

# Medical Indemnity National Collection (Private Sector) 2012-13

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# Medical Indemnity National Collection (Private Sector) 2012-13

## Identifying and definitional attributes

<b>Metadata item type:</b>	Data Quality Statement
<b>METEOR identifier:</b>	582076
<b>Registration status:</b>	<a href="#">AIHW Data Quality Statements</a> , Standard 11/07/2014

## 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.

All 4 medical indemnity insurers (MIs) still trading at the end of the financial year reported unit records to the AIHW for all of their MINC (Private Sector) claims in scope for 2012–13. The QBE claims are represented by a transmission of unit records from Invivo to the AIHW towards the end of the 2012 calendar year, and so are missing any additions and changes to those unit records between January and June 2013.

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

### Description

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 MIs 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.

As for the public sector, the MINC (private sector) data for 2012-13 consists of unit records.

**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 (Cwlth)* 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 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](http://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 MIs which require MIs 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, the AIHW and each of the MIs.

**Timeliness:** The reference period for this data set is 2012–13. The MIs still trading at the end of the financial year provided 2012–13 private sector data over the period July to November 2013. The available data on QBE Insurance claims were received toward the end of December 2012 from Invivo (the underwriting agent for QBE at that time).

The data were originally planned for publication in May 2014 and were published in July 2014.

**Accessibility:** *Australia's medical indemnity claims 2012–13* 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 2012–13*. 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 2 sets of code values.

**Relevance:**

The MINC (Private Sector) includes data for each financial year from 2005–06 to 2012–13. The 2012–13 data cover the period from 1 July 2012 to 30 June 2013.

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 2012–13, 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) 2012–13 data includes new claims in scope that have arisen between 1 July 2012 and 30 June 2013, 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:**

Data providers are primarily responsible for the quality of the data they supply. Some MIs transmit claim records that APRA has previously validated, along with supplementary items not included in APRA's National Claims and Policies Database (NCPD). These records were checked for consistency, paying particular attention to issues connected with their conversion from APRA to MINC unit records and the codes for the supplementary items. Other MIs transmit claim records that are based on the MINC (Public Sector) specifications. These 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 available records from Invivo (QBE's underwriting agent) represent the state of relevant QBE Insurance claims in late 2012 rather than at 30 June 2013. Therefore, the available data are incomplete in missing any new QBE claims between late 2012 and June 2013, and inaccurate in that some of the claims recorded as still current in late 2012 may have been closed by June 2013.

The alignment between the private and public sector data is not always exact (see the section on Coherence, below). For instance, data collected by MIs on *Faulty/contaminated equipment* is used as their data for the MINC *Device failure* category ('incident/allegation type'). Some data such as 'clinical service context' might not be collected by an MI and so cannot be supplied.

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. This point applies with particular force to the 2012–13 data, contrasting with the lower *Not known* rates for previous years' data, which can now incorporate more mature claims information. 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 incidents. 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 or not at all.

**Coherence:** The MINC (Private Sector) specifications were developed as a common ground between 2 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 version of the NCPD developed by Insurance Statistics Australia for reporting claims MII data both to APRA and the MINC (Private Sector).

The change between the 2011–12 and 2012–13 reference years, from some to all of the MIs reporting unit records to the AIHW has generally not affected how the private sector data categories are mapped to the MINC categories for combined public and private sector data reporting. However, 1 MINC data item that has been affected is 'mode of claim finalisation'. The most similar NCPD data item, 'Litigation status', has some categories that map directly to the MINC categories and some—notably, *Plaintiff does not have legal representation*—that do not. For the purposes of the 2012–13 combined public and private sector data, this category has been mapped to the MINC *Discontinued* category. However, not all MIs followed the same course for reporting their claims data to the AIHW for the 2011–12 and preceding years. Accordingly, the combined public and private sector data on mode of claim finalisation are not comparable between 2012–13 and the preceding reference years.

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 MIs 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, 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* and *Obstetrics and gynaecology* categories, as well as the *General practitioner—procedural* and *General practitioner—non-procedural* categories, for combined sector reporting.

APRA produces 'Level 2 reports' that include aggregated financial information on private sector medical indemnity claims. These reports are available at <http://www.ncpd.apra.gov.au/Home/Home.aspx>.

## Data products

**Implementation start date:** 11/07/2014

## Source and reference attributes

**Submitting organisation:** Australian Institute of Health and Welfare

**Reference documents:** Australian Institute of Health and Welfare 2014. Australia's medical indemnity claims 2012–13. Safety and quality of health care series no. 15. Cat. no. HSE 149. Canberra: AIHW.

## Relational attributes

**Related metadata references:** Supersedes [Medical Indemnity National Collection \(Private Sector\) 2011-12 AIHW Data Quality Statements](#), Standard 01/07/2013