

## **3. DATA**

### **3.1 Data collection**

3.1.1. For the purpose of preparing this report, certain data were collected from the MIs and MDOs by Medicare Australia during late 2012 including:

- details of practitioners who were identified as having become eligible for membership of the Scheme before 30 June 2012;
- details of claims (including incidents) notified to MIs and MDOs by 30 June 2012 which might eventually become eligible for reimbursement under the Scheme;
- details of ROC support payments;<sup>4</sup>
- actuarial estimates of that part of the future claims cost of medical incidents projected to be notified during the 2012-13 to 2015-16 financial years which is expected to be reimbursed under the Scheme; and
- actuarial estimates of that part of the future claims cost of medical incidents occurring during 2012-13 which is expected to be reimbursed under the Scheme.

3.1.2. This report also utilises other data and information including that which was previously provided to Medicare Australia for the purpose of section 34ZW of the Medical Indemnity Act.

### **3.2 Data verification**

3.2.1. The results in this report rely on information provided by MIs and MDOs. This information is regarded as the most suitable information available for the current purpose.

3.2.2. Steps were taken to ensure, as far as practicable, that the information provided was prepared on a basis suitable for the purpose. Despite this, it is not possible to guarantee that the information provided is free from material error. The information was not independently audited. As was the case in previous years, there were some notable disparities in the data provided, some of which could not be readily explained. Moreover, there were some inconsistencies between data provided for this review and

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4 A database of ROC support payments is maintained by Medicare Australia.

that provided for the previous review. All of this means that figures and estimates provided in this report need to be treated with some caution.

3.2.3. Historically, MDOs have not maintained data in a form which is directly amenable to ROC analysis. For example, it has not been possible to establish a comprehensive list of doctors who were eligible for the Scheme on 1 July 2004. This is not a criticism of the MDOs. It simply reflects that their business and information systems were not developed with a scheme like the Run-Off Cover Scheme in mind. However, in order to monitor the operation of the Scheme effectively, accurate and timely data is clearly important.

3.2.4. Certain information was sought from industry actuaries. Guidance was provided as to the nature of the data, calculations and information required. Discussions with industry actuaries were held to supplement the data provided.

3.2.5. As was the case last year, a range of assumptions was used by industry actuaries. Although some significant assumptions differ by only a few percentage points between actuaries, substantially different estimates of Scheme costs are produced. This is indicative of the highly uncertain nature of estimates of the costs of the Scheme.

3.2.6. It is to be expected that many of the data issues encountered will diminish in time. This is likely to take a few years. Until data issues subside, Scheme projections will be subject not only to the considerable inherent uncertainty which surrounds medical indemnity insurance business, but also to additional uncertainty associated with the amount and quality of the available data.

3.2.7. In general, the results in this report blend estimates provided by industry actuaries with other actuarial estimates based on data provided by the MIs and assumptions and models developed within this office.

### **3.3 Eligible practitioners**

3.3.1. Practitioners performing private practice become eligible for the Scheme by means of permanent retirement at age 65 years or older, cessation of private practice for three years, death, permanent disability or maternity leave. In addition, practitioners who have worked under a subclass 422 (Medical Practitioner) or 457 (Business (Long Stay)) visa under the *Migration Regulations 1994* become eligible for the Scheme when they have permanently ceased medical practice in Australia and ceased to reside in Australia.

3.3.2. Appendix 2 describes the test of eligibility for the Scheme and the process of issuing and notifying compulsory run-off cover to eligible practitioners. Eligible practitioners are entitled to receive notification of the terms and conditions of compulsory run-off cover from their MII. MIIs are also required to notify Medicare Australia of the details of the compulsory run-off cover provided.

3.3.3. There are inherent lags involved in notification of the details of eligible practitioners to Medicare Australia. As a result, it will be possible only to estimate the number of practitioners who have become eligible for the Scheme at any time. For example, there will often be a delay between the time that a practitioner becomes eligible for the Scheme and the time when the insurer becomes aware of this. More generally, it is also very possible that there will be circumstances where an insurer is unsure of the eligibility status of a practitioner indefinitely; for example, where a practitioner has not renewed their insurance for, say, three years. For all of these reasons, the numbers of eligible practitioners reported by insurers need to be treated with caution.

3.3.4. The number of practitioners eligible for the Scheme in this report is based on:

- data provided to Medicare Australia by the medical indemnity industry relating to practitioners identified as having become eligible between 1 July 2004 and 30 June 2012; and
- industry estimates of practitioners eligible for the Scheme as at 1 July 2004, provided for the purpose of the 2004-05 report.

3.3.5. We have relied largely on the eligibility data provided by the industry. For a small number of records the practitioner's eligibility date provided was clearly not reasonable, and we have made adjustments accordingly. The adjustments were made after considering all of the information provided by Medicare Australia, together with the historical data provided for earlier reviews. Even after these adjustments, a substantial number of eligibility records contain information that is internally inconsistent (in particular, eligibility date and last cover date). As has been the case in all previous reviews, the eligibility data suggests wide variation in the rates of eligibility between MIIs. As a result of the inconsistencies in the data and the substantial variation in the rates of eligibility between MIIs, the results are subject to considerable uncertainty. Table 1 summarises the data provided by the industry, after adjustments.

**Table 1: Run-Off Cover Scheme eligible practitioners**

Eligible from	This year's data <sup>(a)</sup>	Last year's data <sup>(a)</sup>
Start up (that is 1 July 2004)	2,112	2,112
2004-05	433	447
2005-06	608	608
2006-07	736	763
2007-08	829	850
2008-09	830	840
2009-10	852	786
2010-11	1,094	972
2011-12	944	N/A
<b>Total number of practitioners eligible for the Scheme at 30 June 2012</b>	<b>8,438</b>	<b>7,378</b>

(a) Note that these numbers have not been reduced in relation to practitioners whose eligibility has subsequently ceased.

3.3.6. According to the data provided by the industry, 944 practitioners became eligible for cover under the Scheme during 2011-12. In our previous review we estimated that 1,023 practitioners would become eligible for cover during 2012-13. The difference between our estimate and the reported experience is less than 10 per cent.

3.3.7. Table 2 below illustrates the breakup of the 2004-05 to 2011-12 new entrants by reason of eligibility, based on the data provided by the MIs. Also shown are the projected new entrants during 2012-13 from the population of practising at-risk doctors<sup>5</sup> produced by our model.

**Table 2: Run-Off Cover Scheme new entrants by reason of eligibility**

	Industry data								Model
	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Retired	183	297	268	329	294	279	431	425	387
Maternity	68	128	197	173	212	212	238	126	378
Permanent disability	23	18	25	24	13	18	31	19	30
Died	90	74	95	108	87	94	91	65	104
Resigned	52	40	105	89	110	114	143	133	169
Other(a)	17	51	46	106	114	135	160	176	-
<b>Total</b>	<b>433</b>	<b>608</b>	<b>736</b>	<b>829</b>	<b>830</b>	<b>852</b>	<b>1094</b>	<b>944</b>	<b>1068</b>

(a) Overseas trained doctors who had permanently ceased practice under a 422 or 457 visa.

3.3.8. We have not projected any new entrants in the 'other' category. Historically, practitioners in this category have paid very low premiums. Accordingly, we have assumed that medical negligence claims against them are likely to make an immaterial contribution to the Scheme costs.

<sup>5</sup> At-risk practitioners are defined in paragraph A.4.13.

### 3.4 Claims eligible for Run-Off Cover indemnity payments

3.4.1. MII and MDOs are entitled to reimbursement from the Australian Government for the costs of claims which:

- are first notified to the MII or MDO on or after 1 July 2004;
- relate to a practitioner who is eligible under the Scheme at the date of notification;<sup>6</sup> and
- meet the other requirements for 'payable claims'.<sup>7</sup>

3.4.2. MIIs provided details of individual medical incidents which they have identified as potentially being eligible for the Scheme. The data provided was not wholly consistent with that provided for last year's report. Moreover, there were some apparent internal inconsistencies within the data. It is quite possible that other medical incidents have been notified to MIIs since 1 July 2004 which were not included in the data but which will be eligible for the Scheme. It is also possible that some of the incidents notified will not be eligible for the Scheme. Accordingly, these numbers should be treated with caution.

3.4.3. As at 30 June 2012, MIIs and MDOs reported 319 medical incidents relating to eligible medical practitioners since the commencement of the Scheme and 160 of those have either led to a payment or have a case estimate<sup>8</sup> attached to them.

3.4.4. Of the 319 incidents, 28 relate to the 2004-05 new entrants to the Scheme, 31 relate to 2005-06 new entrants, 37 relate to 2006-07 new entrants, 25 relate to 2007-08 new entrants, 27 relate to 2008-09 new entrants, 68 relate to 2009-10 new entrants, 33 relate to 2010-11 new entrants and 10 relate to 2011-12 new entrants. 34 incidents relate to those practitioners who were eligible at the commencement of the Scheme on 1 July 2004. The doctor's ROCS eligibility date was missing for the remaining 26 incidents.

3.4.5. 208 of the incidents were present in last year's data, and the total estimated incurred cost of these incidents was approximately 10 per cent lower than the corresponding amount last year, mostly due to a large downward revision of one claim. Of the other 111 incidents, 42 were notified in 2011-12, and 67 are reported as having been notified in prior periods although they were not present in any previous data.

3.4.6. 71 incidents which were included in the data used for compilation of the first four reports were not included by insurers last year or this year. We have

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6 Refer paragraph A.2.1.

7 Refer paragraph A.3.2.

8 Estimate of likely cost to the insurer.

previously checked the reasons for this with the insurers and were advised that some claims had initially been incorrectly assumed to be ROCS-eligible claims.

3.4.7. The number of medical incidents notified to MIs and MDOs which could potentially give rise to a future ROC indemnity payment is lower than perhaps might have been expected. At this point we are not assigning full credibility to the data, given the inconsistencies in it and its relatively small volume.

### **3.5 Run-Off Cover indemnity payments**

3.5.1. ROC indemnity payments are the payments made by the Australian Government to MDOs and MIs as reimbursement of the costs of eligible claims.

3.5.2. The Scheme also provides for payments in respect of compliance costs and indirect claims handling expenses under the ROC Claims and Administration Protocol (section 34ZN of the Medical Indemnity Act).

3.5.3. ROC indemnity payments totalling \$11 million (including indirect claims handling expenses) had been made up to 30 June 2012, all of them since 1 July 2007. Specifically during 2011-12, \$1.65 million in ROC indemnity payments were made.

3.5.4. \$7.4 million compliance cost payments have been made to MIs up to 30 June 2012, while we have estimated that a further \$2.6 million relating to periods prior to 30 June 2012 remained unpaid as at 30 June 2012.

3.5.5. The Commonwealth's own administration costs are Budget-funded and so are not considered in this report.

### **3.6 Run-Off Cover support payments**

3.6.1. ROC support payments are paid to Medicare Australia in the form of an annual lump sum imposed as a tax on each MI from 1 July 2004 under the MI ROCSPA.

3.6.2. The amount of ROC support payments is calculated using a method set out in the MI ROCSPA. Appendix 1 describes the calculation in detail. Very briefly, it is based on:

*Applicable rate × (premium income less taxes and charges) ÷ (1 + applicable rate).*

3.6.3. In 2011-12, the applicable rate was 5 per cent for all insurers.

3.6.4. Table 3 below summarises the ROC support payments received during the 2011-12 financial year. The total amount decreased slightly from that received during

the 2010-11 financial year. This was consistent with a slight reduction in total medical indemnity premiums paid by practitioners during 2011-12. Some MIs continue to collect membership fees in addition to medical indemnity premiums. In total, the amount of membership fees collected represents around 10 per cent of the amount of medical indemnity premiums collected across the industry. ROC support payments are not payable on membership fees.

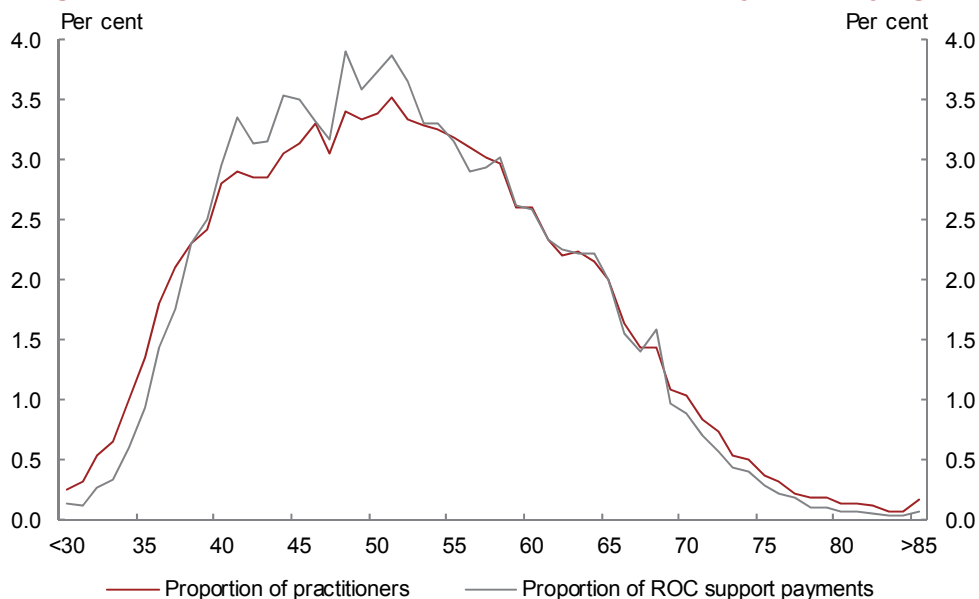
**Table 3: Run-Off Cover support payments**

	ROC support payments (\$'m)	
	Paid 30 June 2012	Paid 30 June 2011
AVANT	7.175	7.426
MDANI	2.332	2.522
MIGA	1.341	1.320
MIPSi	1.781	1.718
QBE	0.877	0.741
<b>Total</b>	<b>13.506</b>	<b>13.727</b>

3.6.5. In order to provide full transparency for practitioners, MIs are required to attribute ROC support payments to individual policyholders. Each premium notice specifies the amount that has been included in the policyholder's invoice to meet the MI's ROC support payment obligations. All amounts are reported to Medicare Australia, which maintains a record of each practitioner's total run-off cover credit. Interest is applied to this balance annually at the short term bond rate in accordance with section 34ZS of the Medical Indemnity Act.

3.6.6. Part 2, Division 2B, Subdivision E of the Medical Indemnity Act provides for certain payments, should the Scheme ever be wound up without alternative arrangements being put in place. Thus, doctors who were still practising at the time of the windup of the Scheme would be entitled to have an amount not exceeding their total run-off cover credit paid to their nominated medical indemnity provider. Practitioners who were eligible for the Scheme at the time of its wind-up would not be entitled to any refund but would continue to be covered for any future claims that might emerge.

3.6.7. Figure 2 below summarises the contribution to ROC support payments by age of practitioner. Note that age and gender were not available for a minority of doctors. The chart is based only on practitioners who paid at least \$1,700 in respect of both medical indemnity premium (net of discounts and loadings) and membership fees during 2011-12. We refer to these practitioners as 'at-risk doctors'. This definition is slightly changed from that used last year, but the shape of the graph is almost identical to that produced in last year's report. The proportion of ROC support payments is greater than the proportion of practitioners for doctors aged between 40 and 50, and the proportions are similar for doctors aged between 50 and 70. The chart also reflects the low level of premiums for interns, trainees and hospital indemnified doctors aged in their 20s and 30s and for doctors over age 70 who may tend to wind down their practice hours and possibly perform fewer risky medical procedures (for example, surgery) as they reach more advanced ages.

**Figure 2: Contribution to Run-Off Cover support payments by age**

3.6.8. Figure 3 below summarises the contribution to ROC support payments by area of specialty. Specialty codes were not available in relation to a small minority of doctors. Similar to Figure 2, this chart only includes 'at-risk' doctors.

3.6.9. Medical indemnity insurance premiums tend to be risk-based. Thus, practitioners operating in higher risk areas of specialty are likely to incur the highest premiums and, accordingly, the highest ROC support payment liabilities. The largest ROC support payments are for obstetricians, gynaecologists, neurosurgeons, cosmetic/plastic/reconstructive surgeons, orthopaedic surgeons, and general surgeons. General practitioners — non-procedural have the smallest average ROC support payments. Note that most medical practitioners not otherwise classified (including interns, trainees and hospital indemnified doctors) are not shown in this chart as they are not included in the 'at-risk' group.



**Figure 3: Contribution to Run-Off Cover support payments by specialisation**

