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

Contents

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Abbreviations

ACCC	Australian Competition and Consumer Commission
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulation Authority
DoHA	Australian Government Department of Health and Ageing
ISA	Insurance Statistics Australia
MDO	medical defence organisation
MIDWG	Medical Indemnity Data Working Group
MII	medical indemnity insurer
MINC	Medical Indemnity National Collection
MINC (PS)	Medical Indemnity National Collection (Public Sector)
MINC CC	Medical Indemnity National Collection Coordinating Committee
NCPD	National Claims and Policies Database
PSS	Premium Support Scheme

Symbols

. .	Not applicable

Summary

This report presents information from the Medical Indemnity National Collection for 2009–10. It describes characteristics and costs for public and private sector medical indemnity claims.

Claims

There were 9,415 medical indemnity claims open at some point between July 2009 and June 2010. This included 2,900 new claims opened during the period, and almost 2,650 claims that were closed during the period. There were more new claims in the public than the private sector (1,620 and 1,280 respectively), but there were more claims closed in the private sector than the public sector (1,471 and 1,176 respectively).

Between 2007–08 and 2009–10 the number of all claims in scope increased from 8,555 to 9,415 and the number of new claims increased from 2,255 to 2,900. However, there were more closed claims in 2007–08 (2,675 claims) and 2008–09 (3,093 claims) than in 2009–10.

Cost and duration

More than half (58%) of closed claims were settled for less than $10,000, including 17% where no payment was made. Just 6% were settled for $500,000 or more. Two-thirds (67%) of closed claims were finalised within 3 years of being opened, compared with 14% that took more than 5 years to be settled.

Just 3% of closed claims were finalised through a court decision, compared with 51% finalised through a negotiated settlement with the claimant. The remaining 46% were discontinued (for instance, following the claimant's withdrawal of the claim).

The alleged incidents and who was involved

As in previous years, the most common allegation of loss for new claims in 2009–10 related to *Procedure*—for example failure of procedure or post-operative complications (24% of claims). *Procedure* was followed by *Diagnosis* (20% of claims) and *Treatment* (15% of claims).

The most common allegation of harm was *Neuromusculoskeletal and movement-related*, accounting for 18% of new claims. The categories *Digestive, metabolic and endocrine systems* and *Death (*both 12%), *Mental and nervous system* and *Genitourinary and reproductive* (both 9%), were also commonly reported. Similar proportions were recorded for 2007–08 and 2008–09 except that the *Digestive, metabolic and endocrine systems* category was lower.

Almost three-quarters of allegedly affected patients were adults (74% of new claims), with female patients outnumbering males. In the case of persons aged 1–17 the patient was more often male than female. Where the patient was a baby, almost one-third of new claims (30%) were associated with *Mental and nervous system* effects.

As in 2007−08 and 2008−09, in 2009–10 the two most commonly recorded clinical specialties were *General practice* (18% of new claims) and *Obstetrics and Gynaecology* (9% of new claims).

About 24% of closed claims were associated with mild injury to the claim subject, 27% with moderate injury and 18% with severe injury. Severe injury was recorded for a higher proportion of the claims associated with *Diagnostic radiology* and *Urology* (29% and 28% respectively) than the claims associated with other clinician specialties. The claim subject's death was associated with 12% of closed claims.

Claim size was generally less than $10,000 when the injury was mild (78%) and often less than $10,000 when the injury was moderate (50%), but usually $10,000 or more when the injury was severe (65%).

1 Introduction

This report presents data on public and private sector medical indemnity claims for the period from 1 July 2009 to 30 June 2010. It is the sixth report of this nature, the first of which was *A national picture of medical indemnity claims in Australia 2004–05*, published in May 2007 (AIHW 2007).

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

The data presented in this report relate to claims that were open at any time during the reporting period, 1 July 2009 to 30 June 2010. With most but not all of these claims, a formal demand for compensation for alleged harm or other loss resulting from health care had been received by an MII or a public sector claims manager. There are five categories of claims represented in the data: all claims, new claims, closed claims, current claims and reopened claims (Box 1.1).

Most health service settings are either public (notably hospitals) or private (for example, hospitals and general practice clinics). However, it should be noted that a proportion of the claims involving public sector health authorities originate from alleged incidents in private settings, and a proportion of MII claims originate from alleged incidents in public settings. As an example of the former, some jurisdictions offer public cover to medical practitioners working in their private health clinics under particular circumstances (for example, if they are rurally based). As an example of the latter, visiting medical officers who treat private patients in public hospitals are often required to hold private medical indemnification (see the appendix 'Policy, administrative and legal features in each jurisdiction' in AIHW 2012).

The report has five chapters, with introductory information provided in Chapter 1 and the background to the collection summarised in Chapter 2. Chapter 3 includes information on the health-care incidents leading to claims, the health service settings in which incidents occurred and the specialties allegedly involved. Chapter 4 includes information on the people affected by claims and the nature of their loss and Chapter 5 provides details about the financial characteristics of claims. There are also four appendices that respectively detail the data items and definitions, the quality of the MINC data, differences between the public and private sectors in their claim management practices, and coding examples for some of the main data items.

Box 1.1: Types of claims in scope for the 2009–10 public and private sector report

All claims: public and private sector claims in scope (see below) that were open at any time between 1 July 2009 and 30 June 2010.

New claims: public sector claims in scope that had their reserve set, or private sector claims reported to the Australian Prudential Regulation Authority (APRA), between 1 July 2009 and 30 June 2010. These can be either closed or current.

Closed claims: any claims that were finalised by discontinuation, negotiation or a court decision, between 1 July 2009 and 30 June 2010.

Current claims: any claims in scope that remained open at 30 June 2010.

Reopened claims: current claims that had been considered closed at some point prior to 30 June 2010.

Potential claims: current claims for which a formal demand for compensation for alleged loss or harm has not been received.

Most of the claims in scope are linked to a formal demand for compensation for alleged loss or harm. However the scope also includes public sector potential claims, which are instances of suspected harm reported to the health authority claim manager that are considered likely to result in a formal demand at some point after the reporting period. The scope also includes potential claims in the private sector, where a medical indemnity insurer (MII) has incurred preparatory expenses from investigating incidents reported to the MII by an insured clinician. With those cases, the MII is legally obligated to report the potential claim to the Australian Prudential Regulation Authority (APRA) even if no formal demand for compensation has been received.

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

A small number of public sector claim records are excluded from particular tables. Some of the records for closed public sector claims aggregate financial data across several similar incidents. However, these claim records include the incident data for only one of the incidents, and the data on the other, similar incidents is contained in linked claim records. Both the claim records that aggregate financial data and their linked claims records are excluded from the tables that compare the cost of closing claims to other variables. This is because, unlike the other closed claims, there is no relationship between the recorded incident and the cost of closing the claim. Also, several of the public sector claim records have been created for the purpose of recording additional payments to some party other than the patient. These records duplicate the incident information already present in the claim record with the information on the payment to the patient. These claim records with duplicate information on the incident are excluded from the tables providing health-care incident data.

1.1 Background to the report

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

Collation of data on public sector medical indemnity claims started in 2003, and was followed by publication of data for the second six months of 2002–03 (January to June 2003) in December 2004 (AIHW 2004). Eight financial year reports on the public sector have been published subsequently, the last covering 2008–09 (AIHW 2011a).

In 2004, the Australian Government introduced the Premium Support Scheme (PSS), as part of a comprehensive medical indemnity package to help eligible clinicians meet the cost of their private medical indemnity insurance (Medicare Australia 2010). MIIs provide information on private sector medical indemnity claims to the Australian Government Department of Health and Ageing (DoHA) and the AIHW under arrangements made following the introduction of the PSS. The claims reported by the MIIs to the AIHW are the same claims that they are required to report to the Australian Prudential Regulation Authority (APRA).

Some of the claims reported by MIIs relate to medical defence organisation (MDO) run-off, which is a scheme for claims lodged with private sector medical indemnity insurers in the years when they were still organised as MDOs rather than MIIs. This claims information is combined with the corresponding public sector data supplied to the AIHW by states and territories in the production of the combined sector medical indemnity reports.

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

1.2 Collaborative arrangements

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

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

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

2 The collection

2.1 Data items and definitions

The MINC includes 23 data items. Definitions, classification codes, a guide for use and a brief history of the development of each item are documented in the *Medical indemnity national collection (public sector) data guide*, which is available from the AIHW on request. The 2004–05 version of the data guide is also available as an on-line publication.

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

2.2 Claim management practices

There are differences between the public and private sectors in the management of claims, with implications for the interpretation of the combined claims data in this report. The main differences in claim management practices between the two sectors relevant to this report are outlined in Box 2.1. Further information on claim management practices can be found in Appendix 3.

2.3 Data completeness and *Not known* rates

For the period from 1 July 2009 to 30 June 2010, 100% of all public sector claims 'in scope', that is, claims known to the jurisdictions as having been open at any time during the reporting period, were reported to the AIHW. The public sector coverage for the 2008–09 report was also 100%, and virtually 100% for the 2007–08 report (AIHW 2011a).

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

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

Box 2.1: Claim management practices

The public sector

A medical indemnity claim in the public sector is defined on the criterion of having a reserve placed against the estimated likely cost of settling the claim. Jurisdictions differ in the degree to which the report of a health-care incident triggers the setting of a reserve prior to any formal allegation of loss or harm. Jurisdictions also differ in whether they report these potential claims to the AIHW or not.

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

Private sector medical indemnity insurers

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

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

Clinical specialty registration

Clinician specialties in the private sector are recorded according to their specialty as registered with their insurer. This is different from the public sector where clinician specialties are registered as recorded with their employing or contracting health service provider. This difference has led to a methodological decision to combine certain categories of specialties for combined sector reporting, for instance, the public sector specialties of 'Obstetrics', 'Gynaecology' and 'Obstetrics and gynaecology' under 'Obstetrics and Gynaecology' (see Appendix 3).

Not known rates tend to be relatively high for new claims, which are those first reported to APRA or reserved during the reporting period. The *Not known* rate for the data item 'primary incident/allegation type' was 19% for new claims compared to 10% for all claims reported during 2009–10. For the data item 'primary body function/structure affected', the *Not known* rate was 19% for new claims and 11% for all claims. For age of claim subject it was 17% for new claims and 15% for all claims; for 'health service setting', 18% for new claims and 12% for all claims; and for clinician specialty, 18% for new claims and 8% for all claims.

The interpretation of the proportions presented in chapters 3 to 5 will be affected by the *Not known* rates particularly where these are in excess of 10%.

3 Claims for 2009–10

Table 3.1 presents the claim numbers for 2009–10 data and compares them with the claim numbers for 2008–09. The definitions of the categories of claims are provided in Box 1.1. Closed claims added to current claims sum to all claims. New claims can be either closed or current depending on whether they were closed in the year when they were opened. Reopened claims are current claims that had previously been closed.

In 2009–10, there were more new, reopened, current and all claims for the public sector than the private sector and more closed claims for the private sector than the public sector (Table 3.1). In comparison, in 2008–09, there were more new claims for the private sector than the public sector and more reopened and closed claims for the public sector than the private sector (AIHW 2011a).

Between 2008–09 and 2009–10, there was a substantial increase in the number of new claims in the public sector (from 1,291 to 1,620), while the number of closed claims decreased (from 1,867 to 1,176). In contrast over this period the number of new claims in the private sector decreased (from 1,334 to 1,280) while the number of closed claims increased (from 1,226 to 1,471).

Overall the number of new claims rose from 2008–09 to 2009–10 by 10%. However, the number of 2009–10 closed claims decreased by 14% from the 3,093 closed claims reported for 2008–09.

Table 3.1: Numbers of public sector claims and private sector (MII) claims, from 1 July 2007 to 30 June 2008 (2007–08) to 1 July 2009 to 30 June 2010 (2009–10)

Claim category	Public sector			Private sector			Total		
	2007–08	2008–09	2009–10	2007–08	2008–09	2009–10	2007–08	2008–09	2009–10
New	1,292	1,291	1,620	963	1,334	1,280	2,255	2,625	2,900
Reopened	154	165	200	66	97	13	220	262	213
Closed	1,851	1,867	1,176	824	1,226	1,471	2,675	3,093	2,647
Current	3,429	3,205	3,688	2,451	2,875	3,080	5,880	6,080	6,768
All	5,280	5,072	4,864	3,275	4,101	4,551	8,555	9,173	9,415

Sources: AIHW 2010 and 2011a.

In the tables that provide data on clinician specialty, all records of an involved health professional are included in the public sector counts; that is, one claim may be reported against several clinician specialties (see Box 2.1). Accordingly, the total reports associated with the various clinician specialties will exceed the number of claims, and would also exceed 100% when expressed as percentages (tables 3.6 to 3.11, 5.11 and 5.12).

3.1 Health service setting

'Health service setting' refers to the setting in which the incident that gave rise to a claim took place. In 2009−10, a larger number of all and new claims were associated with public sector settings than private sector settings.

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

Almost half of all claims (48% or 4,513 claims) and new claims (44% or 1,276 claims) were reported as occurring within a public setting. Of these claims, 98% (4,415) of all claims and 97% (1,242) of new claims occurred within a public hospital or day surgery. *Other public setting*, for instance public community health centres and residential aged care services, was associated with 1% of both all and new claims (tables 3.2 and 3.4).

A private health service setting was the health service setting recorded for 39% (3,678) of all claims and 37% (1,076) of new claims. Of these claims, 40% (1,488) of all claims and 37% (401) of new claims occurred in a private hospital or day surgery (tables 3.2 and 3.4), while about half of all claims (1,811) and new claims (541) were recorded for private medical clinics.

Other private setting, for instance residential aged care services, was associated with 4% of all claims and 5% of new claims (tables 3.2 and 3.4). The health service setting was *Not known* in 12% of all claims and 18% of new claims.

The proportions of 2008–09 claims by health service setting (AIHW 2011a) were similar to those reported here.

3.2 Primary incident/allegation type

'Primary incident/allegation type' describes what is alleged to have gone wrong, that is, the area of possible error, negligence or problem that is determined to be of primary importance in giving rise to the claim. Coding examples for selected incident/allegation types are provided in Appendix 4 (Table A4.2).

The most commonly recorded category was *Procedure,* accounting for 27% (2,570) of all claims and 24% (707) of new claims (tables 3.2 to 3.5). *Diagnosis* and *Treatment* were the next most frequently recorded incident/allegation types and were associated with 24% (2,221) and 15% (1,445) of all claims (respectively). After *Procedure,* these two incident/allegation types were also the most frequently recorded for new claims with 582 claims (20%) recorded for *Diagnosis* and 433 claims (15%) recorded for *Treatment.*

The three most commonly recorded primary incident/allegation types for both all and new claims were *Procedure*, *Diagnosis* and *Treatment*, in that order, from 2004–05 to 2008–09 (AIHW 2007, 2008, 2010, 2011a, 2011b).

General duty of care accounted for 6% of both all and new claims (549 and 174 claims respectively). Except for *Not known*, the other categories each account for 6% or less of all claims and new claims. The primary incident/allegation type was *Not known* for 10% of all claims and 19% of new claims. Similar results were obtained from the 2007–08 and 2008–09 claims data (AIHW 2011a, 2011b).

With the 2009–10 claims data, *Procedure* was the most frequently recorded incident/allegation type for claims arising from an incident that occurred in a public hospital or day surgery. *Procedure*-related claims accounted for about 30% of all and new claims occurring in this health service setting. *Diagnosis* was recorded for 24% of all claims and 22%

of new claims, while *Treatment* was recorded for 21% of all claims and new claims in a public hospital/day surgery.

For claims arising from an incident occurring in private hospitals or day surgeries, *Procedure* was the most frequently recorded primary incident/allegation type, accounting for 58% of all claims and 53% of new claims. However in private medical clinics, *Diagnosis* was the most frequently recorded primary incident/allegation type, accounting for 44% of all claims and 41% of new claims—a substantial increase in these type of claims from 2008–09 (30% and 19% respectively). In *Other private settings, Diagnosis* was recorded for 33% of all claims while *Consent* was recorded for 31% of new claims.

In *Other* health service settings, *Diagnosis* and *General duty of care* accounted for 19% (15 of 80 claims) of all claims. *General duty of care* accounted for 30% (6 of 20) of new claims.

Table 3.2: All claims[a]: primary incident/allegation type, by health service setting, 1 July 2009 to 30 June 2010

Primary incident/ allegation type	Health service setting							
	Public hospital/day surgery[b]	Other public setting[c]	Private hospital/day surgery[d]	Private medical clinic[e]	Other private setting[f]	Other[g]	Not known	Total
Anaesthetic	71	0	100	10	1	1	12	195
Blood/blood product-related	49	3	6	0	0	1	0	59
Consent	149	2	45	27	86	0	5	314
Device failure[h]	19	0	10	5	3	0	0	37
Diagnosis	1,077	38	102	789	124	15	76	2,221
General duty of care	282	9	49	156	16	15	22	549
Infection control	39	0	3	8	1	0	1	52
Medication-related	226	3	25	148	13	4	17	436
Procedure	1,347	16	859	210	58	7	73	2,570
Treatment	945	20	154	231	62	11	22	1,445
Other	84	5	100	187	13	23	124	536
Not known	127	2	35	40	2	3	758	967
Total	**4,415**	**98**	**1,488**	**1,811**	**379**	**80**	**1,110**	**9,381**
Total per cent	*47.1*	*1.0*	*15.9*	*19.3*	*4.0*	*0.9*	*11.8*	*100.0*

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the health service setting and primary incident/allegation data recorded in another claim (see Box 1.1).

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

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

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

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

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

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

Table 3.3: All claims[a]: primary incident/allegation type, by health service setting, 1 July 2009 to 30 June 2010 (per cent)

	Health service setting							
Primary incident/ allegation type	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Anaesthetic	1.6	0.0	6.7	0.6	0.3	1.3	1.1	2.1
Blood/blood product-related	1.1	3.1	0.4	0.0	0.0	1.3	0.0	0.6
Consent	3.4	2.0	3.0	1.5	22.7	0.0	0.5	3.3
Device failure[h]	0.4	0.0	0.7	0.3	0.8	0.0	0.0	0.4
Diagnosis	24.4	38.8	6.9	43.6	32.7	18.8	6.8	23.7
General duty of care	6.4	9.2	3.3	8.6	4.2	18.8	2.0	5.9
Infection control	0.9	0.0	0.2	0.4	0.3	0.0	0.1	0.6
Medication-related	5.1	3.1	1.7	8.2	3.4	5.0	1.5	4.6
Procedure	30.5	16.3	57.7	11.6	15.3	8.8	6.6	27.4
Treatment	21.4	20.4	10.3	12.8	16.4	13.8	2.0	15.4
Other	1.9	5.1	6.7	10.3	3.4	28.8	11.2	5.7
Not known	2.9	2.0	2.4	2.2	0.5	3.8	68.3	10.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the health service setting and primary incident/allegation data recorded in another claim (see Box 1.1).
(b) Includes public psychiatric hospitals.
(c) Includes public community health centres, residential aged care services, hospices and alcohol and drug rehabilitation centres.
(d) Includes private psychiatric hospitals.
(e) Private clinics providing investigation and treatment on a non-residential, day-only basis, including 24-hour medical clinics and general practitioner surgeries.
(f) Includes private residential aged care services, hospices, and alcohol and drug rehabilitation centres.
(g) Includes patient's home and 'Medihotels'.
(h) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

Notes

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

Table 3.4: New claims[a]: primary incident/allegation type, by health service setting, 1 July 2009 to 30 June 2010

Primary incident/ allegation type	Health service setting							
	Public hospital/day surgery[b]	Other public setting[c]	Private hospital/day surgery[d]	Private medical clinic[e]	Other private setting[f]	Other[g]	Not known	Total
Anaesthetic	22	0	33	6	0	0	5	66
Blood/blood product-related	10	0	1	0	0	0	0	11
Consent	25	0	7	6	42	0	0	80
Device failure[h]	7	0	1	2	1	0	0	11
Diagnosis	274	12	29	224	26	4	13	582
General duty of care	92	2	15	55	1	6	3	174
Infection control	9	0	2	1	0	0	0	12
Medication-related	63	1	10	32	0	1	6	113
Procedure	378	5	214	75	22	2	11	707
Treatment	261	10	43	77	35	2	5	433
Other	25	3	31	44	6	5	43	157
Not known	76	1	15	19	1	0	434	546
Total	**1,242**	**34**	**401**	**541**	**134**	**20**	**520**	**2,892**
Total per cent	*42.9*	*1.2*	*13.9*	*18.7*	*4.6*	*0.7*	*18.0*	*100.0*

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the health service setting and primary incident/allegation data recorded in another claim (see Box 1.1).

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

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

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

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

(h) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

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

Table 3.5: New claims[a]: primary incident/allegation type, by health service setting, 1 July 2009 to 30 June 2010 (per cent)

	Health service setting							
Primary incident/ allegation type	**Public hospital/day surgery[b]**	**Other public setting[c]**	**Private hospital/day surgery[d]**	**Private medical clinic[e]**	**Other private setting[f]**	**Other[g]**	**Not known**	**Total**
Anaesthetic	1.8	0.0	8.2	1.1	0.0	0.0	1.0	2.3
Blood/blood product-related	0.8	0.0	0.2	0.0	0.0	0.0	0.0	0.4
Consent	2.0	0.0	1.7	1.1	31.3	0.0	0.0	2.8
Device failure[h]	0.6	0.0	0.2	0.4	0.7	0.0	0.0	0.4
Diagnosis	22.1	35.3	7.2	41.4	19.4	20.0	2.5	20.1
General duty of care	7.4	5.9	3.7	10.2	0.7	30.0	0.6	6.0
Infection control	0.7	0.0	0.5	0.2	0.0	0.0	0.0	0.4
Medication-related	5.1	2.9	2.5	5.9	0.0	5.0	1.2	3.9
Procedure	30.4	14.7	53.4	13.9	16.4	10.0	2.1	24.4
Treatment	21.0	29.4	10.7	14.2	26.1	10.0	1.0	15.0
Other	2.0	8.8	7.7	8.1	4.5	25.0	8.3	5.4
Not known	6.1	2.9	3.7	3.5	0.7	0.0	83.5	18.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the health service setting and primary incident/allegation data recorded in another claim (see Box 1.1).

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

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

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

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

(h) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

Notes

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

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

3.3 Specialty of clinician

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

For claims in the MINC public sector collection, up to four codes may be recorded for this data item to cater for those situations that involved more than one clinician (Appendix 3). Thus a single public sector claim may potentially be counted up to four times in tables 3.6 to 3.9. However, for claims in the private sector, only the specialty of the policy holder (an individual clinician) is recorded for each claim.

The twelve most commonly recorded clinical specialties during 2009–10 feature in tables 3.6 to 3.9. *General practice* (1,958 records) and *Obstetrics and Gynaecology* (1,369 records) were the most frequently recorded specialties, associated with 21% and 15% respectively of all claims—similar proportions to 2008–09 (20% and 16% respectively) (AIHW 2011a). For new claims, the same two specialties were the most frequently recorded, *General practice* on 522 occasions (18%) and *Obstetrics and Gynaecology* in 268 cases (9%). For new claims considerably more 2008–09 claims were associated with *General practice* (690 claims) whereas the number associated with *Obstetrics and Gynaecology* was similar (277 cases) (AIHW 2011a). Three other frequently recorded clinician specialties in 2009–10 were *General surgery*, *Orthopaedic surgery* and *Emergency medicine* each of which was associated with 5–8% of all and new claims.

The clinical specialties of *Obstetrics and Gynaecology*, *General surgery* and *Orthopaedic surgery* were recorded for about twice the proportion of claims that had *Procedure* as their incident/allegation type as they were for total claims.

- In the case of all claims, 26% of *Procedure*-related claims were associated with *Obstetrics and Gynaecology*, 16% with *General surgery* and 14% with *Orthopaedic surgery,* compared with the respective percentages of 15%, 7% and 7% for total claims.
- When new claims that are *Procedure*-related are considered, it can be seen that 19% were associated with *Obstetrics and Gynaecology*, 17% with *General surgery* and 13% with *Orthopaedic surgery*, whereas these clinical specialties were respectively recorded for 9%, 8% and 6% of total new claims.

Since 2007–08 the relationship of *Obstetrics and Gynaecology*, *General surgery* and *Orthopaedic surgery* to *Procedure*-related claims has fluctuated, with the largest change recorded for *Obstetrics and Gynaecology* (declining from 32% to 26% of all claims).

The specialty of *General practice* was associated with a relatively high proportion of claims with incident/allegation types of *Diagnosis* and *Medication-related*. The proportions were about one-third of all claims (33% and 37% respectively) and new claims (32% and 33% respectively), compared to the 21% of all claims and 18% of total new claims associated with *General practice*.

The clinical specialties of *Emergency medicine* and *Diagnostic radiology* were also recorded for a relatively high proportion of all *Diagnosis*-related claims, respectively 13% and 10%, compared to the proportions of 5% and 3% for the total of all claims with which these

specialties were associated. The association between *General practice* and *Diagnosis*-related claims has increased since 2007–08, from 22% of all claims and 28% of new claims, while for *Emergency medicine* the proportion has decreased from 25% of all *Diagnosis*-related claims

The specialty of *Orthopaedic surgery* was associated with about one-fifth of all and new claims with an incident/allegation type of *Device failure* (24% and 18% respectively), compared to the 7% of all claims and 6% of new claims associated with *Orthopaedic surgery*.

In the case of claims with a primary incident/allegation type of *General duty of care*, the proportions associated with *Psychiatry* and with *General nursing* were approximately five times the proportion of total claims. *Psychiatry* was recorded for 14% of both all and new claims with an incident/allegation type of *General duty of care*, compared to 3% of total claims. Similarly, *General nursing* was recorded for 9% of both all and new claims with an incident/allegation type of *General duty of care*, compared to 2% of the totals of all and new claims. The proportions of all *Psychiatry* and *General nursing* claims associated with *General duty of care* declined compared with 2007–08 (from 23% and 19% respectively) (AIHW 2011a, 2011b).

Table 3.6: All claims[a]: specialties of clinicians involved, by primary incident/allegation type, 1 July 2009 to 30 June 2010

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	152	2	3	0	9	5	0	12	64	20	13	8	288
Diagnostic radiology	1	0	2	1	224	6	1	4	33	18	6	6	302
Emergency medicine	0	6	5	0	287	26	2	18	22	134	5	4	509
General nursing	0	4	1	0	21	50	4	17	16	33	6	2	154
General practice[c]	16	4	13	3	731	163	11	162	223	318	228	86	1,958
General surgery	4	4	14	1	98	8	5	16	407	82	16	10	665
Neurosurgery	0	0	3	2	23	4	2	6	61	15	2	4	122
Obstetrics and Gynaecology[d]	9	1	76	4	223	50	1	32	661	230	20	62	1,369
Orthopaedic surgery	3	2	10	9	82	13	5	12	357	88	10	22	613
Paediatric medicine	0	1	1	0	66	6	0	10	14	36	3	4	141
Psychiatry	0	2	3	0	39	78	0	30	0	68	39	7	266
Other hospital-based medical practitioner[e]	5	0	3	0	91	33	0	8	48	34	48	27	297
All other specialties[f]	12	32	182	16	449	118	14	113	705	422	136	71	2,270
Not applicable[g]	0	1	4	0	2	10	2	2	13	16	2	0	52
Not known	2	1	1	1	19	8	8	7	29	21	7	666	770
Total[h]	**195**	**59**	**314**	**37**	**2,221**	**549**	**52**	**436**	**2,570**	**1,445**	**536**	**967**	**9,381**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the specialty of clinician and primary incident/allegation data recorded in another claim (see Box 1.1).

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

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

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

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

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

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

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

Table 3.7: All claims[a]: specialties of clinicians involved, by primary incident/allegation type, 1 July 2009 to 30 June 2010 (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	77.9	3.4	1.0	0.0	0.4	0.9	0.0	2.8	2.5	1.4	2.4	0.8	3.1
Diagnostic radiology	0.5	0.0	0.6	2.7	10.1	1.1	1.9	0.9	1.3	1.2	1.1	0.6	3.2
Emergency medicine	0.0	10.2	1.6	0.0	12.9	4.7	3.8	4.1	0.9	9.3	0.9	0.4	5.4
General nursing	0.0	6.8	0.3	0.0	0.9	9.1	7.7	3.9	0.6	2.3	1.1	0.2	1.6
General practice[c]	8.2	6.8	4.1	8.1	32.9	29.7	21.2	37.2	8.7	22.0	42.5	8.9	20.9
General surgery	2.1	6.8	4.5	2.7	4.4	1.5	9.6	3.7	15.8	5.7	3.0	1.0	7.1
Neurosurgery	0.0	0.0	1.0	5.4	1.0	0.7	3.8	1.4	2.4	1.0	0.4	0.4	1.3
Obstetrics and Gynaecology[d]	4.6	1.7	24.2	10.8	10.0	9.1	1.9	7.3	25.7	15.9	3.7	6.4	14.6
Orthopaedic surgery	1.5	3.4	3.2	24.3	3.7	2.4	9.6	2.8	13.9	6.1	1.9	2.3	6.5
Paediatric medicine	0.0	1.7	0.3	0.0	3.0	1.1	0.0	2.3	0.5	2.5	0.6	0.4	1.5
Psychiatry	0.0	3.4	1.0	0.0	1.8	14.2	0.0	6.9	0.0	4.7	7.3	0.7	2.8
Other hospital-based medical practitioner[e]	2.6	0.0	1.0	0.0	4.1	6.0	0.0	1.8	1.9	2.4	9.0	2.8	3.2
All other specialties[f]	6.2	54.2	58.0	43.2	20.2	21.5	26.9	25.9	27.4	29.2	25.4	7.3	24.2
Not applicable[g]	0.0	1.7	1.3	0.0	0.1	1.8	3.8	0.5	0.5	1.1	0.4	0.0	0.6
Not known	1.0	1.7	0.3	2.7	0.9	1.5	15.4	1.6	1.1	1.5	1.3	68.9	8.2
Total[h]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the specialty of clinician and primary incident/allegation data recorded in another claim (see Box 1.1).

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

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

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

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

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

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

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

Table 3.8: New claims[a]: specialties of clinicians involved, by primary incident/allegation type, 1 July 2009 to 30 June 2010

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	53	1	1	0	1	1	0	5	28	7	7	4	108
Cardiology	0	0	2	0	9	8	0	5	9	7	2	2	44
Diagnostic radiology	0	0	0	0	47	1	0	1	6	5	0	2	62
Emergency medicine	0	2	1	0	74	9	1	6	4	45	1	1	144
General nursing	0	1	0	0	7	16	1	2	7	12	3	0	49
General practice[c]	7	1	1	2	186	47	1	37	66	91	60	23	522
General surgery	1	1	3	1	36	3	1	4	122	39	7	2	220
Obstetrics and Gynaecology[d]	3	0	9	0	57	12	0	7	136	29	6	9	268
Orthopaedic surgery	0	1	1	2	18	7	3	6	95	35	2	8	178
Psychiatry	0	1	1	0	12	25	0	8	0	22	12	1	82
Urology	0	0	1	0	7	0	1	0	16	5	5	3	38
Other hospital-based medical practitioner[e]	1	0	0	0	26	8	0	2	21	9	13	6	86
All other specialties[f]	1	2	60	5	111	31	1	26	186	123	35	13	594
Not applicable[g]	0	1	1	0	0	2	1	1	4	6	0	0	16
Not known	2	0	1	1	11	5	2	4	14	8	4	474	526
Total[h]	**66**	**11**	**80**	**11**	**582**	**174**	**12**	**113**	**707**	**433**	**157**	**546**	**2,892**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the specialty of clinician and primary incident/allegation data recorded in another claim (see Box 1.1).

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

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

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

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

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

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

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

Table 3.9: New claims[a]: specialties of clinicians involved, by primary incident/allegation type, 1 July 2009 to 30 June 2010 (per cent)

	Primary incident/allegation type												
Specialty of clinician(s)[b]	**Anaesthetic**	**Blood/blood product-related**	**Consent**	**Device failure**	**Diagnosis**	**General duty of care**	**Infection control**	**Medication-related**	**Procedure**	**Treatment**	**Other**	**Not known**	**Total**
Anaesthetics	80.3	9.1	1.3	0.0	0.2	0.6	0.0	4.4	4.0	1.6	4.5	0.7	3.7
Cardiology	0.0	0.0	2.5	0.0	1.5	4.6	0.0	4.4	1.3	1.6	1.3	0.4	1.5
Diagnostic radiology	0.0	0.0	0.0	0.0	8.1	0.6	0.0	0.9	0.8	1.2	0.0	0.4	2.1
Emergency medicine	0.0	18.2	1.3	0.0	12.7	5.2	8.3	5.3	0.6	10.4	0.6	0.2	5.0
General nursing	0.0	9.1	0.0	0.0	1.2	9.2	8.3	1.8	1.0	2.8	1.9	0.0	1.7
General practice[c]	10.6	9.1	1.3	18.2	32.0	27.0	8.3	32.7	9.3	21.0	38.2	4.2	18.0
General surgery	1.5	9.1	3.8	9.1	6.2	1.7	8.3	3.5	17.3	9.0	4.5	0.4	7.6
Obstetrics and Gynaecology[d]	4.5	0.0	11.3	0.0	9.8	6.9	0.0	6.2	19.2	6.7	3.8	1.6	9.3
Orthopaedic surgery	0.0	9.1	1.3	18.2	3.1	4.0	25.0	5.3	13.4	8.1	1.3	1.5	6.2
Psychiatry	0.0	9.1	1.3	0.0	2.1	14.4	0.0	7.1	0.0	5.1	7.6	0.2	2.8
Urology	0.0	0.0	1.3	0.0	1.2	0.0	8.3	0.0	2.3	1.2	3.2	0.5	1.3
Other hospital-based medical practitioner[e]	1.5	0.0	0.0	0.0	4.5	4.6	0.0	1.8	3.0	2.1	8.3	1.1	3.0
All other specialties[f]	1.5	18.2	75.0	45.5	19.1	17.8	8.3	23.0	26.3	28.4	22.3	2.4	20.5
Not applicable[g]	0.0	9.1	1.3	0.0	0.0	1.1	8.3	0.9	0.6	1.4	0.0	0.0	0.6
Not known	3.0	0.0	1.3	9.1	1.9	2.9	16.7	3.5	2.0	1.8	2.5	86.8	18.2
Total[h]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the specialty of clinician and primary incident/allegation data recorded in another claim (see Box 1.1).

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

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

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

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

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

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

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

3.4 Closed claims: extent of harm and specialty of clinician

'Extent of harm' is a record of the extent or severity of overall harm to the claim subject resulting from the alleged incident. In cases where the claim subject has pre-existing impairments, activity limitations and/or participation restrictions, the category recorded for this item reflects only the additional harm or disability due to the incident, over and above any pre-existing conditions. This item is reported for closed claims because the claim subjects' extent of harm can be difficult to ascertain while a claim is still open.

Beginning with the 2009–10 data, the MIDWG agreed to revise the MINC extent of harm categories to better align with the Insurance Statistics Australia (ISA) 'severity of loss' data item (Appendix 1). As a consequence this is the first time that extent of harm data have been included in the public and private sector medical indemnity claims reports.

Of the 2,640 claims closed during 2009–10, 24% (635) were associated with *Mild injury*, 27% (710) with *Moderate injury* and 18% (466) with *Severe injury*. A further 325 claims (12%) were associated with the claim subject's death and 190 claims (7%) with no harm to the claim subject. There were 314 closed claims (12%) for which the extent of harm was *Not known* (tables 3.10 and 3.11).

Claims closed between 1 July 2009 and 30 June 2010 were very similar to all claims and new claims during the period in terms of which clinician specialties were most frequently recorded amongst these claims (see Section 3.3). *General practice* and *Obstetrics and Gynaecology* were recorded for 24% and 14% (632 and 359 respectively) of closed claims.

The other frequently recorded specialties were *General surgery*, *Orthopaedic surgery* and *Emergency medicine* (196, 184, 156 claims respectively), each associated with 6–7% of claims (Table 3.10). All other specialities, which include all specialties other than the 12 that are individually listed, were recorded for 27% of closed claims.

Moderate injury was the most commonly recorded 'extent of harm' category for the majority of clinical specialties (Table 3.11). However, its place was taken by *Mild injury* for *Anaesthetics* and *General practice* (40% and 20% of these claims respectively), by *Severe injury* for *Diagnostic radiology* (29% of these claims), and by *Death* for *Psychiatry* (27% of these claims).

Table 3.10: Closed claims[a]: specialties of clinicians involved, by extent of harm, 1 July 2009 to 30 June 2010

	Extent of harm							
Specialty of clinician(s)[b]	**Mild injury**	**Moderate injury**	**Severe injury**	**Death**	**No body function/ structure affected**	**Not known**	**Total**	*Total per cent*
Anaesthetics	36	14	11	7	5	17	90	*3.4*
Diagnostic radiology	20	25	26	10	6	4	91	*3.4*
Emergency medicine	33	54	26	36	3	4	156	*5.9*
General and internal medicine	7	12	5	10	0	5	39	*1.5*
General nursing	10	15	3	9	1	1	39	*1.5*
General practice[c]	128	123	100	97	83	101	632	*23.9*
General surgery	40	82	30	20	10	14	196	*7.4*
Obstetrics and Gynaecology[d]	66	116	95	28	12	42	359	*13.6*
Orthopaedic surgery	40	71	44	4	4	21	184	*7.0*
Psychiatry	13	13	12	23	13	11	85	*3.2*
Urology	6	14	11	4	2	2	39	*1.5*
Other hospital-based medical practitioner[e]	18	18	8	18	18	25	105	*4.0*
All other specialties[f]	227	181	125	65	34	72	704	*26.7*
Not applicable[g]	7	2	2	2	0	1	14	*0.5*
Not known	0	1	1	1	2	0	5	*0.2*
Total[h]	**635**	**710**	**466**	**325**	**190**	**314**	**2,640**	*100.0*

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are 12 public sector claims that duplicate the extent of harm and specialty of clinician data recorded in another claim (see Box 1.1).

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

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

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

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

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

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

(h) This is the total number of claims for which each claim size was recorded. A given specialty may only be recorded once for a single claim in the private sector, but up to four different specialties may be recorded for a public sector claim. Therefore, some public sector claims are represented in more than one row, and so the column totals exceed the number of claims. Also the percentage values in the last column, which show the proportion of claims for which each clinician specialty was recorded, cannot be summed vertically to give 100%.

Table 3.11: Closed claims[a]: specialties of clinicians involved, by extent of harm, 1 July 2009 to 30 June 2010 (per cent)

	Extent of harm						
Specialty of clinician(s)[b]	Mild injury	Moderate injury	Severe injury	Death	No body function/ structure affected	Not known	Total
Anaesthetics	40.0	15.6	12.2	7.8	5.6	18.9	**100.0**
Diagnostic radiology	22.0	27.5	28.6	11.0	6.6	4.4	**100.0**
Emergency medicine	21.2	34.6	16.7	23.1	1.9	2.6	**100.0**
General and internal medicine	17.9	30.8	12.8	25.6	0.0	12.8	**100.0**
General nursing	25.6	38.5	7.7	23.1	2.6	2.6	**100.0**
General practice[c]	20.3	19.5	15.8	15.3	13.1	16.0	**100.0**
General surgery	20.4	41.8	15.3	10.2	5.1	7.1	**100.0**
Obstetrics and Gynaecology[d]	18.4	32.3	26.5	7.8	3.3	11.7	**100.0**
Orthopaedic surgery	21.7	38.6	23.9	2.2	2.2	11.4	**100.0**
Psychiatry	15.3	15.3	14.1	27.1	15.3	12.9	**100.0**
Urology	15.4	35.9	28.2	10.3	5.1	5.1	**100.0**
Other hospital-based medical practitioner[e]	17.1	17.1	7.6	17.1	17.1	23.8	**100.0**
All other specialties[f]	32.2	25.7	17.8	9.2	4.8	10.2	**100.0**
Not applicable[g]	50.0	14.3	14.3	14.3	0.0	7.1	**100.0**
Not known	0.0	20.0	20.0	20.0	40.0	0.0	**100.0**
Total	24.1	26.9	17.7	12.3	7.2	11.9	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are 12 public sector claims that duplicate the extent of harm and specialty of clinician data recorded in another claim (see Box 1.1).

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

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

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

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

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

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

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

4 Patients who were the subjects of claims

This section provides a profile of the patients involved in the alleged health-care incident ('sex and age group of claim subject') and of the patients' alleged body function/structure affected ('primary body function/structure affected'). The 2009–10 data are presented in terms of the seven age groups used in the public sector MINC reports, whereas previous public and private sector reports presented data only in terms of those aged less than 1, between 1–17 and 18 or more.

4.1 Sex and age group of claim subject

The age of claim subjects refers to their age at the time of the alleged incident that gave rise to the claim. During 2009–10, 9% (810) of all claims and 5% (145) of new claims related to babies aged less than 1, 6% of all and 4% of new claims (566 and 110 respectively) related to persons aged 1–17 and 71% of all claims and 74% of new claims (6,623 and 2,143 claims) were related to adults (aged 18+). The age of the claim subject was not known in 15% (1,392) of all claims and 17% (494) of new claims (tables 4.1 to 4.4).

These proportions were similar to those recorded for 2008–09, although the proportion of claims with an adult claim subject was lower (65% and 60% for all and new claims respectively) and the *Not known* proportions were higher (19% and 30% for all and new claims respectively) for 2008–09 (AIHW 2011a).

The claim subject was female in more than half of all and new claims in 2009–10 (55% and 53% respectively) and male in just over one-third of all (36%) and new claims (35%). In the case of persons aged 1–17 the claim subject was more often male than female. Similarly, with the 2008–09 data, female adult claim subjects outnumbered male claim subjects, whereas male claim subjects aged 1–17 outnumbered their female counterparts (AIHW 2011a), as with 2009–10.

In 2009–10, the larger number of female compared to male adult claim subjects was particularly a feature of the 18–39 age group. For both all and new claims, the number of female claim subjects was more than twice the number of male claim subjects.

4.2 Primary incident/allegation type

In 2009–10, *Diagnosis* and *Procedure* were the most frequently recorded incident/allegation types for males, respectively accounting for 27% (919) and 25% (847) of all claims, and 22% (229) and 23% (241) of new claims. *Treatment* was also often recorded, for 19% of both all and new claims (644 and 194 respectively). With females, *Procedure* was the most common incident/allegation type, recorded for 32% (1,656) of all claims and 29% (451) of new claims. *Diagnosis* and *Treatment* followed in frequency, being respectively recorded for 24% (1,223) and 15% (755) of all claims, and 21% (331) and 15% (224) of new claims. Similar results were found for the 2008–09 claims data (AIHW 2011a).

As in 2007–08 and 2008–09, a relatively high proportion of claims with the claim subject recorded as a baby had a primary incident/allegation type of *Procedure* and *Treatment* (AIHW 2011a, 2011b). For 2009–10, this was the case with 28% and 27% respectively of all baby claims and 16% and 21% respectively of new baby claims. *Diagnosis* on the other hand was more a feature of claims with a person aged 1–17 as the claim subject, and was recorded for 237 (43%) of all claims and 37 (34%) of new claims for that age group (figures 4.1 and 4.2).

The proportion of all claims with *Procedure* as the incident/allegation type varied between 34% for adults aged 60–79 and 22% for adults aged 80 or more. *Procedure* was the most common incident/allegation type for every adult age category for new claims (figures 4.1 and 4.2).

The data on claim subjects' age and sex in previous reports up to 2006–07 in this series (AIHW 2007, 2008, 2010) were not presented in a way that allows many direct comparisons with the 2009–10 data. However for new claims since 2004–05, it can be noted that the proportion with baby claim subjects has remained constant at 4–6%, the proportion involving claim subjects aged 1–17 has varied between 4% and 8% and the proportion of adult claim subjects has varied between 60% and 74%. In addition, as of 2006–07 *Treatment* was recorded for a higher proportion of both all and new claims with babies as the claim subject than claims associated with any other age group.

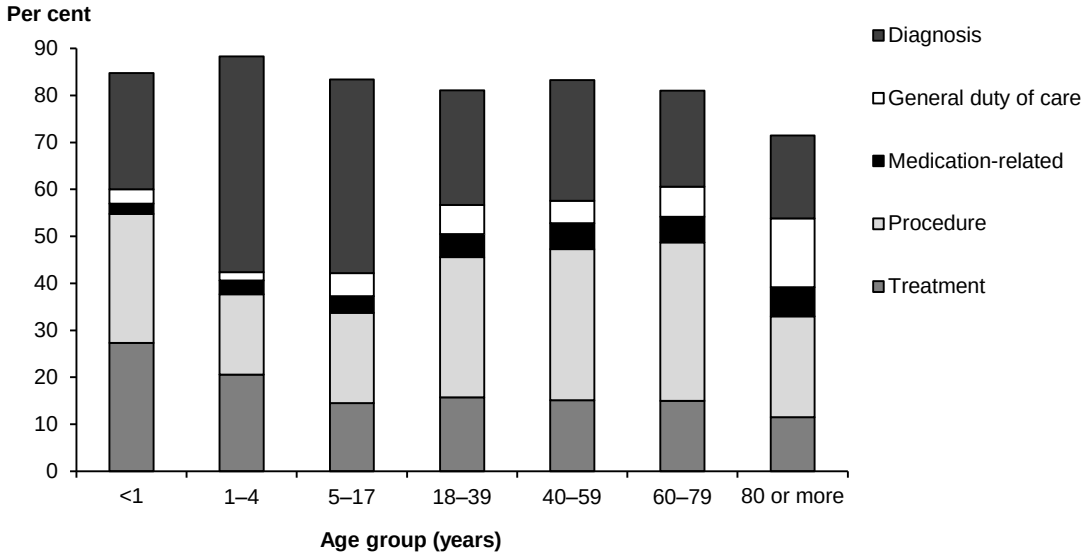

Figure 4.1: All claims: five most common primary incident/allegation types, by claim subject's age group, 2009–10 (per cent)

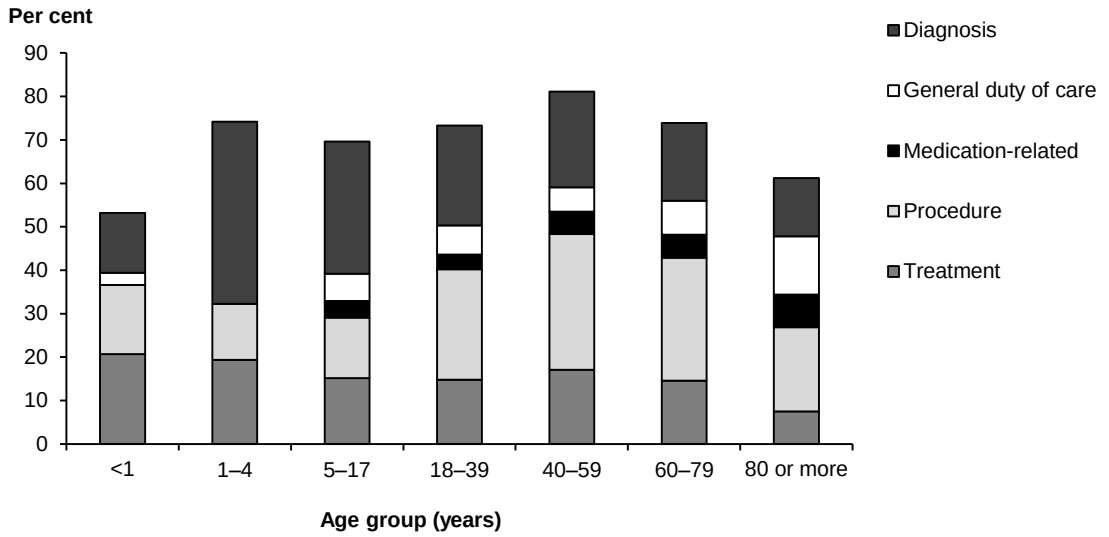

Figure 4.2: New claims: five most common primary incident/allegation types, by claim subject's age group, 2009–10 (per cent)

4.3 Primary body function/structure affected

The 'primary body function/structure affected' specifies the main body function or structure of the claim subject which is alleged to have been affected as a result of the health-care incident. Coding examples for selected categories of this data item are provided in Appendix 4 (Table A4.1).

During 2009–10, the most frequently recorded body function/structure affected was *Neuromusculoskeletal and movement-related* which was recorded for about 18% of both all claims (1,732 of 9,381) and new claims (505 of 2,892) (tables 4.5 to 4.8). The next three most frequently recorded categories for all claims were *Mental and nervous system*, *Death* and *Genitourinary and reproductive*, recorded for 15% (1,388) and 12% (1,135) and 11% (983) respectively. For new claims, *Digestive, metabolic and endocrine systems* and *Death* were the second and third most frequently recorded categories, each recorded for 12% (357 and 344 respectively) of claims (tables 4.5 to 4.8). Those claims where no body function/structure of the claim subject was affected represented 6% (594) of all claims and 7% (215) of new claims.

Neuromusculoskeletal and movement-related was the category most frequently recorded for children aged 1–17 (147 all claims; 22 new claims) and adults aged 40–59 and 60–79. While male adult claims relating to *Neuromusculoskeletal and movement-related* decreased with increasing age, from 28% to 13% for all claims, for females the pattern was reversed, with the proportion of claims generally increasing as age increased (from 15% to 27% for all claims) (tables 4.5 to 4.8).

In 2009–10, 11% of all claims and 19% of new claims recorded the primary body function/structure affected as *Not known*. This compares to 12% of all claims and 25% of new claims in 2008–09.

Death was recorded more frequently for male claim subjects being associated with 15% of both all and new claims where the subject was male (519 and 160 claims respectively), compared to just under 10% of both all and new claims where the claim subject was female (482 and 149 respectively). Similar proportions of claims recording *Death* as the primary body

function/structure were reported for 2008–09: 16–17% for males and 11% for females for both all and new claims (AIHW 2011a).

Where the claim subject was a baby, *Mental and nervous system* was by far the most frequently recorded category, for both sexes and particularly for males. The proportion of all baby claims associated with *Mental and nervous system* damage was 49% (398 claims), and 30% for new baby claims (44 claims) (figures 4.3 and 4.4).

As for 2008–09, the categories *Genitourinary and reproductive* and *Skin and related structures* were recorded for a higher proportion of claims involving female than male adult claim subjects. *Genitourinary and reproductive* was the third most frequent category for adult females for all claims (775 of 5,131 claims, 15%) and the second most frequent category for new claims (208 of 1,546 claims, 13%). This compares to 16% of all claims and 18% of new claims in 2008–09 (AIHW 2011a).

Claims associated with *Digestive, metabolic and endocrine systems* were also common for both males and females, accounting for about one in nine (11%) of all claims for both sexes.

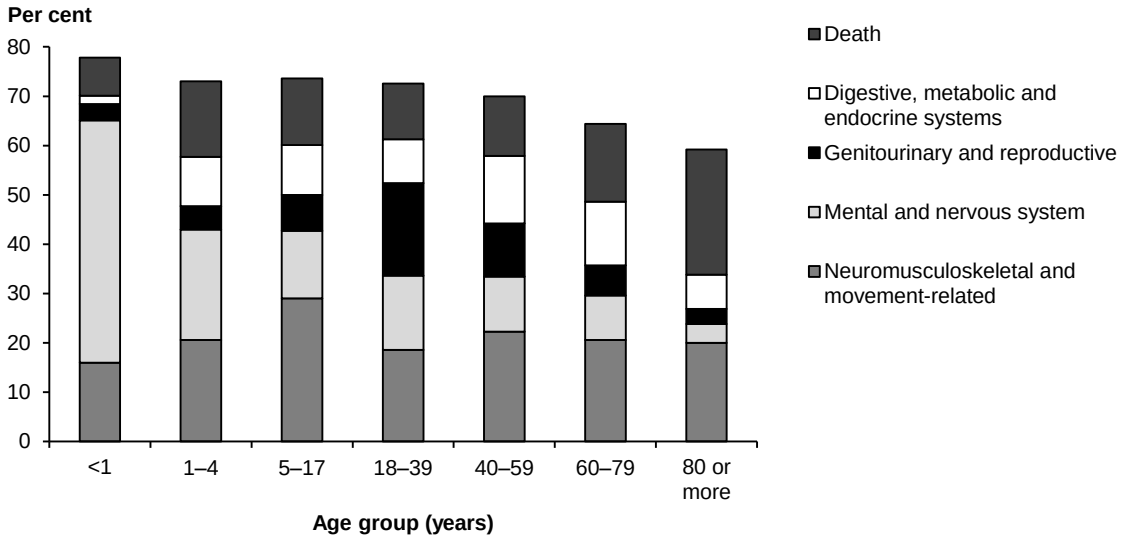

Figure 4.3: All claims: five most common primary body function/structure affected categories, by claim subject's age group, 2009–10 (per cent)

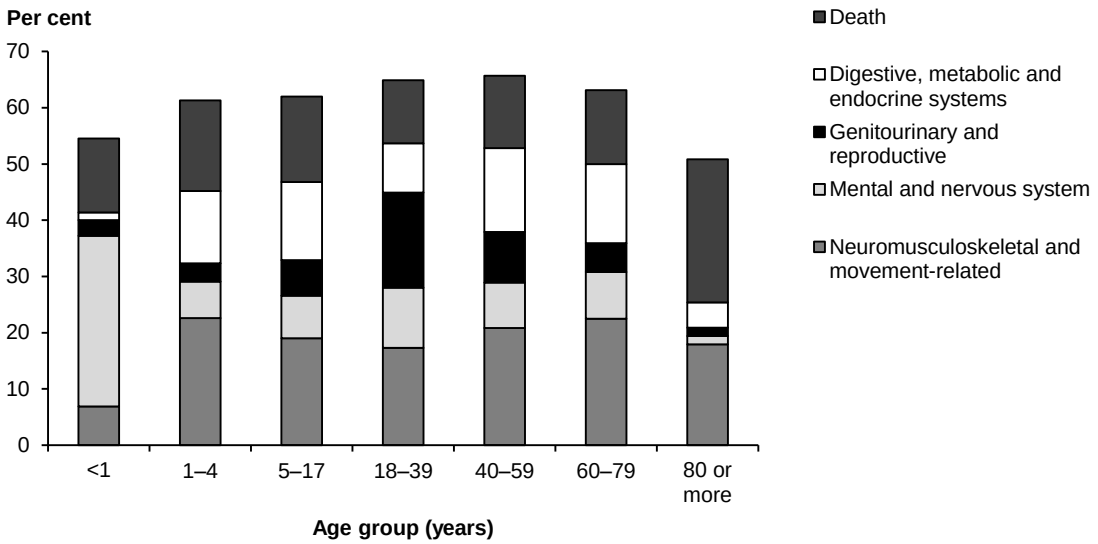

Figure 4.4: New claims: five most common primary body function/structure affected categories, by claim subject's age group, 2009–10 (per cent)

Table 4.1: All claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2009 to 30 June 2010

Primary incident/ allegation type	Age group (years)								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
Males									
Anaesthetic	1	0	3	9	29	19	2	5	68
Blood/blood product-related	4	0	3	11	7	4	0	0	29
Consent	7	1	4	18	33	7	0	12	82
Device failure[b]	0	0	0	1	5	4	2	3	15
Diagnosis	87	41	95	220	304	110	9	53	919
General duty of care	16	3	12	47	63	29	5	19	194
Infection control	2	1	4	4	10	5	0	3	29
Medication-related	6	3	7	53	66	25	4	15	179
Procedure	104	13	31	177	294	170	14	44	847
Treatment	100	18	32	164	189	90	8	43	644
Other	3	0	6	19	26	10	2	18	84
Not known	44	5	15	59	71	37	10	52	293
Total males	*374*	*85*	*212*	*782*	*1,097*	*510*	*56*	*267*	*3,383*
Females									
Anaesthetic	3	1	1	36	29	26	3	15	114
Blood/blood product-related	1	0	2	8	10	3	0	1	25
Consent	4	1	7	79	77	29	1	22	220
Device failure[b]	1	1	1	8	2	6	0	0	19
Diagnosis	111	34	62	416	380	114	14	92	1,223
General duty of care	7	0	5	107	56	38	14	32	259
Infection control	2	0	0	5	4	4	0	6	21
Medication-related	12	2	6	72	82	34	4	9	221
Procedure	114	14	37	611	572	192	14	96	1,656
Treatment	110	17	23	251	211	76	7	60	755
Other	5	0	4	55	57	20	3	57	201
Not known	31	6	12	168	76	28	11	85	417
Total females	*401*	*76*	*166*	*1,816*	*1,556*	*567*	*71*	*478*	*5,131*
Persons[c]									
Anaesthetic	5	1	4	46	58	43	5	33	195
Blood/blood product-related	5	0	5	22	17	7	0	3	59
Consent	11	2	11	97	113	37	1	42	314
Device failure[b]	1	1	1	9	8	10	2	5	37
Diagnosis	201	78	159	649	697	228	23	186	2,221
General duty of care	24	3	19	166	129	72	19	117	549
Infection control	4	1	4	10	14	9	0	10	52
Medication-related	18	5	14	131	149	61	8	50	436
Procedure	223	29	74	796	875	377	28	168	2,570
Treatment	221	35	56	419	409	168	15	122	1,445
Other	8	2	10	83	90	33	5	305	536
Not known	89	13	29	233	155	73	24	351	967
Total persons	**810**	**170**	**386**	**2,661**	**2,714**	**1,118**	**130**	**1,392**	**9,381**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the primary incident/allegation and claim subject demographic data recorded in another claim (see Box 1.1).

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

(c) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

Table 4.2: All claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2009 to 30 June 2010 (per cent)

Primary incident/ allegation type	Age group (years)								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
Males									
Anaesthetic	0.3	0.0	1.4	1.2	2.6	3.7	3.6	1.9	2.0
Blood/blood product-related	1.1	0.0	1.4	1.4	0.6	0.8	0.0	0.0	0.9
Consent	1.9	1.2	1.9	2.3	3.0	1.4	0.0	4.5	2.4
Device failure[b]	0.0	0.0	0.0	0.1	0.5	0.8	3.6	1.1	0.4
Diagnosis	23.3	48.2	44.8	28.1	27.7	21.6	16.1	19.9	27.2
General duty of care	4.3	3.5	5.7	6.0	5.7	5.7	8.9	7.1	5.7
Infection control	0.5	1.2	1.9	0.5	0.9	1.0	0.0	1.1	0.9
Medication-related	1.6	3.5	3.3	6.8	6.0	4.9	7.1	5.6	5.3
Procedure	27.8	15.3	14.6	22.6	26.8	33.3	25.0	16.5	25.0
Treatment	26.7	21.2	15.1	21.0	17.2	17.6	14.3	16.1	19.0
Other	0.8	0.0	2.8	2.4	2.4	2.0	3.6	6.7	2.5
Not known	11.8	5.9	7.1	7.5	6.5	7.3	17.9	19.5	8.7
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females									
Anaesthetic	0.7	1.3	0.6	2.0	1.9	4.6	4.2	3.1	2.2
Blood/blood product-related	0.2	0.0	1.2	0.4	0.6	0.5	0.0	0.2	0.5
Consent	1.0	1.3	4.2	4.4	4.9	5.1	1.4	4.6	4.3
Device failure[b]	0.2	1.3	0.6	0.4	0.1	1.1	0.0	0.0	0.4
Diagnosis	27.7	44.7	37.3	22.9	24.4	20.1	19.7	19.2	23.8
General duty of care	1.7	0.0	3.0	5.9	3.6	6.7	19.7	6.7	5.0
Infection control	0.5	0.0	0.0	0.3	0.3	0.7	0.0	1.3	0.4
Medication-related	3.0	2.6	3.6	4.0	5.3	6.0	5.6	1.9	4.3
Procedure	28.4	18.4	22.3	33.6	36.8	33.9	19.7	20.1	32.3
Treatment	27.4	22.4	13.9	13.8	13.6	13.4	9.9	12.6	14.7
Other	1.2	0.0	2.4	3.0	3.7	3.5	4.2	11.9	3.9
Not known	7.7	7.9	7.2	9.3	4.9	4.9	15.5	17.8	8.1
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[c]									
Anaesthetic	0.6	0.6	1.0	1.7	2.1	3.8	3.8	2.4	2.1
Blood/blood product-related	0.6	0.0	1.3	0.8	0.6	0.6	0.0	0.2	0.6
Consent	1.4	1.2	2.8	3.6	4.2	3.3	0.8	3.0	3.3
Device failure[b]	0.1	0.6	0.3	0.3	0.3	0.9	1.5	0.4	0.4
Diagnosis	24.8	45.9	41.2	24.4	25.7	20.4	17.7	13.4	23.7
General duty of care	3.0	1.8	4.9	6.2	4.8	6.4	14.6	8.4	5.9
Infection control	0.5	0.6	1.0	0.4	0.5	0.8	0.0	0.7	0.6
Medication-related	2.2	2.9	3.6	4.9	5.5	5.5	6.2	3.6	4.6
Procedure	27.5	17.1	19.2	29.9	32.2	33.7	21.5	12.1	27.4
Treatment	27.3	20.6	14.5	15.7	15.1	15.0	11.5	8.8	15.4
Other	1.0	1.2	2.6	3.1	3.3	3.0	3.8	21.9	5.7
Not known	11.0	7.6	7.5	8.8	5.7	6.5	18.5	25.2	10.3
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the primary incident/allegation and claim subject demographic data recorded in another claim (see Box 1.1).

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

(c) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

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

Table 4.3: New claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2009 to 30 June 2010

Primary incident/ allegation type	Age group (years)								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
Males									
Anaesthetic	0	0	1	2	8	9	0	2	22
Blood/blood product-related	0	0	1	2	1	1	0	0	5
Consent	0	1	1	3	9	1	0	8	23
Device failure[b]	0	0	0	1	2	2	1	0	6
Diagnosis	6	6	15	53	89	38	4	18	229
General duty of care	3	0	2	9	20	13	2	7	56
Infection control	1	0	1	3	2	2	0	0	9
Medication-related	0	0	2	11	24	8	3	7	55
Procedure	13	2	4	42	103	49	5	23	241
Treatment	10	3	7	49	73	28	4	20	194
Other	1	0	0	3	10	3	0	3	20
Not known	30	3	9	40	46	27	9	16	180
Total males	*64*	*15*	*43*	*218*	*387*	*181*	*28*	*104*	*1,040*
Females									
Anaesthetic	0	0	0	6	5	1	2	4	18
Blood/blood product-related	0	0	1	1	6	7	0	9	24
Consent	0	0	1	13	17	9	0	10	50
Device failure[b]	1	1	0	1	0	1	0	0	4
Diagnosis	13	5	9	109	113	32	5	45	331
General duty of care	1	0	1	29	27	16	7	9	90
Infection control	0	0	0	0	1	1	0	0	2
Medication-related	0	0	1	8	25	12	2	2	50
Procedure	10	0	7	141	190	58	8	37	451
Treatment	15	3	5	59	85	29	1	27	224
Other	2	0	0	5	12	6	3	17	45
Not known	22	3	7	103	45	24	8	45	257
Total females	*64*	*12*	*32*	*475*	*526*	*196*	*36*	*205*	*1,546*
Persons[c]									
Anaesthetic	1	0	1	9	17	17	2	19	66
Blood/blood product-related	0	0	2	3	3	2	0	1	11
Consent	0	1	2	16	28	11	0	22	80
Device failure[b]	1	1	0	2	3	3	1	0	11
Diagnosis	20	13	24	169	208	71	9	68	582
General duty of care	4	0	5	49	53	31	9	23	174
Infection control	1	0	1	3	3	3	0	1	12
Medication-related	0	0	3	25	49	21	5	10	113
Procedure	23	4	11	187	295	112	13	62	707
Treatment	30	6	12	109	162	58	5	51	433
Other	3	0	0	17	27	11	3	96	157
Not known	62	6	18	146	97	56	20	141	546
Total persons	**145**	**31**	**79**	**735**	**945**	**396**	**67**	**494**	**2,892**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the primary incident/allegation and claim subject demographic data recorded in another claim (see Box 1.1).

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

(c) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

Table 4.4: New claims[a]: primary incident/allegation type, by sex and age group of claim subject, 1 July 2009 to 30 June 2010 (per cent)

Primary incident/ allegation type	Age group (years)								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
Males									
Anaesthetic	0.0	0.0	2.3	0.9	2.1	5.0	0.0	1.9	2.1
Blood/blood product-related	0.0	0.0	2.3	0.9	0.3	0.6	0.0	0.0	0.5
Consent	0.0	6.7	2.3	1.4	2.3	0.6	0.0	7.7	2.2
Device failure[b]	0.0	0.0	0.0	0.5	0.5	1.1	3.6	0.0	0.6
Diagnosis	9.4	40.0	34.9	24.3	23.0	21.0	14.3	17.3	22.0
General duty of care	4.7	0.0	4.7	4.1	5.2	7.2	7.1	6.7	5.4
Infection control	1.6	0.0	2.3	1.4	0.5	1.1	0.0	0.0	0.9
Medication-related	0.0	0.0	4.7	5.0	6.2	4.4	10.7	6.7	5.3
Procedure	20.3	13.3	9.3	19.3	26.6	27.1	17.9	22.1	23.2
Treatment	15.6	20.0	16.3	22.5	18.9	15.5	14.3	19.2	18.7
Other	1.6	0.0	0.0	1.4	2.6	1.7	0.0	2.9	1.9
Not known	46.9	20.0	20.9	18.3	11.9	14.9	32.1	15.4	17.3
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females									
Anaesthetic	0.0	0.0	0.0	1.3	1.0	0.5	5.6	2.0	1.2
Blood/blood product-related	0.0	0.0	3.1	0.2	1.1	3.6	0.0	4.4	1.6
Consent	0.0	0.0	3.1	2.7	3.2	4.6	0.0	4.9	3.2
Device failure[b]	1.6	8.3	0.0	0.2	0.0	0.5	0.0	0.0	0.3
Diagnosis	20.3	41.7	28.1	22.9	21.5	16.3	13.9	22.0	21.4
General duty of care	1.6	0.0	3.1	6.1	5.1	8.2	19.4	4.4	5.8
Infection control	0.0	0.0	0.0	0.0	0.2	0.5	0.0	0.0	0.1
Medication-related	0.0	0.0	3.1	1.7	4.8	6.1	5.6	1.0	3.2
Procedure	15.6	0.0	21.9	29.7	36.1	29.6	22.2	18.0	29.2
Treatment	23.4	25.0	15.6	12.4	16.2	14.8	2.8	13.2	14.5
Other	3.1	0.0	0.0	1.1	2.3	3.1	8.3	8.3	2.9
Not known	34.4	25.0	21.9	21.7	8.6	12.2	22.2	22.0	16.6
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[c]									
Anaesthetic	0.7	0.0	1.3	1.2	1.8	4.3	3.0	3.8	2.3
Blood/blood product-related	0.0	0.0	2.5	0.4	0.3	0.5	0.0	0.2	0.4
Consent	0.0	3.2	2.5	2.2	3.0	2.8	0.0	4.5	2.8
Device failure[b]	0.7	3.2	0.0	0.3	0.3	0.8	1.5	0.0	0.4
Diagnosis	13.8	41.9	30.4	23.0	22.0	17.9	13.4	13.8	20.1
General duty of care	2.8	0.0	6.3	6.7	5.6	7.8	13.4	4.7	6.0
Infection control	0.7	0.0	1.3	0.4	0.3	0.8	0.0	0.2	0.4
Medication-related	0.0	0.0	3.8	3.4	5.2	5.3	7.5	2.0	3.9
Procedure	15.9	12.9	13.9	25.4	31.2	28.3	19.4	12.6	24.4
Treatment	20.7	19.4	15.2	14.8	17.1	14.6	7.5	10.3	15.0
Other	2.1	0.0	0.0	2.3	2.9	2.8	4.5	19.4	5.4
Not known	42.8	19.4	22.8	19.9	10.3	14.1	29.9	28.5	18.9
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the primary incident/allegation and claim subject demographic data recorded in another claim (see Box 1.1).

(b) Aligns to 'Faulty/contaminated equipment' in the APRA NCPD (ISA data item 15, Appendix 1).

(c) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

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

Table 4.5: All claims[(a)]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2009 to 30 June 2010

Primary body function/ structure affected	Age group (years)								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
Males									
Cardiovascular, haematological, immunological and respiratory	28	6	10	46	77	48	3	16	234
Death	20	14	32	120	192	93	21	27	519
Digestive, metabolic and endocrine systems	6	7	16	82	150	63	3	45	372
Genitourinary and reproductive	16	7	16	40	61	34	4	9	187
Mental and nervous system	197	20	29	103	126	43	1	27	546
Neuromusculoskeletal and movement-related	48	17	59	220	253	98	7	35	737
Sensory functions and structures	5	5	13	38	72	51	5	9	198
Skin and related structures	3	5	6	39	60	19	1	10	143
Voice and speech	1	1	3	5	5	4	0	0	19
No function/structure affected	7	0	3	24	28	14	1	26	103
Not known	43	3	25	65	73	43	10	63	325
Total males	*374*	*85*	*212*	*782*	*1,097*	*510*	*56*	*267*	*3,383*
Females									
Cardiovascular, haematological, immunological and respiratory	27	1	8	86	100	37	2	18	279
Death	37	11	19	166	124	73	12	40	482
Digestive, metabolic and endocrine systems	7	9	23	152	215	78	6	83	573
Genitourinary and reproductive	11	1	11	452	229	32	0	39	775
Mental and nervous system	188	17	24	291	172	54	4	41	791
Neuromusculoskeletal and movement-related	80	18	52	273	344	129	19	57	972
Sensory functions and structures	4	7	7	50	71	50	6	20	215
Skin and related structures	6	5	7	109	153	44	1	36	361
Voice and speech	0	0	1	4	16	7	0	1	29
No function/structure affected	4	2	6	57	37	24	8	52	190
Not known	37	5	8	176	95	39	13	91	464
Total females	*401*	*76*	*166*	*1,816*	*1,556*	*567*	*71*	*478*	*5,131*
Persons[(b)]									
Cardiovascular, haematological, immunological and respiratory	58	7	19	141	182	90	5	44	546
Death	62	26	52	300	329	177	33	156	1,135
Digestive, metabolic and endocrine systems	14	17	39	236	371	144	9	142	972
Genitourinary and reproductive	27	8	28	500	293	68	4	55	983
Mental and nervous system	398	38	53	400	300	101	5	93	1,388
Neuromusculoskeletal and movement-related	130	35	112	495	606	230	26	98	1,732
Sensory functions and structures	9	13	21	88	143	104	11	34	423
Skin and related structures	10	10	13	149	216	63	2	52	515
Voice and speech	1	2	4	9	21	11	0	2	50
No function/structure affected	11	2	10	95	76	40	9	351	594
Not known	90	12	35	248	177	90	26	365	1,043
Total persons	**810**	**170**	**386**	**2,661**	**2,714**	**1,118**	**130**	**1,392**	**9,381**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the primary body function/structure affected and claim subject demographic data recorded in another claim (see Box 1.1).

(b) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

Table 4.6: All claims[(a)]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2009 to 30 June 2010 (per cent)

Primary body function/ structure affected	Age group (years)								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
Males									
Cardiovascular, haematological, immunological and respiratory	7.5	7.1	4.7	5.9	7.0	9.4	5.4	6.0	6.9
Death	5.3	16.5	15.1	15.3	17.5	18.2	37.5	10.1	15.3
Digestive, metabolic and endocrine systems	1.6	8.2	7.5	10.5	13.7	12.4	5.4	16.9	11.0
Genitourinary and reproductive	4.3	8.2	7.5	5.1	5.6	6.7	7.1	3.4	5.5
Mental and nervous system	52.7	23.5	13.7	13.2	11.5	8.4	1.8	10.1	16.1
Neuromusculoskeletal and movement-related	12.8	20.0	27.8	28.1	23.1	19.2	12.5	13.1	21.8
Sensory functions and structures	1.3	5.9	6.1	4.9	6.6	10.0	8.9	3.4	5.9
Skin and related structures	0.8	5.9	2.8	5.0	5.5	3.7	1.8	3.7	4.2
Voice and speech	0.3	1.2	1.4	0.6	0.5	0.8	0.0	0.0	0.6
No function/structure affected	1.9	0.0	1.4	3.1	2.6	2.7	1.8	9.7	3.0
Not known	11.5	3.5	11.8	8.3	6.7	8.4	17.9	23.6	9.6
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females									
Cardiovascular, haematological, immunological and respiratory	6.7	1.3	4.8	4.7	6.4	6.5	2.8	3.8	5.4
Death	9.2	14.5	11.4	9.1	8.0	12.9	16.9	8.4	9.4
Digestive, metabolic and endocrine systems	1.7	11.8	13.9	8.4	13.8	13.8	8.5	17.4	11.2
Genitourinary and reproductive	2.7	1.3	6.6	24.9	14.7	5.6	0.0	8.2	15.1
Mental and nervous system	46.9	22.4	14.5	16.0	11.1	9.5	5.6	8.6	15.4
Neuromusculoskeletal and movement-related	20.0	23.7	31.3	15.0	22.1	22.8	26.8	11.9	18.9
Sensory functions and structures	1.0	9.2	4.2	2.8	4.6	8.8	8.5	4.2	4.2
Skin and related structures	1.5	6.6	4.2	6.0	9.8	7.8	1.4	7.5	7.0
Voice and speech	0.0	0.0	0.6	0.2	1.0	1.2	0.0	0.2	0.6
No function/structure affected	1.0	2.6	3.6	3.1	2.4	4.2	11.3	10.9	3.7
Not known	9.2	6.6	4.8	9.7	6.1	6.9	18.3	19.0	9.0
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[(b)]									
Cardiovascular, haematological, immunological and respiratory	7.2	4.1	4.9	5.3	6.7	8.1	3.8	3.2	5.8
Death	7.7	15.3	13.5	11.3	12.1	15.8	25.4	11.2	12.1
Digestive, metabolic and endocrine systems	1.7	10.0	10.1	8.9	13.7	12.9	6.9	10.2	10.4
Genitourinary and reproductive	3.3	4.7	7.3	18.8	10.8	6.1	3.1	4.0	10.5
Mental and nervous system	49.1	22.4	13.7	15.0	11.1	9.0	3.8	6.7	14.8
Neuromusculoskeletal and movement-related	16.0	20.6	29.0	18.6	22.3	20.6	20.0	7.0	18.5
Sensory functions and structures	1.1	7.6	5.4	3.3	5.3	9.3	8.5	2.4	4.5
Skin and related structures	1.2	5.9	3.4	5.6	8.0	5.6	1.5	3.7	5.5
Voice and speech	0.1	1.2	1.0	0.3	0.8	1.0	0.0	0.1	0.5
No function/structure affected	1.4	1.2	2.6	3.6	2.8	3.6	6.9	25.2	6.3
Not known	11.1	7.1	9.1	9.3	6.5	8.1	20.0	26.2	11.1
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were open at any point during the financial year. Excluded are 34 public sector claims that duplicate the primary body function/structure affected and claim subject demographic data recorded in another claim (see Box 1.1).

(b) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

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

Table 4.7: New claims[(a)]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2009 to 30 June 2010

Primary body function/ structure affected	Age group (years)								
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	Total
Males									
Cardiovascular, haematological, immunological and respiratory	5	2	3	10	21	9	0	4	54
Death	4	2	5	31	71	26	10	11	160
Digestive, metabolic and endocrine systems	0	1	5	25	53	31	1	26	142
Genitourinary and reproductive	1	1	2	8	21	10	1	2	46
Mental and nervous system	22	1	4	27	30	14	0	10	108
Neuromusculoskeletal and movement-related	5	4	10	54	90	36	4	16	219
Sensory functions and structures	0	0	0	9	23	11	1	4	48
Skin and related structures	0	3	1	9	17	6	1	5	42
Voice and speech	0	0	2	1	2	1	0	0	6
No function/structure affected	1	0	0	5	13	9	1	10	39
Not known	26	1	11	39	46	28	9	16	176
Total males	*64*	*15*	*43*	*218*	*387*	*181*	*28*	*104*	*1,040*
Females									
Cardiovascular, haematological, immunological and respiratory	5	0	1	12	25	7	0	6	56
Death	10	2	6	40	45	23	7	16	149
Digestive, metabolic and endocrine systems	1	2	6	39	83	24	2	41	198
Genitourinary and reproductive	3	0	3	110	63	10	0	19	208
Mental and nervous system	20	1	2	49	46	16	1	12	147
Neuromusculoskeletal and movement-related	4	3	5	72	105	51	8	31	279
Sensory functions and structures	0	2	2	14	25	13	2	7	65
Skin and related structures	0	0	0	22	50	16	1	13	102
Voice and speech	0	0	0	1	8	2	0	1	12
No function/structure affected	0	0	2	12	18	7	6	20	65
Not known	21	2	5	104	58	27	9	39	265
Total females	*64*	*12*	*32*	*475*	*526*	*196*	*36*	*205*	*1,546*
Persons[(b)]									
Cardiovascular, haematological, immunological and respiratory	10	2	5	25	48	19	0	14	123
Death	19	5	12	82	122	52	17	35	344
Digestive, metabolic and endocrine systems	2	4	11	65	141	56	3	75	357
Genitourinary and reproductive	4	1	5	124	85	20	1	22	262
Mental and nervous system	44	2	6	79	77	33	1	23	265
Neuromusculoskeletal and movement-related	10	7	15	127	197	89	12	48	505
Sensory functions and structures	0	3	2	23	48	25	3	11	115
Skin and related structures	1	3	1	32	68	22	2	19	148
Voice and speech	0	1	2	2	10	3	0	2	20
No function/structure affected	1	0	3	30	39	18	7	117	215
Not known	54	3	17	146	110	59	21	128	538
Total persons	**145**	**31**	**79**	**735**	**945**	**396**	**67**	**494**	**2,892**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the primary body function/structure affected and claim subject demographic data recorded in another claim (see Box 1.1).

(b) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

Table 4.8: New claims[(a)]: primary body function/structure affected, by sex and age group of claim subject, 1 July 2009 to 30 June 2010 (per cent)

Primary body function/ structure affected	Age group (years)								Total
	<1	1–4	5–17	18–39	40–59	60–79	80 or more	Not known	
Males									
Cardiovascular, haematological, immunological and respiratory	7.8	13.3	7.0	4.6	5.4	5.0	0.0	3.8	5.2
Death	6.3	13.3	11.6	14.2	18.3	14.4	35.7	10.6	15.4
Digestive, metabolic and endocrine systems	0.0	6.7	11.6	11.5	13.7	17.1	3.6	25.0	13.7
Genitourinary and reproductive	1.6	6.7	4.7	3.7	5.4	5.5	3.6	1.9	4.4
Mental and nervous system	34.4	6.7	9.3	12.4	7.8	7.7	0.0	9.6	10.4
Neuromusculoskeletal and movement-related	7.8	26.7	23.3	24.8	23.3	19.9	14.3	15.4	21.1
Sensory functions and structures	0.0	0.0	0.0	4.1	5.9	6.1	3.6	3.8	4.6
Skin and related structures	0.0	20.0	2.3	4.1	4.4	3.3	3.6	4.8	4.0
Voice and speech	0.0	0.0	4.7	0.5	0.5	0.6	0.0	0.0	0.6
No function/structure affected	1.6	0.0	0.0	2.3	3.4	5.0	3.6	9.6	3.8
Not known	40.6	6.7	25.6	17.9	11.9	15.5	32.1	15.4	16.9
Total males	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Females									
Cardiovascular, haematological, immunological and respiratory	7.8	0.0	3.1	2.5	4.8	3.6	0.0	2.9	3.6
Death	15.6	16.7	18.8	8.4	8.6	11.7	19.4	7.8	9.6
Digestive, metabolic and endocrine systems	1.6	16.7	18.8	8.2	15.8	12.2	5.6	20.0	12.8
Genitourinary and reproductive	4.7	0.0	9.4	23.2	12.0	5.1	0.0	9.3	13.4
Mental and nervous system	31.3	8.3	6.3	10.3	8.7	8.2	2.8	5.9	9.5
Neuromusculoskeletal and movement-related	6.3	25.0	15.6	15.2	20.0	26.0	22.2	15.1	18.0
Sensory functions and structures	0.0	16.7	6.3	2.9	4.8	6.6	5.6	3.4	4.2
Skin and related structures	0.0	0.0	0.0	4.6	9.5	8.2	2.8	6.3	6.6
Voice and speech	0.0	0.0	0.0	0.2	1.5	1.0	0.0	0.5	0.8
No function/structure affected	0.0	0.0	6.3	2.5	3.4	3.6	16.7	9.8	4.2
Not known	32.8	16.7	15.6	21.9	11.0	13.8	25.0	19.0	17.1
Total females	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Persons[(b)]									
Cardiovascular, haematological, immunological and respiratory	6.9	6.5	6.3	3.4	5.1	4.8	0.0	2.8	4.3
Death	13.1	16.1	15.2	11.2	12.9	13.1	25.4	7.1	11.9
Digestive, metabolic and endocrine systems	1.4	12.9	13.9	8.8	14.9	14.1	4.5	15.2	12.3
Genitourinary and reproductive	2.8	3.2	6.3	16.9	9.0	5.1	1.5	4.5	9.1
Mental and nervous system	30.3	6.5	7.6	10.7	8.1	8.3	1.5	4.7	9.2
Neuromusculoskeletal and movement-related	6.9	22.6	19.0	17.3	20.8	22.5	17.9	9.7	17.5
Sensory functions and structures	0.0	9.7	2.5	3.1	5.1	6.3	4.5	2.2	4.0
Skin and related structures	0.7	9.7	1.3	4.4	7.2	5.6	3.0	3.8	5.1
Voice and speech	0.0	3.2	2.5	0.3	1.1	0.8	0.0	0.4	0.7
No function/structure affected	0.7	0.0	3.8	4.1	4.1	4.5	10.4	23.7	7.4
Not known	37.2	9.7	21.5	19.9	11.6	14.9	31.3	25.9	18.6
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Claims that were opened or notified during the financial year. Excluded are eight public sector claims that duplicate the primary body function/structure affected and claim subject demographic data recorded in another claim (see Box 1.1).

(b) 'Persons' includes claims for males, females and persons whose sex was indeterminate or unknown.

5 Administrative and financial characteristics

5.1 Duration of claims

The start date for measuring the duration of a claim is either the date the claim first had a reserve placed (public sector claims) or the date the claim was reported by the insured medical practitioner to a private insurer (private sector claims). The end date for measuring claim duration is either 30 June 2010 (for claims still open at this time) or the date the claim was closed (for claims closed between 1 July 2009 and 30 June 2010).

Of the claims open at the end of the period, 20% (1,350 of 6,768) had been open for less than 6 months, 66% (4,435 claims) for up to 2 years and 80% (5,389 claims) for up to 3 years (tables 5.1 and 5.2). A lower proportion of claims had been open for less than 6 months than the 30% recorded for 2008–09, reflecting less claims opened during the second half of the financial year in 2009–10. For the 2009–10 period 9% (632 of 6,768) had been open after more than 5 years' duration, the same proportion as for 2007–08 and 2008–09 (AIHW 2011a, 2011b).

Of the claims closed during the period, 7% (195 of 2,647) had been open for less than 6 months, 47% (1,252 claims) for up to 2 years and 67% (1,763 claims) for up to 3 years (tables 5.1 and 5.2). About 14% (379 of 2,647) of closed claims had been open for more than 5 years. In comparison, a lower proportion of claims closed in 2008–09 had been open for over 5 years (9%), but the proportion that had been open for up to 3 years was similar (AIHW 2011a). Of claims reopened during the period, 32% had lasted for a duration of more than 5 years.

5.2 Reserve range of current claims

The 'reserve range' of a claim is the estimated cost, in broad dollar ranges, which is set by the jurisdictional authority or MII against each claim. Tables 5.3 and 5.4 present data relating the reserve range of current claims to their duration.

About 70% of claims (4,741) had a reserve of less than $100,000, including 35% (2,395 claims) with a reserve of less than $10,000. There were 510 current claims (7%) with a reserve set between $250,000 and <$500,000 and 551 (8%) with a reserve set at $500,000 or above.

For claims with a reserve set at less than $10,000, 56% (1,353 of 2,395 claims) had been open for less than 1 year, contrasting with the 8% (182 claims) open for more than 4 years and 5% (124 claims) open for more than 5 years (Figure 5.1).

Claims with their reserve set at $250,000 to <$500,000, and especially $500,000 or more, tended to have remained open for a longer period of time than other current claims. The proportions of these claims open for more than 5 years were respectively 13% in the $250,000 to <$500,000 range (64 of 510 claims) and 32% of those reserved for at least $500,000 (175 of 551 claims). These proportions are the same as those recorded for 2008–09 (AIHW 2011a).

The association between higher reserve sizes and the length of time a claim is open is illustrated in Figure 5.1.

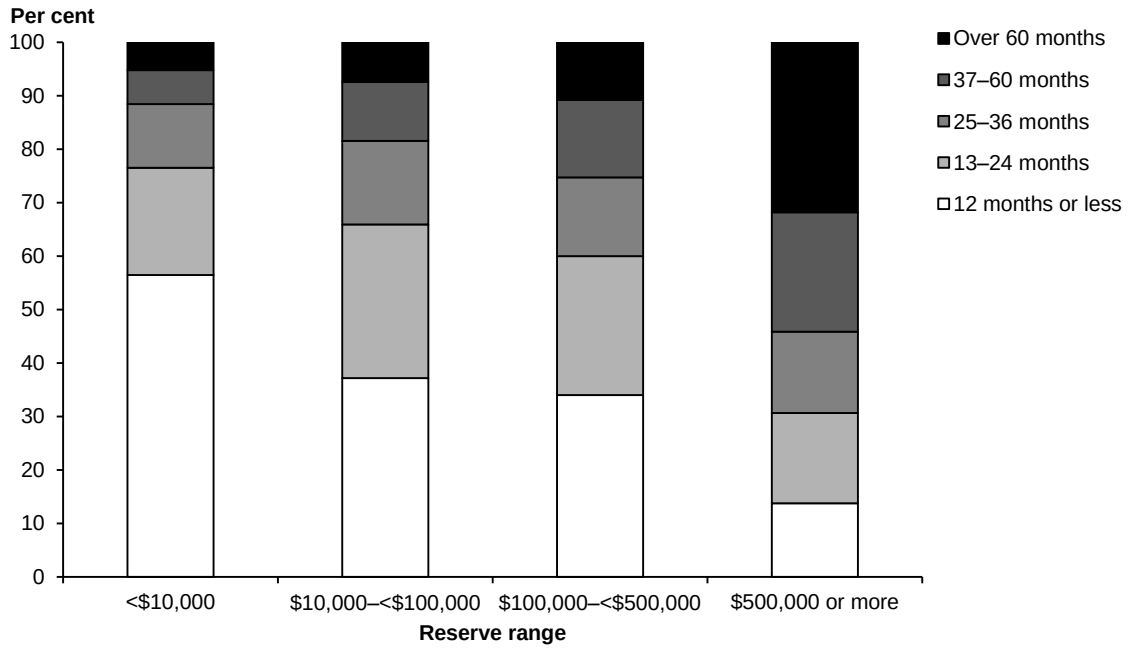

Figure 5.1: Current claims: length of claim (months), by reserve range, 30 June 2010 (per cent)

Table 5.1: All claims: status of claim, by duration of claim (months), at 30 June 2010

	Duration of claim at 30 June 2010 (months)											
Status of claim	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
New claims (1 July 2009 – 30 June 2010)	1,481	1,419	. .	. .	. .	. .	. .	. .	. .	. .	. .	2,900
Reopened	1	7	11	12	20	20	14	28	20	11	69	213
Closed	195	358	368	331	302	209	191	138	103	73	379	2,647
Claims open at 30 June 2010	1,350	1,454	903	728	530	424	259	216	160	112	632	6,768

. . Not applicable.

Notes

1. Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report'. For closed claims it is calculated to the date the claim was closed, and for other claims to 30 June 2010.
2. Closed claims in the MII collection include claims that are closed and no more payments are expected, or all recoveries expected from third parties other than reinsurers have been received.
3. Reopened claims include claims that have previously been recorded as closed, but have then been re-opened and are active.

Table 5.2: All claims: status of claim, by duration of claim (months), at 30 June 2010 (per cent)

	Duration of claim at 30 June 2010 (months)											
Status of claim	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
New claims (1 July 2009 – 30 June 2010)	51.1	48.9	. .	. .	. .	. .	. .	. .	. .	. .	. .	**100.0**
Reopened	0.5	3.3	5.2	5.6	9.4	9.4	6.6	13.1	9.4	5.2	32.4	**100.0**
Closed	7.4	13.5	13.9	12.5	11.4	7.9	7.2	5.2	3.9	2.8	14.3	**100.0**
Claims open at 30 June 2010	19.9	21.5	13.3	10.8	7.8	6.3	3.8	3.2	2.4	1.7	9.3	**100.0**

. . Not applicable.

Notes

1. Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report'. For closed claims it is calculated to the date the claim was closed, and for other claims to 30 June 2010.
2. Closed claims in the MII collection include claims that are closed and no more payments are expected, or all recoveries expected from third parties other than reinsurers have been received.
3. Reopened claims include claims that have previously been recorded as closed, but have then been reopened and are active.
4. Percentages may not add up exactly to 100.0 due to rounding.

Table 5.3: Current claims[(a)]: reserve range, by duration of claim (months), at 30 June 2010

	Duration of claim[(b)]											
Reserve range	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Less than $10,000	728	625	286	194	173	113	64	30	35	23	124	2,395
$10,000–<$30,000	161	216	176	142	103	79	39	34	18	16	60	1,044
$30,000–<$50,000	76	108	67	56	38	28	11	16	15	7	40	462
$50,000–<$100,000	142	170	135	98	62	57	31	29	24	18	74	840
$100,000–<$250,000	152	207	120	117	82	72	52	35	23	11	95	966
$250,000–<$500,000	59	84	71	76	33	30	31	34	13	15	64	510
$500,000 or more	32	44	48	45	39	45	31	38	32	22	175	551
Total	**1,350**	**1,454**	**903**	**728**	**530**	**424**	**259**	**216**	**160**	**112**	**632**	**6,768**

(a) Current claims are claims that are open, including reopened claims, at 30 June 2010.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to 30 June 2010.

Table 5.4: Current claims[(a)]: reserve range, by duration of claim (months), at 30 June 2010 (per cent)

	Duration of claim[(b)]											
Reserve range	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Less than $10,000	30.4	26.1	11.9	8.1	7.2	4.7	2.7	1.3	1.5	1.0	5.2	100.0
$10,000–<$30,000	15.4	20.7	16.9	13.6	9.9	7.6	3.7	3.3	1.7	1.5	5.7	100.0
$30,000–<$50,000	16.5	23.4	14.5	12.1	8.2	6.1	2.4	3.5	3.2	1.5	8.7	100.0
$50,000–<$100,000	16.9	20.2	16.1	11.7	7.4	6.8	3.7	3.5	2.9	2.1	8.8	100.0
$100,000–<$250,000	15.7	21.4	12.4	12.1	8.5	7.5	5.4	3.6	2.4	1.1	9.8	100.0
$250,000–<$500,000	11.6	16.5	13.9	14.9	6.5	5.9	6.1	6.7	2.5	2.9	12.5	100.0
$500,000 or more	5.8	8.0	8.7	8.2	7.1	8.2	5.6	6.9	5.8	4.0	31.8	100.0
Total	**19.9**	**21.5**	**13.3**	**10.8**	**7.8**	**6.3**	**3.8**	**3.2**	**2.4**	**1.7**	**9.3**	**100.0**

(a) Current claims are claims that are open, including reopened claims, at 30 June 2010.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to 30 June 2010.

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

5.3 Total claim size of closed claims

The 'total claim size' is the total amount paid to the claimant, as well as any legal or investigative defence costs, recorded in broad dollar ranges for closed claims (following a negotiated outcome, a court order or a decision by the claim manager to discontinue a claim). The amount paid to the claimant includes any interim payments and may include claimant legal costs. Tables 5.5 and 5.6 present data relating the claim size to the duration of closed claims.

There were 58% (1,524 claims) closed for less than $10,000, including 17% (443 of 2,647 claims) closed for no cost. In 2009–10, 147 claims (accounting for 6% of closed claims) were settled for over $500,000.

About 42% (185 of 443 claims) closed for no cost had durations between 25 and 42 months. The proportions of these no-cost claims settled within 6 months or taking more than 4 years to settle were small, both 8% (respectively 36 and 35 claims).

Half of claims closed for a cost of less than $10,000 (544 of 1,081 claims) were settled in 6 months to 2 years, as were 43% of claims settled for between $10,000 and <$30,000 (130 of 301 claims). About 14% of claims took more than 5 years to be settled, compared to 9% in 2008–09 (AIHW 2011a). A duration of 5 years or more was recorded for 23% (40 of 172) of claims settled for $50,000 to <$100,000, 29% (38 of 132) of claims settled for between $250,000 and <$500,000, and 44% (65 of 147) of claims settled for $500,000 or more. The association between increasing claim size and a longer duration to close the claim is illustrated in Figure 5.2.

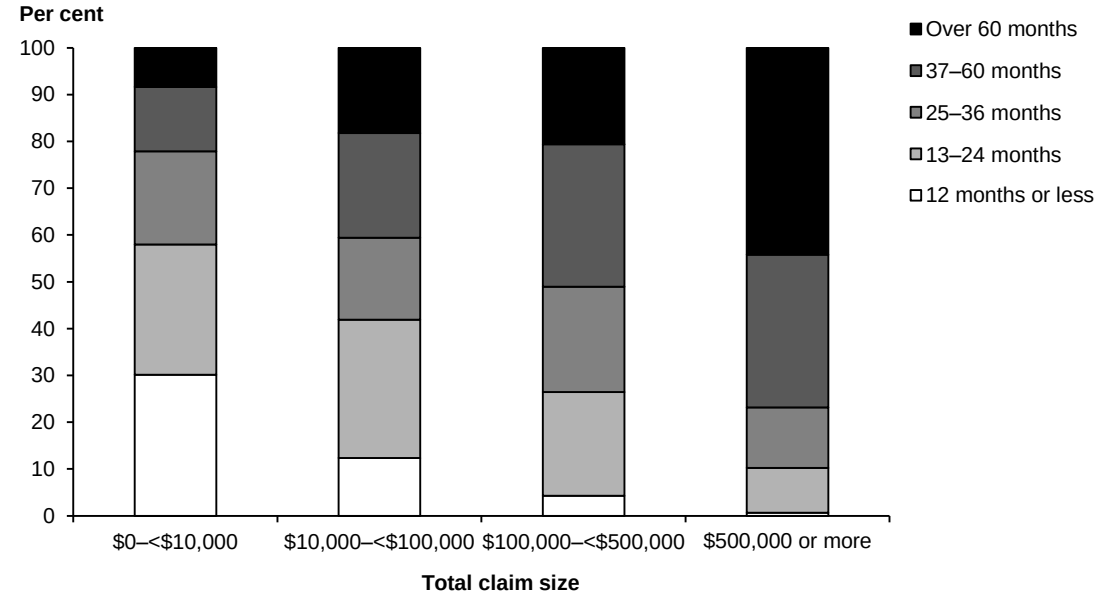

Figure 5.2: Closed claims: total claim size, by duration of claim (months), 1 July 2009 to 30 June 2010 (per cent)

Table 5.5: Closed claims[a]: total claim size, by duration of claim (months), 1 July 2009 to 30 June 2010

	Duration of claim[b]											
Total claim size	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Nil	36	59	52	53	64	58	63	23	12	4	19	443
$1−<$10,000	140	224	187	133	118	63	44	25	21	17	109	1,081
$10,000–<$30,000	11	34	49	47	32	21	20	17	13	10	47	301
$30,000–<$50,000	2	12	20	18	18	13	5	8	5	3	22	126
$50,000–<$100,000	6	9	17	26	12	9	21	13	9	10	40	172
$100,000–<$250,000	0	13	29	23	33	26	21	22	21	15	39	242
$250,000–<$500,000	0	3	11	20	14	11	6	14	11	4	38	132
$500,000 or more	0	1	3	11	11	8	11	16	11	10	65	147
Total[c]	**195**	**358**	**368**	**331**	**302**	**209**	**191**	**138**	**103**	**73**	**379**	**2,647**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to the date when the claim was closed.
(c) There were three private sector claims where the total claim size was not known. These claims are included in the totals for 'duration of claim' even though the *Not known* row is not presented.

Table 5.6: Closed claims[a]: total claim size, by duration of claim (months), 1 July 2009 to 30 June 2010 (per cent)

	Duration of claim[b]											
Total claim size	**<6**	**6–12**	**13–18**	**19–24**	**25–30**	**31–36**	**37–42**	**43–48**	**49–54**	**55–60**	**>60**	**Total**
Nil	8.1	13.3	11.7	12.0	14.4	13.1	14.2	5.2	2.7	0.9	4.3	100.0
$1−<$10,000	13.0	20.7	17.3	12.3	10.9	5.8	4.1	2.3	1.9	1.6	10.1	100.0
$10,000–<$30,000	3.7	11.3	16.3	15.6	10.6	7.0	6.6	5.6	4.3	3.3	15.6	100.0
$30,000–<$50,000	1.6	9.5	15.9	14.3	14.3	10.3	4.0	6.3	4.0	2.4	17.5	100.0
$50,000–<$100,000	3.5	5.2	9.9	15.1	7.0	5.2	12.2	7.6	5.2	5.8	23.3	100.0
$100,000–<$250,000	0.0	5.4	12.0	9.5	13.6	10.7	8.7	9.1	8.7	6.2	16.1	100.0
$250,000–<$500,000	0.0	2.3	8.3	15.2	10.6	8.3	4.5	10.6	8.3	3.0	28.8	100.0
$500,000 or more	0.0	0.7	2.0	7.5	7.5	5.4	7.5	10.9	7.5	6.8	44.2	100.0
Total[c]	**7.4**	**13.5**	**13.9**	**12.5**	**11.4**	**7.9**	**7.2**	**5.2**	**3.9**	**2.8**	**14.3**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010.
(b) Duration of claim is calculated from 'date reserve set' (if known) or else 'date of report' to the date when the claim was closed.
(c) There were three private sector claims where the total claim size was not known. These claims are included in the totals for 'duration of claim' even though the *Not known* row is not presented.

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

5.4 Mode of claim finalisation

A claim can be finalised through a variety of processes, such as a court decision, negotiation or discontinuation (including the claim being withdrawn by the claimant). The definition of these finalisation modes is provided in Appendix 4 (Table A4.3). Of the 2,646 claims closed between 1 July 2009 and 30 June 2010 with known mode of finalisation, 78 (3%) were finalised through a court decision, 1,352 (51%) were finalised through negotiation and 1,216 (46%) were discontinued (tables 5.7 and 5.8).

Discontinuation was the most frequently recorded mode of finalisation for claims closed for no cost (86% or 380 claims) or for a cost of less than $30,000 (55% or 760 claims). Discontinuation was rarely recorded for claims closed for $50,000 or more (45 of 693 claims, or 6%).

The number of nil cost claims that were discontinued decreased from 869 claims in 2008–09 (AIHW 2011a) to 380 claims in 2009–10. This decrease is at least partly due to the introduction of a coding rule for the 2009–10 public sector claims that allowed data providers to 'rescind' claims if legal action had not commenced and no expenses had been incurred ('$0 discontinued potential claims'), rather than report them as discontinued closed claims (AIHW 2012). This decrease is reflected in the lower proportion of nil cost claims and discontinued claims in 2009–10 (17% and 46% respectively) compared with 2008–09 (30% and 65% respectively).

Almost 89% (614) of the 693 claims with a claim size of $50,000 or more were settled through negotiation.

Court decisions were the least frequently recorded mode of claim finalisation for the 2009–10 reporting period, especially if the claim size was less than $10,000. The proportion of closed claims finalised via a court decision was 3% (78 of 2,647 claims), and was 1% (5 of 443) when no payment was made. These proportions are similar to those in 2008–09 (AIHW 2011a).

Table 5.7: Closed claims[a]: total claim size, by mode of claim finalisation, 1 July 2009 to 30 June 2010

	Mode of claim finalisation[b]				
Total claim size	Court decision	Negotiated	Discontinued	Total[c]	Column per cent
Nil	5	57	380	443	16.7
$1–<$10,000	14	450	617	1,081	40.8
$10,000–<$30,000	17	141	143	301	11.4
$30,000–<$50,000	8	89	29	126	4.8
$50,000–<$100,000	16	126	30	172	6.5
$100,000–<$250,000	5	226	11	242	9.1
$250,000–<$500,000	4	124	4	132	5.0
$500,000 or more	9	138	0	147	5.6
Total[c]	**78**	**1,352**	**1,216**	**2,647**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010.

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

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

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

Table 5.8: Closed claims[a]: total claim size, by mode of claim finalisation, 1 July 2009 to 30 June 2010 (per cent)[b]

	Mode of claim finalisation[c]			
Total claim size	Court decision	Negotiated	Discontinued	All closed claims
Nil	1.1	12.9	86.0	100.0
$1–<$10,000	1.3	41.6	57.1	100.0
$10,000–<$30,000	5.6	46.8	47.5	100.0
$30,000–<$50,000	6.3	70.6	23.0	100.0
$50,000–<$100,000	9.3	73.3	17.4	100.0
$100,000–<$250,000	2.1	93.4	4.5	100.0
$250,000–<$500,000	3.0	93.9	3.0	100.0
$500,000 or more	6.1	93.9	0.0	100.0
Total	**2.9**	**51.1**	**45.9**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010.

(b) Percentages are calculated on the basis of the 2,646 claims with known mode of finalisation.

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

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

5.5 Total claim size and health service setting

In 2009–10, the proportions of closed claims related to the various health service settings (tables 5.9 and 5.10) were similar to the proportions recorded for all and new claims (Section 3.1). *Public hospital or day surgery* accounted for 46% (1,224) of closed claims. This category was followed by *Private medical clinic* recorded for 22% (567) of closed claims, and *Private hospital/day surgery*, recorded for 17% (436) of closed claims.

As previously noted, 17% of closed claims did not involve any payment (Table 5.7). Of these claims 70% occurred within a private health setting (304 of 437 claims). Just over one-quarter (28%) of claims associated with a *Private hospital or day surgery* and 26% associated with a *Private medical clinic* were no cost claims. When all of the public health service settings are combined, there were 9% (110 of 1,253 claims) closed for no cost, compared to 27% (304 of 1,147 claims) in private settings where no cost was involved.

Settled claims with a claim size of $100,000 or more accounted for 20% of all closed claims (520, after excluding the seven claims for which there was no relationship between claim size and health service setting). These claims made up a larger proportion of claims associated with public settings (364 of 1,253 claims, 29%) than claims associated with private settings (126 of 1,147 claims, 11%). However, some or all of this discrepancy may be due to different claim management practices between the two sectors. As noted in Section 2.2, public sector claim sizes also generally reflect the costs associated with all providers associated with a single health-care incident, whereas in the private sector the costs arising from a single incident may be spread across several claims.

Table 5.9: Closed claims[a]: total claim size, by health service setting, 1 July 2009 to 30 June 2010

Total claim size	Health service setting							
	Public hospital/day surgery[b]	Other public setting[c]	Private hospital/day surgery[d]	Private medical clinic[e]	Other private setting[f]	Other[g]	Not known	Total
Nil	108	2	124	146	34	3	20	437
$1–<$10,000	447	13	165	242	79	14	121	1,081
$10,000–<$30,000	144	4	38	73	11	2	29	301
$30,000–<$50,000	64	1	23	23	1	2	12	126
$50,000–<$100,000	101	4	20	34	6	3	4	172
$100,000–<$250,000	166	5	28	25	6	1	10	241
$250,000–<$500,000	84	0	18	13	6	0	11	132
$500,000 or more	109	0	19	10	1	0	8	147
Total[h]	**1,224**	**29**	**436**	**567**	**144**	**25**	**215**	**2,640**
Per cent	*46.4*	*1.1*	*16.5*	*21.5*	*5.5*	*0.9*	*8.1*	*100.0*

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are seven public sector claims where there is no relation between claim size and the health service setting (see Box 1.1).

(b) Includes public psychiatric hospitals.

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

(d) Includes private psychiatric hospitals.

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

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

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

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

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

Table 5.10: Closed claims[a]: total claim size, by health service setting, 1 July 2009 to 30 June 2010 (per cent)[b]

	Health service setting							
Total claim size	**Public hospital/day surgery[c]**	**Other public setting[d]**	**Private hospital/day surgery[e]**	**Private medical clinic[f]**	**Other private setting[g]**	**Other[h]**	**Not known**	**Total**
Nil	8.8	6.9	28.4	25.7	23.6	12.0	9.3	16.6
$1–<$10,000	36.5	44.8	37.8	42.7	54.9	56.0	56.3	40.9
$10,000–<$30,000	11.8	13.8	8.7	12.9	7.6	8.0	13.5	11.4
$30,000–<$50,000	5.2	3.4	5.3	4.1	0.7	8.0	5.6	4.8
$50,000–<$100,000	8.3	13.8	4.6	6.0	4.2	12.0	1.9	6.5
$100,000–<$250,000	13.6	17.2	6.4	4.4	4.2	4.0	4.7	9.1
$250,000–<$500,000	6.9	0.0	4.1	2.3	4.2	0.0	5.1	5.0
$500,000 or more	8.9	0.0	4.4	1.8	0.7	0.0	3.7	5.6
Total[i]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are seven public sector claims where there is no relationship between the cost of the claim and the health service setting (see Box 1.1).

(b) Percentages are calculated on the basis of the 2,637 claims with known total claim size.

(c) Includes public psychiatric hospitals.

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

(e) Includes private psychiatric hospitals.

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

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

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

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

Notes

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

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

5.6 Total claim size and specialty of clinician

Data and commentary on the proportions of recorded clinical specialties for closed claims are presented in Section 3.4. With respect to the 12 clinician specialty categories that were most frequently recorded for closed claims, between 40% (*Psychiatry*, 34 claims) and 68% (*Diagnostic radiology*, 62 claims) of claims for each clinician specialty were closed for less than $10,000. One-fifth (19 claims, 22%) of claims with a clinician specialty of *Psychiatry* settled for $10,000–<$30,000, while just under one-quarter (9 claims, 23%) with a clinician specialty of *General and internal medicine* closed for $100,000−<$250,000. *Obstetrics and Gynaecology* and *Urology* had the highest proportion of claims settled for $250,000 or more (70 claims, 19% and 7 claims, 18% respectively).

Table 5.11: Closed claims[a]: specialties of clinicians involved, by total claim size, 1 July 2009 to 30 June 2010

	Total claim size								
Specialty of clinician(s)[b]	**Nil cost**	**$1– <$10,000**	**$10,000– <$30,000**	**$30,000– <$50,000**	**$50,000– <$100,000**	**$100,000– <$250,000**	**$250,000– <$500,000**	**$500,000 or more**	**Total[c]**
Anaesthetics	16	46	6	4	3	5	4	5	90
Diagnostic radiology	33	29	6	5	3	10	4	1	91
Emergency medicine	16	62	15	9	13	27	6	16	164
General and internal medicine	5	13	3	2	4	9	2	1	39
General nursing	5	17	5	2	3	1	2	3	38
General practice[d]	114	275	89	34	43	43	18	17	633
General surgery	19	72	24	13	16	28	11	13	196
Obstetrics and Gynaecology[e]	42	136	37	16	24	37	27	43	362
Orthopaedic surgery	33	65	16	8	13	20	15	14	184
Psychiatry	6	28	19	3	9	10	7	3	85
Urology	4	15	4	3	4	1	3	4	39
Other hospital-based medical practitioner[f]	11	61	14	7	3	1	4	4	105
All other specialties[g]	135	286	70	22	42	62	41	38	697
Not applicable[h]	1	6	3	2	0	1	0	1	14
Not known	2	1	1	0	0	0	0	1	5
Total[i]	**437**	**1,081**	**301**	**126**	**172**	**241**	**132**	**147**	**2,640**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are seven public sector claims where there is no relation between claim size and clinician specialty (see Box 1.1). The clinician specialty totals may be slightly different than those presented in Table 3.10 because different public sector claims are excluded from the counts.
(b) Only the 12 clinician specialty categories that were most frequently recorded for closed claims are listed; all other categories are combined in the category *All other specialties*.
(c) There were three private sector claims where the total claim size was not known. These claims are included in the totals for 'specialty of clinician(s)' even though the *Not known* column is not presented.
(d) Includes both procedural and non-procedural general practitioners.
(e) Includes specialists in *Obstetrics only*, *Gynaecology only*, and *Obstetrics and gynaecology*.
(f) *Other hospital-based medical practitioner* includes junior doctors, resident doctors, house officers and other medical practitioners who do not have a specialty.
(g) Covers all clinician specialty categories other than the 12 which are individually listed.
(h) Indicates that no clinical staff were involved in the incident (for example where the claim relates to actions of hospital administrative staff).
(i) This is the total number of claims for which each claim size was recorded. A given specialty may only be recorded once for a single claim in the private sector, but up to four different specialties may be recorded for a public sector claim. Therefore, some public sector claims are represented in more than one row, and so the column totals exceed the number of claims.

Table 5.12: Closed claims[a]: specialties of clinicians involved, by total claim size, 1 July 2009 to 30 June 2010 (per cent)

	Total claim size								
Specialty of clinician(s)[b]	**Nil cost**	**$1– <$10,000**	**$10,000– <$30,000**	**$30,000– <$50,000**	**$50,000– <$100,000**	**$100,000– <$250,000**	**$250,000– <$500,000**	**$500,000 or more**	**Total**
Anaesthetics	17.8	51.1	6.7	4.4	3.3	5.6	4.4	5.6	**100.0**
Diagnostic radiology	36.3	31.9	6.6	5.5	3.3	11.0	4.4	1.1	**100.0**
Emergency medicine	9.8	37.8	9.1	5.5	7.9	16.5	3.7	9.8	**100.0**
General and internal medicine	12.8	33.3	7.7	5.1	10.3	23.1	5.1	2.6	**100.0**
General nursing	13.2	44.7	13.2	5.3	7.9	2.6	5.3	7.9	**100.0**
General practice[c]	18.0	43.4	14.1	5.4	6.8	6.8	2.8	2.7	**100.0**
General surgery	9.7	36.7	12.2	6.6	8.2	14.3	5.6	6.6	**100.0**
Obstetrics and Gynaecology[d]	11.6	37.6	10.2	4.4	6.6	10.2	7.5	11.9	**100.0**
Orthopaedic surgery	17.9	35.3	8.7	4.3	7.1	10.9	8.2	7.6	**100.0**
Psychiatry	7.1	32.9	22.4	3.5	10.6	11.8	8.2	3.5	**100.0**
Urology	10.3	38.5	10.3	7.7	10.3	2.6	7.7	10.3	**100.0**
Other hospital-based medical practitioner[e]	10.5	58.1	13.3	6.7	2.9	1.0	3.8	3.8	**100.0**
All other specialties[f]	19.4	41.0	10.0	3.2	6.0	8.9	5.9	5.5	**100.0**
Not applicable[g]	7.1	42.9	21.4	14.3	0.0	7.1	0.0	7.1	**100.0**
Not known	40.0	20.0	20.0	0.0	0.0	0.0	0.0	20.0	**100.0**
Total[h]	16.6	40.9	11.4	4.8	6.5	9.1	5.0	5.6	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are seven public sector claims where there is no relation between claim size and clinician specialty (see Box 1.1).

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

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

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

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

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

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

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

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

5.7 Total claim size and extent of harm

There is a strong relationship between claim size and extent of harm (Figure 5.3). Where the extent of harm was *No body function/structure affected*, 17% of claims were closed for no cost and 59% for $1–<$10,000. Similar proportions were recorded for *Mild injury* (28% closed for no cost, 50% for $1–<$10,000 and <1% for $500,000 or more). In the case of *Moderate injury*, 16% of claims were closed for no cost and 34% for $1–<$10,000, compared to 4% closed for $500,000 or more. In contrast, the proportion of claims with *Severe injury* that were closed for less than $10,000 was 35%, while 20% were closed for $500,000 or more (tables 5.13 and 5.14).

Where *Death* was the recorded extent of harm, 10% of claims were closed for no cost, 70% for less than $100,000 and just 2% for $500,000 or more.

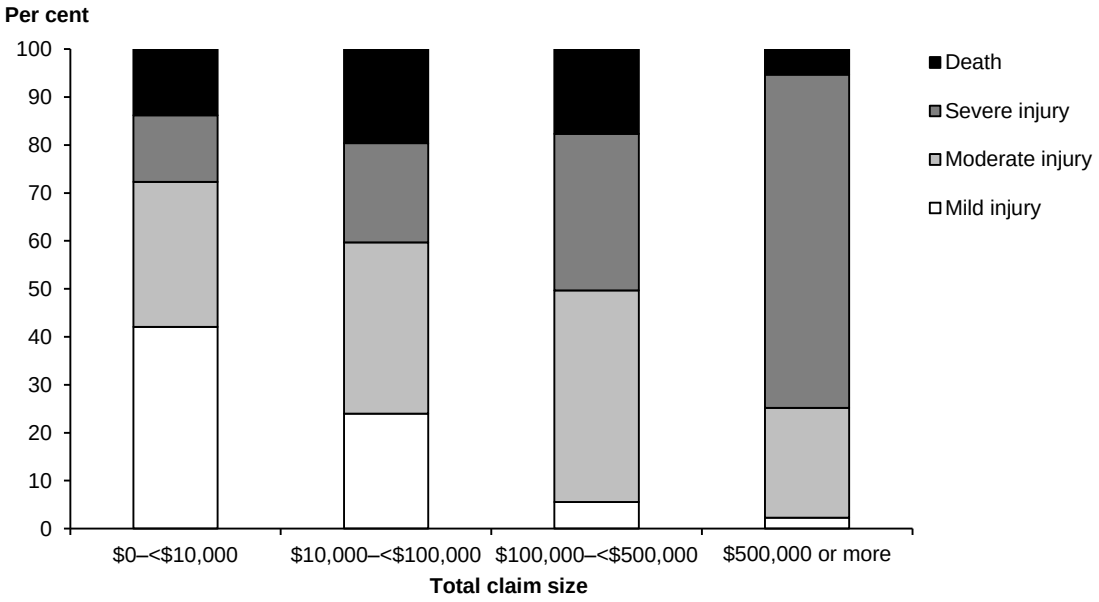

Figure 5.3: Closed claims: total claim size, by extent of harm, 1 July 2009 to 30 June 2010 (per cent)

Table 5.13: Closed claims[a]: total claim size, by extent of harm, 1 July 2009 to 30 June 2010

	Extent of harm						
Total claim size	**Mild injury**	**Moderate injury**	**Severe injury**	**Death**	**No body function/ structure affected**	**Not known**	**Total**
Nil cost	177	113	54	31	33	29	437
$1–<$10,000	320	244	110	132	112	163	1,081
$10,000–<$30,000	67	76	45	48	27	38	301
$30,000–<$50,000	27	41	21	15	5	17	126
$50,000–<$100,000	22	56	34	32	8	20	172
$100,000–<$250,000	18	96	67	42	2	16	241
$250,000–<$500,000	1	54	44	18	0	15	132
$500,000 or more	3	30	91	7	0	16	147
Total	**635**	**710**	**466**	**325**	**190[b]**	**314**	**2,640**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are seven public sector claims where there is no relation between claim size and extent of harm (see Box 1.1).

(b) Includes three private sector claims where the total claim size was not known.

Table 5.14: Closed claims[a]: total claim size, by extent of harm, 1 July 2009 to 30 June 2010 (per cent)[b]

	Extent of harm						
Total claim size	**Mild injury**	**Moderate injury**	**Severe injury**	**Death**	**No body function/ structure affected**	**Not known**	**Total**
Nil cost	27.9	15.9	11.6	9.5	17.4	9.2	16.6
$1–<$10,000	50.4	34.4	23.6	40.6	58.9	51.9	40.9
$10,000–<$30,000	10.6	10.7	9.7	14.8	14.2	12.1	11.4
$30,000–<$50,000	4.3	5.8	4.5	4.6	2.6	5.4	4.8
$50,000–<$100,000	3.5	7.9	7.3	9.8	4.2	6.4	6.5
$100,000–<$250,000	2.8	13.5	14.4	12.9	1.1	5.1	9.1
$250,000–<$500,000	0.2	7.6	9.4	5.5	0.0	4.8	5.0
$500,000 or more	0.5	4.2	19.5	2.2	0.0	5.1	5.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Closed claims are claims that were closed between 1 July 2009 and 30 June 2010. Excluded are seven public sector claims where there is no relation between claim size and extent of harm (see Box 1.1).

(b) Percentages are calculated on the basis of the 2,637 claims with known total claim size.

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

Appendix 1: Data items and definitions

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

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

MINC data item	ISA data item	Definition of MINC and ISA data items and explanation of mapping between collections
4 Claim subject's date of birth	36 Claimant/patient year of birth	Year of birth of claim subject. This data item is used to calculate claim subject's age at incident using MINC item 10, 'Date incident occurred' and ISA item 9, 'Date of loss'.
5 Claim subject's sex	37 Claimant/patient sex	Sex of the claim subject.
6a Primary incident/allegation type	15 Cause of loss	Description of the area of alleged error, negligence or problem that primarily gave rise to the claim. There is concordance between the ISA and the MINC data item.
8a Primary body function/structure affected	16 Body functions or structures affected	The primary body function or structure of the claim subject alleged to have been affected. There is concordance between these items. Death is not included in the ISA item, instead being identified using ISA item 17, 'Severity of injury –patient dies from this incident'.
9 Extent of harm	17 Severity of loss	This data item was mapped as outlined below. Severity of loss (17) — MINC Extent of harm L1, L2 maps to — Mild injury M1, M2 maps to — Moderate injury S1, S2 maps to — Severe injury S6 maps to — Death
10 Date incident occurred	9 Date of loss	Date the alleged harm occurred.
12 Health service setting	14.3 Venue where procedure performed	The venue where health care was delivered, whether public or private sector or other, whether a hospital/day surgery or other. There is concordance between these items.
14 Specialties of clinicians closely involved in incident	14.2 Specialty of practitioner at the time the incident occurred	Clinical specialties of the health care providers involved in the alleged harm that gave rise to the claim. The categories for these items align well between the collections. The ISA specifications have separate codes for several allied health and complementary medicine fields which are subsumed within the MINC category 'Other allied health (including complementary medicine)'. In the ISA collection, 'student practitioner or intern' is a separate category. MINC codes students based on the specialty they are training in, and classifies interns with 'other hospital-based medical practitioners'.

(continued)

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

MINC data item	ISA data item	Definition of MINC and ISA data items and explanation of mapping between collections
15 Date reserve placed	10 Date of report	This ISA item is the date on which the matter is notified to the insurer. It may occur slightly before or after the date that the MII sets a reserve, which corresponds to 'date reserve placed' in the MINC. Because of this potential discrepancy these two data items are not identical.
16 Reserve range	20 Gross payments to date 22 Gross case estimate at end of reporting period	Estimate of the cost of the claim upon its finalisation. For current claims, the ISA items divide the reserve amount between the amount already paid and the amount expected to be paid. Addition of these two dollar amounts produces the reserve estimate, which can be mapped to MINC ranges.
18 Date claim file closed	11 Date finalised	Calendar month and year in which the claim was settled, or a final court decision was delivered or when the claim file was closed because the claim had been inactive for a long time.
19 Mode of claim finalisation 1 Settled through state/territory-based complaints processes 2 Settled through court-based alternative dispute resolution processes 3 Settled through statutorily mandated compulsory conference process 4 Settled—other 5 Court decision 8 Discontinued commenced claim 9 Discontinued potential claim 7 Not yet known	18.2 Settlement outcome A = Award X = No award N = Negotiated W = Withdrawn	Description of the process by which the claim was closed. This data item was mapped as outlined below. Settlement outcome (18.2) — MINC Mode of claim finalisation A maps to 5 X maps to 5 N maps to 1, 2, 3 or 4 W maps to 8 or 9 The mapping is not exact because a claim may be withdrawn as part of an active settlement process rather than through discontinuation of an inactive claim.
20 Total claim size	20 Gross payments to date	The amount to be paid to the claimant in settlement of the claim, plus defence legal and investigation costs, recorded in broad dollar ranges. ISA records exact dollar amounts. These were mapped to MINC ranges.
21 Status of claim 20 Commenced (not yet finalised) 30 Claim file closed 32 Structured settlement—claim file open 33 Structured settlement—claim file closed 40 Claim previously closed now reopened	3 Status at end of reporting period C for Current F for Closed R for Reopened	Status of the claim in terms of the stage in the process from commencement to finalisation. MINC category 20 maps to ISA 'C'. MINC categories 30, 32 and 33 map to ISA 'F'. MINC 40 maps to ISA 'R'.

Table A1.2: Definitions of key terms

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

Appendix 2: Data quality statements

Medical Indemnity National Collection (Public Sector)

Summary of key issues

- The Medical Indemnity National Collection (Public Sector), or MINC (PS), is a dataset that contains information on the number, nature and costs of public sector medical indemnity claims in Australia. Medical indemnity claims are claims for compensation for harm or other loss allegedly due to the delivery of health care.
- Data on medical indemnity claims may change over the life of a claim as new information becomes available or the reserve amount set against the likely cost of closing the claim is revised. For this reason, data reported for a single year's claims are subject to change over time. Readers should refer to the latest published report for the most up-to-date information on past years' claims.
- Although there are coding specifications for national medical indemnity claims data, there are some variations in how jurisdictional health authorities report medical indemnity claims.

Description

The MINC (PS) contains information on medical indemnity claims against providers covered by public sector medical indemnity arrangements. The health service may have been provided in settings such as hospitals, outpatient clinics, private general practitioner surgeries, community health centres, residential aged care facilities or mental health-care establishments or during the delivery of ambulatory care.

States and territories receive their data from public sector medical indemnifiers and government health service providers. They use their data to monitor and regulate the costs incurred from claims of harm or other loss allegedly caused through the delivery of health services covered by public sector medical indemnity arrangements.

The MINC (PS) includes:

- basic demographic information on the 'claim subject' (patient) at the centre of an alleged health-care incident
- related information such as the type of incident or allegation, the health service context and the clinician specialties involved
- the reserve amount set against the likely cost of settling the medical indemnity claim
- the time between setting the reserve and closing the medical indemnity claim, and
- the cost of closing the medical indemnity claim and the nature of any compensatory payments.

The MINC (PS) includes data for January to June 2003 and for each financial year from 2003–04 to 2009–10. The 2009–10 data covers the period from 1 July 2009 to 30 June 2010.

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act* 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health and Ageing portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act* 1987, in conjunction with compliance to the *Privacy Act 1988*, (Cth) ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality. For further information see the AIHW website www.aihw.gov.au.

Data for the MINC (PS) are supplied to the AIHW by state and territory health authorities under the terms of the MINC (PS) Agreement. The MINC (PS) Agreement governs the AIHW's collection and use of the MINC (PS) data. The Agreement includes the state and territory health authorities, the Australian Government Department of Health and Ageing, and the AIHW as co-signatories. Representatives from all of these agencies make up the Medical Indemnity Data Working Group (MIDWG), which oversees the MINC (PS).

Timeliness

According to the MINC (PS) Agreement, data are provided annually by August following the financial year to which the data relate. Data cleaning and validation are scheduled for completion during the following October. For the 2009–10 year, data were received between July and October 2010, and validation was completed in March 2011.

The AIHW's publication of the MINC (PS) data in *Australia's public sector medical indemnity claims 2009–10* was originally planned for release in May 2011. It is being released in May 2012.

Accessibility

Australia's public sector medical indemnity claims 2009–10 is the eighth report in its series. All are available without charge on the AIHW website. Links to the reports are listed sequentially at: <http://www.aihw.gov.au/aihw-statistical-information-on-medical-indemnity-claims-in-australia/>.

Interactive data cubes for MINC PS 2009–10 data will follow the release of the Australia's public sector medical indemnity claims 2009–10 report.

Release or publication of MINC data requires the unanimous consent of the MIDWG. Interested parties can request access to MINC (PS) aggregated data not available online or in reports via the Communications, Media and Marketing Unit on (02) 6244 1032 or via email to info@aihw.gov.au.

Interpretability

Information to aid in the interpretation of the data in *Australia's public sector medical indemnity claims 2009–10* is presented in Chapter 2 and 'Appendix 2: MINC data items and key terms' of the report.

Relevance

Scope and coverage

The MINC (PS) includes information on medical indemnity claims against the public sector including 'potential claims'. A potential claim is a matter considered by the relevant authority as likely to materialise into a claim and that has had a reserve placed against it. The MINC (PS) does not include information on health-care incidents or adverse events which do not result in an actual claim or which are not treated as potential claims.

There is some variation between jurisdictions in terms of which cases fall within the scope of the MINC (PS), due to different reserving practices. For 2009–10, 100% of all public sector claims considered by jurisdictions to fall within scope were reported to the AIHW.

Many of the data items in the MINC (PS) collect information on the patient or 'claim subject', the person who received the health-care service and was involved in the health-care incident that is the basis for the claim, and who may have suffered, or did suffer, harm or other loss as a result. The patient may or may not be a claimant, that is, the person(s) pursuing the claim. In the case of potential claims there may be no claimant. Information is not collected on the claimant as such.

Reference period

The MINC (PS) 2009–10 data covers new claims that had a reserve amount set against them between 1 July 2009 and 30 June 2010, previously closed claims that were reopened during the year, and ongoing claims from the previous year.

Indigenous identification

Information on Indigenous identification was not collected in 2009–10.

Accuracy

Data quality

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

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. These are:

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

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

Not known responses

The time required to collect all the information relevant to a medical indemnity claim can be lengthy. A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. When claims are new, the *Not known* rates for some data items can be quite high. This means that the proportions for the coded values for these same claims will change in the future as *Not known* codings are replaced with the relevant information.

Not applicable responses

The circumstances of a claim may make a data item not applicable; for instance, 'specialty of clinicians closely involved in incident' would be *Not applicable* if no clinician was involved. For the data items 'nature of claim—loss to claim subject' and 'nature of claim—loss to other party/parties' the difference between *Not known* and *Not applicable* is sometimes not clear-cut and the codes have sometimes been used interchangeably.

Incident/allegation category definitions

Three incident/allegation categories, *Treatment*, *Medication-related* and *Procedure*, have not been fully defined. There appear to be some interventions recorded as *Treatment* by some jurisdictions but as *Medication-related* or *Procedure* by other jurisdictions.

Coherence

The AIHW's MINC 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 claim records, and all changes are reflected in the MINC database. As a result of these changes, the data reported by the AIHW on medical indemnity claims for any particular year is subject to change. Readers should refer to the latest published report for the most up-to-date information on past years' claims.

There have been a number of enhancements to the MINC (PS) specifications since the initial data collection in 2003. While the enhancements have been designed to retain comparability with previously collected data, the following changes to the 2009–10 data specifications require comment.

Mode of claim finalisation

A new *Discontinued potential claim* coding option was introduced. Discontinuation means that the claim file is closed without there being any court decision or negotiated settlement with a claimant. Prior to 2009–10, to discontinue a potential claim data providers were required to also give it a claim commencement date, and report it as a *Discontinued commenced claim*.

Status of claim

A new coding option *Rescinded – not a medical indemnity claim* was introduced for erroneous claim records and potential claims that in retrospect should not have had a reserve set against them because their likelihood of eventuating into an actual claim was low. Prior to 2009−10, when data providers wanted to remove these sorts of claim records from their list of current claims, they either reported the claim as closed or requested the AIHW to delete the claim from the master database. This coding option has resulted in a marked drop in the proportion of claims discontinued for $0 compared with the data published for previous years.

Nature of claim—loss to claim subject/other parties

For both data items, *Medical costs* was recognised as a separate category rather than being subsumed under *Other loss*. This change improves the alignment of these data items with the 'Gross Claim Payments by Heads of Damage' data item (No. 25) in the Australian Prudential Regulation Authority (APRA) National Claims and Policies Database (NCPD). However, where these data items are reported on in *Australia's public sector medical indemnity claims 2009–10*, *Medical costs* have been subsumed under *Other loss*, so as to allow comparability with previous years' data.

Extent of harm

Three of the 'extent of harm' categories were changed to bring them into alignment with the World Health Organization's International Classification of Functioning, Disability and Health, and also to allow the codes recognised for NCPD data item 17 'Severity of injury' to be mapped on to the MINC (PS) codes. Analysis of the claims data demonstrated continuity between the 2009−10 categories and those of previous years. By and large, claims that used to have an extent of harm *Temporary – duration of less than 6 months* were now coded *Mild injury*, and claims that used to have an extent of harm *Minor, with duration of 6 months or more* or *Major, with duration of 6 months or more* were now respectively coded *Moderate injury* and *Severe injury*.

Claim subject's date of birth

Prior to 2009–10, only the claim subject's year of birth was collected. Collection of the claim subject's date of birth allows more accurate calculation of the claim subject's age at the time of the incident.

Claim record particulars flag

The great majority of claim records involve a single reserve amount set for a single health-care incident or chain of health-care incidents, with the total costs to the health authority (both legal/investigative and claimant payments) recorded as part of the claim record. The exceptions to the general rule are notified with the 'claim record particulars flag' data item introduced in 2009–10, as detailed in Box 2.1 of *Australia's public sector medical indemnity claims 2009–10*.

Use of *Not known* as a coding option for closed claims

The option to record *Not known* for closed claims was restricted to rare circumstances only. Consequently there was a marked drop in the *Not known* rates for claims closed in 2009–10 compared to previous years. There was also greater consistency between jurisdictions in using the *Not applicable* coding option (rather than *Not known*) to record the absence of any compensatory payment to the claim subject, and/or another party, when a claim was closed.

Comparison with other collections

A number of MINC (PS) data items are identical or similar to NCPD data items collected on private sector medical indemnity claims by APRA and by Insurance Statistics Australia (ISA) on behalf of APRA. The Medical Indemnity National Collection (Private Sector) held at the AIHW is based on data items in common between the MINC PS and the NCPD data collected by ISA. Public and private sector data for 2009–10 are jointly reported in the AIHW's *Public and private sector medical indemnity claims in Australia 2009–10* report, and in previous reports in the same series for earlier years.

Medical Indemnity National Collection (Private Sector)

Summary of key issues

- The Medical Indemnity National Collection (Private Sector), or MINC (Private Sector), is a dataset that contains information on the number, nature and costs of private sector medical indemnity claims in Australia. Medical indemnity claims are claims for compensation for harm or other loss allegedly due to the delivery of health care.
- Data on medical indemnity claims may change over the life of a claim as new information becomes available or the reserve amount set against the likely cost of closing the claim is revised.
- Although there are coding specifications for private sector medical indemnity claims data, there are some variations between medical indemnity insurers (MIIs) in how they report medical indemnity claims.

Description

Medical doctors and some other clinicians who work in the private sector are required to hold professional indemnification to cover costs of claims for compensation arising from allegations of problems with the delivery of health-care services.

The MINC (Private Sector) contains data about claims managed by private sector medical indemnity insurers. The claims reported by the MIIs to the AIHW are the same claims that they are required to report to the Australian Prudential Regulation Authority (APRA).

The MINC (Private Sector) includes:

- basic demographic information on the 'claim subject' (patient) at the centre of the alleged health-care incident
- related information such as the type of incident or allegation and the clinician specialties involved
- the reserve amount set against the likely cost of settling the medical indemnity claim
- the time between setting the reserve and closing the medical indemnity claim, and
- the cost of closing the medical indemnity claim and the nature of any compensatory payments.

The MINC (Private Sector) includes data for each financial year from 2005–06 to 2009–10. The 2009–10 data cover the period from 1 July 2009 to 30 June 2010.

Institutional environment

The AIHW is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act* 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health and Ageing portfolio. The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging

from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act* 1987, in conjunction with compliance to the *Privacy Act* 1988, (Cth) ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality. For further information see the AIHW website www.aihw.gov.au

In 2004, the Australian Government introduced the Premium Support Scheme (PSS) as part of a comprehensive medical indemnity package to help eligible clinicians meet the cost of their private medical indemnity insurance. Under the PSS the Australian Government entered into standard contracts with MIIs which require MIIs to provide medical indemnity claims data to the AIHW.

The MINC Coordinating Committee (MINC CC) oversees the AIHW's collection and use of the MINC (Private Sector) data. The MINC CC includes representatives from the state and territory health authorities, the Australian Government Department of Health and Ageing, the AIHW and each of the MIIs.

Timeliness

The AIHW approaches MIIs and/or their reporting agent (Insurance Statistics Australia (ISA)) for MINC (Private Sector) data once the public sector medical indemnity claims data have been received and are on track for final validation. The AIHW received, cleaned and validated the MINC (Private Sector) 2009–10 data over the period May to August 2011.

The AIHW is publishing data from the MINC (Private Sector) in the *Public and private sector medical indemnity claims in Australia 2009–10* report in May 2012. The original planned date for release of the report was June 2011.

Accessibility

Public and private sector medical indemnity claims in Australia 2009–10 is the sixth report in its series. All are available without charge on the AIHW website. Links to the reports are listed sequentially at:<http://www.aihw.gov.au/aihw-statistical-information-on-medical-indemnity-claims-in-australia/>.

Any other release of private sector medical indemnity claims data, or aggregated public and private sector data, is subject to unanimous consent by the members of the MINC CC. Apart from claim numbers by sector, all published data that uses MINC private sector data combines it with public sector data.

Interpretability

Information to aid in the interpretation of the combined public and private sector medical indemnity claims data may be found in 'Appendix 1: Data items and definitions' of the *Public and private sector medical indemnity claims in Australia 2009–10* report. The information specifies how the public and private sector code values relate to each other and any areas where there is not complete agreement between the two sets of code values.

Relevance

Scope and coverage

The MINC (Private Sector) includes information on medical indemnity claims against individual practitioners who were covered by insurance with an MII for the purposes of the claim. In 2009–10, as in previous years, all private sector medical indemnity claims legally required to be reported to APRA were reported to the AIHW.

Most of the reported claims in scope have arisen from a formal demand for compensation for alleged harm or other loss to the patient and/or a related party. The scope also includes cases where an MII has incurred preparatory expenses from investigating health-care incidents reported to the MII by an insured clinician. With those cases, the MII is legally obliged to report the potential claim to APRA even if no formal demand for compensation has been received.

Private hospital insurance claims, that is, claims against hospitals or hospital employees, do not fall within the scope of the MINC (Private Sector). However, all claims against clinicians who maintain medical indemnity cover with an MII, and who practise within private hospitals, are included.

The MINC (Private Sector) does not include information on health-care incidents or adverse events which have not led to a claim for compensation or which have not resulted in preparatory costs to an MII.

Many of the data items in the MINC (Private Sector) collect information on the patient or 'claim subject', the person who received the health-care service and was involved in the health-care incident that is the basis for the claim, and who may have suffered or did suffer, harm or other loss as a result. The patient may or may not be a claimant, that is, the person(s) pursuing the claim. Where the MII is investigating a case reported by an insured clinician, there may be no claimant. Information is not collected on the claimant as such.

Reference period

The MINC (Private Sector) 2009–10 data includes new claims in scope that have arisen between 1 July 2009 and 30 June 2010, previously closed claims that were reopened during the year, and ongoing claims from the previous year.

Indigenous identification

No information on claim subjects' Indigenous identification is collected.

Accuracy

The MINC (Private Sector) includes a combination of unit record and aggregated claims data. The data received from MIIs as unit records is in accordance with the specifications of the Medical Indemnity National Collection (Public Sector). The data received in aggregated form had been coded according to the specifications of the ISA version of the National

Claims and Policies Database (NCPD). As detailed in Appendix 1 of the report, there is concordance between most MINC (Public Sector) and ISA NCPD codes. However, there are three data items where the alignment between the two sets of coded data is not exact, which may introduce minor inaccuracies to the aggregated private sector data.

Data quality

Data providers are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Potential errors are queried with data providers, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

***Not known* responses**

The time required to collect all the information relevant to a medical indemnity claim can be lengthy. A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. The interpretation of the proportions for a number of data items will be affected by the relatively high *Not known* rates, especially for claims that are new, which tend to have the highest *Not known* rates.

Coherence

The MINC (Private Sector) specifications were developed as a common ground between two previously established data set specifications. One of these was the AIHW's MINC (Public Sector) in use for recording public sector medical indemnity claims data. The other was the National Claims and Policies Database (NCPD) developed by APRA for claims data from MIIs. In consultation with APRA and the AIHW, ISA developed an expanded version of the NCPD. This allowed ISA to report to APRA claims data from MIIs that were members of the Medical Indemnity Insurance Association of Australia, and to report to AIHW claims data from the same MIIs.

The reported data from the MINC (Private Sector) are the common ground between the MINC (Public Sector) and the ISA version of the NCPD.

In 2009−10 the MINC (Public Sector) 'extent of harm' categories were revised to better align with the NCPD data item 17 'severity of loss' categories. As a consequence extent of harm data are able to be reported for the first time for 2009–10.

The public sector and private sector differ in how they deal with claims against multiple clinicians. In the public sector, in most cases a single claim record is created for each health-care incident or chain of health-care incidents, and (except for New South Wales) the involvement of multiple clinician specialties is recorded by recording up to three additional specialties as well as the principal specialty. For MIIs, it is a common practice to open more than one claim for a single health-care incident if more than one clinician was involved in the incident that gave rise to the allegation of harm or other loss. As a result, individual claim sizes will often be less than the aggregated total cost incurred by the MII(s) for a single allegation of harm or other loss. Thus the reported cost of an individual claim in the private sector may not reflect the total payment made by insurers in respect of the claimants. Also, where clinician specialty data are combined across the public and private sectors, the public sector claim record may include multiple clinician specialties, and so the total number of recorded clinician specialties will exceed the number of claims.

In addition, clinician specialties in the private sector are recorded according to their specialty as registered with their insurer rather than with their employing or contracting health service provider (as in the public sector). This difference has led to a methodological decision to combine the *Obstetrics*, *Gynaecology* and *Obstetrics and gynaecology* categories, as well as the *General practitioner – procedural* and *General practitioner – non-procedural* categories, for combined sector reporting

Appendix 3: Public and private sector claim management practices

The public sector

Arrangements for public sector medical indemnity insurance are governed by state and territory legislation and associated policies. Claim management practices vary between jurisdictions, and in some jurisdictions there are different processes for small and large claims. Claims are managed in-house by the state or territory health authority for some jurisdictions; in others, a body independent from the health authority manages claims. Some legal work may be outsourced to private law firms. A full explanation of the policy, administrative, and legal features of each jurisdiction is available in *Australia's public sector medical indemnity claims 2009–10* (AIHW 2012).

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

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

Most public sector records within the MINC correspond to a single claim related to a claimant, usually the 'claim subject' but sometimes a dependent or other relative. Where there are two claimants, the claim subject and one other party, this would also be treated as a single claim. However, there is more variation where the claimants are multiple other parties, in which case the jurisdiction may record multiple claims (Box 1.1). Also, it is possible for a single claim to cover multiple claim subjects; for instance, a class action with a single plaintiff who represents several people who collectively bring a claim to court.

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

The private sector

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

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

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

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

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

Appendix 4: Coding examples for some main data items

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

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

Table A4.2: Coding examples for selected incident/allegation types

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

Table A4.3: Coding examples for mode of claim finalisation

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

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