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Contents

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Abbreviations

ACCC	Australian Competition and Consumer Commission
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulatory Authority
DoHA	Australian Government Department of Health and Ageing
ISA	Insurance Statistics Australia
MIDWG	Medical Indemnity Data Working Group
MII	Medical Indemnity Insurer
MINC	Medical Indemnity National Collection
MINC CC	Medical Indemnity National Collection Coordinating Committee
NCPD	National Claims and Policy Database
PSS	Premium Support Scheme

Summary

This report presents results from the Medical Indemnity National Collection (MINC) for 2007–08. It describes medical indemnity claim characteristics and costs. This is the fourth report in the series that presents data on both public and private sector medical indemnity claims, and the first to publish data on claim numbers.

Claims

In 2007–08 there were 8,555 medical indemnity claims open at some point in time. This included 2,255 new claims, and 2,675 claims that were closed during the period.

Cost and duration

Nearly 70% of closed claims were settled for less than $10,000, including 40% where no payment was made or costs incurred in closing the claim. Just 3% of claims were settled for $500,000 or more. Two-thirds (66%) of closed claims were finalised within 3 years of being opened. Close to 10% of claims took more than 5 years to be settled.

The incidents and who was involved

The most common allegation for loss related to *Procedure*—for example, post-operative complications or failure of procedure (2,278 of all claims and 393 of new claims)—followed by *Diagnosis* (1,679 of all claims, 321 of new claims) and *Treatment* (1,209 of all claims, 287 of new claims). *Procedure*, and then *Diagnosis* and *Treatment*, have been the three most common allegations of loss for both all and new claims since data first became available for the 2004–05 reporting period.

The most common allegation of harm was *Neuromusculoskeletal and movement-related.* This accounted for one-fifth of both all (1,737 claims) and new claims (389 claims). *Mental and nervous system* effects (1,416 of all claims, 228 of new claims) and *Death* (1,062 of all claims, 245 of new claims) were also relatively common for both types of claims. *Neuromusculoskeletal and movement-related* effects was the most frequent allegation of harm for new claims every year since 2004–05, generally followed by *Mental and nervous system* effects.

Adults were the subject of almost 70% of all and new claims, with female claim subjects outnumbering males. In the case of babies (less than 1 year old) and children (1–18 years old), the claim subject was more often a boy than a girl.

Where the claim subject was a baby, the proportion of claims associated with *Mental and nervous system* effects was markedly higher than other types of harm (for both all and new claims).

About one-third of all and new claims alleged the involvement of the clinical specialities *Obstetrics and Gynaecology* (1,439 of all claims, 227 of new claims) or *General practice* (1,419 of all claims, 483 of new claims).

Where incidents occurred

Around 60% of all claims (5,052 claims) related to alleged incidents in a public sector health setting, such as a public hospital. Most other claims (2,776 claims, 32%) related to incidents alleged to have occurred in a private sector health setting, for example, a private medical clinic. In 8% of cases the health setting was *Other* or unknown.

1 Introduction

This report presents data on public and private sector medical indemnity claims for the period from 1 July 2007 to 30 June 2008. It is the fourth report of this nature, the first of which was *A national picture of medical indemnity claims in Australia 2004–05*, published in May 2007 (AIHW 2007), followed by *Public and private sector medical indemnity claims in Australia 2005–06: a summary* (AIHW 2008) and *Public and private sector medical indemnity claims in Australia 2006–07: a summary* (AIHW 2010a). These previous reports did not present claim numbers, and instead provided information in terms of percentages summing by column or row to 100%, whereas the current report provides both claim numbers and percentage information.

Medical indemnity insurance provides clinicians with protection against financial loss resulting from claims of alleged negligence or breach of duty during the performance of health care related services. In Australia, this insurance is mainly provided within the public sector by state and territory health authorities. In the private sector, clinicians hold individual policies with medical indemnity insurers (MIIs).

The data presented in this report relate to claims that were open at any time during the reporting period, 1 July 2007 to 30 June 2008. With most but not all of these claims, a formal demand for compensation for alleged harm or other loss resulting from health care had been received by an MII or a public sector claims manager. There are five categories of claims represented in the data: all claims, new claims, closed claims, current claims and reopened claims (Box 1.1).

This report provides information on the alleged health care incidents giving rise to claims, which specialties were allegedly involved, the age and sex of the people who allegedly suffered loss or harm, the nature of their injury and how and for how much claims were settled. Information of a similar nature was presented in the three previous reports in this series. However, this report also provides information on two data items, health service setting and reserve range, not previously included in combined sector medical indemnity reports. Most health service settings are either public or private, but it should be noted that a proportion of the claims involving public sector health authorities originate from alleged incidents in private settings, and a proportion of MII claims originate from alleged incidents in public settings. As an example of the former, some jurisdictions offer cover to medical practitioners working in their private health clinics under particular circumstances (for example, if they are rurally based). As an example of the latter, Visiting Medical Officers who treat patients in public hospitals are often required to hold private medical indemnification, particularly if treating private patients (see the appendix 'Policy, administrative and legal features in each jurisdiction' in AIHW 2010b).

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

Box 1.1: Types of claims in scope for the 2007–08 combined sector report

All claims: public and private sector claims in scope (see below) that were open at any time between 1 July 2007 and 30 June 2008

New claims: public sector claims in scope that had their reserve set, or private sector claims reported to the Australian Prudential Regulation Authority (APRA), between 1 July 2007 and 30 June 2008

Current claims: any claims in scope that remained open at 30 June 2008

Closed claims: any claims that were finalised by discontinuation, negotiation or a court decision, between 1 July 2007 and 30 June 2008

Reopened claims: current claims that had been considered closed at some point prior to 30 June 2008

Most of the claims in scope are linked to a formal demand for compensation for alleged loss or harm. The scope does not include public sector potential claims, which are instances of suspected harm reported to the health authority claim manager that are considered likely to result in a formal demand at some point after the reporting period. The scope also excludes most potential claims in the private sector, which are cases of incidents reported by an insured clinician to a Medical Indemnity Insurer (MII). Only when the MII has incurred preparatory expenses, and so is legally obliged to report the potential claim to APRA even if no formal demand has been received, would the private sector potential claim be included here. The scope also includes claims discontinued during 2007–08 without any litigation having commenced (discontinued potential claims) if they are private sector claims previously reported to APRA or they are public sector claims.

The rationale for which public sector claims are in scope is that, as far as possible, they should correspond to in-scope private sector claims, which are those required to be reported to APRA for its National Claims and Policies Database (NCPD). Depending on the reporting period, between a third and a quarter of current claims in the public sector are potential claims (AIHW 2010b), which is much higher than the proportion of private sector potential claims required to be reported to APRA. Accordingly, to include those public sector potential claims would result in data less comparable between the sectors.

However, when public sector potential claims from previous years are discontinued, the 2007–08 data reported to the AIHW does not distinguish them from other discontinued claims. Accordingly, they are included in scope by default along with other discontinued public sector claims.

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

1.1 Background to the report

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

A Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC) to oversee the collection of public sector medical indemnity data. In July 2002, AHMAC commissioned the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG to develop the collection. Collation of data on public sector medical indemnity claims started in 2003, and was followed by publication of the first 6 months of the 2003 data in December 2004 (AIHW 2004). Four financial year reports have been published with the fifth to be published at the same time as this report (AIHW 2010b).

In 2004 the Australian Government introduced the Premium Support Scheme (PSS), as part of a comprehensive medical indemnity package, to help eligible clinicians meet the cost of their private medical indemnity insurance. MIIs provide information on private sector medical indemnity claims to the Australian Government Department of Health and Ageing (DoHA) and the AIHW under arrangements made following the introduction of the PSS. The claims reported by the MIIs to the AIHW are the same claims as they are required to report to the Australian Prudential Regulation Authority (APRA) and this claims information is combined with the corresponding public sector data in the production of the combined sector medical indemnity reports (Box 1.1). Further information on the background to the collection is presented elsewhere (AIHW 2010a).

1.2 Collaborative arrangements

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

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

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

2 The collection

2.1 Data items and definitions

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

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

2.2 Claim management practices

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

The public sector

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

In the public sector the states and territories usually treat any allegations related to a single health care incident as a single claim, even if it involves more than one health care professional. All jurisdictions report on the principal clinician specialty involved in the allegation or incident, but (apart from New South Wales) they may also report up to three additional clinician specialties. In 2007–08, 8% of public sector claims had more than one reported clinician specialty (AIHW unpublished analysis). This additional information can be used to make the public sector data on clinician specialties more like the data for the private sector where, as noted below, the involvement of several clinicians is likely to result in more than one claim.

Private sector medical indemnity insurers

MIIs provide professional indemnity insurance to individual clinicians. It is a common, but not uniform, practice for MIIs to open more than one claim for a single health care incident if more than one clinician was involved in the incident that gave rise to the allegation of loss or harm. For example, an incident involving both an anaesthetist and an obstetrician may result in the initiation of a separate claim against each clinician.

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

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

2.3 Data completeness and *Not known* rates

Since the establishment of the MINC public sector collection, data completeness has improved considerably. For the period from 1 July 2007 to 30 June 2008, virtually 100% of all public sector claims in scope, that is claims known to the jurisdictions as having been open at any time during the reporting period, were reported to the AIHW. This is a clear improvement on the 85% public sector coverage recorded for the 2005–06 report and 92% of public sector coverage recorded for the 2006–07 report.

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

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

Not known rates tend to be particularly high for new claims, which are those first reported to APRA or reserved during the reporting period. The *Not known* rate for the data item 'primary incident/allegation type' was 28% for new claims compared to 15% for all claims reported during 2007–08. For the data item 'primary body function/structure affected' the *Not known* rate was 23% for new claims and 8% for all claims. For age of claim subject it was 22% for new claims and 15% for all claims; for 'health service setting', 20% for new claims and 7% for all claims; and for clinician specialty, 15% for new claims and 5% for all claims.

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

3 Claims for 2007–08

The data for 2007–08 presented in this chapter groups claims into four main (but not mutually exclusive) categories: all claims, new claims, current claims and closed claims. An additional minor category involves reopened claims, which are current claims that had been considered closed at some point prior to 30 June 2008 (Box 1.1; Figure 3.1).

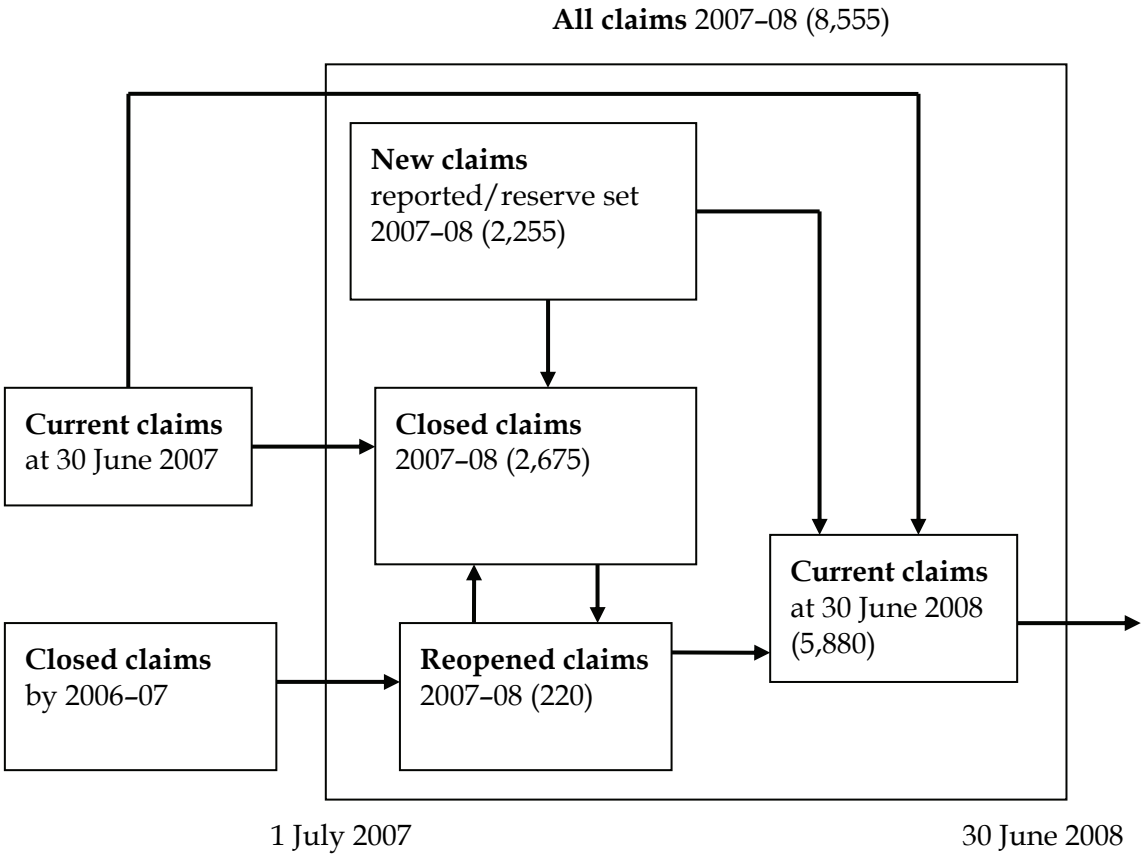


Figure 3.1: Composition of all claims in relation to other claim categories, 1 July 2007 to 30 June 2008

There are more public sector claims than private sector claims in every category of claim (Table 3.1). In the tables that provide data on clinician specialty, all records of an involved health professional are included in the public sector counts; that is, one claim may be reported against several clinician specialties. Accordingly, the total reports associated with the various clinician specialties will exceed the number of claims, and would also exceed 100% when expressed as percentages (tables 3.6–3.9, 3.26–3.27).

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

Claim category	Public sector	Private sector (MII)	Total
New	1,292	963	2,255
Reopened	154	66	220
Closed	1,851	824	2,675
Current (at 30 June 2008)	3,429	2,451	5,880
All	5,280	3,275	8,555

3.1 Health care incidents leading to claims

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

Health service setting

'Health service setting' refers to the setting in which the incident that gave rise to a claim took place. During the 2007–08 reporting period, a larger number of claims were associated with public sector settings compared to private sector settings.

About 60% (5,052) of all claims and 42% (952) of new claims were reported as occurring within a public setting. Of these claims, 97% (4,905) of all claims and 96% (914) of new claims occurred within a public hospital or day surgery. *Other public setting*, for instance public community health centres and residential aged care services, was recorded for less than 2% of all claims and new claims (tables 3.2 to 3.5).

A private health service setting was the health service setting recorded for 32% (2,776) of all claims and 36% (805) of new claims. In the case of all claims very similar proportions, approximately 15%, were recorded for private hospitals or day surgeries and private medical clinics. For new claims the proportion was lower for private hospitals or day surgeries (14%) than private medical clinics (20%). *Other private setting*, for instance residential aged care services, was associated with less than 2% of all claims and new claims.

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 which is determined to be of primary importance in giving rise to the claim. Coding examples for selected incident/allegation types are provided in Appendix 3 (Table A3.2).

The most commonly recorded category was *Procedure*, accounting for 27% (2,278) of all claims and 17% (393) of new claims (tables 3.2 to 3.5). *Diagnosis* and *Treatment* were the next most frequently recorded incident/allegation types and were associated with 20% (1,679) and 14% (1,209) of all claims (respectively). After *Procedure*, these two incident/allegation types were also the most frequently recorded for new claims with 321 claims (14%) recorded for *Diagnosis* and 287 claims (13%) recorded for *Treatment*. The

proportions of all claims in 2007–08 associated with *Procedure*, *Diagnosis* and *Treatment* were similar to the proportions of all claims in 2006–07 (respectively, 28%, 25% and 11%), but in 2006–07 there were higher proportions of new claims recorded for *Procedure* (29%) and *Diagnosis* (26%). The three most commonly recorded primary incident/allegation types for both all and new claims were also *Procedure*, *Diagnosis* and *Treatment*, in that order, in 2004–05 and 2005–06 (AIHW 2007, 2008, 2010a).

General duty of care accounted for 6% (549) of all claims and 8% (174) of new claims. The other six categories of incident/allegation type each accounted for less than 5% of both all claims and of new claims. Very similar results were obtained from the 2004–05, 2005–06 and 2006–07 claims data (AIHW 2007, 2008, 2010a).

With the 2007–08 claims data, *Procedure* and *Diagnosis* were the most frequently recorded incident/allegation types for claims arising from an incident that occurred in a public hospital or day surgery. *Procedure*-related claims accounted for 34% and 27% of all and new claims (respectively) occurring in this health service setting. *Diagnosis* was recorded for 24% and 22% of all and new claims (respectively) occurring in a public hospital/day surgery.

For claims arising from an incident occurring in a private setting, *Procedure* was the most frequently recorded primary incident/allegation type in private hospitals or day surgeries. However, in private medical clinics and *Other private settings*, it was *Diagnosis*. Within private hospitals or day surgeries, *Procedure*-related claims accounted for 35% of all claims and 34% of new claims. In private medical clinics, *Diagnosis* was recorded for 21% of all claims and 17% of new claims. In *Other private settings*, the proportion of claims related to an incident or allegation of *Diagnosis* rose to 57% of all claims and 48% of new claims.

As an incident/allegation type, *General duty of care* accounted for the highest proportion of claims in *Other public settings* and in *Other* health service settings. It was associated with 17% and 21% respectively of all and new claims in *Other public settings*, and 25% and 29% of all and new claims in *Other* settings.

Consent was generally recorded as comprising a small proportion of the recorded types of primary incident/allegation, except in private hospitals/day surgeries where it was associated with 10% of all claims and 15% of new claims. *Treatment*, in contrast, tended to be recorded at an even rate across all health service settings, usually between 10% and 20% but occasionally lower.

Table 3.2: All claims[a]: primary incident/allegation type by health service setting, 1 July 2007 to 30 June 2008

Primary incident/allegation type	Health service setting							
	Public hospital/ day surgery[b]	Other public setting[c]	Private hospital/ day surgery[d]	Private medical clinic[e]	Other private setting[f]	Other[g]	Not known	Total
Anaesthetic	112	0	110	3	1	1	13	240
Blood/blood product-related	25	24	1	0	0	1	0	51
Consent	97	4	135	72	3	1	6	318
Device failure[h]	20	0	8	3	0	0	2	33
Diagnosis	1,182	39	70	276	70	7	35	1,679
General duty of care	357	25	28	86	13	23	17	549
Infection control	79	0	3	12	0	0	3	97
Medication-related	225	4	22	120	5	1	15	392
Procedure	1,670	14	463	76	11	4	40	2,278
Treatment	832	24	141	168	9	13	22	1,209
Other	79	9	30	211	7	28	43	407
Not known	227	4	307	309	3	14	438	1,302
Total	**4,905**	**147**	**1,318**	**1,336**	**122**	**93**	**634**	**8,555**
Total per cent	*57.3*	*1.7*	*15.4*	*15.6*	*1.4*	*1.1*	*7.4*	*100.0*

(a) Claims that were open at any point during the financial year.
(b) Includes public psychiatric hospitals.
(c) Includes public community health centres, residential aged care services, hospices and alcohol and drug rehabilitation centres.
(d) Includes private psychiatric hospitals.
(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.
(f) Includes private residential aged care services, hospices, and alcohol and drug rehabilitation centres.
(g) Includes patient's home and 'Medihotels'. Medihotels provide accommodation and hotel services suited to recipients of acute health care services who are able to care for themselves and are making the transition between the community and the acute hospital sector (Victorian Department of Health 2009).
(h) Aligns to 'Faulty/contaminated equipment' in the APRA National Claim and Policy Database (NCPD).

Notes

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

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

Table 3.3: All claims[a]: primary incident/allegation type by health service setting, 1 July 2007 to 30 June 2008 (per cent)

	Health service setting							
Primary incident/allegation type	**Public hospital/ day surgery[b]**	**Other public setting[c]**	**Private hospital/ day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Anaesthetic	2.3	0.0	8.3	0.2	0.8	1.1	2.1	2.8
Blood/blood product-related	0.5	16.3	0.1	0.0	0.0	1.1	0.0	0.6
Consent	2.0	2.7	10.2	5.4	2.5	1.1	0.9	3.7
Device failure[h]	0.4	0.0	0.6	0.2	0.0	0.0	0.3	0.4
Diagnosis	24.1	26.5	5.3	20.7	57.4	7.5	5.5	19.6
General duty of care	7.3	17.0	2.1	6.4	10.7	24.7	2.7	6.4
Infection control	1.6	0.0	0.2	0.9	0.0	0.0	0.5	1.1
Medication-related	4.6	2.7	1.7	9.0	4.1	1.1	2.4	4.6
Procedure	34.0	9.5	35.1	5.7	9.0	4.3	6.3	26.6
Treatment	17.0	16.3	10.7	12.6	7.4	14.0	3.5	14.1
Other	1.6	6.1	2.3	15.8	5.7	30.1	6.8	4.8
Not known	4.6	2.7	23.3	23.1	2.5	15.1	69.1	15.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

Notes

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

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

Table 3.4: New claims[a]: primary incident/allegation type by health service setting, 1 July 2007 to 30 June 2008

Primary incident/allegation type	Health service setting							
	Public hospital/ day surgery[b]	Other public setting[c]	Private hospital/ day surgery[d]	Private medical clinic[e]	Other private setting[f]	Other[g]	Not known	Total
Anaesthetic	21	0	30	1	0	0	5	57
Blood/blood product-related	4	1	0	0	0	0	0	5
Consent	14	3	48	32	0	0	4	101
Device failure[h]	5	0	1	0	0	0	0	6
Diagnosis	200	9	14	74	19	1	4	321
General duty of care	88	8	7	41	7	11	12	174
Infection control	10	0	1	4	0	0	0	15
Medication-related	41	1	5	40	1	0	3	91
Procedure	248	5	109	21	4	2	4	393
Treatment	178	7	27	65	2	5	3	287
Other	27	4	10	87	6	13	20	167
Not known	78	0	65	83	1	6	405	638
Total	**914**	**38**	**317**	**448**	**40**	**38**	**460**	**2,255**
Total per cent	*40.5*	*1.7*	*14.1*	*19.9*	*1.8*	*1.7*	*20.4*	*100.0*

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

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

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

Table 3.5: New claims[a]: primary incident/allegation type by health service setting, 1 July 2007 to 30 June 2008 (per cent)

	Health service setting							
Primary incident/allegation type	**Public hospital/ day surgery[b]**	**Other public setting[c]**	**Private hospital/ day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Anaesthetic	2.3	0.0	9.5	0.2	0.0	0.0	1.1	2.5
Blood/blood product-related	0.4	2.6	0.0	0.0	0.0	0.0	0.0	0.2
Consent	1.5	7.9	15.1	7.1	0.0	0.0	0.9	4.5
Device failure[h]	0.5	0.0	0.3	0.0	0.0	0.0	0.0	0.3
Diagnosis	21.9	23.7	4.4	16.5	47.5	2.6	0.9	14.2
General duty of care	9.6	21.1	2.2	9.2	17.5	28.9	2.6	7.7
Infection control	1.1	0.0	0.3	0.9	0.0	0.0	0.0	0.7
Medication-related	4.5	2.6	1.6	8.9	2.5	0.0	0.7	4.0
Procedure	27.1	13.2	34.4	4.7	10.0	5.3	0.9	17.4
Treatment	19.5	18.4	8.5	14.5	5.0	13.2	0.7	12.7
Other	3.0	10.5	3.2	19.4	15.0	34.2	4.3	7.4
Not known	8.5	0.0	20.5	18.5	2.5	15.8	88.0	28.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

Notes

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

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

Specialty of clinician

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

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

The twelve most commonly recorded clinical specialties during the period of 1 July 2007 to 30 June 2008 feature in tables 3.6 to 3.9. *Obstetrics and Gynaecology* (1,439 records) and *General practice* (1,419 records) were the most frequently recorded specialities, both associated with about 17% of all claims. For new claims, the same two specialities were the most frequently recorded, *General practice* on 483 occasions (21%) and *Obstetrics and Gynaecology* in 227 cases (10%). Three other frequently recorded clinician specialties were *General surgery*, *Emergency medicine* and *Orthopaedic surgery*, each of which was associated with 7–8% of all claims and 5–6% of new claims.

The clinical specialties *General surgery*, *Orthopaedic surgery* and *Obstetrics and Gynaecology* were recorded for some two to three times the proportion of claims with *Procedure* as their incident/allegation type as they were for total claims. In the case of all claims, 19% of *Procedure*-related claims were associated with *General surgery*, 14% with *Orthopaedic surgery* and 32% with *Obstetrics and Gynaecology*, compared to the respective percentages of 8%, 7% and 17% for total claims. When new claims that are *Procedure*-related are considered, it can be seen that 18% were associated with *General surgery*, 17% with *Orthopaedic surgery* and 24% with *Obstetrics and Gynaecology*, whereas these clinical specialties were respectively recorded for 6%, 6% and 10% of total new claims.

The specialty of *Emergency medicine* was associated with a relatively high proportion of claims with an incident/allegation type of *Diagnosis*. These proportions were 25% and 23% for all and new claims respectively, compared to the 8% of all claims and 6% of total new claims associated with *Emergency medicine*. The clinical specialties of *Diagnostic radiology* and *Paediatric medicine* were also recorded for a relatively high proportion of all *Diagnosis*-related claims, respectively 7% and 4%, compared to the proportions of 3% and 1% of the total of all claims with which these specialties were associated.

In the case of claims with a primary incident/allegation type of *General duty of care*, the proportions associated with *Psychiatry* and with *General nursing* were approximately seven times the respective proportions of total claims. *Psychiatry* was recorded for 23% of all claims with an incident/allegation type of *General duty of care*, and *General nursing* for 19%, compared to their respective association with 3% and 2% of total claims. The corresponding proportions for new claims are 21% for *Psychiatry* and 8% for *General nursing* (where *General duty of care* was the incident/allegation type), compared to 3% and 1% of total new claims.

Comparisons with the clinical specialty data in previous combined sector reports are not possible because the data were presented in a different way.

Table 3.6: All claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2007 to 30 June 2008

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/ blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	182	0	0	2	3	6	3	14	44	17	2	13	286
Diagnostic radiology	1	0	1	0	109	10	1	1	21	13	7	122	286
Emergency medicine	1	1	4	2	414	36	2	25	39	143	5	20	692
General and internal medicine	1	1	3	2	47	13	4	22	12	30	7	8	150
General nursing	2	0	0	2	13	104	6	23	16	37	1	3	207
General practice[c]	11	2	65	3	374	72	12	120	111	198	185	266	1,419
General surgery	14	0	17	1	81	13	3	12	432	67	14	45	699
Neurosurgery	1	1	2	1	20	4	2	2	53	18	3	15	122
Obstetrics and Gynaecology[d]	6	2	34	7	180	46	1	24	738	239	18	144	1,439
Orthopaedic surgery	8	0	19	5	72	14	12	12	319	74	9	72	616
Paediatric medicine	1	1	1	0	58	2	0	12	9	28	2	1	115
Psychiatry	0	1	8	0	22	127	0	20	5	48	42	14	287
Other hospital based medical practitioner[e]	10	1	19	1	81	22	17	12	51	43	41	28	326
All other specialties[f]	18	42	152	7	331	102	31	103	526	325	51	208	1,896
Not applicable[g]	1	1	0	0	7	12	2	3	2	7	11	5	51
Not known	1	1	1	1	15	18	4	7	25	22	11	353	459
Total[h]	**240**	**51**	**318**	**33**	**1,679**	**549**	**97**	**392**	**2,278**	**1,209**	**407**	**1,302**	**8,555**

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

(b) Only the 12 specialties that were most frequently recorded for all claims are listed.

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

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

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

(f) Covers all categories of clinician specialties other than the 13 listed above.

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

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

Table 3.7: All claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2007 to 30 June 2008 (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	75.8	0.0	0.0	6.1	0.2	1.1	3.1	3.6	1.9	1.4	0.5	1.0	3.3
Diagnostic radiology	0.4	0.0	0.3	0.0	6.5	1.8	1.0	0.3	0.9	1.1	1.7	9.4	3.3
Emergency medicine	0.4	2.0	1.3	6.1	24.7	6.6	2.1	6.4	1.7	11.8	1.2	1.5	8.1
General and internal medicine	0.4	2.0	0.9	6.1	2.8	2.4	4.1	5.6	0.5	2.5	1.7	0.6	1.8
General nursing	0.8	0.0	0.0	6.1	0.8	18.9	6.2	5.9	0.7	3.1	0.2	0.2	2.4
General practice[c]	4.6	3.9	20.4	9.1	22.3	13.1	12.4	30.6	4.9	16.4	45.5	20.4	16.6
General surgery	5.8	0.0	5.3	3.0	4.8	2.4	3.1	3.1	19.0	5.5	3.4	3.5	8.2
Neurosurgery	0.4	2.0	0.6	3.0	1.2	0.7	2.1	0.5	2.3	1.5	0.7	1.2	1.4
Obstetrics and Gynaecology[d]	2.5	3.9	10.7	21.2	10.7	8.4	1.0	6.1	32.4	19.8	4.4	11.1	16.8
Orthopaedic surgery	3.3	0.0	6.0	15.2	4.3	2.6	12.4	3.1	14.0	6.1	2.2	5.5	7.2
Paediatric medicine	0.4	2.0	0.3	0.0	3.5	0.4	0.0	3.1	0.4	2.3	0.5	0.1	1.3
Psychiatry	0.0	2.0	2.5	0.0	1.3	23.1	0.0	5.1	0.2	4.0	10.3	1.1	3.4
Other hospital based medical practitioner[e]	4.2	2.0	6.0	3.0	4.8	4.0	17.5	3.1	2.2	3.6	10.1	2.2	3.8
All other specialties[f]	7.5	82.4	47.8	21.2	19.7	18.6	32.0	26.3	23.1	26.9	12.5	16.0	22.2
Not applicable[g]	0.4	2.0	0.0	0.0	0.4	2.2	2.1	0.8	0.1	0.6	2.7	0.4	0.6
Not known	0.4	2.0	0.3	3.0	0.9	3.3	4.1	1.8	1.1	1.8	2.7	27.1	5.4
Total[h]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Only the 12 specialties that were most frequently recorded for all claims are listed.

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

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

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

(f) Covers all categories of clinician specialties other than the 13 listed above.

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

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

Table 3.8: New claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2007 to 30 June 2008

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	43	0	0	0	0	4	0	2	9	3	1	6	68
Diagnostic radiology	0	0	1	0	14	3	0	0	6	3	1	34	62
Emergency medicine	0	0	2	0	73	11	2	7	7	36	1	3	142
General and internal medicine	0	0	2	0	14	5	1	6	3	5	2	0	38
General nursing	0	0	0	1	0	14	0	4	3	4	0	1	27
General practice[c]	4	0	25	0	89	33	2	37	23	58	82	130	483
General surgery	3	0	3	0	7	3	1	2	70	13	6	17	125
Neurosurgery	0	0	1	1	2	1	0	2	8	2	1	4	22
Obstetrics and Gynaecology[d]	0	1	3	0	24	15	0	4	96	45	7	32	227
Orthopaedic surgery	0	0	1	1	13	5	3	3	65	25	3	15	134
Psychiatry	0	0	2	0	1	36	0	5	2	8	15	5	74
Urology	0	0	1	0	5	1	0	0	11	7	1	0	26
Other hospital based medical practitioner[e]	2	0	8	0	12	4	1	3	11	9	18	5	73
All other specialties[f]	5	5	53	3	73	32	5	19	85	85	27	73	465
Not applicable[g]	0	0	0	0	2	6	0	1	0	1	1	3	14
Not known	1	0	1	0	6	7	1	0	13	5	3	311	348
Total[h]	**57**	**5**	**101**	**6**	**321**	**174**	**15**	**91**	**393**	**287**	**167**	**638**	**2,255**

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

(b) Only the 12 specialties that were most frequently recorded for new claims are listed.

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

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

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

(f) Covers all categories of clinician specialties other than the 13 listed above.

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

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

Table 3.9: New claims[a]: specialties of clinicians involved by primary incident/allegation type, 1 July 2007 to 30 June 2008 (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	75.4	0.0	0.0	0.0	0.0	2.3	0.0	2.2	2.3	1.0	0.6	0.9	3.0
Diagnostic radiology	0.0	0.0	1.0	0.0	4.4	1.7	0.0	0.0	1.5	1.0	0.6	5.3	2.7
Emergency medicine	0.0	0.0	2.0	0.0	22.7	6.3	13.3	7.7	1.8	12.5	0.6	0.5	6.3
General and internal medicine	0.0	0.0	2.0	0.0	4.4	2.9	6.7	6.6	0.8	1.7	1.2	0.0	1.7
General nursing	0.0	0.0	0.0	16.7	0.0	8.0	0.0	4.4	0.8	1.4	0.0	0.2	1.2
General practice[c]	7.0	0.0	24.8	0.0	27.7	19.0	13.3	40.7	5.9	20.2	49.1	20.4	21.4
General surgery	5.3	0.0	3.0	0.0	2.2	1.7	6.7	2.2	17.8	4.5	3.6	2.7	5.5
Neurosurgery	0.0	0.0	1.0	16.7	0.6	0.6	0.0	2.2	2.0	0.7	0.6	0.6	1.0
Obstetrics and Gynaecology[d]	0.0	20.0	3.0	0.0	7.5	8.6	0.0	4.4	24.4	15.7	4.2	5.0	10.1
Orthopaedic surgery	0.0	0.0	1.0	16.7	4.0	2.9	20.0	3.3	16.5	8.7	1.8	2.4	5.9
Psychiatry	0.0	0.0	2.0	0.0	0.3	20.7	0.0	5.5	0.5	2.8	9.0	0.8	3.3
Urology	0.0	0.0	1.0	0.0	1.6	0.6	0.0	0.0	2.8	2.4	0.6	0.0	1.2
Other hospital based medical practitioner[e]	3.5	0.0	7.9	0.0	3.7	2.3	6.7	3.3	2.8	3.1	10.8	0.8	3.2
All other specialties[f]	8.8	100.0	52.5	50.0	22.7	18.4	33.3	20.9	21.6	29.6	16.2	11.4	20.6
Not applicable[g]	0.0	0.0	0.0	0.0	0.6	3.4	0.0	1.1	0.0	0.3	0.6	0.5	0.6
Not known	1.8	0.0	1.0	0.0	1.9	4.0	6.7	0.0	3.3	1.7	1.8	48.7	15.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Only the 12 specialties that were most frequently recorded for new claims are listed.

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

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

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

(f) Covers all categories of clinician specialties other than the 13 listed above.

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

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

3.2 People affected by claims

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

Age and sex of claim subject

The age of claim subjects refers to their age at the time of the alleged incident that gave rise to the claim. During 2007–08, 9% (774) of all claims and 5% (109) of new claims related to babies less than 1 year old, about 7% of both all and new claims (621 and 144 respectively) related to children (1–17 years of age) and about 70% of both all and new claims (5,923 and 1,512 claims) were related to adults (18+ years of age). The age of the claim subject was not known in 15% (1,237) of all claims and 22% (490) of new claims (tables 3.10 to 3.13).

The claim subject was female in the majority of all and new claims for the 2007–08 reporting period. The greater representation of female than male claim subjects was particularly a feature of claims involving adults. The claim subject was more often male than female for babies and children.

Procedure and *Diagnosis* were the most frequently recorded incident/allegation types for males, respectively accounting for 24% (796) and 23% (741) of all claims, and 16% (136) and 17% (148) of new claims. *Treatment* was also often recorded, for 547 (17%) of all claims and 119 (14%) of new claims. With females, *Procedure* stood out as the most common incident/allegation type, recorded for 1,413 (30%) of all claims and 237 (20%) of new claims. *Diagnosis* and *Treatment* followed in frequency, being respectively recorded for 871 (19%) and 609 (13%) of all claims, and 153 new claims (13%) each.

A relatively high proportion of claims with the claim subject recorded as a baby had a primary incident/allegation type of *Treatment*. This is the case with 27% of all baby claims and 33% of new baby claims. *Diagnosis* on the other hand was more a feature of claims with a child as the claim subject, and was recorded for 33% of all children's claims and 24% of new children's claims.

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

Table 3.10: All claims[a]: primary incident/allegation type, by sex and age of claim subject, 1 July 2007 to 30 June 2008

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	3	7	76	10	96
Blood/blood product-related	2	2	13	3	20
Consent	7	7	46	8	68
Device failure	0	1	5	3	9
Diagnosis	90	117	472	62	741
General duty of care	13	12	175	25	225
Infection control	2	2	25	7	36
Medication-related	11	22	115	10	158
Procedure	140	61	551	44	796
Treatment	119	56	338	34	547
Other	2	5	64	13	84
Not known	33	43	328	108	512
Total males	*422*	*335*	*2,208*	*327*	*3,292*
Row per cent	*12.8*	*10.2*	*67.1*	*9.9*	*100.0*
Females					
Anaesthetic	2	5	118	13	138
Blood/blood product-related	2	3	16	1	22
Consent	2	8	201	28	239
Device failure	0	0	23	0	23
Diagnosis	62	88	647	74	871
General duty of care	13	9	216	36	274
Infection control	3	2	40	5	50
Medication-related	8	12	148	27	195
Procedure	117	47	1,153	96	1,413
Treatment	86	49	426	48	609
Other	4	10	85	20	119
Not known	32	41	541	124	738
Total females	*331*	*274*	*3,614*	*472*	*4,691*
Row per cent	*7.1*	*5.8*	*77.0*	*10.1*	*100.0*
Persons[b]					
Anaesthetic	5	12	196	27	240
Blood/blood product-related	4	5	29	13	51
Consent	9	15	250	44	318
Device failure	0	1	28	4	33
Diagnosis	155	207	1,137	180	1,679
General duty of care	27	21	397	104	549
Infection control	5	4	66	22	97
Medication-related	19	34	264	75	392
Procedure	265	109	1,726	178	2,278
Treatment	210	106	781	112	1,209
Other	7	20	158	222	407
Not known	68	87	891	256	1,302
Total persons	**774**	**621**	**5,923**	**1,237**	**8,555**
Row per cent	**9.0**	**7.3**	**69.2**	**14.5**	**100.0**

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

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

Table 3.11: All claims[a]: primary incident/allegation type, by sex and age of claim subject, 1 July 2007 to 30 June 2008 (per cent)

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0.7	2.1	3.4	3.1	2.9
Blood/blood product-related	0.5	0.6	0.6	0.9	0.6
Consent	1.7	2.1	2.1	2.4	2.1
Device failure	0.0	0.3	0.2	0.9	0.3
Diagnosis	21.3	34.9	21.4	19.0	22.5
General duty of care	3.1	3.6	7.9	7.6	6.8
Infection control	0.5	0.6	1.1	2.1	1.1
Medication-related	2.6	6.6	5.2	3.1	4.8
Procedure	33.2	18.2	25.0	13.5	24.2
Treatment	28.2	16.7	15.3	10.4	16.6
Other	0.5	1.5	2.9	4.0	2.6
Not known	7.8	12.8	14.9	33.0	15.6
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Anaesthetic	0.6	1.8	3.3	2.8	2.9
Blood/blood product-related	0.6	1.1	0.4	0.2	0.5
Consent	0.6	2.9	5.6	5.9	5.1
Device failure	0.0	0.0	0.6	0.0	0.5
Diagnosis	18.7	32.1	17.9	15.7	18.6
General duty of care	3.9	3.3	6.0	7.6	5.8
Infection control	0.9	0.7	1.1	1.1	1.1
Medication-related	2.4	4.4	4.1	5.7	4.2
Procedure	35.3	17.2	31.9	20.3	30.1
Treatment	26.0	17.9	11.8	10.2	13.0
Other	1.2	3.6	2.4	4.2	2.5
Not known	9.7	15.0	15.0	26.3	15.7
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[b]					
Anaesthetic	0.6	1.9	3.3	2.2	2.8
Blood/blood product-related	0.5	0.8	0.5	1.1	0.6
Consent	1.2	2.4	4.2	3.6	3.7
Device failure	0.0	0.2	0.5	0.3	0.4
Diagnosis	20.0	33.3	19.2	14.6	19.6
General duty of care	3.5	3.4	6.7	8.4	6.4
Infection control	0.6	0.6	1.1	1.8	1.1
Medication-related	2.5	5.5	4.5	6.1	4.6
Procedure	34.2	17.6	29.1	14.4	26.6
Treatment	27.1	17.1	13.2	9.1	14.1
Other	0.9	3.2	2.7	17.9	4.8
Not known	8.8	14.0	15.0	20.7	15.2
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

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

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

Table 3.12: New claims[a]: primary incident/allegation type, by sex and age of claim subject, 1 July 2007 to 30 June 2008

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0	2	17	0	19
Blood/blood product-related	0	0	1	0	1
Consent	0	2	15	2	19
Device failure	0	0	1	1	2
Diagnosis	14	19	100	15	148
General duty of care	4	4	55	7	70
Infection control	0	1	4	3	8
Medication-related	2	5	30	3	40
Procedure	10	6	105	15	136
Treatment	20	9	82	8	119
Other	1	3	22	7	33
Not known	8	23	150	82	263
Total males	*59*	*74*	*582*	*143*	*858*
Row per cent	*6.9*	*8.6*	*67.8*	*16.7*	*100.0*
Females					
Anaesthetic	0	1	32	4	37
Blood/blood product-related	0	0	3	1	4
Consent	0	2	61	15	78
Device failure	0	0	4	0	4
Diagnosis	8	15	111	19	153
General duty of care	4	4	65	15	88
Infection control	1	0	3	1	5
Medication-related	1	1	30	6	38
Procedure	4	14	195	24	237
Treatment	15	8	115	15	153
Other	1	4	40	10	55
Not known	8	13	223	89	333
Total females	*42*	*62*	*882*	*199*	*1,185*
Row per cent	*3.5*	*5.2*	*74.4*	*16.8*	*100.0*
Persons[b]					
Anaesthetic	0	3	50	4	57
Blood/blood product-related	0	0	4	1	5
Consent	0	4	79	18	101
Device failure	0	0	5	1	6
Diagnosis	23	35	220	43	321
General duty of care	9	8	121	36	174
Infection control	1	1	8	5	15
Medication-related	3	6	61	21	91
Procedure	15	21	308	49	393
Treatment	36	17	203	31	287
Other	3	10	64	90	167
Not known	19	39	389	191	638
Total persons	**109**	**144**	**1,512**	**490**	**2,255**
Row per cent	**4.8**	**6.4**	**67.1**	**21.7**	**100.0**

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

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

Table 3.13: New claims[a]: primary incident/allegation type, by sex and age of claim subject, 1 July 2007 to 30 June 2008 (per cent)

Primary incident/allegation type	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Anaesthetic	0.0	2.7	2.9	0.0	2.2
Blood/blood product-related	0.0	0.0	0.2	0.0	0.1
Consent	0.0	2.7	2.6	1.4	2.2
Device failure	0.0	0.0	0.2	0.7	0.2
Diagnosis	23.7	25.7	17.2	10.5	17.2
General duty of care	6.8	5.4	9.5	4.9	8.2
Infection control	0.0	1.4	0.7	2.1	0.9
Medication-related	3.4	6.8	5.2	2.1	4.7
Procedure	16.9	8.1	18.0	10.5	15.9
Treatment	33.9	12.2	14.1	5.6	13.9
Other	1.7	4.1	3.8	4.9	3.8
Not known	13.6	31.1	25.8	57.3	30.7
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Anaesthetic	0.0	1.6	3.6	2.0	3.1
Blood/blood product-related	0.0	0.0	0.3	0.5	0.3
Consent	0.0	3.2	6.9	7.5	6.6
Device failure	0.0	0.0	0.5	0.0	0.3
Diagnosis	19.0	24.2	12.6	9.5	12.9
General duty of care	9.5	6.5	7.4	7.5	7.4
Infection control	2.4	0.0	0.3	0.5	0.4
Medication-related	2.4	1.6	3.4	3.0	3.2
Procedure	9.5	22.6	22.1	12.1	20.0
Treatment	35.7	12.9	13.0	7.5	12.9
Other	2.4	6.5	4.5	5.0	4.6
Not known	19.0	21.0	25.3	44.7	28.1
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[b]					
Anaesthetic	0.0	2.1	3.3	0.8	2.5
Blood/blood product-related	0.0	0.0	0.3	0.2	0.2
Consent	0.0	2.8	5.2	3.7	4.5
Device failure	0.0	0.0	0.3	0.2	0.3
Diagnosis	21.1	24.3	14.6	8.8	14.2
General duty of care	8.3	5.6	8.0	7.3	7.7
Infection control	0.9	0.7	0.5	1.0	0.7
Medication-related	2.8	4.2	4.0	4.3	4.0
Procedure	13.8	14.6	20.4	10.0	17.4
Treatment	33.0	11.8	13.4	6.3	12.7
Other	2.8	6.9	4.2	18.4	7.4
Not known	17.4	27.1	25.7	39.0	28.3
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

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

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

Primary body function/structure affected

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

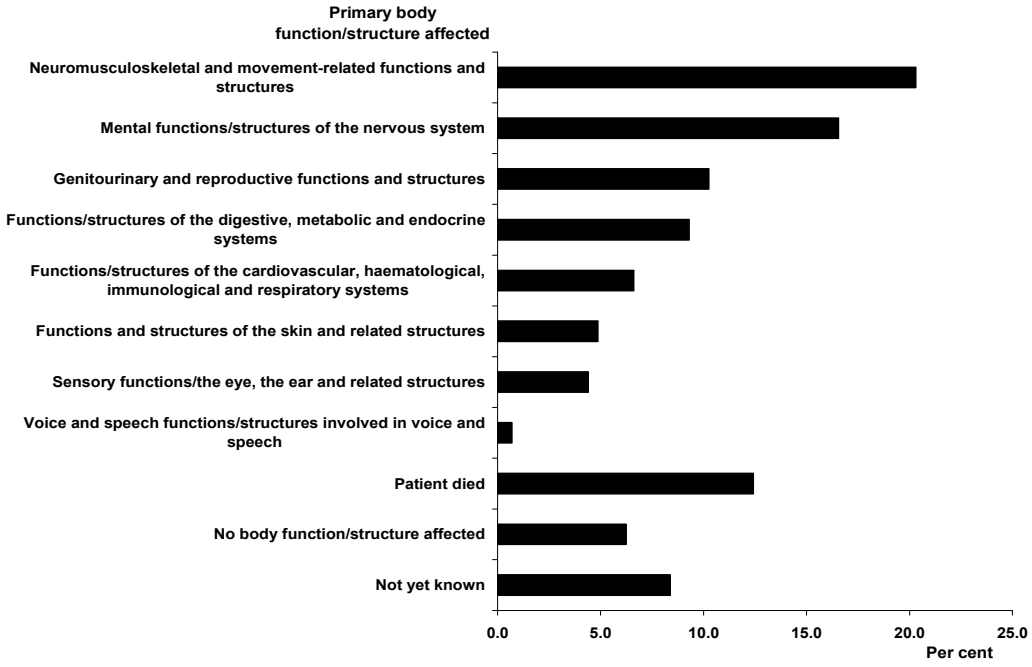
During the period 2007–08 the most frequently recorded body function/structure affected was *Neuromusculoskeletal and movement-related* which was recorded for 20% (1,737 of 8,555) of all claims and 17% (389 of 2,255) of new claims (figures 3.2 and 3.3). The next two most frequently recorded categories were *Mental and nervous system* and *Death*, although their order varied depending on whether all claims or new claims are considered. Their proportions were respectively 17% (1,416) and 12% (1,062) in the case of all claims, compared to 10% (228) and 11% (245) in the case of new claims (tables 3.14 to 3.17). Those claims where no body function/structure of the claim subject was affected represented 6% (534) of all claims and 10% (224) of new claims.

Data on the affected body function/structure are available for new claims pertaining to the 2004–05, 2005–06 and 2006–07 years (AIHW 2007, 2008, 2010a). In all years, *Neuromusculoskeletal and movement-related* was the most frequently recorded category, and in most years the second most often recorded category was *Mental and nervous system*, but in 2005–06 this place was taken by *Digestive, metabolic and endocrine systems*.

Death was recorded more frequently for male claim subjects being associated with about 14% of claims where the subject was male for both all claims (475 of 3,292) and new claims (116 of 858), compared to about 10% of all claims (466 of 4,691 claims) and 9% of new claims (105 of 1,185 claims) where the claim subject was female.

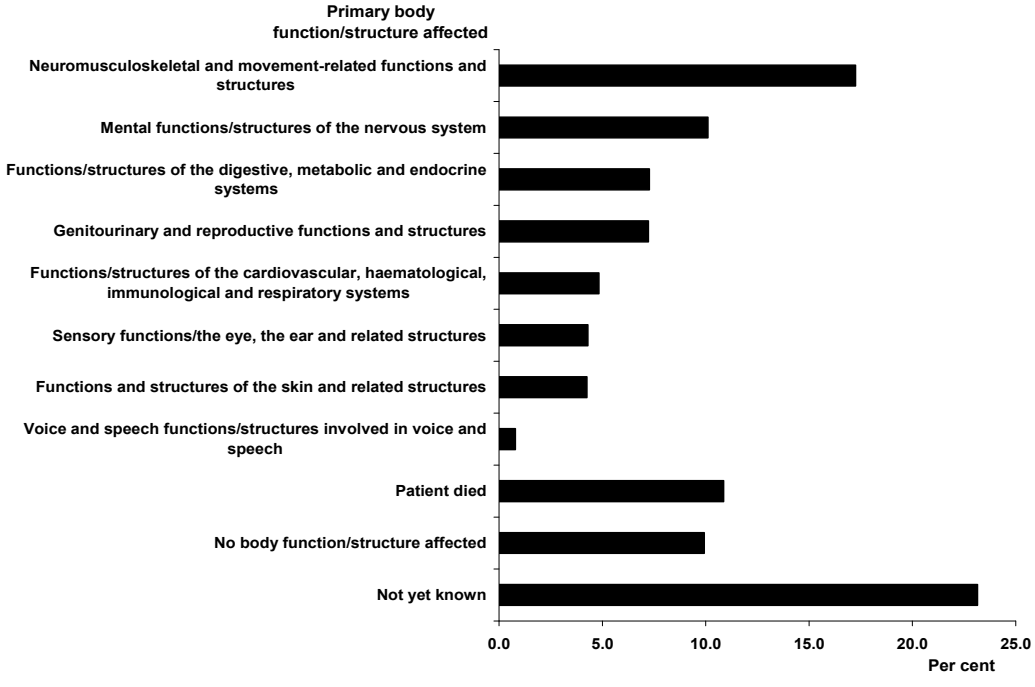
Where the claim subject was a baby, *Mental or nervous system* was by far the most frequently recorded category, for both sexes and particularly for males. The proportion of all baby claims associated with *Mental or nervous system* damage was 49% (374 claims), and the proportion of new baby claims was 27% (29 claims). The most frequently recorded body function/structure affected for claims with a child or an adult as the claim subject was *Neuromusculoskeletal and movement-related*, regardless of the sex of the claim subject or whether all claims or new claims is considered.

The categories *Genitourinary and reproductive* and *Skin and related structures* were recorded for a higher proportion of claims involving female than male adult claim subjects. *Genitourinary and reproductive* was the second most frequent category associated with female adult claims, for both all claims (591 of 3,615 claims, 16%) and new claims (97 of 882 claims, 11%). The proportion of female adult claims associated with damage to the *Skin and related structures* approximated 6%, compared to around 3% for male adult claims.



Source: AIHW analysis of 2007–08 MINC data

Figure 3.2: All claims: primary body function/structure affected, 1 July 2007 to 30 June 2008 (per cent)



Source: AIHW analysis of 2007–08 MINC data

Figure 3.3: New claims: primary body function/structure affected, 1 July 2007 to 30 June 2008 (per cent)

Table 3.14: All claims[a]: primary body function/structure affected, by sex and age of claim subject, 1 July 2007 to 30 June 2008

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	26	19	189	23	257
Death	31	39	351	54	475
Digestive, metabolic and endocrine systems	8	26	260	20	314
Genitourinary and reproductive	12	34	126	15	187
Mental and nervous system	225	64	264	38	591
Neuromusculoskeletal and movement-related	65	83	571	48	767
Sensory functions and structures	10	18	148	6	182
Skin and related structures	7	16	82	8	113
Voice and speech	3	1	16	3	23
No body function/structure affected	2	13	69	26	110
Not known	33	22	132	86	273
Total males	*422*	*335*	*2,208*	*327*	*3,292*
Row per cent	*12.8*	*10.2*	*67.1*	*9.9*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	18	23	224	22	287
Death	33	28	349	56	466
Digestive, metabolic and endocrine systems	4	25	399	36	464
Genitourinary and reproductive	11	15	591	49	666
Mental and nervous system	151	52	517	67	787
Neuromusculoskeletal and movement-related	78	68	718	68	932
Sensory functions and structures	3	16	156	11	186
Skin and related structures	5	13	238	33	289
Voice and speech	0	0	35	1	36
No body function/structure affected	1	15	155	32	203
Not known	27	19	232	97	375
Total females	*331*	*274*	*3,614*	*472*	*4,691*
Row per cent	*7.1*	*5.8*	*77.0*	*10.1*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	46	42	418	59	565
Death	67	69	713	213	1,062
Digestive, metabolic and endocrine systems	12	51	669	64	796
Genitourinary and reproductive	24	49	722	82	877
Mental and nervous system	378	119	789	130	1,416
Neuromusculoskeletal and movement-related	146	152	1,308	131	1,737
Sensory functions and structures	14	34	305	23	376
Skin and related structures	12	30	330	44	416
Voice and speech	3	1	51	4	59
No body function/structure affected	3	28	230	273	534
Not known	69	46	388	214	717
Total persons	**774**	**621**	**5,923**	**1,237**	**8,555**
Row per cent	**9.0**	**7.3**	**69.2**	**14.5**	**100.0**

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

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

Table 3.15: All claims[a]: primary body function/structure affected, by sex and age of claim subject, 1 July 2007 to 30 June 2008 (per cent)

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	6.2	5.7	8.6	7.0	7.8
Death	7.3	11.6	15.9	16.5	14.4
Digestive, metabolic and endocrine systems	1.9	7.8	11.8	6.1	9.5
Genitourinary and reproductive	2.8	10.1	5.7	4.6	5.7
Mental and nervous system	53.3	19.1	12.0	11.6	18.0
Neuromusculoskeletal and movement-related	15.4	24.8	25.9	14.7	23.3
Sensory functions and structures	2.4	5.4	6.7	1.8	5.5
Skin and related structures	1.7	4.8	3.7	2.4	3.4
Voice and speech	0.7	0.3	0.7	0.9	0.7
No body function/structure affected	0.5	3.9	3.1	8.0	3.3
Not known	7.8	6.6	6.0	26.3	8.3
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	5.4	8.4	6.2	4.7	6.1
Death	10.0	10.2	9.7	11.9	9.9
Digestive, metabolic and endocrine systems	1.2	9.1	11.0	7.6	9.9
Genitourinary and reproductive	3.3	5.5	16.4	10.4	14.2
Mental and nervous system	45.6	19.0	14.3	14.2	16.8
Neuromusculoskeletal and movement-related	23.6	24.8	19.9	14.4	19.9
Sensory functions and structures	0.9	5.8	4.3	2.3	4.0
Skin and related structures	1.5	4.7	6.6	7.0	6.2
Voice and speech	0.0	0.0	1.0	0.2	0.8
No body function/structure affected	0.3	5.5	4.3	6.8	4.3
Not known	8.2	6.9	6.4	20.6	8.0
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	5.9	6.8	7.1	4.8	6.6
Death	8.7	11.1	12.0	17.2	12.4
Digestive, metabolic and endocrine systems	1.6	8.2	11.3	5.2	9.3
Genitourinary and reproductive	3.1	7.9	12.2	6.6	10.3
Mental and nervous system	48.8	19.2	13.3	10.5	16.6
Neuromusculoskeletal and movement-related	18.9	24.5	22.1	10.6	20.3
Sensory functions and structures	1.8	5.5	5.1	1.9	4.4
Skin and related structures	1.6	4.8	5.6	3.6	4.9
Voice and speech	0.4	0.2	0.9	0.3	0.7
No body function/structure affected	0.4	4.5	3.9	22.1	6.2
Not known	8.9	7.4	6.6	17.3	8.4
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

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

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

Table 3.16: New claims[a]: primary body function/structure affected, by sex and age of claim subject, 1 July 2007 to 30 June 2008

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	5	3	33	5	46
Death	6	9	90	11	116
Digestive, metabolic and endocrine systems	1	5	57	5	68
Genitourinary and reproductive	4	3	31	6	44
Mental and nervous system	19	11	56	15	101
Neuromusculoskeletal and movement-related	7	11	127	17	162
Sensory functions and structures	1	1	37	2	41
Skin and related structures	2	3	20	3	28
Voice and speech	0	0	3	0	3
No body function/structure affected	0	9	29	7	45
Not known	14	19	99	72	204
Total males	*59*	*74*	*582*	*143*	*858*
Row per cent	*6.9*	*8.6*	*67.8*	*16.7*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	5	5	45	4	59
Death	4	3	76	22	105
Digestive, metabolic and endocrine systems	0	7	71	11	89
Genitourinary and reproductive	4	5	97	7	113
Mental and nervous system	10	6	75	25	116
Neuromusculoskeletal and movement-related	9	11	165	26	211
Sensory functions and structures	0	4	48	2	54
Skin and related structures	2	3	48	10	63
Voice and speech	0	0	15	0	15
No body function/structure affected	1	8	69	15	93
Not known	7	10	173	77	267
Total females	*42*	*62*	*882*	*199*	*1,185*
Row per cent	*3.5*	*5.2*	*74.4*	*16.8*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	11	8	80	10	109
Death	11	12	170	52	245
Digestive, metabolic and endocrine systems	1	12	134	17	164
Genitourinary and reproductive	9	8	129	17	163
Mental and nervous system	29	18	131	50	228
Neuromusculoskeletal and movement-related	17	23	302	47	389
Sensory functions and structures	1	5	86	5	97
Skin and related structures	4	7	71	14	96
Voice and speech	0	0	18	0	18
No body function/structure affected	1	17	101	105	224
Not known	25	34	290	173	522
Total persons	**109**	**144**	**1,512**	**490**	**2,255**
Row per cent	**4.8**	**6.4**	**67.1**	**21.7**	**100.0**

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

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

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

Table 3.17: New claims[a]: primary body function/structure affected, by sex and age of claim subject, 1 July 2007 to 30 June 2008 (per cent)

Primary body function/structure affected	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Not known	Total
Males					
Cardiovascular, haematological, immunological and respiratory	8.5	4.1	5.7	3.5	5.4
Death	10.2	12.2	15.5	7.7	13.5
Digestive, metabolic and endocrine systems	1.7	6.8	9.8	3.5	7.9
Genitourinary and reproductive	6.8	4.1	5.3	4.2	5.1
Mental and nervous system	32.2	14.9	9.6	10.5	11.8
Neuromusculoskeletal and movement-related	11.9	14.9	21.8	11.9	18.9
Sensory functions and structures	1.7	1.4	6.4	1.4	4.8
Skin and related structures	3.4	4.1	3.4	2.1	3.3
Voice and speech	0.0	0.0	0.5	0.0	0.3
No body function/structure affected	0.0	12.2	5.0	4.9	5.2
Not known	23.7	25.7	17.0	50.3	23.8
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females					
Cardiovascular, haematological, immunological and respiratory	11.9	8.1	5.1	2.0	5.0
Death	9.5	4.8	8.6	11.1	8.9
Digestive, metabolic and endocrine systems	0.0	11.3	8.0	5.5	7.5
Genitourinary and reproductive	9.5	8.1	11.0	3.5	9.5
Mental and nervous system	23.8	9.7	8.5	12.6	9.8
Neuromusculoskeletal and movement-related	21.4	17.7	18.7	13.1	17.8
Sensory functions and structures	0.0	6.5	5.4	1.0	4.6
Skin and related structures	4.8	4.8	5.4	5.0	5.3
Voice and speech	0.0	0.0	1.7	0.0	1.3
No body function/structure affected	2.4	12.9	7.8	7.5	7.8
Not known	16.7	16.1	19.6	38.7	22.5
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[b]					
Cardiovascular, haematological, immunological and respiratory	10.1	5.6	5.3	2.0	4.8
Death	10.1	8.3	11.2	10.6	10.9
Digestive, metabolic and endocrine systems	0.9	8.3	8.9	3.5	7.3
Genitourinary and reproductive	8.3	5.6	8.5	3.5	7.2
Mental and nervous system	26.6	12.5	8.7	10.2	10.1
Neuromusculoskeletal and movement-related	15.6	16.0	20.0	9.6	17.3
Sensory functions and structures	0.9	3.5	5.7	1.0	4.3
Skin and related structures	3.7	4.9	4.7	2.9	4.3
Voice and speech	0.0	0.0	1.2	0.0	0.8
No body function/structure affected	0.9	11.8	6.7	21.4	9.9
Not known	22.9	23.6	19.2	35.3	23.1
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

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

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

3.3 Duration of claims

The start date for measuring the duration of a claim is either the date the claim first had a reserve placed (public sector claims) or the date the claim was reported to a private insurer (private sector claims). The end date for measuring claim duration is either 30 June 2008 (for claims still open at this time) or the date the claim was closed (for claims closed between 1 July 2007 and 30 June 2008).

Of the claims open at the end of the period, 76% (4,478 of 5,880) had been open for up to 3 years. This included 20% (1,194 of 5,880) with duration of less than 6 months, and 60% (3,542 of 5,880) with duration of less than 2 years. There were 9% (538 of 5,880) of claims that had been open after more than 5 years' duration.

Of the claims closed during the period, 66% (1,760 of 2,675) had been open for up to 3 years, which included 3% (76 of 2,675) with duration of less than 6 months, and 34% (913 of 2,675) with duration of less than 2 years. There were 9% (251 of 2,675) that had been open for over 5 years (tables 3.18 and 3.19).

3.4 Reserve range of current claims

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

Three-quarters of claims (4,441) had a reserve of less than $100,000, including 43% (2,548 claims) with a reserve of less than $10,000. There were 342 current claims (6%) with a reserve set between $250,000 and < $500,000 and 485 (8%) with a reserve set at $500,000 or above.

Many of the claims with a reserve set at a small amount had been open for just a short period and relatively few of them for a long period. For claims with a reserve set at less than $10,000 almost half (1,191 of 2,548 claims) were open for up to 1 year, contrasting with the 7% (190 claims) open for more than 4 years and 4% (106 claims) open for more than 5 years.

Claims with their reserve set at $250,000–<$500,000, and especially $500,000 or more, tended to have remained open for a longer period of time than other current claims. The proportions of these claims open for more than 5 years were respectively 17% in the $250,000 to <$500,000 range (59 of 342 claims), and 29% of those reserved for at least $500,000 (139 of 485 claims).

Table 3.18: All claims: status of claim by duration of claim (months), at 30 June 2008

Status of claim	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60	Total claims
New claims (1 July 2007 – 30 June 2008)	1,259	996	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2,255
Reopened	5	6	8	29	18	16	17	18	24	19	60	220
Closed	76	185	255	397	446	401	257	222	104	81	251	2,675
Current claims	1,194	977	726	645	546	390	296	236	169	163	538	5,880

n.a. Not applicable

Notes

1. Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report'. For closed claims it is calculated to 'date claim file closed' or 'date finalised', and for other claims to 30 June 2008.
2. Closed claims in the MII collection include claims that are closed and no more payments are expected, or all recoveries expected from third parties other than reinsurers have been received.
3. Reopened claims include claims that have previously been recorded as closed, but have then been reopened and are active.

Table 3.19: All claims: status of claim by duration of claim (months), at 30 June 2008 (per cent)

Status of claim	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60	Total claims
New claims (1 July 2007 – 30 June 2008)	55.8	44.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	100.0
Reopened	2.3	2.7	3.6	13.2	8.2	7.3	7.7	8.2	10.9	8.6	27.3	100.0
Closed	2.8	6.9	9.5	14.8	16.7	15.0	9.6	8.3	3.9	3.0	9.4	100.0
Current claims	20.3	16.6	12.3	11.0	9.3	6.6	5.0	4.0	2.9	2.8	9.1	100.0

n.a. Not applicable

Notes

1. Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report'. For closed claims it is calculated to 'date claim file closed' or 'date finalised', and for other claims to 30 June 2008.
2. Closed claims in the MII collection include claims that are closed and no more payments are expected, or all recoveries expected from third parties other than reinsurers have been received.
3. Reopened claims include claims that have previously been recorded as closed, but have then been reopened and are active.
4. Percentages may not add up exactly to 100.0 due to rounding.

Table 3.20: Current claims[a]: reserve range by duration of claim (months)[b], at 30 June 2008

Reserve range	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60	Total claims
Less than $10,000	760	431	367	289	236	140	83	52	49	35	106	2,548
$10,000–<$30,000	156	200	122	115	120	88	44	42	27	22	49	985
$30,000–<$50,000	52	52	33	31	23	18	20	12	15	7	32	295
$50,000–<$100,000	90	106	73	65	52	37	49	32	16	25	68	613
$100,000–<$250,000	75	96	59	62	50	45	50	37	27	26	85	612
$250,000–<$500,000	36	52	41	37	22	27	23	21	8	16	59	342
$500,000 or more	25	40	31	46	43	35	27	40	27	32	139	485
Total	**1,194**	**977**	**726**	**645**	**546**	**390**	**296**	**236**	**169**	**163**	**538**	**5,880**

(a) Current claims are claims that are open, including reopened claims, at 30 June 2008.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to 30 June 2008.

Table 3.21: Current claims[a]: reserve range by duration of claim (months)[b], at 30 June 2008 (per cent)

Reserve range	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60	Total claims
Less than $10,000	29.8	16.9	14.4	11.3	9.3	5.5	3.3	2.0	1.9	1.4	4.2	100.0
$10,000–<$30,000	15.8	20.3	12.4	11.7	12.2	8.9	4.5	4.3	2.7	2.2	5.0	100.0
$30,000–<$50,000	17.6	17.6	11.2	10.5	7.8	6.1	6.8	4.1	5.1	2.4	10.8	100.0
$50,000–<$100,000	14.7	17.3	11.9	10.6	8.5	6.0	8.0	5.2	2.6	4.1	11.1	100.0
$100,000–<$250,000	12.3	15.7	9.6	10.1	8.2	7.4	8.2	6.0	4.4	4.2	13.9	100.0
$250,000–<$500,000	10.5	15.2	12.0	10.8	6.4	7.9	6.7	6.1	2.3	4.7	17.3	100.0
$500,000 or more	5.1	8.2	6.4	9.5	8.9	7.2	5.6	8.2	5.6	6.6	28.7	100.0
Total	**20.3**	**16.6**	**12.3**	**11.0**	**9.3**	**6.6**	**5.0**	**4.0**	**2.9**	**2.8**	**9.1**	**100.0**

(a) Current claims are claims that are open, including reopened claims, at 30 June 2008.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to 30 June 2008.

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

3.5 Total claim size

The 'total claim size' is the total amount to be paid to the claimant (following either a negotiated outcome or a court order, or a decision by the claim manager to discontinue a claim), recorded in broad dollar ranges for closed claims. The amount includes any interim payments, claimant legal costs and defence costs. During the period between 1 July 2007 and 30 June 2008, 2,668 claims were closed for a known claim size. Tables 3.22 and 3.23 present data relating the claim size to the duration of closed claims.

There were 1,844 claims (accounting for over two-thirds) closed for less than $10,000, including 40% (1,070 of 2,668 claims) closed for no payment. Only 68 claims (accounting for 3% of closed claims) were settled for over $500,000.

The most common duration of claims closed for no payment was between 19 months and 3 years, accounting for over half of them (609 of 1,070 claims). The proportions of these no-payment claims settled within 1 year or taking over 4 years to settle were small, respectively 9% (91 claims) and 4% (48 claims).

In the case of claims closed for a payment of less than $30,000, the most common duration was between 13 and 30 months. This was true of 47% (360 of 774 claims) closed for a payment of less than $10,000, and 38% (89 of 236 claims) settled for between $10,000 and<$30,000.

A duration of 5 years or more was recorded for 22% (39 of 174 claims) of claims settled for $100,000 to <$250,000, 30% (21 of 71 claims) of claims settled for between $250,000 and <$500,000, and 44% (30 of 68 claims) of claims settled for $500,000 or more.

Table 3.22: Closed claims[a]: total claim size by duration of claim (months)[b], 1 July 2007 to 30 June 2008

Total claim size	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60	Total claims
No payment made	37	54	90	173	227	209	135	97	19	5	24	1,070
Less than $10,000	32	93	108	132	120	93	56	39	22	23	56	774
$10,000–<$30,000	4	26	27	36	26	22	15	20	17	13	30	236
$30,000–<$50,000	1	6	5	12	22	12	10	12	4	8	23	115
$50,000–<$100,000	0	1	9	17	19	35	15	18	9	9	28	160
$100,000–<$250,000	0	4	9	16	19	18	15	23	23	8	39	174
$250,000–<$500,000	1	1	5	5	7	5	7	6	7	6	21	71
$500,000 or more	0	0	1	3	6	6	4	7	3	8	30	68
Total[c]	**75**	**185**	**254**	**394**	**446**	**400**	**257**	**222**	**104**	**80**	**251**	**2,668**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to the date when the claim was closed.
(c) Total excludes seven public sector claims where the total claim size was not yet known.

Table 3.23: Closed claims[a]: total claim size by duration of claim (months)[b], 1 July 2007 to 30 June 2008 (per cent)

Total claim size	<6	6–12	13–18	19–24	25–30	31–36	37–42	43–48	49–54	55–60	>60	Total claims
No payment made	3.5	5.0	8.4	16.2	21.2	19.5	12.6	9.1	1.8	0.5	2.2	100.0
Less than $10,000	4.1	12.0	14.0	17.1	15.5	12.0	7.2	5.0	2.8	3.0	7.2	100.0
$10,000–<$30,000	1.7	11.0	11.4	15.3	11.0	9.3	6.4	8.5	7.2	5.5	12.7	100.0
$30,000–<$50,000	0.9	5.2	4.3	10.4	19.1	10.4	8.7	10.4	3.5	7.0	20.0	100.0
$50,000–<$100,000	0.0	0.6	5.6	10.6	11.9	21.9	9.4	11.3	5.6	5.6	17.5	100.0
$100,000–<$250,000	0.0	2.3	5.2	9.2	10.9	10.3	8.6	13.2	13.2	4.6	22.4	100.0
$250,000–<$500,000	1.4	1.4	7.0	7.0	9.9	7.0	9.9	8.5	9.9	8.5	29.6	100.0
$500,000 or more	0.0	0.0	1.5	4.4	8.8	8.8	5.9	10.3	4.4	11.8	44.1	100.0
Total[c]	**2.8**	**6.9**	**9.5**	**14.8**	**16.7**	**15.0**	**9.6**	**8.3**	**3.9**	**3.0**	**9.4**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to the date when the claim was closed.
(c) Total excludes seven public sector claims where the total claim size was not yet known.

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

3.6 Mode of claim finalisation

A claim can be finalised through a variety of processes, such as a court decision, negotiation or discontinuation (including the claim being withdrawn by the claimant). The definition of these finalisation modes is provided in Appendix 3 (Table A3.3). Between 1 July 2007 and 30 June 2008, there were 2,663 closed claims for which the total claim size and 'mode of settlement' were known. Of these, 84 claims (3%) were finalised through a court decision, 879 claims (33%) were finalised through negotiation and 1,700 claims (64%) were discontinued (tables 3.24 and 3.25).

Discontinuation was the most frequently recorded mode of finalisation for total claim size categories under $30,000, as recorded for 94% (1,001 of 1,067 claims) of claims closed for no payment and 66% (662 of 1,008 claims) of claims closed for a payment of less than $30,000. It was rarely recorded for claims settled for $30,000 or more (37 of 588 claims, or 6%).

Claims with their claim size in a category above $50,000 were most frequently finalised through negotiation, as was the case for 425 (90%) of these claims.

Court decisions were the least frequently recorded mode of claim finalisation for the 2007–08 reporting period, especially if the claim size was less than $10,000. The proportion of closed claims finalised via a court decision was 3% (84 of 2,663 claims), and was 1% (12 of 1,067) when no payment was made.

Table 3.24: Closed claims[a]: total claim size by mode of claim finalisation, 1 July 2007 to 30 June 2008

	Mode of claim finalisation				
Total claim size	Court decision	Negotiated	Discontinued	All closed claims	Column per cent
No payment made	12	54	1,001	1,067	40.1
Less than $10,000	15	208	550	773	29.0
$10,000–<$30,000	16	107	112	235	8.8
$30,000–<$50,000	8	85	22	115	4.3
$50,000–<$100,000	9	141	10	160	6.0
$100,000–<$250,000	14	156	4	174	6.5
$250,000–<$500,000	3	67	1	71	2.7
$500,000 or more	7	61	0	68	2.6
Total[b]	**84**	**879**	**1,700**	**2,663**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.
(b) Total excludes 12 public sector claims where the total claim size and/or the mode of finalisation were not yet known.

Table 3.25: Closed claims[a]: total claim size by mode of claim finalisation, 1 July 2007 to 30 June 2008 (per cent)

	Mode of claim finalisation			
Total claim size	Court decision	Negotiated	Discontinued	All closed claims
No payment made	1.1	5.1	93.8	100.0
Less than $10,000	1.9	26.9	71.2	100.0
$10,000–<$30,000	6.8	45.5	47.7	100.0
$30,000–<$50,000	7.0	73.9	19.1	100.0
$50,000–<$100,000	5.6	88.1	6.3	100.0
$100,000–<$250,000	8.0	89.7	2.3	100.0
$250,000–<$500,000	4.2	94.4	1.4	100.0
$500,000 or more	10.3	89.7	0.0	100.0
Total[b]	**3.2**	**33.0**	**63.8**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.
(b) Total excludes 12 public sector claims where the total claim size and/or the mode of finalisation were not yet known.

3.7 Total claim size and specialty of clinician

Claims closed between 1 July 2007 and 30 June 2008 were very similar to all claims and new claims during the period in terms of which clinician specialties were most frequently recorded amongst these claims (see Section 3.1). *Obstetrics and Gynaecology* and *General practice* were each recorded for 16% (421 and 415 respectively) of closed claims. The other frequently recorded specialties (261, 257 and 192 claims respectively) were *General surgery*, *Emergency medicine* and *Orthopaedic surgery*, each associated with 7–10% of claims (tables 3.26 and 3.27). *All other specialties*, which include all specialties other than the 12 that are individually listed, were recorded for 22% of closed claims.

There is little indication that the clinical specialties listed in Table 3.27 differed notably from each other in terms of total claim size. For instance, comparing the column of claims with *No payment made* and the column of total closed claims, the proportions in each row are very similar.

3.8 Total claim size and health service setting

The proportions of closed claims related to the various health service settings (tables 3.28 and 3.29) were similar to the proportions recorded for all and new claims, over the period from 1 July 2007 to 30 June 2008 (see Section 3.1). First was *Public hospital or day surgery*, accounting for 68% (1,806) of closed claims. This category was followed by *Private medical clinic*, recorded for 352 closed claims (13%), and *Private hospital or day surgery*, recorded for 302 closed claims (11%).

As previously noted, 40% of closed claims did not involve any payment (Table 3.24). This was the case with slightly over half of the claims in *Other public setting* (34 of 65 claims, 52%) and *Private medical clinic* (178 of 352 claims, 51%). When all of the public health service settings are combined, there were 39% (723 of 1,871 claims) closed for no payment, compared to 47% (320 of 684 claims) in private settings where no payment was made.

Claims with a total claim size of less than $10,000 represented 69% (1,844 of 2,675 claims) of closed claims during 2007–08, including 78% (275 of 352 claims) of claims associated with a *Private medical clinic* and 74% (224 of 302 claims) associated with a *Private hospital/day surgery*.

Settled claims with a claim size of $100,000 or more accounted for 313 (12%) of all closed claims. These claims made up a larger proportion of claims associated with public health service settings (247 of 1,871 claims, 13%) than claims associated with private health service settings (57 of 684 claims, 8%). However, some or all of this discrepancy may be due to different claim management practices between the two sectors. As noted in Section 2.2, public sector claim sizes generally reflect the costs associated with all providers associated with a single health care incident, whereas in the private sector the costs arising from a single incident may be spread across several claims.

Table 3.26: Closed claims[a]: specialties of clinicians involved by total claim size, 1 July 2007 to 30 June 2008

Specialty of clinician(s)[b]	Total claim size								
	No payment made	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[c]
Anaesthetics	55	38	6	1	0	4	0	0	104
Cardiology	17	8	3	2	1	4	5	1	41
Diagnostic radiology	55	22	6	3	2	3	4	3	98
Emergency medicine	131	51	17	10	18	12	6	11	257
General and internal medicine	21	14	3	1	2	2	3	1	47
General nursing	41	25	10	4	6	6	2	1	95
General practice[d]	138	135	39	21	30	30	11	11	415
General surgery	86	107	14	9	22	16	4	3	261
Obstetrics and Gynaecology[e]	174	124	33	19	24	24	6	15	421
Orthopaedic surgery	55	61	16	8	17	21	9	5	192
Psychiatry	30	25	15	5	5	10	4	2	96
Urology	5	9	9	1	3	3	2	1	34
Other hospital based medical practitioner[f]	23	28	7	6	7	3	4	1	79
All other specialties[g]	236	151	65	26	28	44	17	20	589
Not applicable[h]	3	4	3	0	1	1	0	0	12
Not known	31	19	7	2	0	1	0	0	61
Total[i]	**1,070**	**774**	**236**	**115**	**160**	**174**	**71**	**68**	**2,675**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.

(b) Only the 12 specialties that were most frequently recorded for closed claims are listed.

(c) There were seven public sector claims where the total claim size was not known. The *Not known* column is not presented in the table; however, the numbers are included in the totals.

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

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

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

(g) Covers all categories of clinician specialties other than the 13 listed above.

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

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

Table 3.27: Closed claims[a]: specialties of clinicians involved by total claim size, 1 July 2007 to 30 June 2008 (per cent)

	Total claim size								
Specialty of clinician(s)[b]	**No payment made**	**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**
Anaesthetics	5.1	4.9	2.5	0.9	0.0	2.3	0.0	0.0	3.9
Cardiology	1.6	1.0	1.3	1.7	0.6	2.3	7.0	1.5	1.5
Diagnostic radiology	5.1	2.8	2.5	2.6	1.3	1.7	5.6	4.4	3.7
Emergency medicine	12.2	6.6	7.2	8.7	11.3	6.9	8.5	16.2	9.6
General and internal medicine	2.0	1.8	1.3	0.9	1.3	1.1	4.2	1.5	1.8
General nursing	3.8	3.2	4.2	3.5	3.8	3.4	2.8	1.5	3.6
General practice[c]	12.9	17.4	16.5	18.3	18.8	17.2	15.5	16.2	15.5
General surgery	8.0	13.8	5.9	7.8	13.8	9.2	5.6	4.4	9.8
Obstetrics and Gynaecology[d]	16.3	16.0	14.0	16.5	15.0	13.8	8.5	22.1	15.7
Orthopaedic surgery	5.1	7.9	6.8	7.0	10.6	12.1	12.7	7.4	7.2
Psychiatry	2.8	3.2	6.4	4.3	3.1	5.7	5.6	2.9	3.6
Urology	0.5	1.2	3.8	0.9	1.9	1.7	2.8	1.5	1.2
Other hospital based medical practitioner[e]	2.1	3.6	3.0	5.2	4.4	1.7	5.6	1.5	3.0
All other specialties[f]	22.1	19.5	27.5	22.6	17.5	25.3	23.9	29.4	22.0
Not applicable[g]	0.3	0.5	1.3	0.0	0.6	0.6	0.0	0.0	0.4
Not known	2.9	2.5	3.0	1.7	0.0	0.6	0.0	0.0	2.3
Total[h]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.

(b) Only the 12 specialties that were most frequently recorded for closed claims are listed.

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

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

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

(f) Covers all categories of clinician specialties other than the 13 listed above.

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

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

Table 3.28: Closed claims[a]: total claim size by health service setting, 1 July 2007 to 30 June 2008

	Health service setting							
Total claim size	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
No payment made	689	34	134	178	8	7	20	1,070
Less than $10,000	510	13	90	97	11	8	45	774
$10,000–<$30,000	158	6	24	33	1	2	12	236
$30,000–<$50,000	73	6	14	9	2	0	11	115
$50,000–<$100,000	126	2	11	12	3	2	4	160
$100,000–<$250,000	128	3	19	15	4	0	5	174
$250,000–<$500,000	57	0	7	6	1	0	0	71
$500,000 or more	58	1	3	2	0	1	3	68
Not known	7	0	0	0	0	0	0	7
Total	**1,806**	**65**	**302**	**352**	**30**	**20**	**100**	**2,675**
Total per cent	*67.5*	*2.4*	*11.3*	*13.2*	*1.1*	*0.7*	*3.7*	*100.0*

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

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

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

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

Notes

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

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

Table 3.29: Closed claims[a]: total claim size by health service setting, 1 July 2007 to 30 June 2008 (per cent)

	Health service setting							
Total claim size	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
No payment made	38.2	52.3	44.4	50.6	26.7	35.0	20.0	40.0
Less than $10,000	28.2	20.0	29.8	27.6	36.7	40.0	45.0	28.9
$10,000–<$30,000	8.7	9.2	7.9	9.4	3.3	10.0	12.0	8.8
$30,000–<$50,000	4.0	9.2	4.6	2.6	6.7	0.0	11.0	4.3
$50,000–<$100,000	7.0	3.1	3.6	3.4	10.0	10.0	4.0	6.0
$100,000–<$250,000	7.1	4.6	6.3	4.3	13.3	0.0	5.0	6.5
$250,000–<$500,000	3.2	0.0	2.3	1.7	3.3	0.0	0.0	2.7
$500,000 or more	3.2	1.5	1.0	0.6	0.0	5.0	3.0	2.5
Not known	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2007 and 30 June 2008.

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

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

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

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

Notes

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

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

Appendix 1: Data items and definitions

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

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

MINC data item	ISA data item	Definition of MINC and ISA data items and explanation of mapping between collections
4 Claim subject's year of birth	36 Claimant/patient year of birth	Year of birth of claim subject. This data item is used to calculate claim subject's age at incident using MINC item 10 Date incident occurred and ISA item 9 Date of loss.
5 Claim subject's sex	37 Claimant/patient sex	Sex of the claim subject.
6a Primary incident/allegation type	15 Cause of loss	Description of the area of alleged error, negligence or problem that primarily gave rise to the claim. There is concordance between the ISA and the MINC data item.
8a Primary body function/structure affected	16. Body functions or structures affected	The primary body function or structure of the claim subject alleged to have been affected. There is concordance between these items. Death is not included in the ISA item, instead being identified using ISA item 17, 'Severity of injury – Patient dies from this incident'.
10 Date incident occurred	9 Date of loss	Date the alleged harm occurred.
12 Health service setting	14.3 Venue where procedure performed	The venue where health care was delivered, whether public or private sector or other, whether a hospital/day surgery or other. There is concordance between these items.
14 Specialties of clinicians closely involved in incident	14.2 Speciality of practitioner at the time the incident occurred	Clinical specialties of the health care providers involved in the alleged harm that gave rise to the claim. The categories for these items align well between the collections. The ISA specifications have separate codes for several allied health and complementary fields which are subsumed within the MINC category 'Other allied health' (including complementary medicine). In the ISA collection, 'student practitioner or intern' is a separate category. MINC codes students based on the speciality they are training in, and classifies interns with 'other hospital-based medical practitioners'.
15 Date reserve placed	10 Date of report	This ISA item is the date on which the matter is notified to the insurer. It may occur slightly before or after the date that the MII sets a reserve, which corresponds to 'Date reserve placed' in the MINC. Because of this potential discrepancy these two data items are not identical.

(*continued*)

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

MINC data item	ISA data item	Definition of MINC and ISA data items and explanation of mapping between collections
16 Reserve range	20 Gross payments to date 22 Gross case estimate at end of reporting period	Estimate of the cost of the claim upon its finalisation. For current claims, the ISA items divide the reserve amount between the amount already paid and the amount expected to be paid. Addition of these two dollar amounts produces the reserve estimate, which can be mapped to MINC ranges.
18 Date claim file closed	11 Date finalised	Calendar month and year in which the claim was settled, or a final court decision was delivered or when the claim file was closed because the claim had been inactive for a long time.
19 Mode of claim finalisation 1 Settled through state/territory-based complaints processes 2 Settled through court-based alternative dispute resolution process. 3 Settled through statutorily mandated compulsory conference process. 4 Settled—other. 5 Court decision. 6 Discontinued. 7 Not yet known.	18.2 Settlement outcome A = Award X = No award N = Negotiated W = Withdrawn	Description of the process by which the claim was finalised. This data item was mapped as outlined below. Settlement outcome (18.2) — MINC Mode of claim finalisation A maps to 5 X maps to 5 N maps to 1, 2, 3 or 4 W maps to 6 The mapping is not exact because a claim may be withdrawn as part of an active settlement process rather than through discontinuation of an inactive claim.
20 Total claim size	20 Gross payments to date	The amount to be paid to the claimant in settlement of the claim, plus defence legal costs, recorded in broad dollar ranges. ISA records exact dollar amounts. These were mapped to MINC ranges.
21 Status of claim 20 Commenced (not yet finalised) 30 Claim file closed 32 Structured Settlement—claim file open 33 Structured Settlement—claim file closed 40 Claim previously closed now reopened	3 Status at end of reporting period C for Current F for Finalised R for Reopened	Status of the claim in terms of the stage in the process from commencement to finalisation. MINC category 20 maps to ISA ‘C’. MINC categories 30, 32 and 33 map to ISA ‘F’. MINC 40 maps to ISA ‘R’.

Table A1.2: Definitions of key terms

Term	Definition
Claim	A demand for compensation for **harm** or other **loss** that allegedly resulted from **health care**.
Claimant	The person who has made the claim. The claimant may be the **claim subject** or some **other party** claiming for loss allegedly resulting from harm involving health care.
Claim subject	The person who received the health-care service and was involved in the incident that is the basis for the claim, and who suffered and may have suffered loss as a result of harm.
Current claim	Claim that has yet to be finalised.
Closed claim	Public sector – A claim which has been closed (total claim size determined), settled or where a final court decision has been made, including claims finalised with total claim size yet to be determined. Medical Indemnity Insurers – A claim for which no more payments are expected and all expected recoveries have been received from third parties other than re-insurers.
Harm	Death, disease, injury, suffering and/or disability experienced by a person.
Health care	Services provided to individuals or communities to promote, maintain, monitor, or restore health.
Health care professional	A person who is registered by a state or territory to provide medical, nursing or allied health care.
Insured	A **health-care professional** who holds a medical indemnity policy with a **medical indemnity insurer** or indemnity with a state government. A health-care facility insured under state or territory insurance arrangements.
Loss	Any adverse consequence of the alleged harm experienced by the claimant, including financial loss.
Medical indemnity	A form of professional liability insurance specific to the provision of health care.
Medical indemnity claim	A claim for compensation for **harm** or other **loss** that allegedly resulted from **health care**.
Medical indemnity insurer	A body corporate authorised under section 12 of the *Insurance Act 1973*, or a Lloyd's underwriter within the meaning of that Act, which, in carrying on insurance business in Australia, enters into contracts of insurance providing **medical indemnity** cover.
Other party	Any party or parties not the direct recipient of **health care** but claiming **loss** allegedly resulting from health care.
Reopened claim	A current claim that had been previously categorised as **closed**.

Appendix 2: Public and private sector claim management practices

The public sector

Arrangements for public sector medical indemnity insurance are governed by state and territory legislation and associated policies. Claim management practices vary between jurisdictions, and in some jurisdictions there are different processes for small and large claims. Claims are managed in-house by the state or territory health authority for some jurisdictions; in others, a body independent from the health authority manages claims. Some legal work may be outsourced to private law firms. A full explanation of the policy, administrative and legal features of each jurisdiction is available in *Medical indemnity national data collection public sector 2007–08* (AIHW 2010b).

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

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

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

A public sector claim may be finalised in several ways—through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions settlement through mandated conference processes must be attempted before a claim can go to court. In some cases, a settlement is agreed between claimant and defendant, independent of any formal process. In addition, a claim file that has remained inactive for a long time may be closed. Claims that have been closed can subsequently be reopened.

The private sector

MIIs provide professional indemnity insurance to individual clinicians. Typically, a separate claim is opened for each clinician implicated in the allegation of loss or harm. This is so the relevant proportion of the overall cost of claims can be allocated against the policy limits of individual clinicians, and is an explicit requirement of both the High Cost Claim Scheme and the Exceptional Claims Scheme. (Under the High Cost Claims Scheme, the Australian Government reimburses medical indemnity insurers, on a per claim basis, 50% of the insurance payout over $300,000 up to the limit of the practitioner's cover, for claims notified on or after 1 January 2004. The Exceptional Claims Scheme is the Australian Government's scheme to cover clinicians for 100% of the cost of private practice claims, either a single very large claim or an aggregate of claims, that are above the limit of their medical indemnity contracts of insurance, so that clinicians are not personally liable for 'blue sky' claims.) Also, claims related to a single allegation of loss or harm could appear on more than one MII database when individual defendants hold medical indemnity insurance with different insurers. Where a public hospital is involved, claims may appear on both MII and health authority databases.

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

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

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

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

Appendix 3: Coding examples for some main data items

Table A3.1: Coding examples for 'body function/structure' categories

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

Table A3.2: Coding examples for selected incident/allegation types

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

Table A3.3: Coding examples for mode of claim finalisation

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

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