Medical indemnity national data collection public sector 2004–05

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HEALTH SERVICES SERIES
Number 27

Medical indemnity national data collection public sector 2004–05

June 2006

Australian Institute of Health and Welfare
Canberra

AIHW cat. no. HSE 42

This publication is part of the Australian Institute of Health and Welfare's Health Services Series. A complete list of the Institute's publications is available from the Business Promotion and Media Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's website
< www.aihw.gov.au>.

ISSN 1036–613X

ISBN 1 74024 577 6

Suggested citation

AIHW (Australian Institute of Health and Welfare) 2006. Medical indemnity national data collection, public sector 2004–05. AIHW cat. no. HSE 42. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

Printed by

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Acknowledgments

This report was written by Sally Bullock and Samantha Bricknell. Many thanks to Ros Madden and Nicola Fortune for valued comments and to Elena Ougrinovksi and Rod Hall for their assistance with data management, cleaning and validation.

Special thanks are extended to the Medical Indemnity Data Working Group, the members of which are responsible for coordinating the collection of MINC data in their respective jurisdictions and provided invaluable advice and commentary during the drafting. The members are:

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- Olly Campbell—Western Australia, Department of Health (Deputy Chair)
- Belinda Woolley—New South Wales, NSW Health
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- Tom Saltmarsh—Tasmania, Department of Health and Human Services
- Viv Lang—Northern Territory, Department of Health and Community Services
- Leonie Fisher—Australian Capital Territory, ACT Health
- Maria Travers—Australian Government Department of Health and Ageing

Thanks also to Cecilia Burke and Janine Martin for coordinating the publication process.

Symbols

– nil or rounded to zero

Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulatory Authority
HMO	honorary medical officer
IBNR	incurred but not reported
ISA	Insurance Statistics Australia
MIDWG	Medical Indemnity Data Working Group
MIIAA	Medical Indemnity Industry Association of Australia
MIIs	medical indemnity insurers
MINC	Medical Indemnity National Collection
NSMP	non-salaried medical practitioner
PHO	public health organisation
PIPA	Personal Injuries Proceedings Act 2002
TMF	Treasury Managed Fund
VMIA	Victorian Managed Insurance Authority
VMO	visiting medical officer

Glossary

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.

Summary

This report focuses on public sector medical indemnity claims data for the period 1 July 2004 to 30 June 2005 and is the third 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 outcomes of medical indemnity claims.

There were 6,453 claims active during the year, of which 2,048 were 'potential' claims. Of the total, 1,680 claims were finalised during the year. The MINC now represents 85% of claims in scope and 73% of finalised claims, and this coverage is expected to increase in the future.

Incidents

- The three most frequently recorded clinical service contexts associated with medical indemnity claims were obstetrics (1,141 claims; 18% of all claims), accident and emergency (940 claims; 15%) and general surgery (721; 11%).
- Obstetrics only (715 claims), emergency medicine (610 claims) and general surgery (489 claims) were the most commonly recorded specialties of clinicians involved in incidents that gave rise to claims.
- Data on primary incident/allegation type show that medical or surgical procedures (2,163 claims; 34% of all claims) were most commonly recorded in medical indemnity claims, followed by diagnosis (1,324; 21%) and treatment (947; 15%).
- The majority of claims arose from events that occurred in major cities (4,407 claims; 68%); 1,930 claims (30%) arose from incidents that occurred in regional areas, and 91 claims (1.4%) arose from incidents that occurred in remote areas. This pattern most probably reflects the concentration of medical services in Australia in metropolitan areas.

People

- 645 claims (10%) related to babies less than one year old, 1,237 (19%) related to children and 3,742 (58%) involved adults. Over half of all claims related to females (3,628 claims; 56%).
- Neuromusculoskeletal and movement-related functions and structures were most commonly recorded as the primary body function/structure affected as a result of the incident (1,522 claims; 24%). The next most commonly recorded categories were 'mental functions/structures of the nervous system' (15%) and 'genitourinary and reproductive functions and structures' (13%).

Claims

Current claims

- There were 4,773 current claims remaining open at the end of the reporting period. The majority of these claims had been open for three years or less (80% of claims), with commenced (but not yet finalised) claims being open an average of 2.2 years. Of all current claims, just over half had a reserve value less than $30,000 (52%). A reserve range of $10,000 to $30,000 was the most commonly recorded category (34% of all current claims).

New claims

- There were 1,641 new claims during the reporting period. These were most commonly associated with the clinical service contexts of obstetrics (246 claims; 15% of new claims), accident and emergency (243 claims; 15%) and general surgery (173; 11%).
- Of all new claims, 60% (984 claims) were reserved for less than $30,000 and 3% (55 claims) had a reserve exceeding $500,000.

Finalised claims

- During 2004–05, 1,680 claims were finalised. Of these, 1,478 claims (88%) had an agreed total claim size and were closed.
- The average duration of claims that were closed during the reporting period was 26 months.
- Two-thirds of finalised claims were for less than $100,000 (1,127 claims). In 27 cases payments were more than $500,000.
- Court-based alternative dispute resolution and 'other settlement processes' (including settlement part-way through a trial) were the most common modes of claim finalisation in settled claims, accounting for 11% and 25% respectively of all finalised claims. Court decisions were involved in 4% of finalised claims.

Reporting developments

- The MINC has now entered its fourth year of data transmission and reporting. Since the previous report, data completeness has improved again and is now at 85%. This represents a 35 percentage point increase in completeness since the first report.
- Compilation of a single national report is the next important step in the monitoring of medical indemnity claims. That report will for the first time present combined medical indemnity claims data from the public sector and the medical indemnity insurers.

1 Introduction

The costs associated with health care litigation and the financial viability of medical indemnity insurance in Australia were recognised by health ministers in 2002 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 Medical Indemnity National Collection (MINC) and the collation of data on public sector medical indemnity claims.

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 outcome of medical indemnity claims.

Data for approximately 85% of all claims in the scope of the MINC are included (see further information on data completeness in section 2.4). A claim falls within the scope of the MINC when either legal proceedings have been instigated or the claim is likely to require litigation and has a reserve (best current estimated cost) placed against it. Claims are included if they were current at any time during the reporting period (July 2004 to June 2005)—that is, those that were open at the start of the period, new claims that arose during the period, and claims finalised during the period.

This is the third report originating from the MINC. The first report—*First medical indemnity national data collection report: public sector, January to June 2003* (AIHW 2004: published on the AIHW website only)—described the development of the collection and presented the first six months of data. Annual data, for the period July 2003 to June 2004, were first presented in the second report—*Medical indemnity national data collection public sector: 2003 to 2004* (AIHW 2005)—and expanded the number of data tables, and hence the detail compared with the first report. There have been significant improvements in data quality and completeness between the three reporting periods but quality and scope require further improvement (see section 2.4). Care should therefore be taken when comparing data between reports.

1.1 Background to the collection

The need for a national medical indemnity collection arose in the broader context of national policy concern 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. The Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). On 3 July 2002 AHMAC decided to commission the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG to further develop proposals for a national medical indemnity data collection for the public sector.

1.2 Purposes of the collection

The primary purposes of the MINC are:

- to obtain ongoing information on medical indemnity claims and their outcomes
- to provide a national information base on nationally aggregated data which assist policy makers to identify trends in the nature, incidence and cost of medical indemnity claims
- to 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
- supplement other sources of information on clinical risk prevention and management.

1.3 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.

1.4 Progress towards a single national report on medical indemnity

At the Medical Indemnity Summit in 2002, health ministers recommended that policy-informative full national data be made available on public and private sector medical

indemnity claims. Consequently, there has been considerable information development relating to medical indemnity claims in recent years.

In 2004 the Australian Government introduced the Premium Support Scheme as part of a comprehensive medical indemnity package to help eligible doctors to meet the cost of their medical indemnity insurance. Under the Scheme the Australian Government enters into standard contracts with medical indemnity insurers (MIIs), which stipulate that MIIs must provide information on private sector medical indemnity claims and other information to the Australian Government. These contracts also create a mechanism for providing the Commonwealth, including the AIHW, with data to enable the compilation of a single national medical indemnity report.

In 2004 and 2005 key stakeholders in medical indemnity data had ongoing discussions about the feasibility of a single national report incorporating public sector and MII data. These discussions involved representatives from the Medical Indemnity Insurance Association of Australia (MIIAA), Health Professionals Insurance Australia (HPIA), the Australian Prudential Regulation Authority (APRA), Insurance Statistics Australia (ISA), the MIDWG, the Australian Government Department of Health and Ageing and the AIHW. It was agreed that data consistency and the efficient flow of data between organisations were crucial to the process. MIIs indicated that significant progress has already been made towards meeting the information requirements of the Premium Support Scheme (including the provision of MINC data).

MIIs are also required to submit data to APRA, and earlier work between the AIHW and APRA to improve the consistency of the MINC and APRA collections (see AIHW 2005) has further ensured the efficiency of medical indemnity data collection and transmission. Amendments to data specifications in both collections have aimed to minimise the resource burden on private sector data providers and promote consistency in overlapping areas of reporting.

In mid-2005 it was agreed that work should proceed towards the compilation of a single national report and to establish a group, the MINC Coordinating Committee for this purpose.

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. In the context of the MINC, 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 MINC:

- claims on which legal activity has commenced—as indicated, for example, by a letter of demand, the issue of a writ or a court proceeding
- potential claims that are likely to materialise into a claim and have a reserve placed against them.

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 iatrogenic harm 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 2.

Data for 2004–05 relate to claims that were current at any time during the year—that is, those claims that were open at the start of the period (1 July 2004) and those that arose during the period, including claims finalised during the period.[1]

2.2 Policy, administrative and legal context

In a general sense, indemnity cover is provided where the medical practitioner has diligently and conscientiously endeavoured to carry out their duty and there is no neglect, wilful misconduct or criminal activity on their part. Coverage of public sector medical indemnity insurance is defined by state and territory legislation and associated policies and varies between jurisdictions.

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[1] 'Finalised claims' includes claims that were finalised during the reporting period (1,612 claims had a date of finalisation in July 2004 to June 2005), or that were finalised before the reporting period but not closed (68 claims had a date of finalisation before July 2004).

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 2.

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 and allied health) and academics varies across jurisdictions and could require participating universities to provide financial contributions.

The recent 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 of 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
- 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 as follows:

- 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 2 for claims management bodies operating in each jurisdiction.)
- 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.
- Various events can signal the start of a claim, for example, a writ or letter of demand may be received 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.

- The claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.
- As the claim progresses the reserve is monitored and adjusted if necessary.
- A claim may be finalised 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') was to 'develop and evaluate principled options to limit liability and quantum of awards for damages'.

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 (Commonwealth of Australia 2002). The report also made recommendations on a range of other matters, among them the following:

- 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
- capping 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.

2.3 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.

MINC data are transmitted from health authorities to the AIHW every six months; the AIHW is responsible for 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 2005[2].

No significant changes have been made to data items since the previous report; some changes to data items and specifications are, however, in place for the 2006–07 reporting period (see section 2.4). As the MINC matures, and as greater consistency in private sector claims information is sought, modifications to data items will continue to occur.

[2] It is possible to trace changes to data items over numerous reporting periods through the linkage of claim identifiers, but this is not done for this report.

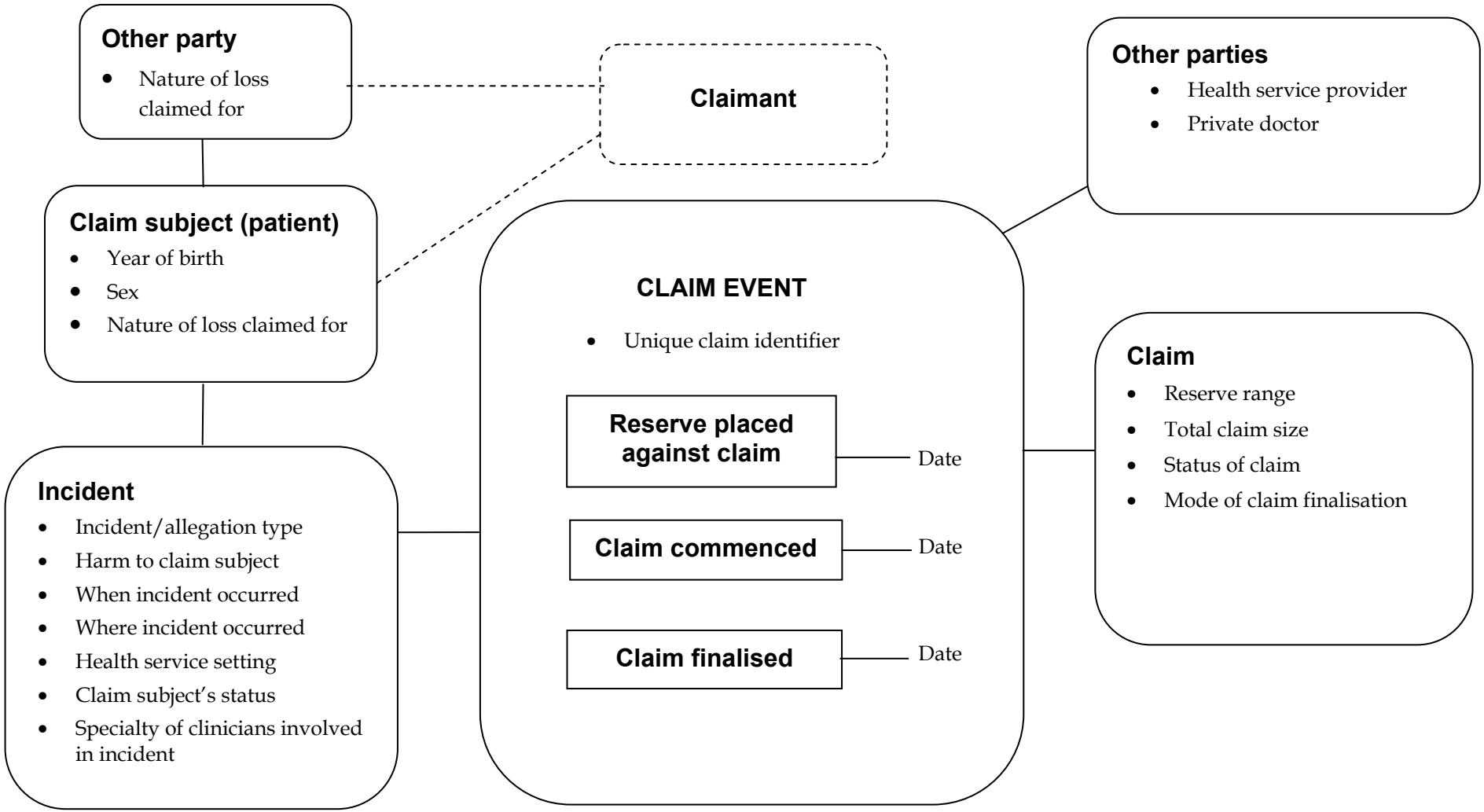
Table 2.1: MINC data items and definitions

Data item	Definition
1. Claim identifier	An identity number that, within each Health Authority, is unique to a single claim, and which 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	Sex 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 3 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 3 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 (ASGC) 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. Specialties 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 finalised	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 sub-sets of claims:

- *Current claims – claims that are open (that is, have a reserve placed against them but have not been finalised) as at the end of the reporting period. There were **4,773 current claims** as at 30 June 2005*
- *Finalised claims – claims that have been finalised during the reporting period (1,612 claims had a date of finalisation between 1 July 2004 and 30 June 2005), or that have been finalised before the reporting period but not closed (68 claims had a date of finalisation before July 2004). A total of **1,680 claims were finalised** for the period 1 July 2004 to 30 June 2005*
- *New claims – claims that were opened during the reporting period, including those that were also finalised during the period. There were **1,641 new claims** for the period 1 July 2004 to 30 June 2005)*
- *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 finalised claims, including claims that were open at the start of the period. There were **6,453 claims in total** in the MINC database for the period 1 July 2004 to 30 June 2005.*

For each claim there is one claim subject – except in some instances, such as class actions, where one claim would 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*
- *Specialties 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 2004–05 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 data between reporting periods.

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 significantly, a trend expected to continue as the collection matures.

The MINC now represents approximately 85% of all claims in scope, 73% of all finalised claims, and 96% of new claims. Two jurisdictions did not provide complete data:

- Victoria provided data for 84% 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, at some expense, 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 claims in scope but not included amounted to 4% of the total dollar value of claims in scope in 2004–05.
- New South Wales provided data for 66% 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 finalised and closed they will represent a smaller proportion of claims in scope of the MINC, and overall data completeness will continue to improve. The claims not provided to the MINC have a reserve value equivalent to about 40% of the reserve value of all New South Wales claims.

Missing data

New South Wales data are not included in tables (specifically Tables 3.2, 3.3 and 3.5) involving the following data items: 'Nature of claim—loss to other party/parties'; 'Additional incident/allegation type'; 'Additional body functions/structures affected—claim subject'; 'Extent of harm—claim subject'; and 'Specialties of clinicians closely involved in the incident'. Consequently, the total number of claims cannot be shown in these tables and data are presented as percentages. New South Wales already 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. All other jurisdictions have established or adapted their data systems to comply with the MINC.

New South Wales is reviewing its medical indemnity data collection. The review will consider the collection and modification of NSW data items with the aim of improving consistency between public and private data; this could lead to improvements in the completeness of NSW MINC data in future.

Data quality

'Not known' rates

'Not known' can be coded when information is either not currently available but expected to become available or not expected to ever be available through the claim's lifetime. The proportion of 'not known' rates across most data items has decreased since the 2003–04 reporting cycle, which may reflect a growing understanding of MINC data collecting and recording practices within jurisdictions.

The items 'Nature of claim—loss to claim subject' and 'Nature of claim—loss to other parties' had the highest 'not known' rates (62% and 60% [excluding NSW claims] respectively) (Table 2.3). This information is not routinely collected during a claim's lifetime and the MIDWG has agreed that the value and usefulness of these items should be monitored over future reporting periods.

'Not known' rates for several other items ranged between 10% and 21%; these items were 'Primary body function/structure affected', 'Claim subject's status', 'Year of birth' and 'Extent of harm'.

The remaining data items each recorded less than 5% 'not known' responses; these items were 'Mode of claim finalisation' and 'Total claim size', for which only 3% of finalised claims were coded 'Not known'.

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, but not yet finalised'. This cross-checking between data custodian and providers promotes the inclusion of accurate and reliable data.

'Clinical service context' comprises 20 service areas with the option for 'other' to be coded and textual information provided. An analysis of the 'other' category—comprising 11% of all claims (see Table A3–1)—found that some text described 'primary incident/allegation type' information (such as, blood transfusion, failure to diagnose or breach of confidentiality) rather than information on the health service area or department where the incident occurred. Additional validation checks for the coding of this item are planned in the future.

Table 2.3: MINC data items: number and percentage of claims for which 'not known' was recorded, 1 July 2004 to 30 June 2005

Items for all states and territories	Number	% of all claims
Nature of claim—loss to claim subject	4,016	62.2
Claim subject's sex	78	1.2
Primary incident/allegation type	306	4.7
Clinical service context	198	3.0
Primary body function/structure affected	772	12.0
Where incident occurred	25	0.4
Health service setting	138	2.1
Claim subject's status	1,025	15.9
Finalised claim items	**Number**	**% of finalised claims**
Mode of claim finalisation	48	2.9
Total claim size	57	3.4
Items for all states and territories except NSW[(a)]	**Number**	**% of non-NSW claims**
Nature of claim—loss to other parties	3,266	60.1
Claim subject's year of birth	770	14.2
Additional incident/allegation types	7	0.1
Additional body functions/structures affected	—	—
Extent of harm	1,119	20.6
Specialties of clinicians closely involved in incident	136	2.2

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

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

- Date incident occurred: this item must be completed with a valid date for all records included in the MINC.
- Date reserve placed against claim: this item must be completed with a valid date for all records included in the MINC.
- Reserve range: this item must be completed with a valid reserve range category for all records included in the MINC.
- Date claim commenced: it is valid for this item to be left blank for claims that have not yet commenced.
- Date claim finalised: it is valid for this item to be left blank for claims that have not yet been finalised.
- Status of claim: this item must be completed with a valid claim status category for all records included in the MINC.

Changes to data specifications in the future

In an effort to improve data quality, and the value and usefulness of information obtained through the MINC, the MIDWG has agreed to make some changes to the coding of data items in the future. These pertain to the data items 'Primary incident/allegation type', 'Total claim size', 'Status of claim' and a new item 'Claim payment details'. The inclusion of 'Claim payment details' is scheduled for the 2006–07 reporting period, although the extent to which all jurisdictions will be able to implement changes by this time varies. Three of the major changes outlined for the 2006–07 reporting period are as follows:

- Primary incident/allegation type. Two new additional codes have been included: 'Procedure—post operative infection' and 'Procedure—intra operative complications'.

- Status of claim. The coding of this item will be simplified and claims will be categorised broadly as: 'Not yet commenced', 'Commenced', 'Closed' and 'Previously closed now reopened'. Since claims will no longer be able to be finalised but not closed (that is, for claims still awaiting determination of total claim size), the categorisation of claims into those that were finalised during the period and those that were finalised before (see Box 2.1) will not be required.
- Claim payment details. 'Claim payment details' shows whether a damages payment was made to the claimant and, if so, whether the payment was to the claim subject and/or other party/parties. This item will be analysed in conjunction with 'Total claim size', which includes, by definition, payments made to the claimant and defence legal costs.

2.5 Future directions for the MINC

The MINC has now entered its fourth year of data transmission and reporting. Since the previous report, data completeness has improved again and is now at 85%. This represents a 35 percentage point increase in completeness since the first report.

The similar patterns described in this and the previous two reports confirm the validity of the MINC in representing the profile and trends of public sector medical indemnity claims in Australia. As the collection matures and completeness continues to improve, more comprehensive analyses (such as presentation of trend data) can be achieved, providing better identification of changes in the nature and costs of medical indemnity claims. This information will be crucial for effective evaluation of tort law reforms and policies aimed at decreasing the incidence and cost of medical indemnity claims.

Compilation of a single national report represents the next important step in the monitoring of medical indemnity claims. The report will for the first time present combined medical indemnity claims data from the public sector and the medical indemnity insurers. It will offer a more comprehensive picture of the incidents giving rise to medical indemnity claims and the processing of these claims in Australia.

3 Public sector medical indemnity claims data

This chapter provides a profile of the 6,453 claims that were active at any time during the reporting period (July 2004 to June 2005). A claim is considered active if it was open at the start of the reporting period, arose during the period or was finalised 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.

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 involved). Information on the geographical region where the event took place is also included.

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 incident occurred. Between July 2004 and June 2005 the four most frequently recorded clinical service contexts were obstetrics (1,141 claims; 18% of all claims), accident and emergency (940 claims; 15%), general surgery (721; 11%) and gynaecology (508; 8%) (Table 3.1). There are 20 possible categories; the eight most common clinical service contexts are presented in Table 3.1 and all other categories are combined in 'all other clinical service contexts', which accounts for 27% of all claims.

There is also the option for clinical service context to be coded as 'other' and additional text information to be provided. During the reporting period 703 claims (11% of all claims) were coded this way (Table A3-1). Of those that provided text, ophthalmology, intensive care and mortuary were most commonly recorded.

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 2004–05, claims relating to medical or surgical procedures (2,163 claims; 34% of all claims) were most common, followed by diagnosis (1,324; 21%) and treatment (947; 15%). Procedures accounted for over half of all incidents in the clinical service contexts of gynaecology (351 claims; 69% of all claims in this category), general surgery (391 claims; 54%)

and obstetrics (608 claims; 53%). Incidents related to diagnosis were relatively more likely in the accident and emergency (59%; 558 of 940 claims) and paediatrics (31%; 59 of 190 claims) clinical service contexts.

Claims with a primary incident allegation/type of anaesthetic were over-represented in the clinical service context of general surgery (62 claims; 9% compared with 3% overall), and other duty of care issues were relatively more common in the clinical service context of psychiatry (146 claims; 53% compared with 10% across all claims).

Device failure and infection control were least likely to be recorded as the alleged grounds for a claim (1% and 2% of all claims respectively).

Table 3.1: All claims (public sector): clinical service context, by primary incident/allegation type, 1 July 2004 to 30 June 2005, Australia

Clinical service context	Primary incident/allegation type												Total	*Column per cent*
	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		
						Number								
Obstetrics	130	23	24	7	608	200	13	13	2	61	10	50	1,141	*17.7*
A&E	558	29	2	1	37	209	5	12	3	59	6	19	940	*14.6*
General surgery	79	14	62	3	391	61	34	25	7	28	2	15	721	*11.2*
Gynaecology	38	5	17	1	351	19	29	3	11	19	5	10	508	*7.9*
Orthopaedics	63	6	13	—	219	52	22	24	8	27	3	13	450	*7.0*
General medicine	59	37	5	6	7	56	3	9	4	97	4	8	295	*4.6*
Psychiatry	25	19	—	—	2	47	2	—	—	146	17	19	277	*4.3*
Paediatrics	59	15	4	2	47	36	2	2	3	13	6	1	190	*2.9*
All other clinical service contexts	301	84	49	78	488	258	102	60	24	212	36	41	1,733	*26.9*
Not known	12	5	1	6	13	9	1	3	3	12	3	130	198	*3.1*
Total	**1,324**	**237**	**177**	**104**	**2,163**	**947**	**213**	**151**	**65**	**674**	**92**	**306**	**6,453**	*100.0*
						Per cent								
Obstetrics	11.4	2.0	2.1	0.6	53.3	17.5	1.1	1.1	0.2	5.3	0.9	4.4	100.0	
A&E	59.4	3.1	0.2	0.1	3.9	22.2	0.5	1.3	0.3	6.3	0.6	2.0	100.0	
General surgery	11.0	1.9	8.6	0.4	54.2	8.5	4.7	3.5	1.0	3.9	0.3	2.1	100.0	
Gynaecology	7.5	1.0	3.3	0.2	69.1	3.7	5.7	0.6	2.2	3.7	1.0	2.0	100.0	
Orthopaedics	14.0	1.3	2.9	—	48.7	11.6	4.9	5.3	1.8	6.0	0.7	2.9	100.0	
General medicine	20.0	12.5	1.7	2.0	2.4	19.0	1.0	3.1	1.4	32.9	1.4	2.7	100.0	
Psychiatry	9.0	6.9	—	—	0.7	17.0	0.7	—	—	52.7	6.1	6.9	100.0	
Paediatrics	31.1	7.9	2.1	1.1	24.7	18.9	1.1	1.1	1.6	6.8	3.2	0.5	100.0	
All other clinical service contexts	17.4	4.8	2.8	4.5	28.2	14.9	5.9	3.5	1.4	12.2	2.1	2.4	100.0	
Not known	6.1	2.5	0.5	3.0	6.6	4.5	0.5	1.5	1.5	6.1	1.5	65.7	100.0	
Total	**20.5**	**3.7**	**2.7**	**1.6**	**33.5**	**14.7**	**3.3**	**2.3**	**1.0**	**10.4**	**1.4**	**4.7**	**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'. Table A3-1 shows the frequency of coding categories for all clinical service contexts.
2. Data for approximately 85% of all claims in scope are included.
3. 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'.

Specialty of clinician(s) involved in incident

The specialties of clinicians involved in an incident indicate the health care providers who played the most prominent roles in the event that gave rise to the claim. 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 2004–05, 87% of claims recorded one specialty and 11% of claims recorded two (Table A3-3). Only 0.5% of claims recorded four specialties. 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 obstetrics only (715 claims), emergency medicine (610 claims) and general surgery (489 claims) (Table 3.2). If the specialties of obstetrics and gynaecology were combined, they would account for 1,342 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, emergency medicine and psychiatry were particularly strongly associated with corresponding clinical service contexts. Not surprisingly, other 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 36% of all claims involving other hospital-based medical practitioners, and general medicine accounted for 27% of claims involving the specialty 'nursing—general'.

Procedure–related incidents were most common in claims associated with the specialties of gynaecology only (73% of all claims), general surgery (64%) and obstetrics only (61%) (Table 3.3). Other general duty of care matters constituted the largest proportion of claims involving the specialties of psychiatry (57% of claims) and general nursing (47% of claims). For claims involving other hospital-based medical practitioners, diagnosis and treatment issues were relatively common (43% and 21% respectively).

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

Table 3.2 All claims (public sector): clinical service context, by specialty of clinician(s) involved, 1 July 2004 to 30 June 2005, Australia[a] (per cent)

	Specialty of clinician(s)[b]													
Clinical service context	**Obstetrics only**	**Emergency medicine**	**General surgery**	**Orthopaedic surgery**	**Nursing—general**	**Gynaecology only**	**Obstetrics and gynaecology**	**Other hospital-based medical practitioner[c]**	**Psychiatry**	**Anaesthetics—general**	**Other specialties**	**Not known**	**N/A[d]**	**Total**
Obstetrics	98.0	0.7	1.0	0.3	3.9	0.6	59.0	13.7	1.3	21.0	12.7	6.6	5.8	20.1
A&E	0.3	93.4	3.5	8.3	9.7	0.6	1.1	35.9	4.4	0.5	6.4	4.4	3.8	14.5
General surgery	0.3	0.5	88.5	1.5	8.3	1.1	1.1	7.7	0.4	32.7	8.3	4.4	7.7	12.1
Gynaecology	0.3	0.2	1.0	—	5.3	93.5	36.5	7.3	—	9.8	1.0	2.9	1.9	8.4
Orthopaedics	—	1.3	0.6	84.0	4.4	—	—	6.4	—	8.3	0.9	0.7	5.8	6.7
General medicine	—	0.8	0.8	—	26.6	—	0.4	3.4	0.9	2.9	9.0	0.7	7.7	5.2
Psychiatry	—	—	0.2	0.3	6.9	—	—	3.8	90.2	—	0.4	1.5	1.9	4.0
Paediatrics	0.1	0.3	0.8	1.8	6.1	—	0.4	5.1	—	3.9	7.5	—	—	3.6
All other clinical service contexts	1.0	2.8	3.3	4.0	27.1	4.2	1.5	16.2	2.7	19.0	53.2	14.7	59.6	23.6
Not known	—	—	0.2	—	1.7	—	—	0.4	—	2.0	0.5	64.0	5.8	1.8
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 no. of claims[e]	*715*	*610*	*489*	*400*	*361*	*356*	*271*	*234*	*225*	*205*	*2,203*	*136*	*52*	

(a) NSW data are not included because data on clinical specialty are not available.

(b) This data item provides information on the clinical specialties of the health care providers 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.

(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) This is the total number of claims for which the particular specialty was recorded. A given specialty may be recorded only once for a single claim. However, up to four different specialties may be recorded for a claim, so a single claim may be counted in the total for several columns; therefore, the totals cannot be summed horizontally to give the total number of claims overall.

Note: The specialties and clinical service context categories listed separately are the 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 (public sector): primary incident/allegation type, by specialty of clinician(s), 1 July 2004 to 30 June 2005, Australia (per cent)[a]

	Primary incident/ allegation type[c]												
Specialty of clinician(s)[b]	**Diagnosis**	**Medication–related**	**Anaesthetic**	**Blood/blood product–related**	**Procedure**	**Treatment**	**Consent**	**Infection control**	**Device failure**	**Other general duty of care**	**Other**	**Not known**	**Total (number)**
Obstetrics only	9.0	2.0	0.8	0.3	61.4	17.3	0.4	1.3	—	2.9	0.8	3.8	100.0
Emergency medicine	63.4	2.6	0.3	—	3.6	19.7	0.5	1.1	0.5	4.8	0.8	2.6	100.0
General surgery	12.7	1.2	1.0	—	63.6	7.8	5.5	2.9	1.0	2.9	0.4	1.0	100.0
Orthopaedic surgery	17.8	1.5	1.0	—	48.5	13.3	4.8	5.0	2.5	2.8	0.5	2.5	100.0
Nursing—general	10.0	10.5	0.6	0.8	8.0	16.1	1.4	2.5	2.2	46.5	1.4	—	100.0
Gynaecology only	6.7	0.6	—	—	72.8	3.9	5.6	0.6	2.8	3.7	0.8	2.5	100.0
Obstetrics and gynaecology	8.5	1.5	1.1	0.4	53.9	20.3	5.2	0.4	0.7	4.4	1.1	2.6	100.0
Other hospital-based medical practitioner[d]	42.7	4.3	1.3	1.3	17.1	20.5	3.4	1.7	0.4	5.6	0.9	0.9	100.0
Psychiatry	10.2	6.2	0.4	—	0.9	13.3	0.4	—	—	57.3	3.1	8.0	100.0
Anaesthetics general	1.5	5.9	60.5	—	15.6	7.3	1.0	1.5	1.0	5.4	—	0.5	100.0
All other specialties	23.6	5.9	1.0	3.6	28.1	17.9	4.2	2.5	1.3	8.3	1.2	2.5	100.0
Not known	12.5	2.9	—	0.7	17.6	13.2	2.2	2.9	1.5	5.9	3.7	36.8	100.0
Not applicable[e]	5.8	1.9	3.8	3.8	7.7	13.5	1.9	13.5	1.9	32.7	11.5	1.9	100.0
Total	**21.3**	**4.1**	**2.8**	**1.5**	**33.9**	**15.6**	**3.2**	**2.1**	**1.2**	**10.0**	**1.2**	**3.2**	**100.0**
Total no. of claims[f]	*1,332*	*257*	*175*	*92*	*2,121*	*974*	*199*	*134*	*72*	*628*	*73*	*200*	

(a) NSW data are not included because data on clinical specialty are not available.

(b) 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.

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

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

(e) '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.

(f) This total indicates the number of claims for which the particular specialty was recorded. Since up to four different specialties may be recorded for a claim, a single claim may be counted in the total for several columns; therefore, the totals cannot be summed horizontally to give the total number of claims overall.

Notes

1. Data for approximately 85% 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 went wrong'.
3. The specialties listed separately are the ten most frequently recorded categories; all other categories are combined in the category 'All other specialties'.

Geographic location

The majority of claims (4,407 claims; or 68%) arose from events that occurred in major cities; 1,930 claims (30%) arose from incidents that occurred in regional areas, and 91 claims (1.4%) arose from incidents that occurred in remote areas (Table 3.4). Of all clinical service contexts, paediatrics and psychiatry had the highest proportion of claims in major cities (78% and 77% respectively), while claims involving general surgery had the lowest (59%). Around 30% of claims in the clinical service contexts of general surgery, orthopaedics and general medicine arose from incidents that occurred in inner regional areas (29%, 27% and 27% respectively).

A comparatively high proportion of claims involving the specialties of neurosurgery (96% of all claims), pathology (92%) and psychiatry (80%) originated from incidents that occurred in major cities (Table 3.5). These numbers generally reflect administrative arrangements and the concentration of some specialties in metropolitan areas. The highest proportion of claims associated with remote regions involved other hospital-based medical practitioners (6%) and general nursing, general surgery and midwifery (all 4%).

Table 3.4: All claims (public sector): clinical service context, by geographic location, 1 July 2004 to 30 June 2005, 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	70.3	19.5	8.9	1.1	0.2	100.0
A&E	65.1	22.6	9.5	2.2	0.6	100.0
General surgery	59.4	28.6	9.8	2.2	—	100.0
Gynaecology	63.8	24.0	10.6	1.4	0.2	100.0
Orthopaedics	61.6	27.3	9.3	1.3	0.4	100.0
General medicine	64.4	26.8	7.1	1.7	—	100.0
Psychiatry	77.3	18.1	3.2	0.4	1.1	100.0
Paediatrics	78.4	14.7	3.7	2.6	0.5	100.0
All other clinical service contexts	73.9	19.6	5.3	0.7	0.5	100.0
Not known	65.7	22.2	9.1	2.5	0.5	100.0
Total	**68.3**	**22.1**	**7.8**	**1.4**	**0.4**	**100.0**
Total no. of claims	*4,407*	*1,425*	*505*	*91*	*25*	*6,453*

(a) The categories for this data item are based on Australian Standard Geographical Classification (ASGC) 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 85% of all claims in scope are included.

Table 3.5: All claims (public sector): specialty of clinician(s) involved, by geographic location, 1 July 2004 to 30 June 2005, Australia[a] (per cent)

	Geographic location of incidents					
Specialty of clinician(s)[b]	Major cities	Inner regional	Outer regional	Remote and very remote	Total	Total number of claims[c]
Obstetrics only	73.0	19.3	6.4	1.1	**100.0**	715
Emergency medicine	69.0	22.8	7.0	1.1	**100.0**	610
General surgery	54.8	30.5	11.0	3.7	**100.0**	489
Orthopaedic surgery	64.0	23.5	10.5	2.0	**100.0**	400
Nursing—general	70.1	20.5	5.5	3.9	**100.0**	361
Gynaecology only	65.4	25.0	8.4	1.1	**100.0**	356
Obstetrics and gynaecology	71.2	16.6	10.7	1.5	**100.0**	271
Other hospital-based medical practitioner[d]	70.5	13.2	10.3	6.0	**100.0**	234
Psychiatry	80.4	16.4	3.1	—	**100.0**	225
Anaesthetics—general	70.2	21.0	7.3	1.5	**100.0**	205
Midwifery	68.5	17.0	10.9	3.6	**100.0**	165
General and internal medicine	60.7	30.0	8.0	1.3	**100.0**	150
Diagnostic radiology	73.4	21.0	5.6	0.0	**100.0**	124
General practice—non–procedural	17.1	66.7	13.8	2.4	**100.0**	123
Pathology	92.0	3.0	4.0	1.0	**100.0**	100
Neurosurgery	95.7	2.1	2.1	0.0	**100.0**	94
All other specialties	77.1	15.1	6.8	1.0	**100.0**	1,447
Not applicable[e]	88.5	3.8	5.8	1.9	**100.0**	52
Not known	72.8	14.7	11.0	1.5	**100.0**	136

(a) NSW data are not included because data on clinical specialty are not available.

(b) 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.

(c) The total number of claims for which the particular specialty was recorded. A given specialty may only be recorded once for a single claim. However, up to four different specialties may be recorded for a claim, so a single claim may be counted in the total for several rows; therefore, the totals cannot be summed vertically to give the total number of claims overall.

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

(e) '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 sex, and the body functions or structures affected is presented.

Age at incident and sex

During 2004–05, 645 claims (10%) related to babies less than one year old, 1,237 claims (19%) related to children, and 3,742 claims (58%) involved adults (Table 3.6). For 829 claims the age at incident was not known. Children were slightly over–represented in claims relating to diagnosis—315 claims out of 1,324, or 24% compared with 19% overall. Among claims involving procedural and treatment issues, babies were over-represented, accounting for 13% (291) and 14% (133) of claims respectively, compared with 10% overall.

Just over half of all claims involved females (3,628 claims; 56%), and the majority of these claims concerned adults (2,369 claims, or 65% of all females). Females accounted for almost three-quarters (998 of 1,362 claims, or 73%) of all procedure-related incidents for adults.

Males were involved in 2,747 claims (43% of total claims) and accounted for 53% of all claims relating to babies and 58% of claims involving children. Approximately two-thirds of procedure-related claims pertaining to children involved males (202 of 300 claims).

Table 3.6: All claims (public sector): sex and age at incident of claim subject, by primary incident/allegation type, 1 July 2004 to 30 June 2005, Australia

Primary incident/ allegation type	Age at incident				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total[a]
Males					
Diagnosis	58	182	347	62	649
Medication-related	7	31	62	18	118
Anaesthetic	2	18	38	9	67
Blood/blood product-related	3	10	27	4	44
Procedure	158	202	364	54	778
Treatment	69	106	202	51	428
Consent	6	22	40	7	75
Infection control	4	17	44	9	74
Device failure	3	6	16	3	28
Other general duty of care	15	67	180	48	310
Other	3	17	17	2	39
Not known	17	40	35	45	137
Total males	*345*	*718*	*1,372*	*312*	*2,747*
Females					
Diagnosis	49	132	430	58	669
Medication-related	11	17	72	17	117
Anaesthetic	3	13	80	13	109
Blood/blood product-related	1	12	25	7	45
Procedure	112	97	998	153	1,360
Treatment	59	97	293	65	514
Consent	4	16	80	37	137
Infection control	2	16	40	9	67
Device failure	0	3	27	4	34
Other general duty of care	8	65	222	66	361
Other	2	19	25	6	52
Not known	15	30	77	41	163
Total females	*266*	*517*	*2,369*	*476*	*3,628*
Persons[b]					
Diagnosis	109	315	777	123	1,324
Medication–related	19	48	134	36	237
Anaesthetic	5	31	118	23	177
Blood/blood product–related	4	22	52	26	104
Procedure	291	300	1,362	210	2,163
Treatment	133	203	495	116	947
Consent	10	38	120	45	213
Infection control	6	33	84	28	151
Device failure	3	9	43	10	65
Other general duty of care	24	132	402	116	674
Other	5	36	42	9	92
Not known	36	70	113	87	306
Total persons	**645**	**1,237**	**3,742**	**829**	**6,453**

(a) Includes 829 claims for which age at incident of claim subject was missing (312 males, 476 females).

(b) Includes 78 claims for which sex of claim subject was not known/indeterminate (34 babies, 2 children, 1 adult, 41 not known).

Note: Data for approximately 85% of all claims in scope are included.

Primary body function/structure affected

Table 3.7 provides a summary of the primary body function or structure of the person allegedly affected as a result of an incident. Neuromusculoskeletal and movement-related functions and structures were most commonly recorded as the primary body function/structure affected as a result of the incident (1,522 claims; 24%). The next most commonly recorded categories were mental functions/structures of the nervous system (15%) and genitourinary and reproductive functions and structures (13%). In 592 cases death occurred (9.2% of all claims).

In the MINC, up to three additional body function/structure areas can be coded.

Table 3.7: All claims (public sector): primary body function/structure[(a)] affected, 1 July 2004 to 30 June 2005, Australia

Primary body function/structure affected	Number	Per cent of all claims
Mental functions/structures of the nervous system	957	14.8
Sensory functions/the eye, ear and related structures	195	3.0
Voice and speech functions/structures involved in voice and speech	93	1.4
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	468	7.3
Functions and structures of the digestive, metabolic and endocrine systems	578	9.0
Genitourinary and reproductive functions and structures	867	13.4
Neuromusculoskeletal and movement-related functions and structures	1,522	23.6
Functions and structures of the skin and related structures	250	3.9
Death	592	9.2
No body function/structure affected	159	2.5
Not known	772	12.0
All claims	**6,453**	**100.0**

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

Note: Data for approximately 85% of all claims in scope are included.

3.3 Claims

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

Status of claim

At 30 June 2005 there were:

- 2,048 claims (32% of all claims) that had a reserve placed against them but had not yet commenced
- 2,690 claims (42%) that had commenced but were not yet finalised
- 1,680 claims (26%) that were finalised
- 35 claims that had been previously closed and were reopened (Table 3.8).

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

The majority of finalised claims (1,478 claims, or 88% of all finalised claims) had an agreed total claim size and were closed. Other finalised claims included those without an agreed claim size (3% of finalised claims) and claims subject to structured settlements (9%).

As with claims overall, the majority of finalised claims related to the primary incident/allegation type of procedure, diagnosis and treatment (totalling 1,142 claims, or 68% of all finalised claims) (Table 3.9; see also Table 3.1 for all claims). A relatively high proportion of claims associated with blood products were not yet commenced (59 claims, or 57% compared with 32% overall).

Table 3.8: All claims (public sector): status of claim, 30 June 2005, Australia

Clinical service context	Reserve placed but not yet commenced[a]	Commenced (not yet finalised)[b]	Finalised					Claim previously closed now reopened[h]	Total
			Claim file closed[c]	Awaiting determination of total size[d]	Structured settlement with total dollar value decided[e]	Structured settlement with total dollar value open[f]	*Total finalised*[g]		
All claims	2,048	2,690	1,478	58	141	3	*1,680*	35	6,453
Total (per cent)	*31.7*	*41.7*	*22.9*	*0.9*	*2.2*	*0.0*	*26.0*	*0.5*	*100.0*

(a) A reserve has been set for the claim but none of the events signalling claim commencement—for example, the issuing of a letter of demand or a writ or an offer made by the defendant to the claimant—has yet occurred.

(b) The claim has commenced but has not yet been finalised.

(c) The total claim size has been determined, and the claim file has been closed; excludes finalised claims where payments to the claimant are made under a structured settlement scheme.

(d) The total claim size has yet to be determined and the claim file has not yet been closed; this may include instances where legal costs are yet to be finally determined.

(e) The health authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme, with the total amount to be paid decided.

(f) The health authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme, with the total amount to be paid remaining open.

(g) Of the 1,680 finalised claims, 68 had a 'date claim finalised' before the reporting period (that is, before 1 July 2004).

(h) The claim has previously been recorded as finalised on the MINC database but has then been reopened.

Note: Data for approximately 85% of all claims in scope are included.

Table 3.9: All claims (public sector): status of claim, by primary incident/allegation type, 30 June 2005, Australia

			Finalised								
Primary incident/ allegation type	**Not yet commenced**	**Commenced (not yet finalised)**	**Claim file closed**	**Awaiting determination of total size[a]**	**Structured settlement with total dollar value decided**	**Structured settlement with total dollar value open**	***Total finalised***	***Total finalised (per cent)***	**Claim previously closed now reopened**	**Total**	***Total (per cent)***
Diagnosis	379	598	300	12	28	1	*341*	*20.3*	6	1,324	*20.5*
Medication-related[b]	69	97	57	2	10	—	*69*	*4.1*	2	237	*3.7*
Anaesthetic	60	52	55	2	7	—	*64*	*3.8*	1	177	*2.7*
Blood/blood product-related	59	25	18	—	2	—	*20*	*1.2*	—	104	*1.6*
Procedure[c]	734	855	497	23	39	1	*560*	*33.3*	14	2,163	*33.5*
Treatment[d]	299	399	212	6	23	—	*241*	*14.3*	8	947	*14.7*
Consent[e]	31	116	54	5	7	—	*66*	*3.9*	—	213	*3.3*
Infection control	40	73	35	—	3	—	*38*	*2.3*	—	151	*2.3*
Device failure	21	19	19	2	4	—	*25*	*1.5*	—	65	*1.0*
Other general duty of care	219	264	167	5	18	1	*191*	*11.4*	—	674	*10.4*
Other	17	44	26	1	—	—	*27*	*1.6*	4	92	*1.4*
Not known	120	148	38	—	—	—	*38*	*2.3*	—	306	*4.7*
All claims	**2,048**	**2,690**	**1,478**	**58**	**141**	**3**	***1,680***	***100.0***	**35**	**6,453**	***100.0***
Total (per cent)	*31.7*	*41.7*	*22.9*	*0.9*	*2.2*	*0.0*	*26.0*	*1.5*	*0.5*	*100.0*	

(a) The total claim size has yet to be determined and the claim file has not yet been closed; this may include instances where legal costs are yet to be finally determined.

(b) 'Medication-related' includes type, dosage and method of administration issues.

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

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

(e) 'Consent' includes failure to warn.

Note: Data for approximately 85% of all claims in scope are included.

Categories of loss claimed

'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 2.4 for all claims during the reporting period (Table 3.10). Pain and suffering, including nervous shock, was recorded in 28% of claims. The other categories of loss were recorded for 14% and 17% of all claims. The category of loss was unknown or the information was not currently available for 62% of claims.

Table 3.10: All claims (public sector): nature of claim—loss to claim subject, 1 July 2004 to 30 June 2005, Australia (per cent)

Nature of claim—loss to claim subject	Care costs[a]	Other economic loss[b]	Pain and suffering[c]	Other loss [d]	N/A	Not known	*Average no. of loss categories[e]*
Per cent of all claims	16.3	16.9	27.6	14.3	6.3	62.2	
Total number of claims[f]	1,051	1,094	1,781	924	403	4,016	*2.4*

(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 recorded for 'Nature of claim—loss to claim subject' may include loss to other parties, as this is not possible to separately identify.
2. Data for approximately 85% 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 2005 (for claims still then open) or to the date the claim was finalised (for claims finalised before then).

For all claims the average duration was 2.1 years (Table 3.11). Those which were closed during the reporting period had an average length of 26 months, similar to that for all finalised claims (27 months). There were 66 claims closed during the reporting period which had been open in excess of five years. The majority of current claims had been open for three years or less (80% claims); commenced but not yet finalised claims had been open an average of 2.2 years.

Not surprisingly, the duration of claims subject to structured settlements was significantly longer since payments are often issued for several years before a claim is closed. For those structured settlements where an amount had been agreed, claims were open for an average of 38 months; for those with an amount yet to be decided the average length was almost five years.

The average duration of claims previously closed but then reopened was 40 months. 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 instead).

Because NSW claims that commenced before 2002 are not included in the 2004–05 reporting period, 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).

Table 3.11: All claims (public sector): status of claim, by length of claim (months), 30 June 2005, Australia

Status of claim[a]	Length of claim at 30 June 2005 (months)												
	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	60+	Total	Mean
						Number							
Reserve placed but not yet commenced	266	381	350	358	239	138	123	47	42	24	80	2,048	22.1
Commenced (not yet finalised)	367	498	338	314	284	259	173	105	81	61	210	2,690	25.9
Finalised claims													
Claim file closed	99	211	243	259	217	184	106	31	42	20	66	1,478	25.6
Awaiting determination of total size	—	2	2	12	8	7	5	6	5	1	10	58	38.7
Structured settlement with total dollar value decided	—	9	11	19	17	17	12	16	15	8	17	141	37.8
Structured settlement with total dollar value undecided	—	—	—	—	—	—	—	1	1	—	1	3	57.4
Total finalised[b]	*99*	*222*	*256*	*290*	*242*	*208*	*123*	*54*	*63*	*29*	*94*	*1,680*	*27.1*
Claim previously closed now reopened	1	1	2	3	8	2	2	1	3	5	7	35	40.1
Total claims	**733**	**1,102**	**946**	**965**	**773**	**607**	**421**	**207**	**189**	**119**	**391**	**6,453**	**25.1**
						Per cent							
Reserve placed but not yet commenced	13.0	18.6	17.1	17.5	11.7	6.7	6.0	2.3	2.1	1.2	3.9	100.0	
Commenced (not yet finalised)	13.6	18.5	12.6	11.7	10.6	9.6	6.4	3.9	3.0	2.3	7.8	100.0	
Finalised claims													
Claim file closed	6.7	14.3	16.4	17.5	14.7	12.4	7.2	2.1	2.8	1.4	4.5	100.0	
Awaiting determination of total size	—	3.4	3.4	20.7	13.8	12.1	8.6	10.3	8.6	1.7	17.2	100.0	
Structured settlement with total dollar value decided	—	6.4	7.8	13.5	12.1	12.1	8.5	11.3	10.6	5.7	12.1	100.0	
Structured settlement with total dollar value undecided	—	—	—	—	—	—	—	33.3	33.3	—	33.3	100.0	
Total finalised[b]	*5.9*	*13.2*	*15.2*	*17.3*	*14.4*	*12.4*	*7.3*	*3.2*	*3.8*	*1.7*	*5.6*	*100.0*	
Claim previously closed now reopened	2.9	2.9	5.7	8.6	22.9	5.7	5.7	2.9	8.6	14.3	20.0	100.0	
Per cent of all claims	**11.4**	**17.1**	**14.7**	**15.0**	**12.0**	**9.4**	**6.5**	**3.2**	**2.9**	**1.8**	**6.1**	**100.0**	

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

(b) Of the 1,680 finalised claims, 1,612 were finalised during 2004–05 and 68 were finalised previously but the claim file was still open at 1 July 2004.

Notes

1. Length of claim is from date reserve was placed to 30 June 2005. If a claim has a status of 'claim file closed', length of claim is from date reserve was placed to date claim is finalised.
2. Data for approximately 85% of all claims in scope are included.

Current claims

There were 4,773 current claims remaining open at the end of the reporting period. Of these, just over half (52%) had a reserve value of less than $30,000, with $10,000–$30,000 being the most commonly recorded category (34% of all current claims) (Table 3.12). This reserve range category accounted for a greater proportion of claims in general medicine (43%), general surgery (38%) and psychiatry (36%).

The reserve value exceeded $500,000 for 272 (5.7%) claims. In the clinical service contexts of obstetrics and paediatrics this reserve range category constituted 15% and 13% of claims respectively. Similarly, claims reserved above $100,000 were relatively more common in these clinical service contexts (33% and 35%, compared with 21% overall). Smaller claims (less than $10,000) were more likely in general medicine and accident and emergency (29% and 24% respectively, compared with 18% overall).

In most categories of primary incident/allegation type, around half (or more) of current claims were reserved at a value less than $50,000 (Table 3.13). Exceptions to this were blood/blood products and consent-related matters, where claims reserved at less than $50,000 constituted 32% and 39% respectively. In each of these categories there was a relatively high proportion of claims reserved between $50,000 and $100,000 (54% and 42% respectively, compared with 20% of claims overall).

Table 3.12: Current claims (public sector): reserve range, by clinical service context, 30 June 2005, Australia

	Clinical service context										
Reserve range	**Obstetrics**	**A&E**	**General surgery**	**Gynaecology**	**Orthopaedics**	**General medicine**	**Psychiatry**	**Paediatrics**	**All other clinical service contexts**	**Not known**	**Total**
						Number					
Less than $10,000	101	163	107	50	54	60	43	17	235	38	868
$10,000–<$30,000	272	228	192	130	95	90	70	38	417	67	1,599
$30,000–<$50,000	59	54	44	40	38	15	12	10	103	8	383
$50,000–<$100,000	164	113	101	79	68	19	35	29	297	31	936
$100,000–<$250,000	109	69	45	53	40	11	18	23	120	24	512
$250,000–<$500,000	53	24	15	15	17	7	11	9	49	3	203
$500,000 or more	134	43	5	3	8	8	8	18	41	4	272
Total	**892**	**694**	**509**	**370**	**320**	**210**	**197**	**144**	**1,262**	**175**	**4,773**
						Per cent					
Less than $10,000	11.3	23.5	21.0	13.5	16.9	28.6	21.8	11.8	18.6	21.7	18.2
$10,000–<$30,000	30.5	32.9	37.7	35.1	29.7	42.9	35.5	26.4	33.0	38.3	33.5
$30,000–<$50,000	6.6	7.8	8.6	10.8	11.9	7.1	6.1	6.9	8.2	4.6	8.0
$50,000–<$100,000	18.4	16.3	19.8	21.4	21.3	9.0	17.8	20.1	23.5	17.7	19.6
$100,000–<$250,000	12.2	9.9	8.8	14.3	12.5	5.2	9.1	16.0	9.5	13.7	10.7
$250,000–<$500,000	5.9	3.5	2.9	4.1	5.3	3.3	5.6	6.3	3.9	1.7	4.3
$500,000 or more	15.0	6.2	1.0	0.8	2.5	3.8	4.1	12.5	3.2	2.3	5.7
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 'All other clinical service contexts'. Table A3-1 shows the frequency of coding categories for all clinical service contexts.
2. Data for approximately 85% of all claims in scope are included.

Table 3.13: Current claims (public sector): reserve range, by primary incident/allegation type, 30 June 2005, 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	159	27	37	7	241	132	17	27	13	121	16	71	868
$10,000–<$30,000	296	57	39	19	582	232	24	29	15	187	23	96	1,599
$30,000–<$50,000	84	16	3	1	132	66	16	10	7	35	4	9	383
$50,000–<$100,000	193	32	18	45	320	128	61	23	4	59	10	43	936
$100,000–<$250,000	123	14	9	11	184	62	17	14	1	40	7	30	512
$250,000–<$500,000	53	7	5	—	60	35	4	3	—	20	4	12	203
$500,000 or more	75	15	2	1	84	51	8	7	—	21	1	7	272
Total	**983**	**168**	**113**	**84**	**1,603**	**706**	**147**	**113**	**40**	**483**	**65**	**268**	**4,773**
						Per cent							
Less than $10,000	16.2	16.1	32.7	8.3	15.0	18.7	11.6	23.9	32.5	25.1	24.6	26.5	18.2
$10,000–<$30,000	30.1	33.9	34.5	22.6	36.3	32.9	16.3	25.7	37.5	38.7	35.4	35.8	33.5
$30,000–<$50,000	8.5	9.5	2.7	1.2	8.2	9.3	10.9	8.8	17.5	7.2	6.2	3.4	8.0
$50,000–<$100,000	19.6	19.0	15.9	53.6	20.0	18.1	41.5	20.4	10.0	12.2	15.4	16.0	19.6
$100,000–<$250,000	12.5	8.3	8.0	13.1	11.5	8.8	11.6	12.4	2.5	8.3	10.8	11.2	10.7
$250,000–<$500,000	5.4	4.2	4.4	—	3.7	5.0	2.7	2.7	—	4.1	6.2	4.5	4.3
$500,000 or more	7.6	8.9	1.8	1.2	5.2	7.2	5.4	6.2	—	4.3	1.5	2.6	5.7
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 85% of claims in scope are included.

Duration of current claims

The average duration of current claims increases with reserve range (Table 3.14). Claims with a reserve of $500,000 or more have been open, on average, for over three years; while claims with a reserve value of less than $10,000 have a mean duration of one-and-a-half years.

Of the 297 claims open for longer than five years, those with a reserve range between $50,000 and less than $100,000 were most common (33%, or 97 claims).

Table 3.14: Current claims (public sector): reserve range, by length of claim (months), 30 June 2005, Australia

	Length of claim at 30 June 2005 (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**
						Number							
Less than $10,000	137	205	143	152	86	53	44	16	12	5	15	868	18.7
$10,000–<$30,000	228	299	279	245	193	114	92	46	42	18	43	1,599	21.3
$30,000–<$50,000	47	53	40	56	59	45	21	17	12	5	28	383	26.2
$50,000–<$100,000	117	182	124	125	73	61	59	34	25	39	97	936	27.4
$100,000–<$250,000	70	74	54	46	63	61	45	19	20	15	45	512	27.9
$250,000–<$500,000	21	27	25	25	22	33	18	6	6	4	16	203	28.7
$500,000 or more	14	40	25	26	35	32	19	15	9	4	53	272	37.4
Total	**634**	**880**	**690**	**675**	**531**	**399**	**298**	**153**	**126**	**90**	**297**	**4,773**	**24.4**
						Per cent							
Less than $10,000	15.8	23.6	16.5	17.5	9.9	6.1	5.1	1.8	1.4	0.6	1.7	100.0	
$10,000–<$30,000	14.3	18.7	17.4	15.3	12.1	7.1	5.8	2.9	2.6	1.1	2.7	100.0	
$30,000–<$50,000	12.3	13.8	10.4	14.6	15.4	11.7	5.5	4.4	3.1	1.3	7.3	100.0	
$50,000–<$100,000	12.5	19.4	13.2	13.4	7.8	6.5	6.3	3.6	2.7	4.2	10.4	100.0	
$100,000–<$250,000	13.7	14.5	10.5	9.0	12.3	11.9	8.8	3.7	3.9	2.9	8.8	100.0	
$250,000–<$500,000	10.3	13.3	12.3	12.3	10.8	16.3	8.9	3.0	3.0	2.0	7.9	100.0	
$500,000 or more	5.1	14.7	9.2	9.6	12.9	11.8	7.0	5.5	3.3	1.5	19.5	100.0	
Per cent of all current claims	*13.3*	*18.4*	*14.5*	*14.1*	*11.1*	*8.4*	*6.2*	*3.2*	*2.6*	*1.9*	*6.2*	*100.0*	

Notes

1. Length of claim is from date reserve was placed to 30 June 2005.
2. Data for approximately 85% of all claims in scope are included.

New claims

There were 1,641 new claims during the reporting period (Table 3.15). These were most commonly associated with the clinical service contexts of obstetrics (246 claims, or 15% of all new claims), accident and emergency (243 claims; 15%) and general surgery (173; 11%) (Table 3.15). Of all new claims, 60% (984 claims) were reserved for less than $30,000 and 3% (55 claims) had a reserve exceeding $500,000.

Of the 246 new obstetrics claims, 46 (or 19%) were reserved above $250,000. This proportion was considerably higher than for accident and emergency claims (6%) and claims overall (6%).

Table 3.15: New claims (public sector): reserve range, by clinical service context, 1 July 2004 to 30 June 2005, Australia

Reserve range	Obstetrics	A&E	General surgery	Gynaecology	Orthopaedics	General medicine	Psychiatry	Paediatrics	All other clinical service contexts	Not known	Total	*Per cent*
Less than $10,000	32	87	50	30	29	33	30	10	123	20	444	*27.1*
$10,000–<$30,000	73	77	73	40	41	39	23	13	132	29	540	*32.9*
$30,000–<$50,000	14	16	10	9	8	7	3	3	26	5	101	*6.2*
$50,000–<$100,000	51	34	29	25	18	3	12	11	95	25	303	*18.5*
$100,000–<$250,000	30	15	8	13	10	4	5	4	38	20	147	*9.0*
$250,000–<$500,000	19	4	3	2	4	2	1	1	12	3	51	*3.1*
$500,000 or more	27	10	—	1	2	1	2	2	6	4	55	*3.4*
Total	**246**	**243**	**173**	**120**	**112**	**89**	**76**	**44**	**432**	**106**	**1,641**	***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 A3-1 shows the frequency of coding categories for all clinical service contexts for all claims.
2. Data for approximately 96% of all claims in scope are included.

Finalised claims

A claim is finalised when the claim is settled, a final court decision is made, or the claim is closed. During 2004–05, 1,680 claims were finalised (1,612 claims finalised during the period and 68 claims finalised but not closed before 1 July 2004) (Box 2.1).

Most claims were finalised for less than $100,000 (1,127 claims; 67% of all finalised claims) (Table 3.16). In 27 cases payments were in excess of $500,000. Of those claims in the smallest payment category (less than $10,000), 514 claims, or 73%, were discontinued. Discontinued claims constituted just over half of all finalised claims (55%, or 917 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—653, or 39% of finalised claims. A claim can be settled in various ways. Court-based alternative dispute resolution and 'other settlement processes' (including settlement part-way through a trial) were most common in settled claims, with 184 and 419 claims respectively, or 11% and 25% of all claims finalised. Court decisions were involved in only 4%, or 62 claims. Of these 62 claims, 23% involved a payment exceeding $250,000. In comparison, only 6%, or 41 settled claims, were associated with payments exceeding $250,000.

In 343 cases (20% of all finalised claims) no payment was made to the claimant and no legal costs were incurred. Most of these were discontinued claims (331, or 97%).

[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 3.16: Finalised claims (public sector): total claim size, by mode of claim finalisation, 1 July 2004 to 30 June 2005, Australia

	Settled								
Total claim size	**State/territory-based complaints processes[a]**	**Court-based alternative dispute resolution processes[b]**	**Statutorily-mandated compulsory conference process[c]**	**Settled—other[d]**	***Total settled***	**Court decision**	**Dis-continued[e]**	**Not known**	**Total[f]**
Less than $10,000	14	11	2	136	*163*	8	514	15	700
$10,000–<$30,000	3	24	6	91	*124*	10	51	4	189
$30,000–<$50,000	—	25	5	48	*78*	4	5	3	90
$50,000–<$100,000	2	63	7	62	*134*	7	2	5	148
$100,000–<$250,000	—	31	2	42	*75*	8	1	4	88
$250,000–<$500,000	—	8	—	14	*22*	10	—	6	38
$500,000 or more	—	12	3	4	*19*	4	1	3	27
No payment made[g]	1	—	—	7	*8*	4	331	—	343
Not known	1	10	4	15	*30*	7	12	8	57
Total	**21**	**184**	**29**	**419**	***653***	**62**	**917**	**48**	**1,680**

(a) 'State/territory-based complaints processes' includes 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) Of the 1,680 finalised claims, 1,612 were finalised during 2004–05 and 68 were finalised previously but claim file was still open at 1 July 2004.

(g) 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 73% of all claims in scope are included.

Duration of finalised claims

Table 3.17 shows the relationship between claim size and duration. There is some suggestion that small claims are finalised more quickly than larger claims. Claims with a total claim size of less than $30,000, were open an average of two years; while those that settled for above $500,000, were finalised on average, in just over three years. The mean duration for all finalised claims was 2.3 years.

Table 3.17: Finalised claims (public sector): total claim size, by length of claim (years), Australia

	Length of claim at 30 June 2005 (years)							
Total claim size	**1**	**2**	**3**	**4**	**5**	**>5**	**Total claims[(a)]**	**Mean**
				Number				
Less than $10,000	203	236	150	50	24	37	700	2.0
$10,000–<$30,000	46	73	29	19	14	8	189	2.1
$30,000–<$50,000	10	34	20	7	11	8	90	2.6
$50,000–<$100,000	14	54	38	22	9	11	148	2.5
$100,000–<$250,000	5	17	30	11	15	10	88	3.1
$250,000–<$500,000	4	8	11	10	2	3	38	2.7
$500,000 or more	—	5	9	6	4	3	27	3.3
No payment made[(b)]	34	102	150	45	8	4	343	2.3
Not known	5	17	13	7	5	10	57	2.9
All finalised claims	**321**	**546**	**450**	**177**	**92**	**94**	**1,680**	**2.3**
				Per cent				
Less than $10,000	29.0	33.7	21.4	7.1	3.4	5.3	100.0	
$10,000–<$30,000	24.3	38.6	15.3	10.1	7.4	4.2	100.0	
$30,000–<$50,000	11.1	37.8	22.2	7.8	12.2	8.9	100.0	
$50,000–<$100,000	9.5	36.5	25.7	14.9	6.1	7.4	100.0	
$100,000–<$250,000	5.7	19.3	34.1	12.5	17.0	11.4	100.0	
$250,000–<$500,000	10.5	21.1	28.9	26.3	5.3	7.9	100.0	
$500,000 or more	—	18.5	33.3	22.2	14.8	11.1	100.0	
No payment made[(b)]	9.9	29.7	43.7	13.1	2.3	1.2	100.0	
Not known	8.8	29.8	22.8	12.3	8.8	17.5	100.0	
All finalised claims	**19.1**	**32.5**	**26.8**	**10.5**	**5.5**	**5.6**	**100.0**	

(a) Of the 1,680 finalised claims, 1,612 were finalised during 2004–05 and 68 were finalised previously but the claim file was still open at 1 July 2004.

(b) 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 2005. If a claim has a status of 'claim file closed', length of claim is from date reserve was placed to date claim finalised.
2. Data for approximately 73% of all claims in scope are included.

Appendix 1: Body function/structure categories

Table A1: 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 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 Generalised abdominal pain Appendicitis
6. Genitourinary and reproductive functions and structures	Injury to the breast Injury to male or female reproductive organs Injury to the kidney
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: 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 2004, 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 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 2005.

For the 2005 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 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 department, which notifies TMF.

When notified of an incident, 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; investigates the incident; provides instructions to the solicitor; and conducts interviews. 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 as follows:

- 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 as follows:

- creating a peer acceptance test for professional negligence
- amending the limitation period within which an action must be brought to a date three 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 VMIA of an incident, 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 six years to three 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 six 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).

IRM3.8–4 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 nine months of the incident (or the appearance of symptoms) or one 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 six 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. Since 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 and the relevant hospital receive 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 treating public patients in public hospitals for MTL claims. The cost of the indemnity is met by the relevant hospital(s). In return, the practitioners are required to support and participate in further safety and quality management programs.

In mid-2004 the scope of the indemnity was extended. It now provides:

- effectively unlimited cover
- IBNR cover dating to the time when the doctor'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 participating in quality improvement committees
- indemnity for medical services provided to private and other 'non-public' patients treated in hospitals administered by the WA Country Health Service.

From 1 July 2004 salaried medical officers have been offered the same contractual indemnity for MTL claims arising from their treatment of public patients and also, where the doctor 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 (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 'Ipp Report'
- the *Civil Liability Amendment Act 2004* which further amended the *Civil Liability Act 2002* in two respects—introducing a new evidentiary test in relation to the standard of care required of health professionals and making 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:

- initial notification of incident
- assessment of notification by claims manager
- if necessary, claim file opened and reserve raised
- if necessary, panel solicitor appointed
- investigation of claim
- decision about approach to liability and quantum
- reserve monitored throughout the claim and adjusted if necessary
- 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 in excess of 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 2004*. 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 as follows:

- 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.
- 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.
- A copy of the claim notification form is forwarded to the Departmental officer responsible for maintaining the database in respect of 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.

- 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 2005). 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 2005
- changes to the limitation period where an action for damages for negligence now cannot be brought after the sooner of three years from the date of discoverability or 12 years from the date of the cause of action (effective from 1 January 2005) (see s.5A of the *Limitation Act 1974*). Previously, the limitation period was three years from the date of the cause of action, with an extension of a further three 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. Claims and circumstances that come to the attention of the responsible entity are to be reported immediately to the ACT Insurance Authority under obligations ACT Health has to that insurance provider. To ensure that all 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 six years to three 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 nine months after the date of the accident or after the date symptoms first appear if they are not immediately

apparent or one 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 three years
- requiring that for child claimants, this notice be given within six 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 six 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 three 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 three 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 six hours or more a week
  - or for six 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.

Appendix 3: Detailed tables

Table A3-1: Clinical service context: number of claims for which each clinical service context recorded, 1 July 2004 to 30 June 2005, Australia

Clinical service context	Number	Per cent of claims
Accident and emergency	940	14.6
Cardiology	135	2.1
Dentistry	137	2.1
Cosmetic procedures	25	0.4
Ear, nose and throat	89	1.4
General medicine	295	4.6
General practice	130	2.0
General surgery	721	11.2
Gynaecology	508	7.9
Hospital outpatient department	78	1.2
Neurology	117	1.8
Obstetrics	1,141	17.7
Oncology	60	0.9
Orthopaedics	450	7.0
Paediatrics	190	2.9
Perinatology	47	0.7
Plastic surgery	44	0.7
Psychiatry	277	4.3
Radiology	68	1.1
Urology	100	1.5
Other	703	10.9
Not known	198	3.1
Total	**6,453**	**100.0**

Table A3-2: Specialties of clinicians closely involved in incident: frequency of coding categories recorded for claims, 1 July 2004 to 30 June 2005, Australia

Specialty of clinician	Number	Per cent of all recorded speciality categories
Anaesthetics—general	205	3.3
Anaesthetics—intensive care	10	0.2
Cardiology	80	1.3
Cardio-thoracic surgery	41	0.7
Chiropractics	—	—
Clinical genetics	11	0.2
Clinical haematology	74	1.2
Clinical pharmacology	—	—
Colorectal surgery	25	0.4
Cosmetic surgery	3	0.0
Dentistry—oral surgery	87	1.4
Dentistry—procedural	40	0.6
Dermatology	9	0.1
Diagnostic radiology	124	2.0
Ear, nose and throat	80	1.3
Emergency medicine	610	9.7
Endocrinology	9	0.1
Endoscopy	7	0.1
Facio-maxillary surgery	10	0.2
Gastroenterology	46	0.7
General and internal medicine	150	2.4
General practice—non procedural	123	2.0
General practice—procedural	85	1.4
General surgery	489	7.8
Geriatrics	4	0.1
Gynaecology only	356	5.7
Infectious diseases	20	0.3
Intensive care	63	1.0
Medical oncology	27	0.4
Midwifery	165	2.6
Neurology	33	0.5
Neurosurgery	94	1.5
Neonatology	82	1.3
Nuclear medicine	5	0.1
Nursing—general	361	5.8
Nursing—nurse practitioner	2	0.0
Nutrition/dietician	—	—
Obstetrics and gynaecology	271	4.3

(continued)

Table A3-2 (continued): Specialties of clinicians closely involved in incident: frequency of coding categories recorded for claims, 1 July 2004 to 30 June 2005, Australia

Specialty of clinician	Number	Per cent of all recorded speciality categories
Obstetrics only	715	11.4
Occupational medicine	1	0.0
Ophthalmology	57	0.9
Orthopaedic surgery	400	6.4
Osteopathy	1	0.0
Paediatric medicine	93	1.5
Paediatric surgery	51	0.8
Paramedical and ambulance staff	20	0.3
Pathology	100	1.6
Pharmacy	8	0.1
Physiotherapy	25	0.4
Plastic surgery	72	1.2
Podiatry	9	0.1
Psychiatry	225	3.6
Psychology	2	0.0
Public health/preventive medicine	7	0.1
Rehabilitation medicine	8	0.1
Renal medicine	13	0.2
Respiratory medicine	13	0.2
Rheumatology	7	0.1
Spinal surgery	4	0.1
Sports medicine	—	—
Therapeutic radiology	13	0.2
Thoracic medicine	5	0.1
Urology	90	1.4
Vascular surgery	50	0.8
Other allied health	43	0.7
Other hospital-based medical practitioner[(a)]	234	3.7
N/A[(b)]	52	0.8
Not known	136	2.2
Total[(c)]	**6,257**	**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 excluding NSW.

Note: NSW data are not included because data on clinical specialty are not available.

Table A3-3: Specialty of clinicians closely involved in incident: percentage of claims with one, two, three and four specialty codes recorded, 1 July 2004 to 30 June 2005, Australia

	One specialty only	Two specialties	Three specialties	Four specialties	Total
Per cent of claims	86.9	10.7	2.0	0.4	100.0

Note: NSW data are not included because data on clinical specialty are not available; therefore only percentages are shown.

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