Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Damages (Return on Investment) Bill: British Medical Association NI

27 May 2021

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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 Alan Stout British Medical Association NI

The Chairperson (Mr Givan): I welcome Dr Alan Stout to the meeting. The session will be reported by Hansard, and a transcript will be published on the Committee web page in due course. You may begin with an outline of your submission, and we will follow that with some questions. Thank you, Alan.

Dr Alan Stout (British Medical Association NI): Good afternoon, Chair and members. Thank you for the opportunity to speak to the Committee on this important legislation. I apologise in advance for any overlap with what you have already been discussing. I listened to the previous discussion. Hopefully, I will reflect the views from within the system that Thomas and Matt referenced. I will be brief with my opening remarks, as my comments are focused on the impacts of the legislation on general practice rather than on the detail of the legislation itself.

It is important that I put on record our support for the purpose of the Bill. We support 100% compensation for claimants. We have no specific comments to make on the methodology used to set the discount rate proposed in the Bill. The Scottish model and the model that is used in England and Wales would both have knock-on effects on general practice and GPs. It is those impacts that we want to raise as part of the discussion on the Bill. I will limit my comments to those.

As you will have noticed in our response to the Committee's call for evidence on the Bill, general practitioners are the only doctors within the health and social care system who must provide and pay for their own indemnity insurance. As we stand, GPs in Northern Ireland are the only healthcare professionals in the entire UK NHS with those high personal costs. The costs vary, depending on a number of factors, but they can run to up to £12,000 per annum for a full-time equivalent GP. The cost of the indemnity insurance is, in part, dictated by the discount rate. When the rate is lower, indemnity costs are higher. It is clear that the Bill and the discount rate have the potential to impact significantly on indemnity costs to our members.

When the discount rate was lowered in England and Wales, it was forecast that the indemnity insurance rates may double or triple. Some GP colleagues were quoted increases that ranged from around £13,000 per year to over £30,000 per year. That forecast increase in England and Wales triggered the automatic, immediate introduction of a state-backed indemnity scheme, which now covers most of their GP indemnity. That was always proposed to be a UK-wide solution because it was a UK-wide problem, but we had no Minister at the time to implement it here. We have received welcome reassurances from some medical defence organisations that increases of that magnitude will not be the case immediately in Northern Ireland, as they have been able to plan for a change to the discount rate here based on changes elsewhere. However, that absolutely cannot be guaranteed on a long-term basis, particularly in an instance where we may inadvertently end up with the interim discount rate for a longer-than-expected period. Should we see those increases to the cost of medical indemnity insurance, it is inevitable that GPs will reduce their workload or even leave the workforce altogether. We have heard already about the impacts of COVID on the workforce. This is a time when we absolutely cannot afford to lose GPs. It would bring additional pressure into a system that is already working under immense pressure.

We fear that costs of that magnitude are also a significant reason why it has become difficult to recruit doctors in training into general practice and also, importantly, to recruit general practitioners from elsewhere to Northern Ireland. There is an additional risk that, as a result of the change to the discount rate, even if it is short term, medical defence organisations may eventually be faced with no choice but to call in debt to cover historical liabilities. That could result in the closure and bankruptcy of practices and an inevitable reduction in the service to patients.

I also note the impact of claims on GP time. Requests for notes and subject access requests nearly always accompany claims now. Each of those is a significant undertaking for GPs. They take a lot of time and take time away from direct patient care. Aside from the workload that is associated with any claims, additional pressure and stress is mounted on a doctor who faces those claims. With a lower discount rate, we expect the number of claims to rise. Therefore, that pressure on workload will also rise.

We acknowledge that the Department of Justice cannot take the impact of the discount rate on indemnity insurance and general practice into the reasoning for the methodology that is chosen to strike the rate. However, it is essential that the Departments of Health and Justice work together to ensure that the effects of the change to the discount rate are not crippling to general practice and the wider health service in Northern Ireland. Our preference is the establishment of a compensation scheme for increased indemnity costs. A scheme such as that would mitigate the impact on GPs and general practice and would allow continued practice on the same basis as we currently operate. It is also very important to general practice that the legislation is passed in this Assembly mandate. We appreciate the tight timescales and the workloads of the Committee, but, should the legislation not pass, we may face the consequences of the lower interim rate for quite some time.

Once again, Chair, I thank the Committee for its time today and for allowing me to highlight issues that are of great importance to our members. I am very happy to take any questions.

The Chairperson (Mr Givan): Thank you very much. That was in tune with the previous presentations, so I will not labour any points unnecessarily.

Ms Dillon: I will not go over the points that I have made previously. We have sympathy for the position that GPs are in. I want to ensure that you are aware of that, Alan. Obviously, it is our job to make sure that people get 100% compensation in the framework, but we absolutely have sympathy for GPs.

I have asked that we, as a Committee, write to the Health Minister to ask about the indemnity issue. You said that there was not a Minister in place, but we have had a Minister in place for the past couple of years. I accept fully that we have been in a pandemic, which, no doubt, would have taken its toll on the plans of any Health Minister. Have there been any conversations? Has the Minister given any indication that the Department would be willing to come to an arrangement around the state or the Department taking on the responsibility of indemnity for GPs? How quickly could that be done, if the intention were UK-wide? Does it require primary legislation? Can it be done more simply than that? Do not worry if you cannot answer; those questions are probably more for the Department. However, if you have had discussions, you may have answers to those questions.

Dr Stout: The answer to your first question is yes. We have had discussions. Indemnity has been an absolute priority for my committee for the past three years and since the English and Welsh

agreement. In fact, it was a UK-wide priority for many years prior to that, because, as you heard, costs have escalated very rapidly and have become unaffordable for our GPs everywhere. We have had lengthy discussions with departmental officials, who are very understanding and have been very good and have created an options paper. Much of the options paper, and how we take it forward, depends on this consultation and its outcome. That has definitely had an impact. When we first discussed it with the Minister, when he came into post, two things happened: first, this consultation started, and secondly, the pandemic hit. Both of those have been a distraction.

My answer to your second question is that I do not know. My understanding is that primary legislation is probably required, which is why we were not able to progress it without a Minister and an Executive in place. I do not know that for definite; I would need to check. We have two options. One is to piggyback on the English and Welsh GP resolution scheme. That should be relatively easy; we are accustomed to copying things that happen in England and Wales, particularly when they work well. The other option, which could be instigated almost immediately — literally overnight — is a scheme for reimbursement of costs. That would simply reimburse costs that are currently there. If a GP had a cost of £12,000, for the sake of argument or example, there would be a scheme to reimburse that cost. Part of that fee is reimbursed already, but it is nowhere near 100% or even 50%.

Ms Dillon: OK. Thank you, Alan. Thank you, Chair. I appreciate being allowed to go down that line of questioning. I know that it is outside our remit, but, as I said before, health is the remit of every MLA. We want to ensure that we do not do anything that might harm our access to GP services.

Ms S Bradley: Thank you, Alan. I appreciate that the Committee is tasked with putting on blinkers, if you like, in setting the framework and aiming for 100% compensation. I welcome the fact that all parties are on board with that. If now is not the time to hear from you, Alan, I am not clear when is. I appreciate your submission and the detail in it. It has made me wonder how the relationship works between GP practices here and the Department of Health. As I understand it, it is distinctly different from other areas, in that GP practices are independent businesses. Does that differential in relationship have an impact on how a possible state indemnity might look?

Secondly, you made a point about reimbursement. I want to be clear: are you talking about buying indemnity cover from a third party and reimbursement then coming from the Department of Health? I wonder whether there is a clash there. Can the health service pick that up? I am not convinced that that is a solution. Alan, can you elaborate a bit on that so that I understand it better?

Dr Stout: OK. Effectively, the two options that I described do the same thing. The difference between them is who ultimately picks up the bill for compensation. At the moment, we have a system whereby we pay into a separate company, which is one of the defence organisations, and it then takes — we heard a few minutes ago about the mutual fund — the risk and responsibility to pay the compensation from that mutual fund. That organisation carries the financial accountability and the financial risk. If we move to a state-backed scheme, we would move all that to the NHS. The financial burden will still be there. The level of compensation will be the same regardless of which scheme you use. It is really about who picks up the cost of paying for that. The fundamental difference between the two is that, with a personal indemnity scheme, we have to pay in advance. The company has to build up a pot and be in a safe and secure position to be able to pay out. With a state-backed scheme, you can almost move to a case-by-case basis, where the system as a whole takes the financial risk on a yearly basis for what is paid out, and it will vary from year to year. Whichever way you look at it, both will have a very significant financial impact.

On your first question, you are absolutely right: we are independent contractors. General practices are independent contractors and have been since the onset of the NHS. That benefits the NHS. We are getting feedback at the moment that it might not necessarily be benefiting practices. The problem is that we take full responsibility for delivering the workload and meeting demand, and the demand is now exceeding what we are able to cope with. You are right: as independent contractors, we are responsible for various parts of, effectively, running a small business, and indemnity is one of those. In being contracted by the NHS, which we solely are, there has to be that shared accountability and responsibility for the sustainability of that service.

Ms S Bradley: OK, Alan. Are you suggesting that it would be a new contractual arrangement that talks to that indemnity piece?

Dr Stout: No, we do not even need a new contractual arrangement. It could become part of the contract — so, in other words, a sum of money that covers costs. That already exists for premises, for

example, and for various other things that we provide through practice. It would be a simple addendum, for want of a better expression, to the contract; it would not need any new complex contractual arrangement.

Ms S Bradley: I appreciate that clarification. Thank you.

The Chairperson (Mr Givan): Nobody else wants to ask a question, so thank you very much, Alan, for coming to the Committee and taking the time with us today. It is much appreciated.

Dr Stout: Thank you, Chair.