect of government subsidies, which have partly offset premium 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 2005). 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 later show undiscounted projected claim costs below the level of premiums, which would be expected to produce a more satisfactory financial outcome after allowing for expenses and investment income. The most recent two years show a considerable gap between premiums and undiscounted expected costs, which is not unexpected given the need for capital to be built up by medical indemnity insurers to achieve the solvency levels required by regulators.

6 Large claims

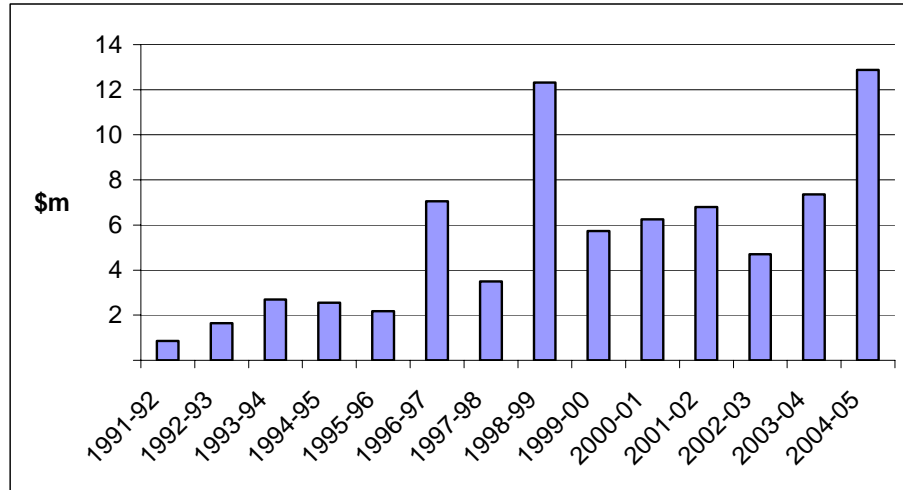
Claims in excess of \$500,000 represented 50% of the total cost of known claims over the ten years to 2004/05, even though they make up only 3% of all reported claims.

Only 1 in 200 claims is greater than \$2m (or 0.5%), but these claims contribute 25% 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 87% of the total cost of claims against obstetricians. While only 1 in 40 claims against gynaecologists exceeds \$500,000, such claims comprise 83% of the costs for that specialty.

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

Figure 6 – Largest Claims Settled



For large claims, the history available goes back to 1992. The largest settled claim over the last 13 years incurred a cost of \$13m and was made against an obstetrician. The largest claim currently open has a cost estimate of \$11m and was also made against an obstetrician. The settlement of a very large claim often sets a new ‘precedent’ or standard for claims, resulting in a general increase in the cost of large claims going forward.

The development of the MIIAA individual claims and policy database has enabled the expansion of the range of data collected and analysed. Information about cause of claim is available from all claims since 1 January 2003 and from large claims settled from 1992 to 2002.

Table 2 summarises the proportion of unsettled large claims recorded on the database at 30 June 2005 by cause of claim, showing their proportions of claim numbers and of total cost of claims respectively. The table represents 262 open claims that exceeded \$0.5 million in expected cost, with estimated total cost of \$448 million. About 30% of settled large claims have not been allocated a cause of claim code, and so we have excluded settled claims from this table.

Table 2 – Causes of Unsettled Large Claims at 30 June 2005

	Proportion of unsettled claim numbers	Proportion of unsettled claim costs
Diagnosis, interpretation	30.2%	26.2%
Procedure - intraoperative complications	22.9%	31.0%
Procedure - other	8.8%	4.1%
Obstetric	8.8%	18.0%
Other issues	29.3%	20.7%
	100.0%	100.0%

7 Reliances and Limitations

This report was prepared by ISA on behalf of 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.

There are some inconsistencies between different insurers on what constitutes a 'procedural physician' versus a 'non-procedural physician', and this is further compounded by the collection of more detailed specialty data through the individual claim and policy database.

Comparability of the incurred claim data over time may also be affected by changes in payment or case estimating practices of the medical indemnity groups, as well as the allocation of members to the various specialty groups. It would be very difficult to track whether such changes had occurred in a systematic way or to quantify their impact. **The information in this report should therefore be regarded as indicative of possible trends rather than representing absolute levels of cost or change, particularly at the level of specialty groups and other subdivisions of the information.**

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