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Australia's public sector medical indemnity claims 2007–08

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Abbreviations

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

Symbols

. .	Not applicable

Summary

This report, the sixth in the series on public sector medical indemnity claims, presents data on claims open during the 2007–08 financial year and updates claim characteristics over the period 2003–04 to 2006–07. Obstetrics-related claims illustrate the detail available on all claims.

Data for this report are from the Australian Institute of Health and Welfare's Medical Indemnity National Collection (MINC). Information is provided on the allegations of loss or harm that gave rise to claims, the people affected, and the cost, duration and mode of settlement of medical indemnity claims.

Public sector claims for 2007–08

Information is reported on all medical indemnity claims open at some time in 2007–08. There were 1,292 'new claims' with a reserve set in response to commenced or anticipated legal action brought against public sector health providers. The principal clinician specialties most frequently recorded for new claims were *Emergency medicine* (15%), *General practice – non-procedural* (13%) and *Obstetrics only* (9%). There were 3,429 claims open at 30 June 2008, about 40% with reserves less than $30,000.

Changes over time for new claims 2003–04 to 2007–08

Information is provided over time on claims open during the period 2003–04 to 2007–08. The number of new claims in 2007–08 (1,292) was similar to 2006–07 (1,306) and less than approximately 2,000 claims each year between 2003–04 and 2005–06. The proportion of 'new claims' related to the clinical service context of *Obstetrics* remained relatively steady over the five year period (14–16%) and *Accident and Emergency* fluctuated between 15% and 21%. 'New claims' relating to *General surgery* made up 12% of claims in 2007–08 and in 2003–04, however there was a peak of 30% in 2005–06. The increased proportion of 'new claims' that year was affected by claims against one general surgeon in one state.

Public sector claims closed between 2003–04 and 2007–08

Information is provided on claims closed between 2003–04 and 2007–08. Numbers of claims closed varied between about 1,600 and 2,200 each year. About 50% to 60% each year were discontinued. Generally, the proportion of claims closed for $100,000 or more increased: it was 9% in 2003–04 and 13% in 2007–08. Generally, claims closed for nil cost also increased over time; they comprised 24% of the total in 2003–04 and 39% in 2007–08.

Obstetrics-related claims

Detailed information is provided on obstetrics-related claims for which the claim subject's age was reported. There were 1,205 *Obstetrics* claims closed between 2003–04 and 2007–08. Of these, 60% involved women and the other 40% involved babies. For babies, the *Mental and nervous system* was allegedly affected for 47% of claims, and 9% of claims were settled for $500,000 or more (more than the 3% of claims overall).

1 Introduction

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

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

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

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

Chapter 4 looks at changes to claim characteristics over the period 2003–04 to 2007–08. The two previous reports in this series (AIHW 2007a, 2009) also looked at changes to selected claim characteristics between the 2003–04 year and the year being reported on. However, these previous reports relied on previously published data in making comparisons across the years. These previously published data are not necessarily the best available data, because many public sector claims have their data updated from year to year. *Australia's public sector medical indemnity claims 2007–08* is the first report in the MINC series to use the most recently updated data on claims.

Chapter 5 describes claim characteristics by presenting data on claims closed over a 5-year period, between 2003–04 and 2007–08. There are two reasons for this approach. The reason for focusing on closed claims is that their data quality is generally better than for open claims. Open claims are still undergoing investigation, and so many of their details are tentative or completely unknown, whereas the information is much more complete when a claim has closed. The reason for considering closed claims over a 5-year period is to include a larger sample size of claims than would be available for any one of those years.

Chapter 6 provides data on two types of obstetric-related claims: those where the mother was the 'claim subject', that is, the person allegedly most affected by the associated incident; and those where the baby was the 'claim subject'. The analysis focuses on claims closed over the 5 years between the 2003–04 and 2007–08 periods, for the same two reasons as noted in relation to the Chapter 5 claims data. This chapter illustrates some of the detail available in the MINC about specific types of claims. It is planned that similar detailed information about other specific types of claims will be included in internet data cubes in the near future.

This report is being published in conjunction with the *Public and private sector medical indemnity claims in Australia 2007–08* report (AIHW 2011). The first report to contain combined public and private sector medical indemnity claims data, *A national picture of medical indemnity claims in Australia 2004–05*, was published by the Australian Institute of

Health and Welfare (AIHW) in May 2007 (AIHW 2007b). It was followed by *Public and private sector medical indemnity claims in Australia 2005–06: a summary* in August 2008 (AIHW 2008) and *Public and private sector medical indemnity claims in Australia 2006–07: a summary* in May 2010 (AIHW 2010).

2 The collection

2.1 Scope and context

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

2.2 Policy, administrative and legal context

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

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

Claims management

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

1. An incident that could lead to a public sector medical indemnity claim is notified to the relevant claims management body. In some jurisdictions claims are managed by the relevant state or territory health authority; however, in others, a body external to the health authority handles most of the claims management process. Occasionally, some of the legal work may be outsourced to private law firms. (See Appendix 3 for claims management bodies operating in each jurisdiction.)
2. If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed on it, based on an estimate of the cost of the claim when closed.
3. Various events can signal the start of a claim, for example, a writ or letter of demand may be issued by the claimant's solicitor (this can occur before an incident has been notified), or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases, no action is taken by the claimant or the defendant.
4. The claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.
5. As the claim progresses the reserve is monitored and adjusted if necessary.
6. A claim may be settled through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In addition, in some jurisdictions

settlement via statutorily mandated conference processes must be attempted before a claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process. A claim file that has remained inactive for a long time may be discontinued. Some claims may be reopened following discontinuation or initial settlement.

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

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

2.3 Data items

The MINC includes 21 data items and 15 key terms as summarised in Appendix 2. Further details are available from the AIHW on request.

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

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

2.4 Data coverage, quality and completeness

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

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

Data coverage and completeness

When the MINC was first established, jurisdictions were not always in a position to report data on every claim that they knew to be 'in scope' for that reporting period. Around 50% of claims in scope for the January to June 2003 reporting period were not included in the data reported to the AIHW (AIHW 2004), and 20% of claims in scope were not included in the MINC 2003–04 collection (AIHW 2005). However, since then data completeness has improved considerably, to virtually 100% of claims in scope included in 2007–08. The only 2007–08 claim not reported was a single closed claim.

Missing data

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

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

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

Data quality

Not known rates

A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. As additional information comes to hand, it is added to the claim record, and so *Not known* rates tend to decrease as claims approach finalisation. Hence, when the claims open at any point during the 2007–08 reporting period are grouped into the categories of *New claims*, *Current claims* and *Closed claims*, it is evident that *New claims* generally have the highest *Not known* rates and *Closed claims* the lowest (Table 2.1). For

instance, the *Not known* rate for 'primary body function/structure affected' is 35% for *New claims*, 16% for *Current claims* (many of which have been open for several years—Chapter 3) and 4% for *Closed claims*.

There are two data items with high *Not known* rates, regardless of the claim category: 'nature of claim—loss to claim subject' (94% for all claim categories) and 'nature of claim—loss to other party/parties' (45–59%, depending on claim category). These data items can be coded for a specific loss category or categories only when the claim documentation includes allegation information. While a claim is still open, or if it is closed through being discontinued, the alleged loss is usually not known and so is recorded as *Not known*. If it is known that no loss categories formed the basis of the claim, then the code *Not applicable* is used. It is understood that the codes for *Not known* and *Not applicable* have sometimes been used interchangeably.

There are two other data items with *Not known* rates greater than 10% for *Closed claims* as well as other claim categories: 'extent of harm—claim subject' and 'claim subject's status' (for example, an admitted patient or resident). It has been agreed that starting with the 2009–10 data transmission, a field other than *Not known* must be selected for these (and other) data items when a claim is closed.

Data cleaning of the collection

As with previous years' data, the AIHW undertook data cleaning and validation checks on the 2007–08 data it received. The AIHW raised queries when changes in data items since the 2006–07 recording period appeared to be illogical or unexpected—for example, claim status changing from *Closed* to *Commenced*. Jurisdictions were informed of discrepancies and asked to investigate and clarify any uncertainties.

In preparing for this report, extensive data cleaning was also undertaken on the MINC master database. One data cleaning exercise was to investigate claim records with a 'clinical service context' of *Obstetrics* or *Gynaecology* but with an adult male recorded as the claim subject. All of these records were corrected on the master database after consultations with the jurisdictions. (The most common reason for these anomalous records is that the claimant was an adult male, but acted as the *Other party* rather than the *Claim subject*.) A second data cleaning exercise was to harmonise the data items 'extent of harm' and 'primary body function/structure affected' when either has the code for *Death*. In a small proportion of affected claims, *Death* had been coded for one of these items but not the other, so the AIHW consulted the jurisdictions to determine how these two data items should be correctly coded for these claims. In a third data cleaning exercise, a number of claims coded as structured settlements were found to have been closed without involving any structured settlement, and their claim status was accordingly corrected.

The decision was made to thoroughly clean the master database in recognition of its value for reporting on public sector medical indemnity claims. In contrast to previous reports in this series, which focused on the data transmitted to the AIHW for the financial year under review, this report draws its information primarily from the master database.

Table 2.1: MINC data items: number and proportion of claims for which *Not known* was recorded, 1 July 2007 to 30 June 2008[(a)]

	New claims		Current claims		Closed claims		All claims	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Nature of claim—loss to claim subject	1,213	93.9	3,218	93.8	1,734	93.7	4,952	93.8
Nature of claim—loss to other party/parties	758	58.7	1,558	45.4	868	46.9	2,426	45.9
Extent of harm—claim subject	616	47.7	1,060	30.9	426	23.0	1,486	28.1
Claim subject's status	507	39.2	756	22.0	336	18.2	1,092	20.7
Primary body function/structure affected	453	35.1	539	15.7	76	4.1	615	11.6
Claim subject's year of birth	278	21.5	436	12.7	161	8.7	597	11.3
Primary incident/ allegation type	444	34.4	514	15.0	51	2.8	565	10.7
Clinical service context	433	33.5	489	14.3	58	3.1	547	10.4
Principal clinician specialty	340	26.3	386	11.3	59	3.2	445	8.4
Health service setting	390	30.2	410	12.0	21	1.1	431	8.1
Where incident occurred	282	21.8	282	8.2	7	0.4	289	5.5
Claim subject's sex	66	5.1	108	3.1	30	1.6	138	2.6
Total	**1,292**	**100.0**	**3,429**	**100.0**	**1,851**	**100.0**	**5,280**	**100.0**
Items relevant only to closed claims								
Mode of claim finalisation	. .	. .	. .	. .	10	0.5	. .	. .
Total claim size	. .	. .	. .	. .	7	0.4	. .	. .
Items reported by jurisdictions other than New South Wales[(b)]								
Additional incident/ allegation types	0	0.0	1	0.1	1	0.3	2	0.2
Additional body function/structure affected	0	0.0	0	0.0	0	0.0	0	0.0
Additional clinician specialties	0	0.0	0	0.0	0	0.0	0	0.0

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

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

2.5 Reporting the collection's claim characteristics

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

Current claims still open at 30 June 2008 provide data relevant to current public sector liability for claims to be finalised at some future point. For this reason, where 'reserve range' is considered (tables 3.8 to 3.10), *Current claims* are reported.

New claims have the advantage of capturing information on alleged health care allegations close to the time of the alleged incidents, and so are sensitive to these allegations' changed characteristics over time. Accordingly, several of the tables in Chapter 4, where data for the years from 2003–04 to 2007–08 are compared, report on *New claims*. In these tables, the *Not known* rates are often lower for claims that were new during the earlier reported years, because the health authorities have been able to provide the AIHW with more complete data on these claims in the years since the claim had its reserve set.

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

The quality of the data for *Closed claims* is higher than for *Current claims*, as indicated by their lower *Not known* rates (Section 2.4). However, the number of claims closed in any year (approximately 2,000) is not large enough to ensure that analysis of the claims data is consistent in detecting informative patterns. From these considerations, this report focuses on closed claims over a representative period—5 years in length—leading up to 2007–08, that is, between the 2003–04 and 2007–08 periods (chapters 5 and 6).

3 Public sector medical indemnity claims for 2007–08

This chapter presents a brief profile of the 5,280 medical indemnity claims that were open at some point between 1 July 2007 and 30 June 2008. Over the period, there were 1,292 new claims opened (marked by the setting of a reserve), 1,851 claims that were closed (settled, for example, through negotiation or a court decision, or being discontinued), and at 30 June 2008 there were 3,429 current claims. Current claims include three subcategories: potential claims, where a reserve has been set but no allegation of loss has yet been received; commenced claims, where the reserve has been set and an allegation of loss received; and reopened claims, which are current claims that had been considered closed at some point prior to 30 June 2008 (Table 3.1).

Table 3.1: Number of public sector claims by claim category, 1 July 2007 to 30 June 2008

Claim category	Description	Number
New	Claims with a reserve set within the reporting period (1 July 2007 to 30 June 2008)	1,292
Current	Claims that remained open at 30 June 2008	3,429
Closed	Claims that were settled during the reporting period (1 July 2007 to 30 June 2008)	1,851
All	Includes all current and closed claims for the reporting period (1 July 2007 to 30 June 2008)	5,280

The data presented in this chapter cover all claims, current claims and closed claims. Data on new claims for 2007–08 are summarised at the end of this chapter and presented in more detail in Chapter 4.

3.1 All claims, 2007–08

Clinical service context

'Clinical service context' specifies the area of clinical practice or hospital department associated with the alleged health care incident. There are 20 possible categories, as well as the option to code the service context as *Other* and provide additional text information.

During 2007–08, the three most commonly recorded clinical service contexts, recorded for almost half of all claims (2,502 of 5,280 claims), were *Obstetrics*, *Accident and Emergency* and *General surgery*. Other clinical service contexts recorded for over 100 claims include *Orthopaedics*, *Gynaecology*, *General medicine*, *Psychiatry*, *Paediatrics*, *Cardiology* and *General practice*, whereas *Perinatology*, *Plastic surgery* and *Cosmetic procedures* were the least frequently recorded clinical service contexts (Table 3.2). These patterns for 2007–08 have not varied from the 2005–06 and 2006–07 data on all claims (AIHW 2007a, 2009).

Primary incident/allegation type

'Primary incident/allegation type' describes what is alleged to have 'gone wrong', that is, the area of possible error, negligence or problem that was of primary importance in giving rise to the claim. During 2007–08, claims relating to *Procedure* (31%) were most common, followed

by *Diagnosis* (23%) and *Treatment* (16%). *Device failure* and *Blood/blood product-related* were the least likely 'primary incident/allegation type' to be recorded as the alleged grounds for a claim (<1% and 1% of all claims respectively) (Table 3.3).

Procedure accounted for more than half of all alleged incidents in the clinical service contexts of *Gynaecology* (72% in this category), *General surgery* (61%), *Obstetrics* (53%) and *Orthopaedics* (51%). Incidents related to *Diagnosis* were relatively more likely in *Accident and Emergency* (57%), *Paediatrics* (39%) and *General medicine* (32%) (Table 3.4).

There is little difference between 2007–08 and the two preceding years (AIHW 2007a, 2009) in terms of these distributions.

Table 3.2: All claims: clinical service context, 1 July 2007 to 30 June 2008

Clinical service context	Number	Per cent
Obstetrics	953	18.0
Accident and emergency	850	16.1
General surgery	699	13.2
Orthopaedics	346	6.6
Gynaecology	303	5.7
General medicine	259	4.9
Psychiatry	232	4.4
Paediatrics	154	2.9
Cardiology	110	2.1
General practice	107	2.0
Neurology	95	1.8
Urology	67	1.3
Oncology	60	1.1
Radiology	55	1.0
Dentistry	45	0.9
Hospital outpatient department	43	0.8
Ear, nose and throat	40	0.8
Perinatology	34	0.6
Plastic surgery	25	0.5
Cosmetic procedures	16	0.3
Other	240	4.5
Not known	547	10.4
Total	**5,280**	**100.0**

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

Table 3.3: All claims: clinical service context, by primary incident/allegation type, 1 July 2007 to 30 June 2008

Clinical service context	Primary incident/allegation type											
	Procedure[(a)]	Diagnosis	Treatment[(b)]	General duty of care	Medication-related[(c)]	Anaesthetic	Consent[(d)]	Infection control	Blood/blood product-related	Device failure	Other	Total
Obstetrics	488	170	153	37	25	19	12	3	2	2	8	953
Accident and emergency	45	469	197	47	43	2	4	2	3	1	7	850
General surgery	420	76	80	15	28	49	12	8	2	0	3	699
Orthopaedics	173	51	56	16	6	9	11	13	0	4	1	346
Gynaecology	215	26	13	4	7	4	20	3	0	6	2	303
General medicine	11	80	61	53	31	1	1	4	7	4	0	259
Psychiatry	4	21	51	112	13	0	6	0	3	0	12	232
Paediatrics	31	60	37	2	14	3	1	1	1	1	2	154
All other clinical service contexts	239	244	173	97	51	16	24	25	30	2	14	937
Total	**1,645**	**1,217**	**836**	**397**	**233**	**106**	**92**	**62**	**51**	**21**	**55**	**5,280**
Per cent	*31.2*	*23.0*	*15.8*	*7.5*	*4.4*	*2.0*	*1.7*	*1.2*	*1.0*	*0.4*	*1.0*	*100.0*

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

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

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

(d) *Consent* includes failure to warn.

Notes

1. The 'clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. There were 565 claims coded *Not known* for 'primary incident/allegation type' and 547 coded *Not known* for 'clinical service context', including 447 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the numbers are included in the totals.

Table 3.4: All claims: clinical service context, by primary incident/allegation type, 1 July 2007 to 30 June 2008 (excluding *Not known*) (per cent)

	Primary incident/allegation type											
Clinical service context	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Anaesthetic**	**Consent**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
Obstetrics	53.1	18.5	16.6	4.0	2.7	2.1	1.3	0.3	0.2	0.2	0.9	100.0
Accident and emergency	5.5	57.2	24.0	5.7	5.2	0.2	0.5	0.2	0.4	0.1	0.9	100.0
General surgery	60.6	11.0	11.5	2.2	4.0	7.1	1.7	1.2	0.3	0.0	0.4	100.0
Orthopaedics	50.9	15.0	16.5	4.7	1.8	2.6	3.2	3.8	0.0	1.2	0.3	100.0
Gynaecology	71.7	8.7	4.3	1.3	2.3	1.3	6.7	1.0	0.0	2.0	0.7	100.0
General medicine	4.3	31.6	24.1	20.9	12.3	0.4	0.4	1.6	2.8	1.6	0.0	100.0
Psychiatry	1.8	9.5	23.0	50.5	5.9	0.0	2.7	0.0	1.4	0.0	5.4	100.0
Paediatrics	20.3	39.2	24.2	1.3	9.2	2.0	0.7	0.7	0.7	0.7	1.3	100.0
All other clinical service contexts	26.1	26.7	18.9	10.6	5.6	1.7	2.6	2.7	3.3	0.2	1.5	100.0
Total	**34.5**	**25.4**	**17.4**	**8.1**	**4.6**	**2.2**	**1.9**	**1.3**	**1.0**	**0.4**	**1.0**	**100.0**

Notes

1. The 'clinical service context' categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. The 565 claims coded *Not known* for 'primary incident/allegation type' and 547 coded *Not known* for 'clinical service context', including 447 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 4,615.
3. Percentages may not add up exactly to 100.0 due to rounding.

Specialties of clinicians

The data item 'specialties of clinicians closely involved in allegation of harm' indicates the health-care providers who allegedly played the most prominent roles in the events that gave rise to a claim. The providers so identified were not necessarily at fault in relation to the alleged incident and may not be defendants in the claim. There are 69 possible categories, including *Not applicable* in cases where no clinician is alleged to have been closely involved. Up to four clinician specialties may be recorded for any one claim, and so a summation of the total number of times that specialties were recorded for 2007–08 claims would exceed the total number of claims.

Emergency medicine, *Obstetrics only* and *General surgery* were the three most frequent clinician specialties, recorded for approximately 10% of claims each (Table 3.5). Six other specialties were recorded for over 200 claims, being *Orthopaedic surgery*, *General practice – non-procedural*, *Gynaecology only*, *Obstetrics and gynaecology*, *Nursing – general* and *Psychiatry*. However, there were many clinical specialties recorded for less than ten 2007–08 claims, including six specialties that had not been recorded for any claims.

The above distributions for 2007–08 claims generally reflect the 2005–06 and 2006–07 claims (AIHW 2007a, 2009). There are differences in some of the details; for instance, in 2005–06 there were over 200 claims associated with *Anaesthetics – general* but less than 200 claims associated with *General practice – non-procedural*.

Table 3.5: All claims: specialties of clinicians closely involved in the alleged incident, 1 July 2007 to 30 June 2008

Specialty of clinician	Number	Per cent of all claims
Emergency medicine	687	13.0
Obstetrics only	641	12.1
General surgery	501	9.5
Orthopaedic surgery	354	6.7
General practice—non-procedural	241	4.6
Gynaecology only	232	4.4
Obstetrics and gynaecology	218	4.1
Nursing—general	207	3.9
Psychiatry	201	3.8
General practice—procedural	139	2.6
Anaesthetics—general	126	2.4
Midwifery	122	2.3
Paediatric medicine	114	2.2
General and internal medicine	104	2.0
Diagnostic radiology	101	1.9
Other hospital-based medical practitioner	94	1.8
Cardiology	83	1.6
Neurosurgery	76	1.4
Intensive care	73	1.4
Urology	71	1.3
Neonatology	59	1.1
Gastroenterology	48	0.9
Nursing—nurse practitioner	46	0.9
Clinical haematology	45	0.9

(continued)

Table 3.5 (continued): All claims: specialties of clinicians closely involved in the alleged incident, 1 July 2007 to 30 June 2008

Specialty of clinician	Number	Per cent of all claims
Neurology	44	0.8
Paramedical and ambulance	44	0.8
Paediatric surgery	44	0.8
Plastic surgery	44	0.8
Vascular surgery	44	0.8
Ear, nose and throat	39	0.7
Pathology	38	0.7
Cardio-thoracic surgery	37	0.7
Ophthalmology	37	0.7
Medical oncology	36	0.7
Dentistry—procedural	28	0.5
Clinical immunology	27	0.5
Colorectal surgery	27	0.5
Psychology	23	0.4
Other allied health	20	0.4
Dentistry—oral surgery	20	0.4
Anaesthetics—intensive care	18	0.3
Renal medicine	15	0.3
Infectious diseases	13	0.2
Clinical genetics	9	0.2
Respiratory medicine	9	0.2
Endoscopy	8	0.2
Geriatrics	8	0.2
Physiotherapy	8	0.2
Rehabilitation medicine	7	0.1
Rheumatology	7	0.1
Facio-maxillary surgery	6	0.1
Public health—preventative medicine	6	0.1
Endocrinology	5	0.1
Nuclear medicine	5	0.1
Therapeutic radiology	5	0.1
Pharmacy	4	0.1
Podiatry	3	0.1
Thoracic medicine	3	0.1
Clinical pharmacology	2	<0.1
Cosmetic surgery	2	<0.1
Dermatology	1	<0.1
Chiropractics	0	0.0
Nutrition/dietician	0	0.0
Occupational medicine	0	0.0
Osteopathy	0	0.0
Spinal surgery	0	0.0
Sports medicine	0	0.0
Not applicable	51	0.9
Not known	445	7.7
Total claims	**5,280**	**100.0**

Primary body function/structure affected

The 'primary body function/structure affected' specifies the main body function or structure of the claim subject which is alleged to have been affected as a result of the events that gave rise to a claim. The two most common categories for 2007–08 claims were *Neuromusculoskeletal and movement-related* (21%) and *Mental and nervous system* (20%). Three categories, *Skin and related structures*, *Sensory, including eye and ear* and *Voice and speech* were recorded for less than 5% of claims. *Death* was recorded for 14% of claims, and in 1% of cases the claim did not relate to any alleged physical or mental harm (Table 3.6).

The proportions of the 'primary body function/structure affected' categories recorded for 2006–07 claims (AIHW 2009) are very similar to those shown in Table 3.6, but there were some differences with the 2005–06 claims (AIHW 2007a), as for instance in the lower proportion associated with *Mental and nervous system* effects (14%).

Extent of harm

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

Temporary harm was recorded for 12% of claims, compared with 22% of claims with minor harm of 6 months or more duration and 23% of claims with major harm of 6 months or more duration. These proportions should be read in the context of the 28% of all claims for which extent of harm was unknown (Table 3.6). In the case of claims with known extent of harm and primary body function/structure affected, temporary harm was recorded for 50% of claims with alleged effects to *Voice and speech* and 43% of claims with alleged effects to *Skin and related structures* (Table 3.7). On the other hand, major harm of 6 months or more duration was more a feature of claims with alleged *Mental and nervous system* effects (69%) and *Sensory, including eye and ear* effects (44%).

Table 3.6: All claims: primary body function/structure affected, by extent of harm, 1 July 2007 to 30 June 2008

Primary body function/structure affected	Extent of harm						Total	Per cent
	Temporary (less than 6 months duration)	Minor (6 months or more)	Major (6 months or more)	Death	Not applicable	Not known		
Neuromusculoskeletal and movement-related	140	424	272	0	0	245	1,081	20.5
Mental and nervous system	101	152	562	0	3	211	1,029	19.5
Genitourinary and reproductive	96	219	114	0	0	137	566	10.7
Digestive, metabolic and endocrine systems	119	178	88	0	0	118	503	9.5
Cardiovascular, haematological, immunological and respiratory	54	89	87	0	0	112	342	6.5
Skin and related structures	60	61	19	0	0	43	183	3.5
Sensory, including eye and ear	15	39	42	0	0	34	130	2.5
Voice and speech	19	11	6	0	2	10	48	0.9
Death	0	0	0	717	0	0	717	13.6
No body function/ structure affected	0	0	0	0	66	0	66	1.3
Not known	17	8	14	0	0	576	615	11.6
Total	**621**	**1,181**	**1,204**	**717**	**71**	**1,486**	**5,280**	**100.0**
Per cent	*11.8*	*22.4*	*22.8*	*13.6*	*1.3*	*28.1*	*100.0*	*. .*

Notes

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

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

Table 3.7: All claims: primary body function/structure affected, by extent of harm, 1 July 2007 to 30 June 2008 (excluding *Not known*) (per cent)

Primary body function/structure affected	Extent of harm					Total
	Temporary (less than 6 months duration)	Minor (6 months or more)	Major (6 months or more)	Death	Not applicable	
Neuromusculoskeletal and movement-related	16.7	50.7	32.5	0.0	0.0	100.0
Mental and nervous system	12.3	18.6	68.7	0.0	0.4	100.0
Genitourinary and reproductive	22.4	51.0	26.6	0.0	0.0	100.0
Digestive, metabolic and endocrine systems	30.9	46.2	22.9	0.0	0.0	100.0
Cardiovascular, haematological, immunological and respiratory	23.5	38.7	37.8	0.0	0.0	100.0
Skin and related structures	42.9	43.6	13.6	0.0	0.0	100.0
Sensory, including eye and ear	15.6	40.6	43.8	0.0	0.0	100.0
Voice and speech	50.0	28.9	15.8	0.0	5.3	100.0
Death	0.0	0.0	0.0	100.0	0.0	100.0
No body function/ structure affected	0.0	0.0	0.0	0.0	100.0	100.0
Total	**16.1**	**31.2**	**31.7**	**19.1**	**1.9**	**100.0**

Notes

1. The 1,486 claims coded *Not known* for 'primary body function/structure affected' and 615 claims coded *Not known* for 'extent of harm', including 576 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 3,755.

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

3.2 Current claims at 30 June 2008

Reserve range and principal clinician specialty

The 'reserve range' of a claim is the estimated cost, in broad dollar ranges, which is set by the jurisdictional authority against each current claim. At 30 June 2008, almost 20% of current claims had been reserved for amounts less than $10,000 and about 40% of claims were reserved for amounts less than $30,000, whilst 14% of current claims had been reserved for $500,000 or more (Table 3.8).

Table 3.8 also presents data on principal clinician specialty for current claims at 30 June 2008. The most commonly recorded principal clinician specialties were *Obstetrics only* and *Emergency medicine* (each accounting for 12% of current claims), followed by *General surgery* (8%).

Childbirth and paediatrics were two areas of health care delivery which show an above-average association with a high reserve range. The specialty *Obstetrics only* was recorded for 26% of current claims with their reserve set at $500,000 or more, compared with just 14% of all current claims. Similarly, claims with the principal clinician specialty of *Midwifery* made up a larger proportion of those reserved for at least $500,000 (5%) than current claims in general (2%). Paediatric-associated claims, although less numerous than obstetric-associated claims, also tended to have a high reserve range. The specialty *Paediatric medicine* accounted for 5% of current claims reserved for at least $500,000, compared with 2% of all current claims (Table 3.9).

In contrast, *General surgery* stands out as a primary clinical specialty that was associated relatively infrequently with a high reserve range. *General surgery* was recorded for just 6% of claims reserved at $250,000–<$500,000, and 3% of claims reserved at $500,000 or more, compared with 9% of all current claims. Also, the clinician specialty of *Gynaecology only* was associated with just 1% of claims reserved at $500,000 or more, compared with 5% of all claims with this primary clinician specialty.

Table 3.8: Current claims: principal clinician specialty, by reserve range ($), 30 June 2008

Principal clinician specialty	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	Per cent
Obstetrics only	24	64	14	63	79	51	116	411	12.0
Emergency medicine	50	95	25	71	64	45	59	409	11.9
General surgery	46	90	22	38	45	16	13	270	7.9
Orthopaedic surgery	23	49	12	43	41	28	24	220	6.4
General practice—non procedural	20	26	14	38	33	18	19	168	4.9
Obstetrics and gynaecology	13	28	10	23	27	13	27	141	4.1
Gynaecology only	11	28	14	34	34	11	6	138	4.0
Psychiatry	16	47	10	14	17	6	11	121	3.5
General practice—procedural	5	10	7	11	19	9	22	83	2.4
General nursing	21	13	7	16	12	2	6	77	2.2
Paediatric medicine	5	8	3	14	12	9	21	72	2.1
Anaesthetics	14	20	5	6	9	1	7	62	1.8
General and internal medicine	12	16	0	13	9	5	5	60	1.7
Midwifery	6	17	1	3	2	5	23	57	1.7
All other specialties	107	166	57	101	120	70	95	716	20.9
Not applicable	7	9	7	3	7	4	1	38	1.1
Not known	258	60	13	20	18	8	9	386	11.3
Total	**638**	**746**	**221**	**511**	**548**	**301**	**464**	**3,429**	**100.0**
Per cent	*18.6*	*21.8*	*6.4*	*14.9*	*16.0*	*8.8*	*13.5*	*100.0*	*. .*

Notes

1. The 'principal clinician specialty' categories listed separately here are the 14 most frequently recorded categories; all other categories are combined in the category *All other specialties*.

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

Table 3.9: Current claims: principal clinician specialty (excluding *Not applicable* and *Not known*), by reserve range ($), 30 June 2008 (per cent)

Principal clinician specialty	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
Obstetrics only	6.4	9.5	7.0	12.9	15.1	17.6	25.6	13.7
Emergency medicine	13.4	14.0	12.4	14.5	12.2	15.6	13.0	13.6
General surgery	12.3	13.3	10.9	7.8	8.6	5.5	2.9	9.0
Orthopaedic surgery	6.2	7.2	6.0	8.8	7.8	9.7	5.3	7.3
General practice— non procedural	5.4	3.8	7.0	7.8	6.3	6.2	4.2	5.6
Obstetrics and gynaecology	3.5	4.1	5.0	4.7	5.2	4.5	5.9	4.7
Gynaecology only	2.9	4.1	7.0	7.0	6.5	3.8	1.3	4.6
Psychiatry	4.3	6.9	5.0	2.9	3.3	2.1	2.4	4.0
General practice— procedural	1.3	1.5	3.5	2.3	3.6	3.1	4.8	2.8
General nursing	5.6	1.9	3.5	3.3	2.3	0.7	1.3	2.6
Paediatric medicine	1.3	1.2	1.5	2.9	2.3	3.1	4.6	2.4
Anaesthetics	3.8	3.0	2.5	1.2	1.7	0.3	1.5	2.1
General and internal medicine	3.2	2.4	0.0	2.7	1.7	1.7	1.1	2.0
Midwifery	1.6	2.5	0.5	0.6	0.4	1.7	5.1	1.9
All other specialties	28.7	24.5	28.4	20.7	22.9	24.2	20.9	23.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'principal clinician specialty' categories listed separately here are the 14 most frequently recorded categories; all other categories are combined in the category *All other specialties*.
2. The 424 claims coded *Not known* or *Not applicable* for 'principal clinician specialty' are excluded for the purposes of calculating the percentages presented in this table, which are based on 3,005 claims.
3. Percentages may not add up exactly to 100.0 due to rounding.

Reserve range and duration

Table 3.10 displays data on 'length of claim' by 'reserve range'. For current claims, the length of a claim is measured from the date the claim first had a reserve placed against it to 30 June 2008. For claims current at 30 June 2008, over one-third (37%) had been open for 12 months or less, with just 11% of claims having remained open beyond 5 years. The most common reserve range is the interval between $10,000 and $100,000 (43%), compared with 19% with a reserve value of less than $10,000, and 14% with a reserve value of at least $500,000.

A strong association is evident between the 'reserve range' and how long a claim was open. For example, looking at current claims with a reserve of less than $10,000, we find that the majority (64%) have been open for 12 months or less, compared with 4% open for more than 5 years. In contrast, current claims reserved at $500,000 or more have usually been open for more than 12 months (86%) and often for more than 5 years (28%).

Table 3.10: Current claims: length of claim (months), by reserve range ($), 30 June 2008

Length of claim at 30 June 2008	Less than 10,000	10,000– <100,000	100,000– <500,000	500,000 or more	Total
12 or less	411	567	232	64	1,274
13–24	90	361	184	74	709
25–36	75	234	133	75	517
37–48	22	128	112	65	327
49–60	14	77	66	55	212
>60	26	111	122	131	390
Total	**638**	**1,478**	**849**	**464**	**3,429**
Per cent	*18.6*	*43.1*	*24.8*	*13.5*	*100.0*
			Per cent		
12 or less	64.4	38.4	27.3	13.8	37.2
13–24	14.1	24.4	21.7	15.9	20.7
25–36	11.8	15.8	15.7	16.2	15.1
37–48	3.4	8.7	13.2	14.0	9.5
49–60	2.2	5.2	7.8	11.9	6.2
>60	4.1	7.5	14.4	28.2	11.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

3.3 Closed claims, 2007–08

Total claim size and mode of settlement

The 'total claim size' is the amount agreed to be paid to the claimant in total settlement of the claim, as well as legal and investigative costs, recorded in broad dollar ranges for closed claims. Two-thirds (67%) of the claims closed during 2007–08 were closed for <$10,000, including 39% closed for no cost. All of the other claim size categories, including the largest of $500,000 or more, accounted for between 3% and 9% of closed claims (Table 3.11).

'Mode of settlement' refers to the mechanisms through which claims are closed. These mechanisms include negotiation, a final decision through the courts, and discontinuation when the claim is withdrawn or it is closed by the claims manager after exceeding the period allowed for by the statute of limitations or after a long period of inactivity. Procedures for negotiation include settlement through state/territory-based complaints processes, court-based alternative dispute resolution processes, and a statutorily mandated compulsory conference process.

The most common mode of settlement for 2007–08 closed claims was discontinuation, recorded for 62% of claims, and notably for claims closed for no cost (96%) and $1–<$10,000 (68%). Less than 4% of claims were closed as a result of a court decision. Negotiated settlements through state/territory-based complaints processes (4%), court-based alternative dispute resolution processes (5%) and a statutorily mandated compulsory conference process (<1%) were also recorded for small proportions of claims. The proportion of 2007–08 claims settled through a process other than those listed above was 26% (Table 3.11).

Table 3.11: Closed claims: mode of settlement, by total claim size ($), 1 July 2007 to 30 June 2008

Mode of settlement	Nil	1–<10,000	10,000–<30,000	30,000–<50,000	50,000–<100,000	100,000–<250,000	250,000–<500,000	500,000 or more	Total
Discontinued	682	357	76	13	6	3	1	0	1,140
Settled—state/territory-based complaints processes	5	42	8	3	7	2	0	0	67
Settled—court-based alternative dispute resolution processes	1	4	9	9	18	28	11	7	87
Settled—statutorily mandated compulsory conference process	1	0	1	0	1	1	0	1	5
Settled—other	17	109	49	44	85	86	40	46	476
Court decision	3	10	16	8	9	12	3	5	66
Total	**712**	**523**	**160**	**77**	**126**	**132**	**55**	**59**	**1,851**
Per cent	*38.5*	*28.3*	*8.6*	*4.2*	*6.8*	*7.1*	*3.0*	*3.2*	*100.0*
				Per cent (excluding *Not known*)					
Discontinued	96.2	68.4	47.8	16.9	4.8	2.3	1.8	0.0	62.0
Settled—state/territory-based complaints processes	0.7	8.0	5.0	3.9	5.6	1.5	0.0	0.0	3.6
Settled—court-based alternative dispute resolution processes	0.1	0.8	5.7	11.7	14.3	21.2	20.0	11.9	4.7
Settled—statutorily mandated compulsory conference process	0.1	0.0	0.6	0.0	0.8	0.8	0.0	1.7	0.3
Settled—other	2.4	20.9	30.8	57.1	67.5	65.2	72.7	78.0	25.9
Court decision	0.4	1.9	10.1	10.4	7.1	9.1	5.5	8.5	3.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. There were 10 claims coded *Not known* for 'mode of settlement' and 7 claims coded *Not known* for 'total claim size', including 5 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 1,839.

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

Extent of harm

The 'extent of harm' category most commonly recorded for claims closed in 2007–08 was minor harm of 6 months or more duration (24%). The categories of temporary harm of less than 6 months duration, major harm of 6 months or more duration, and death were each recorded for between 16% and 18% of claims. However, these proportions should be interpreted within the context of the 23% of 2007–08 closed claims for which the extent of harm was unknown (Table 3.12).

There is a strong relationship between claim size and extent of harm, which is most clearly shown by aggregating the claim size categories into broader bands. Where extent of harm is applicable to the claim and also known, temporary harm accounted for 31% of claims closed for no cost, and 28% closed for $1–<$10,000, compared to just 2% closed for $500,000 or more. Where death was the recorded extent of harm, it accounted for fairly similar proportions of claims in each claim size category as temporary harm. On the other hand, major harm accounted for 68% of claims closed for $500,000 or more compared to just 15% closed for no cost. The category of minor harm was intermediate between temporary harm and major harm in terms of cost, accounting for 24–43% of claims in every claim size category.

Table 3.12: Closed claims: extent of harm, by total claim size ($), 1 July 2007 to 30 June 2008

Extent of harm	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Not known	Total	Per cent
Temporary (less than 6 months duration)	132	108	54	16	1	2	313	16.9
Minor (6 months or more)	102	119	140	77	14	0	452	24.4
Major (6 months or more)	63	86	90	53	40	2	334	18.0
Death	126	78	55	32	4	0	295	15.9
Not applicable	12	8	8	3	0	0	31	1.7
Not known	277	124	16	6	0	3	426	23.0
Total	**712**	**523**	**363**	**187**	**59**	**7**	**1,851**	**100.0**
Per cent	*38.5*	*28.3*	*19.6*	*10.1*	*3.2*	*0.4*	*100.0*	. .
			Per cent (excluding *Not applicable* and *Not known*)					
Temporary (less than 6 months duration)	31.2	27.6	15.9	9.0	1.7	. .	22.4	. .
Minor (6 months or more)	24.1	30.4	41.3	43.3	23.7	. .	32.5	. .
Major (6 months or more)	14.9	22.0	26.5	29.8	67.8	. .	23.9	. .
Death	29.8	19.9	16.2	18.0	6.8	. .	21.2	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

Notes

1. The 461 claims coded *Not known* or *Not applicable* for 'extent of harm' or *Not known* for 'total claim size', including 3 coded *Not known* for both, are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 1,390 claims.
2. Percentages may not add exactly to 100.0 due to rounding.

3.4 New claims, 2007–08

Data on new claims for 2007–08 (tables 4.2 to 4.5) show both similarities and differences to the data on other types of claims covered earlier in this chapter.

The three most frequently recorded clinical service contexts were *Accident and Emergency*, *Obstetrics* and *General surgery*, in that order. These are the same three categories that were most common for all 2007–08 claims, although with *Obstetrics* exceeding *Accident and Emergency* in terms of the number of claims.

The principal clinician specialties *Emergency medicine*, *General practice – non-procedural* and *Obstetrics only* were the first to third most frequently recorded for new claims. All claims and current claims differed from new claims in that *General surgery* joined with *Emergency medicine* and *Obstetrics only* in making up the three most common clinician specialties.

The data for new claims on 'primary incident/allegation type' and 'primary body function/structure affected' reiterate the information provided by all claims on these two data items. *Procedure*, *Diagnosis* and *Treatment* were recorded as the three most common incident/allegation types, while *Neuromusculoskeletal and movement-related* and *Mental and nervous system* were the two most frequently recorded body function/structure categories.

4 Changes over time to public sector medical indemnity claims, 2003–04 to 2007–08

This chapter presents an overview of claims data covering the five reporting periods from July 2003 to June 2008. It is based on the most current data for each reporting period. This is a different approach to previous reports, which instead compared the data as published over successive years. While the published data have been the best available at the time of reporting, they have also been subject to many corrections and updates. The claims information sent to the AIHW includes 'back-coded' records transmitted after the year when the claims had been closed, as well as updates which reflect the increasing availability of information during the life of a claim, and also advice that some previously transmitted records were not in fact medical indemnity claims. All of this supplementary information is captured in the MINC master database, which accordingly is the preferred source for providing claims data over the years.

The 'time series' data presented here differ from earlier reports in another main respect. Previously the focus has been on all claims open at any time during the reporting period, as this is how most of the data had been published. However, many claims remain open over several years (Table 3.10), and so when comparisons were drawn between different years, they were based on sets of claims which overlapped considerably from year to year. For claims representing different years to be different claims, they need to be assigned to one year or another based on the timing of a unique event in a claim's life, such as the date when the reserve was set or when the claim was closed. With that rationale, the comparisons between reporting periods in this chapter focus on new claims and closed claims.

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

As discussed in Chapter 2, closed claims have low *Not known* rates on most data items whereas new claims have particularly high rates. However, claims that are counted as new in previous reporting periods have subsequently been better documented. As a result, the data quality of new claims as reflected in low *Not known* rates is best for earlier years in the 'time series' and least satisfactory for 2007–08 new claims.

4.1 Claim numbers

Table 4.1 presents claim numbers between 2003–04 and 2007–08 in terms of current claims (open at the end of each period) and closed claims (closed during each period), which together make up all of the claims open during the period. Current claims include potential claims, where a reserve has been set but litigation has not begun, commenced claims where litigation has begun, and claims which were reopened after having been closed in a previous period (Figure 4.1). Closed claims include a small number of structured settlements, which are settlements that allow for periodic payments to the claimant rather than a lump sum

payment. Also presented are the numbers of new claims which had their reserve set during each period.

There were between 5,280 and 6,870 claims in total in each of the last five years (Table 4.1, Figure 4.1). The number of current claims declined from 5,014 in 2003–04 to 3,429 in 2007–08. The number of closed claims increased from 1,591 in 2003–04 to 2,241 in 2006–07 before decreasing to 1,851 in 2007–08. The 154 reopened claims in 2007–08 is the largest number recorded. There were 1,767 or more new claims in each of the three years between 2003–04 and 2005–06, compared to approximately 1,300 new claims in the last two years. The number of potential claims was also much fewer in 2006–07 and 2007–08 compared to the previous three years.

Table 4.1: All claims: number of claims, by status of claim, 2003–04 to 2007–08

	Year				
Status of claim	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
			Current claims		
Potential (not yet commenced)	1,810	1,905	1,719	1,270	1,018
Commenced	3,165	2,943	3,067	2,574	2,257
Reopened	39	34	54	100	154
All current claims	*5,014*	*4,882*	*4,840*	*3,944*	*3,429*
Closed claims	1,591	1,898	2,030	2,241	1,851
New claims	2,022	1,767	1,970	1,306	1,292
All claims (open at any time during the period)	**6,605**	**6,780**	**6,870**	**6,185**	**5,280**

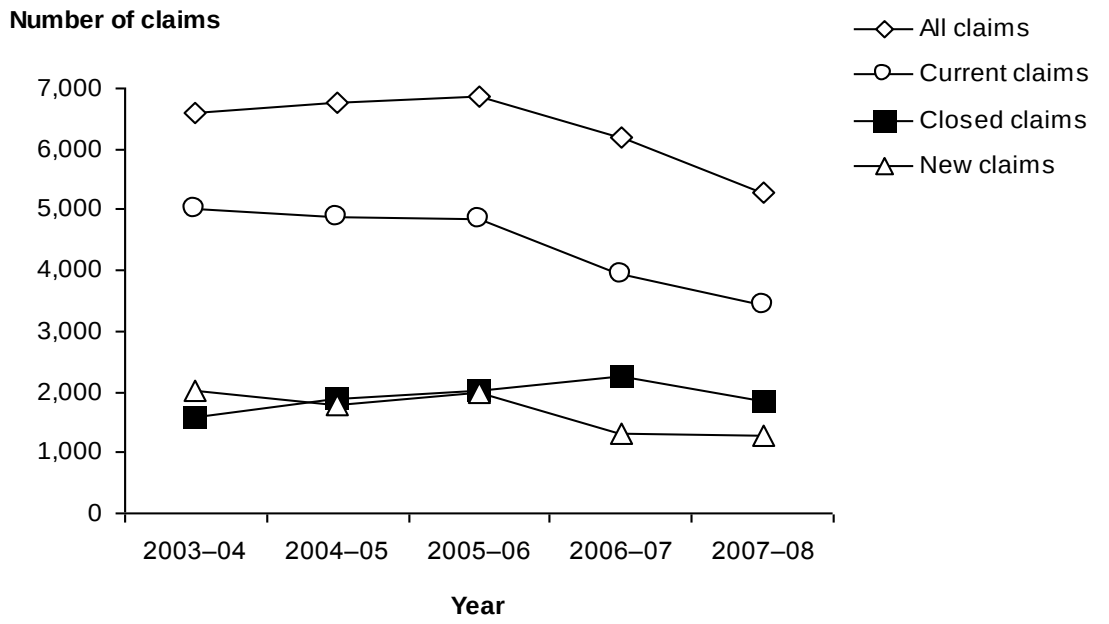

Figure 4.1: New, current, closed and all claims: claim numbers, 2003–04 to 2007–08

4.2 Clinical service context and principal clinician specialty

'Clinical service context' specifies the clinical practice or hospital department associated with the alleged health care incident. Table 4.2 presents the numbers and proportions of new claims associated with the ten clinical service contexts most commonly recorded between 2003–04 and 2007–08. Of these, *Accident and Emergency*, *Obstetrics* and *General surgery* were the three most frequently recorded in each of the years.

'Principal clinician specialty' indicates the health-care provider who allegedly played the most prominent role in the events that gave rise to a claim. The ten principal clinician specialties most commonly recorded for new claims between 2003–04 and 2007–08 are presented in Table 4.3.

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

The high proportion of 2007–08 claims associated with *General practice – non-procedural* is in marked contrast with the years between 2003–04 and 2005–06, when it was recorded for just 2–3% of claims (Table 4.3). This particular change does not appear to be associated with a marked increase in the proportion of claims with *General practice* as their clinical service context (Table 4.2).

The proportions of claims associated with other clinical service contexts and primary clinician specialties appear to have been steady over the years. For instance, *Obstetrics* as a

clinical context has consistently accounted for 14–16% of claims, and *Obstetrics only* as the principal clinician specialty for 9–11% of claims.

New claims in 2007–08

For 2007–08, excluding new claims where the clinical service context was *Not known*, *Accident and Emergency* accounted for 20% (175 of 859 claims), *Obstetrics* for 16% (139 of 859 claims) and *General surgery* for 12% (99 of 859 claims). The proportions for *Accident and Emergency* and *Obstetrics* were similar to those recorded for 2006–07 (21% and 16% respectively), whilst for *General surgery*, the proportion recorded was slightly lower than for 2006–07 (16%).

For 2007–08, the three most frequent principal clinician specialties were *Emergency medicine*, *General practice – non-procedural* and *Obstetrics only*. In terms of claims with a known clinician specialty, *Emergency medicine* accounted for 15% (136 of 938 claims), *General practice – non-procedural* accounted for 13% (124 of 938 claims) and *Obstetrics only* accounted for 9% (81 of 938 claims). *Emergency medicine* and *Obstetrics only* were recorded in similar proportions for 2006–07 claims (16% and 11% respectively), whereas *General practice – non-procedural* increased from 5% in 2006–07.

Table 4.2: New claims: clinical service context, 2003–04 to 2007–08

	Year				
Clinical service context	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
Accident and emergency	350	275	288	258	175
General surgery	238	224	579	205	99
Obstetrics	319	274	275	197	139
Orthopaedics	151	131	131	100	73
Gynaecology	134	137	87	78	47
General medicine	112	119	74	66	55
Psychiatry	87	87	75	79	68
Paediatrics	37	52	31	18	31
General practice	47	37	30	28	33
Cardiology	61	27	43	30	19
All other clinical service contexts	449	370	298	200	130
Not known	37	34	59	47	433
Total	**2,022**	**1,767**	**1,970**	**1,306**	**1,292**
		Per cent (excluding *Not known*)			
Accident and emergency	17.6	15.9	15.1	20.5	20.4
General surgery	12.0	12.9	30.3	16.3	11.5
Obstetrics	16.1	15.8	14.4	15.6	16.2
Orthopaedics	7.6	7.6	6.9	7.9	8.5
Gynaecology	6.8	7.9	4.6	6.2	5.5
General medicine	5.6	6.9	3.9	5.2	6.4
Psychiatry	4.4	5.0	3.9	6.3	6.8
Paediatrics	1.9	3.0	1.6	1.4	3.6
General practice	2.4	2.1	1.6	2.2	3.8
Cardiology	3.1	1.6	2.3	2.4	2.2
All other clinical service contexts	22.6	21.4	15.6	15.9	15.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

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

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

Table 4.3: New claims: principal clinician specialty, 2003–04 to 2007–08

	Year				
Principal clinician specialty	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
Emergency medicine	284	235	243	198	136
General surgery	138	152	483	126	66
Obstetrics only	191	194	179	132	81
Orthopaedic surgery	149	126	122	93	67
Gynaecology only	98	114	66	55	34
Psychiatry	80	71	60	58	46
General nursing	80	73	56	49	20
General practice—non-procedural	44	55	39	66	124
Anaesthetics	96	56	59	46	28
Obstetrics and gynaecology	71	46	69	41	41
All other specialties	744	574	521	389	295
Not applicable	6	30	11	15	14
Not known	41	41	62	38	340
Total	**2,022**	**1,767**	**1,970**	**1,306**	**1,292**
	Per cent (excluding *Not applicable* and *Not known*)				
Emergency medicine	14.4	13.9	12.8	15.8	14.5
General surgery	7.0	9.0	25.5	10.1	7.0
Obstetrics only	9.7	11.4	9.4	10.5	8.6
Orthopaedic surgery	7.5	7.4	6.4	7.4	7.1
Gynaecology only	5.0	6.7	3.5	4.4	3.6
Psychiatry	4.1	4.2	3.2	4.6	4.9
General nursing	4.1	4.3	3.0	3.9	2.1
General practice—non-procedural	2.2	3.2	2.1	5.3	13.2
Anaesthetics	4.9	3.3	3.1	3.7	3.0
Obstetrics and gynaecology	3.6	2.7	3.6	3.3	4.4
All other specialties	37.7	33.8	27.5	31.0	31.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'principal clinician specialty' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other specialties*.

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

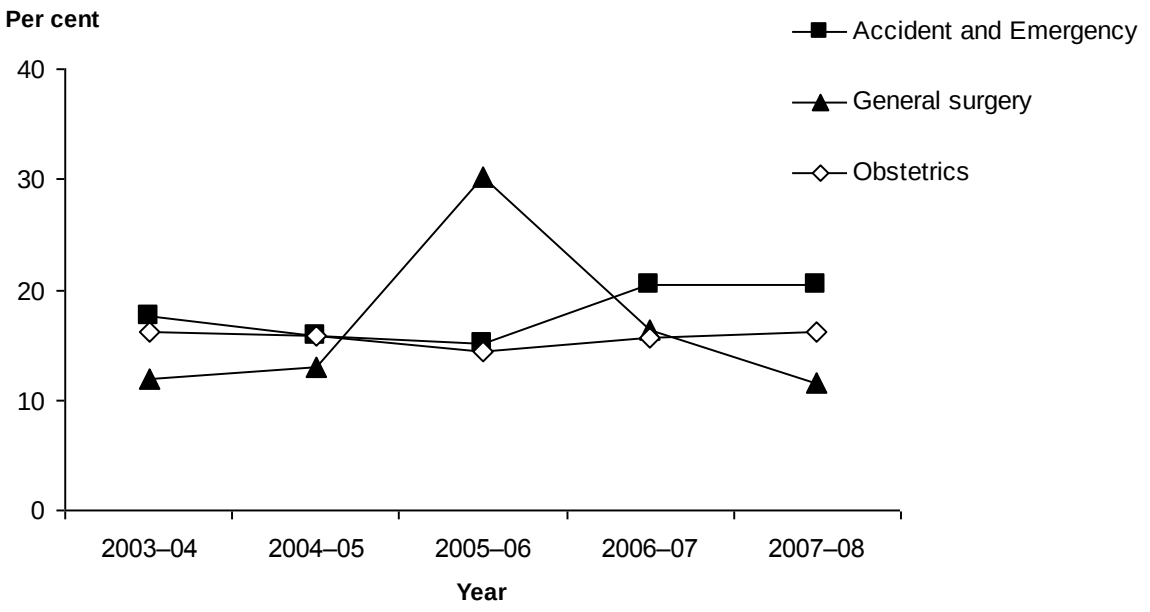

Figure 4.2: New claims: the three most frequently recorded clinical service contexts, 2003–04 to 2007–08 (per cent)

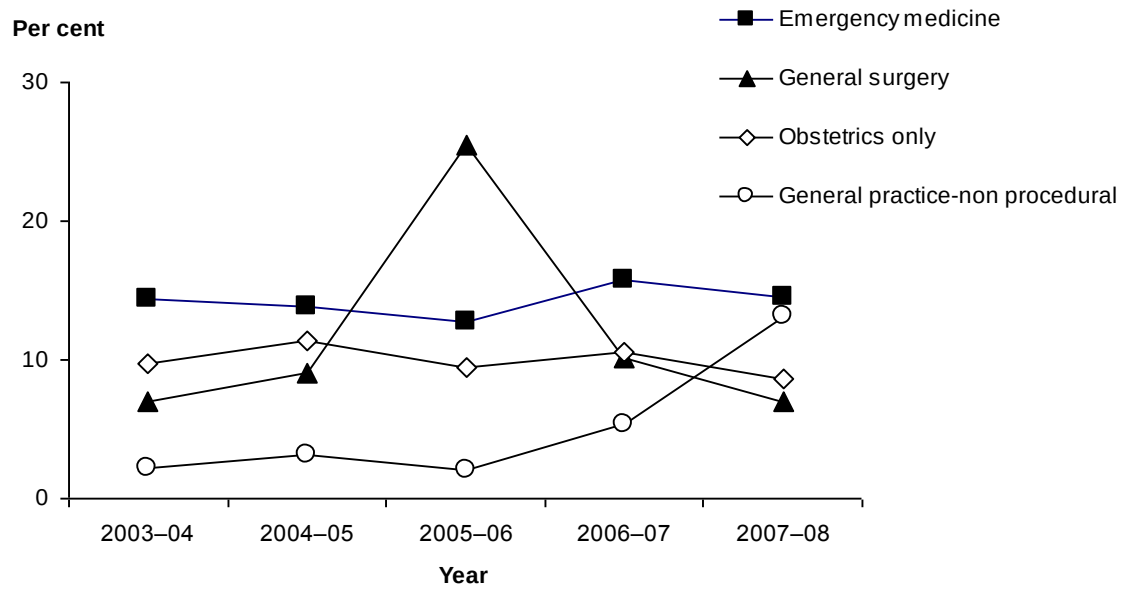

Figure 4.3: New claims: four frequently recorded principal clinician specialties for 2007–08 compared to how frequently they were recorded between 2003–04 and 2006–07 (per cent)

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

'Primary body function/structure affected' specifies the main body function or structure of the claim subject alleged to have been affected as a result of the events that gave rise to a claim. 'Primary incident/allegation type' describes the area of possible error, negligence or problem that was of primary importance in giving rise to the claim.

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

The number of claims with recorded *Neuromusculoskeletal and movement-related* damage decreased continually between 2003–04 and 2007–08, disregarding the unusual circumstances of the 2005–06 reporting period. In contrast, *Death* was recorded as the affected body function/structure category for an increasingly large proportion of the new claims reserved between 2003–04 (12%) and 2007–08 (17%).

Apart from the 2005–06 spike in *Procedure*-related claims, every incident/allegation type has generally been recorded for an increasingly smaller number of claims between 2003–04 and 2007–08. The relative proportions over the reporting periods of incident/allegation types are difficult to interpret owing to the temporary rise in new claims in 2005–06 and the large proportion of claims recorded as *Not known* for 2007–08.

New claims in 2007–08

The 'primary body function/structure affected' category most commonly recorded for new claims during 2007–08 was *Neuromusculoskeletal and movement-related*, followed by the categories *Mental and nervous system*, *Death* and *Genitourinary and reproductive* (Table 4.4). In terms of claims where the body function/structure was known, these four categories were respectively recorded for 190 of 839 claims (23%), 159 claims (19%), 145 claims (17%) and 101 claims (12%). *Neuromusculoskeletal and movement-related*, *Mental and nervous system*, *Death* and *Genitourinary and reproductive* were also the four most frequently recorded body function/structure categories for 2006–07 new claims, and at proportions very similar (23%, 18%, 17% and 14% respectively) to those for 2007–08.

For new claims during 2007–08, the most frequently recorded 'primary incident/allegation types' were *Procedure*, *Diagnosis* and *Treatment* (Table 4.5). They were respectively associated with 237, 209 and 180 new claims, or as a proportion of cases where the primary incident/allegation type was known, 28%, 25% and 21%. The proportions for *Diagnosis* and *Treatment* were similar to those recorded in 2006–07 (28% and 19% respectively). However, the proportion of *Procedure*-related claims was higher in 2006–07 (34%).

Table 4.4: New claims: primary body function/structure affected, 2003–04 to 2007–08

	Year				
Primary body function/ structure affected	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
Neuromusculoskeletal and movement-related	490	420	380	293	190
Mental and nervous system	302	299	302	221	159
Genitourinary and reproductive	276	213	241	175	101
Digestive, metabolic and endocrine systems	213	167	358	144	84
Cardiovascular, haematological, immunological and respiratory	125	116	107	76	65
Skin and related structures	86	70	99	60	43
Sensory, including eye and ear	59	56	52	41	16
Voice and speech	28	31	26	16	16
Death	228	238	296	210	145
No body function/ structure affected	44	27	27	14	20
Not known	171	130	82	56	453
Total	**2,022**	**1,767**	**1,970**	**1,306**	**1,292**
		Per cent (excluding *Not known*)			
Neuromusculoskeletal and movement-related	26.5	25.7	20.1	23.4	22.6
Mental and nervous system	16.3	18.3	16.0	17.7	19.0
Genitourinary and reproductive	14.9	13.0	12.8	14.0	12.0
Digestive, metabolic and endocrine systems	11.5	10.2	19.0	11.5	10.0
Cardiovascular, haematological, immunological and respiratory	6.8	7.1	5.7	6.1	7.7
Skin and related structures	4.6	4.3	5.2	4.8	5.1
Sensory, including eye and ear	3.2	3.4	2.8	3.3	1.9
Voice and speech	1.5	1.9	1.4	1.3	1.9
Death	12.3	14.5	15.7	16.8	17.3
No body function/ structure affected	2.4	1.6	1.4	1.1	2.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. See Appendix 4 for specific examples of types of alleged harm for each of the body function/structure categories.
2. Percentages may not add up exactly to 100.0 due to rounding.

Table 4.5: New claims: primary incident/allegation type, 2003–04 to 2007–08

Primary incident/allegation type	Year				
	2003–04	2004–05	2005–06	2006–07	2007–08
Procedure	678	600	813	425	237
Diagnosis	450	381	422	347	209
Treatment	350	307	299	244	180
General duty of care	196	176	145	103	107
Medication-related	75	62	61	51	41
Anaesthetic	78	56	57	34	22
Consent	54	24	16	22	14
Infection control	36	39	32	7	10
Blood/blood product-related	12	6	16	13	5
Device failure	16	16	5	3	5
Other	27	34	32	12	18
Not known	50	66	72	45	444
Total	**2,022**	**1,767**	**1,970**	**1,306**	**1,292**
	Per cent (excluding *Not known*)				
Procedure	34.4	35.3	42.8	33.7	27.9
Diagnosis	22.8	22.4	22.2	27.5	24.6
Treatment	17.7	18.0	15.8	19.3	21.2
General duty of care	9.9	10.3	7.6	8.2	12.6
Medication-related	3.8	3.6	3.2	4.0	4.8
Anaesthetic	4.0	3.3	3.0	2.7	2.6
Consent	2.7	1.4	0.8	1.7	1.7
Infection control	1.8	2.3	1.7	0.6	1.2
Blood/blood product-related	0.6	0.4	0.8	1.0	0.6
Device failure	0.8	0.9	0.3	0.2	0.6
Other	1.4	2.0	1.7	1.0	2.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 3.3.

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

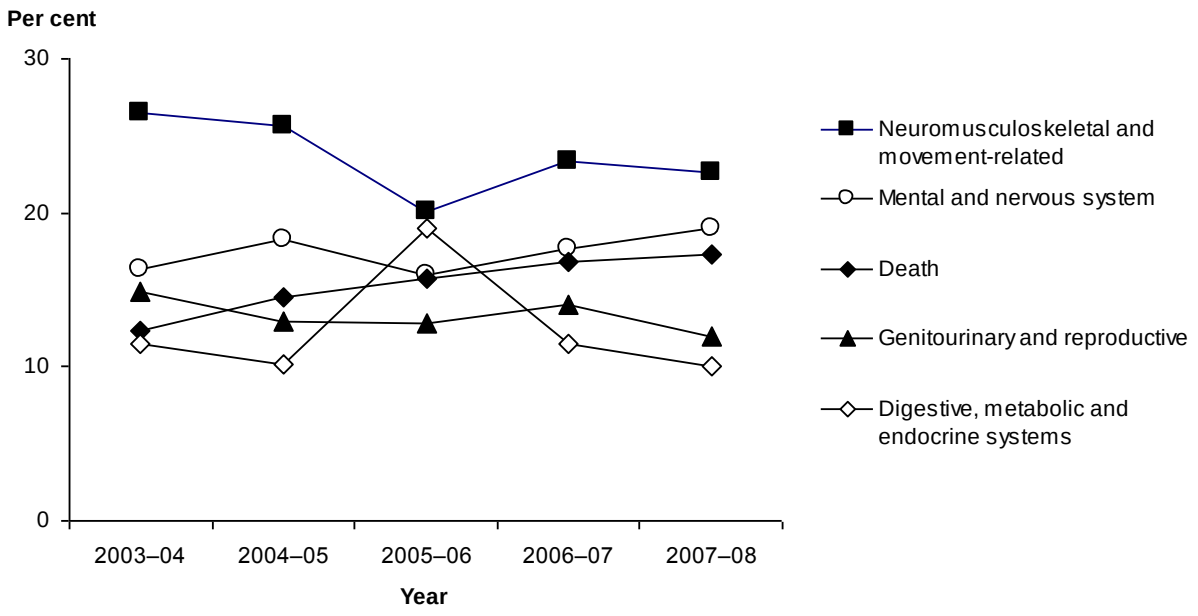

Figure 4.4: New claims: the five most frequently recorded primary body function/structure categories affected, 2003–04 to 2007–08 (per cent)

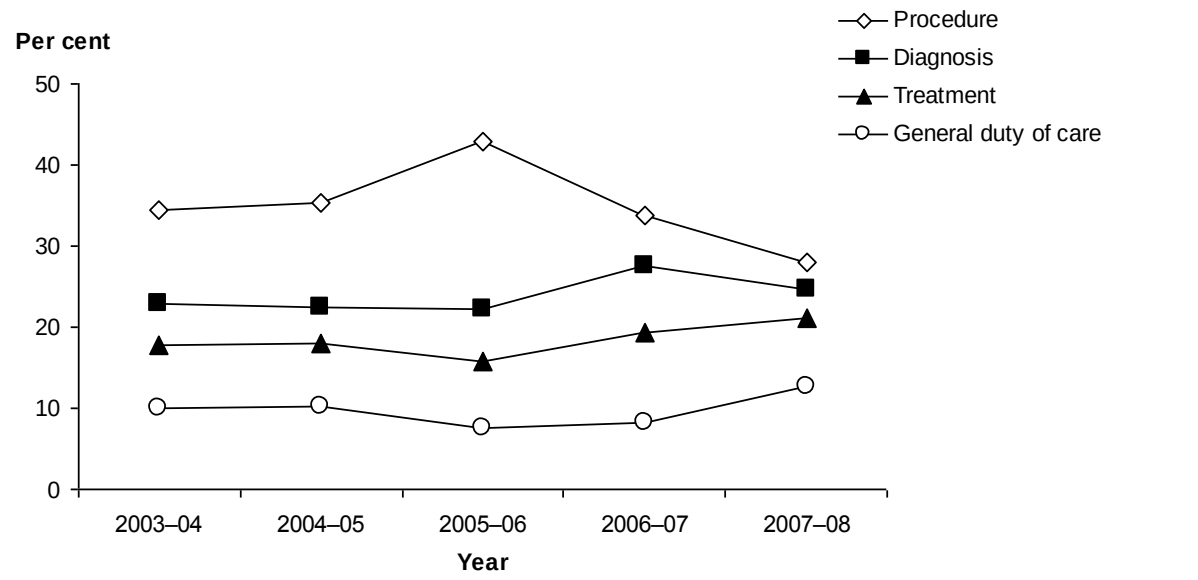

Figure 4.5: New claims: the four most frequently recorded primary incident/allegation types, 2003–04 to 2007–08 (per cent)

4.4 Extent of harm

Extent of harm is analysed with respect to claims closed between 2003–04 and 2007–08, rather than new claims (Table 4.6; Figure 4.6). This is because information on the extent of harm is more complete at the time the claim is closed then when it is new (Table 2.1). One change that is evident for closed claims is a consistent decline in the proportion associated with *Temporary* harm, from 28% in 2003–04 to 22% in 2007–08. It is counterbalanced by an increase in the proportion associated with *Major* harm from 18% to 23% and with *Death* from 12% to 21%.

Table 4.6: Closed claims: extent of harm, 2003–04 to 2007–08

	Year				
Extent of harm	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
Temporary (less than 6 months duration)	316	358	400	519	313
Minor (6 months or more)	402	451	496	666	452
Major (6 months or more)	203	265	299	440	334
Death	138	169	218	305	295
Not applicable	62	40	63	44	31
Not known	470	615	554	267	426
Total	**1,591**	**1,898**	**2,030**	**2,241**	**1,851**
	Per cent (excluding *Not applicable* and *Not known*)				
Temporary (less than 6 months duration)	28.2	27.9	27.1	26.3	22.0
Minor (6 months or more)	35.9	35.2	33.6	33.7	31.7
Major (6 months or more)	18.1	20.7	20.3	22.3	23.4
Death	12.3	13.2	14.8	15.5	20.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

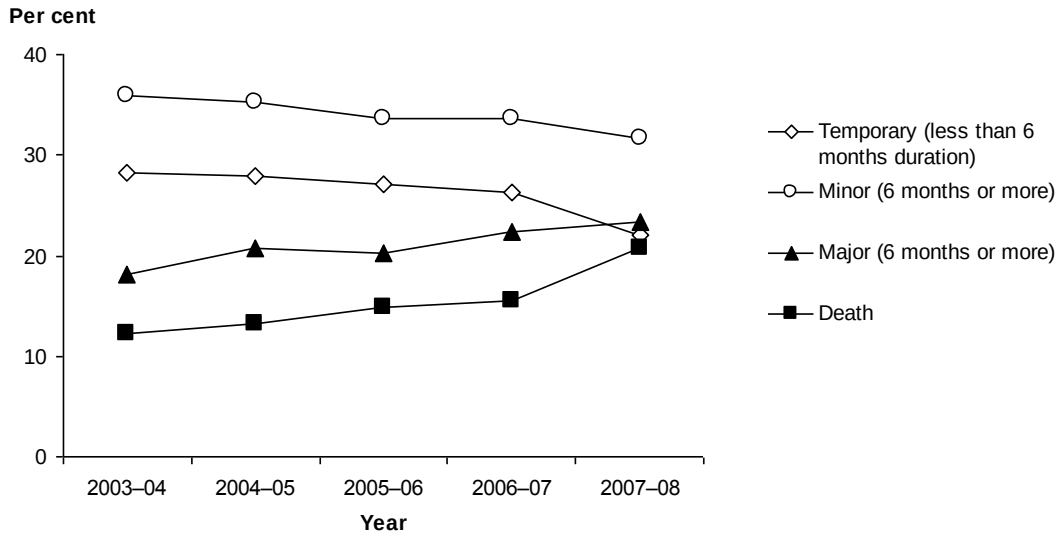

Figure 4.6: Closed claims: extent of harm, 2003–04 to 2007–08 (per cent)

4.5 Mode of settlement and claim size

'Mode of settlement' refers to the mechanism through which a claim is closed, including discontinuation when the claim is withdrawn by the claimant or closed by the claims manager due to operation of the statute of limitations or claim inactivity. Table 4.7 presents data on the mechanisms through which claims were closed between 2003–04 and 2007–08, along with the average length of the claim (between when the reserve was set and the claim was closed). Table 4.8 presents data on the total claim size for closed claims over the same period. Total claim size includes legal and investigative costs as well as any payment made to the claimant(s).

The proportion of claims closed in 2006–07 as a result of being *Discontinued* was relatively low, at 49%, whereas the proportion settled through state/territory-based complaints processes peaked at 9%. This was also the reporting period with the longest average time between when the reserve was set and the claim file was closed, at 31.9 months (Table 4.7). The 2006–07 period additionally witnessed the highest proportions of claims settled for between $10,000 and <$100,000 (28%), $100,000 and <$500,000 (13%), and $500,000 or more (4%). In all other reporting periods, the proportion of claims settled for under $10,000, i.e., including those which incurred no cost, was larger than in 2006–07 (Table 4.8).

If the 2006–07 reporting period were excluded as a special case, there would appear to be little difference over time in the relative proportions of the modes of settlement for closing claims (Figure 4.7). There would however be some suggestion that the proportion of claims closed for the two largest size bands, $100,000–<$500,000 and $500,000 or more, has generally increased between 2003–04 and 2007–08 (Figure 4.8).

Table 4.7: Closed claims: mode of settlement, and average time between dates when reserve placed and claim file closed, 2003–04 to 2007–08

	Year				
Mode of settlement	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
Discontinued	900	1,134	1,178	1,090	1,140
Settled—state/territory-based complaints processes	24	26	41	207	67
Settled—court-based alternative dispute resolution processes	115	164	179	155	87
Settled—statutorily mandated compulsory conference process	19	18	22	29	5
Settled—other	450	456	499	660	476
Court decision	36	52	68	99	66
Not known	47	48	44	1	10
Total	**1,591**	**1,898**	**2,030**	**2,241**	**1,851**
Average time to be closed (months)	*30.3*	*26.2*	*29.0*	*31.9*	*30.7*
	Per cent (excluding *Not known*)				
Discontinued	58.3	61.3	59.3	48.7	61.9
Settled—state/territory-based complaints processes	1.6	1.4	2.1	9.2	3.6
Settled—court-based alternative dispute resolution processes	7.4	8.9	9.0	6.9	4.7
Settled—statutorily mandated compulsory conference process	1.2	1.0	1.1	1.3	0.3
Settled—other	29.1	24.6	25.1	29.5	25.9
Court decision	2.3	2.8	3.4	4.4	3.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

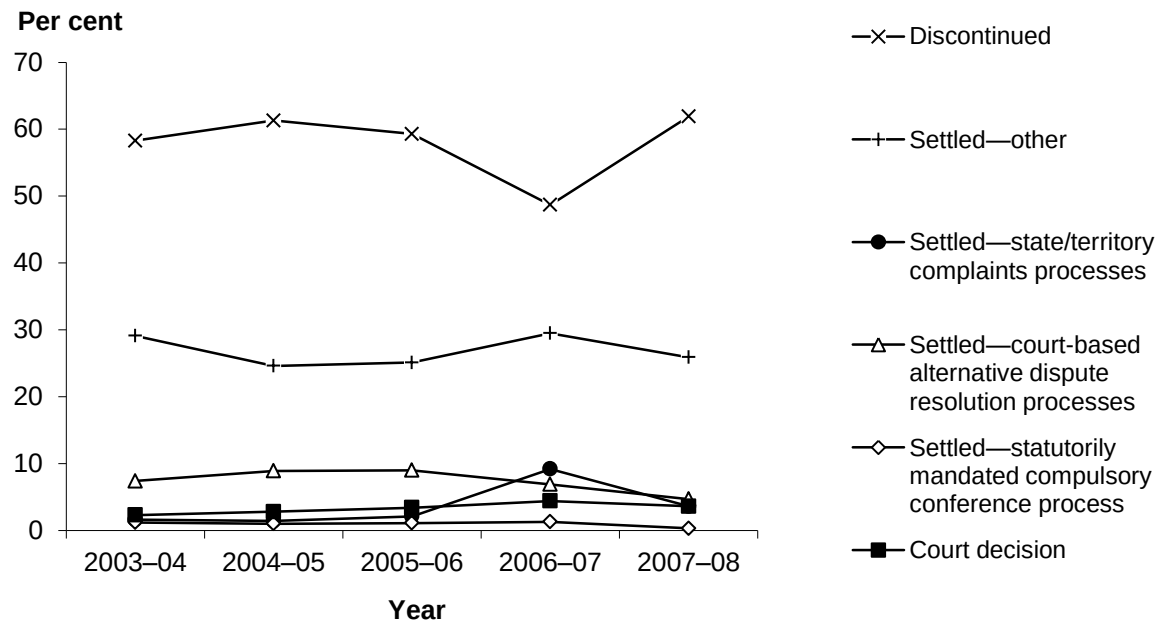

Figure 4.7: Closed claims: mode of settlement, 2003–04 to 2007–08 (per cent)

Table 4.8: Closed claims: total claim size ($), 2003–04 to 2007–08

	Year				
Claim size	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**
Nil	371	494	703	612	712
1–<10,000	645	755	629	613	523
10,000–<30,000	204	203	205	316	160
30,000–<50,000	88	101	94	134	77
50,000–<100,000	125	160	116	185	126
100,000–<250,000	88	101	155	212	132
250,000–<500,000	24	46	45	81	55
500,000 or more	30	23	59	88	59
Not known	16	15	24	0	7
Total	**1,589**	**1,898**	**2,030**	**2,242**	**1,851**
	Per cent (excluding *Not known*)				
Nil	23.5	26.1	35.0	27.3	38.6
1–<10,000	41.0	40.2	31.4	27.4	28.4
10,000–<100,000	26.5	24.7	20.7	28.3	19.7
100,000–<500,000	7.1	7.8	10.0	13.1	10.1
500,000 or more	1.9	1.2	2.9	3.9	3.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

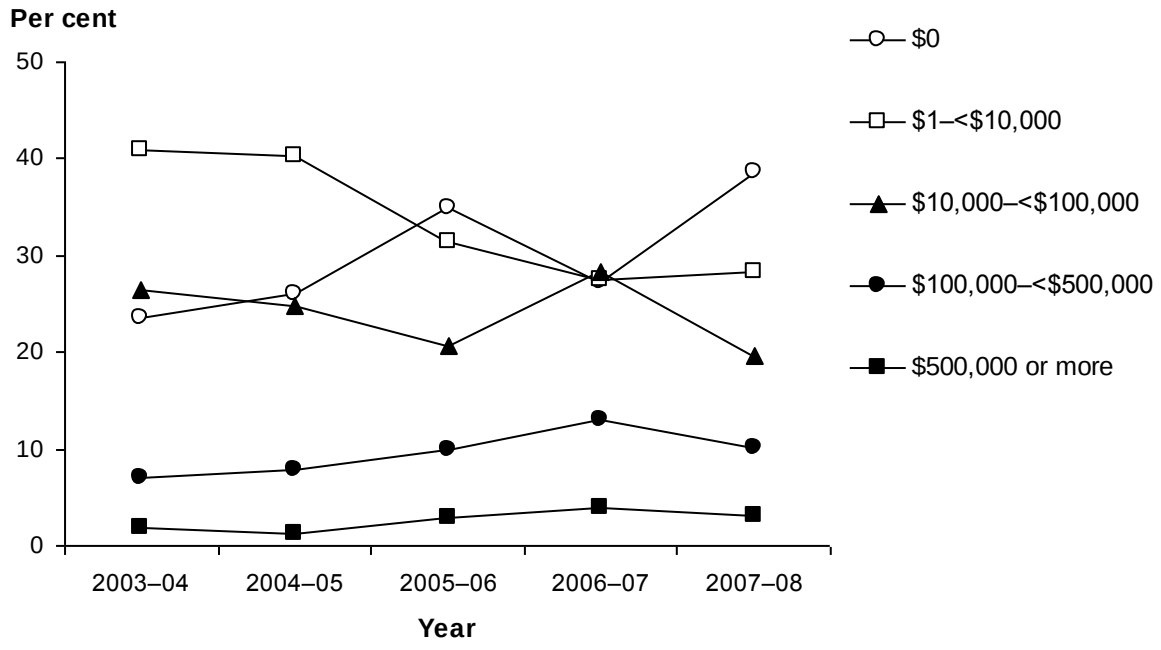

Figure 4.8: Closed claims: total claim size, 2003–04 to 2007–08

5 Public sector medical indemnity claims closed between 2003–04 and 2007–08

This chapter contains a profile of the 9,513 claims that were closed during the period 2003–04 (July 2003 to June 2004) and 2007–08 (July 2007 to June 2008) and remained closed (not reopened) at 30 June 2008. Information is presented on the health care incidents that allegedly led to the claims, the people involved (both the health service providers and claim subject) and claim details (including mode of settlement, duration and financial information).

5.1 Alleged health care incidents leading to claims

This section summarises the records on health care incidents that led to claims. It presents information on claims in terms of the nature of the health service provision ('clinical service context'), what is alleged to have transpired ('primary incident/allegation type'), the setting of the alleged incident ('health service setting') and the professionals principally involved ('principal clinician specialty'). Information on where the alleged incidents occurred ('geographical region'), patient admission status ('claim subject status') and the nature of alleged harm ('primary body function/structure affected') is also included.

Clinical service context

'Clinical service context' categorises the area of clinical practice or hospital department in which the alleged health care incident occurred. The ten most common clinical service contexts accounting for approximately 75% of all claims closed between 2003–04 and 2007–08 are presented in Table 5.1. The three most frequently recorded clinical service contexts were *General surgery* (16%), *Obstetrics* (15%) and *Accident and Emergency* (14%). The seven other clinical service contexts listed in Table 5.1 were recorded for between 2% and 8% of claims.

Primary incident/allegation type

'Primary incident/allegation type' describes the area of possible error, negligence or problem of primary importance in giving rise to the claim. During the period between 2003–04 and 2007–08, claims were frequently related to *Procedure*, accounting for 36% of all closed claims, followed by *Diagnosis* (20%) and *Treatment* (16%). *General duty of care* (9%) was another common primary incident/allegation type, whereas the other six categories were each recorded for less than 4% of claims (Table 5.1).

The clinical service context of the provided health service had a considerable bearing on the primary incident or allegation recorded for a medical claim, as shown in Table 5.2 (which excludes claims *Not known* for either data item). Over half the claims that arose in four clinical service contexts had an incident/allegation relating to a *Procedure*: *Gynaecology* (70%), *General surgery* (60%), *Obstetrics* (54%) and *Orthopaedics* (52%). However, *Procedure* was rarely recorded for claims associated with the clinical service contexts of *Accident and Emergency*, *General medicine* and *Psychiatry*.

Diagnosis was the main primary incident/allegation for *Accident and Emergency*-related claims (56%), and was also common within *General practice* (33%) and *Paediatrics* (28%).

Incidents allegedly involving issues of *General duty of care* accounted for around half (50%) of claims with a *Psychiatry* clinical service context, and nearly one-third of claims related to *General medicine* (31%). *Medication-related* featured as the primary incident/allegation type for a larger proportion of claims in *General practice* (14%) and *General medicine* (12%) than other clinical service contexts.

Table 5.1: Closed claims, 2003–04 to 2007–08: clinical service context, by primary incident/allegation type

	Primary incident/allegation type												
Clinical service context	**Procedure[(a)]**	**Diagnosis**	**Treatment[(b)]**	**General duty of care**	**Medication-related[(c)]**	**Anaesthetic**	**Consent[(d)]**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**	**Per cent**
General surgery	910	181	129	35	43	128	34	37	9	14	7	1,540	16.2
Obstetrics	757	193	254	56	26	45	17	18	9	2	21	1,446	15.2
Accident and emergency	63	756	343	92	43	3	6	17	6	2	15	1,371	14.4
Gynaecology	492	56	35	25	9	24	41	6	1	12	4	723	7.6
Orthopaedics	339	106	83	35	10	16	19	31	0	13	3	661	6.9
General medicine	18	94	109	150	59	6	4	15	12	5	6	491	5.2
Psychiatry	6	46	93	203	24	2	3	0	3	0	27	418	4.4
General practice	41	76	30	32	32	6	2	3	2	0	5	236	2.5
Cardiology	87	37	33	13	13	7	7	4	4	5	1	212	2.2
Paediatrics	52	58	39	17	17	5	4	1	3	3	9	211	2.2
All other clinical service contexts	597	325	311	208	63	67	102	55	102	22	55	1,942	20.4
Total	**3,386**	**1,945**	**1,471**	**884**	**354**	**313**	**241**	**191**	**153**	**79**	**159**	**9,513**	**100.0**
Per cent	*35.6*	*20.4*	*15.5*	*9.3*	*3.7*	*3.3*	*2.5*	*2.0*	*1.6*	*0.8*	*1.7*	*100.0*	*. .*

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

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

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

(d) *Consent* includes failure to warn.

Notes

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

2. There were 337 claims coded *Not known* for 'primary incident/allegation type' and 262 for 'clinical service context', including 157 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the numbers are included in the totals.

Table 5.2: Closed claims, 2003–04 to 2007–08: clinical service context, by primary incident/allegation type (excluding *Not known*) (per cent)

	Primary incident/allegation type											
Clinical service context	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Anaesthetic**	**Consent**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
General surgery	59.6	11.9	8.4	2.3	2.8	8.4	2.2	2.4	0.6	0.9	0.5	100.0
Obstetrics	54.1	13.8	18.2	4.0	1.9	3.2	1.2	1.3	0.6	0.1	1.5	100.0
Accident and emergency	4.7	56.2	25.5	6.8	3.2	0.2	0.4	1.3	0.4	0.1	1.1	100.0
Gynaecology	69.8	7.9	5.0	3.5	1.3	3.4	5.8	0.9	0.1	1.7	0.6	100.0
Orthopaedics	51.8	16.2	12.7	5.3	1.5	2.4	2.9	4.7	0.0	2.0	0.5	100.0
General medicine	3.8	19.7	22.8	31.4	12.3	1.3	0.8	3.1	2.5	1.0	1.3	100.0
Psychiatry	1.5	11.3	22.9	49.9	5.9	0.5	0.7	0.0	0.7	0.0	6.6	100.0
General practice	17.9	33.2	13.1	14.0	14.0	2.6	0.9	1.3	0.9	0.0	2.2	100.0
Cardiology	41.2	17.5	15.6	6.2	6.2	3.3	3.3	1.9	1.9	2.4	0.5	100.0
Paediatrics	25.0	27.9	18.8	8.2	8.2	2.4	1.9	0.5	1.4	1.4	4.3	100.0
All other clinical service contexts	31.3	17.0	16.3	10.9	3.3	3.5	5.3	2.9	5.3	1.2	2.9	100.0
Total	**37.1**	**21.3**	**16.1**	**9.5**	**3.7**	**3.4**	**2.6**	**2.1**	**1.7**	**0.9**	**1.7**	**100.0**

Notes

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

2. The 337 claims coded *Not known* for 'primary incident/allegation type' and 262 claims coded *Not known* for 'clinical service context', including 157 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 9,071.

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

Principal clinician specialty

'Specialty of principal clinician closely involved in incident' indicates the specialty of the health care provider who allegedly played the most prominent role in the events that gave rise to a claim. The three most commonly recorded principal clinician specialties for closed claims in 2003–04 to 2007–08 (tables 5.3 and 5.4) were *Emergency medicine* (12%), *General surgery* (11%) and *Obstetrics only* (10%). These specialties are related to the three most often recorded clinical service contexts (*Accident and Emergency*, *General surgery* and *Obstetrics*). Ten further principal clinical specialties were recorded for 2% to 7% of claims. These specialties either relate to the clinical service contexts recorded for 2–8% of claims (for example, *Orthopaedic surgery* and *Gynaecology only*) or else are specialties which are practised across numerous clinical service contexts (for example, *General nursing* and *Anaesthetics*).

The great majority of the clinical specialties were recorded for less than 1.5% of the claims closed over the 5 years leading up to and including 2007–08 (Table 5.3). Three specialties were not nominated as the principal clinician specialty in any claim, and ten others were recorded fewer than ten times.

Table 5.3 further relates principal clinician specialty data to the 'health service setting' in which the alleged health care incident giving rise to the claim occurred. The great majority of claims (93%) resulted from alleged incidents in public hospitals (including public psychiatric hospitals) or day surgeries and therefore this was also the most frequently recorded health service setting for the majority of clinical specialties. Three exceptions were:

- Claims citing the specialty of *Clinical haematology*, of which 74% related to incidents that allegedly occurred in public health settings other than a hospital/day surgery (accounting for 31% of claims in this setting)
- Claims involving *Paramedical and ambulance* staff, most of which related to incidents either in a public health setting other than a hospital/day surgery (42%) or in an *Other* setting, such as a patient's home (30%)
- Claims citing the specialties of procedural and non-procedural *General practice*, of which 12% and 33% respectively related to incidents in a *Private health setting* (together accounting for 65% of private health setting claims).

Specific incident/allegation types tended to be associated with particular clinical specialties, in ways that are generally similar to the previously noted associations between primary incident/allegation type and clinical service context. Over half of the claims whose recorded specialty was *Gynaecology only* (73%), *General surgery* (70%), *Obstetrics only* (65%), *Obstetrics and gynaecology* (56%) or *Orthopaedic surgery* (54%) had *Procedure* as their incident/allegation type (Table 5.5). The primary incident/allegation type *Diagnosis* was recorded for more than half of the claims whose principal clinician specialty was *Diagnostic radiology* (68%) or *Emergency medicine* (59%). *General duty of care* was recorded more often than not as the incident/allegation type in the case of claims with a clinician specialty of *General nursing* (56%) or *Psychiatry* (55%). Another feature of Table 5.5 is that *Anaesthetics* was the primary incident/allegation type recorded for over two-thirds of claims (70%) where it was also the principal clinician specialty.

Table 5.3: Closed claims, 2003–04 to 2007–08: principal clinician specialty, by health service setting

Principal clinician specialty	Health service setting				Total	Per cent
	Public hospital/ day surgery[(a)]	Other public setting[(b)]	Private setting[(c)]	Other[(d)]		
Emergency medicine	1,076	9	5	0	1,090	11.5
General surgery	1,037	3	4	1	1,046	11.0
Obstetrics only	881	2	9	0	900	9.5
Orthopaedic surgery	630	2	3	0	639	6.7
Gynaecology only	539	1	1	7	550	5.8
Nursing—general	360	23	8	2	396	4.2
Psychiatry	325	12	0	9	348	3.7
Obstetrics and gynaecology	345	2	1	2	351	3.7
Anaesthetics—general	298	1	3	1	305	3.2
General practice—non-procedural	157	12	89	3	270	2.8
General practice—procedural	171	5	23	0	199	2.1
General and internal medicine	185	3	1	2	191	2.0
Diagnostic radiology	161	10	1	0	173	1.8
Cardiology	134	0	0	0	134	1.4
Pathology	116	16	0	0	132	1.4
Urology	124	0	1	0	125	1.3
Clinical haematology	32	90	0	0	122	1.3
Ear, nose and throat	113	0	1	0	114	1.2
Neurosurgery	113	0	3	0	116	1.2
Ophthalmology	114	0	1	0	115	1.2
Dentistry—oral surgery	96	13	1	0	110	1.2
Plastic surgery	102	0	1	0	103	1.1
Midwifery	99	0	0	0	99	1.0
Paediatric medicine	94	1	2	0	98	1.0
Neonatology	78	0	0	0	78	0.8
Intensive care	76	0	0	0	76	0.8
Cardio-thoracic surgery	71	0	0	0	71	0.7
Gastroenterology	65	1	0	1	67	0.7
Dentistry—procedural	64	11	0	0	75	0.8
Colorectal surgery	64	0	2	0	66	0.7
Anaesthetics—intensive care	57	0	0	0	59	0.6
Vascular surgery	57	0	0	0	57	0.6
Paediatric surgery	54	0	0	0	55	0.6
Medical oncology	49	0	0	0	49	0.5
Nursing—nurse practitioner	41	3	0	1	45	0.5
Neurology	43	0	0	1	44	0.5
Paramedical and ambulance	12	18	0	13	43	0.5

(continued)

Table 5.3 (continued): Closed claims, 2003–04 to 2007–08: principal clinician specialty, by health service setting

Principal clinician specialty	Health service setting				Total	Per cent
	Public hospital/ day surgery[(a)]	Other public setting[(b)]	Private setting[(c)]	Other[(d)]		
Nuclear medicine	23	0	0	0	26	0.3
Clinical immunology	23	0	1	0	24	0.3
Physiotherapy	20	3	0	0	23	0.2
Respiratory medicine	21	0	0	0	21	0.2
Renal medicine	19	1	0	0	20	0.2
Infectious diseases	18	1	0	0	19	0.2
Endocrinology	16	1	0	0	17	0.2
Therapeutic radiology	15	0	0	0	15	0.2
Cosmetic surgery	14	0	0	0	14	0.1
Rehabilitation medicine	13	0	0	1	14	0.1
Facio-maxillary surgery	14	0	0	0	14	0.1
Geriatrics	9	4	0	0	13	0.1
Endoscopy	12	0	0	0	12	0.1
Podiatry	6	6	0	0	12	0.1
Public health—preventative medicine	5	5	0	0	10	0.1
Dermatology	9	0	0	0	9	0.1
Clinical genetics	3	4	2	0	9	0.1
Psychology	5	3	1	0	9	0.1
Spinal surgery	7	0	0	0	7	0.1
Pharmacy	5	1	0	0	6	0.1
Thoracic medicine	6	0	0	0	6	0.1
Rheumatology	3	0	0	0	3	<0.1
Clinical pharmacology	2	0	0	0	2	<0.1
Occupational medicine	1	0	0	0	1	<0.1
Chiropractics	0	0	1	0	1	<0.1
Nutrition/dietician	0	0	0	0	0	0.0
Osteopathy	0	0	0	0	0	0.0
Sports medicine	0	0	0	0	0	0.0
Other allied health	35	14	0	3	52	0.5
Other hospital-based practitioners	295	3	1	0	306	3.2
Not applicable[(e)]	59	5	1	6	71	0.7
Total	**8,841**	**294**	**171**	**55**	**9,513**	**100.0**
Per cent	*92.9*	*3.1*	*1.8*	*0.6*	*100.0*	*. .*

(a) Includes public psychiatric hospitals.

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

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

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

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

Note: There were 266 claims coded *Not known* for 'principal clinician specialty' and 152 for 'health service setting', including 105 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the numbers are included in the totals.

Table 5.4: Closed claims, 2003–04 to 2007–08: principal clinician specialty, by primary incident/allegation type

	Primary incident/allegation type												
Principal clinician specialty	**Procedure[a]**	**Diagnosis**	**Treatment[b]**	**General duty of care**	**Medication-related[c]**	**Anaesthetic**	**Consent[d]**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**	**Per cent**
Emergency medicine	41	634	267	56	29	4	5	14	3	1	14	1,090	11.5
General surgery	728	133	74	17	16	10	23	24	1	10	2	1,046	11.0
Obstetrics only	564	88	145	21	9	5	8	12	3	0	10	900	9.5
Orthopaedic surgery	340	117	88	13	11	2	18	26	0	14	3	639	6.7
Gynaecology only	387	44	25	17	6	1	35	2	0	11	2	550	5.8
General nursing	18	21	73	221	26	2	3	12	3	6	10	396	4.2
Anaesthetics[e]	36	15	23	9	14	251	7	1	1	1	2	364	3.8
Obstetrics and gynaecology	192	47	62	13	2	2	11	4	2	2	5	351	3.7
Psychiatry	3	35	76	184	23	0	1	0	1	0	14	348	3.7
General practice—non-procedural	33	92	51	32	31	6	2	4	4	1	7	270	2.8
Cardiology/cardio-thoracic surgery[f]	94	40	25	11	11	2	7	4	3	6	1	205	2.2
General practice—procedural	88	56	34	3	9	3	2	0	1	0	1	199	2.1
General and internal medicine	12	49	44	25	32	0	1	6	4	3	2	191	2.0
Diagnostic radiology	13	117	25	13	0	0	1	0	0	3	1	173	1.8

(continued)

Table 5.4 (continued): Closed claims, 2003–04 to 2007–08: principal clinician specialty by primary incident/allegation type

	Primary incident/allegation type												
Principal clinician specialty	**Procedure[a]**	**Diagnosis**	**Treatment[b]**	**General duty of care**	**Medication-related[c]**	**Anaesthetic**	**Consent[d]**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**	**Per cent**
All other specialties	803	434	427	217	125	22	114	68	126	20	57	2,454	25.8
Not applicable	4	2	7	16	2	2	0	12	0	1	23	71	0.8
Total	**3,386**	**1,945**	**1,471**	**884**	**354**	**313**	**241**	**191**	**153**	**79**	**159**	**9,513**	**100.0**
Per cent	*35.6*	*20.4*	*15.5*	*9.3*	*3.7*	*3.3*	*2.5*	*2.0*	*1.6*	*0.8*	*1.7*	*100.0*	*. .*

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

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

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

(d) *Consent* includes failure to warn.

(e) *Anaesthetics* combines *Anaesthetics—general* and *Anaesthetics—intensive care*.

(f) Combines the principal clinician specialties *Cardiology* and *Cardio-thoracic surgery*.

Notes

1. The principal clinician specialties presented in this table are the 14 most frequently recorded (including two combined specialties). All other categories (see Table 5.3) are included under *All other specialties*.

2. There were 337 claims coded *Not known* for 'primary incident/allegation type' and 266 claims coded *Not known* for 'principal clinician specialty', including 154 coded *Not known* for both. The *Not known* row and column are not presented in the table; however, the figures are included in the totals.

Table 5.5: Closed claims, 2003–04 to 2007–08: principal clinician specialty, by primary incident/allegation type (excluding *Not applicable* and *Not known*) (per cent)

	Primary incident/allegation type											
Principal clinician specialty	**Procedure**	**Diagnosis**	**Treatment**	**General duty of care**	**Medication-related**	**Anaesthetic**	**Consent**	**Infection control**	**Blood/blood product-related**	**Device failure**	**Other**	**Total**
Emergency medicine	3.8	59.3	25.0	5.2	2.7	0.4	0.5	1.3	0.3	0.1	1.3	100.0
General surgery	70.1	12.8	7.1	1.6	1.5	1.0	2.2	2.3	0.1	1.0	0.2	100.0
Obstetrics only	65.2	10.2	16.8	2.4	1.0	0.6	0.9	1.4	0.3	0.0	1.2	100.0
Orthopaedic surgery	53.8	18.5	13.9	2.2	1.7	0.3	2.8	4.1	0.0	2.2	0.5	100.0
Gynaecology only	73.0	8.3	4.7	3.2	1.1	0.2	6.6	0.4	0.0	2.1	0.4	100.0
General nursing	4.6	5.3	18.5	55.9	6.6	0.5	0.8	3.0	0.8	1.5	2.5	100.0
Anaesthetics	10.0	4.2	6.4	2.5	3.9	69.7	1.9	0.3	0.3	0.3	0.6	100.0
Obstetrics and gynaecology	56.1	13.7	18.1	3.8	0.6	0.6	3.2	1.2	0.6	0.6	1.5	100.0
Psychiatry	0.9	10.4	22.6	54.6	6.8	0.0	0.3	0.0	0.3	0.0	4.2	100.0
General practice—non-procedural	12.5	35.0	19.4	12.2	11.8	2.3	0.8	1.5	1.5	0.4	2.7	100.0
Cardiology/cardio-thoracic surgery	46.1	19.6	12.3	5.4	5.4	1.0	3.4	2.0	1.5	2.9	0.5	100.0
General practice—procedural	44.7	28.4	17.3	1.5	4.6	1.5	1.0	0.0	0.5	0.0	0.5	100.0
General and internal medicine	6.7	27.5	24.7	14.0	18.0	0.0	0.6	3.4	2.2	1.7	1.1	100.0
Diagnostic radiology	7.5	67.6	14.5	7.5	0.0	0.0	0.6	0.0	0.0	1.7	0.6	100.0
All other specialties	33.3	18.0	17.7	9.0	5.2	0.9	4.7	2.8	5.2	0.8	2.4	100.0
Total	**37.3**	**21.4**	**16.0**	**9.5**	**3.8**	**3.4**	**2.6**	**2.0**	**1.7**	**0.9**	**1.5**	**100.0**

Notes

1. The principal clinician specialties presented in this table are the 14 most frequently recorded (including two combined specialties). All other categories (see Table 5.3) are included under *All other specialties*.
2. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 5.4.
3. The 337 claims coded *Not applicable* or *Not known* for 'principal clinician specialty' and 337 claims coded *Not known* for 'primary incident/allegation type', including 156 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 8,995.
4. Percentages may not add up exactly to 100.0 due to rounding.

Primary body function/structure affected

'Primary body function/structure affected' specifies the main body function or structure of the claim subject allegedly affected by a health care incident. *Death* is recorded for this data item if the claim subject died, while allowance is also made for claims not alleged to involve any body function/structure.

During the period from 2003–04 to 2007–08 the most frequently affected body function/structure recorded for closed claims was *Neuromusculoskeletal and movement-related* which accounted for 22% of all closed claims (Table 5.6). Between 11% and 15% of claims were associated with the body function/structure categories *Mental and nervous system*, *Genitourinary and reproductive* and *Digestive, metabolic and endocrine systems*. *Death* was recorded for 12% of claims.

Orthopaedics claims, and to a lesser degree *Accident and Emergency* claims, had a strong association with *Neuromusculoskeletal and movement-related* effects. This was the body function/structure category recorded for 83% of *Orthopaedics* claims and 40% of *Accident and Emergency* claims, compared with 24% of claims overall (Table 5.7). *Obstetrics* and *Psychiatry* claims, however, were more closely associated with effects on the *Mental and nervous system*, involving more than one-third of the claims for these two clinical service contexts (*Obstetrics* 38%, *Psychiatry* 36%, compared with 16% of claims overall). *Genitourinary and reproductive* effects were strongly related to *Gynaecology* and *Obstetrics* claims (*Gynaecology* 60%, *Obstetrics* 31%, compared with 15% of claims overall). *General surgery* claims were quite strongly linked to *Digestive, metabolic and endocrine systems* effects (39% of *General surgery* claims were recorded in this body function/structure category, compared with 12% of claims overall).

An outcome involving the claim subject's death was more commonly a feature of claims in the clinical service contexts of *Psychiatry* (38%), *Cardiology* (30%) and *General medicine* (26%) than other clinical service contexts.

Table 5.6: Closed claims, 2003–04 to 2007–08: clinical service context, by primary body function/structure affected

	Primary body function/structure affected												
Clinical service context	**Neuromusculo-skeletal and movement-related**	**Mental and nervous system**	**Genitourinary and reproductive**	**Digestive, metabolic and endocrine systems**	**Cardiovascular, haematological, immunological and respiratory**	**Skin and related structures**	**Sensory, including eye and ear**	**Voice and speech**	**Death**	**No body function/ structure affected**	**Not known**	**Total**	**Per cent**
General surgery	199	97	138	591	121	105	32	39	165	16	37	1,540	16.2
Obstetrics	168	482	392	29	45	32	14	2	91	26	165	1,446	15.2
Accident and emergency	512	172	76	86	105	43	40	8	233	9	87	1,371	14.4
Gynaecology	20	52	424	75	16	19	0	1	18	78	20	723	7.6
Orthopaedics	539	30	2	8	26	19	0	3	17	2	15	661	6.9
General medicine	126	65	13	38	57	35	10	0	124	9	14	491	5.2
Psychiatry	42	137	8	5	6	10	1	0	144	28	37	418	4.4
General practice	46	37	15	21	17	21	7	5	32	10	25	236	2.5
Cardiology	24	24	4	6	71	6	3	2	61	2	9	212	2.2
Paediatrics	39	46	14	22	21	9	5	2	40	4	9	211	2.2
All other clinical service contexts	347	240	210	187	177	124	174	90	163	38	192	1,942	20.4
Not known	25	9	10	14	9	4	1	3	26	2	159	262	2.8
Total	**2,087**	**1,391**	**1,306**	**1,082**	**671**	**427**	**287**	**155**	**1,114**	**224**	**769**	**9,513**	**100.0**
Per cent	*21.9*	*14.6*	*13.7*	*11.4*	*7.1*	*4.5*	*3.0*	*1.6*	*11.7*	*2.4*	*8.1*	*100.0*	*. .*

Notes

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

2. The 'clinical service context' categories listed separately here are the 10 most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

Table 5.7: Closed claims, 2003–04 to 2007–08: clinical service context, by primary body function/structure affected (excluding *Not known*) (per cent)

	Primary body function/structure affected										
Clinical service context	**Neuromusculo-skeletal and movement-related**	**Mental and nervous system**	**Genitourinary and reproductive**	**Digestive, metabolic and endocrine systems**	**Cardiovascular, haematological, immunological and respiratory**	**Skin and related structures**	**Sensory, including eye and ear**	**Voice and speech**	**Death**	**No body function/ structure affected**	**Total**
General surgery	13.2	6.5	9.2	39.3	8.1	7.0	2.1	2.6	11.0	1.1	100.0
Obstetrics	13.1	37.6	30.6	2.3	3.5	2.5	1.1	0.2	7.1	2.0	100.0
Accident and emergency	39.9	13.4	5.9	6.7	8.2	3.3	3.1	0.6	18.1	0.7	100.0
Gynaecology	2.8	7.4	60.3	10.7	2.3	2.7	0.0	0.1	2.6	11.1	100.0
Orthopaedics	83.4	4.6	0.3	1.2	4.0	2.9	0.0	0.5	2.6	0.3	100.0
General medicine	26.4	13.6	2.7	8.0	11.9	7.3	2.1	0.0	26.0	1.9	100.0
Psychiatry	11.0	36.0	2.1	1.3	1.6	2.6	0.3	0.0	37.8	7.3	100.0
General practice	21.8	17.5	7.1	10.0	8.1	10.0	3.3	2.4	15.2	4.7	100.0
Cardiology	11.8	11.8	2.0	3.0	35.0	3.0	1.5	1.0	30.0	1.0	100.0
Paediatrics	19.3	22.8	6.9	10.9	10.4	4.5	2.5	1.0	19.8	2.0	100.0
All other clinical service contexts	19.8	13.7	12.0	10.7	10.1	7.1	9.9	5.1	9.3	2.2	100.0
Total	**23.9**	**16.0**	**15.0**	**12.4**	**7.7**	**4.9**	**3.3**	**1.8**	**12.6**	**2.6**	**100.0**

Notes

1. The ‘clinical service context’ categories listed separately here are the 10 most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.

2. The 262 claims coded *Not known* for ‘clinical service context’ and 769 claims coded *Not known* for ‘primary body function/structure affected’, including 159 coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 8,641.

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

Claim subject patient admission status

'Claim subject status' indicates whether the status of the claim subject, at the time of the alleged health care incident, was a public or private admitted hospital patient, or a resident in a residential health care setting, or *Other*. The category *Other* includes claim subjects attending an outpatient clinic, a general practice surgery, an Accident and Emergency department, or other non-admitted, non-residential service.

Approximately two-thirds (68%) of the claim subjects in a medical indemnity claim closed between 2003–04 and 2007–08 were public admitted patients and 362 (4%) were private admitted patients (Table 5.8). With the claim subjects who were not admitted patients and whose status was known, the majority belonged to the *Other* category (15%).

Patients admitted to a public hospital can elect to be treated as either a public or a private patient. *Public hospital/day surgery* was the 'health service setting' recorded for almost all claims (99.8%) involving public admitted patients and most claims (90%) involving private admitted patients. The other health service setting recorded for public and private hospital patients was *Private hospital/day surgery*.

Table 5.8: Closed claims, 2003–04 to 2007–08: health service setting, by claim subject status

Health service setting	Public admitted hospital patient	Private admitted hospital patient	Resident	Other	Not known	Total	Per cent
Public hospital/ day surgery[(a)]	6,418	326	0	988	1,109	8,841	92.9
Other public setting[(b)]	0	0	18	257	19	294	3.1
Private hospital/day surgery	10	36	0	7	4	47	0.6
Other private setting[(c)]	0	0	1	111	2	114	1.2
Other[(d)]	0	0	0	52	3	55	0.6
Not known	0	0	0	3	149	152	1.6
Total	**6,428**	**362**	**19**	**1,418**	**1,286**	**9,513**	**100.0**
Per cent	*67.6*	*3.8*	*0.2*	*14.9*	*13.5*	*100.0*	*. .*
		Per cent (excluding *Not known*)					
Public hospital/day surgery[(a)]	99.8	90.1	0.0	69.8	. .	94.0	. .
Other public setting[(b)]	0.0	0.0	94.7	18.2	. .	3.3	. .
Private hospital/day surgery	0.2	9.9	0.0	0.5	. .	0.7	. .
Other private setting[(c)]	0.0	0.0	5.3	7.8	. .	1.4	. .
Other[(d)]	0.0	0.0	0.0	3.7	. .	0.6	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

(a) Includes public psychiatric hospitals.

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

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

(d) Includes patient's home and Medihotels.

Note: The 152 claims coded *Not known* for 'health service setting' and 1,286 coded *Not known* for 'claim subject status', including 149 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented here are based is 8,224.

Other public setting was the health service setting for most claims (95%) with a subject who was a resident, while *Public hospital/day surgery* was the health service setting for most claims (70%) where the status of the subject was *Other* (Table 5.8). In the case of claims with known 'claim subject status' and 'clinical service context', almost half (48%) of those involving *Other* claim subjects had an *Accident and Emergency* clinical service context (Table 5.9).

Table 5.9: Closed claims, 2003–04 to 2007–08: clinical service context, by claim subject status

Clinical service context	Public admitted hospital patient	Private admitted hospital patient	Resident	Other	Not known	Total	Per cent
General surgery	1,235	48	0	24	233	1,540	16.2
Obstetrics	1,148	65	0	21	212	1,446	15.2
Accident and emergency	571	49	0	675	76	1,371	14.4
Gynaecology	578	15	0	19	111	723	7.6
Orthopaedics	551	32	0	12	66	661	6.9
General medicine	316	27	1	29	118	491	5.2
Psychiatry	284	16	0	80	38	418	4.4
General practice	106	12	2	104	12	236	2.5
Cardiology	163	13	0	7	29	212	2.2
Paediatrics	157	10	0	9	35	211	2.2
All other clinical service contexts	1,219	68	16	433	206	1,942	20.4
Not known	100	7	0	5	150	262	2.8
Total	**6,428**	**362**	**19**	**1,418**	**1,286**	**9,513**	**100.0**
		Per cent (excluding *Not known*)					
General surgery	19.5	13.5	0.0	1.7	. .	16.1	. .
Obstetrics	18.1	18.3	0.0	1.5	. .	15.2	. .
Accident and emergency	9.0	13.8	0.0	47.8	. .	16.0	. .
Gynaecology	9.1	4.2	0.0	1.3	. .	7.5	. .
Orthopaedics	8.7	9.0	0.0	0.8	. .	7.3	. .
General medicine	5.0	7.6	5.3	2.1	. .	4.6	. .
Psychiatry	4.5	4.5	0.0	5.7	. .	4.7	. .
General practice	1.7	3.4	10.5	7.4	. .	2.8	. .
Cardiology	2.6	3.7	0.0	0.5	. .	2.3	. .
Paediatrics	2.5	2.8	0.0	0.6	. .	2.2	. .
All other clinical service contexts	19.3	19.2	84.2	30.6	. .	21.4	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

Notes

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

2. The 262 claims coded *Not known* for 'clinical service context' and 1,286 coded *Not known* for 'claim subject status', including 150 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented here are based is 8,115.

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

Geographic location

The Australian Standard Geographical Classification Remoteness Structure is used to categorise the 'geographic location' of where an alleged health care incident occurred. A total of 6,227 (66%) of the claims closed between 2003–04 and 2007–08 arose from incidents occurring in *Major cities*. The corresponding figure for *Inner regional* areas was 2,425 claims (26%). Another 7% of claims arose in *Outer regional* areas and 1% in *Remote and very remote* areas (Table 5.10).

The principal clinician speciality recorded for a claim varied to some degree according to geographic location. *Emergency medicine* and *Obstetrics* were the most common specialties for claims related to alleged incidents in *Major cities* (12% and 11% respectively). *General surgery* was the specialty most frequently associated with claims arising from alleged incidents in *Inner regional* areas (23%) and in *Remote and very remote* areas (17%).

Claims with *General practice* (both non-procedural and procedural) made up a relatively small proportion of claims that arose from alleged incidents in *Major cities*. There were less of these claims than *General practice*-related claims associated with *Inner regional* Australia. *General practice* claims were also well represented amongst claims related to *Outer regional* areas and, in the case of procedural general practice, claims related to *Remote and very remote* locations.

Table 5.10: Closed claims, 2003–04 to 2007–08: principal clinician specialty, by geographic location

Principal clinician specialty[(b)]	Geographic location[(a)]				Total	Per cent
	Major cities	Inner regional	Outer regional	Remote and Very remote		
Emergency medicine	712	272	90	13	1,090	11.5
General surgery	406	552	72	16	1,046	11.0
Obstetrics only	653	173	60	11	900	9.5
Orthopaedic surgery	390	188	50	8	639	6.7
Gynaecology only	346	150	48	4	550	5.8
General nursing	282	84	24	6	396	4.2
Anaesthetics	250	86	23	3	364	3.8
Obstetrics and gynaecology	250	64	35	2	351	3.7
Psychiatry	257	74	16	1	348	3.7
General practice—non procedural	81	144	42	3	270	2.8
Cardiology/cardio-thoracic surgery	163	33	9	0	205	2.2
General practice—procedural	67	80	40	11	199	2.1
General and internal medicine	124	56	10	1	191	2.0
Diagnostic radiology	128	35	9	0	173	1.8
All other specialties	1,878	391	153	18	2,454	23.7
Total	**6,227**	**2,425**	**702**	**100**	**9,513**	**100.0**
Per cent	*65.5*	*25.5*	*7.4*	*1.1*	*100.0*	. .
	Per cent (excluding *Not applicable* and *Not known*)					
Emergency medicine	11.9	11.4	13.2	13.4	11.9	. .
General surgery	6.8	23.2	10.5	16.5	11.4	. .
Obstetrics only	10.9	7.3	8.8	11.3	9.8	. .
Orthopaedic surgery	6.5	7.9	7.3	8.2	7.0	. .
Gynaecology only	5.8	6.3	7.0	4.1	6.0	. .
General nursing	4.7	3.5	3.5	6.2	4.3	. .
Anaesthetics	4.2	3.6	3.4	3.1	4.0	. .
Obstetrics and gynaecology	4.2	2.7	5.1	2.1	3.8	. .
Psychiatry	4.3	3.1	2.3	1.0	3.8	. .
General practice—non-procedural	1.4	6.0	6.2	3.1	3.0	. .
Cardiology/cardio-thoracic surgery	2.7	1.4	1.3	0.0	2.2	. .
General practice—procedural	1.1	3.4	5.9	11.3	2.2	. .
General and internal medicine	2.1	2.4	1.5	1.0	2.1	. .
Diagnostic radiology	2.1	1.5	1.3	0.0	1.9	. .
All other specialties	31.4	16.4	22.5	18.6	26.7	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**

(a) The categories for this data item are based on Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

(b) For explanation of clinician specialty categories, see footnotes (e) and (f) and Note 1 in Table 5.4.

Notes

1. There were 71 claims coded *Not applicable* and 266 claims coded *Not known* for 'principal clinician specialty', and 59 claims coded *Not known* for 'geographic location', including 30 coded *Not known* for both. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 9,147.

2. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

5.2 Administrative and financial characteristics of closed claims

This section summarises the administrative and financial characteristics of claims that were closed between 2003–04 and 2007–08 (excluding any claims reopened as at 30 June 2008). Data presentation is focused on relating the 'total claim size' to the duration of the claims, the manner in which they were closed, the 'primary incident/allegation type' and the categories of loss claimed. 'Total claim size' includes any legal and investigative costs as well as any payment made to the claimant(s). The duration of a claim is measured from the date of reserve placement to when the claim was closed.

Length and cost of claims

The length of time taken to finalise closed claims was generally longer for larger settlements (Table 5.11). Over 50% of claims with a claim size up to $100,000, which make up 87% of closed claims, had been closed within 2 years of when the reserve was set. Claims settled for $100,000 or more were comparatively rare (13%), especially those settled for $500,000 or more (3%), but they took a relatively long time to finalise. The most common length of time taken to finalise claims settled for $100,000–<$500,000 was 25–36 months, and over 60 months (5 years) in the case of claims settled for $500,000 or more.

Table 5.11: Closed claims, 2003–04 to 2007–08: length of claim (months), by total claim size ($)

Length of claim	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Total	Per cent
12 or less	517	950	497	62	4	2,051	21.6
13–24	728	974	671	200	25	2,614	27.5
25–36	830	561	411	227	46	2,085	21.9
37–48	561	332	301	170	43	1,415	14.9
49–60	109	133	163	118	50	576	6.1
>60	134	164	229	156	87	772	8.1
Total	**2,879**	**3,114**	**2,272**	**933**	**255**	**9,513**	**100.0**
Per cent	*30.3*	*32.7*	*23.9*	*9.8*	*2.7*	*100.0*	. .
			Per cent (excluding *Not known*)				
12 or less	18.0	30.5	21.9	6.6	1.6	21.6	. .
13–24	25.3	31.3	29.5	21.4	9.8	27.5	. .
25–36	28.8	18.0	18.1	24.3	18.0	21.9	. .
37–48	19.5	10.7	13.2	18.2	16.9	14.9	. .
49–60	3.8	4.3	7.2	12.6	19.6	6.1	. .
>60	4.7	5.3	10.1	16.7	34.1	8.1	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**

Note: There were 60 claims coded *Not known* for 'total claim size'. These claims are included in the total number of 9,513 closed claims even though the *Not known* column is not presented. The percentages shown in the bottom half of the table are based on the 9,453 claims with known claim size.

The 30% of claims closed for no cost generally took longer to finalise than claims with a cost of up to $100,000 (Table 5.11). This may have to do with the amount of time health authorities allow a claim to be inactive before deciding to discontinue it (see below).

Mode of settlement

'Mode of settlement' describes the process by which a claim was closed. Claims may be closed through state/territory-based complaints processes, court-based processes and 'Other' processes (which include cases where a claim is settled part way through a trial) or may be discontinued (Section 4.5).

For the period from 2003–04 to 2007–08, just over half (57%) of all closed claims were finalised through being *Discontinued* (tables 5.12 and 5.13). The great majority (93%) closed for no cost, and three-quarters (75%) closed for a cost under $10,000, had been *Discontinued*. However, despite the small size of discontinued claims, the length of time taken before these claims were closed was very similar to that for all closed claims.

The mode which generally took the shortest time was settlement through *State/territory-based complaints processes*. Although only a relatively small proportion (4%) were settled in this way, over half of them (57%) were finalised within a year and 96% within 3 years. Settlement through a *Statutorily mandated conference process* was effected for a small proportion of claims (1%), involving a length of time comparable with that for closed claims in general (Table 5.12).

Settlement through a *Court decision* was also a comparatively rare event, with less than 4% of closed claims finalised through this mode. Over the same period, approximately twice as many claims were finalised as a result of *Court-based alternative dispute resolution processes*. This mode of settlement appears to have taken the longest time overall, with less than 9% of these claims finalised within 12 months and nearly 16% resolved after more than 5 years.

In terms of claim sizes, there seems to be little difference between claims settled through a *Court decision*, *Court-based alternative dispute resolution processes* or *Settled – other*. In all three cases, these claims were approximately two to three times more strongly represented amongst the most costly claims (settled for $100,000–<$500,000, and settled for $500,000 or more) than would be expected from their respective proportions of all closed claims. In particular, *Settled – other* claims are numerically dominant (over 60%) in both categories of most costly claims (tables 5.12 and 5.13).

Table 5.12: Closed claims, 2003–04 to 2007–08: mode of settlement, by length of claim (months)

Mode of settlement	<13	13–24	25–36	37–48	49–60	>60	Total	Per cent
Discontinued	1,022	1,543	1,362	901	259	293	5,380	56.6
Settled—state/territory-based complaints processes	207	117	24	10	5	0	363	3.8
Settled—court-based alternative dispute resolution processes	61	147	156	130	90	110	694	7.3
Settled—statutorily mandated compulsory conference process	14	30	21	18	5	5	93	1.0
Settled—other	626	655	436	287	191	324	2,519	26.5
Court decision	78	67	60	52	23	39	319	3.4
Total	**2,051**	**2,614**	**2,085**	**1,415**	**576**	**772**	**9,513**	**100.0**
Per cent	*21.6*	*27.5*	*21.9*	*14.9*	*6.1*	*8.1*	*100.0*	*. .*
			Per cent (excluding *Not known*)					
Discontinued	19.0	28.7	25.3	16.7	4.8	5.4	100.0	. .
Settled—state/territory-based complaints processes	57.0	32.2	6.6	2.8	1.4	0.0	100.0	. .
Settled—court-based alternative dispute resolution processes	8.8	21.2	22.5	18.7	13.0	15.9	100.0	. .
Settled—statutorily mandated compulsory conference process	15.1	32.3	22.6	19.4	5.4	5.4	100.0	. .
Settled—other	24.9	26.0	17.3	11.4	7.6	12.9	100.0	. .
Court decision	24.5	21.0	18.8	16.3	7.2	12.2	100.0	. .
Total	**21.4**	**27.3**	**22.0**	**14.9**	**6.1**	**8.2**	**100.0**	**. .**

Note: There were 145 claims coded *Not known* for 'mode of settlement'. These claims are included in the total number of 9,513 closed claims even though the *Not known* row is not presented. The percentages shown in the bottom half of the table are based on the 9,368 claims with known mode of settlement.

Table 5.13: Closed claims, 2003–04 to 2007–08: mode of settlement, by total claim size ($)

Mode of settlement	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Total	Per cent
Discontinued	2,656	2,319	381	9	6	5,380	56.6
Settled—state/territory-based complaints processes	27	113	212	11	0	363	3.8
Settled—court-based alternative dispute resolution processes	2	28	369	241	54	694	7.3
Settled—statutorily mandated compulsory conference process	1	3	56	25	8	93	1.0
Settled—other	119	571	1,100	570	159	2,519	26.5
Court decision	47	57	128	63	24	319	3.4
Total	**2,879**	**3,114**	**2,272**	**933**	**255**	**9,513**	**100.0**
Per cent	*30.3*	*32.7*	*23.9*	*9.8*	*2.7*	*100.0*	*. .*
			Per cent (excluding *Not known*)				
Discontinued	93.1	75.0	17.0	1.0	2.4	57.4	. .
Settled—state/territory-based complaints processes	0.9	3.7	9.4	1.2	0.0	3.9	. .
Settled—court-based alternative dispute resolution processes	0.1	0.9	16.4	26.2	21.5	7.4	. .
Settled—statutorily mandated compulsory conference process	0.0	0.1	2.5	2.7	3.2	1.0	. .
Settled—other	4.2	18.5	49.0	62.0	63.3	26.9	. .
Court decision	1.6	1.8	5.7	6.9	9.6	3.4	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**

Note: There were 145 claims coded *Not known* for 'mode of settlement' and 60 claims coded *Not known* for 'total claim size', including 51 coded *Not known* for both. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 9,359.

Clinical service context and cost of claims

This section reviews the size of claims closed between 2003–04 and 2007–08 for the reported clinical service contexts.

Paediatrics and *Obstetrics* were two clinical service contexts which showed an above-average association with the most costly claims. Of the claims associated with *Paediatrics* and *Obstetrics*, 8% and 5% respectively had a claim size of $500,000 or more, compared with 3% of all claims in this claim size bracket. In contrast, just 1% of claims with *General surgery* and with *Gynaecology* as their clinical service context were closed for $500,000 or more (Table 5.14).

All clinical service contexts other than paediatrics, obstetrics, general surgery and gynaecology, appear quite similar in terms of the general cost of the claims with which they are associated.

Primary incident/allegation type, primary body function/structure affected and cost of claims

The costs involved in settling public sector medical indemnity claims also varied depending on the 'primary incident/allegation type' and the 'primary body function/structure affected'.

During the period 2003–04 to 2007–08, a higher proportion of the claims with the primary incident/allegation types of *Medication-related* (5%) and *Diagnosis* (4%) had a claim size of $500,000 or more, compared with claims that had other primary incident/allegation types (0–3%) (Table 5.15).

Claim sizes varied notably with the claim subject's 'primary body function/structure affected'. The categories *Mental and nervous system*, and to a lesser degree *Neuromusculoskeletal and movement-related*, accounted for an increasing proportion of the claims in each size category as the latter increased from no cost to $500,000 or more (Table 5.16). These two categories together covered nearly four-fifths (78%) of the most costly claims.

Table 5.14: Closed claims, 2003–04 to 2007–08: clinical service context, by total claim size ($)

Clinical service context	Nil	1– <10,000	10,000– <30,000	30,000– <50,000	50,000– <100,000	100,000– <250,000	250,000– <500,000	500,000 or more	Total	Per cent
General surgery	398	512	245	94	134	110	29	17	1,540	16.2
Obstetrics	467	513	113	48	84	89	32	77	1,446	15.2
Accident and emergency	480	434	134	64	88	86	39	42	1,371	14.4
Gynaecology	199	201	85	60	79	75	18	6	723	7.6
Orthopaedics	154	222	90	35	65	59	22	12	661	6.9
General medicine	191	148	45	19	22	34	17	12	491	5.2
Psychiatry	99	132	55	25	28	49	21	9	418	4.4
General practice	58	76	28	17	15	29	6	5	236	2.5
Cardiology	62	66	28	11	11	15	14	4	212	2.2
Paediatrics	61	60	26	7	12	20	6	16	211	2.2
All other clinical service contexts	598	663	217	100	163	103	39	40	1,942	20.4
Total	**2,879**	**3,114**	**1,074**	**489**	**709**	**685**	**248**	**255**	**9,513**	**100.0**
Per cent	*30.3*	*32.7*	*11.3*	*5.1*	*7.5*	*7.2*	*2.6*	*2.7*	*100.0*	. .
					Per cent (excluding *Not known*)					
General surgery	25.9	33.3	15.9	6.1	8.7	7.1	1.9	1.1	100.0	. .
Obstetrics	32.8	36.1	7.9	3.4	5.9	6.3	2.2	5.4	100.0	. .
Accident and emergency	35.1	31.7	9.8	4.7	6.4	6.3	2.9	3.1	100.0	. .
Gynaecology	27.5	27.8	11.8	8.3	10.9	10.4	2.5	0.9	100.0	. .
Orthopaedics	23.4	33.7	13.7	5.3	9.9	9.0	3.3	1.8	100.0	. .
General medicine	39.1	30.3	9.2	3.9	4.5	7.0	3.3	2.5	100.0	. .
Psychiatry	23.7	31.6	13.2	6.0	6.7	11.7	5.0	2.2	100.0	. .
General practice	24.8	32.5	12.0	7.3	6.4	12.4	2.6	2.1	100.0	. .
Cardiology	29.4	31.3	13.3	5.2	5.2	7.1	6.6	1.9	100.0	. .
Paediatrics	29.3	28.8	12.5	3.4	5.8	9.6	2.9	7.7	100.0	. .
All other clinical service contexts	31.1	34.5	11.3	5.2	8.5	5.4	2.0	2.1	100.0	. .
Total	**30.1**	**32.9**	**11.6**	**5.2**	**7.6**	**7.3**	**2.6**	**2.6**	**100.0**	**. .**

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. There were 262 claims coded *Not known* for 'clinical service context' and 60 coded *Not known* for 'total claim size', including 2 coded *Not known* for both. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 9,193.
3. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

Table 5.15: Closed claims, 2003–04 to 2007–08: primary incident/allegation type, by total claim size ($)

Primary incident/allegation type	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Total	Per cent
Procedure	970	1,073	938	324	63	3,386	35.6
Diagnosis	513	655	458	230	85	1,945	20.4
Treatment	450	510	309	150	40	1,471	15.5
General duty of care	308	291	202	63	15	884	9.3
Medication-related	78	118	87	51	18	354	3.7
Anaesthetic	97	134	50	29	3	313	3.3
Consent	45	59	104	26	6	241	2.5
Infection control	73	71	26	17	4	191	2.0
Blood/blood product-related	83	40	15	13	2	153	1.6
Device failure	26	25	24	4	0	79	0.8
Other	46	46	49	13	3	159	1.7
Total	**2,879**	**3,114**	**2,272**	**933**	**255**	**9,513**	**100.0**
Per cent	*30.3*	*32.7*	*23.9*	*9.8*	*2.7*	*100.0*	. .
			Per cent (excluding *Not known*)				
Procedure	28.8	31.9	27.9	9.6	1.9	100.0	. .
Diagnosis	26.4	33.7	23.6	11.8	4.4	100.0	. .
Treatment	30.8	35.0	21.2	10.3	2.7	100.0	. .
General duty of care	35.0	33.1	23.0	7.2	1.7	100.0	. .
Medication-related	22.2	33.5	24.7	14.5	5.1	100.0	. .
Anaesthetic	31.0	42.8	16.0	9.3	1.0	100.0	. .
Consent	18.8	24.6	43.3	10.8	2.5	100.0	. .
Infection control	38.2	37.2	13.6	8.9	2.1	100.0	. .
Blood/blood product-related	54.2	26.1	9.8	8.5	1.3	100.0	. .
Device failure	32.9	31.6	30.4	5.1	0.0	100.0	. .
Other	29.3	29.3	31.2	8.3	1.9	100.0	. .
Total	**29.4**	**33.1**	**24.8**	**10.1**	**2.6**	**100.0**	**. .**

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 5.1.
2. There were 60 claims coded *Not known* for 'Total claim size' and 337 coded *Not known* for 'primary incident/allegation type', including 16 coded *Not known* for both. The rows and column for these claims are not presented in the table; however, the figures are included in the totals in the top half of the table. The number of claims on which the percentages presented in the bottom half of the table are based is 9,132.
3. Percentages in the bottom half of the table may not add up exactly to 100.0 due to rounding.

Table 5.16: Closed claims, 2003–04 to 2007–08: primary body function/structure affected, by total claim size ($)

Primary body function/structure affected	Nil	1–10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Not known	Total	Per cent
Neuromusculoskeletal and movement-related	596	656	525	228	69	13	2,087	21.9
Mental and nervous system	297	473	342	159	109	11	1,391	14.6
Genitourinary and reproductive	468	390	311	118	10	9	1,306	13.7
Digestive, metabolic and endocrine systems	317	337	316	100	9	3	1,082	11.4
Cardiovascular, haematological, immunological and respiratory	270	223	105	62	9	2	671	7.1
Skin and related structures	129	147	128	21	1	1	427	4.5
Sensory, including eye and ear	81	98	75	29	4	0	287	3.0
Voice and speech	30	78	39	6	1	1	155	1.6
Death	389	370	220	119	14	2	1,114	11.7
No body function/structure affected	87	76	33	24	2	2	224	2.4
Not known	215	266	178	67	27	16	769	8.1
Total	**2,879**	**3,114**	**2,272**	**933**	**255**	**60**	**9,513**	**100.0**
Per cent	*30.3*	*32.7*	*23.9*	*9.8*	*2.7*	*0.6*	*100.0*	*. .*
			Per cent (excluding *Not known*)					
Neuromusculoskeletal and movement-related	22.4	23.0	25.1	26.3	30.3	. .	23.8	. .
Mental and nervous system	11.1	16.6	16.3	18.4	47.8	. .	15.9	. .
Genitourinary and reproductive	17.6	13.7	14.9	13.6	4.4	. .	14.9	. .
Digestive, metabolic and endocrine systems	11.9	11.8	15.1	11.5	3.9	. .	12.4	. .
Cardiovascular, haematological, immunological and respiratory	10.1	7.8	5.0	7.2	3.9	. .	7.7	. .
Skin and related structures	4.8	5.2	6.1	2.4	0.4	. .	4.9	. .
Sensory, including eye and ear	3.0	3.4	3.6	3.3	1.8	. .	3.3	. .
Voice and speech	1.1	2.7	1.9	0.7	0.4	. .	1.8	. .
Death	14.6	13.0	10.5	13.7	6.1	. .	12.8	. .
No body function/structure affected	3.3	2.7	1.6	2.8	0.9	. .	2.6	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

Notes

1. The 769 claims coded *Not known* for 'primary body function/structure affected' and 60 coded *Not known* for 'total claim size', including 16 coded *Not known* for both, are excluded from the bottom half of the table. The number of claims on which the percentages presented here are based is 8,700.

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

Allegations of loss and cost of claims

There are two data items whose purpose is to record the allegations of loss to the claimant(s) pursuing the claim. 'Nature of claim—loss to claim subject' allows for up to four categories of alleged loss to the claim subject to be recorded, while 'nature of claim—loss to other party/parties' allows for recording up to six categories of alleged loss to a party other than the claim subject (Box 5.1).

Box 5.1: Nature of claim—loss to claim subject and Nature of claim—loss to other party/parties

'Nature of claim – loss to claim subject' has four broad categories of loss to the claim subject. Up to four categories can be selected for any claim. The categories are:

- Pain and suffering*, including general damages, nervous shock and temporary or ongoing disability*
- Care costs *including long-term care cost, covering both past and future care costs, whether provided gratuitously or otherwise*
- Other economic loss *including past and future economic loss and past and future out-of-pocket expenses, but excluding care costs*
- Other loss *including medical costs (both past and future), which are costs associated with medical treatment, for example, doctor's fees or hospital expenses.*

Not known *or* Not applicable *can be selected instead of a loss category.* Not applicable *is recorded when it is known that the claim is not based on an alleged loss to the claim subject, including when alleged loss to another party forms the basis for the claim. If it is not known whether the claim is based on an alleged loss to the claim subject,* Not known *is reported. It is understood that the codes for* Not known *and* Not applicable *have sometimes been used interchangeably.*

'Nature of claim – loss to other party/parties' has six broad categories of loss to another party. Up to six categories can be selected for any claim. The categories are:

- Nervous shock
- Pain and suffering*, including general damages but excluding nervous shock*
- Loss of consortium*, which covers the deprivation of the benefits of a family relationship due to harm to the claim subject*
- Care costs *including long-term care cost, covering both past and future care costs, whether provided gratuitously or otherwise*
- Other economic loss *including past and future economic loss and past and future out-of-pocket expenses, but excluding care costs*
- Other loss *including medical costs (both past and future), which are costs associated with medical treatment, for example, doctor's fees or hospital expenses.*

Not known *or* Not applicable *can be selected instead of a loss category.* Not applicable *is recorded when it is known that the claim is not based on an alleged loss to any party related to the claim subject. If it is not known whether the claim is based on an alleged loss to another party,* Not known *is reported. It is understood that the codes for* Not known *and* Not applicable *have sometimes been used interchangeably.*

The claims recorded as Not applicable for *'nature of claim – loss to claim subject' and 'nature of claim – loss to other party/parties' are reported as having Nil loss categories in tables in this report.*

Table 5.17 presents data on the categories of loss alleged by the claim subject for claims closed between 2003–04 and 2007–08. Over half of the claims (55%) were recorded as *Not known* or as having Nil loss categories. In the latter case, 90% of claims were closed for less than $10,000, fairly evenly divided between the Nil and $1–<$10,000 claim size categories.

The number of claims with a single loss category was 1,378, or 15%, with *Pain and suffering* the most commonly alleged loss (775 claims) and *Care costs* the least (61 claims). Regardless of the category of loss, claims with a single loss category generally settled for small amounts, most commonly $1–<$10,000. As the number of alleged loss categories increased, so the number of claims decreased, from 1,009 claims with two loss categories to 871 claims with four loss categories. However, claim size increased noticeably with the number of alleged loss categories. Approximately one half of claims with two or three loss categories were settled for $10,000–<$100,000 (51% and 50% respectively), while the most commonly recorded cost for claims with four loss categories was $100,000–<$500,000 (36%). In addition, claims with four loss categories accounted for 58% (148 of 255) of claims settled for $500,000 or more, even though these claims made up only 9% of all closed claims.

Of the claims closed between 2003–04 and 2007–08, 647 recorded an allegation of loss to another party, including 97 claims that also recorded an allegation of loss to the claim subject. Because the number of claims involved is not large and there is overlap with the claims associated with claim subject loss, this additional information is presented in terms of the number of categories of alleged loss, whether to another party or the claim subject. Table 5.18 cross-tabulates the number of categories of alleged loss with the total claim size, to produce a pattern similar to that observed for Table 5.17. The most commonly recorded claim size for claims with nil or one loss category was $1–<$10,000 (80% and 49% respectively), whereas the most common claim size was $10,000–<$100,000 for claims with two or three loss categories (50% and 49% respectively), and $100,000–<$500,000 for claims with four or with five or more loss categories (36% and 39% respectively).

Table 5.17: Closed claims, 2003–04 to 2007–08: nature of claim—loss to claim subject[a], by total claim size ($)

Loss to claim subject	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Not known	Total	Per cent
Nil loss categories[b]	230	275	54	2	0	2	563	5.9
Single loss category								
Pain and suffering	86	403	252	33	0	1	775	8.1
Care costs	15	38	5	2	0	1	61	0.6
Other economic loss	15	64	20	0	0	0	99	1.0
Other loss	78	203	146	14	2	0	443	4.7
Two loss categories	81	297	514	112	5	0	1,009	10.6
Three loss categories	50	175	494	219	46	1	985	10.4
Four loss categories	18	114	279	311	148	1	871	9.2
Not known	2,306	1,545	508	240	54	54	4,707	49.5
Total	**2,879**	**3,114**	**2,272**	**933**	**255**	**60**	**9,513**	**100.0**
Per cent	30.3	32.7	23.9	9.8	2.7	0.6	100.0	. .
			Per cent (excluding *Not known*)					
Nil loss categories[b]	41.0	49.0	9.6	0.4	0.0	. .	100.0	. .
Single loss category								
Pain and suffering	11.1	52.1	32.6	4.3	0.0	. .	100.0	. .
Care costs	25.0	63.3	8.3	3.3	0.0	. .	100.0	. .
Other economic loss	15.2	64.6	20.2	0.0	0.0	. .	100.0	. .
Other loss	17.6	45.8	33.0	3.2	0.5	. .	100.0	. .
Two loss categories	8.0	29.4	50.9	11.1	0.5	. .	100.0	. .
Three loss categories	5.1	17.8	50.2	22.3	4.7	. .	100.0	. .
Four loss categories	2.1	13.1	32.1	35.7	17.0	. .	100.0	. .
Total	**11.9**	**32.7**	**36.8**	**14.4**	**4.2**	**. .**	**100.0**	**. .**

(a) For an explanation of loss categories, see Box 5.1.

(b) Claims with 'nature of claim—loss to claim subject' recorded as *Not applicable* (see Box 5.1).

Notes

1. The 4,713 claims coded *Not known* for 'nature of claim—loss to claim subject' and/or claim size are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 4,800 claims.

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

Table 5.18: Closed claims, 2003–04 to 2007–08: nature of claim—loss to claim subject or other party (number of loss categories), by total claim size ($)

Number of loss categories	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Not known	Total	Per cent
Nil loss categories[(a)]	57	293	12	4	0	0	366	3.8
One loss category	209	759	495	83	2	2	1,550	16.3
Two loss categories	88	322	533	125	8	1	1,077	11.3
Three loss categories	56	199	548	259	50	1	1,113	11.7
Four loss categories	23	123	318	349	153	1	967	10.2
Five or more loss categories	3	16	19	33	13	2	86	0.9
Not known[(b)]	2,443	1,402	347	80	29	53	4,354	45.8
Total	**2,879**	**3,114**	**2,272**	**933**	**255**	**60**	**9,513**	**100.0**
Per cent	*30.3*	*32.7*	*23.9*	*9.8*	*2.7*	*0.6*	*100.0*	*. .*
			Per cent (excluding *Not known*)					
Nil loss categories[(a)]	15.6	80.1	3.3	1.1	0.0	. .	100.0	. .
One loss category	13.5	49.0	32.0	5.4	0.1	. .	100.0	. .
Two loss categories	8.2	29.9	49.5	11.6	0.7	. .	100.0	. .
Three loss categories	5.0	17.9	49.2	23.3	4.5	. .	100.0	. .
Four loss categories	2.4	12.7	32.9	36.1	15.8	. .	100.0	. .
Five or more loss categories	3.6	19.0	22.6	39.3	15.5	. .	100.0	. .
Total	**8.5**	**33.2**	**37.4**	**16.6**	**4.4**	**. .**	**100.0**	**. .**

(a) Claims recorded as *Not applicable* for both 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party' (see Box 5.1).

(b) Includes the situation where it is known that either the claim subject or the other party/parties had Nil loss categories (reported as *Not applicable*) but it is unknown whether there were loss categories reported for the other of these data items.

Notes

1. The 647 claims with recorded loss to other party/parties included 277 associated with a single loss category, 177 associated with two loss categories, 102 associated with three loss categories, 67 associated with four loss categories, 15 associated with five loss categories and 9 associated with all six loss categories. The 277 claims with a single loss category included 89 recorded for *Nervous shock*, 33 recorded for *Pain and suffering*, 49 recorded for *Loss of consortium*, 10 recorded for *Care costs*, 38 recorded for *Other economic loss* and 58 recorded for *Other loss*. For an explanation of other party/parties loss categories, see Box 5.1.
2. The 4,361 claims coded *Not known* for number of loss categories and/or claim size are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 5,152 claims.
3. Percentages may not add up exactly to 100.0 due to rounding.

5.3 Sex and age of claim subjects

This section provides a profile of the claim subjects recorded for medical indemnity claims closed between 2003–04 and 2007–08. Information on the person's sex and their age at the time of the alleged incident is presented in the context of the details of the alleged incidents, including clinical service context, primary incident/allegation type and primary body function/structure affected, as well as the size of the claims.

During the period, 655 *Closed claims* (7%) related to babies less than 1 year old, 584 claims (6%) related to people from 1 to 17 years of age, and 6,465 claims (68%) involved adults (18 years and over). In the case of adult-related claims, the number of claims declined consistently with the claim subject's increasing age, from 2,880 for adults aged 18–39 years to 211 for adults aged 80 years or more. The age of the claim subject was *Not known* for 1,809 claims (Table 5.19).

The claim subject was female in approximately 60% of claims. Female claim subjects outnumbered males in every adult age group, and particularly in the 18–39 year age group. This imbalance was reversed for claims relating to claim subjects less than 18 years of age, where more than half of the claim subjects were male.

Table 5.19: Closed claims, 2003–04 to 2007–08: sex and age group (years) of claim subject

	Age group									
Sex	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**	**Per cent**
Males	340	101	219	869	948	553	92	819	3,941	41.4
Females	296	72	190	2,004	1,263	603	118	891	5,437	57.2
Not known	19	1	1	7	7	0	1	99	135	1.4
Total	**655**	**174**	**410**	**2,880**	**2,218**	**1,156**	**211**	**1,809**	**9,513**	**100.0**
Per cent	*6.9*	*1.8*	*4.3*	*30.3*	*23.3*	*12.2*	*2.2*	*19.0*	*100.0*	. .
	Per cent (excluding *Not known*)									
Males	53.5	58.4	53.5	30.2	42.9	47.8	43.8	. .	40.7	. .
Females	46.5	41.6	46.5	69.8	57.1	52.2	56.2	. .	59.3	. .
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**	**. .**

Note: The 1,845 claims coded *Not known* for 'sex' or 'age group', including 99 coded *Not known* for both, are excluded for the purposes of calculating the percentages presented in the bottom half of the table, which are based on 7,668 claims.

Clinical service context

The most common clinical service contexts recorded for male claim subjects were *General surgery* (21%), *Accident and Emergency* (19%) and *Orthopaedics* (10%). The pattern was quite different for female claim subjects, for whom the most common were *Obstetrics* (21%), *General surgery* (17%) and *Gynaecology* (14%) (tables 5.20 and 5.21).

Table 5.20: Closed claims, 2003–04 to 2007–08: clinical service context, by sex and age group (years) of claim subject

	Age group								
Clinical service context	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**
					Males				
Obstetrics	243	5	7	0	0	0	0	109	364
Paediatrics	34	28	30	7	0	0	0	12	111
Accident and emergency	13	24	69	226	170	68	8	135	713
Psychiatry	2	0	7	108	48	6	1	49	221
General practice	1	3	3	26	22	9	2	35	101
General surgery	4	8	25	161	259	172	18	81	728
Cardiology	2	3	5	14	39	33	2	24	122
Orthopaedics	0	2	25	93	113	58	8	53	352
General medicine	7	5	7	45	59	47	21	37	228
All other clinical service contexts	31	21	39	175	223	150	28	238	905
Not known	3	2	2	14	15	10	4	46	96
Total males	*340*	*101*	*219*	*869*	*948*	*553*	*92*	*819*	*3,941*
					Females				
Obstetrics	211	7	11	667	49	0	0	119	1,064
Paediatrics	22	24	27	6	2	0	0	17	98
Accident and emergency	9	23	43	208	144	79	18	129	653
Psychiatry	0	1	13	73	49	12	4	41	193
Gynaecology	2	0	6	387	214	27	2	83	721
General practice	6	0	3	39	32	18	1	34	133
General surgery	2	6	25	224	302	163	18	63	803
Cardiology	3	1	3	15	24	30	4	10	90
Orthopaedics	1	2	21	64	91	69	17	43	308
General medicine	1	0	6	47	67	62	30	42	255
All other clinical service contexts	36	8	31	256	271	133	21	259	1,015
Not known	3	0	1	18	18	10	3	51	104
Total females	*296*	*72*	*190*	*2,004*	*1,263*	*603*	*118*	*891*	*5,437*
					Persons				
Obstetrics	469	12	18	667	49	0	0	231	1,446
Paediatrics	56	52	57	13	2	0	0	31	211
Accident and emergency	23	48	112	434	315	147	26	266	1,371
Psychiatry	2	1	20	183	99	18	5	90	418
Gynaecology	3	0	6	387	214	27	2	84	723
General practice	7	3	6	65	54	27	4	70	236
General surgery	6	14	50	385	562	335	36	152	1,540
Cardiology	5	4	8	29	63	63	6	34	212
Orthopaedics	1	4	46	157	205	127	25	96	661
General medicine	8	5	13	92	126	109	51	87	491
All other clinical service contexts	68	29	70	431	495	283	49	517	1,942
Not known	7	2	4	37	34	20	7	151	262
Total persons	**655**	**174**	**410**	**2,880**	**2,218**	**1,156**	**211**	**1,809**	**9,513**

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. *Total persons* includes 135 persons of unknown sex.

Table 5.21: Closed claims, 2003–04 to 2007–08: clinical service context (excluding *Not known*), by sex and age group (years) of claim subject (per cent)

	Age group							
Clinical service context	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Total**
				Males				
Obstetrics	72.1	5.1	3.2	0.0	0.0	0.0	0.0	8.3
Paediatrics	10.1	28.3	13.8	0.8	0.0	0.0	0.0	3.2
Accident and emergency	3.9	24.2	31.8	26.4	18.2	12.5	9.1	18.8
Psychiatry	0.6	0.0	3.2	12.6	5.1	1.1	1.1	5.6
General practice	0.3	3.0	1.4	3.0	2.4	1.7	2.3	2.1
General surgery	1.2	8.1	11.5	18.8	27.8	31.7	20.5	21.1
Cardiology	0.6	3.0	2.3	1.6	4.2	6.1	2.3	3.2
Orthopaedics	0.0	2.0	11.5	10.9	12.1	10.7	9.1	9.7
General medicine	2.1	5.1	3.2	5.3	6.3	8.7	23.9	6.2
All other clinical service contexts	9.2	21.2	18.0	20.5	23.9	27.6	31.8	21.7
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Females				
Obstetrics	72.0	9.7	5.8	33.6	3.9	0.0	0.0	21.0
Paediatrics	7.5	33.3	14.3	0.3	0.2	0.0	0.0	1.8
Accident and emergency	3.1	31.9	22.8	10.5	11.6	13.3	15.7	11.7
Psychiatry	0.0	1.4	6.9	3.7	3.9	2.0	3.5	3.4
Gynaecology	0.7	0.0	3.2	19.5	17.2	4.6	1.7	14.2
General practice	2.0	0.0	1.6	2.0	2.6	3.0	0.9	2.2
General surgery	0.7	8.3	13.2	11.3	24.3	27.5	15.7	16.5
Cardiology	1.0	1.4	1.6	0.8	1.9	5.1	3.5	1.8
Orthopaedics	0.3	2.8	11.1	3.2	7.3	11.6	14.8	5.9
General medicine	0.3	0.0	3.2	2.4	5.4	10.5	26.1	4.7
All other clinical service contexts	12.3	11.1	16.4	12.9	21.8	22.4	18.3	16.8
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Persons				
Obstetrics	72.4	7.0	4.4	23.5	2.2	0.0	0.0	16.0
Paediatrics	8.6	30.2	14.0	0.5	0.1	0.0	0.0	2.4
Accident and emergency	3.5	27.9	27.6	15.3	14.4	12.9	12.7	14.6
Psychiatry	0.3	0.6	4.9	6.4	4.5	1.6	2.5	4.3
Gynaecology	0.5	0.0	1.5	13.6	9.8	2.4	1.0	8.4
General practice	1.1	1.7	1.5	2.3	2.5	2.4	2.0	2.2
General surgery	0.9	8.1	12.3	13.5	25.7	29.5	17.6	18.3
Cardiology	0.8	2.3	2.0	1.0	2.9	5.5	2.9	2.3
Orthopaedics	0.2	2.3	11.3	5.5	9.4	11.2	12.3	7.4
General medicine	1.2	2.9	3.2	3.2	5.8	9.6	25.0	5.3
All other clinical service contexts	10.5	16.9	17.2	15.2	22.7	24.9	24.0	18.8
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. The 'clinical service context' categories listed separately here are the ten most frequently recorded categories; all other categories are combined in the category *All other clinical service contexts*.
2. The 262 claims coded *Not known* for 'clinical service context' and 1,809 claims coded *Not known* for claim subject's age group, including 151 claims coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 7,593.
3. Percentages may not add up exactly to 100.0 due to rounding.

Obstetrics was the clinical service context most frequently recorded for babies of both sexes (72%) and was also often recorded for adult females aged 18–39 years (34%). *Gynaecology* was recorded as the clinical service context for 601 of the 3,267 claims (18%) involving adult females aged between 18 and 59 years. *General surgery* figured prominently as the clinical service context for claim subjects of both sexes in the 40–59 (26%) and 60–79 (30%) year age groups. *Paediatrics* was commonly recorded when the claim subject was less than 18 years old, particularly for children in the 1–4 year age group (30%). *Psychiatry* was recorded for 13% of the claims with adult male claim subjects aged 18–39 years.

Cardiology-related claims reached its highest proportion of all claims for both sexes in the 60–79 year age group (5–6%). One-quarter (25%) of the claims in the oldest age group, 80 years or more, had *General medicine* recorded as their clinical service context.

Primary incident/allegation type

Procedure was the most common primary incident/allegation type recorded for both sexes, but it was particularly common for claims where the claim subject was female. This difference between females (43% of their closed claims) and males (32%) is mainly attributable to the large proportion of claims, nearly 50%, for adult females between 18 and 59 years with *Procedure* recorded as the incident/allegation type. *Procedure*-related claims also approached 50% of all claims for babies, in this case affecting both sexes (tables 5.22 and 5.23).

As an incident/allegation type, *Treatment* was more likely to be recorded if the claim involved people less than 18 years old rather than adults. More than 20% of the claims for both male and female claim subjects less than 18 years old involved an incident or allegation related to *Treatment*, whereas this proportion was consistently less than 20% for every adult age group. Similarly, *Diagnosis* was more strongly associated with children than with adults, specifically with males in the 5–17 year age group (37% of these claims) and with females in the 1–4 and 5–17 year age groups (39% and 31%, respectively).

General duty of care appears to increase with claim subject age in terms of the proportion of claims associated with that incident/allegation type. It was the most frequently recorded category in claims where the claim subject was 80 years or older (33%).

Table 5.22: Closed claims, 2003–04 to 2007–08: primary incident/allegation type, by sex and age group (years) of claim subject

Primary incident/ allegation type	Age group								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
					Males				
Procedure	152	29	47	205	306	231	20	200	1,190
Treatment	68	24	50	149	154	74	15	117	651
Diagnosis	66	21	80	238	231	95	12	175	918
Consent	3	5	4	17	19	8	1	24	81
Blood/blood product-related	1	3	1	26	15	5	2	13	66
Infection control	7	0	2	21	26	19	1	17	93
Device failure	3	3	6	6	9	5	3	4	39
Anaesthetic	3	1	5	19	36	16	1	33	114
Medication-related	7	7	8	44	37	26	5	30	164
General duty of care	9	6	8	107	91	57	28	116	422
Other	3	1	3	22	12	10	1	29	81
Not known	18	1	5	15	12	7	3	61	122
Total males	*340*	*101*	*219*	*869*	*948*	*553*	*92*	*819*	*3,941*
					Females				
Procedure	135	14	49	895	571	226	24	268	2,182
Treatment	66	12	42	287	152	84	22	145	810
Diagnosis	50	27	58	356	247	118	13	156	1,025
Consent	3	1	3	70	27	9	2	42	157
Blood/blood product-related	2	3	3	28	16	7	1	11	71
Infection control	2	0	3	29	20	10	4	18	86
Device failure	0	1	2	18	4	8	3	2	38
Anaesthetic	2	0	4	68	47	34	3	39	197
Medication-related	12	4	8	51	48	28	5	29	185
General duty of care	8	4	16	127	92	66	41	103	457
Other	3	3	1	25	14	5	0	24	75
Not known	13	3	1	50	25	8	0	54	154
Total females	*296*	*72*	*190*	*2,004*	*1,263*	*603*	*118*	*891*	*5,437*
					Persons				
Procedure	296	43	96	1,100	879	457	44	471	3,386
Treatment	137	36	92	437	307	158	38	266	1,471
Diagnosis	116	49	138	594	478	213	25	332	1,945
Consent	6	6	7	87	46	17	3	69	241
Blood/blood product-related	3	6	4	54	31	12	3	40	153
Infection control	9	0	5	50	46	29	5	47	191
Device failure	3	4	8	24	13	13	6	8	79
Anaesthetic	5	1	9	87	84	50	4	73	313
Medication-related	20	11	16	95	86	54	10	62	354
General duty of care	18	10	24	236	184	123	69	220	884
Other	7	4	4	48	26	15	1	54	159
Not known	35	4	7	68	38	15	3	167	337
Total persons	**655**	**174**	**410**	**2,880**	**2,218**	**1,156**	**211**	**1,809**	**9,513**

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 3.3.
2. *Total persons* includes 135 persons of unknown sex.

Table 5.23: Closed claims, 2003–04 to 2007–08: primary incident/allegation type (excluding *Not known*), by sex and age group (years) of claim subject (per cent)

Primary incident/ allegation type	Age group							
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Total
				Males				
Procedure	47.2	29.0	22.0	24.0	32.7	42.3	22.5	32.3
Treatment	21.1	24.0	23.4	17.4	16.5	13.6	16.9	17.4
Diagnosis	20.5	21.0	37.4	27.9	24.7	17.4	13.5	24.3
Consent	0.9	5.0	1.9	2.0	2.0	1.5	1.1	1.9
Blood/blood product-related	0.3	3.0	0.5	3.0	1.6	0.9	2.2	1.7
Infection control	2.2	0.0	0.9	2.5	2.8	3.5	1.1	2.5
Device failure	0.9	3.0	2.8	0.7	1.0	0.9	3.4	1.1
Anaesthetic	0.9	1.0	2.3	2.2	3.8	2.9	1.1	2.6
Medication-related	2.2	7.0	3.7	5.2	4.0	4.8	5.6	4.4
General duty of care	2.8	6.0	3.7	12.5	9.7	10.4	31.5	10.0
Other	0.9	1.0	1.4	2.6	1.3	1.8	1.1	1.7
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Females				
Procedure	47.7	20.3	25.9	45.8	46.1	38.0	20.3	43.0
Treatment	23.3	17.4	22.2	14.7	12.3	14.1	18.6	15.0
Diagnosis	17.7	39.1	30.7	18.2	20.0	19.8	11.0	19.5
Consent	1.1	1.4	1.6	3.6	2.2	1.5	1.7	2.6
Blood/blood product-related	0.7	4.3	1.6	1.4	1.3	1.2	0.8	1.3
Infection control	0.7	0.0	1.6	1.5	1.6	1.7	3.4	1.5
Device failure	1.1	4.3	0.5	1.3	1.1	0.8	0.0	1.1
Anaesthetic	0.7	0.0	2.1	3.5	3.8	5.7	2.5	3.6
Medication-related	4.2	5.8	4.2	2.6	3.9	4.7	4.2	3.5
General duty of care	2.8	5.8	8.5	6.5	7.4	11.1	34.7	8.0
Other	0.0	1.4	1.1	0.9	0.3	1.3	2.5	0.8
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
				Persons				
Procedure	47.7	25.3	23.8	39.1	40.3	40.1	21.2	38.7
Treatment	22.1	21.2	22.8	15.5	14.1	13.8	18.3	16.0
Diagnosis	18.7	28.8	34.2	21.1	21.9	18.7	12.0	21.4
Consent	1.0	3.5	1.7	3.1	2.1	1.5	1.4	2.3
Blood/blood product-related	0.5	3.5	1.0	1.9	1.4	1.1	1.4	1.5
Infection control	1.5	0.0	1.2	1.8	2.1	2.5	2.4	1.9
Device failure	0.5	2.4	2.0	0.9	0.6	1.1	2.9	0.9
Anaesthetic	0.8	0.6	2.2	3.1	3.9	4.4	1.9	3.2
Medication-related	3.2	6.5	4.0	3.4	3.9	4.7	4.8	3.9
General duty of care	2.9	5.9	6.0	8.4	8.4	10.8	33.2	8.8
Other	1.1	2.4	1.0	1.7	1.2	1.3	0.5	1.4
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. For explanation of 'primary incident/allegation type' categories, see the footnotes to Table 3.3.
2. The 337 claims coded *Not known* for 'primary incident/allegation type' and 1,809 claims coded *Not known* for claim subject's age, including 167 claims coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 7,534.
3. Percentages may not add up exactly to 100.0 due to rounding.

Primary body function/structure affected

Table 5.24 presents data on the claim subjects' sex and age in relation to the primary body function or structure affected.

The most frequently recorded category for claims involving babies was *Mental and nervous system* (41%). The proportion of claims with alleged *Mental and nervous system* effects was markedly less in every other age group, especially those with claim subjects aged 60 years or over, for whom the proportion was 7% (92 of 1,367 claims).

Genitourinary and reproductive effects were recorded for a higher proportion of claims with female than male claim subjects (21% and 7% respectively). The difference can be attributed to the large number, and high proportion, of claims involving adult females in the 18–39 (31%) and 40–59 (21%) year age groups where this category was recorded. The complementary pattern was the tendency for *Neuromusculoskeletal and movement-related* claims to make up a larger proportion of the claims with male subjects (28%) than female subjects (20%). This particularly affected the 5–17 and 18–39 year age groups, both of which had more male than female claim subjects in this claim category.

Sensory, including eye and ear is one primary body function/structure category that was recorded for an increasing proportion of claims with the claim subjects' advancing age, at least as far as adults were concerned. The proportion rose from 2% for claims associated with adults aged 18–39 years, to 7% for adults aged 80 years or over. The same pattern was also recorded for claims associated with the claim subject's *Death*, recorded for 10% of claims with adults aged 18–39 years, but 26% of claims with adults aged 80 years or more. However, *Death* was also quite commonly recorded for claims involving babies (15%) and children up to 4 years old (17%).

Table 5.24: Closed claims, 2003–04 to 2007–08: primary body function/structure affected, by sex and age group (years) of claim subject

Primary body/function structure affected	Age group								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
Males									
Mental and nervous system	137	19	35	111	96	41	4	81	524
Cardiovascular, haematological, immunological and respiratory	20	9	8	77	106	61	6	50	337
Voice and speech	2	1	2	15	16	11	0	21	68
Genitourinary and reproductive	15	14	18	77	66	32	3	41	266
Digestive, metabolic and endocrine systems	12	7	23	91	147	88	8	68	444
Neuromusculoskeletal and movement-related	60	18	82	266	264	134	29	184	1,037
Skin and related structures	9	9	14	43	35	23	4	16	153
Sensory, including eye and ear	11	3	7	32	45	33	8	15	154
Death	38	17	23	118	147	113	27	65	548
No body function/structure affected	4	3	3	24	11	5	1	13	64
Not known	32	1	4	15	15	12	2	265	346
Total males	*340*	*101*	*219*	*869*	*948*	*553*	*92*	*819*	*3,941*
Females									
Mental and nervous system	99	12	38	407	127	40	7	127	857
Cardiovascular, haematological, immunological and respiratory	17	9	12	109	80	39	5	44	315
Voice and speech	1	0	7	30	25	5	1	18	87
Genitourinary and reproductive	8	1	16	595	260	44	3	111	1,038
Digestive, metabolic and endocrine systems	5	6	23	205	224	100	3	67	633
Neuromusculoskeletal and movement-related	78	14	47	232	275	177	48	174	1,045
Skin and related structures	8	8	14	95	74	25	15	33	272
Sensory, including eye and ear	4	6	3	29	28	39	6	18	133
Death	42	10	27	147	116	118	25	67	552
No body function/structure affected	3	2	2	97	27	8	1	17	157
Not known	31	4	1	58	27	8	4	215	348
Total females	*296*	*72*	*190*	*2,004*	*1,263*	*603*	*118*	*891*	*5,437*

(continued)

Table 5.24 (continued): Closed claims, 2003–04 to 2007–08: primary body function/structure affected, by sex and age group (years) of claim subject

Primary body/function structure affected	Age group								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
					Persons				
Mental and nervous system	238	31	73	519	224	81	11	214	1,391
Cardiovascular, haematological, immunological and respiratory	38	18	20	186	187	100	11	111	671
Voice and speech	3	1	9	45	41	16	1	39	155
Genitourinary and reproductive	24	15	34	672	327	76	6	152	1,306
Digestive, metabolic and endocrine systems	18	13	46	296	372	188	11	138	1,082
Neuromusculoskeletal and movement-related	141	32	129	499	540	311	77	358	2,087
Skin and related structures	17	17	28	139	109	48	19	50	427
Sensory, including eye and ear	15	9	10	61	73	72	14	33	287
Death	86	28	50	265	264	231	53	137	1,114
No body function/structure affected	8	5	5	121	38	13	2	32	224
Not known	67	5	6	77	43	20	6	545	769
Total persons[(a)]	**655**	**174**	**410**	**2,880**	**2,218**	**1,156**	**211**	**1,809**	**9,513**
					Per cent (excluding *Not known*)[(b)]				
					Males				
Mental and nervous system	44.5	19.0	16.3	13.0	10.3	7.6	4.4	. .	14.6
Cardiovascular, haematological, immunological and respiratory	6.5	9.0	3.7	9.0	11.4	11.3	6.7	. .	9.4
Voice and speech	0.6	1.0	0.9	1.8	1.7	2.0	0.0	. .	1.5
Genitourinary and reproductive	4.9	14.0	8.4	9.0	7.1	5.9	3.3	. .	7.4
Digestive, metabolic and endocrine systems	3.9	7.0	10.7	10.7	15.8	16.3	8.9	. .	12.4
Neuromusculoskeletal and movement-related	19.5	18.0	38.1	31.1	28.3	24.8	32.2	. .	28.0
Skin and related structures	2.9	9.0	6.5	5.0	3.8	4.3	4.4	. .	4.5
Sensory, including eye and ear	3.6	3.0	3.3	3.7	4.8	6.1	8.9	. .	4.6
Death	12.3	17.0	10.7	13.8	15.8	20.9	30.0	. .	15.9
No body function/structure affected	1.3	3.0	1.4	2.8	1.2	0.9	1.1	. .	1.7
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .	*100.0*

(continued)

Table 5.24 (continued): Closed claims, 2003–04 to 2007–08: primary body function/structure affected, by sex and age group (years) of claim subject

Primary body/function structure affected	Age group								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
	Per cent (excluding *Not known*)								
	Females								
Mental and nervous system	37.4	17.6	20.1	20.9	10.3	6.7	6.1	. .	16.5
Cardiovascular, haematological, immunological and respiratory	6.4	13.2	6.3	5.6	6.5	6.6	4.4	. .	6.1
Voice and speech	0.4	0.0	3.7	1.5	2.0	0.8	0.9	. .	1.6
Genitourinary and reproductive	3.0	1.5	8.5	30.6	21.0	7.4	2.6	. .	21.0
Digestive, metabolic and endocrine systems	1.9	8.8	12.2	10.5	18.1	16.8	2.6	. .	12.8
Neuromusculoskeletal and movement-related	29.4	20.6	24.9	11.9	22.2	29.7	42.1	. .	19.7
Skin and related structures	3.0	11.8	7.4	4.9	6.0	4.2	13.2	. .	5.4
Sensory, including eye and ear	1.5	8.8	1.6	1.5	2.3	6.6	5.3	. .	2.6
Death	15.8	14.7	14.3	7.6	9.4	19.8	21.9	. .	11.0
No body function/structure affected	1.1	2.9	1.1	5.0	2.2	1.3	0.9	. .	3.2
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*. .*	*100.0*
	Persons								
Mental and nervous system	40.5	18.3	18.1	18.5	10.3	7.1	5.4	. .	15.7
Cardiovascular, haematological, immunological and respiratory	6.5	10.7	5.0	6.6	8.6	8.8	5.4	. .	7.5
Voice and speech	0.5	0.6	2.2	1.6	1.9	1.4	0.5	. .	1.6
Genitourinary and reproductive	4.1	8.9	8.4	24.0	15.0	6.7	2.9	. .	15.4
Digestive, metabolic and endocrine systems	3.1	7.7	11.4	10.6	17.1	16.5	5.4	. .	12.6
Neuromusculoskeletal and movement-related	24.0	18.9	31.9	17.8	24.8	27.4	37.6	. .	23.1
Skin and related structures	2.9	10.1	6.9	5.0	5.0	4.2	9.3	. .	5.0
Sensory, including eye and ear	2.6	5.3	2.5	2.2	3.4	6.3	6.8	. .	3.4
Death	14.6	16.6	12.4	9.5	12.1	20.3	25.9	. .	13.1
No body function/structure affected	1.4	3.0	1.2	4.3	1.7	1.1	1.0	. .	2.6
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

(a) *Total persons* includes 135 persons of unknown sex.

(b) The number of claims on which the percentages presented in this table are based is 7,480. Percentages may not add up exactly to 100.0 due to rounding.

Total claim size

There appears to be little difference in total claim size when related to the sex of the claim subject. For both males and females, approximately 30% of claims were closed for no cost, 33% for $1–<$10,000, 24% for $10,000–<$100,000, 10% for $100,000–<$500,000, and 3% for $500,000 or more (Table 5.25).

There does however appear to be some association between claim size and age group. Half of the claims (50%) with a claim subject aged 80 years or more were settled for no cost, a proportion approximately 20 percentage points higher than any other age group. At the other end of the scale, the proportion of claims settled for $500,000 or more consistently decreased as the claim subject's age increased. It was around 10% for babies, and over 5% for claim subjects between 1 and 17 years old, but 2% or less for adults.

Table 5.25: Closed claims, 2003–04 to 2007–08: total claim size, by sex and age group of claim subject

	Age group (years)								
Claim size ($)	**<1**	**1–4**	**5–17**	**18–39**	**40–59**	**60–79**	**80 or more**	**Not known**	**Total**
					Males				
Nil	107	28	65	218	229	176	51	215	1,089
1–<10,000	147	37	65	262	311	189	22	271	1,304
10,000–<100,000	26	24	50	235	256	149	15	207	962
100,000–<500,000	16	8	24	122	130	33	3	89	425
500,000 or more	38	2	14	31	22	5	0	11	123
Not known	6	2	1	1	0	1	1	26	38
Total males	*340*	*101*	*219*	*869*	*948*	*553*	*92*	*819*	*3,941*
					Females				
Nil	95	21	41	606	385	204	54	321	1,727
1–<10,000	114	22	65	622	410	214	34	308	1,789
10,000–<100,000	38	16	51	511	337	140	24	175	1,292
100,000–<500,000	16	5	26	231	109	38	5	62	492
500,000 or more	28	7	7	31	22	7	1	15	118
Not known	5	1	0	3	0	0	0	10	19
Total females	*296*	*72*	*190*	*2,004*	*1,263*	*603*	*118*	*891*	*5,437*
					Persons				
Nil	213	50	106	827	620	380	105	578	2,879
1–<10,000	264	59	131	886	722	403	57	592	3,114
10,000–<100,000	65	40	101	748	593	289	39	397	2,272
100,000–<500,000	34	13	50	353	239	71	8	165	933
500,000 or more	66	9	21	62	44	12	1	40	255
Not known	13	3	1	4	0	1	1	37	60
Total persons[(a)]	**655**	**174**	**410**	**2,880**	**2,218**	**1,156**	**211**	**1,809**	**9,513**
					Per cent (excluding *Not known*)[(b)]				
					Males				
Nil	32.0	28.3	29.8	25.1	24.2	31.9	56.0	. .	28.1
1–<10,000	44.0	37.4	29.8	30.2	32.8	34.2	24.2	. .	33.2
10,000–<100,000	7.8	24.2	22.9	27.1	27.0	27.0	16.5	. .	24.3
100,000–<500,000	4.8	8.1	11.0	14.1	13.7	6.0	3.3	. .	10.8
500,000 or more	11.4	2.0	6.4	3.6	2.3	0.9	0.0	. .	3.6
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .	*100.0*
					Females				
Nil	32.6	29.6	21.6	30.3	30.5	33.8	45.8	. .	31.0
1–<10,000	39.2	31.0	34.2	31.1	32.5	35.5	28.8	. .	32.6
10,000–<100,000	13.1	22.5	26.8	25.5	26.7	23.2	20.3	. .	24.6
100,000–<500,000	5.5	7.0	13.7	11.5	8.6	6.3	4.2	. .	9.5
500,000 or more	9.6	9.9	3.7	1.5	1.7	1.2	0.8	. .	2.3
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .	*100.0*
					Persons				
Nil	33.2	29.2	25.9	28.8	28.0	32.9	50.0	. .	30.0
1–<10,000	41.1	34.5	32.0	30.8	32.6	34.9	27.1	. .	32.8
10,000–<100,000	10.1	23.4	24.7	26.0	26.7	25.0	18.6	. .	24.4
100,000–<500,000	5.3	7.6	12.2	12.3	10.8	6.1	3.8	. .	10.0
500,000 or more	10.3	5.3	5.1	2.2	2.0	1.0	0.5	. .	2.8
Total persons[(a)]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**

(a) *Total persons* includes 135 persons of unknown sex.

(b) The number of claims on which the percentages presented in the table are based is 7,681. Percentages may not add up exactly to 100.0 due to rounding.

6 Obstetrics claims

This chapter analyses data on claims with a clinical service context of *Obstetrics* which were closed between July 2003 and June 2008. These claims are categorised as obstetrics claims for the purposes of this chapter. The analysis includes information on whether the claim subject was the mother or the baby. These are arguably two different types of claims even though both are obstetrics claims.

A baby-related obstetrics claim is defined here as a claim with a clinical service context of *Obstetrics* and a claim subject aged 1 year or younger at the time of the alleged incident. A mother-related obstetrics claim is defined as a claim with a clinical service context of *Obstetrics* and a female claim subject at least 13 years old at the time of the incident. Of the 1,446 claims with a clinical service context of *Obstetrics*, 241 did not match either definition, almost all of them because the claim subject's age was not known (see Table 5.20), and so are excluded from the analysis. The other 1,205 claims included a larger number where the claim subject was evidently the mother (726 claims) rather than the baby (479 claims).

Both mother and baby-related claims are compared with non-obstetric claims, defined as those with a clinical service context known to be other than *Obstetrics* (7,805 claims closed between July 2003 and June 2008). Non-obstetric claims are included in the comparisons to provide context for the similarities and differences that are apparent between mother and baby-related claims.

The analysis considers the principal clinician specialty involved in the claim, geographic location of the alleged incident that gave rise to the claim, primary body function/structure affected, extent of harm, number of loss categories, the primary incident/allegation type and total claim size.

Principal clinician specialty

As would be expected, the great majority of claims that featured *Obstetrics only* as the principal clinician specialty were obstetrics claims. Obstetrics claims for their part had a wide range of principal clinician specialty categories, but the dominant category was *Obstetrics only*, as recorded for over half of them whether the claim subject was mother or baby. *Midwifery* was much less often recorded as principal clinician specialty than *Obstetrics only* but was otherwise similar in two respects. It was almost exclusively associated with obstetrics claims and it made up a similar proportion of these claims (around 6%) whether the mother or the baby was the claim subject (Table 6.1).

There were three principal clinician specialties recorded at moderate to high frequencies for both obstetrics claims and non-obstetric claims. *Obstetrics and gynaecology* was recorded as the primary specialty for almost 20% of mother-related obstetrics claims but a smaller proportion, 11%, of baby-related obstetrics claims. Also, a record of *Anaesthetics* as the principal clinician specialty was much more a feature of obstetric claims with a mother (6%) than a baby (1%) claim subject. With these latter claims, 6% had *General practice—procedural* recorded as the principal clinician specialty, similar to mother-related obstetrics claims (5%) but higher than the proportion for non-obstetric claims (1%).

Table 6.1: Closed claims, 2003–04 to 2007–08: category of claim, by principal clinician specialty

Category of claim	Principal clinician specialty							
	Obstetrics only	Obstetrics and gynaecology	Midwifery	General practice—procedural	Anaesthetics	All other specialties	Not applicable	Total
Mother-related obstetrics claims	402	143	46	38	43	49	2	726
Baby-related obstetrics claims	321	54	31	27	4	36	0	479
Non-obstetric claims	19	142	3	92	308	7,125	59	7,805
Total	**742**	**339**	**80**	**157**	**355**	**7,210**	**61**	**9,010**
	Per cent (excluding *Not known*)							
Mother-related obstetrics claims	55.6	19.8	6.4	5.3	5.9	6.8	0.3	100.0
Baby-related obstetrics claims	67.9	11.4	6.6	5.7	0.8	7.6	0.0	100.0
Non-obstetric claims	0.2	1.8	<0.1	1.2	4.0	92.0	0.8	100.0
Total	**8.3**	**3.8**	**0.9**	**1.8**	**4.0**	**80.6**	**0.7**	**100.0**

Notes

1. The 'principal clinician specialty' categories listed separately here are the five categories recorded most commonly for obstetrics claims; all other categories are combined in *All other specialties*.
2. There were 66 claims coded *Not known* for 'principal clinician specialty'. These claims are included in the total number of 9,010 closed claims even though the *Not known* column is not presented. The number of claims on which the percentages presented in the bottom half of the table are based is 8,944.
3. Percentages may not add up exactly to 100.0 due to rounding.

Geographic location

There were few obvious differences between obstetrics and non-obstetric claims in terms of whether the alleged incident had occurred in major cities, regional or remote to very remote Australia. One possible difference is the slightly higher proportion of obstetrics claims in *Major cities*, and the correspondingly lower proportion with an *Inner regional* location (Table 6.2).

Table 6.2: Closed claims, 2003–04 to 2007–08: category of claim, by geographic location

	Geographic location[(a)]				
Category of claim	**Major cities**	**Inner regional**	**Outer regional**	**Remote and Very remote**	**Total**
Mother-related obstetrics claims	526	131	56	13	726
Baby-related obstetrics claims	336	95	42	6	479
Non-obstetric claims	5,038	2,095	567	79	7,805
Total	**5,900**	**2,321**	**665**	**98**	**9,010**
	Per cent (excluding *Not known*)				
Mother-related obstetrics claims	72.5	18.0	7.7	1.8	100.0
Baby-related obstetrics claims	70.1	19.8	8.8	1.3	100.0
Non-obstetric claims	64.8	26.9	7.3	1.0	100.0
Total	**65.7**	**25.8**	**7.4**	**1.1**	**100.0**

(a) The categories for this data item are based on the Australian Standard Geographical Classification Remoteness Structure categories (ABS 2001).

Note: There were 26 claims coded Not known for 'geographic location'. These claims are included in the total number of 9,010 closed claims even though the Not known column is not presented. The number of claims on which the percentages presented in the bottom half of the table are based is 8,984.

Primary body function/structure affected

The primary body function/structure affected in obstetrics claims data varied considerably depending on whether the claim subject was the mother or the baby. The most frequently recorded category for mother claim subjects was *Genitourinary and reproductive* (45%), followed by *Mental and nervous system* (32%). This latter body function/structure category was the most frequently recorded for baby-related obstetrics claims (47%), followed by *Neuromusculoskeletal and movement-related* effects (27%). *Death* was recorded for a lower proportion of obstetric-related than non-obstetric claims, whether the claim subject was a mother or baby (Table 6.3).

Table 6.3: Closed claims, 2003–04 to 2007–08: category of claim, by primary body function/structure affected

Category of claim	Primary body function/structure affected						
	Mental and nervous system	Neuromusculo-skeletal and movement-related	Genitourinary and reproductive	Death	All other body function/ structure categories	Not known	Total
Mother-related obstetrics claims	226	36	314	46	82	22	726
Baby-related obstetrics claims	198	114	19	42	48	58	479
Non-obstetric claims	900	1,894	904	997	2,665	445	7,805
Total	**1,324**	**2,044**	**1,237**	**1,085**	**2,795**	**525**	**9,010**
			Per cent (excluding *Not known*)				
Mother-related obstetrics claims	32.1	5.1	44.6	6.5	11.6	. .	100.0
Baby-related obstetrics claims	47.0	27.1	4.5	10.0	11.4	. .	100.0
Non-obstetric claims	12.2	25.7	12.3	13.5	36.2	. .	100.0
Total	**15.6**	**24.1**	**14.6**	**12.8**	**32.9**	**. .**	**100.0**

Notes

1. The primary body function/structure categories presented here are the four categories most commonly recorded for obstetrics claims; all other categories are combined in the category *All other body function/structure categories*.
2. The 525 claims coded Not known for 'primary body function/structure affected' are excluded for the purposes of calculating the percentages shown in the bottom half of the table, which are based on 8,485 claims.
3. Percentages may not add up exactly to 100.0 due to rounding.

Extent of harm and number of loss categories

'Number of loss categories' refers to the number of allegations of loss associated with a claim, which is Nil when the allegation of loss by both the claim subject and by another party/parties is *Not applicable* (Box 5.1). Nil loss categories were recorded for a higher proportion of claims associated with the claim subject's *Death* (19%) than any other 'extent of harm' category (Table 6.5). Claims associated with *Temporary* harm commonly had one to two loss categories recorded (66%), while claims associated with *Minor* harm usually had between one and three loss categories (78%) and claims associated with *Major* harm commonly had between three and four loss categories (60%).

Mother-related obstetrics claims were similar to non-obstetric claims both in the recorded extent of harm and number of alleged loss categories. In both categories of claims, approximately half had their extent of harm recorded as *Temporary* or *Minor*, and less than 20% had four or more loss categories recorded (tables 6.4 and 6.5).

Extent of harm was *Not known* for 34% of baby-related obstetrics claims. Where it was recorded, it was generally *Major* (41%) rather than *Temporary* or *Minor* (14% combined). A particular feature of baby-related obstetrics claims is that four or more loss categories were recorded for almost half of the claims (90 of 201, 45%) where the number of loss categories is known (Table 6.4). However, where the extent of harm was recorded as *Temporary*, the number of loss categories was usually Nil (90%).

Table 6.4: Closed claims, 2003–04 to 2007–08: extent of harm, by category of claim and nature of claim—loss to claim subject or other party (number of loss categories)

	Number of loss categories to claim subject or other party								
Extent of harm	**Nil**	**One**	**Two**	**Three**	**Four**	**Five or more**	**Not known**	**Total**	**Per cent**
					Mother-related obstetrics claims				
Temporary (less than 6 months duration)	36	28	31	19	10	0	57	181	24.9
Minor (6 months or more)	8	32	39	27	21	7	51	185	25.5
Major (6 months or more)	8	24	14	22	19	5	75	167	23.0
Death	3	11	1	5	6	4	16	46	6.3
Not applicable	5	6	1	1	1	0	5	19	2.6
Not known	4	6	5	3	1	0	109	128	17.6
Total mother-related obstetrics claims	**64**	**107**	**91**	**77**	**58**	**16**	**313**	**726**	**100.0**
					Baby-related obstetrics claims				
Temporary (less than 6 months duration)	17	0	1	1	0	0	1	20	4.2
Minor (6 months or more)	5	7	2	3	5	1	26	49	10.2
Major (6 months or more)	6	6	5	19	70	10	80	196	40.9
Death	4	6	3	4	1	1	23	42	8.8
Not applicable	3	0	0	0	0	0	5	8	1.7
Not known	8	10	1	0	1	1	143	164	34.2
Total baby-related obstetrics claims	**43**	**29**	**12**	**27**	**77**	**13**	**278**	**479**	**100.0**
					Non-obstetric claims				
Temporary (less than 6 months duration)	63	466	256	162	93	4	602	1,646	21.1
Minor (6 months or more)	37	407	424	445	297	12	551	2,173	27.8
Major (6 months or more)	39	117	144	191	268	23	315	1,097	14.1
Death	80	167	41	73	52	7	577	997	12.8
Not applicable	13	38	15	26	15	5	92	204	2.6
Not known	13	158	78	94	66	4	1,275	1,688	21.6
Total non-obstetric claims	**245**	**1,353**	**958**	**991**	**791**	**55**	**3,412**	**7,805**	**100.0**
					Total				
Temporary (less than 6 months duration)	116	494	288	182	103	4	660	1,847	20.5
Minor (6 months or more)	50	446	465	475	323	20	628	2,407	26.7
Major (6 months or more)	53	147	163	232	357	38	470	1,460	16.2
Death	87	184	45	82	59	12	616	1,085	12.0
Not applicable	21	44	16	27	16	5	102	231	2.6
Not known	25	174	84	97	68	5	1,527	1,980	22.0
Total	**352**	**1,489**	**1,061**	**1,095**	**926**	**84**	**4,003**	**9,010**	**100.0**

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

Table 6.5: Closed claims, 2003–04 to 2007–08: extent of harm, by category of claim and nature of claim—loss to claim subject or other party (number of loss categories) (excluding *Not known* and *Not applicable*) (per cent)

	Number of loss categories to claim subject or other party						
Extent of harm	**Nil**	**One**	**Two**	**Three**	**Four**	**Five or more**	**Total**
				Mother-related obstetrics claims			
Temporary (less than 6 months duration)	29.0	22.6	25.0	15.3	8.1	0.0	100.0
Minor (6 months or more)	6.0	23.9	29.1	20.1	15.7	5.2	100.0
Major (6 months or more)	8.7	26.1	15.2	23.9	20.7	5.4	100.0
Death	10.0	36.7	3.3	16.7	20.0	13.3	100.0
Total mother-related obstetrics claims	**14.5**	**25.0**	**22.4**	**19.2**	**14.7**	**4.2**	**100.0**
				Baby-related obstetrics claims			
Temporary (less than 6 months duration)	89.5	0.0	5.3	5.3	0.0	0.0	100.0
Minor (6 months or more)	21.7	30.4	8.7	13.0	21.7	4.3	100.0
Major (6 months or more)	5.2	5.2	4.3	16.4	60.3	8.6	100.0
Death	21.1	31.6	15.8	21.1	5.3	5.3	100.0
Total baby-related obstetrics claims	**18.1**	**10.7**	**6.2**	**15.3**	**42.9**	**6.8**	**100.0**
				Non-obstetric claims			
Temporary (less than 6 months duration)	6.0	44.6	24.5	15.5	8.9	0.4	100.0
Minor (6 months or more)	2.3	25.1	26.1	27.4	18.3	0.7	100.0
Major (6 months or more)	5.0	15.0	18.4	24.4	34.3	2.9	100.0
Death	19.0	39.8	9.8	17.4	12.4	1.7	100.0
Total non-obstetric claims	**5.7**	**29.9**	**22.4**	**22.5**	**18.4**	**1.2**	**100.0**
				Total			
Temporary (less than 6 months duration)	9.8	41.6	24.3	15.3	8.7	0.3	100.0
Minor (6 months or more)	2.8	25.1	26.1	26.7	18.2	1.1	100.0
Major (6 months or more)	5.4	14.8	16.5	23.4	36.1	3.8	100.0
Death	18.6	39.2	9.6	17.5	12.6	2.6	100.0
Total	**6.9**	**28.7**	**21.7**	**21.9**	**19.0**	**1.7**	**100.0**

Notes

1. The 4,003 claims coded *Not known* for number of loss categories and 2,211 claims coded *Not known* or *Not applicable* for extent of harm, including 1,629 claims coded *Not known* for both, are excluded from this table. The number of claims on which the percentages presented here are based is 4,425.

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

Primary incident/allegation type and total claim size

Obstetrics claims differed from non-obstetric claims in that they tended to have higher proportions of claims associated with a primary incident/allegation type of *Procedure* and a lower proportion with *Diagnosis*. Irrespective of whether the claim subject was the mother or the baby, *Procedure* was recorded for about half the obstetrics claims but *Diagnosis* for less than 15% (tables 6.6 and 6.7).

A higher proportion of baby-related obstetrics claims were settled for at least $500,000 (9%) than was the case with either non-obstetric (2%) or mother-related obstetrics claims (1%). Mother-related obstetrics claims were also distinguished by having a larger proportion closed for no cost (36%) compared with baby-related obstetrics claims or non-obstetric claims (respectively, 29% and 30%).

In the case of baby-related obstetrics claims, a primary incident/allegation of *Procedure* was more typical of claims closed for smaller amounts or no payment, whereas *Diagnosis* was recorded at an increasingly higher proportion as claim size rose. Moving stepwise from claims with no payment made to those settled for at least $500,000, there was a decrease from 69% to 49% in the proportion for which *Procedure* was recorded, and a corresponding increase from 5% to 32% in *Diagnosis*-related claims (Table 6.7). A similar pattern is evident for mother-related obstetrics claims and non-obstetric claims but with less regularity.

Table 6.6: Closed claims, 2003–04 to 2007–08: primary incident/allegation type, by category of claim and total claim size ($)

Primary incident/ allegation type	Total claim size						
	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Not known	Total
				Mother-related obstetrics claims			
Procedure[(a)]	144	96	69	42	4	0	355
Treatment[(b)]	50	47	24	5	1	2	129
Diagnosis	15	37	36	14	1	0	103
Other incident/ allegation types	41	46	25	15	1	0	128
Not known	10	1	0	0	0	0	11
Total mother-related obstetrics claims	**260**	**227**	**154**	**76**	**7**	**2**	**726**
Per cent	*35.8*	*31.3*	*21.2*	*10.5*	*1.0*	*0.3*	*100.0*
				Baby-related obstetrics claims			
Procedure[(a)]	90	115	19	8	32	6	270
Treatment[(b)]	26	47	7	3	9	2	94
Diagnosis	7	22	5	4	21	0	59
Other incident/ allegation types	8	9	2	1	4	3	27
Not known	17	10	0	0	0	2	29
Total baby-related obstetrics claims	**203**	**284**	**89**	**45**	**67**	**21**	**709**
Per cent	*28.6*	*40.1*	*12.6*	*6.3*	*9.4*	*3.0*	*100.0*
				Non-obstetric claims			
Procedure[(a)]	693	810	814	256	25	7	2,605
Treatment[(b)]	360	398	270	140	29	8	1,205
Diagnosis	485	581	400	203	62	4	1,735
Other incident/ allegation types	668	698	517	192	46	7	2,128
Not known	94	27	1	0	1	9	132
Total non-obstetric claims	**2,300**	**2,514**	**2,002**	**791**	**163**	**35**	**7,805**
Per cent	*29.5*	*32.2*	*25.7*	*10.1*	*2.1*	*0.4*	*100.0*
				Total			
Procedure[(a)]	927	1,021	902	306	61	13	3,230
Treatment[(b)]	436	492	301	148	39	12	1,428
Diagnosis	507	640	441	221	84	4	1,897
Other incident/ allegation types	717	753	544	208	51	10	2,283
Not known	121	38	1	0	1	11	172
Total	**2,704**	**2.944**	**2,189**	**883**	**236**	**50**	**9,010**
Per cent	*30.1*	*32.7*	*24.3*	*9.8*	*2.6*	*0.6*	*100.0*

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

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

Notes

1. The 'primary incident/allegation types' listed separately here are the three most commonly recorded categories; all other categories are combined in the category *Other incident/allegation types*.

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

Table 6.7: Closed claims, 2003–04 to 2007–08: primary incident/allegation type, by category of claim and total claim size ($) (excluding *Not known*) (per cent)

Primary incident/ allegation type	Total claim size					
	Nil	1–<10,000	10,000–<100,000	100,000–<500,000	500,000 or more	Total
			Mother-related obstetrics claims			
Procedure[(a)]	57.6	42.5	44.8	55.3	n.p.	49.8
Treatment[(b)]	20.0	20.8	15.6	6.6	n.p.	17.8
Diagnosis	6.0	16.4	23.4	18.4	n.p.	14.4
Other incident/ allegation types	16.4	20.4	16.2	19.7	n.p.	18.0
Total mother-related obstetrics claims	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Baby-related obstetrics claims			
Procedure[(a)]	68.7	59.6	57.6	50.0	48.5	60.1
Treatment[(b)]	19.8	24.4	21.2	18.8	13.6	21.0
Diagnosis	5.3	11.4	15.2	25.0	31.8	13.4
Other incident/ allegation types	6.1	4.7	6.1	6.3	6.1	5.5
Total baby-related obstetrics claims	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Non-obstetric claims			
Procedure[(a)]	31.4	32.6	40.7	32.4	15.4	34.0
Treatment[(b)]	16.3	16.0	13.5	17.7	17.9	15.7
Diagnosis	22.0	23.4	20.0	25.7	38.3	22.6
Other incident/ allegation types	30.3	28.1	25.8	24.3	28.4	27.7
Total non-obstetric claims	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
			Total			
Procedure[(a)]	35.8	35.1	41.2	34.7	26.0	36.6
Treatment[(b)]	16.9	16.9	13.8	16.8	16.6	16.1
Diagnosis	19.6	22.0	20.2	25.0	35.7	21.5
Other incident/ allegation types	27.7	25.9	24.9	23.6	21.7	25.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

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

Notes

1. The 172 claims coded Not known for 'primary incident/allegation type' and 50 coded Not known for 'total claim size', including 11 coded Not known for both, are excluded from this table. The number of claims on which the percentages presented here are based is 8,799.
2. The 'primary incident/allegation types' listed separately here are the three most commonly recorded categories; all other categories are combined in the category Other incident/allegation types.
3. Percentages may not add up exactly to 100.0 due to rounding.
4. n.p. indicates not published in view of the small number of claims on which these percentages would be based.

Appendix 1 Background to the MINC collection

Background to the collection

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

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

Collaborative arrangements

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

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

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

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

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

Purposes of the collection

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

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

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

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

Appendix 2 MINC data items and key terms

Table A2.1: MINC data items and definitions

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

(continued)

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

Data item	Definition
19.Mode of claim finalisation	Description of the process by which the claim was closed.
20.Total claim size	The amount agreed to be paid to the claimant in total settlement of the claim, plus defence legal costs, recorded in broad dollar ranges.
21.Status of claim	Status of the claim in terms of the stage it has reached in the process from a reserve being set to file closure.

Table A2.2: Definitions of key MINC terms

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

Appendix 3 Policy, administrative and legal features in each jurisdiction

New South Wales

The New South Wales Treasury Managed Fund (TMF) covers all employees of public health organisations (PHOs), as defined in the state's *Health Services Act 1997*. This includes area health services, most statutory health corporations, and affiliated health organisations in respect of recognised establishments.

In some circumstances TMF cover is available to visiting medical officers (VMOs) and honorary medical officers (HMOs) under a separate contract of liability cover. Since 1 January 2002 the government has offered VMOs and HMOs cover by the TMF when treating public patients in public hospitals, subject to certain conditions, including a condition that doctors sign up for comprehensive risk reduction programs. The majority of VMOs have elected to participate. At the same time, the government accepted financial responsibility for unreported incidents of medical defence organisations where the incidents involved public patients in public hospitals and the treating doctor had a VMO or HMO appointment.

Medical indemnity for private patients in rural public hospitals is the responsibility of the VMO or staff specialist (SS). Since 1 July 2003, however, VMOs and SSs levels 2 to 5 who have rights of private practice and work in rural areas and selected hospitals in the Hunter and Illawarra have been able to obtain public sector medical indemnity for private patients they treat in public hospitals, subject to various conditions.

Similarly, medical indemnity for private paediatric patients in public hospitals is the responsibility of the VMOs or SSs. However, since 1 January 2005, VMOs and SSs levels 2 to 5 (having rights of private practice) have been able to access public sector medical indemnity for private paediatric patients they treat in public hospitals in New South Wales. (Note that private paediatric patient indemnity for VMOs and SSs in the rural sector, including specified hospitals in the Hunter and Illawarra, has been available in their indemnity package since 1 July 2003.)

Since 1 January 2002 NSW Health has been providing three specified universities with interim cover (in specified areas of activity) through the TMF, for their clinical academics subject to the universities paying a per-claim excess of up to $250,000 (subject to annual consumer price index movements) capped at around $1 million a year. The period for which this interim cover was provided was extended to 31 December 2008.

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

The TMF fund manager manages all aspects of the claim, including arranging for such legal advice and representation as may be necessary. Incidents involving employees of PHOs are notified to the TMF through PHO risk managers. VMOs and HMOs are required by their contracts of liability coverage to notify their PHOs of all incidents; the PHO then notifies the New South Wales Department of Health, which notifies the TMF.

When notified of an incident, the TMF sets a reserve if it believes the incident is likely to become a claim and, if necessary, arranges to have a solicitor on the record. The TMF then investigates the incident, provides instructions to the solicitor, and conducts interviews. The TMF remains involved in the settlement of the claim through the courts or the settlement process.

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

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

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

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

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

Victoria

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

Rural procedural general practitioners can elect to participate in a Department of Human Services scheme whereby they can purchase medical indemnity cover for their private-practice work undertaken in certain rural and remote public hospitals and bush-nursing hospitals. There were 304 practitioners insured under this scheme in 2007–08. A significant proportion of these doctors are covered for obstetrics.

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

When a public health care agency service notifies the VMIA of an incident, the VMIA sets a financial reserve if it considers the incident is likely to materialise into a claim. This is classified as an 'open' claim and the files are reviewed at least twice in a 12-month period. If a minimum reserve is placed, the amount will at least cover legal defence costs. A claim reserve may be placed before a letter of demand or writ has been received.

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

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

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

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

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

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

Queensland

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

From 4 November 2002 Queensland Health restated its indemnity arrangements in a new indemnity policy for medical practitioners, Industrial Relations Policy Manual IRM 3.8–4. It confirmed the existing policy that Queensland Health indemnifies all medical practitioners engaged by Queensland Health to undertake the public treatment of public patients and medical practitioners treating private patients in limited specified circumstances. Indemnity under the policy is offered to doctors under an insurance-like model, with exclusions (proven criminal conduct and wilful neglect).

IRM 3.8–4 does not apply to doctors who are independent contractors providing services to Queensland Health, doctors engaged by agencies other than Queensland Health, or

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

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

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

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

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

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

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

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

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

- the majority of Justice Ipp's recommendations introduced
- a new way to assess general damages for pain and suffering in personal injury actions where the incident occurred after 1 December 2002

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

Western Australia

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

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

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

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

From 1 July 2004 salaried medical officers have been offered a contractual indemnity for MTL claims arising from their treatment of public patients and, where the salaried medical

officer has assigned his or her billing rights to the hospital, their treatment of private patients.

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

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

South Australia

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

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

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

The main parties involved in the claim process are the plaintiff and their solicitors, the SA Health's panel solicitors (the defendant's solicitors), the health unit from which the claim

emanated, the SA Health's Insurance Services, Minter Ellison lawyers (SA Health—appointed claims manager), and the South Australian Government Captive Insurance Corporation (SAICORP), which is responsible for claims for amounts above the department's excess.

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

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

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

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

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

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

Structured claim settlements are not common in South Australia.

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

- the *Wrongs (Liability and Damages for Personal Injury) Act 2002*. The Act sets limits to the damages that can be claimed for bodily injury. It applies a points scale to injury claims and limits claims for loss of capacity to earn a living. It also protects 'Good Samaritans' from legal liability if they make an error when trying to assist someone in an emergency, and it makes clear that there is no legal liability implied when one person apologises to another for an accident
- the *Statutes Amendment (Structured Settlements) Act 2002*, which allows people to have their compensation paid in instalments rather than as a lump sum if they wish
- the *Law Reform (Ipp Recommendations) Act 2005*. This Act makes changes to the law of negligence so that people are not liable to pay damages if the way in which the injury occurred was unforeseeable or a reasonable person would not have taken action to reduce the injury risk. It also prevents claims for failure to warn the injured person about a risk that should have been obvious to them. Further, the Act makes it harder for people to claim compensation if they have let the legal time limit go by, and requires parents to give early notice of an injury claim by a child, so that insurers can take this into account. Among other things, the Act also provides doctors and other professionals with a defence if they acted in accordance with what is widely accepted in Australia to be proper professional practice.

Tasmania

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

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

The claims management process is:

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

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

- clarification of aspects of the duty of care owed by medical practitioners to patients
- a statement that an apology—for example, by a medical practitioner to a patient—does not constitute an admission of fault or liability
- provision for a court to make an order approving of, or in the terms of, a structured settlement
- changes to the manner in which damages relating to loss of earning capacity, economic loss, and non-economic loss are assessed
- restriction of the circumstances in which a plaintiff may seek to recover damages for pure mental harm
- awarding of payments for gratuitous services (subject to certain conditions and effective from 15 December 2006). No damages were previously payable for such services
- a reduction of the discount rate used in determining a lump-sum payout, from 7 to 5 per cent, effective from 15 December 2006

- changes to the limitation period where an action for damages for negligence now cannot be brought after the sooner of 3 years from the date of discoverability or 12 years from the date of the cause of action (effective from 1 January 2006) (see s.5A of the *Limitation Act 1974*). Previously, the limitation period was 3 years from the date of the cause of action, with an extension of a further 3 years at the discretion of the court.

Australian Capital Territory

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

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

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

The overall manager of claims and provider of public medical indemnity cover in the ACT is ACT Health; the cover is underwritten by the ACT Insurance Authority, which obtains the necessary re-insurance cover internationally. ACT Health limits its excess to $50,000, the balance of any one claim then being covered by the insurance authority.

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

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

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

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

- changes to reduce the limitation period in which injured people can bring legal proceedings, from 6 years to 3 years from the date of the incident for legally competent

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

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

Northern Territory

Current public sector medical indemnity insurance arrangements in the Northern Territory cover VMOs and specialist medical officers providing medical services to any public patient. Cover is also extended to instances where care is provided to a public patient in a private hospital—for example, where care is provided outside the hospital setting. VMOs and specialist medical officers are still, however, required to cover any liability that may arise from services provided outside such agreements.

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

The main players in a medical negligence suit are the plaintiff and their representative lawyers, the defendant (that is, the Northern Territory, the Department of Health and

Community Services, and the hospital and/or staff involved), and the Departmental lawyer or the outsourced defence lawyers engaged by the department.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 4 Body function/structure categories

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

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

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