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.