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Foreword

A national picture of medical indemnity claims in Australia 2004–05 is the first report to present combined public and private sector medical indemnity data to give a national picture of medical indemnity claims in Australia. It arose as a result of a 2002 request by Health Ministers, who identified the potential usefulness of having information available on medical indemnity across the whole health system.

The report represents a significant step towards comprehensive medical indemnity information for the public and private sectors in Australia. A great deal of progress has been made in identifying and creating concordant data items between the public and private sector collections for this report. Progress has also been made, with valuable inputs from public and private sector data providers, in presentation of the data and accompanying explanatory notes, so that the data can be readily interpreted and used by readers.

Not all the information presented in the public sector report can be reproduced here. Differences between the public sector and private sector medical indemnity claims collections remains a limiting factor on the scope of the report at this time. Further data development work needs to occur to improve concordance and to allow a broader range of data to be presented, and the inclusion of more detailed analysis, including of trends.

This report is also currently limited by the non-presentation of information on numbers of claims. Instead it uses percentage distribution information. The Institute is keen to work with stakeholders to address this limitation whilst maintaining appropriate confidentiality of the data.

A review of the national medical indemnity information arrangements is planned for mid-2007. The review will examine the potential of the combined report, and whether it can be comprehensive and informative enough to eventually replace the separate public sector report. The Institute can be contacted for information on how to have input into this review.

The Institute will continue to work with the stakeholders, including jurisdictions and private sector medical indemnity insurers, to improve the timeliness, quality and usefulness of this report. Comments from readers are always welcome.

Penny Allbon

Director

April 2007

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Acknowledgments

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Within the AIHW, the report was written and prepared by Jane Reuter and Jenny Hargreaves with assistance from Sally Bullock and Samantha Bricknell. Cecilia Burke coordinated the publication process.

Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulatory Authority
ISA	Insurance Statistics Australia
MDO	Medical Defence Organisation
MIDWG	Medical Indemnity Data Working Group
MIIAA	Medical Indemnity Industry Association of Australia
MII	Medical Indemnity Insurer
MINC	Medical Indemnity National Collection
NCPD	National Claims and Policy Database
PSS	Premium Support Scheme
VMO	visiting medical officer

Symbols

. .	not applicable

Summary

Background

This report presents the first 12 months' data from the combined Medical Indemnity National Collection (MINC) of public and private sector medical indemnity claims. Public sector medical indemnity data have been published alone in three previous publications, for the periods January to June 2003, 2003–2004 and 2004–05. This report is the first report on medical indemnity in Australia to combine public and private sector data. The data in this report cover claims current at any time during the reporting period 1 July 2004 to 30 June 2005, that is, claims that were open at the start of the period, new claims that arose during the period, and claims finalised during the period. There is information on the incidents that give rise to claims, the medical specialties involved in claims, the people affected by these incidents, the nature of injury, and the size, outcome and length of time claims have been open.

The data presented in this report are not complete. Due to incomplete coverage of claims databases in some jurisdictions, data for approximately 85% of all public sector claims in scope are included. The private sector has reported 100% of claims in scope for this report.

This report presents data concerning claims where a formal demand for compensation for harm or other loss that allegedly resulted from a health care incident has been received by a private sector medical indemnity insurer or a public sector claim manager.

Incidents

The most common incident/allegation type leading to any claim against a clinician in 2004–05 was 'procedure' (30.5%) which includes all surgical interventions, followed by 'diagnosis' (23.6%) and 'treatment' (13.2%).

Claims

A claim is finalised when the claim is settled, a final court decision is made, or the claim is closed. 'Total claim size' is the amount agreed to be paid to the claimant in total settlement, including any interim payments, claimant legal costs and defence costs.

Over three-quarters of claims finalised in the 2004–05 financial year were finalised for less than $100,000 (77.1%). Claims with sizes in excess of $500,000 constituted 1.7% of all finalised claims. Neuromusculo-skeletal and movement–related functions and structures were the most commonly recorded as the primary body function/structure affected as a result of the incident for new claims (21.3%). The next most common category for new claims was mental functions and structures of the nervous system (12.2%), followed by genitourinary and reproductive functions and structures (11.0%).

People

Babies <1 year old were the subject of 3.6% of new claims, 4.7% of claims related to children, and 62.0% involved adults.

1 Introduction

This report presents the first 12 months' data from the combined Medical Indemnity National Collection (MINC) of public and private sector medical indemnity claims. Public sector medical indemnity data have been published alone in three previous publications, *First medical indemnity national data collection report: public sector, January to June 2003* (AIHW 2004), *Medical indemnity national data collection public sector 2003 to 2004* (AIHW 2005) and *Medical indemnity national data collection public sector 2004-05* (AIHW 2006). This report is the first report on medical indemnity in Australia to combine public and private sector data.

Medical indemnity insurance is a form of professional indemnity insurance. In the public sector, this insurance is mostly provided by state and territory health authorities. In the private sector, doctors hold individual policies with medical indemnity insurers (MIIs).

The data in this report cover claims current at any time during the reporting period 1 July 2004 to 30 June 2005, that is, claims that were open at the start of the period, new claims that arose during the period, and claims finalised during the period. There is information on the incidents that give rise to claims, the medical specialties involved in claims, the people affected by these incidents and nature of injury, and the size, outcome and length of time claims have been open. This report differs from previous public sector reports in that it includes only claims where a formal demand for compensation for harm or other loss that allegedly resulted from a health care incident has been received by a medical indemnity insurer or public sector claim manager, or legal action has commenced. Potential claims have not been included due to different management practices for these claims in the public and private sectors. Potential claims are included in previous reports on public sector claims.

The data presented in this report are not complete. Data are included for approximately 85% of all public sector claims in scope due to incomplete data collections in some jurisdictions (see further information on data scope and completeness in Section 2). Private sector medical indemnity insurers have contributed 100% of claims in scope for this report. As data completeness improves in future, the claims profile as illustrated by the data in this report may change. In addition, as this is a new collection, some data quality and coding consistency issues are yet to be resolved.

For these reasons, interpretation of the data in this report must be undertaken with caution and using the notes in Section 2.4 on data quality and completeness. Data presented here should be treated as illustrative of the future potential of the combined national collection to provide insights into the nature of and trends in medical indemnity claims in Australia.

1.1 Background to the report

At the Medical Indemnity Summit in April 2002, health ministers decided that a 'national database for medical negligence claims' should be established, to assist in determining future medical indemnity strategies and monitoring the costs associated with health care litigation and the financial viability of medical indemnity insurance in Australia.

A Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of Australian Health Ministers' Advisory Council (AHMAC) to oversee the collection of public sector medical indemnity data. In July 2002 AHMAC decided to commission the Australian

Institute of Health and Welfare (AIHW) to work with the MIDWG to further develop the Working Group's proposals for a national medical indemnity collection for the public sector.

This led to the development of the public sector MINC. The collation of data on public sector medical indemnity claims commenced in 2003. Data for the first six months of 2003 were published in December 2004 (AIHW 2004). Two full financial year reports on public sector medical indemnity claims followed this initial publication (AIHW 2005, 2006).

In 2004 the Australian Government introduced the Premium Support Scheme (PSS), as part of a comprehensive medical indemnity package to assist eligible doctors to meet the cost of their private medical indemnity insurance. Under the PSS the Australian Government enters into contracts with medical indemnity insurers in which the MIIs agree to provide information on private sector medical indemnity claims and other information to the Australian Government Department of Health and Ageing and the AIHW. This has allowed the national collection of medical indemnity claims data to now cover both the public sector and a significant part of the private sector.

In 2004 and 2005 key stakeholders in medical indemnity met to discuss the feasibility of a single national report incorporating public sector and MII data. These discussions involved representatives from the Insurance Statistics Australia (ISA) Medical Indemnity Syndicate, medical indemnity insurers, the Australian Prudential Regulation Authority (APRA), the MIDWG, the Australian Government Department of Health and Ageing and the AIHW.

In mid-2005 it was agreed that work should proceed towards the compilation of a single national report and to establish a group, the MINC Coordinating Committee (MINC CC), for this purpose.

1.2 Collaborative arrangements

The combined public and private sector MINC is governed by two agreements. One is between the Australian Government Department of Health and Ageing, the AIHW and state and territory health departments, and the second is between the Australian Government Department of Health and Ageing, the AIHW and medical indemnity insurers. The agreements outline the respective roles, responsibilities and collaborative arrangements of all parties.

The MINC CC, comprising representatives from state and territory health authorities, the Department of Health and Ageing, medical indemnity insurers and the AIHW, manages the development and administration of the combined medical indemnity data. The MINC CC also advises and reaches agreement on public release of aggregated public and private sector medical indemnity data.

The AIHW is the national data custodian of public and private sector medical indemnity data and is responsible for collection, quality control, management and reporting of the data.

High-quality data management is ensured by the data custodian through the observance of the Information Privacy Principles and National Privacy Principles (*Privacy Act 1988*), which govern the conduct of all Australian Government agencies and private organisations in their collection, management, use and disclosure of personal records. In addition the AIHW is governed by the AIHW Act 1987 and policies and procedures, approved by the AIHW board, addressing information security and privacy.

All data held by the AIHW for the purpose of producing this report are de-identified and treated in confidence by the AIHW in all phases of collection and custodianship. Any release or publication of aggregated public and private sector medical indemnity data requires the unanimous consent of the MINC CC.

2 MINC data

2.1 Scope of the report

This report presents data concerning claims where a formal demand for compensation for harm or other loss that allegedly resulted from a health care incident has been received by an MII or a public sector claim manager.

This report contains information on medical indemnity claims made against the public sector and managed by state and territory health authorities, and claims made against private sector doctors and managed by medical indemnity insurers.

Potential claims have not been included in this report. These are health care incidents reported to the MII or health authority claim manager that are considered likely to materialise into a claim, but for which a formal demand for compensation for harm or other loss has not been received. Management of potential claims varies between the public and private sectors making merging of the collections difficult for these types of claims. For this reason they have been omitted from this report.

For the private sector, some claims relating to Medical Defence Organisation (MDO) run-off, medical board and Health Insurance Commission matters are included.

Private hospital insurance claims, that is, claims against hospitals as opposed to claims against individual practitioners, are not currently within the scope of the MINC. However, all claims against doctors who maintain medical indemnity cover with an MII arising from incidents within private hospitals are included here.

2.2 Claims management practices

In a general sense, indemnity cover is provided where the clinician has diligently and conscientiously endeavoured to carry out their duty and there is no wilful misconduct or criminal activity on their part.

There are significant differences in claim management between the public sector and private sector. These differences are important to note due to their impact on the interpretation of data presented in this report.

The data presented here relate to claims, not necessarily to incidents, doctors or patients.

Briefly, health care claims managed by the private sector medical indemnity insurers relate to individual clinicians or defendants involved in incidents. Therefore, more than one claim may arise from an incident if it involved several clinicians. Health care claims managed in the public sector generally relate specifically to one claimant. More than one health care professional may be involved, but the incident gives rise to a single claim only.

Claims management practices of private sector medical indemnity insurers

Claims, doctors and incidents

In general, medical indemnity insurers insure individual doctors. It is common, but not consistent, practice for medical indemnity insurers to open more than one claim for a single claimant in respect of a particular health care incident if it involves more than one defendant. Each doctor involved is not necessarily insured by the same medical indemnity insurer, so claims arising from a single incident may be held by several insurers. Most insurers treat the claim of a patient and a separate but related claim of a dependant or relative as one claim.

The practice of opening a separate claim for each doctor involved in an incident allows the cost of claims to be allocated against the policy limits of individual doctors. In addition, because the medical indemnity insurers identify the cost of an individual insured's share of the overall claim, where more than one insured or hospital will be, or is, liable, the incurred cost of the insured's claim is proportionate to that insured's share of liability and does not reflect the total payment made in respect to the patient. This is also a requirement of the High Cost Claim Scheme[1] and the Exceptional Claims Scheme[2].

These practices must be taken into consideration when interpreting data related to claim size. Sharing of financial liability between separate claims may lead to individual claim sizes appearing to be less than the actual total cost incurred by the medical indemnity insurer.

The practices outlined above can mean that multiple claims relating to one incident may be present in the data presented here. Most commonly, multiple claims will be opened for the one incident when there are several doctors involved in an incident and a claim is made against each individual doctor involved. Claims relating to an incident may appear on more than one medical indemnity insurer database when defendants hold medical indemnity insurance with different insurers. Where a public hospital is involved in a claim against a private doctor, claims may appear on both medical indemnity insurer and health authority databases. These factors render reconciliation of claims to accurately reflect incidents in the private sector impossible.

Identification of claims

All medical indemnity insurers open a claim file and place an estimate when a written claim for compensation is made against an insured doctor. An estimate is placed against the claim to reflect the likely cost of that claim; this is termed the 'reserve'. Generally speaking, the reserve reflects the amount of payment to be made on behalf of the doctor insured and allowance is made for the contribution of other clinicians and institutions (hospitals) involved. Estimated plaintiff and defendant legal costs are added to establish the estimate. All insurers regularly review claims estimates. When the claim is closed the incurred cost represents all costs paid in respect to the claim including legal costs.

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[1] Under the High Cost Claims Scheme, the Australian Government reimburses medical indemnity insurers, on a per claim basis, 50% of the insurance payout over $300,000 up to the limit of the practitioner's cover, for claims notified on or after 1 January 2004.

[2] The Exceptional Claims Scheme is the Australian Government's scheme to cover doctors for 100% of the cost of private practice claims (either a single very large claim or an aggregate of claims) that are above the limit of their medical indemnity contracts of insurance, so that doctors are not personally liable for 'blue sky' claims.

Some insurers place reserves against notifications which the insurers consider are likely to give rise to a claim and result in a payment by the insurer. Insurers may accept verbal notifications as an incident or claim notification and reserve those notifications. Other insurers only reserve written claims for compensation, and do not accept verbal notifications. In some instances, incidents for which formal written notification of a claim has not been received may be considered 'incidents likely'. These are not considered to be active claims for the purpose of this report and are not included here.

Claims management practices of public sector claim managers

Claims, doctors and incidents

Coverage of public sector medical indemnity insurance is defined by state and territory legislation and associated policies and varies between jurisdictions. A full explanation of the policy, administrative, and legal features of each jurisdiction is available in *Medical indemnity national data collection public sector 2004–05* (AIHW 2006).

Generally, each public sector record within the MINC represents a single claim related to the claimant (in the majority of cases, the 'patient'), except in some instances, such as class actions, where one claim represents the claims of all claimants party to the action. In addition, some jurisdictions report claims against private doctors working in a public hospital separately from those claims against the hospital (and employees of the hospital).

In some jurisdictions, claims are managed in-house by the state or territory health authority; in others, most of the claims management process is handled by a body that is separate from the health authority. Some of the legal work may be outsourced to private law firms. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed.

Identification of claims

An incident that could lead to a public sector medical indemnity claim is notified to the state or territory claims management body by the health facility concerned.

Various events can signal the start of a claim, for example, a writ or letter of demand may be received from the claimant's solicitor (this can occur before notification); 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.

As the claim progresses the reserve is monitored and adjusted if necessary.

Closure of claims

A claim may be finalised in several ways—through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions settlement via statutorily mandated 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 closed. In some instances claims that have been closed are subsequently re opened.

The detail of this process varies between jurisdictions, and in some jurisdictions there are different processes for small and large claims.

2.3 Data items and definitions

The MINC consists of 21 data items. Definitions, classification codes, a guide for use and a brief history of the development of each item are documented in the *Medical indemnity national collection (public sector) data guide*, which is updated annually and published in summary form on the AIHW website.

In 2004 and 2005 key stakeholders in medical indemnity data had ongoing discussions about the feasibility of a single national report incorporating public sector and MII data. These discussions involved representatives from the Medical Indemnity Insurance Association of Australia (MIIAA), Health Professionals Insurance Australia (HPIA), the Australian Prudential Regulation Authority (APRA), Insurance Statistics Australia (ISA) Medical Indemnity Syndicate, the MIDWG, the Australian Government Department of Health and Ageing and the AIHW. It was agreed that data consistency and the efficient flow of data between organisations were crucial to the process. Work between the AIHW and the ISA Medical Indemnity Syndicate to develop the consistency of the MINC and ISA Medical Indemnity Syndicate collections has ensured the efficiency of medical indemnity data collection and transmission.

The ISA Medical Indemnity Syndicate owns the National Claims and Policy Database (NCPD). Most, but not all medical indemnity insurers report their claims data to the ISA Medical Indemnity Syndicate using the data specifications set out in the NCPD. MIIs that do not report to ISA Medical Indemnity Syndicate report their data directly to the AIHW. Data items for the public sector MINC are decided collaboratively by MIDWG.

Many of the data items collected in the ISA Medical Indemnity Syndicate NCPD are similar to MINC data items. However, not all ISA Medical Indemnity Syndicate NCPD data items map to MINC data items and only those data items with good concordance across the collections were chosen for inclusion in this report. Amendments to data specifications in the ISA Medical Indemnity Syndicate NCPD were made between 2004 and 2005. These amendments aimed to minimise the resource burden on private sector data providers and to promote consistency in overlapping areas of reporting.

The MINC data items, and the ISA Medical Indemnity Syndicate NCPD items they map to, are outlined in Table 2.1. Some explanation is also included where data items do not map directly.

Definitions of key terms used in this report are presented in Table 2.2. These definitions were written and agreed to by the MINC CC.

Table 2.1 ISA Medical Indemnity Syndicate NCPD Data items and MINC data items used for this report

MINC data item	ISA Medical Indemnity Syndicate data item	Definition of MINC and ISA data items and explanation of mapping between collections.
10 Date incident occurred	9 Date of loss	Date the incident leading to the claim is alleged to have occurred. These two data items are equivalent.
15 Date reserve first placed against claim	10 Date of report	This ISA item is the date on which the matter is notified to the insurer (which may be before the claimant takes any legal action). 'Date of report' is not strictly equivalent to the MINC items 'Date reserve first placed against a claim' which is the date that the matter is considered to be a potential claim.
18 Date claim finalised	11 Date finalised	Calendar month and year in which the claim was settled, or a final court decision was delivered, or the claim file was closed.
14 Specialty of clinicians closely involved in the incident	14.2 Speciality of practitioner at the time the incident occurred	Clinical specialties of the health care providers involved in the incident that gave rise to the claim. These items align well between the collections. The ISA specifications have separate codes for several allied health and complementary fields which are subsumed within the MINC category 'Other allied health' (including complementary medicine). In the ISA collection, 'student practitioner or intern' is a separate category. MINC codes students based on the speciality they are training in and interns within 'other hospital-based medical practitioners'.
5 Claim subject's sex	37 Claimant/patient sex	Sex of the claim subject.
4 Claim subject's year of birth	36 Claimant year of birth	Year of birth of claim subject. This data item is used to calculate claim subject's age at incident using MINC item 10 Date incident occurred and ISA item 9 Date of loss.
8a Primary body function/structure affected	16. Body functions or structures affected	The primary body structure or function of the claim subject (that is, the patient) alleged to have been affected as a result of the incident. There is concordance between the ISA and the MINC data item. Death is not included in the ISA item and was identified using ISA item 17, 'Severity of injury – Patient dies from this incident'.
6 Primary incident/allegation type	15 Cause of loss	Description of 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. There is concordance between these items.
21 Status of claim 20 Commenced (not yet finalised) 30 Finalised—claim file closed 31 Finalised—awaiting determination of total size 32 Finalised—structured settlement with total dollar value decided 33 Finalised—structured settlement with total dollar value open 40 Claim previously closed now reopened	3 Status at end of reporting period C for Current F for Finalised R for Reopened	Status of the claim in terms of the stage it has reached in the process from commencement to finalisation. MINC categories 20 map to ISA 'C'. MINC 30, 31& 32 map to ISA 'F'. MINC 40 maps to ISA 'R'.

(continued)

Table 2.1 (continued) ISA Medical Indemnity Syndicate NCPD Data items and MINC data items used for this report

MINC data item	ISA Medical Indemnity Syndicate data item	Definition of MINC and ISA data items and explanation of mapping between collections.
19 Mode of claim finalisation 1 Settled through State/Territory-based complaints processes. 2 Settled through court-based alternative dispute resolution process. 3 Settled through statutorily mandated compulsory conference process. 4 Settled—other. 5 Court decision. 6 Discontinued. 7 Not yet known.	18.2 Settlement outcome A = Award X = No award N = Negotiated W = Withdrawn	Description of the process by which the claim was closed. This data item was mapped as outlined below. Settlement outcome (18.2) → MINC Mode of claim finalisation A → 5 X → 5 N → 1, 2, 3, 4 W → 6
20 Total claim size	20 Gross payments to date	The amount agreed to be paid to the claimant in settlement of the claim, plus defence legal costs, recorded in broad dollar ranges. ISA records exact dollar amounts. These were mapped to MINC ranges.

Table 2.2: Definitions of key terms

Term	Definition
Claim	A demand for compensation for **harm** or other **loss** that allegedly resulted from a **health care incident**.
Claimant	The person who is pursuing the claim. The claimant may be the **claim subject** or an **other party** claiming for loss allegedly resulting from the incident.
Current claim	Claim opened, but not yet finalised.
Finalised claim	**Public sector** – A claim which has been closed (total claim size determined), settled or where a final court decision has been made, including claims finalised with total claim size yet to be determined (MINC(PS)). **Medical Indemnity Insurers** – A claim which is closed and no more payments expected (outstanding claim estimate is zero); all recoveries expected to be received from third parties other than re-insurers have been received (a claim may be finalised even though reinsurance recoveries are outstanding) (MINC (MII)).
Harm	Death, disease, injury, suffering and/or disability experienced by a person.
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** and/or **loss** to a person or complainant.
Health care professional	A person who is registered by a state or territory to provide medical, nursing or allied health care.
Insured	A **health care professional** who holds a medical indemnity policy with a **medical indemnity insurer** or indemnity with a state government. A health care facility insured under state or territory insurance arrangements.
Loss	Any negative consequence, including financial loss, experienced by a person.
Medical indemnity	A form of professional indemnity cover specific to the provision of health care services.
Medical indemnity claim	A claim for compensation for **harm** or other **loss** that allegedly resulted from a **health care incident**.
Medical indemnity insurer	A body corporate authorised under section 12 of the Insurance Act 1973, or a Lloyd's underwriter within the meaning of that Act, who, in carrying on insurance business in Australia, enters into contracts of insurance providing **medical indemnity** cover.
Other party	Any party or parties not directly involved in the **health care incident** but claiming **loss** allegedly resulting from the incident.
Reopened claim	A claim previously closed or **finalised** that has been reopened.

2.4 Data quality and completeness

This section provides an overview of data coverage, completeness and quality for the 2004–05 reporting period. Because data completeness and the proportion of claims for which data are not currently available affect the validity of data, these factors should be taken into account when interpreting the information presented in this report.

Data coverage and completeness

Data in this report taken from the MINC public sector collection represent approximately 85% of all claims in scope, 73% of all finalised claims and 96% of new claims. Two jurisdictions did not provide complete data:

- Victoria provided data for 84% of claims in scope for the period.
- New South Wales provided data for 66% of all claims in scope.

Data provided by the private sector is complete, that is, 100% of claims in scope were provided for this report.

This report includes New South Wales data on 'specialty of clinician closely involved in the incident' (Tables 3.1, 3.2 and 3.3) that have not been included in any previous public sector MINC publication. New South Wales claims that commenced prior to 2002 are not included in the 2004-05 data.

'Not known' rates

The category 'not known' includes instances in which the relevant information is not currently available, but is expected to become available as the claim progresses, and instances in which the information is not likely to become available within the lifetime of the claim.

High 'not known' rates for some data items reflects the fact that, in the private sector, systems and practices are not yet in place to collect some MINC data items. It is hoped that as MINC information capture and recording practices become more well-established, 'not known' rates will decrease.

The data items 'age at incident' and 'primary body function/structure affected' had the highest 'not known' rates (30.3% and 30.4%). These rates impact the data presented in Tables 3.4 and 3.5 and Figures 3.1 and 3.2 respectively. The data item 'specialty of clinician closely involved in the incident' had a 'not known' rate of less than 5.0%, (see Tables 3.1, 3.2 and 3.3). Sex of claimant had a not known rate of 10.4% (see Tables 3.4 and 3.5), and the remaining data items, 'primary incident/allegation type' and 'total claim size' had 'not known' rates of less than 5.0%.

2.5 Ongoing development of the collection

Further development of the combined public and private sector medical indemnity data is expected over the next few years. A great deal of work has occurred over the past four years to improve coordination and consistency between the two collections. This has involved changes to data items and coding categories in both ISA Medical Indemnity Syndicate NCPD

and MINC. Further data development work will be needed to achieve complete consistency between the collections.

In the future, improvements in data concordance between data specifications will increase the number of published tables and improve the comprehensiveness of this report. As the completeness and concordance between the collections continue to improve, greater analysis (such as the presentation of trend data) can be achieved, providing a more comprehensive view of indemnity claims in the public and private sectors.

This report contains combined public and private medical indemnity data for the 2004–05 financial year. This represents a delay of 22 months between the end of the data collection period and publication. It is expected that this delay will be reduced over following publications.

Further work is being considered by the MINC CC towards presenting claim rates for each specialist group. To achieve this, work to ensure the comparability of professional groups used to describe 'specialty of clinician' and medical specialty definitions in the AIHW medical labour force data collection (from which information on numbers of practitioners in each specialty would be sourced) is required.

3 National data 2004–05

In this section, claims are grouped into 'new claims', 'current claims', 'finalised claims', and 'all claims'.

New claims include all claims with a date of commencement (MINC data item 15 'Date reserve first placed' and ISA data item 10 'Date of report') within the reporting period 1 July 2004 and 30 June 2005. New claims may include claims that were also finalised within the reporting period. Current claims are claims that were open at the end of the reporting period (as at 30 June 2005). Finalised claims are claims that have been finalised at any time during the reporting period with a date of finalisation between 1 July 2004 and 30 June 2005, or that have been finalised before the reporting period but not closed. All claims is the total set of claims in the collection during the reporting period (that is, claims open at any time in the period). This is the sum of current and finalised claims, including claims that were open at the start of the period.

The following sections contain a small selection of information from each relevant data table. It is in no way intended to be a comprehensive overview of the data presented in these tables.

3.1 Incidents

This section provides information on the alleged incidents that gave rise to a claim ('primary incident/allegation type') and the professionals alleged to have been directly involved ('specialty of clinician involved').

Primary incident/allegation type

Primary incident/allegation type data describe what is alleged to have 'gone wrong'; that is, the area of the alleged error, negligence or problem that was the primary reason for the claim.

During 2004–05, current claims relating to 'procedure' were the most common (29.1%), followed by 'diagnosis' (23.6%) and 'treatment' (10.8%) (Table 3.1).

Finalised claims related to 'procedure' (25.3%) were the most common, followed by 'diagnosis' (19.5%) (Table 3.2). Similarly, new claims related to 'procedure' (30.5%) were the most common, followed by 'diagnosis' (23.6%) and 'treatment' (13.2%) (Table 3.3).

Specialty of clinicians

Specialty of clinician provides information on the health care providers who were primarily involved in the incident that gave rise to the claim. That these clinicians are recorded does in no way imply that they were at fault.

In the MINC public sector collection, up to four codes may be selected for specialty of clinician reflecting the one claim per incident nature of claim management generally used in the public system. In the private sector medical indemnity claims data, one specialty of

clinician is recorded, reflecting the specialty of the policy holder (See section 2 for further information on claims management practices in the public and private sectors).

Non-procedural general practitioners–this specialty group was most often involved in new claims relating to 'diagnosis' (44.0%), treatment (11.4%) and 'general duty of care' (11.2%) (Table 3.3).

Emergency department physicians–this specialty group was most commonly involved in claims related to diagnosis for current claims (58.8%) (Table 3.1), finalised claims (58.3%) (Table 3.2), and new claims (59.8%) (Table 3.3).

Psychiatrists– this specialty group was most commonly involved in claims citing incident/allegations related to 'general duty of care' and 'other' for current claims (25.6% and 28.9% respectively) (Table 3.1), 'general duty of care' and 'other' for finalised claims (34.3% and 35.7% respectively) (Table 3.2), and 'general duty of care', and 'diagnosis' for new claims (34.0% and 21.7% respectively) (Table 3.3).

3.2 People

Age and sex at the time of incident

During 2004–05, 3.2% of finalised claims related to babies less than one year old, 5.0% related to children (1-<18 years of age), 61.7% related to adults (18+ years of age) and in 30.1% of claims the age of the claimant was not available (Table 3.4). For new claims, 3.6% involved babies, 4.7% of claims related to children, 62.0% involved adults and in 29.7% of claims the age of the claimant was not available (Table 3.5).

For finalised claims, 59.9% related to adult males and 70.6% were related to adult females, age was unknown for 28.1% of males and 22.6% of females (Table 3.4). For new claims, 58.1% related to adult males and 70.5% related to adult females, age was unknown for 29.8% of males and 23.1% of females (Table 3.5).

Primary body function/structure affected

For new and finalised claims, Figures 3.1 and 3.2 provide a summary of the primary body function or structure of the person allegedly affected as a result of an incident. Coding examples for body function/structure categories are listed in Appendix 1.

Neuromusculo-skeletal and movement–related functions and structures were the most commonly recorded as the primary body function/structure affected as a result of the incident for both new and finalised claims, 21.3% and 13.4% respectively. The next most common category for new claims was mental functions and structures of the nervous system (12.2%), followed by genitourinary and reproductive functions and structures (11.0%). The order of these primary body functions/structures was reversed for finalised claims, with 8.1% of claims relating to genitourinary and reproductive functions and structures and 7.0% of claims relating to mental functions and structures of the nervous system. For 46.4% of finalised and 11.2% of new claims this information was not known.

3.3 Claims

Status of claim

Table 3.6 provides information on the status of claims and the primary incident/allegation type prompting the claim. Claims are grouped into those opened within the 2004–05 financial year (new claims), claims that were previously closed and are now reopened, claims finalised within the 2004–05 financial year and claims open at 30 June 2005. Claims may be counted in more than one column, for example, a claim that has been opened, settled and subsequently closed within the period will appear in the 'new claims' column as well as the 'finalised' column.

Claims newly opened in 2004–05 were most commonly related to 'procedure' (29.9%), 'diagnosis' (24.1%) and 'treatment' (12.4%). Of claims finalised within the 2004–05 period, 25.4% were related to 'procedure', 19.2% were related to 'diagnosis' and 16.5% were related to 'other' incident/allegation types.

Duration of claims

The duration of claims is measured from the date the claim was commenced to 30 June 2005 (for claims still open at this time) or to the date the claim was finalised (for claims finalised before 30 June 2005).

Of the claims open at the end of the period, 70.8% had been open for four years or less (Table 3.7) and of the claims finalised during the period, 79.2% had been open for four years or less.

Total claim size and mode of finalisation

A claim is finalised when the claim is settled, a final court decision is made, or the claim is closed. 'Total claim size' is the amount agreed to be paid to the claimant in total settlement, including any interim payments, claimant legal costs and defence costs.

Most claims were settled for less than $10,000 (53.4%) with no payment being made or costs incurred in 12.7% of claims (Table 3.8). Where structured settlements were negotiated, the final size of the claim was less than $30,000 in 53.1% of claims. Where a claim was settled by a court decision of structured settlement, 53.8% of claims were above $100,000. Where a court decision did not involve a structured settlement, 23% of claims were over $100,000.

Over three-quarters of claims finalised in the 2004–05 financial year were finalised for less than $100,000 (77.1%). Claims with sizes in excess of $500,000 constituted 1.7% of all finalised claims.

Table 3.1: Current claims: specialty of clinician, by primary incident/allegation type, 30 June 2005, Australia[a] (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)	**Anaesthetic**	**Blood and blood–product–related**	**Consent[b]**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication–related[c]**	**Procedure[d]**	**Treatment[e]**	**Other[f]**	**Not known**	**Total**
Anaesthetics	44.5	0.3	2.1	1.8	7.9	7.6	0.9	4.5	17.6	4.2	5.5	3.0	100.0
Cardiology	0	1.0	6.0	2.0	26.0	10.0	1.0	5.0	30.0	9.0	8.0	2.0	100.0
Diagnostic radiology	0	0.5	0.9	1.9	69.6	4.2	0.9	0.9	11.2	3.7	6.1	0	100.0
Emergency medicine	0.3	0	1.3	0.7	58.8	3.6	2.0	4.6	5.2	21.6	1.3	0.7	100.0
General and internal medicine	0	0.8	0.8	1.7	38.1	7.6	0.8	19.5	4.2	11.9	14.4	0.0	100.0
General practice– non-procedural	0.1	0.3	3.7	1.5	36.7	14.1	0.7	9.5	8.4	8.1	16.7	0.2	100.0
General practice–procedural	1.9	0	8.4	1.9	24.7	6.0	0.6	5.8	26.5	13.1	10.5	0.4	100.0
General surgery	1.6	0.2	6.0	0.2	15.9	5.4	1.4	1.0	57.7	6.3	4.0	0.4	100.0
Gynaecology only	0.3	0	9.5	2.7	7.8	3.7	0.3	1.0	66.0	3.4	4.1	1.0	100.0
Neurosurgery	1.0	0	6.9	0	19.6	3.9	1.0	0	52.9	9.8	3.9	1.0	100.0
Obstetrics & gynaecology	0.5	0.2	4.2	2.4	9.9	4.9	0.3	0.7	58.9	14.7	3.0	0.3	100.0
Obstetrics only	0.4	0	1.1	0	15.3	4.4	1.5	1.5	56.4	16.0	0.7	2.9	100.0
Orthopaedic surgery	0.6	0.2	8.6	1.8	11.0	4.8	4.2	0.8	54.2	9.8	3.0	1.0	100.0
Psychiatry	0.4	0	3.0	0.8	20.3	25.6	0.0	10.5	1.5	8.3	28.9	0.8	100.0
Urology	0	0	13.9	1.3	12.7	7.6	3.8	3.8	44.3	8.9	3.8	0	100.0
Other hospital–based medical practitioner[g]	4.2	0.6	4.2	0.7	25.8	11.3	1.2	5.6	21.8	14.8	8.8	0.7	100.0
Other specialties	1.2	0.7	10.9	1.1	19.4	10.3	2.1	4.6	28.9	12.3	7.8	0.6	100.0
Not known	0	2.4	2.8	0.9	11.3	4.2	7.5	0.9	12.3	7.5	6.6	43.4	100.0
Not applicable[h]	2.9	5.9	2.9	0	8.8	32.4	2.9	2.9	5.9	17.6	14.7	2.9	100.0
Per cent of current claims	**2.7**	**0.4**	**6.0**	**1.3**	**23.6**	**9.2**	**1.6**	**4.8**	**29.1**	**10.8**	**8.7**	**1.7**	**100.0**

(a) NSW data on specialty of clinician(s) are included although they were not included in the report on public sector data for 2004-05 (AIHW 2006).

(b) 'Consent' includes failure to warn.

(c) 'Medication-related' includes type, dosage and method of administration issues.

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

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

(f) 'Other' Primary incident allegation type includes; medico-legal reports, disciplinary inquiries and other legal issues, breach of confidentiality, record keeping/loss of documents and harassment and discrimination.

(g) 'Other hospital based-medical practitioner' includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(h) 'Not applicable' for this data item indicates that no clinical staff were involved in the incident.

Table 3.2: Finalised claims: specialty of clinician by primary incident/allegation type, 1 July 2004 to 30 June 2005, Australia[a] (per cent)

	Primary incident/allegation type[b]												
Specialty of clinician(s)[c]	**Anaesthetic**	**Blood and blood–product–related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication–related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	52.0	0	3.5	2.0	2.0	4.5	0.5	5.5	16.0	5.0	9.0	0	100.0
Cardiology	2.6	5.1	7.7	0	20.5	12.8	0	7.7	20.5	10.3	12.8	0	100.0
Diagnostic radiology	0	0	3.4	1.1	60.2	3.4	1.1	1.1	15.9	5.7	8.0	0	100.0
Emergency medicine	0.5	0	0.5	0	58.3	7.1	1.4	2.4	5.7	21.3	1.4	1.4	100.0
General and internal medicine	0	1.7	3.4	0	23.7	10.2	1.7	15.3	8.5	15.3	18.6	1.7	100.0
General practice– non–procedural	0.6	0.4	4.0	1.9	28.2	7.8	2.9	5.6	11.1	6.7	30.2	0.6	100.0
General practice–procedural	2.7	0.7	3.4	2.0	18.1	5.4	2.0	2.7	24.8	16.1	22.1	0	100.0
General surgery	0.7	1.1	9.8	2.5	14.2	4.7	4.0	1.1	41.8	6.2	13.8	0	100.0
Gynaecology only	0	0	7.9	3.1	14.2	2.4	0.8	0	58.3	6.3	5.5	1.6	100.0
Neurosurgery	0	0	11.1	0	11.1	8.3	2.8	5.6	41.7	8.3	8.3	2.8	100.0
Obstetrics & gynaecology	1.2	0.8	7.2	1.2	8.4	5.6	0.4	0.8	42.4	13.2	18.0	0.8	100.0
Obstetrics only	0.6	0	1.2	0	8.7	2.5	0.0	1.9	66.5	16.1	0.6	1.9	100.0
Orthopaedic surgery	1.9	1.5	6.2	4.6	18.5	5.0	3.5	0.8	42.1	7.3	7.7	0.8	100.0
Psychiatry	0	0	0.7	2.1	8.6	34.3	0	5.0	4.3	8.6	35.7	0.7	100.0
Urology	0	0	6.5	4.3	13.0	2.2	6.5	0	47.8	6.5	13.0	0	100.0
Other hospital–based medical practitioner	2.3	1.9	6.9	1.4	24.5	11.6	2.3	4.2	11.6	16.7	16.2	0.5	100.0
Other specialties	2.6	1.8	7.5	3.6	13.4	12.8	2.8	4.8	23.9	12.8	12.6	1.4	100.0
Not known	0	3.0	3.0	0	6.1	6.1	3.0	3.0	12.1	9.1	18.2	36.4	100.0
Not applicable	8.3	0	0	0	0	41.7	25.0	0	16.7	8.3	0	0	100.0
Per cent of finalised claims	**4.0**	**1.0**	**5.5**	**2.3**	**19.5**	**8.9**	**2.3**	**3.7**	**25.3**	**10.8**	**15.6**	**1.1**	**100.0**

(a) NSW data on specialty of clinician(s) are included.

(b) See Table 3.1 for definitions of primary incident/allegation type categories.

(c) See Table 3.1 for definitions of specialty of clinician categories.

Table 3.3: New claims: Specialty of clinician by primary incident/allegation type, 1 July 2004 to 30 June 2005, Australia[a] (per cent)

	Primary incident/allegation type[b]												
Specialty of clinician(s)[c]	Anaesthetic	Blood and blood–product related–	Consent	Device failure	Diagnosis	General duty of care	Infection control	Medication–related	Procedure	Treatment	Other	Not known	Total
Anaesthetics	62.4	0	0.8	1.5	6.0	3.8	0	3.8	15.8	2.3	0.8	3.0	100.0
Cardiology	2.7	0	13.5	0	16.2	13.5	2.7	8.1	21.6	8.1	8.1	5.4	100.0
Diagnostic radiology	0	0	1.1	1.1	67.0	3.2	0	0	17.0	4.3	5.3	1.1	100.0
Emergency medicine	0.5	0	0	0.5	59.8	4.6	0.5	1.4	2.7	26.0	1.8	2.3	100.0
General and internal medicine	0.0	1.8	0	1.8	26.3	12.3	5.3	22.8	1.8	17.5	5.3	5.3	100.0
General practice–non–procedural	0	0.7	3.0	0.9	44.0	11.2	1.9	8.1	7.4	11.4	10.2	1.2	100.0
General practice–procedural	2.2	0.7	12.5	2.2	25.0	5.1	0	2.2	27.2	14.7	7.4	0.7	100.0
General surgery	2.7	0.4	5.8	1.8	12.1	4.0	0.4	0.9	61.6	6.3	3.1	0.9	100.0
Gynaecology only	0	0	2.8	2.8	8.5	0.7	0	0.7	75.2	5.0	2.8	1.4	100.0
Neurosurgery	0	0	2.9	2.9	17.6	5.9	0	2.9	47.1	17.6	0	2.9	100.0
Obstetrics & gynaecology	0	0	4.4	3.7	12.6	3.0	0	0	55.6	18.5	2.2	0	100.0
Obstetrics only	0.5	1.0	0	0	12.9	2.6	0.5	1.5	59.3	15.5	1.0	5.2	100.0
Orthopaedic surgery	0.9	0	7.1	0.9	7.1	3.8	4.7	0.5	60.8	10.8	0.5	2.8	100.0
Psychiatry	0.9	0	1.9	0	21.7	34.0	0	5.7	0	9.4	12.3	14.2	100.0
Urology	0	0	0	0	22.7	4.5	0	0	72.7	0	0	0	100.0
Other hospital–based medical practitioner	5.8	0	5.5	0.3	24.4	8.4	1.6	7.1	24.1	16.7	4.5	1.6	100.0
Other specialties	1.8	1.5	6.9	0.8	18.1	12.5	2.5	4.5	30.5	15.6	3.2	2.0	100.0
Not known	0	3.3	0	0.8	5.7	3.3	0	0	5.7	9.8	1.6	69.7	100.0
Not applicable	8.3	0	0	0	8.3	29.2	0	0	12.5	20.8	16.7	4.2	100.0
Per cent of new claims	**3.9**	**0.7**	**4.3**	**1.1**	**23.6**	**8.3**	**1.4**	**3.9**	**30.5**	**13.2**	**4.3**	**4.8**	**100.0**

(a) NSW data on specialty of clinician(s) are included.

(b) See Table 3.1 for definitions of primary incident/allegation type categories.

(c) See Table 3.1 for definitions of specialty of clinician categories.

Table 3.4: Finalised claims: sex and age of claim subject at incident, by primary incident/allegation type, 1 July 2004 to 30 June 2005, Australia (per cent)

Primary incident/allegation type[(a)]	Age at incident				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	1.3	1.3	65.8	31.6	100.0
Blood/blood–product–related	0	0	94.1	5.9	100.0
Consent	1.9	5.8	68.0	24.3	100.0
Device failure	5.3	3.5	66.7	24.6	100.0
Diagnosis	2.5	10.6	68.7	18.2	100.0
General duty of care	1.2	3.0	55.6	40.2	100.0
Infection control	1.4	18.8	69.6	10.1	100.0
Medication	0	3.8	66.3	30.0	100.0
Procedure	12.5	8.3	56.1	23.1	100.0
Treatment	9.5	9.5	51.5	29.5	100.0
Other	0.3	3.2	50.3	46.3	100.0
Not known	11.8	11.8	41.2	35.3	100.0
Total males	*4.7*	*7.3*	*59.9*	*28.1*	*100.0*
Females					
Anaesthetic	0	3.0	68.2	28.8	100.0
Blood/blood–product–related	0	0	81.3	18.8	100.0
Consent	0	4.2	80.6	15.3	100.0
Device failure	0	2.6	80.5	16.9	100.0
Diagnosis	2.2	5.2	77.6	15.0	100.0
General duty of care	1.2	3.1	66.9	28.8	100.0
Infection control	0	10.6	66.7	22.7	100.0
Medication	3.2	5.4	74.2	17.2	100.0
Procedure	3.5	4.0	77.4	15.0	100.0
Treatment	7.6	6.5	60.6	25.3	100.0
Other	0	4.3	56.7	38.9	100.0
Not known	10.5	0	52.6	36.8	100.0
Total females	*2.3*	*4.5*	*70.6*	*22.6*	*100.0*
Persons [(b)]					
Anaesthetic	0.4	1.8	64.0	33.8	100.0
Blood/blood–product–related	0	0	84.6	15.4	100.0
Consent	0.8	3.1	74.4	21.7	100.0
Device failure	2.1	2.7	69.2	26.0	100.0
Diagnosis	2.4	7.4	72.0	18.2	100.0
General duty of care	1.1	2.8	56.9	39.3	100.0
Infection control	0.7	14.5	67.4	17.4	100.0
Medication	1.5	4.0	61.6	32.8	100.0
Procedure	6.8	5.2	68.3	19.6	100.0
Treatment	8.6	7.2	53.6	30.6	100.0
Other	0.1	3.2	44.5	52.2	100.0
Not known	14.3	4.8	42.9	38.1	100.0
Per cent of finalised claims	**3.2**	**5.0**	**61.7**	**30.1**	**100.0**

(a) See Table 3.1 for definitions of primary incident allegation types.

(b) 'Total persons' includes claims for which sex of claim subject was not known / indeterminate.

Note: NSW does not provide data on year of birth so age groupings are used.

Table 3.5: New claims: sex and age of claim subject at incident, by primary incident/allegation type, 1 July 2004 to 30 June 2005, Australia (per cent)

Primary incident/allegation type	Age at incident				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0	5.0	70.0	25.0	100.0
Blood/blood–product–related	0	0	44.4	55.6	100.0
Consent	0	0	73.7	26.3	100.0
Device failure	0	0	71.4	28.6	100.0
Diagnosis	3.6	7.9	63.5	24.9	100.0
General duty of care	2.9	4.4	54.4	38.2	100.0
Infection control	4.5	18.2	45.5	31.8	100.0
Medication	0	15.0	60.0	25.0	100.0
Procedure	8.3	6.7	63.4	21.7	100.0
Treatment	12.6	8.9	54.1	24.4	100.0
Other	1.6	0	7.9	90.5	100.0
Not known	3.7	0	66.7	29.6	100.0
Total males	*5.4*	*6.7*	*58.1*	*29.8*	*100.0*
Females					
Anaesthetic	1.6	3.2	67.7	27.4	100.0
Blood/blood–product–related	0	0	22.2	77.8	100.0
Consent	0	2.2	84.6	13.2	100.0
Device failure	0	5.6	88.9	5.6	100.0
Diagnosis	1.3	7.5	74.4	16.9	100.0
General duty of care	3.2	1.1	58.1	37.6	100.0
Infection control	0	0	46.7	53.3	100.0
Medication	0	2.1	74.5	23.4	100.0
Procedure	3.9	2.0	80.2	13.9	100.0
Treatment	5.3	4.7	61.2	28.8	100.0
Other	0	10.2	53.1	36.7	100.0
Not known	0	0	15.8	84.2	100.0
Total females	*2.6*	*3.8*	*70.5*	*23.1*	*100.0*
Persons [(a)]					
Anaesthetic	0.9	3.7	66.4	29.0	100.0
Blood/blood–product–related	0	0	33.3	66.7	100.0
Consent	0	1.4	75.7	22.9	100.0
Device failure	0	3.8	80.8	15.4	100.0
Diagnosis	2.4	7.3	67.0	23.3	100.0
General duty of care	2.9	2.3	52.9	41.9	100.0
Infection control	2.7	10.8	45.9	40.5	100.0
Medication	0	7.2	62.9	29.9	100.0
Procedure	5.2	3.5	73.4	17.8	100.0
Treatment	9.1	6.3	55.8	28.7	100.0
Other	0.9	4.3	27.8	67.0	100.0
Not known	0.7	0	19.0	80.3	100.0
Per cent of new claims	**3.6**	**4.7**	**62.0**	**29.7**	**100.0**

(a) Persons include claims for which sex of claim subject was not known or indeterminate.

Notes

1. NSW does not provide data on year of birth so age groupings are used.
2. Other' Primary incident allegation type includes: medico-legal reports, disciplinary inquiries and other legal issues, breach of confidentiality, record keeping/loss of documents, and harassment and discrimination.

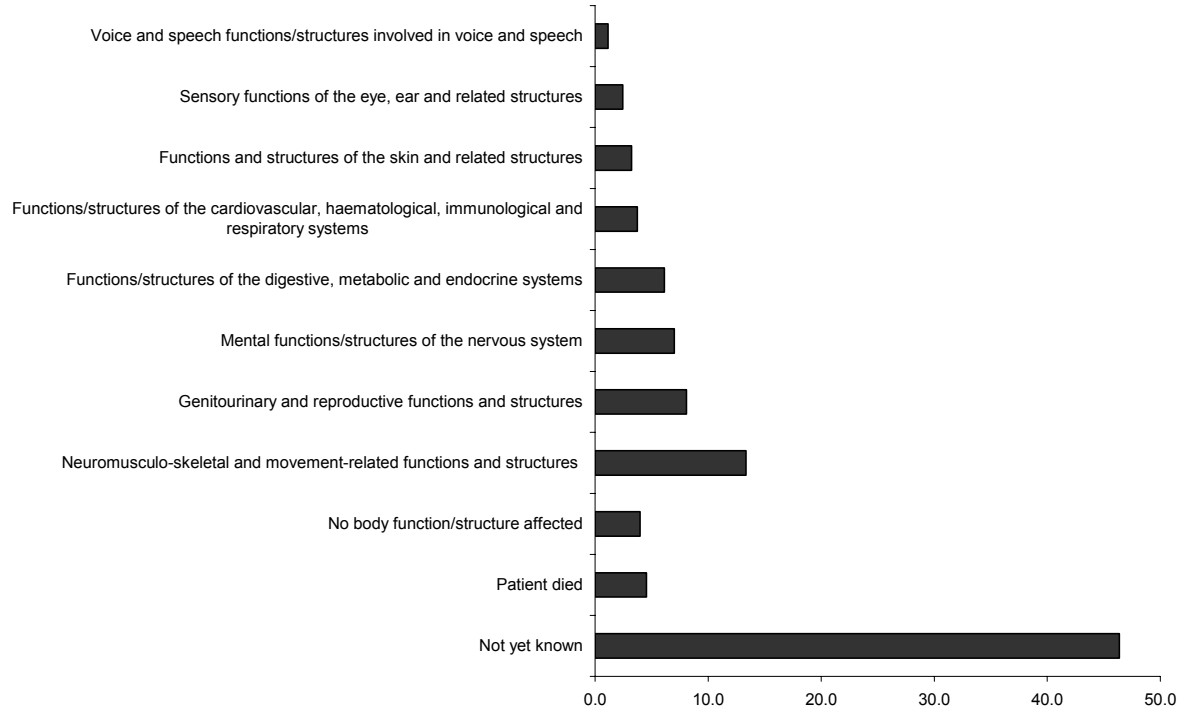

Figure 3.1: Finalised claims: primary body function/structure affected, 1 July to 30 June 2005, Australia (per cent)

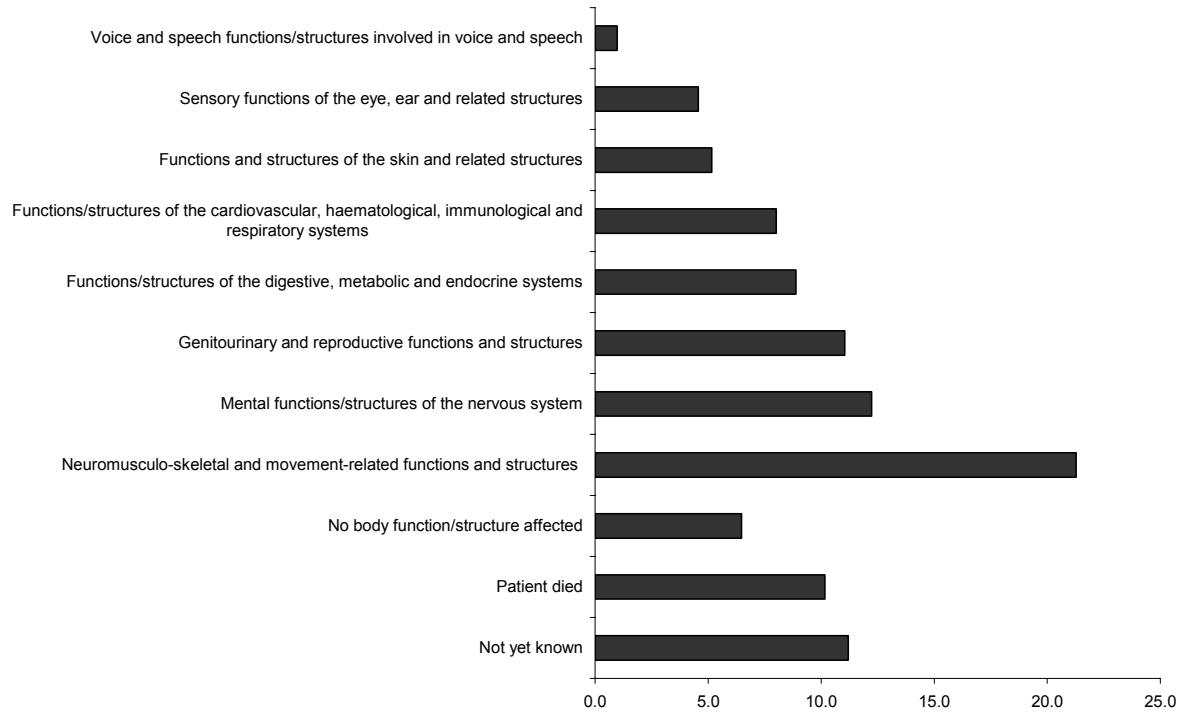

Figure 3.2: New claims: primary body function/structure affected, 1 July 2004 to 30 June 2005, Australia (per cent)

Table 3.6: All claims: Status of claim by primary incident/allegation type, 30 June 2005, Australia (per cent)

	Status of claim			
Primary incident/ allegation type	**New claims (1 July 2004 – 30 June 2005)**	**Reopened**	**Finalised**	**Claims open at 30 June 2005**
Anaesthetic	4.2	4.7	3.9	2.7
Blood / blood product-related	0.7	0	1.0	0.4
Consent / dissatisfaction	5.5	5.4	5.7	6.3
Device failure	1.0	1.4	2.3	1.4
Diagnosis	24.1	23.0	19.2	23.1
General duty of care issues	6.8	4.1	8.9	9.3
Infection control	1.5	0.7	2.4	1.5
Medication-related	3.8	5.4	3.6	4.7
Procedure	29.9	31.1	25.4	29.5
Treatment	12.4	8.1	10.1	10.1
Other	5.2	16.2	16.5	9.0
Not yet known	4.9	0	1.1	1.8
Total	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. Status is at 30 June 2005.
2. 'Finalised' claims in the MINC (PS) include claims which have been closed (and total claim size determined) or, where a final court decision has been made, including claims finalised with total claim size yet to be determined. Finalised claims in the MINC (MII) include claims which are closed and no more payments expected or all recoveries expected to be received from third parties other than re-insurers have been received (a claim may be finalised even though re-insurance recoveries are outstanding).
3. 'Reopened' claims include claims that have previously been recorded as finalised, but have then been re opened and are active.
4. Due to coding inconsistencies and availability of data, structured settlements are not included as a separate category. Structured settlements are included here in the finalised claims category.

Table 3.7: All claims: Status of claim by length of claim (months), 30 June 2005, Australia (per cent)

	Length of claim at 30 June 2005 (months)											
Status of claim	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
New claims (1 July 2004 – 30 June 2005)	52.4	47.6	..	..	..	..	..	..	..	..	..	100.0
Reopened	1.4	1.4	5.4	8.8	16.2	11.5	8.1	11.5	10.1	8.8	16.9	100.0
Finalised	6.1	11.3	13.6	14.0	11.5	10.0	7.9	4.8	4.6	4.3	12.0	100.0
Claims open at 30 June 2005	14.4	10.6	10.2	8.8	8.7	6.6	5.4	6.1	5.1	2.8	21.2	100.0

Notes

1. Length of claim is from date claim commenced.
2. Length of claim for finalised claims is from 'date claim commenced', to 'date claim finalised'. Finalised claims differ in definition for MINC (PS) and MINC (MII) collections (see definitions below).
3. 'Finalised' claims in the MINC public sector claims data include claims which have been closed (and total claim size determined) or, where a final court decision has been made, including claims finalised with total claim size yet to be determined. Finalised claims in the MII collection include claims which are closed and no more payments expected, or all recoveries expected to be received from third parties other than reinsurers have been received (a claim may be finalised even though reinsurance recoveries are outstanding).
4. Status of claim is at 30 June 2005.
5. 'Reopened' claims include claims that have previously been recorded as finalised, but have then been re opened and are active.

Table 3.8: Finalised claims: Total claim, size by mode of claim finalisation, 1 July 2004 to 30 June 2005, Australia (per cent)

	Court decision[a]		Negotiated[b]			
Total claim size	Structured settlement	No structured settlement	Structured settlement	No structured settlement	Withdrawn[c]	% of finalised claims
Less than $10,000	0	63.9	23.9	53.1	60.2	53.4
$10,000–<$30,000	15.4	9.8	29.2	10.1	10.1	11.1
$30,000–<$50,000	15.4	3.3	15.9	7.1	2.2	6.2
$50,000–<$100,000	15.4	0	13.3	8.3	0.8	6.4
$100,000–<$250,000	19.2	4.9	11.5	7.6	0.6	5.9
$250,000–<$500,000	26.9	6.6	3.5	2.8	0.2	2.5
$500,000 or more	7.7	4.9	0.9	2.3	0.0	1.7
No payment made	0	6.6	0	8.6	25.7	12.7
Not known	0	0	1.8	0	0.3	0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) 'Court decision' from MII claims data includes claims where damages were awarded to the plaintiff by court (either initially or on appeal) and where the case was awarded against the plaintiff by the court (either initially or on appeal) and MII incurs costs only.

(b) 'Negotiated' from public sector claims data includes proceedings conducted in state/territory health rights and health complaints bodies; mediation, arbitration, and case appraisal provided under civil procedure rules; settlement conferences required by statute as part of a pre-court process; and other instances where a claim is settled part way through a trial. 'Negotiated' from MII claims data includes settlement outcomes where an amount is paid to the plaintiff other than by court direction.

(c) 'Withdrawn' from public sector claims data includes claims that have been closed due to withdrawal by claimant, or operation of statute of limitations, or where the claim manager decided to close the claim file because of long periods of inactivity, and instances where a claim is discontinued part way through a trial. 'Withdrawn' claims from MII claims data include claims where the claimant withdrew the claim and the MII incurs costs only.

Appendix 1: Body function/structure categories

Table A1: Coding examples for body function/structure categories

Body function/structure coding category	Examples of types of harm
1. Mental functions/structures of the nervous system	Psychological harm (e.g. nervous shock)
	Subdural haematoma
	Cerebral palsy
	Paralysis
2. Sensory functions of the eye, ear and related structures	Loss of hearing
	Loss of sight
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/sepsis
	Deep vein thrombosis
	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	Injury to the gall bladder, bowel, pancreas or liver
6. Genitourinary and reproductive functions and structures	Injury to the breast
	Injury to male or female reproductive organs
	Injury to the kidney
7. Neuromusculo-skeletal and movement-related functions and structures	Loss of function due to inappropriate casting of joint
8. Functions and structures of the skin and related structures	Burns
9. Death	'Death' is recorded where the incident was a contributory cause of the death of the claim subject
10. No body functions/structures affected	Failed sterilisation, where there is no consequent harm to body functions or structures

List of tables

List of figures

References

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