Medical indemnity DSS 2012-14

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Identifying and definitional attributes

Metadata item type:	Data Set Specification
METEOR identifier:	329638
Registration status:	Health!, Superseded 21/11/2013
DSS type:	Data Set Specification (DSS)
Scope:	The Medical indemnity data set specification (DSS) describes the data items and standardised data outputs for medical indemnity claims for the Medical Indemnity National Collection (MINC). The MINC contains information on medical indemnity claims against health providers. These are claims for compensation for harm or other loss allegedly due to the delivery of health care. This health care may occur in settings such as hospitals, outpatient clinics, general practitioner surgeries, community health centres, residential aged care or mental health care establishments or during the delivery of ambulatory care. Adverse events or harm due to medical treatment, which do not result in a medical indemnity claim, are not included in the MINC. In 2002, Australia's Health Ministers decided that a 'national database for medical negligence claims' should be established. In 2003 the Medical Indemnity Data Working Group (MIDWG) came into existence with its membership drawn from health authorities, the Department of Health and Ageing and the Australian Institute of Health and Welfare (AIHW). The MIDWG collaborated on establishing a Medical Indemnity National Collection (Public Sector), comprising data from the jurisdictions. In 2006 private medical indemnity insurers agreed to have their data on medical indemnity claims included in the MINC. In 2008 the Australian Health Ministers' Advisory Council approved funding for data development work. The data items and recording specifications proposed for DSS development are based on those endorsed by the MIDWG for the 2009-10 data transmission period. Medical indemnity claims fit into two categories, i.e. actual claims (on which legal activity has commenced via a letter of demand, the issue of a writ or a court proceeding) and potential claims (where the health authority or private medical indemnity insurer has placed a reserve against a health-care incident in the expectation that it may eventuate to an actual medical indemnity claim). Information in the MINC relates to actual and potential medical indemnity claims and the alleged or reported health-care incidents leading to medical indemnity claims. The MINC includes basic demographic information on the patient at the centre of the alleged health-care incident; related information such as the type of incident or allegation and the clinical specialties involved; the reserve amount set against the likely cost of settling the medical indemnity claim; the time between setting the reserve and closing the medical indemnity claim; and the cost of closing the medical indemnity claim and the nature of any compensatory payments. Compensatory payments may be made to the patient and/or to an other party claiming collateral loss as a result of the loss or harm experienced by the patient. As a general guide, the main steps in the management of public sector medical indemnity claims are: 1. An incident that could lead to a medical indemnity claim is notified to the relevant claims management body. In some jurisdictions medical indemnity claims are managed by the relevant state or territory health authority; however, in others, most of the claims management process is handled by a body external to the health authority. Occasionally, some of the legal work may be outsourced to private law firms. 2. If the likelihood of a medical indemnity claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed. 3. Various events can signal the start of a medical indemnity claim, for example, a

writ or letter of demand may be issued by the claimant's solicitor (this can occur before an incident has been notified) or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases no action is taken by the claimant or the defendant.

4. The medical indemnity claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.

5. As the medical indemnity claim progresses the reserve is monitored and adjusted if necessary.

6. A medical indemnity claim is closed when, in the opinion of the health authority, there will be no future unforeseen costs associated with the claim's investigation, litigation or a payment to a claimant. If a claim is closed and the possibility of future costs arises, the claim may be reopened.

7. A medical indemnity claim may be finalised through several processes—through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions settlement via statutorily mandated conference processes must be attempted before a medical indemnity claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process. A medical indemnity claim file that has remained inactive for a long time may be finalised through discontinuation.

The detail of this process varies between jurisdictions, and in some jurisdictions there are different processes for small and large medical indemnity claims. Private medical indemnity insurers follow a similar process in managing claims reported to them that are covered by the insurance they provide to private medical practitioners.

Collection and usage attributes

Guide for use: The following terminology is used in the Medical indemnity DSS:

- Claim refers to a medical indemnity claim
- Claimant could be another party/parties alleging loss due to the incident, rather than or in addition to the patient.

Collection methods: State and territory health authorities provide data on medical indemnity claims to the AIHW for national collation, annually. Data is for the financial year ending 30 June. Private medical indemnity insurers provide data on the same annual basis for a subset of the data items provided by public sector health authorities.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2014

Comments: The Medical indemnity DSS has been developed by the AIHW in conjunction with the MIDWG.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Has been superseded by Medical indemnity NBPDS 2014-Health!, Standard 21/11/2013

Metadata items in this Data Set Specification

Seq No.	Metadata item	Obligation	Max occurs
1	Medical indemnity claim management episode—Australian state/territory identifier, code N	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
2	Medical indemnity claim—medical indemnity claim identifier, XXXXXX[X(14)]	Mandatory	1
3	Medical indemnity claim—type of compensatory payment to patient, code N[N]	Mandatory	1
4	Medical indemnity claim—type of compensatory payment to other party, code N[N]	Mandatory	1
5	Person—date of birth, DDMMYYYY	Mandatory	1

DSS specific information:

In this data set specification 'Person' refers to the patient.

This data element should be used in conjunction with the data element: *Date—accuracy indicator, code AAA* to flag whether each component of the date of birth is accurate, estimated or unknown.

No linking of client records is envisioned in the Medical Indemnity National Collection.

Insurance Statistics Australia collects claimant/patient year of birth as part of its National Claims and Policies Database, which allows it to report private sector data to the Australian Institute of Health and Welfare in terms of the person's age at the time of the health-care incident.

Information on date of birth allows a more accurate calculation of the patient's age at the time of the health-care incident, especially when babies are involved.

6	Person—sex, code N	Mandatory	1

DSS specific information:

In this data set specification, 'Person' refers to the patient.

The patient should be female when the clinical service context is 'Gynaecology' or when the patient is not a baby and the clinical service context is 'Obstetrics'.

7	Person—Indigenous status, code N	Mandatory	1

DSS specific information:

In this data set specification 'Person' refers to the patient.

8	Medical indemnity claim—primary incident or allegation type, health-care code NN[N]	Mandatory	1
9	Medical indemnity claim—additional incident or allegation type, health-care code NN[N]	Conditional	3

Conditional obligation:

Conditional on more than one health-care incident or allegation type being involved in a medical indemnity claim.

10	Health-care incident—clinical service context, code N[N]	Mandatory	1
11	Health-care incident—clinical service context, text X[X(39)]	Conditional	1

Conditional obligation:

Conditional on recording Code 88 'Other' for the data element *Health-care incident—clinical service context, code N[N].*

DSS specific information:

This data element is only used to capture a description for those cases where the 'Other' code is used in the data element: *Health-care incident—clinical service context, code N[N].*

Seq No.	Metadata item	Obligation	Max occurs
12	Patient—primary body function or structure affected, body function or structure code N[N] ***DSS specific information:*** This data element relates to the primary body function or structure of the patient alleged to have been affected as a result of a health-care incident.	Mandatory	1
13	Patient—additional body function or structure affected, body function or structure code N[N] ***Conditional obligation:*** Conditional on more than one body function or structure being affected as a result of the health-care incident. ***DSS specific information:*** This data element relates to additional body functions or structures of the patient alleged to have been affected as a result of a health-care incident.	Conditional	3
14	Patient—extent of harm from a health-care incident, code N[N]	Mandatory	1
15	Health-care incident—date health-care incident occurred, DDMMYYYY	Mandatory	1
16	Health-care incident—geographic remoteness, remoteness classification (ASGC-RA) N ***DSS specific information:*** When the health-care incident that gave rise to a medical indemnity claim involved a series of events that occurred in more than one location, the code recorded should reflect the location at which the primary incident or allegation type occurred. Where a missed diagnosis was the main, dominant or primary cause giving rise to a medical indemnity claim, the code recorded should be the remoteness category of the place at which the diagnosis should first have been made, but was not, for example the general practitioner's surgery. Code 6 'Migratory' is not a valid code for the Medical Indemnity National Collection. Code 9 'Not stated/inadequately described' should be used only when the information is not currently available, but is expected to become available as the medical indemnity claim progresses.	Mandatory	1
17	Health-care incident—service delivery setting, health service setting code N[N]	Mandatory	1
18	Patient—relationship to health-care service provider, code N	Mandatory	1
19	Health-care incident—principal clinician specialty involved in health-care incident, clinical specialties code N[N]	Mandatory	1
20	Health-care incident—additional clinician specialty involved in health-care incident, clinical specialties code N[N] ***Conditional obligation:*** Conditional on more than one clinician specialty being involved in the health-care incident that gave rise to a medical indemnity claim.	Conditional	3
21	Medical indemnity claim management episode—reserve placement date, DDMMYYYY	Mandatory	1
22	Medical indemnity claim management episode—reserve size, range code N[N]	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
23	Medical indemnity claim—medical indemnity claim commencement date, DDMMYYYY ***Conditional obligation:*** Conditional on the existence of a trigger for commencement of the medical indemnity claim.	Conditional	1
24	Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY ***Conditional obligation:*** Conditional upon a medical indemnity claim being finalised. ***DSS specific information:*** The finalisation date should be reported if a medical indemnity claim has been settled, a final court decision was delivered or the claim file was closed.	Conditional	1
25	Medical indemnity claim—medical indemnity claim finalisation mode, code N[N]	Mandatory	1
26	Medical indemnity claim—medical indemnity claim size, code N[N]	Mandatory	1
27	Medical indemnity claim—medical indemnity claim status, code NN	Mandatory	1
28	Medical indemnity claim management episode—medical indemnity payment recipient type, code N	Mandatory	1
29	Medical indemnity claim management episode—class action indicator, yes/no code N	Mandatory	1
-	Date—accuracy indicator, code AAA ***DSS specific information:*** This data element is to be used in conjunction with the following data elements: *Health-care incident—date incident occurred, date DDMMYYYY; Medical indemnity claim—medical indemnity claim commencement date, DDMMYYYY; Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY; Medical indemnity claim management episode—reserve placement date, DDMMYYYY;* and *Person—date of birth, DDMMYYYY.*	Mandatory	5