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Abbreviations

ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ANU	Australian National University
HMO	honorary medical officer
IRM	Integrated Resource Manual
MBBS	Bachelor of Medicine and Bachelor of Surgery
MIDWG	Medical Indemnity Data Working Group
MINC	Medical Indemnity National Collection
MTL	Medical Treatment Liability
NSMP	non-salaried medical practitioner
NSW	New South Wales
PHO	public health organisation
PIPA	*Personal Injuries Proceedings Act 2002*
SICorp	Self Insurance Corporation
TMF	Treasury Managed Fund
VMIA	Victorian Managed Insurance Authority
VMO	visiting medical officer

Symbols

. .	Not applicable

Summary

This report presents data on the number, nature and costs of public sector medical indemnity claims for the period 2004–05 to 2008–09, with a focus on 2008–09 claims.

Public sector medical indemnity claims for 2008–09

A new claim is created when a dollar amount (reserve) is placed against the costs expected to arise from allegations of faulty health service provision. There were 1,291 new public sector claims in 2008–09. The most frequently involved clinician specialties were *General practice—procedural* (10%), *Obstetrics and gynaecology* and *Emergency medicine* (both 7%). The health service contexts most often implicated were *Accident and emergency*, *Obstetrics* and *General surgery*.

Of the 1,867 claims closed in 2008–09, 51% cost less than $10,000 to close. The claimant pursuing the claim received a payment for 39% of closed claims, whether the claimant was the patient (17%), some party other than the patient (8%) or multiple claimants (14%).

Claims opened between 2004–05 and 2008–09

There were fewer new claims in 2008–09 (1,291) than in any of the four previous years (about 1,330 to 2,000 claims per year).

There was little change over time in the health service context implicated in the claim, except for a spike in *General surgery* in 2005–06 (30%, compared with 13–16% in other years) and a rise in *Gynaecology* claims (from 5% in 2005–06 to 11% in 2008–09). Allegations of *Neuromusculoskeletal and movement-related* harmful effects were reported for a higher proportion of claims each year (20–25%) than allegations of harmful effects to any other physiological or neurological system.

Claims closed between 2004–05 and 2008–09

There were about the same number of claims closed in 2008–09 (1,867) as in the four previous years (about 1,800 to 2,200 claims per year).

The proportion of claims closed for large amounts and for more significant harm tended to rise between 2004–05 and 2008–09. The proportion of claims closed for $100,000 or more, doubled from 9% in 2004–05 to 19% in 2008–09. Over this period, there was a consistent decline in the proportion associated with temporary harm (from 29% to 20%) and an increase in the proportions associated with both major harm (from 21% to 25%) and the patient's death (from 14% to 22%).

The alleged problem in health service delivery was associated with *Procedure*—for instance, a surgical procedure or childbirth delivery—in around one-third of the claims. Post-operative complications were alleged more often than any other *Procedure* subcategory.

Accident and emergency claims

Accident and emergency claims accounted for almost 1,500 of the claims closed between 2004–05 and 2008–09. *Emergency medicine* was the primary clinician specialty associated with 70% of these claims. Allegations of *Neuromusculoskeletal and movement-related* effects were reported for 37% of claims, and the most frequently alleged problem in health service delivery was *Diagnosis* (55% of claims).

1 Introduction

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

This report presents data collected through the MINC and provides information on the number, nature and costs of public sector medical indemnity claims. These are claims for compensation for harm or other loss allegedly due to the delivery of health care covered by public sector medical indemnity insurers. The data include details of the alleged health-care incidents that gave rise to claims, where these incidents occurred, the people affected, and the size, duration and settlement mode of the claims.

Chapter 2 provides some further background to the MINC. (Additional information on the development of the collection can be found in Appendix 1.)

Chapter 3 presents data on claims that were open at some point during the 2008–09 financial year. This is the seventh report to provide annual data for public sector claims. The first report—*First medical indemnity national data collection report: public sector, January to June 2003* (AIHW 2004)—described the development of the collection and presented the first 6 months of data. Annual data, for 2003–04, 2004–05, 2005–06, 2006–07 and 2007–08, were presented in the second, third, fourth, fifth and sixth reports (AIHW 2005, 2006a, 2007, 2009, 2011a).

Chapter 4 looks at changes to claim characteristics over the period 2004–05 to 2008–09 in relation to new claims opened each year and closed claims by the year they were closed. There may be differences between the data reported in Chapter 4 and the data previously published in MINC reports for the years between 2004–05 and 2007–08. This is because many public sector claims have their data updated from year to year, and Chapter 4 makes use of the most recently updated data on claims.

Chapter 5 focuses on 'primary incident/allegation type' data for a combined sample of claims closed over the 5-year period between 2004–05 and 2008–09. There are two reasons for this approach. The reason for focusing on closed claims is that their data quality is generally better than for open claims. Open claims are still undergoing investigation, and so many of their details are tentative or completely unknown, whereas the information is much more complete when a claim has closed. The reason for considering closed claims over a 5-year period is to include a larger sample size of claims than would be available for any one of those years. This allows for a more robust analysis of the data on incident/allegation types than was included in Chapter 4.

Chapter 6 provides data on Accident and emergency-related claims. It summarises data from previous chapters of the report and then provides further analysis on claims closed over the 5 years between 2004–05 and 2008–09. This chapter illustrates some of the detail available in the MINC about specific types of claims. It is planned that similar detailed information about other specific types of claims will be included in internet data cubes in the near future.

This report is being published in conjunction with the *Public and private sector medical indemnity claims in Australia 2008–09* report (AIHW 2011b). This follows previous reporting by the AIHW on public and private sector medical indemnity claims.

2 The collection

2.1 Scope and context

The MINC contains information on medical indemnity claims in the public sector. These claims can arise from any area of health service delivery for which a state or territory health authority has responsibility. Examples include public community health centres, public residential aged care services, and private health providers contracted to deliver public health services, as well as public hospitals. Each state and territory health authority engages personnel to manage medical indemnity claims. The claims managers record claims as they arise, collect information on the associated circumstances, set a reserve amount to cover the likely financial cost to the health authority of settling the claim, and monitor the costs incurred in settling the claim.

Medical indemnity claims fit into two categories—actual claims (on which legal activity has commenced via a letter of demand, the issue of a writ or a court proceeding) and potential claims (where a claims manager has placed a reserve against a health-care incident in the expectation that it may eventuate to an actual claim). Information in the MINC relates to both of these categories, combined. However, while all jurisdictions provide the AIHW with data on commenced claims, just three jurisdictions provide data on potential claims. The MINC does not include information on health-care incidents or adverse events which do not result in an actual claim (commenced claims) or which are not treated as potential claims.

2.2 Policy, administrative and legal context

The state and territory governments manage public sector medical indemnity insurance. The law of negligence, as enacted in each state and territory, provides the legal framework for the management of claims for personal injury and death including medical indemnity claims in both the public and private sectors.

The differences in state and territory legislation and insurance policy affect the nature and scope of MINC claims across Australia. Specific information relating to each jurisdiction is provided in Appendix 3. A particular area of difference is the coverage of visiting medical officers, private practitioners and students. There are also jurisdictional variations in tort law as it relates to medical indemnification (Madden & McIlwraith 2008).

Claims management

As a general guide, the main steps in the management of claims are:

1. An incident that could lead to a public sector medical indemnity claim is notified to the relevant claims management body. In some jurisdictions claims are managed by the relevant state or territory health authority; however, in others, a body external to the health authority handles most of the claims management process. Occasionally, some of the legal work may be outsourced to private law firms. (See Appendix 3 for claims management bodies operating in each jurisdiction.)
2. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed on it, based on an estimate of the cost of the claim when closed.

3. Various events can signal the start of a claim, for example, a writ or letter of demand may be issued by the claimant's solicitor (this can occur before an incident has been notified), or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases, no action is taken by the claimant or the defendant.
4. The claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.
5. As the claim progresses the reserve is monitored and adjusted if necessary.
6. A claim may be settled through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In addition, in some jurisdictions settlement via statutorily mandated conference processes must be attempted before a claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process. A claim file that has remained inactive for a long time may be discontinued. Some claims may be reopened following discontinuation or initial settlement.

The processes vary between jurisdictions, and in some jurisdictions there are different processes for small and large claims.

The status of a claim in any financial year depends on what happened to the claim in terms of the management processes described above. *New claims* are those claims with a reserve placed against them during the financial year. *New claims*, and claims that were open at the start of the financial year, may be closed during the period, or else remain open as *Current claims* until the end of the period. *Closed claims* are claims that are closed at a point in time (and not subsequently reopened) during the reporting period. The category *All claims* refers to any claims open at any point during the reporting period.

2.3 Data items

The MINC includes 22 data items and 15 key terms as summarised in Appendix 2. Further details are available from the AIHW on request.

The MINC collects information about the 'claim subject', the patient who incurred the alleged harm that gave rise to the claim. The information includes the type of allegation of loss or harm, the circumstances surrounding the claim, and the health service providers involved. The sex and year of birth of the claim subject are also collected if available. The claimant (that is, the person pursuing the claim) is often the claim subject but can also be any other person claiming for loss as a result of an incident. Information is not collected about the claimant as such.

State and territory health authorities transmit MINC data to the AIHW annually for collation. The transmitted data represents the claim manager's 'best current knowledge' about the claims at the end of each reporting period. The transmitted data are in the form of single claims (unit records), each typically corresponding to a single and distinct health-care incident (alleged or reported). A very small proportion of records (less than one per cent) represent multiple similar incidents; for instance, where the claim record refers to the test case for a class action being pursued by multiple claimants through the courts. A similarly small proportion of claims provide complementary data on the same incident; specifically, in some of the cases where there are payments to multiple claimants, one claim record contains information on the alleged incident and the payment to one of the claimants, and a linked claim record contains information on the payment to a separate claimant.

2.4 Data coverage, completeness and quality

This section provides an overview of data coverage, completeness and quality, with respect to the claims data periodically transmitted to the AIHW and the claims data on the MINC 'master database'. The periodically transmitted data pertain to a particular reporting period and record, to the jurisdictions' best knowledge, their data at the close of the reporting period. Any claims that are current at the end of one reporting period should be present in the data transmitted for the next reporting period, until such time as the claim is closed. Jurisdictions are not required to report on claims after the reporting period in which they were closed, but they may do so (especially if new information has come to light).

The master database holds the most up-to-date information available on Australia's public sector medical indemnity claims. Several jurisdictions have audited their medical indemnity claims collections in recent years, or detected changes that should be made to the coded data, and all changes are reflected in the master database. Occasionally a health authority has requested the AIHW to remove a previously transmitted record, for instance if it involves public liability rather than medical indemnity, and these records have been excluded.

Data coverage and completeness

The main focus of this report is 2008–09 data although some chapters present data dating back to 2004–05. Over time jurisdictions have improved their capacity to report data on every claim known to be 'in scope' for the reporting period. Data coverage at the time the data was reported has improved from 85% for 2004–05 (AIHW 2006a), to 89% for 2005–06 (AIHW 2007), 93% for 2006–07 (AIHW 2009), virtually 100% (5,279 of 5,280 claims) for 2007–08 (AIHW 2011a) and 100% for 2008–09.

The data coverage available for this report for the 2004–05, 2005–06 and 2006–07 years is better than indicated by the percentages cited above. This is because many of the claims that were originally excluded from the reported data have subsequently been reported to the MINC. Many of these originally excluded claims remained open into 2007–08 and so were reported for that year (when data coverage was virtually 100%). Some of the other originally excluded claims from 2004–05 and 2005–06 were included in the 2006–07 data transmission due to a 'back-coding' exercise undertaken by two jurisdictions to report on closed claims that had not previously been reported to the MINC (AIHW 2009).

Missing data

From 2006–07, every jurisdiction has supplied data for all key data items. However, there are two data items for which data were not provided by New South Wales:

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

In addition, New South Wales has provided data only on the principal clinician for the data item 'specialties of clinicians closely involved in incident'. The other jurisdictions also record the principal clinician but can include data on up to three additional clinical specialties.

Data quality

Not known rates

A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. As additional information comes to hand, it is added to the claim record, and so *Not known* rates tend to decrease as claims approach finalisation. Hence, when the claims open at any point during the 2008–09 reporting period are grouped into the categories of *New claims*, *Current claims* and *Closed claims*, it is evident that *New claims* have the highest *Not known* rates and *Closed claims* the lowest (Table 2.1). For instance, the *Not known* rate for 'primary body function/structure affected' is 33% for *New claims*, 18% for *Current claims* (many of which have been open for several years—Chapter 3) and 11% for *Closed claims*.

There are two data items with *Not known* rates greater than 25% for *Closed claims*. They are 'nature of claim—loss to other party/parties' (31%) and 'nature of claim—loss to claim subject' (28%). These data items can be coded for a specific loss category or categories only when the claim documentation includes allegation information. While a claim is still open, or if it is closed through being discontinued, the alleged loss is usually not known and so is recorded as *Not known*. If it is known that no loss categories formed the basis of the claim, then the code *Not applicable* is used. It is understood that the codes for *Not known* and *Not applicable* have sometimes been used interchangeably.

There are five other data items with *Not known* rates greater than 10% for *Closed claims*: 'extent of harm—claim subject' (21%), 'claim subject's status' (for example, an admitted patient or resident) (18%), 'primary body function/structure affected', 'clinical service context' and 'principal clinician speciality'(all 11%). Starting with the 2009–10 data transmission, data reporting specifications have been put in place to ensure a lower *Not known* rate for these (and other) data items when a claim is closed.

Data cleaning of the collection and subsequent changes

As with previous years' data, the AIHW undertook data cleaning and validation checks on the 2008–09 data it received. The AIHW raised queries when changes in data items since the 2007–08 recording period appeared to be illogical or unexpected—for example, claim status changing from *Closed* to *Commenced*. Jurisdictions were informed of discrepancies and asked to investigate and clarify any uncertainties.

The AIHW also undertook cleaning of the data on the master database. Hence, some of the data presented here for 2007–08 and previous years differ from that presented in the 2007−08 report (AIHW 2011a) because the master database includes amendments to claim records made after the data analysis for the 2007–08 report was completed.

Table 2.1: MINC data items: number and percentages of claims for which *Not known* was recorded, 1 July 2008 to 30 June 2009[a]

	New claims		Current claims		Closed claims		Open at any point during the period	
Items for all states and territories	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Nature of claim—loss to claim subject[b]	976	75.6	2,197	68.5	514	27.5	2,711	53.5
Nature of claim—loss to other party/parties	589	45.6	1,289	40.2	572	30.6	1,861	36.7
Extent of harm—claim subject	564	43.7	972	30.3	400	21.4	1,372	27.1
Claim subject's status	450	34.9	665	20.7	332	17.8	997	19.7
Primary body function/structure affected	422	32.7	565	17.6	212	11.4	777	15.3
Clinical service context	433	33.5	564	17.6	208	11.1	772	15.2
Principal clinician specialty	422	32.7	547	17.1	199	10.7	746	14.7
Primary incident/ allegation type	394	30.5	513	16.0	184	9.9	697	13.7
Claim subject's year of birth	375	29.0	503	15.7	183	9.8	686	13.5
Health service setting	355	27.5	438	13.7	151	8.1	589	11.6
Claim subject's sex	337	26.1	419	13.1	62	3.3	481	9.5
Where incident occurred	62	4.8	71	2.2	10	0.5	81	1.6
Total claims	**1,291**	**100.0**	**3,205**	**100.0**	**1,867**	**100.0**	**5,072**	**100.0**
Items relevant only to closed claims								
Claim payment details	. .	. .	. .	. .	29	1.6	. .	. .
Mode of claim finalisation	. .	. .	. .	. .	1	0.1	. .	. .
Total claim size	. .	. .	. .	. .	1	0.1	. .	. .
Items reported by jurisdictions other than New South Wales[b]								
Additional body functions/structures affected	0	0.0	3	0.8	1	0.4	4	0.7
Additional incident/ allegation type	0	0.0	1	0.2	0	0.0	1	0.1
Additional clinician specialties	0	0.0	0	0.0	0	0.0	0	0.0

(a) Table 2.1 does not include the data items 'Date incident occurred', 'Date reserve first placed against claim', 'Reserve range' and 'Status of claim', which are required to be completed for all MINC data items. It also excludes 'Date claim commenced' and 'Date claim closed' which may be left blank respectively for claims that have not yet been commenced or closed.

(b) New South Wales claim management practices did not involve recording of any additional values for these three MINC data items. (Totals are not provided because to do this would be to indirectly disclose the number of claims reported by New South Wales, which current collaborative arrangements disallow – Appendix 1.)

2.5 Reporting the collection's claim characteristics

The tables in chapters 3 to 6 include information on the number and/or proportion of claims recorded as *Not known*, as an indicator of data quality. However, when the purpose of a table is to compare the relative percentages of 'known' categories, inclusion of the *Not known* category can make interpreting the data difficult, as the percentages do not sum to 100%. Accordingly, in those tables that present the data as percentages summing row or column-wise to 100%, only those claims which are known for all of the data items presented in the table are included.

Current claims still open at 30 June 2009 provide data relevant to current public sector liability for claims to be finalised at some future point. For this reason, where 'reserve range' is considered (Table 3.6), *Current claims* are reported.

New claims have the advantage of capturing information on alleged health care allegations close to the time of the alleged incidents, and so are sensitive to these allegations' changed characteristics over time. Accordingly, several of the tables in Chapter 4, where data for the years from 2004–05 to 2008–09 are compared, report on *New claims*. In these tables, the *Not known* rates are often lower for claims that were new during the earlier reported years, because the health authorities have been able to provide the AIHW with more complete data on these claims in the years since the claim had its reserve set.

Chapter 4 also provides some tabular comparisons over the years for *Closed claims*, because there are some data items, such as 'total claim size', which remain undetermined until a claim is finalised. Some of the claims closed in a given year were subsequently reopened in a later year. Nonetheless they are still included in the data for the year in which they were first closed, because the inter-year comparisons being made here are on claim files that were deemed ready for closure in each of the years compared.

The quality of the data for *Closed claims* is higher than for *Current claims*, as indicated by their lower *Not known* rates (Section 2.4). Accordingly, chapters 5 and 6 of this report use closed claims data amalgamated over a 5-year period between 2004–05 and 2008–09. Use of this amalgamated data provides a robust sample size for detailed cross-tabulations and analysis.

3 Public sector medical indemnity claims for 2008–09

This chapter presents a brief profile of the 5,072 medical indemnity claims that were open at some point between 1 July 2008 and 30 June 2009. Over the period, there were 1,291 new claims opened (marked by the setting of a reserve), 1,867 claims that were closed (settled, for example, through negotiation or a court decision, or discontinued), and at 30 June 2009 there were 3,205 current claims. Current claims include three subcategories: potential claims, where a reserve has been set but no allegation of loss has been received; commenced claims, where the reserve has been set and an allegation of loss received; and reopened claims, which are current claims that had been considered closed at some point before 30 June 2009 (Table 3.1).

Table 3.1: Number of public sector claims by claim category, 1 July 2008 to 30 June 2009

Claim category	Description	Number
New	Claims with a reserve set within the reporting period (1 July 2008 to 30 June 2009)	1,291
Current	Claims that remained open at 30 June 2009	3,205
Closed	Claims that were settled during the reporting period (1 July 2008 to 30 June 2009)	1,867
All	All claims open at some point during the reporting period (1 July 2008 to 30 June 2009)	5,072

The data presented in this chapter cover new claims, current claims and closed claims. Further data on new claims for 2008–09 including comparisons with previous years are presented in Chapter 4.

3.1 New claims, 2008–09

This section provides information on claims that were opened in the 2008–09 year.

Clinical service context

Clinical service context specifies the area of clinical practice associated with the alleged health-care incident. Most of the categories correspond to a hospital department, but some of them relate to public health services usually provided in settings located outside of hospitals. There are 20 possible categories, as well as the option to code the clinical service context as *Other* and provide additional text information.

During 2008–09, the three most commonly recorded clinical service contexts recorded for one-third of new claims (421 of 1,291) were *Accident and emergency*, *Obstetrics* and *General surgery* (Table 3.2). These are the same three categories that have been the most common for new claims for each year from 2003–04 to 2007–08 (AIHW 2011a). The three least frequently recorded clinical service contexts were *Perinatology*, *Plastic surgery* and *Cosmetic procedures*, as was also the case for the years from 2005–06 to 2007–08 (AIHW 2011a).

Geographic location

The Australian Standard Geographical Classification Remoteness Structure is used to categorise the 'geographic location' of where an alleged health-care incident occurred.

Two-thirds (66% or 848 new claims) in 2008–09 arose from incidents occurring in *Major cities*. The corresponding figure for *Inner regional* areas was 231 claims (18%). Another 11% arose in *Outer regional* areas and less than 1% in *Remote and very remote* areas (Table 3.2).

Accident and emergency, Obstetrics and *General surgery* were the three most common clinical service contexts recorded for new claims in *Major cities*, *Inner regional* and *Remote and very remote* areas. For *Outer regional* areas *Gynaecology* (38 claims) was the most common clinical service context. Altogether 105 claims from *Outer regional* areas had a known clinical service context and *Gynaecology* made up 36% of these claims.

Table 3.2: New claims: clinical service context by geographic location, 1 July 2008 to 30 June 2009

	Geographic location					
Clinical service context	**Major cities**	**Inner regional**	**Outer regional**	**Remote and very remote**	**Not known**	**Total**
Accident and emergency	98	35	21	3	5	162
Obstetrics	95	31	8	2	5	141
General surgery	76	27	9	4	2	118
Gynaecology	45	9	38	0	0	92
Psychiatry	43	11	3	0	0	57
Orthopaedics	31	13	5	0	2	51
General practice	31	9	5	1	1	47
Radiology	18	3	1	0	3	25
General medicine	16	2	4	1	1	24
Paediatrics	21	1	1	0	1	24
Cardiology	18	0	2	0	0	20
Neurology	14	0	0	0	0	14
Dentistry	8	3	3	0	0	14
Urology	9	3	1	0	0	13
Hospital outpatient department	6	0	1	0	0	7
Oncology	2	1	2	0	1	6
Otolaryngology	5	1	0	0	0	6
Perinatology	3	0	0	0	0	3
Plastic surgery	3	0	0	0	0	3
Cosmetic procedures	2	0	0	0	0	2
Other	26	1	1	0	1	29
Not known	278	81	33	1	40	433
Total	**848**	**231**	**138**	**12**	**62**	**1,291**
Per cent	*65.7*	*17.9*	*10.7*	*0.9*	*4.8*	*100.0*

Specialties of clinicians

The data item 'specialties of clinicians closely involved in incident' indicates the health-care providers who allegedly played the most prominent roles in the events that gave rise to a claim. The providers so identified were not necessarily at fault in relation to the alleged incident and may not be defendants in the claim. There are 69 possible categories, including *Not applicable* in cases where no clinician is alleged to have been closely involved. Up to four clinician specialties may be recorded for any one claim, and so a summation of the total number of times that clinician specialties were recorded for 2008–09 claims would exceed the total number of claims.

General practice – procedural (10%), *Obstetrics and gynaecology* (7%) and *Emergency medicine* (7%) were the three most frequent clinician specialties recorded and combined make up almost one-quarter (24%) of claims (Table 3.3). For claims with a known clinician specialty, *General practice – procedural* was recorded for 15% (133 of 864 claims), *Obstetrics and gynaecology* for 10% (89 of 864 claims) and *Emergency medicine* for 10% (84 of 864 claims). There was a substantial increase in the proportion of new claims for *General practice – procedural* and *Obstetrics and gynaecology* between 2007–08 and 2008–09 *(*up from less than 2% and 4% respectively in 2007–08).

Table 3.3: New claims: specialties of clinicians closely involved in the alleged incident, 1 July 2008 to 30 June 2009

Specialty of clinician	Number	Per cent of all claims
General practice–procedural	133	10.3
Obstetrics and gynaecology	89	6.9
Emergency medicine	84	6.5
General surgery	62	4.8
Gynaecology only	53	4.1
Obstetrics only	53	4.1
General practice–non-procedural	52	4.0
Orthopaedic surgery	50	3.9
Psychiatry	33	2.6
Nursing–general	24	1.9
Psychology	24	1.9
Cardiology	20	1.5
Diagnostic radiology	18	1.4
General and internal medicine	17	1.3
Anaesthetics–general	15	1.2
Neurology	15	1.2
Urology	15	1.2
Nursing–nurse practitioner	14	1.1
Paediatric medicine	12	0.9
Gastroenterology	10	0.8
Ophthalmology	10	0.8
Neurosurgery	8	0.6
Cardio-thoracic surgery	7	0.5
Medical oncology	7	0.5
Midwifery	7	0.5
Colorectal surgery	6	0.5

(continued)

Table 3.3 (continued): New claims: specialties of clinicians closely involved in the alleged incident, 1 July 2008 to 30 June 2009

Specialty of clinician	Number	Per cent of all claims
Dentistry—procedural	6	0.5
Dentistry—oral surgery	6	0.5
Paediatric surgery	6	0.5
Plastic surgery	6	0.5
Otolaryngology	5	0.4
Endocrinology	5	0.4
Pathology	5	0.4
Neonatology	4	0.3
Paramedical and ambulance	4	0.3
Vascular surgery	4	0.3
Endoscopy	3	0.2
Intensive care	3	0.2
Therapeutic radiology	3	0.2
Anaesthetics–intensive care	2	0.2
Geriatrics	2	0.2
Nuclear medicine	2	0.2
Public health–preventative medicine	2	0.2
Renal medicine	2	0.2
Clinical pharmacology	1	0.1
Dermatology	1	0.1
Facio-maxillary surgery	1	0.1
Infectious diseases	1	0.1
Occupational medicine	1	0.1
Pharmacy	1	0.1
Podiatry	1	0.1
Physiotherapy	1	0.1
Respiratory medicine	1	0.1
Spinal surgery	1	0.1
Clinical haematology	0	0.0
Clinical genetics	0	0.0
Chiropractics	0	0.0
Clinical immunology	0	0.0
Cosmetic surgery	0	0.0
Nutrition	0	0.0
Osteopathy	0	0.0
Rehabilitation medicine	0	0.0
Rheumatology	0	0.0
Sports medicine	0	0.0
Thoracic medicine	0	0.0
Other allied health	5	0.4
Other hospital-based medical practitioner	2	0.2
Not applicable	5	0.4
Not known	422	32.7
All new claims[(a)]	**1,291**	**100.0**

(a) Up to four different specialties may be recorded for each claim, and so some claims are represented in more than one row in this table. Hence the numbers in the table cannot be summed vertically to give the total number of all new claims and the percentage values cannot be summed vertically to give 100%.

Five other specialties were recorded for 50 or more claims each, these being *General surgery*, *Gynaecology only*, *Obstetrics only*, *General practice – non-procedural* and *Orthopaedic surgery*. These clinician specialties were also frequently recorded for new claims in 2007–08 (AIHW 2011a). On the other hand, there were many clinician specialties recorded for less than ten new claims in 2008–09, including eleven specialties not recorded for any claims. This is similar to previous years when most clinical specialties have been recorded for small proportions of MINC public sector claims (AIHW 2007, 2009, 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 was of primary importance in giving rise to the claim. During 2008–09, claims relating to *Procedure* and *Treatment* were the most common (both 18%), followed by *Diagnosis* (16%). *Device failure* and *Infection control* were the least common 'primary incident/allegation type' (both <1%) to be recorded as the alleged grounds for a claim (Table 3.4).

Procedure accounted for more than half (53%) of all alleged incidents in the clinical service context of *General surgery*, 47% of alleged incidents in *Orthopaedics* and one-third (34%) of alleged incidents in *Obstetrics*. Incidents related to *Diagnosis* and *Treatment* were relatively more likely in *Accident and emergency* claims (44% and 32% respectively), while 42% of incidents for *Gynaecology* claims related to *Consent*, and 60% of incidents for *Psychiatry* claims related to *Treatment* (Table 3.5).

Table 3.4: New claims: clinical service context, by primary incident/allegation type, 1 July 2008 to 30 June 2009

	Primary incident/allegation type												
Clinical service context	**Procedure[a]**	**Treatment[b]**	**Diagnosis**	**Consent[c]**	**Medication-related[d]**	**General duty of care**	**Blood/blood product-related**	**Anaesthetic**	**Device failure**	**Infection control**	**Other**	**Not known**	**Total**
Accident and emergency	16	51	72	0	9	9	1	1	0	0	3	0	162
Obstetrics	46	35	40	2	4	4	2	2	0	0	2	4	141
General surgery	62	21	12	4	3	2	5	7	0	1	0	1	118
Gynaecology	23	9	4	38	11	2	1	1	1	0	1	1	92
Psychiatry	0	34	5	0	3	12	1	0	0	0	2	0	57
Orthopaedics	24	12	8	2	2	1	0	0	1	0	1	0	51
General practice	8	20	8	3	4	2	1	1	0	0	0	0	47
Radiology	3	3	13	2	2	0	0	0	0	0	2	0	25
General medicine	2	6	8	0	4	2	0	0	0	1	0	1	24
Paediatrics	7	2	7	0	4	1	1	1	0	1	0	0	24
All other clinical service contexts	40	29	20	5	4	10	3	2	1	0	1	2	117
Not known	7	15	12	1	6	5	2	0	0	0	0	385	433
Total	**238**	**237**	**209**	**57**	**56**	**50**	**17**	**15**	**3**	**3**	**12**	**394**	**1,291**
Per cent[e]	*18.4*	*18.4*	*16.2*	*4.4*	*4.3*	*3.9*	*1.3*	*1.2*	*0.2*	*0.2*	*0.9*	*30.5*	*100.0*

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

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

(c) *Consent* includes failure to warn.

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

(e) Percentages do not add up exactly to 100.0 due to rounding.

Note: The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

Table 3.5: New claims: clinical service context, by primary incident/allegation type (excluding *Not known*), 1 July 2008 to 30 June 2009 (per cent)

	Primary incident/allegation type											
Clinical service context	**Procedure**	**Treatment**	**Diagnosis**	**Consent**	**Medication-related**	**General duty of care**	**Blood/blood product-related**	**Anaesthetic**	**Device failure**	**Infection control**	**Other**	**Total**
Accident and emergency	9.9	31.5	44.4	0.0	5.6	5.6	0.6	0.6	0.0	0.0	1.9	100.0
Obstetrics	33.6	25.5	29.2	1.5	2.9	2.9	1.5	1.5	0.0	0.0	1.5	100.0
General surgery	53.0	17.9	10.3	3.4	2.6	1.7	4.3	6.0	0.0	0.9	0.0	100.0
Gynaecology	25.3	9.9	4.4	41.8	12.1	2.2	1.1	1.1	1.1	0.0	1.1	100.0
Psychiatry	0.0	59.6	8.8	0.0	5.3	21.1	1.8	0.0	0.0	0.0	3.5	100.0
Orthopaedics	47.1	23.5	15.7	3.9	3.9	2.0	0.0	0.0	2.0	0.0	2.0	100.0
General practice	17.0	42.6	17.0	6.4	8.5	4.3	2.1	2.1	0.0	0.0	0.0	100.0
Radiology	12.0	12.0	52.0	8.0	8.0	0.0	0.0	0.0	0.0	0.0	8.0	100.0
General medicine	8.7	26.1	34.8	0.0	17.4	8.7	0.0	0.0	0.0	4.3	0.0	100.0
Paediatrics	29.2	8.3	29.2	0.0	16.7	4.2	4.2	4.2	0.0	0.9	0.0	100.0
All other clinical service contexts	34.8	25.2	17.4	4.3	3.5	8.7	2.6	1.7	0.9	0.0	0.9	100.0
Total	**27.2**	**26.1**	**23.2**	**6.6**	**5.9**	**5.3**	**1.8**	**1.8**	**0.4**	**0.4**	**1.4**	**100.0**

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. The 394 claims coded *Not known* for 'primary incident/allegation type' and 433 coded *Not known* for 'clinical service context', including 385 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 849.
3. Percentages may not add up exactly to 100.0 due to rounding.

3.2 Current claims

This section reports information on claims that were current at 30 June 2009.

Reserve range and duration

Table 3.6 displays data on 'length of claim' by 'reserve range'. For current claims, the length of a claim is measured from the date the claim first had a reserve placed against it to the end of the financial year, in this case 30 June 2009. Over one-third (39%) had been open for 12 months or less, with just 13% of claims having remained open beyond 5 years.

The proportion of current claims with a reserve less than $30,000 was 30% (969 claims), while 20% (372 claims) had a reserve range between $100,000 and <$250,000, and 15% (488 claims) had a reserve value of at least $500,000.

A strong association is evident between the 'reserve range' and how long a claim was open. For example, of the current claims with a reserve of less than $10,000, half (52%) have been open for 12 months or less, compared with 6% open for more than 5 years. In contrast, current claims reserved at $500,000 or more have usually been open for more than 12 months (84%) and often for more than 5 years (32%).

Table 3.6: Current claims: length of claim (months), by reserve range ($), 30 June 2009

	Reserve range							
Length of claim	Less than 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
12 or less	229	237	79	220	242	146	80	1,233
13–24	138	142	57	131	125	53	68	714
25–36	24	67	23	75	89	57	70	405
37–48	14	31	8	32	65	41	63	254
49–60	9	19	12	23	44	28	52	187
>60	27	32	15	54	82	47	155	412
Total	**441**	**528**	**194**	**535**	**647**	**372**	**488**	**3,205**
Per cent	*13.8*	*16.5*	*6.1*	*16.7*	*20.2*	*11.6*	*15.2*	*100.0*
				Per cent				
12 or less	51.9	44.9	40.7	41.1	37.4	39.3	16.4	38.5
13–24	31.3	26.9	29.4	24.5	19.3	14.2	13.9	22.3
25–36	5.4	12.7	11.9	14.0	13.8	15.3	14.4	12.6
37–48	3.1	5.9	4.1	6.0	10.1	11.0	12.9	8.0
49–60	2.1	3.6	6.2	4.3	6.8	7.5	10.7	5.8
>60	6.1	6.1	7.7	10.1	12.7	12.6	31.8	12.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

3.3 Closed claims

This section includes information on claims closed during the 2008–09 year.

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 events that gave rise to a claim. The claim subject's death was the category recorded for this data item for 17% of claims closed during 2008-09 (Table 3.7). This category was recorded if the death of the claim subject was established to be a fact during the investigation into the circumstances of an open or reopened claim. The claimant can be any person claiming for loss as a result of the incident, and need not be the claim subject (Section 2.3), which is why the claim subject may be deceased before a claim is closed.

Apart from *Death*, the three other most common categories were *Neuromusculoskeletal and movement-related* (19%), *Mental and nervous system* (15%) and *Genitourinary and reproductive* (12%). The categories *Skin and related structures*, *Sensory, including eye and ear* and *Voice and speech* were each recorded for less than 5% of claims.

Extent of harm

The extent of harm describes the overall effect of the alleged incident on the claim subject in terms of impairment, activity limitation or participation restriction. The categories include temporary (less than 6 months duration), minor and major injury of 6 months or more duration, and also *Death* and *Not applicable* (corresponding to *Death* and *No body function/structure affected* in terms of the 'primary body function/structure affected'). The category selected by the claim manager represents the claim manager's best estimate after allowing for any pre-existing condition the claim subject may have had prior to the alleged incident.

Temporary harm was recorded for 15% of claims closed during 2008–09, compared with 25% of claims with minor harm of 6 months or more duration and 20% of claims with major harm of 6 months or more duration. These proportions should be read in the context of the 21% of all claims for which extent of harm was unknown (Table 3.7). Temporary harm was recorded for 45% of claims with alleged effects to *Skin and related structures* (for which extent of harm was reported) and for 40% of claims with alleged effects to *Voice and speech* (Table 3.8). On the other hand, major harm of 6 months or more duration was more a feature of claims with alleged *Mental and nervous system* effects (61%) and *Sensory, including eye and ear* effects (40%).

Table 3.7: Closed claims: primary body function/structure affected by extent of harm, 1 July 2008 to 30 June 2009

Primary body function/structure affected	Extent of harm						Total	Per cent
	Temporary (less than 6 months duration)	Minor (6 months or more)	Major (6 months or more)	Death	Not applicable	Not known		
Neuromusculoskeletal and movement-related	61	161	83	0	0	53	358	19.2
Mental and nervous system	42	52	148	0	0	36	278	14.9
Genitourinary and reproductive	59	93	39	0	0	32	223	11.9
Digestive, metabolic and endocrine systems	48	63	33	0	0	27	171	9.2
Cardiovascular, haematological, immunological and respiratory	22	40	33	0	0	27	122	6.5
Skin and related structures	32	32	7	0	0	11	82	4.4
Sensory, including eye and ear	8	20	19	0	0	9	56	3.0
Voice and speech	8	10	2	0	0	3	23	1.2
Death	0	0	0	312	0	0	312	16.7
No body function/ structure affected	0	0	0	0	30	0	30	1.6
Not known	7	3	0	0	0	202	212	11.4
Total	**287**	**474**	**364**	**312**	**30**	**400**	**1,867**	**100.0**
Per cent	*15.4*	*25.4*	*19.5*	*16.7*	*1.6*	*21.4*	*100.0*	*. .*

Note: See Appendix 4 for specific examples of types of alleged harm for each of the body function/structure categories.

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Table 3.8: Closed claims: primary body function/structure affected by extent of harm (excluding *Not applicable* and *Not known*), 1 July 2008 to 30 June 2009 (per cent)

Primary body function/structure affected	Extent of harm				
	Temporary (less than 6 months duration)	Minor (6 months or more)	Major (6 months or more)	Death	Total
Neuromusculoskeletal and movement-related	20.0	52.8	27.2	0.0	100.0
Mental and nervous system	17.4	21.5	61.2	0.0	100.0
Genitourinary and reproductive	30.9	48.7	20.4	0.0	100.0
Digestive, metabolic and endocrine systems	33.3	43.8	22.9	0.0	100.0
Cardiovascular, haematological, immunological and respiratory	23.2	42.1	34.7	0.0	100.0
Skin and related structures	45.1	45.1	9.9	0.0	100.0
Sensory, including eye and ear	17.0	42.6	40.4	0.0	100.0
Voice and speech	40.0	50.0	10.0	0.0	100.0
Death	0.0	0.0	0.0	100.0	100.0
Total	**19.6**	**33.0**	**25.5**	**21.9**	**100.0**

Notes

1. The 212 claims coded *Not known* for 'primary body function/structure affected' and 400 claims coded *Not known* for 'extent of harm', including 202 coded *Not known* for both, and the 30 claims where no body function/structure was affected are excluded from this table. The number of claims on which the percentages presented here are based is 1,427.
2. Percentages may not add up exactly to 100.0 due to rounding.

Length and cost of claims

The length or duration of a closed claim is measured from the date of reserve placement to when the claim was closed. The most frequently recorded duration was 13–24 months (25%), with 23% closed within 12 months of reserve placement, and 22% closed between 25 and 36 months after reserve placement (Table 3.9).

'Total claim size' includes any legal and investigative costs as well as any payment made to the claimant(s). Of the claims closed in 2008–09, 60% cost less than $10,000 to close, including 28% that incurred no cost and 33% that involved a cost under $10,000. Just 6% of claims were settled for $500,000 or more.

The length of time taken to finalise closed claims was generally longer for larger settlements. Over half (807 claims, 54%) of the 1,506 claims closed for under $100,000, which made up 81% of closed claims, had been closed within 2 years of when the reserve was set. In contrast, around three-quarters of claims settled for $100,000–<$500,000 had a duration longer than 2 years (182 of 244 claims, 75%), while the most common length of time to finalise claims settled for $500,000 or more was over 5 years (36%).

Table 3.9: Closed claims: length of claim (months), by total claim size ($), 1 July 2008 to 30 June 2009

	Total claim size									
Length of claim	**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**	**Not known**	**Total**
12 or less	197	157	32	4	14	9	4	2	0	419
13–24	105	203	41	22	32	31	18	12	0	464
25–36	121	132	44	23	21	35	17	19	0	412
37–48	60	45	31	6	22	33	9	19	1	226
49–60	14	35	11	8	15	25	15	22	0	145
>60	20	37	25	12	17	25	23	41	0	200
Total	**517**	**609**	**184**	**75**	**121**	**158**	**86**	**115**	**1**	**1,866**
Per cent	*27.7*	*32.6*	*9.9*	*4.0*	*6.5*	*8.5*	*4.6*	*6.2*	*0.1*	*100.0*
					Per cent (excluding *Not known*)					
12 or less	38.1	25.8	17.4	5.3	11.6	5.7	4.7	1.7	. .	22.5
13–24	20.3	33.3	22.3	29.3	26.4	19.6	20.9	10.4	. .	24.9
25–36	23.4	21.7	23.9	30.7	17.4	22.2	19.8	16.5	. .	22.1
37–48	11.6	7.4	16.8	8.0	18.2	20.9	10.5	16.5	. .	12.1
49–60	2.7	5.7	6.0	10.7	12.4	15.8	17.4	19.1	. .	7.8
>60	3.9	6.1	13.6	16.0	14.0	15.8	26.7	35.7	. .	10.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

Note: The percentages shown in the bottom half of the table are based on the 1,865 claims with known claim size.

Mode of settlement

'Mode of settlement' describes the process by which a claim was closed. Claims may be closed through state/territory-based complaints processes, court-based processes or *Other* processes (which include cases where a claim is settled part way through a trial), or may be discontinued.

For 2008–09, 61% of all closed claims were finalised through being *Discontinued* (Table 3.10). Almost all of the claims closed for no cost were *Discontinued* (98%), as were most of the claims closed for a cost under $10,000 (77%).

Settlement through a *Court decision* was also a comparatively rare event, with just 3% of closed claims finalised through this mode. Over the same period, approximately twice as many claims were finalised as a result of *Court-based alternative dispute resolution processes* (6%).

In terms of claim sizes, *Court-based alternative dispute resolution processes* had the highest proportion closed for $500,000 or more (32 of 103 claims, 31%). The corresponding proportion for both *Settled – other* and *Court decision* was 14% (respectively, 73 of 511 claims and 7 of 51 claims).

Table 3.10: Closed claims: mode of settlement, by total claim size ($), 1 July 2008 to 30 June 2009

	Total claim size									
Mode of settlement	**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**	**Per cent**
Discontinued	506	471	102	24	20	4	1	1	1,129	60.5
Settled—state/territory-based complaints processes	0	17	13	5	1	9	2	0	47	2.5
Settled—statutorily mandated compulsory conference process	0	0	1	2	5	8	7	2	25	1.3
Settled—court-based alternative dispute resolution processes	0	3	7	6	14	24	17	32	103	5.5
Settled—other	12	108	49	32	73	107	57	73	511	27.4
Court decision	0	10	12	6	8	6	2	7	51	2.7
Total	**518**	**609**	**184**	**75**	**121**	**158**	**86**	**115**	**1,867**	**100.0**
	Per cent (excluding *Not known*)									
Discontinued	97.7	77.3	55.4	32.0	16.5	2.5	1.2	0.9	60.5	. .
Settled—state/territory-based complaints processes	0.0	2.8	7.1	6.7	0.8	5.7	2.3	0.0	2.5	. .
Settled—statutorily mandated compulsory conference process	0.0	0.0	0.5	2.7	4.1	5.1	8.1	1.7	1.3	. .
Settled—court-based alternative dispute resolution processes	0.0	0.5	3.8	8.0	11.6	15.2	19.8	27.8	5.5	. .
Settled—other	2.3	17.7	26.6	42.7	60.3	67.7	66.3	63.5	27.4	. .
Court decision	0.0	1.6	6.5	8.0	6.6	3.8	2.3	6.1	2.7	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**

Note: Total includes 1 claim that was coded *Not known* for both 'mode of settlement' and 'total claim size'. The percentages presented in the bottom half of the table are based on the 1,866 claims with known 'mode of settlement' and 'total claim size'.

Claim payment details

The claimant may be the claim subject and/or another party/parties (Section 2.3). 'Claim payment details' provides information on whether or not a compensation payment was made to the claim subject and/or another party/parties. This information has not previously been included in a MINC public sector report.

Of the claims closed in 2008–09, no payment was made to the claim subject or other party/parties in 1,117 (60%) of claims. With these claims where no payment was made to the claim subject or other party/parties, 611 (55%) incurred legal and investigative costs, including 459 costing less than $10,000, 147 costing $10,000–<$100,000 and 5 costing $100,000–<$500,000.

A payment was made only to the claim subject in 17% of closed claims and only to another party/parties in 8% of closed claims. A payment to both the claim subject and another party/parties was recorded for 257 (14%) of closed claims, including about 1 in 5 (21%) with a claim size of $500,000 or more.

No payment was made to the claimant in 965 of the 1,127 claims (86%) closed for under $10,000, 147 of the 380 claims (39%) closed for $10,000–<$100,000, but just 5 of the 359 claims (1%) closed for $100,000 or more.

Table 3.11: Closed claims: claim payment details by total claim size ($), 1 July 2008 to 30 June 2009

	Total claim size						
Claim payment details	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Total**	**Per cent**
No payment to claim subject or other party/parties	506	459	147	5	0	1,117	59.8
Payment to claim subject only	0	79	97	96	41	313	16.8
Payment to other party/parties only	0	50	58	26	17	151	8.1
Payment to claim subject and other party/parties	0	12	75	115	55	257	13.8
Not known	12	9	3	2	2	29	1.6
Total	**518**	**609**	**380**	**244**	**115**	**1,867**	**100.0**
	Per cent (excluding *Not known*)						
No payment to claim subject or other party/parties	45.3	41.1	13.2	0.4	0.0	100.0	. .
Payment to claim subject only	0.0	25.2	31.0	30.7	13.1	100.0	. .
Payment to other party/parties only	0.0	33.1	38.4	17.2	11.3	100.0	. .
Payment to claim subject and other party/parties	0.0	4.7	29.2	44.7	21.4	100.0	. .
Total	**27.5**	**32.6**	**20.5**	**13.2**	**6.1**	**100.0**	**. .**

Notes

1. There were 29 claims coded *Not known* for 'claim payment details' and 1 claim also coded *Not known* for 'total claim size'. The *Not known* row and column are not presented, but the numbers are included in the totals.
2. Percentages may not add up exactly to 100.0 due to rounding.

Extent of harm and cost of claims

There is a strong association between claim size and extent of harm, which is most clearly shown by aggregating the claim size categories into broader bands. Where extent of harm is applicable to the claim and also known, temporary harm (less than 6 months duration) accounted for 27% of claims closed for no cost, and 31% closed for $1–<$10,000, compared with just 1% closed for $500,000 or more. Where death was the recorded extent of harm, 28% of claims closed for no cost, while the remaining claims were fairly evenly distributed across each claim size category. On the other hand, major harm (6 months or more duration) accounted for 63% of claims closed for $500,000 or more compared with just 20% of those closed for no cost. The category of minor harm (6 months or more duration) accounted for approximately 40% of claims closed for $10,000−<$100,000 and $100,000−<$500,000 (Table 3.12).

Table 3.12: Closed claims: extent of harm, by total claim size ($), 1 July 2008 to 30 June 2009

	Total claim size							
Extent of harm	**Nil**	**1–<10,000**	**10,000–<100,000**	**100,000–<500,000**	**500,000 or more**	**Not known**	**Total**	**Per cent**
Temporary (less than 6 months duration)	66	148	56	16	1	0	287	15.4
Minor (6 months or more)	61	143	154	97	19	0	474	25.4
Major (6 months or more)	47	86	77	84	70	0	364	19.5
Death	67	104	76	43	22	0	312	16.7
Not applicable	2	21	5	1	1	0	30	1.6
Not known	275	107	12	3	2	1	400	21.4
Total	**518**	**609**	**380**	**244**	**115**	**1**	**1,867**	**100.0**
Per cent	*27.7*	*32.6*	*20.4*	*13.1*	*6.2*	*0.1*	*100.0*	*. .*
	Per cent (excluding *Not applicable* and *Not known*)							
Temporary (less than 6 months duration)	27.4	30.8	15.4	6.7	0.9	. .	20.0	. .
Minor (6 months or more)	25.3	29.7	42.4	40.4	17.0	. .	33.0	. .
Major (6 months or more)	19.5	17.9	21.2	35.0	62.5	. .	25.3	. .
Death	27.8	21.6	20.9	17.9	19.6	. .	21.7	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

Notes

1. The 400 claims coded *Not known* and 30 claims coded *Not applicable* for 'extent of harm', including 1 also coded *Not known* for 'total claim size', are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 1,437 claims.
2. Percentages may not add exactly to 100.0 due to rounding.

Clinical service context and cost of claims

Obstetrics and *Accident and emergency* were the two clinical service contexts with the most costly claims. Where the clinical service context was known, of the claims associated with *Obstetrics* and *Accident and emergency*, 12% and 11% respectively had a claim size of $500,000 or more, compared with 7% of all claims in this claim size bracket. In contrast, just 3% of claims with *General surgery* and 2% of claims with *Gynaecology* as their clinical service context were closed for $500,000 or more (Table 3.13).

Paediatrics was the clinical service context in which the greatest proportion of closed claims had a claim size under $10,000 (26 claims, 70%). In comparison the other clinical service context categories had between 47% and 62% of claims (respectively, *Accident and emergency* and *Psychiatry*) closed for less than $10,000.

Table 3.13: Closed claims: clinical service context, by total claim size ($), 1 July 2008 to 30 June 2009

	Total claim size							
Clinical service context	**Nil**	**1– <10,000**	**10,000– <100,000**	**100,000– <500,000**	**500,000 or more**	**Not known**	**Total**	**Per cent**
Accident and emergency	73	73	79	52	33	0	310	16.6
Obstetrics	65	99	47	31	33	0	275	14.7
General surgery	47	117	57	45	8	1	275	14.7
Orthopaedics	20	49	29	28	9	0	135	7.2
Gynaecology	23	33	33	16	2	0	107	5.7
General medicine	12	37	24	17	5	0	95	5.1
Psychiatry	15	37	17	10	5	0	84	4.5
Paediatrics	12	14	5	4	2	0	37	2.0
All other clinical service contexts	86	118	80	40	17	0	341	18.3
Not known	165	32	9	1	1	0	208	11.1
Total	**518**	**609**	**380**	**244**	**115**	**1**	**1,867**	**100.0**
Per cent	*27.7*	*32.6*	*20.4*	*13.1*	*6.2*	*0.1*	*100.0*	*. .*
	Per cent (excluding *Not known*)							
Accident and emergency	23.5	23.5	25.5	16.8	10.6	. .	100.0	. .
Obstetrics	23.6	36.0	17.1	11.3	12.0	. .	100.0	. .
General surgery	17.2	42.7	20.8	16.4	2.9	. .	100.0	. .
Orthopaedics	14.8	36.3	21.5	20.7	6.7	. .	100.0	. .
Gynaecology	21.5	30.8	30.8	15.0	1.9	. .	100.0	. .
General medicine	12.6	38.9	25.3	17.9	5.3	. .	100.0	. .
Psychiatry	17.9	44.0	20.2	11.9	6.0	. .	100.0	. .
Paediatrics	32.4	37.8	13.5	10.8	5.4	. .	100.0	. .
All other clinical service contexts	25.2	34.6	23.5	11.7	5.0	. .	100.0	. .
Total	**21.3**	**34.8**	**22.4**	**14.6**	**6.9**	**. .**	**100.0**	**. .**

Notes

1. The 'clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. There were 208 claims coded *Not known* for 'clinical service context' and 1 coded *Not known* for 'total claim size'. The number of claims on which the percentages presented in the bottom half of the table are based is 1,658.
3. Percentages may not add up exactly to 100.0 due to rounding.

4 Changes over time to public sector medical indemnity claims, 2004–05 to 2008–09

This chapter presents an overview of claims data covering the five reporting periods from July 2004 to June 2009. It is based on the most current data for each reporting period. This is a different approach to reports prior to 2007–08, which instead compared the data as published over successive years. The published data were the best available at the time of reporting. However, there have been updates to previously reported data, as noted in Chapter 2 of this report. This chapter is based on the updated data for the 5-year period up to 2008–09.

The 'time series' data presented here differ from reports prior to 2007–08 in another main respect. Previously the focus has been on all claims open at any time during the reporting period, as this is how most of the data had been published. However, many claims remain open over several years (Table 3.6), and so when comparisons were drawn between different years, they were based on sets of claims that overlapped considerably from year to year. To prevent this overlap claims need to be assigned to one year or another based on the timing of a unique event in a claim's life, such as the date when the reserve was set or when the claim was closed. Thus, to ensure that claims are counted just once in each analysis, the comparisons between reporting periods in this chapter focus on new claims and closed claims by year.

New claims are the more useful class of claims to consider when monitoring changes over time in the incidents or allegations giving rise to claims. This is because the reserve is set when a health authority recognises that a claim may arise or has arisen as a result of a health-care incident or allegation. Closed claims on the other hand are more informative when the focus is on claim aspects that relate to claim closure (mode of settlement and claim size).

As discussed in Chapter 2, closed claims have low *Not known* rates on most data items whereas new claims have particularly high rates. In addition, claims that are counted as new in previous reporting periods have subsequently been better documented by the time they are closed. As a result, when analysed retrospectively new claims from several years ago have lower *Not known* rates than those opened in 2008–09.

4.1 Claim numbers

Table 4.1 presents claim numbers between 2004–05 and 2008–09 in terms of current claims (claims open at the end of each period) and closed claims (those closed during each period), which together make up all of the claims open during the period. Current claims include potential claims, where a reserve has been set but litigation has not begun, commenced claims where litigation has begun, and claims that were reopened after having been closed in a previous period. Closed claims include a small number of structured settlements, which are settlements that allow for periodic payments to the claimant rather than a lump sum payment.

There were between 5,072 and 6,922 claims in total in each of the last 5 years (Table 4.1; Figure 4.1). The number of current claims has steadily decreased from 4,905 in 2004–05 to

3,205 in 2008–09. The number of potential claims has also decreased since 2004–05 from 1,866 to one-third of that number in 2008–09 (608 claims). The number of reopened claims has steadily increased since 2004–05, from 34 to 165 claims. The 165 reopened claims in 2008–09 is the largest number recorded. The number of closed claims increased from 1,899 in 2004–05 to 2,233 in 2006–07 before decreasing and plateauing to 1,804 in 2007–08 and 1,867 in 2008–09.

Table 4.1 also presents the numbers of new claims which had their reserve set during each period. They are shown separately as they may be either current or closed at the end of the year when their reserve was set. There were 1,291 new claims in 2008–09, a decrease of 164 claims from the previous year, and considerably lower than the 1,999 new claims reported for 2005–06.

Table 4.1: All claims: number of claims, by status of claim, 2004–05 to 2008–09

	Year				
Status of claim	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
New claims	1,774	1,999	1,330	1,455	1,291
			Current claims		
Potential (not yet commenced)	1,866	1,669	1,197	858	608
Commenced	3,005	3,172	2,735	2,713	2,432
Reopened	34	54	99	155	165
Current claims at the end of each financial year	*4,905*	*4,895*	*4,031*	*3,726*	*3,205*
Closed claims	1,899	2,027	2,233	1,804	1,867
All claims (open at any time during the period)	**6,804**	**6,922**	**6,264**	**5,530**	**5,072**

Note: The claim numbers for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).

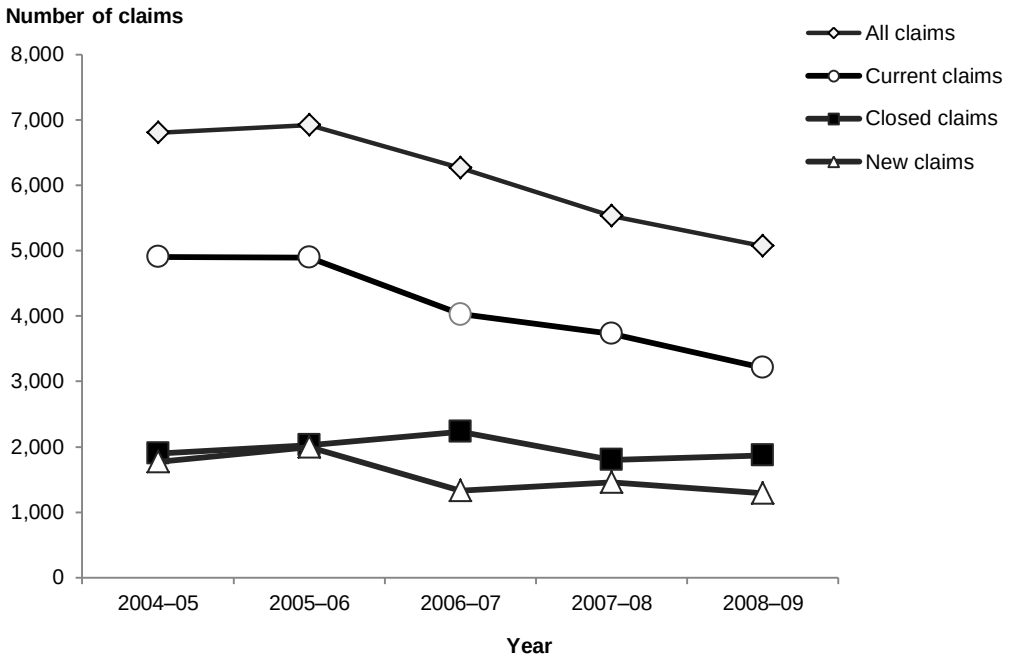

Figure 4.1: New, current, closed and all claims: claim numbers, 2004–05 to 2008–09

4.2 Clinical service context and principal clinician specialty

'Clinical service context' specifies the area of clinical practice associated with the alleged health-care incident (Section 3.1). Table 4.2 presents the numbers and proportions of new claims associated with the ten clinical service contexts most commonly recorded between 2004–05 and 2008–09. Of these, *Accident and emergency*, *General surgery* and *Obstetrics* were the three most frequently recorded in each of the years.

For 2008–09, excluding new claims where the clinical service context was *Not known*, *Accident and emergency* accounted for 19% (162 of 858 claims), *Obstetrics* for 16% (141 of 858 claims) and *General surgery* for 14% (118 of 858 claims). These proportions are similar to those recorded for 2007–08: 19% for *Accident and emergency*, 17% for *Obstetrics* and 13% for *General surgery*. The main difference between 2007–08 and 2008–09 is the rise in the proportion of *Gynaecology* claims from 5% to 11% (Table 4.2).

'Principal clinician specialty' indicates the health-care provider who allegedly played the most prominent role in the events that gave rise to a claim. The ten principal clinician specialties most commonly recorded for new claims between 2004–05 and 2008–09 are presented in Table 4.3.

The number of new claims with *General surgery* as their clinical service context or their principal clinician specialty was much higher in 2005–06 than in any other year (tables 4.2 and 4.3). The proportion of these claims in 2005–06 was approximately three times what it was in any other period (figures 4.2 and 4.3). The claims made against a general surgeon in one jurisdiction affect this spike in *General surgery* claims.

For 2008–09, the three most frequently recorded principal clinician specialties were *General practice – procedural*, *Obstetrics and gynaecology* and *Emergency medicine* (Table 4.3). In terms of claims with a known clinician specialty, *General practice – procedural* accounted for 15% of claims, *Obstetrics and gynaecology* for 10% and *Emergency medicine* for 9%. The proportions recorded for *General practice – procedural* and *Obstetrics and gynaecology* have increased substantially from 2007–08, when they respectively accounted for just 4% and 5% of claims. On the other hand, the proportions of claims associated with *General practice – non-procedural* and with *Emergency medicine* were higher in 2007–08 (respectively, 12% and 14%) than 2008–09 (respectively, 6% and 9%).

Prior to 2007–08 both *General practice – non-procedural* and *General practice – procedural* were recorded as the principal clinician specialty for small proportions of claims, whereas *General practice – non-procedural* claims peaked in 2007–08 and *General practice – procedural* claims rose sharply in 2008–09 (Table 4.3; Figure 4.3). The proportion of claims with a clinical service context of *General practice* was also higher in 2007–08 and 2008–09 compared with previous years but the increase was small. Around 2% of claims between 2004–05 and 2005–06 had *General practice* as their clinical service context compared with 5% in 2007–08 and 6% in 2008–09.

Table 4.2: New claims: clinical service context, 2004–05 to 2008–09

	Year				
Clinical service context	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Accident and emergency	277	301	260	224	162
General surgery	227	585	208	147	118
Obstetrics	276	277	205	198	141
Orthopaedics	133	134	107	92	51
Gynaecology	140	88	82	63	92
Psychiatry	87	79	84	69	57
General medicine	119	76	67	69	24
General practice	38	33	26	54	47
Paediatrics	52	31	22	39	24
Cardiology	28	44	31	23	20
All other clinical service contexts	362	299	202	182	122
Not known	35	52	36	295	433
Total	**1,774**	**1,999**	**1,330**	**1,455**	**1,291**
	Per cent (excluding *Not known*)				
Accident and emergency	15.9	15.5	20.1	19.3	18.9
General surgery	13.1	30.0	16.1	12.7	13.8
Obstetrics	15.9	14.2	15.8	17.1	16.4
Orthopaedics	7.6	6.9	8.3	7.9	5.9
Gynaecology	8.1	4.5	6.3	5.4	10.7
Psychiatry	5.0	4.1	6.5	5.9	6.6
General medicine	6.8	3.9	5.2	5.9	2.8
General practice	2.2	1.7	2.0	4.7	5.5
Paediatrics	3.0	1.6	1.7	3.4	2.8
Cardiology	1.6	2.3	2.4	2.0	2.3
All other clinical service contexts	20.8	15.4	15.6	15.7	14.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories across the 5 years; all other categories are combined in the category *All other clinical service contexts*.
2. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
3. Percentages may not add up exactly to 100.0 due to rounding.

Table 4.3: New claims: principal clinician specialty, 2004–05 to 2008–09

	Year				
Principal clinician specialty	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Emergency medicine	236	244	196	160	79
General surgery	153	485	126	85	59
Obstetrics only	196	181	132	100	50
Orthopaedic surgery	127	123	100	83	45
General practice—non-procedural	56	50	62	133	52
Gynaecology only	116	66	60	44	53
Obstetrics and gynaecology	47	69	46	58	87
Psychiatry	72	65	58	51	31
General practice—procedural	31	39	34	42	131
General nursing	73	57	51	29	19
All other specialties	596	554	417	369	258
Not applicable	31	11	15	15	5
Not known	40	55	33	286	422
Total	1,774	1,999	1,330	1,455	1,291
	Per cent (excluding *Not applicable* and *Not known*)				
Emergency medicine	13.9	12.6	15.3	13.9	9.1
General surgery	9.0	25.1	9.8	7.4	6.8
Obstetrics only	11.5	9.4	10.3	8.7	5.8
Orthopaedic surgery	7.5	6.4	7.8	7.2	5.2
General practice—non-procedural	3.3	2.6	4.8	11.5	6.0
Gynaecology only	6.8	3.4	4.7	3.8	6.1
Obstetrics and gynaecology	2.8	3.6	3.6	5.0	10.1
Psychiatry	4.2	3.4	4.5	4.4	3.6
General practice—procedural	1.8	2.0	2.7	3.6	15.2
General nursing	4.3	2.9	4.0	2.5	2.2
All other specialties	35.0	28.7	32.5	32.0	29.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'principal clinician specialty' categories listed separately here are the ten most frequently recorded categories across the 5 years; all other categories are combined in the category *All other specialties*.
2. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
3. Percentages may not add up exactly to 100.0 due to rounding.

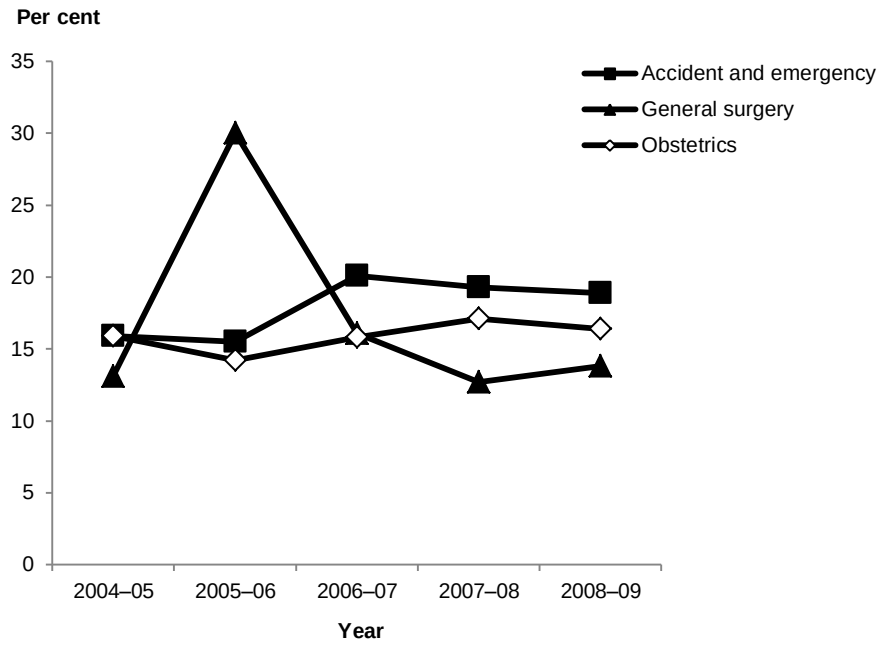

Figure 4.2: New claims: the three most frequently recorded clinical service contexts, 2004–05 to 2008–09 (per cent)

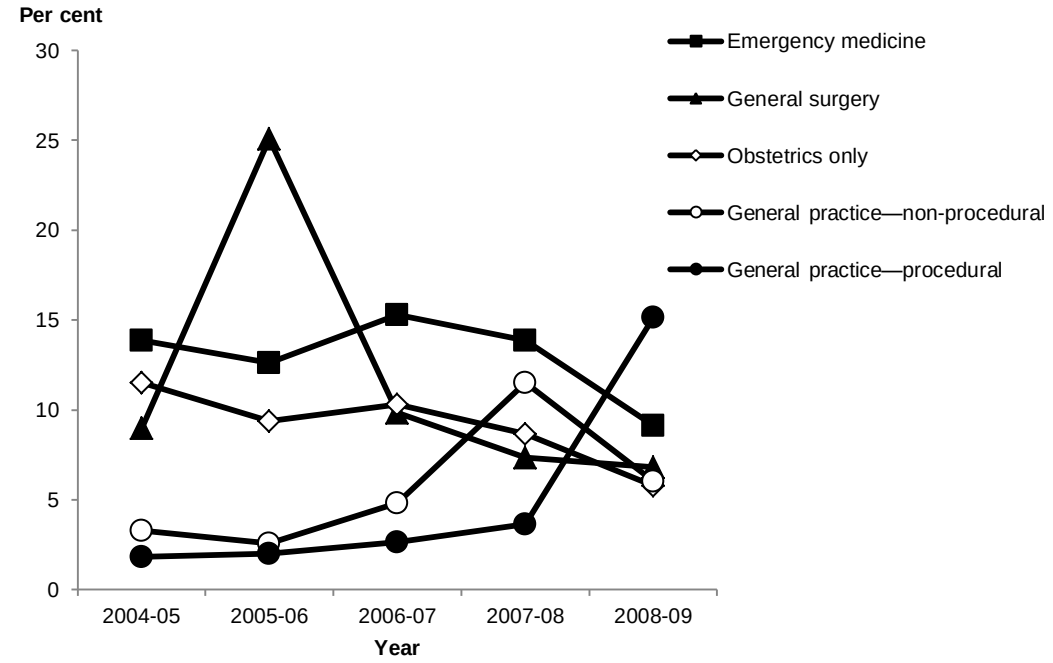

Figure 4.3: New claims: five principal clinician specialties associated with more than ten per cent of claims in one or more years between 2004–05 and 2008–09 (per cent)

4.3 Primary body function/structure affected and primary incident/allegation type

The data item 'primary body function/structure affected' specifies the main body function or structure of the claim subject alleged to have been affected as a result of the events that gave rise to a claim. 'Primary incident/allegation type' describes the area of possible error, negligence or problem that was of primary importance in giving rise to the claim. Three of its categories, *Procedure*, *Treatment* and *Medication-related*, have subcategories. In this report for the first time data are provided on these subcategories.

The 2005–06 reporting period stood out in terms of both 'primary body function/structure affected' and 'primary incident/allegation type'. Allegations of effects to the *Digestive, metabolic and endocrine systems*, and of *Procedure* as the primary incident/allegation type, were recorded at their highest level in 2005–06 new claims (tables 4.4 and 4.5; figures 4.4 and 4.5). This reflects claims made against a general surgeon in one jurisdiction.

The number of claims with recorded *Neuromusculoskeletal and movement-related* effects decreased continually between 2004–05 and 2008–09 (Table 4.4). However, it remained as the most commonly recorded 'primary body function/structure affected' category for every one of those years. In 2008–09 *Neuromusculoskeletal and movement-related* was followed by the categories *Genitourinary and reproductive*, *Death* and *Mental and nervous system*. In terms of claims where the body function/structure was known, these four categories were respectively recorded for 182 of 869 claims (21%), 168 claims (19%), 154 claims (18%) and 141 claims (16%). The *Genitourinary and reproductive* category rose from being recorded for 13% of new claims in 2007–08, whereas the *Neuromusculoskeletal and movement-related*, *Death* and *Mental and nervous system* were recorded in similar proportions for both 2007–08 and 2008–09.

For new claims during 2008–09, the most frequently recorded 'primary incident/allegation types' were *Procedure*, *Treatment* and *Diagnosis* (Table 4.5). They were respectively associated with 238, 237 and 209 new claims, or as a proportion of cases where the primary incident/allegation type was known, 27%, 26% and 23%. The proportions for *Procedure, Treatment* and *Diagnosis* were similar to those recorded in 2007–08 (27%, 23% and 26% respectively).

Because of the high proportion of new claims with a *Procedure* primary incident/allegation type in 2005−06, most other incident/allegation types accounted for a lower proportion of new claims in 2005−06 than in other years. Otherwise there was little difference between the years; for instance, *Diagnosis* was recorded for between 22% and 27% of new claims.

For every year between 2004–05 and 2008–09, *Procedure – post-operative complications* was the most frequently recorded subcategory of claims with a *Procedure* primary incident/allegation type, while the *Procedure – wrong body site* subcategory was the least frequently recorded. *Treatment complications* and *Treatment – other* were the two most frequently recorded *Treatment* subcategories from 2004–05 to 2008–09. The *Medication – type/dosage* subcategory was always more frequently recorded than the *Medication – administration method* subcategory.

Table 4.4: New claims: primary body function/structure affected, 2004–05 to 2008–09

	Year				
Primary body function/ structure affected	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Neuromusculoskeletal and movement-related	420	389	301	243	182
Mental and nervous system	302	307	218	212	141
Genitourinary and reproductive	216	242	179	148	168
Digestive, metabolic and endocrine systems	170	361	146	111	72
Cardiovascular, haematological, immunological and respiratory	119	109	81	89	57
Skin and related structures	70	99	62	60	39
Sensory, including eye and ear	56	52	40	23	32
Voice and speech	31	26	16	22	15
Death	245	313	230	230	154
No body function/ structure affected	29	29	17	24	9
Not known	116	72	40	293	422
Total	**1,774**	**1,999**	**1,330**	**1,455**	**1,291**
		Per cent (excluding *Not known*)			
Neuromusculoskeletal and movement-related	25.3	20.2	23.3	20.9	20.9
Mental and nervous system	18.2	15.9	16.9	18.2	16.2
Genitourinary and reproductive	13.0	12.6	13.9	12.7	19.3
Digestive, metabolic and endocrine systems	10.3	18.7	11.3	9.6	8.3
Cardiovascular, haematological, immunological and respiratory	7.2	5.7	6.3	7.7	6.6
Skin and related structures	4.2	5.1	4.8	5.2	4.5
Sensory, including eye and ear	3.4	2.7	3.1	2.0	3.7
Voice and speech	1.9	1.3	1.2	1.9	1.7
Death	14.8	16.2	17.8	19.8	17.7
No body function/ structure affected	1.7	1.5	1.3	2.1	1.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. See Appendix 4 for specific examples of types of alleged harm for each of the body function/structure categories.
2. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
3. Percentages may not add up exactly to 100.0 due to rounding.

Table 4.5: New claims: primary incident/allegation type, 2004–05 to 2008–09

	Year				
Primary incident/allegation type	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Failure to perform procedure	35	24	26	15	24
Failure of procedure	59	113	46	36	25
Wrong procedure	14	26	19	13	11
Procedure—wrong body site	9	11	9	12	3
Procedure—post-operative complications	274	348	167	107	78
Procedure—intra-operative complications	28	108	73	59	44
Procedure—post-operative infection	10	58	25	12	12
Procedure—other	179	135	67	64	41
Total procedure	**608**	**823**	**432**	**318**	**238**
Treatment not provided	25	41	19	29	16
Delayed treatment	63	76	62	50	34
Failure of treatment	21	19	15	29	29
Treatment complications	96	99	84	90	76
Treatment—other	105	84	77	79	82
Total treatment	**310**	**319**	**257**	**277**	**237**
Medication—type/dosage	44	52	42	55	51
Medication—administration method	21	10	10	11	5
Total medication-related	**65**	**62**	**52**	**66**	**56**
Diagnosis	388	432	356	304	209
General duty of care	179	147	105	124	50
Anaesthetic	56	57	34	27	15
Consent	24	17	25	26	57
Infection control	39	33	7	10	3
Blood/blood product-related	6	16	13	14	17
Device failure	16	5	4	6	3
Other	35	37	13	22	12
Not known	48	51	32	261	394
Total	**1,774**	**1,999**	**1,330**	**1,455**	**1,291**

(continued)

Table 4.5 (continued): New claims: primary incident/allegation type, 2004–05 to 2008–09

Primary incident/allegation type	Year				
	2004–05	2005–06	2006–07	2007–08	2008–09
	Per cent (excluding *Not known*)				
Failure to perform procedure	2.0	1.2	2.0	1.3	2.7
Failure of procedure	3.4	5.8	3.5	3.0	2.8
Wrong procedure	0.8	1.3	1.5	1.1	1.2
Procedure—wrong body site	0.5	0.6	0.7	1.0	0.3
Procedure—post-operative complications	15.9	17.9	12.9	9.0	8.7
Procedure—intra-operative complications	1.6	5.5	5.6	4.9	4.9
Procedure—post-operative infection	0.6	3.0	1.9	1.0	1.3
Procedure—other	10.4	6.9	5.2	5.4	4.6
Total procedure	**35.2**	**42.2**	**33.3**	**26.6**	**26.5**
Treatment not provided	1.4	2.1	1.5	2.4	1.8
Delayed treatment	3.7	3.9	4.8	4.2	3.8
Failure of treatment	1.2	1.0	1.2	2.4	3.2
Treatment complications	5.6	5.1	6.5	7.5	8.5
Treatment—other	6.1	4.3	5.9	6.6	9.1
Total treatment	**18.0**	**16.4**	**19.8**	**23.2**	**26.4**
Medication—type/dosage	2.5	2.7	3.2	4.6	5.7
Medication—administration method	1.2	0.5	0.8	0.9	0.6
Total medication-related	**3.8**	**3.2**	**4.0**	**5.5**	**6.2**
Diagnosis	22.5	22.2	27.4	25.5	23.3
General duty of care	10.4	7.5	8.1	10.4	5.6
Anaesthetic	3.2	2.9	2.6	2.3	1.7
Consent	1.4	0.9	1.9	2.2	6.4
Infection control	2.3	1.7	0.5	0.8	0.3
Blood/blood product-related	0.3	0.8	1.0	1.2	1.9
Device failure	0.9	0.3	0.3	0.5	0.3
Other	2.0	1.9	1.0	1.8	1.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. Percentages for the *Procedure*, *Treatment* and *Medication-related* subcategories may not add up exactly to the percentages for the *Procedure*, *Treatment* and *Medication-related* categories due to rounding.
2. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
3. Percentages may not add up exactly to 100.0 due to rounding.

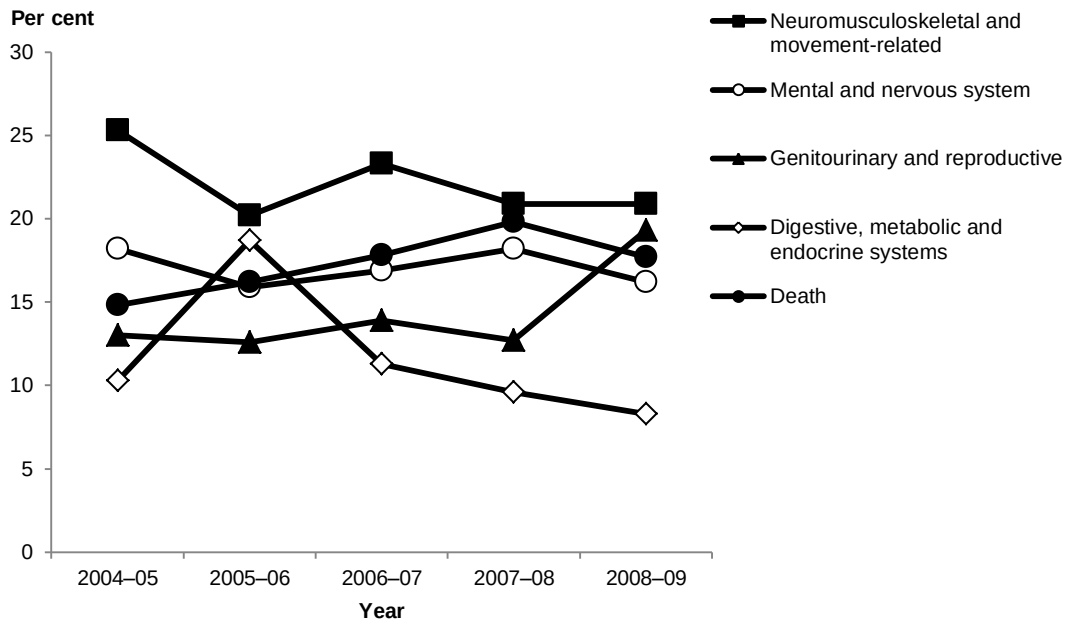

Figure 4.4: New claims: the five most frequently recorded primary body function/ structure categories affected, 2004–05 to 2008–09 (per cent)

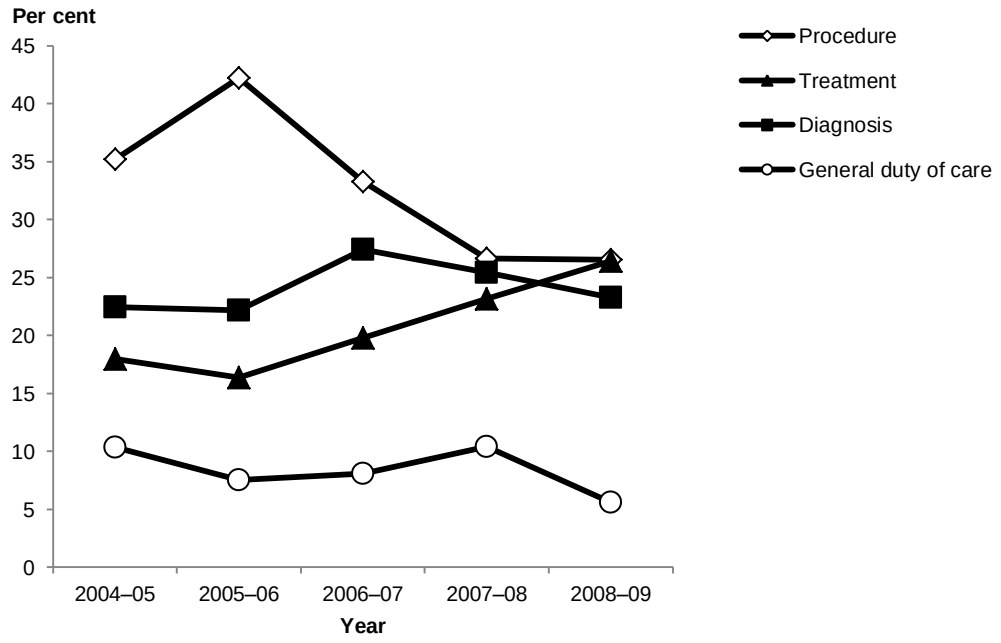

Figure 4.5: New claims: the four most frequently recorded primary incident/allegation types, 2004–05 to 2008–09 (per cent)

4.4 Extent of harm

Extent of harm is analysed with respect to claims closed between 2004–05 and 2008–09, rather than new claims (Table 4.6; Figure 4.6). This is because information on the extent of harm is more complete at the time the claim is closed than when it is new (Table 2.1). One change that is evident for closed claims is a consistent decline in the proportion associated with *Temporary* harm, from 29% in 2004–05 to 20% in 2008–09. This is counterbalanced by an increase in the proportion associated with *Major* harm, from 21% to 25%, and with *Death*, from 14% to 22%.

Table 4.6: Closed claims: extent of harm, 2004–05 to 2008–09

	Year				
Extent of harm	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Temporary (less than 6 months duration)	366	420	537	314	287
Minor (6 months or more)	451	495	665	443	474
Major (6 months or more)	267	306	439	328	364
Death	169	218	302	290	312
Not applicable	40	65	45	32	30
Not known	606	523	245	397	400
Total	**1,899**	**2,027**	**2,233**	**1,804**	**1,867**
	Per cent (excluding *Not applicable* and *Not known*)				
Temporary (less than 6 months duration)	29.2	29.2	27.6	22.8	20.0
Minor (6 months or more)	36.0	34.4	34.2	32.2	33.0
Major (6 months or more)	21.3	21.3	22.6	23.9	25.3
Death	13.5	15.1	15.5	21.1	21.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
2. Percentages may not add up exactly to 100.0 due to rounding.

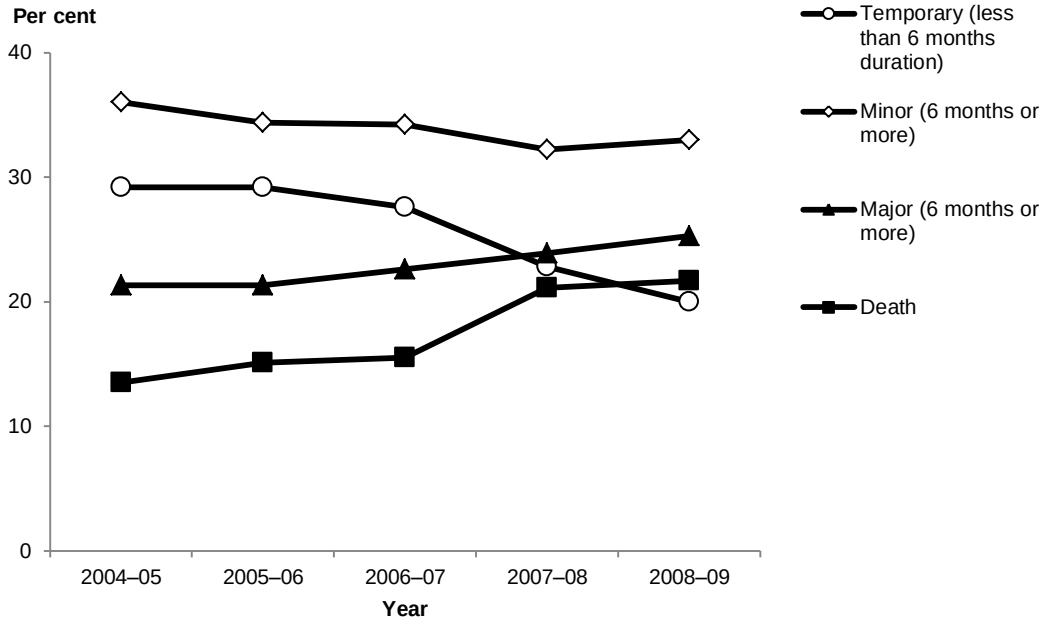

Figure 4.6: Closed claims: extent of harm, 2004–05 to 2008–09 (per cent)

4.5 Mode of settlement and claim size

'Mode of settlement' refers to the mechanism through which a claim is closed, including discontinuation when the claim is withdrawn by the claimant or closed by the claims manager due to operation of the statute of limitations or claim inactivity. Table 4.7 presents data on the mechanisms through which claims were closed between 2004–05 and 2008–09, along with the average length of the claim (between when the reserve was set and the claim was closed). Table 4.8 presents data on the total claim size for closed claims over the same period. Total claim size includes legal and investigative costs as well as any payment made to the claimant(s). Claimants can include both claim subject and/or another party.

The proportion of claims closed through being discontinued was around 60% in every year except 2006–07 when it dropped to 49% (Table 4.7; Figure 4.7). This was also the year when the proportion settled through state/territory-based complaints processes peaked at 9% and the year with the longest average time between when the reserve was set and the claim file was closed, at 31.9 months. The 2006–07 reporting period additionally witnessed relatively high proportions of claims settled for between $10,000 and <$100,000 (28%), $100,000 and <$500,000 (13%), and $500,000 or more (4%). In all other reporting periods, the proportion of claims settled for under $10,000, including those which incurred no cost, was larger than in 2006–07 (Table 4.8).

If 2006–07 were excluded as a special case, there would appear to be little difference over time in the relative proportions of the modes of settlement for closing claims (Figure 4.7). There would however be some suggestion that the proportion of claims closed for the two largest size bands, $100,000–<$500,000 and $500,000 or more, has increased between 2004–05 and 2008–09 (Figure 4.8).

Table 4.7: Closed claims: mode of settlement, and average time between dates when reserve placed and claim file closed, 2004–05 to 2008–09

	Year				
Mode of settlement	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Discontinued	1,142	1,179	1,102	1,116	1,129
Settled—state/territory-based complaints processes	26	40	204	66	47
Settled—statutorily mandated compulsory conference process	18	22	29	4	25
Settled—court-based alternative dispute resolution processes	164	180	153	85	103
Settled—other	459	500	660	460	511
Court decision	48	62	85	65	51
Not known	42	44	0	8	1
Total	**1,899**	**2,027**	**2,233**	**1,804**	**1,867**
Average time to be closed (months)	*26.2*	*29.0*	*31.9*	*30.8*	*30.7*
	Per cent (excluding *Not known*)				
Discontinued	61.5	59.5	49.4	62.1	60.5
Settled—state/territory-based complaints processes	1.4	2.0	9.1	3.7	2.5
Settled—statutorily mandated compulsory conference process	1.0	1.1	1.3	0.2	1.3
Settled— court-based alternative dispute resolution processes	8.8	9.1	6.9	4.7	5.5
Settled—other	24.7	25.2	29.6	25.6	27.4
Court decision	2.6	3.1	3.8	3.6	2.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
2. Percentages may not add up exactly to 100.0 due to rounding.

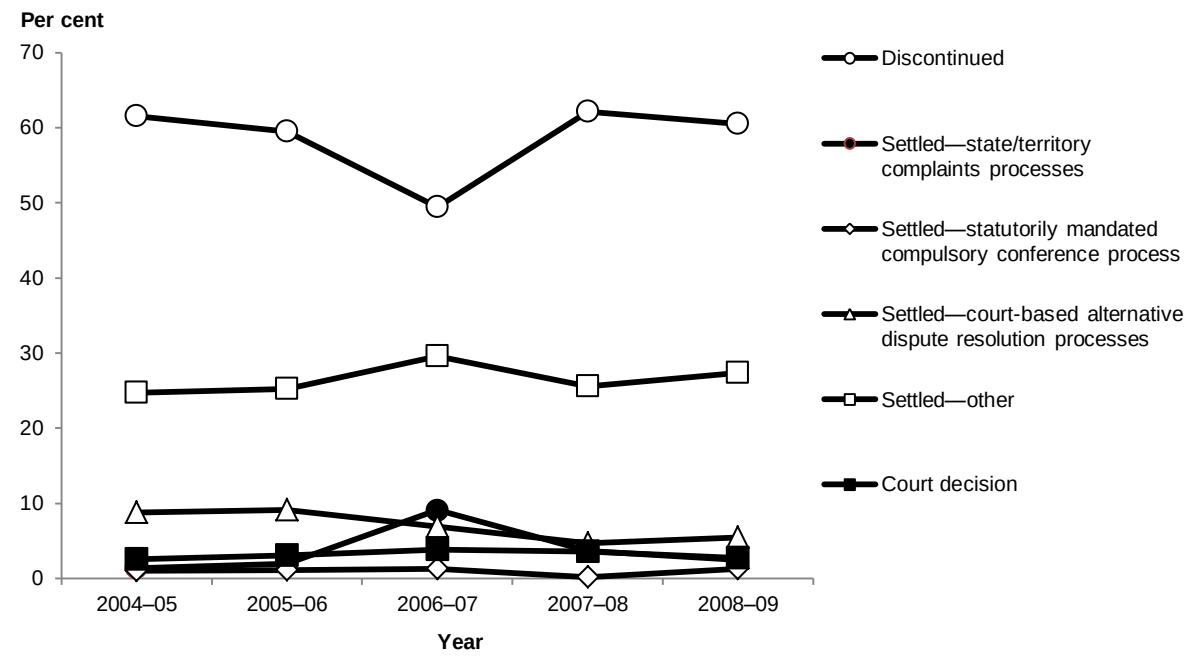

Figure 4.7: Closed claims: mode of settlement, 2004–05 to 2008–09 (per cent)

Table 4.8: Closed claims: total claim size ($), 2004–05 to 2008–09

	Year				
Claim size	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**
Nil	466	633	539	679	518
1–<10,000	787	702	684	537	609
10,000–<30,000	203	204	314	152	184
30,000–<50,000	101	93	135	75	75
50,000–<100,000	160	116	183	124	121
100,000–<250,000	102	157	210	120	158
250,000–<500,000	46	45	81	55	86
500,000 or more	20	56	87	56	115
Not known	14	21	0	6	1
Total	**1,899**	**2,027**	**2,233**	**1,804**	**1,867**
	Per cent (excluding *Not known*)				
Nil	24.7	31.6	24.1	37.8	27.8
1–<10,000	41.8	35.0	30.6	29.9	32.6
10,000–<100,000	24.6	20.6	28.3	19.5	20.4
100,000–<500,000	7.9	10.1	13.0	9.7	13.1
500,000 or more	1.1	2.8	3.9	3.1	6.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The claim numbers and percentages for 2004−05 to 2007−08 may differ from those published in the 2007−08 report (AIHW 2011a) due to updates to the data (see text).
2. Percentages may not add up exactly to 100.0 due to rounding.

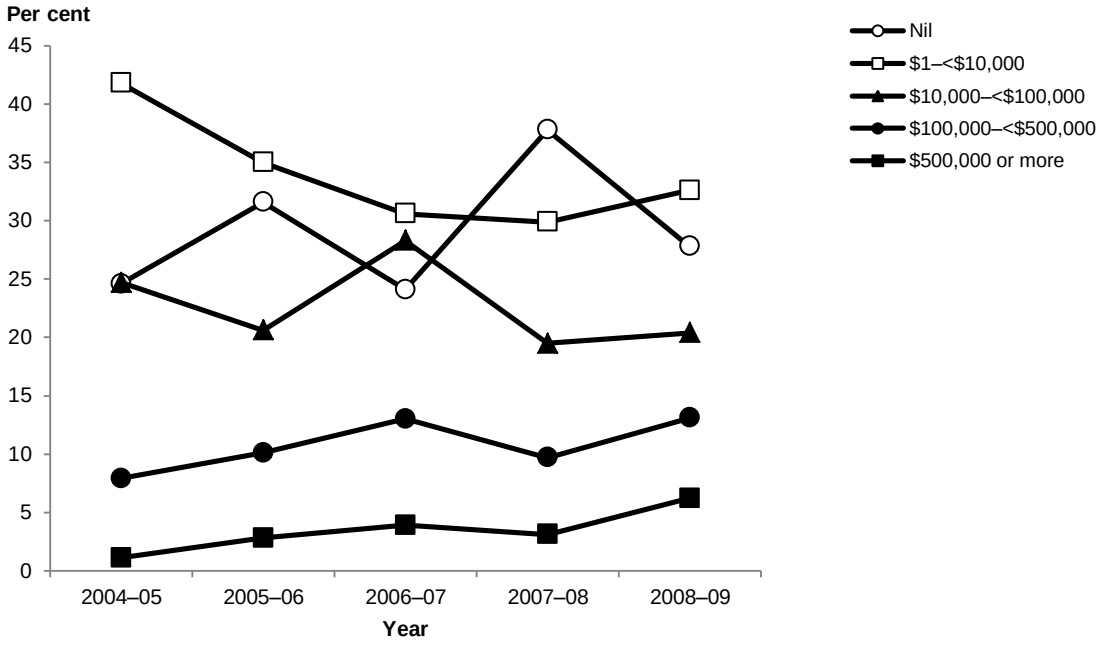

Figure 4.8: Closed claims: total claim size, 2004–05 to 2008–09 (per cent)

5 Primary incident/allegation information on public sector medical indemnity claims closed between 2004–05 and 2008–09

This chapter contains information on the primary incident/allegation categories recorded for the 9,698 claims that were closed during the period 2004–05 (July 2004 to June 2005) and 2008–09 (July 2008 to June 2009) and remained closed (not reopened) at 30 June 2009. This information is presented in the context of the clinical service context in which the alleged incidents occurred (Section 5.1), the claim subject's sex and age at the time of the incident (Section 5.2) and the cost of closing claims (Section 5.3). For the first time data are presented on the subcategories of the procedure, treatment and medication-related incident/allegation types giving rise to a medical indemnity claim.

5.1 Clinical service context

Table 5.1 presents an overview of how clinical service context relates to primary incident/allegation type for claims closed between 2004–05 and 2008–09. The three most frequently recorded clinical service contexts were *General surgery* (1,608 claims, 17%), *Accident and emergency* (1,474 claims, 15%) and *Obstetrics* (1,451 claims, 15%). The four most frequently recorded primary incident/allegation types were *Procedure* (3,340 claims, 34%), *Diagnosis* (2,039 claims, 21%), *Treatment* (1,571 claims, 16%) and *General duty of care* (879 claims, 9%).

Procedure was recorded for 60% or more of the claims with a clinical service context of *Gynaecology* (70%) or *General surgery* (60%). *Diagnosis* and *Treatment* were more associated with a clinical service context of *Accident and emergency*, being respectively recorded for 55% and 26% of these claims. *General duty of care* was associated with 50% of the claims with a *Psychiatry* clinical service context (Table 5.2).

Information is presented on *Procedure* subcategories for the 11 clinical service contexts associated with more than 50 claims with a primary incident/allegation type of *Procedure* (Table 5.3). *Post-operative complications* was the most frequently recorded subcategory overall (1,381 claims), followed by *Procedure – other* (901 claims). The only other *Procedure* subcategories recorded for more than 100 claims were *Failure of procedure* (376 claims), *Intra-operative complications* (275 claims) and *Failure to perform procedure* (156 claims).

There were differences between the clinical service contexts in terms of which subcategory was prominent in accounting for the *Procedure* primary incident/allegation type recorded for these claims (Table 5.4). *Post-operative complications* was the subcategory recorded for over half of the *Procedure*-related claims with a clinical service context of *Otolaryngology* (44 of 67 claims, 66%), *Neurology* (39 of 62 claims, 63%) and *Orthopaedics* (191 of 343 claims, 56%). *Procedure – other* was strongly associated with *Obstetrics* as a clinical service context (416 of 756 claims, 55%). *Failure to perform procedure* was associated with 25% of the 67 *Accident and emergency* claims with a primary incident/allegation type of *Procedure*.

Information is presented on *Treatment* subcategories for the six clinical service contexts associated with more than 50 claims with a primary incident/allegation type of *Treatment* (Table 5.5). *Treatment complications* was the most frequently recorded subcategory overall

(488 claims) particularly for the clinical service contexts of *Obstetrics* (101 of 258 claims, 39%), *General surgery* (52 of 154 claims, 34%) and *Orthopaedics* (27 of 90 claims, 30%). *Treatment – other* was recorded for 487 claims, notably where the clinical service context was *Accident and emergency* (109 of 382 claims, 29%), *Psychiatry* (56 of 97 claims, 58%) or *General medicine* (53 of 116 claims, 46%). The other three *Treatment* subcategories, *Delayed treatment*, *Treatment not provided* and *Failure of treatment*, were associated more frequently with the clinical service context of *Accident and emergency* (respectively, 94 claims, 46 claims and 35 claims) than with any other clinical service context.

Medication-related was not recorded very often as the primary incident/allegation type for claims closed between 2004–05 and 2008–09, but there were three clinical service contexts (*General medicine*, *General surgery* and *Accident and emergency*) associated with more than 50 of these claims (Table 5.6). There were two subcategories, of which *Type and dosage* consistently exceeded *Administration method* in the proportion of *Medication-related* claims with which it was associated, varying between 60% for *General surgery* and a higher proportion for any other clinical service context.

Table 5.1: Closed claims, 2004–05 to 2008–09: clinical service context, by primary incident/allegation type

	Primary incident/allegation type												
Clinical service context	**Procedure[a]**	**Diagnosis**	**Treatment[b]**	**General duty of care**	**Medication-related[c]**	**Anaesthetic**	**Consent[d]**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Not known**	**Total**
General surgery	953	187	154	35	57	124	33	31	8	9	7	10	1,608
Accident and emergency	67	796	382	105	52	4	5	14	8	3	15	23	1,474
Obstetrics	756	221	258	54	26	39	12	17	7	4	21	36	1,451
Orthopaedics	343	93	90	37	11	20	22	33	0	14	5	5	673
Gynaecology	460	53	33	22	8	22	36	7	1	12	4	8	666
General medicine	18	113	116	135	63	6	4	14	10	6	5	11	501
Psychiatry	9	44	97	211	26	1	3	0	6	0	29	6	432
General practice	39	91	31	36	33	5	3	2	2	0	4	7	253
Cardiology	86	40	36	14	12	7	5	5	4	4	1	1	215
Paediatrics	51	63	40	14	22	5	3	1	2	3	7	2	213
All other clinical service contexts	530	321	321	194	69	54	77	56	80	19	46	22	1,789
Not known	28	17	13	22	17	4	10	3	4	1	8	296	423
Total	**3,340**	**2,039**	**1,571**	**879**	**396**	**291**	**213**	**813**	**132**	**75**	**152**	**427**	**9,698**
Per cent[e]	*34.4*	*21.0*	*16.2*	*9.1*	*4.1*	*3.0*	*2.2*	*1.9*	*1.4*	*0.8*	*1.6*	*4.4*	*100.0*

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

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

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

(d) *Consent* includes failure to warn.

(e) Percentages do not add up exactly to 100.0 due to rounding.

Note: The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

Table 5.2: Closed claims, 2004–05 to 2008–09: clinical service context, by primary incident/allegation type (excluding *Not known*) (per cent)

	Primary incident/allegation type											
Clinical service context	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Anaesthetic**	**Consent**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
General surgery	59.6	11.7	9.6	2.2	3.6	7.8	2.1	1.9	0.5	0.6	0.4	100.0
Accident and emergency	4.6	54.9	26.3	7.2	3.6	0.3	0.3	1.0	0.6	0.2	1.0	100.0
Obstetrics	53.4	15.6	18.2	3.8	1.8	2.8	0.8	1.2	0.5	0.3	1.5	100.0
Orthopaedics	51.3	13.9	13.5	5.5	1.6	3.0	3.3	4.9	0.0	2.1	0.7	100.0
Gynaecology	69.9	8.1	5.0	3.3	1.2	3.3	5.5	1.1	0.2	1.8	0.6	100.0
General medicine	3.7	23.1	23.7	27.6	12.9	1.2	0.8	2.9	2.0	1.2	1.0	100.0
Psychiatry	2.1	10.3	22.8	49.5	6.1	0.2	0.7	0.0	1.4	0.0	6.8	100.0
General practice	15.9	37.0	12.6	14.6	13.4	2.0	1.2	0.8	0.8	0.0	1.6	100.0
Cardiology	40.2	18.7	16.8	6.5	5.6	3.3	2.3	2.3	1.9	1.9	0.5	100.0
Paediatrics	24.2	29.9	19.0	6.6	10.4	2.4	1.4	0.5	0.9	1.4	3.3	100.0
All other clinical service contexts	30.0	18.2	18.2	11.0	3.9	3.1	4.4	3.2	4.5	1.1	2.6	100.0
Total	**36.2**	**22.1**	**17.0**	**9.4**	**4.1**	**3.1**	**2.2**	**2.0**	**1.4**	**0.8**	**1.6**	**100.0**

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. The 427 claims coded *Not known* for 'primary incident/allegation type' and 423 coded *Not known* for 'clinical service context', including 296 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 9,144.
3. Percentages may not add up exactly to 100.0 due to rounding.

Table 5.3: Closed claims, 2004–05 to 2008–09: clinical service context, by subcategory of *Procedure* primary incident/allegation type

	***Procedure* primary incident/allegation type subcategory**									
Clinical service context	**Failure to perform procedure**	**Failure of procedure**	**Wrong procedure**	**Procedure—wrong body site**	**Procedure—post-operative complications**	**Procedure—intra-operative complications**	**Procedure—post-operative infection**	**Procedure—other**	**Total**	**Per cent**
General surgery	26	92	39	11	440	120	54	171	953	28.5
Obstetrics	34	44	7	2	209	40	4	416	756	22.6
Gynaecology	17	103	5	4	151	48	5	127	460	13.8
Orthopaedics	13	43	13	12	191	16	18	37	343	10.3
Cardiology	4	12	2	1	43	4	1	19	86	2.6
Urology	4	11	1	5	38	8	1	18	86	2.6
Dentistry	7	4	5	10	27	4	2	21	80	2.4
Accident and emergency	17	9	6	1	16	5	2	11	67	2.0
Otolaryngology	3	7	0	0	44	5	0	8	67	2.0
Neurology	2	5	2	5	39	4	0	5	62	1.9
Paediatrics	2	2	1	3	18	3	0	22	51	1.5
All other clinical service contexts	24	39	9	6	152	17	12	42	301	9.0
Total	**156**	**376**	**92**	**60**	**1,381**	**275**	**99**	**901**	**3,340**	**100.0**
Per cent of all closed claims	*1.6*	*3.9*	*0.9*	*0.6*	*14.2*	*2.8*	*1.0*	*9.3*	*34.4*	*. .*

Notes

1. The 'clinical service context' categories listed separately here are the 11 categories with more than 50 records of a *Procedure* primary incident/allegation type; all other categories are combined in the category *All other clinical service contexts*.

2. There were 28 claims with a *Procedure* primary incident/allegation type which were coded *Not known* for 'clinical service context'. The *Not known* row is not presented in the table; however, the numbers are included in the totals.

Table 5.4: Closed claims, 2004–05 to 2008–09: clinical service context (excluding *Not known*), by subcategory of *Procedure* primary incident/allegation type (per cent)

	***Procedure* primary incident/allegation type subcategory**								
Clinical service context	**Failure to perform procedure**	**Failure of procedure**	**Wrong procedure**	**Procedure—wrong body site**	**Procedure—post-operative complications**	**Procedure—intra-operative complications**	**Procedure—post-operative infection**	**Procedure—other**	**Total**
General surgery	2.7	9.7	4.1	1.2	46.2	12.6	5.7	17.9	100.0
Obstetrics	4.5	5.8	0.9	0.3	27.6	5.3	0.5	55.0	100.0
Gynaecology	3.7	22.4	1.1	0.9	32.8	10.4	1.1	27.6	100.0
Orthopaedics	3.8	12.5	3.8	3.5	55.7	4.7	5.2	10.8	100.0
Cardiology	4.7	14.0	2.3	1.2	50.0	4.7	1.2	22.1	100.0
Urology	4.7	12.8	1.2	5.8	44.2	9.3	1.2	20.9	100.0
Dentistry	8.8	5.0	6.3	12.5	33.8	5.0	2.5	26.3	100.0
Accident and emergency	25.4	13.4	9.0	1.5	23.9	7.5	3.0	16.4	100.0
Otolaryngology	4.5	10.4	0.0	0.0	65.7	7.5	0.0	11.9	100.0
Neurology	3.2	8.1	3.2	8.1	62.9	6.5	0.0	8.1	100.0
Paediatrics	3.9	3.9	2.0	5.9	35.3	5.9	0.0	43.1	100.0
All other clinical service contexts	8.0	13.0	3.0	2.0	50.5	5.6	4.0	14.0	100.0
Total	**4.6**	**11.2**	**2.7**	**1.8**	**41.3**	**8.3**	**3.0**	**27.1**	**100.0**

Notes

1. The 'clinical service context' categories listed separately here are the 11 categories with more than 50 records of a *Procedure* primary incident/allegation type; all other categories are combined in the category *All other clinical service contexts*.

2. The percentages in the bottom row are based on the 3,312 claims with a *Procedure* primary incident/allegation type and known clinical service context.

Table 5.5: Closed claims, 2004–05 to 2008–09: clinical service context, by subcategory of *Treatment* primary incident/allegation type

	***Treatment* primary incident/allegation type subcategory**						
Clinical service context	**Treatment not provided**	**Delayed treatment**	**Failure of treatment**	**Treatment complications**	**Treatment—other**	**Total**	**Per cent**
Accident and emergency	46	94	35	98	109	382	24.3
Obstetrics	18	70	7	101	62	258	16.4
General surgery	22	32	6	52	42	154	9.8
General medicine	12	14	2	35	53	116	7.4
Psychiatry	14	9	10	8	56	97	6.2
Orthopaedics	8	15	14	27	26	90	5.7
All other clinical service contexts	43	81	42	166	129	461	29.3
Total	**164**	**315**	**117**	**488**	**487**	**1,571**	**100.0**
Per cent of all closed claims	*1.7*	*3.2*	*1.2*	*5.0*	*5.0*	*16.2*	. .
			Per cent (excluding *Not known*)				
Accident and emergency	12.0	24.6	9.2	25.7	28.5	100.0	. .
Obstetrics	7.0	27.1	2.7	39.1	24.0	100.0	. .
General surgery	14.3	20.8	3.9	33.8	27.3	100.0	. .
General medicine	10.3	12.1	1.7	30.2	45.7	100.0	. .
Psychiatry	14.4	9.3	10.3	8.2	57.7	100.0	. .
Orthopaedics	8.9	16.7	15.6	30.0	28.9	100.0	. .
All other clinical service contexts	9.3	17.6	9.1	36.0	28.0	100.0	. .
Total	**10.5**	**20.2**	**7.4**	**31.3**	**30.6**	**100.0**	**. .**

Notes

1. The 'clinical service context' categories listed separately here are the six categories with more than 50 records of a *Treatment* primary incident/allegation type; all other categories are combined in the category *All other clinical service contexts*.

2. There were 13 claims with a *Treatment* primary incident/allegation type which were coded *Not known* for 'clinical service context'. The *Not known* row is not presented in the table; however, the numbers are included in the totals in the top half of the table. The percentages in the bottom row of the table are based on the 1,558 claims with a *Treatment* primary incident/allegation type and known clinical service context.

Table 5.6: Closed claims, 2004–05 to 2008–09: clinical service context, by subcategory of *Medication-related* primary incident/allegation type

Clinical service context	*Medication-related* primary incident/allegation type subcategory: Medication-related—type and dosage	Medication-related—administration method	Total	Per cent
General medicine	45	18	63	15.9
General surgery	34	23	57	14.4
Accident and emergency	40	12	52	13.1
All other clinical service contexts	169	38	207	52.3
Total	**297**	**99**	**396**	**100.0**
Per cent of all closed claims	*3.1*	*1.0*	*4.1*	. .
	Per cent (excluding *Not known*)			
General medicine	71.4	28.6	100.0	. .
General surgery	59.6	40.4	100.0	. .
Accident and emergency	76.9	23.1	100.0	. .
All other clinical service contexts	81.6	18.4	100.0	. .
Total	**76.0**	**24.0**	**100.0**	. .

Notes

1. The 'clinical service context' categories listed separately here are the three categories with more than 50 records of a *Medication-related* primary incident/allegation type; all other categories are combined in the category *All other clinical service contexts*.
2. There were 17 claims with a *Medication-related* primary incident/allegation type which were coded *Not known* for 'clinical service context'. The *Not known* row is not presented in the table; however, the numbers are included in the totals in the top half of the table. The percentages in the bottom row of the table are based on the 379 claims with a *Medication-related* primary incident/allegation type and known clinical service context.

5.2 Sex and age of claim subjects

During the 2004–05 and 2008–09 period, 720 *Closed claims* (7%) related to babies less than 1 year old, 628 claims (7%) related to people from 1 to 17 years of age, and 6,764 claims (70%) involved adults (18 years and over). In the case of adult-related claims, the number of claims declined consistently with the claim subject's increasing age, from 2,915 for adults aged 18–39 years to 231 for adults aged 80 years or more. The age of the claim subject was *Not known* for 1,586 claims (Table 5.7).

The claim subject was female in approximately 56% of claims. Female claim subjects outnumbered males in every adult age group, and particularly in the 18–39 year age group. This imbalance was reversed for claims relating to claim subjects less than 18 years of age, where more than half of the claim subjects were male.

The primary incident/allegation types recorded over the 2004–05 and 2008–09 period were similar for males and females (Table 5.8). *Procedure* was the most common primary incident/allegation type recorded for both sexes, but it was particularly common for claims where the claim subject was female (42%) rather than male (32%). For females the most common incident/allegation subcategories included *Procedure – post-operative complications* (17%) and *Procedure – other* (12%).

Procedure-related claims also accounted for almost half (47%) of all claims for babies, notably the subcategory *Procedure – other* (34% of all closed claims with the baby as claim subject).

As an incident/allegation type, *Treatment* was more likely to be recorded if the claim involved people less than 18 years of age rather than adults. More than 20% of the claims for both male and female claim subjects less than 18 years of age involved an incident or allegation related to *Treatment*, whereas this proportion was consistently less than 20% for every adult age group, except those aged 80 years or more where the proportion was 24%. Generally, *Diagnosis* was more strongly associated with claim subjects aged 1–17 years of age than with adults, specifically with males in the 5–17 year age group (39% of these claims) and with females in the 1–4 and 5–17 year age groups (38% and 30%, respectively).

Medication-related claims made up a higher proportion of claims with subjects in the 1–4 year-old age group (9%) than claims associated with any other age category (3–5%).

General duty of care appears to increase with claim subject age in terms of the proportion of claims associated with that incident/allegation type. It was the most frequently recorded category in claims where the claim subject was 80 years or older (30%).

The above findings for primary incident/allegation type are similar to those for claims closed between 2003–04 and 2007–08 (AIHW 2011a).

Table 5.7: Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by sex and age group (years) of claim subject

Primary incident/ allegation type	Age group								
	< 1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
					Males				
Failure to perform procedure	11	1	3	10	18	5	0	16	64
Failure of procedure	6	4	7	22	38	18	2	19	116
Wrong procedure	4	0	2	7	9	3	2	7	34
Procedure—wrong body site	1	2	5	1	11	5	0	6	31
Procedure—post-operative complications	21	7	17	84	174	131	9	68	511
Procedure—intra-operative complications	5	5	1	22	27	33	0	13	106
Procedure—post-operative infection	1	2	1	8	18	19	2	0	51
Procedure—other	122	8	15	29	43	39	2	30	288
Total procedure	**171**	**29**	**51**	**183**	**338**	**253**	**17**	**159**	**1,201**
Treatment not provided	7	0	9	21	15	11	2	10	75
Delayed treatment	21	7	14	34	41	16	2	15	150
Failure of treatment	2	1	5	14	13	4	2	15	56
Treatment complications	35	9	13	38	49	34	6	27	211
Treatment—other	22	5	18	56	51	22	10	33	217
Total treatment	**87**	**22**	**59**	**163**	**169**	**87**	**22**	**100**	**709**
Medication—type/dosage	8	7	8	37	31	24	5	26	146
Medication—administration method	1	4	3	21	12	2	0	3	46
Total medication-related	**9**	**11**	**11**	**58**	**43**	**26**	**5**	**29**	**192**
Diagnosis	80	22	94	251	246	101	12	151	957
General duty of care	7	5	9	112	92	56	26	93	400
Anaesthetic	2	1	5	13	42	17	1	28	109
Consent	3	5	4	16	15	7	1	16	67
Infection control	7	0	1	17	24	17	1	13	80
Blood/blood product-related	2	2	1	23	14	4	1	8	55
Device failure	3	3	4	6	8	5	2	4	35
Other	3	0	4	25	11	10	2	19	74
Not known	14	3	11	19	25	16	8	76	172
Total	**388**	**103**	**254**	**886**	**1,027**	**599**	**98**	**696**	**4,051**
Per cent	*9.6*	*2.5*	*6.3*	*21.9*	*25.4*	*14.8*	*2.4*	*17.2*	*100.0*

(continued)

Table 5.7 (continued): Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by sex and age group (years) of claim subject

Primary incident/ allegation type	Age group								Total
	< 1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
				Females					
Failure to perform procedure	8	2	2	30	22	6	0	22	92
Failure of procedure	5	2	4	135	57	28	3	25	259
Wrong procedure	1	2	3	18	20	9	1	3	57
Procedure—wrong body site	0	0	4	9	9	4	0	3	29
Procedure—post-operative complications	22	1	17	338	264	116	11	93	862
Procedure— intra-operative complications	6	0	7	51	65	23	5	10	167
Procedure—post-operative infection	1	0	1	17	22	4	1	2	48
Procedure—other	104	5	9	270	105	46	4	61	604
Total procedure	**147**	**12**	**47**	**868**	**564**	**236**	**25**	**219**	**2,118**
Treatment not provided	5	0	4	38	19	5	3	13	87
Delayed treatment	17	1	10	58	29	14	5	27	161
Failure of treatment	1	1	5	11	10	10	4	15	57
Treatment complications	24	10	13	105	56	33	9	22	272
Treatment—other	19	4	15	90	56	35	9	40	268
Total treatment	**66**	**16**	**47**	**302**	**170**	**97**	**30**	**117**	**845**
Medication—type/dosage	12	2	8	41	34	25	5	19	146
Medication—administration method	1	2	2	16	19	5	0	7	52
Total medication-related	**13**	**4**	**10**	**57**	**53**	**30**	**5**	**26**	**198**
Diagnosis	56	24	59	385	269	119	17	142	1,071
General duty of care	8	3	16	129	103	76	38	103	476
Anaesthetic	1	0	5	58	48	36	2	29	179
Consent	3	1	5	59	28	11	1	36	144
Infection control	2	0	2	27	24	13	5	17	90
Blood/blood product-related	3	1	2	24	14	7	1	11	63
Device failure	0	1	2	20	3	8	2	2	38
Other	3	2	2	29	13	5	0	18	72
Not known	12	3	2	55	32	12	6	54	176
Total	**314**	**67**	**199**	**2,013**	**1,321**	**650**	**132**	**774**	**5,470**
Per cent	*5.7*	*1.2*	*3.6*	*36.8*	*24.1*	*11.9*	*2.4*	*14.1*	*100.0*

(continued)

Table 5.7 (continued): Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by sex and age group (years) of claim subject

Primary incident/ allegation type	Age group								Total
	< 1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
	Persons[(a)]								
Failure to perform procedure	19	3	5	40	40	11	0	38	156
Failure of procedure	11	6	11	157	95	46	5	45	376
Wrong procedure	5	2	5	25	29	13	3	10	92
Procedure—wrong body site	1	2	9	10	20	9	0	9	60
Procedure—post-operative complications	45	8	34	423	442	248	20	161	1,381
Procedure—intra-operative complications	11	6	8	73	92	56	5	24	275
Procedure—post-operative infection	2	2	2	25	40	23	3	2	99
Procedure—other	232	13	24	300	149	85	6	92	901
Total procedure	**326**	**42**	**98**	**1053**	**907**	**491**	**42**	**381**	**3,340**
Treatment not provided	12	0	13	60	35	16	5	23	164
Delayed treatment	38	8	24	92	72	30	7	44	315
Failure of treatment	4	2	10	25	24	14	6	32	117
Treatment complications	60	19	26	144	106	67	15	51	488
Treatment—other	41	9	33	148	107	57	19	73	487
Total treatment	**155**	**38**	**106**	**469**	**344**	**184**	**52**	**223**	**1,571**
Medication—type/dosage	20	9	16	78	65	50	10	49	297
Medication—administration method	3	6	5	37	31	7	0	10	99
Total medication-related	**23**	**15**	**21**	**115**	**96**	**57**	**10**	**59**	**396**
Diagnosis	137	47	153	637	518	220	30	297	2,039
General duty of care	15	8	25	243	195	132	64	197	879
Anaesthetic	3	1	10	71	91	54	3	58	291
Consent	6	6	9	75	43	18	2	54	213
Infection control	9	0	3	44	48	30	6	43	183
Blood/blood product-related	5	3	3	47	28	11	2	33	132
Device failure	3	4	6	26	11	13	4	8	75
Other	8	2	7	55	24	15	2	39	152
Not known	30	6	15	80	59	29	14	194	427
Total	**720**	**172**	**456**	**2,915**	**2,364**	**1,254**	**231**	**1,586**	**9,698**
Per cent	*7.4*	*1.8*	*4.7*	*30.1*	*24.4*	*12.9*	*2.4*	*16.4*	*100.0*

(a) Includes 177 persons of unknown sex.

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

Table 5.8: Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by sex and age group (years) of claim subject (excluding *Not known*) (per cent)

Primary incident/ allegation type	Age group							
	< 1	1–4	5–17	18–39	40–59	60–79	80 or more	Total
				Males				
Failure to perform procedure	2.9	1.0	1.2	1.2	1.8	0.9	0.0	1.5
Failure of procedure	1.6	4.0	2.9	2.5	3.8	3.1	2.2	3.0
Wrong procedure	1.1	0.0	0.8	0.8	0.9	0.5	2.2	0.8
Procedure—wrong body site	0.3	2.0	2.1	0.1	1.1	0.9	0.0	0.8
Procedure—post-operative complications	5.6	7.0	7.0	9.7	17.4	22.5	10.0	13.6
Procedure—intra-operative complications	1.3	5.0	0.4	2.5	2.7	5.7	0.0	2.9
Procedure—post-operative infection	0.3	2.0	0.4	0.9	1.8	3.3	2.2	1.6
Procedure—other	32.6	8.0	6.2	3.3	4.3	6.7	2.2	7.9
Total procedure	**45.7**	**29.0**	**21.0**	**21.0**	**33.7**	**43.4**	**18.9**	**32.0**
Treatment not provided	1.9	0.0	3.7	2.4	1.5	1.9	2.2	2.0
Delayed treatment	5.6	7.0	5.8	3.9	4.1	2.7	2.2	4.1
Failure of treatment	0.5	1.0	2.1	1.6	1.3	0.7	2.2	1.3
Treatment complications	9.4	9.0	5.3	4.4	4.9	5.8	6.7	5.6
Treatment—other	5.9	5.0	7.4	6.5	5.1	3.8	11.1	5.6
Total treatment	**23.3**	**22.0**	**24.3**	**18.8**	**16.9**	**14.9**	**24.4**	**18.7**
Medication—type/dosage	2.1	7.0	3.3	4.3	3.1	4.1	5.6	3.7
Medication—administration method	0.3	4.0	1.2	2.4	1.2	0.3	0.0	1.3
Total medication-related	**2.4**	**11.0**	**4.5**	**6.7**	**4.3**	**4.4**	**5.6**	**5.0**
Diagnosis	21.4	22.0	38.7	29.0	24.6	17.3	13.3	24.7
General duty of care	1.9	5.0	3.7	12.9	9.2	9.6	28.9	9.4
Anaesthetic	0.5	1.0	2.1	1.5	4.2	2.9	1.1	2.5
Consent	0.8	5.0	1.6	1.8	1.5	1.2	1.1	1.6
Infection control	1.9	0.0	0.4	2.0	2.4	2.9	1.1	2.1
Blood/blood product-related	0.5	2.0	0.4	2.7	1.4	0.7	1.1	1.4
Device failure	0.8	3.0	1.6	0.7	0.8	0.9	2.2	1.0
Other	0.8	0.0	1.6	2.9	1.1	1.7	2.2	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(continued)

Table 5.8 (continued): Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by sex and age group (years) of claim subject (excluding *Not known*) (per cent)

Primary incident/ allegation type	Age group							
	< 1	1–4	5–17	18–39	40–59	60–79	80 or more	Total
				Females				
Failure to perform procedure	2.6	3.1	1.0	1.5	1.7	0.9	0.0	1.5
Failure of procedure	1.7	3.1	2.0	6.9	4.4	4.4	2.4	5.1
Wrong procedure	0.3	3.1	1.5	0.9	1.6	1.4	0.8	1.2
Procedure— wrong body site	0.0	0.0	2.0	0.5	0.7	0.6	0.0	0.6
Procedure—post-operative complications	7.3	1.6	8.6	17.3	20.5	18.2	8.7	16.8
Procedure—intra-operative complications	2.0	0.0	3.6	2.6	5.0	3.6	4.0	3.4
Procedure—post-operative infection	0.3	0.0	0.5	0.9	1.7	0.6	0.8	1.0
Procedure—other	34.4	7.8	4.6	13.8	8.1	7.2	3.2	11.9
Total procedure	**48.7**	**18.8**	**23.9**	**44.3**	**43.8**	**37.0**	**19.8**	**41.5**
Treatment not provided	1.7	0.0	2.0	1.9	1.5	0.8	2.4	1.6
Delayed treatment	5.6	1.6	5.1	3.0	2.2	2.2	4.0	2.9
Failure of treatment	0.3	1.6	2.5	0.6	0.8	1.6	3.2	0.9
Treatment complications	7.9	15.6	6.6	5.4	4.3	5.2	7.1	5.5
Treatment—other	6.3	6.3	7.6	4.6	4.3	5.5	7.1	5.0
Total treatment	**21.9**	**25.0**	**23.9**	**15.4**	**13.2**	**15.2**	**23.8**	**15.9**
Medication—type/dosage	4.0	3.1	4.1	2.1	2.6	3.9	4.0	2.8
Medication—administration method	0.3	3.1	1.0	0.8	1.5	0.8	0.0	1.0
Total medication-related	**4.3**	**6.3**	**5.1**	**2.9**	**4.1**	**4.7**	**4.0**	**3.8**
Diagnosis	18.5	37.5	29.9	19.7	20.9	18.7	13.5	20.3
General duty of care	2.6	4.7	8.1	6.6	8.0	11.9	30.2	8.2
Anaesthetic	0.3	0.0	2.5	3.0	3.7	5.6	1.6	3.3
Consent	1.0	1.6	2.5	3.0	2.2	1.7	0.8	2.4
Infection control	0.7	0.0	1.0	1.4	1.9	2.0	4.0	1.6
Blood/blood product-related	1.0	1.6	1.0	1.2	1.1	1.1	0.8	1.1
Device failure	0.0	1.6	1.0	1.0	0.2	1.3	1.6	0.8
Other	1.0	3.1	1.0	1.5	1.0	0.8	0.0	1.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(continued)

Table 5.8 (continued): Closed claims, 2004–05 to 2008–09: primary incident/allegation type by sex and age group (years) of claim subject (excluding *Not known*) (per cent)

Primary incident/ allegation type	Age group							
	< 1	1–4	5–17	18–39	40–59	60–79	80 or more	Total
				Persons[(a)]				
Failure to perform procedure	2.8	1.8	1.1	1.4	1.7	0.9	0.0	1.5
Failure of procedure	1.6	3.6	2.5	5.5	4.1	3.8	2.3	4.2
Wrong procedure	0.7	1.2	1.1	0.9	1.3	1.1	1.4	1.0
Procedure—wrong body site	0.1	1.2	2.0	0.4	0.9	0.7	0.0	0.6
Procedure—post-operative complications	6.5	4.8	7.7	14.9	19.2	20.2	9.2	15.5
Procedure—intra-operative complications	1.6	3.6	1.8	2.6	4.0	4.6	2.3	3.2
Procedure—post-operative infection	0.3	1.2	0.5	0.9	1.7	1.9	1.4	1.2
Procedure—other	33.7	7.8	5.4	10.6	6.5	6.9	2.8	10.3
Total procedure	**47.2**	**25.3**	**22.2**	**37.1**	**39.3**	**40.1**	**19.4**	**37.6**
Treatment not provided	1.7	0.0	2.9	2.1	1.5	1.3	2.3	1.8
Delayed treatment	5.5	4.8	5.4	3.2	3.1	2.4	3.2	3.4
Failure of treatment	0.6	1.2	2.3	0.9	1.0	1.1	2.8	1.1
Treatment complications	8.7	11.4	5.9	5.1	4.6	5.5	6.9	5.5
Treatment—other	5.9	5.4	7.5	5.2	4.6	4.7	8.8	5.3
Total treatment	**22.5**	**22.9**	**24.0**	**16.5**	**14.9**	**15.0**	**24.0**	**17.1**
Medication—type/dosage	2.9	5.4	3.6	2.8	2.8	4.1	4.6	3.1
Medication—administration method	0.4	3.6	1.1	1.3	1.3	0.6	0.0	1.1
Total medication-related	**3.3**	**9.0**	**4.8**	**4.1**	**4.2**	**4.7**	**4.6**	**4.3**
Diagnosis	19.9	28.3	34.7	22.5	22.5	18.0	13.8	22.1
General duty of care	2.2	4.8	5.7	8.6	8.5	10.8	29.5	8.7
Anaesthetic	0.4	0.6	2.3	2.5	3.9	4.4	1.4	3.0
Consent	0.9	3.6	2.0	2.6	1.9	1.5	0.9	2.0
Infection control	1.3	0.0	0.7	1.6	2.1	2.4	2.8	1.8
Blood/blood product-related	0.7	1.8	0.7	1.7	1.2	0.9	0.9	1.3
Device failure	0.4	2.4	1.4	0.9	0.5	1.1	1.8	0.9
Other	1.2	1.2	1.6	1.9	1.0	1.2	0.9	1.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes 61 persons of unknown sex but known age group.

Notes

1. The number of claims on which the percentages presented in this table are based is 7,879 claims.
2. Percentages for the *Procedure*, *Treatment* and *Medication-related* subcategories may not add up exactly to the percentages for the *Procedure*, *Treatment* and *Medication-related* categories due to rounding.
3. Percentages may not add up exactly to 100.0 due to rounding.

5.3 Cost of claims

'Total claim size' is the amount paid in closing a claim including legal and investigative costs. Of the claims closed between 2004–05 and 2008–09 (Table 5.9), 29% (2,811 claims) were closed for no cost, 34% (3,250 claims) were closed for a cost less than $10,000, and 23% (2,214 claims) for $10,000–<$100,000. The proportion closed for $500,000 or more was 3% (328 claims).

No payment was made for over half of the claims with a *Blood/blood product-related* incident/allegation type (52%), and for around one-third of the claims with *Procedure – other* (37%), *Device failure* (36%), *Infection control* (35%), *General duty of care* (34%), *Anaesthetic* (34%), *Treatment complications* (32%) and *Procedure – post-operative complications* (31%) recorded as their incident/allegation type (Table 5.10).

Claims with a *Medication-related* incident/allegation type were settled for relatively large amounts, especially those in the *Administration method* subcategory. The proportions of *Medication-related* claims settled for $100,000–<$500,000 and at least $500,000 were 17% and 6% respectively. Where *Administration method* was the primary incident/allegation type, 26% of claims were settled for $100,000–<$500,000 and 10% for at least $500,000.

Table 5.9: Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by total claim size ($)

Primary incident/ allegation type	Total claim size						
	No payment made	Less than 10,000	10,000– <100,000	100,000– <500,000	500,000 or more	Not known	Total
Failure to perform procedure	17	57	51	18	8	5	156
Failure of procedure	54	111	139	60	9	3	376
Wrong procedure	7	29	44	10	2	0	92
Procedure—wrong body site	12	16	20	11	1	0	60
Procedure—post-operative complications	420	449	353	135	20	4	1,381
Procedure—intra-operative complications	44	106	89	29	6	1	275
Procedure—post-operative infection	9	40	37	12	1	0	99
Procedure—other	331	307	159	72	31	1	901
Total procedure	**894**	**1,115**	**892**	**347**	**78**	**14**	**3,340**
Treatment not provided	32	64	39	24	5	0	164
Delayed treatment	75	119	61	41	16	3	315
Failure of treatment	14	53	23	16	7	4	117
Treatment complications	156	191	96	32	10	3	488
Treatment—other	127	150	119	72	19	0	487
Total treatment	**404**	**577**	**338**	**185**	**57**	**10**	**1,571**
Medication—type/dosage	71	99	72	40	14	1	297
Medication—administration method	7	27	29	26	10	0	99
Total medication-related	**78**	**126**	**101**	**66**	**24**	**1**	**396**
Diagnosis	514	669	456	278	118	4	2,039
General duty of care	296	321	182	59	19	2	879
Anaesthetic	98	115	47	28	3	0	291
Consent	44	55	81	26	6	1	213
Infection control	64	69	26	21	3	0	183
Blood/blood product-related	69	35	16	12	0	0	132
Device failure	27	22	21	5	0	0	75
Other	38	54	43	13	3	1	152
Not known	285	92	11	14	17	8	427
Total	**2,811**	**3,250**	**2,214**	**1,054**	**328**	**41**	**9,698**
Per cent	*29.0*	*33.5*	*22.8*	*10.9*	*3.4*	*0.4*	*100.0*

Table 5.10: Closed claims, 2004–05 to 2008–09: primary incident/allegation type, by total claim size ($) (excluding *Not known*) (per cent)

	Total claim size					
Primary incident/ allegation type	**No payment made**	**Less than 10,000**	**10,000– <100,000**	**100,000– <500,000**	**500,000 or more**	**Total**
Failure to perform procedure	11.3	37.7	33.8	11.9	5.3	100.0
Failure of procedure	14.5	29.8	37.3	16.1	2.4	100.0
Wrong procedure	7.6	31.5	47.8	10.9	2.2	100.0
Procedure—wrong body site	20.0	26.7	33.3	18.3	1.7	100.0
Procedure—post-operative complications	30.5	32.6	25.6	9.8	1.5	100.0
Procedure—intra-operative complications	16.1	38.7	32.5	10.6	2.2	100.0
Procedure—post-operative infection	9.1	40.4	37.4	12.1	1.0	100.0
Procedure—other	36.8	34.1	17.7	8.0	3.4	100.0
Total procedure	**26.9**	**33.5**	**26.8**	**10.4**	**2.3**	**100.0**
Treatment not provided	19.5	39.0	23.8	14.6	3.0	100.0
Delayed treatment	24.0	38.1	19.6	13.1	5.1	100.0
Failure of treatment	12.4	46.9	20.4	14.2	6.2	100.0
Treatment complications	32.2	39.4	19.8	6.6	2.1	100.0
Treatment—other	26.1	30.8	24.4	14.8	3.9	100.0
Total treatment	**25.9**	**37.0**	**21.7**	**11.9**	**3.7**	**100.0**
Medication—type/dosage	24.0	33.4	24.3	13.5	4.7	100.0
Medication—administration method	7.1	27.3	29.3	26.3	10.1	100.0
Total medication-related	**19.7**	**31.9**	**25.6**	**16.7**	**6.1**	**100.0**
Diagnosis	25.3	32.9	22.4	13.7	5.8	100.0
General duty of care	33.8	36.6	20.8	6.7	2.2	100.0
Anaesthetic	33.7	39.5	16.2	9.6	1.0	100.0
Consent	20.8	25.9	38.2	12.3	2.8	100.0
Infection control	35.0	37.7	14.2	11.5	1.6	100.0
Blood/blood product-related	52.3	26.5	12.1	9.1	0.0	100.0
Device failure	36.0	29.3	28.0	6.7	0.0	100.0
Other	25.2	35.8	28.5	8.6	2.0	100.0
Total	**27.3**	**34.2**	**23.8**	**11.3**	**3.4**	**100.0**

Notes

1. The number of claims on which the percentages presented in this table are based is 9,238 claims.
2. Percentages may not add up exactly to 100.0 due to rounding.

6 Accident and emergency claims, 2004–05 to 2008–09

This chapter focuses on claims with a clinical service context of *Accident and emergency*. These claims account for a substantial proportion of claims in the MINC database. The proportion varied between 16% and 20% of new claims in each year from 2004–05 to 2008–09 (Table 4.2), and accounted for 15% of the pooled claims closed between 2004–05 and 2008–09 (Table 6.2).

The first part of this chapter (Section 6.1) summarises the information from previous chapters on claims with an *Accident and emergency* clinical service context, and presents some supplementary data on *Accident and emergency* claims closed between 2004−05 and 2008−09. Section 6.2 analyses data on the principal clinician specialty recorded for these claims, while Section 6.3 analyses these claims in terms of their extent of harm, claim size and primary incident/allegation type.

6.1 Overview of Accident and emergency claims

There were 162 new claims in 2008–09 with *Accident and emergency* recorded as their clinical service context, more than for any other clinical service context (Table 3.2). The majority (98 claims, 60%) were associated with an alleged incident in *Major cities*, similar to new claims as a whole (66%). In regard to primary incident/allegation types (tables 3.4, 5.1 and 5.2), *Diagnosis* and *Treatment* were the two most commonly recorded categories for new 2008–09 *Accident and emergency* claims (respectively, 72 or 44% and 51 or 32% of claims) and also for the 1,474 *Accident and emergency* claims closed at some point between 2004–05 and 2008–09 (respectively, 796 or 55% and 382 or 26% of claims). The main treatment subcategories were *Treatment – other*, *Treatment complications* and *Delayed treatment*, respectively accounting for 29%, 26% and 25% of the 382 closed *Accident and emergency* claims with *Treatment* recorded as the primary incident/allegation type (Table 5.5).

In terms of claims closed in 2008–09, *Accident and emergency* claims were relatively costly, with 11% closed for $500,000 or more (Table 3.13). This is a higher proportion than the 3% of *Accident and emergency* claims closed at some point between 2003–04 and 2007–08 for $500,000 or more (AIHW 2011a).

Some additional information on *Accident and emergency* claims closed between 2004–05 and 2008–09 is presented in tables 6.1 to 6.3. These tables compare *Accident and emergency* claims with *General surgery* and *Obstetrics* claims (the other two most frequently recorded clinical service contexts).

Clinical service context

A clinical service context of *Accident and emergency* was recorded for more of the claims with a male claim subject (775 of 4,051 claims, 19%) than a female claim subject (688 of 5,470 claims, 13%). The age groups 18–39 and 40–59 years old made up a larger proportion of *Accident and emergency* claims (38% and 29% respectively) than any other age groups, as was the case for claims in general (36% and 29% respectively). The age groups associated with a relatively high proportion of *Accident and emergency* claims were 1–4 years old (4% of *Accident and emergency* claims, 2% of claims overall) and 5–17 years old (11% of *Accident and emergency* claims, 6% of claims overall).

In 96% of *Accident and emergency* claims the 'health service setting' was a public hospital/day surgery, similar to 99% of *General surgery* and *Obstetrics* claims (Table 6.2).

Accident and emergency claims differ from *General surgery* and *Obstetrics* claims in their 'claim subject's status'. This item records whether the claim subject was an admitted hospital patient (public or private), a resident in a residential health care setting or *Other.* The elective status of admitted hospital patients as private or public is a different matter from whether they received their health service delivery at a public or private institution (AIHW 2011a), which is why the number of claims for private admitted hospital patients (Table 6.3) differs from the number of claims for private health service settings (Table 6.2). The *Other* claim subject's status category is defined to include patients attending an outpatient clinic, a general practice surgery, an Accident and emergency ward, or other non-admitted, non-residential service (AIHW 2006b). However, jurisdictions vary in the degree to which *Accident and emergency* claims in a public hospital/day surgery have the claim subject status recorded as *Other* or an admitted patient category. Accordingly, with 49% of *Accident and emergency* claims the claim subject's status was *Other* and with 48% it was an admitted patient category (Table 6.3).

Table 6.1: Closed claims, 2004–05 to 2008–09: clinical service context, by sex and age group (years) of claim subject

	Age group							
Clinical service context	**< 1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Total**
				Males				
Accident and emergency	21	24	81	245	198	78	11	775
General surgery	6	12	26	159	276	197	16	771
Obstetrics	273	4	8	0	0	0	0	361
All other clinical service contexts	85	55	129	457	522	308	61	1,969
Total	**388**	**103**	**254**	**886**	**1,027**	**599**	**98**	**4,051**
				Females				
Accident and emergency	12	22	48	226	154	85	24	688
General surgery	2	4	29	225	308	177	19	824
Obstetrics	222	6	10	683	58	1	0	1,075
All other clinical service contexts	72	35	109	839	769	369	80	2,720
Total	**314**	**67**	**199**	**2,013**	**1,321**	**650**	**132**	**5,470**
				Persons				
Accident and emergency	33	47	129	472	354	163	36	1,474
General surgery	8	16	55	385	586	375	35	1,608
Obstetrics	507	10	18	683	58	1	0	1,451
All other clinical service contexts	159	91	239	1,302	1,299	679	141	4,742
Total	**720**	**172**	**456**	**2,915**	**2,364**	**1,254**	**231**	**9,698**
				Per cent (excluding *Not known*)				
				Males				
Accident and emergency	3.2	3.6	12.3	37.2	30.1	11.9	1.7	100.0
General surgery	0.9	1.7	3.8	23.0	39.9	28.5	2.3	100.0
Obstetrics	95.8	1.4	2.8	0.0	0.0	0.0	0.0	100.0
All other clinical service contexts	5.3	3.4	8.0	28.3	32.3	19.0	3.8	100.0
Total	**11.8**	**2.9**	**7.5**	**26.5**	**30.6**	**17.9**	**2.7**	**100.0**
				Females				
Accident and emergency	2.1	3.9	8.4	39.6	27.0	14.9	4.2	100.0
General surgery	0.3	0.5	3.8	29.5	40.3	23.2	2.5	100.0
Obstetrics	22.7	0.6	1.0	69.7	5.9	0.1	0.0	100.0
All other clinical service contexts	3.2	1.5	4.8	36.9	33.8	16.2	3.5	100.0
Total	**6.7**	**1.5**	**4.3**	**43.0**	**28.1**	**13.8**	**2.7**	**100.0**
				Persons				
Accident and emergency	2.7	3.8	10.5	38.2	28.7	13.2	2.9	100.0
General surgery	0.5	1.1	3.8	26.4	40.1	25.7	2.4	100.0
Obstetrics	39.7	0.8	1.4	53.5	4.5	0.1	0.0	100.0
All other clinical service contexts	4.1	2.3	6.1	33.3	33.2	17.4	3.6	100.0
Total	**9.0**	**2.1**	**5.6**	**36.1**	**29.1**	**15.5**	**2.7**	**100.0**

Notes

1. *Persons* include 177 persons of unknown sex.
2. There were 423 claims coded *Not known* for 'clinical service context' and 1,586 claims coded *Not known* for claim subject's age group. These claims are included in the totals even though the *Not known* row and column are not presented. The number of claims on which the percentages in the bottom half of the table are based is 7,881.
3. Percentages may not add up exactly to 100.0 due to rounding.

Table 6.2: Closed claims, 2004–05 to 2008–09: clinical service context, by health service setting

Clinical service context	Health service setting					Total	Per cent
	Public hospital/ day surgery[(a)]	Other public setting[(b)]	Private setting[(c)]	Other[(d)]	Not known		
Accident and emergency	1,421	32	6	15	0	1,474	15.2
General surgery	1,584	6	11	3	4	1,608	16.6
Obstetrics	1,425	2	11	3	10	1,451	15.0
All other clinical service contexts	4,302	231	132	56	21	4,742	48.9
Not known	169	5	3	2	244	423	4.4
Total	**8,901**	**276**	**163**	**79**	**279**	**9,698**	**100.0**
Per cent	91.8	2.8	1.7	0.8	2.9	100.0	. .
	Per cent (excluding *Not known*)						
Accident and emergency	96.4	2.2	0.4	1.0	. .	100.0	. .
General surgery	98.8	0.4	0.7	0.2	. .	100.0	. .
Obstetrics	98.9	0.1	0.8	0.2	. .	100.0	. .
All other clinical service contexts	91.1	4.9	2.8	1.2	. .	100.0	. .
Total	**94.5**	**2.9**	**1.7**	**0.8**	**. .**	**100.0**	**. .**

(a) Includes public psychiatric hospitals.

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

(c) Includes private hospitals/day surgeries, private clinics providing investigation and treatment on a non-residential, day-only basis, private hospices, and private alcohol and drug rehabilitation centres.

(d) 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).

Notes

1. The 458 claims coded Not known for 'clinical service context' or 'health service setting' are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 9,240 claims.

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

Table 6.3: Closed claims, 2004–05 to 2008–09: clinical service context, by claim subject's status

Clinical service context	Claim subject's status: Public admitted hospital patient	Private admitted hospital patient	Resident	Other	Not known	Total	Per cent
Accident and emergency	664	50	0	681	79	1,474	15.2
General surgery	1,305	47	0	23	233	1,608	16.6
Obstetrics	1,126	71	1	23	230	1,451	15.0
All other clinical service contexts	3,271	178	20	667	606	4,742	48.9
Not known	107	8	0	8	300	423	4.4
Total	**6,473**	**354**	**21**	**1,402**	**1,448**	**9,698**	**100.0**
Per cent	66.7	3.7	0.2	14.5	14.9	100.0	. .
	Per cent (excluding *Not known*)						
Accident and emergency	47.6	3.6	0.0	48.8	. .	100.0	. .
General surgery	94.9	3.4	0.0	1.7	. .	100.0	. .
Obstetrics	92.2	5.8	0.1	1.9	. .	100.0	. .
All other clinical service contexts	79.1	4.3	0.5	16.1	. .	100.0	. .
Total	**78.5**	**4.3**	**0.3**	**17.0**	**. .**	**100.0**	**. .**

Notes

1. The 1,571 claims coded Not known for 'clinical service context' or 'claim subject's status' are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 8,127 claims.
2. Percentages may not add up exactly to 100.0 due to rounding.

6.2 Principal clinician specialties

As shown in previous MINC public sector reports (AIHW 2004, 2005, 2006a, 2007, 2009), claims related to a given clinical service context also tend to record the involvement of clinicians who are specialists in that area of health service delivery; for instance, *General surgery* in both data items, or *Emergency medicine* specialists in *Accident and emergency*. This section provides information on the clinical specialties reported for *Accident and emergency* claims closed between 2004–05 and 2008–09. The aspects of claims considered are geographic location, body function/structure affected, incident/allegation type, extent of harm and claim size.

A clear majority of claims with an *Accident and emergency* clinical service context recorded *Emergency medicine* as the primary clinician specialty (70%), but there were 11 other clinician specialties recorded for between 15 and 62 claims (Table 6.4). Where *General practice – procedural* was the clinician specialty, while only a small number of claims are involved overall (27), 41% of claims were related to alleged incidents in *Outer regional* and *Remote and very remote* locations. Otherwise, the majority of *Accident and emergency* claims were related to *Major cities* regardless of the clinician specialty, although 42% of the 26 claims with *Diagnostic radiology* as the clinician specialty were *Inner regional* in their geographical location.

Over one-third (37%) of *Accident and emergency* claims had the affected primary body function/structure recorded as *Neuromusculoskeletal and movement-related*, which was particularly prevalent when the clinician specialty was *Orthopaedic surgery* (25 claims, 96%) or *Diagnostic radiology* (15 claims, 60%). There were other body function/structure categories recorded at relatively high rates for a particular clinician specialty: 48% of the 23 *General surgery*-related claims were linked to effects to the *Digestive, metabolic and endocrine systems*, and 40% of the 20 claims with *Psychiatry* as the clinician specialty were associated with *Mental and nervous system* effects (tables 6.5 and 6.6).

The claim subject's death was implicated in over one-fifth of *Accident and emergency* claims (300 claims, 22%) and at relatively high rates where the recorded clinician specialty was *Cardiology* (12 of 15 claims, 80%), *Psychiatry* (9 of 20 claims, 45%) or *Paramedical and ambulance staff* (15 of 38 claims, 42%).

Diagnosis was the main primary incident/allegation type recorded for *Accident and emergency* claims (55%), especially when the cited clinician specialty was *Diagnostic radiology* (22 of 26 claims, 85%) or *Other hospital-based medical practitioner* (46 of 62 claims, 74%). An incident/allegation of *Treatment* was recorded for over one-quarter (26%) of *Accident and emergency* claims and for 44–45% where the clinician specialty was recorded as *Paramedical and ambulance staff* (17 of 38 claims), *Orthopaedic surgery* (12 of 28 claims) or *Nursing practitioner* (9 of 20 claims). A *General duty of care* incident/allegation type was recorded for 45% of the claims where *Psychiatry* (9 of 20 claims) was the clinician specialty and 43% where it was *General nursing* (12 of 38 claims) (Table 6.7).

The extent of harm was recorded as *Major* for a higher proportion of *Accident and emergency* claims where the clinician specialty was *Orthopaedic surgery* (8 of 28 claims, 29%) than for any other clinician specialty category (Table 6.8).

Orthopaedic surgery-related claims also had the highest proportion with a settlement size of $100,000 or more (10 of 28 claims, 36%). Nearly three-quarters (28 of 38 claims, 74%) of claims associated with *Paramedical and ambulance staff* were closed for no payment or an amount less than $10,000 (Table 6.9), even though the claim subject was recorded to have died for 60% of these claims (Table 6.8).

Table 6.4: Closed claims with an *Accident and emergency* clinical service context, 2004–05 to 2008–09: principal clinician specialty, by geographic location

Principal clinician specialty[(b)]	Geographic location[(a)]				Total	Per cent
	Major cities	Inner regional	Outer regional	Remote and very remote		
Emergency medicine	683	262	71	12	1,031	69.9
Other hospital-based medical practitioner	36	16	7	3	62	4.2
General practice—non-procedural	30	20	6	1	57	3.9
Paramedical and ambulance staff	22	15	1	0	38	2.6
General nursing	16	7	4	1	28	1.9
Orthopaedic surgery	16	8	2	2	28	1.9
General practice—procedural	9	7	9	2	27	1.8
Diagnostic radiology	15	11	0	0	26	1.8
General surgery	17	4	2	0	23	1.4
Nursing practitioner	13	6	1	0	20	1.4
Psychiatry	15	3	1	1	20	1.4
Cardiology	11	4	0	0	15	1.0
All other specialties	65	17	4	1	87	5.9
Total	**956**	**382**	**110**	**23**	**1,474**	**100.0**
	Per cent (excluding *Not known*)[(c)]					
Emergency medicine	66.4	25.5	6.9	1.2	100.0	. .
Other hospital-based medical practitioner	58.1	25.8	11.3	4.8	100.0	. .
General practice—non-procedural	52.6	35.1	10.5	1.8	100.0	. .
Paramedical and ambulance staff	57.9	39.5	2.6	0.0	100.0	. .
General nursing	57.1	25.0	14.3	3.6	100.0	. .
Orthopaedic surgery	57.1	28.6	7.1	7.1	100.0	. .
General practice—procedural	33.3	25.9	33.3	7.4	100.0	. .
Diagnostic radiology	57.7	42.3	0.0	0.0	100.0	. .
General surgery	73.9	17.4	8.7	0.0	100.0	. .
Nursing practitioner	65.0	30.0	5.0	0.0	100.0	. .
Psychiatry	75.0	15.0	5.0	5.0	100.0	. .
Cardiology	73.3	26.7	0.0	0.0	100.0	. .
All other specialties	74.7	19.5	4.6	1.1	100.0	. .
Total	**65.0**	**26.0**	**7.4**	**1.6**	**100.0**	**. .**

(a) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001). The 3 claims coded *Not known* for geographic location are not listed separately but are included in the totals.

(b) The principal clinician specialty categories listed separately are the 12 categories recorded most commonly for *Accident and emergency* claims. The 12 claims coded *Not known* for principal clinician specialty are not listed separately but are included in the totals. All other categories including *Not applicable* are combined in *All other specialties*.

(c) There were 15 claims coded *Not known* for principal clinician specialty or geographic location. The percentages shown in the bottom half of the table are based on 1,459 claims.

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

Table 6.5: Closed claims with an *Accident and emergency* clinical service context, 2004–05 to 2008–09: principal clinician specialty, by primary body function/structure affected

Principal clinician specialty[(a)]	Primary body function/structure affected										
	Neuromusculo-skeletal and movement-related	Mental and nervous system	Cardiovascular, haematological, immunological and respiratory	Digestive, metabolic and endocrine systems	Genitourinary and reproductive	Skin and related structures	Sensory, including eye and ear	Voice and speech	Death	No body function/ structure affected	Total
Emergency medicine	372	131	82	67	65	29	23	5	190	7	1,031
Other hospital-based medical practitioner	29	6	6	3	8	6	1	0	3	0	62
General practice—non-procedural	16	7	4	3	2	4	0	0	21	0	57
Paramedical and ambulance staff	10	6	1	0	0	1	1	2	15	0	38
General nursing	11	1	0	3	3	4	1	0	5	0	28
Orthopaedic surgery	25	1	0	0	0	0	0	0	0	0	28
General practice—procedural	7	2	1	1	1	5	3	0	7	0	27
Diagnostic radiology	15	4	2	1	0	0	0	1	2	0	26
General surgery	2	1	0	11	6	1	0	0	1	1	23
Nursing practitioner	5	3	3	1	0	3	1	0	4	0	20
Psychiatry	3	8	0	0	0	0	0	0	9	0	20
Cardiology	0	3	0	0	0	0	0	0	12	0	15
All other specialties	14	14	13	2	1	0	8	0	31	2	87
Total	**510**	**189**	**113**	**92**	**91**	**53**	**38**	**8**	**300**	**11**	**1,474**

(a) The principal clinician specialty categories listed separately are the 12 categories recorded most commonly for *Accident and emergency* claims.

Note: There were 12 claims coded *Not known* for principal clinician specialty and 69 claims coded *Not known* for primary body function/structure affected. These claims are included in the totals even though the *Not known* row and column are not presented.

Table 6.6: Closed claims with an *Accident and emergency* clinical service context, 2004–05 to 2008–09: principal clinician specialty, by primary body function/structure affected (excluding *Not known*) (per cent)

	Primary body function/structure affected										
Principal clinician specialty[(a)]	**Neuromusculo-skeletal and movement-related**	**Mental and nervous system**	**Cardiovascular, haematological, immunological and respiratory**	**Digestive, metabolic and endocrine systems**	**Genitourinary and reproductive**	**Skin and related structures**	**Sensory, including eye and ear**	**Voice and speech**	**Death**	**No body function/ structure affected**	**Total**
Emergency medicine	38.3	13.5	8.4	6.9	6.7	3.0	2.4	0.5	19.6	0.7	100.0
Other hospital-based medical practitioner	46.8	9.7	9.7	4.8	12.9	9.7	1.6	0.0	4.8	0.0	100.0
General practice—non-procedural	28.1	12.3	7.0	5.3	3.5	7.0	0.0	0.0	36.8	0.0	100.0
Paramedical and ambulance staff	27.8	16.7	2.8	0.0	0.0	2.8	2.8	5.6	41.7	0.0	100.0
General nursing	39.3	3.6	0.0	10.7	10.7	14.3	3.6	0.0	17.9	0.0	100.0
Orthopaedic surgery	96.2	3.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0
General practice—procedural	25.9	7.4	3.7	3.7	3.7	18.5	11.1	0.0	25.9	0.0	100.0
Diagnostic radiology	60.0	16.0	8.0	4.0	0.0	0.0	0.0	4.0	8.0	0.0	100.0
General surgery	8.7	4.3	0.0	47.8	26.1	4.3	0.0	0.0	4.3	4.3	100.0
Nursing practitioner	25.0	15.0	15.0	5.0	0.0	15.0	5.0	0.0	20.0	0.0	100.0
Psychiatry	15.0	40.0	0.0	0.0	0.0	0.0	0.0	0.0	45.0	0.0	100.0
Cardiology	0.0	20.0	0.0	0.0	0.0	0.0	0.0	0.0	80.0	0.0	100.0
All other specialties	16.5	16.5	15.3	2.4	1.2	0.0	9.4	0.0	36.5	2.4	100.0
Total	**36.5**	**13.4**	**8.0**	**6.6**	**6.2**	**3.8**	**2.7**	**0.6**	**21.5**	**0.7**	**100.0**

(a) The principal clinician specialty categories listed separately are the 12 categories recorded most commonly for *Accident and emergency* claims.

Notes

1. There were 79 claims coded *Not known* for principal clinician specialty or primary body function/structure affected. The percentages shown here are based on 1,395 claims.
2. Percentages may not add up exactly to 100.0 due to rounding.

Table 6.7: Closed claims with an *Accident and emergency* clinical service context, 2004–05 to 2008–09: principal clinician specialty, by primary incident/allegation type

	Primary incident/allegation type				
Principal clinician specialty[(a)]	**Diagnosis**	**Treatment**	**General duty of care**	**All other incident/ allegation types**	**Total**
Emergency medicine	611	246	61	94	1,031
Other hospital-based medical practitioner	46	13	0	3	62
General practice—non-procedural	24	21	1	11	57
Paramedical and ambulance staff	7	17	13	1	38
General nursing	5	8	12	3	28
Orthopaedic surgery	10	12	0	5	28
General practice—procedural	5	14	1	7	27
Diagnostic radiology	22	3	0	1	26
General surgery	10	5	0	8	23
Nursing practitioner	3	9	1	7	20
Psychiatry	3	7	9	1	20
Cardiology	9	6	0	0	15
All other specialties	36	18	5	25	87
Total	**796**	**382**	**105**	**168**	**1,474**
	Per cent (excluding *Not known*)				
Emergency medicine	60.4	24.3	6.0	9.3	100.0
Other hospital-based medical practitioner	74.2	21.0	0.0	4.8	100.0
General practice—non-procedural	42.1	36.8	1.8	19.3	100.0
Paramedical and ambulance staff	18.4	44.7	34.2	2.6	100.0
General nursing	17.9	28.6	42.9	10.7	100.0
Orthopaedic surgery	37.0	44.4	0.0	18.5	100.0
General practice—procedural	18.5	51.9	3.7	25.9	100.0
Diagnostic radiology	84.6	11.5	0.0	3.8	100.0
General surgery	43.5	21.7	0.0	34.8	100.0
Nursing practitioner	15.0	45.0	5.0	35.0	100.0
Psychiatry	15.0	35.0	45.0	5.0	100.0
Cardiology	60.0	40.0	0.0	0.0	100.0
All other specialties	42.9	21.4	6.0	29.8	100.0
Total	**55.0**	**26.3**	**7.2**	**11.5**	**100.0**

(a) The principal clinician specialty categories listed separately are the 12 categories recorded most commonly for *Accident and emergency* claims.

Notes

1. There were 12 claims coded *Not known* for principal clinician specialty and 23 claims coded *Not known* for primary incident/allegation type. These claims are included in the totals even though the *Not known* row and column are not presented. The percentages shown in the bottom half of the table are based on the 1,439 claims with known values for both data items.

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

Table 6.8: Closed claims with an *Accident and emergency* clinical service context, 2004–05 to 2008–09: principal clinician specialty, by extent of harm

Principal clinician specialty[(a)]	Extent of harm					Total
	Temporary—duration of less than 6 months	Minor, with duration of 6 months or more	Major, with duration of 6 months or more	Not applicable	Death	
Emergency medicine	220	235	144	7	190	1,031
Other hospital-based medical practitioner	22	25	4	0	6	62
General practice—non-procedural	5	19	12	0	21	57
Paramedical and ambulance staff	3	5	2	0	15	38
General nursing	12	5	3	0	5	28
Orthopaedic surgery	4	12	8	0	4	28
General practice—procedural	10	7	2	0	7	27
Diagnostic radiology	7	6	5	0	2	26
General surgery	8	9	2	1	1	23
Nursing practitioner	4	6	5	1	4	20
Psychiatry	6	1	3	0	9	20
Cardiology	1	2	0	0	12	15
All other specialties	11	16	19	3	23	87
Total	**316**	**353**	**210**	**12**	**300**	**1,474**
	Per cent (excluding *Not known*)					
Emergency medicine	27.6	29.5	18.1	0.9	23.9	100.0
Other hospital-based medical practitioner	38.6	43.9	7.0	0.0	10.5	100.0
General practice—non-procedural	8.8	33.3	21.1	0.0	36.8	100.0
Paramedical and ambulance staff	12.0	20.0	8.0	0.0	60.0	100.0
General nursing	48.0	20.0	12.0	0.0	20.0	100.0
Orthopaedic surgery	14.3	42.9	28.6	0.0	14.3	100.0
General practice—procedural	38.5	26.9	7.7	0.0	26.9	100.0
Diagnostic radiology	35.0	30.0	25.0	0.0	10.0	100.0
General surgery	38.1	42.9	9.5	4.8	4.8	100.0
Nursing practitioner	20.0	30.0	25.0	5.0	20.0	100.0
Psychiatry	31.6	5.3	15.8	0.0	47.4	100.0
Cardiology	6.7	13.3	0.0	0.0	80.0	100.0
All other specialties	15.3	22.2	26.4	4.2	31.9	100.0
Total	**26.5**	**29.5**	**17.7**	**1.0**	**25.3**	**100.0**

(a) The principal clinician specialty categories listed separately are the 12 categories recorded most commonly for *Accident and emergency* claims.

Notes

1. There were 12 claims coded *Not known* for principal clinician specialty and 283 claims coded *Not known* for extent of harm. These claims are included in the totals even though the *Not known* row and column are not presented. The percentages shown in the bottom half of the table are based on the 1,181 claims with known values for both data items.

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

Table 6.9: Closed claims with an *Accident and emergency* clinical service context, 2004–05 to 2008–09: principal clinician specialty, by total claim size ($)

Principal clinician specialty[(a)]	Total claim size				
	Less than 10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Total
Emergency medicine	704	186	91	48	1,031
Other hospital-based medical practitioner	32	23	6	1	62
General practice—non-procedural	16	27	10	4	57
Paramedical and ambulance staff	28	7	2	1	38
General nursing	14	12	1	1	28
Orthopaedic surgery	10	8	7	3	28
General practice—procedural	17	9	1	0	27
Diagnostic radiology	16	3	6	1	26
General surgery	14	7	2	0	23
Nursing practitioner	9	6	5	0	20
Psychiatry	10	5	5	0	20
Cardiology	8	3	3	1	15
All other specialties	42	16	20	9	87
Total	**928**	**316**	**159**	**69**	**1,474**
	Per cent (excluding *Not known*)				
Emergency medicine	68.4	18.1	8.8	4.7	100.0
Other hospital-based medical practitioner	51.6	37.1	9.7	1.6	100.0
General practice—non-procedural	28.1	47.4	17.5	7.0	100.0
Paramedical and ambulance staff	73.7	18.4	5.3	2.6	100.0
General nursing	50.0	42.9	3.6	3.6	100.0
Orthopaedic surgery	35.7	28.6	25.0	10.7	100.0
General practice—procedural	63.0	33.3	3.7	0.0	100.0
Diagnostic radiology	61.5	11.5	23.1	3.8	100.0
General surgery	60.9	30.4	8.7	0.0	100.0
Nursing practitioner	45.0	30.0	25.0	0.0	100.0
Psychiatry	50.0	25.0	25.0	0.0	100.0
Cardiology	53.3	20.0	20.0	6.7	100.0
All other specialties	48.3	18.4	23.0	10.3	100.0
Total	**63.0**	**21.4**	**10.9**	**4.7**	**100.0**

(a) The principal clinician specialty categories listed separately are the 12 categories recorded most commonly for *Accident and emergency* claims.

Notes

1. There were 12 claims coded *Not known* for principal clinician specialty and 2 claims coded *Not known* for total claim size. These claims are included in the totals even though the *Not known* row and column are not presented. The percentages shown in the bottom half of the table are based on the 1,460 claims with known values for both data items.

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

6.3 Extent of harm, claim size and primary incident/allegation type

This section examines the interrelationship between clinical service context, extent of harm, total claim size and primary incident/allegation type. As previously observed for claims closed in 2008–09 (Table 3.12), extent of harm is related to claim size with temporary harm associated with less costly claims and major harm associated with more costly claims. This section presents information on this relationship for *Accident and emergency* claims as well as claims with other clinical service contexts. It also examines whether the primary incident/allegation type plays any role in the relationship; that is, when a claim is based on a particular incident/allegation type in a particular clinical service context, is there any variation in the relationship between extent of harm and claim size?

In this section, a restricted range of categories for extent of harm, total claim size, clinical service context and primary incident/allegation types are used. For extent of harm, they are *Temporary – duration of less than 6 months*, *Minor – duration of 6 months or more*, *Major – duration of 6 months or more* and patient's *Death*. *Not applicable* is not a category of interest and is not included here as it was recorded for very few *Accident and emergency* claims (Table 6.8). The claim size categories utilised in this section are *less than $10,000*, which includes claims that predominantly involve no payment to a claimant, *$10,000–<$100,000*, which is a category that includes claims that may or may not involve payment to a claimant, and *$100,000 or more*, which includes claims that predominantly involve a payment to a claimant (Table 3.11). Claims with a clinical service context of *General surgery* or *Obstetrics* have been presented separately as well as *Accident and emergency* claims, because together these three clinical service contexts account for approximately half of all claims (Table 6.3). The primary incident/allegation types of interest are *Diagnosis* and *Treatment*, both of which are commonly recorded for *Accident and emergency* claims, and *Procedure*, which is commonly recorded for *General surgery* or *Obstetrics* claims.

The data that are described here are presented in tables 6.10 to 6.17 and illustrated in figures 6.1 to 6.6.

Figures 6.1 to 6.4 also show the previously observed association between extent of harm and claim size. Closed claims were associated with increased cost as the extent of harm increased from *Temporary* to *Major*. *Accident and emergency* claims were similar to all claims in terms of the cost of closing the claim for a given extent of harm. The only exception involved cases where the patient died, where a slightly larger percentage of *Accident and emergency* claims involved a settlement of $100,000 or more (21%) than was the case with all claims (15%).

The clinical service contexts of *General surgery* and *Obstetrics* were somewhat more distinctive in terms of how extent of harm related to claim size. *General surgery* claims tended to have a smaller proportion closed for less than $10,000 than other types of claims when the extent of harm was temporary, minor or major. *Obstetrics* claims, on the other hand, tended to have a higher proportion closed for less than $10,000 than other types of claims. An exception was where the patient died, in which case 53% of *Obstetrics* claims were settled for less than $10,000.

Figure 6.5 introduces primary incident/allegation type into the analysis that relates extent of harm and claim size for *Accident and emergency* claims. As can be seen, when *Diagnosis* was the incident/allegation type, extent of harm and claim size related to each other as was the case in general for *Accident and emergency* claims. The graph depicting major harm shows that when the extent of harm was *Major*, the incident/allegation type of *Treatment* tended to be

associated with less costly claims compared with *Diagnosis* or to all incident/allegation types combined.

Figure 6.6 presents commonly recorded combinations of clinical service context and primary incident/allegation type, and compares the proportions of claims, categorised by extent of harm, where these combinations were recorded. The combination of *Diagnosis* and *Accident and emergency* hardly varied across extent of harm categories, and accounted for around 10% of claims (range 8−11%) whether the extent of harm was temporary, minor, major or involved the patient's death. By way of contrast, *Procedure* in an *Obstetrics* context accounted for just 3% of claims where the patient died but 16% of claims involving major harm.

Table 6.10: Closed claims, *Temporary* extent of harm, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	162	47	11	40	260
$10,000–<$100,000	23	16	2	10	51
$100,000 or more	0	2	0	3	5
Total	**185**	**65**	**13**	**53**	**316**
Per cent	*58.5*	*20.6*	*4.1*	*16.8*	*100.0*
			General surgery		
Less than $10,000	25	29	181	82	317
$10,000–<$100,000	14	6	85	14	119
$100,000 or more	0	3	8	4	15
Total	**39**	**38**	**274**	**100**	**451**
Per cent	*8.6*	*8.4*	*60.8*	*22.2*	*100.0*
			Obstetrics		
Less than $10,000	9	54	107	40	210
$10,000–<$100,000	6	5	27	9	47
$100,000 or more	3	0	2	2	7
Total	**18**	**59**	**136**	**51**	**264**
Per cent	*6.8*	*22.3*	*51.5*	*19.3*	*100.0*
			All other clinical service contexts		
Less than $10,000	74	99	217	257	647
$10,000–<$100,000	15	28	65	59	167
$100,000 or more	5	11	11	11	38
Total	**94**	**138**	**293**	**327**	**852**
Per cent	*11.0*	*16.2*	*34.4*	*38.3*	*100.0*
			All clinical service contexts		
Less than $10,000	270	229	516	419	1,434
$10,000–<$100,000	58	55	179	92	384
$100,000 or more	8	16	21	20	65
Total	**336**	**300**	**716**	**531**	**1,883**
Per cent	*17.8*	*15.9*	*38.0*	*28.2*	*100.0*

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

Table 6.11: Closed claims, *Temporary* extent of harm, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*) (per cent)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	87.6	72.3	84.6	75.5	82.3
$10,000–<$100,000	12.4	24.6	15.4	18.9	16.1
$100,000 or more	0.0	3.1	0.0	5.7	1.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			General surgery		
Less than $10,000	64.1	76.3	66.1	82.0	70.3
$10,000–<$100,000	35.9	15.8	31.0	14.0	26.4
$100,000 or more	0.0	7.9	2.9	4.0	3.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Obstetrics		
Less than $10,000	50.0	91.5	78.7	78.4	79.5
$10,000–<$100,000	33.3	8.5	19.9	17.6	17.8
$100,000 or more	16.7	0.0	1.5	3.9	2.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All other clinical service contexts		
Less than $10,000	78.7	71.7	74.1	78.6	75.9
$10,000–<$100,000	16.0	20.3	22.2	18.0	19.6
$100,000 or more	5.3	8.0	3.8	3.4	4.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All clinical service contexts		
Less than $10,000	80.4	76.3	72.1	78.9	76.2
$10,000–<$100,000	17.3	18.3	25.0	17.3	20.4
$100,000 or more	2.4	5.3	2.9	3.8	3.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

Table 6.12: Closed claims, *Minor* extent of harm, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	105	41	10	13	169
$10,000–<$100,000	62	36	13	18	129
$100,000 or more	31	15	1	9	56
Total	**198**	**92**	**24**	**40**	**354**
Per cent	*55.9*	*26.0*	*6.8*	*11.3*	*100.0*
			General surgery		
Less than $10,000	23	27	147	44	241
$10,000–<$100,000	26	13	155	35	229
$100,000 or more	14	7	46	10	77
Total	**63**	**47**	**348**	**89**	**547**
Per cent	*11.5*	*8.6*	*63.6*	*16.3*	*100.0*
			Obstetrics		
Less than $10,000	19	39	61	25	144
$10,000–<$100,000	11	10	23	6	50
$100,000 or more	10	5	24	3	42
Total	**40**	**54**	**108**	**34**	**236**
Per cent	*16.9*	*22.9*	*45.8*	*14.4*	*100.0*
			All other clinical service contexts		
Less than $10,000	96	102	273	161	632
$10,000–<$100,000	61	66	215	132	474
$100,000 or more	39	38	83	56	216
Total	**196**	**206**	**571**	**349**	**1,322**
Per cent	*14.8*	*15.6*	*43.2*	*26.4*	*100.0*
			All clinical service contexts		
Less than $10,000	243	209	491	243	1,186
$10,000–<$100,000	160	125	406	191	882
$100,000 or more	94	65	154	78	391
Total	**497**	**399**	**1,051**	**512**	**2,459**
Per cent	*20.2*	*16.2*	*42.7*	*20.8*	*100.0*

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

Table 6.13: Closed claims, *Minor* extent of harm, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*) (per cent)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	53.0	44.6	41.7	32.5	47.7
$10,000–<$100,000	31.3	39.1	54.2	45.0	36.4
$100,000 or more	15.7	16.3	4.2	22.5	15.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			General surgery		
Less than $10,000	36.5	57.4	42.2	49.4	44.1
$10,000–<$100,000	41.3	27.7	44.5	39.3	41.9
$100,000 or more	22.2	14.9	13.2	11.2	14.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Obstetrics		
Less than $10,000	47.5	72.2	56.5	73.5	61.0
$10,000–<$100,000	27.5	18.5	21.3	17.6	21.2
$100,000 or more	25.0	9.3	22.2	8.8	17.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All other clinical service contexts		
Less than $10,000	49.0	49.5	47.8	46.1	47.8
$10,000–<$100,000	31.1	32.0	37.7	37.8	35.9
$100,000 or more	19.9	18.4	14.5	16.0	16.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All clinical service contexts		
Less than $10,000	48.9	52.4	46.7	47.5	48.2
$10,000–<$100,000	32.2	31.3	38.6	37.3	35.9
$100,000 or more	18.9	16.3	14.7	15.2	15.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

Table 6.14: Closed claims, *Major* extent of harm, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	48	20	3	5	76
$10,000–<$100,000	26	12	4	7	49
$100,000 or more	61	11	4	7	83
Total	**135**	**43**	**11**	**19**	**208**
Per cent	*64.9*	*20.7*	*5.3*	*9.1*	*100.0*
			General surgery		
Less than $10,000	9	7	42	9	67
$10,000–<$100,000	10	6	28	8	52
$100,000 or more	12	10	31	18	71
Total	**31**	**23**	**101**	**35**	**190**
Per cent	*16.3*	*12.1*	*53.2*	*18.4*	*100.0*
			Obstetrics		
Less than $10,000	36	32	151	11	230
$10,000–<$100,000	17	9	34	1	61
$100,000 or more	42	19	73	10	144
Total	**95**	**60**	**258**	**22**	**435**
Per cent	*21.8*	*13.8*	*59.3*	*5.1*	*100.0*
			All other clinical service contexts		
Less than $10,000	95	48	93	108	344
$10,000–<$100,000	56	30	73	43	202
$100,000 or more	71	59	64	72	266
Total	**222**	**137**	**230**	**223**	**812**
Per cent	*27.3*	*16.9*	*28.3*	*27.5*	*100.0*
			All clinical service contexts		
Less than $10,000	188	107	289	133	717
$10,000–<$100,000	109	57	139	59	364
$100,000 or more	186	99	172	107	564
Total	**483**	**263**	**600**	**299**	**1,645**
Per cent	*29.4*	*16.0*	*36.5*	*18.2*	*100.0*

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

Table 6.15: Closed claims, *Major* extent of harm, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*) (per cent)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	35.6	46.5	27.3	26.3	36.5
$10,000–<$100,000	19.3	27.9	36.4	36.8	23.6
$100,000 or more	45.2	25.6	36.4	36.8	39.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			General surgery		
Less than $10,000	29.0	30.4	41.6	25.7	35.3
$10,000–<$100,000	32.3	26.1	27.7	22.9	27.4
$100,000 or more	38.7	43.5	30.7	51.4	37.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Obstetrics		
Less than $10,000	37.9	53.3	58.5	50.0	52.9
$10,000–<$100,000	17.9	15.0	13.2	4.5	14.0
$100,000 or more	44.2	31.7	28.3	45.5	33.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All other clinical service contexts		
Less than $10,000	42.8	35.0	40.4	48.4	42.4
$10,000–<$100,000	25.2	21.9	31.7	19.3	24.9
$100,000 or more	32.0	43.1	27.8	32.3	32.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All clinical service contexts		
Less than $10,000	38.9	40.7	48.2	44.5	43.6
$10,000–<$100,000	22.6	21.7	23.2	19.7	22.1
$100,000 or more	38.3	37.6	28.7	35.8	34.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

Table 6.16: Closed claims, where patient died, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*)

Total claim size	Primary incident/allegation type				Total
	Diagnosis	Treatment	Procedure	All other incident/ allegation types	
Accident and emergency					
Less than $10,000	81	58	9	29	177
$10,000–<$100,000	25	17	0	9	51
$100,000 or more	26	23	3	8	60
Total	**132**	**98**	**12**	**46**	**288**
Per cent	*45.8*	*34.0*	*4.2*	*16.0*	*100.0*
General surgery					
Less than $10,000	14	15	76	8	113
$10,000–<$100,000	8	10	30	8	56
$100,000 or more	7	3	7	3	20
Total	**29**	**28**	**113**	**19**	**189**
Per cent	*15.3*	*14.8*	*60.0*	*10.1*	*100.0*
Obstetrics					
Less than $10,000	13	12	24	9	58
$10,000–<$100,000	8	8	9	2	27
$100,000 or more	8	1	6	10	25
Total	**29**	**21**	**39**	**21**	**110**
Per cent	*26.4*	*19.1*	*35.5*	*19.1*	*100.0*
All other clinical service contexts					
Less than $10,000	80	86	62	200	428
$10,000–<$100,000	22	25	17	54	118
$100,000 or more	20	15	10	25	70
Total	**122**	**126**	**89**	**279**	**616**
Per cent	*19.8*	*20.5*	*14.4*	*45.3*	*100.0*
All clinical service contexts					
Less than $10,000	188	171	171	246	776
$10,000–<$100,000	63	60	56	73	252
$100,000 or more	61	42	26	46	175
Total	**312**	**273**	**253**	**365**	**1,203**
Per cent	*25.9*	*22.7*	*21.0*	*30.3*	*100.0*

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

Table 6.17: Closed claims, where patient died, 2004–05 to 2008–09: total claim size, by clinical service context and primary incident/allegation type (excluding *Not known*) (per cent)

	Primary incident/allegation type				
Total claim size	**Diagnosis**	**Treatment**	**Procedure**	**All other incident/ allegation types**	**Total**
			Accident and emergency		
Less than $10,000	61.4	59.2	75.0	63.0	61.5
$10,000–<$100,000	18.9	17.3	0.0	19.6	17.7
$100,000 or more	19.7	23.5	25.0	17.4	20.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			General surgery		
Less than $10,000	48.3	53.6	67.3	42.1	59.8
$10,000–<$100,000	27.6	35.7	26.5	42.1	29.6
$100,000 or more	24.1	10.7	6.2	15.8	10.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Obstetrics		
Less than $10,000	44.8	57.1	61.5	42.9	52.7
$10,000–<$100,000	27.6	38.1	23.1	9.5	24.5
$100,000 or more	27.6	4.8	15.4	47.6	22.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All other clinical service contexts		
Less than $10,000	65.6	68.3	69.7	71.7	69.5
$10,000–<$100,000	18.0	19.8	19.1	19.4	19.2
$100,000 or more	16.4	11.9	11.2	9.0	11.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			All clinical service contexts		
Less than $10,000	60.3	62.6	67.6	67.4	64.5
$10,000–<$100,000	20.2	22.0	22.1	20.0	20.9
$100,000 or more	19.6	15.4	10.3	12.6	14.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

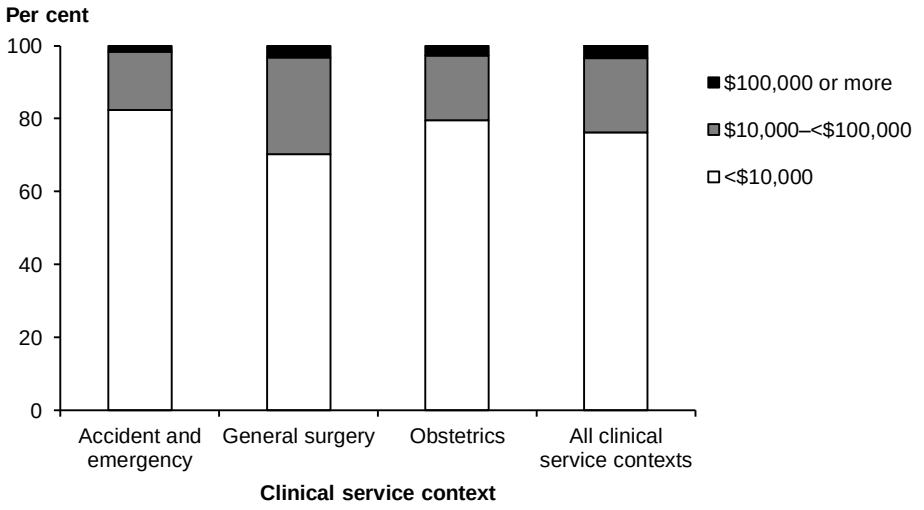

Figure 6.1: Closed claims, 2004–05 to 2008–09: proportions of claims closed for different claim size categories according to clinical service context, where extent of harm to patient was *Temporary*

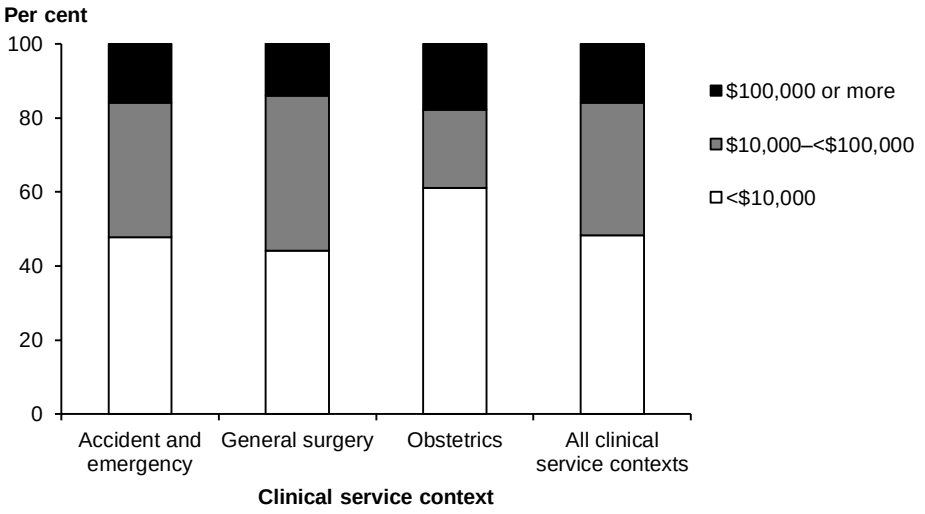

Figure 6.2: Closed claims, 2004–05 to 2008–09: proportions of claims closed for different claim size categories according to clinical service context, where extent of harm to patient was *Minor*

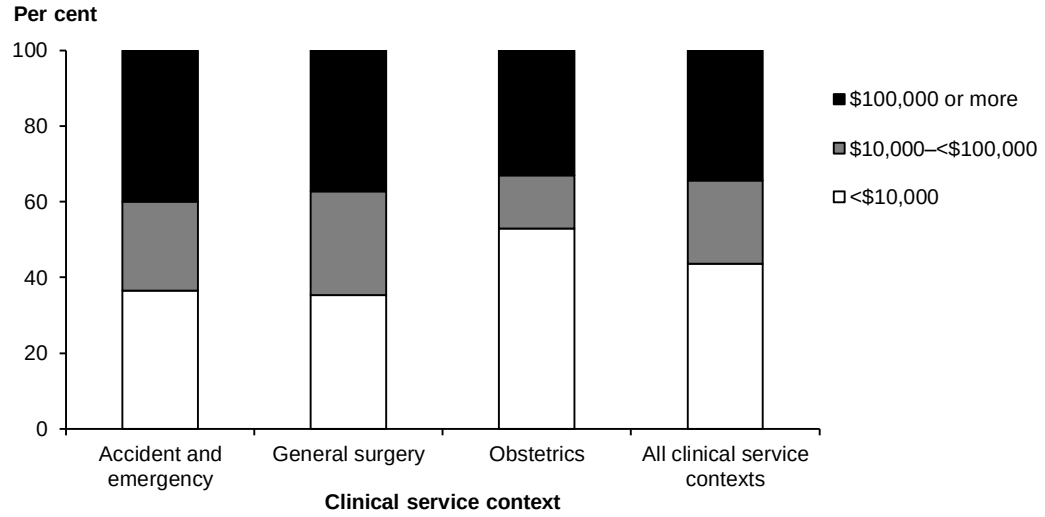

Figure 6.3: Closed claims, 2004–05 to 2008–09: proportions of claims closed for different claim size categories according to clinical service context, where extent of harm to patient was *Major*

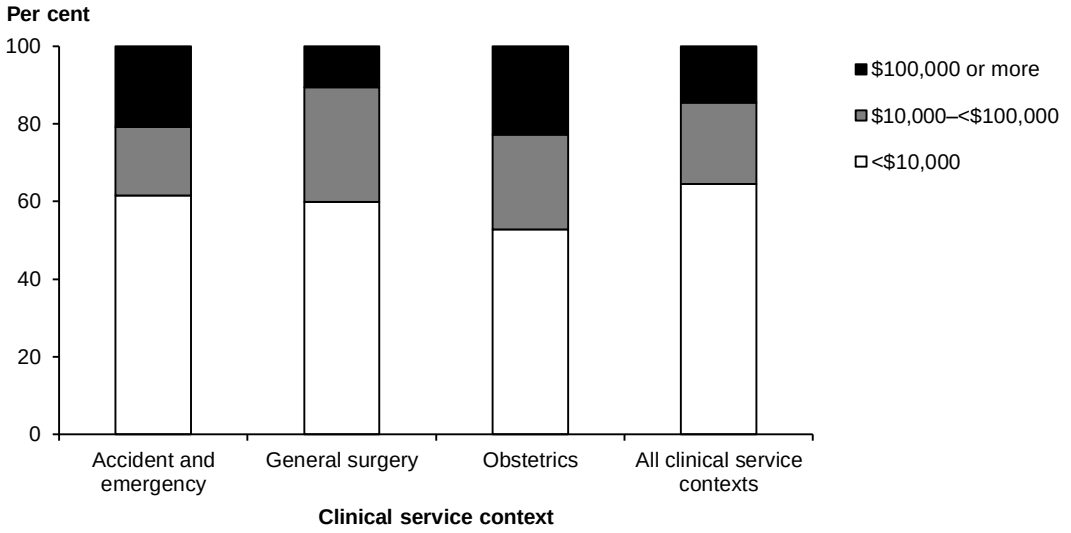

Figure 6.4: Closed claims, 2004–05 to 2008–09: proportions of claims closed for different claim size categories according to clinical service context, where patient died

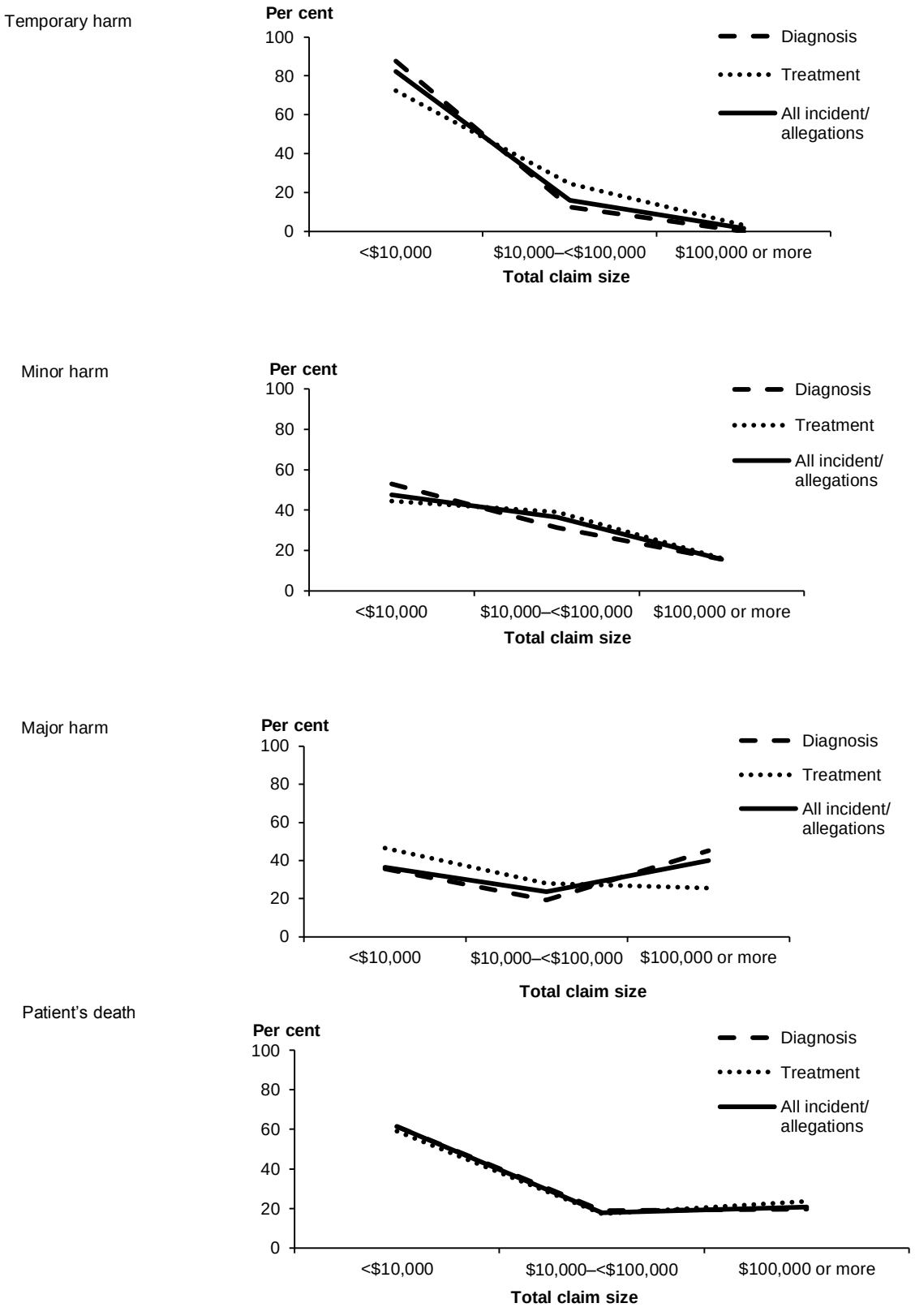

Figure 6.5: Closed claims, 2004–05 to 2008–09: Accident and emergency claims, total claim size categories in relation to primary incident/allegation type, according to extent of harm

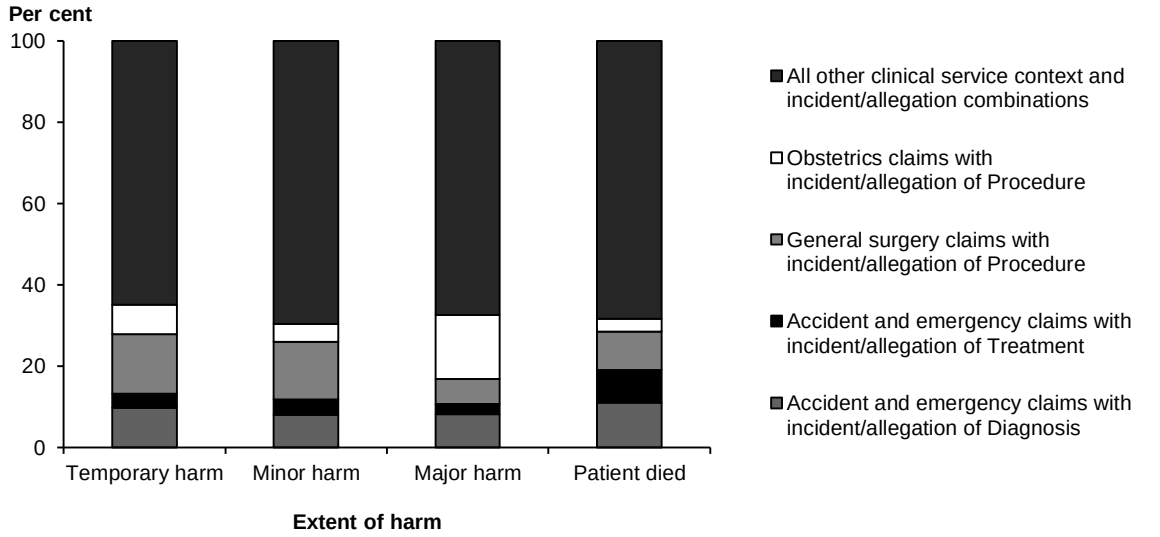

Figure 6.6: Closed claims, 2004–05 to 2008–09: combinations of clinical service context and primary incident/allegation type in relation to extent of harm to patient

Appendix 1: Background to the MINC collection

Background to the collection

The national medical indemnity collection was developed as a response to national policy concerns about health care litigation, the associated costs, and the financial viability of both medical indemnity insurers and medical personnel. Without national data, robust analysis of trends in the number, nature and cost of medical indemnity claims would not be possible.

Health Ministers, at the Medical Indemnity Summit in April 2002, decided to establish a 'national database for medical negligence claims' to assist in determining future medical indemnity strategies. The Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). On 3 July 2002 AHMAC commissioned the AIHW to work with the MIDWG to further develop proposals for a national medical indemnity data collection for the public sector.

Collaborative arrangements

The MINC is governed by an agreement between the Australian Government, state and territory health departments, and the AIHW. It outlines the respective roles, responsibilities and collaborative arrangements of all parties.

The MIDWG, comprising representatives from Australian, state and territory government health authorities and the AIHW, manages the development and administration of the MINC. The MIDWG advises on and reaches agreement on all data resource products, public release of aggregated data, and MINC-related matters. It reports to AHMAC's National Health Information Standards and Statistics Committee.

The AIHW is the national data custodian of the MINC and is responsible for collection, quality control, management and reporting of MINC data. High-quality data management is ensured by the data custodian through observance of:

- the Information Privacy Principles and National Privacy Principles (*The Privacy Act 1988*), which govern the conduct of all Australian government agencies and many private organisations in their collection, management, use and disclosure of personal records
- documented policies and procedures, approved by the AIHW board, addressing information security and privacy.

MINC jurisdictional data are de-identified and treated in confidence by the AIHW in all phases of collection and custodianship. Any release or publication of MINC aggregated data requires the unanimous consent of the MIDWG. An annex to the agreement outlines the protocols for access to and release of MINC data.

Purposes of the collection

The agreement that governs the MINC specifies the primary purposes of the MINC, which are to:

- obtain ongoing information on medical indemnity claims and their outcomes
- provide a national information base on nationally aggregated data to help policy makers identify trends in the nature, incidence and cost of medical indemnity claims
- provide an evidence base from which policy makers can develop and monitor measures to minimise the incidence of medical indemnity claims and the associated costs.

In future, when agreed by the MIDWG, MINC aggregated data may supplement other sources of:

- national medical indemnity claims data, to allow the financial stability of the medical indemnity system to be monitored
- information on clinical risk prevention and management.

Appendix 2: MINC data items and key terms

Table A2.1: MINC data items and definitions

Data item	Definition
1.Claim identifier	An identity number that, within each health authority, is unique to a single claim, and remains unchanged for the life of the claim.
2.Nature of claim—loss to claim subject	A broad description of the categories of loss allegedly suffered by the claim subject (that is, the patient) that form a basis for this claim.
3.Nature of claim—loss to other party/parties	A broad description of the categories of loss allegedly suffered by another party or parties (that is, people other than the patient) that form a basis for this claim.
4.Claim subject's year of birth	Year of birth of the claim subject.
5.Claim subject's sex	Sex of the claim subject.
6.Incident/allegation type	The high-level category describing what is alleged to have 'gone wrong'; that is, the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim, reflecting key causal factors. (Up to three additional incident/allegation categories may also be recorded.)
7.Clinical service context	The area of clinical practice or hospital department in which the patient was receiving a health care service when the incident/allegation occurred.
8.Body function/structure affected—claim subject	The primary body function or structure of the claim subject (that is, the patient) alleged to have been affected as a result of the incident/allegation. (Up to three additional body function/structure categories may also be recorded.)
9.Extent of harm—claim subject	The extent or severity of the overall harm to the claim subject (that is, the patient).
10.Date incident occurred	Calendar month and year in which the incident that is the subject of the claim occurred.
11.Where incident occurred	Australian Standard Geographical Classification Remoteness Structure category for the location where the incident occurred.
12.Health service setting	Health service provider setting in which the incident giving rise to the claim occurred.
13.Claim subject's status	Whether the claim subject (that is, the patient) was a public or private patient, resident or non-admitted patient at the time of the incident.
14.Specialty of clinicians closely involved in incident	Clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim.
15.Date reserve first placed against claim	Calendar month and year in which a reserve was first placed against the claim.
16.Reserve range	The estimated size of the claim, recorded in broad dollar ranges.
17.Date claim commenced	Calendar month and year in which the claim commenced, as signalled by the issue of a letter of demand, issue of writ, an offer made by the defendant, or other trigger.
18.Date claim closed	Calendar month and year in which the claim was settled, a final court decision was delivered, or the claim file was closed (whichever occurred first).

(continued)

Table A2.1 (continued): MINC data items and definitions

Data item	Definition
19.Mode of claim finalisation	Description of the process by which the claim was finalised.
20.Total claim size	The amount agreed to be paid to the claimant in total settlement of the claim, plus defence legal costs, recorded in broad dollar ranges.
21.Status of claim	Status of the claim in terms of the stage it has reached in the process from a reserve being set to file closure.
22.Claim payment details	An indication of whether a damages payment was made to the claimant and, if so, whether the payment was to the claim subject and/or another party/parties.

Table A2.2: Definitions of key MINC terms

MINC term	Definition
Claim	'Claim' is used as an umbrella term to include **medical indemnity claims** that have materialised and **potential claims**. A single claim (that is, a single record) in the MINC may encompass one or more claims made by a single **claimant** in respect of a particular **health-care incident**, and may involve multiple defendants.
Claimant	The person who is pursuing a claim. The 'claimant' may be the **claim subject** or may be an **other party** claiming for loss allegedly resulting from the incident.
Claim manager	The person who is responsible for all or some aspects of the management of the claim, on behalf of the health authority.
Claim subject	The person who received the health-care service and was involved in the **health-care incident** that is the basis for the **claim**, and who may have suffered or did suffer, **harm** or other **loss**, as a result. That is, the 'claim subject' is the person who was the patient during the incident.
Harm	Death, disease, injury, suffering, and/or disability experienced by a person.
Health authority	The government department or agency with responsibility for health care in the Commonwealth of Australia, and in each of the states and territories of Australia.
Health care	Services provided to individuals or communities to promote, maintain, monitor, or restore health.
Health-care incident	An event or circumstance resulting from **health care** that may have led or did lead to unintended and/or unnecessary **harm** to a person, and/or a complaint or **loss**.
Incident	In the context of this data collection, 'incident' is used to mean **health-care incident.**
Loss	Any negative consequence, including financial loss, experienced by a person.
Medical indemnity	'Medical indemnity' includes professional indemnity for health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements.
Medical indemnity claim	A 'medical indemnity claim' is a claim for compensation for **harm** or other **loss** that may have resulted or did result from a **health-care incident**.
Other party	Any party or parties not directly involved in the **health-care incident** but claiming for loss allegedly resulting from the incident. The 'other party' is not the person who was the patient during the incident.
Potential claim	A matter considered by the relevant authority as likely to eventuate into a **claim**, and that has had a **reserve** placed against it.
Reserve	The dollar amount that is the best current estimate of the likely cost of the **claim** when closed. The amount should include claimant legal costs and defence costs but exclude internal claim management costs.

Appendix 3: Policy, administrative and legal features in each jurisdiction

New South Wales

The New South Wales Treasury Managed Fund (TMF) covers all employees of public health organisations (PHOs), as defined in the state's *Health Services Act 1997*. This includes each Area Health Service, selected Statutory Health Corporations listed in Schedule 2 of the Health Services Act and selected affiliated health organisations but only in respect of their recognised establishments and/or recognised services listed in Schedule 3 of the Heath Services Act.

The NSW Self Insurance Corporation (SICorp) oversees the operation of the TMF and sets the policies. Coverage is provided for all claims incurred on or after 1 July 1989.

The TMF provides indemnity to NSW Health as an Agency and, through the Claims Managers, provides a set of defined services that are intended to assist and support NSW Health in managing risks. However, these risks remain the ultimate responsibility of NSW Health's senior management.

TMF medical indemnity cover is provided by NSW Health to visiting medical officers (VMOs), honorary medical officers (HMOs), Staff Specialists Levels 2 to 5 when exercising rights of private practice and other medical practitioner health workers who use NSW health facilities such as locums and agency staff. The VMO/HMO cover, initially with effect from 1 January 2002 in a limited form, requires the Medical Practitioner to sign a Contract of Liability Coverage and have a current Service Contract prior to commencing duty at the PHO.

To maintain this TMF coverage, the VMO/HMO must cooperate with and participate in clinical quality assurance, quality improvement, risk management process and performance review processes, projects and activities as required by the PHO.

From 1 July 2003 Rural VMOs/HMOs and Staff Specialists Levels 2-5 who have rights of private practice were provided with TMF indemnity whilst treating private patients in NSW rural public hospitals.

From 1 July 2004 indemnity was extended to provide cover to VMOs/HMOs whilst treating private paediatric inpatients in NSW public hospitals and in June 2009 cover was again extended to permit VMOs/HMOs to treat privately referred non-inpatients at a NSW public hospital.

Since 1 January 2002 NSW Health has been providing three specified universities with interim cover (in specified areas of activity) through the TMF, for their clinical academics subject to the universities paying a per-claim excess of up to $250,000 (subject to annual consumer price index movements) capped at around $1 million a year. The period for which this interim cover was provided was extended to 30 June 2009.

For the 2006 student intake only, public indemnity was made available to students studying for a Bachelor of Midwifery at University of Technology Sydney and on practicum in public hospitals, but only during the actual birthing process and only whilst under strict PHO supervision.

It is a condition of coverage that the conduct of a claim rests entirely with the Fund Manager and this includes decisions on legal representation, expenses, settlement negotiations, settlements and the like. In order to be indemnified for a claim, full cooperation is required from all PHO employees and staff, including VMOs and HMOs, from the time an incident is reported through to the time a claim is settled or determined.

New South Wales introduced a number of reforms to keep the measure of personal injury damages within reasonable limits, beginning with reforms incorporated in the *Civil Liability Act 2002 (NSW)*. That Act provided a model for legislative reform in a number of other states. That Act was amended to also incorporate reform to the substantive law of negligence.

The Act limits the quantum of damages available in personal injury matters in comparison to those available at common law in NSW prior to the commencement of the Act. This is achieved through the application of thresholds, caps and interest rate changes. Limitations were introduced on claims for mental harm and nervous shock. The Act limits the extent of liability of good Samaritans.

The Act has modified the duty of care owed by professional persons. A professional can rely on compliance with peer professional opinion in Australia to avoid liability, other than in cases where the court considers that opinion to be 'irrational'.

The limitation period within which an action for personal injury must be brought under the *Limitation Act 1969 (NSW)* was amended in 2002. An action must be brought within 3 years after the date of 'discoverability' by the plaintiff, or 12 years from the time the event occurred, whichever is the earlier. (The 12-year period can be extended at the court's discretion.)

Lawyers' costs are capped in personal injury matters for claims up to $100,000, subject to the terms of any legal costs agreement—*Legal Profession Act 2004 (NSW)*.

Victoria

In Victoria, medical indemnity claims for incidents that occur in public health-care agencies are insured by the Victorian Managed Insurance Authority (VMIA), a statutory authority created under the *Victorian Managed Insurance Authority Act* (1996). The insurance covers the health-care agency, employed doctors and other health professionals, and independent contractors (VMOs). Employed doctors with limited private-practice rights who enter into fee-sharing arrangements with a public hospital can be covered for treatment of their private patients in the hospital. These are generally senior specialist practitioners.

Rural procedural general practitioners can elect to participate in a Department of Human Services scheme whereby they can purchase medical indemnity cover for their private-practice work undertaken in certain rural and remote public hospitals and bush-nursing hospitals. There were 304 practitioners insured under this scheme in 2008–09. A significant proportion of these doctors are covered for obstetrics.

Any medical student appointed to a public health service or public hospital by a tertiary education institution for the purposes of accreditation is covered for their clinical duties.

When a public health-care agency service notifies the VMIA of an incident, the VMIA sets a financial reserve if it considers the incident is likely to materialise into a claim. This is classified as an 'open' claim and the files are reviewed at least twice in a 12-month period. If

a minimum reserve is placed, the amount will at least cover legal defence costs. A claim reserve may be placed before a letter of demand or writ has been received.

In 2002, Victoria introduced initial changes to legislation designed to deal with concerns and problems in relation to the affordability and availability of public liability and medical indemnity cover. These changes included:

- a cap on general damages for personal injury awards and a cap on compensation for loss of earnings awards
- initial changes to reduce the limitation period in which injured people can bring legal proceedings from 6 years to 3 years for legally competent adults
- a change in the rate used to calculate lump-sum payments for future economic loss and care costs; this measure is expected to provide significant savings on payouts for large claims
- protection of volunteers and 'good Samaritans' from the risk of being sued
- ensuring that saying 'sorry' or waiving payment of a fee for service does not represent an admission of liability.

In 2003 the Victorian Government introduced additional reforms with the passing of the *Wrongs and Limitation of Actions Acts (Insurance Reform) Act* and the *Wrongs and Other Acts (Law of Negligence) Act*. These changes, applied to personal injury claims (including medical negligence), cover:

- thresholds on general damages
- major reform to limit the time in which proceedings can be brought
- regulation of damages awarded for gratuitous and attendant care.

Of significance to the MINC are the changes made to the limitation of actions so that, where a child is in the custody of their parents, ordinarily it will be presumed that the parent will protect the child's interests by bringing proceedings, where appropriate. The limitation period for minors has been changed to 6 years from the date of discoverability, which means that legal proceedings in relation to minors will generally have to be brought earlier than was previously the case. Some special protections do, however, apply.

The changes also provide that legal proceedings seeking damages for personal injury cannot be brought after 12 years from the date of the incident that is alleged to have caused the injury. There is judicial discretion to extend the limitation period where it is in the interests of justice to do so.

Queensland

Insurance cover for medical indemnity claims made against Queensland Health is provided through the Queensland Government TMF, called the Queensland Government Insurance Fund. The Fund was established on 1 July 2001 and its coverage extends to Crown employees and others who, at the time of the event or incident, are entitled to obtain indemnity in accordance with government policy.

From 4 November 2002 Queensland Health restated its indemnity arrangements in a new indemnity policy for medical practitioners, Industrial Relations Policy Manual IRM 3.8–4. It confirmed the existing policy that Queensland Health indemnifies all medical practitioners engaged by Queensland Health to undertake the public treatment of public patients and medical practitioners treating private patients in limited specified circumstances. Indemnity

under the policy is offered to doctors under an insurance-like model, with exclusions (proven criminal conduct and wilful neglect).

IRM 3.8–4 does not apply to doctors who are independent contractors providing services to Queensland Health, doctors engaged by agencies other than Queensland Health, or contracted VMOs (who must look to the indemnity clauses in their contract of engagement). Other staff engaged by Queensland Health, such as nursing and allied health staff, are covered by a separate indemnity policy, IRM 3.8–3. Queensland Health does not indemnify medical students.

Queensland Health MINC jurisdictional data come primarily from medical indemnity claims information provided to Queensland Health by the litigation panel firms engaged to provide medico-legal litigation services to the department. Therefore, in the main, the pool of MINC jurisdictional data from Queensland Health covers matters that have been briefed to a panel firm.

By and large, these matters are court proceedings and Notices of Claim under s.9 of the *Personal Injuries Proceedings Act 2002* (PIPA) but they can include complaints under the *Health Rights Commission Act 1991* and other demands falling within the scope of the collection.

Queensland Health matters are 'potential claims' within the MINC only where they have been referred to a panel firm and the firm has placed a reserve against the matter. The following do not come within the scope of the MINC, except in cases where a panel firm has placed a reserve against the matter: an initial notice under s.9A of PIPA (a preliminary notice that a claim may eventuate), adverse events, and coronial inquests.

Each claim is evaluated on its own merits and on known facts as they become available, and a reserve is placed where appropriate. Accordingly, a reserve may (and often does) change during the course of a medical indemnity claim and as expert and factual evidence on questions of liability and quantum is obtained and assessed.

In response to community concerns about increases in liability insurance premiums, the Queensland Government passed legislation in June 2002 that affected the way in which compensation claims for damages for personal injuries in a medical context are dealt with before court proceedings are initiated. The legislation also sought to regulate the extent of compensation recoverable in, and various legal matters generally associated with, court proceedings for personal injury. Changes made under PIPA include:

- a positive duty on claimants to bring a claim under PIPA within 9 months of the incident (or the appearance of symptoms) or 1 month of consulting a lawyer
- no legal costs payable for claims under $30,000 and a maximum of $2,500 costs for claims between $30,000 and $50,000
- mandatory exchange of information (including medical reports) to facilitate early settlement and avoid costly litigation
- mandatory offers of settlement and settlement conferences
- capping of claims for economic loss
- exclusion of exemplary, punitive or aggravated damages awards
- provisions for a court to make a consent order for a structured settlement
- recognition and protection for 'expressions of regret'
- exclusion of juries from hearing personal injury trials.

PIPA began operating on 18 June 2002. On 29 August 2002 it was amended to apply retrospectively to injuries, except where a claim had already been lodged with a court or a written offer of settlement had been made before the amendments came into force.

On 9 April 2003 further tort reform initiatives took effect with the passing of the *Civil Liability Act 2003*. These included:

- the majority of Justice Ipp's recommendations introduced
- a new way to assess general damages for pain and suffering in personal injury actions where the incident occurred after 1 December 2002
- capped awards for general damages, at $250,000
- general damages to be assessed on the basis of an injury scale value. Injuries are assessed on a scale of 1 to 100, where 0 is an injury not severe enough to justify an award of general damages and 100 is an injury of the gravest conceivable kind. Monetary values are allocated to each point—for example, 5 = $5,000, 50 = $93,800, 100 = $250,000. The regulation under the *Civil Liability Act 2003* sets out a scale of injuries, with a guide to an appropriate injury scale value for particular injuries. There are limited medico-legal examples in the injury scale value. The *Civil Liability Regulation 2003* commenced on 7 October 2003
- introduction of thresholds for claims for loss of consortium and gratuitous care
- codification of the proactive and reactive duties of doctors to warn of risks
- codification of the standard of care for professionals to protect against liability for acts performed in accordance with a respected body of professional opinion
- amendments to PIPA, including changes to claim notification procedures. One such change relates to claims involving medical negligence in the treatment of a child: the parent or guardian of the child must provide the initial notice and then Part 1 of the notice of claim on behalf of the child within defined time-frames. A Part 1 notice of claim must be given before the earlier of 6 years after the parent(s)/guardian knew that the personal injury occurred or 18 months after the parent(s)/guardian first consults a lawyer about the possibility of seeking damages. A respondent has the right to seek a court order that the claim not proceed if the Part 1 notice is given out of time.

Western Australia

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

All public hospitals and health services are charged an annual 'contribution' to RiskCover to cover the cost of managing and settling claims, including Medical Treatment Liability (MTL) claims. Claims that pre-date RiskCover are managed by the State Solicitor's Office with the Department of Treasury and Finance generally funding settlement costs on a case-by-case basis.

When a MTL claim naming a hospital is lodged, RiskCover liaises with the relevant claims manager or the Department of Health's Legal and Legislative Services. RiskCover oversees the case management and financial aspects of each claim through its appointed legal representatives. The Department of Health or the relevant hospital are provided with regular reports on progress until each matter is settled.

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

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

The state government has introduced a range of tort law reforms including:

- the *Civil Liability Act 2002*, which introduced restrictions on awards of damages and legal advertising, and enabled structured settlements
- various amendments to the *Civil Liability Act 2002* to:
  - codify, and in some cases vary, certain common law rules of negligence in relation to foreseeability, standard of care, causation and remoteness of damage and contributory negligence
  - provide for protection from personal civil liability for a good Samaritan who comes to the aid of another when that good Samaritan is acting in good faith and without recklessness
  - permit a person to give an apology without thereby exposing their self to personal civil liability
  - introduce a new evidentiary test in relation to the standard of care required of health professionals
  - make further provision with respect to proportionate liability.
- amendments to the *Insurance Commission of Western Australia Act 1986* to establish access to a new Community Fund underwritten by the State and managed by the Insurance Commission of Western Australia, to enable the Government to provide insurance cover to 'eligible community organisations' based in Western Australia, which are currently unable to access affordable, or any, private insurance cover; particularly Public Liability insurance
- the *Volunteers and Food and Other Donors (Protection from Liability) Act 2002*, which protects certain volunteers from incurring civil liability when doing community work on a voluntary basis.

South Australia

Public sector insurance arrangements cover the following groups: employees of public hospitals, VMOs providing services to public patients, staff specialists for services to private patients under approved rights of private practice, health professional students, short-term visiting medical practitioners and medical students, rural fee-for-service doctors who have opted to be covered under government arrangements, and clinical academics providing services to public patients.

The main steps in the claims management process are as follows:

1. initial notification of incident
2. assessment of notification by claims manager

3. if necessary, claim file opened and reserve raised
4. if necessary, panel solicitor appointed
5. investigation of claim
6. decision about approach to liability and quantum
7. reserve monitored throughout the claim and adjusted if necessary
8. settlement conference—either informal or compulsory conference convened by the court.

The main parties involved in the claim process are the plaintiff and their solicitors, the SA Health's panel solicitors (the defendant's solicitors), the health unit from which the claim emanated, the SA Health's Insurance Services, Minter Ellison lawyers (SA Health—appointed claims manager), and the Insurance Division of the South Australian Financing Authority (trading as SAICORP) which is responsible for claims for amounts above the department's excess.

In gathering information about claims or potential claims, the claims manager liaises in the first instance with the clinical risk manager or other appointed staff member of the relevant health unit. Where a panel solicitor is appointed, he or she liaises directly with the clinical risk manager or appointed hospital staff member to coordinate the investigation of the claim and interviews with staff.

A claim file is opened at the discretion of the claims manager when he or she considers the incident is likely to result in a claim. A reserve is placed against all open claim files. The reserve is calculated by multiplying the following components:

- the dollar estimate of the worst-case scenario (including plaintiff's legal costs), based on advice from the panel solicitor
- the probability of the claim proceeding, expressed as a percentage
- the probability of success of the claim, expressed as a percentage.

The estimated defence costs are then added to the amount derived.

Independent expert medical opinion on the matter is usually obtained once interviews with medical staff are completed.

If a matter that has had a reserve placed against it remains inactive—that is, does not materialise into a claim—the claim file is usually closed on expiration of the statutory time limitation within which proceedings would have had to have been initiated. Occasionally files are reopened when a plaintiff seeks an extension of time.

Structured claim settlements are not common in South Australia.

A range of tort law reforms have been introduced in the state:

- the *Wrongs (Liability and Damages for Personal Injury) Act 2002*. The Act sets limits to the damages that can be claimed for bodily injury. It applies a points scale to injury claims and limits claims for loss of capacity to earn a living. It also protects 'Good Samaritans' from legal liability if they make an error when trying to assist someone in an emergency, and it makes clear that there is no legal liability implied when one person apologises to another for an accident
- the *Statutes Amendment (Structured Settlements) Act 2002*, which allows people to have their compensation paid in instalments rather than as a lump sum if they wish
- the *Law Reform (Ipp Recommendations) Act 2005*. This Act makes changes to the law of negligence so that people are not liable to pay damages if the way in which the injury occurred was unforeseeable or a reasonable person would not have taken action to

reduce the injury risk. It also prevents claims for failure to warn the injured person about a risk that should have been obvious to them. Further, the Act makes it harder for people to claim compensation if they have let the legal time limit go by, and requires parents to give early notice of an injury claim by a child, so that insurers can take this into account. Among other things, the Act also provides doctors and other professionals with a defence if they acted in accordance with what is widely accepted in Australia to be proper professional practice.

Tasmania

The Tasmanian Government provides indemnity in relation to any services provided by a medical practitioner in a public hospital or other health facility operated by the state, with the exception of medical services provided in the course of private practice in premises that the practitioner or another person occupies pursuant to a lease or other right of exclusive occupation granted by the state.

Insurance coverage for medical indemnity matters is provided through the Tasmanian Risk Management Fund. The Department of Health and Human Services makes an annual contribution to the fund and, under the coverage provided by the fund, the Department is required to meet the first $50,000 in respect of any claim.

The claims management process is:

1. Initial notification of a claim is lodged. This can result from:
   - receipt of a letter of demand or writ, or
   - notification by the responsible Departmental division when it has been determined that the nature of the incident and the potential impact on the department are sufficiently material to warrant notification.
2. Claim notification forms are completed by the relevant medico-legal officer at each of Tasmania's three major public hospitals and duly designated officers in other departmental divisions, including district hospitals, aged care facilities, mental health and disability services, and oral health services. The claim notification forms include all data required under the MINC, as well as additional data required for internal management of the claim.
3. A copy of the claim notification form is forwarded to the departmental officer responsible for maintaining the database for medical indemnity matters. The Office of the Director of Public Prosecutions, which undertakes all litigation matters on behalf of the State of Tasmania, is advised of the (potential) claim. A claim file is opened and a reserve is placed on the matter by the Director of Public Prosecutions.
4. The claim is managed by the relevant medico-legal officer and a representative from the Office of the Director of Public Prosecutions. Claim files are reviewed quarterly.

Tasmania has implemented a number of tort law reforms, largely through amendments to the *Civil Liability Act 2002*. Most of the reforms flow from recommendations of the 'Ipp report' of the law of negligence. Key reforms relevant to medical negligence claims include:

- clarification of aspects of the duty of care owed by medical practitioners to patients
- a statement that an apology—for example, by a medical practitioner to a patient—does not constitute an admission of fault or liability
- provision for a court to make an order approving of, or in the terms of, a structured settlement

- changes to the manner in which damages relating to loss of earning capacity, economic loss, and non-economic loss are assessed
- restriction of the circumstances in which a plaintiff may seek to recover damages for pure mental harm
- awarding of payments for gratuitous services (subject to certain conditions and effective from 15 December 2006). No damages were previously payable for such services
- a reduction of the discount rate used in determining a lump-sum payout, from 7 to 5 per cent, effective from 15 December 2006
- changes to the limitation period where an action for damages for negligence now cannot be brought after the sooner of 3 years from the date of discoverability or 12 years from the date of the cause of action (effective from 1 January 2006) (see s.5A of the *Limitation Act 1974*). Previously, the limitation period was 3 years from the date of the cause of action, with an extension of a further 3 years at the discretion of the court.

Australian Capital Territory

All Australian Capital Territory (ACT) government employees providing clinical services are indemnified under general staff cover for professional officers. Additionally, staff specialists are indemnified for rights of private practice providing they do not bill their private patients directly.

In January 2002, the ACT introduced the Medical Negligence Indemnity Scheme to provide indemnity to VMOs providing public health services to public patients in public health facilities. The term 'public' is crucial in this description because the scheme is specifically limited to that type of service. This indemnity scheme is now incorporated into all VMO service agreements and extends to all incidents incurred that have not otherwise been reported under any policy of insurance or like arrangement. This scheme allows the ACT to be able to recruit and retain doctors more effectively by relieving them of the financial burden of premiums in the provision of public health services.

The ACT also agreed to indemnify Australian National University (ANU) medical students who were placed in the ACT health system as part of their training, in support of the ANU's Bachelor of Medicine and Bachelor of Surgery (MBBS) program.

The overall manager of claims and provider of public medical indemnity cover in the ACT is ACT Health; the cover is underwritten by the ACT Insurance Authority, which obtains the necessary re-insurance cover internationally.

Key providers of medical insurance data are the Canberra Public Hospital, Calvary Public Hospital, Mental Health ACT and Community Health, which monitor and report adverse incidents and/or potential claims.

In September 2006, ACT Health introduced RiskMan, an online reporting tool for reporting adverse clinical incidents or near misses. RiskMan defines an incident as an event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage. RiskMan is used by all clinical staff to report incidents involving both patients and members of the public. It also supports the mandatory reporting of significant incidents policy that was also established in 2006. This level of reporting ensures that potential claims are reported through to the ACT Insurance Authority within mandatory timeframes (during the Period of Insurance) and ensures that adverse events are insured if a claim eventuates.

If at any time the responsible entity is served with court proceedings, the matter is notified immediately to the ACT Insurance Authority who instructs the ACT Government Solicitor's Office to act on behalf of the ACT in the matter and ensure that a defence is filed within the specified timeframe, as required.

In 2003, the ACT Legislative Assembly passed amendments to the *Civil Law (Wrongs) Act* 2002. Elements of the Act relevant to personal injury claims (including medical negligence) are:

- changes to reduce the limitation period in which injured people can bring legal proceedings, from 6 years to 3 years from the date of the incident for legally competent adults; and, in relation to children, other reforms to limit the time in which proceedings can be brought
- provisions for a single expert witness to give evidence
- clarification of the interpretation of the concepts of 'standard of care', 'causation' and 'assumption of risk' in negligence proceedings, by defining the concepts in the Act
- restriction of liability for mental harm to a recognised psychiatric illness
- a limit on damages for non-economic loss and economic loss
- direction as to the apportionment of liability and contributory negligence
- ensuring that saying 'sorry' or waiving payment of a fee for service does not represent an admission of liability
- early notification—procedural reforms designed to make early settlements more likely and to improve the efficiency of court proceedings.

Among other reforms are the following:

- introduction of a 'reasonable prospects' test for cases brought before the court
- imposing obligations on the parties to claims to exchange relevant documents—for example, about the cause of the accident, the extent of injuries
- establishing the principles to apply in deciding whether a public or other authority has a duty of care or has breached a duty of care
- providing for court-ordered mediation in addition to neutral evaluation
- requiring that a claimant notify all respondents of an intention to sue 9 months after the date of the accident, or after the date symptoms first appear if they are not immediately apparent, or 1 month after consulting a lawyer. If these notices are not given, the claimant can proceed only with the leave of the court and at the risk of cost penalties
- requiring that, for adult claimants, this notice be given within 3 years
- requiring that for child claimants, this notice be given within 6 years (there will be significant financial disincentives to delaying the giving of the notice on behalf of child claimants; that is, no medical, legal or gratuitous care costs will be awarded for the period up to the date the notice is given)
- requiring that, once notice is given, the prospective defendant has carriage of the progress of the claim (in the case of children, a prospective defendant can oblige a plaintiff to file suit on 6 months' notice).

Northern Territory

Current public sector medical indemnity insurance arrangements in the Northern Territory cover VMOs and specialist medical officers providing medical services to any public patient. Cover is also extended to instances where care is provided to a public patient in a private

hospital. VMOs and specialist medical officers are still, however, required to cover any liability that may arise from services provided outside such agreements.

Once notification of an incident that might result in a claim is received, a possible legal action file is established and referred to a departmental lawyer. Upon receipt of a writ, a legal action file is established and the matter is either managed by a departmental lawyer or outsourced to a private law firm.

The main players in a medical negligence suit are the plaintiff and their representative lawyers, the defendant (that is, the Northern Territory, the Department of Health and Families, and the hospital and/or staff involved), and the Departmental lawyer or the outsourced defence lawyers engaged by the department.

In investigating a claim, statements are generally obtained from the relevant clinical or medical staff involved, along with medical records. Expert medical advice is normally sought in the initial stages of the claim in order to ascertain potential liability and to assist with preparation of a defence.

When calculating a reserve, factors taken into account can include:

- the liability or otherwise of the Northern Territory
- the gravity of the loss, injury and/or damage to the claimant
- legal advice on quantum.

If a file has been opened on the basis of a potential legal action and no claim or proceedings result, the file remains inactive. Once a litigation file is opened, it is closed only if the department is notified of discontinuance or the matter is settled.

The statute of limitations legislation prescribes that personal injury legal proceedings be initiated within 3 years of the occurrence of an adverse event.

At present no compulsory dispute resolution processes exist as a prerequisite to litigation. An aggrieved person may, however, lodge a complaint through the Health and Community Services Complaints Commission in the first instance to have the matter investigated, conciliated or resolved before the commencement of litigation.

The Northern Territory *Personal Injuries (Civil Claims) Act 2003* contains some provisions in relation to claims for personal injury, but those relating to commencement of proceedings (ss.7–10) and resolution conferences (s.11) have not yet commenced. Therefore the *Limitation Act* continues to apply in that any action in tort must be brought within 3 years of the date of the cause of action.

The *Personal Injuries (Liabilities and Damages) Act 2003* makes the following provision:

- A court must not award aggravated damages or exemplary damages in respect of a personal injury.
- A court may award damages for gratuitous services only if the services are provided for:
  - 6 hours or more a week, or
  - 6 months or more.

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

The award of damages for non-pecuniary loss is determined according to the degree of permanent impairment of the whole person and the relevant percentage of the maximum amount to be awarded.

Structured claim settlements are not common in the Northern Territory. As a general rule, an all-encompassing settlement figure is reached without detailed itemisation of categories of loss and is settled in one lump sum rather than by periodic payments.

Appendix 4: Body function/structure categories

Table A4.1: Coding examples for body function/structure categories

Body function/structure coding category	Examples of types of harm alleged/claimed
1. Mental functions/structures of the nervous system	Psychological harm—for example, nervous shock Subdural haematoma Cerebral palsy
2. Sensory functions/the eye, ear and related structures	Vestibular impairment Injury to the structure of the eye or ear
3. Voice and speech functions/structures involved in voice and speech	Dental injuries Injuries to the structure of the nose or mouth
4. Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	Injury to the spleen or lungs Generalised infection Deep vein thrombosis/pulmonary embolism Vascular or artery damage Conditions affecting major body systems—such as cancer that has progressed and no longer affects a single body part or system
5. Functions and structures of the digestive, metabolic and endocrine systems	Hepatitis Injury to the gall bladder, bowel or liver
6. Genitourinary and reproductive functions and structures	Injury to the breast Injury to male or female reproductive organs Injury to the kidney Injury to the bladder
7. Neuromusculoskeletal and movement-related functions and structures	Loss of function due to inappropriate casting of joint
8. Functions and structures of the skin and related structures	Burns
9. Death	*Death* is recorded where the incident was a contributory cause of the death of the claim subject
10. No body function/structure affected	Failed sterilisation, where there is no consequent harm to body functions or structures

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