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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ANU	Australian National University
APRA	Australian Prudential Regulation Authority
HMO	honorary medical officer
IRM	Integrated Resource Manual
ISA	Insurance Statistics Australia
METeOR	Metadata Online Registry
MIDWG	Medical Indemnity Data Working Group
MINC	Medical Indemnity National Collection
MINC (PS)	Medical Indemnity National Collection (Public Sector)
MTL	Medical Treatment Liability
NCPD	National Claims and Policies Database
NSMP	non-salaried medical practitioners
NSW	New South Wales
PHO	public health organisation
PIPA	*Personal Injuries Proceedings Act 2002*
QGIF	Queensland Government Insurance Fund
SA	South Australia
SMO	salaried medical officer
TMF	Treasury Managed Fund
VMIA	Victorian Managed Insurance Authority
VMO	visiting medical officer

Symbols

. .	Not applicable

Summary

This report presents data on the number, nature and costs of public sector medical indemnity claims for 2005–06 to 2009–10, with a focus on 2009–10 claims.

Public sector medical indemnity claims for 2009–10

A new claim is created when a dollar amount (reserve) is placed against the costs expected to arise from allegations of problems in health service provision. There were 1,620 new public sector claims in 2009–10. The most frequently involved clinician specialties were *Emergency medicine* (9%), *General surgery* (8%) and *Orthopaedic surgery* (6%). The health service contexts most often implicated were *Emergency department*, *General surgery* and *Obstetrics*.

Of the 1,176 claims closed in 2009–10, 43% cost less than $10,000. With 55% of closed claims, the claimant pursuing the claim received a payment. Of those 55%, the claimant was the patient (32%), some party other than the patient (10%) and multiple claimants (13%).

Claims opened between 2005–06 and 2009–10

There were substantially more new claims in 2009–10 (1,620) than in the previous 3 years (about 1,130 to 1,270 claims per year).

Allegations of *Neuromusculoskeletal and movement-related* harmful effects were reported for a higher proportion of new claims each year from 2006–07 to 2009–10 (21–26%) than allegations of harmful effects to any other body system.

Claims closed between 2005–06 and 2009–10

Fewer claims were closed in 2009–10 (1,176) than in the previous 4 years when between 1,260 and 1,800 claims were closed per year.

The proportion of claims closed for a large amount ($500,000 or more) was higher in 2009–10 (9%) than any of the previous 4 years (4–8%). However, the proportion of claims associated either with severe injury to the patient or the patient's death was similar to previous years (respectively, 23% compared with 23–26%, and 18% compared with 14–21%).

With 71% of closed claims, one or more allegations of loss to the claimant were recorded for the claim. Of those 71%, the allegations of loss applied only to the patient (62%), only to some party other than the patient (6%) and to both the patient and some other party (3%). In 29% of claims allegations of loss were either nil or unknown. *Pain and suffering* was the most frequently claimed loss category for patients (3,649 claims, 51%), while for other parties *Nervous shock* was the most common (329 claims, 5%). Claim size increased noticeably with the number of alleged loss categories.

The average time between when the reserve was placed and the claim was closed increased from about 30 months in 2005–06 to 31 months in 2006–07, 33 months in 2007–08 and 2008–09, and 35 months in 2009–10.

The most common grounds for a claim was an alleged problem in the performance of a *Procedure*—for instance, a surgical procedure or childbirth delivery—recorded for about one-third (36%) of the claims.

1 Introduction

The costs of health-care litigation and the financial viability of medical indemnity insurance in Australia were a major concern for health ministers in 2002. The Medical Indemnity National Collection (MINC) was developed so that the costs could be monitored nationally.

This report presents data collected through the MINC and provides information on the number, nature and costs of public sector medical indemnity claims. These are claims for compensation for harm or other loss allegedly due to the delivery of health care covered by public sector medical indemnity insurers. The data include details of the alleged health-care incidents that gave rise to claims, where these incidents occurred, the people affected, and the size, duration and settlement mode of the claims.

Chapter 2 provides some further background to the MINC. Additional information on the development of the collection is in Appendix 1.

Chapter 3 presents data on claims that were open at some point during the 2009–10 financial year. This is the seventh report to provide annual data for public sector claims. The first—*First medical indemnity national data collection report: public sector, January to June 2003* (AIHW 2004)—described the development of the collection and presented the first 6 months of data. Annual data were subsequently presented for the years from 2003–04 to 2008–09 (AIHW 2005, 2006a, 2007, 2009, 2011a, 2011b).

Chapter 4 looks at changes to claim characteristics over time from 2005–06 to 2009–10 for new claims opened each year and for closed claims by the year they were closed. There may be differences between the data reported in Chapter 4 and the data previously published in MINC reports for the years between 2005–06 and 2008–09. This is because many public sector claims have their data updated from year to year, and Chapter 4 makes use of the most recently updated data on claims.

Chapter 5 combines data for all claims closed over the 5 years from 2005–06 and 2009–10. It provides information on the alleged health-care incidents that led to claims, the administrative and financial characteristics of the claims, and the age and sex of patients (claim subjects) in relation to health-care incident and claim characteristics.

This report is being published in conjunction with the *Public and private sector medical indemnity claims in Australia 2009–10* report (AIHW 2012). This report is the next in the series by the Australian Institute of Health and Welfare (AIHW) on public and private sector medical indemnity claims.

2 The collection

2.1 Scope and context

The MINC contains information on medical indemnity claims in the public sector. These claims can arise from any area of health service delivery for which a state or territory health authority has responsibility. Examples include public community health centres, public residential aged care services, private health providers contracted to deliver public health services, and public hospitals.

Each state and territory health authority engages personnel to manage medical indemnity claims. Claims managers record claims as they arise, collect information on the associated circumstances, set a reserve amount to cover the likely financial cost to the health authority of settling the claim, and monitor the costs incurred in settling the claim.

Medical indemnity claims fit into two categories—actual claims (on which legal activity has commenced via a letter of demand, the issue of a writ or a court proceeding) and potential claims (where a claims manager has placed a reserve against a health-care incident in the expectation that it may eventuate in an actual claim). MINC records relate to both of these categories. However, while all jurisdictions provide the AIHW with data on commenced claims, just three jurisdictions provide data on potential claims. The MINC does not include information on health-care incidents or adverse events that do not result in an actual claim or are not treated as potential claims.

2.2 Policy, administrative and legal context

The state and territory governments manage public sector medical indemnity insurance. The law of negligence, as enacted in each state and territory, provides the legal framework for the management of claims for personal injury and death, including medical indemnity claims in both the public and private sectors.

The differences in state and territory legislation and insurance policy affect the nature and scope of MINC claims across Australia. Specific information relating to each jurisdiction is provided in Appendix 4. A particular area of difference is the coverage of visiting medical officers, private practitioners and students. State and territory tort law regarding medical indemnification also varies (Madden & McIlwraith 2008).

Claims management

As a general guide, the main steps in the management of claims are:

1. An incident that could lead to a public sector medical indemnity claim is notified to the relevant claims management body. In some jurisdictions claims are managed by the relevant state or territory health authority; however, in others, a body external to the health authority handles most of the claims management process. Occasionally, some of the legal work may be outsourced to private law firms. (See Appendix 4 for claims management bodies operating in each jurisdiction.)
2. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed on it, based on an estimate of the cost of the claim when closed.

3. Various events can signal the start of a claim; for example, a writ or letter of demand may be issued by the claimant's solicitor (this can occur before an incident has been notified), or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases, no action is taken by the claimant or the defendant.
4. The claim is investigated. This can involve liaising with clinical risk management staff in the health facility concerned and seeking expert medical advice.
5. As the claim progresses the reserve is monitored and adjusted if necessary.
6. A claim may be settled through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In addition, in some jurisdictions settlement via statutorily mandated compulsory conference processes must be attempted before a claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process. A claim file that has remained inactive for a long time may be discontinued, particularly if the 'limitation period' allowed for damages to be sought is exceeded (see Appendix 4). Some claims may be reopened after discontinuation or initial settlement.

The processes vary between jurisdictions, and in some jurisdictions there are different processes for small and large claims.

The status of a claim in any financial year depends on what happened to the claim in terms of the management processes described above. *New claims* are those with a reserve placed against them during the financial year. *New claims*, and claims that were open at the start of the financial year, may be closed during the period, or else remain open as *Current claims* until the end of the period. *Closed claims* are claims that are closed at a point in time (and not subsequently reopened) during the reporting period. The category *All claims* refers to any claims open at any point during the reporting period.

2.3 Data items

The MINC includes 23 data items and 15 key terms as summarised in Appendix 2. Further details are available as part of the Medical Indemnity Data Set Specification published on the AIHW website through its Metadata Online Registry, METeOR.

The MINC collects information about the 'claim subject', the patient who incurred the alleged harm that gave rise to the claim. The information includes the type of allegation of loss or harm, the circumstances surrounding the claim, and the health service providers involved. The sex and date or year of birth of the claim subject are also collected if available. The 2009–10 data included information on the claim subject's date of birth, whereas only the claim subject's year of birth has been provided with previous years.

The claimant (that is, the person pursuing the claim) is often the claim subject but can also be any other person claiming for loss as a result of an incident. Information is not collected about the claimant as such.

State and territory health authorities transmit MINC data to the AIHW annually for collation. The transmitted data represents the claim manager's 'best current knowledge' about the claims at the end of each reporting period. The transmitted data are in the form of single claims (unit records), each typically corresponding to a single and distinct health-care incident (alleged or reported). However, this one-to-one relationship does not hold for a small number of claims (Box 2.1).

Box 2.1: Class actions and other multiple claimants in the MINC data

The 'claim record particulars flag' was introduced to the MINC from 2009–10 in recognition of the existence of class actions, where a lawsuit has one or several named plaintiffs who represent a larger group of people who collectively bring a claim to court. With a class action, the claim record provides the patient and health-care incident details of a representative plaintiff but the financial information covers all of the litigants. Therefore, the claim records overstate the financial implications in relation to the recorded patient or incident. In 2009–10, 2 claims (both current) were class actions.

The MINC can also include records for the other claimants, but with financial information set at nil. Both types of claim records are excluded from the tables that relate financial information to patient or incident information. This is because, if they were included, they would give the misleading impression of one high-cost claim and many nil-cost claims with respect to the variable being compared, whereas in fact the cost is likely to be distributed across all of these claims.

The 'claim record particulars flag' is also used to flag cases where one claim record contains information on the alleged incident and the payment to one of the claimants, and a linked claim record contains information on the payment to a separate claimant. The latter claim record duplicates the patient and incident information in the first claim record. To avoid data duplication, the latter claim records are excluded from the tables presenting data on patient and incident information.

Only a small number of claim records are flagged for exclusion from particular data presentations along the lines described above. Their exclusion has little impact on the numbers of claims reported. However, by excluding these claim records the tables can be read as representing a direct (one-to-one) relationship between the variables being compared.

2.4 Data coverage, completeness and quality

This section provides an overview of data coverage, completeness and quality, with respect to the claims data supplied to the AIHW and the claims data on the MINC 'master database'. The supplied data pertain to a particular reporting period and record, to the jurisdictions' best knowledge, their data at the close of the reporting period. Any claims that are current at the end of one reporting period should be present in the data supplied for the next reporting period, until such time as the claim is closed. Jurisdictions are not required to report on claims after the reporting period in which they were closed, but they may do so (especially if new information has come to light).

The MINC master database holds the most up-to-date information available on Australia's public sector medical indemnity claims. New South Wales and Victoria have audited their medical indemnity claims collections in recent years, and all jurisdictions have advised the AIHW of various changes that should be made to the coded data. These changes are reflected in the master database. Since the 2009–10 data transmission, jurisdictions have been able to flag claim records to be excluded from the MINC reports on the basis of not being medical indemnity claims, for instance, if the claim instead involves public liability. Previously the process that was followed to remove these erroneous records from the MINC reported data was to delete the claim record from the master database.

Data coverage and completeness

For 2005–06 to 2009–10, the jurisdictions have improved their capacity to report data on every claim known to be 'in scope' for the reporting period. Data coverage at the time the data were reported has improved from 89% for 2005–06 (AIHW 2007), 93% for 2006–07 (AIHW 2009), to virtually 100% (5,279 of 5,280 claims) for 2007–08 (AIHW 2011a) and 100% for 2008–09 (AIHW 2011b) and 2009–10.

The data coverage available for this report for the 2005–06 and 2006–07 years is better than indicated by the percentages cited above. This is because many of the claims that were originally excluded from the reported data have subsequently been reported to the MINC. Many of these originally excluded claims remained open into 2007–08 and so were reported for that year (when data coverage was virtually 100%). Some of the other originally excluded claims reported for 2005–06 were subsequently provided in the 2006–07 data transmission due to a 'back-coding' exercise undertaken by New South Wales and Victoria to report on closed claims that had not previously been reported to the MINC (see AIHW 2009).

Missing data

From 2006–07, every jurisdiction supplied data for all key data items. However, there are two data items for which data were not provided by New South Wales:

- Additional incident/allegation type
- Additional body functions/structures affected—claim subject.

In addition, New South Wales provided data only on the principal clinician for the data item 'specialty of clinicians closely involved in incident'. The other jurisdictions also record the principal clinician but can include data on up to three additional clinical specialties.

New South Wales has confirmed that it had made the required additions to the data collections and the above data items will be available as part of the 2010–11 reporting.

Data quality

Not known rates

A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. Beginning with the 2009–10 data transmission, the Medical Indemnity Data Working Group (MIDWG) agreed that when closed claims are reported to the MINC, all of the information fields should be known except in rare circumstances. As a result, the *Not known* rates for 2009–10 closed claims are nil for most data items and no more than 3.5% for any of the data items (Table 2.1).

The time required to collect all of the information relevant to a claim can be lengthy. As a result, *New claims* with their reserve first set in 2009−10 generally have higher *Not known* rates than *Current claims*, many of which have been open for several years (Chapter 3). For example, the *Not known* rate for 'claim subject's status' (Box 2.2) was 36% for *New claims* and 24% for *Current claims* (Table 2.1). Three data items ('nature of claim—loss to claim subject', 'nature of claim—loss to other party/parties' and 'extent of harm—claim subject') had even higher *Not known* rates. This is because the correct value to record for these items is often not possible to determine until the claim is closed.

Table 2.1: MINC data items: number and proportion of claims for which *Not known* was recorded, 1 July 2009 to 30 June 2010[(a)]

	New claims		Current claims		Closed claims		Open at any point during the period	
Items for all states and territories	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Nature of claim—loss to claim subject	1,172	72.3	2,596	70.4	2	0.2	2,598	53.4
Nature of claim—loss to other party/parties	728	44.9	1,426	38.7	0	0.0	1,426	29.3
Extent of harm—claim subject	651	40.2	1,163	31.5	41	3.5	1,204	24.8
Claim subject's status	581	35.9	888	24.1	0	0.0	888	18.3
Clinical service context	541	33.4	780	21.1	0	0.0	780	16.0
Principal clinician specialty	519	32.0	750	20.3	0	0.0	750	15.4
Primary body function/structure affected	485	29.9	748	20.3	0	0.0	748	15.4
Primary incident/ allegation type	487	30.1	706	19.1	0	0.0	706	14.5
Health service setting	420	25.9	597	16.2	0	0.0	597	12.3
Where incident occurred	429	26.5	454	12.3	0	0.0	454	9.3
Claim subject's date of birth	185	11.4	383	10.4	19	1.6	402	8.3
Claim subject's sex	118	7.3	284	7.7	0	0.0	284	5.8
Claim record particulars flag	6	0.4	38	1.0	5	0.4	43	0.9
Total claims	**1,620**	**100.0**	**3,688**	**100.0**	**1,176**	**100.0**	**4,864**	**100.0**
Items relevant only to closed claims								
Claim payment details	. .	. .	. .	. .	0	0.0	. .	. .
Mode of claim finalisation	. .	. .	. .	. .	0	0.0	. .	. .
Total claim size	. .	. .	. .	. .	0	0.0	. .	. .
Items reported by jurisdictions other than New South Wales[(b)]								
Additional body function/structure affected	0	0.0	3	0.8	0	0.0	3	0.6
Additional incident/ allegation type	0	0.0	1	0.2	0	0.0	1	0.1
Additional clinician specialties	0	0.0	0	0.0	0	0.0	0	0.0

. . Not applicable.

(a) Table 2.1 does not include the data items 'Date incident occurred', 'Date reserve first placed against claim', 'Reserve range' and 'Status of claim', which are required to be completed for all MINC data items. It also excludes 'Date claim commenced' and 'Date claim closed' which may be left blank respectively for claims that have not yet been commenced or closed.

(b) New South Wales claim management practices did not involve recording of any additional values for these three MINC data items. (Totals are not provided because this would indirectly disclose the number of claims reported by New South Wales, which current collaborative arrangements disallow – Appendix 1.)

Data cleaning of the collection and subsequent changes

As with previous years' data, the AIHW undertook data cleaning and validation checks on the 2009–10 data it received. The AIHW raised queries when changes in data items since the 2008–09 recording period appeared to be illogical or unexpected, for example, claim status changing from *Closed* to *Commenced*. Jurisdictions were informed of discrepancies and asked to investigate and clarify any uncertainties. In addition, where data items were reported as *Not known* for claims that were closed in 2009–10, the AIHW either ascertained the *Not known* status for the data item or else required the jurisdiction to provide known information.

2.5 Reporting claim characteristics

The tables in chapters 3 to 5 include information on the number and/or proportion of claims recorded as *Not known*, as an indicator of data quality. However, when the purpose of a table is to compare the relative percentages of 'known' categories, inclusion of the *Not known* category can make interpreting the data difficult, as the percentages do not add up to 100%. Accordingly, in those tables that present the data as percentages where the row or column adds up to 100%, only those claims that are known for all of the data items presented in the table are included.

Current claims still open at 30 June 2010 provide data relevant to current public sector liability for claims to be finalised at some future point. For this reason, where 'reserve range' is considered (Table 3.6), *Current claims* are reported.

New claims have the advantage of capturing information on alleged health-care incidents close to the time of the alleged incidents, and so are sensitive to these allegations' changed characteristics over time. Accordingly, several of the tables in Chapter 4, where data for the years from 2005–06 to 2009–10 are compared, report on *New claims*. In these tables, the *Not known* rates are often lower for claims that were new during the earlier reported years, because the health authorities have been able to provide the AIHW with more complete data on these claims in the years since the claim had its reserve set.

Chapter 4 also provides some comparisons over the years for *Closed claims*, because there are some data items, such as 'total claim size', that remain undetermined until a claim is finalised. Some of the claims closed in a given year were subsequently reopened in a later year. They are still included in the data for the year in which they were first closed, because the inter-year comparisons being made here are on claim files that were closed in each of the years compared.

Chapter 5 of this report uses closed claims data amalgamated over the 5 years from 2005–06 to 2009–10. Use of this amalgamated data provides a robust sample size for detailed analysis.

3 Public sector medical indemnity claims for 2009–10

This chapter presents a brief profile of the 4,864 medical indemnity claims that were open at some point between 1 July 2009 and 30 June 2010 (Table 3.1). Over the period, there were 1,620 new claims opened (marked by the setting of a reserve), 1,176 claims that were closed (settled, for example, through negotiation or a court decision, or discontinued), and at 30 June 2010 there were 3,688 current claims (Box 3.1).

Table 3.1: Number of public sector claims by claim category, 1 July 2009 to 30 June 2010

Claim category	Description	Number
New	Claims with a reserve set within the reporting period (1 July 2009 to 30 June 2010)	1,620
Current	Claims that remained open at 30 June 2010	3,688
Closed	Claims that were settled during the reporting period (1 July 2009 to 30 June 2010)	1,176
All	All claims open at some point during the reporting period (1 July 2009 to 30 June 2010)	4,864

Box 3.1: Status of claim

Current claims include three subcategories: potential claims, where a reserve has been set but no allegation of loss has been received; commenced claims, where the reserve has been set and an allegation of loss received; and reopened claims, which are current claims that had been considered closed at some point before 30 June 2010.

Discontinued claims include discontinued potential claims, where litigation has not yet commenced, and discontinued commenced claims, where litigation has commenced but the claim has been withdrawn or else closed by the claims manager due to operation of the statute of limitations or claim inactivity (Section 2.2).

Closed claims include a small number of structured settlements, which are settlements that allow for periodic payments to the claimant rather than a lump sum payment.

The 2009−10 data specifications introduced a new 'status of claim' coding option. This option allows the data provider to notify the claim record as 'rescinded—not a medical indemnity claim'. It covers claim records that are erroneous and also potential claims that in retrospect should not have had a reserve set against them because their likelihood of eventuating into an actual claim was low. Before the 2009−10 data transmission, when data providers wanted to remove these sorts of claim records from their list of current claims, they either reported the claim as closed or requested the AIHW to delete the claim from the master database. These claims can now be readily removed from the list of current claims by reporting their status as 'rescinded—not a medical indemnity claim'.

Analysis of the 2009−10 data revealed a marked drop in the proportion of claims discontinued for $0 compared with the data published for previous years (see Section 3.3). The MIDWG advised the AIHW that this was at least partly due to the introduction of the 'rescinded—not a medical indemnity claim' coding option. Subsequently, the AIHW was advised of a large number of claims reported as closed in previous years that would have been rescinded had that coding option been available. These claim records have been removed from the closed claims reported in chapters 4 and 5.

The data presented in this chapter cover new claims, current claims and closed claims. Further data on new claims for 2009–10, including comparisons with previous years, are presented in Chapter 4.

3.1 New claims

This section provides information on claims that were opened in the 2009–10 year.

Clinical service context

'Clinical service context' specifies the area of clinical practice associated with the alleged health-care incident. Most of the categories correspond to a hospital department, but some relate to health services usually provided in settings outside hospitals. There are 30 possible categories, as well as the option to code the clinical service context as *Other* and provide additional text information.

In 2009–10, the three most commonly recorded clinical service contexts (*Emergency department* (formerly reported as *Accident and emergency)*, *General surgery* and *Obstetrics)* accounted for one-third of new claims (538 of 1,612) (Table 3.2). The same three categories were the most common for new claims for each year from 2004–05 to 2008–09. (Note that the term *Accident and emergency* has been replaced by *Emergency department* in the MINC to reflect the correct terminology as recommended by the Australasian College of Emergency Medicine. This has not changed how the data are collected.)

Half of the clinical service contexts were recorded for fewer than 10 new claims in 2009–10. These included *Perinatology* and *Cosmetic procedures*, which were among the two least frequently recorded clinical service contexts for each year from 2005–06 to 2008–09 (AIHW 2011b). Ten of the less frequently recorded clinical service contexts were introduced as new coding options with the 2009–10 data transmission.

Geographic location

The Australian Standard Geographical Classification Remoteness Structure is used to categorise the remoteness area of where an alleged health-care incident occurred. In 2009–10, 50% of new claims arose from incidents occurring in *Major cities*. The corresponding proportion for *Inner regional* areas was 17%, while 5% arose in *Outer regional* areas and 1% in *Remote and very remote* areas. The remoteness area for 27% of new claims was unknown (Table 3.2).

Emergency department, General surgery and *Obstetrics* were the three most common clinical service contexts recorded for new claims in *Major cities* and *Inner regional areas*. They were also recorded at least as often as any other clinical service context for claims in *Outer regional* and *Remote and very remote* areas.

Table 3.2: New claims[a]: clinical service context, by geographic location, 1 July 2009 to 30 June 2010

	Geographic location					
Clinical service context[b]	**Major cities**	**Inner regional**	**Outer regional**	**Remote and very remote**	**Not known**	**Total**
Emergency department[c]	128	58	8	10	1	205
General surgery	114	64	12	4	3	197
Obstetrics	95	28	11	2	0	136
Orthopaedics	66	23	5	0	3	97
Psychiatry	57	9	5	1	1	73
Gynaecology	41	10	8	0	0	59
General practice	21	19	7	2	0	49
General medicine	30	11	4	1	0	46
Cardiology	21	2	1	0	0	24
Paediatrics	18	3	1	0	0	22
Dentistry	15	3	1	0	0	19
Oncology	12	4	1	0	1	18
Neurology	13	1	1	0	0	15
Radiology	11	2	2	0	0	15
Urology	11	2	0	0	0	13
Hospital outpatient department	8	0	1	0	0	9
Otolaryngology	6	2	0	0	0	8
Plastic surgery	8	0	0	0	0	8
Public health	7	0	1	0	0	8
Ophthalmology	6	0	0	1	0	7
Pathology	5	0	0	0	1	6
Cardio-thoracic surgery	5	0	0	0	0	5
Intensive care	3	1	0	0	0	4
Rehabilitation	2	2	0	0	0	4
Vascular surgery	4	0	0	0	0	4
Neurosurgery	3	0	0	0	0	3
Perinatology	1	1	0	0	0	2
Community-based care	1	0	0	0	0	1
Cosmetic procedures	1	0	0	0	0	1
Oral and maxillofacial surgery	1	0	0	0	0	1
Other clinical service contexts	8	3	1	0	0	12
Not known	91	23	6	2	419	541
Total	**813**	**271**	**76**	**23**	**429**	**1,612**
Per cent	*50.4*	*16.8*	*4.7*	*1.4*	*26.6*	*100.0*

(a) The table excludes eight new claims that duplicate the clinical service context data recorded in another claim (see Box 2.1).

(b) The 2009–10 data include ten more individually coded clinical service contexts than previous years' data.

(c) Previously reported as *Accident and emergency*.

Note: Percentages do not add exactly to 100.0 due to rounding.

Specialties of clinicians

The data item 'specialty of clinicians closely involved in incident' indicates the health-care providers who allegedly played the most prominent roles in the events that gave rise to a claim. These providers were not necessarily at fault and may not be defendants in the claim. There are 66 possible categories, including *Not applicable* in cases where no clinician is alleged to have been closely involved.

Up to four clinician specialties may be recorded for any one claim, so a summation of the total number of times that clinician specialties were recorded for 2009–10 claims would exceed the total number of claims. The list differs slightly from the 69 categories reported for the 2008–09 data (AIHW 2011b) to reflect changes made by the Australian Medical Council (2009) in its list of Australian Recognised Medical Specialties.

Emergency medicine (9%), *General surgery* (8%) and *Orthopaedic surgery* (6%) were the three most frequent clinician specialties recorded and combined made up almost one-quarter (23%) of all new claims (Table 3.3). The corresponding proportions for new claims in 2008–09 were 10%, 7% and 7% respectively. For the 1,093 new claims in 2009–10 where the clinician specialty is known, *Emergency medicine* was recorded for 13%, *General surgery* for 12% and *Orthopaedic surgery* for 9%.

Table 3.3: New claims[(a)]: specialties of clinicians closely involved in the alleged incident, 1 July 2009 to 30 June 2010

Specialty of clinician	Number	Per cent of claims
Emergency medicine	142	8.8
General surgery	132	8.2
Orthopaedic surgery	103	6.4
General practice—procedural	84	5.2
Obstetrics and gynaecology	81	5.0
Obstetrics only	67	4.2
Nursing—general	49	3.0
Psychiatry	46	2.9
General practice—non-procedural	36	2.2
Anaesthetics	28	1.7
Gynaecology only	28	1.7
General and internal medicine	27	1.7
Cardiology	22	1.4
Urology	17	1.1
Vascular surgery	16	1.0
Dentistry	15	0.9
Diagnostic radiology	15	0.9
Neurology	15	0.9
Psychology	13	0.8
Medical oncology	12	0.7
Paramedic and ambulance staff	12	0.7
Neonatology	11	0.7
Neurosurgery	11	0.7
Ophthalmology	11	0.7
Midwifery	10	0.6
Cardio-thoracic surgery	9	0.6
Gastroenterology and hepatology	9	0.6
Nursing—nurse practitioner	9	0.6
Paediatric medicine	9	0.6

(continued)

Table 3.3 (continued): New claims[(a)]: specialties of clinicians closely involved in the alleged incident, 1 July 2009 to 30 June 2010

Specialty of clinician	Number	Per cent of claims
Plastic and reconstructive surgery	9	0.6
Endocrinology	8	0.5
Pathology	7	0.4
Clinical haematology	5	0.3
Intensive care	5	0.3
Paediatric surgery	5	0.3
Respiratory and sleep medicine	5	0.3
Otolaryngology	4	0.2
Dermatology	3	0.2
Oral and maxillofacial surgery	3	0.2
Renal medicine	3	0.2
Infectious diseases	2	0.1
Rehabilitation medicine	2	0.1
Clinical genetics	1	0.1
Clinical immunology	1	0.1
Cosmetic surgery	1	0.1
Geriatrics	1	0.1
Nutrition/dietician	1	0.1
Physiotherapy	1	0.1
Podiatry	1	0.1
Public health	1	0.1
Chiropractics	0	0.0
Clinical pharmacology	0	0.0
Maternal-foetal medicine	0	0.0
Medical administration	0	0.0
Nuclear medicine	0	0.0
Occupational medicine	0	0.0
Osteopathy	0	0.0
Palliative medicine	0	0.0
Pharmacy	0	0.0
Reproductive endocrinology and infertility	0	0.0
Rheumatology	0	0.0
Sports medicine	0	0.0
Urogynaecology	0	0.0
Other allied health	4	0.2
Other hospital-based medical practitioner	7	0.4
Not applicable[(b)]	16	1.0
Not known	519	32.2
All new claims[(c)]	**1,612**	**100.0**

(a) The table excludes eight new claims that duplicate the specialty of clinician data recorded in another claim (see Box 2.1).

(b) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

(c) Up to four different specialties may be recorded for each claim, and so some claims are represented in more than one row in this table. Hence the numbers in the table cannot be summed vertically to give the total number of all new claims and the percentage values cannot be summed vertically to give 100%.

Three other specialties were recorded for 50 or more claims each, these being *General practice – procedural, Obstetrics and gynaecology* and *Obstetrics only*. These clinician specialties were also frequently recorded for new claims in 2008–09 (AIHW 2011b). On the other hand, there were many clinician specialties recorded for fewer than 10 new claims in 2009–10, including 13 specialties not recorded for any claims. This is similar to previous years when

most clinician specialties have been recorded for small proportions of MINC public sector claims (AIHW 2007, 2009, 2011a, 2011b).

Primary incident/allegation type

'Primary incident/allegation type' describes what is alleged to have 'gone wrong', that is, the area of possible error, negligence or problem that was of primary importance in giving rise to the claim. During 2009–10, *Procedure* was the most commonly recorded category for all new claims (22%), followed by *Diagnosis* and *Treatment* (both 17%). *Blood/blood product-related*, *Infection control* and *Device failure* were the least common primary incident/allegation types (each less than 1%) to be recorded as the alleged grounds for a claim (Table 3.4).

Procedure accounted for more than half of all alleged incidents in the clinical service contexts of *Gynaecology* (56%) and *General surgery* (52%) as well as about 45% of alleged incidents in *Orthopaedics* and *Obstetrics*. (These percentage comparisons exclude new claims where the incident/allegation type was not known and/or the clinical service context was not known, to assist the interpretability of the percentages, as explained at Section 2.5.) Incidents related to *Diagnosis* and *Treatment* were relatively more likely in *Emergency department* claims (accounting for 49% and 32% of these claims respectively). *Treatment* was also recorded for 39% of *Psychiatry* claims and 35% of claims with a clinical service context of *General medicine* (Table 3.5).

Table 3.4: New claims[a]: clinical service context, by primary incident/allegation type, 1 July 2009 to 30 June 2010

	Primary incident/allegation type												
Clinical service context[b]	**Procedure[c]**	**Diagnosis**	**Treatment[d]**	**General duty of care**	**Medication-related[e]**	**Consent[f]**	**Anaesthetic**	**Blood/blood product-related**	**Infection control**	**Device failure**	**Other**	**Not known**	**Total**
Emergency department	12	97	64	15	5	3	0	2	1	0	1	5	205
General surgery	103	29	32	10	7	2	10	2	0	1	1	0	197
Obstetrics	56	34	25	6	1	2	3	0	1	0	2	6	136
Orthopaedics	42	8	27	5	4	0	1	0	4	1	1	4	97
Psychiatry	0	5	28	16	15	5	0	1	0	0	1	2	73
Gynaecology	33	17	0	2	3	3	1	0	0	0	0	0	59
General practice	10	13	13	5	4	0	1	1	0	0	0	2	49
General medicine	11	6	16	3	7	1	0	1	1	0	0	0	46
All other clinical service contexts	65	48	49	21	8	7	1	2	2	2	3	1	209
Not known	19	15	16	7	10	1	1	0	0	1	4	467	541
Total	**351**	**272**	**270**	**90**	**64**	**24**	**18**	**9**	**9**	**5**	**13**	**487**	**1,612**
Per cent[g]	*21.8*	*16.9*	*16.7*	*5.6*	*4.0*	*1.5*	*1.1*	*0.6*	*0.6*	*0.3*	*0.8*	*30.2*	*100.0*

(a) The table excludes eight new claims that duplicate the clinical service context and primary incident/allegation type data recorded in another claim (see Box 2.1).

(b) The 'clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

(c) *Procedure* includes failure to perform a procedure, wrong procedure performed, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(d) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(e) *Medication-related* includes type, dosage and method of administration issues.

(f) *Consent* includes failure to warn.

(g) Percentages do not add up exactly to 100.0 due to rounding.

Table 3.5: New claims[(a)]: clinical service context, by primary incident/allegation type (excluding *Not known*), 1 July 2009 to 30 June 2010 (per cent)

	Primary incident/allegation type											
Clinical service context[(b)]	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Consent**	**Anaesthetic**	**Blood/blood product-related**	**Infection control**	**Device failure**	**Other**	**Total**
Emergency department	6.0	48.5	32.0	7.5	2.5	1.5	0.0	1.0	0.5	0.0	0.5	100.0
General surgery	52.3	14.7	16.2	5.1	3.6	1.0	5.1	1.0	0.0	0.5	0.5	100.0
Obstetrics	43.1	26.2	19.2	4.6	0.8	1.5	2.3	0.0	0.8	0.0	1.5	100.0
Orthopaedics	45.2	8.6	29.0	5.4	4.3	0.0	1.1	0.0	4.3	1.1	1.1	100.0
Psychiatry	0.0	7.0	39.4	22.5	21.1	7.0	0.0	1.4	0.0	0.0	1.4	100.0
Gynaecology	55.9	28.8	0.0	3.4	5.1	5.1	1.7	0.0	0.0	0.0	0.0	100.0
General practice	21.3	27.7	27.7	10.6	8.5	0.0	2.1	2.1	0.0	0.0	0.0	100.0
General medicine	23.9	13.0	34.8	6.5	15.2	2.2	0.0	2.2	2.2	0.0	0.0	100.0
All other clinical service contexts	31.3	23.1	23.6	10.1	3.8	3.4	0.5	1.0	1.0	1.0	1.4	100.0
Total	**31.6**	**24.5**	**24.2**	**7.9**	**5.1**	**2.2**	**1.6**	**0.9**	**0.9**	**0.4**	**0.9**	**100.0**

(a) The table excludes eight new claims that duplicate the clinical service context and primary incident/allegation type data recorded in another claim (see Box 2.1).

(b) The 'clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

Notes

1. The 487 claims coded *Not known* for 'primary incident/allegation type' and 541 coded *Not known* for 'clinical service context', including 467 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 1,051.

2. Percentages may not add up exactly to 100.0 due to rounding.

3.2 Current claims

This section reports information on claims that were current at 30 June 2010.

Reserve range and duration

Table 3.6 displays data on 'length of claim' by 'reserve range'. For current claims, the length of a claim is measured from the date the claim first had a reserve placed against it to the end of the financial year, in this case 30 June 2010. More than two-fifths (44%) had been open for 12 months or less, with just 10% having remained open beyond 5 years.

The proportion of current claims with a reserve of less than $30,000 was 34% (1,255 claims), while 21% (757 claims) had a reserve range between $100,000 and <$250,000, and 12% (446 claims) had a reserve value of at least $500,000.

A strong association is evident between the reserve range and how long a claim was open (Figure 3.1). For example, of the current claims with a reserve of less than $10,000, more than two-thirds (70%) have been open for 12 months or less, compared with 3% open for more than 5 years. In contrast, current claims reserved at $500,000 or more have usually been open for more than 12 months (85%) and often for more than 5 years (31%).

Current claims at 30 June 2009 (AIHW 2011b) had a very similar distribution for their reserve range and duration compared with current claims at 30 June 2010.

Table 3.6: Current claims: length of claim (months), by reserve range ($), 30 June 2010

	Reserve range ($)							
Length of claim	Less than 10,000	10,000–<30,000	30,000–<50,000	50,000–<100,000	100,000–<250,000	250,000–<500,000	500,000 or more	Total
12 or less	560	202	125	244	312	122	68	1,633
13–24	123	126	69	153	189	113	75	848
25–36	63	67	29	74	111	43	72	459
37–48	13	23	10	33	58	46	50	233
49–60	14	12	8	24	26	20	42	146
>60	27	25	21	48	61	48	139	369
Total	**800**	**455**	**262**	**576**	**757**	**392**	**446**	**3,688**
Per cent	*21.7*	*12.3*	*7.1*	*15.6*	*20.5*	*10.6*	*12.1*	*100.0*
				Per cent				
12 or less	70.0	44.4	47.7	42.4	41.2	31.1	15.2	44.3
13–24	15.4	27.7	26.3	26.6	25.0	28.8	16.8	23.0
25–36	7.9	14.7	11.1	12.8	14.7	11.0	16.1	12.4
37–48	1.6	5.1	3.8	5.7	7.7	11.7	11.2	6.3
49–60	1.8	2.6	3.1	4.2	3.4	5.1	9.4	4.0
>60	3.4	5.5	8.0	8.3	8.1	12.2	31.2	10.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note: Percentages may not add up exactly to 100.0 due to rounding.

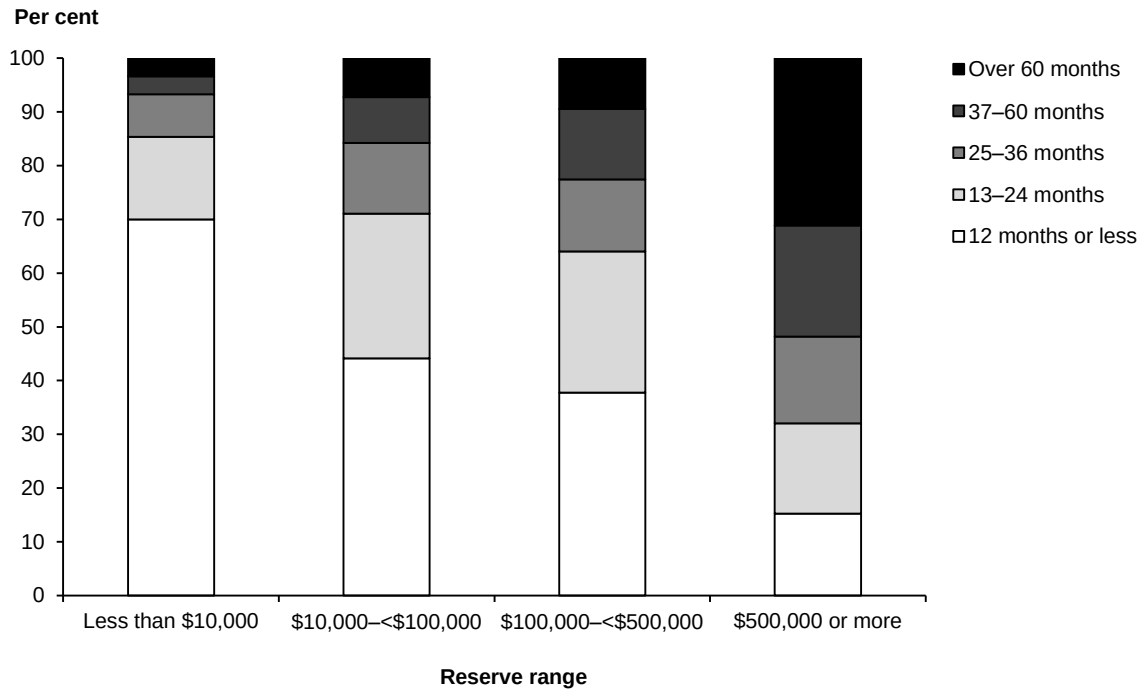


Figure 3.1: Current claims: length of claim (months), by reserve range, 30 June 2010 (per cent)

3.3 Closed claims

This section includes information on claims closed during the 2009–10 year.

Primary body function/structure affected

The 'primary body function/structure affected' specifies the main body function or structure of the claim subject that is alleged to have been affected as a result of the events that gave rise to a claim. The claim subject's death was the category recorded for this data item for 17% of claims closed during 2009–10 (Table 3.7). This category was recorded if the death of the claim subject was established to be a fact during the investigation into the circumstances of an open or reopened claim. The claimant can be any person claiming for loss as a result of the incident, and need not be the claim subject (Section 2.3), which is why the claim subject may be deceased before a claim is closed.

Apart from *Death*, the four most common categories were *Neuromusculoskeletal and movement-related* (23%), *Mental and nervous system* (18%), *Genitourinary and reproductive* (13%) and *Digestive, metabolic and endocrine systems* (12%). The other categories were each recorded for 6% or less of claims.

Extent of harm

The 'extent of harm' describes the overall effect of the alleged incident on the claim subject in terms of impairment, activity limitation or participation restriction. The categories reported for the 2009−10 data are *Mild injury* (up to 25% impairment), *Moderate injury* (within the range of 25−50% impairment) and *Severe injury* (more than 50% impairment), and also *Death* and *Not applicable* (corresponding to *Death* and *No body function/structure affected* in terms of the 'primary body function/structure affected'). The category selected by the claim manager represents the claim manager's best estimate after allowing for any pre-existing condition the claim subject may have had prior to the alleged incident.

Mild injury was recorded for 23% of claims closed during 2009–10, moderate injury for 33% and severe injury for 22% (Table 3.7). Whether the extent of harm involved mild, moderate or severe injury, allegations of *Neuromusculoskeletal and movement-related* effects accounted for just over one-quarter of the claims (26–29%). Almost twice as many claims for harm to the *Mental and nervous system* were for severe injury than mild injury (36% or 92 claims, and 18% or 49 claims, respectively). Where the extent of harm was moderate injury, nearly two-fifths of claims involved allegations of either *Genitourinary and reproductive* effects (20%) or *Digestive, metabolic and endocrine systems* effects (18%).

Table 3.7: Closed claims[(a)]: primary body function/structure affected, by extent of harm, 1 July 2009 to 30 June 2010

Primary body function/structure affected	Extent of harm						
	Mild injury	Moderate injury	Severe injury	Death	Not applicable	Not known	Total
Neuromusculoskeletal and movement-related	70	107	75	0	0	9	261
Mental and nervous system	49	58	92	0	0	14	213
Genitourinary and reproductive	37	75	29	0	0	2	143
Digestive, metabolic and endocrine systems	48	68	19	0	0	5	140
Cardiovascular, haematological, immunological and respiratory	15	28	21	0	1	5	70
Skin and related structures	31	26	5	0	0	4	66
Sensory, including eye and ear	9	17	12	0	0	2	40
Voice and speech	7	1	2	0	0	0	10
Death	0	0	0	193	0	0	193
No body function/ structure affected	0	0	0	0	28	0	28
Total	**266**	**380**	**255**	**193**	**29**	**41**	**1,164**
Per cent	*22.9*	*32.6*	*21.9*	*16.6*	*2.5*	*3.5*	*100.0*
	Per cent (excluding *Not known*)						
Neuromusculoskeletal and movement-related	26.3	28.2	29.4	0.0	0.0	. .	23.0
Mental and nervous system	18.4	15.3	36.1	0.0	0.0	. .	18.2
Genitourinary and reproductive	13.9	19.7	11.4	0.0	0.0	. .	12.9
Digestive, metabolic and endocrine systems	18.0	17.9	7.5	0.0	0.0	. .	12.3
Cardiovascular, haematological, immunological and respiratory	5.6	7.4	8.2	0.0	3.0	. .	5.9
Skin and related structures	11.7	6.8	2.0	0.0	0.0	. .	5.7
Sensory, including eye and ear	3.4	4.5	4.7	0.0	0.0	. .	3.5
Voice and speech	2.6	0.3	0.8	0.0	0.0	. .	0.9
Death	0.0	0.0	0.0	100.0	0.0	. .	17.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

. . Not applicable.

(a) The table excludes 12 closed claims that duplicate the extent of harm and primary body function/structure category data recorded in another claim (see Box 2.1).

Notes

1. See Appendix 5 for examples of types of alleged harm for each of the body function/structure categories.
2. The 70 claims coded *Not applicable* or *Not known* for 'extent of harm' are excluded for the purposes of calculating the percentages in the bottom half of the table. The number of claims on which the percentages presented here are based is 1,094.
3. Percentages may not add up exactly to 100.0 due to rounding.

Length and cost of claims

The length or duration of a closed claim is measured from the date of reserve placement to when the claim was closed. The most frequently recorded duration was 13−24 months (26%), with 19% closed within 12 months of reserve placement, and 20% closed between 25 and 36 months after reserve placement (Table 3.8).

'Total claim size' includes any legal and investigative costs as well as any payment made to the claimant(s). Of the claims closed in 2009−10, 43% cost less than $10,000 to close, including 7% that incurred no cost and 36% that involved a cost under $10,000. Just 9% of claims were settled for $500,000 or more.

The length of time taken to finalise closed claims was generally longer for larger settlements (Figure 3.2). More than half (461 claims, 56%) of the 817 claims closed for under $100,000, which made up 69% of closed claims, had been closed within 2 years of when the reserve was set. In contrast, about three-quarters of claims settled for between $100,000 and <$500,000 had a duration longer than 2 years (192 of 253 claims, 76%), while the most common length of time to finalise claims settled for $500,000 or more was over 5 years (44%). This association between cost of claim and length of time to close a claim was also the case for 2007–08 and 2008–09 claims.

Mode of settlement and cost of claims

'Mode of settlement' describes the process by which a claim was closed. Claims may be closed through state/territory complaints processes, court-based processes or *Other* processes (which include cases where a claim is settled part way through a trial), or may be discontinued.

About 40% of claims closed during 2009–10 were finalised through being *Discontinued*, including 7% which were potential claims and 34% which had commenced (Table 3.9). Most of the claims closed for no cost or for a cost under $10,000 were *Discontinued* (81% and 71% respectively).

Settlement through a *Court decision* was the least commonly recorded mode of settlement, with just 3% of closed claims finalised through this mode. In 2009–10, about four times as many claims were finalised through *Court-based alternative dispute resolution processes* (12%).

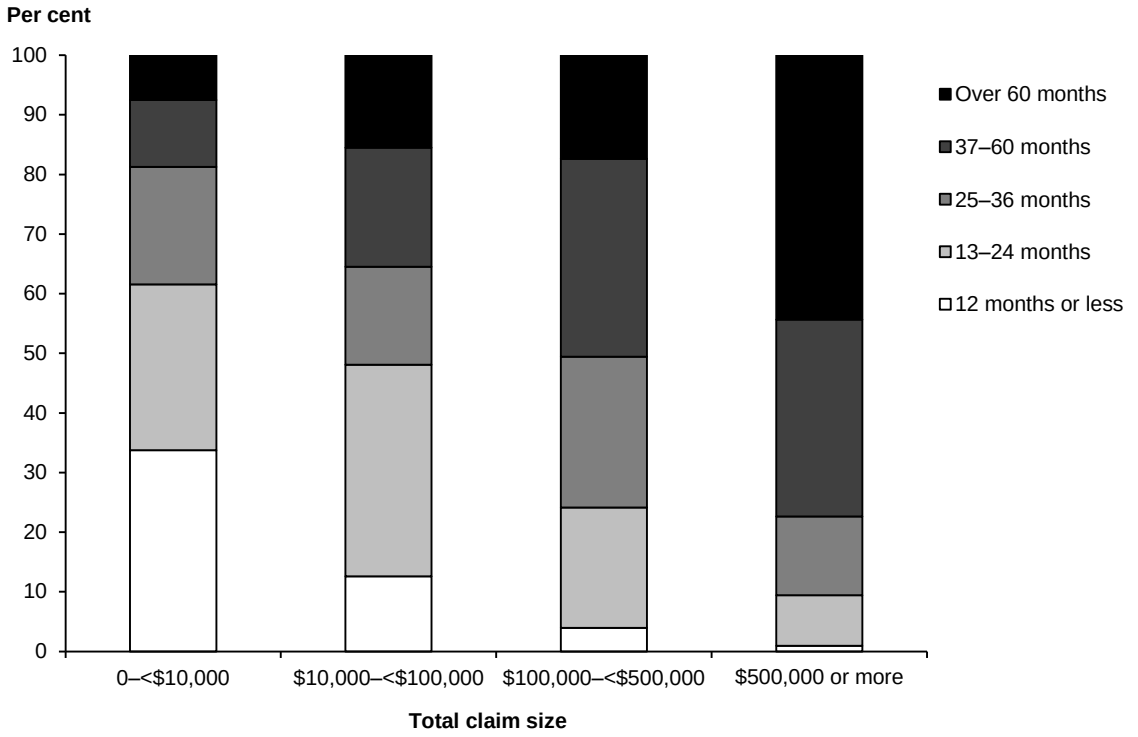
In terms of claim sizes, *Statutorily mandated compulsory conference process* and *Court-based alternative dispute resolution processes* had the highest proportion closed for $500,000 or more (respectively, 8 of 33 claims, 24% and 33 of 142 claims, 23%). They were followed by *Settled – other* (61 of 447 claims, 14%) and *Court decision* (4 of 32 claims, 13%).

Previously published data for closed claims reported 38% with nil cost in 2007–08 (AIHW 2011a) and 28% with nil cost in 2008–09 (AIHW 2011b). Also, 62% of the 2007–08 claims were discontinued, 96% of them for nil cost, and 61% of the 2008–09 claims were discontinued, 98% for nil cost. The corresponding figures for 2009–10 are markedly lower: 8% closed for nil cost, 40% discontinued and just 15% of these (71 of 476 claims) closed for nil cost. The discrepancy is at least partly due to the introduction of a new coding option that allowed data providers to rescind potential claims that had been discontinued for nil cost (Box 3.1). Accordingly, the previously published data on claim size and mode of settlement for years prior to 2009–10 are not comparable with the data in tables 3.8 and 3.9. However, Chapter 4 of this report presents comparable data for cost of claims and mode of settlement between 2005–06 and 2009–10 (tables 4.7 and 4.8).

Table 3.8: Closed claims: length of claim (months), by total claim size ($), 1 July 2009 to 30 June 2010

	Total claim size ($)								
Length of claim	**Nil**	**1–<10,000**	**10,000–<30,000**	**30,000–<50,000**	**50,000–<100,000**	**100,000–<250,000**	**250,000–<500,000**	**500,000 or more**	**Total**
12 or less	29	142	21	6	12	10	0	1	221
13–24	21	120	57	23	30	36	15	9	311
25–36	18	82	23	19	9	45	19	14	229
37–48	6	33	14	3	23	30	16	22	147
49–60	5	13	7	5	10	28	10	13	91
>60	9	29	19	9	20	21	23	47	177
Total	**88**	**419**	**141**	**65**	**104**	**170**	**83**	**106**	**1,176**
Per cent	*7.4*	*35.6*	*12.0*	*5.5*	*8.8*	*14.5*	*7.1*	*9.0*	*100.0*
					Per cent				
12 or less	33.0	33.9	14.9	9.2	11.5	5.9	0.0	0.9	18.8
13–24	23.9	28.6	40.4	35.4	28.8	21.2	18.1	8.5	26.4
25–36	20.5	19.6	16.3	29.2	8.7	26.5	22.9	13.2	19.5
37–48	6.8	7.9	9.9	4.6	22.1	17.6	19.3	20.8	12.5
49–60	5.7	3.1	5.0	7.7	9.6	16.5	12.0	12.3	7.7
>60	10.2	6.9	13.5	13.8	19.2	12.4	27.7	44.3	15.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note: Percentages may not add up exactly to 100.0 due to rounding.



Note: For more detailed information see Table 3.8.

Figure 3.2: Closed claims: length of claim (months), by total claim size, 1 July 2009 to 30 June 2010 (per cent)

Table 3.9: Closed claims: mode of settlement, by total claim size ($), 1 July 2009 to 30 June 2010

	Total claim size ($)								
Mode of settlement	**Nil**	**1–<10,000**	**10,000–<30,000**	**30,000–<50,000**	**50,000–<100,000**	**100,000–<250,000**	**250,000–<500,000**	**500,000 or more**	**Total**
Discontinued potential claim	7	65	5	1	0	0	0	0	78
Discontinued commenced claim	64	233	67	11	14	7	2	0	398
Settled—state/territory-based complaints processes	0	8	13	10	6	6	3	0	46
Settled—statutorily mandated compulsory conference process	0	0	1	3	6	10	5	8	33
Settled—court-based alternative dispute resolution processes	6	4	5	6	17	40	31	33	142
Settled—other	11	102	43	29	57	104	40	61	447
Court decision	0	7	7	5	4	3	2	4	32
Total	**88**	**419**	**141**	**65**	**104**	**170**	**83**	**106**	**1,176**
					Per cent				
Discontinued potential claim	8.0	15.5	3.5	1.5	0.0	0.0	0.0	0.0	6.6
Discontinued commenced claim	72.7	55.6	47.5	16.9	13.5	4.1	2.4	0.0	33.8
Settled—state/territory-based complaints processes	0.0	1.9	9.2	15.4	5.8	3.5	3.6	0.0	3.9
Settled—statutorily mandated compulsory conference process	0.0	0.0	0.7	4.6	5.8	5.9	6.0	7.5	2.8
Settled—court-based alternative dispute resolution processes	6.8	1.0	3.5	9.2	16.3	23.5	37.3	31.1	12.1
Settled—other	12.5	24.3	30.5	44.6	54.8	61.2	48.2	57.5	38.0
Court decision	0.0	1.7	5.0	7.7	3.8	1.8	2.4	3.8	2.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note: Percentages may not add up exactly to 100.0 due to rounding.

Claim payment details

The claimant may be the claim subject and/or another party/parties (Section 2.3). 'Claim payment details' provides information on whether or not a compensation payment was made to the claim subject and/or another party/parties.

Of the claims closed in 2009–10, no payment was made to the claim subject or other party/parties in 529 (45%) of claims (Table 3.10). For those claims where no payment was made, 441 (83%) incurred legal and investigative costs, including 318 that cost less than $10,000, 107 that cost $10,000−<$100,000 and 16 that cost $100,000−<$500,000. Claims with no payment to the claimant accounted for 80% of claims closed for under $10,000 (406 of 507) compared with 18% closed for $10,000 or more (123 of 669).

A payment was made only to the claim subject in 32% of closed claims and only to another party/parties in 10% of closed claims. A payment to both the claim subject and another party/parties was recorded for 153 (13%) of closed claims, including about 1 in 5 (24 of 106 claims, 23%) with a claim size of $500,000 or more.

Data reported for 2008–09 (AIHW 2011b) indicate 60% of closed claims involved no payment to the claimant, compared with just 45% in 2009–10. The decrease would be at least partly attributable to the 2009–10 coding option that allowed data providers to rescind '$0' discontinued potential claims (Box 3.1).

Table 3.10: Closed claims: claim payment details, by total claim size ($), 1 July 2009 to 30 June 2010

	Total claim size ($)						
Claim payment details	**Nil**	**1-<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**	**Per cent**
No payment to claim subject or other party/parties	88	318	107	16	0	529	45.0
Payment to claim subject only	0	74	108	126	71	379	32.2
Payment to other party/parties only	0	21	45	38	11	115	9.8
Payment to claim subject and other party/parties	0	6	50	73	24	153	13.0
Total	**88**	**419**	**310**	**253**	**106**	**1,176**	**100.0**
			Per cent				
No payment to claim subject or other party/parties	16.6	60.1	20.2	3.0	0.0	100.0	. .
Payment to claim subject only	0.0	19.5	28.5	33.2	18.7	100.0	. .
Payment to other party/parties only	0.0	18.3	39.1	33.0	9.6	100.0	. .
Payment to claim subject and other party/parties	0.0	3.9	32.7	47.7	15.7	100.0	. .
Total	**7.5**	**35.6**	**26.4**	**21.5**	**9.0**	**100.0**	**. .**

. . Not applicable.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Extent of harm and cost of claims

The 2009−10 data on closed claims show a strong association between claim size and extent of harm (Figure 3.3) and the same pattern was noted for 2008−09 (AIHW 2011b). Where extent of harm is applicable to the claim and also known, mild injury accounted for 49% of claims closed for no cost, and 34% closed for $1–<$10,000, compared with just 2% closed for $500,000 or more. In contrast, severe injury was recorded for just 5% of claims closed for no cost compared with 71% closed for $500,000 or more. Moderate injury had the highest proportion of claims with total claim sizes between $10,000 and <$100,000 (34%) and $100,000–<$500,000 (47%). Between 14% and 21% of the claims in claim size categories up to $100,000−<$500,000 had the patient's death as their recorded extent of harm, whereas this was the case for just 6% of claims closed for $500,000 or more (Table 3.11).

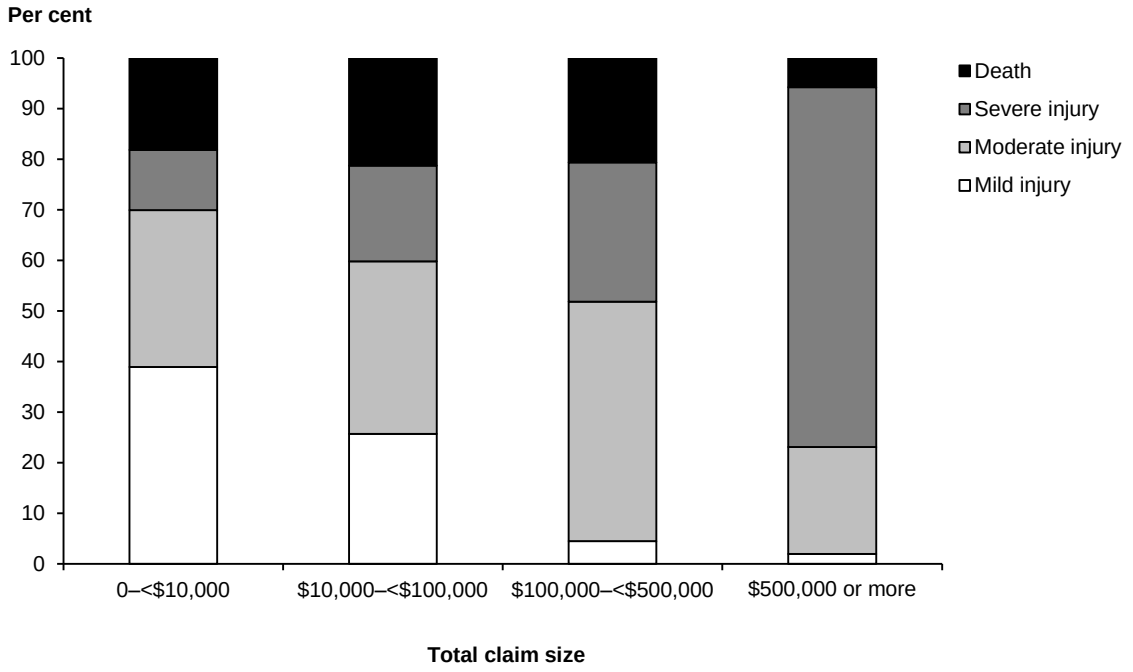


Figure 3.3: Closed claims: extent of harm, by total claim size, 1 July 2009 to 30 June 2010

Table 3.11: Closed claims[a]: extent of harm, by total claim size ($), 1 July 2009 to 30 June 2010

	Total claim size ($)						
Extent of harm	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**	**Per cent**
Mild injury	38	138	76	11	2	265	22.7
Moderate injury	22	118	101	117	22	380	32.5
Severe injury	4	50	56	68	74	252	21.6
Death	11	71	63	51	6	202	17.3
Not applicable	2	25	1	1	0	29	2.5
Not known	5	17	13	4	2	41	3.5
Total	**82**	**419**	**310**	**252**	**106**	**1,169**	**100.0**
Per cent	*7.0*	*35.8*	*26.5*	*21.6*	*9.1*	*100.0*	. .
	Per cent (excluding *Not applicable and Not known*)						
Mild injury	50.7	36.6	25.7	4.5	1.9	23.5	. .
Moderate injury	29.3	31.3	34.1	47.4	21.2	33.7	. .
Severe injury	5.3	13.3	18.9	27.5	71.2	22.3	. .
Death	14.7	18.8	21.3	20.6	5.8	17.9	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and the extent of harm to the patient (see Box 2.1).

Notes

1. The 41 claims coded *Not known* and 29 claims coded *Not applicable* for 'extent of harm' are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 1,099 claims.
2. Percentages may not add exactly to 100.0 due to rounding.

Clinical service context and cost of claims

Obstetrics was the clinical service context with the highest proportion of costly claims. The proportion of *Obstetrics* claims closed for at least $100,000 was 39% (76 of 194 claims), including 19% closed for at least $500,000 (Table 3.12). In contrast, just 22% of *General practice* claims and 26% of both *Psychiatry* and *General medicine* claims were closed for $100,000 or more (respectively, 10 of 46, 20 of 76 and 14 of 53 claims).

Comparisons with the 2008−09 data on the relationship between clinical service context and cost of claims (AIHW 2011b) are difficult to make because of the much higher proportion of 2008−09 claims reported as closed for nil cost (28%, compared with 7%).

Table 3.12: Closed claims[(a)]: clinical service context, by total claim size ($), 1 July 2009 to 30 June 2010

	Total claim size ($)						
Clinical service context	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**	**Per cent**
Emergency department	22	77	43	48	24	214	18.3
General surgery	13	77	51	42	14	197	16.9
Obstetrics	9	73	36	40	36	194	16.6
Orthopaedics	8	29	22	19	7	85	7.3
Psychiatry	2	22	32	20	0	76	6.5
Gynaecology	5	16	28	19	2	70	6.0
General medicine	5	16	18	10	4	53	4.5
General practice	6	14	16	8	2	46	3.9
All other clinical service contexts	12	94	64	46	17	233	19.9
Total	**82**	**419**	**310**	**252**	**106**	**1,169**	**100.0**
			Per cent				
Emergency department	10.3	36.0	20.1	22.4	11.2	100.0	. .
General surgery	6.6	39.1	25.9	21.3	7.1	100.0	. .
Obstetrics	4.6	37.6	18.6	20.6	18.6	100.0	. .
Orthopaedics	9.4	34.1	25.9	22.4	8.2	100.0	. .
Psychiatry	2.6	28.9	42.1	26.3	0.0	100.0	. .
Gynaecology	7.1	22.9	40.0	27.1	2.9	100.0	. .
General medicine	9.4	30.2	34.0	18.9	7.5	100.0	. .
General practice	13.0	30.4	34.8	17.4	4.3	100.0	. .
All other clinical service contexts	5.2	40.3	27.5	19.7	7.3	100.0	. .
Total	**7.0**	**35.8**	**26.5**	**21.6**	**9.1**	**100.0**	**. .**

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and clinical service context (see Box 2.1).

Notes

1. The 'clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. Percentages may not add up exactly to 100.0 due to rounding.

4 Changes over time to public sector medical indemnity claims, 2005–06 to 2009–10

This chapter presents an overview of claims data covering the five reporting periods from July 2005 to June 2010. It is based on the most current data for each reporting period, as recorded in the MINC master database (Chapter 2). In particular, data providers have taken the opportunity to rescind records of questionable status as medical indemnity claims, including those closed prior to 2009–10 (Box 3.1). Therefore, the data presented here for the periods 2005–06 to 2008–09 differ from the data as presented in previous reports (AIHW 2011a, 2011b).

The 'time series' tables in this chapter present data on claims assigned to one year or another based on the timing of a unique event in a claim's life. This is to ensure that claims are counted just once in each analysis. One such unique event is the setting of the reserve, which allows claims to be assigned to different years based on when they became new claims. A second example is closure of the claim, allowing closed claims to be assigned to different years based on when they were closed.

New claims are the more useful class of claims to consider when monitoring changes over time in the incidents or allegations giving rise to claims. This is because the reserve is set when a health authority recognises that a claim may arise or has arisen as a result of a health-care incident or allegation. Closed claims, on the other hand, are more informative when the focus is on claim aspects that relate to claim closure, such as mode of settlement and claim size.

The high *Not known* rates observed for new claims on most data items (Table 2.1) specifically apply to the year in which the claim was new. A claim that was new in one year is likely to be better documented in subsequent years, particularly the year in which the claim was closed. As a result, when analysed retrospectively new claims from several years ago have lower *Not known* rates than those opened in 2009–10.

The denominators in the bottom half of all of the columns in the Chapter 4 tables exclude claims that are recorded as *Not applicable* or *Not known* for the tabulated data item. This allows the proportions for the different years to be directly compared notwithstanding the differences between the years in their *Not known* rates.

4.1 Claim numbers

Table 4.1 presents claim numbers between 2005–06 and 2009–10 in terms of current claims (claims open at the end of each period) and closed claims (those closed during each period), which together make up all of the claims open during the period. Current claims include potential claims where a reserve has been set but litigation has not begun, commenced claims where litigation has begun, and claims which were reopened after having been closed in a previous period. The claim numbers reported for 2005–06 to 2008–09 are less than the numbers previously reported (AIHW 2011a, 2011b) because the numbers in Table 4.1 exclude retrospectively rescinded claims (Box 3.1).

The 2005–06 year had the largest number of claims in terms of all claims (about 5,500) and current claims (about 4,000). Between 2006–07 and 2009–10, the number of all claims was between 4,600 and 5,100 (in round terms), while the number of current claims was between 3,200 and 3,700 in round terms. The number of closed claims reached its peak of about 1,800 in 2006–07, compared with about 1,200 to 1,600 in other years (Figure 4.1). The number of reopened claims has risen steadily from 55 in 2005–06 to 200 in 2009–10.

Table 4.1 also presents the numbers of new claims that had their reserve set during each period. They are shown separately as they may be either current or closed at the end of the year when their reserve was set. There were 1,620 new claims in 2009–10, about 350–500 more than in the previous three years, and slightly more than the 1,617 new claims in 2005–06.

Table 4.1: All claims: number of claims, by status of claim, 2005–06 to 2009–10

	Year				
Status of claim	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
New claims	1,617	1,131	1,270	1,274	1,620
Current claims					
Potential (not yet commenced)	735	470	442	395	755
Commenced	3,129	2,714	2,740	2,623	2,733
Reopened	55	100	152	164	200
Current claims at the end of each financial year	3,919	3,284	3,334	3,182	3,688
Closed claims	1,556	1,805	1,263	1,480	1,176
All claims (open at any time during the period)	5,475	5,089	4,597	4,662	4,864

Note: The claim numbers for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).

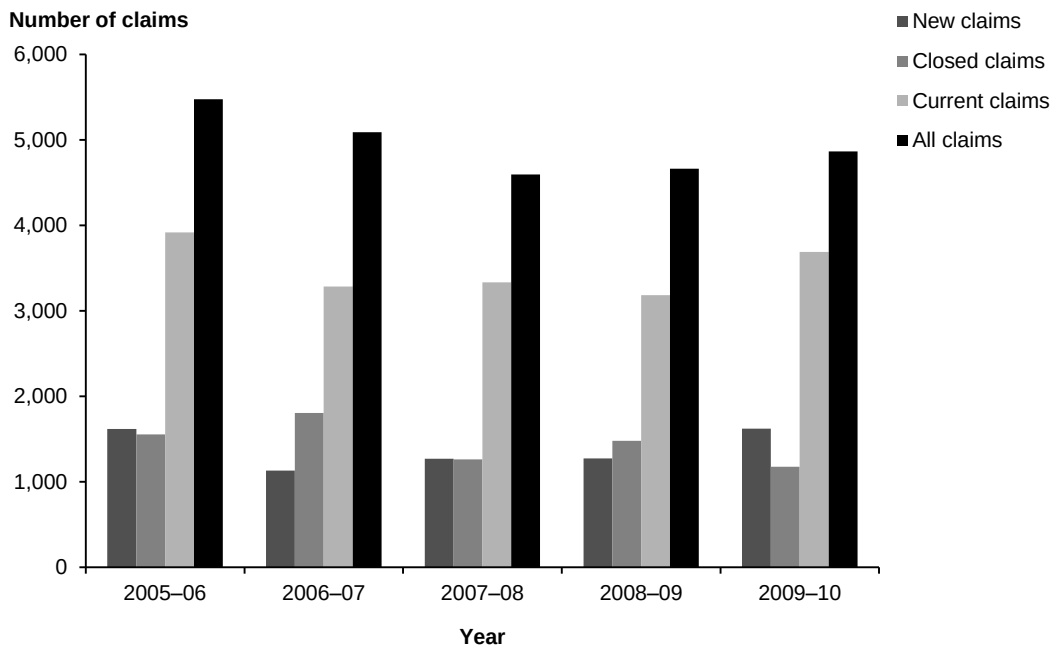


Figure 4.1: Numbers of new, closed, current and all claims: claim numbers, 2005–06 to 2009–10

4.2 Clinical service context and principal clinician specialty

'Clinical service context' specifies the area of clinical practice associated with the alleged health-care incident (Section 3.1). Table 4.2 presents the numbers and proportions of new claims associated with the 10 clinical service contexts most commonly recorded between 2005–06 and 2009–10. Of these, *Emergency department, General surgery,* and *Obstetrics* were the three most frequently recorded in each of the years.

For 2009–10, excluding new claims where the clinical service context was *Not known*, *Emergency department* accounted for 19% (205 of 1,071 claims), *General surgery* for 18% (197 of 1,071 claims) and *Obstetrics* for 13% (136 of 1,071 claims). These proportions are similar to those recorded for 2008–09: 18% for *Emergency department*, 15% for *General surgery* and 17% for *Obstetrics*. The main difference between the years is that *Gynaecology* was the fourth most common clinical service context in 2008–09 but in other years it was *Orthopaedics* (Table 4.2).

'Principal clinician specialty' indicates the health-care provider who allegedly played the most prominent role in the events that gave rise to a claim. The 10 principal clinician specialties most commonly recorded for new claims between 2005–06 and 2009–10 are presented in Table 4.3. For 2009–10, the three most frequently recorded principal clinician specialties were *Emergency medicine*, *General surgery* and *Orthopaedic surgery* (Table 4.3). In terms of claims with a known clinician specialty, *Emergency medicine* accounted for 13% of claims, *General surgery* 12% and *Orthopaedic surgery* 10%.

Emergency medicine has been the most frequently recorded principal clinician specialty since 2006−07, while the second most frequently recorded specialty in 2007–08 was *General practice – non-procedural* (12% of claims) and in 2008−09 it was *Obstetrics and gynaecology* (10% of claims).

The number of new claims with *General surgery* as their clinical service context or their principal clinician specialty was much higher in 2005–06 than in any other year (tables 4.2 and 4.3). The proportion of these claims in 2005–06 was about twice what it was in any other year (figures 4.2 and 4.3). The claims made against a general surgeon in one jurisdiction were associated with this high number of *General surgery* claims.

Table 4.2: New claims[(a)]: clinical service context, 2005–06 to 2009–10

	Year				
Clinical service context	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
General surgery	530	181	158	164	197
Emergency department	218	212	213	191	205
Obstetrics	213	167	193	182	136
Orthopaedics	115	96	95	69	97
Gynaecology	66	73	65	108	59
Psychiatry	70	75	69	71	73
General medicine	62	50	76	24	46
General practice	28	26	60	61	49
Paediatrics	20	24	42	30	22
Cardiology	30	30	25	21	24
All other clinical service contexts	229	167	175	152	163
Not applicable[(b)]	0	0	3	1	0
Not known	35	24	80	199	541
Total	**1,616**	**1,125**	**1,254**	**1,273**	**1,612**
	Per cent (excluding *Not applicable* and *Not known*)				
General surgery	33.5	16.4	13.5	15.3	18.4
Emergency department	13.8	19.3	18.2	17.8	19.1
Obstetrics	13.5	15.2	16.5	17.0	12.7
Orthopaedics	7.3	8.7	8.1	6.4	9.1
Gynaecology	4.2	6.6	5.6	10.1	5.5
Psychiatry	4.4	6.8	5.9	6.6	6.8
General medicine	3.9	4.5	6.5	2.2	4.3
General practice	1.8	2.4	5.1	5.7	4.6
Paediatrics	1.3	2.2	3.6	2.8	2.1
Cardiology	1.9	2.7	2.1	2.0	2.2
All other clinical service contexts	14.5	15.2	14.9	14.2	15.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes new claims that duplicate the clinical service context data recorded in another claim (see Box 2.1).

(b) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories across the 5 years; all other categories are combined in the category *All other clinical service contexts*.
2. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
3. Percentages may not add up exactly to 100.0 due to rounding.

Table 4.3: New claims[(a)]: principal clinician specialty, 2005–06 to 2009–10

	Year				
Principal clinician specialty	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
General surgery	453	115	94	102	129
Emergency medicine	170	156	149	110	141
Obstetrics only	131	102	92	73	63
Orthopaedic surgery	106	92	84	67	103
General practice—non-procedural	44	62	140	73	36
Obstetrics and gynaecology	67	46	63	104	80
General practice—procedural	37	29	45	86	84
Gynaecology only	44	53	46	61	28
Psychiatry	55	46	48	33	45
General nursing	40	36	29	31	40
All other specialties	421	348	369	333	328
Not applicable[(b)]	10	15	15	14	16
Not known	38	25	80	186	519
Total	**1,616**	**1,125**	**1,254**	**1,273**	**1,612**
	Per cent (excluding *Not applicable* and *Not known*)				
General surgery	28.9	10.6	8.1	9.5	12.0
Emergency medicine	10.8	14.4	12.9	10.3	13.1
Obstetrics only	8.4	9.4	7.9	6.8	5.8
Orthopaedic surgery	6.8	8.5	7.2	6.2	9.6
General practice—non-procedural	2.8	5.7	12.1	6.8	3.3
Obstetrics and gynaecology	4.3	4.2	5.4	9.7	7.4
General practice—procedural	2.4	2.7	3.9	8.0	7.8
Gynaecology only	2.8	4.9	4.0	5.7	2.6
Psychiatry	3.5	4.2	4.1	3.1	4.2
General nursing	2.6	3.3	2.5	2.9	3.7
All other specialties	26.8	32.1	31.8	31.0	30.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes new claims that duplicate the principal clinician specialty data recorded in another claim (see Box 2.1).

(b) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Notes

1. The 'principal clinician specialty' categories listed separately here are the ten most frequently recorded categories across the 5 years; all other categories are combined in the category *All other specialties*.
2. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
3. Percentages may not add up exactly to 100.0 due to rounding.

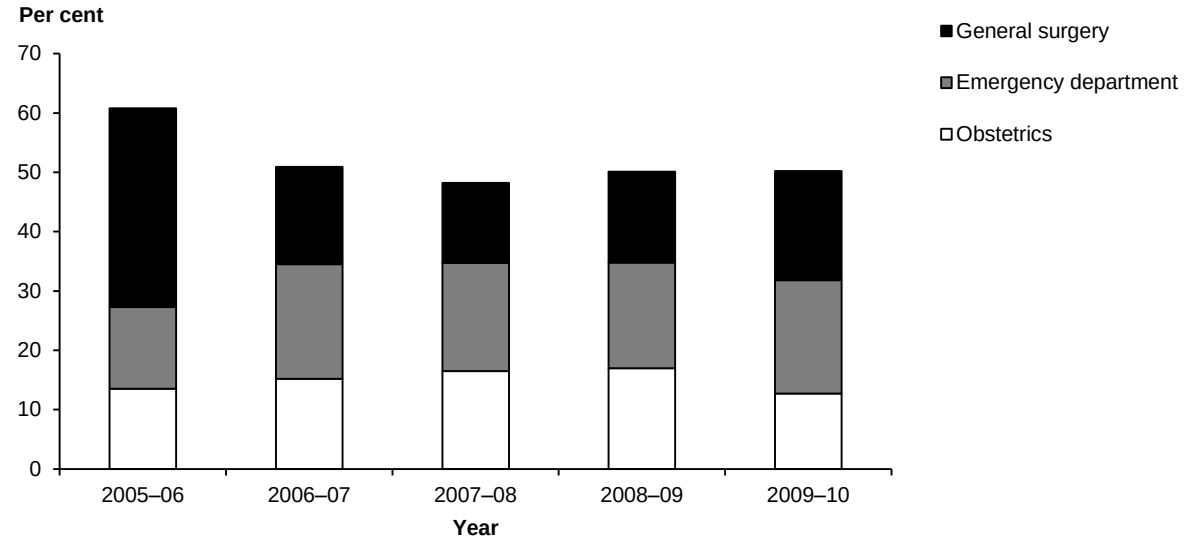


Figure 4.2: New claims: the three most frequently recorded clinical service contexts, 2005–06 to 2009–10 (per cent)

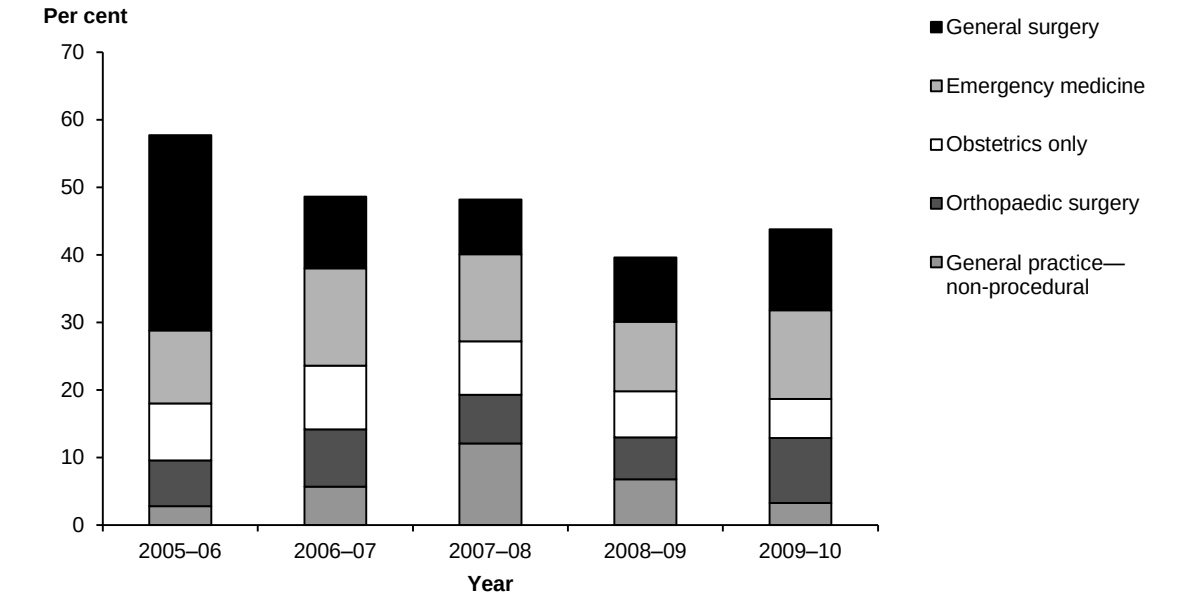


Figure 4.3: New claims: the five most frequently recorded principal clinician specialties, 2005–06 to 2009–10 (per cent)

4.3 Primary body function/structure affected and primary incident/allegation type

The data item 'primary body function/structure affected' specifies the main body function or structure of the claim subject alleged to have been affected as a result of the events that gave rise to a claim. *Death* is recorded for this data item in cases where the patient's death is linked to the claim (Section 3.3).

The two most commonly recorded 'primary body function/structure affected' categories for 2009–10 were *Neuromusculoskeletal and movement-related* and *Death*. As a proportion of new claims (excluding those *Not known* for this data item) they respectively accounted for 26% and 21% of claims. The proportions for both of these categories were marginally lower for 2008–09 new claims, when the *Genitourinary and reproductive* category peaked at 19% compared with 12–13% in other years.

'Primary incident/allegation type' describes the area of possible error, negligence or problem that was of primary importance in giving rise to the claim. Three of its categories, *Procedure*, *Treatment* and *Medication-related*, have subcategories, which are reported in Table 4.5 along with the respective category totals.

For new claims during 2009–10, the most frequently recorded primary incident/allegation types were *Procedure*, *Diagnosis* and *Treatment*. They were respectively associated with 351, 272 and 270 new claims, or as a proportion of cases where the primary incident/allegation type was known, 31%, 24% and 24%. The proportions for *Procedure, Diagnosis* and *Treatment* were similar to those recorded in the years between 2006–07 and 2008–09 (27–33%, 22–28% and 20–26% respectively).

The 2005–06 year had a notably higher proportion of allegations of effects to the *Digestive, metabolic and endocrine systems* compared with any following year (Figure 4.4). It also stood out in terms of its high proportion of new claims (43%) associated with *Procedure* as the primary incident/allegation type (see also Figure 4.5). This reflects claims made against a general surgeon in one jurisdiction.

For every year between 2005–06 and 2009–10, *Procedure – post-operative complications* was the most frequently recorded subcategory of claims with a *Procedure* primary incident/allegation type, while the *Procedure – wrong body site* subcategory was the least frequently recorded overall (Table 4.5). *Treatment complications* and *Treatment – other* were the two most frequently recorded *Treatment* subcategories from 2005–06 to 2009–10. The *Medication – type/dosage* subcategory was always more frequently recorded than the *Medication – administration method* subcategory, by a factor of about four or more.

Table 4.4: New claims[(a)]: primary body function/structure affected, 2005–06 to 2009–10

	Year				
Primary body function/structure affected	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
Neuromusculoskeletal and movement-related	295	265	244	229	287
Mental and nervous system	274	186	203	164	150
Genitourinary and reproductive	187	147	154	203	150
Digestive, metabolic and endocrine systems	306	127	115	102	114
Cardiovascular, haematological, immunological and respiratory	75	69	89	68	64
Skin and related structures	86	53	61	56	63
Sensory, including eye and ear	39	31	24	33	37
Voice and speech	21	15	23	14	10
Death	256	188	232	190	238
No body function/ structure affected	26	16	30	15	14
Not known	51	28	79	199	485
Total	**1,616**	**1,125**	**1,254**	**1,273**	**1,612**
	Per cent (excluding *Not known*)				
Neuromusculoskeletal and movement-related	18.8	24.2	20.8	21.3	25.5
Mental and nervous system	17.5	17.0	17.3	15.3	13.3
Genitourinary and reproductive	11.9	13.4	13.1	18.9	13.3
Digestive, metabolic and endocrine systems	19.6	11.6	9.8	9.5	10.1
Cardiovascular, haematological, immunological and respiratory	4.8	6.3	7.6	6.3	5.7
Skin and related structures	5.5	4.8	5.2	5.2	5.6
Sensory, including eye and ear	2.5	2.8	2.0	3.1	3.3
Voice and speech	1.3	1.4	2.0	1.3	0.9
Death	16.4	17.1	19.7	17.7	21.1
No body function/ structure affected	1.7	1.5	2.6	1.4	1.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes new claims that duplicate the 'primary body function/structure affected' data recorded in another claim (see Box 2.1).

Notes

1. See Appendix 5 for specific examples of types of alleged harm for each of the body function/structure categories.
2. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
3. Percentages may not add up exactly to 100.0 due to rounding.

Table 4.5[a]: New claims: primary incident/allegation type, 2005–06 to 2009–10

	Year				
Primary incident/allegation type	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
Failure to perform procedure	24	24	15	25	27
Failure of procedure	110	41	38	30	31
Wrong procedure	26	21	17	14	8
Procedure—wrong body site	11	6	9	11	10
Procedure—post-operative complications	273	130	108	104	144
Procedure—intra-operative complications	87	67	62	59	73
Procedure—post-operative infection	59	23	12	16	28
Procedure—other	97	51	56	42	30
Total procedure	**687**	**363**	**317**	**301**	**351**
Treatment not provided	40	23	29	21	20
Delayed treatment	61	50	54	37	55
Failure of treatment	20	16	29	38	27
Treatment complications	70	69	94	101	100
Treatment—other	75	64	81	91	68
Total treatment	**266**	**222**	**287**	**288**	**270**
Medication—type/dosage	38	40	57	60	60
Medication—administration method	10	10	11	6	4
Total medication-related	**48**	**50**	**68**	**66**	**64**
Diagnosis	357	310	304	243	272
General duty of care	99	82	106	71	90
Anaesthetic	40	24	26	20	18
Consent	12	21	27	67	24
Infection control	26	5	10	5	9
Blood/blood product-related	14	9	15	22	9
Device failure	4	4	5	3	5
Other	33	14	26	15	13
Not known	30	21	63	172	487
Total	**1,616**	**1,125**	**1,254**	**1,273**	**1,612**

(continued)

Table 4.5 (continued): New claims[(a)]: primary incident/allegation type, 2005–06 to 2009–10

Primary incident/allegation type	Year				
	2005–06	2006–07	2007–08	2008–09	2009–10
	Per cent (excluding *Not known*)				
Failure to perform procedure	1.5	2.2	1.3	2.3	2.4
Failure of procedure	6.9	3.7	3.2	2.7	2.8
Wrong procedure	1.6	1.9	1.4	1.3	0.7
Procedure—wrong body site	0.7	0.5	0.8	1.0	0.9
Procedure—post-operative complications	17.2	11.8	9.1	9.4	12.8
Procedure—intra-operative complications	5.5	6.1	5.2	5.4	6.5
Procedure—post-operative infection	3.7	2.1	1.0	1.5	2.5
Procedure—other	6.1	4.6	4.7	3.8	2.7
Total procedure	**43.3**	**32.9**	**26.6**	**27.3**	**31.2**
Treatment not provided	2.5	2.1	2.4	1.9	1.8
Delayed treatment	3.8	4.5	4.5	3.4	4.9
Failure of treatment	1.3	1.4	2.4	3.5	2.4
Treatment complications	4.4	6.3	7.9	9.2	8.9
Treatment—other	4.7	5.8	6.8	8.3	6.0
Total treatment	**16.8**	**20.1**	**24.1**	**26.2**	**24.0**
Medication—type/dosage	2.4	3.6	4.8	5.4	5.3
Medication—administration method	0.6	0.9	0.9	0.5	0.4
Total medication-related	**3.0**	**4.5**	**5.7**	**6.0**	**5.7**
Diagnosis	22.5	28.1	25.5	22.1	24.2
General duty of care	6.2	7.4	8.9	6.4	8.0
Consent	2.5	2.2	2.2	1.8	1.6
Anaesthetic	0.8	1.9	2.3	6.1	2.1
Blood/blood product-related	1.6	0.5	0.8	0.5	0.8
Infection control	0.9	0.8	1.3	2.0	0.8
Device failure	0.3	0.4	0.4	0.3	0.4
Other	2.1	1.3	2.2	1.4	1.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes new claims that duplicate the primary incident/allegation type data recorded in another claim (see Box 2.1).

Notes

1. Percentages for the *Procedure*, *Treatment* and *Medication-related* subcategories may not add up exactly to the percentages for the *Procedure*, *Treatment* and *Medication-related* categories due to rounding.
2. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
3. Percentages may not add up exactly to 100.0 due to rounding.

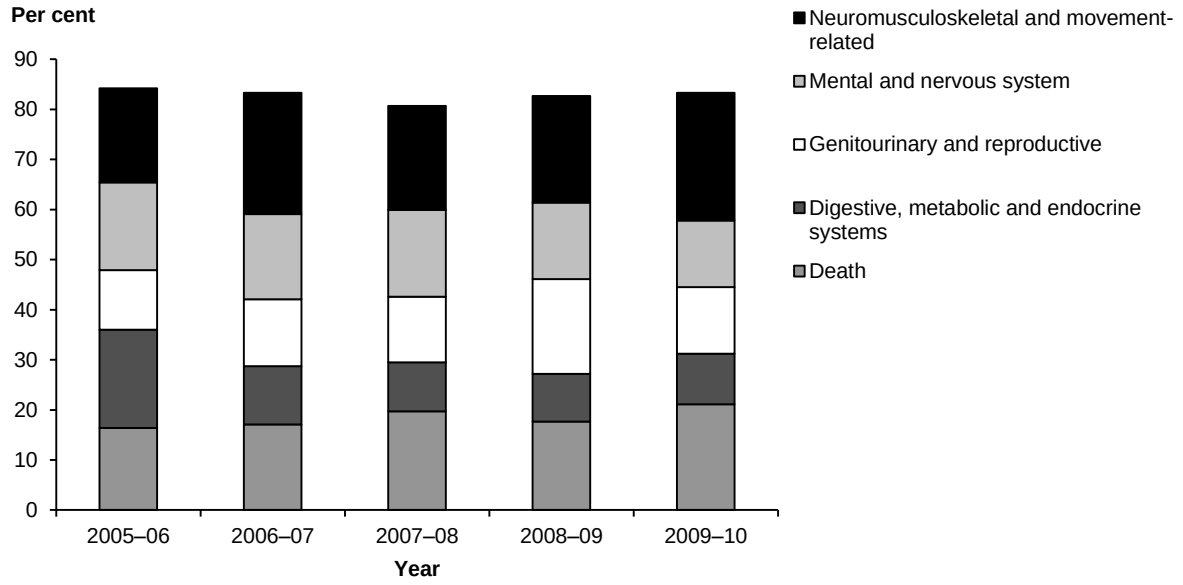


Figure 4.4: New claims: the five most frequently recorded primary body function/structure categories affected, 2005–06 to 2009–10 (per cent)

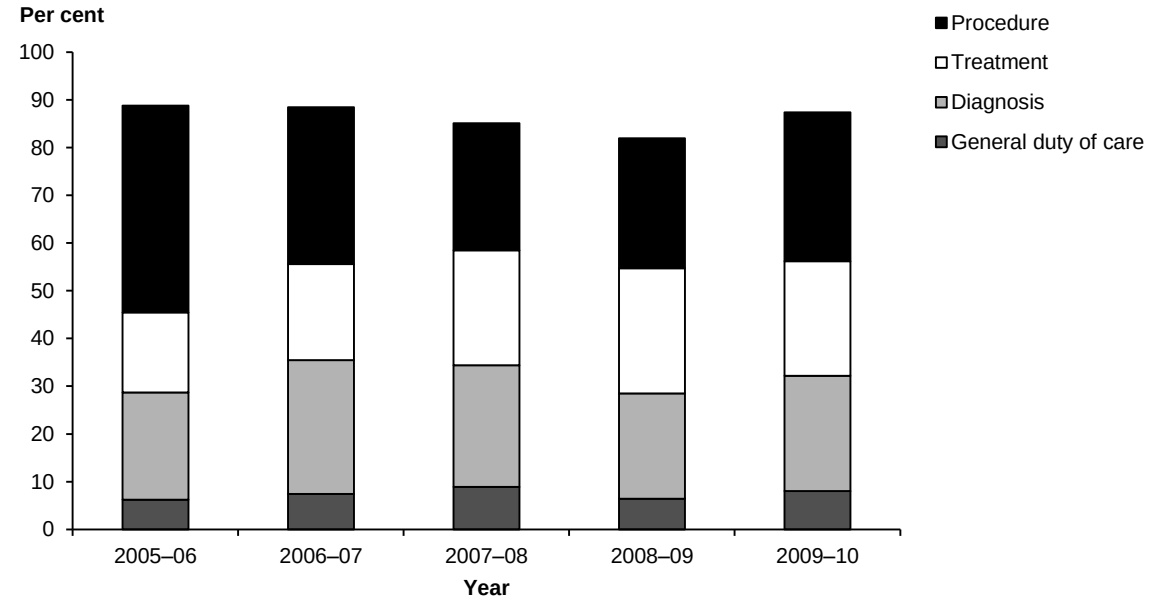


Figure 4.5: New claims: the four most frequently recorded primary incident/allegation types, 2005–06 to 2009–10 (per cent)

4.4 Extent of harm

Extent of harm is analysed with respect to claims closed between 2005–06 and 2009–10, rather than new claims (Table 4.6; Figure 4.6). This is because information on the extent of harm is more complete at the time the claim is closed than when it is new (Table 2.1).

In 2009–10, the reported categories were *Mild injury*, *Moderate injury* and *Severe injury*, as well as *Death*, *Not applicable* and *Not known* (Section 3.3). The MIDWG agreed to use these categories so that the public sector extent of harm data could be aligned with the private sector 'severity of loss' data (AIHW 2012). Previously the MINC categories were *Temporary harm (less than 6 months duration)*, *Minor harm (6 months or more duration)* and *Major harm (6 months or more duration)*, in addition to *Death*, *Not applicable* and *Not known* (which have not changed). Analysis of the claims reported in both the 2008–09 and 2009–10 data supplies from states and territories showed that a clear majority of *Temporary harm* claims in 2008–09 were reported as *Mild injury* claims in 2009–10, and the same was true comparing *Minor harm* with *Moderate injury* and *Major harm* with *Severe injury* between the two years. Accordingly, the MIDWG endorsed the categories used in Table 4.6 to present time series data on extent of harm.

A higher proportion of closed claims was associated with *Minor harm/Moderate injury* than any other category from 2005–06 to 2009–10. There was little variation in the proportion recorded, which stayed between 34% and 36% (excluding claims with *Not applicable* or *Not known* extent of harm). The proportions for the other extent of harm categories also varied within small ranges—23–26% for *Major harm/Severe injury*, 20–26% for *Temporary harm/Mild injury* and 14–21% for *Death*.

Table 4.6: Closed claims[(a)]: extent of harm, 2005–06 to 2009–10

	Year				
Extent of harm	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
Temporary (less than 6 months duration)/ Mild injury	291	420	234	265	266
Minor (6 months or more)/Moderate injury	405	593	375	441	380
Major (6 months or more)/Severe injury	268	385	282	331	255
Death	157	255	192	268	193
Not applicable	46	38	24	30	29
Not known	389	114	155	145	41
Total	**1,556**	**1,805**	**1,262**	**1,480**	**1,164**
	Per cent (excluding *Not applicable* and *Not known*)				
Temporary (less than 6 months duration)/ Mild injury	26.0	25.4	21.6	20.3	24.3
Minor (6 months or more)/Moderate injury	36.1	35.9	34.6	33.8	34.7
Major (6 months or more)/Severe injury	23.9	23.3	26.0	25.4	23.3
Death	14.0	15.4	17.7	20.5	17.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes closed claims that duplicate the extent of harm data recorded in another claim (see Box 2.1).

Notes

1. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
2. Percentages may not add up exactly to 100.0 due to rounding.

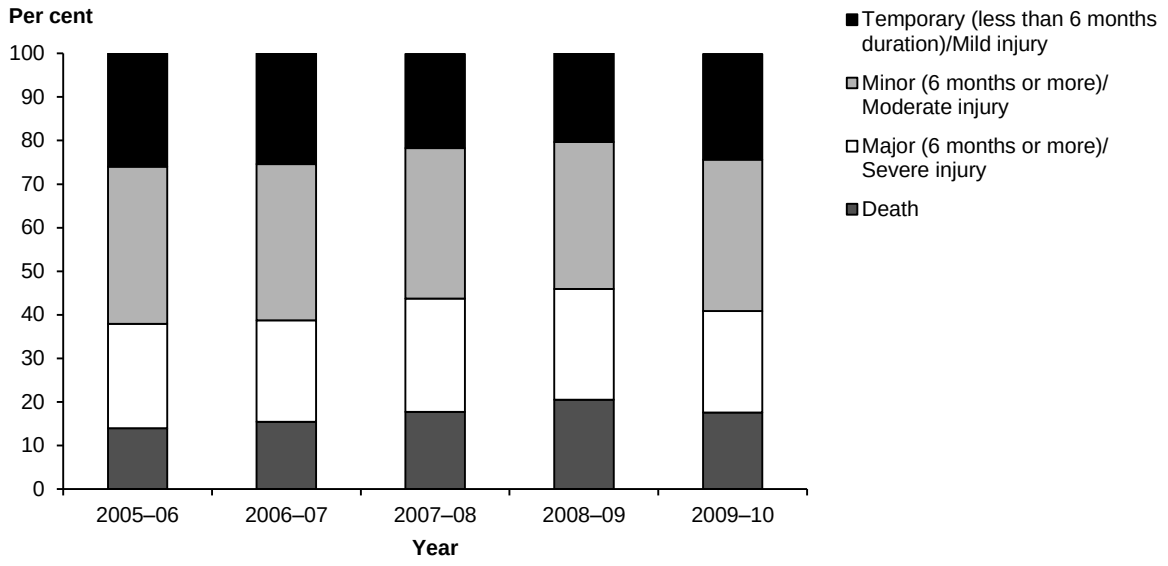


Figure 4.6: Closed claims: extent of harm, 2005–06 to 2009–10 (per cent)

4.5 Mode of settlement and claim size

'Mode of settlement' refers to the mechanism through which a claim is closed, including discontinuation when the claim is withdrawn by the claimant or closed by the claims manager due to operation of the statute of limitations or claim inactivity. The 2009–10 data distinguish between discontinued potential claims and discontinued commenced claims (Section 3.3), but this distinction was not made for previous years' data, and so the time series analysis aggregates all discontinued claims.

Table 4.7 presents data on the mechanisms through which claims were closed between 2005–06 and 2009–10, along with the average length of the claim (between when the reserve was set and the claim was closed). Table 4.8 presents data on the total claim size for closed claims over the same period. Total claim size includes legal and investigative costs as well as any payment made to the claimant(s). Claimants can include both claim subject and/or another party.

Discontinuation was the most common process for closing claims (38–50% of closed claims) followed by *Settled – other*, 33–38% of closed claims. The rarest settlement modes were *Statutorily mandated compulsory conference process* (<1–3% of claims) and *Court decision* (3–5% of claims).

The average time between when the reserve was placed and the claim was closed has stayed between 30 and 35 months, although there does appear to have been an increase in claim length from 2005–06 to 2009–10.

The average cost associated with claims closed in 2009–10 was higher than in any previous year. The proportion closed for $100,000–<$500,000 was 22% compared with 13–17% in previous years, while the proportion closed for $500,000 or more was 9% (compared with 4–8% in previous years) (Table 4.8). These figures are not adjusted for inflation and so the rise in the average cost of closed claims in terms of 2005–06 dollars may be slight or non-existent.

Table 4.7: Closed claims: mode of settlement, and average time between dates when reserve placed and claim file closed, 2005–06 to 2009–10

	Year				
Mode of settlement	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
Discontinued	710	678	574	734	476
Settled—state/territory-based complaints processes	40	202	66	47	46
Settled— statutorily mandated compulsory conference process	23	30	5	27	33
Settled—court-based alternative dispute resolution processes	180	152	86	106	142
Settled—other	501	658	460	512	447
Court decision	60	85	64	52	32
Not known	42	0	8	2	0
Total	**1,556**	**1,805**	**1,263**	**1,480**	**1,176**
Average time to be closed (months)	*30.1*	*30.6*	*32.7*	*32.7*	*35.3*
	Per cent (excluding *Not known*)				
Discontinued	46.9	37.6	45.7	49.7	40.5
Settled—state/territory-based complaints processes	2.6	11.2	5.3	3.2	3.9
Settled—statutorily mandated compulsory conference process	1.5	1.7	0.4	1.8	2.8
Settled—court-based alternative dispute resolution processes	11.9	8.4	6.9	7.2	12.1
Settled—other	33.1	36.5	36.7	34.6	38.0
Court decision	4.0	4.7	5.1	3.5	2.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
2. Percentages may not add up exactly to 100.0 due to rounding.

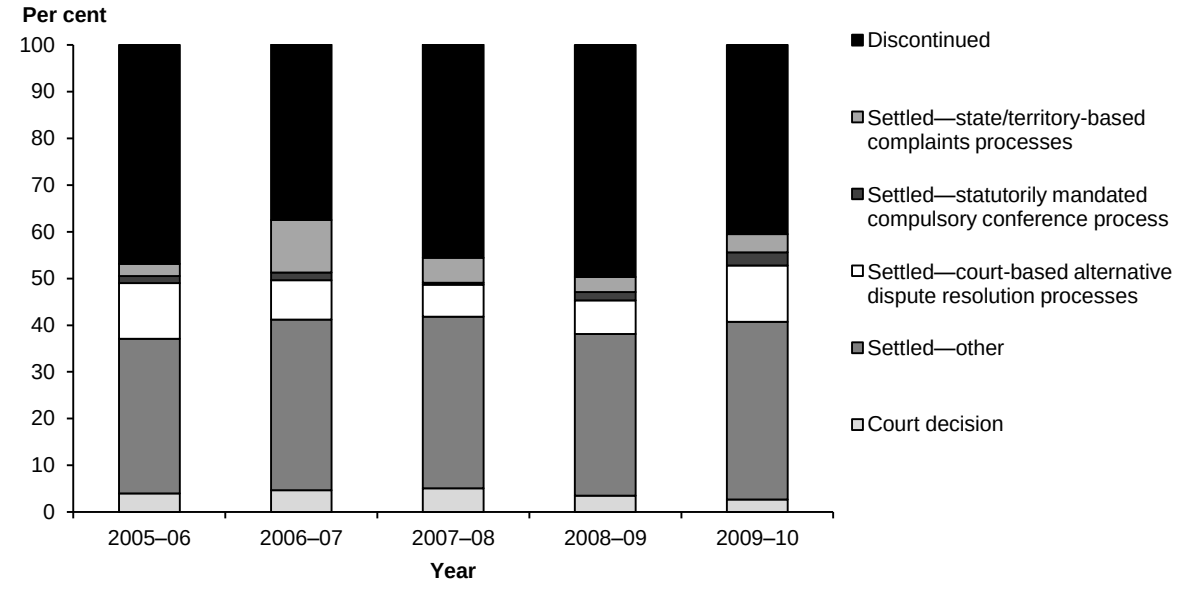


Figure 4.7: Closed claims: mode of settlement, 2005–06 to 2009–10 (per cent)

Table 4.8: Closed claims: total claim size ($), 2005–06 to 2009–10

	Year				
Total claim size ($)	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
Nil	156	110	123	137	88
1–<10,000	706	690	548	596	419
10,000–<30,000	204	313	153	186	141
30,000–<50,000	92	133	77	75	65
50,000–<100,000	118	181	124	122	104
100,000–<250,000	158	210	121	157	170
250,000–<500,000	45	81	54	86	83
500,000 or more	56	87	57	118	106
Not known	21	0	6	3	0
Total	**1,556**	**1,805**	**1,263**	**1,480**	**1,176**
	Per cent (excluding *Not known*)				
Nil	10.2	6.1	9.8	9.3	7.5
1–<10,000	46.0	38.2	43.6	40.4	35.6
10,000–<100,000	27.0	34.7	28.2	25.9	26.4
100,000–<500,000	13.2	16.1	13.9	16.5	21.5
500,000 or more	3.6	4.8	4.5	8.0	9.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The claim numbers and percentages for 2005–06 to 2008–09 may differ from those published in the 2008–09 report (AIHW 2011b) due to updates to the data (see Section 4.1).
2. Percentages may not add up exactly to 100.0 due to rounding.

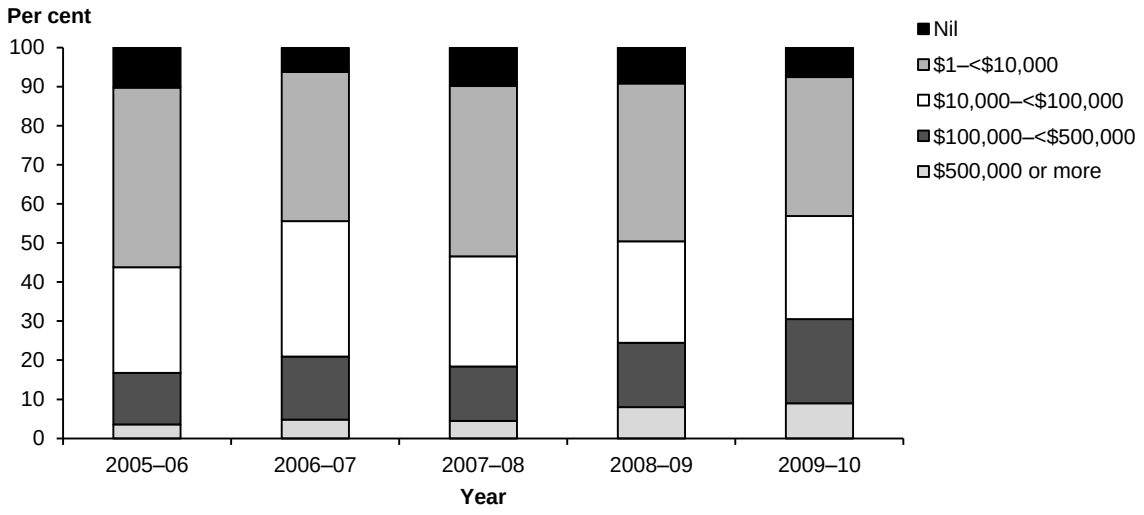


Figure 4.8: Closed claims: total claim size, 2005–06 to 2009–10

5 Public sector medical indemnity claims closed between 2005–06 and 2009–10

This chapter contains a profile of the 7,132 claims that were closed between 2005–06 (July 2005 to June 2006) and 2009–10 (July 2009 to June 2010) and remained closed (not reopened) at 30 June 2010. The data exclude closed claims that have been rescinded, most of which are discontinued potential claims closed for nil cost (Box 3.1).

Information is presented on the health-care incidents that allegedly led to the claims, the people involved (both the health service providers and claim subject) and claim details (including mode of settlement, duration and financial information).

The tables presented here differ from those in the 2008–09 report (Chapter 5) which focused on detailed incident/allegation subcategory data for claims closed between 2004–05 and 2008–09. Instead, the tables here parallel those in the 2007–08 report (AIHW 2011a) for the 9,513 claims closed between 2003–04 and 2007–08. However, claim numbers are not comparable because the data in the 2007–08 report included many claims that have since been rescinded.

5.1 Alleged health-care incidents leading to claims

This section summarises the records on health-care incidents that led to claims. It presents information on claims in terms of the nature of the health service provision ('clinical service context'), what is alleged to have transpired ('primary incident/allegation type'), the setting of the alleged incident ('health service setting') and the professionals principally involved ('principal clinician specialty'). Information on where the alleged incidents occurred ('geographical region'), patient admission status ('claim subject status') and the nature of alleged harm ('primary body function/structure affected') is also included.

Clinical service context

'Clinical service context' categorises the area of clinical practice or hospital department in which the alleged health-care incident occurred. The 10 most common clinical service contexts, accounting for about 83% of all claims closed between 2005–06 and 2009–10, are presented in Table 5.1. The three most frequently recorded clinical service contexts were *General surgery* (19%), *Obstetrics* and *Emergency department* (15% each). The seven other clinical service contexts listed in Table 5.1 were recorded for between 2% and 8% of claims.

Primary incident/allegation type

'Primary incident/allegation type' describes the area of possible error, negligence or problem of primary importance in giving rise to the claim. During 2005–06 to 2009–10, claims were frequently related to *Procedure*, accounting for 34% of all closed claims, followed by *Diagnosis* (23%) and *Treatment* (18%). The other seven categories were each recorded for 8% or less of claims (Table 5.1).

The clinical service context of the provided health service had a considerable bearing on the primary incident or allegation type recorded for a medical claim, as shown in Table 5.2. More than 45% of the claims that arose in four clinical service contexts had an incident/allegation

type relating to a *Procedure*: *Gynaecology* (68%), *General surgery* (59%), *Orthopaedics* (50%) and *Obstetrics* (46%). However, *Procedure* was rarely recorded for claims associated with the clinical service contexts of *Emergency department*, *General medicine* and *Psychiatry*.

Diagnosis was the main primary incident/allegation type for *Emergency department*-related claims (53%), and was also common within *Paediatrics* (40%) and *General practice* (36%). Treatment was recorded as the primary incident/allegation for more than one-quarter of claims in *Psychiatry* (31%), *General medicine* (28%) and *Emergency department* (26%). Incidents allegedly involving issues of *General duty of care* accounted for more than one-third (39%) of claims with a *Psychiatry* clinical service context. *Medication-related* featured as the primary incident/allegation type for a larger proportion of claims in *General medicine* (15%) and *General practice* (11%) than other clinical service contexts.

Table 5.1: Closed claims, 2005–06 to 2009–10[a]: clinical service context, by primary incident/allegation type

	Primary incident/allegation type												
Clinical service context	**Procedure[b]**	**Diagnosis**	**Treatment[c]**	**General duty of care**	**Medication-related[d]**	**Consent[e]**	**Anaesthetic**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**	**Per cent**
General surgery	775	173	147	27	63	22	75	19	5	4	7	1,323	18.6
Obstetrics	489	214	219	39	25	8	24	12	9	0	17	1,068	15.0
Emergency department	58	548	272	64	53	9	3	8	10	2	15	1,049	14.7
Orthopaedics	272	77	85	30	12	18	14	22	0	9	6	549	7.7
Gynaecology	317	45	25	16	10	29	8	5	1	7	4	467	6.6
Psychiatry	8	37	113	141	24	10	1	0	5	0	26	369	5.2
General medicine	19	88	94	63	50	3	2	5	3	6	7	342	4.8
General practice	35	79	38	23	23	3	6	2	3	0	5	223	3.1
Paediatrics	37	66	31	7	15	2	2	2	0	0	5	168	2.4
Cardiology	53	35	27	10	9	3	6	3	1	3	1	151	2.1
All other clinical service contexts	353	253	223	102	51	53	28	29	62	9	30	1,198	16.8
Not applicable[f]	0	0	0	1	0	0	0	0	1	0	0	2	0.0
Total	**2,436**	**1,626**	**1,282**	**535**	**347**	**169**	**172**	**109**	**103**	**40**	**131**	**7,119**	**100.0**
Per cent	34.2	22.8	18.0	7.5	4.9	2.4	2.4	1.5	1.4	0.6	1.8	*100.0*	. .

(a) The table excludes 13 closed claims that duplicate the clinical service context and primary incident/allegation type data recorded in another claim (see Box 2.1).

(b) *Procedure* includes failure to perform a procedure, wrong procedure performed, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(c) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(d) *Medication-related* includes type, dosage and method of administration issues.

(e) *Consent* includes failure to warn.

(f) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. There were 169 claims coded *Not known* for 'primary incident/allegation type' and 210 claims coded *Not known* for 'clinical service context', including 122 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the numbers are included in the totals.

Table 5.2: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context, by primary incident/allegation type (excluding *Not applicable* and *Not known*) (per cent)

	Primary incident/allegation type											
Clinical service context	**Procedure[(b)]**	**Diagnosis**	**Treatment[(c)]**	**General duty of care**	**Medication-related[(d)]**	**Consent[(e)]**	**Anaesthetic**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
General surgery	58.8	13.1	11.2	2.1	4.8	1.7	5.7	1.4	0.4	0.3	0.5	100.0
Obstetrics	46.3	20.3	20.7	3.7	2.4	0.8	2.3	1.1	0.9	0.0	1.6	100.0
Emergency department	5.6	52.6	26.1	6.1	5.1	0.9	0.3	0.8	1.0	0.2	1.4	100.0
Orthopaedics	49.9	14.1	15.6	5.5	2.2	3.3	2.6	4.0	0.0	1.7	1.1	100.0
Gynaecology	67.9	9.6	5.4	3.4	2.1	6.2	1.7	1.1	0.2	1.5	0.9	100.0
Psychiatry	2.2	10.1	31.0	38.6	6.6	2.7	0.3	0.0	1.4	0.0	7.1	100.0
General medicine	5.6	25.9	27.6	18.5	14.7	0.9	0.6	1.5	0.9	1.8	2.1	100.0
General practice	16.1	36.4	17.5	10.6	10.6	1.4	2.8	0.9	1.4	0.0	2.3	100.0
Paediatrics	22.2	39.5	18.6	4.2	9.0	1.2	1.2	1.2	0.0	0.0	3.0	100.0
Cardiology	35.1	23.2	17.9	6.6	6.0	2.0	4.0	2.0	0.7	2.0	0.7	100.0
All other clinical service contexts	29.6	21.2	18.7	8.5	4.3	4.4	2.3	2.4	5.2	0.8	2.5	100.0
Total	**35.2**	**23.5**	**18.6**	**7.6**	**4.9**	**2.3**	**2.5**	**1.6**	**1.4**	**0.6**	**1.8**	**100.0**

(a) The table excludes 13 closed claims that duplicate the clinical service context and primary incident/allegation type data recorded in another claim (see Box 2.1).

(b) *Procedure* includes failure to perform a procedure, wrong procedure performed, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(c) *Treatment* includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(d) *Medication-related* includes type, dosage and method of administration issues.

(e) *Consent* includes failure to warn.

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

2. The 169 claims coded *Not known* for 'primary incident/allegation type' and 212 claims coded *Not applicable* or *Not known* for 'clinical service context' are excluded from this table. The number of claims on which the percentages presented here are based is 6,860.

3. Percentages may not add up exactly to 100.0 due to rounding.

Principal clinician specialty

'Specialty of principal clinician closely involved in incident' indicates the specialty of the health-care provider who allegedly played the most prominent role in the events that gave rise to a claim. The specialties listed for claims closed from 2005–06 to 2009–10 (Table 5.3) differs slightly from the list for 2009–10 new claims (Table 3.3) owing to minor changes made for the clinician specialty categories to be reported with the 2009–10 data (Section 3.1).

The three most commonly recorded principal clinician specialties were *General surgery* (13%), *Emergency medicine* (11%) and *Obstetrics only* (9%). These specialties are related to the three most often recorded clinical service contexts (*General surgery*, *Emergency department* and *Obstetrics*) (Table 5.1). Ten further principal clinical specialties were recorded for 2% to 7% of claims. Generally, these specialties either relate to the clinical service contexts recorded for 2–8% of claims (for example, *Orthopaedic surgery* and *Gynaecology only*) or else are specialties which are practised across numerous clinician service contexts (for example *Nursing – general*).

The great majority of the clinical specialties were recorded for less than 1.5% of the claims closed over the 5 years leading up to and including 2009–10 (Table 5.3). Three specialties were not nominated as the principal clinician specialty in any claim, and 14 others were recorded fewer than 10 times.

Table 5.3 further relates principal clinician specialty data to the 'health-service setting' in which the alleged health-care incident giving rise to the claim occurred. More than 9 in 10 claims (94%) resulted from alleged incidents in public hospitals or day surgeries and therefore this was also the most frequently recorded health service setting for the majority of clinical specialties. The exception involved claims citing the specialty of *Clinical haematology*, of which 58% (51 of 88 claims) related to incidents that allegedly occurred in public health settings other than a hospital/day-surgery (accounting for 27% of claims in this setting). Also, 67 of the 72 claims (93%) within an other private setting cited the involvement of *General practice—non procedural* or *General practice—procedural* as the principal clinician specialty.

The percentages of claims closed between 2003–04 and 2007–08 (AIHW 2011a) associated with each principal clinician specialty are very similar to those reported in Table 5.3.

Specific primary incident/allegation types tended to be associated with particular clinical specialties, in ways that are generally similar to the previously noted associations between primary incident/allegation type and clinical service context. More than half of the claims whose recorded specialty was *Gynaecology only* (73%), *General surgery* (68%), *Obstetrics only (56%)* or *Orthopaedic surgery* (53%) had *Procedure* as their incident/allegation type (tables 5.4 and 5.5). The primary incident/allegation type *Diagnosis* was recorded for more than half of the claims whose principal clinician specialty was *Emergency medicine* (60%). *General duty of care* was recorded as the incident/allegation type for claims with a principal clinician specialty of *Psychiatry* (48%) or *General nursing* (46%). *Anaesthetics* was the primary incident/allegation type recorded for almost two-thirds of claims (62%) where it was also the principal clinician specialty. Similar associations were observed for the claims closed between 2003–04 and 2007–08 (AIHW 2011a).

Table 5.3: Closed claims, 2005–06 to 2009–10[a]: principal clinician specialty, by health service setting

	Health service setting						
Principal clinician specialty	Public hospital/ day surgery[b]	Other public setting[c]	Private hospital/day surgery[d]	Other private setting[e]	Other[f]	Total	Per cent
General surgery	906	2	3	1	0	912	12.8
Emergency medicine	765	5	2	0	0	772	10.8
Obstetrics only	613	1	7	0	0	625	8.8
Orthopaedic surgery	520	2	2	0	0	526	7.4
Gynaecology only	325	1	0	0	7	334	4.7
General practice—non-procedural	251	6	1	53	2	321	4.5
Psychiatry	259	10	1	1	21	294	4.1
Obstetrics and gynaecology	288	2	2	0	1	293	4.1
General practice—procedural	222	3	0	14	0	239	3.4
Nursing—general	201	9	3	0	0	214	3.0
Anaesthetics	189	0	0	0	2	192	2.7
General and internal medicine	127	3	0	0	0	130	1.8
Diagnostic radiology	110	12	0	0	0	123	1.7
Cardiology	99	0	0	0	0	99	1.4
Urology	94	0	2	1	0	97	1.4
Ophthalmology	89	1	0	0	0	90	1.3
Clinical haematology	37	51	0	0	0	88	1.2
Pathology	79	8	0	0	0	87	1.2
Paediatric medicine	82	1	1	0	0	85	1.2
Neurosurgery	82	0	1	0	0	83	1.2
Nursing—nurse practitioner	67	3	1	0	1	72	1.0
Dentistry	52	14	0	0	0	66	0.9
Intensive care	64	0	0	0	0	64	0.9
Midwifery	58	0	0	0	2	60	0.8
Otolaryngology	57	0	0	0	0	57	0.8
Plastic and reconstructive surgery	55	0	1	0	0	56	0.8
Gastroenterology and hepatology	53	0	0	0	0	53	0.7
Vascular surgery	52	0	0	0	0	52	0.7
Oral and maxillofacial surgery	48	3	0	0	0	51	0.7
Paediatric surgery	47	0	0	0	0	47	0.7
Colorectal surgery	47	0	0	0	0	47	0.7
Neonatology	46	0	0	0	0	46	0.6
Cardio-thoracic surgery	45	0	0	0	0	45	0.6
Neurology	39	0	0	0	1	40	0.6
Medical oncology	34	2	0	0	0	36	0.5
Paramedic and ambulance staff	14	10	0	0	11	35	0.5
Clinical immunology	32	0	1	0	0	33	0.5
Psychology	23	3	0	1	0	27	0.4
Renal medicine	17	1	0	0	0	18	0.3
Infectious diseases	16	0	0	0	0	16	0.2

(continued)

Table 5.3 (continued): Closed claims, 2005–06 to 2009–10[a]: principal clinician specialty, by health service setting

	Health service setting						
Principal clinician specialty	Public hospital/day surgery[b]	Other public setting[c]	Private hospital/day surgery[d]	Other private setting[e]	Other[f]	Total	Per cent
Physiotherapy	13	2	0	0	0	15	0.2
Respiratory and sleep medicine	15	0	0	0	0	15	0.2
Endocrinology	13	1	0	0	0	14	0.2
Nuclear medicine	13	0	0	0	0	13	0.2
Geriatrics	8	2	0	0	0	10	0.1
Public health	4	5	0	0	0	9	0.1
Endoscopy	8	0	0	0	0	8	0.1
Clinical genetics	4	2	0	1	0	7	0.1
Podiatry	6	1	0	0	0	7	0.1
Therapeutic radiology	7	0	0	0	0	7	0.1
Cosmetic surgery	7	0	0	0	0	7	0.1
Rehabilitation medicine	5	0	0	0	1	6	0.1
Spinal surgery	5	0	0	0	0	5	0.1
Dermatology	4	0	0	0	0	4	0.1
Pharmacy	3	0	0	0	0	3	<0.1
Rheumatology	3	0	0	0	0	3	<0.1
Clinical pharmacology	1	0	0	0	0	1	<0.1
Chiropractics	0	0	1	0	0	1	<0.1
Occupational medicine	1	0	0	0	0	1	<0.1
Nutrition/dietician	0	0	0	0	0	0	0.0
Osteopathy	0	0	0	0	0	0	0.0
Sports medicine	0	0	0	0	0	0	0.0
Other allied health	21	13	0	0	2	37	0.5
Other hospital-based practitioner	145	2	0	0	0	148	2.1
Not applicable[g]	63	5	0	0.	3	71	1.0
Total	**6,663**	**189**	**30**	**72**	**54**	**7,119**	**100.0**
Per cent	**93.6**	**2.7**	**0.4**	**1.0**	**0.8**	**100.0**	**. .**

(a) The table excludes 13 closed claims that duplicate the principal clinician specialty and health service setting data recorded in another claim (see Box 2.1).

(b) Includes public psychiatric hospitals.

(c) Includes public community health centres, residential aged care services, hospices, and alcohol and drug rehabilitation centres.

(d) Includes private psychiatric hospitals.

(e) Includes private clinics providing investigation and treatment on a non-residential, day-only basis, private hospices, and private alcohol and drug rehabilitation centres.

(f) Includes patient's home and Medihotels. Medihotels provide accommodation and hotel services suited to recipients of acute health-care services who are able to care for themselves and are making the transition between the community and the acute hospital sector (Victorian Department of Health 2009).

(g) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Note: There were 202 claims coded *Not known* for 'principal clinician specialty' and 111 claims coded *Not known* for 'health service setting', including 88 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the numbers are included in the totals.

Table 5.4: Closed claims, 2005–06 to 2009–10[a]: principal clinician specialty, by primary incident/allegation type

	Primary incident/allegation type											
Principal clinician specialty	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Consent**	**Anaesthetic**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
Emergency medicine	35	457	177	37	29	6	2	8	4	2	10	772
General surgery	614	125	86	13	20	19	12	15	2	1	1	912
Obstetrics only	342	98	129	16	10	5	4	5	3	0	3	625
Orthopaedic surgery	275	82	83	13	14	17	5	19	0	9	5	526
Gynaecology only	244	28	13	14	6	20	0	1	0	7	1	334
General practice—non-procedural	42	110	74	23	36	4	7	4	8	0	7	321
Psychiatry	4	25	84	138	17	2	0	0	2	0	18	294
Obstetrics and gynaecology	137	55	64	10	2	9	1	4	2	0	7	293
General nursing	10	14	52	97	19	2	1	6	0	5	7	214
Anaesthetics	31	8	14	7	6	2	118	0	2	0	2	192
General practice—procedural	88	75	46	6	14	2	5	1	0	0	0	239
General and internal medicine	13	39	35	11	24	0	0	3	0	3	1	130
All other specialties	566	489	397	128	141	75	15	38	80	13	46	1,994
Not applicable[b]	10	7	10	10	4	4	1	4	0	0	20	71
Total	**2,436**	**1,626**	**1,282**	**535**	**347**	**169**	**172**	**109**	**103**	**40**	**131**	**7,119**

(a) The table excludes 13 closed claims that duplicate the principal clinician specialty and primary incident/allegation type data recorded in another claim (see Box 2.1).

(b) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Notes

1. The principal clinician specialties presented in this table are the 12 most frequently recorded categories. All other categories (see Table 5.3) are included under *All other specialties*.
2. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 5.1.
3. There were 202 claims coded *Not known* for 'principal clinician specialty' and 169 claims coded *Not known* for 'primary incident/allegation type', including 121 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the figures are included in the totals.

Table 5.5: Closed claims, 2005–06 to 2009–10[(a)]: principal clinician specialty, by primary incident/allegation type (excluding *Not applicable* and *Not known*) (per cent)

	Primary incident/allegation type											
Principal clinician specialty	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Consent**	**Anaesthetic**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
Emergency medicine	4.6	59.6	23.1	4.8	3.8	0.8	0.3	1.0	0.5	0.3	1.3	100.0
General surgery	67.6	13.8	9.5	1.4	2.2	2.1	1.3	1.7	0.2	0.1	0.1	100.0
Obstetrics only	55.6	15.9	21.0	2.6	1.6	0.8	0.7	0.8	0.5	0.0	0.5	100.0
Orthopaedic surgery	52.7	15.7	15.9	2.5	2.7	3.3	1.0	3.6	0.0	1.7	1.0	100.0
Gynaecology only	73.1	8.4	3.9	4.2	1.8	6.0	0.0	0.3	0.0	2.1	0.3	100.0
General practice—non-procedural	13.3	34.9	23.5	7.3	11.4	1.3	2.2	1.3	2.5	0.0	2.2	100.0
Psychiatry	1.4	8.6	29.0	47.6	5.9	0.7	0.0	0.0	0.7	0.0	6.2	100.0
Obstetrics and gynaecology	47.1	18.9	22.0	3.4	0.7	3.1	0.3	1.4	0.7	0.0	2.4	100.0
General nursing	4.7	6.6	24.4	45.5	8.9	0.9	0.5	2.8	0.0	2.3	3.3	100.0
Anaesthetics	16.3	4.2	7.4	3.7	3.2	1.1	62.1	0.0	1.1	0.0	1.1	100.0
General practice—procedural	37.1	31.6	19.4	2.5	5.9	0.8	2.1	0.4	0.0	0.0	0.0	100.0
General and internal medicine	10.1	30.2	27.1	8.5	18.6	0.0	0.0	2.3	0.0	2.3	0.8	100.0
All other specialties	28.5	24.6	20.0	6.4	7.1	3.8	0.8	1.9	4.0	0.7	2.3	100.0
Total	**35.3**	**23.6**	**18.4**	**7.5**	**5.0**	**2.4**	**2.5**	**1.5**	**1.5**	**0.6**	**1.6**	**100.0**

(a) The table excludes 13 closed claims that duplicate the principal clinician specialty and primary incident/allegation type data recorded in another claim (see Box 2.1).

Notes

1. The principal clinician specialties presented in this table are the 12 most frequently recorded categories. All other categories (see Table 5.3) are included under *All other specialties*.
2. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 5.1.
3. The 273 claims coded *Not applicable* or *Not known* for 'principal clinician specialty' and 169 claims coded *Not known* for 'primary incident/allegation type' are excluded from this table. The number of claims on which the percentages presented here are based is 6,799.
4. Percentages may not add up exactly to 100.0 due to rounding.

Primary body function/structure affected

'Primary body function/structure affected' specifies the main body function or structure of the claim subject allegedly affected by a health-care incident. *Death* is recorded for this data item if the claim subject died, while allowance is also made for claims not alleged to involve any body function/structure.

Between 2005–06 and 2009–10 the most frequently affected primary body function/structure recorded for closed claims was *Neuromusculoskeletal and movement-related,* which accounted for 23% of all closed claims (tables 5.6 and 5.7). Other frequently recorded body function/structure categories included *Mental and nervous system*, *Genitourinary and reproductive* and *Digestive, metabolic and endocrine systems,* accounting for 19%, 14% and 13% respectively of claims. *Death* was recorded for 16% of claims.

Orthopaedics claims, and to a lesser degree *Emergency department* claims, had a strong association with *Neuromusculoskeletal and movement-related* effects. This was the body function/structure category recorded for 82% of *Orthopaedics* claims and 31% of *Emergency department* claims, compared with 23% of claims overall (Table 5.7). *Obstetrics* and *Psychiatry* claims, however, were more closely associated with effects on the *Mental and nervous system*, involving more than one-third of the claims for these two clinical service contexts (*Obstetrics* 42%, *Psychiatry* 45%, compared with 19% of claims overall). *Genitourinary and reproductive* effects were strongly related to *Gynaecology* and *Obstetrics* claims (*Gynaecology 67%*, *Obstetrics* 26%, compared with 14% of claims overall). *General surgery* claims were quite strongly linked to *Digestive, metabolic and endocrine systems* effects (37% of *General surgery* claims were recorded in this body function/structure category, compared with 13% of claims overall).

An outcome involving the claim subject's death was more commonly a feature of claims in the clinical service contexts of *Psychiatry* (42%), *Cardiology* (37%) and *Emergency department* (25%) than other clinical service contexts.

Table 5.6: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context, by primary body function/structure affected

	Primary body function/structure affected											
Clinical service context	**Neuromusculo-skeletal and movement-related**	**Mental and nervous system**	**Genitourinary and reproductive**	**Digestive, metabolic and endocrine systems**	**Cardiovascular, haematological, immunological and respiratory**	**Skin and related structures**	**Sensory, including eye and ear**	**Voice and speech**	**Death**	**No body function/ structure affected**	**Not known**	**Total**
General surgery	179	88	129	475	83	104	35	32	165	15	18	1,323
Emergency department	312	167	48	67	77	48	31	7	255	10	27	1,049
Obstetrics	104	417	262	26	40	20	5	1	116	28	49	1,068
Orthopaedics	444	22	2	8	28	18	2	1	17	1	6	549
Gynaecology	12	38	279	56	8	6	0	2	18	45	3	467
Psychiatry	34	151	1	4	2	1	0	1	141	21	13	369
General medicine	76	66	4	31	35	28	12	1	84	3	2	342
General practice	45	40	15	23	19	17	7	5	36	3	13	223
Paediatrics	26	43	11	17	12	6	8	0	36	6	3	168
Cardiology	10	19	2	8	48	2	1	3	55	2	1	151
All other clinical service contexts	234	165	136	120	127	68	116	59	108	21	44	1,198
Not applicable[(b)]	0	0	0	0	1	1	0	0	0	0	0	2
Not known	18	14	4	16	6	4	3	4	15	1	125	210
Total	**1,494**	**1,230**	**893**	**851**	**486**	**323**	**220**	**116**	**1,046**	**156**	**304**	**7,119**

(a) The table excludes 13 closed claims that duplicate the clinical service context and primary body function/structure affected data recorded in another claim (see Box 2.1).

(b) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Notes

1. See Appendix 5 for specific examples of types of alleged harm for each of the body function/structure categories.

2. The 'clinical service context' categories listed separately here are the 10 most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

Table 5.7: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context, by primary body function/structure affected (excluding *Not applicable* and *Not known*) (per cent)

	Primary body function/structure affected									
Clinical service context	**Neuromusculo-skeletal and movement-related**	**Mental and nervous system**	**Genitourinary and reproductive**	**Digestive, metabolic and endocrine systems**	**Cardiovascular, haematological, immunological and respiratory**	**Skin and related structures**	**Sensory, including eye and ear**	**Voice and speech**	**Death**	**Total**
General surgery	13.9	6.8	10.0	36.8	6.4	8.1	2.7	2.5	12.8	100.0
Emergency department	30.8	16.5	4.7	6.6	7.6	4.7	3.1	0.7	25.2	100.0
Obstetrics	10.5	42.1	26.4	2.6	4.0	2.0	0.5	0.1	11.7	100.0
Orthopaedics	81.9	4.1	0.4	1.5	5.2	3.3	0.4	0.2	3.1	100.0
Gynaecology	2.9	9.1	66.6	13.4	1.9	1.4	0.0	0.5	4.3	100.0
Psychiatry	10.1	45.1	0.3	1.2	0.6	0.3	0.0	0.3	42.1	100.0
General medicine	22.6	19.6	1.2	9.2	10.4	8.3	3.6	0.3	24.9	100.0
General practice	21.7	19.3	7.2	11.1	9.2	8.2	3.4	2.4	17.4	100.0
Paediatrics	16.4	27	6.9	10.7	7.5	3.8	5.0	0.0	22.6	100.0
Cardiology	6.8	12.8	1.4	5.4	32.4	1.4	0.7	2.0	37.2	100.0
All other clinical service contexts	20.7	14.6	12.0	10.6	11.2	6.0	10.2	5.2	9.5	100.0
Total	**22.5**	**18.5**	**13.5**	**12.7**	**7.3**	**4.8**	**3.3**	**1.7**	**15.7**	**100.0**

(a) The table excludes 13 closed claims that duplicate the clinical service context and primary body function/structure affected data recorded in another claim (see Box 2.1).

Notes

1. The 'clinical service context' categories listed separately here are the 10 most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. The 212 claims coded *Not Applicable* or *Not known* for 'clinical service context' and 304 claims coded *Not known* for 'primary body function/structure affected', including 125 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 6,573.
3. Percentages may not add up exactly to 100.0 due to rounding.

Claim subject patient admission status

'Claim subject status' indicates whether the status of the claim subject, at the time of the alleged health-care incident, was a public or private admitted hospital patient, or a resident in a residential health-care setting, or *Other* (Box 5.1).

More than three-quarters (79%) of the claim subjects in a medical indemnity claim closed between 2005–06 and 2009–10 were reported to have been public admitted patients (Table 5.8). The majority of the remainder were private admitted patients (4%) or belonged to the *Other* category (12%). Patients admitted to a public hospital can elect to be treated as either a public or a private patient. *Public hospital/day surgery* was the 'health service setting' recorded for almost all claims (99.9%) involving public admitted hospital patients and most claims (92%) involving private admitted hospital patients. The other health service setting recorded for public and private hospital patients was *Private hospital/day surgery*.

Other public setting was the health-service setting for more than three-quarters (79%) of claims with a subject who was a resident, while *Public hospital/day surgery* was the health-service setting for two-thirds of claims (66%) where the status of the subject was *Other* (Table 5.8). In the case of claims with known 'claim subject's status' and 'clinical service context', just over two-fifths (44%) of those involving *Other* claim subjects had an *Emergency department* clinical service context (Table 5.9).

There are only minor differences between the distributional data reported here and that for claims closed between 2003–04 and 2007–08 (AIHW 2011a).

Box 5.1: Claim subject's status

The purpose of this data item is to record whether the patient (claim subject) was a public admitted hospital patient, private admitted hospital patient, resident or non-admitted patient (*Other*) at the time of the alleged incident.

The MINC definition of a *public admitted hospital patient* is a person, enrolled in Medicare who, on admission to a recognised hospital or soon after, receives, or elects to receive, a public hospital service free of charge. This includes patients for whom treatment is contracted to a private hospital.

The MINC definition of a *private admitted hospital patient* is more wide-ranging. It includes a person who, on admission to a recognised hospital or soon after, elects to be a private patient treated by a medical practitioner of their choice, or elects to occupy a bed in a single room, or who chooses to be admitted to a private hospital. The definition also includes Department of Veterans' Affairs patients, and 'compensable patients' who are entitled to claim damages under motor vehicle third party insurance, worker's compensation, public liability or common law damages.

The MINC definition of a *hospital patient* (whether publicly or privately admitted) includes persons receiving long-term nursing or respite care in a recognised hospital, including psychiatric hospitals. It also includes persons admitted to the hospital from its Emergency department, based on admission criteria that vary between jurisdictions (AIHW 2011b: 61).

The MINC definition of a *resident* includes patients in a residential aged care or mental health establishment or a similar residential health-care setting at the time of the incident. The definition excludes residential patients in a recognised hospital.

The MINC definition for *Other* covers patients attending an outpatient clinic, general practitioner surgery, Emergency department (if not an admitted patient at the time of the incident) or similar non-admitted, non-residential service. This definition would also cover patients waiting to receive a health-care service or being transported to a health-care facility if they were not already an admitted hospital patient or resident.

Table 5.8: Closed claims, 2005–06 to 2009–10[a]: health service setting, by claim subject's status

Health service setting	Claim subject's status						
	Public admitted hospital patient	Private admitted hospital patient	Resident	Other	Not known	Total	Per cent
Public hospital/ day surgery[b]	5,619	253	0	556	235	6,663	*93.6*
Other public setting[c]	0	0	11	171	7	189	*2.7*
Private hospital/day surgery[d]	6	22	0	2	0	30	*0.4*
Other private setting[e]	0	0	0	71	1	72	*1.0*
Other[f]	0	0	3	45	6	54	*0.8*
Not known	0	0	0	5	106	111	*1.6*
Total	**5,625**	**275**	**14**	**850**	**355**	**7,119**	**100.0**
Per cent	*79.0*	*3.9*	*0.2*	*11.9*	*5.0*	*100.0*	*. .*
	Per cent (excluding *Not known*)						
Public hospital/day surgery[b]	99.9	92.0	0.0	65.8	. .	95.1	. .
Other public setting[c]	0.0	0.0	78.6	20.2	. .	2.7	. .
Private hospital/day surgery[d]	0.1	8.0	0.0	0.2	. .	0.4	. .
Other private setting[e]	0.0	0.0	0.0	8.4	. .	1.1	. .
Other[f]	0.0	0.0	21.4	5.3	. .	0.7	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

. . Not applicable.

(a) The table excludes 13 closed claims that duplicate the health service setting and claim subject's status data recorded in another claim (see Box 2.1).

(b) Includes public psychiatric hospitals.

(c) Includes public community health centres, residential aged care services, hospices, and alcohol and drug rehabilitation centres.

(d) Includes private psychiatric hospitals.

(e) Includes private clinics providing investigation and treatment on a non-residential, day-only basis, private hospices, and private alcohol and drug rehabilitation centres.

(f) Includes patient's home and Medihotels.

Note: The 111 claims coded *Not known* for 'health service setting' and 355 coded *Not known* for 'claim subject's status', including 106 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented here are based is 6,759.

Table 5.9: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context, by claim subject's status

Clinical service context	Claim subject's status					Total	Per cent
	Public admitted hospital patient	Private admitted hospital patient	Resident	Other	Not known		
General surgery	1,222	40	1	17	43	1,323	18.6
Emergency department	629	39	0	370	11	1,049	14.7
Obstetrics	944	56	1	20	47	1,068	15.0
Orthopaedics	501	24	0	8	16	549	7.7
Gynaecology	423	9	0	14	21	467	6.6
Psychiatry	259	17	3	73	17	369	5.2
General medicine	281	17	1	20	23	342	4.8
General practice	135	15	0	64	9	223	3.1
Paediatrics	154	7	0	3	4	168	2.4
Cardiology	132	10	0	6	3	151	2.1
All other clinical service contexts	861	34	8	248	47	1,198	16.8
Not applicable	1	0	0	1	0	2	0.0
Not known	83	7	0	6	114	210	2.9
Total	**5,625**	**275**	**14**	**850**	**355**	**7,119**	**100.0**
	Per cent (excluding *Not applicable* and *Not known*)						
General surgery	22.1	14.9	7.1	2.0	. .	19.2	. .
Emergency department	11.4	14.6	0.0	43.9	. .	15.6	. .
Obstetrics	17.0	20.9	7.1	2.4	. .	15.3	. .
Orthopaedics	9.0	9.0	0.0	0.9	. .	8.0	. .
Gynaecology	7.6	3.4	0.0	1.7	. .	6.7	. .
Psychiatry	4.7	6.3	21.4	8.7	. .	5.3	. .
General medicine	5.1	6.3	7.1	2.4	. .	4.8	. .
General practice	2.4	5.6	0.0	7.6	. .	3.2	. .
Paediatrics	2.8	2.6	0.0	0.4	. .	2.5	. .
Cardiology	2.4	3.7	0.0	0.7	. .	2.2	. .
All other clinical service contexts	15.5	12.7	57.1	29.4	. .	17.3	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

(a) The table excludes 13 closed claims that duplicate the clinical service context and claim subject's status data recorded in another claim (see Box 2.1).

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. The 210 claims coded *Not known* for 'clinical service context' and 355 coded *Not known* for 'claim subject 's status', including 114 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented here are based is 6,666.
3. Percentages may not add up exactly to 100.0 due to rounding.

Geographic location

The Australian Standard Geographical Classification Remoteness Structure is used to categorise the 'geographic location' of an alleged health-care incident. Almost two-thirds (63%, or 4,507 claims) closed between 2005–06 and 2009–10 arose from incidents occurring in *Major cities*. The corresponding figure for *Inner regional* areas was 26%, or 1,869 claims. Another 9%, or 604 claims, arose in *Outer regional* areas and 2%, or 116 claims, arose in *Remote and very remote* areas (Table 5.10).

The principal clinician speciality recorded for a claim varied to some degree according to geographic location. *Emergency medicine* and *Obstetrics only* were the most common specialties for claims related to alleged incidents in *Major cities* (12% and 10% respectively). *General surgery* was the specialty most frequently associated with claims arising from alleged incidents in *Inner regional* (29%), *Outer regional* (12%) and *Remote and very remote* areas (18%).

In every geographic location the proportions of closed claims associated with the principal clinician specialty *General practice – non-procedural* were higher between 2005–06 and 2009–10 than between 2003–04 and 2007–08 (AIHW 2011a). The number of these claims was also higher for *Major cities*, *Outer regional* and *Remote and very remote* areas but not for *Inner regional* areas.

Table 5.10: Closed claims, 2005–06 to 2009–10[a]: principal clinician specialty, by geographic location

Principal clinician specialty[c]	Geographic location[b]					
	Major cities	Inner regional	Outer regional	Remote and very remote	Not known	Total
General surgery	284	536	72	20	0	912
Emergency medicine	500	192	63	17	0	772
Obstetrics only	445	121	42	14	3	625
Orthopaedic surgery	312	149	52	12	1	526
Gynaecology only	216	85	29	4	0	334
General practice—non-procedural	132	123	61	5	0	321
Psychiatry	230	48	15	1	0	294
Obstetrics and gynaecology	211	51	29	2	0	293
General nursing	144	47	16	7	0	214
Anaesthetics	128	49	15	0	0	192
General practice—procedural	109	75	43	11	1	239
General and internal medicine	80	35	12	3	0	130
All other specialties	1,520	319	133	15	7	1,994
Not applicable[d]	57	8	6	0	0	71
Not known	139	31	16	5	11	202
Total	**4,507**	**1,869**	**604**	**116**	**23**	**7,119**
Per cent	*63.3*	*26.3*	*8.5*	*1.6*	*0.3*	*100.0*
	Per cent (excluding *Not applicable* and *Not known*)					
General surgery	6.6	29.3	12.4	18.0	. .	13.3
Emergency medicine	11.6	10.5	10.8	15.3	. .	11.3
Obstetrics only	10.3	6.6	7.2	12.6	. .	9.1
Orthopaedic surgery	7.2	8.1	8.9	10.8	. .	7.7
Gynaecology only	5.0	4.6	5.0	3.6	. .	4.9
General practice—non-procedural	3.1	6.7	10.5	4.5	. .	4.7
Psychiatry	5.3	2.6	2.6	0.9	. .	4.3
Obstetrics and gynaecology	4.9	2.8	5.0	1.8	. .	4.3
General nursing	3.3	2.6	2.7	6.3	. .	3.1
Anaesthetics	3.0	2.7	2.6	0.0		2.8
General practice—procedural	2.5	4.1	7.4	9.9	. .	3.5
General and internal medicine	1.9	1.9	2.1	2.7	. .	1.9
All other specialties	35.3	17.4	22.9	13.5	. .	29.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

. . Not applicable.

(a) The table excludes 13 closed claims that duplicate the principal clinician specialty and geographic location data recorded in another claim (see Box 2.1).

(b) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2006).

(c) The principal clinician specialties presented in this table are the 12 most frequently recorded categories. All other categories (see Table 5.3) are included under *All other specialties*.

(d) Indicates that no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff).

Notes

1. The 273 claims coded *Not applicable* or *Not known* for 'principal clinician specialty' and 23 claims coded *Not known* for 'geographic location', including 11 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 6,834.
2. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

5.2 Administrative and financial characteristics of closed claims

This section summarises the administrative and financial characteristics of claims that were closed between 2005–06 and 2009–10 (excluding any claims reopened as at 30 June 2010). Data presentation is focused on relating 'total claim size' to the duration of the claims, the manner in which they were closed, the 'primary incident/allegation type' and the categories of loss claimed. 'Total claim size' includes any legal and investigative costs as well as any payment made to the claimant(s). The duration of a claim is measured from the date of reserve placement to when the claim was closed.

Length and cost of claims

The length of time taken to finalise claims was generally longer for larger settlements (Table 5.11; Figure 5.1). More than half of claims with a claim size up to $100,000 (3,128 of 5,526 claims, 57%), which made up 77% of closed claims, had been closed within 2 years of when the reserve was set. Claims settled for $100,000 or more were comparatively rare, especially those settled for $500,000 or more (6%), but they took a relatively long time to finalise. The most common length of time taken to finalise claims settled for $100,000–<$500,000 was 25–36 months, and more than 60 months (5 years) in the case of claims settled for $500,000 or more.

A relationship between claim size and length of claim was also observed for claims closed between 2003–04 and 2007–08 (AIHW 2011a), even though a noticeably larger proportion of those claims, 30%, had been closed for nil cost (see Box 3.1).

Table 5.11: Closed claims, 2005–06 to 2009–10: length of claim (months), by total claim size ($)

	Total claim size ($)					
Length of claim	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**
12 or less	213	957	391	56	7	1,632
13–24	149	867	551	222	39	1,838
25–36	91	519	390	275	66	1,343
37–48	52	279	302	217	73	928
49–60	15	120	161	160	74	531
>60	56	143	270	229	160	860
Total	**576**	**2,885**	**2,065**	**1,159**	**419**	**7,132**
Per cent	*8.1*	*40.5*	*29.0*	*16.3*	*5.9*	*100.0*
	Per cent (excluding *Not known*)					
12 or less	37.0	33.2	18.9	4.8	1.7	22.9
13–24	25.9	30.1	26.7	19.2	9.3	25.7
25–36	15.8	18.0	18.9	23.7	15.8	18.9
37–48	9.0	9.7	14.6	18.7	17.4	13.0
49–60	2.6	4.2	7.8	13.8	17.7	7.5
>60	9.7	5.0	13.1	19.8	38.2	12.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

. . Not applicable.

Notes

1. There were 28 claims coded *Not known* for 'total claim size'. These claims are included in the total number of 7,132 closed claims even though the *Not known* column is not presented. The percentages shown in the bottom half of the table are based on the 7,104 claims with known claim size.
2. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

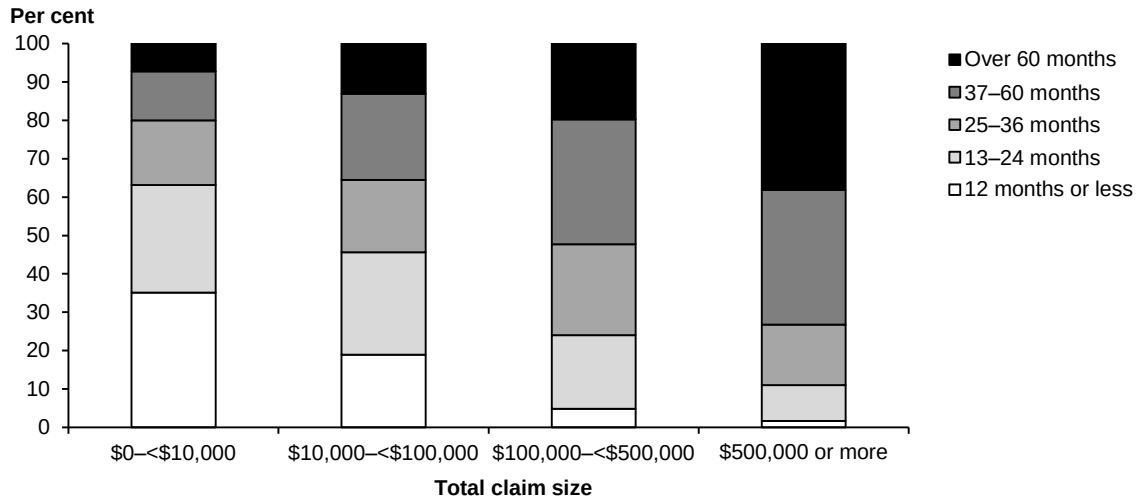


Figure 5.1: Closed claims, 2005–06 to 2009–10: length of claim (months), by total claim size (per cent)

Mode of settlement

'Mode of settlement' describes the process by which a claim was closed. Claims may be closed through state/territory-based complaints processes, court-based processes and 'Other' processes (which include cases where a claim is settled part way through a trial) or may be discontinued (Section 4.5).

Between 2005–06 and 2009–10, 3,054 (43%) of all closed claims were finalised through being *Discontinued* (tables 5.12 and 5.13). Discontinued claims accounted for about three-quarters of claims closed for no cost (73%) or a cost under $10,000 (75%). Discontinued claims were similar to other claims in terms of length of claim, with 55% (1,681 of 3,054) closed within 2 years compared with the corresponding proportion of 49% for all closed claims.

The mode which generally took the shortest time was settlement through *State/territory-based complaints processes*. Although only a relatively small proportion (6%) were settled in this way, half of them (50%) were finalised within a year and 81% (324 of 399) within 2 years. The majority of these claims (59%) were settled for $10,000–<$100,000.

Settlement through a *Statutorily mandated compulsory conference process* was effected for a small proportion of claims (2%). More than half of these claims (71 of 124, 57%) were settled for at least $100,000, and two in three (66%) took more than 2 years to be closed.

Settlement through a *Court decision* was also a comparatively rare event, with 4% of closed claims finalised through this mode. During the same period, more than twice as many claims were finalised as a result of *Court-based alternative dispute resolution processes*, and more than 8 times as many were *Settled – other*. Claims settled through court-based alternative dispute resolution processes were the category with the largest proportion settled for $500,000 or more (100 of 660, 15%) and the largest proportion that took more than 5 years to close (23%).

Table 5.12: Closed claims, 2005–06 to 2009–10: mode of settlement, by total claim size ($)

	Total claim size ($)						
Mode of settlement	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**	**Per cent**
Discontinued	405	2,148	475	22	1	3,054	*42.8*
Settled—state/territory-based complaints processes	21	114	237	27	0	399	*5.6*
Settled—court-based alternative dispute resolution processes	7	21	256	276	100	660	*9.3*
Settled—statutorily mandated compulsory conference process	0	1	52	56	15	124	*1.7*
Settled—other	112	539	904	725	274	2,554	*35.8*
Court decision	9	61	140	53	29	292	*4.1*
Total	**576**	**2,885**	**2,065**	**1,159**	**419**	**7,132**	**100.0**
Per cent	*8.1*	*40.5*	*29.0*	*16.3*	*5.9*	*100.0*	*. .*
	Per cent (excluding *Not known*)						
Discontinued	73.1	74.5	23.0	1.9	0.2	43.1	. .
Settled—state/territory-based complaints processes	3.8	4.0	11.5	2.3	0.0	5.6	. .
Settled—court-based alternative dispute resolution processes	1.3	0.7	12.4	23.8	23.9	9.3	. .
Settled—statutorily mandated compulsory conference process	0.0	<0.1	2.5	4.8	3.6	1.8	. .
Settled—other	20.2	18.7	43.8	62.6	65.4	36.1	. .
Court decision	1.6	2.1	6.8	4.6	6.9	4.1	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**

. . Not applicable.

Notes

1. There were 49 claims coded *Not known* for 'mode of settlement' and 28 claims coded *Not known* for 'total claim size', including 25 coded *Not known* for both. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 7,080.
2. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

Table 5.13: Closed claims, 2005–06 to 2009–10: mode of settlement, by length of claim (months)

	Length of claim							
Mode of settlement	**<13**	**13–24**	**25–36**	**37–48**	**49–60**	**>60**	**Total**	**Per cent**
Discontinued	770	911	619	348	166	240	3,054	*42.8*
Settled—state/territory-based complaints processes	199	125	49	17	8	1	399	*5.6*
Settled—court-based alternative dispute resolution processes	46	124	130	128	80	152	660	*9.3*
Settled—statutorily mandated compulsory conference process	16	26	34	26	13	9	124	*1.7*
Settled—other	536	561	450	355	239	413	2,554	*35.8*
Court decision	48	77	56	42	25	44	292	*4.1*
Total	**1,632**	**1,838**	**1,343**	**928**	**531**	**860**	**7,132**	**100.0**
Per cent	*22.9*	*25.8*	*18.8*	*13.0*	*7.4*	*12.1*	*100.0*	. .
	Per cent (excluding *Not known*)							
Discontinued	25.2	29.8	20.3	11.4	5.4	7.9	100.0	. .
Settled—state/territory-based complaints processes	49.9	31.3	12.3	4.3	2.0	0.3	100.0	. .
Settled—court-based alternative dispute resolution processes	7.0	18.8	19.7	19.4	12.1	23.0	100.0	. .
Settled—statutorily mandated compulsory conference process	12.9	21.0	27.4	21.0	10.5	7.3	100.0	. .
Settled—other	21.0	22.0	17.6	13.9	9.4	16.2	100.0	. .
Court decision	16.4	26.4	19.2	14.4	8.6	15.1	100.0	. .
Total	**22.8**	**25.8**	**18.9**	**12.9**	**7.5**	**12.1**	**100.0**	**. .**

. . Not applicable.

Notes

1. There were 49 claims coded *Not known* for 'mode of settlement'. These claims are included in the total number of 7,132 closed claims even though the *Not known* row is not presented. The percentages shown in the bottom half of the table are based on the 7,083 claims with known mode of settlement.
2. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

In comparison, 10% of *Court decision* claims (29 of 292) were settled for $500,000 or more and 15% took more than 5 years to close.

Comparisons with the published data for claims closed between 2003–04 and 2007–08 (AIHW 2011a) are difficult to make because of the much larger number (2,656 claims) reported to have been discontinued for nil costs (see Box 3.1).

Clinical service context and cost of claims

Claims closed between 2005–06 and 2009–10 showed some differences in claim size by clinical service context (Table 5.14). The proportion of claims closed for nil cost or less than $10,000 varied between 42% for *Cardiology* and 55% for *Obstetrics*. *Obstetrics* and *Paediatrics* were the two clinical service contexts with the highest proportion settled for $500,000 or more—12% in both cases, contrasting with 3% of *General surgery* and 1% of *Gynaecology* claims settled for $500,000 or more.

Claims closed between 2003–04 and 2007–08 showed the same tendency for relatively high proportions of *Obstetrics* and *Paediatrics* claims and low proportions of *General surgery* and *Gynaecology* claims that cost at least $500,000 to close (AIHW 2011a).

Primary incident/allegation type, primary body function/structure affected and cost of claims

The costs involved in settling public sector medical indemnity claims varied depending on the 'primary incident/allegation type' and the 'primary body function/structure affected'.

Between 2005–06 and 2009–10, a higher proportion of the claims with the primary incident/allegation types of *Diagnosis* (9%) and *Medication-related* (8%) had a claim size of $500,000 or more, compared with claims that had other primary incident/allegation types (0–6%). Claims with a primary incident/allegation type of *Blood/blood-product related* were the least costly overall, with 45% closed for nil cost and nearly half of the remainder closed for less than $10,000 (Table 5.15). These same relationships between primary incident/allegation type and claim size were apparent for claims closed between 2003–04 and 2007–08 (AIHW 2011a).

Claim sizes varied notably with the claim subject's 'primary body function/structure affected' for claims closed between 2005–06 and 2009–10 (Table 5.16). Similar to 2003–04 to 2007–08 closed claims (AIHW 2011a), the *Mental and nervous system* category recorded a gradual increase in the proportion of claims in each size category from nil cost to $100,000–<$500,000 (14% to 18% of claims) and was the category with the highest proportion of claims for $500,000 or more (44%). The categories *Skin and related structures* and *Voice and speech* showed the opposite trend in accounting for a decreasingly smaller proportion of claims as claim size increased. The *Neuromusculoskeletal and movement-related category* was recorded for between 20% and 28% of claims in each size category.

Table 5.14: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context, by total claim size ($)

Clinical service context	Total claim size ($)									
	Nil	1–<10,000	10,000–<30,000	30,000–<50,000	50,000–<100,000	100,000–<250,000	250,000–<500,000	500,000 or more	Total	Per cent
General surgery	69	552	247	95	130	144	50	35	1,323	*18.6*
Emergency department	86	394	132	56	106	129	61	90	1,057	*14.8*
Obstetrics	74	508	109	34	60	103	49	129	1,072	*15.0*
Orthopaedics	47	217	68	36	51	71	33	24	549	*7.7*
Gynaecology	24	153	70	45	68	70	30	6	467	*6.6*
Psychiatry	20	142	52	21	34	60	26	14	369	*5.2*
General medicine	19	137	55	17	26	45	24	17	343	*4.8*
General practice	26	79	26	20	19	29	10	12	223	*3.1*
Paediatrics	15	63	21	4	11	26	7	20	168	*2.4*
Cardiology	12	51	23	11	14	16	16	7	151	*2.1*
All other clinical service contexts	125	497	167	89	118	102	36	49	1,191	*16.7*
Total	**570**	**2,885**	**981**	**440**	**644**	**811**	**347**	**419**	**7,125**	**100.0**
Per cent	*8.0*	*40.5*	*13.8*	*6.2*	*9.0*	*11.4*	*4.9*	*5.9*	*100.0*	. .
	Per cent (excluding *Not applicable* and *Not known*)									
General surgery	5.2	41.8	18.7	7.2	9.8	10.9	3.8	2.6	100.0	. .
Emergency department	8.2	37.4	12.5	5.3	10.1	12.2	5.8	8.5	100.0	. .
Obstetrics	6.9	47.7	10.2	3.2	5.6	9.7	4.6	12.1	100.0	. .
Orthopaedics	8.6	39.7	12.4	6.6	9.3	13.0	6.0	4.4	100.0	. .
Gynaecology	5.2	32.8	15.0	9.7	14.6	15.0	6.4	1.3	100.0	. .
Psychiatry	5.4	38.5	14.1	5.7	9.2	16.3	7.0	3.8	100.0	. .
General medicine	5.6	40.3	16.2	5.0	7.6	13.2	7.1	5.0	100.0	. .
General practice	11.8	35.7	11.8	9.0	8.6	13.1	4.5	5.4	100.0	. .
Paediatrics	9.0	37.7	12.6	2.4	6.6	15.6	4.2	12.0	100.0	. .
Cardiology	8.0	34.0	15.3	7.3	9.3	10.7	10.7	4.7	100.0	. .
All other clinical service contexts	10.6	42.0	14.1	7.5	10.0	8.6	3.0	4.1	100.0	. .
Total	**7.5**	**40.6**	**14.1**	**6.2**	**9.3**	**11.5**	**5.0**	**5.9**	**100.0**	**. .**

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and clinical service context (see Box 2.1).

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. There were 212 claims coded *Not applicable* or *Not known* for 'clinical service context' and 28 claims coded *Not known* for 'total claim size'. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 6,885.
3. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

Table 5.15: Closed claims, 2005–06 to 2009–10[(a)]: primary incident/allegation type, by total claim size ($)

	Total claim size ($)						
Primary incident/allegation type	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**	**Per cent**
Procedure	133	992	823	370	108	2,426	35.0
Diagnosis	95	617	460	307	150	1,629	23.5
Treatment	107	548	336	218	71	1,280	18.5
General duty of care	54	253	145	59	23	534	7.7
Medication-related	13	121	102	81	29	346	5.0
Consent	18	46	70	25	9	168	2.4
Anaesthetic	20	86	32	30	4	172	2.5
Infection control	10	48	24	22	4	108	1.6
Blood/blood product-related	44	25	12	15	1	97	1.4
Device failure	6	17	11	5	0	39	0.6
Other	21	54	40	12	3	130	1.9
Total	**521**	**2,807**	**2,055**	**1,144**	**402**	**6,929**	**100.0**
	Per cent (excluding *Not known*)						
Procedure	5.5	40.9	33.9	15.3	4.5	100.0	. .
Diagnosis	5.8	37.9	28.2	18.8	9.2	100.0	. .
Treatment	8.4	42.8	26.3	17.0	5.5	100.0	. .
General duty of care	10.1	47.4	27.2	11.0	4.3	100.0	. .
Medication-related	3.8	35.0	29.5	23.4	8.4	100.0	. .
Consent	10.7	27.4	41.7	14.9	5.4	100.0	. .
Anaesthetic	11.6	50.0	18.6	17.4	2.3	100.0	. .
Infection control	9.3	44.4	22.2	20.4	3.7	100.0	. .
Blood/blood product-related	45.4	25.8	12.4	15.5	1.0	100.0	. .
Device failure	15.4	43.6	28.2	12.8	0.0	100.0	. .
Other	16.2	41.5	30.8	9.2	2.3	100.0	. .
Total	7.5	40.5	29.7	16.5	5.8	**100.0**	**. .**

. . Not applicable

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and primary incident/allegation type (see Box 2.1).

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 5.1.
2. There were 169 claims coded *Not known* for 'primary incident/allegation type' and 28 claims coded *Not known* for 'total claim size', including 1 claim coded *Not known* for both. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 6,929.
3. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

Table 5.16: Closed claims, 2005–06 to 2009–10[(a)]: primary body function/structure affected, by total claim size ($)

	Total claim size ($)							
Primary body function/structure affected	**Nil**	**1–10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Not known**	**Total**	**Per cent**
Neuromusculoskeletal and movement-related	115	548	428	283	110	10	1,494	*21.0*
Mental and nervous system	69	444	341	202	173	2	1,231	*17.3*
Genitourinary and reproductive	65	386	275	143	20	4	893	*12.5*
Digestive, metabolic and endocrine systems	40	334	318	141	16	2	851	*11.9*
Cardiovascular, haematological, immunological and respiratory	60	210	118	73	18	2	481	*6.8*
Skin and related structures	29	153	107	27	7	0	323	*4.5*
Sensory, including eye and ear	15	80	76	41	8	0	220	*3.1*
Voice and speech	17	56	36	5	1	1	116	*1.6*
Death	86	450	294	183	41	1	1,055	*14.8*
No body function/structure affected	13	94	25	22	2	1	157	*2.2*
Not known	61	130	47	38	23	5	304	*4.3*
Total	**570**	**2,885**	**2,065**	**1,158**	**419**	**28**	**7,125**	**100.0**
Per cent	*8.0*	*40.5*	*29.0*	*16.3*	*5.9*	*0.4*	*100.0*	*. .*
			Per cent (excluding *Not known*)					
Neuromusculoskeletal and movement-related	22.6	19.9	21.2	25.3	27.8	. .	21.8	. .
Mental and nervous system	13.6	16.1	16.9	18.0	43.7	. .	18.1	. .
Genitourinary and reproductive	12.8	14.0	13.6	12.8	5.1	. .	13.1	. .
Digestive, metabolic and endocrine systems	7.9	12.1	15.8	12.6	4.0	. .	12.5	. .
Cardiovascular, haematological, immunological and respiratory	11.8	7.6	5.8	6.5	4.5	. .	7.0	. .
Skin and related structures	5.7	5.6	5.3	2.4	1.8	. .	4.8	. .
Sensory, including eye and ear	2.9	2.9	3.8	3.7	2.0	. .	3.2	. .
Voice and speech	3.3	2.0	1.8	0.4	0.3	. .	1.7	. .
Death	16.9	16.3	14.6	16.3	10.4	. .	15.5	. .
No body function/structure affected	2.6	3.4	1.2	2.0	0.5	. .	2.3	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and primary body function/structure affected (see Box 2.1).

Notes

1. The 304 claims coded *Not known* for 'primary body function/structure affected' and 28 claims coded *Not known* for 'total claim size', including 5 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented here are based is 6,798.
2. Percentages may not add up exactly to 100.0 due to rounding.

Allegations of loss and cost of claims

There are two data items whose purpose is to record the allegations of loss to the claimant(s) pursuing the claim. 'Nature of claim—loss to claim subject' allows for up to four categories of alleged loss to the claim subject to be recorded, while 'nature of claim—loss to other party/parties' allows for recording up to six categories of alleged loss to a party other than the claim subject (Box 5.1).

Box 5.1: Nature of claim—loss to claim subject and Nature of claim—loss to other party/parties

'Nature of claim—loss to claim subject' has four broad categories of loss to the claim subject. Up to four categories can be selected for any claim:

- Pain and suffering, including general damages, nervous shock and temporary or ongoing disability.
- Care costs, including long-term care cost, covering both past and future care costs, whether provided for free or otherwise.
- Other economic loss, including past and future economic loss and past and future out-of-pocket expenses, but excluding care costs.
- Other loss, including medical costs (both past and future), which are costs associated with medical treatment, for example, doctors' fees or hospital expenses.

Not known or *Not applicable* can be selected instead of a loss category. *Not applicable* is recorded when it is known that the claim is not based on an alleged loss to the claim subject, including when alleged loss to another party forms the basis for the claim. If it is not known whether the claim is based on an alleged loss to the claim subject, *Not known* is reported. It is understood that the codes for *Not known* and *Not applicable* have sometimes been used interchangeably.

'Nature of claim—loss to other party/parties' has six broad categories of loss to another party. Up to six categories can be selected for any claim:

- Nervous shock.
- Pain and suffering, including general damages but excluding nervous shock.
- Loss of consortium, which covers the deprivation of the benefits of a family relationship due to harm to the claim subject.
- Care costs, including long-term care cost, covering both past and future care costs, whether provided for free or otherwise.
- Other economic loss, including past and future economic loss and past and future out-of-pocket expenses, but excluding care costs.
- Other loss, including medical costs (both past and future), which are costs associated with medical treatment, for example, doctors' fees or hospital expenses.

Not known or *Not applicable* can be selected instead of a loss category. *Not applicable* is recorded when it is known that the claim is not based on an alleged loss to any party related to the claim subject. If it is not known whether the claim is based on an alleged loss to another party, *Not known* is reported. It is understood that the codes for *Not known* and *Not applicable* have sometimes been used interchangeably.

The claims recorded as *Not applicable* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party/parties' are reported as having Nil loss categories in tables in this report.

Table 5.17 presents data on the categories of loss alleged by the claimant in terms of whether the claimant(s) was the patient (claim subject) and/or another party. More than half of claims closed between 2005–06 and 2009–10 were associated with *Claim subject loss only* (62%). Much smaller proportions of claims were associated with *Other party loss only* (6%) or with allegations of loss to both the patient and another party (3%). There were nil allegations of loss to either the patient or another party for 10% of claims, and for 19% of claims the situation was unknown.

Two-thirds of the claims associated with a claimant's allegation of loss had a claim size of $10,000 or more (3,381 of 5,058 claims, 67%). Claims with both *Claim subject and other party loss* were the most costly with 25 of them (14%) settling for $500,000 or more. In contrast, 86% of claims with nil or unknown loss categories (1,781 of 2,067 claims) were closed for less than $10,000.

Table 5.18 focuses on the number and proportion of claims overall, and in each claim size category, for which any claim subject loss category or other party loss category was recorded. A claim can have multiple loss categories and so the number of claims associated with each of the loss categories, totalled, will exceed the number of claims associated with one or more of the loss categories. For instance, with the 419 claims closed for a cost of at least $500,000, 373 of these claims were associated with at least one of the four claim subject loss categories, and of these 373 claims, 312 were associated with *Other economic loss*, 318 with *Care costs*, 345 with *Other loss* and 365 with *Pain and suffering* to the claim subject. The figures for these four claim subject loss categories do not add up to the total number of claims with at least one claim subject loss category because up to four claim subject loss categories can be recorded for any claim.

All four claim subject loss categories were frequently recorded, and were associated with a larger proportion of claims as claim size increased. *Pain and suffering* was claimed for 51% of claims, including 87% of the claims settled for $500,000 or more. *Care costs*, *Other economic loss* and *Other loss* were respectively claimed for 25%, 29% and 43% of claims, including 76%, 75% and 82% of the claims settled for $500,000 or more. All six other party loss categories, however, were infrequently recorded, ranging between 1% (*Loss of consortium*) and 5% (*Nervous shock*). These other party loss categories were recorded particularly infrequently when the claim size was nil or an amount less than $10,000.

It is difficult to use the data in Table 5.18 as an indication of whether any loss category tended to be associated with claims that were more costly or less costly than any other claim category. This is because of the general tendency for any loss category to be recorded for a larger proportion of claims as claim size increased. For instance, claim subject *Pain and suffering* was recorded for 25% of claims closed for nil cost, 30% of claims closed for $1–<$10,000, 66% of claims closed for $10,000–<$100,000, 78% of claims closed for $100,000–<$500,000 and 87% of claims closed for at least $500,000. Because more loss categories were generally recorded for high cost claims than for low cost claims, the number of loss categories rather than the type of loss category appears to be the variable most strongly related to claim size.

Accordingly, Table 5.19 relates claim size to the number of alleged loss categories regardless of the category of loss. The strong relationship between these variables is also illustrated in Figure 5.2. For claims closed for nil cost, the most frequently recorded number of loss categories was nil; for claims closed for a cost of less than $10,000, it was one loss category; for claims settled for $10,000–<$100,000, it was two loss categories; and for claims settled for

$100,000–<$500,000 or at least $500,000, it was four loss categories. In addition, as claim size increased an increasing proportion of claims were associated with five or more loss categories. The same relationship between claim size and number of alleged loss categories was recorded for claims closed between 2003–04 and 2007–08 (AIHW 2011a).

Table 5.17: Closed claims, 2005-06 to 2009-10[a]: claimant loss categories,[b] by total claim size ($)

	Total claim size ($)							
Claimant loss categories	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Not known**	**Total**	**Per cent**
Nil loss categories[c]	142	497	40	3	0.	1	683	9.6
Claim subject loss only	172	1,309	1,648	942	348	3	4,422	62.1
Other party loss only	14	120	166	133	25	0	458	6.4
Claim subject and other party loss	11	48	57	37	25	0	178	2.5
Not known[d]	231	911	154	43	21	24	1,384	19.4
Total	**570**	**2,885**	**2,065**	**1,158**	**419**	**28**	**7,125**	**100.0**
	Per cent (excluding claim size *Not known*)							
Nil loss categories[c]	20.8	72.9	5.9	0.4	0.0	. .	100.0	. .
Claim subject loss only	3.9	29.6	37.3	21.3	7.9	. .	100.0	. .
Other party loss only	3.1	26.2	36.2	29.0	5.5	. .	100.0	. .
Claim subject and other party loss	6.2	27.0	32.0	20.8	14.0	. .	100.0	. .
Not known[d]	17.0	67.0	11.3	3.2	1.5	. .	100.0	. .
Total	**8.0**	**40.7**	**29.1**	**16.3**	**5.9**	**. .**	**100.0**	. .

. . Not applicable.

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and claimant loss categories (see Box 2.1).

(b) For an explanation of loss categories, see Box 5.1.

(c) Claims recorded as *Not applicable* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party' (see Box 5.1).

(d) Claims recorded as *Not known* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party', or else as *Not known* for one of these data items and *Not applicable* for the other.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Table 5.18: Closed claims, 2005–06 to 2009–10[(a)]: nature of claim—loss to claim subject or other party[(b)], by total claim size ($)

	Total claim size ($)					
Claimant loss categories	**Nil**	**1– <10,000**	**10,000– <100,000**	**100,000– <500,000**	**500,000 or more**	**Total**
Nil loss categories[(c)]	142	497	40	3	0	683
Claim subject loss						
Pain and suffering	140	873	1,362	906	365	3,649
Care costs	42	258	568	588	318	1,775
Other economic loss	56	400	723	603	312	2,095
Other loss	71	701	1,143	797	345	3,058
Any claim subject loss category	183	1,357	1,705	979	373	4,600
Other party loss						
Pain and suffering	7	42	61	63	25	198
Care costs	5	25	47	50	12	139
Loss of consortium	1	11	36	30	11	89
Nervous shock	10	89	103	95	32	329
Other economic loss	6	54	71	103	28	262
Other loss	4	43	92	83	30	252
Any other party loss category	25	168	223	170	50	636
Total claims	**570**	**2,885**	**2,065**	**1,158**	**419**	**7,125**
			Per cent			
Nil loss categories[(c)]	24.9	17.2	1.9	0.3	0.0	9.6
Claim subject loss						
Pain and suffering	24.6	30.3	66.0	78.2	87.1	51.2
Care costs	7.4	8.9	27.5	50.8	75.9	24.9
Other economic loss	9.8	13.9	35.0	52.1	74.5	29.4
Other loss	12.5	24.3	55.4	68.8	82.3	42.9
Any claim subject loss category	32.1	47.0	82.6	84.5	89.0	64.6
Other party loss						
Pain and suffering	1.2	1.5	3.0	5.4	6.0	2.8
Care costs	0.9	0.9	2.3	4.3	2.9	2.0
Loss of consortium	0.2	0.4	1.7	2.6	2.6	1.2
Nervous shock	1.8	3.1	5.0	8.2	7.6	4.6
Other economic loss	1.1	1.9	3.4	8.9	6.7	3.7
Other loss	0.7	1.5	4.5	7.2	7.2	3.5
Any other party loss category	4.4	5.8	10.8	14.7	11.9	8.9
Total claims	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and claimant loss categories (see Box 2.1).

(b) For an explanation of loss categories, see Box 5.1.

(c) Claims recorded as *Not applicable* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party' (see Box 5.1).

Notes

1. There were 1,384 claims coded *Not known* for 'claimant loss categories' and 28 claims coded *Not known* for 'total claim size'. The *Not known* row and column are not presented; however, these claims are included in the totals in the top half of the table.
2. The figures presented in this table show the number and proportion of claims in each claim size category for which nil loss categories, or a claim subject loss category or other party loss category, were recorded. Any claim can have up to four claim subject loss categories and up to six other party loss categories. Therefore the figures cannot be summed vertically to produce inclusive counts or percentages.

Table 5.19: Closed claims, 2005–06 to 2009–10[a]: nature of claim—loss to claim subject or other party (number of loss categories), by total claim size ($)

	Total claim size ($)							
Number of loss categories	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Not known**	**Total**	**Per cent**
Nil loss categories[b]	142	497	40	3	0	1	683	*9.6*
One loss category	105	878	570	107	5	1	1,666	*23.4*
Two loss categories	57	326	586	250	29	1	1,249	*17.5*
Three loss categories	21	152	435	345	98	1	1,052	*14.8*
Four loss categories	13	108	256	391	242	0	1,010	*14.2*
Five or more loss categories	1	13	24	19	24	0	81	*1.1*
Not known[c]	231	911	154	43	21	24	1,384	*19.4*
Total	**570**	**2,885**	**2,065**	**1,158**	**419**	**28**	**7,125**	**100.0**
Per cent	*8.0*	*40.5*	*29.0*	*16.3*	*5.9*	*0.4*	*100.0*	
	Per cent (excluding *Not known*)							
Nil loss categories[b]	41.9	25.2	2.1	0.3	0.0	. .	11.9	. .
One loss category	31.0	44.5	29.8	9.6	1.3	. .	29.0	. .
Two loss categories	16.8	16.5	30.7	22.4	7.3	. .	21.8	. .
Three loss categories	6.2	7.7	22.8	30.9	24.6	. .	18.3	. .
Four loss categories	3.8	5.5	13.4	35.1	60.8	. .	17.6	. .
Five or more loss categories	0.3	0.7	1.3	1.7	6.0	. .	1.4	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

. . Not applicable.

(a) The table excludes seven closed claims where there was no relationship between the reported claim size and claimant loss categories (see Box 2.1).

(b) Claims recorded as *Not applicable* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party' (see Box 5.1).

(c) Claims recorded as *Not known* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party', or else as *Not known* for one of these data items and *Not applicable* for the other.

Notes

1. For an explanation of the loss categories, see Box 5.1.
2. The 1,384 claims coded *Not known* for number of loss categories and 28 claims coded *Not known for* claim size, including 24 claims coded *Not known* for both, are excluded for the purposes of calculating the percentages presented in the bottom half of the table. The number of claims on which these percentages are based is 5,737.
3. Percentages may not add up exactly to 100.0 due to rounding

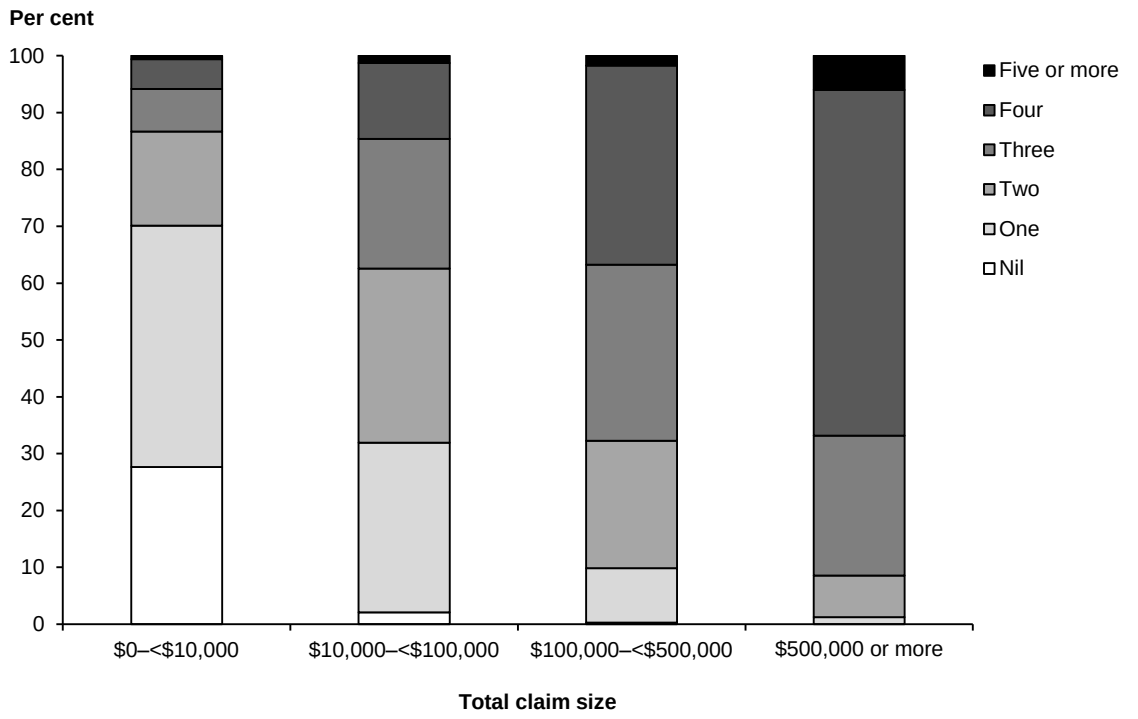


Figure 5.2: Closed claims, 2005–06 to 2009–10: number of claimant loss categories, by total claim size (per cent)

5.3 Sex and age of claim subjects

This section provides a profile of the claim subjects recorded for medical indemnity claims closed between 2005–06 and 2009–10. Information on the person's sex and age at the time of the alleged incident is presented in terms of the clinical service context, primary incident/allegation type, primary body function/structure affected, and size of the claims. The associations observed are similar to those recorded for claims closed between 2003–04 and 2007–08 (AIHW 2011a).

During the period, 605 *Closed claims* (8%) related to babies, 495 claims (7%) related to people aged 1 to 17, and 5,349 claims (75%) involved adults (18 and over) (Table 5.20). The age of the claim subject was *Not known* for 670 claims.

The claim subject was female in about 57% of claims. Female claim subjects outnumbered males in every adult age group, and particularly in the 18–39 age group. This imbalance was reversed for claims relating to claim subjects less than 18, where more than half of the claim subjects were male.

Table 5.20: Closed claims, 2005–06 to 2009–10[(a)]: sex and age group (years) of claim subjects

	Age group									
Sex	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**	**Per cent**
Males	332	68	207	787	837	452	55	282	3,020	*42.4*
Females	265	53	163	1,603	1,033	473	74	312	3,976	*55.9*
Not known	8	1	3	15	15	5	0	76	123	*1.7*
Total	**605**	**122**	**373**	**2,405**	**1,885**	**930**	**129**	**670**	**7,119**	**100.0**
Per cent	*8.5*	*1.7*	*5.2*	*33.8*	*26.5*	*13.1*	*1.8*	*9.4*	*100.0*	
	Per cent (excluding *Not known*)									
Males	55.6	56.2	55.9	32.9	44.8	48.9	42.6	. .	42.8	. .
Females	44.4	43.8	44.1	67.1	55.2	51.1	57.4	. .	57.2	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

. . Not applicable.

(a) The table excludes 13 closed claims that duplicate the claim subject sex and age data recorded in another claim (see Box 2.1).

Notes

1. The 123 claims coded *Not known* for 'sex' and 670 claims coded *Not known* for 'age group', including 76 coded *Not known* for both, are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 6,402 claims.

2. Percentages may not add up exactly to 100.0 due to rounding

Clinical service context

The most common clinical service contexts recorded for male claim subjects were *General surgery* (23%), *Emergency department* (20%) and *Orthopaedics* (10%). For female claim subjects, the most common clinical service contexts were *Obstetrics* (21%), *General surgery* (18%) and *Gynaecology* (12%) (tables 5.21 and 5.22).

Table 5.21: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context, by sex and age group (years) of claim subject

	Age group								
Clinical service context	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**
				Males					
Obstetrics	221	0	0	0	0	0	0	32	253
Paediatrics	32	20	26	5	2	0	0	4	89
Emergency department	18	19	59	221	153	53	6	40	569
Psychiatry	2	2	7	106	53	3	1	19	193
General practice	5	3	7	32	26	14	3	15	105
Orthopaedics	0	2	28	78	95	52	5	20	280
General surgery	5	10	32	149	248	159	14	30	647
Cardiology	2	0	7	12	30	25	2	8	86
General medicine	9	2	11	46	48	33	10	11	170
All other clinical contexts	36	7	25	125	169	111	12	72	557
Not known	2	3	5	13	13	2	2	31	71
Total males	*332*	*68*	*207*	*787*	*837*	*452*	*55*	*282*	*3,020*
				Females					
Obstetrics	187	1	9	532	39	2	0	41	811
Paediatrics	24	16	23	10	2	0	0	2	77
Emergency department	15	13	37	163	134	56	13	40	471
Psychiatry	0	1	19	77	44	9	1	22	173
Gynaecology	3	1	4	280	135	19	2	22	466
General practice	9	0	1	32	39	19	0	17	117
Orthopaedics	0	6	19	64	86	64	8	14	261
General surgery	2	7	22	188	273	140	15	21	668
Cardiology	1	1	3	15	17	22	3	2	64
General medicine	2	1	3	50	38	40	18	17	169
All other clinical contexts	18	6	22	177	211	96	13	87	630
Not known	4	0	1	15	15	6	1	27	69
Total females	*265*	*53*	*163*	*1,603*	*1,033*	*473*	*74*	*312*	*3,976*
				Persons					
Obstetrics	411	1	9	532	39	2	0	74	1,068
Paediatrics	56	36	49	15	4	0	0	8	168
Emergency department	33	32	96	385	289	110	19	85	1,049
Psychiatry	2	3	26	185	98	12	2	41	369
Gynaecology	4	1	4	280	135	19	2	22	467
General practice	14	3	8	64	65	33	3	33	223
Orthopaedics	0	9	48	145	183	117	13	34	549
General surgery	7	17	54	338	523	300	29	55	1,323
Cardiology	3	1	10	27	48	47	5	10	151
General medicine	11	3	14	97	87	73	28	29	342
All other clinical contexts	54	13	47	302	382	207	25	170	1,200
Not known	10	3	8	35	32	10	3	109	210
Total persons	**605**	**122**	**373**	**2,405**	**1,885**	**930**	**129**	**670**	**7,119**

(a) The table excludes 13 closed claims that duplicate the clinical service context and claim subject sex and age data recorded in another claim (see Box 2.1).

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category All other clinical contexts.
2. Total persons includes123 persons of unknown sex.

Table 5.22: Closed claims, 2005–06 to 2009–10[(a)]: clinical service context (excluding *Not applicable* and *Not known*), by sex and age group (years) of claim subject (per cent)

	Age group							
Clinical service context	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Total**
				Males				
Obstetrics	67.0	0.0	0.0	0.0	0.0	0.0	0.0	8.2
Paediatrics	9.7	30.8	12.9	0.6	0.2	0.0	0.0	3.2
Emergency department	5.5	29.2	29.2	28.6	18.6	11.8	11.3	19.6
Psychiatry	0.6	3.1	3.5	13.7	6.4	0.7	1.9	6.5
General practice	1.5	4.6	3.5	4.1	3.2	3.1	5.7	3.3
Orthopaedics	0.0	3.1	13.9	10.1	11.5	11.6	9.4	9.6
General surgery	1.5	15.4	15.8	19.3	30.1	35.3	26.4	22.9
Cardiology	0.6	0.0	3.5	1.6	3.6	5.6	3.8	2.9
General medicine	2.7	3.1	5.4	5.9	5.8	7.3	18.9	5.9
All other clinical contexts	10.9	10.8	12.4	16.1	20.4	24.7	22.6	17.9
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Females				
Obstetrics	71.6	1.9	5.6	33.5	3.8	0.4	0.0	21.3
Paediatrics	9.2	30.2	14.2	0.6	0.2	0.0	0.0	2.1
Emergency department	5.7	24.5	22.8	10.3	13.2	12.0	17.8	11.9
Psychiatry	0.0	1.9	11.7	4.8	4.3	1.9	1.4	4.2
Gynaecology	1.1	1.9	2.5	17.6	13.3	4.1	2.7	12.3
General practice	3.4	0.0	0.6	2.0	3.8	4.1	0.0	2.8
Orthopaedics	0.0	11.3	11.7	4.0	8.4	13.7	11.0	6.8
General surgery	0.8	13.2	13.6	11.8	26.8	30.0	20.5	17.9
Cardiology	0.4	1.9	1.9	0.9	1.7	4.7	4.1	1.7
General medicine	0.8	1.9	1.9	3.1	3.7	8.6	24.7	4.2
All other clinical contexts	6.9	11.3	13.6	11.1	20.7	20.6	17.8	15.0
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Persons				
Obstetrics	69.1	0.8	2.5	22.4	2.1	0.2	0.0	15.7
Paediatrics	9.4	30.3	13.4	0.6	0.2	0.0	0.0	2.5
Emergency department	5.5	26.9	26.3	16.2	15.6	12.0	15.1	15.2
Psychiatry	0.3	2.5	7.1	7.8	5.3	1.3	1.6	5.2
Gynaecology	0.7	0.8	1.1	11.8	7.3	2.1	1.6	7.0
General practice	2.4	2.5	2.2	2.7	3.5	3.6	2.4	3.0
Orthopaedics	0.0	7.6	13.2	6.1	9.9	12.7	10.3	8.1
General surgery	1.2	14.3	14.8	14.3	28.2	32.6	23.0	20.0
Cardiology	0.5	0.8	2.7	1.1	2.6	5.1	4.0	2.2
General medicine	1.8	2.5	3.8	4.1	4.7	7.9	22.2	4.9
All other clinical contexts	9.1	10.9	12.9	12.7	20.6	22.5	19.8	16.2
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes 13 closed claims that duplicate the clinical service context and claim subject sex and age data recorded in another claim (see Box 2.1).

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical contexts*.
2. The 212 claims coded *Not applicable* or *Not known* for 'clinical service context' and 670 claims coded *Not known* for claim subject's age group, including 110 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 6,347.
3. Percentages may not add up exactly to 100.0 due to rounding.

Obstetrics was the clinical service context most frequently recorded for babies of both sexes (69%) and was also often recorded for adult females aged 18–39 (34%) (figures 5.3 and 5.4). *Emergency department* accounted for a higher proportion of claims for patients aged 1–17 (128 of 495 claims, 26%) than any other age group. *Gynaecology* was recorded as the clinical service context for 415 of the 2,636 claims (16%) involving adult females aged 18–59. *General surgery* figured prominently as the clinical service context for claim subjects of both sexes in the 40–59 (28%) and 60–79 (33%) age groups. Just under one-quarter (23%) of the claims in the oldest age group, 80 or more, had *General medicine* recorded as their clinical service context.

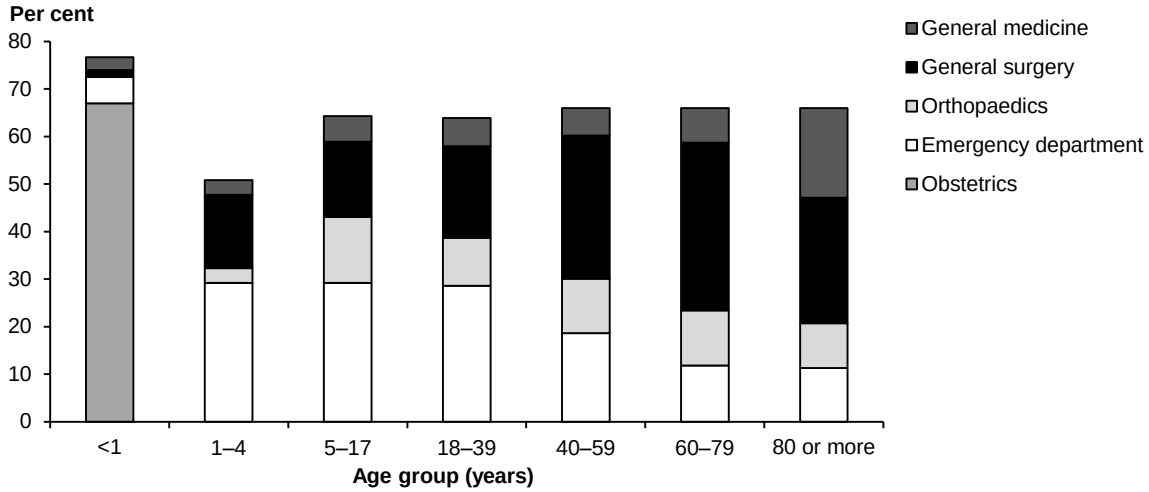


Figure 5.3: Closed claims, 2005–06 to 2009–10: five commonly recorded clinical service contexts for male claim subjects, by age group (per cent)

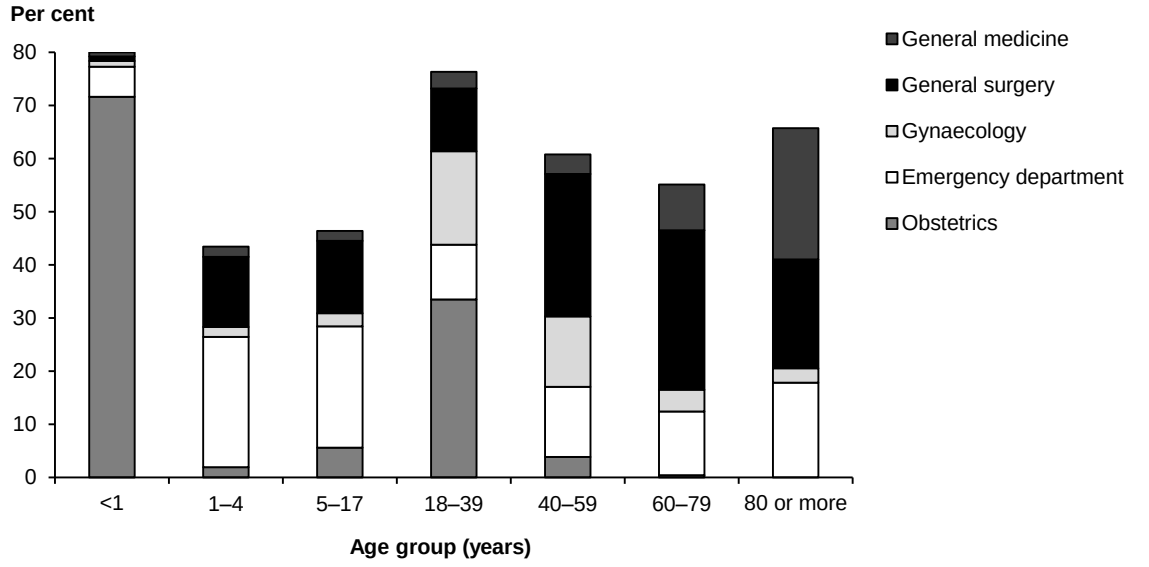


Figure 5.4: Closed claims, 2005–06 to 2009–10: five commonly recorded clinical service contexts for female claim subjects, by age group (per cent)

Paediatrics was commonly recorded when the claim subject was aged under 18, particularly for children aged 1–4 (30%). *Cardiology*-related claims reached its highest proportion of all claims for both sexes in the 60–79 age group (5–6%). *Psychiatry* was recorded for 14% of the claims with adult male claim subjects aged 18–39.

Primary incident/allegation type

Procedure was the most common primary incident/allegation type recorded for both sexes, but it was particularly common for claims where the claim subject was female. This difference between females (39% of their closed claims) and males (32%) is mainly attributable to the large proportion of claims, 41%, for adult females between 18 and 59 with *Procedure* recorded as the primary incident/allegation type. *Procedure*-related claims also accounted for 41% of all claims for babies, affecting both sexes to the same degree (tables 5.23 and 5.24).

As a primary incident/allegation type, *Treatment* was more likely to be recorded if the claim involved patients aged under 18 or 80 or more. Between 23% and 30% of the claims for both male and female claim subjects in these age categories involved an incident or allegation related to *Treatment*, whereas this proportion was consistently less than 18% for adults aged 18 to 79. *Diagnosis* was more strongly associated with patients in the 1–4 and 5–17 age groups (28% and 35%, respectively) than with adult patients (13–24%, depending on age group.

General duty of care was more commonly reported for older claim subjects. It was the most frequently recorded category (23%) in claims where the claim subject was 80 or older (Figure 5.5).

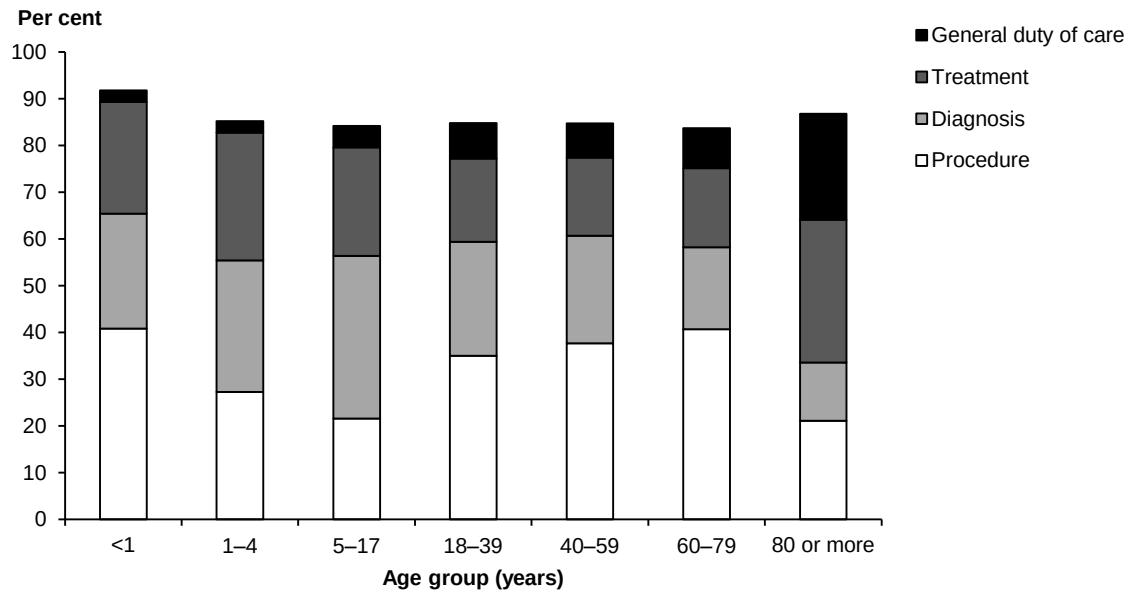


Figure 5.5: Closed claims, 2005–06 to 2009–10: four commonly recorded principal incident/allegation types, by claim subject age group (per cent)

Table 5.23: Closed claims, 2005–06 to 2009–10[(a)]: primary incident/allegation type, by sex and age group (years) of claim subject

Primary incident/ allegation type	Age group								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
					Males				
Procedure	132	15	44	175	277	198	13	61	915
Diagnosis	82	17	79	228	199	73	9	57	744
Treatment	76	21	46	147	152	73	16	44	575
General duty of care	10	2	7	88	65	35	10	37	254
Medication-related	9	6	16	61	43	21	1	14	171
Consent	7	4	3	13	10	9	0	6	52
Anaesthetic	0	1	2	10	33	13	0	10	69
Infection control	5	0	1	12	21	10	0	5	54
Blood/blood-product related	3	1	3	17	11	1	0	6	42
Device failure	0	1	3	4	6	3	1	2	20
Other	4	0	3	24	13	11	4	9	68
Not known	4	0	0	8	7	5	1	31	56
Total males	*332*	*68*	*207*	*787*	*837*	*452*	*55*	*282*	*3,020*
					Females				
Procedure	110	17	36	656	424	175	14	77	1,509
Diagnosis	63	17	50	352	229	87	7	69	874
Treatment	64	12	40	272	155	83	23	44	693
General duty of care	5	1	10	91	71	44	19	37	278
Medication-related	8	2	13	52	58	25	5	10	173
Consent	3	1	4	50	26	11	1	20	116
Anaesthetic	2	0	3	41	23	22	1	10	102
Infection control	1	0	0	18	14	8	3	7	51
Blood/blood-product related	1	0	4	25	12	6	1	4	53
Device failure	0	0	2	10	3	5	0	0	20
Other	2	2	1	27	12	4	0	9	57
Not known	6	1	0	9	6	3	0	25	50
Total females	*265*	*53*	*163*	*1,603*	*1,033*	*473*	*74*	*312*	*3,976*
					Persons				
Procedure	242	33	80	833	705	375	27	141	2,436
Diagnosis	146	34	129	581	431	161	16	128	1,626
Treatment	142	33	86	423	312	156	39	91	1,282
General duty of care	15	3	17	181	136	79	29	75	535
Medication-related	18	8	29	113	101	47	6	25	347
Consent	10	5	7	63	36	20	1	27	169
Anaesthetic	2	1	5	51	57	35	1	20	172
Infection control	6	0	1	30	35	18	3	16	109
Blood/blood-product related	4	1	7	42	23	7	1	18	103
Device failure	0	1	5	14	9	8	1	2	40
Other	8	2	5	52	25	15	4	20	131
Not known	12	1	2	22	15	9	1	107	169
Total persons	**605**	**122**	**373**	**2,405**	**1,885**	**930**	**129**	**670**	**7,119**

(a) The table excludes 13 closed claims that duplicate the primary incident/allegation type and claim subject sex and age data recorded in another claim (see Box 2.1).

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 3.4.
2. *Total persons* include 123 persons of unknown sex.

Table 5.24: Closed claims, 2005–06 to 2009–10[(a)]: primary incident/allegation type, by sex and age group (years) of claim subject (excluding *Not known*) (per cent)

Primary incident/ allegation type	Age group							Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	
				Males				
Procedure	40.2	22.1	21.3	22.5	33.4	44.3	24.1	31.5
Diagnosis	25.0	25.0	38.2	29.3	24.0	16.3	16.7	25.3
Treatment	23.2	30.9	22.2	18.9	18.3	16.3	29.6	19.6
General duty of care	3.0	2.9	3.4	11.3	7.8	7.8	18.5	8.0
Medication-related	2.7	8.8	7.7	7.8	5.2	4.7	1.9	5.8
Consent	2.1	5.9	1.4	1.7	1.2	2.0	0.0	1.7
Anaesthetic	0.0	1.5	1.0	1.3	4.0	2.9	0.0	2.2
Infection control	1.5	0.0	0.5	1.5	2.5	2.2	0.0	1.8
Blood/blood-product related	0.9	1.5	1.4	2.2	1.3	0.2	0.0	1.3
Device failure	0.0	1.5	1.4	0.5	0.7	0.7	1.9	0.7
Other	1.2	0.0	1.4	3.1	1.6	2.5	7.4	2.2
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Females				
Procedure	42.5	32.7	22.1	41.2	41.3	37.2	18.9	39.4
Diagnosis	24.3	32.7	30.7	22.1	22.3	18.5	9.5	22.1
Treatment	24.7	23.1	24.5	17.1	15.1	17.7	31.1	17.8
General duty of care	1.9	1.9	6.1	5.7	6.9	9.4	25.7	6.6
Medication-related	3.1	3.8	8.0	3.3	5.6	5.3	6.8	4.5
Consent	1.2	1.9	2.5	3.1	2.5	2.3	1.4	2.6
Anaesthetic	0.8	0.0	1.8	2.6	2.2	4.7	1.4	2.5
Infection control	0.4	0.0	0.0	1.1	1.4	1.7	4.1	1.2
Blood/blood-product related	0.4	0.0	2.5	1.6	1.2	1.3	1.4	1.3
Device failure	0.0	0.0	1.2	0.6	0.3	1.1	0.0	0.5
Other	0.8	3.8	0.6	1.7	1.2	0.9	0.0	1.3
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Persons				
Procedure	40.8	27.3	21.6	35.0	37.7	40.7	21.1	35.9
Diagnosis	24.6	28.1	34.8	24.4	23.0	17.5	12.5	23.5
Treatment	23.9	27.3	23.2	17.8	16.7	16.9	30.5	18.6
General duty of care	2.5	2.5	4.6	7.6	7.3	8.6	22.7	7.2
Medication-related	3.0	6.6	7.8	4.7	5.4	5.1	4.7	5.0
Consent	1.7	4.1	1.9	2.6	1.9	2.2	0.8	2.2
Anaesthetic	0.3	0.8	1.3	2.1	3.0	3.8	0.8	2.4
Infection control	1.0	0.0	0.3	1.3	1.9	2.0	2.3	1.5
Blood/blood-product related	0.7	0.8	1.9	1.8	1.2	0.8	0.8	1.3
Device failure	0.0	0.8	1.3	0.6	0.5	0.9	0.8	0.6
Other	1.3	1.7	1.3	2.2	1.3	1.6	3.1	1.7
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The table excludes 13 closed claims that duplicate the primary incident/allegation type and claim subject sex and age data recorded in another claim (see Box 2.1).

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 3.4.
2. The 169 claims coded *Not known* for 'primary incident/allegation type' and 670 claims coded *Not known* for claim subject's age, including 107 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 6,387.
3. Percentages may not add up exactly to 100.0 due to rounding.

Primary body function/structure affected

Table 5.25 presents data on the claim subjects' sex and age group in relation to the primary body function or structure affected.

The most frequently recorded category for claims involving babies was *Mental and nervous system* (47%). The proportion of claims with alleged *Mental and nervous system* effects was markedly less in every other age group, especially those with claim subjects aged 60 or over, for whom the proportion was 7% (84 of 1,059 claims).

Genitourinary and reproductive effects were recorded for a higher proportion of claims with female than male claim subjects (18% and 7% respectively). The difference can be attributed to the large number, and high proportion, of claims involving adult females in the 18–39 (27%) and 40–59 (17%) age groups where this category was recorded. The complementary pattern was the tendency for *Neuromusculoskeletal and movement-related* claims to make up a larger proportion of the claims with male subjects (26%) than female subjects (19%). This particularly affected the 5–17 and 18–39 age groups, both of which had more male than female claim subjects in this claim category.

The patient's death was the most common category for claim subjects aged 80 or more (33%), and was otherwise recorded for 14–21% of claims in each of the other age categories (Figure 5.6).

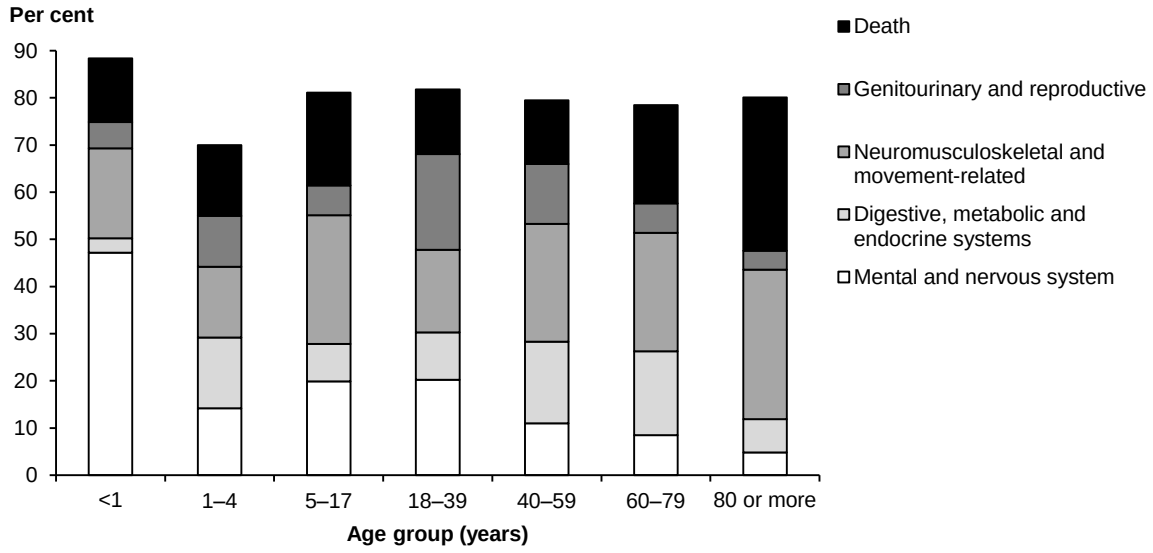


Figure 5.6: Closed claims, 2005–06 to 2009–10: five commonly recorded primary body function/ structure affected categories, by claim subject age group (per cent)

Table 5.25: Closed claims, 2005–06 to 2009–10[(a)]: primary body function/structure affected, by sex and age group (years) of claim subject

Primary body function/structure affected	Age group								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
					Males				
Mental and nervous system	160	13	35	117	83	40	1	41	490
Skin and related structures	7	6	12	31	46	20	4	5	131
Sensory, including eye and ear	6	5	9	26	40	27	5	3	121
Digestive, metabolic and endocrine systems	13	9	13	87	142	79	3	26	372
Neuromusculoskeletal and movement-related	51	7	71	222	221	104	15	61	752
Genitourinary and reproductive	19	11	14	59	61	26	3	18	211
Voice and speech	1	0	1	11	16	8	0	10	47
Cardiovascular, haematological, immunological and respiratory	21	5	10	66	71	45	3	20	241
Death	38	11	37	135	141	94	19	30	505
No body function/structure affected	6	1	3	18	5	4	0	4	41
Not known	10	0	2	15	11	5	2	64	109
Total males	*332*	*68*	*207*	*787*	*837*	*452*	*55*	*282*	*3,020*
					Females				
Mental and nervous system	110	4	38	359	121	38	5	60	735
Skin and related structures	2	10	6	71	58	19	7	12	185
Sensory, including eye and ear	0	5	6	23	31	28	3	3	99
Digestive, metabolic and endocrine systems	3	9	16	153	179	85	6	23	474
Neuromusculoskeletal and movement-related	58	11	28	189	238	126	25	56	731
Genitourinary and reproductive	12	2	9	420	174	31	2	29	679
Voice and speech	0	0	6	23	28	7	0	5	69
Cardiovascular, haematological, immunological and respiratory	18	1	14	92	65	31	3	11	235
Death	37	7	35	187	106	97	22	39	530
No body function/structure affected	6	2	2	67	20	7	0	9	113
Not known	19	2	3	19	13	4	1	65	126
Total females	*265*	*53*	*163*	*1,603*	*1,033*	*473*	*74*	*312*	*3,976*

(continued)

Table 5.25 (continued): Closed claims, 2005–06 to 2009–10[(a)]: primary body function/structure affected, by sex and age group (years) of claim subject

Primary body function/structure affected	Age group								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
					Persons				
Mental and nervous system	270	17	73	478	204	78	6	104	1,230
Skin and related structures	9	17	18	104	105	40	11	19	323
Sensory, including eye and ear	6	10	15	49	71	55	8	6	220
Digestive, metabolic and endocrine systems	17	18	29	240	322	164	9	52	851
Neuromusculoskeletal and movement-related	109	18	100	414	464	231	40	118	1,494
Genitourinary and reproductive	32	13	23	480	236	57	5	47	893
Voice and speech	1	0	7	34	44	15	0	15	116
Cardiovascular, haematological, immunological and respiratory	39	6	24	158	137	77	6	39	486
Death	77	18	72	323	251	192	41	72	1,046
No body function/structure affected	12	3	5	85	25	11	0	15	156
Not known	33	2	7	40	26	10	3	183	304
Total persons[(b)]	**605**	**122**	**373**	**2,405**	**1,885**	**930**	**129**	**670**	**7,119**
					Per cent (excluding *Not known*)[(c)]				
					Males				
Mental and nervous system	49.7	19.1	17.1	15.2	10.0	8.9	1.9	. .	16.7
Skin and related structures	2.2	8.8	5.9	4.0	5.6	4.5	7.5	. .	4.7
Sensory, including eye and ear	1.9	7.4	4.4	3.4	4.8	6.0	9.4	. .	4.4
Digestive, metabolic and endocrine systems	4.0	13.2	6.3	11.3	17.2	17.7	5.7	. .	12.8
Neuromusculoskeletal and movement-related	15.8	10.3	34.6	28.8	26.8	23.3	28.3	. .	25.7
Genitourinary and reproductive	5.9	16.2	6.8	7.6	7.4	5.8	5.7	. .	7.2
Voice and speech	0.3	0.0	0.5	1.4	1.9	1.8	0.0	. .	1.4
Cardiovascular, haematological, immunological and respiratory	6.5	7.4	4.9	8.5	8.6	10.1	5.7	. .	8.2
Death	11.8	16.2	18.0	17.5	17.1	21	35.8	. .	17.6
No body function/structure affected	1.9	1.5	1.5	2.3	0.6	0.9	0.0	. .	1.4
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .	*100.0*

(continued)

Table 5.25 (continued): Closed claims, 2005–06 to 2009–10[(a)]: primary body function/structure affected, by sex and age group (years) of claim subject

Primary body function/structure affected	Age group								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
	Per cent (excluding *Not known*)								
	Females								
Mental and nervous system	44.7	7.8	23.8	22.7	11.9	8.1	6.8	. .	18.7
Skin and related structures	0.8	19.6	3.8	4.5	5.7	4.1	9.6	. .	4.8
Sensory, including eye and ear	0.0	9.8	3.8	1.5	3.0	6.0	4.1	. .	2.7
Digestive, metabolic and endocrine systems	1.2	17.6	10.0	9.7	17.5	18.1	8.2	. .	12.5
Neuromusculoskeletal and movement-related	23.6	21.6	17.5	11.9	23.3	26.9	34.2	. .	18.7
Genitourinary and reproductive	4.9	3.9	5.6	26.5	17.1	6.6	2.7	. .	18.0
Voice and speech	0.0	0.0	3.8	1.5	2.7	1.5	0.0	. .	1.8
Cardiovascular, haematological, immunological and respiratory	7.3	2.0	8.8	5.8	6.4	6.6	4.1	. .	6.2
Death	15.0	13.7	21.9	11.8	10.4	20.7	30.1	. .	13.6
No body function/structure affected	2.4	3.9	1.3	4.2	2.0	1.5	0.0	. .	2.9
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*. .*	*100.0*
	Persons								
Mental and nervous system	47.2	14.2	19.9	20.2	11.0	8.5	4.8	. .	17.8
Skin and related structures	1.6	14.2	4.9	4.4	5.6	4.3	8.7	. .	4.8
Sensory, including eye and ear	1.0	8.3	4.1	2.1	3.8	6.0	6.3	. .	3.4
Digestive, metabolic and endocrine systems	3.0	15.0	7.9	10.1	17.3	17.8	7.1	. .	12.6
Neuromusculoskeletal and movement-related	19.1	15.0	27.3	17.5	25.0	25.1	31.7	. .	21.7
Genitourinary and reproductive	5.6	10.8	6.3	20.3	12.7	6.2	4.0	. .	13.4
Voice and speech	0.2	0.0	1.9	1.4	2.4	1.6	0.0	. .	1.6
Cardiovascular, haematological, immunological and respiratory	6.8	5.0	6.6	6.7	7.4	8.4	4.8	. .	7.1
Death	13.5	15.0	19.7	13.7	13.5	20.9	32.5	. .	15.4
No body function/structure affected	2.1	2.5	1.4	3.6	1.3	1.2	0.0	. .	2.2
Total persons[(b)]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

. . Not applicable.

(a) The table excludes 13 closed claims that duplicate the primary body function/structure affected and claim subject sex and age data recorded in another claim (see Box 2.1).

(b) *Total persons* include 123 persons of unknown sex.

(c) The 304 claims coded *Not known* for 'primary body function/structure affected' and 670 claims coded *Not known* for claim subject's age, including 183 coded *Not known* for both, are excluded for the purposes of calculating the percentages presented in this table. The number of claims on which the percentages presented here are based is 6,328.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Total claim size

There appears to be little difference between male and female claim subjects in terms of total claim size. For both males and females, about 7% of claims were closed for no cost, 40% for $1–<$10,000, 30% for $10,000–<$100,000, 17% for $100,000–<$500,000, and 6% for $500,000 or more (tables 5.26 and 5.27).

However, there does appear to be some association between claim size and age group. Where the claim subject was a baby, relatively high proportions of claims were closed for either less than $10,000 (56%) or at least $500,000 (21%). Where the claim subject was aged 5–17, a relatively small proportion (41%) was closed for less than $10,000 and a relatively high proportion (7%) for $500,000 or more. In contrast, for claim subjects aged 80 or more, 65% of claims were closed for less than $10,000 and 0% for $500,000 or more (Table 5.27; Figure 5.7).

Table 5.26: Closed claims, 2005–06 to 2009–10[(a)]: total claim size ($), by sex and age group (years) of claim subject

	Age group								
Total claim size ($)	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**
					Males				
Nil	24	8	16	39	63	38	5	39	232
1–<10,000	165	29	66	266	305	212	30	115	1,188
10,000–<100,000	40	17	61	243	278	145	15	66	865
100,000–<500,000	33	10	47	181	142	47	4	39	503
500,000 or more	69	4	16	54	49	9	0	8	209
Not known	1	0	1	1	0	1	1	16	21
Total males	*332*	*68*	*207*	*784*	*837*	*452*	*55*	*283*	*3,018*
					Females				
Nil	14	4	14	117	83	34	7	38	311
1–<10,000	131	20	53	597	413	237	41	167	1,659
10,000–<100,000	46	19	47	504	334	141	19	64	1,174
100,000–<500,000	22	6	38	322	165	49	6	29	637
500,000 or more	54	3	11	65	39	13	0	11	196
Not known	0	1	0	2	0	0	1	3	7
Total females	*267*	*53*	*163*	*1,607*	*1,034*	*474*	*74*	*312*	*3,984*
					Persons				
Nil	39	12	31	160	151	73	12	92	570
1–<10,000	300	49	121	868	723	453	71	300	2,885
10,000–<100,000	87	37	108	753	613	286	34	147	2,065
100,000–<500,000	56	16	85	503	311	96	10	81	1,158
500,000 or more	124	7	27	119	88	22	0	32	419
Not known	1	1	1	3	0	1	2	19	28
Total persons[(b)]	**607**	**122**	**373**	**2,406**	**1,886**	**931**	**129**	**671**	**7,125**

(a) The table excludes seven closed claims where there was no relationship between claim size and claim subject sex and age group (see Box 2.1).

(b) *Total persons* include 123 persons of unknown sex. The total persons in the *Not known* age group (671) differs from the 670 such persons in tables 5.20 to 5.25 because the claims used for producing this table are not exactly the same as the claims used for tables 5.20 to 5.25 (see footnote (a) in each table).

Table 5.27: Closed claims, 2005–06 to 2009–10[a]: total claim size ($), by sex and age group (years) of claim subject (excluding *Not known*) (per cent)[b]

	Age group								
Total claim size ($)	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**
					Males				
Nil	7.3	11.8	7.8	5.0	7.5	8.4	9.3	. .	7.1
1–<10,000	49.8	42.6	32.0	34.0	36.4	47.0	55.6	. .	39.3
10,000–<100,000	12.1	25.0	29.6	31.0	33.2	32.2	27.8	. .	29.3
100,000–<500,000	10.0	14.7	22.8	23.1	17.0	10.4	7.4	. .	17.0
500,000 or more	20.8	5.9	7.8	6.9	5.9	2.0	0.0	. .	7.4
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*. .*	*100.0*
					Females				
Nil	5.2	7.7	8.6	7.3	8.0	7.2	9.6	. .	7.4
1–<10,000	49.1	38.5	32.5	37.2	39.9	50	56.2	. .	40.7
10,000–<100,000	17.2	36.5	28.8	31.4	32.3	29.7	26.0	. .	30.3
100,000–<500,000	8.2	11.5	23.3	20.1	16.0	10.3	8.2	. .	16.6
500,000 or more	20.2	5.8	6.7	4.0	3.8	2.7	0.0	. .	5.0
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*. .*	*100.0*
					Persons				
Nil	6.4	9.9	8.3	6.7	8.0	7.8	9.4	. .	7.4
1–<10,000	49.5	40.5	32.5	36.1	38.3	48.7	55.9	. .	40.1
10,000–<100,000	14.4	30.6	29.0	31.3	32.5	30.8	26.8	. .	29.8
100,000–<500,000	9.2	13.2	22.8	20.9	16.5	10.3	7.9	. .	16.7
500,000 or more	20.5	5.8	7.3	5.0	4.7	2.4	0.0	. .	6.0
Total persons[c]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

. . Not applicable.

(a) The table excludes seven closed claims where there is no relationship between claim size and claim subject sex and age group (see Box 2.1).

(b) The 28 claims coded *Not known* for 'total claim size' and 671 claims coded *Not known* for claim subject's age, including 19 coded *Not known* for both, are excluded for the purposes of calculating the percentages presented in this table. The number of claims on which the percentages presented here are based is 6,445.

(c) *Total persons* include 123 persons of unknown sex.

Note: Percentages may not add up exactly to 100.0 due to rounding.

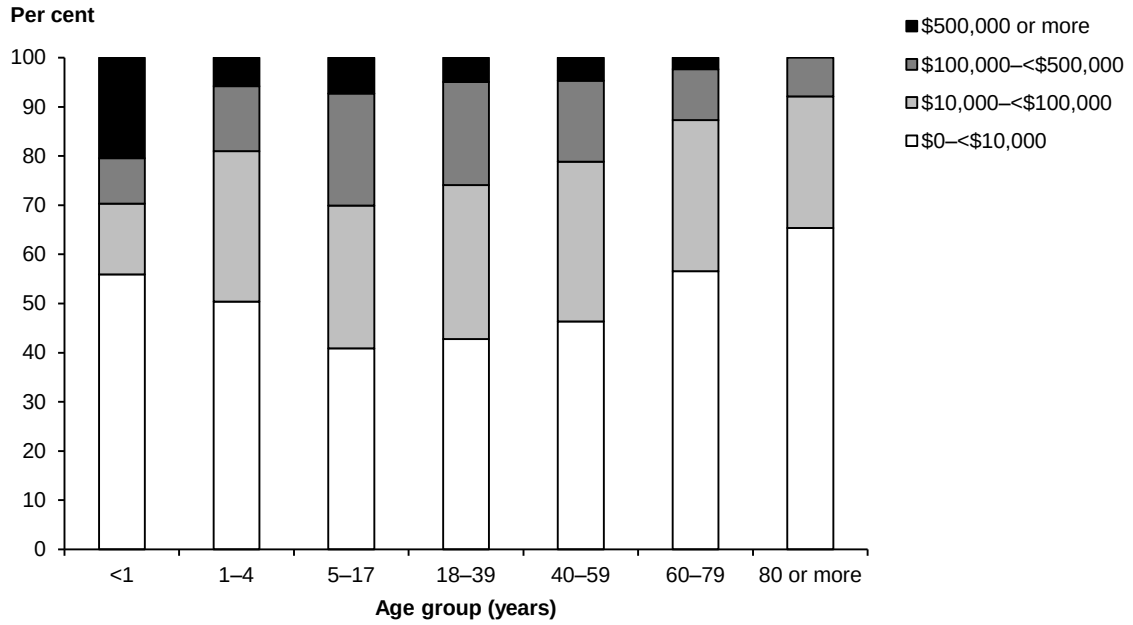


Figure 5.7: Closed claims, 2005–06 to 2009–10: total claim size, by claim subject age group (per cent)

Appendix 1: Background to the MINC collection

Background to the collection

The national medical indemnity collection was developed as a response to national policy concerns about health-care litigation, the associated costs, and the financial viability of both medical indemnity insurers and medical personnel. Without national data, robust analysis of trends in the number, nature and cost of medical indemnity claims would not be possible.

Health ministers, at the Medical Indemnity Summit in April 2002, decided to establish a 'national database for medical negligence claims' to assist in determining future medical indemnity strategies. The Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). Since July 2002, AHMAC has funded the AIHW to work with the MIDWG to develop a national medical indemnity data collection for the public and private sectors.

Collaborative arrangements

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

The MIDWG, comprising representatives from Australian, state and territory government 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 to AHMAC's National Health Information Standards and Statistics 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 many 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 de-identified 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 annex to the agreement outlines the protocols for access to, and release of, MINC data.

Purposes of the collection

The agreement that governs the MINC specifies the primary purposes of the MINC, which 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.

Appendix 2: MINC data items and key terms

Table A2.1: MINC data items and definitions

Data item	Definition
1. Claim identifier	An identity number that, within each health authority, is unique to a single claim, and remains unchanged for the life of the claim.
2. Nature of claim — loss to claim subject	A broad description of the categories of loss allegedly suffered by the claim subject (that is, the patient) that form a basis for this claim.
3. Nature of claim — loss to other party/parties	A broad description of the categories of loss allegedly suffered by another party parties (that is, people other than the patient) that form a basis for this claim.
4. Claim subject′s date/year of birth	Date or year of birth of the claim subject (beginning with the 2009−10 data reporting period, jurisdictions have agreed to supply the day and month as well as the year of the patient's birth).
5. Claim subject′s sex	Sex of the claim subject.
6. Incident/allegation type	The high-level category describing what is alleged to have 'gone wrong'; that is, the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim, reflecting key causal factors. (Up to three additional incident/allegation categories may also be recorded.)
7. Clinical service context	The area of clinical practice or hospital department in which the patient was receiving a health-care service when the incident/allegation occurred.
8. Body function/structure affected — claim subject	The primary body function or structure of the claim subject (that is, the patient) alleged to have been affected as a result of the incident/allegation. (Up to three additional body function/structure categories may also be recorded.)
9. Extent of harm — claim subject	The extent or severity of the overall harm to the claim subject (that is, the patient).
10. Date incident occurred	Calendar month and year in which the incident that is the subject of the claim occurred.
11. Where incident occurred	Australian Standard Geographical Classification Remoteness Structure category for the location where the incident occurred.
12. Health service setting	Health service provider setting in which the incident giving rise to the claim occurred.
13. Claim subject′s status	Whether the claim subject (that is, the patient) was a public or private patient, resident or non-admitted patient at the time of the incident.
14. Specialty of clinicians closely involved in incident	Clinical specialties of the health-care providers who played the most prominent roles in the incident that gave rise to the claim.
15. Date reserve first placed against claim	Calendar month and year in which a reserve was first placed against the claim.
16. Reserve range	The estimated size of the claim, recorded in broad dollar ranges.
17. Date claim commenced	Calendar month and year in which the claim commenced, as signalled by the issue of a letter of demand, issue of writ, an offer made by the defendant, or other trigger.
18. Date claim closed	Calendar month and year in which the claim was settled, a final court decision was delivered, or the claim file was closed (whichever occurred first).
19. Mode of claim finalisation	Description of the process by which the claim was finalised.
20. Total claim size	The amount agreed to be paid to the claimant in total settlement of the claim, plus defence legal costs, recorded in broad dollar ranges.
21. Status of claim	Status of the claim in terms of the stage it has reached in the process from a reserve being set to file closure.
22. Claim payment details	An indication of whether a damages payment was made to the claimant and, if so, whether the payment was to the claim subject and/or another party/parties.
23. Claim record particulars flag	Aspects of the claim record relevant to its interpretation.

Table A2.2: Definitions of key MINC terms

MINC term	Definition
Claim	'Claim' is used as an umbrella term to include **medical indemnity claims** that have materialised and **potential claims**. A single claim (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 eventuate 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.

Appendix 3: Medical Indemnity National Collection (Public Sector) data quality statement

Summary of key issues

- The Medical Indemnity National Collection (Public Sector), or MINC (PS), is a dataset that contains information on the number, nature and costs of public sector medical indemnity claims in Australia. Medical indemnity claims are claims for compensation for harm or other loss allegedly due to the delivery of health care.
- Data on medical indemnity claims may change over the life of a claim as new information becomes available or the reserve amount set against the likely cost of closing the claim is revised. For this reason, data reported for a single year's claims are subject to change over time. Readers should refer to the latest published report for the most up-to-date information on past years' claims.
- Although there are coding specifications for national medical indemnity claims data, there are some variations in how jurisdictional health authorities report medical indemnity claims.

Description

The MINC (PS) contains information on medical indemnity claims against providers covered by public sector medical indemnity arrangements. The health service may have been provided in settings such as hospitals, outpatient clinics, private general practitioner surgeries, community health centres, residential aged care facilities or mental health-care establishments or during the delivery of ambulatory care.

States and territories receive their data from public sector medical indemnifiers and government health service providers. They use their data to monitor and regulate the costs incurred from claims of harm or other loss allegedly caused through the delivery of health services covered by public sector medical indemnity arrangements.

The MINC (PS) includes:

- basic demographic information on the 'claim subject' (patient) at the centre of an alleged health-care incident
- related information such as the type of incident or allegation, the health service context and the clinician specialties involved
- the reserve amount set against the likely cost of settling the medical indemnity claim
- the time between setting the reserve and closing the medical indemnity claim, and
- the cost of closing the medical indemnity claim and the nature of any compensatory payments.

The MINC (PS) includes data for January to June 2003 and for each financial year from 2003–04 to 2009–10. The 2009–10 data covers the period from 1 July 2009 to 30 June 2010.

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act* 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a **management Board**, and accountable to the Australian Parliament through the Health and Ageing portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act* 1987, in conjunction with compliance to the *Privacy Act 1988*, (Cth) ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality. For further information see the AIHW website www.aihw.gov.au.

Data for the MINC (PS) are supplied to the AIHW by state and territory health authorities under the terms of the MINC (PS) Agreement. The MINC (PS) Agreement governs the AIHW's collection and use of the MINC (PS) data. The Agreement includes the state and territory health authorities, the Australian Government Department of Health and Ageing, and the AIHW as co-signatories. Representatives from all of these agencies make up the Medical Indemnity Data Working Group (MIDWG), which oversees the MINC (PS).

Timeliness

According to the MINC (PS) Agreement, data are provided annually by August following the financial year to which the data relate. Data cleaning and validation are scheduled for completion during the following October. For the 2009–10 year, data were received between July and October 2010, and validation was completed in March 2011.

The AIHW's publication of the MINC (PS) data in *Australia's public sector medical indemnity claims 2009–10* was originally planned for release in May 2011. It is being released in May 2012.

Accessibility

Australia's public sector medical indemnity claims 2009–10 is the eighth report in its series. All are available without charge on the AIHW website. Links to the reports are listed sequentially at: <http://www.aihw.gov.au/aihw-statistical-information-on-medical-indemnity-claims-in-australia/>.

Interactive data cubes for MINC PS 2009–10 data will follow the release of the *Australia's public sector medical indemnity claims 2009–10* report.

Release or publication of MINC data requires the unanimous consent of the MIDWG. Interested parties can request access to MINC (PS) aggregated data not available online or in reports via the Communications, Media and Marketing Unit on (02) 6244 1032 or via email to info@aihw.gov.au.

Interpretability

Information to aid in the interpretation of the data in *Australia's public sector medical indemnity claims 2009–10* is presented in Chapter 2 and 'Appendix 2: MINC data items and key terms' of the report.

Relevance

Scope and coverage

The MINC (PS) includes information on medical indemnity claims against the public sector including 'potential claims'. A potential claim is a matter considered by the relevant authority as likely to materialise into a claim and that has had a reserve placed against it. The MINC (PS) does not include information on health-care incidents or adverse events which do not result in an actual claim or which are not treated as potential claims.

There is some variation between jurisdictions in terms of which cases fall within the scope of the MINC (PS), due to different reserving practices. For 2009–10, 100% of all public sector claims considered by jurisdictions to fall within scope were reported to the AIHW.

Many of the data items in the MINC (PS) collect information on the patient or '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. The patient may or may not be a claimant, that is, the person(s) pursuing the claim. In the case of potential claims there may be no claimant. Information is not collected on the claimant as such.

Reference period

The MINC (PS) 2009–10 data covers new claims that had a reserve amount set against them between 1 July 2009 and 30 June 2010, previously closed claims that were reopened during the year, and ongoing claims from the previous year.

Indigenous identification

Information on Indigenous identification was not collected in 2009–10.

Accuracy

Data quality

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Missing data

From 2006–07, every jurisdiction has supplied data for all key data items. However, there are two data items for which data were not provided by New South Wales. These are:

- Additional incident/allegation type
- Additional body functions/structures affected—claim subject.

Also, New South Wales has provided data only on the principal clinician for the data item 'specialty of clinicians closely involved in incident'. The other jurisdictions also record the principal clinician but can include data on up to three additional clinician specialties.

Not known responses

The time required to collect all the information relevant to a medical indemnity claim can be lengthy. A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. When claims are new, the *Not known* rates for some data items can be quite high. This means that the proportions for the coded values for these same claims will change in the future as *Not known* codings are replaced with the relevant information.

Not applicable responses

The circumstances of a claim may make a data item not applicable; for instance, 'specialty of clinicians closely involved in incident' would be *Not applicable* if no clinician was involved. For the data items 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party/parties' the difference between *Not known* and *Not applicable* is sometimes not clear-cut and the codes have sometimes been used interchangeably.

Incident/allegation category definitions

Three incident/allegation categories, *Treatment*, *Medication-related* and *Procedure*, have not been fully defined. There appear to be some interventions recorded as *Treatment* by some jurisdictions but as *Medication-related* or *Procedure* by other jurisdictions.

Coherence

The AIHW's MINC database holds the most up-to-date information available on Australia's public sector medical indemnity claims. Several jurisdictions have audited their medical indemnity claims collections in recent years, or detected changes that should be made to the claim records, and all changes are reflected in the MINC database. As a result of these changes, the data reported by the AIHW on medical indemnity claims for any particular year is subject to change. Readers should refer to the latest published report for the most up-to-date information on past years' claims.

There have been a number of enhancements to the MINC (PS) specifications since the initial data collection in 2003. While the enhancements have been designed to retain comparability with previously collected data, the following changes to the 2009–10 data specifications require comment.

Mode of claim finalisation

A new *Discontinued potential claim* coding option was introduced. Discontinuation means that the claim file is closed without there being any court decision or negotiated settlement with a claimant. Prior to 2009–10, to discontinue a potential claim data providers were required to also give it a claim commencement date, and report it as a *Discontinued commenced claim*.

Status of claim

A new coding option *Rescinded – not a medical indemnity claim* was introduced for erroneous claim records and potential claims that in retrospect should not have had a reserve set against them because their likelihood of eventuating into an actual claim was low. Prior to 2009−10, when data providers wanted to remove these sorts of claim records from their list of current claims, they either reported the claim as closed or requested the AIHW to delete the claim from the master database. This coding option has resulted in a marked drop in the proportion of claims discontinued for $0 compared with the data published for previous years.

Nature of claim—loss to claim subject/other parties

For both data items, *Medical costs* was recognised as a separate category rather than being subsumed under *Other loss*. This change improves the alignment of these data items with the 'Gross Claim Payments by Heads of Damage' data item (No. 25) in the Australian Prudential Regulation Authority (APRA) National Claims and Policies Database (NCPD). However, where these data items are reported on in *Australia's public sector medical indemnity claims 2009–10*, *Medical costs* have been subsumed under *Other loss*, so as to allow comparability with previous years' data.

Extent of harm

Three of the 'extent of harm' categories were changed to bring them into alignment with the World Health Organization's International Classification of Functioning, Disability and Health, and also to allow the codes recognised for NCPD data item 17 ('Severity of injury') to be mapped on to the MINC (PS) codes. Analysis of the claims data demonstrated continuity between the 2009−10 categories and those of previous years. By and large, claims that used to have an extent of harm *Temporary – duration of less than 6 months* were now coded *Mild injury*, and claims that used to have an extent of harm *Minor, with duration of 6 months or more* or *Major, with duration of 6 months or more* were now respectively coded *Moderate injury* and *Severe injury*.

Claim subject's date of birth

Prior to 2009–10, only the claim subject's year of birth was collected. Collection of the claim subject's date of birth allows more accurate calculation of the claim subject's age at the time of the incident.

Claim record particulars flag

The great majority of claim records involve a single reserve amount set for a single health-care incident or chain of health-care incidents, with the total costs to the health authority (both legal/investigative and claimant payments) recorded as part of the claim record. The exceptions to the general rule are notified with the 'claim record particulars flag' data item introduced in 2009–10, as detailed in Box 2.1 of *Australia's public sector medical indemnity claims 2009–10*.

Use of *Not known* as a coding option for closed claims

The option to record *Not known* for closed claims was restricted to rare circumstances only. Consequently there was a marked drop in the *Not known* rates for claims closed in 2009–10 compared to previous years. There was also greater consistency between jurisdictions in using the *Not applicable* coding option (rather than *Not known*) to record the absence of any compensatory payment to the claim subject, and/or another party, when a claim was closed.

Comparison with other collections

A number of MINC (PS) data items are identical or similar to NCPD data items collected on private sector medical indemnity claims by APRA and by Insurance Statistics Australia (ISA) on behalf of APRA. The Medical Indemnity National Collection (Private Sector) held at the AIHW is based on data items in common between the MINC PS and the NCPD data collected by ISA. Public and private sector data for 2009–10 are jointly reported in the AIHW's *Public and private sector medical indemnity claims in Australia 2009–10* report, and in previous reports in the same series for earlier years.

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 each Area Health Service, selected Statutory Health Corporations listed in Schedule 2 of the Health Services Act and selected affiliated health organisations but only in respect of their recognised establishments and/or recognised services listed in Schedule 3 of the Heath Services Act.

The NSW Self Insurance Corporation (SICorp) oversees the operation of the TMF and sets the policies. Coverage is provided for all claims incurred on or after 1 July 1989.

The TMF provides indemnity to NSW Health as an Agency and, through the Claims Managers, provides a set of defined services that are intended to assist and support NSW Health in managing risks. However, these risks remain the ultimate responsibility of NSW Health's senior management.

TMF medical indemnity cover is provided by NSW Health to visiting medical officers (VMOs), honorary medical officers (HMOs), Staff Specialists Levels 2 to 5 when exercising rights of private practice and other medical practitioner health workers who use NSW health facilities such as locums and agency staff. The VMO/HMO cover, initially with effect from 1 January 2002 in a limited form, requires the Medical Practitioner to sign a Contract of Liability Coverage and have a current Service Contract prior to commencing duty at the PHO.

To maintain this TMF coverage, the VMO/HMO must cooperate with and participate in clinical quality assurance, quality improvement, risk management process and performance review processes, projects and activities as required by the PHO.

From 1 July 2003 Rural VMOs/HMOs and Staff Specialists Levels 2-5 who have rights of private practice were provided with TMF indemnity whilst treating private patients in NSW rural public hospitals.

From 1 July 2004 indemnity was extended to provide cover to VMOs/HMOs whilst treating private paediatric inpatients in NSW public hospitals and in June 2009 cover was again extended to permit VMOs/HMOs to treat privately referred non-inpatients at a NSW public hospital.

Since 1 January 2002 NSW Health has been providing three specified universities with interim cover (in specified areas of activity) through the TMF, for their clinical academics subject to the universities paying a 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 2009.

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.

It is a condition of coverage that the conduct of a claim rests entirely with the Fund Manager and this includes decisions on legal representation, expenses, settlement negotiations, settlements and the like. In order to be indemnified for a claim, full cooperation is required from all PHO employees and staff, including VMOs and HMOs, from the time an incident is reported through to the time a claim is settled or determined.

New South Wales introduced a number of reforms to keep the measure of personal injury damages within reasonable limits, beginning with reforms incorporated in the *Civil Liability Act 2002* (NSW). That Act provided a model for legislative reform in a number of other states. That Act was amended to also incorporate reform to the substantive law of negligence.

The Act limits the quantum of damages available in personal injury matters in comparison to those available at common law in NSW prior to the commencement of the Act. This is achieved through the application of thresholds, caps and interest rate changes. Limitations were introduced on claims for mental harm and nervous shock. The Act limits the extent of liability of good Samaritans.

The Act has modified the duty of care owed by professional persons. A professional can rely on compliance with peer professional opinion in Australia to avoid liability, other than in cases where the court considers that opinion to be 'irrational'.

The limitation period within which an action for personal injury must be brought under the *Limitation Act 1969 (NSW)* was amended in 2002. An action must be brought within 3 years after the date of 'discoverability' by the plaintiff, or 12 years from the time the event occurred, whichever is the earlier. (The 12 year period can be extended at the court's discretion.)

Lawyers' costs are capped in personal injury matters for claims up to $100,000, subject to the terms of any legal costs agreement—*Legal Profession Act 2004 (NSW)*.

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) for public patient work. 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 Health 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 288 practitioners insured under this scheme in 2009–10. 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 and managed through the Queensland Government Treasury Managed Fund (TMF), called the Queensland Government Insurance Fund (QGIF). 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 December 2009 Queensland Health restated its indemnity arrangements in a new indemnity policy for medical practitioners, Human Resources Policy I2. 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).

I2 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, I3. Queensland Health does not indemnify medical students.

Queensland Health MINC jurisdictional data is provided to the department by the QGIF. The data comes primarily from medical indemnity claims information supplied by the litigation panel firms engaged to provide medico-legal litigation services to the department. Therefore, the majority of Queensland Health MINC jurisdictional data 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 Quality and Complaints Commission Act 2006* 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 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 (claim limits adjusted annually)
- 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.

On 29 August 2002 PIPA was amended to apply retrospectively to injuries, except where a claim had already been lodged with a court or a written offer of settlement had been made before 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 0 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
- 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, for example, claims involving medical negligence in the treatment of a child.

Western Australia

Employees of Western Australian health system are indemnified under the State Government's policy 'Guidelines relevant to Ministers and Officers involved in Legal Proceedings' ('1990 Guidelines') tabled in the Legislative Council on 10 July 1990. In essence, the 1990 Guidelines provides that, in the ordinary course, government employees will be covered if their conduct was in good faith and reasonable and in the discharge of official responsibilities.

Commencing on 1 July 1997, RiskCover, a Division of the Insurance Commission of Western Australia, has acted on behalf of the Department of Treasury to manage the self-insurance fund covering liability claims arising from the operations of the state's agencies. Agencies are covered for, amongst other things, civil liability relating to the negligence of the employee or specified persons (e.g., students, volunteers, persons undertaking work experience) when those persons are acting in an authorised capacity on behalf of the agency.

All agencies, including 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 generally funding settlement costs on a case by case basis.

When a MTL claim naming a teaching hospital is lodged, RiskCover liaises with that hospital's claims manager. For non-teaching hospitals, RiskCover liaises with the Department of Health's Legal and Legislative Services. RiskCover oversees the case management and financial aspects of each claim through its appointed legal representatives and provides regular reports on progress through to conclusion.

From 1 July 2003, the Minister for Health has provided a contractual indemnity to eligible non-salaried medical practitioners (NSMPs) for claims of negligence, omission or trespass arising from the treatment of public and, in country areas, private patients, in public hospitals. In return, NSMPs have a number of obligations, including supporting and participating in safety and quality management programs.

A similar contractual indemnity was made available to salaried medical officers (SMOs) from 1 July 2004. In addition to covering the treatment of public patients the indemnity covers SMOs for claims relating to the treatment of private patients where the SMO, exercising a right of private practice, has assigned his or her billing rights to the hospital.

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
- various amendments to the *Civil Liability Act 2002* to:
  - codify, and in some cases vary, certain common law rules of negligence in relation to foreseeability, standard of care, causation and remoteness of damage and contributory negligence
  - provide for protection from personal civil liability for a good Samaritan who comes to the aid of another when that good Samaritan is acting in good faith and without recklessness
  - permit a person to give an apology without thereby exposing their self to personal civil liability
  - introduce a new evidentiary test in relation to the standard of care required of health professionals
  - make further provision with respect to proportionate liability.
- amendments to the *Insurance Commission of Western Australia Act 1986* to establish access to a new Community Fund underwritten by the State and managed by the Insurance Commission of Western Australia, to enable the Government to provide insurance cover to 'eligible community organisations' based in Western Australia, which are currently unable to access affordable, or any, private insurance cover; particularly Public Liability insurance
- 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.

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 SA Health's panel solicitors (the defendant's solicitors), the health unit from which the claim emanated, the SA Health's Insurance Services, Minter Ellison lawyers (SA Health—appointed claims manager), and the Insurance Division of the South Australian Financing Authority (trading as SAICORP) which is responsible for claims for amounts above the department's excess.

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 Australian Capital Territory (ACT) government employees providing clinical services are indemnified under general staff cover for professional officers. Additionally, staff specialists are 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. This indemnity scheme is now incorporated into all VMO service agreements and extends to all incidents incurred that have not otherwise been reported under any policy of insurance or like arrangement. This scheme allows the ACT to be able to recruit and retain doctors more effectively by relieving them of the financial burden of premiums in the provision of public health services.

The ACT also agreed to indemnify Australian National University (ANU) medical students who were placed in the ACT health system as part of their training, in support of the ANU's Bachelor of Medicine and Bachelor of Surgery (MBBS) program.

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 cover internationally.

Key providers of medical insurance data are the Canberra Public Hospital, Calvary Public Hospital, Mental Health ACT and Community Health, which monitor and report adverse incidents and/or potential claims.

In September 2006, ACT Health introduced RiskMan, an online reporting tool for reporting adverse clinical incidents or near misses. RiskMan defines an incident as an event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage. RiskMan is used by all clinical staff to report incidents involving both patients and members of the public. It also supports the mandatory reporting of significant incidents policy that was also established in 2006. This level of reporting ensures that potential claims are reported through to the ACT Insurance Authority within mandatory time frames (during the Period of Insurance) and ensures that adverse events are insured if a claim eventuates.

If at any time the responsible entity is served with court proceedings, the matter is notified immediately to the ACT Insurance Authority who instructs the ACT Government Solicitor's Office to act on behalf of the ACT in the matter and ensure that a defence is filed within the specified timeframe, as required.

In 2003, the ACT Legislative Assembly passed amendments to the *Civil Law (Wrongs) Act* 2002. 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 has 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. Cover is also extended to instances where care is provided to a public patient in a private hospital. 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 departmental lawyer. Upon receipt of a writ, a legal action file is established and the matter is either managed by a departmental lawyer or outsourced to a private law firm.

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 the hospital and/or staff involved), and the Departmental lawyer or the 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
  - 6 months or more.

The maximum amount of damages the court may award for non-pecuniary loss is as declared by the Minister on or before 1 October each year after the year in which the Act commenced. On 1 October 2009 the Minister declared this amount to be $457,000.

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 discretionary in the Northern Territory. Section 32 of the *Personal Injuries (Liabilities and Damages) Act 2003* empowers the court, with the consent of the parties, to make an order for a structured settlement. However, 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.

The *Compensation (Fatal Injuries) Act 1979* applies to medical negligence claims whereby family members of the deceased may make claim for burial expenses, medical expenses, loss of consortium and other usual heads of claim for such actions.

Appendix 5: Body function/structure categories

Table A5.1: 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 function/structure affected	Failed sterilisation, where there is no consequent harm to body functions or structures

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