

Appendix 1 Body function/structure categories

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

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

Appendix 2 Detailed tables

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

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

Notes

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

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

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

(continued)

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

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

- (a) Other hospital-based medical practitioner includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.
- (b) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.
- (c) Total number of specialty categories recorded. Since up to four specialty codes can be recorded for a single claim, the total may be greater than the total number of claims in all jurisdictions.

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

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

Appendix 3 Background to the MINC collection

Background to the collection

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

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

Purposes of the collection

The primary purposes of the MINC are to:

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

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

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

Collaborative arrangements

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

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

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

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

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

Appendix 4 Policy, administrative and legal features in each jurisdiction

New South Wales

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Victoria

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

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

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

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

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

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

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

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

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

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

Queensland

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Western Australia

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

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

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

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

The NSMP indemnity provides:

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

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

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

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

South Australia

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

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

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

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

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

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

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

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

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

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

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

Structured claim settlements are not common in South Australia.

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

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

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

Tasmania

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

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

The claims management process is:

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

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

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

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

Australian Capital Territory

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

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

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

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

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

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

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

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

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

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

Among other reforms are the following:

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

Northern Territory

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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