



Medical Indemnity Report

**An analysis of premium and claim trends
for Australian medical indemnity insurance in
Australia
from 1996 to 2006**

**Prepared by Insurance Statistics Australia Limited
using data supplied by its members:**

Members of the Medical Indemnity Industry Association of Australia (MIIAA):

Avant Insurance Ltd (comprising Australasian Medical Insurance Ltd (AMIL) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA)) And Avant Mutual Group (formerly United Medical Protection and the Medical Defence Association of Victoria)	MDA National Insurance Pty Ltd (MDANI) and MDA National;
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and

**Medical Insurance Australia Pty Ltd and
the Medical Defence Association of South Australia (MDASA)
(together, Medical Insurance Group Australia (MIGA))**

Released 22 August 2007

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Executive Summary

Insurance Statistics Australia Limited (ISA) has compiled data in relation to medical indemnity claims on behalf of three of ISA's members which are major underwriters of this class of business in Australia.

Those members are:

- Medical Insurance Australia Pty Ltd and the Medical Defence Association of South Australia (MDASA) (together, Medical Insurance Group Australia (MIGA))

and the members of the Medical Indemnity Industry Association of Australia:

- Avant Insurance Ltd (comprising Australasian Medical Insurance Ltd (AMIL) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA)) and Avant Mutual Group (formerly United Medical Protection and the Medical Defence Association of Victoria), and
- MDA National Insurance Pty Ltd (MDANI) and MDA National.

The report, therefore, is representative of approximately 85% of Australia's private medical practitioners.

The objective of this report and the analysis completed is to help inform the debate in the public and with the profession about emerging trends and issues in medical indemnity. The Medical Indemnity Industry Association of Australia was instrumental in establishing the report under its then-chairman Ms Mandy Anderson, and ISA is grateful for the continuing support for the database from the above insurance groups that founded that organisation.

The analysis looked at the 11 major speciality groups listed in Table 1 and also at total information for the practitioners covered by the database participants.

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ISA advises that this report is based on data sourced from third parties, which ISA has not been able to verify as accurate. You should make your own enquiries prior to relying on any data contained in this report.



1 Claims

The report, Figure 1, details the number of claims per 1,000 practitioners 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 ISA member. For convenience, in this report we have referred to all such practitioners as having being 'insured' and to all database contributors as 'insurers'. The claim numbers include estimates of current notifications that will become claims in due course.

Figure 1 – Claim frequency ultimately expected by year

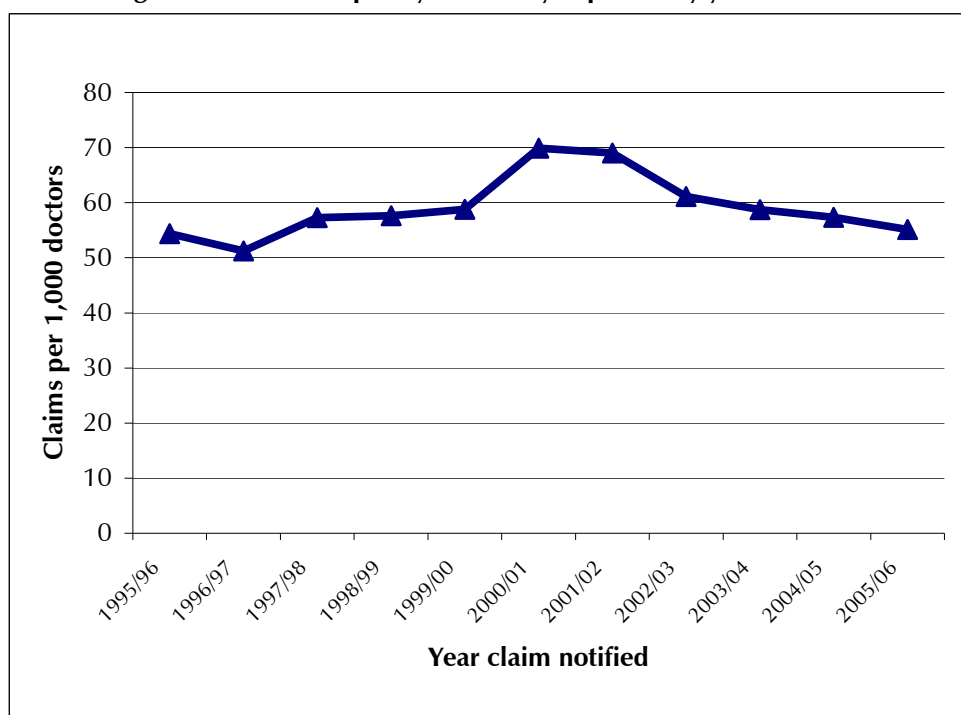


Table 1 shows the annual claim frequency projected for each of the 11 speciality groups, averaged over the first three notification years and the most recent three notification years. The data has been grouped in order to smooth the volatility from year to year within individual speciality groups caused by small numbers of practitioners in some groups. The resulting percentage change for each speciality is also shown.



Table 1 - Claim frequency change - specialty groups

	Claims per 1,000 doctors reported in		
	1995/96	2003/04	Change
	-1997/98	-2005/06	
Anaesthetics	57	44	-23%
General practice - non-procedural	27	41	52%
General practice - procedural	63	80	27%
General surgery	159	146	-8%
Gynaecology no obstetrics	129	155	20%
Neurosurgery	378	234	-38%
Obstetrics (with or without gynaecology)	228	280	23%
Orthopaedic surgery	255	191	-25%
Physician	32	24	-25%
Plastic surgery and cosmetic practice	238	335	41%
Psychiatry	31	28	-10%
Above specialty groups combined	54	57	6%
Other	20	34	70%
All specialty groups including 'Other'	45	51	13%

The small numbers of practitioners in some groups, the combination of some craft groups into the specialties shown and the different (and possibly changing) rates of conversion of incidents and notifications to claims between the specialty groups means that these results (and others later in this report) need to be interpreted with caution.

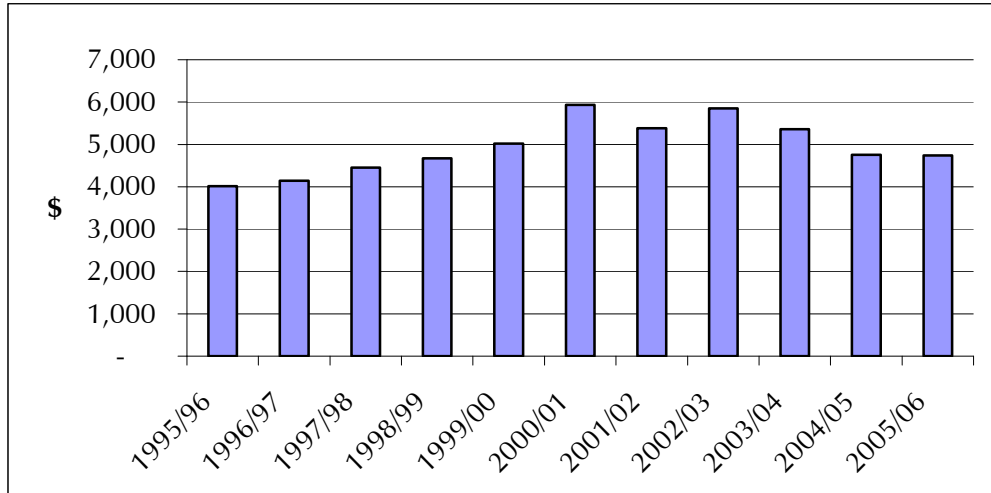
2 Cost of claims

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.

Figure 2 provides the average undiscounted annual cost per indemnified practitioner of all the claims notified, based on the actuarial assessments undertaken on behalf of each insurer by their own actuaries. Note that since 2003, half of the cost of claims in excess of a specified threshold has been covered by the Federal Government through the High Cost Claims Scheme (HCCS). From 1 January 2004, that threshold has been \$300,000. The figure below excludes HCCS costs. In his “Second report on the costs of the Australian Government’s Run-Off Cover Scheme (ROCS) for medical indemnity insurers”, the Australian Government Actuary estimated “at least 40 per cent of the cost of all medical indemnity claims relates to claims which are larger than \$500,000”, suggesting that HCCS covers more than 20% of gross claim costs that medical indemnity insurers would otherwise meet. The impact of the HCCS is illustrated by the trend in this figure.



Figure 2 - Average (actuarial undiscounted) claim cost per policy (all policies)



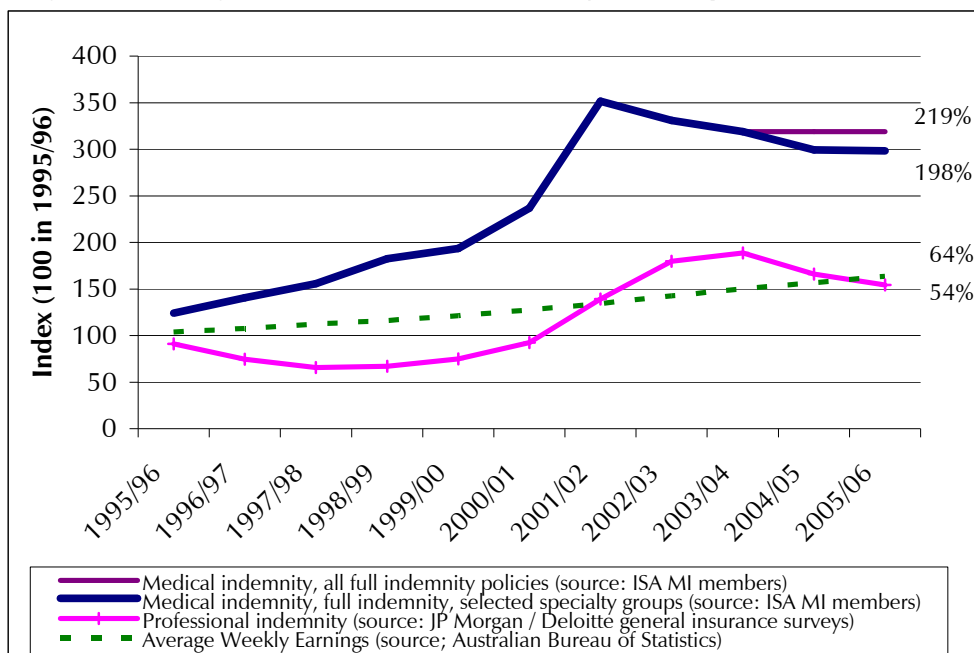
3 Subscriptions and premiums paid by practitioners

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 any GST and stamp duty paid by the practitioner. Information was collected for 11 speciality groups, representing about 90% of the total premium income of the insurers.

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 2003/04 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 2006) and average weekly earnings for Australia (from the Australian Bureau of Statistics) are shown for comparison.



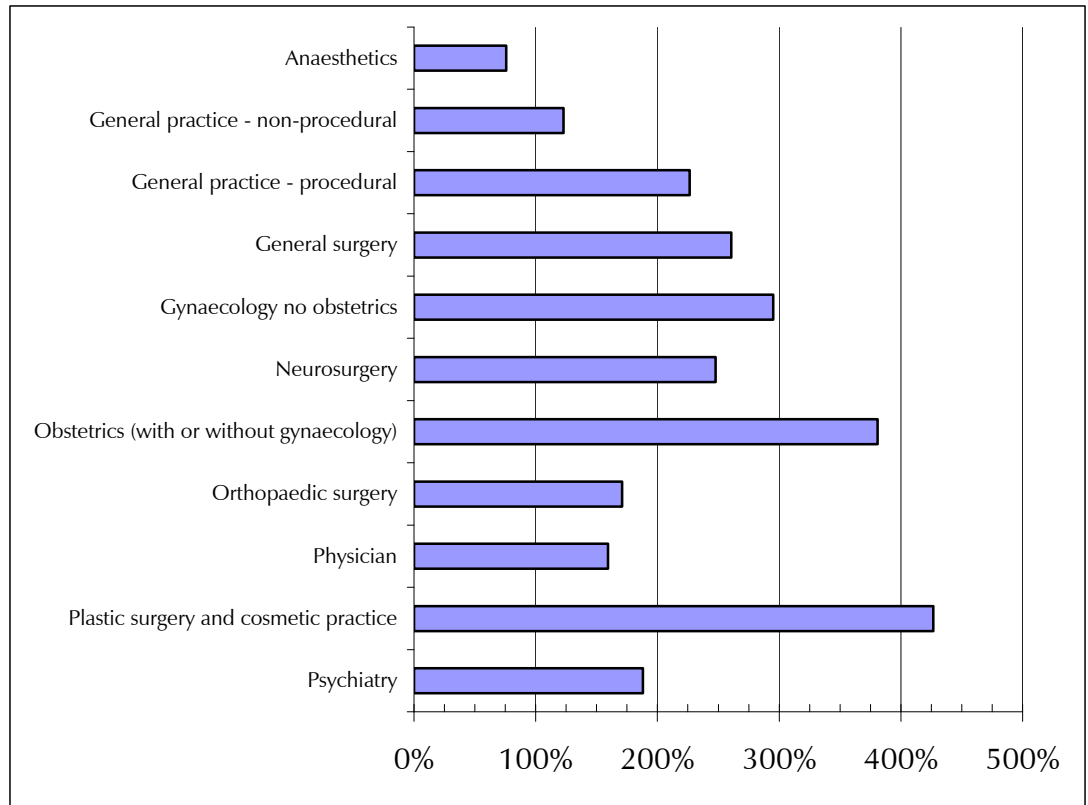
Figure 3 – Average increases in cost of indemnity cover to practitioners



4 Premiums for individual specialties

Figure 4 shows the change in average premium for each of the 11 speciality groups, cumulative over the ten years between 1995/96 and 2005/06. For policy years to 2004/05, these figures were based on the 'typical rate' for each speciality as assessed by each insurer and may reflect different billing bands or other criteria used for rating purposes.

Figure 4 – Cumulative premium increases by specialty from 1995/96 to 2005/06

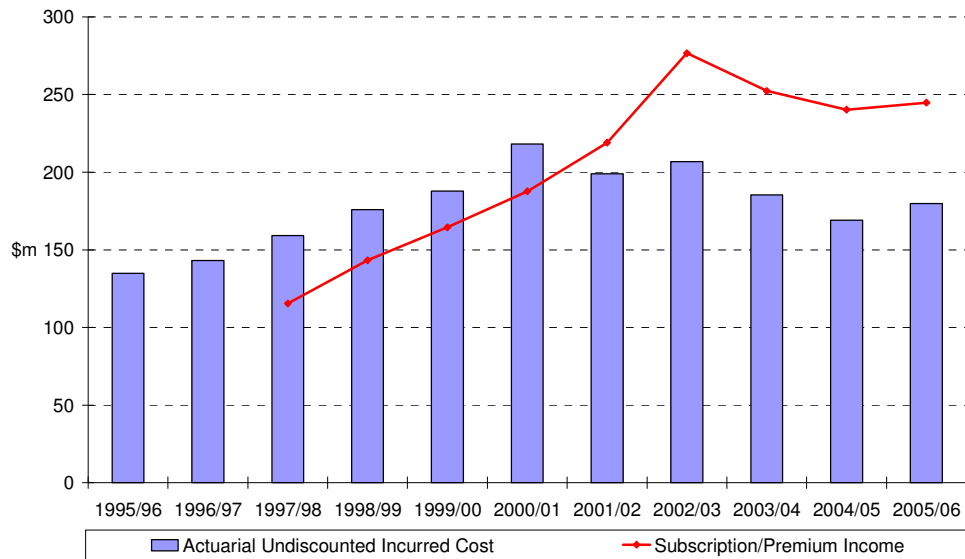


5 Comparison of claims and premiums

Figure 5 below compares the total premium revenue of the insurers 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 2006). These figures include all practitioners covered by the insurers, not just the 11 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. Both premiums and projected claim costs are net of the impact of the HCCS and ROCS arrangements.



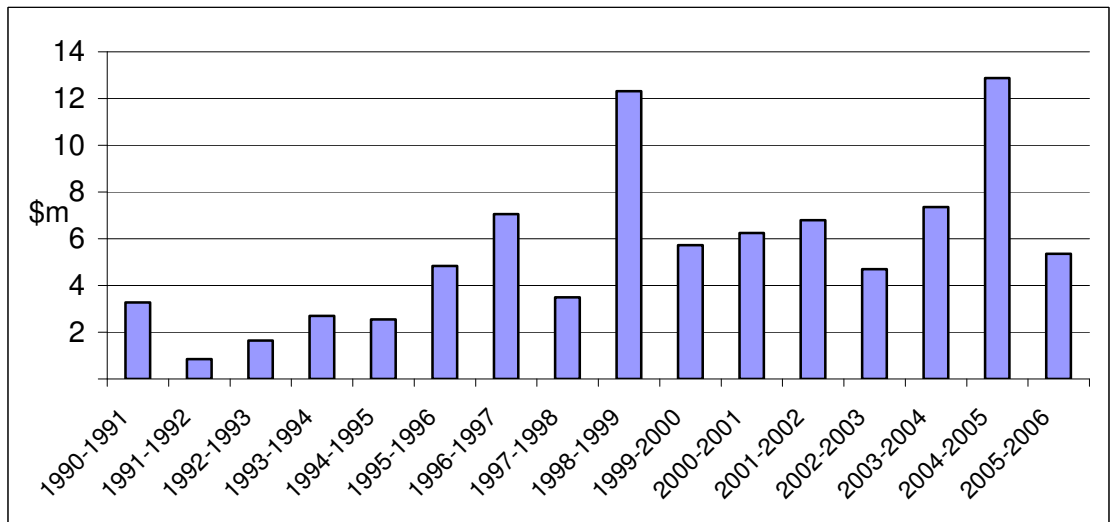
Figure 5 - Premium income versus actuarial undiscounted cost of claims



6 Large claims

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

Figure 6 - Largest claim settled in each financial year since 1990/91





7 Reliances and Limitations

This report was prepared by ISA on behalf of the insurers. 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 the specialty group to which particular practitioners are allocated (in particular, cosmetic practitioners), and this has been compounded by the collection of more detailed specialty data on the individual claim and policy database since 2004.

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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