MEDICAL INDEMNITY INDUSTRY ASSOCIATION OF AUSTRALIA

Submission to the Productivity Commission Issues Paper into the Medical Workforce

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Introduction

The Medical Indemnity Industry Association (MIIAA) is the peak consultative group for the medical insurance sector in Australia. The members are:

- Medical Insurance Australia Group – MDASA and Medical Insurance Australia
- MDA Victoria and PIICA
- UNITED Medical Protection and AMIL
- MDA National and MDA National Insurance

The MIIAA represents all but one of the medical indemnity insurers (MIPS/HPIA) and covers more than 75 percent of doctors in Australia. The MIIAA is therefore well placed to provide an industry wide view of the impact of medical indemnity issues on workforce recruitment and retention.

There would be no private practice of medicine in Australia if it were not for the existence and effective operation of the Medical Indemnity Insurers (MIIs). This responsibility is taken seriously by MIIAA members and it is important to note that while the sector operates under the stringent general insurance regime, regulated by APRA, ASIC, HIC, the ACCC and others, there are no profit making commercial insurers involved. All the companies that are members of the MIIAA are wholly owned by mutuals that are in turn owned by the medical profession.

This submission seeks to identify those areas of concern in the issues paper which have a direct link to medical indemnity insurance, and provide up to date information based on the experience of members of the MIIAA.

Medical training

The Productivity Commission issues paper contends that with the movement of medical services to the private sector that "mechanisms to redistribute the training load will inevitably be required" but that this may be impeded by "issues of indemnity cover".

The issues surrounding indemnity cover for training in the private sector are relatively straightforward. MIIs have already recognised that training is increasingly being provided by the private sector, and have also recognised that trainees must be provided with cost effective cover to facilitate training in the private sector.

Supervisory medical indemnity coverage

Most MIIs provide cover for a supervising doctor to ensure they are protected when a claim is brought by a patient which arises from the provision of clinical care by a person in a trainee or teaching role in the doctor's practice. Generally, the wordings state that for the supervisor's policy to apply the trainee doctors is employed under an accredited training programme approved by the trainee doctor's or registrar's training college or institution.

By way of example, the specific clause in one Professional Indemnity Insurance Policy is:

> *Subject to clauses 2, 3 and 4 and all other terms and conditions of this policy and subject to notification in compliance with clause 9, we agree to indemnify you against any civil liability including claimant's costs for medical negligence arising out of a claim:*
>
> *a) against you and which arises from the provision of medical services:*
>
> *ii) by a medical practitioner trainee supervised by you as part of an accredited training program; or*
> *iii) by you when supervising a medical student who is participating in a scholarship placement or student elective*

Most MIIs have similar policy wordings. Generally the wording states that the trainee doctor or registrar must be employed under an accredited training programme approved by the trainee doctor's or registrar's training college or institution for the supervisor's policy to apply.

Trainee/Registrar access to medical indemnity

Trainees may be indemnified by their employer (eg where they are seconded to the position from a state teaching hospital) or they may arrange their own medical indemnity insurance. All medical indemnity insurers offer cover for students and trainees and the cost of these policies is targeted at such a level such as not to place any significant financial imposts on the trainee or student.

Generally the supervisor does not have to pay an additional premium to maintain cover under their own policy for their vicarious liability for the acts and omissions of the trainee.

In most cases the supervisor does not have to pay an additional premium for the vicarious liability coverage for the acts and omissions of the trainee.

Insurance premiums for trainees vary depending on whether they are still a student or what year of their training they are in.

As an example, one MII's 2005 indemnity costs for trainees on accredited training programs, or medical students on placements or scholarships, are as follows:

Student/Trainee Indemnity costs – (Australia wide)

Cover Required	Subscription	Premium	TOTAL
Medical Student (Nil income)	15	0	$15.00
Intern/First Year Post Grad (income app $60k)	10	10	$20.00
Second Year Post Grad (>$60k)	40	40	$80.00
Third Year Post Grad (>$60k)	75	75	$150.00
Fourth Year Post Grad (>$60k)	75	150	$225.00
Doctor in Training (Accredited Scheme) (>$60k)	100	375	$475.00

NB: Excludes Government Charges (ROCS = 8.5%) and GST/Stamp Duty

Most MIIs in Australia offer reduced premiums to these groups.

Medical indemnity insurers in Australia have generally recognised the issues of indemnity for training both in terms of coverage and cost and addressed them, and offer policies which are readily available and cost effective to support training provision in the private sector.

It is also worth noting, that post graduates who earn greater than $1000 in gross billings are eligible to access the Commonwealths Premium Support Scheme, which is discussed in detail below.

Examples of successful training in private hospitals/medical practices

With the increasing focus of public hospitals on trauma and urgent medical problems, many registrars and trainees are not able to gain exposure to more routine medical problems and procedures, which are now being treated in the private system. To enable them to access the full range of practice it is important that trainees and registrars are exposed to the broader application of their craft. There are many private institutions which have successfully adapted to the changed environment and provide training.

The Queensland example in the issues paper is not isolated. Another example is that of plastic and reconstructive surgery trainees in Western Australia and New South Wales. Due to the focus on trauma in the public hospital system and frequent cancellation of elective cases the training system has adapted to include a term of rotation through the major private hospitals. Trainees there assist with a wide range of elective cases that are not commonly seen, if at all, in the rest of their training.

There are also examples of hospitals contracted to provide services to public patients where the trainee staff carry out roles analogous with those in direct state funded hospitals (Peel and Joondalup Health Campuses in Western Australia for example). Their indemnity can either be provided by the state when on secondment or through a corporate or MII policy.

Indemnity concerns should thus be no barrier to training doctors in the private sector.

Overseas trained doctors

The issues paper mentions some of the issues surrounding policy reform and settings in the area of skilled migration.

The increasing reliance on overseas trained doctors (OTDs) in the Australian health care system has posed challenges for the members of MIIAA. Before being registered to work in Australia it is imperative that overseas trained doctors undergo appropriate screening.

The following factors should be verified by the Medical Board in the relevant state before they are licensed and/or indemnified:

- training
- experience
- compliance with Australian standards of clinical competence
- appropriate risk management tools such as ongoing training and supervision are customized to the individual OTD
- adequate communications skills

The verification of the qualifications of overseas qualified doctors is vital. Some medical boards require that the qualification is sent directly from the source to them to avoid fraud. MIIs must be confident that when a doctor is licensed to practice in Australia, their experience and qualifications have been verified and that society and insurers are not exposed to doctors who do not meet the expected levels of quality and safety in the health system.

The universal coverage provisions which apply to medical indemnity insurance in Australia result in easy access to indemnity for any registered doctor irrespective of whether they are an OTD or not. MIIAA members have no issue with indemnifying these doctors, provided that they have been appropriately screened, and agree to engage in risk management initiatives where they may be required.

The Federal Government Department of Health and Ageing has entered into a contract with MIIAA member insurers (the HIC Services Contract) which includes a requirement on the MIIs to ensure that all doctors registered in Australia can access medical indemnity insurance. The Contract ensures that in every state there is effectively at least one MII that is obligated to provide medical indemnity to all registered doctors in that state (universal cover).

OTDs who are accredited by the Australian Medical Council can generally be considered to be qualified to an equivalent level to Australian trained doctors. The process these doctors undertake to obtain the AMC recognition is sufficiently rigorous to provide MIIs with comfort in providing insurance products to these doctors.

Doctors who are fast tracked to areas of need, however, may be more problematic as there is a less rigorous assessment of their skills in the haste to get them placed in areas with insufficient doctor numbers. It is in this area that more rigorous assessment by the medical boards is required.

Whilst insurers can place premium loadings on doctors whose skill levels are uncertain, and can also apply practice limitations under the provisions of the HIC Services Contract, these are not sufficient to prevent damage to patients prospectively if a doctor is truly under skilled. Such incidents will sabotage the effective use of OTDs to help with workforce shortages, as they will introduce community resistance to the placement of OTDs where it is not warranted.

Insurers must be confident that the registration authority has rigorously assessed the qualifications of the doctor to practice in the area into which they are to be placed, and the expectation would be that the medical boards would be undertaking a nationally consistent, timely, rigorous and effective assessment of the qualifications of each doctor who applies for registration, irrespective of the geographic need.

There are comprehensive risk management tools available to the MIIs when underwriting OTDs. These include the ability to impose supervisory and other requirements. The relevant clause from the HIC Services Contract reads as follows:

> 27.2 *Clause 27.1 does not prevent the Insurer from taking any of the following actions, based on an individual Member's claim history or other matters relevant to an individual Member or an individual Member's practice:*
>
> *a. complying with any applicable Laws, including Laws that restrict the Insurer's ability to enter into an insurance-contract;*
> *b. imposing a deductible, where appropriate;*
> *c. applying a Risk Surcharge, where appropriate, up to the Risk Surcharge Cap;*
> *d. excluding from cover certain procedures that in the case of a particular Member impose an unreasonable risk in the circumstances;*
> *e. imposing as a condition of cover that a Member undertake additional training, including referring a Member for risk management;*
> *f. imposing as a condition of cover that a Member be chaperoned or have qualified supervisory assistance for the performance of certain procedures;*
> *g. refusing cover to a Member who has not met his or her information provision obligations to the Insurer, so that the Insurer is unable to meet its obligations under this Contract;*
> *h. exercising its rights in relation to non-payment of Premiums; or*
> *i. exercising its rights and performing its obligations under the insurance Contract&Act 1984, the Health Care Liability Act 2001 (NSW), and other applicable Laws including in relation to disclosure obligations and fraudulent claims.*

Application of supervisory requirements is particularly difficult in areas of need, as these areas are generally deficient in doctor coverage to begin with, and often are isolated. With OTDs being seemingly fast tracked into placement in these areas, often with cultural and linguistic differences to overcome upon placement, differentials in medical practices between their country of origin and those in their new community are often not adequately addressed, and without adequate supervision become more problematic. It

is particularly in these environments that the community and insurers must be confident that the doctor is adequately qualified to provide the level of medical care required.

Cost of medical indemnity insurance causing doctors to cease or change area of practice

In relation to costs the issues paper states that the "Commission is interested in whether recent policy responses will see these sorts of problems plateau or diminish in the future, or whether further initiatives are required."

The MIIAA has recently released a report on the cost of premiums and claims for medical indemnity insurance for the period to 30 June 2004. The report represents the indemnity experience of more that 75 percent of Australian doctors. A copy of the report is attached to this submission.

In summary, the data shows that in the twelve months to June 30th 2004:

- claims frequency decreased 4 percent
- claims costs continue to rise at 3 percent over inflation
- premiums reduced on average 4 percent BEFORE government subsidies are taken into account
- the industry is sustainable, collecting enough capital to satisfy all future claims on a vigorous actuarial model

Movement of doctors

The report shows how the membership categories have changed in the last ten years. Whilst there is data available from many other sources on the constitution of the medical workforce it does show a reduction in obstetric specialist practitioners, general surgeons and procedural GPs. Limitations on this data are described in the report thus at page 12:

> Movements in insured practitioner numbers would reflect changes in the number of medical practitioners in the Australian community, the reclassification of practitioners between specialty groups and movements in or out of the participating medical indemnity groups, either because of changes in medical indemnity requirements eg visiting medical officers being covered by state governments, for work in public hospitals in some states, or due to obtaining cover from other medical indemnity groups.

The overall number of doctors insured has increased 3 percent in nine years.

Cost of indemnity as a driver of workforce movements

Premiums for medical indemnity cover have risen on average 245 percent over the nine years to June 2004. In the last two years, since the majority of reforms, premiums have decreased.

The capacity of the industry to decrease premiums in the face of rising claims costs is due to

- federal government subsidies
    - High Cost Claims Scheme
    - Run Off Cover Scheme
- collection of adequate capital to cover actuarially projected claims, which in some cases are reduced due to anticipated effects of tort reforms

The premium actually paid by the doctor can also be subsidised at source by the Premium Subsidy Scheme (PSS) or its forbear the Medical Indemnity Subsidy Scheme (MISS) and State subsidies.

The Federal Government schemes and State tort reforms in place have increased affordability and security and stabilised the industry. Further emphasis on risk management and tort reform are expected to reduce claims costs over the medium term.

Federal Government schemes

1. The High Cost Claims Scheme (HCCS) provides support by government funding for 50% of claims payments over three hundred thousand dollars.
    - This has caused a significant reduction in the IBNR of the industry by reducing the burden of large claims.
    - It may also reduce reinsurance costs.

2. The Premium Subsidy Scheme (PSS) supplements 80% of indemnity premium costs when they are over 7.5% of the doctor's gross billings.

    - Approximately 10 per cent of doctors can, or have chosen to, access PSS meaning that the total cost of indemnity for 90 per cent of doctors is less than 7.5% of their gross income. The majority of that 10 per cent would be obstetricians (who all qualify for PSS), and a small number of other high risk specialists and part time workers.

    - In addition, a legacy scheme, the Medical Indemnity Subsidy Scheme (MISS), which was superseded by the PSS, continues to provide alternate subsidies for certain specialty groups on the basis that the PSS was not to disadvantage any doctor. In other words the effect of the MISS is extant for those who are eligible and successfully applied for the MISS prior to 30 June 2004.
        - The MISS applies to Obstetricians, Neurosurgeons and GPs who practice Obstetrics.
            - *GP Obstetrics*
                - *The Government will subsidise 50% (metro) and 80% (rural) of the difference between the premium cost to an Obstetrician to that of a GP (Non Procedural) in the same income band/state*
            - *Obstetrics*
                - *The Government will subsidise 50% (metro) and 80% (rural) of the difference between the premium cost to an Obstetrician to that of a Gynaecologist in the same income band/state*
            - *Neurosurgery*
                - *If the total amount of premium for the premium year is $50,000 or less and the premium of a General Surgeon in the same state and income band is less than $50,000, the MISS support is equal to 50% of the difference in premium.*

- *If the total amount of premium is more than $50,000 and the premium of a General Surgeon in the same state and income band is less than $50,000, the MISS support is equal to:*
  - *80% of the amount by which the total amount of premium exceeds $50,000, PLUS*
  - *50% of the difference between $50,000 and the premium of the General Surgeon.*
- *If the total amount of the premium is more than $50,000 and the premium of a General Surgeon in the same state and income band is $50,000 or more, the PSS support is equal to 80% of the difference in premium.*

A hypothetical case of net indemnity cost was provided to a group of one MII's Obstetric members in 2004:

Item	Amount
Member Subscription	100
Premium	82,500
ROCS Contribution	7,012
GST	8,961
Stamp Duty	9,846
TOTAL	108,419
Deductions	
50% Difference on Gyn Premium	*(23,944)*
GST ITC	*(8,961)*
Total Deduction	*(32,906)*
Balance Paid for Insurance	75,514
*Tax Deduction (cashflow effect) **	(36,637)
NET COST	$38,876

** Personal Income Tax rate*

3. Run Off Cover Scheme (ROCS)

This scheme provides security for doctors' indemnity arrangements after they leave the workforce at no cost once they become eligible. Doctors are typically eligible upon, inter alia

- Retirement
- Maternity leave
- An overseas doctor on a 422 or 457 visa returning to their country
- Death or permanent disablement.

It is funded by a levy on practicing doctors, currently set at 8.5 percent of the premium. The funds are held by the Federal Government then the MIIs can apply for reimbursement for claims against eligible doctors.

The ROCS is an important initiative both in reducing IBNR costs for MIIs and in providing security for doctors in retirement. It has an important psychological effect in the current medical population who seek reassurance that their retirement will be secure. Importantly, it means that doctors don't have the impost of paying annual premiums well into their retirement.

State subsidies aimed at specific workforce issues

In some States, in addition to the federal government subsidies, the State Government also provides assistance for higher risk specialties, particularly in rural areas. For example, in South Australia, the State Government supports rural obstetric GPs to the extent that their premiums are the equivalent fee to that of a non-procedural GP. This is specifically designed to ensure that obstetrics in rural areas continues.

Tort reform can also address these issues, as in New South Wales where section 22(2)c of the *Health Care Liability Act* (2001) NSW provides for a regulation that premiums charged by MIIs for high risk specialties may not exceed certain multiples of the base premium for GPs.

Subsidies and part time work

The medical workforce is also increasingly choosing to work part time, and the trend may be expected to continue given the increasing feminization of the medical workforce. Specific provisions which enable medical indemnity to be provided in a cost effective way for part time doctors have been incorporated in the PSS described above. Once any doctor bills over $1000 the subsidy over 7.5% of billings applies. Thus even with very low income the indemnity costs will be effectively capped. The application of these provisions ensures that the cost of medical indemnity insurance should not act as a deterrent to individuals who wish to practice part time, or practice in private medicine part time.

Tort reform impact on cost of indemnity

Tort reform has been an important component of providing certainty and stabilization in the medical indemnity industry. MIIAA members support the retention of current reforms, which are summarised in a table attached (used with permission of Sparke Helmore Lawyers). The measures around the country include prescriptive pre-litigation requirements, caps on the various heads of damage and importantly regulations in regard to legal costs and professional conduct.

It is important to note that most of the reforms apply to all personal injury matters, not just medical negligence, and have been directed by exhaustive inquiry including the Tito, Ipp and Abbott reports. The tort reforms are designed to provide a fair and just distribution of finite resources. Minor, frivolous and vexatious claims being removed from

the process will reduce legal costs to the community and leave more money available for those who really need it.

Uniform national reform whilst desirable is difficult to achieve politically. The current reforms will need time to settle and achieve their full impact and the MIIAA will monitor the need for further harmonization between the states, balanced with specific requirements in each jurisdiction.

Whilst the application of the recommendations of the Ipp Report have been applied differently in each state, it is true to say that the medical indemnity crisis had different implications in each jurisdiction. To a certain extent the requirement to apply the legislation in each state has added complexity to the medical indemnity environment for each insurer. It would be the normal practice, however, that each insurer (recognizing their historic geographic origins) would brief lawyers in each state on a claim, thus ensuring that the relevant provisions in each jurisdiction are applied. Their internal expertise would generally be based around their historic coverage, and they would seek advice on their 'non-core' jurisdictions. To grow their markets insurers increasingly are marketing beyond their historical geographic areas, and as such they need to understand the environment in which they seek members. Their premium calculations will also generally reflect the perceived application of tort law in that jurisdiction.

The quid pro quo for tort law reform from the medical profession has included:

- Commitment to risk management with the development of a National Working Party on Risk Management where the medical Colleges, The AMA and the MIIAA have already developed a national framework for a minimum standard of risk management education. There is a strong culture within the profession of seeking an evidence base and MIIAA supports this with significant resources and collaboration with the profession wherever it can.

- The contribution of a great deal of capital to its insurers to ensure that money is available to patients with significant and justifiable claims of medical negligence.

It is the view of MIIAA that further initiatives in the way of policy responses at this time may be detrimental as they may cause destabilisation in an already complex infrastructure surrounding medical indemnity.

Factors other than indemnity costs that affect workforce

While data is not collected on these issues, MIIs have close contact with the profession and form corporate impressions as to the reasons for growth and decline in specific areas.

Whilst it may be perceived that the number of obstetric GPs has reduced as a consequence of medical indemnity, the anecdotal experience of MIIs is that GPs more recently will cease to undertake obstetrics for the following reasons:

- In rural areas their hospital has resolved to cease providing obstetric cover as their staffing and equipment levels are reduced
- Lifestyle issues, whereby they no longer want to be on call as much
- Centralisation of maternity services to better equipped hospitals

Of concern remains the perception in medical schools and universities that Obstetrics is a “no-go” area because of indemnity issues. MIIAA believes there is a requirement for education and responsible communication.

In this context the emotional effects and stress of being involved in medical negligence litigation should also be mentioned as a disincentive to be involved in legal high risk areas. With the collegiate support of medically owned insurers and the reduction in frequency of claims the experience of defending a medical negligence claim will hopefully not be a problem out of proportion to the benefits of the tort system for resolving complaints for patients.

New Zealand makes an interesting comparison in that medical indemnity has not been an important issue in medical workforce discussions since the conversion to a No Fault regime. However NZ General Practice faces similar issues to Australia it would seem, of shortages, reliance on OTDs and difficulty with rural recruitment (see for example http://www.nzma.org.nz/news/media-releases/20040506-gp-numbers-declining.html). The skill shortage lists of the New Zealand Immigration Department list Obsterics and many other medical specialties as a priority area (NZ IMMIGRATION INSTRUCTIONS: Amendment Circular No. 2004/18).

Workplace practices and productivity

The issues paper suggests that the "indemnity environment" may be driving "unnecessary reporting and referrals" and an "increased documentation load".

The MIIAA is of the view that there is no evidence that such defensive medicine is useful in the legal risk management of medical practitioners. MIIAA members spend significant resources on appropriate risk management in concert with the Colleges and professional associations.

If indemnity concerns and perceptions do indeed drive these inappropriate activities in spite of MIIs advising against them, then the stabilization and support of the industry should lead to a reduction in "defensive medicine".

Compliance with a professional standard of documentation, and addressing issues surrounding communication and consent, does not include unnecessary reporting and referrals. Increased documentation load comes from many sources, but appropriate clinical documentation is essential for the high standard of care that is rightly expected in Australia. It is the experience of insurers that the majority of claims result from failure to document appropriately, communicate with patients and obtain consent. It is essential that doctors ensure that they document appropriately all issues related to patient care. They must communicate appropriately to ensure that patients understand their medical treatment, and consent must be based on an understanding by their patients of the medical care they require. Any reporting associated with these tasks should not be considered a 'defensive medicine' but rather as the minimum level of clinical practice and is appropriate.

There has been some anecdotal reporting of professional risk managers within hospitals placing a heavy burden on doctors in terms of compliance and form completion, but that is a matter for the hospital management and medical workforce to reach a sensible mediation where the hospital's risk management process does not impede the delivery of safe medical services. MIIs generally do not require their members to practice 'defensive' medicine, but rather to apply sound principles of risk management to their daily activities. Most MIIs have not changed the level of documentation required by their members, and have always required that appropriate documentation be undertaken.

Collaboration between the MIIAA, the Australian Medical Association and the Medical Colleges in the form of a National Working Party on Risk Management has made good progress in the last twelve months and will contribute to the education of medical practitioners to avoid "defensive" medicine. The focus of this Working Party is on ensuring that areas where problems have been identified are addressed quickly and appropriately. Risk management is an important component in ensuring the cost of medical indemnity remains stable and that workplace practices are appropriate.

Miscellaneous issues

A number of other issues raised during discussions with the Productivity Commission are addressed below.

Emerging new practices in medicine

MIIAA was asked whether the indemnity industry adequately caters to innovation in medical practice.

The indemnity policies provided to the profession typically covers an area of practice such as “General Surgery”. It does not preclude the use of new techniques and practices, within reasonable limits. Thus indemnity cannot be characterized as a limit to innovation.

Most MIIAA members have processes to recognise when trends in claims are consistent across the industry and identify practices which overcome problems. One example of this is the early identification of claims which could be directly related to failure of an implantable contraceptive device (Implanon). Members identified an increase in the number of births for women who had used the contraceptive device. MIIs then developed a strategy, involving GPs, which addressed the failure of this device in some instances and ensured that GPs were more adequately trained on insertion and follow up of the device. The result has been a marked decrease in claims for Implanon failure.

Group practices/corporatisation of medicine

It has been suggested to the MIIAA that the increased incidence of doctors moving to corporate owned group practices in 2002/03 was driven by medical indemnity costs. The experience of the members of the MIIAA is that the move by some to group practice was unrelated to medical indemnity issues. It is our understanding that the foundation of the move was:

- the financial incentives offered by some corporate practices made it attractive to relocate
- recognition of economies of scale in co-location, particularly with regard to practice management staff
- reduced working hours from sole practice or small group practice, thus allowing for a greater focus on lifestyle
- reduction in involvement in the business requirements of practice

There is no evidence that there is an indemnity advantage in corporate practice, given that usually the doctors will carry individual PI policies. They may attract a group discount but this will be marginal and on a policy that is inexpensive initially.

Indemnity for allied health practitioners

MIIAA has been asked to comment on its members' possible role in indemnifying allied health professionals such as nurse practitioners.

The choice of product offering by MIIAA members, who are all registered general insurers is a matter for each company and is a competitive issue.

What can be stated objectively is that indemnity will be required to be provided by either the state or general insurers. There is no legislative or regulatory barrier to MIIs developing product offerings in these areas.

Conclusion

MIIAA was formed during a time of instability in medical indemnity. The subsequent industry reforms have provided a sustainable basis on which the medical profession and patients can resolve issues of medical negligence within the common law. This underpins the provision of private medicine which is a vital pillar of Australian health care.

Indemnity has thus been largely neutralised as an issue driving medical workforce issues, as long as current reforms are not undone.

MIIAA would be pleased to be involved in further consultation and discussion regarding these matters or any other of interest to the Productivity Commission.

TORT REFORM ACROSS AUSTRALIA

This table reflects the current state of the law as at February 2005.

	NSW	QLD	VIC	ACT	WA	SA	TAS	NT
	Civil Liability Act 2002 (NSW) Civil Liability Amendment (Personal Responsibility) Act 2002 Legal Profession Act 1987 Limitation Act 1969 Trade Practices Amendment (Liability for Recreational Services) Act 2002 Trade Practices Amendment (Personal Injuries & Death) Act (No 2) 2004	Personal Injury Proceedings Act 2002 (QLD) Personal Injury Proceedings Amendment Act 2002 Civil Liability Act 2003	Amendments to Wrongs Act 1958 Limitations of Actions Act 1958	Civil Law (Wrongs) Act 2002 Civil Law (Wrongs) Amendment Act 2003 Justice and Community Safety Legislation Amendment Act 2004 Limitation Act 1985	Civil Liability Act (WA) 2002 Civil Liability Amendment Act 2003 Volunteers (Protection from Liability) Act 2002 Insurance Commission of Western Australia Amendment Act 2003	Civil Liability Act 1936 Limitation of Actions Act 1936 Volunteers Protection Act 2001 Recreational Services (Limitation of Liability) Act 2002	Civil Liability Act 2002 (TAS)	Personal Injuries (Liabilities and Damages) Act 2003 Personal Injuries (Liabilities and Damages) (Consequential Amendments) Act 2003 Consumer Affairs and Fair Trading Amendment Act 2003 Personal Injuries (Civil Claims) Act 2003
SCOPE	All personal injury and death claims excluding motor vehicle, workers' compensation, dust diseases, personal accident claims and those arising from an intentional tort.	All personal injury and death claims excluding motor vehicle, workers' compensation and criminal compensation matters.	Personal injury and death claims excluding statutory schemes, intentional torts, asbestos and tobacco related matters.	Personal injury and death claims excluding statutory schemes.	All personal injury and death claims, excluding motor vehicle, workers' compensation, dust disease and claims under the Civil Aviation (Carrier's Liability) Act 1961.	All claims for personal injury excluding workers' compensation.	Civil Liability Act 2002 (Tas) applies to civil liability of any kind (including for damages for 'harm', ie. personal injury or death, damage to property or pure economic loss) except for civil liability excluded from the Act (ie an intentional act).	All personal injury claims excluding motor vehicle, workers compensation, dust diseases, criminal compensation matters and claims related to personal injury arising from supply of certain goods.

TORT REFORM	Impacts liability: ☐ recreational activities ☐ professional negligence ☐ public authorities ☐ intoxication ☐ criminal actions ☐ good samaritans ☐ volunteers ☐ mental harm ☐ duty to warn. ☐ Includes as term of contract for the provision of recreational services the exclusion, restriction or modification of liability.	Impacts liability: ☐ good samaritans ☐ recreational activities ☐ professional negligence ☐ public authorities ☐ intoxication ☐ criminal actions ☐ volunteers ☐ duty to warn. ☐ causation ☐ contributory negligence ☐ professionals ☐ failed sterilisation	Impacts liability: ☐ good samaritans ☐ volunteers ☐ intoxication ☐ food donors ☐ contributory negligence ☐ reduces limitation periods ☐ allows structured settlements ☐ codifies common law re negligence and mental harm ☐ clarifies tortious liability of public authorities ☐ new test for professional negligence claims.	Impacts liability: ☐ occupiers' liability ☐ mental harm ☐ reduces limitation periods ☐ contributory negligence ☐ volunteers ☐ criminal actions ☐ good samaritans ☐ apologies ☐ equine activities ☐ public authorities ☐ partial codification of duty of care and causation.	Impacts liability: ☐ partial codification of duty of care and causation ☐ recreational activities ☐ contributory negligence (including intoxication) ☐ mental harm ☐ public authorities ☐ good samaritans ☐ apologies. ☐ professional negligence ☐assumption of risk ☐ proportionate liability ☐ allows structured settlements	Impacts liability: ☐ recreational activities ☐ nervous shock ☐ good samaritans ☐ criminal actions ☐ road authorities ☐ assumption of risk ☐ contributory negligence (including intoxication) ☐ mental harm ☐ allows structured settlements.	Impacts liability: ☐ apologies ☐ contributory negligence ☐ dangerous recreational activities ☐ obvious risks ☐ volunteers ☐ public activities ☐ intoxication ☐ professional negligence ☐ mental harm ☐ criminal actions.	Impacts liability: ☐ good samaritans ☐ volunteers ☐ recreational activities ☐ assumption of risk ☐ 'expressions of regret' ☐ occupiers' liability ☐ intoxication ☐ criminal actions ☐ allows structured settlements.
PRE-LITIGATION	No requirements.	Provides for significant pre-proceedings steps, including a written notice of claim form, mandatory disclosure between parties, mandatory conferences and mandatory final offers.	No requirements.	Recent amendments provide for written notification of claims, limited response times, further disclosure and discovery obligations, court ordered mediation and limits the use of expert evidence.	No requirements.	No change to existing requirements prescribed in other legislation applying generally to civil claims. Change to 'material fact' for extension of time under the Limitation of Actions Act.	No procedures.	Personal Injuries (Civil Claims) Act contains sections prescribing pre-litigation steps, but those sections were not operational as at 10.02.05.

	NSW	QLD	VIC	ACT	WA	SA	TAS	NT
DAMAGES NON-ECONOMIC LOSS (NEL)	CLA: Most extreme case capped at $350,000. Assessed on a sliding scale. Indexed annually. 15% threshold. No interest on NEL. Extinguishes exemplary punitive and aggravated damages. TPA: Limited to $250,000.	$250,000. Extinguishes exemplary punitive and aggravated damages.	Capped at $371,380 (indexed). Introduction of threshold requirement: may not claim non-economic loss unless a 'significant injury', being at least 5% AMA (4th edn) for physical injuries and 10% for psychiatric injuries.	No caps. No threshold.	Threshold of $12,000 (indexed annually). No caps.	Most extreme case capped at $241,500. Assessed on points system of 0 to 60. Threshold - must be significantly impaired for minimum of 7 days; or minimum medical expenses incurred ($2,960). No interest on NEL.	Threshold of $4,000 No cap.	Capped at $350,000. No damages for NEL if less than 5% whole person impairment. No interest on NEL. Extinguishes aggravated and exemplary damages.
ECONOMIC LOSS	CLA: Capped at 3 x Average Weekly Earnings (AWE). Discounted on 5% Tables. TPA: Capped at 2 x AWE.	Capped at 3 x AWE. Discounted on 5% Tables.	Capped at 3 x AWE. Discounted on 5% Tables.	Capped at 3 x AWE (seasonally adjusted for the ACT, all male total earnings). Discounted on 3% Tables.	Capped at 3 x AWE. Discounted on 6% table.	Capped at $2,200,000. Indexed annually. Discounted on 5% Tables.	4.25 x AWE. No discount rate.	Capped at 3 x AWE. Discount rate of 5%.

GRATUITOUS CARE/ ASSISTANCE	CLA & TPA: Only when services are required for at least 6 hours or more per week and for not less than 6 months. Capped at AWE.	Only when services are required for at least 6 hours or more per week and for not less than 6 months. No caps.	☐ No damages unless reasonable need for domestic assistance, solely attributable to the accident, and such care would not have been provided but for the injury ☐ No damages if less than 6 hours care per week for less than 6 months. ☐ Not entitled to more than the average Victorian weekly wage, or proportion thereof.	No threshold. No caps on damages. No caps on rates claimed for services.	Threshold of $5,000. (indexed annually)	No threshold. Capped at 4 x AWE of SA.	Under the Common Law (Miscellaneous Actions) Act 1986, Tasmania abolished the awarding of damages for gratuitous attendant care under the Act.	Only where services are reasonable and required soley because of the accident, required for at least 6 hours or more per week, and for 6 months or more. Capped at AWE.
COSTS	Either 20% up to $100,000 claim or $10,000, whichever is greater. Regulates professional conduct for services provided after 7 May 2002 - must be satisfied of reasonable prospects of success.	No costs on claims under $30,000. $2,500 costs for claims between $30,000 - $50,000. Over $50,000 normal cost scales apply.	No restrictions.	Either 20% up to $50,000 claim or $10,000, which-ever is greater. Regulates professional conduct for services for proceedings filed after 9 March 2004 - must be satisfied of reasonable prospects of success.	No restrictions.	No restrictions.	No restrictions.	Personal Injuries (Civil Claims) Act contains sections prescribing costs, but those sections were not operational as at 10.02.05.

The information set out in this table does not constitute legal advice. If you would like further information, please contact one of our lawyers as set out below.

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