Australian Government

Australian Institute of Health and Welfare

Better information and statistics for better health and wellbeing

SAFETY AND QUALITY OF HEALTH CARE SERIES

Number 6

Public and private sector medical indemnity claims in Australia 2006–07

A summary

May 2010

Australian Institute of Health and Welfare

Canberra

Cat. no. HSE 86

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This publication is part of the Australian Institute of Health and Welfare's Safety and quality of health care series. A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISSN 1833-7422

ISBN 978-1-74249-010-6

Suggested citation

Australian Institute of Health and Welfare 2010. Public and private sector medical indemnity claims in Australia 2006–07: a summary. Safety and quality of health care series no. 6. HSE 86. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

Foreword

Public and private sector medical indemnity claims in Australia 2006–07: a summary is the third report to present combined public and private sector medical indemnity data and to give a national picture of medical indemnity claims in Australia.

As with the two previously published reports, the information that can be reported at the national level about medical indemnity claims is limited due to a lack of concordance between the public sector and private sector medical indemnity claims collections. Another continuing restriction in this publication is non-presentation of information on numbers of claims and the use of percentage distribution information instead.

The Institute is continuing to work with stakeholders, including jurisdictions and private sector medical indemnity insurers, to address the limitations of the data and improve the quality and usefulness of the combined sector medical indemnity reports. A review of the Medical Indemnity National Collection (MINC), currently underway, is examining how the collection could be made more effective for current and potential new users, and how the data and information could be reported with greater consistency across the private and public sectors.

Comments from readers are welcome.

Dr Penny Allbon

Director

March 2010

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Acknowledgments

This report has been prepared in close consultation with the Medical Indemnity National Collection Coordinating Committee (MINC CC), the members of which include data providers representing the health authorities of each state and territory and medical indemnity insurers. The Australian Institute of Health and Welfare expresses its appreciation to committee members for the supply of data and invaluable advice and commentary during the planning and writing of this report. The members are:

- Mandy Anderson—Medical Insurance Group Australia
- Julie Barnes—Western Australia, Department of Health
- Liam Barrett—MDA National
- Sandra Blake—Queensland, Queensland Health
- Rose Bovey—Queensland, Queensland Health
- Troy Browning—Medical Indemnity Protection Society
- Milena Canil—Victoria, Department of Health
- Sylvia Cecchin—Northern Territory, Department of Health and Families
- Lisa Clarke—Avant
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- Olivia King—New South Wales, NSW Health
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- David Minty—Insurance Statistics Australia
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- Julien Wicks—Australian Government Department of Health and Ageing

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Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulatory Authority
DoHA	Australian Government Department of Health and Ageing
ISA	Insurance Statistics Australia
MDO	Medical Defence Organisation
MIDWG	Medical Indemnity Data Working Group
MIIAA	Medical Indemnity Industry Association of Australia
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 is the third report to present information on public and private sector medical indemnity claims. The information was obtained from the Medical Indemnity National Collection (MINC), which is a national information base to assist policy makers in developing measures to minimise the incidence of medical indemnity claims and the associated costs.

The data in this report cover claims which were current at any time during the reporting period, 1 July 2006 to 30 June 2007. These claims include those which were open at the start of the reporting period, new claims which arose during the period and claims which had previously been finalised but were reopened during the period.

About four-fifths (85%) of claims finalised during the period were settled for less than $100,000. More than half (58%) were settled for less than $10,000, which included 22% where no payment was made. Claims with sizes in excess of $500,000 constituted 3% of all finalised claims.

Claims most commonly involved damage to *Neuromusculo-skeletal and movement related structures and functions*, such as paralysis of the arms or legs (21% of new claims). The next most common category of primary body function/structure affected was *Mental functions/structures of the nervous system* (15%), followed by *Functions/structures of the digestive, metabolic and endocrine systems* (12%).

For new claims where the age of the claim subject was specified, 5% of subjects were babies under 1 year of age, 8% were children aged from 1 to 17 years, and the remainder (87%) were adults aged 18 years and over.

The most common primary incident/allegation types recorded for claims were Procedure and Diagnosis problems. General surgery, Gynaecology and Neurosurgery were the clinician specialties where Procedure-related claims were the most common, while Diagnosis-related claims were the most common for *Diagnostic Radiology* and *Emergency Medicine*.

1 Introduction

This report, the third of its kind, presents data for public and private sector medical indemnity claims for the period from 1 July 2006 to 30 June 2007. The first report, *A national picture of medical indemnity claims in Australia 2004–05* was published in May 2007 (AIHW 2007).

Medical indemnity insurance protects clinicians against financial loss arising from actions brought against them relating to the performance of their professional duties. In the public sector, this insurance is mostly provided by state and territory health authorities. In the private sector, clinicians hold individual policies with medical indemnity insurers (MIIs).

The data presented here relate to claims which were current at any time during the reporting period, 1 July 2006 to 30 June 2007. This includes claims which were open at the start of the reporting period, new claims which arose during the period, and claims that had been deemed finalised either prior to or during the reporting period but which were reopened by 30 June 2007. The information includes the circumstances giving rise to claims, the age and sex of people who allegedly suffered harm, the nature of their injury, the medical specialties of the clinicians involved, the size and finalisation mode of claims and the length of time they have been open.

Private sector medical indemnity insurers have contributed data for this report covering all claims 'in scope' (that is, claims which satisfy the definition of a claim for inclusion in this report).[1] Data relating to the public sector cover about 92% of all claims in scope as some jurisdictions provided incomplete data. This is an improvement on the 85% public sector coverage recorded for the 2005–06 report. Section 2.5 provides information on data quality and completeness.

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 as well as monitoring the costs associated with health care litigation and the financial viability of the medical indemnity insurance sector in Australia.

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 the AHMAC commissioned the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG on the further development of proposals for such a collection for the public sector.

This led to the development of the public sector MINC, with collation of data on public sector medical indemnity claims commencing in 2003. Data for the first six months of 2003 were published in December 2004 (AIHW 2004). Four financial year reports have been published subsequently, the last covering 2006–07 (AIHW 2009).

In 2004 the Australian Government introduced the Premium Support Scheme (PSS), as part of a comprehensive medical indemnity package to assist eligible clinicians to meet the cost of

[1] Private hospital claims are not in scope.

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 agreed following the introduction of the PSS. This has enabled a national collection of medical indemnity claims data to be developed to cover both the public sector and a significant part of the private sector. Medical indemnity data relating to claims which have been made against private hospitals are not available for the purposes of this report.

1.2 Collaborative arrangements

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

The AIHW is the national data custodian of public sector medical indemnity data. In this role, it is responsible for the collection, quality control, management and reporting of the data. Information Privacy Principles (*Privacy Act 1988*), which govern the conduct of all Australian Government agencies in the collection, use and disclosure of personal records are observed. In addition the AIHW Act 1987, together with policies and procedures approved by the AIHW board, address information security and privacy.

The MINC Coordinating Committee (MINC CC), established in mid-2005, consists of representatives from state and territory health authorities, the DoHA, MIIs and the AIHW. The committee manages the development and administration of the combined medical indemnity data and also advises on the public release of aggregated public and private sector medical indemnity data. It also oversees the production of the combined sector reports.

The AIHW receives a combination of aggregated and unit record claims data from the private sector and is 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 MINC data

2.1 Scope of the report

This report presents information on claims where a formal demand for compensation for alleged harm or other loss resulting from health care has been received by an MII or a public sector claim manager. It also includes information on claims in the private sector where a formal demand has not yet been received, but where preparatory expenses have been incurred by the MII in advance of a formal claim.[2]

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

2.2 National reporting of medical indemnity

In 2004 the Australian Prudential Regulatory Authority (APRA) established its National Claims and Policy Database (NCPD) for public and products liability and professional indemnity insurance. Along with other insurers the MIIs were required to report their claims data to APRA for inclusion in the NCPD. The reported data include information on the insured parties and the size and cost of the insurance premium, as well as information on claims. The first data collection, in early 2005, included claims and policies data covering all of 2003 and 2004, and data for each following period of six months have subsequently been reported to APRA at half-yearly intervals (APRA 2005, 2009).

In 2004 Insurance Statistics Australia (ISA) began publishing reports on medical indemnity trends based on the claims data it received from those MIIs which were members of the Medical Indemnity Insurance Association of Australia (MIIAA). Following the establishment of the NCPD, ISA increased its set of data items so as to be able to report claims data to APRA, which it did on behalf of MIIAA members. These additional ISA data items were designed in such a way that they captured MINC information beyond that necessary for reporting to APRA. In 2005 key stakeholder agreed to produce a single national medical indemnity report incorporating public sector and MII data. It was agreed that ISA would provide data to the AIHW on behalf of its members. It was also agreed that those MIIs which did not provide claims data to ISA would report the required claims data directly to the AIHW.

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

2.3 Claim management practices

The significant differences which exist between the public and private sectors in the management of claims have implications for the interpretation of the combined claims data in this report. For example:

- Health care claims managed by the private sector MIIs relate to individual clinicians or defendants. Therefore, more than one claim may arise from a single allegation of harm arising from health care if it involves several clinicians. As an example, an incident involving both an anaesthetist and a general surgeon may result in the initiation of a separate claim against each clinician.
- Health care claims managed in the public sector, on the other hand, generally relate specifically to a single health care incident. More than one health care professional may be involved, but the ensuing allegation of harm usually gives rise to a single claim.

Claim management practices of 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 which gave rise to the allegation of harm. Most insurers, however, treat the claim of a patient and any separate but related claim of a dependant or other relative as a single claim.

Typically, a separate claim is opened for each clinician involved so that the relevant proportion of the overall cost of claims can be allocated against the policy limits of individual clinicians. This is an explicit requirement of the High Cost Claims Scheme[3] and the Exceptional Claims Scheme[4]. As a result, individual claim sizes will often be less than the actual total cost incurred by the MII for a single allegation of harm. Thus the 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).

The number of claims cannot be used to estimate the number of clinical incidents leading to claims. As noted above, an allegation of harm involving several clinicians may generate multiple claims. Claims related to a single allegation of harm could also 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.

'Potential claims' are included for the purposes of this report if preparatory legal expenses have been incurred and the claim has been reported to APRA and to ISA. 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.

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[3] Under the High Cost Claims Scheme, the Australian Government (through Medicate Australia) 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.

[4] 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.

An estimate is derived 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 (e.g. hospitals) involved. Estimated plaintiff and defendant legal costs are included in the reserve. Estimates are reviewed regularly. When the claim is finalised, the incurred cost represents all costs paid (usually, on behalf of a single insured) in respect of the claim including legal costs.

Claim management practices of public sector claim managers

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. A full explanation of the policy, administrative, and legal features of each jurisdiction is available in *Medical indemnity national data collection public sector 2006–07* (AIHW 2009).

Normally, each public sector record within the MINC represents a single claim related to the claimant. The claimant is usually the 'claim subject' but may also be a dependent or other relative. In addition, some jurisdictions report claims against private clinicians working in a public hospital as well as claims against the hospital (and employees of the hospital).

This practice differs from that in the private sector where a single claimant can generate multiple claims—one for each clinician being sued. There could be more than one claim for each clinician involved depending on the clinician's insurance arrangements.

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. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed.

An allegation of harm that could lead to a public sector medical indemnity claim is notified to the state or territory claims management body by the health facility concerned. Various events can signal the start of a claim: for example, a writ or letter of demand may be received from the claimant's solicitor, or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. As a claim progresses the reserve is monitored and adjusted if necessary.

A claim may be finalised in several ways—through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions, settlement 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 finalised or closed can subsequently be reopened.

2.4 Data items and definitions

The MINC consists of 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 updated annually and distributed to data

providers. For details see the 2004–05 data guide published on the AIHW website (AIHW 2006).

Many of the data items collected by ISA are similar to MINC data items. However, not all ISA data items can be mapped to MINC data items and only those data items which are defined similarly in both collections have been chosen for inclusion in the combined sector reports. The MINC data items which map to ISA items are outlined in Table 2.1. 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 presented in Table 2.2.

Table 2.1: 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 at the time of the incident. 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.
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. 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'.
17 Date claim commenced	10 Date of report	This ISA item is the date on which the matter is notified to the insurer. It may be slightly before or after the date that the claimant takes legal action, which defines 'Date claim commenced' in the MINC collection. Because of this potential discrepancy these two data items are not identical.
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.

(*continued*)

Table 2.1 (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
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. These ISA and MINC data items were mapped as outlined below: Settlement outcome (18.2) — MINC mode of claim finalisation A maps to 5 X maps to 5 N maps to 1, 2, 3 or 4 W maps to 6
20 Total claim size	20 Gross payments to date	The amount 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 Finalised—claim file closed 32 Structured Settlement—claim file open 33 Structured Settlement—claim file closed 40 Claim previously closed now reopened	3 Status at end of reporting period C for Current F for Finalised R for Reopened	Status of the claim in terms of the stage in the process from commencement to finalisation. MINC category 20 maps to ISA ‘C’. MINC categories 30, 32 & 33 map to ISA ‘F’. MINC 40 maps to ISA ’R’.

Table 2.2: Definitions of key terms

Term	Definition
Claim	A demand for compensation for **harm** or other **loss** that allegedly resulted from **health care**.
Claimant	The person who 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.
Finalised 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 **finalised**.
Run-off claim	A claim made against a medical practitioner who has ceased medical practice and who holds **run-off cover** with a **medical indemnity insurer**.
Run-off cover	Insurance protection for medical practitioners who have ceased medical practice.

2.5 Data quality and completeness

This section provides an overview of data coverage, completeness and quality for the 2006–07 reporting period.

Data coverage

Data from the MINC public sector collection relate to about 92% of all claims in scope and 80% of finalised claims. The details for some claims which were open during the reporting period have not been coded. Typically, these are claims that had commenced several years prior to the establishment of medical indemnity databases by jurisdictions to record details of claims for the MINC.

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

Not known category

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.

The high *Not known* rates for some data items in the private sector have been recognised as a data quality issue. One problem has been the lack of systems and practices required to collect the data for some MINC data items. However, it should be noted that the *Not known* rates have decreased over time as MINC information capture and recording practices have improved.

The data item 'age at incident' had the highest *Not known* rate (20%) for new claims and 17% for finalised claims during 2006–07. These rates have reduced from 28% and 30% respectively during 2005–06 and 30% each for new and finalised claims during 2004–05.

The *Not known* rate for the data item 'primary body function/structure affected' was 3% for finalised and 9% for new claims. The *Not known* rates for these items have reduced from 6% and 13% respectively during 2005–06 and 46% and 11% during 2004–05.

2.6 Ongoing development of the collection

Currently, the combined public and private sector MINC is limited by the number of comparable data items between the public and private sector collections. A review of the MINC, commissioned by the MIDWG and undertaken in August 2007, recommended that priority be given to improving the national reporting of medical indemnity on a consistent basis across the public and private sectors.

Review of the definitions of MINC data items indicates that there is scope for a better alignment across the two sectors. However, some items cannot be compared and hence a comprehensive common set of definitions across both collections remains a long-term objective.

The medical indemnity data currently included in the MINC do not extend to claims which are made against private hospitals. The possibility of including these data in the future will be explored in order to achieve a more comprehensive view of medical indemnity claims across the combined public and private sectors.

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

3. Claims data for 2006–07

In this chapter, claims are grouped into four main categories—new claims, current claims, finalised claims, and all claims.

Current claims are claims that remained open at 30 June 2007. Finalised claims are claims that were finalised between 1 July 2006 and 30 June 2007. Reopened claims, as reported in Table 3.1, are the subcategory of current claims that had been deemed finalised before a change in circumstances led to their being reopened. The category of all claims encompasses both current and finalised claims.

New claims are claims with a date of commencement within the reporting period (1 July 2006 to 30 June 2007). They can be either current or finalised claims depending on their status at 30 June 2007.

The results in this report have been presented as proportions rather than the actual number of claims. In part, this is a consequence of the different claims management practices for the two sectors (as discussed in section 2.3), which has implications for how claims are counted in both sectors.

3.1 Claims

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

Primary incident/allegation type

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

During 2006–07, *Procedure* and *Diagnosis* were the most frequently recorded primary incident/allegation type for current (28% and 25% respectively), finalised (34% and 23% respectively) and new claims (27% and 26% respectively) (Table 3.1). The next most frequently recorded primary incident/allegation type was *Treatment* with 11% for current claims and 13% for both finalised and new claims.

Table 3.1: All claims: status of claim by primary incident/allegation type, at 30 June 2007, Australia (per cent)

	Status of claim			
Primary incident/ allegation type[a]	**New claims (1 July 2006–30 June 2007)**	**Reopened**	**Finalised**	**Claims open at 30 June 2007**
Anaesthetic	3.6	2.3	3.3	2.8
Blood / blood product-related	0.3	1.7	1.1	0.6
Consent	4.0	4.0	3.7	3.7
Device failure	0.2	1.2	0.5	0.4
Diagnosis	26.1	23.1	22.7	24.7
General duty of care issues	5.2	6.4	6.5	9.2
Infection control	0.5	0.6	1.4	1.3
Medication-related	5.6	5.8	5.0	5.1
Procedure	26.7	33.5	33.9	27.9
Treatment	12.8	13.3	12.5	11.1
Other	5.1	6.4	8.1	9.2
Not yet known	9.8	1.7	1.3	3.9
Total	100.0	100.0	100.0	100.0

(a) See Appendix 1 for an explanation of the primary incident/allegation type categories of *Consent*, *Medication-related*, *Procedure*, *Treatment* and *Other*.

Notes:

1. Finalised claims in the MINC (PS) include claims which have been closed (and total claim size determined) or, where a final court decision has been made, including claims finalised with total claim size yet to be determined. Finalised claims in the MINC (MII) include claims which are closed and no more payments are expected or all recoveries expected to be received from third parties other than re-insurers have been received (a claim may be finalised even though re-insurance recoveries are outstanding).
2. Reopened claims include claims that have previously been recorded as finalised, but have then been reopened and are active.
3. Structured settlements are included here in the finalised claims category.

Specialty of clinician

The data item 'specialty of clinician' relates to the health care provider or providers involved in an allegation of harm that gave rise to a claim. In the public sector, up to four codes may be selected for this data item to cater for those situations where more than one clinician might have been involved in the allegation of harm. In the private sector, a single clinical specialty is recorded relating to the claim, being the specialty of the policy holder (see Section 2.3 for further information on claim management practices in the public and private sectors).

During 2006–07, the two clinical specialties where *Procedure* was the most common primary incident/allegation type for current and finalised claims were *Gynaecology only* and *General surgery* (Tables 3.2 and 3.3). *Procedure* was recorded for 66% and 77% respectively for current and finalised claims against *Gynaecology only*, and 61% and 71% respectively against *General surgery*. For new claims, *Neurosurgery* and *General surgery* were the two specialties where *Procedure* was the most common primary incident/allegation type, with 63% of claims related to *Procedure* for each (Table 3.4).

Diagnostic radiology and *Emergency medicine* were the two clinical specialties where *Diagnosis* was the most common primary incident/allegation type for current, finalised and new claims. During 2006–07 *Diagnosis* was recorded for 69%, 67% and 64% of current, finalised and new claims respectively for the specialty of *Diagnostic radiology*, and 63%, 56% and 63% of claims respectively for the specialty of *Emergency medicine* (Tables 3.2, 3.3 and 3.4).

The primary incident/allegation type *General duty of care* occurred most frequently for claims involving the specialty *Psychiatry* (33% for current claims, 22% for finalised claims and 45% for new claims).

Table 3.2: Current claims: specialty of clinician, by primary incident/allegation type, at 30 June 2007, Australia (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[(a)]	Anaesthetic	Blood and blood product-related	Consent	Device failure	Diagnosis	General duty of care	Infection control	Medication-related	Procedure	Treatment	Other	Not known	Total
Anaesthetics	49.8	0.4	0.9	0.4	4.0	6.3	1.3	4.5	17.5	4.0	6.7	4.0	100.0
Cardiology	0.0	1.3	4.0	0.0	42.7	6.7	0.0	8.0	14.7	16.0	5.3	1.3	100.0
Diagnostic radiology	0.6	0.6	0.0	0.0	69.0	5.1	0.6	1.3	12.7	2.5	5.1	2.5	100.0
Emergency medicine	0.0	0.0	0.3	0.0	63.3	6.4	0.0	3.9	6.1	17.4	1.3	1.3	100.0
General and internal medicine	1.4	0.0	1.4	1.4	31.9	13.9	0.0	8.3	9.7	20.8	6.9	4.2	100.0
General practice–non-procedural	0.1	0.4	1.4	0.1	36.3	15.1	0.8	8.7	6.7	9.6	16.5	4.3	100.0
General practice–procedural	1.9	0.0	9.3	1.0	28.8	6.1	1.3	6.4	24.4	9.0	10.6	1.3	100.0
General surgery	2.3	0.0	3.5	0.2	13.3	4.7	0.4	1.6	60.9	7.4	3.3	2.3	100.0
Gynaecology only	0.5	0.0	7.7	2.4	7.7	0.0	0.0	2.4	66.3	5.3	3.8	3.8	100.0
Neurosurgery	2.1	0.0	3.1	0.0	14.6	4.2	2.1	2.1	56.3	12.5	3.1	0.0	100.0
Obstetrics & gynaecology	1.2	0.9	2.5	0.7	13.9	6.2	0.7	1.2	43.0	18.5	9.2	2.1	100.0
Orthopaedic surgery	1.6	0.5	5.4	0.9	15.1	4.9	2.4	1.9	51.3	10.4	3.8	1.9	100.0
Psychiatry	0.0	0.0	3.0	0.0	17.7	32.5	0.0	7.4	2.5	12.3	20.7	3.9	100.0
Urology	0.0	0.0	8.5	0.0	11.9	3.4	5.1	5.1	47.5	11.9	3.4	3.4	100.0
Other hospital-based medical practitioner[(b)]	1.5	1.4	2.2	0.2	22.7	10.5	2.7	6.6	27.4	15.9	6.2	2.7	100.0
Other specialties	1.8	0.8	8.8	0.3	24.5	7.0	1.0	3.3	30.0	8.5	11.5	2.7	100.0
Total[(c)]	**2.8**	**0.6**	**3.5**	**0.4**	**25.4**	**9.3**	**1.3**	**5.0**	**27.5**	**11.4**	**8.9**	**3.8**	**100.0**

(a) There was also a small proportion of claims with clinician specialty categorised as *Not applicable*, indicating that there was no clinical staff involvement, or as *Not known*. Data for these claims are not individually listed but are included in the percentages presented in the bottom row.

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

(c) The cited percentages refer to the recorded instances of clinician involvement. Up to four clinician specialties can be recorded for a single public sector claim, and so the recorded instances of clinician involvement slightly exceed the number of claims. Accordingly the cited percentages differ slightly from those given for current claims in Table 3.1.

Table 3.3: Finalised claims: specialty of clinician by primary incident/allegation type, 1 July 2006 to 30 June 2007, Australia (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[a]	Anaesthetic	Blood and blood product-related	Consent	Device failure	Diagnosis	General duty of care	Infection control	Medication-related	Procedure	Treatment	Other	Not known	Total
Anaesthetics	59.1	1.8	1.8	0.0	6.4	2.3	0.6	1.2	17.5	4.1	4.7	0.6	100.0
Cardiology	0.0	0.0	10.0	0.0	27.5	2.5	0.0	7.5	45.0	7.5	0.0	0.0	100.0
Diagnostic radiology	0.0	0.0	0.0	1.9	67.3	3.7	0.9	1.9	13.1	6.5	4.7	0.0	100.0
Emergency medicine	0.0	0.4	0.7	0.7	56.0	5.1	1.1	3.6	5.1	24.4	2.2	0.7	100.0
General and internal medicine	0.0	0.0	0.0	0.0	29.4	8.8	1.5	26.5	5.9	16.2	10.3	1.5	100.0
General practice–non–procedural	0.5	1.7	1.7	0.3	40.2	10.3	0.5	8.8	7.4	10.3	17.1	1.0	100.0
General practice–procedural	4.0	0.0	10.9	1.0	23.8	4.0	0.5	7.4	24.3	9.4	13.9	1.0	100.0
General surgery	1.2	0.0	1.8	0.4	14.2	1.8	1.2	0.8	71.1	5.9	1.4	0.4	100.0
Gynaecology only	0.0	0.0	4.0	0.7	4.7	6.7	0.0	0.0	77.2	5.4	0.7	0.7	100.0
Neurosurgery	0.0	0.0	0.0	0.0	17.8	2.2	0.0	2.2	64.4	6.7	2.2	4.4	100.0
Obstetrics & gynaecology	1.0	0.5	3.9	0.5	12.7	3.9	0.5	0.5	56.4	15.2	2.9	2.0	100.0
Orthopaedic surgery	0.8	0.8	6.5	1.5	10.0	2.3	5.8	1.5	60.4	8.8	1.5	0.0	100.0
Psychiatry	0.0	2.4	0.6	0.0	16.3	22.3	0.0	6.6	0.6	24.7	23.5	3.0	100.0
Urology	0.0	0.0	12.2	0.0	10.2	10.2	0.0	4.1	53.1	8.2	2.0	0.0	100.0
Other hospital-based medical practitioner[b]	1.9	2.5	2.8	0.4	14.3	9.0	2.2	7.2	33.0	20.6	4.3	1.7	100.0
Other specialties	0.5	0.5	10.5	0.0	23.6	3.9	0.3	5.0	33.9	6.8	14.2	0.8	100.0
Total[c]	**3.4**	**1.1**	**3.7**	**0.5**	**22.6**	**6.6**	**1.3**	**5.1**	**33.8**	**12.9**	**7.6**	**1.3**	**100.0**

(a) There was also a small proportion of claims with clinician specialty categorised as *Not applicable*, indicating that there was no clinical staff involvement, or as *Not known*. Data for these claims are not individually listed but are included in the percentages presented in the bottom row.

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

(c) The cited percentages refer to the recorded instances of clinician involvement. Up to four clinician specialties can be recorded for a single public sector claim, and so the recorded instances of clinician involvement slightly exceed the number of claims. Accordingly the cited percentages differ slightly from those given for finalised claims in Table 3.1.

Table 3.4: New claims: specialty of clinician by primary incident/allegation type, 1 July 2006 to 30 June 2007, Australia (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[a]	Anaesthetic	Blood and blood product-related	Consent	Device failure	Diagnosis	General duty of care	Infection control	Medication-related	Procedure	Treatment	Other	Not known	Total
Anaesthetics	65.6	0.0	2.1	0.0	4.2	1.0	0.0	1.0	14.6	4.2	0.0	7.3	100.0
Cardiology	0.0	0.0	6.9	0.0	37.9	3.4	0.0	6.9	24.1	17.2	3.4	0.0	100.0
Diagnostic radiology	0.0	0.0	0.0	0.0	63.6	4.5	0.0	0.0	16.7	4.5	4.5	6.1	100.0
Emergency medicine	0.0	0.0	0.5	0.0	63.4	5.9	0.0	2.7	7.5	16.1	1.1	2.7	100.0
General and internal medicine	3.8	3.8	0.0	0.0	15.4	7.7	0.0	7.7	7.7	38.5	3.8	11.5	100.0
General practice–non-procedural	0.0	0.6	0.6	0.0	38.2	6.1	0.3	8.5	9.1	12.7	8.5	15.5	100.0
General practice–procedural	2.0	0.0	17.2	1.0	23.2	2.0	0.0	6.1	24.2	9.1	10.1	5.1	100.0
General surgery	0.5	0.0	2.1	0.0	15.5	1.6	0.0	2.7	62.6	5.9	2.7	6.4	100.0
Gynaecology only	0.0	0.0	9.6	1.4	11.0	0.0	0.0	1.4	57.5	8.2	2.7	8.2	100.0
Neurosurgery	3.7	0.0	0.0	0.0	7.4	7.4	0.0	7.4	63.0	11.1	0.0	0.0	100.0
Obstetrics & gynaecology	2.1	0.0	1.1	0.0	20.0	4.2	1.1	1.1	42.1	15.8	1.1	11.6	100.0
Orthopaedic surgery	1.4	0.0	4.8	1.4	10.9	3.4	1.4	2.7	58.5	12.9	0.7	2.0	100.0
Psychiatry	0.0	0.0	1.3	0.0	12.0	45.3	0.0	6.7	0.0	16.0	9.3	9.3	100.0
Urology	0.0	0.0	3.4	0.0	13.8	3.4	0.0	0.0	62.1	13.8	0.0	3.4	100.0
Other hospital-based medical practitioner[b]	1.2	1.4	2.0	0.0	21.7	9.8	0.6	3.5	30.3	19.1	3.9	6.5	100.0
Other specialties	2.4	0.5	11.4	0.0	22.7	2.8	0.5	2.4	35.1	6.6	5.2	10.4	100.0
Total[c]	**3.7**	**0.5**	**3.5**	**0.2**	**25.6**	**6.7**	**0.4**	**4.0**	**29.1**	**12.9**	**4.2**	**9.2**	**100.0**

(a) There was also a small proportion of claims with clinician specialty categorised as *Not applicable*, indicating that there was no clinical staff involvement, or as *Not known*. Data for these claims are not individually listed but are included in the percentages presented in the bottom row.

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

(c) The cited percentages refer to the recorded instances of clinician involvement. Up to four clinician specialties can be recorded for a single public sector claim, and so the recorded instances of clinician involvement slightly exceed the number of claims. Accordingly the cited percentages differ slightly from those given for new claims in Table 3.1.

Age and sex of claim subject

The 'age of claim subject' is the age at the time that the alleged harm occurred. During 2006–07, 6% of claim subjects for finalised claims for which the age was known were babies less than 1 year old, 7% were children (1–17 years of age), and the remaining 87% were adults (18+ years of age) (Table 3.5). Of new claims, 5% involved babies, 8% involved children and 87% involved adults (Table 3.6).

A relatively high proportion of claims with a primary incident/allegation type of *Treatment* had the claim subject recorded as a baby or child. Also, *Diagnosis*–related claims involved a higher proportion of children as claim subjects than when the primary incident/allegation type was *Procedure* or *Other*.

Table 3.5: Finalised claims: sex and age of claim subject at incident, by primary incident/allegation type, 1 July 2006 to 30 June 2007, Australia (per cent)

	Age of claim subject at time alleged harm occurred [(b)]			
Sex/Primary incident/allegation type[(a)]	**Baby (<1 year)**	**Child (1–<18 years)**	**Adult (18+ years)**	**Total**
Males				
Diagnosis	6.8	13.0	80.2	100.0
Procedure	9.2	4.6	86.2	100.0
Treatment	11.6	13.0	75.4	100.0
Other [(c)]	2.4	6.1	91.5	100.0
Total males	*7.2*	*8.7*	*84.1*	*100.0*
Females				
Diagnosis	4.3	8.5	87.2	100.0
Procedure	5.9	2.8	91.3	100.0
Treatment	8.8	8.3	82.9	100.0
Other [(c)]	2.0	6.6	91.4	100.0
Total females	*5.0*	*5.6*	*89.4*	*100.0*
Persons [(d)]				
Diagnosis	5.5	10.5	84.0	100.0
Procedure	7.0	3.4	89.6	100.0
Treatment	10.1	10.6	79.3	100.0
Other [(c)]	2.3	6.0	91.7	100.0
Total persons	**5.9**	**6.7**	**87.4**	**100.0**

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

(b) Excludes claims where age of claim subject was unknown.

(c) All types except *Diagnosis*, *Procedure* and *Treatment*.

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

Table 3.6: New claims: sex and age of claim subject at incident, by primary incident/allegation type, 1 July 2006 to 30 June 2007, Australia (per cent)

	Age of claim subject at time alleged harm occurred [(b)]			
Sex/Primary incident/allegation type[(a)]	Baby (<1 year)	Child (1–<18 years)	Adult (18+ years)	Total
Males				
Diagnosis	4.4	18.1	77.5	100.0
Procedure	7.1	3.6	89.3	100.0
Treatment	11.7	12.6	75.7	100.0
Other [(c)]	4.0	10.5	85.5	100.0
Total males	*5.8*	*11.4*	*82.8*	*100.0*
Females				
Diagnosis	4.2	7.0	88.8	100.0
Procedure	3.7	4.1	92.2	100.0
Treatment	5.7	8.9	85.4	100.0
Other [(c)]	2.1	6.3	91.6	100.0
Total females	*3.5*	*6.1*	*90.4*	*100.0*
Persons [(d)]				
Diagnosis	5.3	10.9	83.8	100.0
Procedure	5.0	4.0	91.0	100.0
Treatment	8.5	11.0	80.5	100.0
Other [(c)]	3.5	7.1	89.4	100.0
Total persons	**5.1**	**7.8**	**87.1**	**100.0**

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

(b) Excludes claims where age of claim subject was unknown.

(c) All types except *Diagnosis*, *Procedure* and *Treatment*.

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

Primary body function/structure affected

For new and finalised claims, Figures 3.1 and 3.2 provide a summary of the primary body function or structure that was allegedly harmed. Coding examples for body function/structure categories are listed in Appendix 1. *Patient died* has been listed as a separate category and was associated with 10% of finalised claims and 8% of new claims.

Neuromusculo-skeletal and movement-related functions and structures was the most common recorded category of primary body function/structure affected for both finalised and new claims, 18% and 20% respectively (Figure 3.1 and 3.2). *Mental functions/structures of the nervous system* was the next most common (14% and 15%).

Duration of claims

The duration of claims is measured from the date the claim was commenced to 30 June 2007 (for claims still open at this time) or to the date the claim was finalised (for claims finalised between 1 July 2006 and 30 June 2007).

Of the claims open at the end of the period, 70% had been open for up to four years. This includes 13% with duration of less than six months, and 48% with duration of less than two years. There were 22% of claims which were open for over five years. Of the claims finalised during the period, 78% had been open for up to four years, which includes 7% with duration of less than six months, and 41% with duration of less than two years. There were 15% that had been open for over five years (Table 3.7).

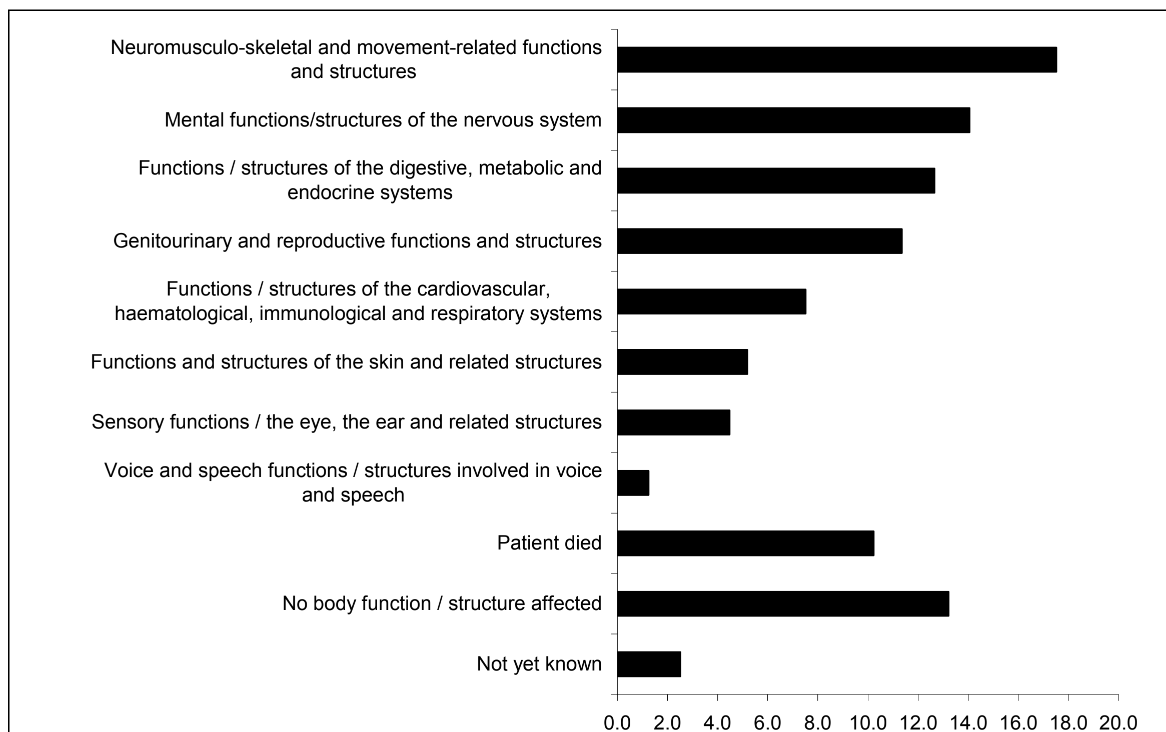

Figure 3.1: Finalised claims: primary body function/structure affected, 1 July 2006 to 30 June 2007, Australia (per cent)

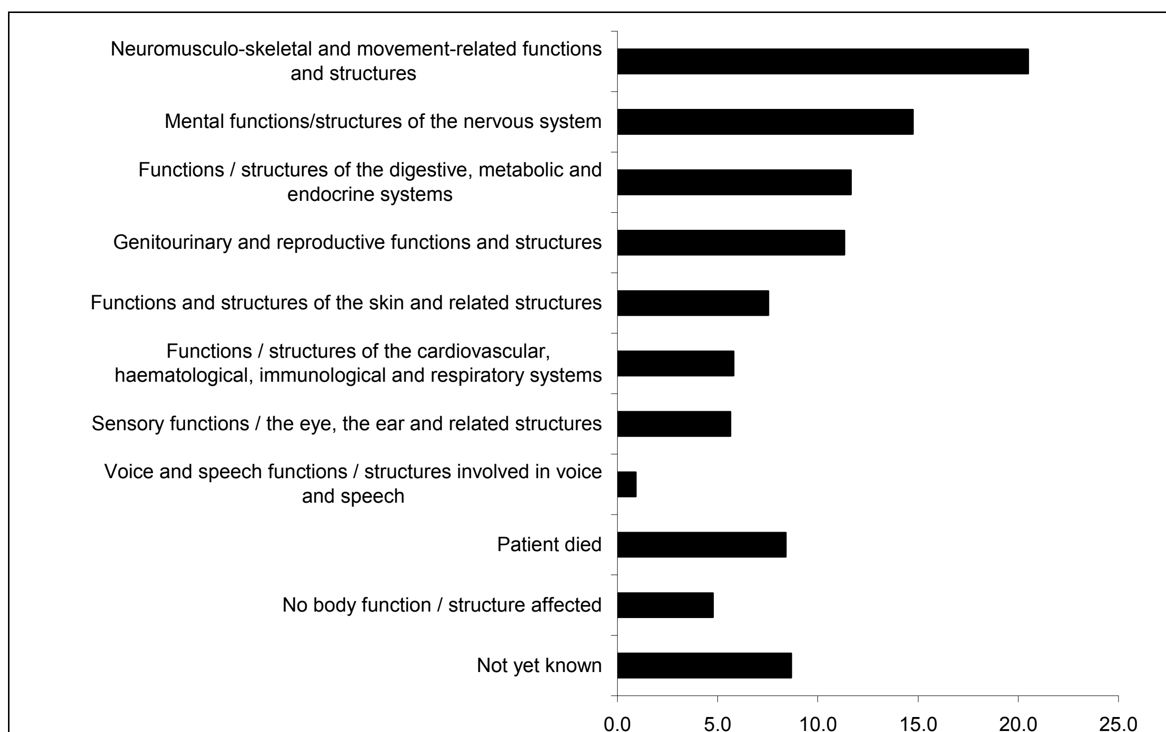

Figure 3.2: New claims: primary body function/structure affected, 1 July 2006 to 30 June 2007, Australia (per cent)

Table 3.7: All claims: status of claim by length of claim (months), at 30 June 2007, Australia (per cent)

	Length of claim at 30 June 2007 (months)											
Status of claim	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
New claims (1 July 2006 – 30 June 2007)	52.1	47.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	100.0
Reopened	1.7	5.2	5.8	3.5	9.8	9.8	10.4	9.2	9.2	5.8	31.8	100.0
Finalised	7.1	12.8	11.3	9.9	9.3	9.3	11.4	6.8	4.3	3.0	14.9	100.0
Claims open at 30 June 2007	13.0	13.0	12.4	9.8	7.5	6.9	3.8	4.1	4.3	2.9	22.4	100.0

n.a. Not applicable

Notes:

1 Length of claim is calculated from date claim commenced.

2 Length of claim for finalised claims is calculated from date claim commenced to date claim finalised. Finalised claims differ in definition for MINC (PS) and MINC (MII) collections (see definitions below).

3 Finalised claims in the MINC public sector claims data include claims which have been closed (and total claim size determined) or where a final court decision has been made, including claims finalised with total claim size yet to be determined. Finalised claims in the MII collection include claims which are closed and no more payments are expected, or all recoveries expected to be received from third parties other than reinsurers have been received (a claim may be finalised even though reinsurance recoveries are outstanding).

4 Reopened claims include claims that have previously been recorded as finalised, but have then been reopened and are active.

Total claim size and mode of finalisation

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

Most claims were settled for less than $10,000 (58%). No payment was made or costs incurred for 22% of finalised claims (Table 3.8).

The majority (85%) of claims finalised in the 2006–07 financial year settled for less than $100,000. Claims with sizes in excess of $500,000 constituted 3% of all finalised claims.

Table 3.8: Finalised claims: total claim size by mode of claim finalisation[(a)], 1 July 2006 to 30 June 2007, Australia (per cent)

Total claim size	Court decision	Negotiated	Withdrawn	Per cent of finalised claims
No payment made	13.3	6.7	37.1	21.8
Less than $10,000	26.7	21.6	50.7	36.1
$10,000–<$30,000	20.7	18.0	9.1	13.6
$30,000–<$50,000	14.7	9.6	1.7	5.9
$50,000–<$100,000	8.0	14.1	0.9	7.4
$100,000–<$250,000	8.7	16.5	0.6	8.4
$250,000–<$500,000	4.7	6.9	0.0	3.5
$500,000 or more	3.3	6.6	0.0	3.3
Total	100.0	100.0	100.0	100.0

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

Appendix 1: Coding examples for some main data items

Table A1: Coding examples for body function/structure categories

Body function/structure coding category		Examples of types of harm
1.	Mental functions/structures of the nervous system	Psychological harm (e.g. nervous shock)
		Subdural haematoma
		Cerebral palsy
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.	Neuromusculo-skeletal and movement-related functions and structures	Loss of function due to inappropriate casting of joint
		Loss of function due to restricted blood flow and nerve damage
		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 function/structure affected	Failed sterilisation, where there is no consequent harm to body functions or structures

Table A2: Coding examples for selected incident/allegation types

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

Table A3: Coding examples for mode of claim finalisation

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

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