Medical Indemnity National Collection (Public Sector) 2011-12

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Identifying and definitional attributes

Metadata item type:	Data Quality Statement
Synonymous names:	MINC (PS)
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Data quality

Data quality statement summary:

The Medical Indemnity National Collection (Public Sector), or MINC (PS), is a dataset that contains information on the number, nature and costs of public sector medical indemnity claims in Australia. These 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.
Western Australia's data are not available for the MINC (PS) for the 2011–12 year. Otherwise, coverage was 100% in terms of the claims that reporting jurisdictions considered to fall within the scope of the collection.

Although there are coding specifications for national medical indemnity claims data, there are some variations between jurisdictional health authorities that are party to the MINC (PS) in how they report their medical indemnity claims.

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

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

The MINC (PS) includes:

- basic demographic information on the patient at the centre of an alleged health-care incident
- information on the alleged incident, such as the incident date, a description of what allegedly 'went wrong', the clinical service context and the clinician specialties involved
- the alleged harm to the patient
- when the reserve was set and for how much
- the status of the claim along the process towards being closed
- for closed claims, when and how they were closed, the cost of closing the claim and the details of any payments to claimants (whether the patient or a related party).

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

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

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

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

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

Data for the MINC (PS) are supplied to the AIHW by state and territory health authorities under the terms of the MINC (PS) Agreement. The MINC (PS) Agreement governs the AIHW's collection and use of the MINC (PS) data. The Agreement includes the state and territory health authorities (excluding Western Australia since January 2011), the Australian Government Department of Health and Ageing, and the AIHW as cosignatories. Representatives from all of these agencies make up the Medical Indemnity Data Working Group (MIDWG), which oversees the MINC.

The MINC (PS) includes data for January to June 2003 and for each financial year from 2003–04 to 2011–12. The 2011–12 data cover the period from 1 July 2011 to 30 June 2012. Western Australian data were not available for 2011–12.

Timeliness: The reference period for this data set is 2011–12. Participating states and territories agreed to provide 2011–12 data to the AIHW by August 2012. The initial transmission was completed by November 2012 and all data were transmitted in their final form by December 2012.

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 dedicated to public sector claims data. There are nine previous AIHW reports on public sector medical indemnity claims between 2002–03 (6 months only) and 2010–11. 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/.

Interactive data cubes for MINC PS 2011–12 data will follow the release of the *Australia's medical indemnity claims 2011–12* report. Interactive data cubes for earlier years are available at:

http://www.aihw.gov.au/medical-indemnity-datacubes/.

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

Interpretability:

Information to aid in the interpretation of the public sector data in *Australia's medical indemnity claims 2011–12* is presented in Chapter 2 and Appendix A, and in the Medical Indemnity Data Set Specification at:

/content/index.phtml/itemId/329638.

Relevance:

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

Western Australia did not report any data to the MINC (PS) for 2011–12 and so the available national data excludes Western Australia for 2011–12. This was also the case for 2010–11.

There is some variation between reporting jurisdictions in terms of which cases fall within the scope of the MINC (PS), due to different reserving practices. For 2011–12, as for 2010–11, 100% of all public sector claims considered by reporting jurisdictions to fall within scope were reported to the AIHW. All jurisdictions including Western Australia reported nearly or exactly 100% of their claims data between 2007–08 and 2009–10.

Many of the data items in the MINC (PS) 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. In the case of potential claims there may be no claimant. Information is not collected on the claimant as such.

The MINC (PS) 2011–12 data covers new claims that had a reserve amount set against them between 1 July 2011 and 30 June 2012, previously closed claims that were reopened during the year, and ongoing claims from the previous year.

Information on patients' Indigenous identification was collected in 2011–12. This was the first year that this information was collected for the MINC, and it was reported for just 27% of 2011–12 claims. Accordingly, the data quality is too low to be considered for reporting.

Accuracy:

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

New claims are of particular interest to the MINC because they reflect differences between the year being reported on and previous years in terms of claim characteristics. However, the information that health authorities can provide for new claims may be less reliable than the information that can be provided for claims from previous years. This is because it takes time to investigate the circumstances of a claim and to ascertain the information collected during preliminary investigations. 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. Only a minority of data items, such as the date of an alleged incident and the patient's demographic information, can be reliably established for the great majority of public sector claims at an early stage in the investigations.

Coherence:

MINC data pertain to a particular reporting period and record, to the jurisdictions' best knowledge, their data at the close of the reporting period. Jurisdictions report a data item as *Not known* if the information is not currently available but may become available during the lifetime of a claim. Data items may also become *Not known* when a previously closed claim is reopened. For instance, total claim size for a reopened claim is *Not known* because the additional cost that will be incurred in reclosing the claim should be aggregated with the previously reported cost of closing the claim. These sorts of changes to the data are registered in the AIHW MINC (PS) master database, which holds the most up-to-date information available on Australia's public sector medical indemnity claims.

The jurisdictions may also advise the AIHW on an ad hoc basis of updates that

should be made to their data on the master database. For instance, several jurisdictions audited their medical indemnity claims collections in the late 2000s. Jurisdictions have also advised the AIHW of changes that should be made to unit records, including requests to remove previously transmitted records; for instance, if they involve public liability rather than medical indemnity. As a result of these changes, the data reported by the AIHW on medical indemnity claims for any particular year are subject to change.

There have been a number of enhancements to the MINC (PS) specifications since the initial data collection in 2003. While the enhancements have been designed to retain comparability with previously collected data, the following changes to the 2009–10 and 2011–12 data specifications require comment.

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

A new coding option *Rescinded—not a medical indemnity claim* was introduced for 2009–10. This option is selected for erroneous claim records and potential claims that, in retrospect, should not have had a reserve set against them because their likelihood of eventuating into an actual claim was low. Prior to 2009–10, when data providers wanted to remove these sorts of claim records from their list of current claims, they reported the claim as closed, or requested the AIHW to delete the claim from the master database (applying also to closed claims). Before this coding option became available, the MINC reports reported a higher proportion of claims discontinued for $0 than is the case with the 2009–10 and later MINC reports.

For the data items ‘type of compensatory payment to patient’ and ‘type of compensatory payment to another party/parties’, *Medical costs* used to be subsumed under *Other loss*, but it was recognised as a separate category beginning with the 2009–10 specifications. This change improved the alignment of these data items with the ‘Gross Claim Payments by Heads of Damage’ data item (No. 25) for the private sector MIIs in the Australian Prudential Regulation Authority (APRA) National claims and Policies Database (NCPD).

The 2009–10 specifications also changed three of the ‘extent of harm’ categories to align them with the World Health Organization’s International Classification of Functioning, Disability and Health. This also allowed the MINC (PS) codes to be mapped on to the codes recognised for NCPD data item 17 ‘Severity of injury’. Analysis of the MINC (PS) claims data demonstrated continuity between the 2009–10 and 2010–11 categories and those of previous years. By and large, claims that used to have an extent of harm *Temporary—duration of less than 6 months* were now coded *Mild injury*, and claims that used to have an extent of harm *Minor, with duration of 6 months or more* or *Major, with duration of 6 months or more* were now respectively coded *Moderate injury* and *Severe injury*.

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

Prior to 2011–12, the dates for when the incident occurred, the reserve was placed, the claim was commenced and the claim was closed were collected just in terms of their month and year. Beginning in 2011–12, information on the day field of these dates was also collected.

An additional change made with the 2011–12 specifications involved renaming the data item ‘nature of claim—loss to claim subject (patient)’ as ‘type of compensatory payment to patient’, and renaming the data item ‘nature of claim—loss to other party/parties’ as ‘type of compensatory payment to other party/parties’. These name changes followed MIDWG advice that these data items were being used specifically to record the basis on which a claimant or claimants were awarded compensation, which may differ from the categories of loss alleged by the claimant(s). Also, coding options were introduced to record all cases where the patient and/or other parties did not receive any compensatory payment. Previously, there had been some inconsistency between jurisdictions in whether to record cases like these as Not applicable or Not known. Due to the specification changes,

for claims that were closed in 2011–12, the data items 'type of compensatory payment to patient' and 'type of compensatory payment to other party/parties' were unambiguously reported — as either irrelevant to the issue of compensatory payment to the claimant or in terms of the one or more loss categories for which the claimant was compensated.

The 2011–12 data specifications also included more complete definitions of the *Treatment*, *Medication-related* and *Procedure* incident/allegation types than had previously been set down. In the 2010–11 and earlier data transmissions, some interventions reported as *Treatment* by some jurisdictions had been reported as *Medication-related* or *Procedure* by other jurisdictions.

A number of MINC (PS) data items are identical or similar to NCPD data items collected on private sector medical indemnity claims by APRA and by Insurance Statistics Australia (ISA) for provision to APRA. The MINC (Private Sector) held at the AIHW is based on data items in common between the MINC (PS) and the NCPD data collected by ISA. Public and private sector data for 2011–12 are jointly reported in the AIHW's *Australia's medical indemnity claims 2011–12* report.

APRA produces 'Level 2 reports' that include aggregated financial information on private sector medical indemnity claims. These reports are available free of charge to subscribers who create an account at http://www.ncpd.apra.gov.au/Home/Home.aspx. ISA formerly published statistical reports based on the claims data from MIIs that were members of the Medical Indemnity Industry Association of Australia. Its last report covered the years from 1995–96 to 2006–07.

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

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

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 (Public Sector) 2012-13
AIHW Data Quality Statements, Standard 11/07/2014

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

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