Medical Indemnity National Collection (Private Sector) 2011-12

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Identifying and definitional attributes

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Data quality

Data quality statement summary:

The Medical Indemnity National Collection (Private Sector), or MINC (Private Sector), is a dataset that contains information on the number, nature and costs of private sector medical indemnity claims in Australia. Medical indemnity claims are claims for compensation for harm or other loss allegedly due to the delivery of health care.

Data on medical indemnity claims may change over the life of a claim as new information becomes available or the reserve amount set against the likely cost of closing the claim is revised.

Data were reported to the AIHW for all MINC (Private Sector) claims in scope for 2011–12.

Although there are coding specifications for private sector medical indemnity claims data, there are some variations between medical indemnity insurers (MIIs) in how they report medical indemnity claims.

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

The MINC (Private Sector) contains data about claims managed by private sector medical indemnity insurers. The claims reported by the MIIs to the AIHW are the same claims that they are required to report to the Australian Prudential Regulation Authority (APRA). Claims made against private hospitals covered by private hospital insurance arrangements are not included in the collection.

The MINC (Private Sector) includes:

- basic demographic information on the patient at the centre of the alleged health-care incident
- information on the alleged incident such as a description of what allegedly went wrong and the clinician specialties involved
- the alleged harm to the patient
- when the reserve was set and for how much
- for closed claims, when and how they were closed, and the cost of closing the claims.

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

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

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

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

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

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

The MINC (Private Sector) includes data for each financial year from 2005–06 to 2011–12. The 2011–12 data cover the period from 1 July 2011 to 30 June 2012.

Timeliness: The reference period for this data set is 2011–12. MIIs and/or their reporting agent Insurance Statistics Australia (ISA) provided 2011–12 private sector data over the period November to December 2012. This was in compliance with the MIIs' agreement to provide the AIHW with annual claims data on negotiated request.

The data were originally planned for publication in April 2013 and were published in June 2013.

Accessibility: *Australia's medical indemnity claims 2011–12* includes two chapters that report on private sector claims combined with public sector claims. This follows the format for the MINC reports established for the 2010–11 data. There are also five previous AIHW reports on combined public and private sector claims data covering the years 2005–06 to 2009–10. All are available without charge on the AIHW website. Links to the reports are listed sequentially at: http://www.aihw.gov.au/publications/medical-indemnity/.

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

Interpretability: Information to aid in interpreting the combined public and private sector medical indemnity claims data may be found in 'Appendix A: MINC data items and key terms' of *Australia's medical indemnity claims 2011–12*. The information specifies how the public and private sector code values relate to each other and any areas where there is not complete agreement between the two sets of code values.

Relevance:

The MINC (Private Sector) includes information on medical indemnity claims against individual practitioners who were covered by insurance with an MII for the purposes of the claim. In 2011–12, as in previous years, all private sector medical indemnity claims legally required to be reported to APRA were reported to the AIHW. Some of the claims reported by MIIs relate to medical defence organisation (MDO) run-off, which is a scheme for claims lodged with private sector medical indemnity insurers in the years when they were still organised as MDOs rather than MIIs.

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

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

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

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

The MINC (Private Sector) 2011–12 data includes new claims in scope that have arisen between 1 July 2011 and 30 June 2012, previously closed claims that were reopened during the year, and ongoing claims from the previous year.

No information on patients' Indigenous identification is collected.

Accuracy:

The MINC (Private Sector) includes a combination of unit record and aggregated claims data. The MIIs can elect to submit their data either directly to the AIHW, as unit records or as aggregated data in a pre-publication format, or through ISA. ISA provides MII data to the AIHW as aggregated data.

With the data items reported by the AIHW for the public and private sectors combined, the alignment between the private and public sector data is not always exact (see the section on Coherence, below). For instance, data collected by MIIs on *Faulty/contaminated equipment* is utilised as their data for the MINC *Device failure* category ('incident/allegation type').

With the data items not included in the MINC reports, the MII data submitted as unit records vary in their accordance with the specifications of the MINC (Public Sector). For instance, information on 'clinical service context' might not be collected by an MII and so cannot be provided.

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

The time required to collect all the information relevant to a medical indemnity claim can be lengthy. A coding of *Not known* is used when information is not currently available but may become available during the lifetime of a claim. Some data items have relatively high *Not known* rates and this may affect the interpretation of the proportions that can be presented. Also, some claim characteristics, such as the extent of harm to a patient and the body function or structure primarily affected, may change during the lifetime of a claim.

Compared to public sector claims, private sector claims are more focused on the insured clinician and less focused on hospital incident reports. Accordingly, compared with public sector claims, some information such as clinician specialty tends to be ascertained at an earlier stage of investigation for private sector claims, whereas other information such as patient demographics may be ascertained at a later stage.

Coherence:

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

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

The public sector and private sector differ in how they deal with claims against multiple clinicians. In the public sector, in most cases a single claim record is created for each health-care incident, and the involvement of multiple clinician specialties is recorded by recording up to three additional specialties as well as the principal specialty. In the private sector, it is a common practice for a single health-care incident to result in more than one claim if more than one clinician was involved in the incident that gave rise to the allegation of harm or other loss. As a result, individual claim sizes will often be less than the aggregated total cost incurred by the MII/s for a single allegation of harm or other loss. Thus, the reported cost of an individual claim in the private sector may not reflect the total payment made by insurers in respect of the claimants.

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Institute of Health and Welfare 2013. Australia's medical indemnity claims 2011−12. Safety and quality of health care series no. 14. Cat. no. HSE 137. Canberra: AIHW.

Relational attributes

Related metadata references:

Has been superseded by Medical Indemnity National Collection (Private Sector) 2012-13
AIHW Data Quality Statements, Standard 11/07/2014

See also Medical Indemnity National Collection (Public Sector) 2010-11
AIHW Data Quality Statements, Standard 18/05/2012

See also Medical Indemnity National Collection (Public Sector) 2011-12
AIHW Data Quality Statements, Standard 01/07/2013