Medical indemnity national data collection public sector 2004–05

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Symbols

– nil or rounded to zero

Abbreviations

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

Glossary

Claim	Claim is used as an umbrella term to include medical indemnity claims that have materialised and potential claims. A single claim (that is, a single record) in the MINC may encompass one or more claims made by a single claimant in respect of a particular health care incident, and may involve multiple defendants.
Claimant	The person who is pursuing a claim. The claimant may be the claim subject or may be an other party claiming for loss allegedly resulting from the incident.
Claim manager	The person who is responsible for all or some aspects of the management of the claim, on behalf of the Health Authority.
Claim subject	The person who received the health care service and was involved in the health care incident that is the basis for the claim, and who may have suffered or did suffer, harm or other loss, as a result. That is, the claim subject is the person who was the patient during the incident.
Harm	Death, disease, injury, suffering and/or disability experienced by a person.
Health Authority	The government department or agency with responsibility for health care in the Commonwealth of Australia, and in each of the states and territories of Australia
Health care	Services provided to individuals or communities to promote, maintain, monitor, or restore health.
Health care incident	An event or circumstance resulting from health care that may have led or did lead to unintended and/or unnecessary harm to a person, and/or a complaint or loss.
Incident	In the context of this data collection, 'incident' is used to mean health care incident
Loss	Any negative consequence, including financial loss, experienced by a person.
Medical indemnity	Medical indemnity includes professional indemnity for health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements.
Medical indemnity claim	A medical indemnity claim is a claim for compensation for harm or other loss that may have resulted or did result from a health care incident.

Other party	Any party or parties not directly involved in the health care incident but claiming for loss allegedly resulting from the incident. The 'other party' is not the person who was the patient during the incident.
Potential claim	A matter considered by the relevant authority as likely to materialise into a claim, and that has had a reserve placed against it.
Reserve	The dollar amount that is the best current estimate of the likely cost of the claim when closed. The amount should include claimant legal costs and defence costs but exclude internal claim management costs.

Summary

This report focuses on public sector medical indemnity claims data for the period 1 July 2004 to 30 June 2005 and is the third report in the series. The data in this report, which are collected through the Medical Indemnity National Collection (MINC), provide information on the incidents that gave rise to claims, the people affected by these incidents, and the size, duration and outcomes of medical indemnity claims.

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

Incidents

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

People

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

Claims

Current claims

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

New claims

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

Finalised claims

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

Reporting developments

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