Medical indemnity national data collection public sector 2005–06

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Medical indemnity national data collection public sector 2005–06

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Abbreviations

ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
HMO	honorary medical officer
MIDWG	Medical Indemnity Data Working Group
MINC	Medical Indemnity National Collection
MTL	Medical Treatment Liability
N.A.	not applicable
NSMP	non-salaried medical practitioner
PHO	public health organisation
PIPA	*Personal Injuries Proceedings Act 2002*
SS	Staff Specialist
TMF	Treasury Managed Fund
VMIA	Victorian Managed Insurance Authority
VMO	visiting medical officer

Summary

This report focuses on public sector medical indemnity claims data for the period 1 July 2005 to 30 June 2006 and is the fourth report in the series. The data in this report, which are collected through the Medical Indemnity National Collection (MINC), provide information on the incidents that gave rise to claims, the people affected by these incidents, and the size, duration and mode of settlement of medical indemnity claims.

The AIHW now holds three full financial years' MINC data, and for the first time, selected MINC data items have been presented as a time series in this report. Time series data includes summary information on the number, nature and cost of medical indemnity claims in 2003–04, 2004–05 and 2005–06.

The MINC now represents 89% of claims in scope and 75% of closed claims. Rates of 'not known' being coded in the MINC has decreased since the 2004–05 reporting period for the majority of data items. The AIHW continues to work closely with the states and territories to improve the coverage and accuracy of the collection.

Claims

There were 6,922 claims active during the year, of which 2,038 were 'potential' claims. There were 1,943 new claims arising during the reporting period. At the end of the reporting period, there were 5,294 current claims remaining open.

During 2005–06, 1,628 claims were closed. In 28.1% of closed claims there was no payment made to the claimant and no defence costs or claimant costs incurred. Of those claims where payment was made to the claimant, 55.2% were settled for less than $100,000. Payments exceeding $500,000 were made in 62 claims (3.8%).

Court based alternative dispute resolution processes and other settlement methods, including settlement part way through a trial, were the most common modes of settlement accounting for 9.1% and 28.9% of closed claims respectively.

Incidents

The three most frequently recorded clinical service contexts associated with all medical indemnity claims were obstetrics (1,156 claims; 16.7% of all claims), general surgery (1,004 claims; 14.5%) and accident and emergency (935 claims; 13.5%). New claims arising during the year were most commonly associated with the clinical service contexts of general surgery (514 claims; 26.5%), obstetrics (247 claims; 12.7%) and accident and emergency (238 claims; 12.2%).

General surgery (816 claims), obstetrics only (813 claims) and emergency medicine (791 claims) were the most commonly recorded specialties of clinicians allegedly involved in incidents that gave rise to claims.

Data on 'Primary incident/ allegation type' show that medical or surgical procedures (2361 claims; 34.1% of all claims) were most commonly recorded in medical indemnity claims, followed by diagnosis (1372 claims; 19.8%) and treatment (946 claims; 13.7%).

The majority of claims arose from events that allegedly occurred in major cities (4,439; 64.1% of all claims); 1,856 (26.8%) arose from incidents that occurred in inner regional areas and 91 claims (1.3%) arose from incidents that occurred in remote or very remote areas.

People

Babies less than 1 year old were the subject of 687 claims (10.0%), 520 claims (7.5%) related to children and 4,802 claims (69.4%) related to adults.

Neuromusculoskeletal and movement-related functions and structures were most commonly recorded as the 'Primary body function/structure affected' as a result of an incident (1,452 claims; 21% of all claims). Mental functions and structures of the nervous system were the next most commonly recorded category (972 claims; 14.0%) followed by genitourinary and reproductive functions and structures (796 claims; 11.5%).

Time series data

The number of new claims rose between 2003–04 and 2005–06, however this increase should be interpreted with caution as there was also an improvement from 80% of claims in scope reported in 2003–04 to 89% in 2005–06.

Overall, time series data indicate there has been little change in the profile of medical indemnity claims over the last three reporting periods. Changes that can be observed include an increase in the percentage of all claims originating in inner regional areas from 21.4% in 2003–04 to 26.8% in 2005–06. An increase in the proportion of claims arising from treatment in the clinical context of general surgery can be seen, from 11.3% of all claims in 2003–04 to 14.5% of all claims in 2005–06. The proportion of claims where an incident related to a procedure is alleged to have occurred increased from 32.8% of all claims in 2003–04 to 34.1% of all claims in 2005–06.

1 Introduction

In 2002, health ministers recognised the costs associated with health-care litigation and the financial viability of medical indemnity insurance in Australia as a policy concern that could not be monitored properly without national data on medical indemnity claims. This recognition led to the development of the MINC and the collation of data on public sector medical indemnity claims. In 2006, the MINC expanded to include claims data from private sector medical indemnity insurers. The first report containing combined public and private sector medical indemnity claims data *A national picture of medical indemnity claims in Australia 2004–05* was published by the Australian Institute of Health and Welfare in May 2007. Further information on the development of the MINC is in Appendix 3.

This report presents data collected through the MINC and information on the number, nature, incidence and costs of public sector medical indemnity claims. These data provide details of the incidents that gave rise to claims, the people affected by those incidents, and the size, duration and settlement of medical indemnity claims.

Data for approximately 89% of all claims in the scope of the MINC are included for 2005–06 (see further information on data completeness in section 2.4). A claim falls within the scope of the MINC when either a legal proceeding has been instigated or the claim is likely to require litigation and has a reserve (best current estimated cost of the claim once it has been finalised) placed against it.

This is the fourth report originating from the public sector MINC. The first report—*First medical indemnity national data collection report: public sector, January to June 2003* (AIHW 2004)—described the development of the collection and presented the first six months of data. Annual data, for the 2003–04 and 2004–05 financial years, were presented in the second and third reports—*Medical indemnity national data collection public sector 2003 to 2004* (AIHW 2005) and *Medical indemnity national data collection public sector: 2004–05* (AIHW 2006).

The combined public and private sector report on medical indemnity claims, *A national picture of medical indemnity claims in Australia 2004–05,* was published in May 2007. This was the first report on medical indemnity in Australia to combine public and private sector medical indemnity claims data and presents information on the incidents giving rise to claims, the specialties of clinicians involved in claims, people affected by incidents, the nature of injury, and the size, method of settlement and length of time claims have been open. The combined public and private sector collection is now under review to determine whether the data underlying the combined reporting can be improved to eventually replace this public sector-only report.

There have been significant improvements in data quality and completeness since the first MINC publication but quality and scope require further improvement (see section 2.4). Care should therefore be taken when comparing data between reports.

2 The collection

2.1 Scope and context

The MINC contains information on medical indemnity claims made against the public sector and managed by state and territory health authorities. A medical indemnity claim is a claim for compensation for harm or other loss as a result of a health-care incident. There are two categories of claims within the public sector MINC: potential claims, which are likely to materialise into a claim and which have had a reserve placed against them, and actual claims, on which legal activity has commenced via a letter of demand, the issue of a writ or a court proceeding.

A reserve is the dollar amount that is the best current estimate of the likely cost of the claim when closed. Although there is some jurisdictional variation in reserving practices, it is likely that the profile of claims within the MINC is similar, since the placement of reserves is central to defining liability and potential risk. The information provided in the MINC represents only those incidents actually or potentially resulting in legal proceedings and hence is not necessarily representative of the wider spectrum of adverse events or harm caused by medical treatment that can occur within the health-care system.

Management of public sector medical indemnity insurance varies across jurisdictions. The states and territories differ in their coverage of visiting medical officers, private practitioners and students. Furthermore, jurisdictional variations in the implementation of tort law reform might affect the scope, nature and quantum of medical indemnity claims in the future. These variations are discussed in Section 2.2 and Appendix 4.

Data for 2005–06 relate to claims that were current at any time during the reporting period (July 2005 to June 2006), that is, those claims that were open at the start of the period (1 July 2005), those that arose during the period, and claims closed during the period[1].

2.2 Policy, administrative and legal context

Indemnity cover is provided where there is no neglect, wilful misconduct or criminal activity on the part of the clinician. Coverage of public sector medical indemnity insurance is defined by state and territory legislation and associated policies and varies between jurisdictions.

With the enactment of tort law reform and changes to medical indemnity legislation, the MINC operates in a changing policy and legal environment. Although the reforms aim to improve national consistency in claims management and legal proceedings, jurisdictional variations in medical indemnity arrangements still exist. This section describes differences in state and territory legislation and insurance policy potentially affecting the nature and scope of MINC claims across Australia. Specific information relating to each jurisdiction is provided in Appendix 4.

1 Closed claims are claims that were closed during the reporting period (1,628 claims had a closed date from July 2005 to June 2006).

Policy relating to public sector medical indemnity

In all states and territories health professionals employed by public health authorities are covered in relation to their public work. The coverage of students (medical, nursing and allied health) and academics varies across jurisdictions and could require participating universities to provide financial contributions.

Changes to public sector medical indemnity policy arose following concerns that rising premiums for doctors in private practice might endanger the availability of health services. In response, many jurisdictions expanded their public sector medical indemnity insurance to cover private sector medical practitioners, including non-salaried doctors treating public patients in public hospitals, employed doctors with limited private-practice rights entering into fee-sharing arrangements with public hospitals, and general practitioners working in rural and remote health services.

In one jurisdiction indemnity was extended to include clinicians' involvement in activities such as clinical audits or the investigation of adverse events.

Since the scope of the MINC includes all claims falling under public sector medical indemnity arrangements, any changes in policy affecting coverage in jurisdictions across Australia will change the effective scope of the MINC.

Administrative arrangements and claims management

As a general guide, the main steps involved in the claims management process are:

1. An incident that could lead to a public sector medical indemnity claim is notified to the relevant claims management body. In some jurisdictions claims are managed in-house by the state or territory health authority; in others most of the claims management process is handled by a body that is separate from the health authority. Some of the legal work may be outsourced to private law firms. (See Appendix 4 for claims management bodies operating in each jurisdiction.)
2. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed.
3. Various events can signal the start of a claim, for example, a writ or letter of demand may be issued by the claimant's solicitor (this can occur before notification) or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases no action is taken by the claimant or the defendant.
4. The claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.
5. As the claim progresses the reserve is monitored and adjusted if necessary.
6. A claim may be closed in several ways—through state-/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions settlement via statutorily mandated conference processes must be attempted before a claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process.
   A claim file that has remained inactive for a long time may be closed. In some instances claims that have been closed are subsequently re-opened.

The detail of this process varies between jurisdictions, and in some jurisdictions there are different processes for small and large claims.

Legal reforms

In 2002 the Commonwealth and state and territory governments established a panel to review the law of negligence as it applies to claims for personal injury and death. One of the terms of reference of the review (described in the 'Ipp Report'[2]) was to 'develop and evaluate principled options to limit liability and quantum of awards for damages' (Commonwealth of Australia 2002).

A central recommendation of the review was that a single statute be enacted in all jurisdictions to ensure national consistency in proceedings relating to claims for personal injury and death. The report also made recommendations on a range of other matters, among them:

- a test for determining the standard of care in cases where negligence is alleged against a medical practitioner
- the limitation period within which a claim for damages for personal injury or death resulting from negligence may be brought
- restrictions on the requirement for a defendant to pay a plaintiff's legal costs
- a cap on awards for general damages and damages for loss of earning capacity
- damages relating to mental harm—that these should be recoverable only where there is a recognised psychiatric illness
- principles guiding the determination of other types of damages—for example, health-care costs, gratuitous services, and future economic loss
- a requirement that, under certain circumstances, parties must attend mediation proceedings with a view to securing a structured settlement.

All jurisdictions have legislated limitation periods within which legal action relating to a medical indemnity claim must be initiated, and some have legislation that limits awards of damages for negligence claims for personal injury or death (including medical indemnity claims). There is considerable variation in these provisions between jurisdictions.

To date, all jurisdictions have enacted some tort law reforms consistent with recommendations from the Ipp Report. These reforms are designed to:

- decrease the incidence of minor claims
- improve outcomes for both plaintiffs and defendants
- improve the general efficiency of the claims management process.

2 The Ipp report or *Review of the law of negligence* was released on 2 October 2002 following the Ministerial Meeting on Public Liability Insurance on 30 May 2002. The Commonwealth, in consultation with the states and territories, agreed to jointly appoint an expert panel to examine the law of negligence. Broadly, the review examined a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death.

2.3 Data items

The MINC consists of 21 data items, as summarised in Table 2.1. Definitions, classification codes, a guide for use and a brief history of the development of each item are documented in the *Medical indemnity national collection (public sector) data guide*, which is updated annually and published in summary form on the AIHW website.

An information model was created to aid in the development of the MINC and the data items (Figure 2.1). It depicts relationships between key data entities. The MINC collects information about the claim subject (that is, the person who was the patient during the incident that gave rise to the claim), the incident that gave rise to the claim, the claim itself, and other parties involved (including any other parties alleged to have suffered loss, and health service providers). The claimant (that is, the person who is pursuing the claim) is often also the claim subject; the MINC does not, however, collect information about the claimant as such. Table 2.2 provides definitions of key MINC terms. Records in the MINC database do not contain information that would allow the identification of individuals or health service providers involved in claims.

Public sector MINC data are transmitted from health authorities to the AIHW every 6 months; the AIHW is responsible for the collation, analysis and reporting of the data. The information transmitted represents the claim manager's 'best current knowledge' about the claim. As more information becomes available, it is expected that the profile of a claim might change considerably. This report presents the most up-to-date information as at 30 June 2006.

As the MINC matures, and as greater consistency in public sector claims information is sought, modifications to data items will continue to occur.

Table 2.1: MINC data items and definitions

Data item	Definition
1. Claim identifier	An identity number that, within each Health Authority, is unique to a single claim, and remains unchanged for the life of the claim.
2. Nature of claim—loss to claim subject	A broad description of the categories of loss allegedly suffered by the claim subject (that is, the patient) that form a basis for this claim.
3. Nature of claim—loss to other party/parties	A broad description of the categories of loss allegedly suffered by an other party or parties (that is, people other than the patient) that form a basis for this claim.
4. Claim subject's year of birth	Year of birth of claim subject.
5. Claim subject's sex	Gender of the claim subject.
6. Incident/allegation type	The high-level category describing what is alleged to have 'gone wrong'; that is, the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim, reflecting key causal factors. (Up to three additional incident/allegation type categories may also be recorded.)
7. Clinical service context	The area of clinical practice or hospital department in which the patient was receiving a health-care service when the incident occurred.
8. Body function/structure affected—claim subject	The primary body structure or function of the claim subject (that is, the patient) alleged to have been affected as a result of the incident. (Up to three additional body function/structure categories may also be recorded.)
9. Extent of harm—claim subject	The extent or severity of the overall harm to claim subject (that is, the patient).
10. Date incident occurred	Calendar month and year in which the incident that is the subject of the claim occurred.
11. Where incident occurred	Australian Standard Geographical Classification Remoteness Structure category for the location where the incident occurred.
12. Health service setting	Health service provider setting in which the incident giving rise to the claim occurred.
13. Claim subject's status	Whether the claim subject (that is, the patient) was a public or private, resident or non-admitted patient at the time of the incident.
14. Specialty of clinicians closely involved in incident	Clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim.
15. Date reserve first placed against claim	Calendar month and year in which a reserve was first placed against the claim.
16. Reserve range	The estimated size of the claim, recorded in broad dollar ranges.
17. Date claim commenced	Calendar month and year in which the claim commenced, as signalled by the issue of a letter of demand, issue of writ, an offer made by defendant, or other trigger.
18. Date claim closed	Calendar month and year in which the claim was settled, or a final court decision was delivered, or the claim file was closed (whichever occurred first).
19. Mode of claim finalisation	Description of the process by which the claim was closed.
20. Total claim size	The amount agreed to be paid to the claimant in total settlement of the claim, plus defence legal costs, recorded in broad dollar ranges.
21. Status of claim	Status of the claim in terms of the stage it has reached in the process from a reserve being set to file closure.

Table 2.2: Definitions of key MINC terms

MINC term	Definition
Claim	Claim is used as an umbrella term to include **medical indemnity claims** that have materialised and **potential claims**. A single claim (that is, a single record) in the MINC may encompass one or more claims made by a single **claimant** in respect of a particular **health-care incident**, and may involve multiple defendants.
Claimant	The person who is pursuing a claim. The claimant may be the **claim subject** or may be an **other party** claiming for loss allegedly resulting from the incident.
Claim manager	The person who is responsible for all or some aspects of the management of the claim, on behalf of the health authority.
Claim subject	The person who received the health-care service and was involved in the **health-care incident** that is the basis for the **claim**, and who may have suffered or did suffer, **harm** or other **loss**, as a result. That is, the claim subject is the person who was the patient during the incident.
Harm	Death, disease, injury, suffering, and/or disability experienced by a person.
Health authority	The government department or agency with responsibility for health care in the Commonwealth of Australia, and in each of the states and territories of Australia.
Health care	Services provided to individuals or communities to promote, maintain, monitor, or restore health.
Health-care incident	An event or circumstance resulting from **health care** that may have led or did lead to unintended and/or unnecessary **harm** to a person, and/or a complaint or **loss**.
Incident	In the context of this data collection, 'incident' is used to mean **health-care incident.**
Loss	Any negative consequence, including financial loss, experienced by a person.
Medical indemnity	Medical indemnity includes professional indemnity for health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements.
Medical indemnity claim	A medical indemnity claim is a claim for compensation for **harm** or other **loss** that may have resulted or did result from a **health-care incident**.
Other party	Any party or parties not directly involved in the health-care incident but claiming for loss allegedly resulting from the incident. The 'other party' is not the person who was the patient during the incident.
Potential claim	A matter considered by the relevant authority as likely to materialise into a **claim**, and that has had a **reserve** placed against it.
Reserve	The dollar amount that is the best current estimate of the likely cost of the **claim** when closed. The amount should include claimant legal costs and defence costs but exclude internal claim management costs.

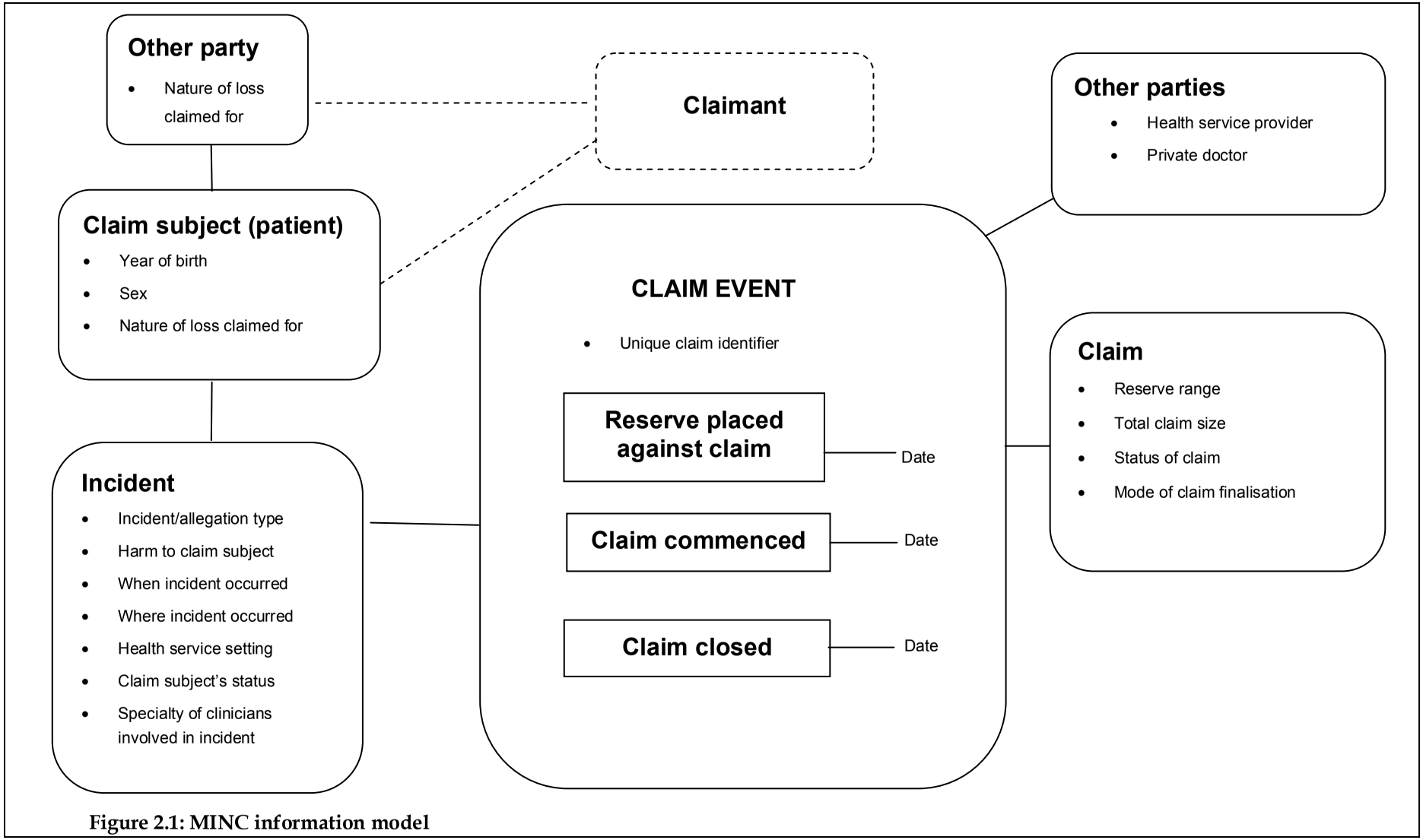

Figure 2.1: MINC information model

Key counts

Each record in the MINC represents a single claim except in some instances such as class actions, where one claim represents the claims of all claimants' party to the action. Data can be used to produce different counts, as described in Box 2.1, and these counts are reflected in the tables presented in Chapter 3.

Box 2.1 Counting rules for the MINC data set

The definition of 'claim' includes 'potential claims' (See section 2.1). Some tables present data for particular subsets of claims:

- *Current claims – claims that are open (that is, have a reserve placed against them but have not been closed) as at the end of the reporting period. There were* ***5,294 current claims*** *as at 30 June 2006*
- *Closed claims – claims that have been closed during the reporting period. A total of* ***1,628 claims were closed*** *for the period 1 July 2005 to 30 June 2006*
- *New claims – claims that were opened during the reporting period, including those that were also closed during the period. There were* ***1,943 new claims*** *for the period 1 July 2005 to 30 June 2006)*
- *All claims – the total set of claims in the MINC during the reporting period (that is, claims open at any time during the period). This is the sum of current and closed claims, including claims that were open at the start of the period. There were* ***6,922 claims in total*** *in the MINC database for the period 1 July 2005 to 30 June 2006.*

For each claim there is one claim subject except in some instances such as class actions, where one claim represents the claims of all the claimants party to the action.

For some MINC data items more than one code may be recorded per claim. These items are:

- *Nature of claim – loss to claim subject*
- *Nature of claim – loss to other party/parties*
- *Incident/allegation type*
- *Body function/structure affected – claim subject*
- *Specialty of clinicians closely involved in the incident.*

For each of these items data may be presented as the number of coding categories recorded (which in most cases will be greater than the number of claims).

2.4 Data quality and completeness

This section provides an overview of data coverage, completeness and quality for the 2005–06 reporting period, and a summary of agreed changes to data items for the future. Because data completeness and *not known* rates affect the reliability of data, these factors should be taken into account when interpreting the information presented in this report and comparing time series data.

Review processes occurring in some jurisdictions may affect the number, nature and trends of medical indemnity data, and any implications of tort law reform might not necessarily be immediately evident.

Data coverage and completeness

Since the first reporting period, data completeness has improved from 80% of claims in scope included in2003–04 to 89% of claims in scope included in 2005–06 (See table 4.1), a trend expected to continue as the collection matures.

The MINC now represents approximately 89.0% of all claims in scope, 73.6% of all closed claims, and 97.3% of new claims. Two jurisdictions did not provide complete data:

- Victoria provided data for 85% of claims in scope for the period. Even though Victoria had a claims data collection system that contained more than two decades of claim records, many of the data items in that system did not map readily to data items developed for the MINC. Consequently, Victoria has manually coded all open files since 1 January 2003, in addition to any new claims raised. The total dollar value of reserves against Victorian claims in scope but not included amounted to 15.2% of the total dollar value of Victorian claims in scope in 2005–06.
- New South Wales provided data for 86.6% of all claims in scope. Records were provided for all claims that have been opened since January 2002. Claims in scope for the current reporting period but opened before 2002 were not provided. As New South Wales claims predating 2002 are closed they will represent a smaller proportion of claims in scope of the MINC, and overall data completeness will continue to improve. For the first time, New South Wales data on specialty of clinician was provided.

Missing data

New South Wales data are not included in tables involving the following data items:

- Nature of claim—loss to other party/parties
- Additional incident/allegation type
- Additional body functions/structures affected—claim subject
- Claim subjects' year of birth
- Extent of harm – claim subject.

When the MINC was commenced, New South Wales had in place a data system with specifications that differed from those of the MINC and has been unable to provide data for these items. Consequently, the total number of claims cannot be shown in tables containing these data items and data are presented as percentages. All other jurisdictions have established or adapted their data systems to comply with the MINC.

Data quality

Not known rates

A coding of *not known* can occur when information is either not currently available but expected to become available or not expected to ever be available through the lifetime of the claim. The proportion of *not known* rates across most data items has decreased since the 2004–05 reporting cycle, which may reflect a growing understanding of MINC data collecting and recording practices within jurisdictions.

The item 'Nature of claim—loss to claim subject' (45.2%) had the highest *not known* rate (Table 2.3). This information is not routinely collected during the lifetime of a claim and the Medical Indemnity data Working Group (MIDWG) has agreed that the value and usefulness of this item should be monitored over future reporting periods.

Not known rates for several other items ranged between 10% and 20%. Items containing data for all states and territories were 'Primary incident/allegation type', 'Primary body function/structure affected', and 'Claim subject's status'.

The item 'Claim subject's year of birth' had a not known rate of 12.8%. This item was not reported by New South Wales. The remaining data items each recorded less than 8% *not known* responses.

Coding consistency

Overall, the MINC data indicate a sound understanding of data definitions and coding practices. During data cleaning and validation checks, changes in data items across recording periods are monitored. Those changes that are illogical or unexpected are flagged to data providers, and a small number of coding errors and inconsistencies were identified for the reporting period—for example, claim status changing from *closed* to *commenced*. This cross-checking between data custodian and providers promotes the inclusion of accurate and reliable data.

Table 2.3: MINC data items: number and percentage of claims for which 'not known' was recorded, 1 July 2005 to 30 June 2006

Items for all states and territories	Number	% of all claims
Nature of claim—loss to claim subject	3,128	45.2
Claim subject's status	1,415	20.4
Primary body function/structure affected	1,145	16.5
Primary incident/allegation type	691	10.0
Primary specialty of clinician closely involved in incident	520	7.5
Clinical service context	498	7.2
Health service setting	479	6.9
Claim subject's sex	287	4.1
Where incident occurred	24	0.3
Closed claim items		
Mode of claim finalisation	48	2.9
Total claim size	26	1.6
Items for all states and territories except NSW[(a)]	**Number**	**% of non-NSW claims**
Nature of claim—loss to other parties	3,165	57.2
Extent of harm – claim subject	1,300	23.5
Claim subject's year of birth	711	12.8
Additional incident/allegation types	5	0.1
Additional body functions/structures affected	4	0.1

(a) NSW was not able to provide data for any of the data items in this section of the table.

Notes

'Not known' rates are not presented for the following data items, for the reasons stated:

'Date incident occurred', 'Date reserve first placed against claim', 'Reserve range' and 'Status of claim' must be completed for all records included in the MINC.

'Date claim commenced' and 'Date claim closed' can be left blank for claims that have not yet been commenced or closed.

3 Public sector medical indemnity claims data, 2005–06

This chapter contains a profile of the 6,922 claims that were active at any time during the reporting period (1 July 2005 to 30 June 2006). A claim is considered active if it was open at the start of the reporting period, arose during the period or was closed during the period. Information on the incident that precipitated the claim, the people involved (both the claim subject and professionals) and claim details (including status, duration and financial information) is provided.

Several changes have been made to data items and specifications since the previous report. These changes came into effect from 1 July 2005. Changes affect the data items 'Total claim size' and 'Status of claim'. A summary of pre-July 2005 claim codes and their corresponding post-July 2005 codes can be found in Table 2.4.

The coding of the item 'Status of claim' has been changed in this report and claims are presented under the headings *not yet commenced, commenced, closed* and *previously closed, now reopened*. For the purpose of this report, claims coded as *structured settlement–claim file open* have been included in the *commenced* category and claims coded *structured settlement–claim file closed* have been included under the *closed* category.

Where previously the item 'Total claim size' was coded *no payment made*, it is now coded *$0* (zero dollars).

Table 2.4: Changes to MINC data items from 1 July 2005

Data item	Pre-July 2005	Post-July 2005
20 Total claim size	Code 11 *No payment made*	Code 0 *$0*.
21 Status of claim	Code 31 *Finalised—structured settlement with total dollar value open*	Code 20 *Commenced*
	Code 32 *Finalised—structured settlement with total dollar value decided'*	Code 32 *Structured settlement—claim file open*
	Code 33 *Finalised claim—structured settlement with total dollar value open*	Code 33 *Structured settlement—claim file closed*

3.1 Incidents

This section provides information on the event that gave rise to a claim, describing what was alleged to have occurred ('primary incident/allegation type'), the setting in which the incident arose ('clinical service context') and the professionals directly involved ('Specialty of clinician(s)'). Information on the geographical region where the event took place is also included. Table 3.1 contains data on the 'Primary incident/allegation type'or what is alleged to have gone wrong, by the clinical context in which the incident is alleged to have occurred. Table 3.2 outlines the specialty of the primary clinician involved in the alleged incident and the clinical context in which the incident is alleged to have occurred. Table 3.3 shows the

'Primary incident/allegation type' by 'Specialty of clinician(s)'. Specialty of clinician data includes the primary and up to three additional specialties for all states except New South Wales which only reports the specialty of the primary clinician.

Clinical service context

'Clinical service context' provides information on the area of clinical practice or hospital department in which the patient was receiving a health-care service when the alleged incident occurred. There are 20 possible categories; the eight most common clinical service contexts are presented in Table 3.1. These eight specialties constituted 68% of all claims. Clinical service context was *not known* in 7.2% of claims. All other categories are combined into the category *all other clinical service contexts*, which accounts for 24.8% of all claims.

In the 2005–06 financial year, the four most frequently recorded clinical service contexts were *obstetrics* (1,156 claims; 16.7% of all claims), *general surgery* (1,004; 14.5%), *accident and emergency* (935 claims; 13.5%), and *gynaecology* (449; 6.5%) (Table 3.1).

There is also the option for clinical service context to be coded as *other* and additional text information provided. During the reporting period 718 claims (10.4% of all claims) were coded this way (Appendix Table A2.1).

Primary incident/allegation type

Primary incident/allegation type data describe what is alleged to have 'gone wrong', that is, the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim. During 2005–06, claims relating to medical or surgical *procedure* (2,361 claims; 34.1% of all claims) were most common, followed by *diagnosis* (1,372; 19.8%) and *treatment* (946; 13.7%) (Table 3.1). Procedures accounted for over half of all incidents in the clinical service contexts of *gynaecology* (328 claims; 73.1% of all claims in this category), *general surgery* (664 claims; 66.1%), *orthopaedics* (231 claims; 52.0%) and *obstetrics* (587 claims; 50.8%). Incidents related to *diagnosis* were relatively more likely in the *accident and emergency* (57.8%; 540 of 935 claims) and *paediatrics* (32.4%; 59 of 182 claims) clinical service contexts.

Claims with a primary incident allegation/type of *anaesthetic* were relatively more common in the clinical service context of *general surgery* (66 claims; 6.6% compared with 2.3% overall), and *other general duty of care* issues were relatively more common in the clinical service context of *psychiatry* (148 claims; 55.0% compared with 9.2% across all claims).

Device failure and *blood/blood product-related* were least likely primary incident/allegation type to be recorded as the alleged grounds for a claim (0.7% and 1.3% of all claims respectively).

Specialty of clinician(s) closely involved in incidents

'Specialty of clinicians closely involved in incidents' indicates the health-care providers who allegedly played the most prominent roles in the events that gave rise to the claims. Recording of these providers does not, however, imply that they were at fault, and they may or may not be defendants in the claim. In the MINC, up to four codes may be selected for 'Specialty of clinician'. During 2005–06, 91.5% of claims recorded one specialty and 7.0% of claims recorded two (Table A2.3). Four specialties were recorded in 0.2% of claims. Since up to four specialties can be recorded for a claim, the column totals in Tables 3.2 and 3.3 cannot be summed to provide the total claims overall. The most commonly recorded specialties

were *general surgery* (816 claims), *obstetrics only* (813 claims) and *emergency medicine* (791 claims) (Table 3.2). If the specialties of *obstetrics* and *gynaecology* were combined, they would account for 1,428 claims[3].

The specialties of clinicians who played the most prominent roles in an incident are closely related to the clinical service context in which the event occurred. The specialties of *obstetrics only*, *gynaecology only*, *general surgery*, *emergency medicine*, *orthopaedics* and *psychiatry* were particularly strongly associated with corresponding clinical service contexts (Table 3.2). O*ther hospital-based medical practitioners* (including residents and interns) and *general nursing* were associated with events occurring across a broad range of clinical service contexts. *Accident and emergency* accounted for 16.5% of all claims involving *other hospital-based medical practitioners*, and *general medicine* accounted for 24.8% of claims involving the specialty of *general nursing*.

Procedure-related incidents were most common in claims associated with the specialties of *gynaecology only* (75.5% of all claims), *general surgery* (72.1%), *obstetrics only* (57.9%) and *orthopaedics* (52.1%) (Table 3.3). *Other general duty of care* matters constituted the largest proportion of claims involving the specialties of *psychiatry* (57.1% of claims) and *general nursing* (47.5% of claims). For claims involving *other hospital-based medical practitioners*, issues with *diagnosis* and *procedures* were relatively common (28.2% and 22.0% respectively).

3 This calculation includes three categories of speciality of clinician: *obstetrics only*, *gynaecology only* and *obstetrics and gynaecology*.

Table 3.1: All claims: eight most common clinical service contexts, by primary incident/allegation type, 1 July 2005 to 30 June 2006, Australia

	Primary incident/allegation type													
Clinical service context	Diagnosis	Medication-related[(a)]	Anaesthetic	Blood/ blood product-related	Procedure[(b)]	Treatment[(c)]	Consent[(d)]	Infection control	Device failure	Other general duty of care	Other	Not known	Total	Per cent
						Number								
Obstetrics	150	18	35	7	587	198	13	17	0	51	11	69	1,156	16.7
General surgery	110	13	66	1	664	71	14	16	5	24	2	18	1,004	14.5
Accident & Emergency	540	26	2	1	34	215	5	8	2	71	7	24	935	13.5
Gynaecology	30	4	7	1	328	15	25	3	10	14	2	10	449	6.5
Orthopaedics	55	7	10	0	231	51	15	20	8	27	4	16	444	6.4
Psychiatry	18	14	0	0	2	43	2	0	0	148	18	24	269	3.9
General medicine	51	41	3	3	5	55	3	9	4	81	3	9	267	3.9
Paediatrics	59	14	5	1	42	33	4	2	1	9	5	7	182	2.6
All other clinical service contexts	345	67	32	71	448	251	72	60	13	199	61	99	1,718	24.8
Not known	14	3	2	5	20	14	0	4	3	14	4	415	498	7.2
Total	1,372	207	162	90	2,361	946	153	139	46	638	117	691	6,922	100.0
						Per cent								
Obstetrics	13.0	1.6	3.0	0.6	50.8	17.1	1.1	1.5	0	4.4	1.0	6.0	100.0	
General surgery	11.0	1.3	6.6	0.1	66.1	7.1	1.4	1.6	0.5	2.4	0.2	1.8	100.0	
Accident & Emergency	57.8	2.8	0.2	0.1	3.6	23.0	0.5	0.9	0.2	7.6	0.7	2.6	100.0	
Gynaecology	6.7	0.9	1.6	0.2	73.1	3.3	5.6	0.7	2.2	3.1	0.4	2.2	100.0	
Orthopaedics	12.4	1.6	2.3	0.0	52.0	11.5	3.4	4.5	1.8	6.1	0.9	3.6	100.0	
Psychiatry	6.7	5.2	0	0	0.7	16.0	0.7	0.0	0	55.0	6.7	8.9	100.0	
General medicine	19.1	15.4	1.1	1.1	1.9	20.6	1.1	3.4	1.5	30.3	1.1	3.4	100.0	
Paediatrics	32.4	7.7	2.7	0.5	23.1	18.1	2.2	1.1	0.5	4.9	2.7	3.8	100.0	
All other clinical service contexts	20.1	3.9	1.9	4.1	26.1	14.6	4.2	3.5	0.8	11.6	3.6	5.8	100.0	
Not known	2.8	0.6	0.4	1.0	4.0	2.8	0.0	0.8	0.6	2.8	0.8	83.3	100.0	
Total	**19.8**	**3.0**	**2.3**	**1.3**	**34.1**	**13.7**	**2.2**	**2.0**	**0.7**	**9.2**	**1.7**	**10.0**	**100.0**	

(a) *Medication-related* includes type, dosage and method of administration issues.

(b) *Procedure* includes failure to perform a procedure, wrong procedure performed, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(c) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(d) *Consent* includes failure to warn.

Notes

1. The 'Clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *all other clinical service contexts*. Appendix 2 Table A2.1 shows the frequency of coding categories for all clinical service contexts.

2. Data for approximately 89% of all claims in scope are included.

Table 3.2: All claims: eight most common clinical service contexts, by specialty of clinician(s) involved, 1 July 2005 to 30 June 2006, Australia (per cent)

	Specialty of clinician(s)[a]													
Clinical service context	**General surgery**	**Obstetrics only**	**Emergency medicine**	**Orthopaedic surgery**	**Other hospital-based medical practice[b]**	**Gynaecology only**	**General nursing**	**Obstetrics and gynaecology**	**Psychiatry**	**General anaesthetics**	**All other specialties**	**Not known**	**N.A.[c]**	**Total**
Obstetrics	0.4	98.2	0.4	0.2	6.2	0.5	3.5	63.6	1.3	22.9	12.3	1.3	7.3	17.8
General surgery	94.2	0.1	1.1	1.1	3.4	0.3	7.1	0.8	0.4	42.9	6.3	1.0	7.3	14.1
Accident & Emergency	1.2	0.5	93.4	5.3	16.5	0.3	8.6	1.2	5.8	0.5	5.9	1.3	4.9	13.6
Gynaecology	0.7	0.2	0.0	0	2.6	95.1	3.2	31.2	0.9	4.9	0.7	1.2	2.4	6.4
Orthopaedics	0.4	—	1.4	89.6	2.6	—	3.2	0.4	1.3	6.3	0.7	0.4	7.3	6.3
Psychiatry	0.1	—	—	0.2	13.4	—	10.6	—	88.1	—	0.5	0.4	4.9	4.0
General medicine	0.5	—	0.4	—	2.1	—	24.8	—	0.9	2.0	7.5	1.0	4.9	3.9
Paediatrics	0.4	0.1	0.4	1.1	2.1	—	4.4	0.8	—	3.4	7.6	0.4	—	3.0
All other clinical service contexts	2.0	0.9	2.9	2.2	50.9	3.8	31.9	2.0	1.3	13.7	57.8	3.8	53.7	24.3
Not known	0.1	—	—	0.2	0.3	—	2.7	—	—	3.4	0.6	89.3	7.3	6.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)[d]	*816*	*813*	*791*	*451*	*387*	*368*	*339*	*247*	*226*	*205*	*2,425*	*521*	*41*	

(a) This data item provides information on the clinical specialties of the health care provider(s) who played the most prominent role(s) in the incident that gave rise to the claim. There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault. Data for all jurisdictions include the primary and up to three additional specialties, except for NSW, which only include the specialty of primary clinician.

(b) *Other hospital-based medical practitioner* includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(c) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

(d) Up to four different specialities may be recorded for **each** claim (see Table A2.3). This means that some claims are counted more than once in the totals for this table. Therefore, the total numbers (and percentages) in this table do not relate to the actual number of claims.

Note: The specialties and clinical service context categories listed separately are the eight most frequently recorded categories; all other categories are combined in the categories *all other specialties* and *all other clinical service contexts* respectively.

Table 3.3: All claims: primary incident/allegation type, by specialty of clinician(s), 1 July 2005 to 30 June 2006, Australia (per cent)[a]

	Primary incident/ allegation type[b]												
Specialty of clinician(s)[a]	**Diagnosis**	**Medication related**	**Anaesthetic**	**Blood/blood product–related**	**Procedure**	**Treatment**	**Consent**	**Infection control**	**Device failure**	**Other general duty of care**	**Other**	**Not known**	**Total**
General surgery	11.8	0.9	1.8	0.1	72.1	6.6	1.6	1.5	0.4	1.7	0.2	1.3	100.0
Obstetrics only	11.6	1.4	1.6	0.2	57.9	15.5	0.9	1.1	0	2.8	0.7	6.3	100.0
Emergency medicine	59.2	2.9	0.3	0.1	3.8	21.9	0.5	1.0	0.4	6.2	0.9	2.9	100.0
Orthopaedic surgery	15.5	1.6	0.7	0	52.1	12.9	3.3	4.4	1.8	3.5	0.4	3.8	100.0
Other hospital-based medical practitioner[c]	28.2	2.8	0.3	1.0	22.0	14.2	2.3	2.8	0	12.9	8.3	5.2	100.0
Gynaecology only	6.5	1.1	0	0	75.5	3.3	4.6	0.3	2.4	3.3	0.5	2.4	100.0
General nursing	8.3	10.0	0.6	0.3	5.9	17.1	0.6	3.8	1.5	47.5	2.7	1.8	100.0
Obstetrics and gynaecology	8.9	1.2	0.8	0.8	47.0	25.9	5.3	1.2	0.4	4.0	1.6	2.8	100.0
Psychiatry	7.5	4.4	0.4	0	0.4	13.3	1.3	0.0	0	57.1	6.2	9.3	100.0
General anaesthetics	4.4	3.4	59.5	0	15.6	6.3	0.5	1.5	0	4.4	0	4.4	100.0
All other specialties	25.5	5.2	1.1	3.1	26.4	17.1	3.0	2.6	0.7	8.4	1.6	5.3	100.0
Not known	4.0	0.6	0.0	1.0	6.0	4.6	0.6	0.8	0.4	1.9	1.2	79.1	100.0
Not applicable[d]	4.9	2.4	2.4	4.9	7.3	19.5	0	9.8	2.4	24.4	19.5	2.4	100.0
Total	**20.7**	**3.2**	**2.5**	**1.2**	**33.1**	**14.3**	**2.1**	**2.0**	**0.6**	**9.1**	**1.7**	**9.4**	**100.0**
Total (number)[e]	*1,579*	*247*	*188*	*94*	*2,529*	*1,090*	*160*	*150*	*49*	*697*	*132*	*715*	

(a) This data item provides information on the clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim. There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault. Data for all jurisdictions include the primary and up to three additional specialties, except for NSW, which only include the specialty of primary clinician.

(b) See Table 3.1 for definitions of primary incident/allegation type categories.

(c) *Other hospital-based medical practitioner* includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(d) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

(e) Up to four different specialities may be recorded for **each** claim (see Table A2.3). This means that some claims are counted more than once in the totals for this table. Therefore, the total numbers (and percentages) in this table do not relate to the actual number of claims.

Notes

1. Data for approximately 89% of all claims in scope are included.
2. As well as the 'Primary incident/allegation type' category, up to three additional categories may be recorded in the MINC, to describe other aspects of 'what allegedly went wrong'.
3. The specialties listed separately are the 10 most frequently recorded categories; all other categories are combined in the category *all other specialties*.

Geographic location

The majority of claims (4,439 claims, or 64.1%) arose from events that occurred in major cities; 2,368 claims (34.2%) arose from incidents that occurred in r*egional areas*, and 91 claims (1.3%) arose from incidents that occurred in r*emote or very remote areas* (Table 3.4). Of clinical service contexts, *paediatrics* and *psychiatry* had the highest proportion of claims in Major cities (76.4% and 74.0% respectively), while claims involving *general surgery* had the lowest (37.5%). Over half (54.5%) of claims in the clinical service contexts of *general surgery* arose from incidents that occurred in inner regional areas.

When the specialty of clinician(s) involved in claims is examined (Table 3.5) a comparatively high proportion of claims involving the specialties of *diagnostic radiology* (78.1%), *psychiatry* (77.9%) and *obstetrics only* (72.2%) are found to have originated from incidents that occurred in Major cities (Table 3.5). These numbers may reflect administrative arrangements and the concentration of some specialties in metropolitan areas. The highest proportion of claims associated with Remote regions involved *general practice – procedural* (5.0%), *general nursing* (3.5%) and *midwifery* (3.4%).

Table 3.4: All claims: clinical service context, by geographic location, 1 July 2005 to 30 June 2006, Australia (per cent)

	Geographic location where incident occurred[(a)]					
Clinical service context	**Major cities**	**Inner regional**	**Outer regional**	**Remote and Very remote**	**Not known**	**Total**
Obstetrics	69.1	20.8	8.5	1.3	0.3	100.0
General surgery	37.5	54.5	6.7	1.3	0.0	100.0
A&E	63.6	25.5	8.2	2.6	0.1	100.0
Gynaecology	62.4	26.7	9.4	1.6	0.0	100.0
Orthopaedics	59.9	29.7	8.8	1.4	0.2	100.0
Psychiatry	74.0	19.7	4.5	0.4	1.5	100.0
General medicine	62.9	27.3	7.5	2.2	0.0	100.0
Paediatrics	76.4	14.3	7.1	1.6	0.5	100.0
All other clinical service contexts	72.7	19.6	6.6	0.7	0.4	100.0
Not known	73.7	17.9	6.2	0.8	1.4	100.0
Total	**64.1**	**26.8**	**7.4**	**1.3**	**0.3**	**100.0**
Total (number)	*4,439*	*1,856*	*512*	*91*	*24*	*6,922*

(a) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

Notes

1. The 'Clinical service context' categories listed separately are the eight most frequently recorded categories; all other categories are combined in *all other clinical service contexts*.
2. Data for approximately 89% of all claims in scope are included.

Table 3.5: All claims: specialty of clinician(s) involved, by geographic location, 1 July 2005 to 30 June 2006, Australia (per cent)

	Geographic location of incidents						
Specialty of clinician(s)[a]	**Major cities**	**Inner regional**	**Outer regional**	**Remote and Very remote**	**Not known**	**Total**	***Total (number)[b]***
General surgery	29.4	62.0	6.7	1.8	0.0	100.0	*816*
Obstetrics only	72.2	19.6	6.6	1.2	0.4	100.0	*813*
Emergency medicine	66.5	24.5	7.0	2.0	0.0	100.0	*791*
Orthopaedic surgery	59.4	29.9	8.9	1.6	0.2	100.0	*451*
Other hospital-based medical practitioner[c]	62.8	21.2	11.6	2.6	1.8	100.0	*387*
Gynaecology only	62.5	28.5	7.9	1.1	0.0	100.0	*368*
General nursing	67.3	23.0	6.2	3.5	0.0	100.0	*339*
Obstetrics and gynaecology	71.7	17.4	10.1	0.8	0.0	100.0	*247*
Psychiatry	77.9	18.1	3.5	0.4	0.0	100.0	*226*
General anaesthetics	64.4	27.3	7.3	1.0	0.0	100.0	*205*
General practice—non-procedural	24.0	54.6	17.9	3.1	0.5	100.0	*196*
Midwifery	62.8	22.1	11.7	3.4	0.0	100.0	*145*
General practice—procedural	21.6	48.9	23.0	5.0	1.4	100.0	*139*
General and internal medicine	58.7	31.2	8.7	1.4	0.0	100.0	*138*
Diagnostic radiology	78.1	17.2	4.7	0.0	0.0	100.0	*128*
Paediatric medicine	68.3	20.0	10.0	0.8	0.8	100.0	*120*
All other specialties	81.3	12.9	5.1	0.5	0.1	100.0	*1,559*
Not applicable[d]	82.9	4.9	9.8	2.4	0.0	100.0	*41*
Not known	72.9	18.0	6.7	1.0	1.3	100.0	*521*
Total	**64.5**	**26.1**	**7.6**	**1.5**	**0.3**	**100.0**	***7,630***

(a) This data item provides information on the clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim (up to four codes may be recorded). There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault. Data for all jurisdictions include up to four different additional specialties, except for NSW, which only include the primary specialty of clinician.

(b) Up to four different specialities may be recorded for **each** claim (see Table A2.3). This means that some claims are counted more than once in the totals for this table. Therefore, the total numbers (and percentages) in this table do not relate to the actual number of claims.

(c) *Other hospital-based medical practitioner* includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(d) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

Note: The clinical specialties listed separately here are the 16 most frequently recorded specialties; all other specialties are combined in *all other specialties.*

3.2 People

This section provides a profile of the person directly affected by a health care incident. Information on the person's age at the time of the incident, their gender, and the body functions or structures affected is presented.

Age at incident and gender

Table 3.6 contains data on 'Age at incident' and 'Primary incident/allegation type'. During 2005–06, 687 claims (9.9%) related to babies less than 1 year old, 520 claims (7.5%) related to 1–17 year olds, and 4,802 claims (69.4%) involved adults 18 years and over. For 913 claims the age at incident was not known.

Just over half of all claims involved females (3,740 claims; 54.0%), and the majority of these claims concerned adults (2,745 claims, or 73.4% of all females). Females accounted for 66.1% (or 1,139 of 1,723 claims) of all procedure-related incidents for adults.

Males were involved in 2,895 claims (41.8% of total claims) and accounted for 51.5% of all claims relating to babies and 53.8% of claims involving children. Males also accounted for over half (59.1%) of procedure-related claims pertaining to children (75 of 127 claims).

Table 3.6: All claims: gender and age at incident of claim subject, by primary incident/allegation type, 1 July 2005 to 30 June 2006, Australia

	Age at incident				
Primary incident/allegation type	**<1year**	**1–<18 years**	**18+ years**	**Not known**	**Total[a]**
		Males			
Diagnosis	61	82	435	89	667
Medication-related	9	13	67	17	106
Anaesthetic	3	2	46	14	65
Blood/blood product-related	2	4	24	7	37
Procedure	143	75	583	75	876
Treatment	79	53	247	47	426
Consent	6	8	30	9	53
Infection control	8	4	39	10	61
Device failure	0	4	11	3	18
Other general duty of care	14	17	219	56	306
Other	5	2	39	5	51
Not known	24	16	147	42	229
Total males	*354*	*280*	*1,887*	*374*	*2,895*
		Females			
Diagnosis	41	69	515	74	699
Medication-related	12	8	61	19	100
Anaesthetic	3	4	78	12	97
Blood/blood product-related	1	3	26	8	38
Procedure	117	51	1,139	152	1,459
Treatment	67	42	336	69	514
Consent	4	6	58	30	98
Infection control	2	4	52	10	68
Device failure	0	1	23	3	27
Other general duty of care	10	17	231	68	326
Other	7	5	43	8	63
Not known	17	20	183	31	251
Total females	*281*	*230*	*2,745*	*484*	*3,740*
		Persons[b]			
Diagnosis	106	151	950	165	1,372
Medication-related	22	21	128	36	207
Anaesthetic	6	6	124	26	162
Blood/blood product-related	3	7	50	30	90
Procedure	281	127	1,723	230	2,361
Treatment	151	95	584	116	946
Consent	10	14	89	40	153
Infection control	10	8	91	30	139
Device failure	0	5	34	7	46
Other general duty of care	25	34	451	128	638
Other	12	8	84	13	117
Not known	61	44	494	92	691
Total persons	**687**	**520**	**4,802**	**913**	**6,922**

(a) Includes 913 claims for which age at incident of claim subject was missing (374 males, 484 females, 55 not known).

(b) Includes 287 claims for which gender of claim subject was not known/indeterminate (52 babies, 14 children, 166 adult, 55 not known).

Note: Data for approximately 89% of all claims in scope are included.

Primary body function/structure affected

In the MINC, the primary and up to three additional 'body function/structure' areas can be coded. However, this section focuses on the principal body function or structure of the claim subject allegedly affected as a result of an incident. Table 3.7 shows the distribution of claims across body function/structure categories.

Neuromusculoskeletal and movement-related functions and structures was the most commonly recorded primary body function/structure affected as a result of an incident (1,452 claims; 21.0%). The next most commonly recorded categories were *mental functions/structures of the nervous system* (14.0%) and *genitourinary and reproductive functions and structures* (11.5%). There were 683 claims which recorded that the patient died (9.9% of all claims).

Table 3.7: All claims: primary body function/structure[(a)] affected, 1 July 2005 to 30 June 2006, Australia

Primary body function/structure affected	Number	Per cent
Neuromusculoskeletal and movement-related functions and structures	1,452	21.0
Mental functions/structures of the nervous system	972	14.0
Genitourinary and reproductive functions and structures	796	11.5
Functions and structures of the digestive, metabolic and endocrine systems	748	10.8
Death	683	9.9
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	466	6.7
Functions and structures of the skin and related structures	241	3.5
Sensory functions/the eye, ear and related structures	181	2.6
Voice and speech functions/structures involved in voice and speech	83	1.2
No body function/structure affected	155	2.2
Not known	1,145	16.5
All claims	**6,922**	**100.0**

(a) See Appendix 1 for examples of coding categories for body function/structure affected.

Note: Data for approximately 89% of all claims in scope are included.

3.3 Claims

This section summarises the administrative and financial characteristics of all claims, and of current, closed and new claims. A profile of claim status, categories of loss claimed and duration is provided. For closed claims, data on the total claim size and mode of claim finalisation are also presented.

All claims

Status of claim

At 30 June 2006 there were:

- 2,038 claims (29.4% of all claims) that had a reserve placed against them but had not yet commenced
- 3,199 claims (46.3%) that had commenced but were not yet closed
- 1,628 claims (23.5%) that were closed
- 57 claims that had been previously closed and were reopened (0.8%) (Table 3.8).

A claim may be reopened where new evidence arises or there are changes in a claim subject's functioning and/or health that may be attributable to a health-care incident.

As with all aspects of claims, the majority of closed claims (see Table 3.9) related to the 'Primary incident/allegation type' of procedure, diagnosis and treatment (totalling 1,114 claims, or 68.4% of all closed claims).

Table 3.8: All claims: status of claim, 30 June 2006, Australia

	Not yet commenced[(a)]	Commenced[(b)]	Closed[(c)]	Claim previously closed, now reopened[(d)]	Total
All claims	2,038	3,199	1,628	57	6,922
Total (per cent)	29.4	46.3	23.5	0.8	100.0

(a) *Not yet commenced* indicates that a reserve has been set for the claim but none of the events signalling claim commencement (e.g. the issuing of a letter of demand or a writ, or an offer made by the defendant to the claimant) have yet occurred.

(b) *Commence*d indicates that the claim has commenced and remains open. Includes 'Structures settlement – claim file open'.

(c) *Claim file closed* indicates that the total claim size has been determined, and the claim file has been closed. Includes 'Structured settlement – claim file closed'.

(d) *Claim previously closed, now reopened* indicates that the claim has previously been recorded as closed on the MINC database, but has then been re-opened.

Note: Data for approximately 89% of all claims in scope are included.

Table 3.9: All claims: status of claim by primary incident/allegation type, 30 June 2006, Australia

Primary incident/ allegation type	Not yet commenced	Commenced	Total closed	*Total closed (%)*	Claim previously closed now reopened	Total	*Total (%)*
Diagnosis	402	630	326	*20.0*	14	1,372	*19.8*
Medication-related[(a)]	67	93	46	*2.8*	1	207	*3.0*
Anaesthetic	68	47	46	*2.8*	1	162	*2.3*
Blood/blood product–related	26	33	31	*1.9*	0	90	*1.3*
Procedure[(b)]	751	1,047	545	*33.5*	18	2,361	*34.1*
Treatment[(c)]	274	422	243	*14.9*	7	946	*13.7*
Consent[(d)]	28	76	47	*2.9*	2	153	*2.2*
Infection control	38	65	35	*2.1*	1	139	*2.0*
Device failure	15	14	17	*1.0*	0	46	*0.7*
Other general duty of care	232	254	144	*8.8*	8	638	*9.2*
Other	21	68	24	*1.5*	4	117	*1.7*
Not known	116	450	124	*7.6*	1	691	*10.0*
Total	**2,038**	**3,199**	**1,628**	***100.0***	**57**	**6,922**	***100.0***
Total (per cent)	*29.4*	*46.3*	*23.5*	*1.4*	*0.8*	*100.0*	

(a) *Medication-related* includes type and dosage issues, and method of administration issues.

(b) *Procedure* includes failure to perform a procedure, wrong procedure, wrong body site, intra-operative complications, post-operative complications, post-operative infection, failure of procedure, and other procedure-related issues.

(c) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment and other treatment-related issues.

(d) *Consent* includes failure to warn.

Note: Data for approximately 89% of all claims in scope are included.

Categories of loss claimed

The MINC data element 'Nature of claim—loss to claim subject' provides a broad description of the categories of loss allegedly suffered by the claim subject. The average number of categories of loss recorded was 1.4 for all claims during the reporting period (Table 3.10). *Pain and suffering*, including nervous shock, was recorded in 25.9% of claims. *Other loss* accounted for 15.0% of all claims, while *other economic loss* accounted for 14.2%. For over half (53.0%) of all claims, the category of loss was either not known or the information was not applicable.

Table 3.10: All claims: nature of claim—loss to claim subject, 1 July 2005 to 30 June 2006, Australia (per cent)

	Care costs[a]	Other economic loss[b]	Pain and suffering[c]	Other loss[d]	N.A.	Not known	*Total claims*	Average no. of loss categories[e]
Per cent of all claims	12.0	14.2	25.9	15.0	7.8	45.2		—
Total number of claims[f]	832	983	1,792	1,040	540	3,128	*6,922*	1.4

(a) *Care costs* include long-term care costs, covering both past and future care costs, whether provided gratuitously or otherwise.

(b) *Other economic loss* includes past and future economic loss and past and future out-of-pocket expenses; excludes care costs.

(c) *Pain and suffering* includes nervous shock and temporary or ongoing disability; includes general damages.

(d) *Other loss* includes any other loss claimed for, including medical costs (both past and future). Medical costs are costs associated with medical treatment—for example, doctor's fees, hospital expenses.

(e) The average number of coding categories for the data item 'Nature of claim—loss to claim subject' recorded per claim (the average is calculated excluding claims for which not applicable or not known was recorded for 'Nature of claim—loss to claim subject)'.

(f) The total number of claims for which the particular loss category was recorded. A given loss category may only be recorded once for a single claim. However, several loss categories may be recorded for a single claim, so a single claim may be counted in the total for several columns; therefore, these totals cannot be summed horizontally to give the total number of claims overall.

Notes

1. For the NSW data included in this table, loss categories may include loss to other parties, as this is not possible to separately identify.
2. Data for approximately 89% of all claims in scope are included.

Duration of claims

The duration of a claim is measured from the date of reserve placement to 30 June 2006 (for claims open at that date) or to the date the claim was closed (for claims closed before that date).

For all claims the average duration was 2.3 years (Table 3.11). Claims closed during the reporting period had an average length of 2.5 years. There were 137 claims closed during the reporting period which had been open in excess of 5 years (60 months). The majority of commenced claims had been open for three years or less (73.8% claims); commenced claims had been open an average of 2.3 years.

The average duration of claims previously closed but then reopened was 3.4 years. As there is some variation in the coding of reserve date for claims in this category, this length may be an underestimate. Should a claim be reopened, 'date reserve placed' should represent the date when the original reserve was placed, although sometimes the date of reopening is recorded.

New South Wales claims that commenced before 2002 are not included in the 2005–06 reporting period, therefore the average duration of claims presented in this report might be lower than the actual average values (see also tables 3.14 and 3.16).

Current claims

Table 3.12 presents data on 'Reserve range' by 'Clinical service context'. There were 5,294 current claims remaining open at the end of the reporting period. Of these, half (50.2%) had a reserve value of less than $30,000, with 33.6% of all current claims falling within $10,000–$30,000. This reserve range category accounted for a higher proportion of claims in *general medicine* (44.9%), *general surgery* (42.0%) and *accident and emergency* (36.2%).

The reserve value exceeded $500,000 for 399 (7.5%) claims. In the clinical service contexts of *obstetrics* and *paediatrics* this reserve range category constituted 17.2% and 13.7% of claims respectively. Similarly, claims reserved above $100,000 were relatively more common in these clinical service contexts (36.7% and 36.0%, compared with 24.4% overall). Smaller claims (less than $10,000) were more likely in *general medicine* and *psychiatry* (28.5% and 21.4% respectively, compared with 16.6% overall) (Table 3.12).

Table 3.13 presents 'Reserve range' by 'Primary incident/allegation type'. More than half (59.0%) of current claims were reserved at a value less than $50,000. Exceptions to this were *blood/blood product–related* and *consent* related matters, where claims reserved at less than $50,000 constituted 38.9% and 38.6% respectively. In each of these categories there was a relatively high proportion of claims reserved between $50,000 and $100,000 (33.9% and 32.1% respectively, compared with 16.5% of claims overall).

Table 3.11: All claims: status of claim by length of claim (months), 30 June 2006, Australia

Status of claim[(a)]	Length of claim at 30 June 2006 (months)											Total	Mean (years)
	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60		
						Number							
Not yet commenced	194	351	272	297	297	264	155	57	48	29	74	2,038	2.0
Commenced	659	556	364	307	210	195	189	152	94	69	404	3,199	2.3
Closed	158	243	186	159	185	180	188	92	55	45	137	1,628	2.5
Claim previously closed now reopened	1	3	3	6	6	11	10	2	2	1	12	57	3.4
Total claims	**1,012**	**1,153**	**825**	**769**	**698**	**650**	**542**	**303**	**199**	**144**	**627**	**6,922**	**2.3**
						Per cent							
Not yet commenced	9.5	17.2	13.3	14.6	14.6	13.0	7.6	2.8	2.4	1.4	3.6	100.0	
Commenced	20.6	17.4	11.4	9.6	6.6	6.1	5.9	4.8	2.9	2.2	12.6	100.0	
Closed	9.7	14.9	11.4	9.8	11.4	11.1	11.5	5.7	3.4	2.8	8.4	100.0	
Claim previously closed now reopened	1.8	5.3	5.3	10.5	10.5	19.3	17.5	3.5	3.5	1.8	21.1	100.0	
Total claims (%)	**14.6**	**16.7**	**11.9**	**11.1**	**10.1**	**9.4**	**7.8**	**4.4**	**2.9**	**2.1**	**9.1**	**100.0**	

(a) See Table 3.8 for definitions of status of claim categories.

Notes

1. Length of claim is from date reserve placed to 30 June 2006. If a claim has a status of 'claim file closed', length of claim is from the date the reserve is placed to the date the claim was closed.
2. Data for approximately 89% of all claims in scope are included.

Table 3.12: Current claims: reserve range, by clinical service context, 30 June 2006, Australia

	Clinical service context										
Reserve range ($)	**Obstetrics**	**General surgery**	**A&E**	**Gynaecology**	**Orthopaedics**	**Psychiatry**	**General medicine**	**Paediatrics**	**All other clinical service contexts**	**Not known**	**Total**
						Number					
Less than 10,000	83	132	151	49	63	45	61	18	225	51	878
10,000–<30,000	276	338	266	116	107	69	96	39	388	85	1,780
30,000–<50,000	47	186	47	33	24	10	12	7	77	24	467
50,000–<100,000	149	90	118	65	64	45	21	25	245	50	872
100,000–<250,000	114	37	77	45	34	13	13	21	171	91	616
250,000–<500,000	57	19	31	11	19	16	5	10	71	43	282
500,000 or more	151	2	44	6	14	12	6	19	80	65	399
Total	**877**	**804**	**734**	**325**	**325**	**210**	**214**	**139**	**1,257**	**409**	**5,294**
						Per cent					
Less than 10,000	9.5	16.4	20.6	15.1	19.4	21.4	28.5	12.9	17.9	12.5	16.6
10,000–<30,000	31.5	42.0	36.2	35.7	32.9	32.9	44.9	28.1	30.9	20.8	33.6
30,000–<50,000	5.4	23.1	6.4	10.2	7.4	4.8	5.6	5.0	6.1	5.9	8.8
50,000–<100,000	17.0	11.2	16.1	20.0	19.7	21.4	9.8	18.0	19.5	12.2	16.5
100,000–<250,000	13.0	4.6	10.5	13.8	10.5	6.2	6.1	15.1	13.6	22.2	11.6
250,000–<500,000	6.5	2.4	4.2	3.4	5.8	7.6	2.3	7.2	5.6	10.5	5.3
500,000 or more	17.2	0.2	6.0	1.8	4.3	5.7	2.8	13.7	6.4	15.9	7.5
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'Clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in *all other clinical service contexts*. Table A2.2 shows the frequency of claims for all clinical service contexts.
2. Data for approximately 89% of all claims in scope are included.

Table 3.13: Current claims: reserve range, by primary incident/allegation type, 30 June 2006, Australia

Reserve range ($)	Primary incident/allegation type												
	Diagnosis	Medication-related[(a)]	Anaesthetic	Blood/ blood product-related	Procedure[(b)]	Treatment[(c)]	Consent[(d)]	Infection control	Device failure	Other general duty of care	Other	Not known	Total
						Number							
Less than 10,000	147	31	35	12	229	130	10	28	10	130	17	99	878
10,000–<30,000	338	55	43	11	705	227	23	26	9	187	31	125	1,780
30,000–<50,000	76	12	3	0	234	58	8	9	5	27	4	31	467
50,000–<100,000	194	20	16	20	294	118	34	16	3	63	22	72	872
100,000–<250,000	131	22	10	12	176	80	14	13	2	38	13	105	616
250,000–<500,000	62	8	7	1	76	34	7	7	0	24	3	53	282
500,000 or more	98	13	2	3	102	56	10	5	0	25	3	82	399
Total	**1,046**	**161**	**116**	**59**	**1,816**	**703**	**106**	**104**	**29**	**494**	**93**	**567**	**5,294**
						Per cent							
Less than 10,000	14.1	19.3	30.2	20.3	12.6	18.5	9.4	26.9	34.5	26.3	18.3	17.5	16.6
10,000–<30,000	32.3	34.2	37.1	18.6	38.8	32.3	21.7	25.0	31.0	37.9	33.3	22.0	33.6
30,000–<50,000	7.3	7.5	2.6	0	12.9	8.3	7.5	8.7	17.2	5.5	4.3	5.5	8.8
50,000–<100,000	18.5	12.4	13.8	33.9	16.2	16.8	32.1	15.4	10.3	12.8	23.7	12.7	16.5
100,000–<250,000	12.5	13.7	8.6	20.3	9.7	11.4	13.2	12.5	6.9	7.7	14.0	18.5	11.6
250,000–<500,000	5.9	5.0	6.0	1.7	4.2	4.8	6.6	6.7	0	4.9	3.2	9.3	5.3
500,000 or more	9.4	8.1	1.7	5.1	5.6	8.0	9.4	4.8	0	5.1	3.2	14.5	7.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) *Medication-related* includes type, dosage and method of administration issues.

(b) *Procedure* includes failure to perform procedure, wrong procedure, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(c) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(d) *Consent* includes failure to warn.

Note: Data for approximately 89% of claims in scope are included.

Duration of current claims

The average duration of current claims varied between 1.7 years and 4 years, and increased with reserve range (Table 3.14). Claims with a reserve of $500,000 or more had been open, on average, for 4 years, while claims with a reserve value of less than $10,000 had a mean duration of over one-and-a-half years.

New claims

Table 3.15 indicates that there were 1,943 new claims during the reporting period. These were most commonly associated with the clinical service contexts of *general surgery* (514 claims, or 26.5% of all new claims), *obstetrics* (247 claims; 12.7%) and *accident and emergency* (238 claims; 12.2%). Of all new claims, 62.8% (1,220 claims) were reserved for less than $30,000 and 2.5% (49 claims) had a reserve exceeding $500,000.

Closed claims

A claim is closed when the claim is settled via negotiations, a final court decision is made, or the claim is discontinued. During 2005–06, 1,628 claims were closed (see Box 2.1 on page 9).

Table 3.16 shows 'Total claim size' by 'Mode of claim finalisation' for closed claims. Most closed claims, including claims with a total size of $0, had a total claim size of less than $100,000 (1,356 claims; 83.3% of all closed claims). In 62 claims payments were in excess of $500,000. Of those claims in the smallest payment category (less than $10,000), 387 claims, or 73.4%, were *discontinued*. Discontinued claims constituted just over half of all closed claims (51.5%, or 838 claims). Any payments associated with discontinued claims are likely to be attributable to legal costs for either or both parties[4].

Settlement was the second most common method of finalisation. Of closed claims, 679 (or 41.7%) underwent a settlement process. A claim can be settled in a number of ways. *Court-based alternative dispute resolution processes* (148 claims; 9.1% of closed claims) and *other settlement processes* (including settlement part-way through a trial) (470 claims; 28.9%) were most common in settled claims. *Court decision* was involved in 3.9%, or 63 claims. Of these 63 claims, 17.5% involved a payment exceeding $250,000.

In 458 cases (28.1% of all closed claims) no payment was made to the claimant and no legal costs were incurred. Most of these were *discontinued* claims (373, or 81.4%).

4 *Total claim size* is the amount agreed to be paid to the claimant in total settlement, including any interim payments, claimant legal costs and defence legal costs.

Table 3.14: Current claims: reserve range, by length of claim (months), 30 June 2006, Australia

	Length of claim at 30 June 2006 (months)												
Reserve range ($)	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**	**Mean (years)**
						Number							
Less than 10,000	187	166	110	120	89	93	49	13	15	8	28	878	1.7
10,000–<30,000	344	357	200	210	216	176	116	46	32	14	69	1,780	1.8
30,000–<50,000	112	85	67	26	33	30	33	21	12	6	42	467	2.0
50,000–<100,000	95	147	121	113	75	81	63	33	24	18	102	872	2.4
100,000–<250,000	59	98	81	76	46	39	42	47	28	14	86	616	2.7
250,000–<500,000	37	28	27	33	25	22	21	21	17	8	43	282	3.0
500,000 or more	20	29	33	32	29	29	30	30	16	31	120	399	4.0
Total	**854**	**910**	**639**	**610**	**513**	**470**	**354**	**211**	**144**	**99**	**490**	**5,294**	**2.2**
						Per cent							
Less than 10,000	21.3	18.9	12.5	13.7	10.1	10.6	5.6	1.5	1.7	0.9	3.2	100.0	
10,000–<30,000	19.3	20.1	11.2	11.8	12.1	9.9	6.5	2.6	1.8	0.8	3.9	100.0	
30,000–<50,000	24.0	18.2	14.3	5.6	7.1	6.4	7.1	4.5	2.6	1.3	9.0	100.0	
50,000–<100,000	10.9	16.9	13.9	13.0	8.6	9.3	7.2	3.8	2.8	2.1	11.7	100.0	
100,000–<250,000	9.6	15.9	13.1	12.3	7.5	6.3	6.8	7.6	4.5	2.3	14.0	100.0	
250,000–<500,000	13.1	9.9	9.6	11.7	8.9	7.8	7.4	7.4	6.0	2.8	15.2	100.0	
500,000 or more	5.0	7.3	8.3	8.0	7.3	7.3	7.5	7.5	4.0	7.8	30.1	100.0	
Total (%)	**16.1**	**17.2**	**12.1**	**11.5**	**9.7**	**8.9**	**6.7**	**4.0**	**2.7**	**1.9**	**9.3**	**100.0**	

Notes

1. Length of claim is from the date the reserve was placed to 30 June 2006.
2. Data for approximately 89% of all claims in scope are included.

Table 3.15: New claims: reserve range, by clinical service context, 1 July 2005 to 30 June 2006, Australia

Reserve range ($)	General surgery	Obstetrics	A&E	Orthopaedics	Gynaecology	General medicine	Psychiatry	General practice	All other clinical service contexts	Not known	Total	Per cent
Less than 10,000	83	46	69	40	19	22	13	18	123	38	471	24.2
10,000–<30,000	239	103	97	45	27	31	30	8	133	36	749	38.5
30,000–<50,000	147	12	10	9	5	1	3	5	11	1	204	10.5
50,000–<100,000	30	37	30	17	18	5	9	8	65	25	244	12.6
100,000–<250,000	11	25	22	7	7	1	3	7	51	27	161	8.3
250,000–<500,000	4	10	5	1	1	0	1	6	23	14	65	3.3
500,000 or more	0	14	5	2	0	1	0	3	15	9	49	2.5
Total	**514**	**247**	**238**	**121**	**77**	**61**	**59**	**55**	**421**	**150**	**1,943**	**100.0**

Notes

1. The 'Clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in *all other clinical service contexts*. Appendix 2, Table A2.2 shows the frequency of coding categories for all clinical service contexts for all claims.
2. Data for approximately 89% of all claims in scope are included.

Table 3.16: Closed claims: total claim size, by mode of claim finalisation, 1 July 2005 to 30 June 2006, Australia

	Settled								
Total claim size ($)	State/territory complaints process [a]	Court-based alternative dispute resolution process [b]	Statutorily mandated compulsory conference process[c]	Settled—other[d]	Total settled	Court decision	Discontinued[e]	Not known	Total
0[f]	11	0	0	43	54	9	373	22	458
Less than 10,000	8	4	0	117	129	9	387	2	527
10,000–<30,000	14	12	5	90	121	12	56	1	190
30,000–<50,000	4	19	3	39	65	4	11	1	81
50,000–<100,000	0	31	3	59	93	6	1	0	100
100,000–<250,000	0	51	11	66	128	11	2	1	142
250,000–<500,000	1	12	1	24	38	4	0	0	42
500,000 or more	0	19	0	32	51	7	4	0	62
Not known	0	0	0	0	0	1	4	21	26
Total	**38**	**148**	**23**	**470**	**679**	**63**	**838**	**48**	**1,628**

(a) *State/territory-based complaints processes* include proceedings conducted in state or territory health rights and health complaints bodies.

(b) *Court-based alternative dispute resolution processes* includes mediation, arbitration, and case appraisal provided under civil procedure rules.

(c) *Statutorily-mandated compulsory conference processes* includes settlement conferences required by statute as part of a pre-court process.

(d) *Settled–other* includes instances where a claim is settled part-way through a trial.

(e) *Discontinued* includes claims that have been closed due to withdrawal by claimant or operation of statute of limitations or where the claim manager decides to close the claim file because of long periods of inactivity. *Discontinued* also includes instances where a claim is discontinued part-way through a trial.

(f) The claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Note: Data for approximately 89% of all claims in scope are included.

Duration of closed claims

Table 3.17 shows the relationship between claim size and duration. Claims with a total claim size of less than $10,000 were open an average of 23.6 months, while those that settled for above $500,000 were closed, on average, in 53.5 months. The mean duration for all closed claims was 30.1 months.

Table 3.17: Closed claims: total claim size, by length of claim (months), Australia

	Length of claim at 30 June 2006 (months)							
Total claim size ($)	**<12**	**13–24**	**25–36**	**37–48**	**49–60**	**>60**	**Total**	**Mean (months)**
				Number				
0[(a)]	129	86	140	80	7	16	458	26.0
Less than 10,000	191	126	95	68	21	26	527	23.6
10,000–<30,000	47	39	33	35	16	20	190	31.6
30,000–<50,000	8	18	12	18	10	15	81	40.5
50,000–<100,000	4	33	21	23	8	11	100	35.2
100,000–<250,000	12	20	42	27	18	23	142	41.6
250,000–<500,000	0	9	9	8	7	9	42	47.7
500,000 or more	1	6	11	15	13	16	62	53.5
Not known	9	8	2	6	0	1	26	22.5
Total	**401**	**345**	**365**	**280**	**100**	**137**	**1,628**	**30.1**
				Per cent				
0[(a)]	28.2	18.8	30.6	17.5	1.5	3.5	100.0	
Less than 10,000	36.2	23.9	18.0	12.9	4.0	4.9	100.0	
10,000–<30,000	24.7	20.5	17.4	18.4	8.4	10.5	100.0	
30,000–<50,000	9.9	22.2	14.8	22.2	12.3	18.5	100.0	
50,000–<100,000	4.0	33.0	21.0	23.0	8.0	11.0	100.0	
100,000–<250,000	8.5	14.1	29.6	19.0	12.7	16.2	100.0	
250,000–<500,000	0.0	21.4	21.4	19.0	16.7	21.4	100.0	
500,000 or more	1.6	9.7	17.7	24.2	21.0	25.8	100.0	
Not known	34.6	30.8	7.7	23.1	0.0	3.8	100.0	
Total	**24.6**	**21.2**	**22.4**	**17.2**	**6.1**	**8.4**	**100.0**	

(a) The claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Notes

1. Length of claim is from date reserve was placed to 30 June 2006. If a claim has a status of 'claim file closed', length of claim is from the date the reserve was placed to the date the claim was closed.
2. Data for approximately 89% of all claims in scope are included.

4 Public sector medical indemnity claims data 2003–04 to 2005–06

This section presents an overview of MINC data from the available reporting periods, 2003–04, 2004–05 and 2005–06.

The data for each reporting period should be interpreted and compared with caution, since there have been significant changes in data completeness and *not known* rates, and this will affect the comprability of the data. The percentage of claims in scope rose from 80.0% to 89.0% over the three years of the MINC collection (Table 4.1).

In addition, the review processes occurring in some jurisdictions may affect the number, nature and trends of medical indemnity data, and any implications of tort law reform might not necessarily be immediately evident.

4.1 Data completeness and claim status

Data completeness improved from 80% of captured claims in scope in the first full-year reporting period 2003–04 to 89% in 2005–06 (Table 4.1).

Overall claim numbers rose over the 3 years of the MINC collection, from 4,956 in 2003–04 to 6,922 in 2005–06. This may not accurately reflect an actual rise in claims over this period and may be affected by the overall improvement in the scope of the collection.

Closed claims, as a percentage of total claims rose from 17.4% in the first year of the MINC to around one-quarter of all claims in the following 2 years. For these reasons, the data presented in this section should be interpreted with caution.

Table 4.1: All claims: 2003–04 to 2005–06

	2003–04	2004–05	2005–06
New claims[(a)]	1,641	1,641	1,943
Current claims	4,096	4,773	5,294
Closed claims	860	1,680	1,628
All claims[(b)]	**4,956**	**6,453**	**6,922**
Percentage of all claims in scope	*80.0*	*85.0*	*89.0*
		Per cent	
Current claims	82.6	74.0	76.5
Closed claims	17.4	26.0	23.5
All claims	*100.0*	*100.0*	*100.0*

(a) New claims are claims that were opened during the reporting period, including those that were closed during the period. See Box 2.1 on page 9 for a detailed explanation of the counting rules for the MINC dataset.

(b) All claims is the total set of claims in the MINC during the reporting periods the sum of the closed and current claims, including all claims that were open at the start of the period.

Clinical service context

The clinical service context is the area of clinical practice in which the patient was receiving a health-care service when the incident that gave rise to the claim occurred.

Obstetrics was most frequently recorded clinical service context for the last three reporting periods (Table 4.2). The proportions of claims for which gynaecology, orthopaedics and psychiatry were reported as the clinical service context decreased between 2003–04 and 2005–06.

Table 4.2: All claims: clinical service context, 2003–04 to 2005–06

Clinical service context	2003–04	2004–05	2005–06
		Number	
Obstetrics	825	1,141	1,156
General surgery	561	721	1,004
A&E	710	940	935
Gynaecology	414	508	449
Orthopaedics	386	450	444
Psychiatry	234	277	269
General medicine	204	295	267
Paediatrics	135	190	182
All other clinical service contexts	1,294	1,733	1,718
Not known	193	198	498
Total	**4,956**	**6,453**	**6,922**
		Per cent	
Obstetrics	16.6	17.7	16.7
General surgery	11.3	11.2	14.5
A&E	14.3	14.6	13.5
Gynaecology	8.4	7.9	6.5
Orthopaedics	7.8	7.0	6.4
Psychiatry	4.7	4.3	3.9
General medicine	4.1	4.6	3.9
Paediatrics	2.7	2.9	2.6
All other clinical service contexts	26.1	26.9	24.8
Not known	3.9	3.1	7.2
Total	*100.0*	*100.0*	*100.0*

Notes

1. The 'Clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *all other clinical service contexts*. Table A2.2 shows the frequency of coding categories for all clinical service contexts.
2. As well as the 'Primary incident/allegation type' category, up to three additional categories may be recorded in the MINC to describe other aspects of 'what went wrong'.

Geographic location

The majority of claims in the last three reporting periods arose from incidents that occurred in Major cities (68.0% in 2003–04, 68.3% in 2004–05 and 64.1% in 2005–06) (Table 4.3). The proportion of claims from events that occurred in Inner regional areas increased from 21.4% in 2003–04 to 22.1% in 2004–05 and 26.8% in 2005–06.

Table 4.3: All claims: geographic location, 2003–04 to 2005–06

Geographic location where incident occurred[(a)]	2003–04	2004–05	2005–06
		Number	
Major cities	3,369	4,407	4,439
Inner regional	1,059	1,425	1,856
Outer regional	434	505	512
Remote and Very remote	75	91	91
Not known	19	25	24
Total	**4,956**	**6,453**	**6,922**
		Per cent	
Major cities	68.0	68.3	64.1
Inner regional	21.4	22.1	26.8
Outer regional	8.8	7.8	7.4
Remote and Very remote	1.5	1.4	1.3
Not known	0.4	0.4	0.3
Total	*100.0*	*100.0*	*100.0*

(a) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

4.2 People

Primary body function/structure affected

The pattern of reporting of 'Primary body function/structure affected' remained largely unchanged between 2003–04 and 2005–06. *Neuromusculoskeletal and movement-related functions and structures* were the most commonly recorded primary body function/structure affected as result of the incident that gave rise to the claim, accounting for just under one-quarter of claims in the last three reporting periods (22.5% in 2003–04, 23.6% in 2004–05 and 21.0% in 2005–06) (Table 4.4). The proportion of claims involving allegation of harm to *functions and structures of the digestive* and *metabolic and endocrine systems* increased over the period.

Table 4.4: All claims: primary body function/structure[(a)] affected, 2003–04 to 2005–06

Primary body function/structure affected	2003–04	2004–05	2005–06
		Number	
Neuromusculoskeletal and movement-related functions and structures	1,117	1,522	1,452
Mental functions/structures of the nervous system	635	957	972
Genitourinary and reproductive functions and structures	679	867	796
Functions and structures of the digestive, metabolic and endocrine systems	425	578	748
Death	456	592	683
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	334	468	466
Functions and structures of the skin and related structures	218	250	241
Sensory functions/the eye, ear and related structures	144	195	181
Voice and speech functions/structures involved in voice and speech	74	93	83
No body function/structure affected	145	159	155
Not known	729	772	1,145
All claims	**4,956**	**6,453**	**6,922**
		Per cent	
Neuromusculoskeletal and movement-related functions and structures	22.5	23.6	21.0
Mental functions/structures of the nervous system	12.8	14.8	14.0
Genitourinary and reproductive functions and structures	13.7	13.4	11.5
Functions and structures of the digestive, metabolic and endocrine systems	8.6	9.0	10.8
Death	9.2	9.2	9.9
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	6.7	7.3	6.7
Functions and structures of the skin and related structures	4.4	3.9	3.5
Sensory functions/the eye, ear and related structures	2.9	3.0	2.6
Voice and speech functions/structures involved in voice and speech	1.5	1.4	1.2
No body function/structure affected	2.9	2.5	2.2
Not known	14.7	12.0	16.5
All claims	*100.0*	*100.0*	*100.0*

(a) See Appendix 1 for an explanation of coding categories for 'Body function/structure affected'.

4.3 Claims

Primary incident/allegation type

'Primary incident/allegation type' data describe what is alleged to have 'gone wrong', that is, the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim. Table 4.5 shows that over the past three reporting periods, the proportion of claims reporting *procedure* as the primary incident/allegation type increased (32.8% in 2003–04, 33.5% in 2004–05 and 34.1% in 2005–06) whilst the proportion for which other primary incident/allegation types were represented decreased or remained stable. The percentage of claims for which primary incident/allegation type is currently unknown rose to 10.0% from 4.7% in 2004–05.

Table 4.5: All claims: primary incident/allegation type, 2003–04 to 2005–06

Primary incident/ allegation type	2003–04	2004–05	2005–06	2003–04	2004–05	2005–06
	Number			Per cent		
Diagnosis	1,028	1,324	1,372	20.7	20.5	19.8
Medication-related[(a)]	167	237	207	3.4	3.7	3.0
Anaesthetic	126	177	162	2.5	2.7	2.3
Blood/blood product–related	71	104	90	1.4	1.6	1.3
Procedure[(b)]	1,627	2,163	2,361	32.8	33.5	34.1
Treatment[(c)]	676	947	946	13.6	14.7	13.7
Consent[(d)]	187	213	153	3.8	3.3	2.2
Infection control	112	151	139	2.3	2.3	2.0
Device failure	53	65	46	1.1	1.0	0.7
Other general duty of care	512	674	638	10.3	10.4	9.2
Other	77	92	117	1.6	1.4	1.7
Not known	320	306	691	6.5	4.7	10.0
Total	**4,956**	**6,453**	**6,922**	**100.0**	**100.0**	**100.0**

(a) *Medication*-related includes type and dosage issues, and method of administration issues.

(b) *Procedure* includes failure to perform a procedure, wrong procedure, wrong body site, intra-operative complications, post-operative complications, post-operative infection, failure of procedure, and other procedure-related issues.

(c) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment and other treatment-related issues.

(d) *Consent* includes failure to warn.

Reserve range

Table 4.6 presents the trends in reserve ranges of claims from 2003–04 to 2005–06. The reserve placed on a claim is the best current estimate of the size of the claim (total claim size). The reserve may be revised over the life of the claim.

Over half of all new claims were reserved for less than $30,000 in the last three reporting periods (61.8% in 2003–04, 60.0% in 2004–05 and 62.7% in 2005–06).

In the last three reporting years, around half of all current claims were reserved for less than $30,000 (52.1% in 2003–04, 51.7% in 2004–05 and 50.2% in 2005–06).

Current claims with a reserve exceeding $500,000 increased from 5.0% in 2003–04 to 7.5% in 2005–06 while new claims with a reserve more than $500,000 remained stable.

Table 4.6: Current and new claims: reserve range, 2003–04 to 2005–06

	Current claims			New claims		
Reserve range ($)	**2003–04**	**2004–05**	**2005–06**	**2003–04**	**2004–05**	**2005–06**
			Number			
Less than 10,000	771	868	878	436	444	471
10,000–<30,000	1,365	1,599	1,780	577	540	749
30,000–<50,000	416	383	467	137	101	204
50,000–<100,000	728	936	872	293	303	244
100,000–<250,000	445	512	616	118	147	161
250,000–<500,000	167	203	282	45	51	65
500,000 or more	204	272	399	35	55	49
Total	**4,096**	**4,773**	**5,294**	**1,641**	**1,641**	**1,943**
			Per cent			
Less than 10,000	18.8	18.2	16.6	26.6	27.1	24.2
10,000–<30,000	33.3	33.5	33.6	35.2	32.9	38.5
30,000–<50,000	10.2	8.0	8.8	8.3	6.2	10.5
50,000–<100,000	17.8	19.6	16.5	17.9	18.5	12.6
100,000–<250,000	10.9	10.7	11.6	7.2	9.0	8.3
250,000–<500,000	4.1	4.3	5.3	2.7	3.1	3.3
500,000 or more	5.0	5.7	7.5	2.1	3.4	2.5
Total (%)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

Total claim size

In the three last reporting periods, over three-quarters of closed claims (80.0% in 2003–04, 87.6% in 2004–05 and 83.3% in 2005–06) were closed with a total claim size of less than $100,000 each (Table 4.7). Those claims that were closed for between $100,000 and $250,000 increased from 4.0% in 2003–04 to 8.7% in 2005–06.

The percentage of closed claims for which no payment was made increased from 17.2% in 2003–04 to 28.1% in 2005–06. There was a decrease in the percentage of closed claims for which the total claim size was recorded as *not known* between 2003–04 and 2005–06.

Table 4.7: Closed claims: total claim size, 2003–04 to 2005–06

	Closed claims					
Total claim size ($)	**2003–04**	**2004–05**	**2005–06**	**2003–04**	**2004–05**	**2005–06**
	Number			**Per cent**		
$0[(a)]	148	343	458	17.2	20.4	28.1
Less than 10,000	318	700	527	37.0	41.7	32.4
10,000–<30,000	110	189	190	12.8	11.3	11.7
30,000–<50,000	45	90	81	5.2	5.4	5.0
50,000–<100,000	67	148	100	7.8	8.8	6.1
100,000–<250,000	34	88	142	4.0	5.2	8.7
250,000–<500,000	12	38	42	1.4	2.3	2.6
500,000 or more	15	27	62	1.7	1.6	3.8
Not known	111	57	26	12.9	3.4	1.6
Total	**860**	**1680**	**1628**	**100.0**	**100.0**	**100.0**

(a) The claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Appendix 1 Body function/structure categories

Table A1.1: Coding examples for body function/structure categories

Body function/structure coding category		Examples of types of harm alleged/claimed
1.	Mental functions/structures of the nervous system	Psychological harm—for example, nervous shock
		Subdural haematoma
		Cerebral palsy
2.	Sensory functions/the eye, ear and related structures	Vestibular impairment
		Injury to the structure of the eye or ear
3.	Voice and speech functions/structures involved in voice and speech	Dental injuries
		Injuries to the structure of the nose or mouth
4.	Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	Injury to the spleen or lungs
		Generalised infection
		Deep vein thrombosis/pulmonary embolism
		Vascular or artery damage
		Conditions affecting major body systems—such as cancer that has progressed and no longer affects a single body part or system
5.	Functions and structures of the digestive, metabolic and endocrine systems	Hepatitis
		Injury to the gall bladder, bowel or liver
6.	Genitourinary and reproductive functions and structures	Injury to the breast
		Injury to male or female reproductive organs
		Injury to the kidney
		Injury to the bladder
7.	Neuromusculoskeletal and movement-related functions and structures	Loss of function due to inappropriate casting of joint
8.	Functions and structures of the skin and related structures	Burns
9.	Death	‘Death’ is recorded where the incident was a contributory cause of the death of the claim subject
10.	No body functions/structures affected	Failed sterilisation, where there is no consequent harm to body functions or structures

Appendix 2 Detailed tables

Table A2.1: All claims: number of claims for which each clinical service context recorded, 1 July 2005 to 30 June 2006, Australia

Clinical service context	Number	Per cent
Obstetrics	1,156	16.7
General surgery	1,004	14.5
Accident and emergency	935	13.5
Gynaecology	449	6.5
Orthopaedics	444	6.4
Psychiatry	269	3.9
General medicine	267	3.9
Paediatrics	182	2.6
General practice	166	2.4
Cardiology	136	2.0
Neurology	120	1.7
Dentistry	109	1.6
Urology	82	1.2
Ear, nose and throat	81	1.2
Radiology	72	1.0
Hospital outpatient department	67	1.0
Oncology	65	0.9
Perinatology	49	0.7
Plastic surgery	32	0.5
Cosmetic procedures	21	0.3
Other	718	10.4
Not known	498	7.2
Total	**6,922**	**100.0**

Notes

1. All clinical service contexts are included in this table. *Other* can only be used where no other clinical service context is applicable.
2. Data for approximately 89% of all claims in scope are included.

Table A2.2: Specialties of clinicians closely involved in incident: frequency of coding categories recorded for all claims, 1 July 2005 to 30 June 2006, Australia

Specialty of clinician	Number	Per cent of all recorded specialty categories
General surgery	816	10.7
Obstetrics only	813	10.7
Emergency medicine	791	10.4
Orthopaedic surgery	451	5.9
Other hospital-based medical practitioner[(a)]	387	5.1
Gynaecology only	368	4.8
Nursing—general	339	4.4
Obstetrics and gynaecology	247	3.2
Psychiatry	226	3.0
Anaesthetics—general	205	2.7
General practice—non procedural	196	2.6
Midwifery	145	1.9
General practice—procedural	139	1.8
General and internal medicine	138	1.8
Diagnostic radiology	128	1.7
Paediatric medicine	120	1.6
Neurosurgery	104	1.4
Cardiology	98	1.3
Pathology	90	1.2
Intensive care	88	1.2
Neonatology	85	1.1
Clinical haematology	78	1.0
Urology	73	1.0
Ear, nose and throat	72	0.9
Ophthalmology	62	0.8
Dentistry—oral surgery	60	0.8
Plastic surgery	56	0.7
Paediatric surgery	54	0.7
Gastroenterology	51	0.7
Dentistry—procedural	49	0.6
Cardiothoracic surgery	48	0.6
Other allied health	47	0.6
Colorectal surgery	45	0.6
Vascular surgery	45	0.6
Medical oncology	42	0.6
Neurology	41	0.5
Paramedical and ambulance staff	39	0.5
Physiotherapy	24	0.3
Anaesthetics—intensive care	23	0.3
Infectious diseases	20	0.3
Nuclear medicine	18	0.2

(continued)

Table A2.2 (continued): Specialties of clinicians closely involved in incident: frequency of coding categories recorded for all claims, 1 July 2005 to 30 June 2006, Australia

Specialty of clinician	Number	Per cent of all recorded specialty categories
Cosmetic surgery	13	0.2
Endocrinology	13	0.2
Renal medicine	13	0.2
Public health/preventive medicine	12	0.2
Clinical genetics	9	0.1
Geriatrics	9	0.1
Rehabilitation medicine	9	0.1
Respiratory medicine	9	0.1
Dermatology	7	0.1
Endoscopy	7	0.1
Facio-maxillary surgery	7	0.1
Therapeutic radiology	7	0.1
Podiatry	6	0.1
Spinal surgery	5	0.1
Pharmacy	4	0.1
Rheumatology	4	0.1
Psychology	3	<0.1
Thoracic medicine	3	<0.1
Clinical immunology	2	<0.1
Nursing—nurse practitioner	2	<0.1
Clinical pharmacology	1	<0.1
Occupational medicine	1	<0.1
Osteopathy	1	<0.1
Chiropractics	0	0
Nutrition/dietician	0	0
Sports medicine	0	0
N.A.[(b)]	41	0.5
Not known	521	6.8
Total[(c)]	**7630**	**100.0**

(a) Other hospital-based medical practitioner includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(b) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

(c) Total number of specialty categories recorded. Since up to four specialty codes can be recorded for a single claim, the total may be greater than the total number of claims in all jurisdictions.

Table A2.3: Specialty of clinicians closely involved in incident: percentage of claims with one, two, three and four specialty codes recorded, 1 July 2005 to 30 June 2006, Australia

	One specialty only	Two specialties	Three specialties	Four specialties	Total
Number	6,335	483	87	17	6,922
Per cent	91.5	7.0	1.3	0.2	100.0

Appendix 3 Background to the MINC collection

Background to the collection

The need for a national medical indemnity collection arose in the broader context of national policy concerns about health-care litigation, the associated costs, and the financial viability of both medical indemnity insurers and medical personnel. The absence of national data compromised any robust analysis of trends in the number, nature and cost of medical indemnity claims.

At the Medical Indemnity Summit in April 2002, Health Ministers decided that a 'national database for medical negligence claims' should be established, to assist in determining future medical indemnity strategies. MIDWG was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). On 3 July 2002 AHMAC decided to commission the AIHW to work with the MIDWG to further develop proposals for a national medical indemnity data collection for the public sector.

Purposes of the collection

The primary purposes of the MINC are to:

- obtain ongoing information on medical indemnity claims and their outcomes
- provide a national information base on nationally aggregated data to help policy makers identify trends in the nature, incidence and cost of medical indemnity claims
- provide an evidence base from which policy makers can develop and monitor measures to minimise the incidence of medical indemnity claims and the associated costs.

In future, when agreed by the MIDWG, MINC aggregated data may supplement other sources of:

- national medical indemnity claims data, to allow the financial stability of the medical indemnity system to be monitored
- information on clinical risk prevention and management.

Collaborative arrangements

The MINC is governed by an agreement between the Australian Government, state and territory health departments, and the AIHW. The agreement outlines the respective roles, responsibilities and collaborative arrangements of all parties.

The MIDWG, comprising representatives from state, territory and Commonwealth health authorities and the AIHW, manages the development and administration of the MINC. The MIDWG advises on and reaches agreement on all data resource products, public release of aggregated data, and MINC-related matters. It reports on statistical matters to the Statistical Information Management Committee.

The AIHW is the national data custodian of the MINC and is responsible for collection, quality control, management and reporting of MINC data. High-quality data management is ensured by the data custodian through observance of:

- the Information Privacy Principles and National Privacy Principles (*The Privacy Act 1988*), which govern the conduct of all Australian government agencies and private organisations in their collection, management, use and disclosure of personal records
- documented policies and procedures, approved by the AIHW board, addressing information security and privacy.

MINC jurisdictional data are unidentifiable and treated in confidence by the AIHW in all phases of collection and custodianship. Any release or publication of MINC aggregated data requires the unanimous consent of the MIDWG. An annexe to the agreement outlines the protocols for access to and release of MINC data.

Appendix 4 Policy, administrative and legal features in each jurisdiction

New South Wales

The New South Wales Treasury Managed Fund (TMF) covers all employees of public health organisations (PHOs), as defined in the state's *Health Services Act 1997*. This includes area health services, most statutory health corporations, and affiliated health organisations in respect of recognised establishments.

In some circumstances TMF cover is available to visiting medical officers (VMOs) and honorary medical officers (HMOs) under a separate contract of liability cover. Since 1 January 2002 the government has offered VMOs and HMOs cover by the TMF when treating public patients in public hospitals, subject to certain conditions, including a condition that doctors sign up for comprehensive risk reduction programs. The majority of VMOs have elected to participate. At the same time, the government accepted financial responsibility for unreported incidents of medical defence organisations where the incidents involved public patients in public hospitals and the treating doctor had a VMO or HMO appointment.

Medical indemnity for private patients in rural public hospitals is the responsibility of the VMO or staff specialist (SS). Since 1 July 2003, however, VMOs and SSs levels 2 to 5 who have rights of private practice and working in rural areas and selected hospitals in the Hunter and Illawarra have been able to obtain public sector medical indemnity for private patients they treat in public hospitals, subject to various conditions.

Similarly, medical indemnity for private paediatric patients in public hospitals is the responsibility of the VMOs or SSs. However, since 1 January 2005, VMOs and SSs levels 2 to 5 (having rights of private practice) have been able to access public sector medical indemnity for private paediatric patients they treat in public hospitals in New South Wales. (Note that private paediatric patient indemnity for VMOs and SSs in the rural sector, including specified hospitals in the Hunter and Illawarra, has been available in their indemnity package since 1 July 2003.)

Since 1 January 2002 NSW Health has been providing clinical academics with interim cover (in specified areas of activity) through the TMF, subject to the universities paying an per-claim excess of up to $250,000 (subject to annual consumer price index movements) capped at around $1 million a year. The period for which this interim cover was provided was extended to 30 June 2006.

For the 2006 student intake only, public indemnity was made available to students studying for a Bachelor of Midwifery at University of Technology Sydney and on practicum in public hospitals, but only during the actual birthing process and only whilst under strict PHO supervision.

The TMF fund manager manages all aspects of the claim, including arranging for such legal advice and representation as may be necessary. Incidents involving employees of PHOs are notified to the TMF through PHO risk managers. VMOs and HMOs are required by their

contracts of liability coverage to notify their PHOs of all incidents; the PHO then notifies the New South Waled Department of Health, which notifies the TMF.

When notified of an incident, the TMF sets a reserve if it believes the incident is likely to become a claim and, if necessary, arranges to have a solicitor on the record. The TMF then investigates the incident, provides instructions to the solicitor; and conducts interviews. The TMF remains involved in the settlement of the claim through the courts or the settlement process.

New South Wales has introduced various law reforms that affect medical indemnity claims. Relevant reforms implemented in the *Health Care Liability Act 2001* are:

- raising to 5% the discount rate for future economic loss damages
- capping damages for loss of earnings and for non-economic loss (general damages for pain and suffering)
- abolishing exemplary and punitive damages
- enabling structured settlements.

The *Civil Liability Act 2002* generally applies the tort law changes enacted in the *Health Care Liability Act 2001* to civil actions for damages. It also:

- introduced threshold and capping for gratuitous care
- capped lawyers' costs when the amount recovered on the claim was to be less than $100,000, unless there was a cost agreement
- amended the *Legal Professional Act 1987* (NSW) to introduce a stipulation that solicitors and barristers are not to act on a claim or defence unless they reasonably believe the claim or defence has reasonable prospects of success; cost orders may be awarded against barristers or solicitors who fail to do so.

Relevant reforms implemented in the *Civil Liability (Personal Responsibility) Amendment Act 2002* are:

- creating a peer acceptance test for professional negligence
- amending the limitation period within which an action must be brought to a date 3 years after the date of 'discoverability' or 12 years from the time the event occurred, whichever is earlier (the 12-year period can be extended at the discretion of a court)
- limiting the claims for pure mental harm or nervous shock
- protecting 'Good Samaritans' and volunteers from civil liability claims
- providing that apologies made are not relevant to the determination of liability in connection with the matter.

The following other reforms were introduced by legislation amending the *Civil Liability Amendment Act 2002*:

- limiting the damages payable to a person if the person's losses resulted from conduct that would have constituted a serious criminal offence if the person had not been suffering from a mental illness at the time of the conduct
- precluding the recovery of damages for the costs of rearing or maintaining a child, or for lost earnings while rearing or maintaining a child, in proceedings where there is a civil liability for the birth of a child

- restricting damages that can be recovered by a person from personal injury resulting from the negligence of a protected defendant suffered while the person was an offender in custody
- providing protection from civil liability in respect of food donations
- providing for the satisfaction of personal injury damages claims by victims of crime from certain damages awarded to offenders.

Victoria

In Victoria, medical indemnity claims for incidents that occur in public health-care agencies are insured by the Victorian Managed Insurance Authority (VMIA), a statutory authority created under the *Victorian Managed Insurance Authority Act* (1996). The insurance covers the health-care agency, employed doctors and other health professionals, and independent contractors (VMOs). Employed doctors with limited private-practice rights who enter into fee-sharing arrangements with a public hospital can be covered for treatment of their private patients in the hospital. These are generally senior specialist practitioners.

Rural procedural general practitioners can elect to participate in a Department of Human Services scheme whereby they can purchase medical indemnity cover for their private-practice work undertaken in certain rural and remote public hospitals and bush-nursing hospitals. There were 320 practitioners insured under this scheme in 2004–05. A significant proportion of these doctors are covered for obstetrics.

Any medical student appointed to a public health service or public hospital by a tertiary education institution for the purposes of accreditation is covered for their clinical duties.

When a public health care agency service notifies the VMIA of an incident, the VMIA sets a financial reserve if it considers the incident is likely to materialise into a claim. This is classified as an 'open' claim and the files are reviewed at least twice in a 12-month period. If a minimum reserve is placed, the amount will at least cover legal defence costs. A claim reserve may be placed before a letter of demand or writ has been received.

In 2002 Victoria introduced initial changes to legislation designed to deal with concerns and problems in relation to the affordability and availability of public liability and medical indemnity cover. These changes included:

- a cap on general damages for personal injury awards and a cap on compensation for loss of earnings awards
- initial changes to reduce the limitation period in which injured people can bring legal proceedings from 6 years to 3 years for legally competent adults
- a change in the rate used to calculate lump-sum payments for future economic loss and care costs; this measure is expected to provide significant savings on payouts for large claims
- protection of volunteers and 'Good Samaritans' from the risk of being sued
- ensuring that saying 'sorry' or waiving payment of a fee for service does not represent an admission of liability.

In 2003 the Victorian Government introduced additional reforms with the passing of the *Wrongs and Limitation of Actions Acts (Insurance Reform) Act* and the *Wrongs and Other Acts (Law of Negligence) Act*. These changes, applied to personal injury claims (including medical negligence), cover:

- thresholds on general damages
- major reform to limit the time in which proceedings can be brought
- regulation of damages awarded for gratuitous and attendant care.

Of significance to the MINC are the changes made to the limitation of actions so that, where a child is in the custody of their parents, ordinarily it will be presumed that the parent will protect the child's interests by bringing proceedings, where appropriate. The limitation period for minors has been changed to 6 years from the date of discoverability, which means that legal proceedings in relation to minors will generally have to be brought earlier than was previously the case. Some special protections do, however, apply.

The changes also provide that legal proceedings seeking damages for personal injury cannot be brought after 12 years from the date of the incident that is alleged to have caused the injury. There is judicial discretion to extend the limitation period where it is in the interests of justice to do so.

Queensland

Insurance cover for medical indemnity claims made against Queensland Health is provided through the Queensland Government TMF, called the Queensland Government Insurance Fund. The Fund was established on 1 July 2001 and its coverage extends to Crown employees and others who, at the time of the event or incident, are entitled to obtain indemnity in accordance with government policy.

From 4 November 2002 Queensland Health restated its indemnity arrangements in a new indemnity policy for medical practitioners, IRM 3.8–4. It confirmed the existing policy that Queensland Health indemnifies all medical practitioners engaged by Queensland Health to undertake the public treatment of public patients and medical practitioners treating private patients in limited specified circumstances. Indemnity under the policy is offered to doctors under an insurance-like model, with exclusions (proven criminal conduct and wilful neglect).

IRM 3.8–4 does not apply to doctors who are independent contractors providing services to Queensland Health, doctors engaged by agencies other than Queensland Health, or contracted VMOs (who must look to the indemnity clauses in their contract of engagement). Other staff engaged by Queensland Health, such as nursing and allied health staff, are covered by a separate indemnity policy, IRM 3.8–3. Queensland Health does not indemnify medical students.

Queensland Health MINC jurisdictional data come primarily from medical indemnity claims information provided to Queensland Health by the litigation panel firms engaged to provide medico-legal litigation services to the department. Therefore, in the main, the pool of MINC jurisdictional data from Queensland Health covers matters that have been briefed to a panel firm.

By and large, these matters are court proceedings and notices of claim under s.9 of the *Personal Injuries Proceedings Act 2002* (PIPA) but they can include complaints under the *Health Rights Commission Act 1991* and other demands falling within the scope of the collection.

Queensland Health matters are 'potential claims' within the MINC only where they have been referred to a panel firm and the firm has placed a reserve against the matter. The following do not come within the scope of the MINC, except in cases where a panel firm has

placed a reserve against the matter: an initial notice under s.9A of PIPA (a preliminary notice that a claim may eventuate), adverse events, and coronial inquests.

Each claim is evaluated on its own merits and on known facts as they become available, and a reserve is placed where appropriate. Accordingly, a reserve may (and often does) change during the course of a medical indemnity claim and as expert and factual evidence on questions of liability and quantum is obtained and assessed.

In response to community concerns about increases in liability insurance premiums, the Queensland Government passed legislation in June 2002 that affected the way in which compensation claims for damages for personal injuries in a medical context are dealt with before court proceedings are initiated. The legislation also sought to regulate the extent of compensation recoverable in, and various legal matters generally associated with, court proceedings for personal injury. Changes made under PIPA include:

- a positive duty on claimants to bring a claim under PIPA within 9 months of the incident (or the appearance of symptoms) or 1 month of consulting a lawyer
- no legal costs payable for claims under $30,000 and a maximum of $2,500 costs for claims between $30,000 and $50,000
- mandatory exchange of information (including medical reports) to facilitate early settlement and avoid costly litigation
- mandatory offers of settlement and settlement conferences
- capping of claims for economic loss
- exclusion of exemplary, punitive or aggravated damages awards
- provisions for a court to make a consent order for a structured settlement
- recognition and protection for 'expressions of regret'
- exclusion of juries from hearing personal injury trials.

PIPA began operating on 18 June 2002. On 29 August 2002 it was amended to apply retrospectively to injuries, except where a claim had already been lodged with a court or a written offer of settlement had been made before the amendments came into force.

On 9 April 2003 further tort reform initiatives took effect with the passing of the *Civil Liability Act 2003*. These included:

- the majority of Justice Ipp's recommendations introduced
- a new way to assess general damages for pain and suffering in personal injury actions where the incident occurred after 1 December 2002
- capped awards for general damages, at $250,000
- general damages to be assessed on the basis of an injury scale value. Injuries are assessed on a scale of 1 to 100, where 0 is an injury not severe enough to justify an award of general damages and 100 is an injury of the gravest conceivable kind. Monetary values are allocated to each point—for example, 5 = $5,000, 50 = $93,800, 100 = $250,000. The regulation under the *Civil Liability Act 2003* sets out a scale of injuries, with a guide to an appropriate injury scale value for particular injuries. There are limited medico-legal examples in the injury scale value. The *Civil Liability Regulation 2003* commenced on 7 October 2003
- introduction of thresholds for claims for loss of consortium and gratuitous care
- codification of the proactive and reactive duties of doctors to warn of risks

- codification of the standard of care for professionals to protect against liability for acts performed in accordance with a respected body of professional opinion
- amendments to PIPA, including changes to claim notification procedures. One such change relates to claims involving medical negligence in the treatment of a child: the parent or guardian of the child must provide the initial notice and then Part 1 of the notice of claim on behalf of the child within defined time-frames. A Part 1 notice of claim must be given before the earlier of 6 years after the parent(s)/guardian knew that the personal injury occurred or 18 months after the parent(s)/guardian first consults a lawyer about the possibility of seeking damages. A respondent has the right to seek a court order that the claim not proceed if the Part 1 notice is given out of time.

Western Australia

Public sector hospitals and health services in Western Australia are insured through the RiskCover Division of the Insurance Commission of Western Australia. Commencing on 1 July 1997, RiskCover has acted on behalf of the Department of Treasury and Finance to manage the self¬–insurance fund covering liability claims arising from the operations of the state's agencies.

All public hospitals and health services are charged an annual 'contribution' to RiskCover to cover the cost of managing and settling claims, including Medical Treatment Liability (MTL) claims. Claims that pre-date RiskCover are managed by the State Solicitor's Office with the Department of Treasury and Finance generally funding settlement costs on a case-by-case basis.

When a MTL claim naming a hospital is lodged, RiskCover liaises with the relevant claims manager and the Department of Health's Legal and Legislative Services. RiskCover manages the case management and financial aspects of each claim through its appointed legal representatives. The Department of Health and relevant hospital is provided with regular reports on progress until each matter is settled.

Since 1 July 2003, the Department of Health, through RiskCover, has contractually indemnified all Non Salaried Medical Practitioners (NSMPs) treating public patients in public hospitals for MTL claims. The cost of the indemnity is met by the relevant hospital(s). In return, NSMPs have a number of obligations, including supporting and participating in further safety and quality management programs.

The NSMP indemnity provides:

- effectively unlimited cover,
- Incurred but not reported cover dating to the time when the NSMP's Medical Defence Organisation changed from 'claims incurred' to 'claims made' cover,
- full death, disability and retirement cover,
- indemnity for participating in authorised clinical governance activities, including clinical audit, reporting and investigation of adverse events, and participation in quality improvement committees,
- indemnity for medical services provided to private and other 'non-public' patients treated in hospitals administered by the Western Australian Country Health Service.

From 1 July 2004 salaried medical officers have been offered a contractual indemnity for MTL claims arising from their treatment of public patients and, where the salaried medical officer has assigned his or her billing rights to the hospital, their private patients.

The state government has introduced a range of tort law reforms including:

- the *Civil Liability Act 2002*, which introduced restrictions on awards of damages and legal advertising, and enabled structured settlements,
- the *Volunteers and Food and Other Donors (Protection from Liability) Act 2002*, which protects certain volunteers from incurring civil liability when doing community work on a voluntary basis,
- the *Insurance Commission of Western Australia Amendment Act 2002*, which allows for the establishment of a Community Insurance Fund,
- the *Civil Liability Amendment Act 2002*, which contributes to containing insurance problems and also assists in changing social and legal attitudes towards the assumption of and liability for risk,
- the *Civil Liability Amendment Act 2003*, which expanded on the *Civil Liability Act 2002* by clarifying, and in some cases modifying, certain common law rules of negligence in relation to foreseeability, standard of care, causation and remoteness of damage and contributory negligence. Of particular relevance to medical practitioners, the Act also introduced protection for 'Good Samaritans' and in relation to apologies. Most of the amendments give effect to key recommendations of the *Review of the law of negligence* (the 'Ipp Report'),
- the *Civil Liability Amendment Act 2004* further amending the *Civil Liability Act 2002* in two respects. It introduced a new evidentiary test in relation to the standard of care required of health professionals and made further provision with respect to proportionate liability. The Act provides a new test for medical negligence that will preclude a finding of negligence against a health professional if their conduct was found to be compatible with the views of a responsible body of their peers.

South Australia

Public sector insurance arrangements cover the following groups: employees of public hospitals, VMOs providing services to public patients, staff specialists for services to private patients under approved rights of private practice, health professional students, short–term visiting medical practitioners and medical students, rural fee-for-service doctors who have opted to be covered under government arrangements, and clinical academics providing services to public patients.

The main steps in the claims management process are as follows:

1. initial notification of incident
2. assessment of notification by claims manager
3. if necessary, claim file opened and reserve raised
4. if necessary, panel solicitor appointed
5. investigation of claim
6. decision about approach to liability and quantum
7. reserve monitored throughout the claim and adjusted if necessary

8. settlement conference—either informal or compulsory conference convened by the court.

The main parties involved in the claim process are the plaintiff and their solicitors, the Department of Health's panel solicitors (the defendant's solicitors), the health unit from which the claim emanated, the Department of Health's Insurance Services Unit, Minter Ellison, lawyers (Department of Health—appointed claims manager), and the South Australian Government Captive Insurance Corporation (SAICORP), which is responsible for claims for amounts above the department's deductible.

In gathering information about claims or potential claims, the claims manager liaises in the first instance with the clinical risk manager or other appointed staff member of the relevant health unit. Where a panel solicitor is appointed, he or she liaises directly with the clinical risk manager or appointed hospital staff member to coordinate the investigation of the claim and interviews with staff.

A claim file is opened at the discretion of the claims manager when he or she considers the incident is likely to result in a claim. A reserve is placed against all open claim files. The reserve is calculated by multiplying the following components:

- the dollar estimate of the worst–case scenario (including plaintiff's legal costs), based on advice from the panel solicitor
- the probability of the claim proceeding, expressed as a percentage
- the probability of success of the claim, expressed as a percentage.

The estimated defence costs are then added to the amount derived.

Independent expert medical opinion on the matter is usually obtained once interviews with medical staff are completed.

If a matter that has had a reserve placed against it remains inactive—that is, does not materialise into a claim—the claim file is usually closed on expiration of the statutory time limitation within which proceedings would have had to have been initiated. Occasionally files are reopened when a plaintiff seeks an extension of time.

Structured claim settlements are not common in South Australia.

A range of tort law reforms have been introduced in the state:

- the *Wrongs (Liability and Damages for Personal Injury) Act 2002*. The Act sets limits to the damages that can be claimed for bodily injury. It applies a points scale to injury claims and limits claims for loss of capacity to earn a living. It also protects 'Good Samaritans' from legal liability if they make an error when trying to assist someone in an emergency, and it makes clear that there is no legal liability implied when one person apologises to another for an accident
- the *Statutes Amendment (Structured Settlements) Act 2002*, which allows people to have their compensation paid in instalments rather than as a lump sum if they wish
- the *Law Reform (Ipp Recommendations) Act 2005*. This Act makes changes to the law of negligence so that people are not liable to pay damages if the way in which the injury occurred was unforeseeable or a reasonable person would not have taken action to reduce the injury risk. It also prevents claims for failure to warn the injured person about a risk that should have been obvious to them. Further, the Act makes it harder for people to claim compensation if they have let the legal time limit go by, and requires parents to give early notice of an injury claim by a child, so that insurers can take this into account. Among other things, the Act also provides doctors and other professionals with a

defence if they acted in accordance with what is widely accepted in Australia to be proper professional practice.

Tasmania

The Tasmanian Government provides indemnity in relation to any services provided by a medical practitioner in a public hospital or other health facility operated by the state, with the exception of medical services provided in the course of private practice in premises that the practitioner or another person occupies pursuant to a lease or other right of exclusive occupation granted by the state.

Insurance coverage for medical indemnity matters is provided through the Tasmanian Risk Management Fund. The Department of Health and Human Services makes an annual contribution to the fund and, under the coverage provided by the fund, the Department is required to meet the first $50,000 in respect of any claim.

The claims management process is:

1. Initial notification of a claim is lodged. This can result from
- receipt of a letter of demand or writ
- or notification by the responsible Departmental division when it has been determined that the nature of the incident and the potential impact on the department are sufficiently material to warrant notification.
2. Claim notification forms are completed by the relevant medico-legal officer at each of Tasmania's three major public hospitals and duly designated officers in other departmental divisions, including district hospitals, aged care facilities, mental health and disability services, and oral health services. The claim notification forms include all data required under the MINC, as well as additional data required for internal management of the claim.
3. A copy of the claim notification form is forwarded to the departmental officer responsible for maintaining the database for medical indemnity matters. The Office of the Director of Public Prosecutions, which undertakes all litigation matters on behalf of the State of Tasmania, is advised of the (potential) claim. A claim file is opened and a reserve is placed on the matter by the Director of Public Prosecutions.
4. The claim is managed by the relevant medico-legal officer and a representative from the Office of the Director of Public Prosecutions. Claim files are reviewed quarterly.

Tasmania has implemented a number of tort law reforms, largely through amendments to the *Civil Liability Act 2002*. Most of the reforms flow from recommendations of the 'Ipp report' of the law of negligence. Key reforms relevant to medical negligence claims include:

- clarification of aspects of the duty of care owed by medical practitioners to patients
- a statement that an apology—for example, by a medical practitioner to a patient—does not constitute an admission of fault or liability
- provision for a court to make an order approving of, or in the terms of, a structured settlement
- changes to the manner in which damages relating to loss of earning capacity, economic loss, and non-economic loss are assessed

- restriction of the circumstances in which a plaintiff may seek to recover damages for pure mental harm
- awarding of payments for gratuitous services (subject to certain conditions and effective from 15 December 2006). No damages were previously payable for such services
- a reduction of the discount rate used in determining a lump-sum payout, from 7 to 5 per cent, effective from 15 December 2006
- changes to the limitation period where an action for damages for negligence now cannot be brought after the sooner of 3 years from the date of discoverability or 12 years from the date of the cause of action (effective from 1 January 2006) (see s.5A of the *Limitation Act 1974*). Previously, the limitation period was 3 years from the date of the cause of action, with an extension of a further 3 years at the discretion of the court.

Australian Capital Territory

All ACT government employees providing clinical services are indemnified under general staff cover for professional officers. Staff specialists are also indemnified for rights of private practice providing they do not bill their private patients directly.

In January 2002 the ACT introduced the Medical Negligence Indemnity Scheme to provide indemnity to VMOs providing public health services to public patients in public health facilities. The term 'public' is crucial in this description because the scheme is specifically limited to that type of service. A recent change to sessional and fee-for-service contracts with VMOs has seen the scheme now rolled into the VMO service agreements.

In 2003 the ACT also agreed to indemnify medical and nursing students who were placed in the ACT health system as part of their training.

The overall manager of claims and provider of public medical indemnity cover in the ACT is ACT Health; the cover is underwritten by the ACT Insurance Authority, which obtains the necessary re-insurance covers internationally. ACT limits its deductible to $50,000, the balance of any one claim then being covered by the insurance authority.

Key providers of medical insurance data are the two public hospitals, Mental Health ACT and Community Health, which monitor and report adverse incidents and/or potential claims. Potential claims and circumstances that come to the attention of the responsible entity are to be reported immediately to the ACT Insurance Authority under the obligations that ACT Health has to that insurance provider. To ensure that all potential claims and circumstances are notified to the insurer in accordance with policy conditions, claims and circumstances must be reported to ACT Health and the ACT Insurance Authority as soon as possible (and during the Period of Insurance).

If at any time the responsible entity is served with court proceedings or becomes aware of a serious incident, the matter is to be notified immediately to the Government Solicitor's Office, which will ensure that a defence is filed within the specified timeframe, as required.

Legal reforms are under way with the *Civil Law (Wrongs) Amendment Act* having been passed by the Legislative Assembly in 2003. Elements of the Act relevant to personal injury claims (including medical negligence) are:

- changes to reduce the limitation period in which injured people can bring legal proceedings, from 6 years to 3 years from the date of the incident for legally competent

adults, and, in relation to children, other reforms to limit the time in which proceedings can be brought

- provisions for a single expert witness to give evidence
- clarification of the interpretation of the concepts of 'standard of care', 'causation' and 'assumption of risk' in negligence proceedings, by defining the concepts in the Act
- restriction of liability for mental harm to a recognised psychiatric illness
- a limit on damages for non-economic loss and economic loss
- direction as to the apportionment of liability and contributory negligence
- ensuring that saying 'sorry' or waiving payment of a fee for service does not represent an admission of liability
- early notification—procedural reforms designed to make early settlements more likely and to improve the efficiency of court proceedings.

Among other reforms are the following:

- introduction of a 'reasonable prospects' test for cases brought before the court
- imposing obligations on the parties to claims to exchange relevant documents—for example, about the cause of the accident, the extent of injuries
- establishing the principles to apply in deciding whether a public or other authority has a duty of care or has breached a duty of care
- providing for court ordered mediation in addition to neutral evaluation
- requiring that a claimant notify all respondents of an intention to sue 9 months after the date of the accident or after the date symptoms first appear if they are not immediately apparent or 1 month after consulting a lawyer. If these notices are not given, the claimant can proceed only with the leave of the court and at the risk of cost penalties
- requiring that, for adult claimants, this notice be given within 3 years
- requiring that for child claimants, this notice be given within 6 years (there will be significant financial disincentives to delaying the giving of the notice on behalf of child claimants; that is, no medical, legal or gratuitous care costs will be awarded for the period up to the date the notice is given)
- requiring that, once notice is given, the prospective defendant have carriage of the progress of the claim (in the case of children, a prospective defendant can oblige a plaintiff to file suit on 6 months' notice).

Northern Territory

Current public sector medical indemnity insurance arrangements in the Northern Territory cover VMOs and specialist medical officers providing medical services to any public patient. Recent amendments extend cover to instances where care is provided to a public patient in a private hospital—for example, where the territory 'buys' beds from a private hospital or where care is provided outside the hospital setting. VMOs and specialist medical officers are still, however, required to cover any liability that may arise from services provided outside such agreements.

Once notification of an incident that might result in a claim is received, a possible legal action file is established and referred to a legal practitioner in a private law firm or to a

departmental lawyer. Upon receipt of a writ, a legal action file is established and the matter is outsourced to a private law firm.

When a possible legal action is identified as the result of a complaint or inquiry, the Legal Support Branch of the Department of Health and Community Services will usually refer the complainant to the Health and Community Services Complaints Commission in an effort to pre-empt litigation.

The main players in a medical negligence suit are the plaintiff and their representative lawyers, the defendant (that is, the Northern Territory, the Department of Health and Community Services, and the hospital and/or staff involved), and outsourced defence lawyers engaged by the department.

In investigating a claim, statements are generally obtained from the relevant clinical or medical staff involved, along with medical records. Expert medical advice is normally sought in the initial stages of the claim in order to ascertain potential liability and to assist with preparation of a defence.

When calculating a reserve, factors taken into account can include:

- the liability or otherwise of the Northern Territory
- the gravity of the loss, injury and/or damage to the claimant
- legal advice on quantum.

If a file has been opened on the basis of a potential legal action and no claim or proceedings result, the file remains inactive. Once a litigation file is opened, it is closed only if the department is notified of discontinuance or the matter is settled.

The statute of limitations legislation prescribes that personal injury legal proceedings be initiated within 3 years of the occurrence of an adverse event.

At present no compulsory dispute resolution processes exist as a prerequisite to litigation. An aggrieved person may, however, lodge a complaint through the Health and Community Services Complaints Commission in the first instance to have the matter investigated, conciliated or resolved before the commencement of litigation.

The Northern Territory *Personal Injuries (Civil Claims) Act 2003* contains some provisions in relation to claims for personal injury, but those relating to commencement of proceedings (ss.7–10) and resolution conferences (s.11) have not yet commenced. Therefore the *Limitation Act* continues to apply in that any action in tort must be brought within 3 years of the date of the cause of action.

The *Personal Injuries (Liabilities and Damages) Act 2003* makes the following provision,

- A court must not award aggravated damages or exemplary damages in respect of a personal injury.
- A court may award damages for gratuitous services only if the services are provided
  - for 6 hours or more a week

  or
  - for 6 months or more.

The maximum amount of damages a court may award for non-pecuniary loss is $350,000 at commencement of the Act (May 2003) and as declared by the minister on or before 1 October in each year after the year in which the Act commences.

The award of damages for non-pecuniary loss is determined according to the degree of permanent impairment of the whole person and the relevant percentage of the maximum amount to be awarded.

Structured claim settlements are not common in the Northern Territory. As a general rule, an all-encompassing settlement figure is reached without detailed itemisation of categories of loss and is settled in one lump sum rather than by periodic payments.

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