1 Introduction to the Medical Indemnity National Collection

1.1 Why and how has a Medical Indemnity National Collection (MINC) been developed?

The need for a national medical indemnity collection has arisen in the broader context of national policy concern related to health care litigation, associated costs, and the financial viability of medical indemnity insurers. The absence of a national database has made it difficult to analyse trends in the number, nature and cost of medical indemnity claims. Analysis of the somewhat patchy data from various existing sources has produced an equivocal picture – it has not been possible, for instance, to reach a definitive understanding of trends in the size of claims. There is now a general recognition of the need for greater understanding of these and a range of other issues related to health care litigation.

At the Medical Indemnity Forum in April 2002, Health Ministers decided that a 'national database for medical negligence claims' should be established, to assist in determining future medical indemnity strategies. They also agreed that urgent work was needed on a range of related medical indemnity issues:

- reforms to existing administrative and legal processes, aimed at reducing the costs of litigation and claims processes;
- ways to contain the cost of damages awards in medical indemnity cases;
- the development of a workable model to provide an equitable and effective way of managing the long-term care needs and costs of people who are catastrophically injured;
- clinical risk management (CRM) programs aimed at improving the quality of health care, health outcomes and patient satisfaction, and thus potentially reducing the number and cost of medical indemnity claims; and
- the development of arrangements for prudential supervision of the medical defence industry.

A Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). On 3 July 2002 AHMAC decided to commission the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG to further develop the proposals of the MIDWG for a national medical indemnity collection for the public sector. Funding was provided for data development, the establishment of a national database, and collection and reporting in 2002–03.

The MIDWG and AIHW prepared a report on progress with the development of Medical Indemnity National Collection (MINC) for consideration at the AHMAC meeting of 17 October 2002. AHMAC noted the progress made since July and work towards a commencement data of 1 January 2003, and endorsed the main purposes of the proposed collection and proposed content of the national reports.

1.2 What are the purposes of MINC?

The high-level purposes for the collection, as set out in the MINC Agreement, are:

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

When agreed by the MIDWG and the Parties, MINC aggregated data may:

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

Three broad applications and areas of information need have been identified for the medical indemnity collection. Below, these applications and information needs are grouped under three headings—high-level policy, public sector financial management, and health administration and clinical risk management.

High-level policy

The MINC will provide an important evidence base to inform high level policy in the areas of public health, health administration and government finance. The MINC will facilitate the analysis of:

- current patterns of claims, in terms of factors such as number, cost, setting, clinical specialty, and type of incident;
- interactions between these factors (e.g. are costs higher for claims arising in certain clinical specialties);
- trends over time in these factors;
- emerging trends and warning signs in potential claims, and claims not yet closed;
- which claims result in payment of damages or compensation;
- patterns of claim finalisation, and factors influencing mode of finalisation; and
- the relationship of different factors to the size of claims, and to trends in claim size.

Public sector management

MINC information will assist in:

- predicting future trends in claims, in terms of factors such as number, size, and type of incident;
- managing costs better, based on information on the number and size of claims 'in the pipeline', and data on average times from reserve setting to finalisation;
- monitoring patterns of reporting/notification as a basis for estimating numbers of incurred but not reported claims;
- providing information as a basis for understanding overall public sector liability;
- identifying potential ways of reducing 'transaction costs' of the system (e.g. by looking at how long it takes for different types of claims to be settled); and
- aiding in the development of new options for providing for the long-term care needs resulting from health care incidents.

Health administration and clinical risk prevention and management

MINC information will:

- inform programs aimed at improving quality of care through better risk management;
- contribute to the understanding of the impact of clinical risk management (CRM) strategies, including assessing the costs of health care incidents; and
- identify health care settings, clinical specialties, and procedures that are associated with disproportionate numbers of claims.

1.3 What information will the MINC data provide?

MINC data will be used to answer questions such as the following:

- How many new claims and 'potential claims' arise each year?
- What is the average period of time between an incident occurring and a reserve being set against the resulting claim; how does this vary for different types of claims?
- How many incurred but not reported claims are there likely to be at any point in time?
- What are the average periods of time between a reserve being set and claim finalisation; how does this vary for different types of claims?
- What are the trends over time in the total size of claims?
- What are the most common types of incident/allegation reported as claims?
- What types of incident/allegation account for the most 'large' claims?
- What are the characteristics of patients involved in incidents that give rise to claims (e.g. age, sex)?
- In what clinical specialties do most claims arise; in what clinical specialties do the most 'large' claims arise?

As experience builds up, the data could also be used to investigate forward-looking questions such as the following:

- How many claims are likely to arise during the coming year?
- What is the likely total cost of claims finalised during the coming year?
- How might new CRM strategies be targeted to deliver the greatest reduction in claim costs?

The data items included within the national data collection are detailed in Section 3, each accompanied by its definition, coding classification, guide for use, and justification for inclusion within the national collection.

1.4 Who contributes to and manages the MINC

MINC data are provided by the Health Authorities (the 'Data Providers') in each of the States and Territories of Australia. As stated in Clause 13.1 of the MINC Agreement, Data Providers will:

(a) provide MINC jurisdictional data in accordance with the Annual documents, solely for the purposes outlined in this Agreement;

(b) advise the National Data Custodian on data quality issues and data interpretation for their MINC jurisdictional data;

(c) subject to clause 12.6 (of the MINC Agreement), control access to and use of their MINC jurisdictional data which are included in the MINC aggregated data, according to protocols agreed by the MIDWG; and

(d) work in consultation and cooperation with the National Data Custodian.

The MIDWG is a body established by and reporting to AHMAC—it oversees the MINC on behalf of AHMAC. The MIDWG is composed of representatives of State, Territory and Commonwealth Health Authorities and the AIHW. Its functions include:

- to develop and manage the MINC;
- to advise the AIHW and AHMAC on matters relating to the MINC; and
- to seek the agreement of Health Authorities on changes to MINC data materials and protocols, and on a range of matters relating to the public release of MINC aggregated data.

The National Data Custodian is the agency that holds MINC jurisdictional data on behalf of each Data Provider, and the MINC on behalf of the MIDWG. It is also responsible for the secure storage and management of MINC data, and the analysis of MINC aggregated data. Under the current MINC Agreement, the AIHW is the National Data Custodian.

The role and functions of the National Data Custodian cover the following areas:

- management of the MINC (including security and confidentiality);
- development of MINC infrastructure;
- support and collation of the MINC; and
- data Access and Release.

The roles and responsibilities of Data Providers, the MIDWG and the National Data Custodian are set out in more detail in the MINC Agreement.

1.5 What is the Data Guide for and how is it organised?

The Data Guide is designed to assist all those involved in supplying or analysing MINC data. It is organised in the following sections:

- Section 2 details the scope and context of the MINC, and then presents the medical indemnity information model and counting rules.
- Section 3 provides detailed information about every data item in the MINC.

1.6 Updating the Data Guide

This Data Guide will be reviewed and enhanced every year under the guidance of the MIDWG. Comments and suggestions are welcome, and can be recorded and retained by Health Authorities or forwarded at any time to the National Data Custodian.

Further information and comments

Comments on and queries regarding this document may be forwarded directly to the AIHW. The contact person at AIHW is Sally Bullock: sally.bullock@aihw.gov.au
phone 02 6244 1008

2 Scope and context of the MINC

2.1 Introduction

Before detailing the data items that make up the Medical Indemnity National Collection (MINC), it is important to have an appreciation of the broader context within which the MINC sits, and to understand the bounds of the collection within that broader context. This section outlines these issues for the MINC.

2.2 Scope: a claims collection

The MINC includes information on medical indemnity claims against the public sector, including 'potential claims':

- A medical indemnity claim is a claim for compensation for harm or other loss that may have resulted or did result from a health care incident.
- 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.

Thus, the scope of the MINC is not as broad as 'adverse events', nor as narrow as just 'claims made'. Public liability claims should not generally be included within the scope of the MINC. However, incidents involving breaches of general patient care resulting in injury to the patient (e.g. patient being showered by a nurse falls when left alone) should be included in the MINC if the relevant Health Authority would normally record the claim as a 'health care incident'.

'Potential claims' may have different names in different States/Territories, but essentially they are matters that are considered by the relevant 'responsible expert' to have the potential to materialise into actual claims. The 'expert' may be someone in the health administration, with or without a further layer of advice from an insurance, risk or fund manager or legal adviser. This expert places, or arranges to have placed, a reserve in respect of the matter, and it is at this point that the matter is considered to be a 'medical indemnity claim' within the scope of the MINC.

In practice, the scope of the collection will be affected by information flows and reserving practices in different jurisdictions. However, reserving practices in all jurisdictions aim to ensure that health authorities gain an accurate picture of their future liabilities, so there should be a 'natural' tendency to reserve matters that are likely to result in pay-outs, and avoid reserving those that are not. Therefore, MIDWG has agreed that the placing of a reserve against a matter is the best basis on which to define the scope of the MINC.

In any publication of MINC data it will be stated that there is some variation between jurisdictions in terms of which matters fall within the scope of the MINC, due to different reserving practices. The MIDWG only intends to publish nationally aggregated data, so inter-jurisdiction comparisons, which would raise this issue more directly, will not be published.

'Against the public sector', in practice, means potential claims for which the public sector (generally the Health Authority) could be responsible. The data collection may include, in some jurisdictions for instance, claims against Visiting Medical Officers (VMOs) treating

public patients. In some jurisdictions it may also include claims against private specialists who have been brought under public sector insurance arrangements, e.g. as a measure to protect service provision in remote areas.

2.3 Context

Figure 2.1 depicts the broader context in which medical indemnity claims arise. It is not a 'model' or a flow diagram. The figure is designed to serve as:

- a reminder of the broader systems – health, insurance and public administration – in which the data collection is being developed; and
- an aid to visualisation, to see how the national data collection will sit in relation to other systems and processes (e.g clinical risk management strategies).

The other areas and stakeholders depicted may:

- have useful materials to help develop the MINC;
- 'connect' at some future time with the data system;
- affect the design of the MINC data system;
- affect the flow of claims; and/or
- need to be understood and their data monitored in some way to enable national medical indemnity data to be interpreted and a full national picture to be developed.

It is recognised that it is important to ensure that development of this collection should be consistent, where possible, with other related data developments, including data collections for medical indemnity claims in the private sector.

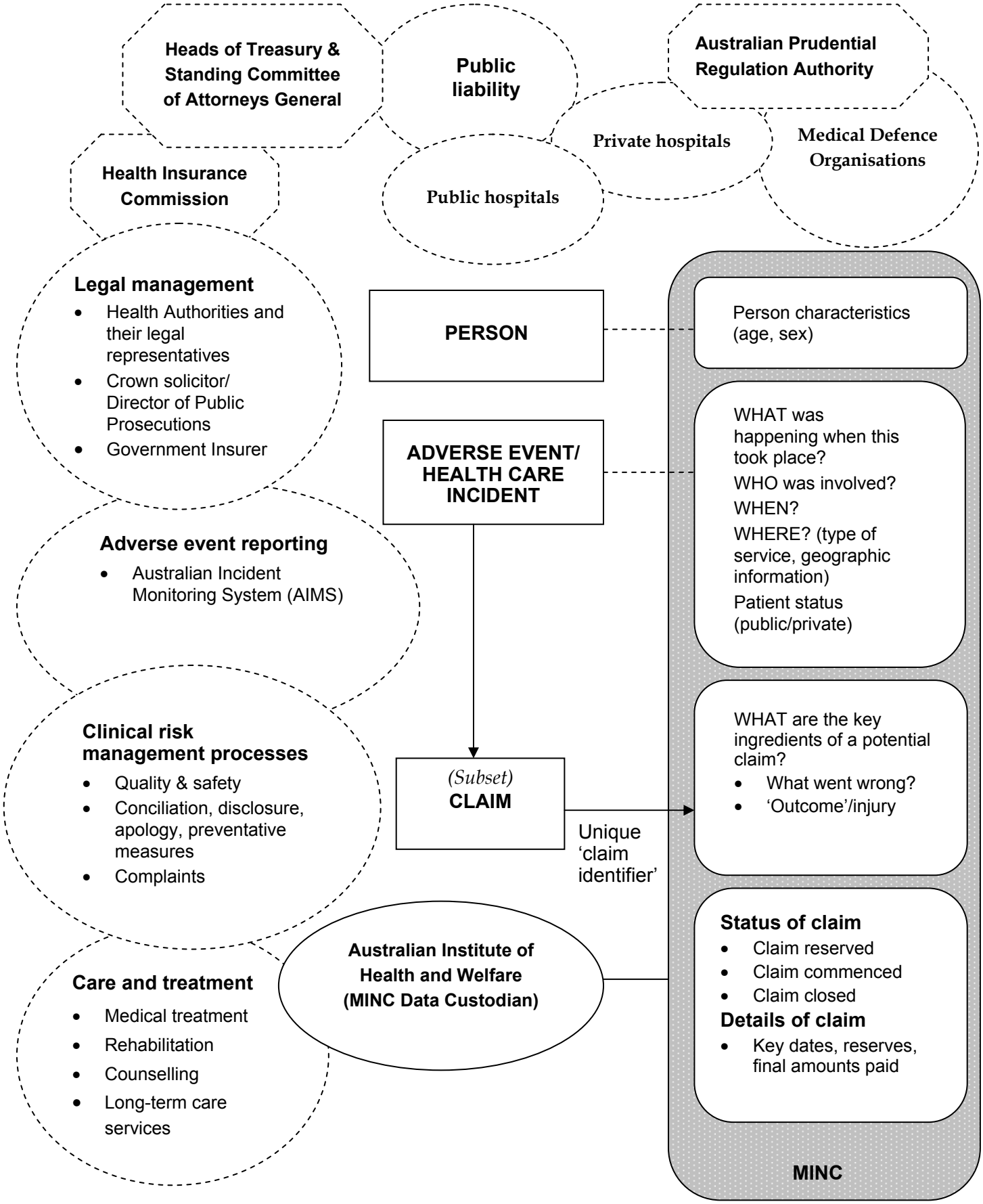


Figure 2.1: The context of the medical indemnity national collection (public sector)

2.5 Medical indemnity information model

An information model was developed to aid in the development of data items for the MINC (Figure 2.2).

This is a model of 'reality', greatly simplified to describe likely data structures. It depicts relationships between key data entities, but does not specify the nature of these relationships (whether they are one-to-one, one-to-many, etc). The dot points indicate the information that could be collected for each of the entities (whether or not it is intended to be collected via MINC).

The dotted line around the 'Claimant' indicates that no information is actually collected about the claimant. For some claims the 'Claim subject' and/or 'Other party' may in fact be the 'Claimant'. This relationship is indicated by dotted lines connecting these entities.

The lines connecting the three boxes on the left of the diagram indicate the essential links between these three entities. The 'Claim subject', as defined in the MINC, is the person who was involved in the health care incident that gave rise to the claim. The 'Other party' only comes into the picture if there is a claim for indirect loss (e.g. nervous shock suffered by the spouse of the claim subject as a result of the incident).

2.6 Units for collection

A claimant may make several claims (usually against different defendants) in relation to a single incident. However, in most instances, for most Health Authorities, this will generate only one database record. That is, the record represents the 'matter' as a whole, although there may be several claims involved (and several defendants).

In general, if two claimants make separate claims in respect of a single incident, two separate records will be generated on the database. For instance, if the person directly injured in the incident makes a claim, and their spouse makes a separate claim based on psychological harm they have allegedly suffered as a consequence, there will be two separate records.

The MINC adopts the following convention**: A record in the collection represents a 'claim', where 'claim' is defined as one or more claims made by a single claimant in respect of a particular incident**. However, it is anticipated that there will be exceptions to this convention. Some examples of exceptions are:

- Class actions: one record would represent the claims of all of the claimants party to the action.
- Dependency claims: where multiple dependants of the claim subject pursue a claim in relation to loss they have allegedly suffered as a result of the loss suffered by the claim subject, a single record should be entered.
- Loss of consortium claims: some Health Authorities combine the losses allegedly suffered by both spouses and a single reserve is set; in such cases a single record should be entered.

The guiding principle should be that where related claims are treated together as a single 'matter'—i.e. a single reserve is set, and key dates and processes will be in common—a single record should be entered. Where related claims are treated as separate 'matters', and will be progressed separately with different reserves, key dates and processes, separate records should be entered. It is recognised that practice may vary between Health Authorities.

Many of the data items in the MINC collect information about the 'Claim subject'. The claim subject is the person who received the health care service and was involved in the health care incident that is the basis for the claim, and who may have suffered or did suffer, harm or other loss, as a result. That is, the claim subject is the person who was the patient during the incident. Sometimes it will be difficult to identify which party involved in a health care incident is the claim subject, particularly when a mother and baby are both involved in the incident.

Where a mother and child are both involved in an incident (including where a baby is harmed in utero), and both survive, ideally two separate claims should be recorded. In such cases, both mother and baby would be recorded as claim subjects in their respective claims. However, where only a single claim is recorded for both mother and baby (as is the practice in some jurisdictions), the following guidance may help decide which party should be recorded as the claim subject.

Where the claim relates principally to the harm suffered by one of the parties, that party should be the claim subject. In many cases this may in fact be the party more severely harmed (although this may not always be so, particularly as the extent of harm to the baby may not be immediately evident). The following examples may be helpful:

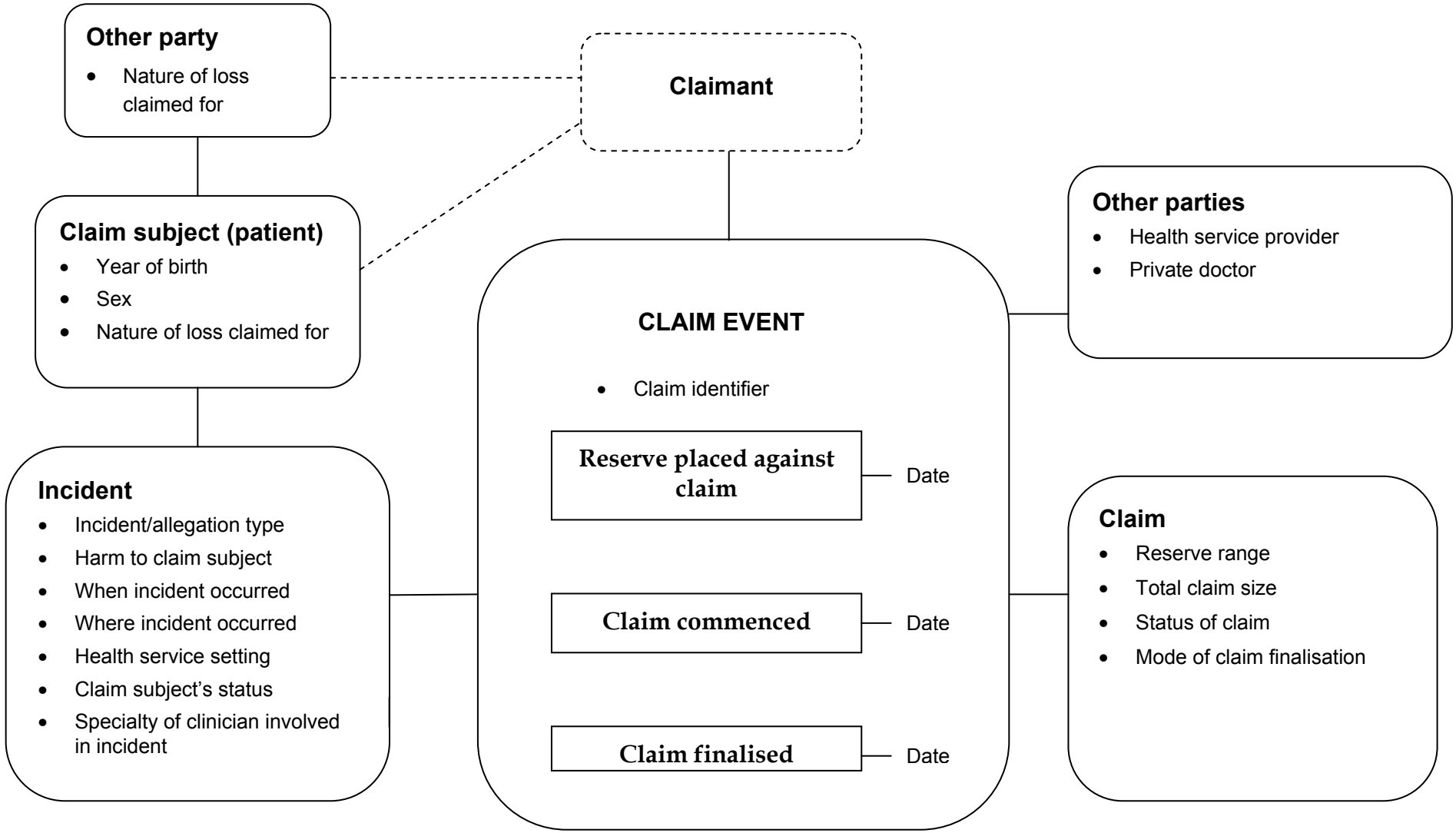
- if a baby is born with Erbs Palsy and there are no allegations of injury to the mother then the claim subject will generally be the baby.
- if a baby is stillborn then the mother will generally be the claim subject.

2.7 Collation of national data

The AIHW will collect MINC data six-monthly from Health Authorities, to assemble a series of national snapshots relating to the end of each six-month period. Each six months' data will include new claims that have arisen during the period, claims finalised during the period, and ongoing claims (i.e. claims continuing from the previous period). The initial six-month's data (1 January to 30 June 2003) will include all claims that are 'on the books' at 1 January 2003.

It is recognised that some information may not be available when a reserve is initially placed against a claim, and also that the code for some data items may change over the life of a claim, as new information becomes available or reserve estimates are revised. Coding for all items should reflect the most recently available information at the time of each six-monthly data transmission.

Figure 2.2: MINC Information Model



3 Data items

3.1 Data items included within the MINC

The following section details each data item included within the MINC.

For most data items, the following are provided:

- data item name
- definition
- classification code (i.e. response options)
- guide for use
- why this data item is collected
- development history and relationship to national standards.

The information recorded for a particular claim will often reflect events and circumstances as alleged by the claimant, or by other parties to the claim (e.g. the defendant clinician). Recording this information does not imply that it is fact. It is recognised that accounts of events or circumstances as reflected in MINC records will, in many cases, not yet have been substantiated.

All data items in the MINC should be completed according to the judgement of the claim manager, based on all information currently available. Although the definitions of some data items refer to what is alleged, the information recorded need not always reflect what the claimant alleges. For example, where a claimant's allegations appear fanciful and are at odds with other sources of information about the incident, the claim manager may decide to place greater weight on those other sources of information.

The guiding principle should be to record the key aspects of the incident and outcome that, based on the information available, seem most likely to constitute the real substance of the claim, and thus relate to the possible medical indemnity liability of the Health Authority. Completion of data items should be based on information actually available, and not on assumptions or guesswork as this could undermine the quality of the data.

As stated above in Section 2.7, coding for all items should reflect the most recently available information at the time of each six-monthly data transmission. It is recognised that some information may be 'missing' at the time of transmission; where it is expected that the information will become available 'Not yet known' coding categories should be used. Where a key date is not yet known the relevant date data item should be left blank—it was decided that using a dummy date (e.g. 999999) to indicate 'not yet known' could be problematic. However, all items should be properly coded by the time the claim is closed, and most should be coded much earlier in the life of the claim.

1 Claim identifier

Defined as: An identity number that, within each Health Authority, is unique to a single claim, and which remains unchanged for the life of the claim.

Classification code: Numeric or alpha-numeric identification

Guide for use:

- This item must be completed for all claims on the MINC database.
- The claim identifier must be at least 6 characters in length, but no more than 20 characters.
- The claim identifier may be numeric or alphanumeric, but should not identify a claim subject by name.
- The claim identifier must be unique to a single claim within the Health Authority; values must not be repeated, to ensure that claims are uniquely identifiable.
- The claim identifier must remain unchanged for the life of the claim so that subsequent records for a single, ongoing claim can be reliably linked over time.
- As long as claim identifiers used within Health Authority databases comply with the above requirements, they may be sent to the National Data Custodian as they are.
- Reopened claims: where a claim that has previously been recorded as finalised on the MINC database has been re-opened (see code 40, Item 21), the claim identifier should be the same as the original claim identifier for the claim when it was initially entered on the MINC database.

Why is this data item collected?

Unique claim identifiers will enable records for individual claims to be linked between six-monthly data transmissions, thus enabling analysis of the data over longer time periods (e.g. financial years). They will also be important for database management, should the National Data Custodian have queries about or need to discuss a particular record with a Data Provider.

This data item would enable questions such as the following to be answered:

- How many new claims and potential claims arise each year?

2 Nature of claim — loss to claim subject

Defined as: A broad description of the categories of loss allegedly suffered by the claim subject (i.e. the patient) that form a basis for this claim.

Classification code:
1 Care costs
2 Other economic loss
3 Pain and suffering (including nervous shock)
4 Other loss
5 Not applicable—loss suffered by claim subject is not a basis for this claim
6 Not yet known

Guide for use:

- More than one code may be selected
- Only categories of loss that are the subject of the current claim should be recorded.
- The 'claim subject' is the person who was involved in the health care incident that is the basis for the claim; i.e. the patient during the incident.
- Where a claim relates to a loss suffered by an other party, not the claim subject, code 5 'Not applicable' should be recorded. For example, where the claimant ('other party') is a spouse claiming for nervous shock allegedly suffered as a result of the injuries to the claim subject, code 5 should be recorded.
- Loss suffered by an 'other party' (i.e. not the patient) that is a basis for this claim should be recorded at Item 3 ('Nature of claim—loss to other party/parties').
- Care costs includes long-term care costs, and covers both past and future care costs, whether provided gratuitously or otherwise.
- Other economic loss includes past and future economic loss and past and future out-of-pocket expenses; excludes care costs.
- Pain and suffering includes nervous shock and temporary or ongoing disability; includes general damages.
- Other loss includes any other loss claimed for, not covered by codes 1, 2 or 3; includes medical costs (both past and future). Medical costs are costs associated with medical treatment, e.g. doctor's fees, hospital expenses.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

The purpose of this data item is to collect broad information on the categories of loss that form a basis for the claim, and therefore relate to the reserve set and final size of the claim. It will be possible to use this information to broadly characterise the nature of claims.

Claims may relate to:

1. loss suffered by the claim subject
2. loss suffered by an other party, as an indirect result of loss suffered by the claim subject

3. both 1 and 2.

This item, together with Item 3, will allow claims to be divided into these three categories.

Details of the personal harm suffered by the claim subject should be recorded at Items 8 and 9, regardless of whether loss suffered by the claim subject forms a basis for the claim.

History of development and relationship to national standards

During development of the data collection it was decided that an item for recording broad categories of loss was needed in addition to items relating to the outcome of the incident for the claim subject, in terms of resulting injuries or conditions.

3 Nature of claim — loss to other party/parties

Defined as: A broad description of the categories of loss allegedly suffered by an other party or parties (i.e. people other than the patient) that form a basis for this claim.

Classification code:

1 Care costs
2 Other economic loss
3 Nervous shock
4 Other pain and suffering (excluding nervous shock)
5 Loss of consortium
6 Other loss
7 Not applicable—loss suffered by other party/parties is not a basis for this claim
8 Not yet known

Guide for use:

- More than one code may be selected
- Only categories of loss that are the subject of the current claim should be recorded.
- Where the claim does not relate to losses suffered by an other party, code 7 'Not applicable' should be recorded.
- Loss suffered by the claim subject (i.e. the patient) that is a basis for this claim should be recorded at Item 2.
- Care costs includes long-term care costs, and covers both past and future care costs, whether provided gratuitously or otherwise; care costs relating to care of the claim subject should be recorded at Item 2 if these come under the current claim.
- Other economic loss includes past and future economic loss and past and future out-of-pocket expenses; excludes care costs.
- Other pain and suffering includes general damages; excludes nervous shock.
- Other loss includes any other loss claimed for, not covered by codes 1,to 5.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.
- Where the claim is a dependency claim following the death of the claim subject, loss of the economic benefits provided by the claim subject should be recorded using code 2 'Other economic loss', and loss of services provided by the claim subject should be recorded using code 6 'other loss'.

Why is this data item collected?

The purpose of this data item is to collect broad information on the categories of loss that form a basis for the claim, and therefore relate to the reserve set and final size of the claim. This information will provide a basis for broadly characterising the nature of claims.

Claims may relate to:

1. loss suffered by the claim subject
2. loss suffered by an other party, as an indirect result of loss suffered by the claim subject.
3. both 1 and 2.

This item, together with Item 2, will allow claims to be divided into these three categories.

History of development and relationship to national standards

During development of the data collection it was decided that an item for recording broad categories of loss was needed. Where the claim relates to loss suffered by an other party or parties, solely or in combination with loss suffered by the claim subject, it is relevant to record the nature of this loss separately to the loss suffered by the claim subject.

4 Claim subject's year of birth

Defined as: Year of birth of claim subject.

Classification code: yyyy

Guide for use:

- Year should always be recorded in its full 4-digit format.
- The 'claim subject' is the person who was involved in the health care incident that is the basis for the claim; i.e. the patient during the incident.
- Not yet known: where the claim subject's year of birth is not yet known this item may remain blank, however, once the claim subject's year of birth becomes known the correct year should be entered.

Why is this data item collected?

Age is an accepted demographic data item in health-related data collections. Information on the year of birth of medical indemnity claim subjects will enable the data to be understood in relation to information from other health-related data sources (e.g. hospital morbidity data). For instance, it may be that patients in certain age groups are over-represented among claim subjects, when compared with patients generally.

This data item would enable questions such as the following to be answered:

- What are the characteristics of patients involved in incidents that give rise to claims (e.g. age, sex)?

History of development and relationship to national standards

During development of the collection, the MIDWG agreed that the claim subjects' year of birth should be included. It was agreed that collecting date of birth would provide an unnecessary level of detail, and potentially create greater problems regarding record identifiability.

5 Claim subject's sex

Defined as: Sex of the claim subject.

Classification code:
1 Male
2 Female
3 Indeterminate
4 Not yet known

Guide for use:

- The term 'sex' refers to the biological differences between males and females.
- The 'claim subject' is the person who was involved in the health care incident that is the basis for the claim; i.e. the patient during the incident.
- Indeterminate – this code should be used only in relation to perinatal cases, where it is not possible for sex of the claim subject to be determined.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

Sex is an accepted demographic data item in health-related data collections. Information on the sex of medical indemnity claim subjects will enable the data to be understood in relation to information from other health-related data sources (e.g. hospital morbidity data).

This data item would enable questions such as the following to be answered:

- What are the characteristics of patients involved in incidents that give rise to claims (e.g. age, sex)?

History of development and relationship to national standards

The coding guidance for this data item is based on the data element 'sex' in the National Health Data Dictionary (NHDD) V10 (AIHW 2001).

6 Incident/allegation type

6a Primary incident/allegation type

Defined as: The high level category describing what is alleged to have 'gone wrong'; i.e. the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim, reflecting key causal factors.

Classification code:

10	Diagnosis
20	Medication-related: type and dosage
21	Medication-related: method of administration
30	Anaesthetic
40	Blood/product-related (includes blood transfusions)
50	Procedure—failure to perform
51	Procedure—wrong procedure
52	Procedure—wrong body site
53	Procedure—post-operative complications
54	Procedure—failure of procedure
55	Procedure—other
60	Treatment—delayed
61	Treatment—not provided
62	Treatment—complications
63	Treatment—failure of treatment
64	Treatment—other
70	Consent (includes failure to warn)
80	Infection control
90	Device failure (includes problems with implanted devices)
100	Other general duty of care issues
110	Other
120	Not yet known

Guide for use:

- Only **one** code may be selected for this data item. Additional codes may be recorded under Item 6b 'Additional incident/allegation type'.
- The code recorded as the primary incident/allegation type should be that which, on the judgement of the claim manager based on all information currently available, best reflects the main, dominant or primary cause giving rise to the claim. In some cases this may differ from what is alleged by claimant.

- Where a series of events contributed to the incident that gave rise to the claim, and it is difficult to identify the primary Incident/allegation type based on the guidance above, the first event in the series should be coded.
- It should be recognised that, in more complex cases, the claim manager's decision about which event was the main, dominant or primary cause giving rise to the claim will affect the information recorded against several other data items—Item 10 'Date incident occurred', Item 11 'Where incident occurred', Item 12 'Health service setting', and Item 13 'Claim subject's status'. The code recorded for each of these items should reflect the circumstances at the time of the event that was the main, dominant or primary cause giving rise to the claim (as recorded in this data item).
- Diagnosis – includes missed, delayed or incorrect diagnosis.
- Medication-related: type and dosage – includes issues related to type of medication or dosage; excludes anaesthetic.
- Medication-related: method of administration – includes issues related to method of administration of medication; excludes anaesthetic.
- Anaesthetic – includes all issues related to epidural, anaesthetic substances, equipment, monitoring/resuscitation and patient awareness.
- Blood and blood product related – includes issues related to blood transfusions; excludes infection control issues arising in the course of a blood transfusion.
- 'Procedure' is defined as an invasive clinical intervention, where there is an incision and/or the body cavity is entered; procedures may be therapeutic or diagnostic (AIHW 2001:327). A vaginal delivery is also considered a procedure for the purposes of this data item.
- Procedure–wrong procedure — includes unnecessary procedures, e.g. removal of a healthy appendix.
- Procedure–post-operative complications — includes incidents involving unintentionally retained objects following a procedure.
- Procedure–other — includes alleged negligent procedure (where no further information is available). Includes intraoperative complications, but see also guidance regarding optional transitional code 56 (Intraoperative complications), below.
- Intraoperative complications may be recorded as code 56. This is an optional transitional code, not yet mandatory at national level. It may be used to record complications that arise during the course of a procedure. If this code is not used to record such issues, code 55 (Procedure—other) should be used. Until this code becomes mandatory at national level it will not be reported separately in national reports, but will be combined with code 55.
- Treatment—complications – includes, for example, developing ulcers under a plaster or dressing.
- Treatment—failure of treatment – includes incorrectly setting a broken bone.
- Consent – includes no valid consent and failure to warn, cessation or continuation of treatment without consent or against patient's stated wishes, and disposing of a foetus without the consent of the parents.
- Infection control – should be recorded as primary incident/allegation type only where the acquisition of the infection was not clearly linked to undergoing a procedure (including a blood transfusion, administration of anaesthetic, or other invasive clinical intervention). This may, for instance, include contraction of hospital-acquired infections such as Legionnaires disease.
- Where the incident involved a patient who acquired an infection in association with a procedure, primary incident/allegation type should be coded as follows:

- Code 30 where the procedure concerned was the administration of anaesthetic;
- Code 40 where the procedure concerned was a blood transfusion;
- Code 53 for any other type of procedure.

In such cases, code 80 (infection control) should be recorded at item 6b.

- Device failure – includes problems with implanted devices (excluding problems due to the surgical implantation procedure). Where a device fails during insertion and the insertion procedure is consequently aborted, 'device failure' (code 90) should be recorded.
- Other general duty of care issues – includes falls, administrative errors (e.g. placing a 'nil by mouth' sign on the bed of the wrong patient), and patient monitoring and follow-up issues. Where, for example, failure to follow-up a patient was a key factor in a missed or delayed diagnosis, 'Other general duty of care issues' (code 100) should be recorded for this item, and 'diagnosis' should be recorded at Item 6b (Additional incident/allegation type).
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

This data item is aimed at collecting information on 'what went wrong', categorising the type of incident that has given rise to the claim. Information on 'what went wrong' is important in order to characterise the nature of claims. It will enable MINC data to be analysed and understood in light of information from related data sources, such as adverse events data. The information will also be useful for Clinical Risk Management (CRM) applications. Being able to broadly classify the problems that give rise to claims, in particular high cost claims, may indicate the types of underlying issues to be addressed (e.g. training, staffing issues, approaches to obtaining consent, etc.)

This data item will enable questions such as the following to be answered:

- What are the most common types of primary incident/allegation giving rise to claims?
- What types of primary incident/allegation most commonly give rise to high cost claims?
- How might new CRM strategies be targeted to deliver the greatest reduction in claim costs?

History of development and relationship to national standards

The coding categories for this data item have been developed with reference to a range of classifications currently in use, among which there is a high degree of commonality in terms of the categories identified.

In New South Wales a list of 46 categories of 'clinical incident category alleged in claim' is used to record this information. This list has also been adopted for use in Tasmania. In Western Australia eight broad 'incident type' categories are currently used to collect this information on clinical incident notification forms. Three studies of the epidemiology of adverse events (one Australian and two from the United States of America) used similar, broad categories of the nature of adverse events to analyse data (Brennan et al. 1991, Thomas et al. 2000, Wilson et al. 1995).

The ICD–10–AM provides a classification of external causes of morbidity. However, these codes were not specifically designed for categorising adverse events and do not include all categories of interest; for instance, there is no code for wrong or delayed diagnosis.

The Australian Incident Monitoring System (AIMS) uses quite a different approach to recording the important aspects of an incident. The approach is multidimensional—it allows a great deal of detail to be recorded and great flexibility of analysis. However, it is reliant on the sophisticated, purpose-built AIMS software.

Earlier in its development, the coding categories for this item more closely resembled those in the list used by NSW and Tasmania. However, test coding revealed problems with poor coding consistency, which seemed due in part to the fact that several dimensions of information were combined into a single code list. For example, an incident that involved problems with the administration of an epidural could be coded to ‘obstetrics’ or to ‘anaesthetic’. It was agreed by the MIDWG that separating out the concepts of ‘what went wrong’ and ‘clinical service context’ into separate data items would help to achieve greater coding consistency, as well as providing greater flexibility of analysis. Thus, ‘incident/allegation type’ now focuses on ‘what went wrong’, while item 7 is used to code the ‘clinical service context’ relating to the primary incident/allegation type.

6b Additional incident/allegation type

Defined as: The high level category describing other factors in what is alleged to have 'gone wrong' (in addition to the 'primary incident/allegation type'), which contributed in giving rise to the claim.

Classification code:

10	Diagnosis
20	Medication-related: type and dosage
21	Medication-related: method of administration
30	Anaesthetic
40	Blood/product-related (includes blood transfusions)
50	Procedure—failure to perform
51	Procedure—wrong procedure
52	Procedure—wrong body site
53	Procedure—post-operative complications
54	Procedure—failure of procedure
55	Procedure—other
60	Treatment—delayed
61	Treatment—not provided
62	Treatment—complications
63	Treatment—failure of treatment
64	Treatment—other
70	Consent (includes failure to warn)
80	Infection control
90	Device failure (includes problems with implanted devices)
100	Other general duty of care issues
110	Other
120	Not yet known

Guide for use:

- Up to three codes may be selected for this item.
- The code selected for Item 6a 'primary incident/allegation type' may not be recorded against this item.
- Definitions and guidance relating to the coding categories for this item can be found in the 'Guide for use' under Item 6a, above.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.
- Where there are no additional factors in what is alleged to have 'gone wrong' (i.e. other than those recorded at item 6a 'primary incident/allegation type') this item should remain blank.

Why is this data item collected?

This data item is intended to complement data Item 6a, 'Primary incident/allegation type', by providing a greater depth of information on 'what went wrong'. It will enable MINC data to be analysed and understood in light of information from related data sources, such as adverse events data. The information will also be useful for CRM applications.

Collecting information on additional incident/allegation types will enable the identification of all claims involving a certain type of incident/allegation (e.g. diagnosis issues), whether or not it is considered to be the primary incident/allegation type. Also, it will enable the detection of patterns of association among types of incident/allegation; for example, consent issues (code 70) and post-operative complications (code 53) may often be found to be recorded together.

This data item will enable questions such as the following to be answered:

- What proportion of claims arise from incidents involving diagnosis issues?
- How might new CRM strategies be targeted to deliver the greatest reduction in claim costs?

History of development and relationship to national standards

The coding categories for this data item have been developed with reference to a range of classifications currently in use (see notes for Item 6a, for further detail).

During development of the collection, the MIDWG acknowledged that the incidents that give rise to medical indemnity claims are often complex, and may involve a series of events in which something can be said to have 'gone wrong'. Therefore, recording only the primary incident/allegation type would not provide a complete picture of the circumstances out of which claims arise.

7 Clinical service context

Defined as: The area of clinical practice or hospital department in which the patient was receiving a health care service when the incident occurred.

Classification code:

1 Accident and Emergency
2 Cardiology
3 Dentistry
4 Elective cosmetic procedures
5 Ear, Nose and Throat (ENT)
6 General medicine
7 General practice
8 General surgery
9 Gynaecology
10 Hospital outpatient department
11 Neurology
12 Obstetrics
13 Oncology
14 Orthopaedics
15 Paediatrics
16 Perinatology
17 Plastic surgery (non-elective)
18 Psychiatry
19 Radiology
20 Urology
21 Other—please specify (free text field provided)
22 Not yet known

Guide for use:

- Only one code may be selected for this data item.
- The clinical service context coded using this item should relate to the primary incident/allegation type recorded at Item 6a.
- The code recorded for this data item should be that which, on the judgement of the claim manager based on all information currently available, best reflects the clinical service context in which the incident took place.
- Where the incident occurred in a hospital, the name of the hospital department in which the incident occurred may provide the most appropriate description of the clinical service context. In many cases, the clinical service context will reflect the specialty of the main clinician treating the patient, but this will not always be the case. For example, where a patient is treated in Accident and Emergency by a gynaecologist, 'Accident and Emergency' (code 13) should be recorded for this data item.

- Perinatology – this code should only be recorded where the health care incident that is the basis for the claim occurred shortly before or shortly after the birth of the claim subject; includes neonatal cases.
- Where the 'primary incident/allegation type' recorded at Item 6a is 'Anaesthetic', the code chosen for this item should relate to the main procedure that was being carried out, in the context of which the anaesthetic was being administered.
- Where none of the codes 1 to 20 applies, select code 21 ('other') and enter a brief description of the relevant clinical service area in the text field provided. In choosing an appropriate description, coders may refer to the code list for Item 14 ('Specialties of clinicians closely involved in incident') and the list of procedures grouped by body system provided in Appendix 2. If any item on these lists is appropriate please use it as a basis of the text description, with comments as needed. (Note: in the MINC Transmission Specifications this text field is field 7b; classification codes should be entered in field 7a.)
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

This data item is intended to provide information on the health care context in which the incident occurred—i.e. 'what was happening when something went wrong'. It will supplement data item 6, which provides a high-level categorisation of 'what went wrong'. Together, items 6 and 7 provide a picture of the nature of the incident that has given rise to the claim.

This information will enable MINC data to be analysed and understood in light of information from related data sources, such as adverse events data. The information will also be useful for CRM applications. Being able to broadly classify the clinical areas in which claims arise, in particular for high-cost claims, may assist in targeting CRM strategies.

History of development and relationship to national standards

As explained under Item 6a, the MIDWG decided that the concepts of 'what went wrong' and 'clinical service context' should be split into two separate data items in order to help achieve greater coding consistency, as well as providing greater flexibility of analysis. In developing this item, the MIDWG agreed on a short list of key clinical areas of particular interest for medical indemnity claims analysis. However, it is hoped that, where the codes provided do not adequately describe the clinical service context within which the incident occurred, the text descriptions provided by coders in the free text field will provide important information that will lead to further refinement of this item in the future.

Earlier in the development of the MINC a separate data item to record information about procedures was included. It used a list of procedures broadly classified by body system, based on the chapter headings of the Australian Classification of Health Interventions (ACHI), which is part of the ICD–10–AM. However, this item proved conceptually difficult and problematic in testing. It was therefore decided to incorporate information on problems with procedures into data item 6. The classification of procedures based on ACHI chapter headings is provided in Appendix 2—the categories may prove useful to coders as a basis for the description of clinical context entered in the free text field for this Item (when using code 15, 'other').

There is likely to be a strong relationship between this item and Item 14, 'Specialties of clinicians closely involved in the incident', and coders are encouraged to refer to the code list at Item 14 as a guide when entering a description of the clinical service context in the free text field for this item. However, the concepts underpinning the two items are quite distinct. 'Specialty', in the context of item 14, is an attribute of an individual clinician that remains unchanged although the clinician may work across a range of clinical service contexts (e.g. a

urologist may work in Accident and Emergency, and possibly in other clinical service contexts where hospital resource needs dictate). Conversely, clinicians of various specialties may work together in a given clinical service context (e.g. a cardio-thoracic surgeon, a vascular surgeon and an anaesthetist may work together in the operating theatre).

8 Body function/structure affected—claim subject

8a Primary body function/structure affected—claim subject

Defined as: The primary body structure or function of the **claim subject** (i.e. the patient) alleged to have been affected as a result of the incident.

Classification code:

1 Mental functions/structures of the nervous system
2 Sensory functions / the eye, ear and related structures
3 Voice and speech functions/structures involved in voice and speech
4 Functions/structures of the cardiovascular, haematological, immunological and respiratory systems
5 Functions and structures of the digestive, metabolic and endocrine systems
6 Genitourinary and reproductive functions and structures
7 Neuromusculoskeletal and movement-related functions and structures
8 Functions and structures of the skin and related structures
9 Death
10 Not applicable – no body function/structure affected
11 Not yet known

Guide for use:

- This data item should be completed even where the harm to the claim subject (i.e. the patient) is not a basis for the current claim, as it provides important background information about the nature and outcome of the incident.
- The 'claim subject' is the person who was involved in the health care incident that is the basis for the claim; i.e. the patient during the incident.
- The primary body function/structure affected should be that which, on the judgement of the claim manager based on all the information currently available, has the greatest impact on the individual (claim subject). In some cases this may differ from the primary body function/structure as alleged by the claimant.
- Only one primary body function/structure may be selected. If additional body functions/structures have been affected these should be recorded under Item 8b 'Other body functions/structures affected – claim subject'.
- Psychological harm should be coded as 1 'Mental functions/structures of the nervous system'.
- Where the claim subject experiences pain as a result of the incident, record the code for the body structure with which the pain is most closely associated.
- Where it is the judgement of the claim manager that the incident was a contributory cause of the death of the claim subject, record code 9 'Death'.
- Where a claim is in relation to a failed sterilisation procedure, and there is no consequent harm to body structures or functions, record code 10 'Not applicable'

- Where a claim is in relation to awareness during a procedure, due to anaesthetic failure, and there is no consequent harm to body structures or functions (including no resulting psychological impairment) record code 10 'Not applicable'.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.
- To help decide which code is appropriate, coders should refer to the on-line version of the International Classification of Functioning, Disability and Health (ICF) on the WHO website – http://www3.who.int/icf/onlinebrowser/icf.cfm. Some coding examples:
  - dental injury — code 3 (voice & speech)
  - subdural haematoma — code 1 (nervous system)
  - hepatitis — code 5 (digestive, metabolic and endocrine systems)
  - veins and arteries — code 4 (cardiovascular, haematological, immunological and respiratory systems)
- In the case of cancer primarily affecting a single organ or body part, the appropriate code for that organ or body part should be recorded. Where the cancer has progressed and affects major body systems code 4 (cardiovascular, haematological, immunological and respiratory systems) should be recorded (this rule should also be followed for other conditions affecting major body systems).

Why is this data item collected?

Often the harm suffered by the claim subject is the primary reason, or provides the main impetus, for a claim being made. Together with data Item 8b ('Additional body functions/structures affected'), this data item provides information on the nature of the harm alleged to have resulted from the incident. This information will be important as a basis for characterising claims.

The nature and extent of harm suffered may be a predictor of the size of a claim. Where there is long-term disability, long-term care costs can account for a substantial proportion of total claim costs. Information on harm may also be of use in predicting mode of finalisation (e.g. whether the patient may be content with a mediated settlement, including an apology/explanation, or is likely to want a court award of damages to cover life-long care costs).

Ideally, information more specifically on long-term outcome would be valuable, but it is unlikely to be possible to collect this type of information via the MINC.

History of development and relationship to national standards

The coding categories for this data item are based on the chapter headings for body functions and body structures in the Body component of the World Health Organization's International Classification of Functioning, Disability and Health (ICF) (WHO 2001).

Ideally, a full description of the disability or long-term outcome resulting from the incident would include other components of the ICF, e.g. activity limitation, participation restriction. But it was agreed that this level of detail was unlikely to be available to claim managers.

During development of the collection the MIDWG considered including a data item to record diagnosis information based on the ICD–10–AM (relating to health conditions arising from the incident). To ensure quality data, coding of diagnosis information should, ideally, be undertaken by coders trained in the use of the classification. Diagnoses are routinely coded for hospital patients, so for some claims this information could potentially flow to medical indemnity data collections held by Health Authorities. However, if the incident did not occur in

a hospital, or if the injury/condition is not diagnosed until later, information on diagnosis may not be available.

It was agreed that two data items were needed, to provide information on the body structure or function affected (Item 8), and the extent, or severity of harm (Item 9).

8b Additional body functions/structures affected—claim subject

Defined as: The body structure(s) or function(s) (of the **claim subject**) alleged to have been affected as a result of the incident, in addition to the body structure/function recorded under data Item 8a.

Classification code:

1 Mental functions/structures of the nervous system

2 Sensory functions / the eye, ear and related structures

3 Voice and speech functions/structures involved in voice and speech

4 Functions/structures of the cardiovascular, haematological, immunological and respiratory systems

5 Functions and structures of the digestive, metabolic and endocrine systems

6 Genitourinary and reproductive functions and structures

7 Neuromusculoskeletal and movement-related functions and structures

8 Functions and structures of the skin and related structures

9 Not yet known

Guide for use:

- Up to three codes may be selected for this item.
- This data item should be used to record all other body functions/structures of the claim subject affected in addition to that recorded under data Item 8a.
- The code selected for Item 8a 'Primary body function/structure affected—claim subject' may not be recorded against this item.
- Psychological harm should be coded as 1 'Mental functions/structures of the nervous system'
- Where only one body function/structure was affected as a result of the incident, and is recorded at Item 8a, this item should be left blank.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

This data item is intended to complement data Item 8a, 'Primary body function/structure affected—claim subject', by providing a greater depth of information on the harm alleged to have resulted from the incident.

Often, the harm suffered by the claim subject is the primary reason, or trigger, for a claim being made. In some claims, harm to multiple body functions/structures is alleged, and it is important that this information can be captured. For example, psychological harm due to trauma associated with, for instance, a failed procedure, may accompany physical harm. This data item enables such associations to be identified.

History of development and relationship to national standards

The coding categories for this data item are based on the chapter headings for body functions and body structures in the Body component of the World Health Organization's International Classification of Functioning, Disability and Health (WHO 2001) (see notes for Item 8a for further detail).

9 Extent of harm—claim subject

Defined as: The extent or severity of the overall harm to claim subject (i.e. the patient).

Classification code:
1 Temporary—duration of less than 6 months
2 Minor, with duration of 6 months or more
3 Major, with duration of 6 months or more
4 Death
5 Not applicable – no body function/structure affected
6 Not yet known

Guide for use:

- This data item relates to the overall effect of the incident on the person in terms of impairment, activity limitation or participation restriction (see 'History of development and relationship to national standards' below).
- Code 1 'Temporary—duration of less than 6 months' should be recorded where, on the judgement of the claim manager based on all the information currently available, the harm or disability resulting from the incident has lasted for, or is likely to last, for less than 6 months (regardless of severity). This category includes pain and suffering lasting less than six months.
- Code 2 'Minor—duration of 6 months or more' should be recorded where, on the judgement of the claim manager based on all the information currently available, the overall harm or disability is not major **and** has been, or is likely to be, ongoing for at least 6 months. That is, while there are some ongoing impairments, activity limitations and/or participation restrictions the claim subject is able to function, possibly with a small degree of difficulty, in all areas of life.
- Code 3 'Major— duration of 6 months or more' should be recorded where, on the judgement of the claim manager based on all the information currently available, the overall harm is moderate or severe **and** has been, or is likely to be, ongoing for at least 6 months. That is, the ongoing impairments, activity limitations and/or participation restrictions are such that they impact severely on the claim subject's ability to function in one or more areas of life.
- When deciding whether the harm or disability is 'minor' or 'major', the claim manager should consider the effect of the harm or disability on the claim subject's quality of life, earning power, and ability to do activities or participate in areas of life. Factors that should be taken into consideration in choosing the most appropriate code for this item include the presence of pain that affects quality of life and ability to do activities, and the need for ongoing care.
- In cases where the claim subject has pre-existing impairments, activity limitations and/or participation restrictions, the coding category chosen for this item should reflect only the additional harm or disability due to the incident, over and above any pre-existing conditions.
- Code 4 'Death' should be recorded for this item where code 9 (Death) has been recorded for Item 8a (i.e. where, on the judgement of the claim manager based on all the information currently available, the incident was a contributory cause of the death of the claim subject).

- Code 5 'Not applicable' should be recorded where code 10 'Not applicable' has been recorded for Item 8a.
- Code 6 'Not yet known' should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.
- Where the claim is for foetal distress and the outcome for the child will not be known until some future time, record code 6 'not yet known'.

Why is this data item collected?

Often the harm suffered by the claim subject is the primary reason, or trigger, for a claim being made. This data item on 'Extent of harm' is intended to provide an indication of the severity and duration of the harm alleged to have resulted from the incident.

The nature and extent of harm suffered can be a good predictor of the size of a claim. Where there is long-term disability, long-term care costs can account for a substantial proportion of total claim costs. Information on the nature and extent of personal harm may also be related to mode of finalisation (e.g. whether the patient may be content with a mediated settlement including an apology/explanation, or is likely to want a court award of damages to cover life-long care costs).

This data item would enable questions such as the following to be answered:

- How does size of claim vary with severity of outcome for the claim subject?
- Does mode of claim settlement vary with severity of outcome for the claim subject?

History of development and relationship to national standards

This data item has been developed with reference to the World Health Organization's International Classification of Functioning, Disability and Health (ICF) (WHO 2001) and the trial 'impairment extent' data element in the National Community Services Data Dictionary V2 (AIHW 2000).

Functioning and disability are multi-dimensional concepts, relating to the body functions and structures of people, the activities they do, the life areas in which they participate, and the factors in their environment which affect these experiences. In the ICF, a person's functioning or disability is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6 and Figure 3.1).

Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation.

The ICF contains a hierarchy of classifications and codes for each of its main components: Body Functions and Structures, Activities and Participation, and Environmental Factors. Measures can be recorded against each of the neutral codes, to indicate the extent of 'problem' with any of these aspects of functioning. Environmental Factors can be recorded as being either barriers to or facilitators of a person's functioning.

The ICF was endorsed for international use by the World Health Assembly in May 2001. It is regarded by the World Health Organization as one of the two core international classifications for health and health-related information, the other being the International Classification of Diseases and Related Health Problems (ICD).

The potential value of using the ICF in Australia is that it:

- combines the major models of disability, recognising the role of environmental factors in the creation of disability and the importance of participation as a desired outcome, as well as the relevance of underlying health conditions and their effects; and

- provides a framework within which a wide variety of information relevant to disability and functioning can be developed, assembled and related.

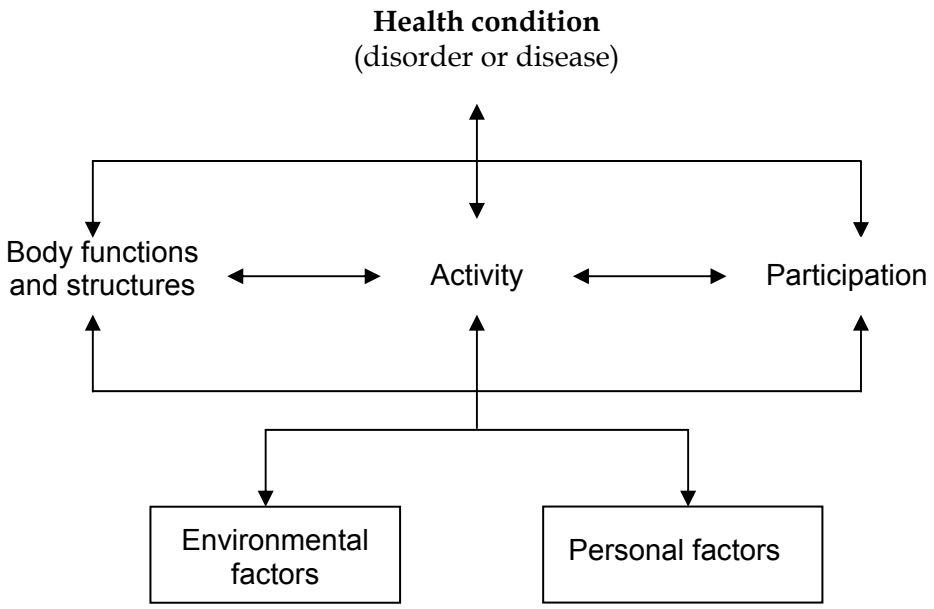


Figure 3.1: Interactions between the components of ICF

Source: WHO 2001:18

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10 Date incident occurred

Defined as: Calendar month and year in which the incident that is the subject of the claim occurred.

Classification code: mmyyyy

Guide for use:

- This item must be completed for all claims on the MINC database.
- This data item should always be recorded as a 6-digit date comprising month and year. Year should always be recorded in its full 4-digit format.
- In cases where it is not clear exactly when the incident occurred, the month and year recorded should be the claim manager's best estimate, based on the information available.
- The month and year recorded should reflect when the event coded in Item 6a (Primary incident/allegation type) occurred. Where the 'Primary incident/allegation type' coded in Item 6a reflects a series of events that occurred over a period of months (e.g. repeated failure to diagnose a condition), the month and year in which the first event occurred should be recorded.
- For example, where a missed diagnosis was the main, dominant or primary cause giving rise to the claim, the month and year recorded for this item should reflect when the diagnosis should first have been made, but was not.

Why is this data item collected?

Date information will be crucial for analysis of temporal patterns in the national data collection. In particular, data on when a reserve is placed against a claim in relation to when the incident occurred can be used to estimate the number of incurred but not reported claims at a particular point in time.

History of development and relationship to national standards

In general, it is the date on which the incident happened that is used in actuarial calculations relating to 'incurred but not reported' claims (IBNRs). 'Date incident occurred' is therefore an important item to include in the MINC collection.

It is recognised that 'date of discoverability' is recorded in some jurisdictions, and may also be used in the specification of the statutes of limitations in some jurisdictions. The date of discoverability may be some time after the incident occurred; for example, where a doctor fails to diagnose a problem, this may not be discovered for some months. After discussion the MIDWG agreed that the date 'when something went wrong' is likely to be more relevant in the context of the MINC than 'when it was discovered that something had gone wrong'. However, this issue may be revisited in the future.

11 Where incident occurred

Defined as: ASGC Remoteness Structure category for the location where the incident occurred.

Classification code:
1 Major city of Australia
2 Inner regional Australia
3 Outer regional Australia
4 Remote Australia
5 Very remote Australia
6 Not yet known

Alternatively, this item may be coded using the standard five-digit numerical code to indicate the Statistical Local Area (SLA) of the location where the incident occurred, as defined in the Australian Standard Geographical Classification (ASGC) (ABS catalogue number 1216.0).

(Standard postcode coding is also acceptable, but is not the preferred format for this item. See pages 9–10 of the MINC Data Transmission Specifications for guidance on coding options for this data item.)

Guide for use:

- The code chosen for this item must be derived by mapping the postcode or SLA for the location where the incident occurred to the appropriate ASGC Remoteness Structure category, using the concordance developed by the Australian Bureau of Statistics and available free of charge.
- Alternatively, Health Authorities may provide the SLA code or postcode of the location where the incident occurred, which the National Data Custodian will convert to an ASGC code before loading onto the national database.
- Data for this item must be provided in a consistent form for all records within a data transmission for a given jurisdiction; a mix of ASGC codes, postcodes and SLA codes will not be acceptable.
- Where the incident that gave rise to the claim involved a series of events that occurred in more than one location, the code recorded for this item should reflect the location at which the event coded in Item 6a (Primary incident/allegation type) occurred.
- Where a missed diagnosis was the main, dominant or primary cause giving rise to the claim, the code recorded for this item should be the ASGC remoteness category of the place where the diagnosis should first have been made, but was not (e.g. the GP's surgery).
- The ASGC Remoteness Structure will be updated by the ABS every census year; Health Authorities should ensure that the concordance they use for coding this item is current.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

This item will facilitate the identification of geographic patterns in the occurrence of incidents that give rise to claims. It will show where risk lies, for example, whether disproportionate

numbers of incidents that give rise to claims occur in regional areas, major cities etc. This could inform strategies aimed to better financial management of public sector liability.

The main use for this item is to identify broad geographic patterns (e.g. differences between major cities, regional and remote areas, at national level).

Development history and relationship to national standards

The coding categories for this item are from the Australian Bureau of Statistics' Australian Standard Geographic Classification (ASGC) Remoteness Structure. The option of providing SLA coded data for this item is consistent with the NHDD V10 data element 'Geographical location of establishment'.

The ASGC is a hierarchical classification system consisting of seven interrelated geographical classification structures (ABS 2001). It was developed by the ABS for collecting and disseminating geographically classified statistics. It provides a common framework of statistical geography that enables the production of statistics that are comparable and can be spatially integrated. Statistical Local Area (SLA) is one of the spatial units on which the classification structure is based.

During development of the MINC it was initially proposed that this data item should be based on postcode. However, some MIDWG members were concerned that postcode data would enable individual health care providers to be identified from MINC data. Therefore, it was agreed that data for this item should be stored on the MINC database as ASGC Remoteness Structure categories. Data providers have the option of providing data to the National Data Custodian in this form, or as SLA codes or postcodes, which will be translated to ASGC Remoteness Structure categories before being loaded onto the database.

12 Health service setting

Defined as: Health service provider setting in which the incident giving rise to the claim occurred.

Classification code:

1 Public hospital/day surgery centre (includes public psychiatric hospital)
2 Private hospital/day surgery centre (includes private psychiatric hospital)
3 Public community health centre
4 Private community health centre
5 Public residential aged care service
6 Private residential aged care service
7 Private medical practitioner rooms/surgery
8 Other public health service provider setting
9 Other private health service provider setting
10 Other (includes patient's home)
11 Not yet known

Guide for use:

- A health service provider setting is public if it is operated by or on behalf of a Commonwealth, State or local government agency.
- Hospital/day surgery centre – An establishment that provides at least minimal medical, surgical or obstetric services and/or care, and that provides comprehensive qualified nursing service as well as other necessary professional services. Must be licensed by State, Territory or Commonwealth health department, or controlled by government departments. Includes psychiatric hospitals, and hospitals that specialise in dental, ophthalmic aids, and other specialised medical or surgical care. Includes free-standing day surgery centres.
- Community health centre – An establishment that provides a range of non-residential health services, or which provides for the coordination of health services elsewhere in the community.
- Residential aged care service – An establishment that provides long-term residential care, involving regular basic nursing care, primarily to older people who are frail or have disabilities. Must be approved by the Commonwealth Department of Health and Ageing and/or licensed by the State, or controlled by government departments.
- Private medical practitioner rooms/surgery – Private medical clinics providing investigation and treatment for acute conditions on a non-residential, day-only basis. Includes 24-hour medical clinics and general practitioner surgeries.
- Other health service provider setting – Includes hospices, and alcohol and drug treatment centres.
- Other – mainly covers services provided in the patient's home (e.g. domiciliary nursing services).

- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.
- Where the incident that gave rise to the claim involved a series of events that occurred in different health service settings, the code recorded for this item should reflect the health service setting in which the event coded in Item 6a (Primary incident/allegation type) occurred.
- Where a missed diagnosis was the main, dominant or primary cause giving rise to the claim, the code recorded for this item should reflect the health service setting where the diagnosis should first have been made, but was not (e.g. code 7 for GP's surgery).

Why is this data item collected?

This item will be important for looking at where risk lies, in terms of the health service provider settings in which claims of different type and size originate. This information could inform CRM strategies by indicating what issues need to be addressed in which health service settings, in order to minimise the occurrence of adverse events that give rise to claims.

Development history and relationship to national standards

This data item was developed with reference to the following data elements in the NHDD V10: Establishment type; Hospital; Type and sector of employment establishment.

13 Claim subject's status

Defined as: Whether the claim subject (i.e. the patient) was a public or private, resident or non-admitted patient at the time of the incident.

Classification code:
1 Public admitted hospital patient
2 Private admitted hospital patient
3 Resident
4 Other
5 Not yet known

Guide for use:

- Public admitted hospital patient – a person, eligible for Medicare who, on admission to a recognised hospital or soon after, receives, or elects to receive a public hospital service free of charge. This includes patients for whom treatment is contracted to a private hospital. It does not include Department of Veterans' Affairs patients and compensable patients.
- Private admitted hospital patient – a person who, on admission to a recognised hospital or soon after:
  - elects to be a private patient treated by a medical practitioner of his or her choice; or
  - elects to occupy a bed in a single room (where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by an treating medical or dental practitioner); or
  - a person, eligible for Medicare, who chooses to be admitted to a private hospital (where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner).

  Private admitted hospital patient also includes:
  - Department of Veterans' Affairs patients – eligible people whose charges for their hospital admission are met by the Department of Veterans' Affairs; and
  - Compensable patients – a person who is entitled to receive or has received a compensation payment with respect to an injury or disease. A compensable patient is a person who:
    - is entitled to claim damages under Motor Vehicle Third Party insurance; or
    - is entitled to claim damages under worker's compensation; or
    - has an entitlement to claim under public liability or common law damages.
- Code 1 'Public admitted hospital patient' and code 2 'Private admitted hospital patient' should only be recorded for this item where Item 12 (Health service setting) is coded 1 (Public hospital/day surgery centre) or 2 (Private hospital/day surgery centre) **and** the claim subject was an admitted patient at the time of the incident.
- Whether a patient is an admitted patient will depend on administrative practices within particular jurisdictions. If the claim subject was considered to be an admitted patient by the relevant health service provider at the time of the incident then code 1 or 2 should be

recorded (as appropriate). Code 1 or 2 should also be used for patients receiving long-term nursing or respite care in a hospital, if they are considered admitted hospital patients.

- 'Resident – should be recorded where, at the time of the incident, the claim subject was a resident in a residential aged care or mental health care establishment, or in a similar residential health care setting. Code 3 should not be recorded where Item 11 (Health service setting) is coded 1 or 2. It is recognised that some hospitals (particularly in rural areas) use hospital beds to provide long-term nursing or respite care. However, where patients receiving such care are admitted hospital patients this code should not be recorded.
- Code 4 'other' should be recorded where, at the time of the incident, the claim subject was attending an outpatient clinic, GP surgery, Accident and Emergency ward, or similar non-admitted, non-residential service.
- Where, at the time of the incident, the claim subject was a patient admitted to a public hospital as a private patient, record code 2 'Private admitted hospital patient'.
- Where, at the time of the incident, the claim subject was a patient admitted to a private hospital as a public patient, record code 1 'Public admitted hospital patient'.
- Where the incident that gave rise to the claim involved a series of events, the code recorded for this item should reflect the claim subject's status when the event coded in Item 6a (Primary incident/allegation type) occurred.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is the data item collected?

In some jurisdictions, claims against the public sector may arise out of incidents involving private patients, for example, where private specialists have been brought under public sector insurance arrangements as a measure to protect service provision in remote areas. It will be useful to be able to distinguish claims arising out of incidents involving private patients, and establish the proportion of total costs accounted for by these claims.

Information on numbers of claims involving public and private admitted hospital patients can be viewed in the context of relevant denominator data on numbers of episodes of hospital care provided to these two classes of patient (e.g. from the National Hospital Morbidity Database). This type of analysis could provide some insight into whether public or private patients are over-represented in claims data.

Development history and relationship to national standards

The coding category definitions have been developed with reference to the following data items in the NHDD V10 (AIHW 2001): Admitted patient election status; Compensable status; Funding source for hospital patient; Medicare eligibility status.

During development of this data item it was decided to distinguish only between public and private admitted patients. It is difficult to develop guidance to clearly distinguish between public and private non-admitted patients, and the relevant NHDD data elements all apply to hospital patients only. Also, as mentioned above, national data on numbers of hospital separations for public and private patients are available, whereas similar denominator data are not readily available for non-admitted patients.

14 Specialties of clinicians closely involved in incident

Defined as: Clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim

Classification code:

1 Anaesthetics-general
2 Anaesthetics-intensive care
3 Cardiology
4 Cardio-thoracic surgery
5 Chiropractics
6 Clinical genetics
7 Clinical haematology
8 Clinical immunology
9 Clinical pharmacology
10 Colorectal surgery
11 Cosmetic surgery
12 Dentistry—oral surgery
13 Dentistry—other
14 Dermatology
15 Diagnostic radiology
16 Ear, nose and throat (ENT)
17 Emergency Medicine
18 Endocrinology
19 Endoscopy
20 Facio-maxillary surgery
21 Gastroenterology
22 General and internal medicine
23 General Practice—non-procedural
24 General Practice—procedural
25 General surgery
26 Geriatrics
27 Gynaecology only
28 Infectious diseases
29 Intensive care
30 Medical Oncology
31 Midwifery
32 Neurology
33 Neurosurgery
34 Neonatology

35 Nuclear medicine
36 Nursing—general
37 Nursing—nurse practitioner
38 Nutrition
39 Obstetrics & Gynaecology
40 Obstetrics only
41 Occupational medicine
42 Ophthalmology
43 Oral surgery - medical
44 Orthopaedic surgery
45 Osteopathy
46 Paediatric medicine
47 Paediatric surgery
48 Paramedical and ambulance staff
49 Pathology
50 Pharmacy
51 Physiotherapy
52 Plastic surgery
53 Podiatry
54 Psychiatry
55 Psychology
56 Public health/preventive medicine
57 Rehabilitation medicine
58 Renal medicine
59 Respiratory medicine
60 Rheumatology
61 Spinal surgery
62 Sports medicine
63 Therapeutic radiology
64 Thoracic medicine
65 Urology
66 Vascular surgery
67 Other allied health (including alternative medicine)
68 Other hospital-based medical practitioner
69 Not applicable
70 Not yet known

Guide for use:

- Up to four codes may be selected for this item.
- This data item should be used to record the specialties of the clinicians who played prominent roles in the incident that gave rise to the claim; that is, the individuals whose

actions/omissions are directly implicated in 'what went wrong'. However, recording the specialty of an individual clinician at this item does not imply that the individual was 'at fault'. These individuals may or may not be defendants in the claim.

- For a particular clinician, the specialty recorded should be the main clinical area:
  - in which that clinician has formal qualifications (or, in the case of a specialist-in training, is working towards gaining formal qualifications), and/or
  - in which that clinician primarily practices.
- The specialty recorded may not be the area in which the clinician was working at the time of the incident. For example, if a clinician involved in the incident was a general surgeon, but was working in emergency when the incident occurred, code 2 'General surgery' should be recorded for this item. Thus, the specialty recorded at this item may not 'match' the clinical service context recorded at item 7.
- Other hospital-based medical practitioners – includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.
- Nursing—general – includes enrolled and registered nurses
- Nursing—nurse practitioner – includes registered nurse practitioners only
- Midwifery – includes registered midwives only
- General and internal medicine – includes physicians.
- Where it is known a clinician specialises solely in Gynaecology, code 27 should be recorded. Where it is known a clinician specialises solely in Obstetrics, code 40 should be recorded. Code 39 should be recorded where it is known a clinician specialises in both Obstetrics and Gyneaecology, or where it is known that a clinician specialises in either Obstetrics or Gyneaecology or both, but there is no further information.
- Where a **registrar** was closely involved in the incident, the specialty for which the registrar was training at the time of the incident should be recorded.
- Where no clinical staff were involved in the incident (e.g. where the claim relates to actions of hospital administrative staff) code 68 'Not applicable' should be recorded.
- This item should be completed on the basis of available information about the specialty of clinicians closely involved in the incident; specialty should not be assumed based on other information. For example, if the incident occurred in the course of a bowel operation code 10 'colorectal surgery' should only be recorded where there is information to confirm that a colorectal surgeon was among the clinicians involved.
- Where a private doctor was closely involved in the incident, the specialty of the private doctor should be recorded.
- Not yet known – this code should be used only when the information is not currently available, but is expected to become available as the claim progresses. Once the information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

Information on clinical specialty is important both for financial management (e.g. for looking at cross-subsidisation between specialties) and clinical risk management.

In the private sector, clinical speciality is a key factor in determining premiums, as different specialties are recognised to carry different levels of liability risk. This has had implications for the public sector – in some jurisdictions, private specialists have been brought under public sector insurance arrangements in order to protect the provision of services that have

been threatened by large increases in the cost of premiums for certain specialists. In order to monitor the implications of these types of arrangements, it is important for information on specialty to be included in the MINC.

From a CRM perspective, information on specialty may indicate quality of care issues – for example, the proportion of claims associated with a procedure performed by a consultant not within the appropriate specialty (e.g. a breast operation performed by an orthopaedic surgeon).

This data item will enable questions such as the following to be answered:

- In what clinical specialties do most claims arise?
- In what clinical specialties do most high cost claims arise?

Development history and relationship to national standards

There is currently no complete, nationally recognised list of clinical specialties in Australia. There are two data elements related to clinical specialty in the NHDD V10 ('Principal area of clinical practice' and 'Surgical specialty'), but neither covers the full spectrum of specialties needed in a medical indemnity collection. Some Health Authorities have developed lists of clinical specialties, of varying length and detail, for use in their medical indemnity data collections. There is also a list of specialties used by the Commonwealth Department of Health and Ageing to manage Medicare billing.

The coding categories for this data item were developed with reference to all these lists; the aim was to include all categories that might be of relevance to medical indemnity claims.

15 Date reserve first placed against claim

Defined as: Calendar month and year in which a reserve was first placed against the claim.

Classification code: mmyyyy

Guide for use:

- This item must be completed for all claims on the MINC database.
- This item should always be recorded as a 6-digit date comprising month and year. Year should always be recorded in its full 4-digit format.
- 'Date reserve first placed against claim' must be a date that is the same as or after 'Date incident occurred' (Item 10).

Why is this data item collected?

Date information will be crucial for analysis of temporal patterns in the national data collection. This item will enable all claims against which a reserve was placed in a particular period (e.g. financial year) to be identified and analysed as a group. Also, data on when a reserve is placed against a claim in relation to when the incident occurred can be used to predict the number of incurred but not reported claims at a particular point in time.

'Potential claims' are matters that are considered by the relevant 'responsible expert' to have the potential to materialise into actual claims. The 'expert' may be someone in the health administration, with or without a further layer of advice from an insurance, risk or fund manager or legal adviser. This expert places, or arranges to have placed, a reserve in respect of the matter, and it is at this point that the matter is considered to be a 'medical indemnity claim' within the scope of the MINC.

While a potential claim may have come to the attention of the relevant body some time before, the date a reserve was placed against it is used to represent the date at which the matter came to be considered as one likely to materialise into a claim.

Development history and relationship to national standards

During the development of the collection, this item was initially proposed as 'when claim reported'. However, as the process for reporting claims varies between Health Authorities, sometimes involving a series of steps, MIDWG agreed that 'when reserve placed against claim' would provide more nationally consistent data. This date is of particular significance in the context of the MINC, as the placing of a reserve against a matter is the trigger for including the matter as a potential claim within the scope of the MINC.

16 Reserve range

Defined as: The estimated size of the claim, recorded in broad dollar ranges.

Classification code:
1 less than $10,000
2 $10,000 – <$30,000
3 $30,000 – <$50,000
4 $50,000 – <$100,000
5 $100,000 – <$250,000
6 $250,000 – <$500,000
7 $500,000 – <$1 million
8 $1 million– <$2 million
9 $2 million– <$5 million
10 $5 million or more

Guide for use:

- This item must be completed for all claims on the MINC database.
- 'Reserve' is defined as the dollar amount that is the best current estimate of the likely cost of the claim when closed. This amount will normally include claimant and defence legal costs but exclude internal claim management costs and any anticipated contributions from third parties (e.g. Medical Defence Organisations (MDOs).
- The amount recorded should reflect the current reserve against the claim at the end of the six-month period to which the data relate. That is, if the reserve is revised during the life of the claim the most recent estimate should be recorded in the database, over-writing any previous estimate. When a claim is closed the most recent reserve estimate should be reported; the reserve should not be deleted or altered when a claim is closed.
- The National Data Custodian will keep a record of previous reserve amounts reported to it for ongoing claims (as at the end of each reporting period).

Why is this data item collected?

Information on the estimated size of open claims is important for estimating potential future liability, being aware of emerging trends and, together with information on the final cost of claims, assessing the adequacy of current reserving practices.

While data on the size of closed claims provides information on past trends, information on reserves placed against claims currently 'on the books' provides a more accurate indication of current and future liabilities.

It is recognised that reserving practices, and methods of estimation, vary between Health Authorities. In general, however, the reserve amount will include claimant and defence legal costs but exclude internal claim management costs and any anticipated contributions from third parties (e.g. MDOs). An adjustment for the probability that the claimant will be successful may also be made.

Development history and relationship to national standards

During the development of the collection there was discussion among members of the MIDWG concerning whether specific dollar amounts could be recorded for this data item. While this would provide more detailed information and allow greater flexibility of analysis, providing detailed cost information was not acceptable to some MIDWG members, for confidentiality reasons.

17 Date claim commenced

Defined as: Calendar month and year in which the claim commenced, as signalled by the issue of a letter of demand, issue of writ, an offer made by defendant, or other trigger.

Classification code: mmyyyy

Guide for use:

- This item should always be recorded as a 6-digit date comprising month and year. Year should always be recorded in its full 4-digit format.
- Events that signal claim commencement (triggers) can include the issuing of a letter of demand or a writ, an offer made by the defendant to the claimant, or some other event that clearly signals claim commencement.
- Triggers for commencement are not limited to triggers of formal legal proceedings.
- The date recorded should be the date of the first 'trigger'. For example, if a letter of demand is received and, subsequently, a writ is issued, the date recorded for this item should be the date of the letter of demand.
- This item may remain blank if the claim has not yet commenced. However, once the claim has commenced the correct date should be entered.

Why is this data item collected?

Date information will be crucial for analysis of temporal patterns in the national data collection. This item will allow an important change in claim status to be recorded – i.e. the point at which a process was put in train with a view to ultimately concluding the matter.

18 Date claim finalised

Defined as: Calendar month and year in which the claim was settled, or a final court decision was delivered, or the claim file was closed (whichever occurred first).

Classification code: mmyyyy

Guide for use:

- This item should always be recorded as a 6-digit date comprising month and year. Year should always be recorded in its full 4-digit format.
- 'Date claim finalised' must be a date that is the same as or after 'Date claim commenced' (Item 17).
- This item must remain blank if the claim has not yet been finalised, or where Item 21 (Status of claim) is coded 'Claim previously closed now reopened' (40). However, once the claim has been finalised the correct date should be entered.
- It is understood that, in some cases, the final size of the claim may not be known for some time after the claim has been finalised, and the claim file may remain open for some time after the claim has been finalised. However, this item should be completed as soon as the claim has been finalised, in accordance with the definition given above.

Why is this data item collected?

This item will enable all claims finalised in a particular period (e.g. financial year) to be identified and analysed as a group. It is important for analysis of 'stocks and flows', e.g. average time between when a reserve is placed against a claim and finalisation, and how this varies for different types of claims. Date information will be crucial for analysis of temporal patterns in the national data collection.

Item 19 'Mode of claim finalisation' will provide important information for the interpretation of 'date claim finalised', by indicating whether the matter was settled, the claim discontinued, etc.

Development history and relationship to national standards

During the development of the collection, this item was initially defined as 'The date on which the file for the claim was closed'. However, there was concern from some members of the MIDWG that this definition would create problems in cases where a file stays open long after a final agreement has been reached, e.g. because of staged payments. From an analysis perspective, it seems logical that as soon as any of the processes listed under in Item 19 'Mode of claim finalisation' can be said to have concluded, the claim should be considered closed.

19 Mode of claim finalisation

Defined as: Description of the process by which the claim was closed.

Classification code:
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
6 Discontinued
7 Not yet known

Guide for use:

- Settled through State/Territory-based complaints processes, includes proceedings conducted in State/Territory health rights and health complaints bodies, e.g. Health Rights Commission (Qld), Health Complaints Commission (Tas).
- Settled through court-based alternative dispute resolution processes includes mediation, arbitration, and case appraisal provided for under civil procedure rules.
- Settled through statutorily mandated compulsory conference process includes settlement conferences required by statute as part of a pre-court process.
- Settled – other includes instances where a claim is settled part way through a trial.
- Discontinued includes claims that have been closed due to withdrawal by claimant, or operation of statute of limitations, or where the claim manager decides to close the claim file because there has been a long period of inactivity on the matter. Discontinued also includes instances where a claim is discontinued part way through a trial.
- Not yet known – this code should be used for claims that have not yet been finalised (i.e. where Item 18 'Date claim finalised' is blank), including claims for which Item 21 'Status of claim' is coded 'Claim previously closed now reopened' (40).

Why is this data item collected?

This information is particularly important because of the relationship between mode of claim finalisation and the administrative and legal costs associated with claim settlement. Data on mode of finalisation, together with information on characteristics of claims (e.g. Item 18 'Total claim size (finalised)', Item 13 'Specialties of clinicians closely involved in incident'), could usefully inform strategies aimed at streamlining the management of claims and reducing the costs associated with court settlements.

20 Total claim size

Defined as: The amount agreed to be paid to the claimant in total settlement of the claim, plus defence legal costs, recorded in broad dollar ranges.

Classification code:
1 less than $10,000
2 $10,000 – <$30,000
3 $30,000 – <$50,000
4 $50,000 – <$100,000
5 $100,000 – <$250,000
6 $250,000 – <$500,000
7 $500,000 – <$1 million
8 $1 million– <$2 million
9 $2 million– <$5 million
10 $5 million or more
11 No payment made
12 Not yet known

Guide for use:

- This item should only be completed if a date has been recorded for 'Date claim finalised' (Item 18).
- The total claim size is the total amount paid to the claimant in settlement of the matter, including any interim payments and claimant legal costs, plus defence legal costs. The amount should not include internal claim management costs. Total claim size should reflect costs paid (or agreed to be paid) by the Health Authority only; any third party contributions (e.g. payments from MDOs) should be excluded.
- Code 11 'No payment made' should only be used where the claim has been closed and no payment has been or is to be made to the claimant **and** there have been no claimant or defence legal costs. If no payment was made to the claimant but legal costs were incurred then the appropriate dollar range should be selected to report this.
- Where Item 21 ('Status of claim') is coded 33 'Finalised—Structured settlement with total dollar value open', the total claim size recorded at this item should reflect the total paid to date (i.e. at the time of transmission to the National Data Custodian).
- Not yet known – this code should be used for claims that have not yet been finalised (i.e. where Item 18 'Date claim finalised' is blank), including claims for which Item 21 'Status of claim' is coded 'Claim previously closed now reopened' (40). It may also be used for finalised claims when information on total claim size is not yet available. Once this information is available 'Not yet known' should be replaced by the correct code.

Why is this data item collected?

This item is crucial for tracking trends over time in claim size, and in numbers of claims of different sizes. Being able to examine the characteristics of claims of different sizes will aid in

understanding the drivers behind trends in the cost of claims, and may inform strategies aimed at managing and containing costs.

As claimant and defence legal costs are included in the total claim size it will not be possible to analyse the data to look at damages awards per se. However, it is considered important that the data include the total amounts paid out to plaintiffs, and the costs of defending claims, to provide a more realistic reflection of Health Authorities' liabilities.

Development history and relationship to national standards

During the development of the collection there was discussion among members of the MIDWG concerning whether specific dollar amounts could be recorded for this data item. While this would provide more detailed information and allow greater flexibility of analysis, providing detailed cost information was not acceptable to some MIDWG members, for confidentiality reasons.

21 Status of claim

Defined as: Status of the claim in terms of the stage it has reached in the process from a reserve being set to file closure.

Classification code:
10 Not yet commenced
20 Commenced (not yet finalised)
30 Finalised—claim file closed
31 Finalised—awaiting determination of total size
32 Finalised—structured settlement with total dollar value decided
33 Finalised—structured settlement with total dollar value open
40 Claim previously closed now reopened

Guide for use:

- This item must be completed for all claims on the MINC database.
- Not yet commenced – indicates that a reserve has been set for the claim but none of the events signalling claim commencement (see Item17 'Date claim commenced') have yet occurred.
- Commenced (not yet finalised) – indicates that the claim has commenced (i.e. a date has been entered at Item17 'Date claim commenced') but has not yet been finalised (i.e. no date is yet entered at Item 18 'Date claim finalised').
- Finalised—claim file closed – indicates that the total claim size has been determined, and the claim file has been closed; excludes finalised claims where payments to the claimant are made under a structured settlement scheme (codes 32 and 33). After a claim record with this code has been transmitted to the National Data Custodian once, it should not be transmitted again; the National Data Custodian will freeze the claim record on the MINC database. (See also notes on 'Claim previously closed now reopened', below.)
- Finalised—awaiting determination of total size – indicates that the claim has been finalised (and a date has been entered at Item 18 'Date claim finalised') but the total claim size has yet to be determined; the claim file has not yet been closed. Further transmissions to the National Data Custodian will take place.
- Finalised—structured settlement with total dollar value decided – should be recorded where the claim has been finalised and the Health Authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme **and** the total amount to be paid has been decided. After a claim record with this code has been transmitted to the National Data Custodian once it should not be transmitted again; the National Data Custodian will freeze the claim record on the MINC database. (See also notes on 'Claim previously closed now reopened', below.)
- Finalised—structured settlement with total dollar value open – should be recorded where the claim has been finalised and the Health Authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme **and** the total amount to be paid is open. For example, the Health Authority may have undertaken to reimburse the claimant for care costs incurred each year for the rest of the claimant's life.

- Claim previously closed now reopened – should be used to record instances where a claim previously recorded as finalised on the MINC database has been re-opened. In these cases, the claim identifier (Item 1) should not change (i.e. should be the same as the original claim identifier for the claim when it was initially entered on the MINC database), but all other relevant data items may be updated.
  - When a claim is initially reopened, Item 18 (Date claim finalised) should be blank, and Items 19 (Mode of claim finalisation) and 20 (Total claim size) should be recorded as 'Not yet known', until this information is known (i.e. when the claim is finalised for the second time).
  - For this data Item, code 40 (Claim previously closed now reopened) should remain until the claim is finalised for the second time, when the appropriate finalisation code (30, 31, 32, or 33) should be recorded.
  - Code 10 (Not yet commenced) and code 20 (Commenced (not yet finalised)) should never be recorded for a reopened claim.
- This item should be updated whenever the status of the claim changes.

Why is this data item collected?

This item will indicate the stage in the process (i.e. reserve placed, claim commenced or claim closed) that a claim has reached at the time that the data are provided to the National Data Custodian. This item will provide a convenient way to select a subset of claims for analysis (e.g. all closed claims).

Several sub-categories of 'finalised' are included in recognition of the fact that finalisation of a claim is not always the end of the matter. It may be some time after finalisation before the size of the final payment to the claimant is determined (hence code 31); or the claimant may be paid under a structured settlement scheme over a long period of time and the total amount may or may not be agreed in advance (codes 32 and 33, respectively). The capacity to identify structured settlements for claims in the MINC database will be particularly important, in order to monitor the uptake of this method of payment.

Where there is an agreement that the claimant will receive payments over a long period of time, and the total amount is not agreed in advance, the claim record should continue to be transmitted to the National Data Custodian every six months, with 'total claim size' (Item 20) adjusted to reflect the total amount paid to date, for as long as payments continue.

In some cases, a claim that has previously been closed may re-open. Recording code 40 for this item will signal to the National Data Custodian to freeze the information for the original claim on the MINC database and store new information for the reopened claim as a separate but linked record.