First medical indemnity national data collection report: public sector

January to June 2003

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Symbols

–	nil or rounded to zero
..	not applicable

1 Introduction

This report describes the development of and presents the first six months' data from the newly developed national collection of data on medical indemnity claims in the public sector.

The medical indemnity national collection (MINC) includes both claims that have materialised (e.g. where legal action has commenced) and potential claims (i.e. matters considered likely to materialise into a claim, where a reserve has been set). The data in this report cover claims current at any time during the reporting period 1 January to 30 June 2003, that is, claims that were open at the start of the period, new claims that arose during the period, and claims finalised during the period. There is information on the incidents that give rise to claims, the people affected by these incidents, and the size, outcome and key aspects of the processing of claims. Records in the MINC database do not contain information that would allow the identification of individuals or health service providers involved in claims.

The data presented in this report are not complete—that is, data for only approximately 50% of all claims in scope are included. As data completeness improves in future, the claims profile as illustrated by the data in this report may change significantly. In addition, as this is a new collection, some data quality and coding consistency issues are yet to be resolved.

For these reasons, the data in this report must be interpreted with caution, and should be treated as mainly illustrative of the future potential of the collection to provide insights into the nature of and trends in medical indemnity claims in the public sector.

1.1 Background to the collection

The need for a national medical indemnity collection arose in the broader context of national policy concern related to health care litigation, associated costs, and the financial viability of medical indemnity insurers. To date, the absence of national data has made it difficult to analyse trends in the number, nature and cost of medical indemnity claims.

At the Medical Indemnity Summit in April 2002, Health Ministers decided that a 'national database for medical negligence claims' should be established, to assist in determining future medical indemnity strategies. A Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). On 3 July 2002 AHMAC decided to commission the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG to further develop the proposals of the MIDWG for a national medical indemnity collection for the public sector.

1.2 Purposes of the collection

The primary purposes of the MINC are:

- to obtain ongoing information on medical indemnity claims and their outcomes;
- to provide a national information base on nationally aggregated data which assist policy makers to identify trends in the nature, incidence and cost of medical indemnity claims; and
- to 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; and
- supplement other sources of information on clinical risk prevention and management.

As the collection matures, MINC data will be important in providing an evidence base to inform high level policy in the areas of public health, health administration and government finance. The collection will also be an important information resource for those working in public sector claims management and clinical risk prevention and management.

1.3 Collaborative arrangements

The MINC is governed by an Agreement, the parties to which are Commonwealth, State, and Territory Health Authorities and the AIHW. The Agreement outlines the roles and responsibilities of, and the nature of the collaborative arrangements between the parties.

The MIDWG is composed of representatives of State, Territory and Commonwealth Health Authorities and the AIHW. Its functions include:

- to develop and manage the MINC;
- to advise the AIHW and AHMAC on matters relating to the MINC; and
- to seek the agreement of Health Authorities on changes to MINC data materials and protocols, and on a range of matters relating to the public release of MINC aggregated data.

MINC jurisdictional data are provided by Health Authorities in each of the States and Territories of Australia (the 'Data Providers'). The AIHW is the National Data Custodian—the agency that holds MINC jurisdictional data on behalf of each Data Provider, and the MINC on behalf of the MIDWG. It is responsible for the secure storage, management and analysis of MINC data. The roles and responsibilities of Data Providers, the MIDWG and the National Data Custodian are set out in more detail in the MINC Agreement.

The collection, storage and use of MINC data by AIHW are governed by the *Privacy Act* 1988 which establishes the Information Privacy Principles (IPPs) and National Privacy Principles (NPPs). Together, the IPPs and NPPs govern the conduct of Commonwealth agencies and private organisations in their collection, management, use and disclosure of records containing personal information. The AIHW has documented policies and procedures, approved by its Board, covering information security and privacy. MINC jurisdictional data are treated in confidence by the AIHW in all phases of collection and custodianship. Data Providers retain ownership of the information they supply to the AIHW, and the unanimous approval of MIDWG is necessary before any MINC data may be released or published.

1.4 Ongoing development of the collection

MINC data are provided by Health Authorities to the AIHW for national collation and analysis every six months. This report represents the first public release of preliminary MINC data. A full 2003–2004 financial year report is planned for completion in early 2005.

Further development of the MINC is anticipated over the next couple of years. The MINC has been developed as a public sector collection in the first instance. However, the goal articulated by Health Ministers at the Medical Indemnity Summit in April 2002 remains to make full national data on both public and private sector medical indemnity claims available to inform policy.

Under the *Financial Sector (Collection of Data) Act 2001*, the Australian Prudential Regulation Authority (APRA) is currently implementing a data collection covering public and products liability and professional liability (including medical indemnity) insurance policy and claims data. As there is some overlap of content between APRA's private sector collection and the MINC, AIHW and APRA have been working together to improve coordination and consistency between the two collections. This has involved some changes to data items and coding categories in both the APRA and MINC data specifications, and it is envisaged that more changes will be required to achieve complete consistency.

Discussions involving APRA, AIHW, the Australian Government Department of Health and Ageing, and Medical Indemnity Insurers (MIIs) are underway to agree on efficient and mutually acceptable arrangements for data collection from MIIs and transmission to AIHW for the purpose of compiling full national reports covering both the public and private sectors. There is also discussion about how data on run-off claims managed by Medical Defence Organisations (not to be covered in APRA's collection) could be captured. The objective is that, in future, it will be possible to compile reports that provide a complete national picture of medical indemnity claims experience, including, for example, how claim profile differs between the public and private sectors, and how risk is divided between the sectors.

2 The collection

2.1 Scope and context

The MINC includes information on medical indemnity claims against the public sector handled by state and territory Health Authorities. In some instances, visiting medical officers are covered by public sector indemnity arrangements, and claims made under such arrangements come within the scope of the MINC. In some of these cases the claims against the private doctors are reported in addition to those claims against the hospitals (and employees of the hospitals), so in those cases where private doctors and hospitals were all involved in the one incident more than one claim record may be recorded. However, the collection does not currently include data on claims managed by insurers in the private sector.

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. For the purposes of the MINC, a matter becomes a claim when it has a 'reserve' placed against it. A reserve is the dollar amount that is the best current estimate of the likely cost of the claim when closed. Thus, the collection includes both claims that have materialised (e.g. where legal action has commenced) and potential claims (i.e. matters considered likely to materialise into a claim, where a reserve has been set). The scope of the MINC is therefore not as broad as 'adverse events', nor as narrow as 'claims made'.

2.2 The policy, administrative and legal context

Figure 2.1 provides a visual representation of the types of information gathered via the MINC, set within the broader context in which medical indemnity claims arise. It shows the systems, processes and players that do or may affect information flow into the MINC, or benefit from data provided by the MINC.

This section provides brief information on key aspects of the policy, legal and administrative arrangements relevant to medical indemnity claims, as a context for the data presented in this report. It is intended to sketch a broad national picture, noting where there is variation between jurisdictions.

Policy relating to public sector medical indemnity

Coverage of public sector medical indemnity arrangements varies between jurisdictions. In all jurisdictions doctors, nurses and allied health staff employed by public health authorities are covered in relation to their public work. Independent doctors (visiting medical officers) are also covered in all jurisdictions when they are treating public patients. Medical students working in public hospitals are covered by the public sector in many jurisdictions, though different arrangements apply in some.

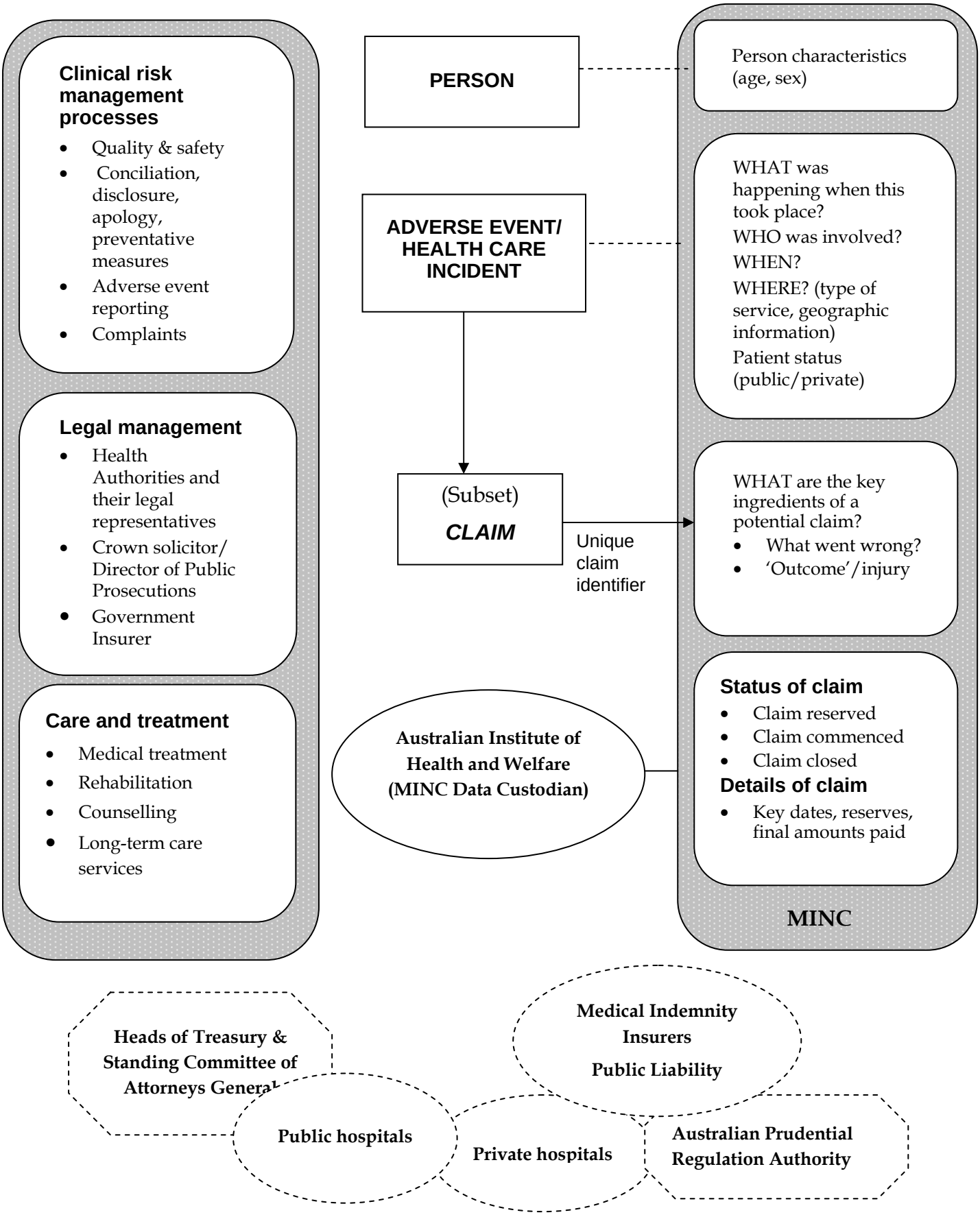

Figure 2.1: The context of the medical indemnity national collection (public sector)

Generally, cover is provided where the medical practitioner has diligently and conscientiously endeavoured to carry out their duty and there is no wilful misconduct, wilful neglect or criminal activity on the part of the person seeking indemnity.

Over recent years there has been a trend towards expanding public sector medical indemnity arrangements. This has been in response to concerns that the availability of important health services (e.g. obstetrics services) may be threatened by rising premiums for medical indemnity insurance offered by medical defence organisations to doctors in private practice; there are particular concerns around service availability in rural Australia.

Thus, in some jurisdictions arrangements exist under which, in specified circumstances, doctors not employed by public health authorities or not treating public patients may have access to public sector medical indemnity cover. Examples include:

- non-salaried doctors treating public patients in public hospitals;
- employed doctors with limited private practice rights entering into fee-sharing arrangements with public hospitals;
- rural general practitioners working in public and bush nursing hospitals.

Under some of these arrangements doctors must pay a premium in order to receive cover.

The scope of the MINC includes all claims that fall under public sector medical indemnity arrangements. Therefore, as policy relating to coverage changes in jurisdictions across Australia, the effective scope of the MINC will change accordingly.

Administrative arrangements and claims management

As a general guide, key steps involved in the claim management process include:

- An incident that may lead to a public sector medical indemnity claim is notified to the relevant claims management body.
- 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; a claim file is opened.
- Various events may signal the commencement of the claim—a writ or letter of demand may be received from the claimant's solicitor (this may occur before notification); or the defendant may make an offer to the claimant to settle the matter, before a writ or letter of demand has been issued. In some cases no action is taken by the claimant or the defendant.
- The claim is investigated. This may include liaising with clinical risk management staff within the health facility concerned, and seeking expert medical advice.
- As the claim progresses the reserve is monitored and adjusted if necessary.

- A claim may be finalised in various ways, including 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 may be agreed between the claimant and defendant, independent of any formal process.
- A claim file that has remained inactive for a long period may be closed. In some instances, claims that have been closed may subsequently be re-opened.

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

In some jurisdictions claims are largely managed in-house, by the state or territory health authority. Some of the legal work may be out-sourced to private law firms. In other jurisdictions most of the claims management process is handled by a body that is separate to the health authority.

Legal reforms

In 2002 Commonwealth, State and Territory governments established a panel to review the law of negligence as it applies to claims for personal injury and death. One of the terms of reference of the *Review of the Law of Negligence Report* (the 'Ipp Report') was to 'develop and evaluate principled options to limit liability and quantum of awards for damages'.

A key recommendation of the review was that a single statute should be enacted in all jurisdictions to ensure national consistency in proceedings relating to claims for personal injury and death (Commonwealth of Australia 2002). The report also made recommendations on a range of issues, including:

- a test for determining the standard of care in cases where negligence is alleged against a medical practitioner;
- the limitation period within which a claim for damages for personal injury or death resulting from negligence may be brought;
- restrictions on the requirement for a defendant to pay a plaintiff's legal costs;
- capping awards for general damages and damages for loss of earning capacity;
- damages relating to mental harm (that these should be recoverable only where there is a recognised psychiatric illness);
- principles guiding the determination of other types of damages (e.g. health care costs, gratuitous services, and future economic loss);
- a requirement that, under certain circumstances, parties must attend mediation proceedings with a view to securing a structured settlement.

All jurisdictions have legislated limitation periods within which legal action relating to a medical indemnity claim must be initiated, and some have legislation that limits awards of damages for negligence claims for personal injury or death (including

medical indemnity claims). There is considerable variation in these provisions between jurisdictions.

Some jurisdictions have already enacted legislation implementing the recommendations from the Ipp Report. Others are currently engaged in, or planning, tort law reform, including implementing Ipp recommendations. As changes in the law relating to medical indemnity claims are implemented, these may be reflected in the number, nature and quantum of claims that fall within the scope of the MINC.

2.3 Data items

The MINC consists of 21 data items. For each item, the MINC Data Guide 2003 provides a definition, classification codes (i.e. response options), guide for use, and information on why the item is collected and its developmental history and relationship to national data standards (AIHW 2003 (unpublished)). The items and their definitions are listed in Table 2.1.

An information model was developed to aid in the development of the MINC and the data items (Figure 2.2). It depicts relationships between key data entities. The MINC collects information about the claim subject (i.e. the person who was the patient during the incident that gave rise to the claim), the incident that gave rise to the claim, the claim itself, and other parties involved (including any other parties alleged to have suffered loss, and health service providers). The claimant (i.e. the person who is pursuing the claim) is often also the claim subject; however, the MINC does not collect information about the claimant as such. Definitions of key MINC terms are given in Table 2.2. Records in the MINC database do not contain information that would allow the identification of individuals or health service providers involved in claims.

The information recorded for a particular claim will often reflect events and circumstances as alleged by the claimant, or by other parties to the claim (e.g. the defendant clinician). In recording information about a claim, the claim manager aims to reflect the key aspects of the incident and outcome that, based on the information available, seem most likely to constitute the real substance of the claim, and thus relate to the possible medical indemnity liability of the Health Authority. It must be recognised, however, that the accounts of events or circumstances as reflected in MINC records will, in many cases, not yet have been substantiated.

The information recorded for a claim may change over the life of the claim, reflecting changes in the information available to the claim manager. For each 6-monthly reporting period the information contained in each claim record is up-to-date as at the end of the reporting period. Unique claim identifiers allow claim records to be linked between reporting periods; thus, for claims that remain open for more than one reporting period, it will be possible to look at how information recorded for various data items has been updated over the life of the claim.

Table 2.1: MINC data items and definitions

Data item	Definition
1. Claim identifier	An identity number that, within each Health Authority, is unique to a single claim, and which 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 (i.e. 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 (i.e. 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'; i.e. 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 3 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 (i.e. the patient) alleged to have been affected as a result of the incident. (Up to 3 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 (i.e. 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 (ASGC) 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 (i.e. the patient) was a public or private, resident or non-admitted patient at the time of the incident.
14. Specialties 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 finalised	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.

Note: Further information on these data items can be found in the MINC Data Guide: September 2003 (AIHW 2003 unpublished).

Table 2.2: Definitions of key MINC terms

MINC Term	Definition
Claim	Claim is used as an umbrella term to include **medical indemnity claims** that have materialised and **potential claims**. A single claim (i.e. 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, 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 materialise 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.

Source: MINC Data Guide: September 2003 (AIHW 2003 unpublished).

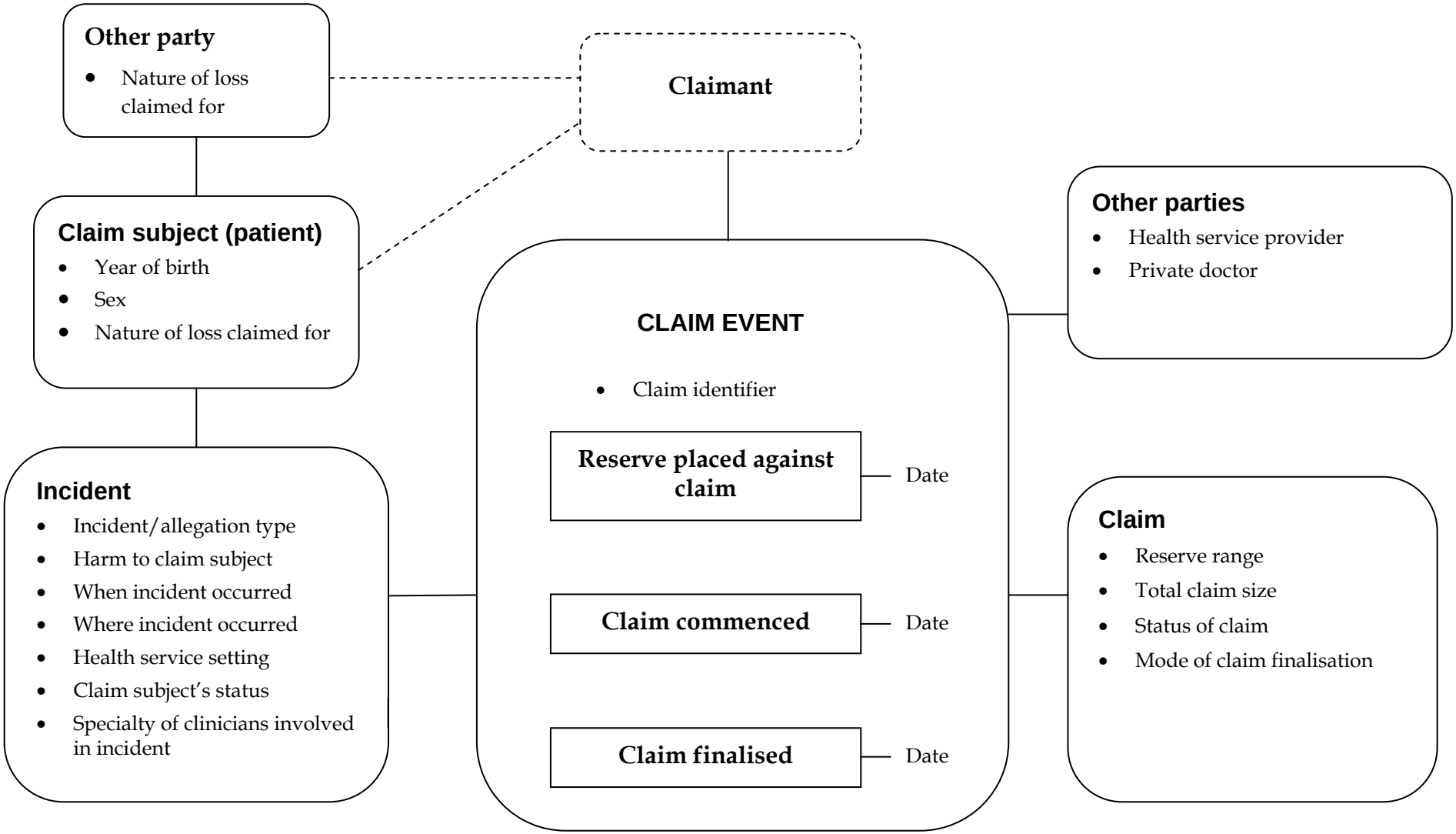

Figure 2.2: MINC Information Model

2.4 Key counts

Each record in the MINC data set represents one claim except in some instances where claims brought by family members concerning the one incident are grouped into one claim record. However, the data can be used to produce different types of counts, as explained in Box 2.1, and these different counts are reflected in tables in the following chapter.

Box 2.1: Counting rules for the MINC data set

The definition of 'claim' includes 'potential claims' (see Section 2.1 and Table 2.2). Some tables present data for particular sub-sets of claims:

- *Current claims – claims that are open (i.e. have a reserve placed against them but have not been finalised) as at the end of the reporting period (there were 2,394 current claims as at 30 June 2003).*
- *Finalised claims – claims that have been closed during the reporting period (there were 272 finalised claims for the period 1 January to 30 June 2003).*
- *New claims – claims that were opened during the reporting period, including those that were also finalised during the period (there were 787 new claims for the period 1 January to 30 June 2003).*
- *All claims – the total set of claims in the MINC during the reporting period (i.e. claims open at any time during the period). This is the sum of current and finalised claims, including claims that were open at the start of the period (there were **2,666 claims in total in the MINC database** for the period 1 January to 30 June 2003).*

For each claim there is one claim subject except in some cases where more than one family member is bringing an action relating to the same incident.

For some MINC data items more than one code may 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*
- *Specialties of clinicians closely involved in the incident*

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

3 Public sector medical indemnity claims data

3.1 Data quality and completeness

Data presented in this chapter must be interpreted with caution, and some data quality and completeness issues, outlined below, must be considered. Data quality and completeness are expected to improve rapidly as the collection matures. However, care will be needed in future when comparing MINC data over time, as changes in coding quality for some data items may affect the validity of such comparisons.

Data completeness

When interpreting any of the data in this report it is important to bear in mind that the data are not complete—in some jurisdictions not all claims open during the reporting period were included. It is estimated that the data available represent approximately 50% of public sector claims in scope during the reporting period 1 January to 30 June 2003.

Reasons for incomplete data provision differed between jurisdictions. Some jurisdictions had medical indemnity claims data systems in place prior to the development of the MINC, and were not able to quickly modify their systems to supply data in MINC format. In some jurisdictions it was not possible in the available time to access or upload data for older claims.

Because New South Wales already had a data system in place with data specifications that differed from those of the MINC, New South Wales was unable to provide data for the following data items: 'Nature of claim—loss to other party/parties'; 'Additional incident/allegation type'; 'Additional body functions/structures affected—claim subject'; 'Extent of harm—claim subject'; and 'Specialties of clinicians closely involved in the incident'. New South Wales data are not included in tables involving these data items; consequently, the total number of claims cannot be shown in these tables and data are presented as percentages.

In practice, the scope of the data provided varied slightly between jurisdictions. For instance, some jurisdictions included records relating to coronial matters, while others did not (except where there was subsequently a claim made). Different reserving practices operating in different jurisdictions also mean that there is variation in terms of which matters come within scope.

Data quality

For some data items there are variations in coding between jurisdictions and, in this first reporting period, 'not known' was recorded for a relatively high proportion of claims for some data items.

'Not known' rates

The category 'not known' includes instances in which the information concerned is not currently available, but is expected to become available as the claim progresses, and instances in which the information is not likely to become available. The latter may be the case in some jurisdictions where, due to the nature of administrative arrangements for claims management, certain information is not readily available.

High 'not known' rates for some data items may reflect the fact that, in some jurisdictions, systems and practices are not yet in place to collect and input all information relevant to MINC data items in a timely manner. It is hoped that as MINC information capture and recording practices become more well-established in jurisdictions 'not known' rates will decrease for most data items.

Table 3.1 shows number and percentage of claims for which 'not known' was recorded for individual data items. Those with the highest 'not known' rates were Nature of claim—loss to other parties ('not known' was recorded for 38% of claims), Primary body function/structure affected (17%), and Extent of harm (16%).

Coding consistency

In analysing the MINC data for the period 1 January to 30 June 2003, cross tabulations of some data items suggested some inconsistency in the use of coding categories for certain items. Coding consistency issues also arose for some data items where NSW data could not be perfectly mapped to MINC coding categories.

For the data item 'total claim size' the coding category 'no payment made' must be interpreted with caution. In some jurisdictions this category was recorded in all cases where no payment had been or would be made to the claimant, regardless of how much may have been expended on legal costs. In other jurisdictions 'no payment made' was only recorded where no payment was made to the claimant and there were no claimant or defence legal costs—if legal costs were incurred then the appropriate dollar range was recorded. Thus, at national level, the number of claims for which 'no payment made' was recorded is an underestimate of the number of finalised claims for which no payment has been or will be made to the claimant, but an overestimate of the number of finalised claims for which there was no expenditure by the Health Authority on either damages or legal costs.

Overall, however, coding consistency in this first reporting period has been sufficiently good to allow interesting and informative patterns to emerge from the MINC data. Caution should be used when interpreting these patterns, as they may not accurately depict all claims in the period; the report only contains approximately 50% of the claims data for the period.

Table 3.1: MINC data items: number and percentage of claims for which 'not known' was recorded, 1 January to 30 June 2003, Australia

Items for all states/territories	Number	% of all claims
Nature of claim—loss to subject	278	10.4
Claim subject's sex	25	0.9
Primary incident/allegation type	108	4.1
Clinical service context	114	4.3
Primary body function/structure affected	441	16.5
Where incident occurred	14	0.5
Health service setting	59	2.2
Claim subject's status	122	4.6
Finalised claim items	**Number**	**% of finalised claims**
Mode of claim finalisation (finalised claims only)	11	4.0
Total claim size (finalised claims only)	30	11.0
Items for all states/territories except NSW[(a)]	**Number**	**% of non-NSW claims**
Nature of claim—loss to other parties	. .	38.4
Claim subject's year of birth	. .	9.5
Additional incident/allegation types	. .	0.9
Additional body functions/structures affected	. .	0.3
Extent of harm	. .	16.4
Specialties of clinicians closely involved in incident	. .	3.3

(a) NSW was not able to provide data for any of the data items in the bottom section of the table.

Note: Not known rates are not presented for the following data items, for the reasons stated:

- Date incident occurred: this item must be completed with a valid date for all records included in the MINC.
- Date reserve placed against claim: this item must be completed with a valid date for all records included in the MINC.
- Reserve range: this item must be completed with a valid reserve range category for all records included in the MINC.
- Date claim commenced: it is valid for this item to be left blank for claims that have not yet commenced.
- Date claim finalised: it is valid for this item to be left blank for claims that have not yet been finalised.
- Status of claim: this item must be completed with a valid claim status category for all records included in the MINC.

Further investigation of coding anomalies is warranted, with a view to improving coding consistency and possibly revising coding categories for some data items. This type of analysis is a normal and necessary aspect of the maintenance of national data collections.

Implications for data reporting

Because of the problems outlined above, regarding the quality and completeness of data for the first 6 months of the collection, it is not appropriate to report here on all data items. In future, as data quality and completeness improve, it will be possible to present more detailed and in depth analyses of MINC data, covering the full range of information captured by the collection.

As data completeness improves in future, the claims profile as illustrated by the data in this report may change significantly. Therefore, the data presented below must be interpreted with caution, and should be treated as mainly illustrative of the future potential of the collection to provide insights into the nature of and trends in medical indemnity claims in the public sector.

3.2 Preliminary medical indemnity claims data: January–June 2003

The data in this report cover claims current at any time during the reporting period 1 January to 30 June 2003, that is, claims that were open at the start of the period, new claims that arose during the period, and claims finalised during the period.

The data included in this report are not complete—in some jurisdictions not all claims open during the reporting period were included in the data. It is estimated that the data available represent approximately 50% of public sector claims in scope during the reporting period. Thus, data tables presented below should be interpreted with care, remembering that they do not include data for all claims in scope during the reporting period.

The data tables referred to in this section are presented in Section 3.3, below.

Findings from the first reporting period

Nationally, data were provided on 2,666 public sector claims open during the period 1 January to 30 June 2003 and within the scope of the MINC. Of these, 272 were finalised during the period and 2,394 remained open as at 30 June 2003. There were 787 new claims opened during the reporting period.

Incidents

The MINC provides information on clinical service context (or area of clinical practice) in which an incident occurred, the incident/allegation type (i.e. what allegedly went wrong), specialties of clinicians closely involved in the incident, where the incident occurred, and the health service setting. Data on specialties of clinicians and health service setting are not presented in this report due to data quality issues during this first reporting period.

Clinical service context and incident/allegation type

The most frequently recorded clinical service context category was obstetrics (398 claims, or 15% of all claims), followed by accident and emergency (346 claims, or 13%), general surgery (302 claims, or 11%) and gynaecology (251 claims, or 9%) (Table 3.2).

The most commonly recorded primary incident/allegation type categories were procedure (845 claims, or 32% of all claims), diagnosis (572 claims, or 22%), treatment (313 claims, or 12%) and other general duty of care issues (289 claims, or 11%).

Compared with claims overall, the primary incident/allegation type category 'other general duty of care issues' was over-represented among claims with a clinical service context of psychiatry (69 claims, or 54%, compared with 11% across all claims). Among claims with a clinical service context of gynaecology, 'procedure' was over-represented (152 claims, or 61%, compared with 32% across all claims), as was 'consent' (37 claims, or 15%, compared with 5% across all claims). 'Treatment' was over-represented among claims with a clinical service context of obstetrics (85 claims, or 21%, compared with 12% for all claims).

Where incidents occurred

Overall, 1,724 claims (65%) arose from incidents that occurred in major cities, 551 (21%) from incidents in inner regional areas, 327 (12%) from incidents in outer regional areas, and 50 (2%) from incidents in remote and very remote areas (Table 3.3). This distribution largely reflects the distribution of the Australian population, and of health care facilities.

People

Several MINC data items relate to the claim subject—the person who was the patient during the health care incident that is the basis for the claim. In many cases the claim subject is also the claimant, but this is not always the case.

Age and sex of claim subjects

Babies aged less than 1 year and children aged under 18 years each accounted for about 8% of all claims (201 and 224 claims, respectively), while adults accounted for 2,002 claims, or 75%; age of the claim subject was not known for 239 claims (9%) (Table 3.4). Of all claim subjects, 43% were male. Males accounted for 54% of claim subjects aged less than 1 year, 46% of those aged between 1 and 18 years, and 43% of those aged over 18 years.

Body functions and structures affected

The MINC provides information on the body functions and structures of the claim subject affected as a result of the incident. While only primary body functions/structures affected are reported here, the MINC also captures data on up to 3 additional body functions and structures affected per claim subject.

The most commonly recorded primary body function/structure affected was 'neuromusculoskeletal and movement-related functions and structures' (593 claims, or 22% of all claims), followed by 'mental functions/structures of the nervous system' (333 claims, or 13%) (Table 3.5). For 208 claims (8% of all claims) 'death' was recorded, indicating that the incident was alleged to have been a contributory cause of the death of the claim subject.

Claims

At 30 June 2003, there were 2,394 current claims (i.e. claims that had a reserve placed against them but were not yet finalised) (Table 3.6). Of these, 1,882 had commenced,

502 had a reserve placed against them but had not yet commenced, and 10 had been re-opened, having previously been closed.

During the period 1 January to 30 June 2003, 272 claims were finalised. For 42 of these the claim file remained open awaiting determination of total claim size, and 8 claims had been finalised with a structured settlement for which the total dollar amount had been decided.

Categories of loss claimed

Data on 'nature of claim—loss to claim subject' provides broad information on the categories of loss that form a basis for the claim. More than one category of loss may be recorded—an average of 2.1 categories of loss were recorded per claim. The most common category of loss to the claim subject was pain and suffering, which was recorded for 41% of all claims, followed by other economic loss (21%), care costs (19%), and other loss (10%) (Table 3.7). The MINC also collects data on loss to other parties that form a basis for the claim; these data are not presented here due to data quality issues during this first reporting period.

Reserves placed on claims

The most commonly recorded reserve range was $10,000–<$30,000, which accounted for 29% of the 2,394 current claims (Table 3.8). Reserve range profile varied considerably by clinical service context. Of particular note, 58 (16%) of the 367 claims with a clinical service context of obstetrics were reserved for $500,000 or more, compared with just 6% of claims overall. Paediatrics was also associated with higher reserves—a higher proportion of these claims were reserved for $100,000 or more (33%, compared with 24% for claims overall) and a lower proportion were reserved for under $30,000 (36%, compared with 45% for claims overall). In contrast, a high proportion of claims with a clinical service context of psychiatry were reserved for under $30,000—69 of the 119 claims in this category, or 58%, compared with 45% for all claims.

Size of finalised claims, mode of claim finalisation, and duration of the claims process

Of the 272 finalised claims, 94 (35%) had a total claim size of less than $10,000 and 10% had a total claim size of $100,000 or more (Table 3.9).

Twenty claims were finalised by a court decision, 147 were settled outside court and 94 were discontinued. Of the 94 discontinued claims, a total size of less than $10,000 was recorded for 51 and 'no payment made' was recorded for 29.

Overall, for finalised claims, 2.4 years was the mean period of time between the occurrence of the incident giving rise to the claim and the placement of a reserve (the maximum was 15.4 years). The mean period from reserve placement to finalisation was 1.7 years (the maximum was 6.8 years) (Table 3.10).

New claims

There were 787 new claims that opened during the reporting period. The profile of reserve ranges for new claims differed from that for claims overall. Of new claims,

61% were reserved at less than $30,000, compared with 45% of all claims current at 30 June 2003; 5% of new claims were reserved for $250,000 or more, compared with 3% of current claims (Table 3.11).

3.3 Data tables

This section contains the data tables referred to in Section 3.2.

Table 3.2: All claims (public sector): clinical service context by primary incident/allegation type, 1 January to 30 June 2003, Australia

Clinical service context[e]	Primary incident/allegation type												Total (number)	*Column per cent*
	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		
	Number of claims													
Obstetrics	65	16	13	4	165	85	10	3	—	22	5	10	398	*14.9*
A&E	194	18	—	1	24	59	2	5	1	27	7	8	346	*13.0*
General surgery	47	5	15	3	146	23	19	24	5	9	2	4	302	*11.3*
Gynaecology	25	2	5	1	152	8	37	—	2	14	2	3	251	*9.4*
Orthopaedics	49	2	6	1	114	20	15	8	2	14	—	3	234	*8.8*
Psychiatry	21	9	1	—	1	13	1	—	—	69	10	2	127	*4.8*
Paediatrics	27	7	1	—	21	15	1	2	1	6	3	—	84	*3.2*
General medicine	21	14	1	3	7	6	1	—	2	25	3	—	83	*3.1*
All other clinical service contexts	116	28	14	39	210	80	55	27	13	92	43	10	727	*27.3*
Not known	7	8	—	3	5	4	1	2	2	11	3	68	114	*4.3*
Total (number)	*572*	*109*	*56*	*55*	*845*	*313*	*142*	*71*	*28*	*289*	*78*	*108*	*2,666*	*100.0*
	Per cent within rows													
Obstetrics	16.3	4.0	3.3	1.0	41.5	21.4	2.5	0.8	—	5.5	1.3	2.5	100.0	
A&E	56.1	5.2	—	0.3	6.9	17.1	0.6	1.4	0.3	7.8	2.0	2.3	100.0	
General surgery	15.6	1.7	5.0	1.0	48.3	7.6	6.3	7.9	1.7	3.0	0.7	1.3	100.0	
Gynaecology	10.0	0.8	2.0	0.4	60.6	3.2	14.7	—	0.8	5.6	0.8	1.2	100.0	
Orthopaedics	20.9	0.9	2.6	0.4	48.7	8.5	6.4	3.4	0.9	6.0	—	1.3	100.0	
Psychiatry	16.5	7.1	0.8	—	0.8	10.2	0.8	—	—	54.3	7.9	1.6	100.0	
Paediatrics	32.1	8.3	1.2	—	25.0	17.9	1.2	2.4	1.2	7.1	3.6	—	100.0	
General medicine	25.3	16.9	1.2	3.6	8.4	7.2	1.2	—	2.4	30.1	3.6	—	100.0	
All other clinical service contexts	16.0	3.9	1.9	5.4	28.9	11.0	7.6	3.7	1.8	12.7	5.9	1.4	100.0	
Not known	6.1	7.0	—	2.6	4.4	3.5	0.9	1.8	1.8	9.6	2.6	59.6	100.0	
Total (%)	*21.5*	*4.1*	*2.1*	*2.1*	*31.7*	*11.7*	*5.3*	*2.7*	*1.1*	*10.8*	*2.9*	*4.1*	*100.0*	

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

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

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

(d) 'Consent' includes failure to warn.

(e) The clinical service context categories listed separately here are the 8 most frequently recorded categories. The category 'All other clinical service contexts' includes: cardiology, dentistry, elective cosmetic procedures, ear, nose and throat, general practice, hospital outpatient department, neurology, oncology, perinatology, plastic surgery, radiology, urology, not yet known and other.

Note: Only data for approximately 50% of all claims in scope are included.

Table 3.3: All claims (public sector): clinical service context by geographic location, 1 January to 30 June 2003, Australia (per cent)

	Geographic location where incident occurred[(a)]					
Clinical service context	**Major cities**	**Inner regional**	**Outer regional**	**Remote and very remote**	**Not known**	**Total**
Obstetrics	62.8	21.9	13.1	1.5	0.8	100.0
A&E	59.0	25.4	12.7	2.6	0.3	100.0
General surgery	58.3	21.5	17.5	2.6	—	100.0
Gynaecology	54.6	26.7	15.9	2.4	0.4	100.0
Orthopaedics	61.1	22.6	14.5	1.3	0.4	100.0
Psychiatry	78.7	13.4	6.3	1.6	—	100.0
Paediatrics	69.0	19.0	7.1	4.8	—	100.0
General medicine	62.7	21.7	12.0	3.6	—	100.0
Not known	64.9	19.3	13.2	—	2.6	100.0
All other clinical service contexts	72.9	16.2	8.9	1.2	0.7	100.0
Total	64.7	20.7	12.3	1.9	0.5	100.0
Total number	*1,724*	*551*	*327*	*50*	*14*	*2,666*

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

Notes

1. The clinical service context categories listed separately here are the most frequently recorded categories. 'All other clinical service contexts' include: cardiology, dentistry, elective cosmetic procedures, ear, nose and throat, general practice, hospital outpatient department, neurology, oncology, perinatology, plastic surgery, radiology, urology and other.
2. Only data for approximately 50% of all claims in scope are included.

Table 3.4: All claims (public sector): sex and age at incident of claim subject, by primary incident/allegation type, 1 January to 30 June 2003, Australia

Primary incident/ allegation type	Age at incident				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total[a]
Males					
Diagnosis	26	34	192	16	268
Medication	3	7	30	4	44
Anaesthetic	1	—	18	1	20
Blood/blood-product-related	2	2	20	1	25
Procedure	39	23	231	17	310
Treatment	23	15	90	11	139
Consent	4	6	33	5	48
Infection control	1	3	34	7	45
Device failure	—	3	10	1	14
Other general duty of care	4	8	121	15	148
Other	2	1	41	3	47
Not known	3	1	33	12	49
Total males	*108*	*103*	*853*	*93*	*1,157*
Females					
Diagnosis	14	37	236	17	304
Medication	5	4	50	4	63
Anaesthetic	—	—	31	4	35
Blood/blood-product-related	—	3	17	3	23
Procedure	28	31	428	40	527
Treatment	27	22	115	9	173
Consent	2	5	78	9	94
Infection control	1	2	19	1	23
Device failure	—	1	12	—	13
Other general duty of care	3	10	106	20	139
Other	1	3	22	4	30
Not known	3	2	35	17	57
Total females	*84*	*120*	*1,149*	*128*	*1,481*
Persons[b]					
Diagnosis	40	71	428	33	572
Medication	9	11	80	9	109
Anaesthetic	1	—	49	6	56
Blood/blood-product-related	2	5	37	11	55
Procedure	72	55	659	59	845
Treatment	51	37	205	20	313
Consent	6	11	111	14	142
Infection control	2	5	53	11	71
Device failure	—	4	22	2	28
Other general duty of care	7	18	227	37	289
Other	3	4	63	8	78
Not known	8	3	68	29	108
Total persons	*201*	*224*	*2,002*	*239*	*2,666*
Total %	**7.5**	**8.4**	**75.1**	**9.0**	**100.0**

(a) This column includes 239 claims for which age at incident of claim subject was missing (93 male, 128 female, 18 not known/indeterminate).

(b) Persons includes 10 claims for which sex of claim subject was not known/indeterminate (9 baby, 1 child).

Note: Only data for approximately 50% of all claims in scope are included.

Table 3.5: All claims (public sector): primary body function/structure affected, 1 January to 30 June 2003, Australia

Primary body function/structure affected	Number of claims	% of all claims
Mental functions/structures of the nervous system	333	12.5
Sensory functions/the eye, ear and related structures	78	2.0
Voice and speech functions/structures involved in voice and speech	40	1.5
Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	192	7.2
Functions and structures of the digestive, metabolic and endocrine systems	218	8.2
Genitourinary and reproductive functions and structures	345	12.9
Neuromusculoskeletal and movement-related functions and structures	593	22.2
Functions and structures of the skin and related structures	133	5.0
Death	208	7.8
Not applicable—no body function/structure affected	85	3.2
Not yet known	441	16.5
Total	**2,666**	**100.0**

Note: Only data for approximately 50% of all claims in scope are included.

Table 3.6: All claims (public sector): status of claim, 30 June 2003, Australia

			Finalised in reporting period					
Clinical service context	**Reserve placed but not yet commenced[(a)]**	**Commenced (not yet finalised) [(b)]**	**Claim file closed[(c)]**	**Awaiting determination of total size[(d)]**	**Structured settlement with total dollar value decided[(e)]**	***Total finalised***	**Claim previously closed now reopened[(f)]**	**Total**
All claims	**502**	**1,882**	**222**	**42**	**8**	***272***	**10**	**2,666**
Total (%)	*18.8*	*70.6*	*8.3*	*1.6*	*0.3*	*10.2*	*0.4*	*100.0*

(a) Reserve placed but 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 yet occurred.

(b) Commenced (not yet finalised) – indicates that the claim has commenced but has not yet been finalised.

(c) Claim file closed – indicates that the total claim size has been determined, and the claim file has been closed; excludes finalised claims where payments to the claimant are made under a structured settlement scheme.

(d) Awaiting determination of total size – indicates that the claim has been finalised but the total claim size has yet to be determined; the claim file has not yet been closed; this may include instances where legal costs have yet to be finally determined.

(e) Structured settlement with total dollar value decided – indicates that the claim has been finalised and the Health Authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme and the total amount to be paid has been decided. There were no finalised claims for which there was a structured settlement with the total dollar value open as at 30 June 2003.

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

Note: Only data for approximately 50% of all claims in scope are included.

Table 3.7: All claims (public sector): nature of claim—loss to claim subject, 1 January to 30 June 2003, Australia (per cent)[a]

	Nature of claim—loss to claim subject							
	Care costs[a]	Other economic loss[b]	Pain and suffering[c]	Other loss[d]	N/A	Not known	Total	*Average no. of loss categories[e]*
% of all claims	19.1	20.8	40.9	10.3	9.9	27.6	100.0	
Total number of claims[f]	**508**	**555**	**1,091**	**275**	**263**	**737**	2,666	**2.1**

(a) Care costs includes long-term care costs, and covers 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, and includes medical costs (both past and future). Medical costs are costs associated with medical treatment, e.g. doctor's fees, hospital expenses.

(e) The average number of coding categories for the data item 'nature of claim—loss to claim subject' recorded per claim, for each 'Primary incident/allegation type' category (the average is calculated excluding claims for which 'not applicable' or 'not known' was recorded for 'nature of claim—loss to claim subject').

(f) This is 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.

Notes

1. For the NSW data included in this table, loss categories recorded for 'nature of claim—loss to claim subject' may include loss to other parties, as this is not possible to separately identify.
2. Only data for approximately 50% of all claims in scope are included.

Table 3.8: Current claims (public sector): reserve range by clinical service context, 30 June 2003, Australia

	Clinical service context										
Reserve range	**Obstetrics**	**A&E**	**General surgery**	**Gynaecology**	**Orthopaedics**	**Psychiatry**	**Paediatrics**	**General medicine**	**All other clinical service contexts**	**Not known**	**Total**
					Number						
Less than $10,000	47	60	35	16	22	20	9	10	129	18	366
$10,000–<$30,000	83	90	82	56	55	49	19	27	191	48	700
$30,000–<$50,000	31	33	37	31	31	9	9	11	78	2	272
$50,000–<$100,000	76	56	59	58	50	16	15	8	126	25	489
$100,000–<$250,000	55	37	37	35	47	18	10	9	76	9	333
$250,000–<$500,000	17	7	13	14	5	5	7	2	28	1	99
$500,000 or more	58	22	3	5	4	2	9	3	23	6	135
Total number	*367*	*305*	*266*	*215*	*214*	*119*	*78*	*70*	*651*	*109*	*2,394*
					Per cent within columns						
Less than $10,000	12.8	19.7	13.2	7.4	10.3	16.8	11.5	14.3	19.8	16.5	15.3
$10,000–<$30,000	22.6	29.5	30.8	26.0	25.7	41.2	24.4	38.6	29.3	44.0	29.2
$30,000–<$50,000	8.4	10.8	13.9	14.4	14.5	7.6	11.5	15.7	12.0	1.8	11.4
$50,000–<$100,000	20.7	18.4	22.2	27.0	23.4	13.4	19.2	11.4	19.4	22.9	20.4
$100,000–<$250,000	15.0	12.1	13.9	16.3	22.0	15.1	12.8	12.9	11.7	8.3	13.9
$250,000–<$500,000	4.6	2.3	4.9	6.5	2.3	4.2	9.0	2.9	4.3	0.9	4.1
$500,000 or more	15.8	7.2	1.1	2.3	1.9	1.7	11.5	4.3	3.5	5.5	5.6
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 8 most frequently recorded categories. All other clinical service contexts' include: cardiology, dentistry, elective cosmetic procedures, ear, nose and throat, general practice, hospital outpatient department, neurology, oncology, perinatology, plastic surgery, radiology, urology and other.
2. Only data for approximately 50% of all claims in scope are included.

Table 3.9: Finalised claims (public sector): total claim size by mode of claim finalisation, 1 January to 30 June 2003, Australia

Total claim size	Settled[(a)]	Court decision	Discontinued	Not known	Total	*Column per cent*
Less than $10,000	30	8	51	5	**94**	*34.6*
$10,000 –<$30,000	34	6	5	—	**45**	*16.5*
$30,000 –<$50,000	17	—	2	—	**19**	*7.0*
$50,000 –<$100,000	23	2	—	—	**25**	*9.2*
$100,000 –<$250,000	18	2	—	—	**20**	*7.4*
$250,000 –<$500,000	5	—	—	—	**5**	*1.8*
$500,000 or more	3	—	—	—	**3**	*1.1*
No payment made	2	—	29	—	**31**	*11.4*
Not known	15	2	7	6	**30**	*11.0*
Total	**147**	**20**	**94**	**11**	**272**	*100.0*

(a) This category includes all claims settled out of court, including through State/Territory-based complaints processes, court-based alternative dispute resolution processes, and statutorily mandated compulsory conference process; claims settled part way through a trial are also included.

Note: Only data for approximately 50% of all claims in scope are included.

Table 3.10: Finalised claims (public sector): total claim size by time from incident to reserve placement, and reserve placement to finalisation in years, 1 January to 30 June 2003, Australia

	Incident to placement of reserve (years)		Placement of reserve to finalisation (years)	
Total claim size	**Mean**	**Maximum**	**Mean**	**Maximum**
Less than $10,000	2.3	15.4	1.2	3.7
$10,000 –<$30,000	1.2	5.8	2.0	4.2
$30,000 –<$50,000	2.4	7.3	2.1	3.9
$50,000 –<$100,000	3.3	8.7	2.0	4.0
$100,000 –<$250,000	2.9	6.3	2.3	6.8
$250,000 –<$500,000	2.6	4.0	2.2	3.1
$500,000 or more	4.8	11.6	3.1	3.8
No payment made	2.9	11.4	1.8	3.8
Not known	2.6	10.7	1.9	4.6
All claims	**2.4**	**15.4**	**1.7**	**6.8**

Note: Only data for approximately 50% of all claims in scope are included.

Table 3.11: New claims (public sector): reserve range by clinical service context, 1 January to 30 June 2003, Australia

Reserve range	A&E	Obstetrics	General surgery	Gynaecology	Orthopaedics	Psychiatry	General medicine	Paediatrics	All other clinical service contexts	Not known	Total	*Column per cent*
Less than $10,000	31	14	25	7	6	5	3	4	52	11	158	*20.1*
$10,000 –<$30,000	46	40	37	26	17	23	13	8	73	38	321	*40.8*
$30,000 –<$50,000	11	12	13	11	11	1	3	2	16	1	81	*10.3*
$50,000 –<$100,000	17	21	17	9	12	2	—	3	24	22	127	*16.1*
$100,000 –<$250,000	7	10	8	8	10	1	2	—	12	5	63	*8.0*
$250,000 –<$500,000	1	2	2	—	—	—	—	1	6	—	12	*1.5*
$500,000 or more	4	8	—	1	—	—	2	2	3	5	25	*3.2*
Total	**117**	**107**	**102**	**62**	**56**	**32**	**23**	**20**	**186**	**82**	**787**	*100.0*

Notes

1. The clinical service context categories listed separately here are the 8 most frequently recorded categories. 'All other clinical service categories' include: cardiology, dentistry, elective cosmetic procedures, ear, nose and throat, general practice, hospital outpatient department, neurology, oncology, perinatology, plastic surgery, radiology, urology and other.

2. Only data for approximately 50% of all claims in scope are included.

Appendix 1

Coding examples for body function/structure categories

Body function/structure coding category	Examples of body functions/structures affected
1. Mental functions/structures of the nervous system	Psychological harm (e.g. nervous shock) Effects of subdural haematoma Effects of brain injury associated with birth
2. Sensory functions / the eye, ear and related structures	Vestibular impairment Injury to 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 Effects of deep vein thrombosis Effects of vascular or artery damage Effects of 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 and its effects Injury to the gall bladder, bowel, or liver Generalised abdominal pain Appendicitis
6. Genitourinary and reproductive functions and structures	Injury to the breast Injury to male or female reproductive organs Injury to the kidney
7. Neuromusculoskeletal and movement-related functions and structures	Impairment of limb function due to inappropriate casting of joint Paralysis of legs (e.g. as in paraplegia)
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. Not applicable	Failed sterilisation, where there is no consequent harm to body functions or structures

References

AIHW (Australian Institute of Health and Welfare) 2003 (unpublished). Medical Indemnity National Collection (public sector) data guide: data items and definitions.

Commonwealth of Australia 2002. Review of the law of negligence: first report. Canberra: Commonwealth of Australia. Viewed 12 June 2004, <http://revofneg.treasury.gov.au/content/review2.asp>.