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Foreword

This short report presents a limited range of information at the national level about combined public and private sector medical indemnity claims.

At this stage we are unable to report actual numbers of claims, in order to maintain the confidentiality of the private sector data. The Institute is keen to work with stakeholders to address this limitation. Public sector claim numbers are reported separately by the Institute (AIHW 2007b).

Moreover, differences in the medical indemnity claims data collected in the public sector and private sector collections continue to be limiting factors for the data items that can be reported.

The usefulness of this combined report rests on the information it provides about claim size, age and sex of claimants, the relative distribution of claims across clinical specialties, and body structures and functions.

Discussions are ongoing about the potential usefulness of this combined reporting and the level of investment required to improve its usefulness.

Dr Penny Allbon

Director

July 2008

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- Troy Browning— Medical Indemnity Protection Society.

Within the AIHW, the report was written and prepared by Jane McIntyre and Jason Thomson. Cecilia Burke coordinated the publication process.

Abbreviations

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

Summary

This is the second report to contain data from the Medical Indemnity National Collection (MINC) on public and private sector medical indemnity claims. The purpose of the MINC, and this report, is to provide a national information base to assist policy makers to recognise trends in the nature, incidence and financial 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.

The data in this report cover claims current at any time during the reporting period 1 July 2005 to 30 June 2006; 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 circumstances giving rise to claims, the age and sex of people who allegedly suffered harm, the medical specialties involved in claims, the nature of injury, and the size, financial outcome and length of time claims have been open.

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

Most claims were settled for less than $10,000 (42.7%), with 67% being settled for less than $100,000. No payment was made, or costs incurred, in 19.2% of finalised claims. Claims with sizes in excess of $500,000 constituted 2.8% of all finalised claims. The pattern of total claim size has changed since the 2004–05 reporting period. The proportion of claims settled for less than $100,000 decreased from 77.1% to 67% and the proportion of claims where no payment was made increased from 12.7% to 19.2% between 2004–05 and 2005–06 (AIHW 2007a).

The most common incident/allegation type leading to a new claim against a clinician in 2005–06 related to 'procedure' (33.9%), followed by 'diagnosis' (21.4%) and 'treatment' (11.2%).

Neuromusculo-skeletal and movement–related functions and structures, for example loss of function due to inappropriate casting of a joint or restricted blood flow causing nerve damage, were the most commonly recorded primary body function/structure affected as a result of the alleged harm for new claims (17.7%). The next most common category for new claims was *Functions / structures of the digestive, metabolic and endocrine systems*, for example injury to gall bladder, bowel or pancreas, (15.8%), followed by *genitourinary and reproductive functions and structures*, for example injury to the reproductive organs, kidney, ureters or bladder (10.5%).

Babies under 1 year of age were the subject of 5.5% of new claims; 4.7% of new claims related to children aged 1 to 18 years; and 62% involved adults aged over 18. For 27.8% of new claims the age of the claimant was not available.

Due to incomplete coverage of claims databases in some jurisdictions, data for approximately 89% of all public sector claims in scope are included. The private sector has reported 100% of claims in scope for this report.

1 Introduction

This report presents data collected through the combined Medical Indemnity National Collection (MINC) of public and private sector medical indemnity claims in the 12 months from 1 July 2005 to 30 June 2006. It is the second report on medical indemnity in Australia to combine public and private sector data. The first report, *A national picture of medical indemnity claims in Australia 2004–05* (AIHW 2007a) was published by the Australian Institute of Health and Welfare in May 2007.

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

The data here cover claims current at any time during the reporting period 1 July 2005 to 30 June 2006; 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 circumstances giving rise to claims, the age and sex of people who allegedly suffered harm, the medical specialties involved in claims, the nature of injury, claim size and length of time claims have been open.

The data presented in this report are not complete. Data are included for approximately 89% of all public sector claims in scope, due to incomplete data collections in some jurisdictions (see further information on data scope and completeness in Section 2). This has increased from 2004–05 when 85% of public sector claims were in scope. Private sector MIIs have contributed 100% of claims in scope for this report. As data completeness improves, the claims profile as illustrated by the data in this report may change. In addition, as this is a relatively new collection, some data quality and coding consistency issues are yet to be resolved.

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

1.1 Background to the report

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

A Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of Australian Health Ministers' Advisory Council (AHMAC) to oversee the collection of public sector medical indemnity data. In July 2002, AHMAC decided to commission the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG to further develop the Working Group's proposals for a national medical indemnity collection for the public sector.

This led to the development of the public sector MINC. Collation of data on public sector medical indemnity claims commenced in 2003. Data for the first six months of 2003 were

published in December 2004 (AIHW 2004). Three full financial year reports on public sector medical indemnity claims followed this initial publication (AIHW 2005, 2006, 2007b).

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

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

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

1.2 Collaborative arrangements

The combined public and private sector MINC is governed by two agreements. One is between the DoHA, the AIHW and state and territory health departments, and the second is between the DoHA, the AIHW and MIIs. The agreements outline the respective roles, responsibilities and collaborative arrangements of all parties.

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

The AIHW is the national data custodian of public sector medical indemnity data and is responsible for collection, quality control, management and reporting of the data. The AIHW receives aggregate claims data from the private sector separately and is responsible for managing and reporting the data.

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

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

2 The collection

2.1 Scope of the report

This report presents data concerning claims where a formal demand for compensation for harm or other loss that allegedly resulted from health care has been received by an MII or a public sector claim manager. This report may also contain information about claims in the private sector where a formal demand has not been received but where a clinician has a reasonable belief that a claim may arise and has reported this to their insurer.

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

Potential claims from the public sector have been excluded from this report. These are instances of alleged harm reported to the MII or health authority claim manager that are considered likely to materialise into a claim, but for which a formal demand for compensation for harm or other loss has not been received.

For the private sector, some claims relating to Medical Defence Organisation (MDO) run-off, medical board and Medicare Australia matters are included. MDO run-off claims are specific to the private sector and the public sector MINC does not include medical board or Medicare Australia matters.

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

2.2 Claims management practices

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

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

It is important to note the data presented here relate directly to claims. There is no direct link between claims and adverse incidents, doctors or patients in the data presented here.

Briefly, health-care claims managed by the private sector MIIs relate to individual clinicians or defendants. Therefore, more than one claim may arise from an allegation of harm arising from health care if it involved several clinicians. Health-care claims managed in the public sector generally relate specifically to one claimant. More than one health-care professional may be involved, but the allegation usually gives rise to a single claim only.

Claims management practices of private sector medical indemnity insurers

In general, MIIs insure individual doctors. It is a common, but not consistent, practice for MIIs to open more than one claim for a single claimant if it involves more than one defendant. Each doctor involved is not necessarily insured by the same MII, so claims relating to an allegation of harm may be held by several insurers. Most insurers treat the claim of a patient and the separate, but related, claim of a dependant or relative as a single claim.

The practice of opening a separate claim for each doctor involved in an allegation of harm allows the cost of claims to be allocated against the policy limits of individual doctors. Where more than one insured or hospital may be liable, the MII establishes the cost of an individual insured's share of the overall claim. Therefore, where the insured is one of a group of defendants found liable, the cost of the insured's claim is proportionate to that insured's share of the liability. This is also a requirement of the High Cost Claim Scheme[1] and the Exceptional Claims Scheme[2].

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

The practices outlined above mean that multiple claims relating to one allegation of harm may be present in the data presented in this report. Most commonly, multiple claims will be opened for the one allegation when there are several doctors involved and a claim is made against each of the doctors involved. Claims related to a single allegation of harm may appear on more than one MII database when individual defendants hold medical indemnity insurance with different insurers. Where a public hospital is involved in a claim against a private doctor, claims may appear on both MII and health authority databases. Thus, the number of claims cannot be used as a surrogate for estimating the number of clinical incidents.

All MIIs open a claim file and place an estimate when a written claim for compensation is made against an insured doctor. Some MIIs may open a claim when a possible claim for compensation has been reported by a policy holder and there is an expectation that a claim will arise as a result.

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

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

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

Some insurers place reserves against notifications that the insurers consider are likely to give rise to a claim and result in a payment by the insurer. Insurers may accept verbal notifications of a claim and place a reserve against it. Other insurers only reserve written claims for compensation, and do not accept verbal notifications. In some instances, where formal written notification of a claim has not been received from a claimant, insurers may consider the verbal notification an incident likely to result in a claim against the insured and place a reserve against it.

Claims management practices of public sector claim managers

Coverage of public sector medical indemnity insurance is defined by state and territory legislation and associated policies and varies between jurisdictions. An explanation of the policy, administrative, and legal features of each jurisdiction is available in *Medical indemnity national data collection public sector: 2005–06* (AIHW 2007b).

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

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

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

Various events can signal the start of a claim: for example, a writ or letter of demand may be received from the claimant's solicitor (this can occur before notification); or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases no action is taken by the claimant or the defendant.

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

A claim may be finalised in several ways—through state/territory-based complaints processes, court-based alternative dispute resolution processes or in court. In some jurisdictions, settlement via statutorily mandated conference processes must be attempted before a claim can go to court. In some cases, settlement is agreed between claimant and defendant, independently of any formal process.

A claim file that has remained inactive for a long time may be closed. In some instances claims that have been closed are subsequently re opened.

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

2.3 Data items and definitions

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

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

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

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

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

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

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

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

(*continued*)

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

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

Table 2.2: Definitions of key terms

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

2.4 Data quality and completeness

This section provides an overview of data coverage, completeness and quality for the 2005–06 reporting period. Because data completeness and the proportion of claims for which data are not currently available affect the validity of data, these factors should be taken into account when interpreting the information presented in this report.

Data coverage and completeness

Data in this report taken from the MINC public sector collection represent approximately 89% of all claims in scope, 74% of all finalised claims and 97% of new claims. Two jurisdictions did not provide complete data.

- Victoria provided data for 85% of claims in scope for the period.
- New South Wales provided data for 87% of all claims in scope.

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

New South Wales claims which commenced before 2002 are not included in the 2005–06 data.

'Not known' rates

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

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

The data item 'age at incident' had the highest *not known* rate (30.2%) for finalised claims and 27.8% for new claims. The *not known* rate for 'primary body function/structure affected' for finalised claims fell from 46.4% to 5.9% for the 2004–05 report. The data item 'Primary incident/allegation' type had a *not known* rate of 10.6% for current claims and 11.5% for new claims (tables 3.1 and 3.3)

2.5 Ongoing development of the collection

A review of the MINC was commissioned by the MIDWG and undertaken in 2007. The terms of reference for the review were agreed to by AHMAC's Statistical Information Management Committee (SIMC) and the review was overseen by a MINC Review Steering Committee, with representation from the states and territories, MIIs and DoHA. Issues considered in the scope of the review included the ongoing value of the annual public sector report and the annual combined public–private sector report, as well as the potential for a combined publication to replace the two current MINC publications with a single MINC publication covering both the private and public sector.

The review established that data development work needs to be undertaken to improve the comparability of medical indemnity data between the public and private sectors, including expansion of the number of MINC data items reported by the private sector. The inclusion of claims against private hospitals was also considered for inclusion in the MINC. The inclusion of such claims would provide a more comprehensive view of indemnity claims across the combined public and private sectors.

The focus of the MINC (CC) over the next couple of years will be the improvement of the comparability between the public and private sector collection, with a view to increasing the number of MINC data items reported in the combined report. There are, however, some items across the collections that cannot be compared and total alignment of these two collections may not be achieved.

The format of this report has not changed significantly since the publication of *A national picture of medical indemnity claims in Australia 2004-05* (AIHW 2007a). If the comparability between the public and private sector collections improves over the following years, this report will expand to incorporate the reporting of a greater number of MINC data items.

3 Claims data for 2005–06

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

'New claims' include all claims with a date of commencement (MINC data item 15 'Date reserve first placed' and ISA data item 10 'Date of report') within the reporting period 1 July 2005 and 30 June 2006. 'New claims' may include claims that were also finalised within the reporting period. 'Current claims' are claims that were open at the end of the reporting period (as at 30 June 2006). 'Finalised claims' are claims with a date of finalisation between 1 July 2005 and 30 June 2006. 'All claims' is the total number of claims in the collection during the reporting period (that is, claims open at any time in the period). This is the sum of current and finalised claims, including claims that were open at the start of the period.

3.1 Claims

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

Primary incident/allegation type

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

During 2005–06, claims relating to 'Procedure' were most common for current (30.3%), finalised (29.1%) and new claims (33.9%) (tables 3.1, 3.2 and 3.3, respectively). These were followed by claims relating to *Diagnosis* and *Treatment* for new and finalised claims, and by *Diagnosis* for current claims.

Specialty of clinician

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

In the MINC public sector collection, up to four codes may be selected for specialty of clinician. Therefore, one public sector claim can be counted up to four times in tables 3.1 to 3.3. This reflects the fact that only one claim is opened in the public sector regardless of the number of clinicians involved. In the private sector, the specialty of the policy holder is recorded for each claim (see Section 2 for further information on claims management practices in the public and private sectors).

General and internal medicine—this specialty group was most often involved in new claims relating to *diagnosis* (23.8%) and *treatment* (23.8%) (table 3.3). Finalised claims involving

general and internal medicine specialists related to *diagnosis* (30.4%), *medication-related* (19.6%) and *treatment* (12.5%) (table 3.2).

Cardiology—current claims involving cardiologists related to *diagnosis* (34.6%), *procedure* (28.4%) and *treatment* (8.6%) (table 3.1). Finalised claims involving cardiologists related to *procedure* (30.8%), *diagnosis* (21.2%) and *treatment* (11.5%) (table 3.2). New claims involving cardiologists related to *diagnosis* (44.4%), *procedure* (27.8%) and *treatment* (11.1%) (table 3.3).

Table 3.1: Current claims: specialty of clinician, by primary incident/allegation type, at 30 June 2006, Australia (per cent)

	Primary incident/allegation type[a]												
Specialty of clinician(s)	**Anaesthetic**	**Blood and blood-product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Not known**	**Other**	**Total**
Anaesthetics	50.5	0.0	1.0	1.7	5.5	6.6	1.4	3.8	18.3	3.8	6.9	0.3	100.0
Cardiology	0.0	0.0	7.4	0.0	34.6	7.4	0.0	4.9	28.4	8.6	7.4	1.2	100.0
Diagnostic radiology	0.4	0.4	0.9	1.3	72.6	2.6	0.9	1.7	11.7	3.0	3.9	0.4	100.0
Emergency medicine	0.0	0.0	1.2	0.6	58.7	6.8	0.9	3.2	5.3	20.6	2.1	0.6	100.0
General and internal medicine	0.0	1.0	0.0	1.0	32.3	9.4	1.0	18.8	7.3	16.7	9.4	3.1	100.0
General practice–non-procedural	0.2	0.4	2.9	1.4	37.6	15.0	0.9	8.1	7.8	8.3	16.2	1.3	100.0
General practice–procedural	2.2	0.0	10.0	1.5	27.2	5.0	1.2	4.5	25.2	12.5	10.0	0.7	100.0
General surgery	2.3	0.0	3.0	0.3	12.7	3.3	0.7	0.7	68.5	6.3	1.9	0.3	100.0
Gynaecology only	0.0	0.0	7.1	2.2	5.6	3.0	0.4	1.1	72.1	3.7	3.7	1.1	100.0
Neurosurgery	1.0	0.0	3.0	0.0	20.8	2.0	1.0	0.0	60.4	6.9	5.0	0.0	100.0
Obstetrics and gynaecology	0.7	0.1	2.8	1.6	13.2	4.7	0.5	0.9	54.5	16.9	3.1	0.9	100.0
Orthopaedic surgery	1.0	0.2	7.2	1.9	11.3	4.5	4.3	1.6	56.7	7.2	3.9	0.4	100.0
Psychiatry	0.5	0.0	4.2	0.9	22.6	28.8	0.0	9.4	2.4	7.5	19.3	4.2	100.0
Urology	0.0	0.0	16.1	0.0	12.5	7.1	5.4	5.4	41.1	8.9	3.6	0.0	100.0
Other hospital-based medical practitioner[b]	0.9	1.4	8.1	1.0	19.4	10.7	2.1	4.5	29.9	12.3	6.9	2.7	100.0
Other specialties	3.0	0.5	3.9	1.0	23.8	14.2	1.4	4.9	19.3	11.1	11.5	5.4	100.0
Not known	0.0	1.2	0.5	0.0	3.2	1.7	4.2	0.5	4.2	4.4	79.3	0.7	100.0
Not applicable[c]	4.0	8.0	0.0	0.0	4.0	28.0	4.0	4.0	8.0	16.0	4.0	20.0	100.0
All current claims	**2.7**	**0.5**	**4.6**	**1.1**	**23.1**	**8.9**	**1.5**	**4.0**	**30.3**	**10.1**	**11.5**	**1.7**	**100.0**

(a) See Appendix 1 for an explanation of 'Incident/allegation type' categories *'consent'*, *medication-related'*, *'treatment'* and *'other'*.

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

(c) 'Not applicable' for this data item indicates that no clinical staff were involved.

Table 3.2: Finalised claims: specialty of clinician by primary incident/allegation type, 1 July 2005 to 30 June 2006, Australia (per cent)

	Primary incident/allegation type[a]												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood and blood-product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Not known**	**Other**	**Total**
Anaesthetics	54.8	0.6	3.2	0.6	6.4	3.8	0.0	3.2	15.9	5.7	1.9	3.8	100.0
Cardiology	1.9	3.8	3.8	3.8	21.2	9.6	0.0	5.8	30.8	11.5	0.0	7.7	100.0
Diagnostic radiology	0.0	0.0	1.0	3.0	66.3	5.0	0.0	1.0	7.9	7.9	2.0	5.9	100.0
Emergency medicine	1.3	0.6	0.6	0.0	58.8	5.0	3.1	1.9	3.1	23.1	1.3	1.3	100.0
General and internal medicine	0.0	0.0	1.8	1.8	30.4	12.5	0.0	19.6	3.6	12.5	3.6	14.3	100.0
General practice–non-procedural	0.0	0.0	3.5	1.2	37.7	9.2	0.5	11.5	7.0	9.3	1.4	18.7	100.0
General practice–procedural	1.0	0.0	10.5	1.5	24.5	5.0	0.5	7.0	25.5	11.0	1.0	12.5	100.0
General surgery	0.7	0.7	3.4	0.3	15.7	2.0	2.4	1.4	63.5	5.5	0.7	3.8	100.0
Gynaecology only	0.0	0.0	6.3	4.0	8.7	3.2	0.0	0.8	69.0	1.6	2.4	4.0	100.0
Neurosurgery	0.0	0.0	7.7	0.0	7.7	10.3	0.0	0.0	46.2	17.9	2.6	7.7	100.0
Obstetrics and gynaecology	1.7	0.7	3.5	0.9	10.4	3.5	1.4	0.2	53.9	18.0	3.8	1.9	100.0
Orthopaedic surgery	0.3	0.0	7.4	1.9	11.9	4.2	1.9	0.6	55.8	12.3	1.3	2.3	100.0
Psychiatry	0.0	0.0	0.8	0.0	11.8	28.3	0.0	6.3	0.0	15.0	3.9	33.9	100.0
Urology	0.0	0.0	10.0	2.5	17.5	5.0	2.5	2.5	45.0	12.5	0.0	2.5	100.0
Other specialties	1.7	2.8	11.1	1.2	18.7	10.3	2.6	4.6	24.9	13.3	1.7	7.1	100.0
Other hospital-based medical practitioner	2.0	1.0	2.4	0.5	23.4	13.2	2.4	6.8	25.4	10.2	1.5	11.2	100.0
Not known	0.0	0.0	3.6	1.4	10.1	3.6	0.0	0.0	15.9	5.1	55.8	4.3	100.0
Not applicable[c]	0.0	0.0	0.0	0.0	10.0	20.0	0.0	0.0	10.0	40.0	0.0	20.0	100.0
All finalised claims	**3.0**	**0.9**	**5.7**	**1.2**	**22.2**	**7.7**	**1.4**	**4.6**	**29.1**	**11.7**	**3.7**	**8.7**	**100.0**

(a) See Appendix 1 for definitions of 'Primary incident/allegation type' categories *'consent'*, *medication-related'*, *'treatment'* and *'other'*.

(b) See Appendix 1 for definitions of 'specialty of clinician' categories.

(c) 'Not applicable' for this data item indicates that no clinical staff were involved.

Table 3.3: New claims: specialty of clinician by primary incident/allegation type, 1 July 2005 to 30 June 2006, Australia[a] (per cent)

	Primary incident/allegation type[a]												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood and blood-product related-**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Not known**	**Other**	**Total**
Anaesthetics	68.8	0.0	0.0	0.0	1.6	1.6	0.8	3.1	14.1	3.1	6.3	0.8	100.0
Cardiology	0.0	0.0	0.0	0.0	44.4	2.8	0.0	5.6	27.8	11.1	5.6	2.8	100.0
Diagnostic radiology	0.9	0.0	0.9	0.9	75.0	2.7	0.0	2.7	9.8	2.7	1.8	2.7	100.0
Emergency medicine	0.0	0.0	0.0	0.0	47.6	11.0	0.0	2.2	4.8	27.8	5.7	0.9	100.0
General and internal medicine	0.0	0.0	0.0	2.4	23.8	9.5	4.8	16.7	7.1	23.8	11.9	0.0	100.0
General practice–non-procedural	0.0	0.0	0.6	0.3	39.0	9.8	0.6	7.7	4.2	10.7	16.7	10.4	100.0
General practice–procedural	2.5	0.0	18.2	0.0	27.3	2.5	2.5	4.1	19.8	7.4	6.6	9.1	100.0
General surgery	2.2	0.0	0.6	0.2	11.4	0.4	0.6	0.6	75.6	6.9	1.2	0.4	100.0
Gynaecology only	0.0	0.0	7.3	0.0	6.3	0.0	0.0	1.0	75.0	2.1	8.3	0.0	100.0
Neurosurgery	0.0	0.0	0.0	0.0	23.8	2.4	0.0	0.0	59.5	7.1	4.8	2.4	100.0
Obstetrics and gynaecology	0.4	0.4	2.5	0.7	10.9	3.9	1.4	0.7	53.0	17.9	7.0	1.4	100.0
Orthopaedic surgery	1.1	0.0	2.6	1.6	14.3	3.2	1.1	3.2	61.4	7.9	3.2	0.5	100.0
Psychiatry	0.0	0.0	2.4	0.0	11.0	42.7	0.0	3.7	0.0	13.4	8.5	18.3	100.0
Urology	0.0	0.0	0.0	0.0	23.5	0.0	5.9	5.9	52.9	11.8	0.0	0.0	100.0
Other specialties	1.0	2.0	5.7	0.5	18.1	12.5	3.1	3.4	27.5	12.7	9.9	3.6	100.0
Other hospital-based medical practitioner	2.8	0.0	4.0	0.6	16.9	6.8	1.7	3.4	27.1	10.7	10.2	15.8	100.0
Not known	0.0	0.0	0.6	0.0	5.1	3.2	0.6	1.3	6.4	5.8	74.4	2.6	100.0
Not applicable[c]	0.0	0.0	0.0	0.0	0.0	0.0	33.3	0.0	16.7	33.3	0.0	16.7	100.0
All new claims	**3.7**	**0.4**	**2.9**	**0.4**	**21.4**	**6.9**	**1.4**	**3.1**	**33.9**	**11.2**	**10.6**	**4.1**	**100.0**

(a) See Appendix 1 for definitions of 'Primary incident/allegation type' categories '*consent*', *'medication-related'*, *'treatment'* and *'other'*.

(b) See Appendix1 for definitions of 'specialty of clinician' categories.

(c) 'Not applicable' for this data item indicates that no clinical staff were involved.

Age and sex of claimant

Age of claimant refers to the age of the patient at the time of the alleged harm that gave rise to the claim occurred. During 2005–06, 3.5% of finalised claims related to babies less than one year old, 3.7% related to children (1–18 years of age), and 62.6% related to adults (18+ years of age). In 30.2% of claims the age of the claimant was not available (table 3.4).

Of new claims, 5.5% involved babies, 4.7% of claims related to children, and 62% involved adults. For 27.8% of claims the age of the claimant was not available (table 3.5).

Of finalised claims relating to males, 65.5% related to adults, and age was unknown for 24.3%. Adults constituted 72.2% of finalised claims relating to females, and age was unknown for 21.8% (table 3.4).

For new claims, 58.2% of claims involving males related to adults and 74.1% of claims involving females related to adults, while age was unknown for 26.6% of males and 18.3% of females (table 3.5).

Table 3.4: Finalised claims: sex and age of claim subject at incident, by primary incident/allegation type, 1 July 2005 to 30 June 2006, Australia (per cent)

Primary incident/allegation type[(a)]	Age of claimant at time alleged harm occurred				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0.0	0.0	70.2	29.8	100.0
Blood/blood-product-related	0.0	14.3	71.4	14.3	100.0
Consent	3.9	0.0	88.2	7.8	100.0
Device failure	0.0	7.1	64.3	28.6	100.0
Diagnosis	4.3	6.7	66.1	22.8	100.0
General duty of care	0.0	2.7	65.8	31.5	100.0
Infection control	6.3	0.0	62.5	31.3	100.0
Medication related	1.4	7.0	71.8	19.7	100.0
Procedure	6.0	7.9	77.5	8.7	100.0
Treatment	9.1	7.5	63.6	19.8	100.0
Other	0.0	1.1	49.4	49.4	100.0
Not known	4.0	0.8	16.8	78.4	100.0
Total males	*4.5*	*5.7*	*65.5*	*24.3*	*100.0*
Females					
Anaesthetic	0.0	0.0	81.5	18.5	100.0
Blood/blood-product-related	0.0	20.0	80.0	0.0	100.0
Consent	0.0	4.3	80.0	15.7	100.0
Device failure	0.0	0.0	100.0	0.0	100.0
Diagnosis	1.4	6.1	72.6	19.9	100.0
General duty of care	0.7	2.1	68.3	29.0	100.0
Infection control	0.0	0.0	86.4	13.6	100.0
Medication related	3.9	1.3	72.4	22.4	100.0
Procedure	3.5	2.5	81.9	12.2	100.0
Treatment	5.3	3.1	68.0	23.6	100.0
Other	2.4	4.1	52.8	40.7	100.0
Not known	3.7	2.2	25.2	68.9	100.0
Total females	*2.7*	*3.3*	*72.2*	*21.8*	*100.0*
Persons[(b)]					
Anaesthetic	0.0	0.0	75.4	24.6	100.0
Blood/blood-product-related	0.0	14.3	64.3	21.4	100.0
Consent	1.0	2.6	76.0	20.4	100.0
Device failure	0.0	3.0	84.8	12.1	100.0
Diagnosis	3.0	5.8	67.8	23.4	100.0
General duty of care	0.3	1.9	56.5	41.2	100.0
Infection control	2.3	0.0	65.9	31.8	100.0
Medication	2.1	3.1	61.1	33.7	100.0
Procedure	5.3	4.4	77.8	12.5	100.0
Treatment	7.1	4.8	63.1	24.9	100.0
Other	0.6	1.2	29.8	68.4	100.0
Not known	5.1	1.5	21.0	72.4	100.0
All finalised claims	**3.5**	**3.7**	**62.6**	**30.2**	**100.0**

(a) See Appendix 1 for definitions of 'primary incident allegation' types.

(b) 'Persons' includes claims for which sex of claim subject was not known or indeterminate.

Table 3.5: New claims: sex and age of claim subject at incident, by primary incident/allegation type, 1 July 2005 to 30 June 2006, Australia (per cent)

Primary incident/allegation type[(a)]	Age of claimant at time alleged harm occurred				
	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0.0	0.0	73.1	26.9	100.0
Blood/blood-product-related	7.1	7.1	64.3	21.4	100.0
Consent	3.6	21.4	60.7	14.3	100.0
Device failure	0.0	18.2	63.6	18.2	100.0
Diagnosis	6.8	8.6	62.5	22.1	100.0
General duty of care	2.0	7.0	60.0	31.0	100.0
Infection control	16.0	0.0	52.0	32.0	100.0
Medication related	4.9	12.2	56.1	26.8	100.0
Procedure	8.8	7.5	59.5	24.1	100.0
Treatment	15.1	11.1	52.4	21.4	100.0
Other	3.6	0.0	50.0	46.4	100.0
Not known	7.6	1.5	34.8	56.1	100.0
Total males	*7.5*	*7.7*	*58.2*	*26.6*	*100.0*
Females					
Anaesthetic	0.0	1.7	74.6	23.7	100.0
Blood/blood-product-related	0.0	0.0	75.0	25.0	100.0
Consent	2.2	2.2	70.8	24.7	100.0
Device failure	0.0	0.0	100.0	0.0	100.0
Diagnosis	3.9	3.9	75.1	17.1	100.0
General duty of care	2.2	5.5	68.1	24.2	100.0
Infection control	0.0	0.0	84.2	15.8	100.0
Medication related	4.1	4.1	75.5	16.3	100.0
Procedure	4.0	2.5	79.5	14.0	100.0
Treatment	10.1	3.7	68.1	18.1	100.0
Other	3.3	10.0	53.3	33.3	100.0
Not known	6.4	3.8	55.1	34.6	100.0
Total females	*4.4*	*3.3*	*74.1*	*18.3*	*100.0*
Persons[(b)]					
Anaesthetic	0.0	0.9	73.2	25.9	100.0
Blood/blood-product-related	2.8	2.8	50.0	44.4	100.0
Consent	2.5	6.7	68.1	22.7	100.0
Device failure	0.0	7.7	84.6	7.7	100.0
Diagnosis	5.0	5.8	66.7	22.6	100.0
General duty of care	2.9	5.7	58.4	33.0	100.0
Infection control	8.3	0.0	60.4	31.3	100.0
Medication related	4.0	7.0	61.0	28.0	100.0
Procedure	5.9	4.2	72.0	17.9	100.0
Treatment	12.8	6.4	59.0	21.9	100.0
Other	2.0	2.9	30.4	64.7	100.0
Not known	4.9	1.6	27.0	66.4	100.0
All new claims	**5.5**	**4.7**	**62.0**	**27.8**	**100.0**

(a) See Appendix 1 for definitions of primary incident allegation types.

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

Primary body function/structure affected

For new and finalised claims, Figures 3.1 and 3.2 provide a summary of the primary body function or structure that was allegedly harmed. A full list of coding examples for body function/structure categories is included in Appendix 1.

Neuromusculo-skeletal and movement-related functions and structures was the most commonly recorded primary body function/structure affected for both new and finalised claims, 17.7% and 17.8% respectively (figure 3.1 and 3.2). The next most common category for new claims was *Functions/ structures of the digestive, metabolic and endocrine systems* (15.8%), followed by *Genitourinary and reproductive functions and structures* (10.5%) and *Mental functions and structures of the nervous system* (9.9%). For finalised claims, the next most common categories were related to *Genitourinary and reproductive functions and structures* (11.8%) and *Mental functions and structures of the nervous* system (10.8%).

In 5.9% of finalised and 12.5% of new claims the primary body function or structure was not known. *No body function/structure affected* was recorded for 20.2% of finalised and 6.1% of new claims.

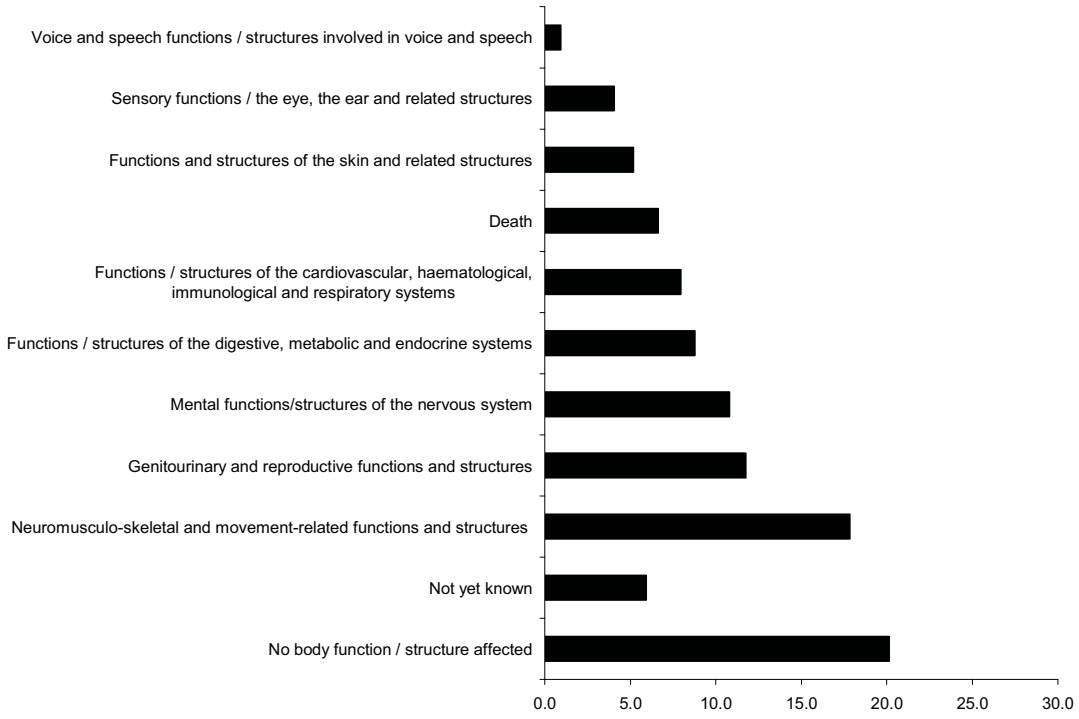

Figure 3.1: Finalised claims: primary body function/structure affected, 1 July to 30 June 2006, Australia (per cent)

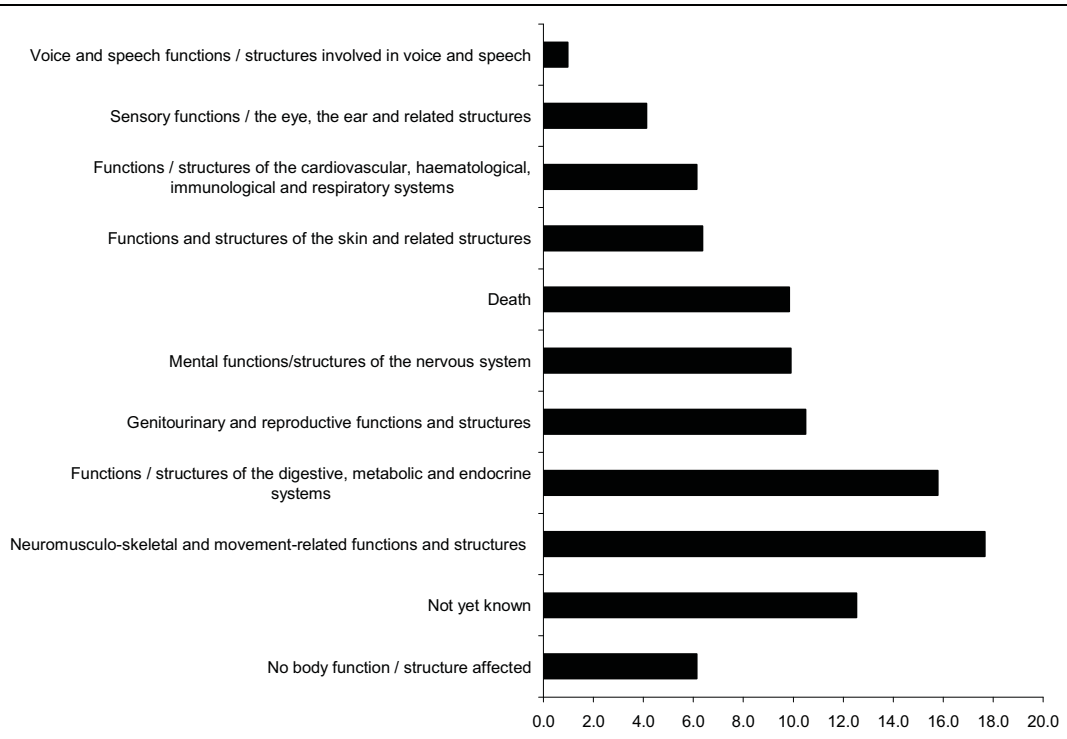

Figure 3.2: New claims: primary body function/structure affected, 1 July 2005 to 30 June 2006, Australia (per cent)

Status of claim

Table 3.6 provides information on the status of claims and the primary incident or allegation that prompted the claim. Claims are grouped into those opened within the 2005–06 financial year (new claims), claims that were previously closed and are now reopened, claims finalised within the 2005–06 financial year (finalised claims) and claims remaining open at 30 June 2006 (current claims). Claims may be counted in more than one category: for example, a claim that has been opened, settled and subsequently finalised within the period will appear in the new claim, as well as the finalised claim, categories. A claim that has been opened in the financial year and remains open at the end of the period will appear in the new and current claim categories.

Claims newly opened in 2005–06 were most commonly related to *procedure* (33.7%), *diagnosis* (22.1%) and *treatment* (10.3%). Of claims finalised within the 2005–06 period, 29.8% were related to *procedure*, 21.8% were related to *diagnosis* and 11.0% were related to *treatment* (table 3.6).

Duration of claims

The duration of claims is measured from the date the claim was commenced to 30 June 2006 (for claims still open at this time) or to the date the claim was finalised (for claims finalised before 30 June 2006).

Of the claims open at the end of the period, 75.5% had been open for four years or fewer. Of the claims finalised during the period, 71.1% had been open for four years or fewer and 17.7% had been open for over five years (table 3.7).

Table 3.6: All claims: status of claim by primary incident/allegation type, at 30 June 2006, Australia (per cent)

	Status of claim			
Primary incident/allegation type	**New claims (1 July 2005 – 30 June 2006)**	**Reopened**	**Finalised**	**Claims open at 30 June 2006**
Anaesthetic	3.8	2.3	3.0	2.7
Blood / blood-product-related	0.2	0.0	0.9	0.5
Consent	3.4	5.6	6.1	4.8
Device failure	0.5	0.6	1.3	1.2
Diagnosis	22.1	26.6	21.8	22.7
General duty of care	5.5	7.3	7.6	8.8
Infection control	1.2	0.6	1.3	1.5
Medication-related	3.3	2.8	4.5	4.0
Procedure	33.7	31.1	29.8	30.5
Treatment	10.3	9.0	11.0	9.6
Other	4.8	13.6	9.0	6.9
Not yet known	11.2	0.6	3.7	6.7
Total	100.0	100.0	100.0	100.0

Notes

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

Table 3.7: All claims: status of claim by length of claim (months), at 30 June 2006, Australia (per cent)

	Length of claim at 30 June 2006 (months)											
Status of claim	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
New claims (1 July 2005 – 30 June 2006)	53.0	47.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	100.0
Reopened	0.6	4.0	7.9	7.9	9.0	11.9	12.4	8.5	8.5	2.3	27.1	100.0
Finalised	6.4	10.8	9.2	8.5	9.5	9.2	9.4	8.1	6.1	5.0	17.7	100.0
Claims open at 30 June 2006	15.5	13.8	12.2	9.1	7.7	6.4	6.6	4.2	2.8	2.7	18.9	100.0

Notes

1. Length of claim is calculated from date claim commenced.
2. Length of claim for finalised claims is calculated from 'date claim commenced', to 'date claim finalised'.
3. 'Finalised' claims in the public sector claims data include claims that have been closed (and total claim size determined) or, where a final court decision has been made, including claims finalised with total claim size yet to be determined. Finalised claims in the private sector collection include claims that are closed and no more payments are expected, or all recoveries expected to be received from third parties, other than reinsurers, have been received (a claim may be finalised even though reinsurance recoveries are outstanding).
4. 'Reopened' claims include claims that have previously been recorded as finalised, but have then been re-opened and are active.

Total claim size and mode of finalisation

A claim is finalised when the claim is settled, a final court decision is made or the claim is closed. 'Total claim size' is the amount agreed to be paid to the claimant in total settlement, including any interim payments, claimant legal costs and defence costs. For the private sector, the sharing of financial liability between separate claims may lead to individual claim sizes appearing to be less than the actual total cost incurred by the MII.

Most claims were settled for less than $10,000 (42.7%), with 67% being settled for less than $100,000. No payment was made, or costs incurred, in 19.2% of finalised claims. Claims with sizes in excess of $500,000 constituted 2.8% of all finalised claims (table 3.8).

Table 3.8: Finalised claims: total claim, size by mode of claim finalisation[(a)], 1 July 2005 to 30 June 2006, Australia (per cent)

Total claim size	Court decision	Negotiated	Withdrawn	Per cent of finalised claims
No payment made	14.6	7.7	30.8	19.2
Less than $10,000	20.8	29.6	57.3	42.7
$10,000–<$30,000	16.7	16.1	8.4	12.1
$30,000–<$50,000	5.2	9.5	1.8	5.6
$50,000–<$100,000	10.4	12.6	0.8	6.6
$100,000–<$250,000	14.6	13.6	0.4	7.1
$250,000–<$500,000	6.3	5.7	0.1	2.9
$500,000 or more	10.4	5.2	0.2	2.8
Not known	1.0	0.0	0.2	0.1
Total	**100.0**	**100.0**	**100.0**	**100.0**

(a) See Appendix 1 for explanation of modes of claim finalisation.

Note: Due to coding inconsistencies and availability of data, structured settlements are not included as a separate category. Structured settlements are included here in the *Court decision* and *Negotiated* categories.

Appendix 1 Body function/structure categories

Table A1: Coding examples for 'Body function/structure' categories

Body function/structure coding category		Examples of types of harm
1.	Mental functions/structures of the nervous system	Psychological harm (e.g. nervous shock)
		Subdural haematoma
		Cerebral palsy
		Paralysis
2.	Sensory functions of the eye, ear and related structures	Loss of hearing
		Loss of sight
3.	Voice and speech functions/structures involved in voice and speech	Dental injuries
		Injuries to the structure of the nose or mouth
4.	Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	Injury to the spleen or lungs
		Generalised infection/sepsis
		Deep vein thrombosis
		Vascular or arterial damage
		Conditions affecting major body systems, such as cancer that has progressed and no longer affects a single body part or system
5.	Functions and structures of the digestive, metabolic and endocrine systems	Injury to the gall bladder, bowel, pancreas or liver
6.	Genitourinary and reproductive functions and structures	Injury to the breast
		Injury to male or female reproductive organs
		Injury to the kidney, ureters or bladder
7.	Neuromusculo-skeletal and movement-related functions and structures	Loss of function due to inappropriate casting of joint
		Loss of function due to restricted blood flow and nerve damage
8.	Functions and structures of the skin and related structures	Burns
9.	Death	'Death' is recorded where the alleged harm 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

Table A2: Coding examples for selected incident/allegation types

Incident/allegation type	Example of incident or allegation
Consent	Failure to warn
Medication-related	Includes type, dosage and method of administration issues
Procedure	Failure to perform a procedure
	Wrong procedure performed
	Wrong body site
	Post-operative complications
	Failure of procedure
Treatment	Delayed treatment
	Treatment not provided
	Complications of treatment
	Failure of treatment
Other	Medico-legal reports
	Disciplinary inquiries and other legal issues
	Breach of confidentiality
	Record keeping/loss of documents
	Harassment and discrimination

Table A3: Coding examples for mode of claim finalisation

Mode of finalisation	Explanation
Court decision	In private sector claims data, 'court decision' includes claims where damages were awarded to the plaintiff by court (either initially or on appeal) and where the case was awarded against the plaintiff by the court (either initially or on appeal) and MII incurs costs only.
	In the public sector data 'Court decision' includes claims where a court decision has directed the outcome of a claim.
Negotiated	From public sector claims, data includes: proceedings conducted in state/territory health rights and health complaints bodies; mediation, arbitration, and case appraisal provided under civil procedure rules; settlement conferences required by statute as part of a pre-court process; and other instances where a claim is settled part way through a trial. 'Negotiated' from private sector claims data includes settlement outcomes where an amount is paid to the plaintiff other than by court direction.
Withdrawn	From public sector claims data 'withdrawn' includes claims that have been closed due to withdrawal by the claimant, or operation of statute of limitations, or where the claim manager decided to close the claim file because of long periods of inactivity, and instances where a claim is discontinued part way through a trial. 'Withdrawn' claims from private sector claims data include claims where the claimant withdrew the claim and the MII incurs costs only.

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