Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Damages (Return on Investment) Bill: Medical Defence Union

27 May 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Paul Givan (Chairperson)
Ms Linda Dillon (Deputy Chairperson)
Mr Doug Beattie
Ms Sinéad Bradley
Ms Jemma Dolan
Mr Paul Frew

Witnesses:

Dr Matt Lee	Medical Defence Union
Mr Thomas Reynolds	Medical Defence Union

The Chairperson (Mr Givan): I welcome representatives from the Medical Defence Union (MDU) to the Justice Committee. Briefing us today is Dr Lee, executive director of professional services, and Mr Reynolds, head of government and external relations. The session is being recorded, and a Hansard transcript will be published in due course. I will hand over for a briefing on your submission, and we will follow that with some questions.

Mr Thomas Reynolds (Medical Defence Union): Thank you. On behalf of the Medical Defence Union, I thank the Chair, Deputy Chair and other members of the Committee for inviting us to appear this morning.

The Medical Defence Union is a mutual, not-for-profit organisation, and it is owned and run solely for the benefit of our members. In their number are doctors, GPs, dentists and other healthcare professionals across Northern Ireland. Our supports for members span a number of areas of their professional practice, from investigation by a regulator to disciplinary proceedings by their employer and claims of criminal negligence. We are in constant awe of our members' dedication to delivering safe and effective compassionate patient care. On a day when Northern Ireland leads the way in opening up COVID-19 vaccinations to all adults, it is clear to see that our GPs have done the heavy lifting in recent months.

Our concern in coming before the Committee today is particularly acute, and it is about a policy decision by the Government on the personal injury discount rate (PIDR). Either the interim rate, which I am very conscious that we cannot go into today, or the mechanism in the Bill for setting that rate in the future, could have a severe and adverse effect on GPs, and that is deeply regrettable. We have profound concerns about the revised rate methodology proposed in the Bill, and there are changes that we would like to see. However, we very much echo the sentiments given by Mark and Alphy, and it is very heartening to hear the Deputy Chair's comments and those of other members of the Committee on their commitment to getting the Bill through, but that really is our central message to the

Committee today. The prospect of a -1·75% rate enduring indefinitely or for any longer than is necessary would have profound consequences for the costs of clinical negligence in Northern Ireland, and it really should be avoided at all costs.

However, with all that being the case, we have to emphasise to the Committee that we are coming before you today to say that, if and when the Bill is passed, it cannot be considered job done. There is a piece of work here for a future Executive and Assembly to look at again, and I will provide a very quick summary of that now, if I may. The key change that we would like to see is that the Department of Justice should be under a duty to gather evidence of what claimant investment behaviour actually is in the real world, rather than based on the hypotheses and assumptions built into this legislation. Alphy and Mark touched on that a moment ago. We cannot escape the fact, and there is that balance to be struck, that, for every pound that leaves the healthcare system to pay for a cost of clinical negligence, there is less money for front-line patient care for the countless other patients who may be suffering or be subject to a similar ongoing health need but cannot prove negligence and require a properly funded healthcare system. So we need to see the full picture.

We also believe that a framework for the PIDR should rule out any retrospective effects. Any new discount rate should apply only to compensation awards relating to incidents that took place after the date of the change in rate.

Finally — I am pleased to see that this point has been made already — there absolutely must be political accountability here. I know the steer that the Committee has been given by the Minister of Justice about its remit, but, somewhere in this process, there has to be political accountability, given the significant ramifications that this policy decision can have. Its implications can be profound, as I said, so we would like to see a proper impact assessment built into the legislation that requires the Government, before a rate review comes up, to go out and speak across government, particularly to the Department of Health, to build a full picture and for that impact assessment to be laid before the Assembly so that Members can see in advance the possible ramifications of a discount rate of x, y or z.

At that point, just to conclude our opening remarks, I will pass over to my senior colleague Dr Matthew Lee, who will contextualise what impact a change in the rate can mean for our members and also what we have seen in other jurisdictions when those rates have changed recently.

Dr Matt Lee (Medical Defence Union): Thank you, Tom. Just to explain, I am a doctor, but I am 21 years out of medical practice, having been in the MDU for over 20 years. My remit includes our provision of legal services, our medico-legal advice and our claims handling. I also cover our underwriting department, so I have a broad range of experience about how changes in regulation and law can impact on claims costs and, fundamentally, how they are pushed through to indemnity costs and how those indemnity costs can impact on the health service at its heart.

Even before we saw the changes to the discount rate in Northern Ireland, indemnity costs were becoming a very unaffordable burden for GPs. They have been cited as a significant factor in early retirements, in our members dropping their sessions and even in the recruitment of new doctors into primary care. In England and Wales, we saw a similar effect, which was partly — well, largely — addressed by the introduction of state indemnity for GPs. It is probably worth my highlighting that removing the indemnity for NHS clinical negligence claims from English and Welsh GPs had the effect of pushing the average indemnity cost down from around £8,000 to £10,000 per individual GP to under £1,000.

The cost of indemnity is really driven by the cost of clinical negligence claims, but not just any claims. It is specifically driven by the cost of high-value clinical negligence claims. Across our UK-wide GP claims portfolio, around 70% of case reserves are held against just 7% of the highest-value cases. It is those exact high-value cases that are predominantly affected by changes in the discount rate, so there is a very real prospect that a sustained -1·75% discount rate will push through to very significant changes in indemnity costs, but, even long term, a discount rate that overcompensates in any way will push through to a bigger burden on the health service and individual GPs.

The size of most high-value claims is driven by lifelong care costs. Those are both health costs and social costs, and, in the absence of legal reforms, those care costs will continue to be calculated on the basis that the care, both socially and health, will be provided privately, although the reality is that very few compensated patients receive all aspects of that social care and healthcare for the rest of their lives on a private basis. We have had cases where we have made lump sum settlements despite the injured party being settled into local authority care, with all their health needs being met by the

NHS, yet the system at the moment will compensate on the basis that, at some point in their lives, which could be tomorrow, that will have to change to a private arrangement, and, therefore, a full lump sum private payment is made. So this is very significant, and there is a very significant prospect that very low discount rates will lead to significant overcompensation.

A drop of the magnitude recently seen in Northern Ireland could have the effect of pushing up some of the claims values two- or threefold. Mark Harvey mentioned some examples. A real-world example for us was when the discount rate dropped in England from 2·5% to -0·25%, and one of our GP claims that had previously been valued by us at £4·5 million subsequently settled for £10·6 million. It was more than double what we felt it was worth with the previous discount rate, and that was a -0·5% effect. The position in Northern Ireland at the moment is a drop from 2·5% to -1·75%, so it is even more profound.

I will wrap up at that point, but it is key to echo what Tom said and what was being said by Health and Social Care Northern Ireland. A sustained negative rate of -1·75% will have very profound effects on the size of claims brought against hospital practitioners and the health service, and also against individual GPs, who are responsible for their own indemnity costs. A question was raised a few minutes ago about why GPs are responsible for their own indemnity costs, and I think that the core answer is that they are independent contractors to the health service. They run their own businesses and they have their own responsibilities. As things stand, they sort out their own insurance and their own indemnity. In England and Wales, the state has come to an arrangement whereby those independent contractors are centrally indemnified. We would support something similar in Northern Ireland, because this burden really is damaging our members significantly on a day-by-day basis. With that, I am happy to work with Tom to answer any questions that you have.

The Chairperson (Mr Givan): Thank you. That has been very helpful. I have two questions. Can you elaborate on why you believe that the methodology that is proposed in the Bill for calculating the rate is greatly flawed? Secondly, the Department of Justice has said that the Scottish model gives greater transparency and clarity in comparison to the English and Welsh model. That maybe ties in to your points around accountability and who takes the final decision. Will you address those points for me?

Mr Reynolds: I will take the second question, if I may, and hand over to Matt for the first. You have gone to the very heart of our concerns in that final comment. While it is true that there is a great degree of transparency around the methodology proposed in this Bill, the assumptions built into it are very hard to test. The methodology by which the rate-setters will operate is not a perfect science, as has already been discussed this morning. It needs to be open to the widest possible group of stakeholders so that we get the fullest possible picture. We feel that, without building in that broad oversight and need to consult a large number of stakeholders, we are not delivering the best and most accurate possible rate.

At the moment, we have seen a situation where there is a strong argument in favour of the 2·5% rate leading to under-compensation. There is now no doubt in our minds that the -1·75% rate is likely to significantly veer towards overcompensation. This is not an exact science, and for a rate to be arrived at that properly reflects the realities of the day and the moving nature of the economy and everything else — the multitude of factors — there needs to be regular engagement with a broader group of stakeholders than is proposed in the Bill. That is a fundamental concern for us and something that we would like to see changed.

Matt, I will hand over to you for that first question.

Dr Lee: I suppose that I fall back on the comments that Tom made earlier about what the methodologies are trying to achieve. In the real world, this money is paid by the defence organisations, generally as a lump sum, to the claimants. It is not necessarily used *[Inaudible owing to poor sound quality]* for healthcare and social care. When a lump sum is paid, provisions are put in place to provide suitable accommodation. With a significant amount of money in hand, there is more flexibility as to how that works, but, equally, of course, some of the money is invested. The basis of the rates that we are seeing is on a very low-risk portfolio, but the reality is that we do not think that that is the basis on which most claimants are advised to invest. It would be very unusual to go to an investment adviser, and I should point out that many of the law firms that are pursuing these claims have their own investment arms that advise their own clients. It would be very unusual to advise someone to invest at a rate that was going to lose them money significantly in the longer term. In fact, realistically, one would expect that you would take a degree of risk, diversify that risk and put that into a portfolio that was safe but not without risk.

We are not sure that some of the basic premises in these methodologies should not be revisited. The worst-case scenario is that someone puts their investments into something that does not fully compensate them for the rest of their life. In the world that we live in at the moment, as Tom pointed out, there are many, many individuals with health issues who do not have these enormous lump sums or these enormous payments or ongoing periodic payments to fall back on, and the health service is there for them and social services are there for them. So, it is not an absolute disaster if, at the later stages, you do not have sufficient funds to meet every type of unanticipated medical care that might be needed in the future or every type of social arrangement that might be needed in the future because the state remains there to support all individuals. What is a disaster is if you have a system that massively overcompensates, both in that it has a significant impact on front-line clinicians but, equally, takes money out of the health service.

We have also had cases where we know that we have made significant lump sum payments and we have heard that a patient has died shortly afterwards. That money never comes back to the health service, and it never comes back to the defence organisations, which rely on their mutual members to contribute towards the funds that are spent on claims. That money stays out there, so this is a development of a system that will almost automatically overcompensate in the majority of cases, in many cases very significantly. That has a real burden on health service provision.

The Chairperson (Mr Givan): That is helpful. You have made some good points on the need for a broader impact assessment right across the different stakeholders who are interested in this and have a view on it before a new rate would be set. For absolute clarity, is it the view that, ultimately, this should be signed off at ministerial level, having taken into account a very broad assessment as to the implications of what the new rate would be?

Mr Reynolds: We believe so, Chair, yes. It is absolutely essential for our members, particularly our GP members, who are paying these subscriptions out of their hard-earned money, that, in any decision of this magnitude, they have someone to go to. There is accountability in this legislation, of course there is. However, there can never be any greater accountability than a Minister drawn from an elected Assembly, such as the Northern Ireland Assembly, so that is something that we firmly support.

Ms Dillon: Thank you, Thomas and Matthew, for your submission. I am going back to some of the issues that we raised in the previous presentation. On the issue around indemnity, I think that we need to get some clarity, even from the Health Minister, on whether there is any intention to bring GPs in under the NHS on indemnity. I think that that would deal with a lot — not all — of the issues that are being raised in relation to the impact on GPs. I do have sympathy with GPs on that issue of indemnity. At the end of the day, we need to have GPs and we need to have a front-line service. We are very well aware of that.

Matthew, I take a wee bit of issue with what you say about somebody who does not have access to compensation in later life and the state being there to look after them. At this time, our health service is not there for a lot of people — it is a disaster for them — and I am sure that it is no different across the water. I am being frank about that. It should not be the case. I like to think that, in the years to come, with a lot of work from us, we will have a better health service. However, I have sympathy, because we will have a better health service only if we have a better front-line GP service. There needs to be some ideas around how we achieve that. The indemnity issue is outside the remit of the Committee. When this issue first came to us, I asked what the Health Minister's view was on the legislation. We did not get that. Maybe he saw it as outside his remit, which is fair enough, but it has a serious impact on the Department and on the provision of GP services. I have sympathy, but I would like to bottom out the issue around indemnity, Chair.

I also have sympathy around how you reach 100% compensation and how that is worked out. I do not think that there is a perfect system. Again, that is why I go back to what was raised in the previous presentation and alluded to here: the periodical payments orders (PPOs). Perhaps we could look at more of those happening, particularly in cases involving a public body. It will be much more difficult — almost impossible — when it is not a public body. I would not blame anybody for not agreeing to a periodical payments order where it is not a public body, but we should be looking at them in cases in which it is a public body. They protect the individual and ensure that the money is spent on what they need rather than what somebody else might spend it on.

Chair, the issues are the same as those in the previous session. Some are within our remit, and some are not. We all have a remit to be concerned about health, so I want to find out from the Health Minister the plans around indemnity for GPs and insurance. I would like to check that out.

Those were not questions for you; they were points. I assure you that we have sympathy for some of the issues that you raise, but we have a responsibility to ensure that there is 100% compensation. I accept some of what you say around overcompensation. We want to ensure that that does not happen. It is not an easy one for any of us to address, but we will work with you to try to get the best outcome for everybody.

Ms S Bradley: Thank you, Matt and Thomas. I would like you to elaborate on a couple of points. First, you say that you do not think that it should be retrospective. We know that some parties, for different reasons at different times, hold back on getting a final settlement. Will you elaborate on that, because, if we move to an interim, for even a short period, what will the effect be? Do you think that there should be a clean slate? I am interested to hear more thoughts on that.

Secondly, you made a recommendation to the Department about understanding the outcomes further. I am torn on that. I would like to hear your thinking on that because, ultimately, the money stops being public money at the point at which determination and judgement are made on the settlement, in whatever form it takes. It becomes private and personal. How far into that could we hope to reach? What would be reasonable? You talked about the Bill being flawed because the stakeholders were not party to regular reviews; reviews were intermittent. You are saying that they are not there and that they have no part to play in this. I appreciate that. I do not fully understand the complexities of the Government Actuary's Department. What it does is very complex, but, although there is a very precise and, almost, cold calculation, my understanding is that the realities of life at that moment in time are factored in. Are you suggesting that that is not captured and that the Government Actuary's Department is devoid of your reality and the reality of the claimant?

Dr Lee: I will pick up the last and, possibly, the first of those points. When it comes to stakeholder involvement, you can do actuarial calculations based on factors such as life expectancy, anticipated care costs and anticipated future developments in care costs, because healthcare changes all the time, and care costs change very significantly for some lifelong conditions. The reality is that very few claims are actually settled based on an actuarial calculation. Only about 2% of our claims are resolved in court. About 98% of claims are settled based on a negotiation. That negotiation takes all sorts of factors into account. One of those factors is the strength of the evidence that negligence occurred in the first place and the impact that that negligence had that possibly worsened a condition that may have been experienced anyway.

An awful lot of the work that is done to determine how the negotiations will pan out is handled outside of any form of mathematical calculations or actuarial input. It is worked out by using a number of factors, such as what experts say in those cases and the dynamics of the meetings, when one involves mediation, hot-tubbing experts and formal, round-table negotiations, and there may even be cases where one goes to court. All those can change over time, so if one reviews the rate every five years, it may not be only the actuarial rates that change, but all sorts of other factors may change around how the claims are resolved in the real world. That is why we feel that a number of stakeholders need to be involved in the assessment of the quantum of the claims.

Equally, a number of the things that Tom and I spoke about in relation to the effect on the health service are significant. If one puts in place a system that relies purely on an actuarial calculation or assessment, that information is less relevant. The sort of things that the Committee hears regarding the impact on GP recruitment and retention change over time, and they have become significantly more acute over the past five to 10 years. I have been with the MDU for 20 years, and GP indemnity costs have tripled during my time here. That is driven purely by claims inflation. Not having the voice of those on the front line of the health service, who are being directly impacted on, is not the way to put a structure in place to determine the long-term rate. It is about having a voice not just for the doctors but for the patients who will potentially be impacted on if the health service struggles with staffing and resourcing and with the ability to provide a service. We think that all those voices need to be heard.

I will make a point about the retrospective effect, which goes back to the previous evidence session, in which people asked whether claims are actually being delayed in settlements and about the effect of having pending changes in the rate. If you have a system in which the rate changes every five years, retrospectively changing the value of all the claims, there are all sorts of dynamics: whether we are really going to settle; what we think the rate will be in the future; whether we have collected enough money; whether we need to subsequently put up our subscription; or what we do if we have over-collected money because we anticipated that the situation would be worse than it turns out to be, and we push GPs out of the health service as a result. All those factors are taken away if you have a rate that is effective, based on the date that proceedings are brought in the case. If the proceedings are brought on a date when the rate is -0·75% and, three years down the line, the rate changes to -1·75%,

should the whole case be revalued, or should it progress on the basis of the date that the proceedings were brought? That is our point about the retrospective effect: it takes away all the uncertainty for those who handle the cases and those who are looking for cases to be concluded. Some of the dynamics could lead to delays, or even to cases being accelerated, which is not always in people's interest.

Mr Reynolds: Matt, I will add a few points in answer to the questions that were posed to us. On the point about the role of the Department of Health at the stage at which it is consulted, we think that it has a great role to play because, as has been mentioned in the hearing today, the Department of Justice is required to be blind to all the external factors; the question is about 100% compensation. That is a theme that runs through many of the limbs of the law that surrounds clinical negligence.

We have already touched on this briefly, but section 3(4) of the Law Reform (Miscellaneous Provisions) Act (Northern Ireland 1948 requires the court, when determining a compensation award, to completely discount the availability of public healthcare provision either in Northern Ireland or in Great Britain. As a consequence, we are blind to the wider effects, not only in setting the compensation award in the first instance but in assessing the ongoing ability of the HSC and others to provide that care. We are simply not sure about that because the Department has not got the evidence on whether people with those compensation awards are receiving that care in an HSC facility, which in all likelihood they are, and thus the HSC is having to pay twice.

It is a source of great concern, because, as we know, there is a very high bar to successfully establish a clinical negligence claim. For every person who is able to make that claim, there will be patients in the system with comparable long-term healthcare needs for whom that money is not available. That is why we think that there is a role for the Department of Health somewhere in the process. We are not coming with an absolute blueprint. In the spirit of absolute candour, we are not saying that we have a magic solution to this. That entire framework is not an exact science. We just think that the more people there are in the room, the better the likelihood of a more-rounded decision, which is why enhanced stakeholder engagement is worth exploring.

Ms S Bradley: I appreciate that, Thomas and Matt. Matt, you mentioned a figure that I would like to follow up on. You talked about the negotiation and the settlement happening largely outside court. We talked earlier — I do not whether you heard our earlier presentation — about trying to lean in more to encourage the use of PPOs, certainly in the public sector where you can better manage and plan budgets. Reference was made to the fact that there may be legislation in other parts, or that legislation is being looked at, that gives judges the power to settle, based on a PPO. Given that you are saying that 98% of settlements happen outside court, do you think that any legislation on that part may be redundant?

Dr Lee: I would not necessarily say that it is redundant, because although a settlement may be reached out of court, the court may still need to agree that the settlement is appropriate for the patient concerned. In higher-value cases, the court still has final sign-off on the agreement that has been reached between the parties.

One point in that respect is that the defence organisations work on a discretionary basis. It is different from insurance. We are not insurers. We hold a mutual fund from which we make a payment on behalf of a member. As such, we are not regulated insurers, and we cannot make a straightforward periodic payments order in the way in which an insurer or government can.

If one was looking at that type of legislation and wanted it to work through for primary care as well as secondary care in Northern Ireland, you would need to look at a state scheme effectively to support GPs to be able to provide those periodic payments for GP claims as well as hospital claims.

Of course many of the cases are not clear-cut between being general practice or secondary care. Many of our cases involve someone who is seen and assessed by a GP and who is, at some point, referred to an A&E department. After a further assessment is made in the hospital, the person may be discharged back home. There may be quite a bit of a dynamic in the delay that occurred in the ultimate diagnosis and treatment that sits with both the primary care involvement and the secondary care involvement.

We have had some success in England and Wales, where NHS Resolution deals with the hospital cases. Previously, the defence organisations dealt with individual GP involvement in the cases and settled on the basis that the defence organisations paid a lump sum, and then the periodic payments

were met by government funding available through NHS Resolution. Generally, one of the reasons the Government were keen to pull everything into a state scheme in England and Wales was that it simplified that settlement process. They are now in a position in which the cases are being dealt with wholly by NHS Resolution, with GPs and secondary care providing periodic payments across the piece. As it stands in Northern Ireland, if there is a mixed case, where you have a GP and a secondary care health service involved, you may not be in a position to offer a periodic payments if you are looking to split the apportionment.

Ms S Bradley: Thank you, I appreciate that it is, perhaps, a step away from the framework that we are looking at, but it recognises the reality beyond that framework. It is very insightful. Thank you to you both.

Mr Beattie: Apologies for being late, Chair. I thank Matthew and Thomas.

The framework is a deeply complicated issue. On the margins of that, why is the GP indemnity cost here higher than anywhere else in the UK? Is there a reason for that, and can it be addressed?

In addition, are you saying that if we get this wrong and if we do not look at the framework in a sensible manner and strike the right balance, we could price GPs out of the market? In that case, is the danger that we could stop people wanting to be GPs?

Dr Lee: That is exactly the danger that we are in. The first part of your question is quite easy, but it also comes with a reassuring message in the tail. The indemnity costs for GPs in Northern Ireland are the highest across the UK primarily because the state scheme has been introduced in England and Wales. Prior to that, the indemnity cost for GPs in England and Wales was slightly higher than in Northern Ireland, speaking from my own experience in the MDU. The cost in Scotland is significantly lower. Those costs are driven by the litigation environment and the law in the various countries. You were not the leaders in respect of the worst indemnity costs until the English and Welsh Governments put those indemnity schemes in place.

Will you remind me of the second part of your question?

Mr Beattie: It was about the danger of pricing GPs out of the market and stopping new GPs coming forward, if we were to end up with a structure that sets a rate that could have a detrimental effect.

Dr Lee: That has the potential to accelerate the effect that you are talking about, but, to be honest, we are already seeing signs that the cost of indemnity is doing exactly what you are describing. It is becoming an increasing burden for general practitioners, who are struggling for resource, and if they want to bring more GPs into their practices to help with the under-resourcing, the indemnity costs go up even further.

It could compound the problem, but the problem is developing almost exponentially anyway. We are seeing a doubling of claims costs about every seven to eight years, and those are behind 90% of the cost of indemnity that the GPs are buying. Irrespective of where it ultimately goes, if the -1·75% rate stays any longer than a short interim, that rate itself will cause a step change in indemnity costs, because, without the certainty that we will move back to something lower, it could be a very significant burden for the mutual indemnity providers to have to pull some more money in from GPs. However, even if everything stays at +2·5%, things are starting to reach breaking point. It is a completely different subject from state indemnity for GPs, but this may really make the case, once and for all, for that state indemnity coming in.

Mr Beattie: If we look at the architecture around how that rate is set, can we see the effect that it has had on GPs in England and Scotland? Is there any way that we can compare the effect that the different systems in England and Scotland have had on GPs, to see whether there is a haemorrhaging of GPs, or an increase of GPs because it is more attractive in any way? Is there any data that can help us with that?

Mr Reynolds: When we were in a similar situation in England, in which the rates were making GP subscriptions almost untenable, the MDU was the first medical defence organisation to put its hand up and say that there needed to be a state indemnity for GPs, as it was becoming unsustainable. As Matt says, if this situation endures for more than a short period in Northern Ireland — we are in a precarious situation anyway — something needs to be done.

We said in our written evidence to the Committee, at paragraph 8, that we were in discussions with the Department of Health about any policy intervention that it might be able to make in the short term to offset the worst impacts of this on GP subscriptions. To date, we have had no indication that it is able or willing to make that sort of intervention. Therefore, the MDU, along with other defence organisations and other bodies, will have to go away and look at this in the interests of the mutual funds to make sure that we are pricing accordingly for the risk that GPs have been exposed to because of the policy decision that has been made.

It comes back to our central point. This policy decision is not simply a legal technicality. The discount rate is not an abstract legal concept. It is not an exact science, but a complex piece, which is why we are all coming to this with a very open mind. We are here today to try to assist the Committee in any way that we can. However, the central message is that someone needs to be accountable for these decisions, and there needs to be the widest pool of consultation as well.

Matt, do you want to add anything to that?

Dr Lee: Just one thing. What we were seeing before this, over this past, say, five years, was a steadily reducing age at which GPs were choosing to retire and, within our portfolio of GPs, we were seeing more and more of them moving to work part-time and do fewer days each week. There was some clear evidence that people were, effectively, moving out of full-time general practice or even stopping early.

That was prior to COVID, however, and that is going to have a really significant effect on the pre- and post-change evidence that might be available. All sorts of GPs have come back into the profession to help out with the COVID response. However, it seems that COVID itself has caused around 25% of doctors to question whether they want to carry on being a doctor, if you take the BMA's figures. Quite what effect that will have on ongoing retirement rates and recruitment is hard to say. If we had not had COVID-19, I might be able to say to you now that those retirement rates had changed. The recruitment rates were going up. There were signs that recruitment into general practice was starting to improve. The vacancies that we saw a couple of years ago were starting to be filled, but then COVID-19 came along, and that is going to mess up any evidence that we might have been able to take, pre- and post-change, of the nature that you describe.

Mr Beattie: Thank you, Matt and Tom. I had paragraph 8 open as you were talking about the interventions. That is what Linda referred to. We must make sure that we get that from the Health Minister. Thank you very much.

The Chairperson (Mr Givan): Sinéad, did you want back in?

Ms S Bradley: I have just a quick point, while we are talking about the ethical dimension. Are there any safeguards inbuilt from the organisations' perspective? I come from a predominantly rural constituency, South Down. What role do you have to support GP practices, to make sure that there is fairer access to GPs, and that they are able to stay open while this is all unravelling?

Mr Reynolds: One of the questions that is not established for any of the defence organisations is whether the short-term change to -1.75% will have any immediate effect on indemnity costs, or whether the organisations feel able to look towards the future and the certainty that we might see then. The question is whether we should try to restrict any immediate swings of indemnity costs now, on the basis that we hope that the rate will even out, to some extent, in the medium term. That is not clear.

It is difficult. Certainly, there have been broad discussions around the possibility of state indemnity in Northern Ireland, and that, I guess, is the one thing that really protects the profession from potentially soaring indemnity costs in the future. It is a matter of public record that those talks have not progressed in the way that they have in England and Wales. It has not resulted in a scheme yet. This whole subject may turn the focus back on to that question of state indemnity. I am concerned that, in the medium to long term, this will reach a point where it becomes unsustainable. However the discount rate ultimately pans out, unless it goes to a very positive rate, which I do not see happening for many years, indemnity costs are going to keep pushing up.

There are other factors as well. The discount rate is not the only factor that pushes up claims inflation. There are a number of others. It tends to ratchet up. When a precedent is set in a court case, that becomes the new norm. That ratchets up costs further. When there is a medical development, a new expensive drug, or a new robotic aid to help people who have weakness in their lower body, all those,

immediately, change the dynamic around the cost of cases. There are, therefore, a number of other factors that will bring this to a head, regardless of whether the discount rate does or does not. However, this may focus attention on the need for state indemnity, and we support that. It may sound odd to say, as an indemnifier, that we would like the state to take over the indemnity arrangements for GPs, but we are a members' mutual organisation, and we do not exist for anything other than our members. In England and Wales, our GP membership numbers have grown since state indemnity came in, partly because GPs can afford to choose the service that they want to go to. We have seen a healthy development of our company simply because GPs still need the non-claims benefits that we are providing to them. We absolutely support a future introduction of state indemnity, because we do not see how this will end if that does not happen.

Mr Reynolds: I am conscious of the Committee's time, but I will come in with a couple of quick observations on the back of what Matt has just said. Our obligation to our members is to protect the mutual fund so that when anyone needs to call on us for assistance, we are able to assist. That is why we believe that the system should rule out any retrospective effects, to go back to your initial question, Sinéad. It is simply because of the money that was charged for subscription rates two or three years ago for GPs who may have since retired. If the retrospective effect is not ruled out, it will fall to the practising GPs of the future and today to pick up the shortfall.

As Matt says, we are in this for the members. We are a mutual organisation, so we are governed by what is in the best interests of our members. That is why we have come before you to say, unequivocally, that this will have an effect, if it lasts for any longer than a very short period. Regardless of whether we are the indemnifiers or a defence organisation that is supporting the good name of the profession and doctors' professional interests, our members want to work in a healthcare system that is firing on all cylinders and has maximum resource open to it. Any money that goes on compensation awards is money that is coming out of front-line patient care. We fully acknowledge that fair compensation is needed, but, in the great balance, that fact cannot be lost.

Ms S Bradley: Thank you.

The Chairperson (Mr Givan): Matt and Thomas, thank you for your time today. It has been helpful and much appreciated.

Mr Reynolds: We are very grateful. Thank you very much.