Appropriate Clinical Negligence Cover Consultation
Acute Care and Quality Directorate, Fifth Floor
Department of Health and Social Care
39 Victoria Street
London SW1H 0EU

22 February 2019

AFM Response to DHSC consultation on appropriate clinical negligence cover

I am writing in response to this consultation paper, on behalf of the Association of Financial Mutuals. The objectives we seek from our response are to:

- Comment on issues raised in the update paper that have potential consequences for healthcare professionals and providers of indemnity cover.

About AFM and its members

The Association of Financial Mutuals (AFM) represents insurance and healthcare providers that are owned by their customers, or which are established to serve a defined community (on a not for profit basis). Between them, mutual insurers manage the savings, pensions, protection and healthcare needs of over 30 million people in the UK and Ireland, collect annual premium income of £19.6 billion, and employ nearly 30,000 staff[1].

The nature of their ownership and the consequently lower prices, higher returns or better service that typically results, make mutuals accessible and attractive to consumers, and have been recognised by Parliament as worthy of continued support and promotion. In particular, FCA and PRA are required to analyse whether new rules impose any significantly different consequences for mutual businesses[2] and to take account of corporate diversity[3].

[1] ICMIF, https://www.icmif.org/publications/market-insights/market-insights-uk-2016
[2] Financial Services Act 2012, section 138 K: http://www.legislation.gov.uk/ukpga/2012/21/section/24/enacted
[3] http://www.legislation.gov.uk/ukpga/2016/14/section/20/enacted

AFM's general comments on the paper

1. We are pleased to receive and comment on this important and long-awaited consultation. We very much agree with the objective that "patients harmed by the negligence of regulated healthcare professionals can access appropriate compensation": we have responded with this goal uppermost in mind.

2. Within AFM membership there is one medical defence organisation. As a trade body that represents the mutual sector and the interests of all its members, it is not appropriate for us to respond on the detail of the proposals where they effect one organisation in our membership. We do though naturally support the general tone of our member's own response to the consultation.

3. Be that as it may, a number of AFM members operate discretionary mutuals in non-indemnity fields, and we are very concerned that the language adopted in the consultation would risk being perceived as the government casting doubt on the viability of this particular business model more generally. We see no justification for this:

    a. Some of our members with a discretionary benefits business model have been successfully operating for over 100 years and have a much greater longevity than the average insurance company;
    b. Discretionary benefit providers generally pay out on a higher proportion of claims, because they are not limited by a restrictive contract, and see their primary role as a mutual being to serve customers and pay all justified claims. In contrast, the primary motive of a PLC insurer is to provide a return to shareholders, and as can be seen by Financial Ombudsman Service data, this can result in a higher number of claims being rejected;
    c. Many of AFM's discretionary mutuals have adopted a 'hybrid' model, where they directly underwrite, or self-insure, claims up to a certain limit, and reinsure single high-value claims or claims in aggregate beyond that limit. Whilst we do not believe MDOs currently adopt this model, we were surprised it was not considered as a less radical option for reform;
    d. Operating under a discretionary model may imply a different form of regulatory scrutiny, as opposed to the inference given in the paper that there is no regulatory oversight.

Answers to specific questions in the consultation comments on the paper

6.1 What are your views on the proposed options for meeting the Government's policy objectives (please see paragraph 4.1)?

With regard to the objectives set in paragraph 4.1, we consider that the first should be the primary aim for this review. The remaining objectives are secondary and whilst valid, appear to have been written in a leading manner that presupposes the validity of DHSC's preferred option.

6.2 What are your views on the potential costs and benefits of these options, for example the familiarisation and administrative costs for individuals, businesses, and other groups, in complying with potential changes to regulation?

A significant cost that is only tangentially addressed in the consultation is the additional regulatory and tax impacts of moving away from a discretionary benefits model. Insurance Premium Tax will automatically add 12% at least (and currently) to the cost of cover, whilst Solvency 2 alone has been estimated by the Prudential Regulatory Authority to have cost the UK insurance industry around £5 billion to implement. These and other regulatory costs will inevitably be passed on to customers.

The commentary in the paper, such as in paragraph 5.31 gives a misleading expectation that extra costs will not be passed on to medical professionals. In every other market where Insurance Premium Tax has been levied (at 12% or higher), the extra cost has been met by policyholders.

6.3 Are there any other options that the Government should consider?

The approach taken is very black and white and we consider other options should have been considered. These include reform to the current arrangements such as:

- Where the kind of problems highlighted in the consultation results largely from operating constraints within one provider, the decision to seek a solution across all MDOs seems unwarranted: government might have addressed the perceived problems directly;
- As we highlight in our introductory comments, the benefits of a hybrid discretionary model have not been explored: these would create a stop-loss position that would remove the risk of a MDO being unable to pay claims; see: http://www.financialmutuals.org/files/files/Discretionary%20mutuals.pdf

In addition, the proposals do nothing to address the root cause of the issue- which is the unrelenting increase in indemnity costs to the NHS and to healthcare professionals, as a result both of the higher volumes of claims and their higher values. In the last 18 months the governments decision to move to a negative level of discount rate has intensified this issue significantly and heightened problems.

6.7 Do you have a view on when regulations should come into force and should these involve a transitional period, considering the potential impact on indemnity providers and healthcare professionals?

The nature of change the government is proposing will be significant, both for healthcare professionals and for providers of cover. A particular issue to consider is transitional and run-off arrangements, as covered in the paper, to ensure continuity of cover.

We would welcome the opportunity to discuss further the issues raised by our response.

Yours sincerely,

Martin Shaw
Chief Executive
Association of Financial Mutuals