Medical indemnity national data collection public sector

2003 to 2004

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MIDWG members are:

- John Markic (South Australia–Department of Health) (Chair)
- Mark Kendall (ACT–ACT Health) (Deputy Chair)
- Belinda Woolley (NSW–NSW Health)
- Lloyd Stuart (Victoria–Department of Human Services)
- Milena Canil (Victoria–Department of Human Services)
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- Maria Travers (Australian Government Department of Health and Ageing)

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Symbols

– nil or rounded to zero

Abbreviations

AIHW	Australian Institute of Health and Welfare
AHMAC	Australian Health Ministers' Advisory Council
APRA	Australian Prudential Regulatory Authority
MIIAA	Medical Indemnity Industry Association of Australia
MIDWG	Medical Indemnity Data Working Group
MINC	Medical Indemnity National Collection
PIPA	Personal Injuries Proceedings Act 2002
PHO	public health organisation
SS	staff specialist
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 (i.e. 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, 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.

1 Introduction

There has been increasing policy concern about the costs associated with health care litigation and the financial viability of medical indemnity insurance in Australia. It was recognised by Health Ministers that the systematic collection and analysis of medical indemnity claims data is critical to the nation's ability to understand and monitor the situation.

This report presents the first full financial year's data collected through the Medical Indemnity National Collection (MINC) and provides information on the number, nature, incidence and costs of public sector medical indemnity claims. There is information on the incidents that give rise to claims, the people affected by these incidents, and the size, outcome and key aspects of the processing of claims.

Data for approximately 80% of all claims in the scope of the MINC are included. 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 placed against it. Claims are included if they were current at any time during the reporting period (July 2003–June 2004); that is, those that where open at the start of the period and those that arose during the period.

This is the second report originating from the MINC. The initial report, *First Medical Indemnity National Data Collection Report: Public Sector, January to June 2003* describes the development of the collection and presents the first six months' data. While significant improvements (particularly in regard to data completeness) have occurred, the data presented in this report must be interpreted cautiously as further improvements in quality and scope are needed (see section 2.4, Data quality and completeness). Particular care should be taken when attempting to compare data in this report with those in the previous publication.

1.1 Background to the collection

The need for a national medical indemnity collection arose in the broader context of national policy concern related to health care litigation, associated costs, and the financial viability of medical indemnity insurers. To date, the absence of national data has made it difficult to analyse 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 the proposals of the MIDWG 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; and
- 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; and
- supplement other sources of information on clinical risk prevention and management.

Work on the compilation of a single national report incorporating public and private sectors is currently underway. Its completion will be a substantial step towards a meaningful and accurate portrayal of the medical indemnity insurance sector nationwide.

1.3 Collaborative arrangements

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

A Medical Indemnity Data Working Group (MIDWG), consisting of members representing all 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, aggregated data publications and MINC-related matters. The MIDWG reports on statistical matters to the Statistical Information Management Committee and any unresolved issues are presented to AHMAC for resolution.

AIHW is the national data custodian of the MINC and is responsible for the collection, cleaning, 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; and
- documented policies and procedures, approved by the board of AIHW, 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 approval and consent of MIDWG. An annex to the Agreement outlines the protocols for access to and release of MINC data.

1.4 Ongoing development of the collection and progress towards a full national report on medical indemnity

The goal articulated by Health Ministers at the Medical Indemnity Summit in 2002 was to make full national data on public and private sector medical indemnity claims available to inform policy. There are now two relevant collections: the MINC, collecting public sector information, and the Australian Prudential Regulatory Authority (APRA), collecting private sector information covered by public and products liability and professional liability (including medical indemnity) insurance under the *Financial Sector (Collection of Data) Act, 2001*. Both collections hold information on open claims from 1 January 2003; MINC has been collecting data since that year, while APRA's first transmission of data occurred in 2004.

The two collections have evolved with different purposes. MINC collects (in addition to some financial information) data on the nature of claims and the people affected by and involved in allegedly harmful events. APRA is legislatively bound to collect information that will assist in the prudential regulation of insurance agencies. APRA and AIHW have been working together to improve coordination and consistency in data content between the two collections. This has resulted in some changes to data items and coding categories in both the APRA and MINC data specifications. These efforts are expected to continue in an attempt to optimise consistency across the two collections.

A single national report

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

Key stakeholders in medical indemnity data met to discuss the development and coordination of a national report in July 2004 and again in May 2005. These meetings involved representatives from the Medical Indemnity Industry Association of Australia (MIIAA), APRA, Insurance Statistics Australia, MIDWG and the AIHW. Ongoing discussions between all parties have resulted in general agreement about

the importance of data consistency between the collections and of the efficient flow of data between organisations. Since July 2004 the MIIAA members have made significant progress towards meeting the information requirements of the Premium Support Scheme (which include the provision of MINC data). The compilation of a single national report by AIHW is a realistic possibility in the near future (possibly a limited 2003–2004 report and a more complete 2004–2005 report to be published in mid–2006).

2 The collection

2.1 Scope and context

A medical indemnity claim is a claim for compensation for harm or other loss as a result of a health care incident. The MINC contains information on medical indemnity claims that are made against the public sector and managed by state and territory health departments. Claims within the MINC fall within two categories:

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

A reserve is the dollar amount of the best current estimate of the total cost of a claim when it is closed. Jurisdictions vary in their reserving practices; however, as the placement of reserves plays a crucial role in defining liability and potential risk, it is likely that the profile of claims within the scope of MINC is similar nation wide. The information provided within MINC is representative of only those incidents that have resulted in legal proceedings, or may be likely to. The collection is therefore not necessarily representative of the wider spectrum of adverse events or iatrogenic harm within the health care system.

Management of public sector medical indemnity insurance varies across jurisdictions. Claims within the MINC are not exclusively limited to public sector patients or publicly employed health professionals. States and territories differ in their indemnity coverage of visiting medical officers, students and private practitioners. Jurisdictions are also in various stages of enacting tort law reform, which may impact the scope, nature and quantum of medical indemnity claims in the future. These variations are explored further in Section 2.2 and Appendix 2.

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

2.2 Policy, administrative and legal context

Public sector medical indemnity insurance coverage is defined by state legislation and policies vary between jurisdictions. Generally cover is provided where the medical practitioner seeking indemnity has diligently and conscientiously

[1] Finalised claims include claims that have been finalised during the reporting period (827 claims had a date of finalisation in July 2003–June 2004), or which have been finalised before the reporting period but not closed (33 claims had a date of finalisation before July 2003).

endeavoured to carry out their duty and there is no wilful neglect or criminal activity on their part. With the implementation of tort law reform and changes to medical indemnity legislation, the MINC is operating in a changing policy and legal environment. While these reforms aim to improve national consistency in claims management and legal proceedings, variation in jurisdictional medical indemnity arrangements continues. This section describes the differences in state and territory legislation and insurance policy that may affect 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 agencies are indemnified for their public work. The coverage of students (medical and allied health) and academics varies by jurisdiction and may require financial contributions from participating universities.

In recent years changes have been made to public sector medical indemnity policy in response to concerns that rising premiums for doctors in private practice will endanger the availability of important health services. Many jurisdictions have expanded their public sector medical indemnity insurance of private medical practitioners (in specified circumstances) to address these concerns. Examples under this arrangement include:

- non-salaried doctors treating public patients in public hospitals;
- employed doctors with limited private–practice rights entering into fee-sharing arrangements with public hospitals; and
- rural general practitioners working in country health services.

In one jurisdiction indemnity has recently been extended to include clinician involvement in activities such as clinical audits or the investigation of adverse events.

The scope of MINC includes all claims that fall under public sector medical indemnity arrangements. Therefore, as policy relating to coverage changes in jurisdictions, the scope of MINC will change accordingly.

Administrative arrangements and claims management

As a general guide, key steps involved in the claim management process include:

- An incident that may lead to a public sector medical indemnity claim is notified to the relevant claims management body.
- 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 may signal the commencement of the claim—a writ or letter of demand may be received from the claimant's solicitor (this may occur before notification), or the defendant may make an offer to the claimant to settle the

matter before a writ or letter of demand has been issued. In some cases no action is taken by the claimant or the defendant.

- The claim is investigated. This may include liaising with clinical risk management staff within the health care 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 various ways, including 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 may be agreed between the claimant and defendant, independent of any formal process.
- A claim file that has remained inactive for a long period may be closed. In some instances claims that have been closed may subsequently be re-opened.

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

In some jurisdictions claims are largely managed in-house, by the state or territory health authority. Some of the legal work may be outsourced to private law firms. In other jurisdictions most of the claims management process is handled by a body that is separate to the health authority.

Legal reforms

In 2002 Australian, 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 of the Law of Negligence Report* (resulting in the Ipp Report) was to 'develop and evaluate principled options to limit liability and quantum of awards for damages'.

A key recommendation of the review was that a single statute should be enacted in all jurisdictions to ensure national consistency in proceedings relating to claims for personal injury and death (Commonwealth of Australia 2002). The Ipp Report also made recommendations on a range of issues, including:

- a test for determining the standard of care in cases where negligence is alleged against a medical practitioner;
- reducing 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 (such as health care costs, gratuitous services and future economic loss); and

- 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 introduced some tort law reforms consistent with recommendations in the Ipp Report and many are currently engaged in, or planning, further tort reform initiatives. These reforms are designed to:

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

2.3 Data items

The MINC consists of 21 data items documented in the *Medical Indemnity National Collection (Public sector) Data guide 2003–2004* and summarised in Table 2.1. The data guide is updated annually and provides definitions, a guide for use and a brief history of development for each data item. Key MINC terms are defined in Table 2.2.

An information model was developed to aid 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 (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 (the person who is pursuing the claim) is often also the claim subject; however, the MINC does not collect information about the claimant as such. Records in the MINC database are unidentifiable; that is, they do not contain information that would allow the identification of individuals or health service providers involved in claims.

Health Authorities transmit MINC data to AIHW every six months. The AIHW then collates, analyses and reports on the information. The information transmitted represents the 'best current knowledge' of the claim manager about the claim. It is expected that, as more information becomes available, the profile of a claim may change considerably. This report presents the most up–to–date information as at 30 June 2004.[2] As the MINC matures and works towards greater consistency with the private sector claims data some modifications to data items are expected. However, at present, no significant changes to data items have been made since the first report on this collection.

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

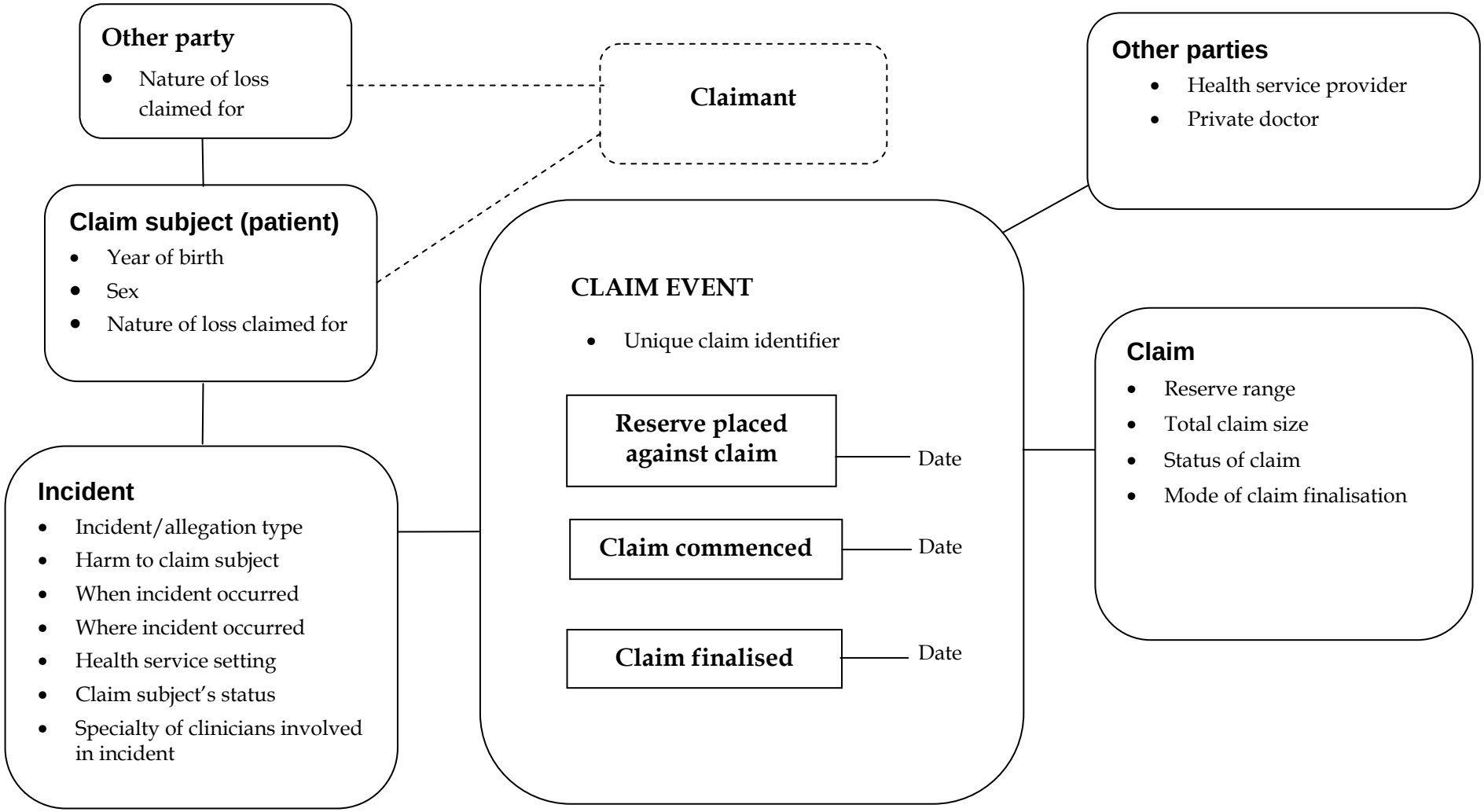
Table 2.1: MINC data items and definitions

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 (i.e. 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 (i.e. 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'; i.e. 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 (i.e. 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 (i.e. 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 (i.e. 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 (i.e. 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, 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 where claims brought by family members concerning the one incident are grouped into one claim record. Box 2.1 shows how the data can be used to produce different counts, and these counts are reflected in the tables of 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 (i.e. have a reserve placed against them but have not been finalised) as at the end of the reporting period (there were **4,096 current claims** as at 30 June 2004).*

*•Finalised claims – claims that have been finalised during the reporting period (827 claims had a date of finalisation of July 2003–June 2004), or which have been finalised before the reporting period but not closed (33 claims had a date of finalisation before July 2003**). A total of 860 claims were finalised** for the period 1 July 2003 to 30 June 2004.*

*•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 2003 to 30 June 2004).*

*•All claims – the total set of claims in the MINC during the reporting period (i.e. 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 **4,956 claims in total in the MINC database for the period 1 July 2003 to 30 June 2004**).*

For each claim there is one claim subject, except in some cases where more than one family member is bringing an action relating to the same incident.

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

MINC is a newly established collection and, as such, data quality and completeness are still being improved. Over the last two years, several jurisdictions have committed additional resources to the collection and recording of medical indemnity claims in a centralised database. This has resulted in a significant improvement of data completeness since the establishment of the collection in 2002. As the collection matures, data completeness and quality are expected to improve further. In the meantime, interpretation of data needs to be made in the context of data coverage and quality.

Data coverage and completeness

Approximately 80% of claims in the scope of the MINC are reflected in this report. Six jurisdictions have provided 100% of their medical indemnity claims for the period July 2003–June 2004. The following jurisdictions did not provide full data:

- Victoria provided data for 85% of claims in scope for the period. Even though Victoria had in place a claims data collection system that contained more than two decades of claims 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 had to manually code all open claims files since 1 January 2003 in addition to any new claims files raised. Of the claims not reported to MINC to date, 79% were current claims and 21% were new in the period. A significant proportion of claims not provided related to rural doctors, community health and ambulance services.

  The total dollar value of reserves against claims in scope but not included was just under half of the total dollar value of all Victorian claims in scope. It is anticipated that a complete Victorian data set should be available for inclusion in the 2004–2005 report.

- New South Wales has provided data for 52% of 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 prior to 2002 were not provided to MINC. The claims not provided to MINC have an estimated reserve value equivalent to approximately 70% of the reserve value of all New South Wales claims in scope. As New South Wales claims predating 2002 are finalised and closed they will represent a smaller proportion of claims in scope of MINC, and overall data completeness will improve.

  Thus, claims not included in New South Wales and Victoria data have larger reserves then those included.

Missing data

New South Wales data are not included in tables involving the following data items; 'Nature of claim—loss to other party/parties'; 'Additional incident/allegation type'; 'Additional body functions/structures affected—claim subject'; '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 a data system in place with data specifications that differed from those of the MINC and has been unable to provide data for these data items. All other jurisdictions have established or adapted other data systems to comply with MINC specifications.

Data quality

'Not known' rates

The proportion of 'not known' rates remains relatively high for some data items. 'Not known' can be coded when the information is either not currently available but expected to become available, or not expected to ever be available throughout the lifetime of the claim.

For just over half of all claims (57%), 'not known' was recorded for the 'Nature of claim—loss to claim subject' data item (Table 2.3). Similarly, for 54% of all claims (excluding New South Wales) 'not known' was recorded for 'Nature of claim—loss to other parties' (Table 2.3). Information on loss to other parties is not routinely collected by claim managers and MIDWG is currently discussing possible modifications to this data item. Of those claims finalised 29% still had 'not known' coded for this data item.

Several other data items had 'not known' rates between 13% and 17%. These included primary body function/structure affected, claim subject's status, claim subject's year of birth and extent of harm.

For finalised claims, total claim size had a similar 'not known' rate of 13%. More than three–quarters of these claims with total claim size unknown had a claim status of 'claim file closed'.

Medical indemnity claim records will develop over time as further information becomes available. It is recognised that some information may be 'missing' at the time of transmission, but it is expected that the information will become available at a later date.

Table 2.3: MINC data items: number and percentage of claims for which 'not known' was recorded, 1 July 2003 to 30 June 2004

Items for all states and territories	Number	% of all claims
Nature of claim—loss to claim subject	2,805	56.6
Claim subject's sex	46	0.9
Primary incident/allegation type	320	6.5
Clinical service context	193	3.9
Primary body function/structure affected	729	14.7
Where incident occurred	19	0.4
Health service setting	121	2.4
Claim subject's status	660	13.3
Finalised claim items	**Number**	**% of finalised claims**
Mode of claim finalisation	101	11.7
Total claim size	111	12.9
Items for all states and territories except NSW[(a)]	**Number**	**% of non-NSW claims**
Nature of claim—loss to other parties	2,241	53.8
Claim subject's year of birth	522	14.3
Additional incident/allegation types	6	0.2
Additional body functions/structures affected	5	0.1
Extent of harm	688	16.5
Specialties of clinicians closely involved in incident	124	2.5

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

Coding consistency

Coding consistency can be an issue within and between jurisdictions. Systematic validation checks monitor changes in data items for individual claims between reporting periods. These have highlighted expected and unexpected changes in items and have identified a number of coding errors. As information infrastructure and claim recording procedures improve it is expected that these errors will decrease.

Overall the data indicate a good general understanding of data items and codes. Inconsistencies may exist in the coding of the relatively small number of claims that have been closed and then reopened. The MINC Data Guide states that the date on which a reserve was first set should be recorded as 'date reserve placed' for reopened claims. However, some jurisdictions record the date the claim was reopened instead;

such that the duration of the claim, as calculated from key dates in the MINC, is artificially shortened.

Differences between six–month and financial–year data

This is the second publication of MINC data in the medical indemnity national collection. The first publication, *First Medical Indemnity National Data Collection Report: Public Sector, January to June 2003,* contained the first six months' data. Differences in reporting timeframes, data completeness and general data quality mean that the two reports are not generally comparable. Following improvements in data completeness, additional claims that were in scope for the first report, but not included within it, are now presented in this report. This will also be the case for future annual publications.

2.5 Future directions for MINC

The MINC data collection is currently entering its third year of data transmission and reporting. The collection will continue, with health authorities providing data to AIHW to compile and analyse twice a year. Data completeness has improved by approximately 30% since the first report. As the collection moves towards complete inclusion of all public sector medical indemnity claims, it is expected that more comprehensive analysis and an increasing number of data items will be reported on.

Similar patterns exist in this report to the first national report, indicating the potential value of MINC to consistently represent the profile and trends of medical indemnity claims. In the future, MINC data will be able to identify trends in the nature and cost of medical indemnity claims, which will be crucial for the effective evaluation of tort law reforms and policies aimed at decreasing the incidence and cost of medical indemnity claims. Further to this the compilation of a single national report incorporating public and private sector claims will provide a coherent national picture to inform the evaluation and development of national medical indemnity strategies (see discussion in Section 1.4).

MINC data may also complement data emerging from the patient quality and safety field, such as those collected through incident management or sentinel event systems, and provide a general indication of the proportion of reported public health care incidents that result in litigation.

3 Public sector medical indemnity claims data

The data in this chapter cover claims that were current at any time during the reporting period (July 2003–June 2004); that is, those that were open at the start of the period and those that arose during the period, including those finalised during the period. First a description of the incidents giving rise to the claims is provided, followed by a profile of the people affected. Details of current (including new) claims and finalised claims are also given, in terms of numbers, duration and amounts (reserves and final costs).

3.1 Incidents

This section provides a 'snapshot' of the incident giving rise to a claim and the environment in which it occurred. Information will be presented on the event that precipitated a claim (primary incident/allegation type), the clinical context in which the incident occurred and the clinicians who played the most prominent role in the incident (specialty of clinician). Data on the geographic location where the event occurred are also included.

Clinical service context

Clinical service context describes the area of clinical practice or hospital department in which the patient was receiving a health care service when the incident occurred. There are 20 clinical service context categories in the MINC. The tables in this report list the eight most frequently recorded items and collapse all additional items into the category 'all other clinical service contexts'. This category accounts for 26% of claims. There is also the option for claim managers to code 'other' and provide further textual information for clinical contexts that are not included in the classification code list (for example, hospice or intensive care). This was the case for 526 claims (11%).

Between July 2003 and June 2004 the clinical service contexts most frequently recorded were obstetrics (825 claims, or 17% of all claims), accident and emergency (710 claims, or 14%), general surgery (561 claims, or 11%) and gynaecology (414 claims, or 8%) (Table 3.1).

Primary incident/allegation type

Data collected under primary incident/allegation type 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 a claim. Claims concerning allegations of

procedural-related issues were most commonly recorded (1,627 claims, 33% of all claims), followed by diagnosis (1,028 claims, 21%), treatment (676 claims, 14 %) and other general duty of care (512 claims, 10%) (Table 3.1). Incidents involving device failure and blood/blood–product-related incidents were least commonly recorded.

Incidents associated with procedures were most common in the clinical service contexts of gynaecology (263 claims, 64% of these claims compared with 33% of all claims), general surgery (292 claims, 52%), orthopaedics (185 claims, 48%) and obstetrics (390 claims, 47%). Over half of all claims arising in accident and emergency (414 claims, 58%) were associated with diagnostic issues, compared with 21% of all claims. Diagnostic issues were also relatively common in paediatrics (43 claims, 32%) and general medicine (45 claims, 22%). In claims arising in the psychiatry service context, other general duty of care issues were over–represented (126 claims, 54 % of these claims, compared to 10% overall).

Table 3.1: All claims (public sector): clinical service context by primary incident/allegation type, 1 July to 31 December 2003, Australia

Clinical service context	Primary incident/allegation type												Total (number)	*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 of claims													
Obstetrics	93	22	21	6	390	167	17	10	1	40	8	50	825	*16.6*
A&E	414	23	1	1	41	142	4	10	2	42	6	24	710	*14.3*
General surgery	68	9	41	3	292	47	30	26	7	22	2	14	561	*11.3*
Gynaecology	32	3	13	1	263	20	39	2	8	19	2	12	414	*8.4*
Orthopaedics	68	4	10	1	185	45	20	17	5	17	2	12	386	*7.8*
Psychiatry	37	13	1	—	2	27	3	—	—	126	15	10	234	*4.7*
General medicine	45	22	2	6	11	36	2	2	4	61	5	8	204	*4.1*
Paediatrics	43	10	—	2	33	22	1	1	2	9	7	5	135	*2.7*
All other clinical service contexts	214	51	35	48	393	163	69	42	22	163	26	68	1,294	*26.1*
Not known	14	10	2	3	17	7	2	2	2	13	4	117	193	*3.9*
Total (number)	**1,028**	**167**	**126**	**71**	**1,627**	**676**	**187**	**112**	**53**	**512**	**77**	**320**	**4,956**	*100.0*
	(per cent)													
Obstetrics	11.3	2.7	2.5	0.7	47.3	20.2	2.1	1.2	0.1	4.8	1.0	6.1	100.0	
A&E	58.3	3.2	0.1	0.1	5.8	20.0	0.6	1.4	0.3	5.9	0.8	3.4	100.0	
General surgery	12.1	1.6	7.3	0.5	52.0	8.4	5.3	4.6	1.2	3.9	0.4	2.5	100.0	
Gynaecology	7.7	0.7	3.1	0.2	63.5	4.8	9.4	0.5	1.9	4.6	0.5	2.9	100.0	
Orthopaedics	17.6	1.0	2.6	0.3	47.9	11.7	5.2	4.4	1.3	4.4	0.5	3.1	100.0	
Psychiatry	15.8	5.6	0.4	—	0.9	11.5	1.3	—	—	53.8	6.4	4.3	100.0	
General medicine	22.1	10.8	1.0	2.9	5.4	17.6	1.0	1.0	2.0	29.9	2.5	3.9	100.0	
Paediatrics	31.9	7.4	—	1.5	24.4	16.3	0.7	0.7	1.5	6.7	5.2	3.7	100.0	
All other clinical service contexts	7.3	5.2	1.0	1.6	8.8	3.6	1.0	1.0	1.0	6.7	2.1	60.6	100.0	
Not known	16.5	3.9	2.7	3.7	30.4	12.6	5.3	3.2	1.7	12.6	2.0	5.3	100.0	
Total (per cent)	**20.7**	**3.4**	**2.5**	**1.4**	**32.8**	**13.6**	**3.8**	**2.3**	**1.1**	**10.3**	**1.6**	**6.5**	**100.0**	

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

(b) 'Procedure' includes failure to perform a procedure, wrong procedure 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 row labelled 'All other clinical service contexts'. Appendix 3, Table A3-1 shows frequency of coding categories for all clinical service contexts.
2. Data for approximately 80% of all claims in scope are included.
3. This table represents the primary incident/allegation type. 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 involved in incident

The specialties most commonly represented in medical indemnity claims were obstetrics and gynaecology (977 claims),[3] emergency medicine (439 claims), general surgery (378 claims) and orthopaedic surgery (359 claims) (Table 3.2).

The clinical service context and specialty of the clinician involved in an incident often reflect similar areas of health practice. Claims associated with the clinical specialties of obstetrics, emergency medicine, general surgery, gynaecology, orthopaedic surgery, and psychiatry overwhelmingly occurred in closely related clinical service contexts. In the specialty areas of general nursing and general anaesthetics, claims were widely distributed across clinical service contexts.

As numerous health care providers can be closely involved in an incident, MINC provides the opportunity for up to four specialties to be coded. Of all claims 86% involved just one clinician, 11% involved two clinicians and 2% recorded the involvement of three clinicians. Frequencies of all specialties recorded and the extent of additional clinician involvement in a claim can be found in Appendix 3 (Table A3-2).

[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 specialties of clinicians involved, 1 July 2003 to 30 June 2004, Australia[a] (per cent)

	Specialty of clinician(s)[b]													
Clinical service context	**Obstetrics only**	**Emergency medicine**	**General surgery**	**Orthopaedic surgery**	**Nursing–general**	**Gynae-cology only**	**Other hospital based medical practitioner[c]**	**Obstetrics and gynaecology**	**Psychiatry**	**Anaesthetics –general**	**Other specialties**	**Not known**	**N/A[d]**	**Total**
Obstetrics	98.3	0.9	1.3	0.6	5.9	1.4	11.9	57.4	0.5	24.7	13	6.5	—	18.7
A&E	0.2	92.5	4.5	11.4	12.5	1.1	40.3	1.7	5.8	1.3	5.9	2.4	—	15.1
General surgery	—	0.5	85.2	1.4	9.2	1.4	7.6	0.9	0.5	29.7	9.5	4.8	6.5	12.2
Gynaecology	0.2	—	1.3	—	6.3	92.2	7.2	38.3	—	10.1	1.4	0.8	—	8.9
Orthopaedics	—	2.1	1.1	80.5	3.6	—	6.5	—	0.5	8.9	1.4	—	9.7	7.6
Psychiatry	—	—	0.3	0.3	10.6	—	3.2	—	89.9	0.6	0.6	1.6	—	5
General medicine	0.2	0.7	0.8	—	17.8	—	2.9	—	—	3.2	9.1	1.6	—	4.6
Paediatrics	0.2	0.2	1.1	1.4	5.6	—	4.3	0.4	—	2.5	7.5	0.8	—	3.4
All other clinical service contexts	—	0.5	0.3	0.3	2.6	1.1	0.7	0.4	—	2.5	1.3	66.9	3.2	2.6
Not known	0.9	2.7	4.2	4.2	25.7	2.8	15.5	0.9	2.9	16.5	50.3	14.5	80.6	22
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]	459	439	378	359	303	283	278	235	207	158	1,625	124	31	

(a) NSW data are not included in this table as NSW 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) '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 (e.g. 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, these totals cannot be summed horizontally to give the total number of claims overall.

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

Geographic location

The data in Table 3.3 describe the geographic location where the incident that gave rise to a claim occurred. Almost all claims arose from incidents in major cities (3,369 claims or 68% of all claims) or inner regional areas (1,059 claims or 21%), reflecting the concentration of health services in more densely populated areas. Only 75 claims (2%) related to incidents occurring in remote and very remote areas. Of all clinical contexts, psychiatry had the highest proportion of claims (79%) in major cities, while general surgery and gynaecology had the lowest (60% and 61% respectively).

A relatively high proportion of claims involving neurosurgery, cardiology and psychiatry specialists originated from incidents that occurred in major cities (96%, 84% and 82% respectively), while a relatively low proportion of claims involving general surgery specialists occurred in major cities (58%) (Table 3.4).

Table 3.3: All claims (public sector): clinical service context by geographic location, 1 July 2003 to 30 June 2004, 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	67.4	21.5	9.5	1.5	0.2	100.0
A&E	65.8	22.1	10.1	1.8	0.1	100.0
General surgery	60.2	26.4	11.2	2.1	—	100.0
Gynaecology	60.9	24.6	12.6	1.7	0.2	100.0
Orthopaedics	62.2	24.9	10.9	1.3	0.8	100.0
Psychiatry	79.1	15.8	4.7	—	0.4	100.0
General medicine	65.7	24.0	6.9	3.4	0.0	100.0
Paediatrics	74.8	17.0	5.2	2.2	0.7	100.0
Not known	67.9	19.2	11.9	0.5	0.5	100.0
All other clinical service contexts	74.6	18.0	5.6	1.2	0.7	100.0
Total	**68.0**	**21.4**	**8.8**	**1.5**	**0.4**	**100.0**
Total number	*3,369*	*1,059*	*434*	*75*	*19*	*4,956*

(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 here are the eight most frequently recorded categories; all other categories are combined in the row labelled 'All other clinical service contexts'.
2. Data for approximately 80% of all claims in scope are included.

Table 3.4: All claims (public sector): specialties of clinicians involved by geographic location, 1 July 2003 to 30 June 2004, 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	69.7	22.2	6.8	1.1	100.0	459
Emergency medicine	67.9	22.1	8.9	1.2	100.0	439
General surgery	57.4	27.8	11.4	3.4	100.0	378
Orthopaedic surgery	64.3	21.7	12.3	1.7	100.0	359
Nursing—general	68.6	18.8	8.6	4.0	100.0	303
Gynaecology only	61.8	26.5	9.9	1.8	100.0	283
Other hospital based medical practitioner[d]	68.7	14.7	10.8	5.8	100.0	278
Obstetrics and gynaecology	72.3	14.0	12.3	1.3	100.0	235
Psychiatry	81.6	15.5	2.9	—	100.0	207
Anaesthetics—general	67.1	23.4	8.2	1.3	100.0	158
Midwifery	63.2	18.4	14.0	4.4	100.0	114
General and internal medicine	65.8	22.5	9.9	1.8	100.0	111
Diagnostic radiology	75.6	19.2	5.1	—	100.0	78
Urology	73.3	21.3	5.3	—	100.0	75
Cardiology	83.6	14.9	1.5	—	100.0	67
Neurosurgery	95.5	—	4.5	—	100.0	67
All other specialties	76.0	14.8	7.1	2.0	100.0	1,113
Not applicable[e]	83.9	16.1	—	—	100.0	31
Not known	68.5	18.5	11.3	1.6	100.0	124

(a) NSW data are not included in this table as NSW 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) This is 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 these 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 (e.g. where the claim relates to actions of hospital administrative staff).

Note: The clinical specialties listed separately here are the sixteen most frequently recorded specialties; all other specialties are combined in the row labelled 'All other specialties'.

3.2 People

This section describes factors relating to the person immediately affected by the incident. Key data items relating to the person are: age at incident from which the claim arose, sex and primary body function/structure affected.

Sex and age at incident

Almost three quarters of claim subjects were adults 18 years and older (3,523 claims, 71% of all claims) (Table 3.5). Babies (<1 year) and children (1–18 years) comprised 9% (431 claims) and 8% (413 claims) of all claims, respectively. Information on age was not supplied for 589 claims (12%).

Females represented more than half (58%) of all claims involving adults and 56% of all claims in total (2,759 claims). Males were involved in 2,151 claims overall (43%), with 51% of claims relating to children and 53% of claims relating to babies.

Female adults were relatively more likely to be involved in procedural-related incidents than other persons (66% of the 1,192 claims in this category). Of claims related to treatment, babies were involved in 15% (105 of 676) of claims compared with 8% overall. Children were involved in 142 claims (14%) concerning allegations relating to diagnosis, compared with 8% overall; and female children were more likely than male children to be involved in claims involving duty–of–care issues (21 claims or 68% of the 31 claims in this group).

Table 3.5: All claims (public sector): sex and age at incident of claim subject, by primary incident/allegation type, 1 July 2003 to 30 June 2004, Australia

Primary incident/ allegation type	Age at incident				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total[(a)]
Males					
Diagnosis	44	80	354	37	515
Medication	7	7	53	10	77
Anaesthetic	1	1	41	2	45
Blood/blood-product-related	2	4	27	2	35
Procedure	90	41	401	48	580
Treatment	49	31	189	33	302
Consent	5	9	52	7	73
Infection control	3	4	41	10	58
Device failure	2	8	15	2	27
Other general duty of care	10	10	192	34	246
Other	2	1	33	4	40
Not known	14	8	75	56	153
Total males	*229*	*204*	*1,473*	*245*	*2,151*
Females					
Diagnosis	26	62	383	40	511
Medication	11	6	64	7	88
Anaesthetic	1	1	70	8	80
Blood/blood-product-related	—	3	19	6	28
Procedure	69	52	791	123	1,035
Treatment	50	41	236	41	368
Consent	3	5	98	8	114
Infection control	—	3	41	6	50
Device failure	—	3	20	2	25
Other general duty of care	5	21	203	35	264
Other	—	5	27	5	37
Not known	14	6	97	42	159
Total females	*179*	*208*	*2,049*	*323*	*2,759*
Persons[(b)]					
Diagnosis	70	142	737	79	1,028
Medication	19	13	117	18	167
Anaesthetic	2	2	111	11	126
Blood/blood-product-related	2	7	46	16	71
Procedure	170	94	1,192	171	1,627
Treatment	105	72	425	74	676
Consent	8	14	150	15	187
Infection control	3	7	63	20	93
Device failure	2	11	54	5	72
Other general duty of care	15	31	395	71	512
Other	2	6	60	9	77
Not known	33	14	173	100	320
Total	**431**	**413**	**3,523**	**589**	**4,956**

(a) This column includes 589 claims for which age at incident of claim subject was missing (245 males, 323 females).

(b) Persons includes 46 claims for which sex of claim subject was not known/indeterminate (23 babies, 1 child, 1 adult, 21 not known).

Note: Data for approximately 80% of all claims in scope are included.

Primary body function/structure

The data item 'primary body function/structure' reflects the function or structure that is alleged to be most affected as a result of the incident. Neuromusculo-skeletal and movement–related structures/functions were most commonly reported (23% of all claims), followed by genitourinary and reproductive (14%) and mental functions/structures of the nervous system (13%). Death occurred in 9% of claims. Data relating to body functions/structures must be interpreted cautiously due to the high rate of 'not known' responses (15%).

Table 3.6: All claims (public sector): primary body function/structure[(a)] affected, 1 July 2003 to June 2004, Australia

Primary body function/structure affected	Number	Per cent of all claims
Mental functions/structures of the nervous system	635	12.8
Sensory functions/ the eye, ear and related structures	144	2.9
Voice and speech functions/structures involved in voice and speech	74	1.5
Functions/ structures of the cardiovascular, haematological, immunological and respiratory systems	334	6.7
Functions and structures of the digestive, metabolic and endocrine systems	425	8.6
Genitourinary and reproductive functions and structures	679	13.7
Neuromusculo-skeletal and movement-related functions and structures	1,117	22.5
Functions and structures of the skin and related structures	218	4.4
Death	456	9.2
No body function/structure affected	145	2.9
Not known	729	14.7
All claims	**4,956**	**100.0**

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

Note: Data for approximately 80% of all claims in scope are included.

3.3 Claims

Claim status

For the financial year 2003–2004, half of all claims were 'commenced (not yet finalised)', 32% were considered potential claims with 'reserve placed but not yet commenced' and 17% were finalised (Table 3.7).

Of those claims finalised, the majority were closed (765 claims, 89%) and 4% (34 claims) were finalised under a structured settlement arrangement. A structured settlement involves the payment of awarded damages periodically rather than in a lump sum. It is expected that this number will increase following recent policy recommendations that favour this form of settlement (in some jurisdictions).

Only 40 claims (1% of all claims) were previously closed and reopened during the collection period. Claims may be reopened in cases where additional relevant information becomes available; for example, in cases of a latent disease or delayed harm after a medical procedure.

Of all finalised claims 33% (283 claims) were related to a procedural issue, 21% (184 claims) were related to diagnosis and 14% (116 claims) involved issues related to treatment (Table 3.8). Of claims involving a blood/blood–product–related incident a substantial proportion were not yet commenced (46 claims or 65% compared with 32% overall).

Table 3.7: All claims (public sector): status of claim, 30 June 2004, Australia

Clinical service context	Reserve placed but not yet commenced[a]	Commenced (not yet finalised)[b]	Finalised in reporting period						
			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]	Claim previously closed now reopened[h]	Total
All claims	1,591	2,465	765	61	32	2	***860***	40	4,956
Total (%)	*32.1*	*49.7*	*15.4*	*1.2*	*0.6*	—	*17.4*	*0.8*	*100.0*

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

(b) 'Commenced (not yet finalised)' indicates that the claim has commenced but has not yet been finalised.

(c) 'Claim file closed' indicates that 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) 'Awaiting determination of total size' indicates that the claim has been finalised but the total claim size has yet to be determined; the claim file has not yet been closed; this may include instances where legal costs have yet to be finally determined.

(e) 'Structured settlement with total dollar value decided' indicates that the claim has been finalised and 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) 'Structured settlement with total dollar value open' indicates that the claim has been finalised and 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 860 finalised claims, 33 had a 'date claim finalised' before the reporting period (before July 2003).

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

Note: Data for approximately 80% of all claims in scope are included.

Table 3.8: All claims (public sector): status of claim by primary incident/allegation type, 30 June 2004, 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	291	545	161	16	6	1	*184*	*21.4*	8	1,028	20.7
Medication-related[b]	45	104	15	1	1	—	*17*	*2.0*	1	167	3.4
Anaesthetic	42	59	22	1	—	—	*23*	*2.7*	2	126	2.5
Blood/blood-product-related	46	21	3	—	1	—	*4*	*0.5*	—	71	1.4
Procedure[c]	586	746	249	27	7	—	*283*	*32.9*	12	1,627	32.8
Treatment[d]	235	314	105	5	6	—	*116*	*13.5*	11	676	13.6
Consent[e]	15	131	32	7	2	—	*41*	*4.8*	—	187	3.8
Infection control	32	58	18	1	3	—	*22*	*2.6*	—	112	2.3
Device failure	13	28	9	2	—	—	*11*	*1.3*	1	53	1.1
Other general duty of care	158	260	83	—	6	1	*90*	*10.5*	4	512	10.3
Other	17	40	18	1	—	—	*19*	*2.2*	1	77	1.6
Not known	111	159	50	—	—	—	*50*	*5.8*	—	320	6.5
All claims	**1,591**	**2,465**	**765**	**61**	**32**	**2**	***860***	***100.0***	**40**	**4,956**	**100.0**
Total (per cent)	*32.1*	*49.7*	*15.4*	*1.2*	*0.6*	—	*17.4*		*0.8*	*100.0*	

(a) 'Awaiting determination of total size' indicates that the claim has been finalised but 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 have yet to be finally determined.

(b) 'Medication related' includes type and dosage issues, 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 80% of all claims in scope are included.

Categories of loss claimed

The data item 'Nature of claim—loss to claim subject' provides an indication of the categories of loss allegedly suffered by the claim subject. The average number of loss categories recorded was 2.4 per claim (Table 3.9). The most common category of loss recorded was pain and suffering, in 32% of claims, followed by other economic loss (21%) and care costs (18%). A high percentage of all claims had 'not known' recorded for this data item (57%) (this is discussed in more detail in Section 2.4).

Table 3.9: All claims (public sector): nature of claim—loss to claim subject, 1 July 2003 to 30 June 2004, 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	18.1	20.8	31.6	14.2	7.8	56.6	*2.4*
Total number of claims[(f)]	896	1,032	1,567	703	388	2,805	

(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, and includes medical costs (both past and future). Medical costs are costs associated with medical treatment, e.g. 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) This is 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 80% of all claims in scope are included.

Duration of all claims

The duration of a claim provides useful information that may assist in monitoring the efficacy of claims management policies, the allocation of resources during claims administration and the assessment of litigation burden on plaintiffs (such as additional stress experienced during the claim settlement process).

The average duration of claims in scope for the reporting period was 20 months (1.6 years, Table 3.10). This was longer for finalised claims, which had a mean duration of 28 months (2.3 years). Within finalised claims those settled with the total dollar value undecided and those awaiting determination of total size had been open, on average, for the longest period of time (50 months and 38 months, respectively). In 207 cases (4.2% of all claims) the claim had been open in excess of five years, as at 30 June 2004.

Although small in number, claims that have been closed and then re-opened may appear of shorter duration than they actually are, as there is some variability between jurisdictions in the coding of the date the reserve was placed for these claims (refer to discussion of coding consistency in Section 2.4).

The duration of current and finalised claims is discussed later in the report (see Tables 3.13 and 3.15). It is likely that the mean duration in Tables 3.10, 3.13 and 3.15 is an underestimate, as 45% of New South Wales claims (opened pre–2002, but still current) are not included.

Table 3.10: All claims (public sector): status of claim by length of claim (months)

	Length of claim at 30 June 2004 (months)												
Status of claim[a]	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**60+**	**Total**	**Mean**
Reserve placed but not yet commenced	350	403	353	222	117	73	15	12	11	—	35	1,591	15.8
Commenced (not yet finalised)	421	521	412	388	251	141	87	53	71	31	89	2,465	20.5
Finalised claims													
Claim file closed	102	174	166	86	52	43	20	19	21	8	74	765	26.3
Awaiting determination of total size	1	4	9	9	5	4	11	4	5	2	7	61	37.9
Structured settlement with total dollar value decided	—	2	1	2	7	9	2	3	3	3	—	32	34.8
Structured settlement with total dollar value undecided	—	—	—	—	—	—	1	—	—	—	1	2	50.1
Total finalised[b]	*103*	*180*	*176*	*97*	*64*	*56*	*34*	*26*	*29*	*13*	*82*	*860*	*27.5*
Claim previously closed now reopened	3	5	3	4	1	6	4	4	8	1	1	40	32.7
Total claims	**877**	**1,109**	**944**	**711**	**433**	**276**	**140**	**95**	**119**	**45**	**207**	**4,956**	**20.3**
						(per cent)							
Reserve placed but not yet commenced	22.0	25.3	22.2	14.0	7.4	4.6	0.9	0.8	0.7	—	2.2	100.0	
Commenced (not yet finalised)	17.1	21.1	16.7	15.7	10.2	5.7	3.5	2.2	2.9	1.3	3.6	100.0	
Finalised claims													
Claim file closed	13.3	22.7	21.7	11.2	6.8	5.6	2.6	2.5	2.7	1.0	9.7	100.0	
Awaiting determination of total size	1.6	6.6	14.8	14.8	8.2	6.6	18.0	6.6	8.2	3.3	11.5	100.0	
Structured settlement with total dollar value decided	—	6.3	3.1	6.3	21.9	28.1	6.3	9.4	9.4	9.4	—	100.0	
Structured settlement with total dollar value undecided	—	—	—	—	—	—	50.0	—	—	—	50.0	100.0	
Total finalised[b]	*12.0*	*20.9*	*20.5*	*11.3*	*7.4*	*6.5*	*4.0*	*3.0*	*3.4*	*1.5*	*9.5*	*100.0*	
Claim previously closed now reopened	7.5	12.5	7.5	10.0	2.5	15.0	10.0	10.0	20.0	2.5	2.5	100.0	
Per cent of all claims	**17.7**	**22.4**	**19.0**	**14.3**	**8.7**	**5.6**	**2.8**	**1.9**	**2.4**	**0.9**	**4.2**	**100.0**	

(a) See Table 3.7 for definitions of status of claim categories.

(b) Of the 860 finalised claims, 827 were finalised during 2003–2004 and 33 were finalised previously but claim file was still open at July 2003.

Notes

1. Length of claim is from date reserve placed to 30 June 2004. If a claim has a status of ‘claim file closed’, length of claim is from date reserve placed to date claim finalised.
2. Data for approximately 80% of all claims in scope are included.

Current claims

Of all MINC claims, 83% (4,096 claims) were current; that is, they had not been finalised by the end of the financial year (Table 3.11).

Just over half (52%) of all current claims had a reserve range less than $30,000. Claims within this reserve range (less than $30,000) accounted for a greater proportion of claims in the clinical service contexts of psychiatry (65%), general medicine (63%) and accident and emergency (58%).

Claims with a reserve range greater than $500,000 were over-represented in the clinical service contexts of paediatrics and obstetrics, accounting for 14%, and 13% of such claims respectively, compared with 5% overall.

The majority of claims in the incident/allegation type categories of anaesthetic and other general duty of care had a reserve less than $30,000 (64% and 63% of claims respectively) (Table 3.12). Almost half (42%) of blood/blood–product-related incidents involved claims with a reserve between $50,000 and $100,000.

Table 3.11: Current claims (public sector): reserve range by clinical service context, 30 June 2004, Australia

Reserve range	Obstetrics	A&E	General surgery	Gynaecology	Orthopaedics	Psychiatry	General medicine	Paediatrics	All other clinical service contexts	Not known	Total
						Number					
Less than $10,000	93	134	37	108	57	32	43	10	201	56	771
$10,000–<$30,000	203	213	113	147	89	86	70	33	350	61	1,365
$30,000–<$50,000	49	54	51	58	44	17	22	15	100	6	416
$50,000–<$100,000	132	93	65	101	48	23	21	27	202	16	728
$100,000–<$250,000	89	51	51	43	44	17	14	16	114	6	445
$250,000–<$500,000	48	20	18	9	11	4	5	5	45	2	167
$500,000 or more	91	31	4	4	6	4	4	17	34	9	204
Total (number)	*705*	*596*	*339*	*470*	*299*	*183*	*179*	*123*	*1,046*	*156*	*4,096*
						(per cent)					
Less than $10,000	13.2	22.5	10.9	23.0	19.1	17.5	24.0	8.1	19.2	35.9	18.8
$10,000–<$30,000	28.8	35.7	33.3	31.3	29.8	47.0	39.1	26.8	33.5	39.1	33.3
$30,000–<$50,000	7.0	9.1	15.0	12.3	14.7	9.3	12.3	12.2	9.6	3.8	10.2
$50,000–<$100,000	18.7	15.6	19.2	21.5	16.1	12.6	11.7	22.0	19.3	10.3	17.8
$100,000–<$250,000	12.6	8.6	15.0	9.1	14.7	9.3	7.8	13.0	10.9	3.8	10.9
$250,000–<$500,000	6.8	3.4	5.3	1.9	3.7	2.2	2.8	4.1	4.3	1.3	4.1
$500,000 or more	12.9	5.2	1.2	0.9	2.0	2.2	2.2	13.8	3.3	5.8	5.0
Total (per cent)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

Notes

1. The clinical service context categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the row labelled 'All other clinical service contexts'. Appendix 3, Table A3-1 shows frequency of coding categories for all clinical service contexts.
2. Data for approximately 80% of all claims are included.

Table 3.12: Current claims (public sector): reserve range by primary incident/allegation type, 30 June 2004, Australia (per cent)

	Primary incident/allegation type												
Reserve range	**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**
Less than $10,000	142	31	30	12	215	107	18	24	9	82	11	90	771
$10,000–<$30,000	249	47	36	15	463	188	32	23	12	184	21	95	1,365
$30,000–<$50,000	86	15	8	2	134	61	26	11	11	49	7	6	416
$50,000–<$100,000	165	21	11	28	252	89	36	19	7	52	12	36	728
$100,000–<$250,000	103	14	14	7	165	55	16	7	2	36	5	21	445
$250,000–<$500,000	39	9	3	2	53	23	12	3	1	10	1	11	167
$500,000 or more	60	13	1	1	62	37	6	3	0	9	1	11	204
Total (number)	*844*	*150*	*103*	*67*	*1,344*	*560*	*146*	*90*	*42*	*422*	*58*	*270*	*4,096*
						(per cent)							
Less than $10,000	16.8	20.7	29.1	17.9	16.0	19.1	12.3	26.7	21.4	19.4	19.0	33.3	18.8
$10,000–<$30,000	29.5	31.3	35.0	22.4	34.4	33.6	21.9	25.6	28.6	43.6	36.2	35.2	33.3
$30,000–<$50,000	10.2	10.0	7.8	3.0	10.0	10.9	17.8	12.2	26.2	11.6	12.1	2.2	10.2
$50,000–<$100,000	19.5	14.0	10.7	41.8	18.8	15.9	24.7	21.1	16.7	12.3	20.7	13.3	17.8
$100,000–<$250,000	12.2	9.3	13.6	10.4	12.3	9.8	11.0	7.8	4.8	8.5	8.6	7.8	10.9
$250,000–<$500,000	4.6	6.0	2.9	3.0	3.9	4.1	8.2	3.3	2.4	2.4	1.7	4.1	4.1
$500,000 or more	7.1	8.7	1.0	1.5	4.6	6.6	4.1	3.3	0.0	2.1	1.7	4.1	5.0
Total (per cent)	*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 and dosage issues, 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 80% of claims are included.

Duration of current claims

The mean duration of current claims was 19 months (Table 3.13). Claims with a reserve range of less than $10,000 had an average duration of 15 months, while claims with a reserve in excess of $500,000 had been open, on average, for 37 months. Of claims with a duration longer than five years reserve ranges between $50,000 and $100,000 (38 claims, or 30% of the claims in this category) were most common, followed by reserves greater than $500,000 (24 claims, 19%).

Table 3.13: Current claims (public sector): reserve range by length of claim (months)

	Length of claim at 30 June 2004 (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**
Less than $10,000	197	200	139	114	63	30	4	7	8	3	6	771	14.7
$10,000–<$30,000	299	330	303	186	111	72	24	12	13	6	9	1,365	15.7
$30,000–<$50,000	58	93	89	78	32	17	15	4	13	1	16	416	19.5
$50,000–<$100,000	133	183	110	85	70	41	23	18	20	7	38	728	20.4
$100,000–<$250,000	47	76	73	81	50	33	20	15	16	10	24	445	24.3
$250,000–<$500,000	21	29	18	31	21	9	9	8	10	3	8	167	25.3
$500,000 or more	19	18	36	39	22	18	11	5	10	2	24	204	36.7
Total	**774**	**929**	**768**	**614**	**369**	**220**	**106**	**69**	**90**	**32**	**125**	**4,096**	***18.8***
						(per cent)							
Less than $10,000	25.6	25.9	18.0	14.8	8.2	3.9	0.5	0.9	1.0	0.4	0.8	100.0	
$10,000–<$30,000	21.9	24.2	22.2	13.6	8.1	5.3	1.8	0.9	1.0	0.4	0.7	100.0	
$30,000–<$50,000	13.9	22.4	21.4	18.8	7.7	4.1	3.6	1.0	3.1	0.2	3.8	100.0	
$50,000–<$100,000	18.3	25.1	15.1	11.7	9.6	5.6	3.2	2.5	2.7	1.0	5.2	100.0	
$100,000–<$250,000	10.6	17.1	16.4	18.2	11.2	7.4	4.5	3.4	3.6	2.2	5.4	100.0	
$250,000–<$500,000	12.6	17.4	10.8	18.6	12.6	5.4	5.4	4.8	6.0	1.8	4.8	100.0	
$500,000 or more	9.3	8.8	17.6	19.1	10.8	8.8	5.4	2.5	4.9	1.0	11.8	100.0	
Per cent of all claims	***18.9***	***22.7***	***18.8***	***15.0***	***9.0***	***5.4***	***2.6***	***1.7***	***2.2***	***0.8***	***3.1***	***100.0***	

Notes

1. Length of claim is from date reserve placed to 30 June 2004.
2. Data for approximately 80% of all claims in scope are included.

Finalised claims

There were 860 finalised claims as at 30 June 2004 (including 827 claims finalised during 2003–2004 and 33 claims finalised before the period) (Box 2.1). More than one–third of finalised claims had a total claim size of less than $10,000 (37% or 318 claims, Table 3.14). Another 148 claims (17%) had 'no payment made'.

Mode of claim finalisation describes the process by which the claim was finalised. Of finalised claims, 340 (40%) were settled out of court. Within this group, the majority were settled by other processes (282 claims); for instance, part–way through a trial. Relatively few claims were settled through state or territory complaints processes or statutorily mandated compulsory conference processes (3%, or 11 claims, in both cases). Of claims with a total claim size exceeding $100,000, 82% (50 claims) were settled out of court compared with 16% (10 claims) decided in court.

Only 48 finalised claims (6%) were settled by a court decision. Almost half (43%) of finalised claims were discontinued. Of those discontinued 56% (207 claims) resulted in a total claim size of less than $10,000 and for 33% (122 claims) no payment was made. Of those claims finalised through a court decision, almost half resulted in no payment being made.

In 11% of cases, information on either the mode of claim finalisation or the total claim size was not yet known.

Table 3.14: Finalised claims (public sector): total claim size by mode of claim finalisation, 1 July 2003 to 30 June 2004, Australia

	Settled								
Total claim size	**State/Territory 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	6	6	1	86	99	6	207	6	**318**
$10,000–<$30,000	3	7	2	61	73	2	34	1	**110**
$30,000–<$50,000	1	3	1	36	41	1	3	—	**45**
$50,000–<$100,000	1	9	5	48	63	4	—	—	**67**
$100,000–<$250,000	—	4	1	24	29	4	—	1	**34**
$250,000–<$500,000	—	3	1	7	11	1	—	—	**12**
$500,000 or more	—	3	—	7	10	5	—	—	**15**
No payment made[g]	—	—	—	4	4	20	122	2	**148**
Not known	—	1	—	9	10	5	5	91	**111**
Total	**11**	**36**	**11**	**282**	***340***	**48**	**371**	**101**	**860**

(a) 'State/territory-based complaints processes' includes proceedings conducted in state/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' include 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 860 finalised claims, 827 were finalised during 2003–2004 and 33 were finalised previously but claim file was still open at July 2003.

(g) 'No payment made' is used where 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 80% of all claims in scope are included.

Duration of finalised claims

The average duration of finalised claims was two years (Table 3.15). Duration was longer for those claims with a total claim size of $500,000 or more, and where no payment was made (both four years). In 82 cases (9.5% of all claims) the claim had been open in excess of five years.

It is possible that the mean durations are an underestimate, given 45% of open New South Wales claims (predating 2002) are not included.

Table 3.15: Finalised claims (public sector): total claim size by length of claim (months)

	Length of claim at 30 June 2004 (years)							
Total claim size	**1**	**2**	**3**	**4**	**5**	**>5**	**Total claims[(a)]**	**Mean**
Less than $10,000	143	96	35	13	11	20	318	1.8
$10,000–<$30,000	34	35	19	11	4	7	110	2.3
$30,000–<$50,000	16	13	6	4	4	2	45	2.0
$50,000–<$100,000	16	23	15	4	5	4	67	2.2
$100,000–<$250,000	7	13	6	1	7	—	34	2.2
$250,000–<$500,000	1	2	4	2	1	2	12	3.2
$500,000 or more	1	3	3	3	2	3	15	4.1
No payment made[(b)]	36	30	25	13	4	40	148	3.7
Not known	29	58	7	9	4	4	111	1.8
All claims	**283**	**273**	**120**	**60**	**42**	**82**	**860**	**2.3**
			(per cent)					
Less than $10,000	45.0	30.2	11.0	4.1	3.5	6.3	100.0	
$10,000–<$30,000	30.9	31.8	17.3	10.0	3.6	6.4	100.0	
$30,000–<$50,000	35.6	28.9	13.3	8.9	8.9	4.4	100.0	
$50,000–<$100,000	23.9	34.3	22.4	6.0	7.5	6.0	100.0	
$100,000–<$250,000	20.6	38.2	17.6	2.9	20.6	—	100.0	
$250,000–<$500,000	8.3	16.7	33.3	16.7	8.3	16.7	100.0	
$500,000 or more	6.7	20.0	20.0	20.0	13.3	20.0	100.0	
No payment made[(b)]	24.3	20.3	16.9	8.8	2.7	27.0	100.0	
Not known	26.1	52.3	6.3	8.1	3.6	3.6	100.0	
All claims	**32.9**	**31.7**	**14.0**	**7.0**	**4.9**	**9.5**	**100.0**	

(a) Of the 860 finalised claims, 827 were finalised during 2003–2004 and 33 were finalised previously but the claim file was still open at July 2003.

(b) 'No payment made' is used where 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 placed to 30 June 2004. If a claim has a status of 'claim file closed', length of claim is from date reserve placed to date claim finalised.
2. Data for approximately 80% of all claims in scope are included.

New claims

There were 1,641 new claims in the period 1 July 2003 to 30 June 2004 (Table 3.16). A new claim has a date reserve placed within the reporting period. Claims with a reserve range between $10,000 and less than $30,000 represented the highest proportion of all new claims (35%) and those with a reserve exceeding $500,000 comprised the smallest (2%). The most common clinical service contexts recorded for new claims were accident and emergency (16%, 261 claims), obstetrics (14%, 231 claims) and general surgery (12%, 188 claims). Obstetrics claims were over-represented in claims with reserves exceeding $100,000 (44 claims or 22%), compared with 14% of claims overall. Claims associated with psychiatry were relatively more likely to have a reserve below $30,000 (79% compared with 62% of claims overall).

Table 3.16: New claims (public sector): reserve range by clinical service context, 1 July 2003 to 30 June 2004, Australia

Reserve range	A&E	Obstetrics	General surgery	Orthopaedics	Gynaecology	General medicine	Psychiatry	Paediatrics	All other clinical service contexts	Not known	Total	*Per cent*
Less than $10,000	75	39	58	43	20	22	17	2	124	36	436	*26.6*
$10,000–<$30,000	103	80	61	30	34	28	41	12	170	18	577	*35.2*
$30,000–<$50,000	15	15	18	17	14	9	5	4	36	4	137	*8.3*
$50,000–<$100,000	45	53	43	18	22	14	7	6	75	10	293	*17.9*
$100,000–<$250,000	13	20	6	15	10	4	3	3	39	5	118	*7.2*
$250,000–<$500,000	6	13	1	5	—	2	—	—	16	2	45	*2.7*
$500,000 or more	4	11	1	1	3	1	—	1	6	7	35	*2.1*
Total	**261**	**231**	**188**	**129**	**103**	**80**	**73**	**28**	**466**	**82**	**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 the row labelled 'All other clinical service contexts'. Appendix 3, Table A3-1 shows frequency of coding categories for all clinical service contexts.
2. Data for approximately 80% of all claims are included.

Appendix 1

Table A1: Coding examples for body function/structure categories

Body function/structure coding category	Examples of types of harm
1. Mental functions/structures of the nervous system	Psychological harm (e.g. nervous shock) Subdural haematoma Cerebral palsy
2. Sensory functions / the eye, ear and related structures	Vestibular impairment Injury to 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 jurisdictions

New South Wales

The New South Wales Treasury Managed Fund (TMF) covers all employees of public health organisations (PHOs) as defined in the Health Services Act 1997. This includes area health services, 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 under a separate contract of liability cover. Since 1 January 2002 the government has offered VMOs and honorary medical officers 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 honorary medical officer appointment.

Medical indemnity for private patients in rural public hospitals is the responsibility of the VMO or staff specialist (SS). However, since 1 July 2003 VMOs and SSs Levels 2 to 5 (having rights of private practice) in rural areas and selected hospitals in the Hunter and Illawarra have been able to access 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 from 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 excess per claim of up to about $250,000 (subject to annual consumer price index) capped at around $1million per annum. The period for which this interim cover was provided was extended to 30 June 2005.

The TMF Fund Manager manages all aspects of the claim, including arranging for such legal advice and representation as may be necessary. Incidents involving

employees of PHOs are notified to the TMF through PHO risk managers. VMOs and honorary medical officers 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 TMF is 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 undertakes interviews. TMF remains involved in the settlement of the claim through courts or settlement process.

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

- raising the discount rate for future economic loss damages to 5%;
- capping damages for loss of earnings and for non-economic loss (general damages for pain and suffering);
- abolishing exemplary and punitive damages; and
- 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. The *Civil Liability Act 2002* also:

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

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

- 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 that 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; and
- providing that apologies made are not relevant to the determination of liability in connection with the matter.

Relevant reforms implemented in the *Civil Liability Amendment Act 2003* included:

- 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; and
- 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 civil liability for the birth of a child.

Relevant reforms implemented in the *Civil Liability Amendment (Offender Damages) Acts 2004* and *2005* included:

- 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.

Victoria

Public sector insurance arrangements cover all Victorian public health care agencies (those subject to a Department of Human Services funding and service agreement). Employed doctors and independent contractors (VMOs) have been covered for public patient work since the late 1980s. Employed doctors with limited private practice rights entering into fee-sharing arrangements with public hospitals can avail themselves of Department of Human services cover for their private patients treated in the hospital. These are generally senior specialist practitioners.

As from 1 July 1996 rural general practitioners were able to participate in a Department of Human Services scheme whereby, on payment of a premium, they would be also covered for their private practice work undertaken in certain rural and remote public hospitals and bush nursing hospitals. By 1 July 2003, 250 practitioners had taken up this offer. A significant proportion of these doctors are covered for obstetrics work.

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

Medical indemnity claims are managed by the Department of Human Services insurer, Victorian Managed Insurance Authority (VMIA). When an incident is notified by a public health service or hospital to VMIA, VMIA sets a financial reserve if it believes the incident is likely to materialise into a claim. There is a minimum reserve amount for all matters reserved, which at least covers legal defence costs. The reserve may be placed before a letter of demand or writ has been received.

In 2002 Victoria enacted initial changes to legislation designed to address concerns and problems in the affordability and availability of public liability and medical indemnity cover. These legislative 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; and
- 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 introduction of the *Wrongs and Limitation of Actions Acts (Insurance Reform) Act* and *Wrongs and Other Acts (Law of Negligence) Act*. These changes applied to personal injury claims (including medical negligence) covering:

- thresholds on general damages;
- major reform to limit the time in which proceedings can be brought; and
- 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. However, some special protections 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 Treasury Managed Fund, called the Queensland Government Insurance Fund. The Queensland Government Insurance Fund was established on 1 July 2001. Coverage also 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 undertaking the treatment of private patients in limited specified circumstances. Indemnity under the policy is offered to doctors under an insurance-like model, with exclusions (proven criminal conduct, 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 or 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 are sourced 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 comprises matters that have been briefed to a panel firm.

By and large these matters comprise court proceedings and Notices of Claim under s9 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 a reserve has been placed against the matter by the firm. 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 s9A 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 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 issues 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 prior to court proceedings being issued. 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 included:

- 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;
- a requirement for the 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'; and

- exclusion of juries from hearing personal injury trials.

PIPA operated from 18 June 2002. On 29 August 2002 PIPA 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 commencement of the amendments.

On 9 April 2003 further tort reform initiatives took effect in Queensland with 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 occured after 1 December 2002;
- capped awards of general damages at $250,000;
- general damages are to be assessed on the basis of an injury scale value. Injuries are assessed on a scale of 1–100, 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 (e.g. 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 duty 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; and
- 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 timeframes. A Part 1 Notice of Claim must be given before the earlier of six years after the parent(s)/guardian know 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.

South Australia

Public sector insurance arrangements cover the following groups: employees of public hospitals, VMOs providing services to public patients, SSs 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 regarding approach to liability and quantum;
- reserve monitored throughout the claim and adjusted if necessary; and
- 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—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 where he or she considers that 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:

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

then adding the estimated defence costs.

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

Where a matter that has had a reserve placed against it remains inactive (i.e. does not materialise into a claim) the claim file will usually be closed upon expiration of the statutory time limitation within which proceedings would have had to have been issued. Occasionally files are reopened where a plaintiff seeks an extension of time.

Structured claim settlements are not common in South Australia.

Western Australia

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

All public hospitals and health services are charged an annual 'contribution' to RiskCover to cover the cost of managing and settling claims, including medical treatment liability 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 medical treatment liability 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 relevant hospital is provided with regular reports on progress until each matter is settled.

Since 1 July 2003 the Department of Health, through RiskCover, has contractually indemnified all visiting medical practitioners treating public patients in public hospitals for medical treatment liability claims. The cost of the indemnity is met by the relevant hospital(s). In return visiting medical practitioners are required to support and participate in further safety and quality management programs.

In mid-2004, the scope of the indemnity was extended and 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 participation in quality improvement committees; and
- indemnity for medical services provided to private and other 'non-public' patients treated in hospitals administered by the WA Country Health Service and the South West Health Board.

Since 1 July 2004 salaried medical officers have been offered the same contractual indemnity for medical treatment liability 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 *Review of the Law of Negligence* (the 'Ipp Report'); and
- the *Civil Liability Amendment Act 2004* further amending the *Civil Liability Act 2002* in two respects. It introduced a new evidentiary test in relation to the standard of care required of health professionals and made further provision with respect to proportionate liability. The Act provides a new test for medical negligence that will preclude a finding of negligence against a health professional if their conduct was found to be compatible with the views of a responsible body of their peers.

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, except for medical services that are 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 Tasmanian Risk Management Fund. Under the coverage provided by the Tasmanian Risk Management Fund, the Department of Health and Human Services is required to meet the first $50,000 in respect of any one 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 Department of Health and Human Services division, where it has been assessed that the nature of the incident and potential impact on the department is material enough 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 responsible officer in the Department of Health and Human Services 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.
- Management of the claim is undertaken by the relevant medico-legal officer and a representative form the Office of the Director of Public Prosecutions. Claim files are reviewed quarterly.

Tasmania has implemented a number of tort law reforms, largely via amendments to the *Civil Liability Act 2002.* Most of the reforms flow from recommendations in the Ipp review 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;
- statement that an apology (e.g. 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; and
- restriction of the circumstances in which a plaintiff may seek to recover damages for pure mental harm.

In addition to the recent reforms, existing provisions relating to the awarding of damages are being reviewed in the light of Ipp recommendations, including:

- no payments for gratuitous services may be awarded;
- the discount rate used in determining a lump sum payout of 7 per cent; and
- the limitation period of three years from the date of the cause of action, with a possible extension of a further three years at the discretion of the court.

Australian Capital Territory

All employees of the ACT Government undertaking 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 a Medical Negligence Indemnity Scheme to provide indemnity to VMOs providing public health services to public patients in public health facilities. The term 'public' is critical in this description as the scheme is specifically limited to that type of service. A recent change to sessional and fee-for-service contracts with VMO's has seen the Medical Negligence Indemnity 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; this 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 covers.

Key providers of medical insurance data are the two public hospitals, the Mental Health Service and the Community Health Service, 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 ACT Health, which then notifies the Government Solicitor's Office and the ACT Insurance Authority under obligations that ACT Health have 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, ACT Insurance Authority and the Government Solicitor's Office as soon as practicable (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 required timeframe, as required.

Legal reforms are underway with the *Civil Law (Wrongs) Amendment Act* having been passed by the Territorial Assembly in 2003. Elements of the Bill 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 date of 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;
- support to the development of 'tariffs' for general damages;
- ensuring that saying sorry, or waiving payment of a fee for service, does not represent an admission of liability; and

- early notification—procedural reforms designed to make early settlements more likely and to improve the efficiency of court proceedings.

Other reforms include:

- introduction of a 'reasonable prospects' test for cases brought before the court;
- imposing obligations on the parties to claims to exchange relevant documents (e.g. about the cause of the accident, 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 must 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 only proceed with the leave of the court and at the risk of cost penalties);
- requiring that, for adult claimants, this notice is given within three years;
- requiring that for child claimants, this notice is given within six years (there will be significant financial disincentives to delaying the giving of the notice on behalf of child claimants, i.e. no medical, legal or gratuitous care costs will be awarded for the period up to the date the notice is given); and
- requiring that, once notice is given, the prospective defendant has 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).

The government is also considering further reform measures. These include a number of proposals that would have an impact upon medical negligence proceedings:

- introduction of efficiency into court procedures;
- introduction of proportionate liability;
- precluding the awarding of pre-judgement interest on damages for non-economic loss; and
- legislation that clarifies the standard of care to be observed by medical practitioners.

Northern Territory

Current public sector medical indemnity insurance arrangements 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 NT 'buys' beds from a private hospital) or where care is provided outside of 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 may 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 out-sourced to a private law firm.

When a possible legal action is identified as the result of a complaint or inquiry, the Legal Support Branch 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 include the plaintiff and their representative lawyers, the defendant (i.e. the Northern Territory of Australia, the Department of Health and Community Services, and the hospital and/or staff involved), and out-sourced 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.

In calculating a reserve, factors taken into account may include:

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

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

The Statute of Limitations legislation prescribes that personal injury legal proceedings must be commenced within three years of the occurrence of an adverse event.

Presently there are no compulsory dispute resolution processes that exist as a pre-requisite to litigation. However, an aggrieved person may lodge a complaint through the Health and Community Services Complaints Commission in the first instance to have the matter investigated, conciliated or resolved prior to the commencement of litigation.

The Personal Injuries (Civil Claims) Act 2003 (NT) includes some provisions in relation to claims for personal injury; however, those relating to commencement of proceedings (ss7-10) and resolution conferences (s11) have not yet commenced. Therefore the *Limitation Act NT* 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 (NT)* provides that:

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:

a) for six hours or more per week; and

b) 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 subsequent to 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 NT. 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

Table A3-1: Clinical service context: number of claims for which each clinical service context recorded, 1 July 2003 to 30 June 2004, Australia

Clinical service context	Number	Per cent of claims
Accident and emergency	710	14.3
Cardiology	123	2.5
Dentistry	102	2.1
Cosmetic procedures	15	0.3
Ear, nose and throat	71	1.4
General medicine	204	4.1
General practice	58	1.2
General surgery	561	11.3
Gynaecology	414	8.4
Hospital outpatient department	58	1.2
Neurology	78	1.6
Obstetrics	825	16.6
Oncology	54	1.1
Orthopaedics	386	7.8
Paediatrics	135	2.7
Perinatology	24	0.5
Plastic surgery	39	0.8
Psychiatry	234	4.7
Radiology	62	1.3
Urology	84	1.7
Other	526	10.6
Not known	193	3.9
Total	**4,956**	**100.0**

Table A3-2: Specialties of clinicians closely involved in incident: frequency of coding categories recorded for claims, 1 July 2003 to 30 June 2004, Australia

Specialty of clinician	Number	Per cent of all recorded speciality categories
Anaesthetics—general	158	3.2
Anaesthetics—intensive care	11	0.2
Cardiology	67	1.4
Cardio-thoracic surgery	41	0.8
Clinical genetics	5	0.1
Clinical haematology	49	1.0
Clinical pharmacology	—	—
Colorectal surgery	25	0.5
Cosmetic surgery	1	0.0
Dentistry—oral surgery	65	1.3
Dentistry—other	31	0.6
Dermatology	7	0.1
Diagnostic radiology	78	1.6
Ear/nose/throat	66	1.4
Emergency medicine	439	9.0
Endocrinology	9	0.2
Endoscopy	6	0.1
Facio-maxillary surgery	10	0.2
Gastroenterology	43	0.9
General and internal medicine	111	2.3
General practice—non procedural	45	0.9
General practice—procedural	43	0.9
General surgery	378	7.7
Geriatrics	3	0.1
Gynaecology only	283	5.8
Infectious diseases	25	0.5
Intensive care	41	0.8
Medical oncology	25	0.5
Midwifery	114	2.3
Neurology	24	0.5
Neurosurgery	67	1.4
Neonatology	59	1.2
Nuclear medicine	7	0.1
Nursing—general	303	6.2
Nursing—nurse practitioner	1	—
Nutrition	—	—
Obstetrics and gynaecology	235	4.8
Obstetrics only	459	9.4
Occupational medicine	1	0.0
Opthamology	46	0.9
Oral surgery—medical	4	0.0

(continued)

Table A3-2 (continued): Specialties of clinicians closely involved in incident: frequency of coding categories recorded for claims, 1 July to 31 December 2003, Australia

Specialty of clinician	Number	Per cent of all recorded speciality categories
Orthopaedic surgery	359	7.4
Osteopathy	1	—
Paediatric medicine	66	1.4
Paediatric surgery	40	0.8
Pathology	67	1.4
Paramedical and ambulance staff	2	0.0
Pharmacy	5	0.1
Physiotherapy	23	0.5
Plastic surgery	62	1.3
Podiatry	3	0.1
Psychiatry	207	4.2
Psychology	2	0.0
Public health/preventive medicine	4	0.1
Rehabilitation medicine	5	0.1
Renal medicine	12	0.2
Respiratory medicine	13	0.3
Rheumatology	7	0.1
Spinal surgery	3	0.1
Therapeutic radiology	13	0.3
Thoracic medicine	5	0.1
Urology	75	1.5
Vascular surgery	44	0.9
Other allied health	42	0.9
Other hospital based medical practitioner[(a)]	278	5.7
N/A[(b)]	31	0.6
Not known	124	2.5
Total	**4,879**	**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 (e.g. where the claim relates to actions of hospital administrative staff).

(c) This is the total number of specialty categories recorded. As up to four specialty codes can be recorded for a single claim, this total may be greater than the total number of claims in all jurisdictions excluding NSW.

Note: NSW data are not included in this table as NSW data on specialty are not available.

Table A3-3: Specialty of clinicians involved in the incident: percentage of claims with one, two, three and four specialty codes recorded for claims, 1 July to 31 December 2003, Australia

	One specialty only	Two specialties	Three specialties	Four specialties	Total
Per cent of claims	86.2	10.9	2.3	0.6	100.0

Note: NSW data are not included in this table as NSW data on specialty and are not available; therefore only percentages are shown.