Medical indemnity national data collection public sector 2006–07

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SAFETY AND QUALITY OF HEALTH CARE SERIES
Number 5

Medical indemnity national data collection public sector 2006–07

2009

Australian Institute of Health and Welfare
Canberra
Cat. no. HSE 67

This publication is part of the Australian Institute of Health and Welfare's Safety and quality of health care series. A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISSN 1833-7422

ISBN 978 1 74024 869 3

Suggested citation

Australian Institute of Health and Welfare 2009. Medical indemnity national data collection public sector 2006–07. Cat. no. HSE 67. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

Printed by Bluestar Digital, ACT

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Acknowledgments

Special thanks are extended to the Medical Indemnity Data Working Group, the members of which have been responsible for coordinating the collection of the Medical Indemnity National Collection (MINC) data in their respective jurisdictions. They have provided invaluable advice and commentary during the drafting.

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Abbreviations

A&E	Accident and Emergency
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
HMO	honorary medical officer
IRM	Integrated Resource Manual
MIDWG	Medical Indemnity Data Working Group
MINC	Medical Indemnity National Collection
MTL	Medical Treatment Liability
NSMP	non-salaried medical practitioner
PHO	public health organisation
PIPA	*Personal Injuries Proceedings Act 2002*
SS	staff specialist
TMF	Treasury Managed Fund
VMIA	Victorian Managed Insurance Authority
VMO	visiting medical officer

Symbols

. .	Not applicable

Summary

This is the fifth report in a series reporting on public sector medical indemnity claims data. It covers the period from 1 July 2006 to 30 June 2007. The report draws on data from the Medical Indemnity National Collection (MINC), which was developed in 2003–04. The collection provides information on the allegations of harm that gave rise to claims, the people affected, and the size, duration and mode of finalisation of medical indemnity claims.

The quality of the collection has steadily improved over the last four years. The coverage has increased to 93% of all claims in scope (80% of closed claims) and data completeness has also improved, as seen by the decreasing rates of *Not known* being coded.

Claims

Some 4,100 claims were current at the end of the reporting period—a decline by almost one thousand over the course of the year, with 1,300 new claims and 2,200 finalised claims. 'Potential' claims are included and comprised roughly 20% of total claims.

No payment was made to the claimant and no defence or claimant legal costs incurred for roughly 27% of finalised claims, and over half (1,218 claims, 55%) had a total claim size of less than $10,000. Total claim size including legal costs was less than $100,000 for approximately 83% of finalised claims, and in excess of $500,000 for roughly 4% of finalised claims. The most common 'Mode of claim finalisation' was for claims to be *Discontinued*, affecting nearly half of finalised claims. For the other finalised claims, almost two-thirds were recorded as *Settled—other* (including those settled part way through a trial), about a fifth were settled through a *State/territory complaints process* and less than 5% were finalised via a *Court decision*.

General surgery was the most frequently recorded 'Clinical service context' for the current reporting period, overtaking *Obstetrics* for the first time. Three recorded clinical service contexts (*General surgery, Obstetrics,* and *Accident and emergency*) were associated with roughly half of all claims. The pattern was similar for new claims arising during the year. Medical or surgical *Procedures* (36%) were the most commonly recorded 'Primary incident/allegation type' in medical indemnity claims, followed by *Diagnosis* (23%) and *Treatment* (16%).

Almost two thirds of all claims arose from incidents in *Major cities*. This contrasts with the 1% that arose in *Remote and very remote areas*.

People

Almost 70% of claims involved adults and 10% involved babies (less than 1 year old) with a similar figure for children. The age was not specified in 10% of claims.

Alleged harm to *Neuromusculoskeletal and movement-related functions and structures* accounted for some 20% of claims. There was a similar figure for *Mental functions and structures of the nervous system*. For 13%, the claim subject died allegedly as a result of the harm that gave rise to the claim.

Data comparisons 2003–04 to 2006–07

The number of new claims increased from about 1,600 to 1,900 between 2003–04 and 2005–06 but declined to around 1,300 claims in 2006–07. When adjusted for a one-off factor affecting one jurisdiction, new claims have been declining over the 4-year period by about 15% per annum. The profile of medical indemnity claims has been similar over the four reporting periods. However, one observed change has been in the proportion of claims arising from treatment in the clinical context of *General surgery*; it increased from 11% of all claims in 2003–04 to 18% of all claims in 2006–07.

1 Introduction

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

This report presents data collected through the MINC and provides information on the number, nature, incidence and costs of public sector medical indemnity claims. These data include details of the incidents that gave rise to claims, the people affected, and the size, duration and settlement of medical indemnity claims.

This is the fifth report in the series. The first report—*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 six months of data. Annual data, for the 2003–04 2004–05 and 2005–06 financial years, were presented in the second, third and fourth reports—*Medical indemnity national data collection public sector 2003 to 2004* (AIHW 2005), *Medical indemnity national data collection public sector 2004–05* (AIHW 2006a), and *Medical indemnity national data collection public sector 2005–06* (AIHW 2007a).

In 2006, the MINC was expanded to include claims data from private sector medical indemnity insurers. The first report containing combined public and private sector medical indemnity claims data, *A national picture of medical indemnity claims in Australia 2004–05,* was published by the Australian Institute of Health and Welfare in May 2007 (AIHW 2007b). It was followed by *Public and private sector medical indemnity claims in Australia 2005–06: a summary* in August 2008 (AIHW 2008). The combined public and private sector collection is now under review to determine whether the data underlying the combined reporting can be improved sufficiently to replace this public sector-only report.

Further information on the development of the MINC is in Appendix 3.

2 The collection

2.1 Scope and context

The MINC contains information on medical indemnity claims in the public sector. They are claims for compensation for harm or other loss resulting from health care as a result of an allegation of harm or other loss. They 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 (those that are likely to eventuate in an actual claim and have had a reserve placed against them).

Each claim has a reserve amount placed against it, which is an estimate of the cost of resolving the claim. Information in the MINC relates only to allegations of harm resulting or potentially resulting in legal proceedings. Adverse events or harm caused by medical treatment, which do not result in a claim, are not reported in this report.

Data for 2006–07 relate to claims that were current at any time during the reporting period (July 2006 to June 2007). It includes claims that were open at the start of the period (1 July 2006) and new claims that arose during the period. A proportion of current claims were closed (or finalised) during the period[1].

2.2 Policy, administrative and legal context

The state and territory governments manage public sector medical indemnity insurance. In 2002, an expert panel established by all governments reviewed the law of negligence as it applies to claims for personal injury and death. One of its terms of reference (as set out in the 'Ipp Report'[2]) was to 'develop and evaluate principled options to limit liability and quantum of awards for damages' (Commonwealth of Australia 2002).

The review recommended that a single statute be enacted in all jurisdictions to achieve national consistency in proceedings relating to claims for personal injury and death. While this did not eventuate, state and territory legislation largely conforms to a set of principles formulated by the expert panel that conducted the review.

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. There are also jurisdictional variations in the implementation of tort law reform.

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1 Closed claims are claims that were closed during the reporting period (2,214 claims had a closed date from 1 July 2006 to 30 June 2007).

2 The Ipp report or *Review of the law of negligence* was released on 2 October 2002 following the Ministerial Meeting on Public Liability Insurance on 30 May 2002. The Commonwealth, in consultation with the states and territories, agreed to jointly appoint an expert panel to examine the law of negligence. Broadly, the review examined a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death.

Administrative arrangements and 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 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. (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, based on an estimate of the likely 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 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.
4. The claim is investigated. This can involve liaising with clinical risk management staff within 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 closed 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 it is 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

The MINC has 21 data items as summarised in Table 2.2. Table 2.3 provides definitions of key MINC terms. 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*. For details see the 2004–05 data guide published on the AIHW website (AIHW 2006b).

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 harm, the circumstances surrounding the claim, and other parties involved (including any other parties alleged to have suffered loss, and health service providers). The sex and year of birth of the claim subject are also collected if available. 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 the incident. Information is not collected about the claimant as such. MINC records do not contain information that would allow the identification of either the individual or health service provider involved in a claim.

Health authorities transmit MINC data to the AIHW every 6 months for collation. The data transmitted represents the claim manager's 'best current knowledge' about the claims at the end of each reporting period.

Changes were made to some data items and specifications with effect from 1 July 2005. These relate to the data items 'Total claim size' and 'Status of claim'. A summary of pre-July 2005 claim codes and their corresponding post-July 2005 codes is set out in Table 2.1.

Where previously there was no payment or legal costs, and 'Total claim size' had been coded *No payment made*, it is now coded *$0* (zero dollars). The post-July 2005 specifications also removed the category for finalised claims awaiting determination of total claim size (aggregating such claims with other commenced claims). The codes for structured settlements which are open (undecided) and closed (decided) were also revised.

The item 'Status of claim' was reported under eight headings in the 2004–05 report (AIHW 2006a). In the 2005–06 and current report, claims are presented under the four headings: *Not yet commenced, Commenced, Closed* and *Previously closed, now reopened*. This simplification has been achieved with the removal of a category for finalised claims awaiting claim size determination, the inclusion of claims coded as *Structured settlement—claim file open* in the *Commenced* category, and the inclusion of claims coded *Structured settlement—claim file closed* in the *Closed* category.

Table 2.1: Changes to MINC data items from 1 July 2005

Data item	Pre-July 2005	Post-July 2005
20 Total claim size	Code 11 *No payment made*	Code 0 *$0*.
21 Status of claim	Code 20 *Commenced (not yet finalised)*	Code 20 *Commenced*
	Code 31 *Finalised—awaiting determination of total size*	Code 20 *Commenced*
	Code 32 *Finalised—structured settlement with total dollar value decided'*	Code 32 *Structured settlement—claim file open*
	Code 33 *Finalised—structured settlement with total dollar value open*	Code 33 *Structured settlement—claim file closed*

Table 2.2: 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 an other party or parties (that is, people other than the patient) that form a basis for this claim.
4. Claim subject's year of birth	Year of birth of claim subject.
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 type 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 occurred.
8. Body function/structure affected—claim subject	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. (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 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, 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 defendant, or other trigger.
18. Date claim closed	Calendar month and year in which the claim was settled, or 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 closed.
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.

Table 2.3: 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.

Key counts

While each record in the MINC represents a single claim, the data can be used to produce different counts of claims, as described in Box 2.1.

Box 2.1 Counting rules for the MINC data set

The definition of 'claim' includes 'potential claims' (See section 2.1). Claims are categorised as follows:

- *The term 'claim' unless otherwise specified is a claim that was open at any time during the reporting period. There were **6,284 claims** in the MINC database for the period 1 July 2006 to 30 June 2007 comprising:*
  - *Current claims **(4,070 claims)** – claims that were open at the end of the reporting period.*
  - *Closed claims **(2,214 claims)** – claims that were finalised during the reporting period.*
- *New claims **(1,251 claims)** are those that were opened during the reporting period. New claims can either be current or closed.*

Each claim has a single 'claim subject' (the patient directly involved in the incident that led to the claim). On occasions there may be more than one person pursuing the claim (more than one claimant), for instance where multiple dependents of the claim subject allege loss to themselves due to the health care incident.

For some MINC data items more than one category can be recorded per claim. These items are:

- *Nature of claim – loss to claim subject.*
- *Nature of claim – loss to other party/parties.*
- *Incident/allegation type.*
- *Body function/structure affected – claim subject.*
- *Specialty of clinicians closely involved in the incident.*

For each of these items data may be presented as the total number recorded across all categories (which in most cases will be greater than the number of claims).

2.4 Data quality and completeness

This section provides an overview of data coverage, completeness and quality. Data completeness and *Not known* rates are important because they affect the reliability of data and can influence the interpretation of the analysis (in particular, in relation to time series data).

Data coverage and completeness

Data completeness has improved from 80% of claims in scope being included in 2003–04 to 93% of claims in scope being included in 2006–07 (see Table 4.1). Nearly all new claims had complete data but only 80% of closed claims did. New South Wales provided 100% of claims in scope during this reporting period compared to 87% in the previous report. This could have resulted if claims opened prior to 2002, which were not previously included in the MINC, had been closed or back-coded for the purposes of the 2006–07 data submission.

Both New South Wales and Victoria audited their medical indemnity claims collections leading up to the 2006–07 data submission. Consequently they were able to report on a larger number of their claims in scope.

Missing data

New South Wales now provides data for the data items 'Nature of claim—loss to other party/parties', 'Claim subject's year of birth' and 'Extent of harm—claim subject'. It does not, however, provide data for:

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

New South Wales provides data only on the primary clinician for the data item *Specialty of clinicians closely involved in incident*. However, the other jurisdictions can record up to four clinicians. The decision has been made to incorporate this information on additional clinical specialty involvement when relating clinician specialty to other data items of interest.

Data quality

Not known rates

A coding of *not known* is used when information is either not currently available but expected to become available or not expected to be available through the lifetime of the claim. *Not known* rates across most data items have decreased whether in comparison to the 2004–05 or 2005–06 reporting period.

For the 2006–07 reporting period, the item 'Nature of claim—loss to other parties' had a *Not known rate* of 54.9%. The item 'Nature of claim—loss to claim subject' (52.8%) had the next highest *Not known* rate (Table 2.4). The Medical Indemnity Data Working Group (MIDWG) has agreed to examine the value and usefulness of this item.

Not known rates for the following three items ranged between 12% and 24%—'Extent of harm—claim subject', 'Claim subject's status,' and 'Claim subject's year of birth'. The remaining data items each recorded less than 10% for *Not known* responses.

Coding consistency

The AIHW undertakes data cleaning and validation checks on the data it receives. It raises queries when changes in data items across recording periods appear to be illogical or unexpected—for example, claim status changing from *Closed* to *Commenced*.

Table 2.4: MINC data items: number and percentage of claims for which 'not known' was recorded, 1 July 2006 to 30 June 2007

Items for all states and territories	Number	Per cent of all claims
Nature of claim—loss to other parties[(a)]	2,691	54.9
Nature of claim—loss to claim subject	3,320	52.8
Extent of harm—claim subject	1,483	23.6
Claim subject's status	961	15.3
Claim subject's year of birth	788	12.5
Primary body function/structure affected	376	6.0
Clinical service context	305	4.9
Primary incident/allegation type	278	4.4
Primary specialty of clinician closely involved in incident	188	3.0
Health service setting	134	2.1
Claim subject's sex	68	1.1
Where incident occurred	9	0.1
Closed claim items		
Mode of claim finalisation	6	0.3
Total claim size	6	0.3
Items for all states and territories except NSW[(b)]		**Per cent of non-NSW claims**
Additional incident/allegation type	2	<0.1
Additional body functions/structures affected	4	0.1

(a) A total of 1,384 claims have not been coded for 'Nature of claim—loss to other parties', and the 'Not known' rate is calculated with respect to only those claims that have been coded for this data item.

(b) NSW was not able to provide data for either of the data items in this section of the table.

Notes

1. 'Not known' rates are not presented for the following data items, for the reasons stated: 'Date incident occurred', 'Date reserve first placed against claim', 'Reserve range' and 'Status of claim' must be completed for all records included in the MINC. 'Date claim commenced' and 'Date claim closed' may be respectively left blank for claims that have not yet been commenced or closed.

2. The 'Not known' counts for 'Additional incident/allegation type' and 'Additional body function/structure affected' refer only to those claims where the 'Primary incident/allegation type' and 'Primary body function/structure affected' are known.

3 Public sector medical indemnity claims 2006–07

This chapter contains a profile of the 6,284 claims that were active at any time during the reporting period (1 July 2006 to 30 June 2007). A claim is considered active if it was open at the start of the reporting period, arose during the period or was closed during the period. Information is presented on the allegation of harm that precipitated the claim, the people involved (both the claim subject and professionals) and claim details (including status, duration and financial information).

3.1 Claims

This section summarises the reporting of allegations of harm in terms of what was alleged to have occurred (Primary incident/allegation type), the setting of the alleged harm (Clinical service context) and the professionals directly involved ('Specialty of clinician(s)').

Information on the geographical region where the claim arose is also included.

Clinical service context

'Clinical service context' categorises the areas of clinical practice or hospital department associated with the allegation of harm. There are 20 possible categories, as well as the option to code clinical service context as *Other* and provide additional text information. During the reporting period 400 claims (6.4% of all claims) were coded this way (Appendix Table A2.1).

The eight most common clinical service contexts accounting for 75% of all claims are presented in Table 3.1. In the 2006–07 financial year, the three most frequently recorded clinical service contexts were *General surgery* (17.8%), *Obstetrics* (17.3%) and *Accident and emergency* (14.9%).

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 2006–07, claims relating to medical or surgical *Procedure* (36.0%) were most common, followed by *Diagnosis* (22.8%) and *Treatment* (16.1%) (Table 3.1).

Procedures accounted for more than half of all alleged incidents in the Clinical service contexts of *Gynaecology* (71.1% in this category), *General surgery* (63.3%), *Obstetrics* (52.3%) and *Orthopaedics* (51.1%). Incidents related to *Diagnosis* were relatively more likely in *Accident and emergency* (56.4%), *Paediatrics* (33.7%) and *General medicine* (25.4%).

Device failure and *Blood/blood product-related* were the least likely Primary incident/allegation type to be recorded as the alleged grounds for a claim (0.4% and 1.2% of all claims respectively).

Specialty of clinician

'Specialty of clinicians closely involved in incidents' indicates the health-care providers who allegedly played the most prominent roles in the events that gave rise to a claim. The providers so identified have not necessarily been at fault in relation to the alleged claim and may not be defendants in the claim. During 2006–07, 92.6% of claims recorded one Specialty of clinician and 6.3% of claims recorded two (Table A2.3), but up to four codes may be selected. Accordingly there is some multiple counting of claims in the reported data.

As expected, the specialties of clinicians who played the most prominent roles in an allegation of harm closely match the corresponding clinical service context. This was particularly true for the specialties of *General surgery*, *Obstetrics only*, *Emergency medicine*, *Orthopaedic surgery*, *Gynaecology only* and *Psychiatry* (Table 3.2). *General nursing*, *General Anaesthetics* and *Other hospital-based medical practitioners* (including residents and interns) were associated with events occurring across a broad range of clinical service contexts. Nonetheless *General nursing* accounted for 23.2% of claims in the 'clinical service context' of *General medicine*.

Claims involving procedure-related incidents were most commonly associated with the specialties of *General surgery* (26.0%), *Obstetrics only* (19.8%), *Gynaecology only* (10.0%), and *Orthopaedic surgery* (9.7%) (Table 3.3). Claims involving *Other general duty of care* matters were strongly associated with the specialties *General nursing* (26.7%) and *Psychiatry* (26.2%). Over one third (33.6%) of claims with *Diagnosis* as the primary incident/allegation type were associated with the clinical specialty *Emergency medicine*.

Note: The information in tables 3.2 and 3.3 is presented in a different format to previous reports of public sector medical indemnity claims. These tables now report Specialty of clinician in terms of the percentages of the claims indicated by the column heading for which each specialty of clinician category is nominated.

Table 3.1: All claims: eight most common clinical service contexts, by primary incident/allegation type, 1 July 2006 to 30 June 2007, Australia

	Primary incident/allegation type													
Clinical service context	Diagnosis	Medication-related[(a)]	Anaesthetic	Blood/ blood product-related	Procedure[(b)]	Treatment[(c)]	Consent[(d)]	Infection control	Device failure	Other general duty of care	Other	Not known	Total	Per cent
						Number								
General surgery	134	28	62	2	708	101	18	12	3	22	7	22	1,119	17.8
Obstetrics	191	24	26	7	567	161	13	6	0	33	9	48	1,085	17.3
Accident & Emergency	530	36	0	3	47	220	2	5	1	49	12	34	939	14.9
Orthopaedics	56	7	13	0	213	54	14	21	6	22	5	6	417	6.6
Gynaecology	23	5	9	1	273	21	22	4	6	11	1	8	384	6.1
General medicine	80	39	2	8	12	74	1	10	3	70	5	11	315	5.0
Psychiatry	30	12	1	2	5	76	1	0	0	113	21	24	285	4.5
Paediatrics	55	13	5	1	40	33	5	0	1	4	4	2	163	2.6
All other clinical service contexts	290	80	28	48	350	227	47	35	4	105	33	25	1,272	20.2
Not known	41	32	3	1	48	45	2	5	1	17	12	98	305	4.9
Total	1,430	276	149	73	2,263	1,012	125	98	25	446	109	278	6,284	100.0
						Per cent								
General surgery	12.0	2.5	5.5	0.2	63.3	9.0	1.6	1.1	0.3	2.0	0.6	2.0	100.0	. .
Obstetrics	17.6	2.2	2.4	0.6	52.3	14.8	1.2	0.6	0.0	3.0	0.8	4.4	100.0	. .
Accident & Emergency	56.4	3.8	0.0	0.3	5.0	23.4	0.2	0.5	0.1	5.2	1.3	3.6	100.0	. .
Orthopaedics	13.4	1.7	3.1	0.0	51.1	12.9	3.4	5.0	1.4	5.3	1.2	1.4	100.0	. .
Gynaecology	6.0	1.3	2.3	0.3	71.1	5.5	5.7	1.0	1.6	2.9	0.3	2.1	100.0	. .
General medicine	25.4	12.4	0.6	2.5	3.8	23.5	0.3	3.2	1.0	22.2	1.6	3.5	100.0	. .
Psychiatry	10.5	4.2	0.4	0.7	1.8	26.7	0.4	0.0	0.0	39.6	7.4	8.4	100.0	. .
Paediatrics	33.7	8.0	3.1	0.6	24.5	20.2	3.1	0.0	0.6	2.5	2.5	1.2	100.0	. .
All other clinical service contexts	22.8	6.3	2.2	3.8	27.5	17.8	3.7	2.8	0.3	8.3	2.6	2.0	100.0	. .
Not known	13.4	10.5	1.0	0.3	15.7	14.8	0.7	1.6	0.3	5.6	3.9	32.1	100.0	. .
Total	**22.8**	**4.4**	**2.4**	**1.2**	**36.0**	**16.1**	**2.0**	**1.6**	**0.4**	**7.1**	**1.7**	**4.4**	**100.0**	. .

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

(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) *Consent* includes failure to warn.

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*. Appendix 2 Table A2.1 shows the frequency of coding categories for all clinical service contexts.

2. Data for approximately 93% of all claims in scope are included.

Table 3.2: All claims: eight most common clinical service contexts, by specialty of clinician(s)[a] involved, 1 July 2006 to 30 June 2007, Australia (per cent)[b]

	Clinical service context										
Specialty of clinician(s)	**General surgery**	**Obstetrics**	**Accident & Emergency**	**Orthopaedics**	**Gynaecology**	**Psychiatry**	**General medicine**	**Paediatrics**	**All other clinical service contexts**	**Not known**	**Total**
General surgery	67.9	0.2	1.1	1.0	1.6	0.7	2.5	2.5	2.9	4.6	13.5
Obstetrics only	0.5	64.4	0.7	0.2	1.0	0.4	0.6	0.6	0.6	3.6	11.8
Emergency medicine	2.1	0.5	70.1	3.4	0.3	4.6	7.6	0.6	3.5	3.3	12.6
Orthopaedic surgery	0.8	0.2	2.0	86.3	0.8	0.4	0.6	1.8	1.2	2.0	6.7
Gynaecology only	0.7	0.2	0.3	0.0	70.6	0.0	0.0	0.0	0.8	3.0	4.8
Psychiatry	0.1	0.6	2.1	1.0	0.5	77.9	1.0	0.0	0.4	1.3	4.3
General nursing	2.5	1.2	2.6	2.6	1.6	8.1	23.2	4.3	5.4	3.0	4.2
Obstetrics & gynaecology	0.1	13.9	0.3	0.2	18.0	0.0	0.6	0.6	0.6	2.3	3.9
General anaesthetics	5.3	3.4	0.3	3.4	3.4	0.4	0.6	3.7	2.2	3.9	2.8
Other hospital-based medical practitioner[c]	0.8	1.9	6.0	2.4	1.3	3.2	1.0	1.8	1.7	0.0	2.2
All other specialties	23.2	27.0	21.6	7.2	4.4	13.3	65.4	98.8	85.4	34.8	38.2
Not known	1.1	0.9	1.4	0.2	2.1	0.4	2.5	1.2	1.8	36.4	3.0
Not Applicable[d]	0.5	0.3	0.4	0.7	0.5	1.8	1.0	0.6	2.1	2.6	1.0
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	*1,119*	*1,085*	*939*	*417*	*384*	*285*	*315*	*163*	*1,272*	*305*	*6,284*

(a) This data item provides information on the clinical specialties of the health care provider(s) who played the most prominent role(s) in the incident that gave rise to the claim, in relation to the clinical service context. There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault.

(b) Data for all jurisdictions include the primary and up to three additional specialties, except for NSW, which only include the specialty of the primary clinician. Up to four different specialties may be recorded for **each** claim (Table A2.3), and so some claims are represented in more than one row in this table. Hence the percentage values, which show the proportion of claims in each clinical service context for which each clinician specialty was recorded, cannot be summed vertically to give 100%. See Table A2.2 for the number of claims for which each clinician specialty was recorded.

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

(d) Not applicable for this data item 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 eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*. Appendix 2 Table A2.1 shows the frequency of coding categories for all clinical service contexts.

2. The specialties listed separately are the 10 most frequently recorded categories; all other categories are combined in the category *All other specialties*.

3. Data for approximately 93% of all claims in scope are included.

Table 3.3: All claims: primary incident/allegation type, by specialty of clinician(s)[a] involved, 1 July 2006 to 30 June 2007, Australia (per cent)[b]

	Primary incident/ allegation type[c]												
Specialty of clinician(s)	**Procedure**	**Diagnosis**	**Treatment**	**Other general duty of care**	**Medication related**	**Anaesthetic**	**Consent**	**Infection control**	**Blood/blood product–related**	**Device failure**	**Other**	**Not known**	**Total**
General surgery	26.0	7.9	6.1	3.4	4.7	8.7	13.6	8.2	0.0	8.0	2.8	4.3	13.5
Obstetrics only	19.8	7.8	9.5	3.8	4.0	4.0	6.4	3.1	1.4	0.0	4.6	11.9	11.8
Emergency medicine	1.9	33.6	16.5	9.0	10.1	0.0	2.4	3.1	1.4	8.0	8.3	6.5	12.6
Orthopaedic surgery	9.7	4.9	5.6	2.9	2.9	4.0	10.4	17.3	0.0	24.0	2.8	2.5	6.7
Gynaecology only	10.0	1.3	1.7	2.0	1.4	0.0	12.8	0.0	0.0	20.0	0.0	2.9	4.8
Psychiatry	0.1	2.0	6.2	26.2	4.3	0.0	2.4	0.0	5.5	0.0	13.8	8.6	4.3
General nursing	0.9	1.4	5.2	26.7	9.4	2.0	0.0	9.2	1.4	8.0	7.3	0.7	4.2
Obstetrics and gynaecology	4.8	2.4	5.9	2.5	1.1	2.0	7.2	2.0	1.4	4.0	1.8	2.2	3.9
General anaesthetics	1.7	0.4	0.9	0.9	2.2	67.8	0.0	3.1	0.0	0.0	0.0	2.5	2.8
Other hospital-based medical practitioner[d]	1.0	5.0	2.5	0.9	1.1	1.3	3.2	1.0	1.4	0.0	1.8	0.4	2.2
All other specialties	29.0	43.8	46.7	29.1	61.2	23.5	44.0	46.9	86.3	28.0	41.3	33.8	38.2
Not known	0.8	1.2	2.8	3.4	4.3	0.0	1.6	3.1	1.4	4.0	6.4	30.2	3.0
Not applicable[e]	0.3	0.2	1.0	1.8	1.1	1.3	0.0	5.1	2.7	4.0	15.6	1.4	1.0
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	*2,263*	*1,430*	*1,012*	*446*	*276*	*149*	*125*	*98*	*73*	*25*	*109*	*278*	*6,284*

(a) This data item provides information on the clinical specialties of the health care provider(s) who played the most prominent role(s) in the incident that gave rise to the claim, in relation to the primary incident/allegation type. There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault.

(b) Data for all jurisdictions include the primary and up to three additional specialties, except for NSW, which only include the specialty of the primary clinician. Up to four different specialties may be recorded for **each** claim (Table A2.3), and so some claims are represented in more than one row in this table. Hence the percentage values, which show the proportion of claims (of each primary incident/allegation type) for which each clinician specialty was recorded, cannot be summed vertically to give 100%. See Table A2.2 for the number of claims for which each clinician specialty was recorded.

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

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

(e) Not applicable for this data item 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 specialties listed separately are the 10 most frequently recorded categories; all other categories are combined in the category *All other specialties*.

2. Data for approximately 93% of all claims in scope are included.

Geographic location

A total of 3,998 claims (63.6%) arose from incidents occurring in *Major cities.* The corresponding figure for *Inner regional* areas was 1,707 claims (27.2%). For *Outer regional* areas, it was 493 (7.8%) and for *Remote and very remote* areas it was 77 claims (1.2%) (Table 3.4).

The three clinical service contexts most frequently associated with claims were *General surgery* (17.8%), *Obstetrics* (17.3%) and *Accident and emergency* (14.9%). These proportions varied according to geographic location. *Obstetrics* was the most common for major cities (19.4%), while *General surgery* (33.1%) was most common for inner regional locations, and *Accident and emergency* (23.4%) for remote and very remote areas.

Emergency medicine and *Obstetrics only* were the most frequent specialties recorded for claims from *Major cities* (13.3% and 13.4% respectively). *General surgery* was the specialty most frequently associated with *Inner regional areas* (30.2%), whereas *Emergency medicine* was the most frequently recorded specialty for claims arising in *Remote and very remote areas* (15.6%) (Table 3.5).

Table 3.4: All claims: clinical service context, by geographic location, 1 July 2006 to 30 June 2007, Australia (per cent)

	Geographic location of incidents[a]				
Clinical service context	**Major cities**	**Inner regional**	**Outer regional**	**Remote and very remote**	**Total**
Obstetrics	19.4	12.3	17.8	13.0	17.3
General surgery	11.6	33.1	15.4	14.3	17.8
Accident & Emergency	15.2	14.1	14.8	23.4	14.9
Gynaecology	6.1	5.9	6.5	9.1	6.1
Orthopaedics	6.1	7.3	8.9	7.8	6.6
Psychiatry	5.2	3.4	3.9	2.6	4.5
General medicine	4.9	4.7	6.5	7.8	5.0
Paediatrics	3.1	1.2	3.4	1.3	2.6
All other clinical service contexts	23.5	13.6	17.2	14.3	20.2
Not known	4.9	4.3	5.5	6.5	4.9
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	*3,998*	*1,707*	*493*	*77*	*6,284*[b]

(a) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

(b) Includes 9 claims for which geographical location was unknown.

Notes

1. The 'Clinical service context' categories listed separately are the eight most frequently recorded categories; all other categories are combined in *All other clinical service contexts.*
2. Data for approximately 93% of all claims in scope are included.

Table 3.5: All claims: specialty of clinician(s)[a] involved, by geographic location, 1 July 2006 to 30 June 2007, Australia (per cent)[b]

	Geographic location of incidents				
Specialty of clinician(s)	**Major cities**	**Inner regional**	**Outer regional**	**Remote and very remote**	**Total (Per cent)**
General surgery	6.4	30.2	13.2	13.0	13.5
Emergency medicine	13.3	11.4	11.4	15.6	12.6
Obstetrics only	13.4	8.6	9.9	9.1	11.8
Orthopaedic surgery	6.0	7.4	9.3	10.4	6.7
Gynaecology only	4.9	5.0	3.4	5.2	4.8
Psychiatry	5.1	3.0	2.8	1.3	4.3
General nursing	4.3	3.5	4.7	10.4	4.2
General practice—non-procedural	2.7	6.0	6.7	5.2	3.9
Obstetrics and gynaecology	4.1	2.8	5.7	2.6	3.9
General anaesthetics	3.1	2.3	2.0	2.6	2.8
General practice—procedural	1.4	3.3	6.9	13.0	2.5
Other hospital-based medical practitioner[c]	2.3	1.3	4.5	5.2	2.2
General and internal medicine	1.9	2.2	2.2	2.6	2.0
Midwifery	1.8	1.4	3.0	3.9	1.8
Paediatric medicine	1.8	1.5	2.4	2.6	1.8
Diagnostic radiology	2.1	1.3	1.2	0.0	1.8
All other specialties	30.3	12.8	18.5	10.4	24.3
Not applicable[d]	1.1	0.5	1.6	1.3	1.0
Not known	3.3	2.0	3.7	3.9	3.0
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	*3,998*	*1,707*	*493*	*77*	*6,284*

(a) This data item provides information on the clinical specialties of the health care provider(s) who played the most prominent role(s) in the incident that gave rise to the claim. There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault. The clinical specialties listed separately here are the 16 most frequently recorded specialties; all other specialties are combined in *All other specialties.*

(b) Data for all jurisdictions include the primary and up to three additional specialties, except for NSW, which only include the specialty of the primary clinician. Up to four different specialties may be recorded for **each** claim (Table A2.3), and so some claims are represented in more than one row in this table. Hence the percentage values, which show the proportion of claims in each geographic location for which each clinician specialty was recorded, cannot be summed vertically to give 100%. See Table A2.2 for the number of claims for which each clinician specialty was recorded.

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

(d) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

Note: The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

Note: The information presented in tables 3.4 and 3.5 is reported in a different format to previous public sector medical indemnity publications. These tables now provide the clinical service context and specialty of clinician as the proportion of claims from the particular geographical location of the allegation that gave rise to those claims.

3.2 People

This section provides a profile of the persons directly affected by the allegation of harm leading to a medical indemnity claim. Information on the person's age at the time of the incident, their sex, and the body functions or structures affected is presented.

Age at incident and sex

Table 3.6 contains data on 'Age at incident' and 'Primary incident/allegation type'. During 2006–07, 665 claims (10.6%) related to babies less than 1 year old, 502 claims (8.0%) related to children (from 1 to 18 years of age), and 4,328 claims (68.9%) involved adults 18 years and over. The age of the claim subject was not known for 789 claims.

The distribution of claims by the sex of the claim subject exhibits a pattern similar to previous years. In more than half of all claims, the subject of the claim was female (55.6%). However, more than half were for male babies and for children under 18 years of age. In the adult category, 58.9% were female. The greatest sex disparity was for procedure-related allegations of harm. These comprised 36.0% of all claims, predominately involved adults and 65.1% of claim subjects were female. In all other categories of 'primary incident/allegation type', there were more female adults than male adults as claim subjects but generally the difference was not as great as for procedure-related claims.

Table 3.6: All claims: sex and age at incident of claim subject, by primary incident/allegation type, 1 July 2006 to 30 June 2007, Australia

	Age at incident				
Primary incident/allegation type	**<1year**	**1–<18 years**	**18+ years**	**Not known**	**Total[a]**
		Males			
Diagnosis	85	103	414	82	684
Medication-related	9	22	85	19	135
Anaesthetic	2	2	37	7	48
Blood/blood product-related	2	3	22	6	33
Procedure	145	65	571	66	847
Treatment	78	58	311	54	501
Consent	4	1	25	4	34
Infection control	2	1	34	3	40
Device failure	0	1	7	3	11
Other general duty of care	10	10	157	36	213
Other	3	3	44	8	58
Not known	12	9	48	46	115
Total males	352	278	1,755	334	2,719
		Females			
Diagnosis	57	79	516	90	742
Medication-related	11	9	95	22	137
Anaesthetic	2	3	81	13	99
Blood/blood product-related	2	3	23	2	30
Procedure	145	46	1,078	130	1,399
Treatment	56	52	342	53	503
Consent	4	6	61	17	88
Infection control	3	1	43	5	52
Device failure	0	1	11	1	13
Other general duty of care	6	9	176	38	229
Other	2	4	37	5	48
Not known	13	8	86	47	154
Total females	301	221	2,549	423	3,494
		Persons[b]			
Diagnosis	143	183	931	173	1,430
Medication-related	22	31	181	42	276
Anaesthetic	4	5	120	20	149
Blood/blood product-related	4	6	45	18	73
Procedure	298	111	1,655	198	2,263
Treatment	135	111	658	108	1,012
Consent	8	7	87	23	125
Infection control	5	2	77	14	98
Device failure	0	2	18	5	25
Other general duty of care	16	19	336	75	446
Other	5	8	83	13	109
Not known	25	17	137	99	278
Total persons	**665**	**502**	**4,328**	**789**	**6,284**

(a) Includes 789 claims for which age at incident of claim subject was missing (334 males, 423 females, 32 not known).

(b) Includes 71 claims for which sex of claim subject was not known/indeterminate (12 babies, 3 children, 24 adult, 32 not known).

Note: Data for approximately 93% of all claims in scope are included.

Primary body function/structure affected

This section focuses on the 'primary body function or structure' associated with medical indemnity claims (a claim record can also have up to three additional body function/ structure areas coded). Table 3.7 shows the distribution of claims across primary body function or structure categories.

Neuromusculoskeletal and movement-related functions and structures was the most commonly recorded body function or structure affected (20.8%). The next most commonly recorded categories were *Mental functions/structures of the nervous system* (20.1%)—a substantial increase when compared with previous years. *Functions and structures of the digestive, metabolic and endocrine systems* accounted for 12.0% and *Genitourinary and reproductive functions and structures* accounted for 11.9%. In 13.0% of claims, the patient died.

Table 3.7: All claims: primary body function/structure[(a)] affected, 1 July 2006 to 30 June 2007, Australia

Primary body function/structure affected	Number	Per cent
Neuromusculoskeletal and movement-related functions and structures	1310	20.8
Mental functions/structures of the nervous system	1264	20.1
Death	820	13.0
Functions and structures of the digestive, metabolic and endocrine systems	755	12.0
Genitourinary and reproductive functions and structures	745	11.9
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	419	6.7
Functions and structures of the skin and related structures	241	3.8
Sensory functions/the eye, ear and related structures	191	3.0
Voice and speech functions/structures involved in voice and speech	68	1.1
No body function/structure affected	95	1.5
Not known	376	6.0
All claims	**6,284**	**100.0**

(a) See Appendix 1 for examples of coding categories for body function/structure affected.

Note: Data for approximately 93% of all claims in scope are included.

3.3 Administrative and financial characteristics of claims

This section summarises the administrative and financial characteristics of new claims, current claims, closed claims and all claims. A profile of claim status, categories of loss claimed and duration of claims is provided. For closed claims, data on the total size of the claim and method of claim finalisation are also presented.

All claims

Status of claim

At 30 June 2007:

- 1,368 claims (21.8% of all claims) had a reserve placed against them but had not yet commenced
- 2,597 claims (41.3%) had commenced but were not yet closed
- 2,214 claims (35.2%) were closed
- 105 claims (1.7%) had been previously closed and were reopened (Table 3.8).

A claim may be reopened where new evidence arises or there are changes in a claim subject's functioning and/or health that may be attributable to the harm sustained.

The majority of claims (74.9%) related to the *Procedure*, *Diagnosis* or *Treatment* Primary incident/allegation types (Table 3.9).

Table 3.8: All claims: status of claim, 30 June 2007, Australia

	Not yet commenced[(a)]	Commenced[(b)]	Closed[(c)]	Claim previously closed, now reopened[(d)]	Total
All claims	1,368	2,597	2,214	105	6,284
Proportion of total (per cent)	21.8	41.3	35.2	1.7	100.0

(a) *Not yet commenced* indicates that a reserve has been set for the claim but none of the events signalling claim commencement (e.g. the issuing of a letter of demand or a writ, or an offer made by the defendant to the claimant) have occurred.

(b) *Commence*d indicates that the claim has commenced and remains open. Includes 'Structured settlement—claim file open'.

(c) *Closed* indicates that the total claim size has been determined, and the claim file has been closed. Includes 'Structured settlement—claim file closed'.

(d) *Claim previously closed, now reopened* indicates that the claim has previously been recorded as closed on the MINC database, but has then been re-opened.

Note: Data for approximately 93% of all claims in scope are included.

Table 3.9: All claims: status of claim by primary incident/allegation type, 30 June 2007, Australia

Primary incident/ allegation type	Not yet commenced	Commenced	Total closed	*Total closed (%)*	Claim previously closed now reopened	Total	*Total (%)*
Procedure[(a)]	540	821	868	*39.2*	34	2,263	*36.0*
Diagnosis	295	663	446	*20.1*	26	1,430	*22.8*
Treatment[(b)]	196	415	384	*17.3*	17	1,012	*16.1*
Other general duty of care	123	167	147	*6.6*	9	446	*7.1*
Medication-related[(c)]	36	139	94	*4.2*	7	276	*4.4*
Anaesthetic	38	51	60	*2.7*	0	149	*2.4*
Consent[(d)]	17	63	42	*1.9*	3	125	*2.0*
Infection control	13	44	40	*1.8*	1	98	*1.6*
Blood/blood product-related	21	18	31	*1.4*	3	73	*1.2*
Device failure	4	11	9	*0.4*	1	25	*0.4*
Other	13	37	58	*2.6*	1	109	*1.7*
Not known	72	168	35	*1.6*	3	278	*4.4*
Total	**1,368**	**2,597**	**2,214**	***100.0***	**105**	**6,284**	***100.0***
Total (per cent)	21.8	41.3	35.2	. .	1.7	100.0	. .

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

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

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

(d) *Consent* includes failure to warn.

Note: Data for approximately 93% of all claims in scope are included.

Categories of loss claimed

The data element 'Nature of claim—loss to claim subject' provides a broad description of the categories of loss allegedly suffered by the claim subject. The average number of categories of loss recorded was 1.5 for all claims during the reporting period (Table 3.10). *Pain and suffering*, including nervous shock, was recorded in 31.7% of claims. *Other loss* accounted for 21.6% of all claims, while *Other economic loss* accounted for 19.8%. For 52.8% of all claims, the category of loss was not known.

Table 3.10: All claims: nature of claim—loss to claim subject, 1 July 2006 to 30 June 2007, Australia (per cent)

	Care costs[(a)]	Other economic loss[(b)]	Pain and suffering[(c)]	Other loss[(d)]	Not applicable[(e)]	Not known	*Total claims*	Average no. of loss categories[(f)]
Per cent of all claims	17.1	19.8	31.7	21.6	10.0	52.8	. .	. .
Total number of claims[(g)]	1,075	1,242	1,993	1,360	631	3,320	*6,284*	1.5

(a) *Care costs* include long-term care costs, covering both past and future care costs, whether provided gratuitously or otherwise.

(b) *Other economic loss* includes past and future economic loss and past and future out-of-pocket expenses; excludes care costs.

(c) *Pain and suffering* includes nervous shock and temporary or ongoing disability; includes general damages.

(d) *Other loss* includes any other loss claimed for, including medical costs (both past and future). Medical costs are costs associated with medical treatment—for example, doctor's fees, hospital expenses.

(e) *Not applicable* covers cases where there is no consequent harm to body functions or structures, such as failed sterilisation.

(f) The average number of coding categories for the data item 'Nature of claim—loss to claim subject' recorded per claim (the average is calculated excluding claims for which not applicable or not known was recorded for 'Nature of claim—loss to claim subject').

(g) The total number of claims for which the particular loss category was recorded. A given loss category may only be recorded once for a single claim. However, several loss categories may be recorded for a single claim, so a single claim may be counted in the total for several columns; therefore, these totals cannot be summed horizontally to give the total number of claims overall.

Note: Data for approximately 93% of all claims in scope are included.

Duration of claims

The duration of a claim is measured from the date of reserve placement to 30 June 2007 (for claims open at that date) or to the date the claim was closed (for claims closed before that date).

Commenced claims are claims that were open at the end of the reporting period (excluding potential and previously closed claims). Some of them appear to be of relatively long duration. Their average duration was 32.0 months, marginally higher than for claims that were closed during the reporting period (Table 3.11). And 13.1% of them had been open in excess of 5 years, higher than the proportion of claims (10.0%) closed during the reporting period but of duration greater than 5 years.

The average duration of claims previously closed but then reopened was 47.2 months. This is likely to be an underestimate because the 'date reserve placed' in some cases has been recorded as the date of reopening rather than the original date when a reserve amount was placed against the claim (tables 3.14 and 3.17).

Current claims

Table 3.12 presents data on 'Reserve range' by Clinical service context. About 42% of current claims had a reserve value of less than $30,000. The reserve value exceeded $500,000 for 10.6% of current claims, including 22.0% within the Clinical service context of *Obstetrics*, and 19.2% within the Clinical service context of *Paediatrics*.

Table 3.13 presents Reserve range by Primary incident/allegation type. For *Blood/blood product-related* category, 71.4% of claims had a reserve range less than $10,000. The largest contributor to claims with a reserve amount greater than $500,000 was *Diagnosis* accounting for 37.6% (162/431) of all claims in this category.

Duration of current claims

The duration of a current claim is measured from the date of reserve placement to the end of the current reporting period (30 June 2007).

For current claims the average duration was 29.6 months (Table 3.14) with duration ranging from 26.1 months to 48.2 months, and increased with reserve range.

New claims

There were 1,251 new claims during the reporting period (Table 3.15). The most common Clinical service contexts were *Accident and emergency* (233 claims, 18.6%), *General surgery* (185 claims, 14.8%) and *Obstetrics* (185 claims, 14.8%). Two of these categories, *Accident and emergency* and *Obstetrics,* contributed more than half of the claims having a reserve greater than $500,000.

Closed claims

A claim is closed when the claim is settled via negotiation, a final court decision is made, or the claim is discontinued. During 2006–07, 2,214 claims were closed.

More than half of all closed claims (1,218 claims, 55%) had a 'total claim size' less than $10,000 and the majority (82.1%) of these claims were discontinued (Table 3.16). Any costs associated with discontinued claims are likely to be attributable to legal costs for either or both parties. For 27.4% (606 claims) of all closed claims, no payment was made to the claimant and no legal costs were incurred. Of these, 91.6% (555 claims) were *Discontinued* claims. Total claim size was less than $100,000 for approximately 83% (1,837 claims) of all closed claims, compared to around 4% (87 claims) closed for $500,000 or more.

Nearly half of all closed claims were finalised through being *Discontinued* (1,085 claims, 49.0%). Less than 5% (99 claims) were finalised as a result of a *Court decision*, and 29.4% (650 claims) were finalised through *Settled – other* processes (including settlement part-way through a trial). This includes 78.1% of claims with a total claim size greater than $500,000.

Duration of closed claims

Claims where no payment was made, and those with a total claim size of less than $10,000, were open an average of 33.2 and 24.0 months respectively. Those that settled for above $500,000 were closed, on average, in 57.8 months (Table 3.17). The average duration for all closed claims was 31.7 months.

Table 3.11: All claims: status of claim by length of claim (months), 30 June 2007, Australia

Status of claim[(a)]	Length of claim at 30 June 2007 (months)											Total	Average (months)
	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60		
						Number							
Not yet commenced	159	239	214	242	159	148	66	33	29	15	64	1,368	23.6
Commenced (not yet closed)	297	390	417	270	193	210	135	112	130	104	339	2,597	32.0
Closed	163	356	285	204	174	216	301	149	83	61	222	2,214	31.7
Claim previously closed now reopened	2	8	7	6	8	11	15	8	8	4	28	105	47.2
Total claims	**621**	**993**	**923**	**722**	**534**	**585**	**517**	**302**	**250**	**184**	**653**	**6,284**	**30.3**
						Per cent							
Not yet commenced	11.6	17.5	15.6	17.7	11.6	10.8	4.8	2.4	2.1	1.1	4.7	100.0	. .
Commenced (not yet closed)	11.4	15.0	16.1	10.4	7.4	8.1	5.2	4.3	5.0	4.0	13.1	100.0	. .
Closed	7.4	16.1	12.9	9.2	7.9	9.8	13.6	6.7	3.7	2.8	10.0	100.0	. .
Claim previously closed now reopened	1.9	7.6	6.7	5.7	7.6	10.5	14.3	7.6	7.6	3.8	26.7	100.0	. .
Total claims (%)	**9.9**	**15.8**	**14.7**	**11.5**	**8.5**	**9.3**	**8.2**	**4.8**	**4.0**	**2.9**	**10.4**	**100.0**	. .

(a) See Table 3.8 footnotes for definitions of status of claim categories.

Notes

1. Length of claim is from date reserve placed to 30 June 2007. If a claim has a status of 'claim file closed', length of claim is from the date the reserve is placed to the date the claim was closed.
2. Data for approximately 93% of all claims in scope are included.

Table 3.12: Current claims: reserve range, by clinical service context, 30 June 2007, Australia

	Clinical service context										
Reserve range ($)	**Obstetrics**	**General surgery**	**A&E**	**Gynaecology**	**Orthopaedics**	**Psychiatry**	**General medicine**	**Paediatrics**	**All other clinical service contexts**	**Not known**	**Total**
						Number					
Less than 10,000	57	80	96	29	46	35	51	12	152	41	599
10,000–<30,000	183	218	193	69	70	46	55	33	193	66	1,126
30,000–<50,000	34	73	46	20	27	18	13	4	57	17	309
50,000–<100,000	137	94	99	60	44	27	29	24	138	35	687
100,000–<250,000	135	68	91	51	45	20	26	20	109	44	609
250,000–<500,000	74	31	52	15	25	7	11	8	54	32	309
500,000 or more	175	12	70	5	19	15	17	24	67	27	431
Total	**795**	**576**	**647**	**249**	**276**	**168**	**202**	**125**	**770**	**262**	**4,070**
						Per cent					
Less than 10,000	7.2	13.9	14.8	11.6	16.7	20.8	25.2	9.6	19.7	15.6	14.7
10,000–<30,000	23.0	37.8	29.8	27.7	25.4	27.4	27.2	26.4	25.1	25.2	27.7
30,000–<50,000	4.3	12.7	7.1	8.0	9.8	10.7	6.4	3.2	7.4	6.5	7.6
50,000–<100,000	17.2	16.3	15.3	24.1	15.9	16.1	14.4	19.2	17.9	13.4	16.9
100,000–<250,000	17.0	11.8	14.1	20.5	16.3	11.9	12.9	16.0	14.2	16.8	15.0
250,000–<500,000	9.3	5.4	8.0	6.0	9.1	4.2	5.4	6.4	7.0	12.2	7.6
500,000 or more	22.0	2.1	10.8	2.0	6.9	8.9	8.4	19.2	8.7	10.3	10.6
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'Clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in *all other clinical service contexts*. Table A2.2 shows the frequency of claims for all clinical service contexts.
2. Data for approximately 93% of all claims in scope are included.

Table 3.13: Current claims: reserve range, by primary incident/allegation type, 30 June 2007, Australia

	Primary incident/allegation type												
Reserve range ($)	Diagnosis	Medication-related[(a)]	Anaesthetic	Blood/ blood product-related	Procedure[(b)]	Treatment[(c)]	Consent[(d)]	Infection control	Device failure	Other general duty of care	Other	Not known	Total
						Number							
Less than 10,000	118	30	24	30	145	90	7	14	3	75	12	51	599
10,000–<30,000	219	34	24	7	445	172	21	10	3	97	15	79	1,126
30,000–<50,000	64	9	5	0	118	44	7	6	2	33	5	16	309
50,000–<100,000	177	29	18	1	249	95	20	13	3	38	7	37	687
100,000–<250,000	166	42	8	2	225	81	11	7	4	26	7	30	609
250,000–<500,000	78	17	6	0	96	65	7	5	1	8	4	22	309
500,000 or more	162	21	4	2	117	81	10	3	0	22	1	8	431
Total	**984**	**182**	**89**	**42**	**1,395**	**628**	**83**	**58**	**16**	**299**	**51**	**243**	**4,070**
						Per cent							
Less than 10,000	12.0	16.5	27.0	71.4	10.4	14.3	8.4	24.1	18.8	25.1	23.5	21.0	14.7
10,000–<30,000	22.3	18.7	27.0	16.7	31.9	27.4	25.3	17.2	18.8	32.4	29.4	32.5	27.7
30,000–<50,000	6.5	4.9	5.6	0.0	8.5	7.0	8.4	10.3	12.5	11.0	9.8	6.6	7.6
50,000–<100,000	18.0	15.9	20.2	2.4	17.8	15.1	24.1	22.4	18.8	12.7	13.7	15.2	16.9
100,000–<250,000	16.9	23.1	9.0	4.8	16.1	12.9	13.3	12.1	25.0	8.7	13.7	12.3	15.0
250,000–<500,000	7.9	9.3	6.7	0.0	6.9	10.4	8.4	8.6	6.3	2.7	7.8	9.1	7.6
500,000 or more	16.5	11.5	4.5	4.8	8.4	12.9	12.0	5.2	0.0	7.4	2.0	3.3	10.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) *Procedure* includes failure to perform a procedure, wrong procedure, wrong body site, intra-operative complications, post-operative complications, post-operative infection, 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) *Consent* includes failure to warn.

Note: Data for approximately 93% of all claims in scope are included.

Table 3.14: Current claims: reserve range, by length of claim (months), 30 June 2007, Australia

Reserve range ($)	Length of claim at 30 June 2007 (months)											Total	Average (months)
	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60		
						Number							
Less than 10,000	83	112	114	76	39	55	24	25	18	5	48	599	26.1
10,000–<30,000	165	228	215	191	104	92	44	23	19	11	34	1,126	20.7
30,000–<50,000	34	46	70	33	27	15	16	11	16	12	29	309	28.0
50,000–<100,000	71	96	94	93	71	70	41	27	39	19	66	687	30.0
100,000–<250,000	55	76	63	71	68	63	40	26	36	34	77	609	33.6
250,000–<500,000	28	43	44	29	22	32	13	16	17	17	48	309	35.6
500,000 or more	22	36	38	25	29	42	38	25	22	25	129	431	48.2
Total	**458**	**637**	**638**	**518**	**360**	**369**	**216**	**153**	**167**	**123**	**431**	**4,070**	**29.6**
						Per cent							
Less than 10,000	13.9	18.7	19.0	12.7	6.5	9.2	4.0	4.2	3.0	0.8	8.0	100.0	. .
10,000–<30,000	14.7	20.2	19.1	17.0	9.2	8.2	3.9	2.0	1.7	1.0	3.0	100.0	. .
30,000–<50,000	11.0	14.9	22.7	10.7	8.7	4.9	5.2	3.6	5.2	3.9	9.4	100.0	. .
50,000–<100,000	10.3	14.0	13.7	13.5	10.3	10.2	6.0	3.9	5.7	2.8	9.6	100.0	. .
100,000–<250,000	9.0	12.5	10.3	11.7	11.2	10.3	6.6	4.3	5.9	5.6	12.6	100.0	. .
250,000–<500,000	9.1	13.9	14.2	9.4	7.1	10.4	4.2	5.2	5.5	5.5	15.5	100.0	. .
500,000 or more	5.1	8.4	8.8	5.8	6.7	9.7	8.8	5.8	5.1	5.8	29.9	100.0	. .
Total (%)	**11.3**	**15.7**	**15.7**	**12.7**	**8.8**	**9.1**	**5.3**	**3.8**	**4.1**	**3.0**	**10.6**	**100.0**	. .

Notes

1. Length of claim is from the date the reserve was placed to 30 June 2007.
2. Data for approximately 93% of all claims in scope are included.

Table 3.15: New claims: reserve range, by clinical service context, 1 July 2006 to 30 June 2007, Australia

Reserve range ($)	General surgery	Obstetrics	A&E	Orthopaedics	Gynaecology	General medicine	Psychiatry	General practice	All other clinical service contexts	Not known	Total	Per cent
Less than 10,000	47	23	40	30	13	18	16	10	65	17	279	22.3
10,000–<30,000	79	55	84	29	23	20	27	10	70	40	437	34.9
30,000–<50,000	12	11	20	9	4	3	7	2	11	8	87	7.0
50,000–<100,000	34	33	27	9	14	6	5	3	29	15	175	14.0
100,000–<250,000	11	31	28	8	12	6	5	2	18	21	142	11.4
250,000–<500,000	1	13	20	6	2	0	3	1	13	12	71	5.7
500,000 or more	1	19	14	4	0	1	2	0	11	8	60	4.8
Total	**185**	**185**	**233**	**95**	**68**	**54**	**65**	**28**	**217**	**121**	**1,251**	**100.0**
Total (%)	14.8	14.8	18.6	7.6	5.4	4.3	5.2	2.2	17.3	9.7	100.0	. .

Notes

1. The 'Clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in *all other clinical service contexts*. Appendix 2, Table A2.1 shows the frequency of coding categories for all clinical service contexts for all claims.
2. Data for approximately 99% of new claims in scope are included.

Table 3.16: Closed claims: total claim size, by mode of claim finalisation, 1 July 2006 to 30 June 2007, Australia

	Settled							
Total claim size ($)	State/territory complaints process [a]	Court-based alternative dispute resolution process [b]	Statutorily mandated compulsory conference process[c]	Settled—other[d]	Total settled	Court decision	Discontinued[e]	Total
0[f]	6	0	0	29	**35**	16	555	606
Less than 10,000	40	6	1	96	**143**	24	445	612
10,000–<30,000	109	20	8	87	**224**	24	60	308
30,000–<50,000	21	17	2	59	**99**	15	16	130
50,000–<100,000	25	39	6	97	**167**	8	6	181
100,000–<250,000	6	36	9	144	**195**	7	3	205
250,000–<500,000	0	6	1	70	**77**	2	0	79
500,000 or more	0	13	3	68	**84**	3	0	87
Total[g]	**207**	**137**	**30**	**650**	**1,024**	**99**	**1,085**	**2,214**

(a) *State/territory-based complaints processes* include proceedings conducted in state or territory health rights and health complaints bodies.

(b) *Court-based alternative dispute resolution processes* includes mediation, arbitration, and case appraisal provided under civil procedure rules.

(c) *Statutorily-mandated compulsory conference processes* includes settlement conferences required by statute as part of a pre-court process.

(d) *Settled—other* includes instances where a claim is settled part-way through a trial.

(e) *Discontinued* includes claims that have been closed due to withdrawal by claimant or operation of statute of limitations or where the claim manager decides to close the claim file because of long periods of inactivity. *Discontinued* also includes instances where a claim is discontinued part-way through a trial.

(f) The claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

(g) Includes 6 claims for which the size of the claim and the mode of finalisation were unknown.

Note: Data for approximately 80% of closed claims in scope are included.

Table 3.17: Closed claims: total claim size, by length of claim (months), at 30 June 2007, Australia

Total claim size ($)	Length of claim at 30 June 2007 (months) 0–12	13–24	25–36	37–48	49–60	>60	Total	Average (months)
				Number				
0[(a)]	96	88	145	206	40	31	606	33.2
Less than 10,000	222	161	75	101	27	26	612	24.0
10,000–<30,000	122	87	33	29	13	24	308	23.5
30,000–<50,000	34	30	26	10	4	26	130	33.9
50,000–<100,000	29	46	33	41	11	21	181	34.6
100,000–<250,000	9	52	44	35	23	42	205	43.4
250,000–<500,000	4	16	21	13	10	15	79	42.5
500,000 or more	2	9	11	13	16	36	87	57.8
Not known	1	0	2	2	0	1	6	34.4
Total	**519**	**489**	**390**	**450**	**144**	**222**	**2,214**	**31.7**
				Per cent				
0[(a)]	15.8	14.5	23.9	34.0	6.6	5.1	100.0	. .
Less than 10,000	36.3	26.3	12.3	16.5	4.4	4.2	100.0	. .
10,000–<30,000	39.6	28.2	10.7	9.4	4.2	7.8	100.0	. .
30,000–<50,000	26.2	23.1	20.0	7.7	3.1	20.0	100.0	. .
50,000–<100,000	16.0	25.4	18.2	22.7	6.1	11.6	100.0	. .
100,000–<250,000	4.4	25.4	21.5	17.1	11.2	20.5	100.0	. .
250,000–<500,000	5.1	20.3	26.6	16.5	12.7	19.0	100.0	. .
500,000 or more	2.3	10.3	12.6	14.9	18.4	41.4	100.0	. .
Not known	16.7	0.0	33.3	33.3	0.0	16.7	100.0	. .
Total	**23.4**	**22.1**	**17.6**	**20.3**	**6.5**	**10.0**	**100.0**	. .

(a) The claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Notes

1. Length of claim is from date reserve was placed to 30 June 2006. If a claim has a status of 'claim file closed', length of claim is from the date the reserve was placed to the date the claim was closed.
2. Data for approximately 80% of closed claims in scope are included.

4 Public sector medical indemnity claims 2003–04 to 2006–07

This section presents an overview of data from the available reporting periods from 2003–04 to 2006–07.

The time series reported in this chapter employs the data published in previous AIHW medical indemnity reports. The data from each year including 2006–07 is the best available at the time of reporting but is not frozen. Various jurisdictions have refined their claims data through review and audit processes, which can result in data being entered in fields previously recorded as *Not known*, the retrospective closure of claims and other updates. The net effect of these processes is to decrease comparability between reporting years, and so comparisons between years should be interpreted with caution.

With the significant improvements in data completeness and *not known* rates over time, and the corrections to claims data occasioned through review and auditing, more robust time series comparisons can be anticipated in future reports.

4.1 Data completeness and claim status

Data completeness improved from 80% of captured claims in scope in the first full-year reporting period (2003–04) to 93% in 2006–07 (Table 4.1).

Overall, the number of claims increased from 4,956 in 2003–04 to 6,922 in 2005–06, with numbers reducing to 6,284 in 2006–07. New claims also peaked at 1,943 in 2005–06, compared to 1,641 in the two previous years and 1,251 in 2006–07. However, allowing for the significantly increased number of new claims that affected one jurisdiction in 2005–06, new claims have declined by about 15% per year over the 4-year period.

Table 4.1: All claims: 2003–04 to 2006–07

	2003–04	2004–05	2005–06	2006–07
		Number		
Current claims	4,096	4,773	5,294	4,070
Closed claims	860	1,680	1,628	2,214
New claims[(a)]	1,641	1,641	1,943	1,251
All claims[(b)]	**4,956**	**6,453**	**6,922**	**6,284**
		Per cent		
Current claims	82.6	74.0	76.5	64.8
Closed claims	17.4	26.0	23.5	35.2
All claims	*100.0*	*100.0*	*100.0*	*100.0*
Proportion of all claims in scope (%)	*80*	*85*	*89*	*93*

(a) New claims are claims that were opened during the reporting period, including those that were closed during the period. See Box 2.1 on page 7 for a detailed explanation of the counting rules for the MINC dataset.

(b) All claims represent all claims active during the reporting period, i.e. the sum of the closed and current claims, including all claims that were open at the start of the period.

Clinical service context

General surgery was the most frequently recorded Clinical service context for the current reporting period and has been increasing as a proportion over the 4-year reporting period, from around 11% in 2003–04 and 2004–05 to nearly 18% in 2006–07. The proportion of claims for which *Gynaecology* was reported as the Clinical service context has declined gradually over the period, from over 8% in 2003–04 to around 6% in 2006–07 (Table 4.2).

Table 4.2: All claims: clinical service context, 2003–04 to 2006–07

Clinical service context	2003–04	2004–05	2005–06	2006–07
		Number		
General surgery	561	721	1,004	1,119
Obstetrics	825	1,141	1,156	1,085
Accident & Emergency	710	940	935	939
Orthopaedics	386	450	444	417
Gynaecology	414	508	449	384
General medicine	204	295	267	315
Psychiatry	234	277	269	285
Paediatrics	135	190	182	163
All other clinical service contexts	1,294	1,733	1,718	1,272
Not known	193	198	498	305
Total	**4,956**	**6,453**	**6,922**	**6,284**
		Per cent		
General surgery	11.3	11.2	14.5	17.8
Obstetrics	16.6	17.7	16.7	17.3
Accident & Emergency	14.3	14.6	13.5	14.9
Orthopaedics	7.8	7.0	6.4	6.6
Gynaecology	8.4	7.9	6.5	6.1
General medicine	4.1	4.6	3.9	5.0
Psychiatry	4.7	4.3	3.9	4.5
Paediatrics	2.7	2.9	2.6	2.6
All other clinical service contexts	26.1	26.9	24.8	20.2
Not known	3.9	3.1	7.2	4.9
Total	***100.0***	***100.0***	***100.0***	***100.0***

Note: 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.

Geographic location

The majority of claims in all reporting periods occurred in *Major cities* (Table 4.3). As noted in the comments relating to Table 4.1, there was an increase in the number of new claims in 2005–06 attributable to a one-off factor within one jurisdiction. These new claims account for most of the increase in the proportion of claims that have recently arisen in *Inner regional* areas (around 27% in 2005–06 and 2006–07, compared with approximately 22% in 2003–04 and 2004–05).

Table 4.3: All claims: geographic location, 2003–04 to 2006–07

Geographic location where incident occurred[(a)]	2003–04	2004–05	2005–06	2006–07
		Number		
Major cities	3,369	4,407	4,439	3,998
Inner regional	1,059	1,425	1,856	1,707
Outer regional	434	505	512	493
Remote and very remote	75	91	91	77
Not known	19	25	24	9
Total	**4,956**	**6,453**	**6,922**	**6,284**
		Per cent		
Major cities	68.0	68.3	64.1	63.6
Inner regional	21.4	22.1	26.8	27.2
Outer regional	8.8	7.8	7.4	7.8
Remote and very remote	1.5	1.4	1.3	1.2
Not known	0.4	0.4	0.3	0.1
Total	***100.0***	***100.0***	***100.0***	***100.0***

(a) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

4.2 People

Primary body function/structure affected

The distribution of claims across 'Primary body function/structure' has been reasonably stable over the four years reported (Table 4.4). The reduction between 2005–06 and 2006–07 in the proportion of claims where the Primary body function/structure was not known would at least partly account for the increase in those categories where the proportion increased between those years.

Table 4.4: All claims: primary body function/structure[(a)] affected, 2003–04 to 2006–07

Primary body function/structure affected	2003–04	2004–05	2005–06	2006–07
		Number		
Neuromusculoskeletal and movement-related functions and structures	1,117	1,522	1,452	1310
Mental functions/structures of the nervous system	635	957	972	1264
Death	456	592	683	820
Functions and structures of the digestive, metabolic and endocrine systems	425	578	748	755
Genitourinary and reproductive functions and structures	679	867	796	745
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	334	468	466	419
Functions and structures of the skin and related structures	218	250	241	241
Sensory functions/the eye, ear and related structures	144	195	181	191
Voice and speech functions/structures involved in voice and speech	74	93	83	68
No body function/structure affected	145	159	155	95
Not known	729	772	1,145	376
All claims	**4,956**	**6,453**	**6,922**	**6,284**
		Per cent		
Neuromusculoskeletal and movement-related functions and structures	22.5	23.6	21.0	20.8
Mental functions/structures of the nervous system	12.8	14.8	14.0	20.1
Death	9.2	9.2	9.9	13.0
Functions and structures of the digestive, metabolic and endocrine systems	8.6	9.0	10.8	12.0
Genitourinary and reproductive functions and structures	13.7	13.4	11.5	11.9
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	6.7	7.3	6.7	6.7
Functions and structures of the skin and related structures	4.4	3.9	3.5	3.8
Sensory functions/the eye, ear and related structures	2.9	3.0	2.6	3.0
Voice and speech functions/structures involved in voice and speech	1.5	1.4	1.2	1.1
No body function/structure affected	2.9	2.5	2.2	1.5
Not known	14.7	12.0	16.5	6.0
All claims	***100.0***	***100.0***	***100.0***	***100.0***

(a) See Appendix 1 for an explanation of coding categories for 'Body function/structure affected'.

4.3 Claims

Primary incident/allegation type

'Primary incident/allegation type' describes 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. Over the past four reporting periods, the proportion of claims reporting *Procedure* as the Primary incident/allegation type has increased (Table 4.5). The number of claims recording *consent* has decreased over the four years.

Table 4.5: All claims: primary incident/allegation type, 2003–04 to 2006–07

Primary incident/ allegation type	2003–04	2004–05	2005–06	2006–07	2003–04	2004–05	2005–06	2006–07
	Number				Per cent			
Diagnosis	1,028	1,324	1,372	1,430	20.7	20.5	19.8	22.8
Medication-related[(a)]	167	237	207	276	3.4	3.7	3.0	4.4
Anaesthetic	126	177	162	149	2.5	2.7	2.3	2.4
Blood/blood product-related	71	104	90	73	1.4	1.6	1.3	1.2
Procedure[(b)]	1,627	2,163	2,361	2,263	32.8	33.5	34.1	36.0
Treatment[(c)]	676	947	946	1,012	13.6	14.7	13.7	16.1
Consent[(d)]	187	213	153	125	3.8	3.3	2.2	2.0
Infection control	112	151	139	98	2.3	2.3	2.0	1.6
Device failure	53	65	46	25	1.1	1.0	0.7	0.4
Other general duty of care	512	674	638	446	10.3	10.4	9.2	7.1
Other	77	92	117	109	1.6	1.4	1.7	1.7
Not known	320	306	691	278	6.5	4.7	10.0	4.4
Total	**4,956**	**6,453**	**6,922**	**6,284**	***100.0***	***100.0***	***100.0***	***100.0***

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

(b) *Procedure* includes failure to perform a procedure, wrong procedure, wrong body site, intra-operative complications, post-operative complications, post-operative infection, 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) *Consent* includes failure to warn.

Reserve range

Table 4.6 presents the trends in reserve ranges of claims from 2003–04 to 2006–07. The reserve placed on a claim is the best current estimate of the size of the claim (total claim size). The reserve may be revised over the life of the claim.

More than half of all new claims have the reserve range set at less than $30,000 for each of the four years. Current claims with a reserve exceeding $500,000 increased from 5.0% in 2003–04 to 10.6% in 2006–07.

Table 4.6: Current and new claims: reserve range, 2003–04 to 2006–07

	Current claims				New claims			
Reserve range ($)	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2003–04**	**2004–05**	**2005–06**	**2006–07**
				Number				
Less than 10,000	771	868	878	599	436	444	471	279
10,000–<30,000	1,365	1,599	1,780	1,126	577	540	749	437
30,000–<50,000	416	383	467	309	137	101	204	87
50,000–<100,000	728	936	872	687	293	303	244	175
100,000–<250,000	445	512	616	609	118	147	161	142
250,000–<500,000	167	203	282	309	45	51	65	71
500,000 or more	204	272	399	431	35	55	49	60
Total	**4,096**	**4,773**	**5,294**	**4,070**	**1,641**	**1,641**	**1,943**	**1,251**
				Per cent				
Less than 10,000	18.8	18.2	16.6	14.7	26.6	27.1	24.2	22.3
10,000–<30,000	33.3	33.5	33.6	27.7	35.2	32.9	38.5	34.9
30,000–<50,000	10.2	8.0	8.8	7.6	8.3	6.2	10.5	7.0
50,000–<100,000	17.8	19.6	16.5	16.9	17.9	18.5	12.6	14.0
100,000–<250,000	10.9	10.7	11.6	15.0	7.2	9.0	8.3	11.4
250,000–<500,000	4.1	4.3	5.3	7.6	2.7	3.1	3.3	5.7
500,000 or more	5.0	5.7	7.5	10.6	2.1	3.4	2.5	4.8
Total (%)	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***

Total claim size

In the four last reporting periods, over three-quarters of closed claims (83.0% in 2006–07) were closed with a total claim size of less than $100,000 each (Table 4.7). There has been a significant decrease in the percentage of closed claims for which the total claim size was recorded as *Not known* between 2003–04 and 2006–07.

Table 4.7: Closed claims: total claim size, 2003–04 to 2006–07

	Closed claims							
Total claim size ($)	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2003–04**	**2004–05**	**2005–06**	**2006–07**
	Number				**Per cent**			
$0[(a)]	148	343	458	606	17.2	20.4	28.1	27.4
Less than 10,000	318	700	527	612	37.0	41.7	32.4	27.6
10,000–<30,000	110	189	190	308	12.8	11.3	11.7	13.9
30,000–<50,000	45	90	81	130	5.2	5.4	5.0	5.9
50,000–<100,000	67	148	100	181	7.8	8.8	6.1	8.2
100,000–<250,000	34	88	142	205	4.0	5.2	8.7	9.3
250,000–<500,000	12	38	42	79	1.4	2.3	2.6	3.6
500,000 or more	15	27	62	87	1.7	1.6	3.8	3.9
Not known	111	57	26	6	12.9	3.4	1.6	0.3
Total	**860**	**1,680**	**1,628**	**2,214**	***100.0***	***100.0***	***100.0***	***100.0***

(a) The claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Appendix 1 Body function/structure categories

Table A1.1: 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 functions/structures affected	Failed sterilisation, where there is no consequent harm to body functions or structures

Appendix 2 Detailed tables

Table A2.1: All claims: number of claims for which each clinical service context was recorded, 1 July 2006 to 30 June 2007, Australia

Clinical service context	Number	Per cent
General surgery	1,119	17.8
Obstetrics	1,085	17.3
Accident and emergency	939	14.9
Orthopaedics	417	6.6
Gynaecology	384	6.1
General medicine	315	5.0
Psychiatry	285	4.5
Paediatrics	163	2.6
General practice	135	2.1
Cardiology	127	2.0
Neurology	117	1.9
Urology	81	1.3
Radiology	73	1.2
Oncology	74	1.2
Dentistry	69	1.1
Ear, nose and throat	58	0.9
Hospital outpatient department	55	0.9
Perinatology	37	0.6
Plastic surgery	29	0.5
Cosmetic procedures	17	0.3
Other	400	6.4
Not known	305	4.9
Total	**6,284**	**100.0**

Notes

1. All clinical service contexts are included in this table. *Other* can only be used where no other clinical service context is applicable.
2. Data for approximately 93% of all claims in scope are included.

Table A2.2: Specialties of clinicians closely involved in allegation of harm: frequency of coding categories recorded for all claims, 1 July 2006 to 30 June 2007, Australia

Specialty of clinician	Number	Per cent of all recorded specialty categories
General surgery	847	12.4
Emergency medicine	793	11.6
Obstetrics only	740	10.8
Orthopaedic surgery	420	6.1
Gynaecology only	303	4.4
Psychiatry	268	3.9
Nursing—general	263	3.9
General practice—non procedural	247	3.6
Obstetrics and gynaecology	242	3.5
Anaesthetics—general	175	2.6
General practice—procedural	159	2.3
Other hospital-based medical practitioner[(a)]	138	2.0
General and internal medicine	127	1.9
Midwifery	113	1.7
Paediatric medicine	113	1.7
Diagnostic radiology	111	1.6
Cardiology	96	1.4
Neurosurgery	93	1.4
Urology	81	1.2
Intensive care	76	1.1
Ophthalmology	75	1.1
Clinical haematology	68	1.0
Pathology	67	1.0
Plastic surgery	61	0.9
Neonatology	57	0.8
Gastroenterology	55	0.8
Ear, nose and throat	52	0.8
Paediatric surgery	52	0.8
Vascular surgery	52	0.8
Neurology	46	0.7
Medical oncology	45	0.7
Colorectal surgery	44	0.6
Dentistry—procedural	44	0.6
Nursing—nurse practitioner	44	0.6
Cardiothoracic surgery	41	0.6
Clinical immunology	40	0.6
Paramedical and ambulance staff	35	0.5
Other allied health	34	0.5
Dentistry—oral surgery	32	0.5
Anaesthetics—intensive care	25	0.4
Nuclear medicine	23	0.3

(continued)

Table A2.2 (continued): Specialties of clinicians closely involved in allegation of harm: frequency of coding categories recorded for all claims, 1 July 2006 to 30 June 2007, Australia

Specialty of clinician	Number	Per cent of all recorded specialty categories
Renal medicine	21	0.3
Physiotherapy	19	0.3
Infectious diseases	18	0.3
Endocrinology	13	0.2
Respiratory medicine	13	0.2
Rehabilitation medicine	12	0.2
Clinical genetics	11	0.2
Psychology	11	0.2
Facio-maxillary surgery	10	0.2
Endoscopy	9	0.1
Public health/preventive medicine	8	0.1
Podiatry	7	0.1
Rheumatology	6	<0.1
Therapeutic radiology	6	<0.1
Geriatrics	5	<0.1
Spinal surgery	5	<0.1
Cosmetic surgery	4	<0.1
Dermatology	4	<0.1
Thoracic medicine	4	<0.1
Pharmacy	3	<0.1
Chiropractics	1	<0.1
Clinical pharmacology	1	<0.1
Occupational medicine	1	<0.1
Osteopathy	0	0
Nutrition/dietician	0	0
Sports medicine	0	0
Not Applicable[(b)]	62	0.9
Not known	189	2.8
Total[(c)]	**6,840**	**100.0**

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

(b) Not applicable for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

(c) Total number of specialty categories recorded. The total is greater than the total number of claims because up to four specialty codes can be recorded for a single claim.

Table A2.3: Specialty of clinicians closely involved in incident: percentage of claims with one, two, three and four specialty codes recorded, 1 July 2006 to 30 June 2007, Australia

	One specialty only	Two specialties	Three specialties	Four specialties	Total
Number	5,816	393	62	13	6,284
Per cent	92.6	6.3	1.0	0.2	100.0

Appendix 3 Background to the MINC collection

Background to the collection

A 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, no robust analysis of trends in the number, nature and cost of medical indemnity claims could be undertaken.

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). On 3 July 2002 AHMAC commissioned the AIHW to work with the MIDWG to further develop proposals for a national medical indemnity data collection for the public sector.

Purposes of the collection

The primary purposes of the MINC 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.

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 state, territory and Commonwealth 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. Currently it reports on statistical matters to the 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 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 unidentifiable 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.

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 area health services, most statutory health corporations, and affiliated health organisations in respect of recognised establishments.

In some circumstances TMF cover is available to visiting medical officers (VMOs) and honorary medical officers (HMOs) under a separate contract of liability cover. Since 1 January 2002 the government has offered VMOs and HMOs cover by the TMF when treating public patients in public hospitals, subject to certain conditions, including a condition that doctors sign up for comprehensive risk reduction programs. The majority of VMOs have elected to participate. At the same time, the government accepted financial responsibility for unreported incidents of medical defence organisations where the incidents involved public patients in public hospitals and the treating doctor had a VMO or HMO appointment.

Medical indemnity for private patients in rural public hospitals is the responsibility of the VMO or staff specialist (SS). Since 1 July 2003, however, VMOs and SSs levels 2 to 5 who have rights of private practice and work in rural areas and selected hospitals in the Hunter and Illawarra have been able to obtain public sector medical indemnity for private patients they treat in public hospitals, subject to various conditions.

Similarly, medical indemnity for private paediatric patients in public hospitals is the responsibility of the VMOs or SSs. However, since 1 January 2005, VMOs and SSs levels 2 to 5 (having rights of private practice) have been able to access public sector medical indemnity for private paediatric patients they treat in public hospitals in New South Wales. (Note that private paediatric patient indemnity for VMOs and SSs in the rural sector, including specified hospitals in the Hunter and Illawarra, has been available in their indemnity package since 1 July 2003.)

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 31 December 2008.

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.

The TMF fund manager manages all aspects of the claim, including arranging for such legal advice and representation as may be necessary. Incidents involving employees of PHOs are notified to the TMF through PHO risk managers. VMOs and HMOs are required by their

contracts of liability coverage to notify their PHOs of all incidents; the PHO then notifies the New South Wales Department of Health, which notifies the TMF.

When notified of an incident, the TMF sets a reserve if it believes the incident is likely to become a claim and, if necessary, arranges to have a solicitor on the record. The TMF then investigates the incident, provides instructions to the solicitor, and conducts interviews. The TMF remains involved in the settlement of the claim through the courts or the settlement process.

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). 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 Human Services 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 320 practitioners insured under this scheme in 2004–05. 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 through the Queensland Government TMF, called the Queensland Government Insurance Fund. 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 4 November 2002 Queensland Health restated its indemnity arrangements in a new indemnity policy for medical practitioners, IRM 3.8–4. 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).

IRM 3.8–4 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, IRM 3.8–3. Queensland Health does not indemnify medical students.

Queensland Health MINC jurisdictional data come primarily from medical indemnity claims information provided to Queensland Health by the litigation panel firms engaged to provide medico-legal litigation services to the department. Therefore, in the main, the pool of MINC jurisdictional data from Queensland Health 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 Rights Commission Act 1991* 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 and 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
- 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.

PIPA began operating on 18 June 2002. On 29 August 2002 it 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 1 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—for example, 5 = $5,000, 50 = $93,800, 100 = $250,000. The regulation under the *Civil Liability Act 2003* sets out a scale of injuries, with a guide to an appropriate injury scale value for particular injuries. There are limited medico-legal examples in the injury scale value. The *Civil Liability Regulation 2003* commenced on 7 October 2003
- 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. One such change relates to claims involving medical negligence in the treatment of a child: the parent or guardian of the child must provide the initial notice and then Part 1 of the notice of claim on behalf of the child within defined time-frames. A Part 1 notice of claim must be given before the earlier of 6 years after the parent(s)/guardian knew that the personal injury occurred or 18 months after the parent(s)/guardian first consults a lawyer about the possibility of seeking damages. A respondent has the right to seek a court order that the claim not proceed if the Part 1 notice is given out of time.

Western Australia

Public sector hospitals and health services in Western Australia are insured through the RiskCover Division of the Insurance Commission of Western Australia. Commencing on 1 July 1997, RiskCover has acted on behalf of the Department of Treasury and Finance to manage the self-insurance fund covering liability claims arising from the operations of the state's agencies.

All 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 and Finance generally funding settlement costs on a case-by-case basis.

When a MTL claim naming a hospital is lodged, RiskCover liaises with the relevant claims manager and 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. The Department of Health and the relevant hospital are provided with regular reports on progress until each matter is settled.

Since 1 July 2003, the Department of Health, through RiskCover, has contractually indemnified all eligible non-salaried medical practitioners (NSMPs) for any claims of negligence, omission or trespass that may arise from the treatment of public and, in country areas, private patients, in public hospitals or other agreed health care institutions. In return, NSMPs have a number of obligations, including supporting and participating in further safety and quality management programs.

From 1 July 2004 salaried medical officers have been offered a contractual indemnity for MTL claims arising from their treatment of public patients and, where the salaried medical officer has assigned his or her billing rights to the hospital, their treatment of private patients.

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 South Australian Government Captive Insurance Corporation (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 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. ACT Health limits its excess to $50,000, the balance of any one claim then being covered by the insurance authority.

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 timeframes (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—for example, where care is provided outside the hospital setting. 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 Community Services, 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
  - for 6 months or more.

The maximum amount of damages a court may award for non-pecuniary loss is $350,000 at commencement of the Act (May 2003) and as declared by the minister on or before 1 October in each year after the year in which the Act commences.

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 not common in the Northern Territory. 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.

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