

DISCUSSION PAPER 56
MEDICAL INDEMNITY : CRISIS AND RESPONSE

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**MEDICAL INDEMNITY :
CRISIS AND RESPONSE**

Discussion Paper
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The Centre for Health Economics Research and Evaluation (CHERE) was established in 1991. CHERE is a centre of excellence in health economics and health services research. It is a joint Centre of the Faculties of Business and Nursing, Midwifery and Health at the University of Technology, Sydney, in collaboration with Central Sydney Area Health Service. It was established as a UTS Centre in February, 2002. The Centre aims to contribute to the development and application of health economics and health services research through research, teaching and policy support.

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OVERVIEW

Medical indemnity is a form of professional liability insurance, which falls within the broader category of general insurance and is distinct from life insurance. Liability insurance protects the insured against the consequences of being legally liable for injury or damage to third parties. Professional liability insurance indemnifies professional persons such as accountants, architects, engineers, lawyers, physicians and others for their legal liability to their clients and others relying on their advice¹. 'One of the features of liability insurance is its long tail in that it may be many years between an injury or incident occurring and the time an insurer receives notice of a claim'².

The last two decades have seen major changes to the medical indemnity system in Australia, the number and size of claims has soared, cover type has been restricted, premiums have become risk-rated and there has been a move from an unregulated system of mutual organisations offering discretionary cover to a regulated insurance market offering contractual agreements. Whilst medical indemnity is not mandatory for doctors, all physicians treating public patients in public hospitals have an indemnity policy covered by their employer.

This paper provides a synopsis of the medical indemnity system; however, in light of events in 2003, with the resignations of more than 100 NSW and Queensland doctors being submitted, the paper will also attempt to provide an explanation as to why this medical indemnity crisis has come about.

1 <http://www.ica.com.au>

2 Commonwealth of Australia 2002

MEDICAL INDEMNITY

The world's first Medical Defence Organisation (MDO), the Medical Defence Union, was established in the UK in 1885 to defend the reputation of doctors; in 1924 their role was extended beyond the coverage of legal fees to include indemnifying the doctor in full for any payment s/he may be required to pay to a patient in compensation¹.

Medical Defence Organisations were established in Australia in 1893 and operated as mutual organisations pooling subscriptions and offering discretionary claim payments. However, in 1991, against a background of increasing litigation, the Commonwealth Government established a Review of Professional Indemnity Arrangements for Health Care Professionals to examine arrangements relating to professional indemnity and compensation for medical misadventure. The findings of the four and a half year investigation, known as the Tito report, after the review's chair Fiona Tito, offered 168 detailed recommendations for changes including implementing clinical practice guidelines. Interestingly, the Review reported that "evidence for a so-called claims crisis was scant", and that a crisis mentality had been fostered by some Medical Defence Organisations to deflect attention from their own "irresponsible financial management"; it called for the MDOs to become insurers not only requiring them to be licensed, but also replacing the discretionary approach of cover with contracts. However, some commentators such as Blomberg⁴ criticised it for raising more questions than it answered and for not offering real assessment of the financial effect or impact on medical practice of its recommendations

> MUTUALITY & COVER RESTRICTIONS

Traditionally, MDOs were mutual insurance organisations and provided discretionary assistance to their members. Subscriptions were the same for all members and the subscription funds pool financed the organisation and claim payments. Originally the MDOs offered claims-incurred cover, whereby the annual subscription covered the doctor in perpetuity for any claims arising from incidents during that year, regardless of when a claim is made.

Claims-incurred cover provided doctors with the security of knowing that they would be covered forever for any incident that occurred during that policy year. Claims-incurred cover was offered by most MDOs on a discretionary basis; as it was not an insurance contract, payment could theoretically be refused if the organisation lacked the ability to pay, although denial of support was rare. This type of cover is no longer offered by MDOs; now the only cover available is claims-made cover whereby a doctor is only covered if they have paid a premium for the year in which the claim was made. Whilst claims-made cover means that insurers are better equipped to calculate its liabilities it causes particular problems for doctors wishing to retire or take leave as they have to purchase run-off cover for any claims that may arise after they have stopped working.

> RISK-RATED PREMIUMS

Another major change in the medical indemnity system was the introduction of risk-rated premiums. Until the mid 1980s, under the MDOs old system of charging, all members paid the same subscription regardless of the risk of being sued, this then changed with the higher risk specialties and practices such as obstetrics, neurosurgery and procedural general practice being charged higher premiums.

³ <http://www.the-mdu.com>

⁴ Blomberg, C. (1996)

> REGULATION & REINSURANCE

Prior to 1 July 2003 medical indemnity providers were unregulated and there is evidence that many providers were not adequately providing for their outstanding claims liability⁵. The provision for outstanding claims is a critical aspect of the accounts of any general insurer and is the largest single item on the liabilities side of their balance sheet⁶. In July 2003 the Medical Indemnity (Prudential Supervision and Product Standards) Act was passed, prohibiting institutions from providing medical indemnity cover unless the institution is an authorised general insurer under the Insurance Act 1973; this was just one of a number of recent interventions by the Government discussed in more detail below. The Act is designed to 'strengthen prudential supervision of the market and introduce a number of product standards. These measures are intended to promote commercial sustainability, implement greater government oversight and ensure that adequate indemnity cover is available for medical practitioners.'⁷ The Australian Prudential Regulation Authority (APRA) is responsible for the administration of the Act.

Most MDO's rely heavily on reinsurance to protect their financial position. Reinsurance, as traditionally understood, is a mechanism whereby an insurer transfers part of the risk it has assumed on behalf of its policyholders. It is widely used by general insurers to manage underwriting and financial risk. One purpose of reinsurance is to transfer the risk of future adverse developments in relation to claims. It is thus important when the level of outstanding claims provisions and other factors affecting an insurer's financial statements are being considered. Under the new Act MDOs have to become authorised insurers and will therefore need to comply with the Insurance Act 1973, which requires insurance companies to meet minimal capital requirements and have sufficient resources to pay claims.

⁵ see later comments regarding UMP

⁶ HIH Royal Commission 2003

⁷ Patterson 2003

CRISIS & RESPONSE

While some causes of the current domestic medical indemnity crisis are particular to Australia it has to be remembered that it has developed in the context of a broader crisis in liability insurance.

> RISE IN CLAIMS AND AWARDS

Since the 1980s the number of claims for medical negligence and malpractice has been on the increase. Australia has witnessed a dramatic rise in recent years with the number of medical indemnity claims rising from 1,090 in 1998 to 2,300 in 2002 reflecting an increase of 111 per cent in just four years⁸.

The cost of claims has also grown considerably. During the 1990s the cost of claims increased 350%. In 1997 the ultimate claims costs totalled about \$72 million and by 2002 this had risen to \$271 million, reflecting an increase of around 276 per cent⁹. In addition to this, the size of individual financial awards has also jumped significantly; table 1 shows the increase in individual personal injury settlements in Australia since 1979.

Table 1: Individual medical indemnity awards

Year	Largest amount awarded
1979	\$270,000 (1.2 million in present day value)
1992	\$833,000
2001	\$5.8 million
2003	\$11 million

Source: Commonwealth of Australia (2003)

The \$11 million settlement in 2003 not only represents an increase in claims costs of more than 900% over a 24 year period, it also highlights the 'long tail' of liability insurance as this claim related to an incident that occurred in 1979¹⁰.

> THE INSURANCE CYCLE & SEPTEMBER 11 2001

The insurance market is considered by many to be cyclical and therefore subject to pricing cycles caused by supply and demand. The second half of the 1990s was a period of poor global market conditions for commercial insurance, supply was reduced and there was a move away from the common practice of under-pricing to higher pricing of premiums. The market of rising premiums and falling capacity was evident and worsening from the beginning of 2001 and this was confounded by events in New York on September 11, 2001¹¹. The destruction of the World Trade Centre is the largest insurance event in history and not only stretched the industry's resources but also led to a recalculation of the risk/reward position which resulted in increased premiums¹². The insurance industry was forced to recoup huge losses and revise its underwriting practices. The subsequent premium price increases were passed from re-insurers to local insurers to policyholders

8 Commonwealth of Australia 2004

9 Commonwealth of Australia 2004

10 Commonwealth Government 2003

11 Commonwealth of Australia 2002

12 <http://www.aph.gov.au> 2003

> **THE COLLAPSE OF HIH INSURANCE GROUP & UNITED MEDICAL PROTECTION LTD**

United Medical Protection Ltd (UMP) - now known as UNITED and operating as the UNITED Medical Protection Group of Companies - was created from the NSW Medical Defence Union in 1997 and pursued an aggressive market growth strategy. At its height it was the largest medical insurer in Australia with coverage of approximately 60% of medical practitioners nationally and 90% in NSW and Queensland¹³. Its major re-insurer HIH Insurance was Australia's second largest insurance company whose market share of liability insurance was gained by offering discounted premiums; HIH went into liquidation on 15 March 2001.

MDOs can raise further capital due to their mutuality structure by charging additional subscriptions or as it's known 'making a call' to members for extra money. Prior to the collapse of HIH Insurance, UMP was already 'making calls' on its members. Indeed by the end of the 1990s the increase in claims and awards saw most MDOs having to make calls. The need for the calls for supplementary contributions is a major indicator that the premiums being collected from subscribing members and existing reinsurance arrangements were no longer adequate to cover their ever increasing liability. On 24 November 2000 UMP announced at its annual general meeting that it would call on members to contribute an extra years subscription, spread over 5 years (estimated to total \$75 million), and that premiums would increase by 8%. In June 2001 UMP announced that it had written off \$30 million due to the collapse of HIH. In November 2001 it was reported that UMP had not recorded approximately \$455 million of Incurred But Not Reported (IBNR) claims which it expected to pay over the next 20 years¹⁴ by the end of April 2002 UMP was placed into provisional liquidation due to a combination of the increase in the number and size of claims and the impact of the financial collapse of HIH. HIH Insurance collapsed with \$5.3 billion debt which was primarily blamed on poor management and insufficient underwriting¹⁵.

The predicament of UMP is seen by many as the catalyst to the current medical indemnity crisis - if an MDO or insurer becomes insolvent then the individual doctor becomes liable - to avoid the potential detrimental impact on health services and to prevent a total collapse of the insurance industry as a whole the Government stepped in with a package of financial assistance schemes. 'The measures contained in the package were designed to make the medical indemnity market more sustainable and give doctors the certainty they need to continue practicing'¹⁶.

> **GOVERNMENT RESPONSE**

One Government scheme in particular, the IBNR levy proved to be the 'straw that broke the camel's back'. In June 2002 the Government agreed to take on UMP's IBNR liabilities - all the unfunded incurred-but-not-reported liabilities of the MDO as UMP did not have adequate reserves to cover these liabilities - and this was to be financed by the levy to all doctors who were members of UMP as at 30 June 2000¹⁷. At the time, practically all doctors throughout Australia were expressing frustration and concern with the ever increasing cost of indemnity premiums but it was those doctors who were members of UMP - approximately 80% of all doctors in NSW and Queensland - who were called upon to pay the additional levy that finally revolted. IBNR levy bills were sent out in August 2003, the majority being for less than \$5,000 but the highest being \$200,000. This resulted in approximately 100 doctors in NSW and Queensland tendering their resignation from public hospitals. This in turn triggered further response from the Government as it attempted to avert disruption to the public hospital service. Table 2 highlights the timeframe of the major events and the Government responses throughout this crisis period.

13 <http://www.aph.gov.au>

14 <http://www.aph.gov.au>

15 <http://www.smh.com.au>

16 DoHA 2003

17 DoHA 2003

Table 2: Timeframe of current medical indemnity crisis & Government schemes

Late 1990s/2000	Calls made by MDOs to members for additional funding
March 2001	Collapse of HIH Insurance, re-insurers to United Medical Protection
April 2002	UMP placed into provisional liquidation
30 June 2002	IBNR - Government provides a short-term guarantee that UMPs claim liabilities would be paid. This is to be funded through an IBNR (Incurred But Not Reported) levy on all members of UMP as at 30 June 2000 – this resulted in a threat to resign from public hospitals by many NSW and Queensland doctors
October 2002	Blue Sky Scheme for large indemnity claims - under the Scheme, the Government will assume liability for 100 per cent of amounts payable by a doctor that exceed the threshold of \$20 million. The Blue Sky Scheme is now known as the Exceptional Claims Scheme (ECS)
	Medical Indemnity Subsidy Scheme (MISS) to help those doctors who undertake high risk procedures - neurosurgeons, obstetricians and procedural GPs – meet particularly high premiums
	High Cost Claims Scheme – to help medical indemnity insurers by reimbursing them on a per claim basis, 50% of a payout over \$2 million for claims notified on or after 1 January 2003.
1 July 2003	Medical Indemnity Act passed to regulate the system
August 2003	IBNR levy bills received by doctors – some as high as \$200,000 – the “straw that broke the camels back” as 100 NSW and Queensland doctors submit their resignations
3 October 2003	Government announced an 18 month moratorium on the payment of annual IBNR liabilities over \$1000
10 October 2003	Government extends the High cost Claims Scheme to cover 50% of all claims between \$500,000 and \$20 million and exempts a number of doctors from the IBNR levy
16 October 2003	Government announces the membership and terms of reference for the New Medical Indemnity Policy Review Panel, which will make recommendations to ensure a fair, affordable and sustainable medical indemnity insurance system by 10 December 2003
17 December 2003	Government responds to the report from Medical Indemnity Policy Review Panel.

Primary source media releases: <http://www.health.gov.au/medicalindemnity/media.htm>

The Government's initial medical indemnity framework package was announced on 23 October 2002 with subsequent statements being made throughout 2003. The numerous amendments and developments make it difficult to keep track of the schemes, primarily because when they are redesigned there is invariably a name change. For example the Premium Subsidy Scheme was initially called the Medical Indemnity Subsidy Scheme and has since been replaced by the premium support scheme. The subsidy applies to the same group of doctors but they no longer have to apply for it as the subsidy is now paid directly to the insurer.

The latest offering from the Government was presented on 17 December 2003 in response to the Medical Indemnity Panel report. A media release was issued stating that the Government was to adopt the following recommendations¹⁸:

- High Cost Claims Scheme to be extended to cover 50 per cent of the cost of all claims against doctors over \$300,000
- Claims against retired doctors, doctors on maternity leave and doctors who have been permanently out of the workforce for more than three years be met by a government backed Run-off Reinsurance Vehicle (RRV) funded by a charge over medical insurers. In effect, this provides doctors with the security of "claims-incurred cover". The Panel also recommended that Incurred But Not Reported claims (IBNR) against doctors who have become eligible for cover under the Run-off Reinsurance Vehicle should be assumed by the vehicle.
- Existing premium subsidy scheme – the MISS – to be replaced by Premium Support Scheme paid to medical insurers for doctors whose actuarially assessed premiums passed a "trigger" percentage of private medical income; it will be administered by the Health Insurance Commission.
- The Panel noted that stability in the medical work force would be best achieved if doctors paid no further levies under the IBNR scheme but considered that, if the Government decided to retain a levy, it should be set at a small percentage of doctors' current income. The Government decided to replace the IBNR levy with UMP support arrangements. Doctors who were members of UMP in 2000 and who have medical incomes above \$5000 a year pay either the former IBNR annual levy, 2 per cent of gross private medical income, or \$5000; whichever is the least.
- The Panel called on the states and territories to continue the process of tort law reform and work on developing a scheme for the long-term care of the catastrophically injured.
- The Panel also recommended that, within 18 months, the Government convene a new working group, to consider the effectiveness of these recommendations – including further tort law reform – and, if necessary, the feasibility of a doctor-owned monopoly medical insurer.

SO HOW DID THE CRISIS COME ABOUT?

Whilst the near collapse of UMP in 2002 is seen as the trigger with the IBNR levy on UMP members resulting in doctor's tendering their resignations, there are a number of other factors that have contributed over time. Factors operating at both domestic and international levels, such as the worldwide low in the cycle of the insurance market, the impact and consequences of events in the US on September 11, 2001 and the general rise in litigation have all helped fuel the decline of the system.

The origins of the crisis lie in the fact that the original MDO system was unsustainable; the ever increasing number of claims and claim awards could, quite simply, not be covered. 'As NSW came to rival California and New York as the world's litigation capital'¹⁹ a more litigious society coupled with unprecedented awards took its toll on a system set up at a time when such a level of litigation would have been unimaginable.

Currently, all cases for negligence are dealt with as part of common law through the law of torts. The purpose of tort law is described as "adjustment of losses and the affording of compensation for injury sustained by one person as a result of the conduct of another"²⁰, it is one of the major areas of law (along with contract, real property and criminal law) and results in more civil litigation than any other category²¹. Some members of the legal profession have started to advertise 'no win, no fee' offers coupled with the high monetary awards attracting media attention. The general public is now much more aware of opportunities to sue. Some commentators have expressed concern at how Australian society has changed in its views and actions regarding litigation "Australians once made fun of the American litigation system, where people sued everybody over everything. But the laughing has stopped, particularly among the medical profession, where more and more patients are deciding to sue their doctors"²².

Problems within the insurance industry itself have also contributed. Poor management, underwriting and a lack of provision for future liabilities has resulted in insurers struggling to cover claim costs and in extreme cases, as witnessed with HIH, the collapse of the company. The loss of any major player, such as HIH, reverberates throughout the industry effectively reducing supply and ultimately raising the cost of premiums. The effect is even bigger when the company has been offering discounted premiums as the loss to the market is particularly felt by customers as they are left to seek out alternative, usually more expensive, cover. In addition to this is the fact that HIH was also the major re-insurer to UMP whose own threatened collapse had the potential to leave a large percentage of doctors, especially in NSW and Queensland without cover, and as this would mean doctors would become personally liable, it necessitated Government intervention.

A further contributing factor to the crisis has been the relationship between the additional levy and doctors' ability to pay. The difference between the earning power of public and private practice was not adequately accounted for in the IBNR levy, for example a NSW orthopaedic surgeon working entirely in private hospitals earning approximately \$1 million a year was faced with an \$80,000 levy, and an orthopaedic surgeon working in public hospitals and earning \$200,000 was faced with a \$40,000 levy; hence the threat to resign from public hospitals to work in private where they have to pay the premium themselves but can earn much more²³. There are also many issues regarding the change in cover being offered, from claims-incurred to claims-made, which has resulted in retired doctors having to purchase run-off cover and part-time doctors being faced with premiums that are so high that in some cases it is not financially worthwhile continuing in practice. This potentially has dire consequences in areas where the workforce is already under resourced. The workforce will also be affected when premiums are high for certain high risk specialties if doctors stop providing these services and trainees decide to avoid them.

¹⁹ Medical Indemnity Policy Review Panel 2003

²⁰ Commonwealth of Australia 1992

²¹ www.dictionary.law.com

²² www.abc.net.au 2003

²³ Commonwealth of Australia 2003

CONCLUSION

The current medical indemnity crisis has come about primarily due to premiums escalating beyond what doctors are prepared to, and in many cases, are able to pay. However, as this paper has highlighted there are a number of other factors that have contributed over time and have caused further escalation of the problem. In brief, it is a cocktail of events and practices that have caused the crisis. Poor underwriting and the escalating number and size of claims has resulted in some insurance companies being unable to keep pace in an increasingly litigious environment. With fewer insurance providers and higher costs, premiums were raised, add to this the events in the US on September 11, 2001 and on the domestic front the near-collapse of a major player in the insurance market and there is a crisis in that there is suddenly a very realistic chance that a large number of doctors would be without any liability insurance. If the insurance provider fails the individual becomes liable. The Government stepped in, but only to heighten the problem with some of its suggested quick fixes, particularly the IBNR scheme which turned out to be beyond what many doctors were willing to accept.

While this cocktail of events and practices may be unique to Australia, It should be highlighted that it is not alone in its experience of changing attitudes towards litigation and problems with medical indemnity. In the UK, despite reports that the public are increasingly irritated and suspicious of the 'no win no fee' offers from legal services, enthusiastic forecasts say that the number of personal injury claims will grow by an annual average of 9.9% until 2006²⁴. Argentina has also seen a huge increase in medical malpractice claims, although this has been attributed to the fact that the country remains mired in economic chaos, with at least two-thirds of litigation regarded as frivolous claims by Argentines desperate for cash²⁵. In the USA, the New York Times reported in May 2002 that the MILX Group, which provided malpractice insurance to nearly 40 percent of New Jersey's doctors, was shutting its doors, leaving doctors scrambling for coverage just as other insurers were getting out of the business or cutting back and in late 2002 the US State Legislature Magazine headlined that at least 60 specialists at the University Medical Centre in Las Vegas walked off their jobs during the summer. The reason given was the rising cost of medical malpractice insurance.

While some commentators reported that the Government efforts announced on 17 December 2003 went some way to resolving the crisis, there are still a large number of calls for a long term major rethink of the entire medical indemnity system. Particular emphasis is being placed on reforming tort law. As it currently stands tort law is an issue for State Governments so if the Commonwealth Government wishes to avoid differences in tort law appearing throughout various jurisdictions it needs to cooperate with the State Governments to ensure unified claim laws and damage awards. Capping claims is just one of a number of suggestions for reforming the medical indemnity system. Others include moving away from the free-market to a single monopolistic insurer, and even a move away from relying on the tort law system altogether with the adoption of a completely new model. The most commonly suggested being based on the New Zealand no-fault accident compensation scheme, which emphasises rehabilitation in contrast to the tort-based systems, "which deliver lump-sum payments in varying amounts, almost encouraging an injured person to delay rehabilitation to demonstrate to the court the severity of the injury"²⁶. See Appendix 1

Interestingly, the Tito report 1995 recommended against the introduction of a "no-fault" scheme of compensation in Australia as such a scheme would remove the need to prove negligence (fault) to receive compensation, so it was rejected on grounds of inequity. Some, more recent commentators are highlighting its benefits with regards to cost, a paper prepared by actuaries for the New Zealand affiliate of Towers Perrin calculated that "medical misadventure" injuries compensation is financed by a levy equal to \$NZ7 a year (about \$A4.20), in its entirety the New Zealand system provides personal accident compensation for its entire economy at a fraction of the cost of the tort law system which operates in Australia and the US²⁷.

24 <http://www.marketresearch.com>

25 The Lancet 2002

26 Davidson 2003

27 Davidson 2003

APPENDIX 1

The New Zealand compensation scheme is managed by the Accident Compensation Corporation (ACC), and provides 24 hour no-fault personal accident insurance cover for all New Zealand citizens, residents and temporary visitors to New Zealand. In return people do not have the right to sue for personal injury, other than for exemplary damages.

The ACC scheme²⁸:

- provides cover for injuries, no matter who is at fault
- eliminates the slow and costly process of using the courts for each injury
- reduces personal, physical and emotional suffering by providing timely care and rehabilitation that gets people back to work or independence as soon as possible
- minimises personal financial loss by paying weekly earnings compensation to injured people who are off work – up to 80% of income
- focuses on reducing the causes of these problems – the circumstances that lead to accidents at work, at home, on the road and elsewhere.

In total the ACC spends around NZ\$1.4 billion each year (approximately 2% of its GDP) on rehabilitation, treatment and weekly compensation; this covers the cost for all accident claims not just medical misadventure. To fund these services, premiums are collected and invested. All New Zealanders pay premiums for ACC cover. Premiums are set to pay for the current and future costs of all claims made in that year. The government funds the costs of injuries to people who are not in the paid workforce on a 'pay-as-you-go' basis, meaning that ACC collects enough today to pay for all costs today. Premium levels are set by the government based on recommendations from the ACC's Board of Directors following a formal public consultation process. As a result of improved scheme performance, premiums have begun to fall and over the past two years have reduced by nearly NZ\$500 million, a 25% drop.

The ACC manages seven injury accounts including the medical misadventure account which provides cover and entitlements to claimants who have been injured during medical treatment. The criteria under which a medical misadventure claim can be accepted is restricted by legislation. The law is specific about what ACC can cover; the injury must be caused by a medical mishap or error. The definition of "medical mishap" is when the right treatment was properly given but it resulted in a complication which was both rare and severe. This complication must clearly be because of the treatment, not the medical condition. A medical error occurs when the injured person does not receive treatment of a reasonable standard, given the circumstances. It includes situations when the health professional fails to correctly diagnose, obtain informed consent or provide treatment²⁹.

²⁸ www.acc.co.nz

²⁹ www.acc.co.nz

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