Government Indemnity Scheme for GPs – Preparing for Change

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Preparing for Change - Introduction and Oveview

For those in attendance, the announcement of a Government-backed indemnity scheme by Jeremy Hunt at the RCGP conference in *Liverpool last October* heralded a new era of indemnity provision. For the GP community the announcement was long-overdue.

The BMA and figurehead GPs have been calling for reform of their indemnity options for many years, and while the insurance market has slowly encroached on the Medical Defence Organisations' (MDO) market share, a vast majority of GPs remain loyal to their MDO.

While choices between defence organisations are often considered as broadly similar, the insurance market has, in recent years, presented an alternative to the traditional routes, enabling GPs the ability to consider their options more fully.

So, when Mr Hunt announced a 'third way', there was much written in the medical press to publicise and support this proposal. In fact, the GP community welcomed the announcement, but equally it was met with a level of cynicism. History has shown that when significant changes in Primary Care are announced - such as changes to commissioning, contracts, NHS structure and more recently the introduction of the CQC in 2009 - there will always be a range of views for and against.

Discussion and debate are healthy and, importantly, show a level of interest in the subject at hand. While there were positive quantities of both in October 2017, the hubbub around GP indemnity seems to have fallen quite considerably, at least in the mainstream publications. So the question is, has the GP community accepted the Hunt announcement and moved on, or *dismissed it out-of-hand through sheer fatigue of talking about it?* After all, with such a significant and long awaited development, surely Mr Hunt was expecting a far more sustained reaction?

I would propose an alternative view; that the *apparent lack of detail* surrounding the October 2017 announcement, and brief Department of Health (DOH) press releases, means that GPs simply cannot get excited about what they don't fully understand. It is therefore this article's intention to shed a little more light on some of the common questions MIAB has been posed by GPs, Allied Healthcare Professionals, LMCs, Federations and Partnerships.

Starting with the most immediate point, running an indemnity scheme requires serious thought, preparation and number-crunching, not to mention the right financials to support claims losses. The Government have introduced a state-backed indemnity scheme before in secondary care, *back in 1990*, so it would be fair to say there should be confidence in being able to do it again in 2019.

Should I Cancel All My Cover In April 2019?

We would urge caution on this point. The Government scheme is being designed to align with the cover available to those working in secondary care, the Clinical Negligence Scheme for Trusts (CNST).

In brief, the indemnity for those working for NHS Trusts is paid-for at a Trust level for all those staff employed by that specific Trust, to deliver Trust contracts. Contrary to popular belief, indemnity in the secondary care sector is not free, but simply paid for at a much higher level than the individual. The cover is vastly different to that being provided by defence organisations in that its primary function is to offer the patient the ability to seek recourse against the clinician's wrongdoing, and provide a financial remedy for this.

Crucially the scope of the indemnity provided under the CNST is limited to the extent of an employee's contracted role. Therefore a heart surgeon will not normally be covered for giving ophthalmic treatment and vice versa.

In contrast, defence organisations and insurers offer a more rounded offering that defends against compensation claims across the scope of the clinician's role, therefore will respond to medico-legal support requests, coroners' cases, GMC hearings and other professional regulation matters. The Government has already ***confirmed*** that cover "would only cover clinical negligence risks arising from the delivery of GMS/PMS/APMS contracts and any other integrated urgent care delivered through NHS Standard Contracts".

As such, private non-NHS work undertaken by GPs, including medicals for individuals, corporates and other ancillary services, will not be covered. Furthermore because of the complex structure of Primary Care, it remains unclear whether local authority-tendered contracts of public health, such as smoking cessation clinics and weight loss, will be covered by this approach."would only cover clinical negligence risks arising from the delivery of GMS/PMS/APMS contracts and any other integrated urgent care delivered through NHS Standard Contracts".

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Financing - Who Pays For It?

No money?
Let us first review Theresa May's comments made while as a guest on BBC's Question Time on the 2nd June 2017, when she said to an NHS nurse who had not seen a pay rise since 2009 that *"there is no magic money tree"*.

We have known for a long time that NHS resource is finite and this is exemplified in local variances presented by the 'postcode lottery' that appears to exist around patient access to specific medications and treatments.

It was a founding principal of the NHS that care would be free at the point of use and available to all, but in 1948 Mr Bevan could hardly have predicted the increase in life expectancy and advances in medical developments that now make the NHS *five times more expensive* to run in real terms now, than it did at its conception.

Commercial Viability
With these financial challenges in mind we must also now consider the commerciality of the indemnity market. As a GP you will be more than aware of how your indemnity costs have increased over the past few years.

Our society has become more litigious, spurred on by no-win, no-fee organisations offering representation for claims for compensation ranging from medical negligence to holiday-related gastroenteritis. There is little legislation to enable an external body to regulate legal costs associated with such representation and often the costs of compensation awards are equal to the additional legal costs of the organisation representing the client.

Therefore MDOs have been left with little choice but to increase their annual subscriptions to align with the growing value and volume of claims requiring defence. We also know that premiums relate to the type of work being undertaken (eg, out of hours or urgent care) and the claims history of those undertaking it.

Similarly, the insurance market has to consider these issues when rating premiums, but because the policies are written in a different way to MDOs, premiums also reflect market conditions more accurately in their pricing. This has become increasingly relevant for all premiums since the change in discount rate (or the Ogden Rate as it is officially known), which has meant that claim settlements are now around 2.5 times higher now than before the adjustment in early 2017.

Overall, an insurer or MDO has to balance their books. Whatever is being paid out in claims has to be offset by what is gathered in premiums, as a minimum, but then there needs to be further consideration for other costs such as overheads, salaries, reinsurance and dare I say it, a little bit of profit. The prices being charged for indemnity today reflect a minimum income level required by the provider, any less, and margins and sustainability of the product begin to be compromised.

So what is the Government proposing? After all there is no magic money tree, and so to offer indemnity to over

33,000 full-time equivalent GPs will come at a significant cost. In fact, based on an NHS England/DOH *GP Indemnity Review* the average in-hours indemnity premium in 2016 was over £7,500. Scale this up by 33,000 and without some form of contribution the Government will be required to fill a quarter of a billion pound black hole.

So It Won't Be Free Then?
It is our understanding from our own conversations with the Department of Health and UK Government Investments that the cost of indemnity for the GP community will be borne by the GP community.

To dispel any myths or misconception that the cover will be provided free of charge, the DOH statement in October 2017 notes "Our ambition is to deliver a more stable, and more affordable indemnity system for general practice" - with the key word being affordable. Based on the previous outline of how the commercials need to align to simply break even, it therefore becomes almost improbable that the Government will fully fund this proposal.

The question then moves to how these new costs will be met. From the limited information available, there are a number of methods through which costs could transfer.

The first is the invoicing of individual members for their own cover. This would be the most labour intensive method of administration and also places a reliance on individuals subscribing to the scheme to give it enough critical mass from premium contribution to be profitable and sustainable, especially if there are any large early losses.

By providing cover at a practice level or higher, a second option, there is reasoned argument that any proposed cover would be simpler to administer, to pay for and to audit trail. We are aware that consideration has been given to the notion of offering 'ready-indemnified' GMS, PMS and APMS contracts, so that those GPs delivering the service can do so, safe in the knowledge that they are indemnified as long as the claim relates back to the provisions of the contract.

Clearly the provision of ready-indemnified cover will have ramifications on the overall value of the contract to the practice, with a deduction being made from the global sum in order that the costs of indemnity can be met, notwithstanding the robust nature of GMS contracts and the challenges faced in changing them. In simple terms, contracts may be worth less in the future, but mitigate the need for those delivering them to pay for additional indemnity.

The third option is that costs will be met 'further up the food chain', by the CCGs, before any funds are distributed to the practices. In all instances, these proposals suggest cover will be mandatory, though this hasn't yet been confirmed.

Tax Relief
One of the advantages of purchasing cover as an individual (or as a practice) is the ability to claim *tax relief on your indemnity contributions*. This process is simplified because many partners will elect to 'self-assess', by engaging the services of a financial advisor or a good accountant. By moving how indemnity is paid for, it might prevent practices from claiming tax relief as a much needed source of alternative income.

It also poses the need for the Government to consider the pricing of their indemnity to ensure that it is more cost effective than current options, once tax relief is considered.

As we have explored above, driving pricing downwards may conflict with the actuarial pressure of ensuring the scheme is profitable and sustainable.

What Else To Consider Before Moving To A Government Scheme?

Group Membership Perks
For many insured clinicians, a common perk of group indemnity via a defence organisation is the additional cover provided to other members of the practice team. For example, depending on provider and percentage of members with that provider, a practice may find their HCAs, management team and lower-grade nurses are covered under the group indemnity within the premiums paid. A key consideration for GPs should be the impact on the practice of dissolving a group scheme in favour of a more affordable individual indemnity solution.

The automatic imposition of such cover at a practice, contract or even CCG level might force a decision to discontinue group cover with a defence organisation, but such a move would compromise access to some of the perks of a group arrangement such as cover for the entity.

This presents a new issue of sourcing indemnity for those who would have previously been covered for 'free' under the defence organisation scheme, especially if those individuals work across multiple employers or in private settings. Moreover such a requirement for indemnity will present additional costs to the practice which may fall outside of the practice's financial forecast, leading to a tightening of the metaphorical belt, rather than the loosening of it.

Other Covers
As we have discovered, the Government indemnity scheme will not provide the broad scope of cover that GPs have historically enjoyed. That doesn't mean that the need for additional covers – medico-legal support, legal defence costs, GMC investigation and coroners' queries – will disappear.

Providers of indemnity have indicated that there will still be a demand for 'everything except indemnity' cover and you can expect to see a range of choices become available in April 2019 to dovetail around a state-backed indemnity scheme. The plans will present an additional cost to those purchasing them, but commercially won't command sufficient premium to allow such providers to include the added perks found with full defence organisation membership.

At this stage we understand that there will be a need to purchase Government indemnity and a wraparound policy for the other covers not included by the state-backed scheme. If you wish to continue to practice on a private level you will also need to consider the purchase of a separate policy to cover the indemnity for such work. As we have identified, private work will fall outside of the scope of Government indemnity and so there are important questions to consider around the sustainability and cost effectiveness of undertaking infrequent or irregular work, in the context of the additional costs of indemnifying against negligence.

Improved Access for Hard-to-Cover GPs
The Government proposal for a state-backed indemnity scheme is a door opener for a minority of GPs who

fall in to the category of 'distressed'. These individuals have historically found it difficult to secure indemnity, perhaps because of GMC intervention, sanctions, a poor track-record with defence organisations or because of an illness that compromises their fitness to practice.

With defence organisations and insurers becoming increasingly selective around who they indemnify in the wake of the changes to the discount rate, the number of 'distressed' individuals is growing. More and more GPs are looking to specialist insurers to provide cover, but because of the perceived increased risk posed by these individuals, premiums and cover terms can often be prohibitive.

This becomes relevant in the context of meeting the minimum indemnity requirements as outlined by the GP Performer's List. Some practitioners have found that to comply with the minimum expectation of £10m, cover is unaffordable. Even those who have been able to afford the £10m limit required, have then found it difficult to attain Performer's List accreditation because of the terms of the cover, such as the excess applicable at claim stage being too high. In some cases we have encountered rehabilitated GPs, desperate to get back to work, only to find that the inability to secure competitive or appropriate indemnity eludes them.

The state-backed scheme is open to everyone. At this stage we are unsure how it will be underwritten as the complexities associated with a mass intake of members will need to be carefully managed. It does however mean that those who are presently struggling to find appropriate indemnity will be able to take advantage of job opportunities within Primary Care and equally, of affordable indemnity.

With this degree of opportunity, those who have previously been ostracised from general practice through indemnity challenges, will now be able to return and bolster the shortfall of clinicians currently faced by the NHS.

There is a wider consideration that the enhanced selection criteria employed by insurers and defence organisations has helped control premiums at the average level previously outlined. There is reasoned actuarial argument to suggest that blending the claims experience of those with less desirable claims history will seek to increase premiums for all, as the losses of the few become paid for by the premiums of the many.

The Government-backed scheme in secondary care replicates this aggregation of claims experience and reflects this in the premiums of all subscribing Trust members and private companies. Those closest to the development of the Primary Care scheme are known to be considering a similar option and this has been hinted at with the announcement of NHS Resolution as the lead administrator of the scheme when in launches in April 2019.

Locum GPs

From all that has been published by the Government, there is little conclusive information to determine a robust viewpoint regarding Locum GPs. The DOH announcement highlights that cover will be provided to those offering primary medical services and activities of practice staff in the provision of such services. It would be a reasonable conclusion to suggest that Locum GPs will therefore be indemnified when they engage in practice-based work, but will not be separately individually indemnified.

For Locum GPs this presents a cost saving, as their indemnity cost will be borne by the practice contracting their service, but it also limits the Locum in providing a range of services across the Primary Care spectrum in both a private and publically funded capacity.

Run-Off Cover – Little Understood But Crucially Important

Insurance vs Defence Organisations
Many GPs are surprised when they find there are inherent differences between insurance-backed contracts and medical defence organisation subscriptions. One of the biggest differences is the principle of discretion.

Under a discretionary arrangement, as used by the defence organisation, the willingness to support a member's claim is at the discretion of the indemnifying organisation. While this decline to support is a rare event, it creates uncertainty in whether the cover will respond when called upon to do so, and if it fails to respond there is often no recourse option available.

Insurers however operate FCA-regulated, insurance-backed contracts that are enforceable at law. There is a policy wording with clearly defined cover limits, and should this contract decline to respond when it should, the insured clinician has avenues to contest and overturn claims decisions.

Occurrence, Claims-Made and Run-Off Cover
A further difference is that defence organisation cover is usually provided on an 'occurrence' basis. This means that as long as there was cover in force at the time of an alleged failure in professional duty, the policy should respond even if the clinician was notified of the litigation many years after the event.

In contrast, insurance policies are usually offered on a 'claims-made' basis. Under this type of cover, failure in professional duty is picked up by the insurer at the time of the notification. For this reason, it is important that when an individual is insured on a claims-made basis, they consider maintaining cover even after retirement in the event claims come to light that have arisen from past works.

Failure to maintain this 'Run-Off' cover after cessation of practice means any new claims notifications become the responsibility of the individual to defend and settle.

Why Is Run-Off Cover Relevant To State-Backed Indemnity?
The *Government announced* that the new indemnity scheme will provide seamless cover for those presently insured on an occurrence basis. Such individuals will be able to roll-in their cover as it falls due. Some clinicians however are insured on claims-made policies, and while cover will be made available for these individuals from expiry of their current policy in 2019, it will only cover clinical activities (and claims arising from such activities) from the date of joining onwards, in 2019.

As we have explored already, such a condition will require those on claims-made policies to explore the need for Run-Off cover for their expiring policy, while also subscribing to a new state indemnity scheme. Historically, those on claims-made policies have been relatively few in number and limited to those who have failed to secure coverage through the more traditional defence organisation routes.

However changes to the MDU policy in November 2017 has meant this form of cover is far more prevalent and is now offered as an alternative to all renewing and new members in exchange for a lower annual subscription. Referred to as *Transitional Benefits* or 'claims-paid', the MDU has moved away from its more traditional occurrence model, with a view to an interim solution until the Government assumes the cost of the claims exposure.

With specific reference to the MDU, the *Government has in response advised* "The Government does not currently plan to include this run-off cover in a state-backed scheme. GPs with claims-paid or claims-made indemnity policies would therefore be required to purchase such cover separately themselves at the point they move to a state-backed scheme."

Consequently, until further information is available, the Government's current position is that 'claims-made' and 'claims-paid type covers will require a Run-Off solution in tandem with any indemnity provision made by the state.

Managing Claims And Balancing The Books

It is essential that as a GP you feel that your indemnity provider is there to support you as much as possible to ensure that there is recourse for the affected party. Those GPs who have been practicing for many years will often be able to empathise with others who have been wrongly accused of negligence and agree the value of an indemnity provider offering the much needed legal advice and support. Such accusations can be reputationally damaging and indemnity providers may spend much more than is sought in compensation to defend their client.

Premiums vs Claims
Under the CNST model, member premiums are calculated on the basis of projected claims in the coming 12 months with precise actuarial management required to calculate income (premium) against expenditure (claims). Therefore it should be considered that the CNST may not take the same stance as a defence organisation/ insurer at the point of claim, with the need to balance the books being a clear incentive to spend less money contesting contentious claims, especially if it is not economic to do so.

The CNST has to tread a fine line between managing volume, maintaining a cost neutral balance sheet and the ongoing case management of long-tail claims which are both complex and expensive. In return they offer competitive premiums free of insurance premium tax, with no need to satisfy profit-hungry shareholders and no commission payable to brokers.

The CNST arrangement is burgeoning with pros and cons and clearly for many there is a desire to get the best of all worlds, with a policy that is both cheap and rooted in protecting the member, rather than considering decisions with one eye on the commerciality of the loss.

Introducing Helpful Legislation
Of course, from a premium perspective the saving on insurance premium tax is just one consideration. The other is that the Government is ideally positioned to tailor legislation to effectively limit the scale of losses incurred to indemnity providers, whether this is in a reversal of the discount rate to pre-2017 levels, or by capping maximum compensation awards for certain losses.

In extremis, the Government has already demonstrated the ability to legislate in their favour through *the banning of whiplash compensation without medical evidence*, which was welcomed by the motor insurance industry as a whole. Such legislative intervention is helpful in keeping future premiums in check, especially as the secondary care state indemnity is based on forecasted settlements over the coming 12 months.

If claims can be controlled, member premiums could theoretically be lowered over time. Likewise, the aggregation of all grades of GP risk to a common indemnity scheme means that those with less desirable claims will cause all member premium contributions to increase in line with premise of subsidising the associated scheme loss.

With little or no planned regulation as to who will be eligible to join the state-backed scheme, it is important that the Government introduce some degree of measurement and rating to ensure premiums are proportional to risk. This approach works well in the CNST, but it has taken some time to establish subscriber claims history, exposure and risk profile to achieve premium scales.

In Conclusion

The Government indemnity scheme is still in its development phase. An update on the subject is expected from the DOH in the summer, with a view to the final blueprint being completed in the late autumn. The ability for the final proposal to satisfy all camps is almost inconceivable at this stage.

For individual GPs, there is a real chance that the new scheme will be thrust upon them, doing away with the need to maintain defence organisation coverage, in its current form at least. Conversely, those who have sourced claims-made and claims-paid cover will find themselves liable for a separate 'tail' of insurance premiums unless there is a significant step-change in the way in which members can migrate to the Government scheme.

Practices are genuinely concerned about their financial position, in spite of costs savings made through collaborative working and embracing the directives of the *GP Five Year Forward View*.

For many there is a lack of understanding around just how complex their future indemnity arrangements may be; will they be forced to take basic Government indemnity, with bolt-on insurance cover for legal benefits and private peripheral services? The concept of a prescriptive policy enforced upon those delivering care removes the freedom of choice for a practice (or GP) to shop around. Certainly, if not more expensive, it feels more complex.

That said, we have seen how these indemnity changes will lower and normalise the premiums being charged, at least to begin with, while allowing those previously limited by circumstance to once again re-engage with Primary Care.

What is important is that GPs and clinicians alike can rest easy that whatever solution is implemented should be cost effective, simple and clear. The commerciality of the proposition both from a customer and claim perspective are integral to the positive reception it will receive. If there isn't a compelling argument to take the state-backed cover, and it becomes a mandatory requirement, there will likely be discontent among the GP population and the scheme will fail before it begins.

We will continue to maintain a watching brief on the situation and update the information as it crystallises. For now, at least, the best advice is inaction. Keep your options open and avoid making fundamental changes to your indemnity contract until such time that you can make an appropriate and informed decision. If in doubt, seek advice and importantly, let's get everyone talking about the state-backed scheme again!