

Litigation, regulation and the cost of indemnity

Mike Devlin

Many will be familiar with the saying “if it ain’t broke, don’t fix it,” although I suspect fewer could attribute it to President Carter’s Director of the US Office of Management and Budget, Bert Lance¹. What Lance also said is as true today as it was in 1977, “that’s the trouble with government: fixing things that aren’t broken and not fixing things that are broken”. When explaining to doctors why there is a sustained rise in their indemnity subscriptions, Lance’s sentiments have a certain resonance.



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Spiralling cost of damages - failing to fix what is broken in the market

They key driver impacting on indemnity subscriptions is the cost of damages. Figure 1 below graphically illustrates the stark comparison between clinical negligence claims inflation and other common measures of inflation over a ten year period. NHS Resolution, which indemnifies NHS Trusts in England, has seen its total liabilities grow at a rate that is plainly unsustainable, and in 2018 were reported as £77 billion².

It is the size of individual compensation awards that lie behind the enormous total liabilities burden the NHS faces. The essential principle of compensation, where a patient is negligently harmed during treatment, is to put them in the position they would have been in had the injury not occurred. This includes amounts for future medical costs, social care costs and lost earnings.

It may surprise many to know that future medical costs are calculated, in accordance with 1948 legislation³, on the basis that they will be provided on a private basis, despite the

availability of NHS care. Future care costs (for example residential support) are also calculated on a private basis⁴ and can be a substantial component of a high-value claim. The trend is inexorably upward, but there is evidence from

other countries, notably the US, is that reform of the laws governing clinical negligence claims is effective⁵ (so called ‘tort reform’) because it goes to the root of the problem, how damages are calculated.

The rise in total clinical negligence liabilities is not a reflection of increasing claims numbers. After a peak in 2013/14, there has been a levelling-off in numbers⁶, which are largely a reflection of civil litigation reforms⁷ that were brought in during 2013 and which resulted in an anticipatory ‘surge’ in personal injury claims. It is interesting to note that this levelling-off trend in claims numbers

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is occurring despite the increase in demand for clinical care and staff shortages. A key GMC report in 2018⁸ described it in terms of the profession being at a ‘critical juncture’:

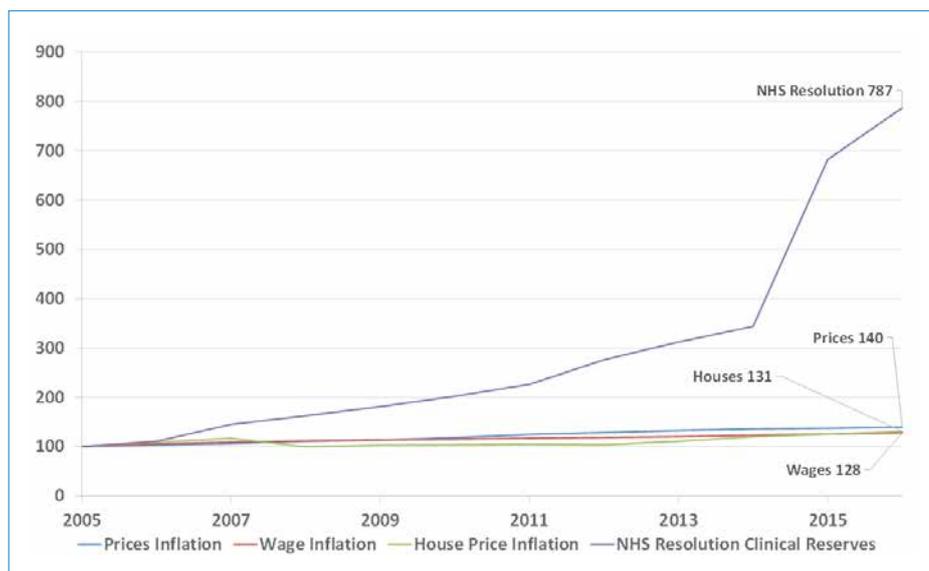


Figure 1: All values set to zero in 2005 and y-axis represents the relative increase in costs.

“Demand for care is increasing in volume and complexity. Combined with severe shortages of staff in some areas of the UK and in some parts of health and social care provision, this creates huge pressures on the medical workforce.”

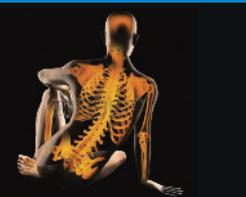
Even with these pressures, the GMC notes that “doctors are still delivering good care in very trying circumstances”. An NAO report⁹ on managing the costs of litigation in the NHS also found that there was no evidence that the rise in litigation awards was related to poorer

patient safety. It noted that the rises were more related to things outside the control of NHS staff and organisations, such as increasing life expectancy, more expensive treatments and legal reforms and market developments in legal services, which are referred to above.

A key example of the type of external influence on the market the NAO report alluded to is the decision in February 2017 by the Lord Chancellor¹⁰ to cut the discount rate from 2.5% to minus 0.75%. The effect of the discount rate change is particularly pronounced in high-value claims (in which there are, characteristically, considerable and enduring future care costs), where damages were roughly doubled and in some cases trebled, at a stroke.

In its response to the NAO report and subsequent review by the Public Accounts Committee¹¹ the government accepted the PAC’s recommendation that the Department of Health, Ministry of Justice and NHS Resolution, “must take urgent and coordinated action to address the risking costs of clinical negligence”¹². While the work to address the spiralling costs of claims by the bodies referred to is ongoing, unsustainable liabilities continue to accrue and action is needed now to bring about meaningful and effective legal change so that compensation is fair and affordable¹³. >>

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Spiralling cost of damages - fixing what is not broken in the market

Lance's prescient maxim can be neatly applied to the government's consultation on appropriate clinical negligence cover¹⁴. The government identified the following four objectives that it believed should be addressed:

- Patients harmed by the negligence of regulated healthcare professionals can access appropriate compensation;
- Regulated healthcare professionals hold stable and sufficiently funded clinical negligence cover, thereby reducing potential risks of prohibitive costs to healthcare workforce and the patients they treat failing to access appropriate compensation;
- Regulated healthcare professionals have greater clarity and confidence about the security and terms of their cover, as well as suitable patient protection in the event of a dispute with their indemnity provider; and
- Patients have greater clarity and confidence of their recourse to any compensation.

Furthermore, the government has clearly indicated that its preferred option is to "change legislation to ensure that all regulated healthcare professionals in the UK not covered by a state-backed indemnity scheme hold appropriate clinical negligence cover that is subject to appropriate supervision, in the case of UK insurers, by the Financial Conduct Authority and Prudential Regulation Authority". The implication in the consultation is that the objectives above are not provided by discretionary indemnity. This is plainly not the case, since long before the NHS existed, the medical defence organisations have been providing appropriate indemnity to doctors in England and the rest of the UK, and patients receive compensation where it is found that they have been negligently harmed.

What the consultation fails to do is provide evidence that the current indemnity arrangements in the UK are failing either doctors or patients. This is a paradox as doctors we are used to assiduously following and applying evidence; we would be reluctant to treat patients where there was no proof of clinical effectiveness. We should rightly be wary of accepting regulatory changes to the provision of medical indemnity, which has served doctors' needs for over a century, in the absence of cogent evidence of the need for change or that suggested alternatives are better.

The effect of the government's policy objective, if successful, would be the requirement that future medical indemnity is either provided under a contract of insurance or would have to be subject to a regulator's oversight, and both of these options are likely to increase the cost of indemnity

for surgeons. In addition, insurance brings with it its own costs, such as profit for shareholders, Insurance Premium Tax, regulatory and brokers' fees. Oversight by a regulator would have to be paid for, and ultimately this would likely fall to doctors and other healthcare professionals through increased insurance premiums.

There is also an important point to consider that relates to one of the characteristics of medical indemnity. Clinical negligence claims have what is described as a 'long tail', meaning that a claim may not be brought for many years, sometimes decades, after the

event that gave rise to it. An illustrative example of this is where an MDU member reported a 1959 incident three decades later, in 1989, which was subsequently settled in 1998 for £866,000¹⁵. This has implications for caps that insurance policies may have in place. For example, an insurance policy in 1985 that had a cap of £1 million might have been adequate, as the MDU's first claim

of that amount was not paid until 1988. Indeed, a £10 million cap might have been adequate until 2010, but with the sudden and dramatic cut to the discount rate in 2017 we now see high-value claims settled for sums that may exceed £30 million. Traditional occurrence indemnity, provided by the medical defence organisations, is not constrained by caps on indemnity. However, the government consultation does not properly address this point, an insured cap that might have been adequate in 2004 may be substantially less so if the claim is brought 15 years after the incident when the policy was taken out.

A final point is that the consultation does not appear to acknowledge the limitations of regulation. Simply being an insurance company, and regulated by the FCA and PRA, does not stop it withdrawing from unprofitable lines of business, such as was seen with the St Paul withdrawing clinical negligence cover worldwide in 2001¹⁶, leaving thousands of UK doctors to make arrangements for their tail cover. Nor does it eliminate the risk that an insurer may fail¹⁷, leaving policyholders without cover and needing to make urgent alternative arrangements.

Conclusions

Most surgeons with some private practice are acutely aware that indemnity costs continue to rise, and understand that having appropriate indemnity in place for the whole scope of their practice is a GMC requirement. However, fewer will be familiar with the factors driving the inexorable rise in the cost indemnity, and this article aims to have tried to shed much needed light on the subject. It is a reminder that the drivers of indemnity costs have to date not been addressed by government – if anything potentially new inflationary costs might result due to the regulation of indemnity consultation. And as the article is primarily to inform, rather than act as a call to arms, it is of course open to any interested party to find out more and take action to make their voice, and that of their profession, heard. ■

References

References can be found online at www.boa.ac.uk/publications/JTO.

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