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Abbreviations

ACCC	Australian Competition and Consumer Commission
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulation 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
MINC	Medical Indemnity National Collection
MINC CC	Medical Indemnity National Collection Coordinating Committee
NCPD	National Claims and Policies Database
PSS	Premium Support Scheme

Symbols

. .	Not applicable

Summary

This report presents information from the Medical Indemnity National Collection for 2008–09. It describes characteristics and costs for public and private sector medical indemnity claims.

Claims

There were 9,173 medical indemnity claims open at some point between July 2008 and June 2009. This included over 2,600 new claims opened during the period, and almost 3,100 claims that were closed during the period. There were similar numbers of new claims in the public and private sectors (1,291 and 1,334 respectively). The public sector had more closed claims, and claims overall (1,867 and 5,072 respectively) than the private sector (1,226 and 4,101 respectively).

More claims were reported for 2008–09 than 2007–08. In 2007–08 there were 2,255 new claims, 2,675 closed claims and 8,555 claims overall.

Cost, duration and mode of claim finalisation

Nearly two-thirds (66%) of closed claims were settled for less than $10,000, including 30% where no payment was made. Just 4% were settled for $500,000 or more. Approximately 70% of closed claims were finalised within 3 years of being opened, compared with 9% that took more than 5 years to be settled.

Just 6% were finalised through a court decision, compared with 29% finalised through a negotiated settlement with the claimant. The remaining 65% were discontinued (for instance, following the claimant's withdrawal of the claim).

Similar proportions were recorded for 2007–08 medical indemnity claims.

The incidents and who was involved

As in previous years, the most common allegation for loss in 2008−09 related to *Procedure*—for example, failure of procedure or post-operative complications (28% of claims)—followed by *Diagnosis* (21% of claims) and *Treatment* (16% of claims).

The most common allegation of harm was *Neuromusculoskeletal and movement-related*, accounting for 19% of claims. Allegations of *Mental and nervous system* effects (15%), *Death* (13%) and *Genitourinary and reproductive* effects (10%) were also commonly reported. Similar proportions were recorded for 2007–08 medical indemnity claims.

Almost two-thirds of allegedly affected patients were adults (65% of claims), with female patients outnumbering males. In the case of babies (less than 1 year old) and persons 1–17 years old, the patient was more often male than female. Where the claim subject was a baby, the majority of claims (53%) were associated with *Mental and nervous system* effects.

About one-third of 2008–09 claims alleged the involvement of the clinical specialties *General practice* (20% of claims) or *Obstetrics and Gynaecology* (16% of claims). The proportions for 2007–08 were similar (17% of claims in both cases).

Just over half of claims (52%) related to alleged incidents in a public sector health setting, such as a public hospital. Most other claims (38%) related to incidents alleged to have occurred in a private sector setting, for example, a private medical clinic.

1 Introduction

This report presents data on public and private sector medical indemnity claims for the period from 1 July 2008 to 30 June 2009. It is the fifth report of this nature, the first of which was *A national picture of medical indemnity claims in Australia 2004–05*, published in May 2007 (AIHW 2007).

Medical indemnity insurance provides clinicians with protection against financial loss resulting from claims of alleged negligence or breach of duty during the performance of health-care related services. In Australia, this insurance is mainly provided within the public sector by state and territory health authorities. In the private sector, clinicians hold individual policies with medical indemnity insurers (MIIs). Private hospitals also have medical indemnification cover but their claims are out of scope for the Medical Indemnity National Collection (MINC) on which this report is based.

The data presented in this report relate to claims that were open at any time during the reporting period, 1 July 2008 to 30 June 2009. With most but not all of these claims, a formal demand for compensation for alleged harm or other loss resulting from health care had been received by an MII or a public sector claims manager. There are five categories of claims represented in the data: all claims, new claims, closed claims, current claims and reopened claims (Box 1.1).

This report provides information on the alleged health-care incidents giving rise to claims, which specialties were allegedly involved, the health service setting, reserve range, the age and sex of the people who allegedly suffered loss or harm, the nature of their loss and how and for how much claims were settled.

Most health service settings are either public or private, but it should be noted that a proportion of the claims involving public sector health authorities originate from alleged incidents in private settings, and a proportion of MII claims originate from alleged incidents in public settings. As an example of the former, some jurisdictions offer public cover to medical practitioners working in their private health clinics under particular circumstances (for example, if they are rurally based). As an example of the latter, visiting medical officers who treat private patients in public hospitals are often required to hold private medical indemnification (see the appendix 'Policy, administrative and legal features in each jurisdiction' in AIHW 2011b).

The report has three chapters, with introductory information provided in Chapter 1 and the background to the collection summarised in Chapter 2. Chapter 3 includes information on the claims. There are also three appendices that respectively detail the data items and definitions, differences between the public and private sectors in their claim management practices, and coding examples for some of the main data items.

Box 1.1: Types of claims in scope for the 2008–09 combined sector report

All claims: public and private sector claims in scope (see below) that were open at any time between 1 July 2008 and 30 June 2009.

New claims: public sector claims in scope that had their reserve set, or private sector claims reported to the Australian Prudential Regulation Authority (APRA), between 1 July 2008 and 30 June 2009.

Current claims: any claims in scope that remained open at 30 June 2009.

Closed claims: any claims that were finalised by discontinuation, negotiation or a court decision, between 1 July 2008 and 30 June 2009.

Reopened claims: current claims that had been considered closed at some point prior to 30 June 2009.

Most of the claims in scope are linked to a formal demand for compensation for alleged loss or harm. The scope does not include public sector potential claims, which are instances of suspected harm reported to the health authority claim manager that are considered likely to result in a formal demand at some point after the reporting period. The scope also excludes most potential claims in the private sector, which are cases of incidents reported by an insured clinician to a medical indemnity insurer (MII). Only when the MII has incurred preparatory expenses, and so is legally obliged to report the potential claim to APRA even if no formal demand has been received, would the private sector potential claim be included here. The scope also includes claims discontinued during 2008–09 without any litigation having commenced (discontinued potential claims) if they are private sector claims previously reported to APRA or they are public sector claims.

The rationale for which public sector claims are in scope is that, as far as possible, they should correspond to in-scope private sector claims, which are those required to be reported to APRA for its National Claims and Policies Database (NCPD) (APRA 2009). Depending on the reporting period, between one-third and one-fifth of current claims in the public sector are potential claims (AIHW 2011c). This is much higher than the proportion of private sector claims required to be reported to APRA that are potential claims. Accordingly, to include public sector open potential claims would result in data less comparable between the sectors. Those public sector claims are however included in the accompanying report on public sector claims in 2008–09 (AIHW 2011c).

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

1.1 Background to the report

Health Ministers decided at the Medical Indemnity Summit in April 2002 to establish a 'national database for medical negligence claims' to assist with informing future medical indemnity strategies. The collection was intended to help monitor the costs associated with health-care litigation and the financial viability of the medical indemnity insurance sector.

Collation of data on public sector medical indemnity claims started in 2003, and was followed by publication of the first six months of the 2003 data in December 2004 (AIHW 2004). Seven financial year reports on the public sector have been published subsequently, the last covering 2008–09 (AIHW 2011c).

In 2004 the Australian Government introduced the Premium Support Scheme (PSS), as part of a comprehensive medical indemnity package to help eligible clinicians meet the cost of their private medical indemnity insurance (Medicare Australia 2010). MIIs provide information on private sector medical indemnity claims to the Australian Government Department of Health and Ageing (DoHA) and the AIHW under arrangements made following the introduction of the PSS. The claims reported by the MIIs to the AIHW are the same claims as they are required to report to the Australian Prudential Regulation Authority (APRA). Some of the claims reported by MIIs relate to medical defence organisation (MDO) run-off, which is a scheme for claims lodged with private sector medical indemnity insurers in the years when they were still organised as MDOs rather than MIIs. This claims information is combined with the corresponding public sector data supplied to the AIHW by states and territories in the production of the combined sector medical indemnity reports (Box 1.1).

Further information on the collection's background is presented in the *Public and private sector medical indemnity claims in Australia 2006–07: a summary* report (AIHW 2010).

1.2 Collaborative arrangements

The public sector MINC is governed by an agreement between DoHA, AIHW and state and territory health departments. A second agreement relating to the private sector MINC exists between DoHA, AIHW and individual MIIs. The agreements outline the respective roles, responsibilities and collaborative arrangements of all parties.

The MINC Coordinating Committee (MINC CC) was established in mid-2005 to manage the development and administration of medical indemnity data combined across the public and private sectors and to advise on the public release of these data. The Committee consists of representatives from state and territory health authorities, DoHA, MIIs and the AIHW, and also oversees the production of the combined public and private sector reports.

The AIHW is the national data custodian of public sector medical indemnity data contained in the MINC and is responsible for the collection, quality control, management and reporting of these data. The AIHW receives a combination of aggregated and unit record claims data from the private sector and is also responsible for managing and reporting these data. All data held by the AIHW for the purpose of producing this report are de-identified and treated in confidence by the AIHW. Any release or publication of aggregated public and private sector medical indemnity data is subject to agreement by the members of the MINC CC.

2 The collection

2.1 Data items and definitions

The MINC includes 22 data items. Definitions, classification codes, a guide for use and a brief history of the development of each item are documented in the *Medical indemnity national collection (public sector) data guide*, which is available from the AIHW on request. The 2004–05 version of the data guide is also available as an online publication (AIHW 2006).

Some MIIs transmit their claims data directly to the AIHW, while other MIIs transmit claims data to Insurance Statistics Australia (ISA) which are then forwarded as data extracts to the AIHW. Many of the data items collected by ISA are similar to MINC data items, and those data items defined similarly in both collections are chosen for inclusion in the combined database. The MINC data items that map to ISA items are outlined in Appendix 1 (Table A1.1). Some explanation is also included where data items do not map precisely. Definitions of key terms used in this report as endorsed by the MINC CC are also presented in Appendix 1 (Table A1.2).

2.2 Claim management practices

There are differences between the public and private sectors in the management of claims, with implications for the interpretation of the combined claims data in this report. The main differences in claim management practices between the two sectors relevant to this report are outlined below. Further information on claim management practices can be found in Appendix 2.

The public sector

A medical indemnity claim in the public sector is defined on the criterion of having a reserve placed against the estimated likely cost of settling the claim. Jurisdictions differ in the degree to which the report of a health-care incident triggers the setting of a reserve prior to any formal allegation of loss or harm. Jurisdictions also differ in whether they report these potential claims to the AIHW or not. This variation between jurisdictions has a limited impact on the data presented in this report, because the only claims included are those that have formally commenced and/or have been closed by the responsible health authority (Box 1.1).

In the public sector the states and territories usually treat any allegations related to a single health-care incident as a single claim, even if it involves more than one health-care professional. All jurisdictions report on the principal clinician specialty involved in the allegation or incident, but (apart from New South Wales) they may also report up to three additional clinician specialties. This additional information can be used to make the public sector data on clinician specialties more like the data for the private sector where, as noted below, the involvement of several clinicians is likely to result in more than one claim.

Private sector medical indemnity insurers

MIIs provide professional indemnity insurance to individual clinicians. It is a common, but not uniform, practice for MIIs to open more than one claim for a single health-care incident if

more than one clinician was involved in the incident that gave rise to the allegation of loss or harm. For example, an incident involving both an anaesthetist and an obstetrician may result in the initiation of a separate claim against each clinician.

As a result, individual claim sizes will often be less than the aggregated total cost incurred by the MII(s) for a single allegation of loss or harm. Thus the reported cost of an individual claim in the private sector may not reflect the total payment made by insurers in respect of the claimant(s).

In addition, clinician specialties in the private sector are recorded according to their specialty as registered with their insurer rather than with their employing or contracting health service provider (as in the public sector). This difference has led to a methodological decision to combine certain categories of specialties for combined sector reporting (see Appendix 2).

2.3 Data completeness and *Not known* rates

Since the establishment of the MINC public sector collection, data completeness has improved considerably. For the period from 1 July 2008 to 30 June 2009, 100% of all public sector claims 'in scope', that is claims known to the jurisdictions as having been open at any time during the reporting period, were reported to the AIHW. This is similar to the public sector coverage recorded for the 2007–08 report (AIHW 2011b). This is a clear improvement on the 89% public sector coverage recorded for the 2005–06 report and 92% of public sector coverage recorded for the 2006–07 report (AIHW 2008, 2010).

As is the case with the previous combined sector reports, data provided by the private sector for medical indemnity claims are complete, that is, data on 100% of claims legally required to be reported to APRA (Box 1.1) were reported to the AIHW.

The category *Not known* is used when the relevant information is not currently available. In some cases, the information is expected to become available as the claim progresses. In others, information is incomplete and likely to remain so over the lifetime of the claim.

Not known rates tend to be particularly high for new claims, which are those first reported to APRA or reserved during the reporting period. The *Not known* rate for the data item 'primary incident/allegation type' was 16% for new claims compared with 8% for all claims reported during 2008–09. For the data item 'primary body function/structure affected' the *Not known* rate was 25% for new claims and 12% for all claims. For age of claim subject it was 30% for new claims and 19% for all claims; for 'health service setting', 18% for new claims and 9% for all claims; and for clinician specialty, 17% for new claims and 9% for all claims.

The interpretation of the proportions discussed in Chapter 3 will be affected by the *Not known* rates particularly where these are in excess of 10%.

3 Claims for 2008–09

The data for 2008–09 presented in this chapter groups claims into four main (but not mutually exclusive) categories: all claims, new claims, current claims and closed claims. An additional minor category involves reopened claims, which are current claims that had been considered closed at some point prior to 30 June 2009 (Box 1.1).

In 2008−09 there were more public sector claims than private sector claims in every category of claim, except new claims (Table 3.1). In comparison, in 2007−08 there were fewer new claims for the private sector than the public sector. Overall the number of new claims rose from 2007−08 to 2008–09 by 16%. Also, the number of 2008–09 closed claims rose by 16% from the 2,675 closed claims reported for 2007−08.

Table 3.1: Numbers of public sector claims and private sector (MII) claims, 1 July 2007 to 30 June 2008 (2007−08) and 1 July 2008 to 30 June 2009 (2008−09)

	Public sector		Private sector		Total	
Claim category	**2007−08**	**2008−09**	**2007−08**	**2008−09**	**2007−08**	**2008−09**
New	1,292	1,291	963	1,334	2,255	2,625
Reopened	154	165	66	97	220	262
Closed	1,851	1,867	824	1,226	2,675	3,093
Current	3,429	3,205	2,451	2,875	5,880	6,080
All	5,280	5,072	3,275	4,101	8,555	9,173

Source for 2007−08 data: AIHW 2011a.

In the tables that provide data on clinician specialty, all records of an involved health professional are included in the public sector counts; that is, one claim may be reported against several clinician specialties. Accordingly, the total reports associated with the various clinician specialties will exceed the number of claims, and would also exceed 100% when expressed as percentages (tables 3.6 to 3.9, 3.26, 3.27).

3.1 Health-care incidents leading to claims

This section provides information on where the alleged health-care incident occurred ('health service setting'), as well as the alleged reason for a claim ('primary incident/allegation type') and the professionals alleged to have been directly involved in the incident ('specialty of clinician involved').

Health service setting

'Health service setting' refers to the setting in which the incident that gave rise to a claim took place. During the 2008−09 reporting period, a larger number of all claims were associated with public sector settings, whereas for new claims a larger number of claims were associated with private sector settings.

Public sector claims can arise from alleged incidents in private sector health settings and vice versa. Therefore the number of claims in public settings and private settings (tables 3.2 and 3.4) does not equal the respective number of public sector and private sector claims in Table 3.1.

Approximately half of all claims (52% or 4,773 claims) and two-fifths of new claims (39% or 1,025 claims) were reported as occurring within a public setting. Of these claims, 98% (4,656) of all claims and 99% (1,013) of new claims occurred within a public hospital or day surgery (tables 3.2 and 3.4). *Other public setting*, for instance public community health centres and residential aged care services, was associated with 1% of all claims and new claims (tables 3.2 and 3.4).

A private health service setting was the health service setting recorded for 38% (3,520) of all claims and 42% (1,115) of new claims. Of these claims, 51% (1,791) of all claims and 55% (615) of new claims occurred in a private medical clinic (tables 3.2 and 3.4). For both all and new claims, these were higher proportions than those recorded for private hospitals or day surgeries (41% for all claims and 28% for new claims). *Other private setting*, for instance residential aged care services, was associated with 3% of all claims and 7% of new claims (tables 3.2 and 3.4).

In 2007–08 the proportion of all claims (59%) and new claims (42%) in a public setting was higher than in 2008–09, while the proportion of all claims (32%) and new claims (36%) in a private setting was lower (AIHW 2011a).

Primary incident/allegation type

'Primary incident/allegation type' describes what is alleged to have gone wrong, that is, the area of possible error, negligence or problem that is determined to be of primary importance in giving rise to the claim. Coding examples for selected incident/allegation types are provided in Appendix 3 (Table A3.2).

The most commonly recorded category was *Procedure*, accounting for 28% (2,527) of all claims and 20% (523) of new claims (tables 3.2 to 3.5). *Diagnosis* and *Treatment* were the next most frequently recorded incident/allegation types and were associated with 21% (1,935) and 16% (1,453) of all claims (respectively). After *Procedure*, these two incident/allegation types were also the most frequently recorded for new claims with 411 claims (16%) recorded for *Treatment* and 403 claims (15%) recorded for *Diagnosis*. The three most commonly recorded primary incident/allegation types for both all and new claims were *Procedure*, *Diagnosis* and *Treatment*, in that order, in 2004–05, 2005–06, 2006–07 and 2007–08 (AIHW 2007, 2008, 2010, 2011a). However, the proportion of claims (whether all or new) associated with *Treatment* was lower in those years (10–13%) than in 2008–09 (16%).

General duty of care accounted for 6% (509) of all claims and 5% (131) of new claims. An incident/allegation type of *Consent* also accounted for 6% (151) of new claims. The other categories of incident/allegation type each accounted for less than 5% of all claims and of new claims. Similar results were obtained from the 2004–05, 2005–06, 2006–07 and 2007–08 claims data (AIHW 2007, 2008, 2010, 2011a).

With the 2008–09 claims data, *Procedure* and *Diagnosis* were the most frequently recorded incident/allegation types for claims arising from an incident that occurred in a public hospital or day surgery. *Procedure*-related claims accounted for 31% and 25% of all and new claims (respectively) occurring in this health service setting. *Diagnosis* was recorded for 25% of all claims, while *Treatment* was recorded for 25% of new claims in a public hospital/day surgery.

For claims arising from an incident occurring in a private setting, *Procedure* was the most frequently recorded primary incident/allegation type in private hospitals or day surgeries, accounting for 55% of all claims and 50% of new claims. However, in private medical clinics,

Diagnosis was the most frequently recorded primary incident/allegation type, accounting for 30% of all claims and 19% of new claims. In *Other private settings*, *Diagnosis* was recorded for 28% of all claims, while *Consent* was recorded for 28% of new claims.

As an incident/allegation type, *General duty of care* accounted for its highest proportion of claims in *Other public settings* and *Other* health service settings. It was associated with 10% of all claims in O*ther public settings* and 27% of all claims in *Other* settings.

Table 3.2: All claims[a]: primary incident/allegation type by health service setting, 1 July 2008 to 30 June 2009

Primary incident/allegation type	Health service setting							
	Public hospital/day surgery[b]	Other public setting[c]	Private hospital/day surgery[d]	Private medical clinic[e]	Other private setting[f]	Other[g]	Not known	Total
Anaesthetic	81	0	105	4	3	1	5	199
Blood/blood product-related	38	15	0	0	0	1	0	54
Consent	150	4	84	72	52	0	2	364
Device failure[h]	20	0	12	8	2	0	2	44
Diagnosis	1,156	34	87	543	79	13	23	1,935
General duty of care	291	12	37	106	18	28	17	509
Infection control	57	0	7	14	1	0	1	80
Medication-related	223	5	27	142	13	5	7	422
Procedure	1,451	21	794	179	46	6	30	2,527
Treatment	959	19	173	236	39	13	14	1,453
Other	106	4	116	459	23	34	94	836
Not known	124	3	8	28	3	2	582	750
Total	**4,656**	**117**	**1,450**	**1,791**	**279**	**103**	**777**	**9,173**
Total per cent	*50.8*	*1.3*	*15.8*	*19.5*	*3.0*	*1.1*	*8.5*	*100.0*

(a) Claims that were open at any point during the financial year.

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.

(f) Includes private residential aged care services, hospices, and alcohol and drug rehabilitation centres.

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

(h) Aligns to 'Faulty/contaminated equipment' in the APRA National Claims and Policies Database (NCPD), corresponding to ISA data item 15 (see Appendix 1).

Note: Public sector claims can arise from alleged incidents in private sector health settings and vice versa. Therefore, the number of claims in public settings and private settings does not equal the respective number of public sector and private sector claims. See Table 3.1 for numbers of public sector and private sector claims.

Table 3.3: All claims[a]: primary incident/allegation type by health service setting, 1 July 2008 to 30 June 2009 (per cent)

	Health service setting							
Primary incident/allegation type	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Anaesthetic	1.7	0.0	7.2	0.2	1.1	1.0	0.6	2.2
Blood/blood product-related	0.8	12.8	0.0	0.0	0.0	1.0	0.0	0.6
Consent	3.2	3.4	5.8	4.0	18.6	0.0	0.3	4.0
Device failure[h]	0.4	0.0	0.8	0.4	0.7	0.0	0.3	0.5
Diagnosis	24.8	29.1	6.0	30.3	28.3	12.6	3.0	21.1
General duty of care	6.3	10.3	2.6	5.9	6.5	27.2	2.2	5.5
Infection control	1.2	0.0	0.5	0.8	0.4	0.0	0.1	0.9
Medication-related	4.8	4.3	1.9	7.9	4.7	4.9	0.9	4.6
Procedure	31.2	17.9	54.8	10.0	16.5	5.8	3.9	27.5
Treatment	20.6	16.2	11.9	13.2	14.0	12.6	1.8	15.8
Other	2.3	3.4	8.0	25.6	8.2	33.0	12.1	9.1
Not known	2.7	2.6	0.6	1.6	1.1	1.9	74.9	8.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year.
(b) Includes public psychiatric hospitals.
(c) Includes public community health centres, residential aged care services, hospices and alcohol and drug rehabilitation centres.
(d) Includes private psychiatric hospitals.
(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.
(f) Includes private residential aged care services, hospices, and alcohol and drug rehabilitation centres.
(g) Includes patient's home and 'Medihotels'.
(h) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD, (ISA data item 15).

Notes

1. Public sector claims can arise from incidents in private sector health settings and vice versa. Therefore, the number of claims in public settings and private settings does not equal the respective number of public sector and private sector claims. See Table 3.1 for numbers of public sector and private sector claims.
2. Percentages may not add up exactly to 100.0 due to rounding.

Table 3.4: New claims[(a)]: primary incident/allegation type by health service setting, 1 July 2008 to 30 June 2009

	Health service setting							
Primary incident/allegation type	**Public hospital/day surgery[(b)]**	**Other public setting[(c)]**	**Private hospital/day surgery[(d)]**	**Private medical clinic[(e)]**	**Other private setting[(f)]**	**Other[(g)]**	**Not known**	**Total**
Anaesthetic	20	0	23	1	2	0	0	46
Blood/blood product-related	17	0	0	0	0	0	0	17
Consent	55	0	22	22	51	0	1	151
Device failure[(h)]	3	0	3	0	2	0	0	8
Diagnosis	223	3	21	119	27	0	10	403
General duty of care	48	1	10	43	9	8	12	131
Infection control	3	0	3	2	1	0	1	10
Medication-related	55	1	5	40	8	3	5	117
Procedure	253	5	158	56	34	0	17	523
Treatment	249	1	29	90	31	4	7	411
Other	39	0	40	225	16	10	55	385
Not known	48	1	3	17	2	0	352	423
Total	**1,013**	**12**	**317**	**615**	**183**	**25**	**460**	**2,625**
Total per cent	*38.6*	*0.5*	*12.1*	*23.4*	*7.0*	*1.0*	*17.5*	*100.0*

(a) Claims that were opened or notified during the financial year.
(b) Includes public psychiatric hospitals.
(c) Includes public community health centres, residential aged care services, hospices and alcohol and drug rehabilitation centres.
(d) Includes private psychiatric hospitals.
(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.
(f) Includes private residential aged care services, hospices, and alcohol and drug rehabilitation centres.
(g) Includes patient's home and 'Medihotels'.
(h) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15).

Note: Public sector claims can arise from incidents in private sector health settings and vice versa. Therefore, the number of claims in public settings and private settings does not equal the respective number of public sector and private sector claims. See Table 3.1 for numbers of public sector and private sector claims.

Table 3.5: New claims[a]: primary incident/allegation type by health service setting, 1 July 2008 to 30 June 2009 (per cent)

	Health service setting							
Primary incident/allegation type	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Anaesthetic	2.0	0.0	7.3	0.2	1.1	0.0	0.0	1.8
Blood/blood product-related	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.6
Consent	5.4	0.0	6.9	3.6	27.9	0.0	0.2	5.8
Device failure[h]	0.3	0.0	0.9	0.0	1.1	0.0	0.0	0.3
Diagnosis	22.0	25.0	6.6	19.3	14.8	0.0	2.2	15.4
General duty of care	4.7	8.3	3.2	7.0	4.9	32.0	2.6	5.0
Infection control	0.3	0.0	0.9	0.3	0.5	0.0	0.2	0.4
Medication-related	5.4	8.3	1.6	6.5	4.4	12.0	1.1	4.5
Procedure	25.0	41.7	49.8	9.1	18.6	0.0	3.7	19.9
Treatment	24.6	8.3	9.1	14.6	16.9	16.0	1.5	15.7
Other	3.8	0.0	12.6	36.6	8.7	40.0	12.0	14.7
Not known	4.7	8.3	0.9	2.8	1.1	0.0	76.5	16.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year.
(b) Includes public psychiatric hospitals.
(c) Includes public community health centres, residential aged care services, hospices and alcohol and drug rehabilitation centres.
(d) Includes private psychiatric hospitals.
(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.
(f) Includes private residential aged care services, hospices, and alcohol and drug rehabilitation centres.
(g) Includes patient's home and 'Medihotels'.
(h) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15).

Notes

1. Public sector claims can arise from incidents in private sector health settings and vice versa. Therefore, the number of claims in public settings and private settings does not equal the respective number of public sector and private sector claims. See Table 3.1 for numbers of public sector and private sector claims.

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

Specialty of clinician

The 'specialty of clinician(s) closely involved in incident' provides information relating to the specialty of the health-care provider or providers who allegedly played the most prominent role(s) in the events that led to a claim. Certain clinician specialties such as *General practice* are more common in the private sector whereas others such as *Emergency medicine* are more concentrated in the public sector.

For claims in the MINC public sector collection, up to four codes may be recorded for this data item to cater for those situations that involved more than one clinician. Thus a single public sector claim may potentially be counted up to four times in tables 3.6 to 3.9. However, for claims in the private sector, only the specialty of the policy holder (an individual clinician) is recorded for each claim.

The eleven most commonly recorded clinical specialties during the 2008–09 reporting period feature in tables 3.6 to 3.9. *General practice* (1,838 records) and *Obstetrics and Gynaecology* (1,421 records) were the most frequently recorded specialties, associated with 20% and 16% respectively of all claims. For new claims, the same two specialties were the most frequently recorded, *General practice* on 690 occasions (26%) and *Obstetrics and Gynaecology* in 277 cases (11%). Considerably fewer 2007–08 claims (AIHW 2011a) were associated with *General practice* (1,419 of all claims, 483 of new claims) whereas the numbers associated with *Obstetrics and Gynaecology* were similar. Three other frequently recorded clinician specialties in 2008–09 were *General surgery*, *Orthopaedic surgery* and *Emergency medicine* each of which was associated with 6–7% of all claims and 3–5% of new claims.

The clinical specialties of *Obstetrics and Gynaecology*, *General surgery* and *Orthopaedic surgery* were recorded for about twice the proportion of claims with *Procedure* as their incident/allegation type as they were for total claims. In the case of all claims, 28% of *Procedure*-related claims were associated with *Obstetrics and Gynaecology, 16%* with *General surgery* and 15% with *Orthopaedic surgery,* compared with the respective percentages of 16%, 7% and 7% for total claims. When new claims that are *Procedure*-related are considered, it can be seen that 19% were associated with *Obstetrics and Gynaecology*, 13% with *General surgery* and 12% with *Orthopaedic surgery*, whereas these clinical specialties were respectively recorded for 11%, 5% and 5% of total new claims.

The specialty of *General practice* was associated with a relatively high proportion of claims with an incident/allegation type of *Diagnosis*. These proportions were 29% and 35% for all and new claims respectively, compared with the 20% of all claims and 26% of total new claims associated with *General practice*. The clinical specialties of *Emergency medicine* and *Diagnostic radiology* were also recorded for a relatively high proportion of all *Diagnosis*-related claims, respectively 17% and 11%, compared with the proportions of 6% and 3% for the total of all claims with which these specialties were associated.

In the case of claims with a primary incident/allegation type of *General duty of care*, the proportions associated with *Psychiatry* and with *General nursing* were approximately seven times the proportion of total claims. *Psychiatry* was recorded for 21% of all claims with an incident/allegation type of *General duty of care*, compared with 3% of total claims. The corresponding proportion for new claims was 11% for *Psychiatry* compared with 3% of total new claims. Similarly, *General nursing* was recorded for 13% of all claims and 7% of new claims with an incident/allegation type of *General duty of care*, compared with 2% and 1% of the totals of all claims and new claims respectively.

The relationships described above between clinician specialty and primary incident/allegation type for 2008−09 claims are similar to those observed for 2007−08 claims (AIHW 2011a).

Table 3.6: All claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2008 to 30 June 2009

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/ blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	150	1	0	2	6	8	4	12	55	15	9	3	265
Diagnostic radiology	0	0	3	2	206	5	0	2	41	13	12	0	284
Emergency medicine	0	1	4	1	337	29	4	21	29	128	4	6	564
General and internal medicine	1	0	3	1	52	7	4	18	14	30	12	3	145
General nursing	1	2	1	2	12	65	1	20	9	32	4	3	152
General practice[c]	13	11	40	3	557	102	9	163	193	336	385	26	1,838
General surgery	8	2	14	1	78	9	3	10	402	62	39	5	633
Neurosurgery	1	0	3	2	22	4	2	3	66	14	7	3	127
Obstetrics and Gynaecology[d]	7	3	78	6	199	50	2	31	708	289	25	23	1,421
Orthopaedic surgery	6	0	22	7	67	10	11	11	370	80	27	6	617
Psychiatry	0	1	9	0	26	108	0	19	4	62	54	6	289
Other hospital-based medical practitioner[e]	11	0	13	1	73	30	2	11	43	41	62	10	297
All other specialties[f]	15	34	174	15	418	99	20	110	672	422	174	21	2,174
Not applicable[g]	0	0	3	0	5	9	2	2	5	10	9	0	45
Not known	1	1	2	1	29	13	18	6	30	26	19	650	796
Total[h]	**199**	**54**	**364**	**44**	**1,935**	**509**	**80**	**422**	**2,527**	**1,453**	**836**	**750**	**9,173**

(a) Claims that were open at any point during the financial year.

(b) Only the 12 clinician specialty categories that were most frequently recorded for all claims are listed; all other categories are combined in the category *All other specialties*.

(c) Includes both procedural and non-procedural general practitioners.

(d) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.

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

(f) Covers all clinician specialty categories other than the 12 which are individually listed.

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

(h) This is the total number of claims for which each primary incident/allegation type was recorded. A given specialty may only be recorded once for a single claim in the private sector, but up to four different specialties may be recorded for a public sector claim. Therefore, some public sector claims are represented in more than one row, and so the column totals exceed the number of claims.

Table 3.7: All claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2008 to 30 June 2009 (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	75.4	1.9	0.0	4.5	0.3	1.6	5.0	2.8	2.2	1.0	1.1	0.4	2.9
Diagnostic radiology	0.0	0.0	0.8	4.5	10.6	1.0	0.0	0.5	1.6	0.9	1.4	0.0	3.1
Emergency medicine	0.0	1.9	1.1	2.3	17.4	5.7	5.0	5.0	1.1	8.8	0.5	0.8	6.1
General and internal medicine	0.5	0.0	0.8	2.3	2.7	1.4	5.0	4.3	0.6	2.1	1.4	0.4	1.6
General nursing	0.5	3.7	0.3	4.5	0.6	12.8	1.3	4.7	0.4	2.2	0.5	0.4	1.7
General practice[c]	6.5	20.4	11.0	6.8	28.8	20.0	11.3	38.6	7.6	23.1	46.1	3.5	20.0
General surgery	4.0	3.7	3.8	2.3	4.0	1.8	3.8	2.4	15.9	4.3	4.7	0.7	6.9
Neurosurgery	0.5	0.0	0.8	4.5	1.1	0.8	2.5	0.7	2.6	1.0	0.8	0.4	1.4
Obstetrics and Gynaecology[d]	3.5	5.6	21.4	13.6	10.3	9.8	2.5	7.3	28.0	19.9	3.0	3.1	15.5
Orthopaedic surgery	3.0	0.0	6.0	15.9	3.5	2.0	13.8	2.6	14.6	5.5	3.2	0.8	6.7
Psychiatry	0.0	1.9	2.5	0.0	1.3	21.2	0.0	4.5	0.2	4.3	6.5	0.8	3.2
Other hospital-based medical practitioner[e]	5.5	0.0	3.6	2.3	3.8	5.9	2.5	2.6	1.7	2.8	7.4	1.3	3.2
All other specialties[f]	7.5	63.0	47.8	34.1	21.6	19.4	25.0	26.1	26.6	29.0	20.8	2.8	23.7
Not applicable[g]	0.0	0.0	0.8	0.0	0.3	1.8	2.5	0.5	0.2	0.7	1.1	0.0	0.5
Not known	0.5	1.9	0.5	2.3	1.5	2.6	22.5	1.4	1.2	1.8	2.3	86.7	8.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year.

(b) Only the 12 clinician specialty categories that were most frequently recorded for all claims are listed; all other categories are combined in the category *All other specialties*.

(c) Includes both procedural and non-procedural general practitioners.

(d) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.

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

(f) Covers all clinician specialty categories other than the 12 which are individually listed.

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

(h) In the public sector, up to four different specialties may be recorded for each claim, and so some claims are represented in more than one row in the table. Hence the percentage values, which show the proportion of claims with each incident/allegation type for which each clinician specialty was recorded, cannot be summed vertically to give 100%.

Table 3.8: New claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2008 to 30 June 2009

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	33	0	0	0	1	2	0	4	12	3	7	0	62
Cardiology	0	0	1	0	14	0	0	1	9	6	3	0	34
Diagnostic radiology	0	0	1	1	47	0	0	1	6	4	7	0	67
Emergency medicine	0	0	0	0	46	4	1	2	4	27	1	2	87
General and internal medicine	0	0	0	0	12	0	1	2	2	5	4	1	27
General nursing	0	1	1	0	5	9	0	2	1	4	0	1	24
General practice[c]	5	8	13	0	140	49	1	62	65	136	198	13	690
General surgery	0	2	3	0	14	3	1	1	66	13	21	4	128
Obstetrics and Gynaecology[d]	3	0	43	1	41	9	0	8	100	55	12	5	277
Orthopaedic surgery	0	0	4	2	11	1	1	2	65	15	20	2	123
Psychiatry	0	0	1	0	6	14	0	6	0	24	14	4	69
Other hospital-based medical practitioner[e]	1	0	1	0	5	10	1	2	6	8	24	2	60
All other specialties[f]	4	6	83	4	62	29	4	22	194	116	69	8	601
Not applicable[g]	0	0	0	0	0	0	0	0	1	2	2	0	5
Not known	1	0	0	0	14	5	0	4	7	12	6	384	433
Total[h]	**46**	**17**	**151**	**8**	**403**	**131**	**10**	**117**	**523**	**411**	**385**	**423**	**2,625**

(a) Claims that were opened or notified during the financial year.

(b) Only the 12 clinician specialty categories that were most frequently recorded for new claims are listed; all other categories are combined in the category *All other specialties*.

(c) Includes both procedural and non-procedural general practitioners.

(d) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.

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

(f) Covers all clinician specialty categories other than the 12 which are individually listed.

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

(h) This is the total number of claims for which each primary incident/allegation type was recorded. A given specialty may only be recorded once for a single claim in the private sector, but up to four different specialties may be recorded for a public sector claim. Therefore, some public sector claims are represented in more than one row, and so the column totals exceed the number of claims.

Table 3.9: New claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2008 to 30 June 2009 (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[b]	Anaesthetic	Blood/blood product-related	Consent	Device failure	Diagnosis	General duty of care	Infection control	Medication-related	Procedure	Treatment	Other	Not known	Total
Anaesthetics	71.7	0.0	0.0	0.0	0.2	1.5	0.0	3.4	2.3	0.7	1.8	0.0	2.4
Cardiology	0.0	0.0	0.7	0.0	3.5	0.0	0.0	0.9	1.7	1.5	0.8	0.0	1.3
Diagnostic radiology	0.0	0.0	0.7	12.5	11.7	0.0	0.0	0.9	1.1	1.0	1.8	0.0	2.6
Emergency medicine	0.0	0.0	0.0	0.0	11.4	3.1	10.0	1.7	0.8	6.6	0.3	0.5	3.3
General and internal medicine	0.0	0.0	0.0	0.0	3.0	0.0	10.0	1.7	0.4	1.2	1.0	0.2	1.0
General nursing	0.0	0.0	0.7	0.0	1.2	6.9	0.0	1.7	0.2	1.0	0.0	0.2	0.9
General practice[c]	10.9	47.1	8.6	0.0	34.7	37.4	10.0	53.0	12.4	33.1	51.4	3.1	26.3
General surgery	0.0	11.8	2.0	0.0	3.5	2.3	10.0	0.9	12.6	3.2	5.5	0.9	4.9
Obstetrics and Gynaecology[d]	6.5	0.0	28.5	12.5	10.2	6.9	0.0	6.8	19.1	13.4	3.1	1.2	10.6
Orthopaedic surgery	0.0	0.0	2.6	25.0	2.7	0.8	10.0	1.7	12.4	3.6	5.2	0.5	4.7
Psychiatry	0.0	0.0	0.7	0.0	1.5	10.7	0.0	5.1	0.0	5.8	3.6	0.9	2.6
Other hospital-based medical practitioner[e]	2.2	0.0	0.7	0.0	1.2	7.6	10.0	1.7	1.1	1.9	6.2	0.5	2.3
All other specialties[f]	8.7	35.3	55.0	50.0	15.4	22.1	40.0	18.8	37.1	28.2	17.9	1.9	22.9
Not applicable[g]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.5	0.5	0.0	0.2
Not known	2.2	0.0	0.0	0.0	3.5	3.8	0.0	3.4	1.3	2.9	1.6	90.8	16.5
Total[h]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year.

(b) Only the 12 clinician specialty categories that were most frequently recorded for new claims are listed; all other categories are combined in the category *All other specialties*.

(c) Includes both procedural and non-procedural general practitioners.

(d) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.

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

(f) Covers all clinician specialty categories other than the 12 which are individually listed.

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

(h) In the public sector, up to four different specialties may be recorded for each claim, and so some claims are represented in more than one row in the table. Hence the percentage values, which show the proportion of claims with each incident/allegation type for which each clinician specialty was recorded, cannot be summed vertically to give 100%.

3.2 People affected by claims

This section provides a profile of the patients involved in the alleged health-care incident ('age and sex of claim subject') and of the patients' alleged body function/structure affected ('primary body function/structure affected').

Age and sex of claim subject

The age of claim subjects refers to their age at the time of the alleged incident that gave rise to the claim. During 2008–09, 9% (780) of all claims and 4% (93) of new claims related to babies less than 1 year old, between 7% and 8% of both all and new claims (693 and 181 respectively) related to persons 1–17 years of age and 65% of all claims and 60% of new claims (5,970 and 1,572 claims) were related to adults (18+ years of age). The age of the claim subject was not known in 19% (1,730) of all claims and 30% (779) of new claims (tables 3.10 to 3.13). The proportions were similar to those recorded for the 2007–08 reporting period, although the adult proportions were slightly higher (approaching 70% for both all and new claims) and the *Not known* proportions were slightly lower (15% and 22% for all and new claims respectively) for 2007–08 (AIHW 2011a).

The claim subject was female in the majority of all and new claims for the 2008–09 reporting period (as for 2007–08). The greater representation of female than male claim subjects was particularly a feature of claims involving adults. The claim subject was more often male than female for claim subjects aged less than 18 years.

Procedure and *Diagnosis* were the most frequently recorded incident/allegation types for males, respectively accounting for 27% (837) and 26% (802) of all claims, and 21% (157) and 23% (166) of new claims. *Treatment* was also often recorded, for 20% (616) of all claims, and 21% (152) of new claims. With females, *Procedure* was the most common incident/allegation type, recorded for 33% (1,566) of all claims and 27% (342) of new claims. *Diagnosis* and *Treatment* followed in frequency, being respectively recorded for 21% (1,019) and 16% (752) of all claims, and 17% (215) and 19% (246) of new claims. Similar results were found for the 2007–08 claims data (AIHW 2011a).

As in 2007–08, a relatively high proportion of claims with the claim subject recorded as a baby had a primary incident/allegation type of *Treatment*. For 2008–09, this was the case with 30% of all baby claims and 27% of new baby claims. *Diagnosis* on the other hand was more a feature of claims with a person 1–17 years of age as the claim subject, and was recorded for 34% of these claims.

The data on claim subjects' age and sex in previous reports up to 2006–07 in this series (AIHW 2007, 2008, 2010) was not presented in a way that allows many direct comparisons with the 2008–09 data. However, in the case of new claims in 2004–05 and 2005–06, it is noted that the proportion with baby claim subjects varied between 4% and 6%, the proportion involving claim subjects 1–17 years of age was 5%, and the proportion involving adults was 62%, similar to new claims in 2008–09. In addition, a higher proportion of the claims associated with *Treatment* had babies recorded as the claim subject than was the case for claims associated with any other incident/allegation type, for 2005–06 to 2007–08 (comparable data for 2004–05 was not available).

Table 3.10: All claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2008 to 30 June 2009

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	1	2	59	7	69
Blood/blood product-related	3	4	17	1	25
Consent	8	5	57	12	82
Device failure[b]	0	1	7	5	13
Diagnosis	97	137	521	47	802
General duty of care	11	10	134	19	174
Infection control	1	7	16	3	27
Medication-related	7	23	114	13	157
Procedure	123	56	613	45	837
Treatment	117	72	399	28	616
Other	2	33	91	22	148
Not known	14	20	102	63	199
Total males	*384*	*370*	*2,130*	*265*	*3,149*
Row per cent	*12.2*	*11.7*	*67.6*	*8.4*	*100.0*
Females					
Anaesthetic	3	4	96	10	113
Blood/blood product-related	2	1	21	1	25
Consent	3	11	213	32	259
Device failure[b]	1	1	25	1	28
Diagnosis	81	97	790	51	1,019
General duty of care	9	8	198	38	253
Infection control	2	1	31	8	42
Medication-related	9	11	169	15	204
Procedure	126	58	1,285	97	1,566
Treatment	105	64	538	45	752
Other	5	22	215	60	302
Not known	11	8	147	51	217
Total females	*357*	*286*	*3,728*	*409*	*4,780*
Row per cent	*7.5*	*6.0*	*78.0*	*8.6*	*100.0*
Persons[c]					
Anaesthetic	4	6	156	33	199
Blood/blood product-related	5	5	38	6	54
Consent	11	16	272	65	364
Device failure[b]	1	2	32	9	44
Diagnosis	185	237	1,338	175	1,935
General duty of care	22	19	336	132	509
Infection control	3	8	49	20	80
Medication-related	16	37	285	84	422
Procedure	261	115	1,932	219	2,527
Treatment	232	138	957	126	1,453
Other	8	78	313	437	836
Not known	32	32	262	424	750
Total persons	**780**	**693**	**5,970**	**1,730**	**9,173**
Row per cent	**8.5**	**7.6**	**65.1**	**18.9**	**100.0**

(a) Claims that were open at any point during the financial year.

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15).

(c) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Table 3.11: All claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2008 to 30 June 2009 (per cent)

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0.3	0.5	2.8	2.6	2.2
Blood/blood product-related	0.8	1.1	0.8	0.4	0.8
Consent	2.1	1.4	2.7	4.5	2.6
Device failure[b]	0.0	0.3	0.3	1.9	0.4
Diagnosis	25.3	37.0	24.5	17.7	25.5
General duty of care	2.9	2.7	6.3	7.2	5.5
Infection control	0.3	1.9	0.8	1.1	0.9
Medication-related	1.8	6.2	5.4	4.9	5.0
Procedure	32.0	15.1	28.8	17.0	26.6
Treatment	30.5	19.5	18.7	10.6	19.6
Other	0.5	8.9	4.3	8.3	4.7
Not known	3.6	5.4	4.8	23.8	6.3
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Anaesthetic	0.8	1.4	2.6	2.4	2.4
Blood/blood product-related	0.6	0.3	0.6	0.2	0.5
Consent	0.8	3.8	5.7	7.8	5.4
Device failure[b]	0.3	0.3	0.7	0.2	0.6
Diagnosis	22.7	33.9	21.2	12.5	21.3
General duty of care	2.5	2.8	5.3	9.3	5.3
Infection control	0.6	0.3	0.8	2.0	0.9
Medication-related	2.5	3.8	4.5	3.7	4.3
Procedure	35.3	20.3	34.5	23.7	32.8
Treatment	29.4	22.4	14.4	11.0	15.7
Other	1.4	7.7	5.8	14.7	6.3
Not known	3.1	2.8	3.9	12.5	4.5
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[c]					
Anaesthetic	0.5	0.9	2.6	1.9	2.2
Blood/blood product-related	0.6	0.7	0.6	0.3	0.6
Consent	1.4	2.3	4.6	3.8	4.0
Device failure[b]	0.1	0.3	0.5	0.5	0.5
Diagnosis	23.7	34.2	22.4	10.1	21.1
General duty of care	2.8	2.7	5.6	7.6	5.5
Infection control	0.4	1.2	0.8	1.2	0.9
Medication-related	2.1	5.3	4.8	4.9	4.6
Procedure	33.5	16.6	32.4	12.7	27.5
Treatment	29.7	19.9	16.0	7.3	15.8
Other	1.0	11.3	5.2	25.3	9.1
Not known	4.1	4.6	4.4	24.5	8.2
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year.

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15).

(c) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Table 3.12: New claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2008 to 30 June 2009

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0	0	13	3	16
Blood/blood product-related	0	1	6	0	7
Consent	2	0	16	6	24
Device failure[b]	0	0	1	1	2
Diagnosis	8	23	123	12	166
General duty of care	2	4	24	4	34
Infection control	0	2	3	0	5
Medication-related	0	5	32	4	41
Procedure	8	12	124	13	157
Treatment	14	13	117	8	152
Other	0	25	36	11	72
Not known	4	6	32	17	59
Total males	*38*	*91*	*527*	*79*	*735*
Row per cent	*5.2*	*12.4*	*71.7*	*10.7*	*100.0*
Females					
Anaesthetic	1	2	20	4	27
Blood/blood product-related	1	0	9	0	10
Consent	1	3	100	21	125
Device failure[b]	0	0	3	1	4
Diagnosis	16	11	178	10	215
General duty of care	0	2	53	9	64
Infection control	0	0	3	1	4
Medication-related	2	2	51	4	59
Procedure	15	16	290	21	342
Treatment	10	22	188	26	246
Other	0	13	87	31	131
Not known	4	1	41	16	62
Total females	*50*	*72*	*1,023*	*144*	*1,289*
Row per cent	*3.9*	*5.6*	*79.4*	*11.2*	*100.0*
Persons[c]					
Anaesthetic	1	2	33	10	46
Blood/blood product-related	1	1	15	0	17
Consent	3	3	117	28	151
Device failure[b]	0	0	4	4	8
Diagnosis	24	36	304	39	403
General duty of care	2	6	78	45	131
Infection control	0	2	6	2	10
Medication-related	2	9	84	22	117
Procedure	24	28	421	50	523
Treatment	25	35	308	43	411
Other	0	50	123	212	385
Not known	11	9	79	324	423
Total persons	**93**	**181**	**1,572**	**779**	**2,625**
Row per cent	**3.5**	**6.9**	**59.9**	**29.7**	**100.0**

(a) Claims that were opened or notified during the financial year.

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15).

(c) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Table 3.13: New claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2008 to 30 June 2009 (per cent)

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0.0	0.0	2.5	3.8	2.2
Blood/blood product-related	0.0	1.1	1.1	0.0	1.0
Consent	5.3	0.0	3.0	7.6	3.3
Device failure[b]	0.0	0.0	0.2	1.3	0.3
Diagnosis	21.1	25.3	23.3	15.2	22.6
General duty of care	5.3	4.4	4.6	5.1	4.6
Infection control	0.0	2.2	0.6	0.0	0.7
Medication-related	0.0	5.5	6.1	5.1	5.6
Procedure	21.1	13.2	23.5	16.5	21.4
Treatment	36.8	14.3	22.2	10.1	20.7
Other	0.0	27.5	6.8	13.9	9.8
Not known	10.5	6.6	6.1	21.5	8.0
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Anaesthetic	2.0	2.8	2.0	2.8	2.1
Blood/blood product-related	2.0	0.0	0.9	0.0	0.8
Consent	2.0	4.2	9.8	14.6	9.7
Device failure[b]	0.0	0.0	0.3	0.7	0.3
Diagnosis	32.0	15.3	17.4	6.9	16.7
General duty of care	0.0	2.8	5.2	6.3	5.0
Infection control	0.0	0.0	0.3	0.7	0.3
Medication-related	4.0	2.8	5.0	2.8	4.6
Procedure	30.0	22.2	28.3	14.6	26.5
Treatment	20.0	30.6	18.4	18.1	19.1
Other	0.0	18.1	8.5	21.5	10.2
Not known	8.0	1.4	4.0	11.1	4.8
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[c]					
Anaesthetic	1.1	1.1	2.1	1.3	1.8
Blood/blood product-related	1.1	0.6	1.0	0.0	0.6
Consent	3.2	1.7	7.4	3.6	5.8
Device failure[b]	0.0	0.0	0.3	0.5	0.3
Diagnosis	25.8	19.9	19.3	5.0	15.4
General duty of care	2.2	3.3	5.0	5.8	5.0
Infection control	0.0	1.1	0.4	0.3	0.4
Medication-related	2.2	5.0	5.3	2.8	4.5
Procedure	25.8	15.5	26.8	6.4	19.9
Treatment	26.9	19.3	19.6	5.5	15.7
Other	0.0	27.6	7.8	27.2	14.7
Not known	11.8	5.0	5.0	41.6	16.1
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year.

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15).

(c) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Primary body function/structure affected

The 'primary body function/structure affected' specifies the main body function or structure of the claim subject which is alleged to have been affected as a result of the health-care incident. Coding examples for selected categories of this data item are provided in Appendix 3 (Table A3.1).

During the period 2008−09, the most frequently recorded body function/structure affected was *Neuromusculoskeletal and movement-related* which was recorded for 19% (1,721 of 9,173) of all claims and 15% (398 of 2,625) of new claims (figures 3.1 and 3.2). The next two most frequently recorded categories for all claims were *Mental and nervous system* and *Death*, recorded for 15% (1,385) and 13% (1,178) (respectively). For new claims, *Death* and *Digestive, metabolic and endocrine systems* were the second and third most frequently recorded categories, recorded for 11% (288) and 9% (243) of claims (tables 3.14 to 3.17). Those claims where no body function/structure of the claim subject was affected represented 9% (784) of all claims and 11% (281) of new claims.

Data on the affected body function/structure are available for new claims pertaining to the financial years from 2004–05 (AIHW 2007, 2008, 2010, 2011a). In all years, *Neuromusculoskeletal and movement-related* was the most frequently recorded category, and in most years the second most often recorded category was *Mental and nervous system*, but in 2005–06 this place was taken by *Digestive, metabolic and endocrine systems*.

Death was recorded more frequently for male claim subjects being associated with 16% of claims where the subject was male for all claims (513 of 3,149) and 17% for new claims (122 of 735), compared with 11% of both all claims (513 of 4,780 claims) and of new claims (139 of 1,289 claims) where the claim subject was female. Female children had a relatively high proportion of *Death* claims—16% of all claims and 18% of new claims. A higher proportion of claims in 2008–09 than 2007–08 recorded *Death* as the primary body function/structure affected (AIHW 2011a).

The most frequently recorded body function/structure affected for claims with a child or an adult as the claim subject was *Neuromusculoskeletal and movement-related*, regardless of the sex of the claim subject or whether all claims or new claims are considered.

As has been documented for public sector medical indemnity claims (the same information is not available for private sector claims), claims associated with the delivery of obstetric services make up the majority of claims with a baby as the claim subject. For instance, 469 of the 655 public sector claims closed between 2003–04 and 2007–08 with a baby claim subject were obstetric-related (72%). Where the claim subject was a baby, *Mental and nervous system* was by far the most frequently recorded primary body function/structure category, for both sexes and particularly for males (AIHW 2011b). The same distribution was also apparent for 2008–09 public and private sector claims (tables 3.14 to 3.17). The proportion of all baby claims associated with *Mental and nervous system* damage was 53% (413 claims), and 40% for new baby claims (37 claims).

As for 2007–08, the categories *Genitourinary and reproductive* and *Skin and related structures* were recorded for a higher proportion of claims involving female than male adult claim subjects. *Genitourinary and reproductive* was the second most frequent category associated with female adult claims, for both all claims (610 of 3,728 claims, 16%) and new claims (179 of 1,023 claims, 18%). This compares to 16% of all claims and 11% of new claims in 2007–08.

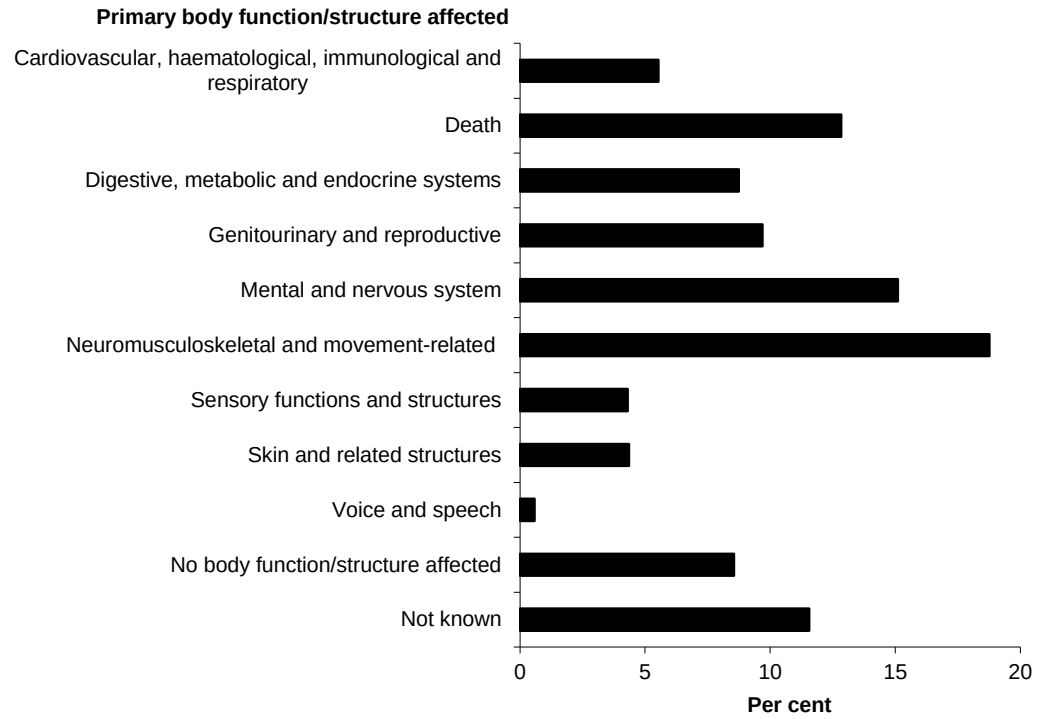

Figure 3.1: All claims: primary body function/structure affected, 1 July 2008 to 30 June 2009 (per cent)

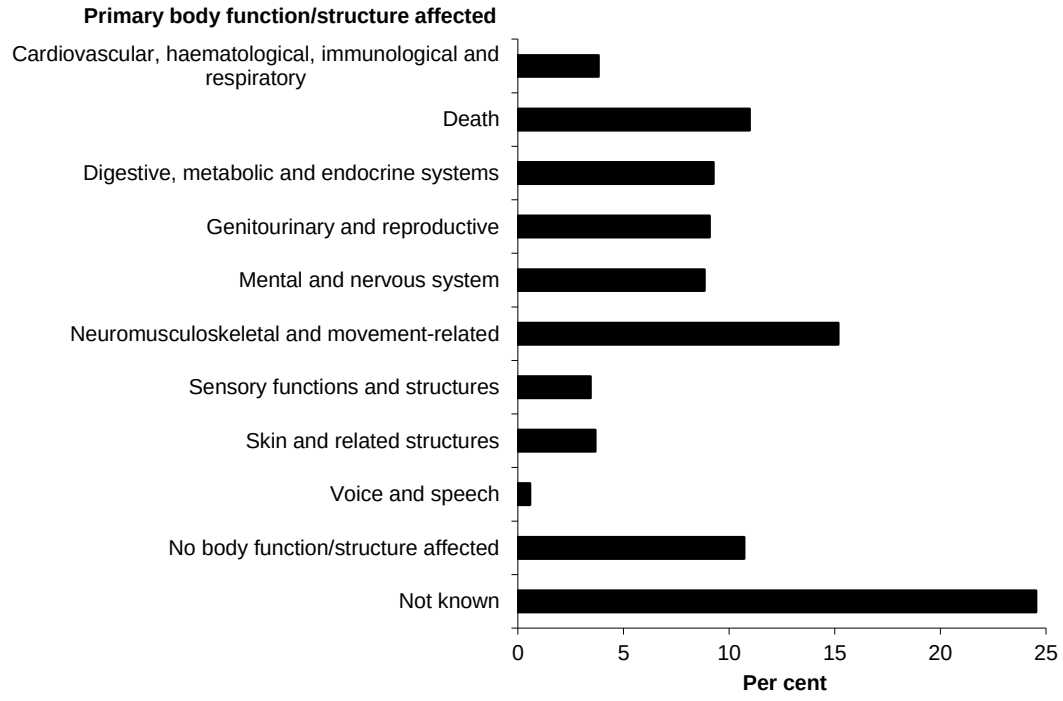

Figure 3.2: New claims: primary body function/structure affected, 1 July 2008 to 30 June 2009 (per cent)

Table 3.14: All claims[a]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2008 to 30 June 2009

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	27	17	153	13	210
Death	26	53	389	45	513
Digestive, metabolic and endocrine systems	8	26	219	22	275
Genitourinary and reproductive	11	30	122	12	175
Mental and nervous system	217	68	239	31	555
Neuromusculoskeletal and movement-related	52	73	527	28	680
Sensory functions and structures	8	20	149	4	181
Skin and related structures	6	13	84	3	106
Voice and speech	2	1	13	2	18
No body function/structure affected	5	41	82	29	157
Not known	22	28	153	76	279
Total males	*384*	*370*	*2,130*	*265*	*3,149*
Row per cent	*12.2*	*11.7*	*67.6*	*8.4*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	21	15	219	11	266
Death	26	47	399	41	513
Digestive, metabolic and endocrine systems	4	23	406	56	489
Genitourinary and reproductive	16	14	610	37	677
Mental and nervous system	180	44	478	52	754
Neuromusculoskeletal and movement-related	80	74	749	50	953
Sensory functions and structures	3	16	163	11	193
Skin and related structures	5	14	235	24	278
Voice and speech	0	1	30	3	34
No body function/structure affected	2	17	189	42	250
Not known	20	21	250	82	373
Total females	*357*	*286*	*3,728*	*409*	*4,780*
Row per cent	*7.5*	*6.0*	*78.0*	*8.6*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	51	32	384	40	507
Death	55	101	799	223	1,178
Digestive, metabolic and endocrine systems	12	49	637	104	802
Genitourinary and reproductive	27	45	740	77	889
Mental and nervous system	413	115	730	127	1,385
Neuromusculoskeletal and movement-related	137	150	1,299	135	1,721
Sensory functions and structures	12	37	315	31	395
Skin and related structures	11	28	328	32	399
Voice and speech	2	2	43	6	53
No body function/structure affected	8	70	274	432	784
Not known	52	64	421	523	1,060
Total persons	**780**	**693**	**5,970**	**1,730**	**9,173**
Row per cent	**8.5**	**7.6**	**65.1**	**18.9**	**100.0**

(a) Claims that were open at any point during the financial year.
(b) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Table 3.15: All claims[(a)]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2008 to 30 June 2009 (per cent)

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	7.0	4.6	7.2	4.9	6.7
Death	6.8	14.3	18.3	17.0	16.3
Digestive, metabolic and endocrine systems	2.1	7.0	10.3	8.3	8.7
Genitourinary and reproductive	2.9	8.1	5.7	4.5	5.6
Mental and nervous system	56.5	18.4	11.2	11.7	17.6
Neuromusculoskeletal and movement-related	13.5	19.7	24.7	10.6	21.6
Sensory functions and structures	2.1	5.4	7.0	1.5	5.7
Skin and related structures	1.6	3.5	3.9	1.1	3.4
Voice and speech	0.5	0.3	0.6	0.8	0.6
No body function/structure affected	1.3	11.1	3.8	10.9	5.0
Not known	5.7	7.6	7.2	28.7	8.9
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	5.9	5.2	5.9	2.7	5.6
Death	7.3	16.4	10.7	10.0	10.7
Digestive, metabolic and endocrine systems	1.1	8.0	10.9	13.7	10.2
Genitourinary and reproductive	4.5	4.9	16.4	9.0	14.2
Mental and nervous system	50.4	15.4	12.8	12.7	15.8
Neuromusculoskeletal and movement-related	22.4	25.9	20.1	12.2	19.9
Sensory functions and structures	0.8	5.6	4.4	2.7	4.0
Skin and related structures	1.4	4.9	6.3	5.9	5.8
Voice and speech	0.0	0.3	0.8	0.7	0.7
No body function/structure affected	0.6	5.9	5.1	10.3	5.2
Not known	5.6	7.3	6.7	20.0	7.8
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[(b)]					
Cardiovascular, haematological, immunological and respiratory	6.5	4.6	6.4	2.3	5.5
Death	7.1	14.6	13.4	12.9	12.8
Digestive, metabolic and endocrine systems	1.5	7.1	10.7	6.0	8.7
Genitourinary and reproductive	3.5	6.5	12.4	4.5	9.7
Mental and nervous system	52.9	16.6	12.2	7.3	15.1
Neuromusculoskeletal and movement-related	17.6	21.6	21.8	7.8	18.8
Sensory functions and structures	1.5	5.3	5.3	1.8	4.3
Skin and related structures	1.4	4.0	5.5	1.8	4.3
Voice and speech	0.3	0.3	0.7	0.3	0.6
No body function/structure affected	1.0	10.1	4.6	25.0	8.5
Not known	6.7	9.2	7.1	30.2	11.6
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year.

(b) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Table 3.16: New claims[a]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2008 to 30 June 2009

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	2	3	33	4	42
Death	2	13	95	12	122
Digestive, metabolic and endocrine systems	0	6	61	14	81
Genitourinary and reproductive	2	5	28	1	36
Mental and nervous system	18	9	40	5	72
Neuromusculoskeletal and movement-related	5	11	123	5	144
Sensory functions and structures	2	4	26	1	33
Skin and related structures	0	1	23	0	24
Voice and speech	0	0	6	1	7
No body function/structure affected	0	27	27	9	63
Not known	7	12	65	27	111
Total males	*38*	*91*	*527*	*79*	*735*
Row per cent	*5.2*	*12.4*	*71.7*	*10.7*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	5	3	45	0	53
Death	4	13	111	11	139
Digestive, metabolic and endocrine systems	1	7	115	33	156
Genitourinary and reproductive	3	2	179	8	192
Mental and nervous system	17	6	110	11	144
Neuromusculoskeletal and movement-related	10	17	190	18	235
Sensory functions and structures	1	4	41	4	50
Skin and related structures	0	2	60	6	68
Voice and speech	0	0	6	2	8
No body function/structure affected	0	9	57	13	79
Not known	9	9	109	38	165
Total females	*50*	*72*	*1,023*	*144*	*1,289*
Row per cent	*3.9*	*5.6*	*79.4*	*11.2*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	7	6	81	6	100
Death	6	26	206	50	288
Digestive, metabolic and endocrine systems	1	13	177	52	243
Genitourinary and reproductive	5	8	208	17	238
Mental and nervous system	37	16	151	28	232
Neuromusculoskeletal and movement-related	16	29	318	35	398
Sensory functions and structures	3	9	70	8	90
Skin and related structures	0	3	85	8	96
Voice and speech	0	0	12	3	15
No body function/structure affected	0	43	84	154	281
Not known	18	28	180	418	644
Total persons	**93**	**181**	**1,572**	**779**	**2,625**
Row per cent	**3.5**	**6.9**	**59.9**	**29.7**	**100.0**

(a) Claims that were opened or notified during the financial year.

(b) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

Table 3.17: New claims[a]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2008 to 30 June 2009 (per cent)

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	5.3	3.3	6.3	5.1	5.7
Death	5.3	14.3	18.0	15.2	16.6
Digestive, metabolic and endocrine systems	0.0	6.6	11.6	17.7	11.0
Genitourinary and reproductive	5.3	5.5	5.3	1.3	4.9
Mental and nervous system	47.4	9.9	7.6	6.3	9.8
Neuromusculoskeletal and movement-related	13.2	12.1	23.3	6.3	19.6
Sensory functions and structures	5.3	4.4	4.9	1.3	4.5
Skin and related structures	0.0	1.1	4.4	0.0	3.3
Voice and speech	0.0	0.0	1.1	1.3	1.0
No body function/structure affected	0.0	29.7	5.1	11.4	8.6
Not known	18.4	13.2	12.3	34.2	15.1
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	10.0	4.2	4.4	0.0	4.1
Death	8.0	18.1	10.9	7.6	10.8
Digestive, metabolic and endocrine systems	2.0	9.7	11.2	22.9	12.1
Genitourinary and reproductive	6.0	2.8	17.5	5.6	14.9
Mental and nervous system	34.0	8.3	10.8	7.6	11.2
Neuromusculoskeletal and movement-related	20.0	23.6	18.6	12.5	18.2
Sensory functions and structures	2.0	5.6	4.0	2.8	3.9
Skin and related structures	0.0	2.8	5.9	4.2	5.3
Voice and speech	0.0	0.0	0.6	1.4	0.6
No body function/structure affected	0.0	12.5	5.6	9.0	6.1
Not known	18.0	12.5	10.7	26.4	12.8
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	7.5	3.3	5.2	0.8	3.8
Death	6.5	14.4	13.1	6.4	11.0
Digestive, metabolic and endocrine systems	1.1	7.2	11.3	6.7	9.3
Genitourinary and reproductive	5.4	4.4	13.2	2.2	9.1
Mental and nervous system	39.8	8.8	9.6	3.6	8.8
Neuromusculoskeletal and movement-related	17.2	16.0	20.2	4.5	15.2
Sensory functions and structures	3.2	5.0	4.5	1.0	3.4
Skin and related structures	0.0	1.7	5.4	1.0	3.7
Voice and speech	0.0	0.0	0.8	0.4	0.6
No body function/structure affected	0.0	23.8	5.3	19.8	10.7
Not known	19.4	15.5	11.5	53.7	24.5
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year.
(b) 'Persons' includes claims for which sex of claim subject was indeterminate or unknown.

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

3.3 Duration of claims

The start date for measuring the duration of a claim is either the date the claim first had a reserve placed (public sector claims) or the date the claim was reported by the insured medical practitioner to a private insurer (private sector claims). The end date for measuring claim duration is either 30 June 2009 (for claims still open at this time) or the date the claim was closed (for claims closed between 1 July 2008 and 30 June 2009).

Of the claims open at the end of the period, 30% (1,797 of 6,080) had been open for less than 6 months, 66% (4,012 of 6,080) for less than 2 years and 79% (4,777 of 6,080) for less than 3 years (tables 3.18 and 3.19). These proportions were higher than those recorded for the 2007–08 reporting period, which were 20%, 60% and 66% respectively (AIHW 2011a). For the 2008–09 period, 9% (551 of 6,080 claims) had been open after more than 5 years' duration, the same proportion as for 2007−08.

Of the claims closed during the period, 8% (237 of 3,093) had been open for less than 6 months, 50% (1,548 of 3,093) for less than 2 years and 72% (2,226 of 3,093) for less than 3 years (tables 3.18 and 3.19). There were 9% (292 of 3,093) that had been open for over 5 years. In comparison, a lower proportion of claims closed in 2007–08 had been open for up to 2 years (34%), but the proportion that had been open for up to 3 years was similar (66%).

3.4 Reserve range of current claims

The 'reserve range' of a claim is the estimated cost, in broad dollar ranges, which is set by the jurisdictional authority or MII against each claim. Tables 3.20 and 3.21 present data relating the reserve range of current claims to their duration.

About 70% of claims (4,230) had a reserve of less than $100,000, including 34% (2,079 claims) with a reserve of less than $10,000. There were 462 current claims (8%) with a reserve set between $250,000 and <$500,000 and 559 (9%) with a reserve set at $500,000 or above.

For claims with a reserve set at less than $10,000 two-thirds (1,374 of 2,079 claims) had been open for less than 1 year, contrasting with the 5% (107 claims) open for more than 4 years and 3% (68 claims) open for more than 5 years.

Claims with their reserve set at $250,000 to <$500,000, and especially $500,000 or more, tended to have remained open for a longer period of time than other current claims. The proportions of these claims open for more than 5 years were respectively 13% in the $250,000 to <$500,000 range (60 of 462 claims) and 32% of those reserved for at least $500,000 (180 of 559 claims).

The proportions stated above are similar to those recorded for 2007−08 (AIHW 2011a).

Table 3.18: All claims: status of claim by duration of claim (months), at 30 June 2009

	Duration of claim at 30 June 2009 (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 2008 – 30 June 2009)	1,730	895	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2,625
Reopened	13	10	20	22	17	35	25	17	20	11	72	262
Closed	237	538	437	336	347	331	230	132	112	101	292	3,093
Claims open at 30 June 2009	1,797	1,000	678	537	395	370	248	201	174	129	551	6,080

n.a. Not applicable.

Notes

1. Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report'. For closed claims it is calculated to the date the claim was closed, and for other claims to 30 June 2009.
2. Closed claims in the MII collection include claims that are closed and no more payments are expected, or all recoveries expected from third parties other than reinsurers have been received.
3. Reopened claims include claims that have previously been recorded as closed, but have then been re-opened and are active.

Table 3.19: All claims: status of claim by duration of claim (months), at 30 June 2009 (per cent)

	Duration of claim at 30 June 2009 (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 2008 – 30 June 2009)	65.9	34.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	100.0
Reopened	5.0	3.8	7.6	8.4	6.5	13.4	9.5	6.5	7.6	4.2	27.5	100.0
Closed	7.7	17.4	14.1	10.9	11.2	10.7	7.4	4.3	3.6	3.3	9.4	100.0
Claims open at 30 June 2009	29.6	16.4	11.2	8.8	6.5	6.1	4.1	3.3	2.9	2.1	9.1	100.0

n.a. Not applicable.

Notes

1. Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report'. For closed claims it is calculated to the date the claim was closed, and for other claims to 30 June 2009.
2. Closed claims in the MII collection include claims that are closed and no more payments are expected, or all recoveries expected from third parties other than reinsurers have been received.
3. Reopened claims include claims that have previously been recorded as closed, but have then been reopened and are active.
4. Percentages may not add up exactly to 100.0 due to rounding.

Table 3.20: Current claims[a]: reserve range by duration of claim (months), at 30 June 2009

	Duration of claim[b]											
Reserve range	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Less than $10,000	1,096	278	245	125	86	68	43	31	23	16	68	2,079
$10,000–<$30,000	245	207	134	111	91	75	43	38	23	13	50	1,030
$30,000–<$50,000	68	69	48	49	28	26	17	10	16	9	22	362
$50,000–<$100,000	133	155	93	92	57	58	35	22	25	19	70	759
$100,000–<$250,000	144	136	83	86	61	55	49	50	41	21	101	827
$250,000–<$500,000	75	98	35	37	35	38	25	24	20	15	60	462
$500,000 or more	35	57	39	37	37	50	36	26	26	36	180	559
Total[c]	**1,797**	**1,000**	**678**	**537**	**395**	**370**	**248**	**201**	**174**	**129**	**551**	**6,080**

(a) Current claims are claims that are open, including reopened claims, at 30 June 2009.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to 30 June 2009.
(c) There were two private sector claims where the reserve range was not known. These claims are included in the totals for 'duration of claim' even though the *Not known* row is not presented.

Table 3.21: Current claims[a]: reserve range by duration of claim (months), at 30 June 2009 (per cent)

	Duration of claim[b]											
Reserve range	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Less than $10,000	52.7	13.4	11.8	6.0	4.1	3.3	2.1	1.5	1.1	0.8	3.3	100.0
$10,000–<$30,000	23.8	20.1	13.0	10.8	8.8	7.3	4.2	3.7	2.2	1.3	4.9	100.0
$30,000–<$50,000	18.8	19.1	13.3	13.5	7.7	7.2	4.7	2.8	4.4	2.5	6.1	100.0
$50,000–<$100,000	17.5	20.4	12.3	12.1	7.5	7.6	4.6	2.9	3.3	2.5	9.2	100.0
$100,000–<$250,000	17.4	16.4	10.0	10.4	7.4	6.7	5.9	6.0	5.0	2.5	12.2	100.0
$250,000–<$500,000	16.2	21.2	7.6	8.0	7.6	8.2	5.4	5.2	4.3	3.2	13.0	100.0
$500,000 or more	6.3	10.2	7.0	6.6	6.6	8.9	6.4	4.7	4.7	6.4	32.2	100.0
Total[c]	**29.5**	**16.5**	**11.1**	**8.8**	**6.5**	**6.1**	**4.1**	**3.3**	**2.9**	**2.1**	**9.1**	**100.0**

(a) Current claims are claims that are open, including reopened claims, at 30 June 2009.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to 30 June 2009.
(c) There were two private sector claims where the reserve range was not known. These claims are included in the totals for 'duration of claim' even though the *Not known* row is not presented.

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

3.5 Total claim size of closed claims

The 'total claim size' is the total amount paid to the claimant, as well as any legal or investigative defence costs, recorded in broad dollar ranges for closed claims (following a negotiated outcome, a court order or a decision by the claim manager to discontinue a claim). The amount paid to the claimant includes any interim payments and may include claimant legal costs. Tables 3.22 and 3.23 present data relating the claim size to the duration of closed claims.

There were 2,034 claims (accounting for two-thirds of claims) closed for less than $10,000, including 30% (928 of 3,093 claims) closed for no payment. Just 136 claims (accounting for 4% of closed claims) were settled for over $500,000.

The most common duration of claims closed for no cost was between 6 and 12 months, accounting for 26% of them (244 of 928 claims). The proportions of these no-cost claims settled within 6 months or taking over 4 years to settle were small, respectively 10% (96 claims) and 5% (43 claims).

Half of claims closed for a payment of less than $10,000 (551 of 1,106 claims) were settled in a time frame between 6 months and 2 years, as were 40% of claims settled for between $10,000 and <$30,000 (117 of 291 claims).

A duration of 5 years or more was recorded for 18% (39 of 215 claims) of claims settled for $100,000 to <$250,000, 29% (33 of 114 claims) of claims settled for between $250,000 and <$500,000, and 37% (50 of 136 claims) of claims settled for $500,000 or more. Similar results were obtained for 2007–08, when a duration of 5 years or more was recorded for 21% of claims settled for $100,000 to <$250,000, 25% of claims settled for between $250,000 and <$500,000, and 41% of claims settled for $500,000 or more.

Table 3.22: Closed claims[a]: total claim size by duration of claim (months), 1 July 2008 to 30 June 2009

	Duration of claim[b]											
Total claim size	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Nil	96	244	121	86	119	110	86	23	9	5	29	928
$1−<$10,000	128	216	196	139	118	101	62	28	26	30	62	1,106
$10,000–<$30,000	6	44	29	44	27	39	22	24	11	8	37	291
$30,000–<$50,000	1	4	21	15	27	6	9	7	7	8	18	123
$50,000–<$100,000	3	16	26	16	21	16	17	13	16	10	24	178
$100,000–<$250,000	1	8	26	17	21	30	16	23	15	19	39	215
$250,000–<$500,000	2	4	10	11	5	16	6	8	12	7	33	114
$500,000 or more	0	2	7	8	9	13	11	6	16	14	50	136
Total[c]	**237**	**538**	**437**	**336**	**347**	**331**	**230**	**132**	**112**	**101**	**292**	**3,093**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to the date when the claim was closed.

(c) There were one private sector claim and one public sector claim where the total claim size was not known. These claims are included in the totals for 'duration of claim' even though the *Not known* row is not presented.

Table 3.23: Closed claims[a]: total claim size by duration of claim (months), 1 July 2008 to 30 June 2009 (per cent)

	Duration of claim[b]											
Total claim size	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Nil	10.3	26.3	13.0	9.3	12.8	11.9	9.3	2.5	1.0	0.5	3.1	100.0
$1−<$10,000	11.6	19.5	17.7	12.6	10.7	9.1	5.6	2.5	2.4	2.7	5.6	100.0
$10,000–<$30,000	2.1	15.1	10.0	15.1	9.3	13.4	7.6	8.2	3.8	2.7	12.7	100.0
$30,000–<$50,000	0.8	3.3	17.1	12.2	22.0	4.9	7.3	5.7	5.7	6.5	14.6	100.0
$50,000–<$100,000	1.7	9.0	14.6	9.0	11.8	9.0	9.6	7.3	9.0	5.6	13.5	100.0
$100,000–<$250,000	0.5	3.7	12.1	7.9	9.8	14.0	7.4	10.7	7.0	8.8	18.1	100.0
$250,000–<$500,000	1.8	3.5	8.8	9.6	4.4	14.0	5.3	7.0	10.5	6.1	28.9	100.0
$500,000 or more	0.0	1.5	5.1	5.9	6.6	9.6	8.1	4.4	11.8	10.3	36.8	100.0
Total[c]	**7.7**	**17.4**	**14.1**	**10.9**	**11.2**	**10.7**	**7.4**	**4.3**	**3.6**	**3.3**	**9.4**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to the date when the claim was closed.

(c) There were one private sector claim and one public sector claim where the total claim size was not known. These claims are included in the totals for 'duration of claim' even though the *Not known* row is not presented.

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

3.6 Mode of claim finalisation

A claim can be finalised through a variety of processes, such as a court decision, negotiation or discontinuation (including the claim being withdrawn by the claimant). The definition of these finalisation modes is provided in Appendix 3 (Table A3.3). Of the 3,093 claims closed between 1 July 2008 and 30 June 2009, 174 (6%) were finalised through a court decision, 903 (29%) were finalised through negotiation and 2,013 (65%) were discontinued (tables 3.24 and 3.25).

Discontinuation was the most frequently recorded mode of finalisation for claims closed for no payment or for a payment of less than $30,000. The respective proportions are 94% (869 of 928) claims closed for no payment and 75% (1,044 of 1,397) claims closed for a payment of less than $30,000. Discontinuation was rarely recorded for claims closed for $50,000 or more (51 of 643 claims, or 8%).

Claims with their claim size in a category above $50,000 were generally settled through negotiation, as was the case for 84% (540) of these claims.

Court decisions were the least frequently recorded mode of claim finalisation for the 2008–09 reporting period, especially if the claim size was less than $10,000. The proportion of closed claims finalised via a court decision was 6% (174 of 3,090 claims), and was 3% (31 of 928) when no payment was made.

Table 3.24: Closed claims[a]: total claim size by mode of claim finalisation, 1 July 2008 to 30 June 2009

	Mode of claim finalisation[b]				
Total claim size	Court decision	Negotiated	Discontinued	Total[c]	Column per cent
Nil	31	27	869	928	30.0
$1–<$10,000	58	178	870	1,106	35.8
$10,000–<$30,000	23	94	174	291	9.4
$30,000–<$50,000	10	64	49	123	4.0
$50,000–<$100,000	18	122	38	178	5.8
$100,000–<$250,000	17	190	8	215	7.0
$250,000–<$500,000	7	105	2	114	3.7
$500,000 or more	10	123	3	136	4.4
Total	**174**	**903**	**2,013**	**3,093**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Refer to *Appendix 1: Data items and definitions* for an explanation of mapping between the MINC and ISA collections for the different modes of claim finalisation.

(c) Total excludes two private sector claims and one public sector claim where the mode of finalisation was not known, including two claims where the total claim size was not known. These claims are included in the totals even though the *Not known* row and column are not presented.

Note: The percentage does not add up exactly to 100.0 due to rounding.

Table 3.25: Closed claims[a]: total claim size by mode of claim finalisation, 1 July 2008 to 30 June 2009 (per cent)[b]

	Mode of claim finalisation[c]			
Total claim size	Court decision	Negotiated	Discontinued	All closed claims
Nil	3.3	2.9	93.7	100.0
$1–<$10,000	5.2	16.1	78.7	100.0
$10,000–<$30,000	7.9	32.3	59.8	100.0
$30,000–<$50,000	8.1	52.0	39.8	100.0
$50,000–<$100,000	10.1	68.5	21.3	100.0
$100,000–<$250,000	7.9	88.4	3.7	100.0
$250,000–<$500,000	6.1	92.1	1.8	100.0
$500,000 or more	7.4	90.4	2.2	100.0
Total	**5.6**	**29.2**	**65.1**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Percentages are calculated on the basis of the 3,090 claims with known mode of finalisation.

(c) Refer to *Appendix 1: Data items and definitions* for an explanation of mapping between the MINC and ISA collections for the different modes of claim finalisation.

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

3.7 Closed claims: specialty of clinician

Claims closed between 1 July 2008 and 30 June 2009 were very similar to all claims and new claims during the period in terms of which clinician specialties were most frequently recorded amongst these claims (see Section 3.1). *General practice* and *Obstetrics and Gynaecology* were recorded for 18% and 14% (550 and 446 respectively) of closed claims. The other frequently recorded specialties were *General surgery*, *Emergency medicine* and *Orthopaedic surgery* (250, 242 and 231 claims respectively), each associated with 7–8% of claims (tables 3.26 and 3.27). All other specialities, which include all specialities other than the 12 that are individually listed, were recorded for 23% of closed claims. The most frequently recorded clinician specialties and proportions of claims against each clinician specialty were similar to those in 2007–08 (AIHW 2011a).

3.8 Closed claims: health service setting

The proportions of closed claims related to the various health service settings (tables 3.28 and 3.29) were similar to the proportions recorded for all and new claims, over the period from 1 July 2008 to 30 June 2009 (see Section 3.1). First was *Public hospital or day surgery*, accounting for 57% (1,748) of closed claims. This category was followed by *Private medical clinic*, recorded for 19% (573) of closed claims, and *Private hospital or day surgery*, recorded for 14% (439) of closed claims.

As previously noted, 30% of closed claims did not involve any payment (Table 3.24). This was the case with just over one-third of the claims in *Private hospital or day surgery* (156 of 439 claims, 36%) and *Private medical clinic* (202 of 573 claims, 35%). When all of the public health service settings are combined, there were 22% (400 of 1,793 claims) closed for no payment, compared with 35% (379 of 1,085 claims) in private settings where no payment was made.

Claims with a total claim size of less than $10,000 represented 66% (2,034 of 3,093 claims) of closed claims during 2008–09 including 80% (457 of 573 claims) of claims associated with a *Private medical clinic* and 68% (298 of 439 claims) associated with a *Private hospital/day surgery*.

Settled claims with a claim size of $100,000 or more accounted for 465 (15%) of all closed claims. These claims made up a larger proportion of claims associated with public settings (371 of 1,793 claims, 21%) than claims associated with private settings (85 of 1,085 claims, 8%). However, some or all of this discrepancy may be due to different claim management practices between the two sectors. As noted in Section 2.2, public sector claim sizes generally reflect the costs associated with all providers associated with a single health-care incident, whereas in the private sector the costs arising from a single incident may be spread across several claims.

Table 3.26: Closed claims[a]: specialties of clinicians involved by total claim size, 1 July 2008 to 30 June 2009

	Total claim size								
Specialty of clinician(s)[b]	**Nil**	**$1– <$10,000**	**$10,000– <$30,000**	**$30,000– <$50,000**	**$50,000– <$100,000**	**$100,000– <$250,000**	**$250,000– <$500,000**	**$500,000 or more**	**Total[c]**
Anaesthetics	36	44	8	3	1	4	2	2	100
Diagnostic radiology	36	28	7	5	6	6	1	4	93
Emergency medicine	52	72	23	7	20	28	15	25	242
General and internal medicine	14	24	10	0	6	2	1	3	60
General nursing	15	14	15	5	5	5	2	3	64
General practice[d]	159	224	54	27	35	33	10	8	550
General surgery	46	110	27	10	15	25	8	9	250
Neurosurgery	8	22	6	0	4	2	2	3	47
Obstetrics and Gynaecology[e]	103	165	46	17	26	33	18	38	446
Orthopaedic surgery	51	73	19	15	16	28	16	12	231
Psychiatry	19	54	9	2	5	4	4	3	100
Other hospital-based medical practitioner[f]	13	42	16	5	6	4	6	3	95
All other specialties[g]	221	245	72	29	38	53	30	35	723
Not applicable[h]	12	2	0	1	2	0	1	0	18
Not known	157	35	4	2	4	3	7	4	217
Total[i]	**928**	**1,106**	**291**	**123**	**178**	**215**	**114**	**136**	**3,093**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Only the 12 clinician specialty categories that were most frequently recorded for closed claims are listed; all other categories are combined in the category *All other specialties*.

(c) There were one private sector claim and one public sector claim where the total claim size was not known. These claims are included in the totals for 'specialty of clinician(s)' even though the *Not known* column is not presented.

(d) Includes both procedural and non-procedural general practitioners.

(e) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.

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

(g) Covers all clinician specialty categories other than the 12 which are individually listed.

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

(i) This is the total number of claims for which each claim size was recorded. A given specialty may only be recorded once for a single claim in the private sector, but up to four different specialties may be recorded for a public sector claim. Therefore, some public sector claims are represented in more than one row, and so the column totals exceed the number of claims.

Table 3.27: Closed claims[a]: specialties of clinicians involved by total claim size, 1 July 2008 to 30 June 2009 (per cent)

	Total claim size								
Specialty of clinician(s)[b]	**Nil**	**$1–< $10,000**	**$10,000–<$30,000**	**$30,000–<$50,000**	**$50,000–<$100,000**	**$100,000–<$250,000**	**$250,000–<$500,000**	**$500,000 or more**	**Total**
Anaesthetics	3.9	4.0	2.7	2.4	0.6	1.9	1.8	1.5	3.2
Diagnostic radiology	3.9	2.5	2.4	4.1	3.4	2.8	0.9	2.9	3.0
Emergency medicine	5.6	6.5	7.9	5.7	11.2	13.0	13.2	18.4	7.8
General and internal medicine	1.5	2.2	3.4	0.0	3.4	0.9	0.9	2.2	1.9
General nursing	1.6	1.3	5.2	4.1	2.8	2.3	1.8	2.2	2.1
General practice[c]	17.1	20.3	18.6	22.0	19.7	15.3	8.8	5.9	17.8
General surgery	5.0	9.9	9.3	8.1	8.4	11.6	7.0	6.6	8.1
Neurosurgery	0.9	2.0	2.1	0.0	2.2	0.9	1.8	2.2	1.5
Obstetrics and Gynaecology[d]	11.1	14.9	15.8	13.8	14.6	15.3	15.8	27.9	14.4
Orthopaedic surgery	5.5	6.6	6.5	12.2	9.0	13.0	14.0	8.8	7.5
Psychiatry	2.0	4.9	3.1	1.6	2.8	1.9	3.5	2.2	3.2
Other hospital-based medical practitioner[e]	1.4	3.8	5.5	4.1	3.4	1.9	5.3	2.2	3.1
All other specialties[f]	23.8	22.2	24.7	23.6	21.3	24.7	26.3	25.7	23.4
Not applicable[g]	1.3	0.2	0.0	0.8	1.1	0.0	0.9	0.0	0.6
Not known	16.9	3.2	1.4	1.6	2.2	1.4	6.1	2.9	7.0
Total[h]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Only the 12 clinician specialty categories that were most frequently recorded for closed claims are listed; all other categories are combined in the category *All other specialties*.

(c) Includes both procedural and non-procedural general practitioners.

(d) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.

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

(f) Covers all clinician specialty categories other than the 12 which are individually listed.

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

(h) In the public sector, up to four different specialties may be recorded for each claim, and so some claims are represented in more than one row in the table. Hence the percentage values, which show the proportion of claims of each claim size for which each clinician specialty was recorded, cannot be summed vertically to give 100%.

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

Table 3.28: Closed claims[a]: total claim size by health service setting, 1 July 2008 to 30 June 2009

	Health service setting							
Total claim size	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Nil	385	15	156	202	21	10	139	928
$1–<$10,000	617	17	142	255	37	17	21	1,106
$10,000–<$30,000	180	5	39	49	5	7	6	291
$30,000–<$50,000	73	2	24	19	2	1	2	123
$50,000–<$100,000	124	3	27	17	4	3	0	178
$100,000–<$250,000	160	2	28	21	2	1	1	215
$250,000–<$500,000	92	0	13	8	0	0	1	114
$500,000 or more	117	0	9	2	2	0	6	136
Total[h]	**1,749**	**44**	**439**	**573**	**73**	**39**	**176**	**3,093**
Per cent	*56.5*	*1.4*	*14.2*	*18.5*	*2.4*	*1.3*	*5.7*	*100.0*

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.

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

(g) Includes patient's home and 'Medihotels'.

(h) There were one private sector claim and one public sector claim where the total claim size was not known. These claims are included in the totals for 'health service setting' even though the *Not known* column is not presented.

Note: Public sector claims can arise from incidents in private sector health settings and vice versa. Therefore, the number of claims in public settings and private settings does not equal the respective number of public sector and private sector claims. See Table 3.1 for numbers of public sector and private sector claims.

Table 3.29: Closed claims[a]: total claim size by health service setting, 1 July 2008 to 30 June 2009 (per cent)[b]

	Health service setting							
Total claim size	**Public hospital/day surgery[c]**	**Other public setting[d]**	**Private hospital/day surgery[e]**	**Private medical clinic[f]**	**Other private setting[g]**	**Other[h]**	**Not known**	**Total**
Nil	22.0	34.1	35.6	35.3	28.8	25.6	79.0	30.0
$1–<$10,000	35.3	38.6	32.4	44.5	50.7	43.6	11.9	35.8
$10,000–<$30,000	10.3	11.4	8.9	8.6	6.8	17.9	3.4	9.4
$30,000–<$50,000	4.2	4.5	5.5	3.3	2.7	2.6	1.1	4.0
$50,000–<$100,000	7.1	6.8	6.2	3.0	5.5	7.7	0.0	5.8
$100,000–<$250,000	9.2	4.5	6.4	3.7	2.7	2.6	0.6	7.0
$250,000–<$500,000	5.3	0.0	3.0	1.4	0.0	0.0	0.6	3.7
$500,000 or more	6.7	0.0	2.1	0.3	2.7	0.0	3.4	4.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2008 and 30 June 2009.

(b) Percentages are calculated on the basis of the 3,091 claims with known total claim size.

(c) Includes public psychiatric hospitals.

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

(e) Includes private psychiatric hospitals.

(f) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.

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

(h) Includes patient's home and 'Medihotels'.

Notes

1. Public sector claims can arise from incidents in private sector health settings and vice versa. Therefore, the number of claims in public settings and private settings does not equal the respective number of public sector and private sector claims. See Table 3.1 for numbers of public sector and private sector claims.

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

Appendix 1: Data items and definitions

Insurance Statistics Australia (ISA) receives claims data from several MIIs and then transmits the data to the AIHW. Accordingly, only those data items which are compatible between the ISA database and the MINC (Table A1.1) are available for inclusion in combined sector medical indemnity reports. Table A1.2, which follows, provides definitions of key terms used in this report as endorsed by the MINC CC.

Table A1.1: MINC and ISA data items used for this report

MINC data item	ISA data item	Definition of MINC and ISA data items and explanation of mapping between collections
4 Claim subject's year of birth	36 Claimant/patient 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'.
5 Claim subject's sex	37 Claimant/patient sex	Sex of the claim subject.
6a Primary incident/allegation type	15 Cause of loss	Description of the area of alleged error, negligence or problem that primarily gave rise to the claim. There is concordance between the ISA and the MINC data item.
8a Primary body function/structure affected	16 Body functions or structures affected	The primary body function or structure of the claim subject alleged to have been affected. There is concordance between these items. Death is not included in the ISA item, instead being identified using ISA item 17, 'Severity of injury – Patient dies from this incident'.
10 Date incident occurred	9 Date of loss	Date the alleged harm occurred.
12 Health service setting	14.3 Venue where procedure performed	The venue where health care was delivered, whether public or private sector or other, whether a hospital/day surgery or other. There is concordance between these items.
14 Specialties of clinicians closely involved in incident	14.2 Specialty 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. The categories for 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 specialty they are training in, and classifies interns with 'other hospital-based medical practitioners'.

(continued)

Table A1.1 (continued): MINC and ISA data items used for this report

MINC data item	ISA data item	Definition of MINC and ISA data items and explanation of mapping between collections
15 Date reserve placed	10 Date of report	This ISA item is the date on which the matter is notified to the insurer. It may occur slightly before or after the date that the MII sets a reserve, which corresponds to 'date reserve placed' in the MINC. Because of this potential discrepancy these two data items are not identical.
16 Reserve range	20 Gross payments to date 22 Gross case estimate at end of reporting period	Estimate of the cost of the claim upon its finalisation. For current claims, the ISA items divide the reserve amount between the amount already paid and the amount expected to be paid. Addition of these two dollar amounts produces the reserve estimate, which can be mapped to MINC ranges.
18 Date claim file closed	11 Date finalised	Calendar month and year in which the claim was settled, or a final court decision was delivered or when the claim file was closed because the claim had been inactive for a long time.
19 Mode of claim finalisation 1 Settled through state/territory-based complaints processes 2 Settled through court-based alternative dispute resolution processes 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 The mapping is not exact because a claim may be withdrawn as part of an active settlement process rather than through discontinuation of an inactive claim.
20 Total claim size	20 Gross payments to date	The amount to be paid to the claimant in settlement of the claim, plus defence legal and investigation costs, recorded in broad dollar ranges. ISA records exact dollar amounts. These were mapped to MINC ranges.
21 Status of claim 20 Commenced (not yet finalised) 30 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 Closed R for Reopened	Status of the claim in terms of the stage in the process from commencement to finalisation. MINC category 20 maps to ISA 'C'. MINC categories 30, 32 and 33 map to ISA 'F'. MINC 40 maps to ISA 'R'.

Table A1.2: 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 has made the claim. The claimant may be the **claim subject** or some **other party** claiming for loss allegedly resulting from harm involving health care.
Claim subject	The person who received the health-care service and was involved in the incident that is the basis for the claim, and who suffered and may have suffered loss as a result of harm.
Current claim	A claim that has yet to be finalised.
Closed claim	Public sector – A claim which has been closed (total claim size determined), settled or where a final court decision has been made, including claims finalised with total claim size yet to be determined. Medical indemnity insurers – A claim for which no more payments are expected and all expected recoveries have been received from third parties other than reinsurers.
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 or territory government. A health-care facility insured under state or territory insurance arrangements.
Loss	Any adverse consequence of the alleged harm experienced by the claimant, including financial loss.
Medical indemnity	A form of professional liability insurance specific to the provision of health care.
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, which, 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 of **health care** but claiming **loss** allegedly resulting from health care.
Reopened claim	A current claim that had been previously categorised as **closed**.

Appendix 2: Public and private sector claim management practices

The public sector

Arrangements for public sector medical indemnity insurance are governed by state and territory legislation and associated policies. Claim management practices vary between jurisdictions, and in some jurisdictions there are different processes for small and large claims. Claims are managed in-house by the state or territory health authority for some jurisdictions; in others, a body independent from the health authority manages claims. Some legal work may be outsourced to private law firms. A full explanation of the policy, administrative, and legal features of each jurisdiction is available in *Australia's public sector medical indemnity claims 2008–09* (AIHW 2011c).

An allegation of harm or, in some jurisdictions, a health-care incident that could lead to a public sector medical indemnity claim is notified to the state or territory claims management body by the health facility concerned. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of settling the claim. 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, or the defendant may make an offer to a claimant to settle a matter before a writ or letter has been issued. As a claim progresses the reserve is monitored and adjusted if necessary.

In the public sector, the defendant of a claim is typically the health authority responsible for having employed or contracted the health-care professional(s) alleged to have been negligent in the performance of their duties. Accordingly the allegation of harm usually gives rise to a single claim even if more than one health-care professional is involved. This is a different practice from the private sector where a single claimant can generate multiple claims—one for each clinician being sued. Another difference is that nurses and administrative staff, who would generally be hospital employees rather than individually insured clinicians in terms of private sector medical indemnification, may well be amongst the professionals involved in public sector claims. However, some jurisdictions report claims against private clinicians working in public hospitals as well as claims against the hospital (and employees of the hospital).

Most public sector records within the MINC correspond to a single claim related to a claimant, usually the 'claim subject' but sometimes a dependent or other relative. Where there are two claimants, the claim subject and one other party, this would also be treated as a single claim. However, there is more variation where the claimants are multiple other parties, in which case the jurisdiction may record multiple claims, or a single claim as for a 'class action'.

A public sector 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 through a mandated conference process must be attempted before a claim can go to court. In some cases, a settlement is agreed between the claimant and defendant, independent of any formal process. In addition, a claim file that has remained inactive for a long time may be closed. Claims that have been closed can subsequently be reopened.

The private sector

MIIs provide professional indemnity insurance to individual clinicians. Typically, a separate claim is opened for each clinician implicated in the allegation of loss or harm. This is so the relevant proportion of the overall cost of claims can be allocated against the policy limits of individual clinicians, and is an explicit requirement of both the High Cost Claims Scheme and the Exceptional Claims Scheme. (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. The Exceptional Claims Scheme is the Australian Government's scheme to cover clinicians 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 clinicians are not personally liable for 'blue sky' claims.) Also, claims related to a single allegation of loss or harm could appear on more than one MII database when individual defendants hold medical indemnity insurance with different insurers. Where a public hospital is involved, claims may appear on both MII and health authority databases.

As a result of the above, the reported cost of an individual claim in the private sector may not reflect the total payment made by each insurer in respect of the claimant(s). Also, the reported number of claims cannot be assumed to equal the number of clinical incidents leading to claims against insured clinicians.

MIIs derive an estimate for the likely cost of a claim. This is referred to as the 'reserve', which is the expected total amount of payment to be made on behalf of the insured clinician. It takes into account estimated payments to be made by any other clinicians and institutions (for example, hospitals) involved. Estimated plaintiff and defendant legal costs are included in the reserve. Estimates are reviewed regularly. When the claim is closed, the incurred cost represents all costs paid (usually, on behalf of a single insured) in respect of the claim including legal costs.

'Potential claims' in the private sector claims are considered in scope for the purposes of this report if preparatory legal expenses have been incurred and the claim has been reported to APRA. They are not included if the only action taken is to record an estimate relating to a possible claim that may ensue against an insured clinician.

MIIs charge different premiums for different clinical specialties based on the complexity of the medical procedures typically performed by the insured clinician (ACCC 2009). In addition, private sector clinicians are not covered to practise outside of their registered specialty or specialties. Accordingly, they are subject to financial incentives to adjust their provision of services in line with affordable premium levels, in ways that do not apply to public sector practitioners. As an example of differences in average premiums, an obstetrician pays approximately twice what a gynaecologist does, and procedural general practitioners pay more than non-procedural general practitioners, especially if the procedures include cosmetic surgery or obstetrics (ACCC 2009). The MINC CC has recommended, for the purposes of the combined sector report, that the AIHW combine the MINC *Obstetrics*, *Gynaecology* and *Obstetrics and gynaecology* categories, as well as the *General practitioner – procedural* and *General practitioner – non-procedural* categories. This is to minimise the distortions that may arise from assuming strict comparability between the public and private sector specialty categories.

Appendix 3: Coding examples for some main data items

Table A3.1: 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 (for example, nervous shock)
		Subdural haematoma
		Cerebral palsy
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 kidneys, ureters or bladder
7.	Neuromusculoskeletal 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
		Paralysis
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 A3.2: 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
	Post-operative infection
	Intra-operative complications
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 A3.3: Coding examples for mode of claim finalisation

Mode of finalisation	Explanation
Court decision	From MII claims data ─ includes claims where damages were awarded to the plaintiff by court (either initially or on appeal) and where the case was awarded against the plaintiff by the court (either initially or on appeal) and the 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 MII claims data includes settlement outcomes where an amount is paid to the plaintiff other than by court direction.
Withdrawn	From public sector claims data ─ includes claims that have been closed due to withdrawal by claimant, or operation of statute of limitations, or where the claim manager decided to close the claim file because of long periods of inactivity, and instances where a claim is discontinued part way through a trial. *Withdrawn* claims from MII claims data include claims where the claimant withdrew the claim and the MII incurs costs only.

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