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BMA GUERNSEY AND JERSEY MEDICAL SOCIETY

BRIEFING PAPER ON PROFESSIONAL INDEMNITY WITHIN THE CHANNEL ISLANDS A CRISIS AND A WINDOW OF OPPORTUNITY

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1 Introduction

1.1 This paper has been commissioned by the medical profession in Jersey and Guernsey through the British Medical Association and Jersey Medical Society. The authors are English healthcare lawyers at Hempsons based in London, Jersey and Guernsey. The paper describes:

1.1.1 the indemnity arrangements in the Channel Islands, contrasting this to the position in England,

1.1.2 the crisis in clinical negligence funding in England,

1.1.3 how the present position threatens the provision of healthcare services in the Islands, and

1.1.4 sets out some proposed avenues for the States to consider in order to secure the healthcare services in the Channel Islands.

1.2 Healthcare is a necessity in any society. We need doctors to deliver our babies, treat our emergencies and provide primary care wherever we live. Whilst elective specialist surgery can be outsourced to the mainland the vast majority of medicine must be provided in the Channel Islands.

1.3 Because interactions with doctors are fraught with life-changing risks they are required by the GMC[1] to have appropriate indemnity arrangements in place. The indemnity arrangements prevailing in the Channel Islands are unsustainable in some areas and it is our recommendation that the Islands move now to protect their health services before the issue is forced upon them.

[1] General Medical Council

2 The Situation in England

2.1 In order to have a licence to practise medicine in England or the Channel Islands doctors must have appropriate indemnity arrangements in place[2]. In England, doctors working for NHS hospitals ('Trusts') rely upon the Clinical Negligence Scheme for Trusts (CNST), an unlimited indemnity scheme operated by a not-for-profit arms length body of the Department for Health (NHS Resolution "NHSR"). Private providers of NHS care (independent sector treatment centres (ISTCs)) are also able to obtain membership of the CNST. CNST is paid for by members (the Trusts or ISTCs), backed up by central government, the doctors do not contribute. It is funded on a pay-as-you-go basis with members collectively required to contribute sufficient funds to meet the liabilities that are expected to fall due in the financial year. There is a reasonable expectation[3] that the government will fund the future liabilities through taxation and borrowing and so NHSR is not required to hold assets to cover its liabilities. There is no need to provide for the liabilities that must be met at some future date. Therefore, the liabilities have been allowed to increase at a remarkable rate so that in 2016/17 they accounted for 10% of hospital turnover.[4] NHS doctors are involved only as witnesses-of-fact to the events that have created the liabilities and any personal culpability will be dealt with through the employers' disciplinary process or occasionally by the GMC.

2.2 A doctor performing private work or general practice in England is not today covered by CNST and therefore indemnity arrangements must be arranged by the doctor. Any subsequent negligence claim will find the doctor as the named defendant. These indemnity arrangements have historically been provided by one of three MDOs or a commercial insurer with the doctor paying a yearly and variable premium. MDOs have absolute discretion as to whether grant indemnity to a paid-up member and insurers have a cap on damages paid.

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[2] *Good Medical Practice* para 63, plus under the Health Care and Associated Professions (Indemnity Arrangements) Order 2014 the GMC has regulatory powers to check whether doctors have adequate and appropriate insurance or indemnity. The type and level of insurance or indemnity a doctor requires depends on a number of factors but ultimately the responsibility lies with the doctor.

[3] There is a present legal obligation under NHS Act 2006 s70 that the liabilities of the Trusts will revert to the state, so that they cannot go bust, and under s71 that the Secretary of State will administer the CNST so as to ensure that the liabilities are dealt with. The reasonable expectation is that the law will not be changed so as to renege on the liabilities.

[4] Although the increase from £28bn to £56bn in 2015 was dismissed as being largely artefactual, because it resulted in part from the change to the Discount Rate used by the Treasury to cost the tail of liabilities, the following year the figure increased by a further £8.557bn to £64.998bn. In that year, 2016/17, the NHS only had to pay £1.707bn and the Trusts only had to pay £1.785bn. Thus the Trusts only had to pay 17.4% of the real cost of the negligent acts and omissions of their staff in the year. To put it another way, claimants and their lawyers receive under 2% of NHS hospital turnover per annum, but the real cost of the negligence is over 10%. See: http://www.nhsla.com/AboutUs/Documents/NHS Resolution Annual Report 2016-17.pdf

2.3 For reasons discussed below, MDO premiums have increased to an extent that is impacting the GP workforce and the availability of private care in England. Private obstetric and spinal surgery cover is becoming much harder to obtain and doctors with poor claims records are finding it hard to work in private practice. The government announced in October 2017[5] that a state backed indemnity scheme for GP practices in England will be developed in order to secure the primary care system.[6] NHS doctors in England are still likely to maintain partial MDO membership for support in inquests, GMC proceedings and *ad hoc* legal advice but unless they opt to do private work, indemnity cover for any negligence action will be provided by the English State. This is in stark contrast to the position within the Channel Islands.

3 The Situation in the Channel Islands

3.1 Guernsey and Jersey have no equivalent of the CNST and no appetite to accumulate such future liabilities. The doctors are required to have individual agreements with MDOs or insurance policies to cover all types of patient (State or private), with the States making varying contributions to the premiums for secondary care doctors. The doctor who is usually the named defendant in a claim relies on their MDO. An employing hospital sued on the basis of being vicariously liable could try and seek an indemnity from the doctor. Because an employer is vicariously liable, the States retains an inescapable liability to the extent that it is unable to recover from the doctor or other culpable member of staff. Most midwives and nurses do not have any personal insurance with the State already indemnifying them.

3.2 There is no legally binding guarantee that the MDO will represent a doctor in a claim and no guarantee to any patient that there will be sufficient money to settle a valid claim. Whilst the MDOs act in a highly responsible fashion, if the level of awards is allowed to spiral out of control there will come a point where the medical profession cannot be expected to withstand the strain. Every doctor and every patient in the Channel Islands has taken on a personal burden: the doctors given the risk to their livelihoods and the patients in the risk to full compensation. If a MDO does not indemnify a doctor then the doctor will need to find the funds for legal costs and the potential damages award. For a

[5] www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2017-10-12/HCWS159/

[6] There are conceptual difficulties about how a pay as you go state-backed scheme can cater for individual doctors who are free to leave whenever they like, but these will probably be overcome if the political will is strong enough.

one-off low value case this may be feasible, but not for a high value claim. NHS birth injury claims are being pleaded upwards of £20 million with over £1 million in legal costs on the claimant's side alone. Interim payments on account of damages pending settlement of a valid claim can be over £1 million. Such high value cases are not confined to obstetrics: a recent GP out-of-hours case settling for nearly £15 million (after periodical payments), a figure that may well have been higher had the claim been made a year later[7]. Certainly, such large claims are rare outside obstetrics, but they are not impossible.

3.3 The population of high net worth individuals combined with the absence of a statutory discount rate (see below) means that a pleaded case in the Channel Islands could be in excess of the claims we have so far seen in England. Few if any doctors would be able to fund a high value claim should the MDO use its discretion against him/her. In the last resort, the doctor will go bankrupt and the States as the employer or contractor of care for States' patients is likely to be found vicariously liable and so will have to pick up liability. The liability could in theory exceed the record claim that we have heard of, which is over £64 million. We are not saying that is likely: no award of that scale has yet been made in England, but the circumstances in Jersey and Guernsey are unusual.

4 Obstetrics

4.1 A recent study[8] by the Royal College of Obstetricians and Gynecologists in the UK found that the incidence of stillbirth, early neonatal death or severe brain injury is 1 in 635 term babies or 1.57 per 1000 term births. The same study found that in 76% of such cases at least one independent reviewer considered different management might have made a difference to the outcome. Stillbirth or early neonatal death claims rarely settle for millions, but the brain injury cases are now regularly pleaded at over £20 million[9]. The 2016/17 NHSR annual report found that obstetrics accounts for 10% of the claims received but represents over 50% of the value. In England we have estimated that in 2016/17 we spent 2-3 times as much on such claims as we did on delivering the service. NHS commissioners spent £1.9bn on obstetric services:[10]

[7] http://www.cloisters.com/latest/simon-taylor-qc-and-lisa-sullivan-win-record-meningitis-clinical-negligence-claim-involving-out-of-hours-doctors settlement before the change in the discount rate

[8] Each Baby Counts : https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts-2015-full-report.pdf

[9] http://www.nhsla.com/AboutUs/Documents/NHS%20ResolutionAnnuareportandaccounts2016-17.pdf

[10] See our submission to Department of Heath Consultation 2017. Since that was written NHS Resolution has published its Annual Report for 2016/17, revealing that in those 12 months reserves for future liabilities increased by a further £8bn, see footnote 4 above. The addition of that figure means that we are spending three times as much on increasing liabilities as we are on delivering the service.

damages and increased reserves were near to £10bn and it is reasonable to surmise that at least £6bn of that relates to obstetric claims. This increase is probably the result of the statutory change in the discount rate, which has provoked a surge in inflationary expectations and on that basis, it may be regarded as a one-off event that will not be repeated next year, especially when we have been promised legislation to moderate the change in the discount rate. However, history shows us that such inflationary processes are difficult to bring under control and the speed with which claims are increasing shows no signs of slowing. We have seen several schedules of over £40m and as mentioned above we have heard of one in which £64m is claimed on a single case: that does not of course mean that they will succeed in recovering so much, but that is what they are claiming.

4.2 Because each doctor in the Channel Islands is individually indemnified with an MDO or a commercial insurer (as opposed to a State-backed body) we are unable to find publicly collated data on the number of cerebral palsy claims brought against obstetricians in each island. If we assume there is no significant difference in the quality of the health of the population and the quality of obstetric services, as the available data suggests,[11] the volume of claims that are incurred but not reported (IBNR in the rhetoric of insurers) that may come to light in the future leads us to anticipate that there is on average one potentially avoidable brain injury case every two years in Guernsey and one a year in Jersey. Whether these claims will ever be made is a proposition about the candour of healthcare workers towards their patients, which may limit the families' ability to understand what has happened, and the propensity of the families to make claims. Both of these can change with surprising rapidity in a population that is affected by knowledge of what is happening in England. Healthcare workers and the public on the Islands will have read about events in Stafford Hospital[12] and the consequent enactment of a new duty of candour.[13] Experience from other countries, such as Israel and South Africa, indicates that societies that appear to have a low prevalence of litigation can catch on remarkably quickly as solicitors acting for individuals with valid claims perceive that their clients are entitled to the full level of compensation that they would

[11] See Jersey Health Profile 2016, data for 2013-2015, published by States of Jersey November 2016 which suggests comparable rates of stillbirth, infant mortality and low birth weight. Publichealthstatistics@gov.je
See Also Health Profile for Guernsey and Alderney 2013-15. Publichealthintelligence@hssd.gov.gg

[12] See Mid Staffordshire Report:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

[13] For a useful summary of the Duty of Candour in practice in UK, see http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

receive elsewhere. Indeed, in England no claim was made by a baby born with cerebral palsy until 1975 – we know that because when that claim was made we undertook the legal research to establish whether an unborn child was owed a duty of care at common law and the following year the Congenital Disabilities Act 1976 was passed to put the matter beyond dispute. So, it has become the norm for all such children to investigate the possibility of making a claim over the last 40 years, from a default position in which no claims were made.

4.3 Obviously, we cannot predict what would happen to an individual claim, but we can outline a scenario. If a cerebral palsy claim was made along English lines and the damages were in excess of £40m (a rare but real possibility) an MDO might meet such a bill,[14] or it might exercise its discretion and refuse to do so. Because there is no precedent we do not know. If, for example, the States of Guernsey had to step into the breach in a claim involving its Island's hospital, it would need to find the funds out of an already allocated budget or ask each member of the population (adults and children alike) to contribute nearly £650[15].

4.4 In Guernsey, two midwives were struck off the register at the end of 2017[16] following concerns surrounding the death of a baby in September 2012 and another in January 2014. Should these babies have survived in a poor condition, then if negligence were conceded or found (meaning both breach of duty and causation) the States could have been looking at a multi-million pound damages bill.

4.5 There is no reason to suppose that the Channel Islands are immune to a valid cerebral palsy claim and thus the failure to have encountered one so far is a matter of luck as well as what we may call the litigation climate. It also presents the Islands with a precious window of opportunity - when such a claim is in existence, any proposal to change the arrangements will be seen as an attempt to interfere with the rights of that person to receive compensation. In England, any change will be opposed by a legion of lawyers and advisors working in the industry that supports these claims.

4.6 Furthermore, once such a claim were made for one person, those caring for other disabled people born any time in the last 40-50 years might feel obliged

[14] We are not aware of any occasion when a British MDO has paid more than £10m on an individual claim.
[15] 62,299 people in Guernsey/£40,000,000 = £642. As we say, the figure of £40m is higher than any settlement that we have heard of in England, but we are aware of a number of claims above this figure and one claim of £64m.
[16] https://www.nmc.org.uk/globalassets/sitedocuments/ftpoutcomes/2017/sept-2017/reasons-roussel-cccsh-046767-20170929.pdf

to make a claim before the law were changed and you could be faced with a modest flood. The prevalence of say 1:1,000 deliveries suggests there are 50 potential living claimants who could bring such claims against doctors and midwives working in Jersey and a further 30 who could sue those in Guernsey.

5 No Offer of Membership

5.1 More immediately, the Islands may be faced with the lack of available insurance/indemnity for individual doctors. If the MDO does indemnify a doctor for one claim, it may then decide not to offer membership the following year, or not to offer membership to the department, or to increase the amount of the yearly premium to a level that would make practice non-viable. This is not a remote hypothesis. In light of escalating damages in high value cases, MDOs in England are now setting their yearly premiums to a level that makes private obstetrics and spinal surgery untenable for most. In England, a number of doctors in those specialties have closed their private practices and have moved into the NHS while patients who otherwise would be willing to pay for private care are forced into the State system.

5.2 In the Channel Islands there is no option for a doctor to move to another employer with different indemnity arrangements (in England they can move from private practice to the NHS) and yet the medical workforce in both Islands may not be able to arrange appropriate indemnity cover individually or by department/GP practice. Ultimately, this impacts on the attraction of moving to the islands for both the medical profession and the population it treats. For obvious reasons, doctors who understand the risks would be unwilling to move their families and livelihood to the islands whilst they can work for the NHS with the benefit of an employing Trust taking on their professional liability. Those already here must be expected to look for less risky employment if the situation in England is not resolved.

5.3 We are aware of at least one doctor in the Channel Islands being unable to secure appropriate indemnity arrangements resulting in the doctor being unable to use his skills locally. The level of the additional premium for out of hours work for GPs in Jersey makes the work comparatively unattractive. The same problem was acknowledged by the Department of Health in England when it published its GP Indemnity Review in July 2016[17] and found that indemnity inflation is broadly around 10% per annum, with the average annual

indemnity cost inflation for out-of-hours GPs being around 20% per annum. The Review found that following discussions with the MDOs and NHSR, the cost of indemnity will continue:

'…to push upwards at a similar annual rate to that seen in recent years.'

Importantly, this review was carried out before the change in the discount rate (see below) that overnight increased NHSR's 2017/18 liabilities by £500 million and had the same effect on the MDO's liabilities and so the premiums offered.

5.4 In order to protect out-of-hours provision and the NHS 111 service, additional funding was provided by NHS England to offset the additional premium over this winter[18]. We understand that the States have not provided the same support to the GPs on the Islands who have personally faced increased costs.

5.5 The risk of losing the doctor's indemnity arrangements goes far beyond the medical profession and must impact on the populations it serves. A wealthy individual otherwise attracted by the taxation levels would be unlikely to choose to move his young family to an island where there was no obstetric service. Able and mobile young residents of the Islands cannot be expected to remain during their childbearing years if there is no obstetric service and they perceive themselves as having a choice. They may choose to live in England during the last three months of their pregnancies and seek NHS care, but that will not be practical for most and would increase the hazards created by unexpected premature delivery in an environment where there is no competent obstetric service. Ultimately, a population needs to have a local obstetric service.

6 Who Pays the Premiums?

6.1 Today the States of Guernsey pay the total premium for secondary care providers. We are aware of some private obstetricians in London being quoted £660k for their yearly premium, whilst many others have been refused cover altogether. In Ireland, the level quoted by the MDU increased in 2001 from £68,000 to £393,000.[19] Of course, similar hikes could occur in other specialities, but the risks are much greater in obstetrics. We assume that the funds for any increase in indemnity premium in the Channel Islands would need to be found from the States already allocated budgets.

[17] https://www.england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf
[18] https://www.england.nhs.uk/2017/09/nhs-england-to-help-tackle-rising-costs-og-gp-indemnity-with-10-million-boost/
[19] https://www.irishtimes.com/news/dispute-over-medical-insurance-escalates-1.1155962

6.2 In Jersey, we understand that HSSD either pays a doctor's entire premium if they earn 10% or less of their total income from private practice, or 50% of their premium if they earn more than 10% from private work. In Jersey there are four Consultant obstetricians plus junior doctors. If we assume that the four Consultants earn less than 10% of their income from private work, then the States would need to find the total amount of increase in premiums which could reasonably anticipated as being over £1 million.

6.3 We also believe that not all obstetricians in Jersey have indemnity cover provided by a MDO. As we discuss below, indemnity cover provided by the commercial insurance market is associated with different risks and disadvantages.

7 MDOs versus Commercial Insurers

7.1 MDOs work on an occurrence basis meaning that they will consider indemnifying a claim made against a doctor at any time if the doctor was a member at the time of the incident. This is attractive because a negligence claim can be made well past retirement or indeed death. Membership on an occurrence basis means that a doctor can retire without having to continue to pay into the MDO with the expectation that the MDO will manage and pay for any subsequent claim.

7.2 In contrast to MDOs, commercial insurance policies are always in our experience written on a claims-made basis with the policy paying out should the claim be made and notified during the 12-month lifetime of the policy. Therefore, doctors who have opted to indemnify themselves with the insurance market need to continue to buy insurance throughout their career at rates that will be controlled entirely by the insurers, and to fund run-off cover after their retirement. Run-off cover depends upon the policy holder being able to meet the premium which may increase unexpectedly until the contract is signed. Any doctor on the Channel Islands who is indemnified with a commercial insurer needs to have an arrangement to fund run-off cover when the doctor retires, but the cost of that cover may be unpredictable. We do not know what arrangements either the doctors or the States have made to ensure that such run-off cover is available. Plainly, if the market perceives that there is a reasonable risk of a claim being made against a practitioner of say £10 million, the premium will be priced accordingly.

7.3 Analysis of the healthcare insurance market commissioned by the Department of Health in England[20] highlights other issues that should be considered by the States if commercial insurance for their doctors is considered. For example:

7.3.1 There may be a gap in cover if a doctor moves between insurers with different reporting requirements. Where the doctor leaves a 'claims made' policy for an occurrence arrangement, it is obvious that neither will be liable for the IBNR[21] claims that occurred during the 'claims made' epoch. Or where a doctor leaves the occurrence-based MDO for a cheaper 'claims made' policy the MDO may[22] exercise its discretion against the doctor on the assumption that the period is covered by the much cheaper claims made policy; and the insurer may refuse on the basis of a material non-disclosure of the events giving rise to the claim. We have experience of such a case.

7.3.2 Most commercial insurance has a limit, typically of £10m on the level of cover available. As far as we know there is no cover conventionally available for higher claims and it would be prodigiously expensive to write a policy for an individual. A cover of £10 million is self-evidently not enough to cover a liability of £20 million to £40 million.

7.3.3 Insurers may and do refuse to indemnify a doctor should the policy conditions not be adhered to, such as reporting time frames. This also means that if a doctor notifies the insurer of a high risk event where no claim has been made, the insurer will be free to increase the premium to an unaffordable level before the claim is made.

7.3.4 If two doctors are involved in a claim an insurer may require legal proceedings between them leading to increased costs, poor working relationships and adverse publicity.

7.3.5 Where the commercial arrangement promises run-off cover if the doctor remains in benefit until retirement, this is dependent on the doctor being able to afford the renewal premiums that are set on a

[20] Comparison of the NHS Litigation Authority and the Commercial Insurance Market http://www.nhsla.com/CurrentActivity/Documents/NHSLA Report MarshReport.pdf

[21] Incurred But Not Reported claims are particularly large in obstetric cases because such claims are frequently notified much later, often when the children are over 5 years of age and problems emerge starting school, but sometimes in adulthood. Late claims are almost impossible to investigate by asking the clinicians what happened and liability is determined on the basis of the clinical notes.

[22] The MDOs cannot and will not declare a general policy to that effect because that would itself be to fetter their discretion

one-off basis each year by the insurer who holds a discretion that is to all intents and purposes unfettered.

7.3.6 Reliance on commercial insurance could undermine public confidence in the Islands' health services with a knock-on effect on recruitment and staff morale. The doctor and the Islands may suffer reputational issues if insurers deny a claim or patients are not indemnified as a result of any deficiency in these arrangements.

8 A Perfect Storm

8.1 The nature of MDOs cover has been well known since their inception; however, the high moral standing of the organisations and those running them has meant that the courts have held them to be immune from the restrictions governing the insurance industry[23]. However, the escalation in both the number and cost of clinical negligence claims in England has had a knock-on effect on the premiums and availability of membership of MDOs. One MDO has analysed claims and found that a full time GP is twice as likely to receive a clinical negligence claim as nine years ago, and can expect to receive two claims over a career[24]. Premiums on the Channel Islands have escalated during the years following the Guernsey case of *Helmot v Simon*[25] (see below) while the 2017 change in the discount rate (see below) in England along with the rise in the number and value of claims is making MDOs revaluate their liabilities across the board.

9 Escalating Cost of Claims

9.1 A large economy like England has choices that are not available on the Channel Islands. NHSR's 2016/17 Annual Report[26] found that total provisions (reflecting the true cost to the NHS in today's prices of the payments that will have to be made in the future) increased by over 250% in three years from £26 billion in 2014 to £65 billion in 2017. That figure is widely seen as unsustainable within the envelope of present NHS financing, but it is manageable in political terms because it has been kicked into the long grass of the future, alongside the only comparable liability on the public-sector balance

[23] *MDU v Department of Trade* 1980 Ch 82
[24] http://www.medicalprotection.org/docs/default-source/pdfs/press-releases/uk-press-releases/88-per-cent-gps-believe-more-likely-to-get-sued.pdf
[25] *Dylan Simon v Manuel Paul Helmot (By his next friends and guardians Rosemary Helmot and Kenneth Raymond Jordan)* Privy Council Appeal No 0064 of 2011, Court of Appeal of Guernsey, [2012] UKPC 5
[26] http://www.nhsla.com/AboutUs/Documents/NHSResolutionAnnua0reportandaccounts2016-17.pdf

sheet, namely, the cost of decommissioning nuclear power stations. In the long term it will either be managed in England by fundamental tort reform, as happened in Australia when there was a crisis in medical indemnity financing in 2002, or there will be a progressive silent adjustment in attitudes. Society can adjust to spending ever-larger sums on lawyers and compensation claims without ever deciding whether it is a desirable state of affairs, so long as there are sufficient buffers to disguise what is happening. Every so often there will be a jolt when the state of affairs is brought to public attention, but at each stage the shock may be manageable. This process, akin to boiling a frog by raising the temperature so slowly that it does not notice, would not be the case in the Islands.

9.2 The projected expenditure for CNST in 2017/18 is £1.95 billion, a 17.5% increase compared to 2016/17 and it is expected to increase rapidly over the next few years in line with the recent increase in the reserves. NHSR advises that as well as the change in the discount rate (see below); increases are due to continued inflation in damages awards and legal costs, and a growing number of cases where NHSR provides for the costs of care for life (on a private basis). Importantly, there is no evidence that the quality of care has reduced[27]; therefore, the cost of clinical negligence claims is rising without any correlation to patient safety.

9.3 In September 2017 the National Audit Office[28] advised that Government should take a stronger and more integrated approach to reining in the cost of clinical negligence claims. It highlighted that spending on CNST has quadrupled in ten years, while the number of claims where damages were awarded had merely doubled. The increase in the number of claims accounted for 45% of the total increase in costs, while increases in damages accounted for 33% and claimant legal costs for 21%.

9.4 The House of Commons Public Accounts Committee then published a paper[29] in December 2017 referencing the NAO report. It found that the annual cost of clinical negligence is taking already scarce resources away from frontline services and patients. It observed that there are two main factors contributing to rising costs – increasing damages for a small but stable number of high-

[27] O'Connor E et al (2010) Disclosure of patient safety incidents: a comprehensive review. International Journal of Quality Health Care 22(5); 371-379
[28] https://www.nao.org.uk/report/managing-the-costs-of-clinical-negligence-in-trusts/
[29] *Managing the costs of clinical negligence in hospital trusts,* https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/397/397.pdf

value (mostly maternity) claims and increasing legal costs resulting from an increase in the number and average cost of low-value claims.

9.5 It is understood that today only 4% of people in England experiencing a harmful incident make a claim and therefore a small change to that figure could have a significant impact. It is true that most harmful incidents will not be the result of negligence, just as most negligent mistakes do not cause harm, but the prevalence of litigation within any society varies greatly between different places for reasons that are not always very clear. Experience shows that places that have seemed relatively benign may change very suddenly. The prevalence of claims in the Islands and the fact that costs have remained under control so far strongly suggests that today there is less appetite for litigation. Not only is there is no reason to suppose that there will not be an increase in line with England, the probability is that the gap between the two societies will close suddenly and sharply, possibly as a result of one significant scandal, more likely as a result of the inexorable cumulative effect of smaller events.

10 The Discount Rate

10.1 The discount rate is a means of recognising the value of money over time, of calculating the net present cost of meeting an annual stream of payments. Lawyers use various actuarial tables to find a multiplier which we then apply to the yearly payments for care, to take the most expensive example, to calculate the lump sum a defendant needs to pay now. The objective is to arrive at a lump sum which will provide a fair amount of compensation for an individual's lifetime.

10.2 The Damages Act 1996 gave the Lord Chancellor the power to set the default[30] discount rate in England. While the Act came into force in September 1996 the then Lord Chancellor waited for the decision of the courts in three linked cases before setting the rate. Hempsons acted for a Defendant in one of those appeals, which reached the House of Lords in 1999. The Lords ruled that the lump sum should be calculated on the rate of return of Index Linked Gilts (ILGS) and settled on a guideline rate of 3%. The Lord Chancellor then set the rate in 2001 at 2.5% based on the three-year average yield on ILGS. In March 2017 the Lord Chancellor set a new rate of -0.75%, following the example of HM Treasury, who had adopted this figure the year before.

[30] the courts can use a different rate of return if more appropriate

10.3 The change in the discount rate reflects a new and more cautious attitude to investment and the much lower interest rates available on ILGS: where it used to be assumed that a liability that would fall due 10 years ahead should be halved to reflect the return on the money in the interim, now it is assumed that it should be increased on the basis that inflation will exceed the return on the invested funds. This negative discount for accelerated receipt, as it is called by insurers and their actuaries, applies to pension funds, annuities and most other long-term investments.

10.4 Damages are assessed on the premise that the victim will invest their award in the most conservative security available[31]. Where funds used to be invested in a broad spread of equities and gilts, fund managers are now expected to be much more cautious. It may seem ironic that this should have happened at the precise time as the return on ILGS has fallen below the rate of inflation, but that is to misunderstand the way the market works. Returns on ILGS have fallen precisely because of the risk aversion – it is because people want security that the Treasury is able to sell ILGS at a rate that will fail to match inflation.

10.5 As a result of the change in the statutory discount rate from 2.5% to -0.75% one MDO calculated that the value of a hypothetical but realistic case went from £8.4 million to £17.5 million[32]. Similarly, NHSR has estimated that the change added an additional £500 million to the cost of claims for 2017/18[33] (even though the rate was already being used by HM Treasury to calculate the capitalised cost of a stream of Periodical Payments). The increase in the NHSR reserves and the advent of claims over £60m points to a more significant psychological change.

10.6 The change in the discount rate has made MDOs re-evaluate their liabilities because it impacts the valuation of <u>all</u> claims on the books of indemnifiers. MDOs act on an occurrence basis and many of the doctors who are responsible for the long tail of IBNR claims are no longer paying into the pot. The IBNR claims and the 'reported but not settled' claims have jumped in value as a result of the discount rate change and so premiums must rise and

31 This is because the courts have endorsed the proposition that any investment represents two things, a return for the use of the money and compensation for the risk that the capital will not be returned intact or be worth less when it is as a result of inflation. Since the reward for the second sort of return should go to the investor who takes the risk, the courts now assume the lowest return available. This was the basis of the decision of the House of Lords in *Thomas v Brighton Health Authority* (also known as *Wells v Wells* (1999) and the Privy Council in the Guernsey case of *Helmot v Simon* (2012). *Helmot* was a case about personal injury rather than medical negligence and so covered by commercial insurance.

32 https://www.themdu.com/about-mdu/save-general-practice/what-does-it-mean-for-you

33 http://www.nhsla.com/AboutUs/Documents/NHS%20Resolution%20-%20%20Annual%20report%20and%20accounts%202016-17.pdf

arguably the MDOs' may have to exercise their absolute discretion against a doctor for a high value claim to ensure liquidity.

10.7 In the Channel Islands there is no statutory discount rate because the Damages Act 1996 does not apply. However, the courts in the Islands do try to follow the English common law. In the 2012 Guernsey case of *Helmot v Simon*[34] the court found that the proper rate for earnings related losses was less than 0%. This was a personal injury case resulting from a road traffic accident covered by a commercial insurer and focused on future loss and care costs. This decision was based on conventional English common law principles and it delivered a significant body-blow to confidence among English insurers. A discount rate of -0.75% was subsequently adopted by HM Treasury when evaluating its liabilities. In 2017, this was adopted by the Lord Chancellor when setting the default rate, giving rise to the shock revaluation of liabilities and the arrival of claims pleaded in excess of £20m. It is thus in Guernsey that we find the origins of the present crisis in clinical negligence insurance in England, even if it took five years for the implications of the decision to penetrate the body politic and the practical implications are still being obscured in the accounts of the NHS Trusts who will eventually have to foot the bill.

11 Potential Solutions

11.1 In England it has been widely recognised that the system is unsustainable. The NHSR Annual Report 2016/17 made it clear that law reform is needed:

> **'We have a duty to compensate patients fairly where they are harmed by negligent care, but the current costs to the NHS are unsustainable, particularly given the other financial challenges facing the system. However, increases in costs are also unavoidable without significant law reform.[35],**

11.2 As there is no State provision akin to the backing of the CNST by HM Treasury within the Channel Islands today, you are much closer to the position in Australia in the early 2000s. Then there was a sudden crisis in medical indemnity, where one funder effectively went bust and another withdrew from the market. The State set up a review of the law of negligence under the chairmanship of a Court of Appeal Judge, Mr Justice Ipp and the result was a series of reforms (outlined below).

[34] [2012] UKPC 5

[35] NHSLA Annual Report 2016/17 Page 20

11.3 In line with the NHSR's recommendation, the National Audit Office in its recent report[36] recommended that by September 2018 the Department of Health, with the Ministry of Justice and others set out a clearly coordinated strategy to manage the growth in the CNST. It recommended that the strategy should identify the balance that the government wants to strike between access to justice and access to health services, to consider what is a proportionate response to harm, and to address all factors contributing to the costs of rising clinical negligence claims that can be influenced by the government, including the number of claims, legal costs and damages awarded. Similarly, the House of Commons Public Accounts Committee[37] found that:

> **'…tackling the rising costs of clinical negligence requires urgent and far-reaching action by more than one government department, but currently there is no overarching cross-government approach.'**

11.4 However, serious the problem may be in England, the arrangement by which the State stands behind NHS bodies (who provide 90% of care) means that we have a choice about whether to act or to kick the can further down the road. We can continue to ignore the increase in the CNST long term liabilities for a few more years at least. In private medicine, where there is no such arrangement, it seems that the most high-risk specialties, obstetrics and spinal surgery are in effect ceasing to exist. In the Channel Islands, there is no insulating arrangement with the States, merely a contractual arrangement between individual doctors and their indemnifiers. The States seem to have organised this arrangement, but they have no assurance that it will continue to be renewed from year to year, or that when the indemnity is called upon in a catastrophic case the MDO will be able to exercise its discretion in favour of the individual doctor under fire. The reality is that when liabilities on individual cases may be in excess of £20 million it is unreasonable and impractical to expect a mutual arrangement between doctors to support the system.

11.5 We advise that the current indemnity arrangements in the Channel Islands will prove to be unsustainable unless something effective is done to reduce the level of the liabilities. It is at root an arrangement between the medical profession and society as expressed by the State, and it must be premised on an assumption that the State will act so as to keep the liabilities down to a level where it is reasonable to expect the profession to meet the bill out of their collective income. They may lay this liability off, either through commercial

[36] https://www.nao.org.uk/report/managing-the-costs-of-clinical-negligence-in-trusts/
[37] *Managing the costs of clinical negligence in hospital trusts,*

insurance or a mutual fund such as the MDOs so as to smooth out the cost of meeting it over a number of years, but that cannot serve to shift it. Either society acts reasonably in what it expects of its doctors or the arrangement will break down.

11.6 There are a number of areas that the States should investigate as a matter of urgency if they wish to provide stable healthcare systems that will provide reasonable compensation to those injured and appropriate care for those who are disabled through negligence.

11.7 This is a list of ideas that we could explore in more detail for you if you wished. Some of them raise more practical problems than others, but all are perfectly deliverable.

11.7.1 Legislating for a set and positive discount rate not linked to a risk-free investment (ILGS). The common law used the 4.5% discount rate table until 1999 and people who recovered compensation on that basis did not run out of money.[38]

11.7.2 Legislating for the courts to award periodical payments.

11.7.3 Legislating for a cap on the amount of damages payable – both individual heads and the capitalised sum.

11.7.4 Removing care, other therapies, and accommodation as recoverable heads of loss. If people need these things they should make use of services provided by the States and the States should acknowledge an obligation to provide adequate care for the disabled, whether they are victims of tort or not. The problem with the contrary assumption that we have seen in England is that every claimant demands a one-patient institution, which has proved to be a prodigiously expensive way of providing care. Furthermore, there are obvious advantages in maintaining quality of the care if delivered in a properly run residential care homes with adequate processes of supervision. In short, the States should be able to provide care that is much cheaper and of more reliable quality than the individual (be they disabled through negligence or otherwise) can provide for themselves.

11.7.5 Enacting an assumption that claimants will make use of State care where it is available. One of the mistakes in England has been the

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https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/397/397.pdf

[38] The first of these massive claims, Dr Lim Poh Choo recovered £229,000 in 1978. When she died in 2006 aged 70, her fund had grown to over £1m *Lim Poh Choo v Camden and Islington Area Health Authority* [1980] AC 174, [1979] UKHL 1

failure to revisit the opposite assumption, which was enacted at the dawn of the NHS when state care was a new and unfamiliar feature of the landscape[39].

11.7.6 Instituting a system whereby the States indemnifies all doctors and their estates so as to remove the need for doctors and patients to rely on a MDO's discretion in negligence claims against doctors. That would replicate the situation in England and it would be perfectly affordable until the litigation climate changed. The trouble is that once you get a large claim you will be faced with the *ad hominem* arguments at the same time as you face a potential swarm of imitative claims.

11.8 We touch on these briefly below but note that this is not a comprehensive review and other matters such as tightening up the limitation period, limiting legal costs and removing interest awards could also be considered.

12 Set Discount Rate

12.1 In England, the Lord Chancellor adopted the rate of -0.75% in 2017 provoking widespread concern in the insurance industry as well as the NHS. This excessively prudent assumption is one that has been followed by those selling annuities. When HM Treasury adopted the same assumption in 2015 it led to a doubling of the provision for CNST liabilities. There is nothing wrong with providing for a liability on the footing that the capital will not be put to useful work, that the tort victim will not invest the capital so as to make a proper return, but there is nothing right about it either. The debate is as old as human society: it was resolved in favour of the prudent investor in the Parable of the Talents[40], but the arguments in favour of those who would forbid all payments of interest as usury are even older[41]. Today those who pay the damages, the working population depend upon pension funds that invest their savings and consistently aim for the returns available from investment in a broad basket of securities, including equities. The proposition that the claimant should be compensated on the assumption that their investors will act differently is in practice a device to increase damages.

12.2 In England, we are victims of the assumption that the way matters are currently is necessarily the way in which they should in fairness be organised.

[39] Law Reform (Personal Injury) Act 1948.s2(4)
[40] Matthew 25:14–30

12.3 The uncertainty in the lack of a discount rate makes the Islands an unknown on the indemnifiers' books. The Islands should consider introducing legislation to allow for a set statutory discount rate based on an investor's portfolio. A positive rate above that of England would immediately make the Islands a more attractive proposition for indemnifiers.

13 Periodical Payments

13.1 Section 2(1) of the Damages Act 1996 was amended in 2003 to give the courts in England the power to award damages by way of periodical payments - yearly payments usually for care and case management. These have proved enormously attractive in England because:

13.1.1 Such payments are treated as a stream of damages payments rather than a return on an investment fund and so they do not attract income tax;

13.1.2 Because they are fixed and index linked to appropriate rates of wage inflation[42] they are relatively secure;

13.1.3 They do away with the uncertainty arising from the need to debate the life expectancy of the claimant;

13.1.4 Because they abolish the need to pay a capital sum at the time of judgment they are attractive to the politicians responsible for HM Treasury in an era when it seems that anything that happens much after the next general election is of comparatively little concern.

13.2 In the Channel Islands there is no ability for the courts to award damages by periodical payments. As with the RTA case *Helmot v Simon*, the bulk of awards in clinical negligence claims are the care costs. In *Helmot,* the Privy Council found that to ensure the Claimant did not suffer under-compensation (in light of the acknowledged disparity between earnings and ILGS linked RPI inflation) a negative discount rate was applied to earnings related losses (mainly care and lost earnings). This caused an immediate hike in local premiums (at the time the discount rate in the UK was 2.5%).

13.3 The Privy Council in *Helmot* made it clear that it would be desirable for Guernsey to pass legislation to allow for payment by periodical payments. Even though there are fewer attractions for a society that does not organise its affairs

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[41] Psalm 15:5

[42] Periodical payments for care and case management are tracked to data provided by the Office of National Statistics which sets out earnings inflation through an annual survey. Therefore, the yearly earnings related payments in a claim are index linked to the level of earnings of similar employees.

on the basis of having a national debt, you may see the force of this view. It is difficult to see why that authoritative guidance has not found favour with the legislators in the intervening five years. Legislation could be passed to allow the indemnifiers to spread their liabilities and claimants to have guaranteed lifetime payments where appropriate and without the need to invest a lump sum.

13.4 Section 2(3) of the Damages Act 1996 allows for the English court to award periodical payments only if it is satisfied that the continuity of the payments is reasonably secure. The Act provides that payment will be 'reasonably secure' if it is protected by government guarantee, protected by the Financial Services Compensation Scheme (FSCS), or the source of payment is a government or health service body. MDOs are not insurers backed by the FSCS and so are not viewed as reasonably secure providers for the purpose of periodical payments. Were the Channel Islands to legislate in the same vein to allow for periodical payments, any clinical negligence damages payment from a MDO would still have to be by way of a lump sum. If doctors were insured on the commercial market the insurers would need to satisfy the court that they can comply with a PPO in the face of a limited and so costly market for annuities for impaired individuals[43]. Therefore, even if you were to follow the guidance of the Privy Council in *Helmot,* it would only provide a partial solution to the presenting problems.

14 Cap on Damages

14.1 The principle that a patient is entitled to be compensated for all pecuniary loss has a long and lofty legal history[44]. Yet, at least one Law Lord has argued that we should not assume that it is the '*only sensible compensation system.*[45]' The tone of the recent governmental papers in England given the escalating costs of clinical negligence and the negative impact on frontline care, suggests that the principle is starting to be questioned. Of course, it is impossible to return a cerebral palsy child to the condition that he would have been in had he been delivered sooner, and the legal exercise of trying to do so through money is

[43] Comparison of the NHS Litigation Authority and the Commercial Insurance Market, http://www.nhsla.com/mwg-internal/de5fs23hu73ds/progress?id=HLQaV7vvYmb1KA-PRx9JCPrJ2iFSAN7-ReV0n5S8a7s,

[44] *Livingstone v. Rawyards Coal Co.* (1880) 5 App.Cas. 25, 39; *Lim Poh Choo v. Camden and Islington Area Health Authority [1980] A.C. 174* , 187e, per Lord Scarman. The technique employed to achieve this result is to provide an annuity of an annual amount equivalent to the streams of future losses of earnings and cost of future expenses: *Hodgson v. Trapp* [1989] A.C. 807 , 826d-e, per Lord Oliver of Aylmerton.

[45] Lord Steyn *Wells v Wells Thomas v Brighton Health Authority, Page v Sheerness Steel Co. Plc.* [1999] 1 A.C. 345

undermining the health service in England and could cripple the entire health service in the Islands. Were legislation passed capping total damages payable per claim then the Islands would again become a more attractive customer for indemnifiers. We understand that six USA states have capped total damages with corresponding decrease in indemnity premiums and litigation[46].

14.2 There are a number of ways in which the enormous range of services from primary care, contraception and allied health professionals at one end, to major trauma and elective neurosurgery at the other can be provided to small communities and the two Islands do not have exactly the same detailed provisions. However, patients already accept that by living on the Islands, GP appointments are paid for and that certain treatments are not locally available[47]. Patients are transferred off Islands in emergencies or for certain elective procedures. As happens with any isolated community needing care that can only be provided in a large centre of population, outcomes are occasionally influenced by the inevitable delay through the transfer and perhaps inclement weather conditions. The advent of percutaneous coronary angioplasty, Hyper Acute Stroke Units and effective treatment for dissecting aortic aneurysms has brought a silent revolution in the last 10 years that has increased the advantages of living in large cities and seen far more centralisation of services within England. The volume of certain types of patient on the Islands and the need for an on-call service means that patients are not seen by sub-specialists. Residents accept these limitations as part of their decision to live on the Islands. Just as the organisation of healthcare has to be adapted to provide what is appropriate in an island setting, so the arrangements for compensating victims of tort and providing care for the most damaged members of society have to be appropriate for a comparatively small community.

14.3 Any limit to the amount of damages awarded would be a radical '*departure from established principle*[48]' with resources and social policy arguments being a matter for government after full consideration of all factors and is therefore not within the scope of this paper. Nonetheless, should the Islands either step into the breach[49] when a multi-million pound claim is brought without available indemnity cover or decide to set up its own system for indemnifying its

[46] https://www.medicalprotection.org/docs/default-source/sab-docs/5892-striking-a-balance-policy-paper-web.pdf
[47] Two treatments for a heart attacks/coronary artery disease (cardiac catheritsation and coronary artery bypass grafts) are not offered on Guernsey (and Jersey?); neonates under 28 weeks and neurosurgical bleeds (e.g. sub-arachnoid haemorrhage)
[48] Lord Steyn *Wells v Wells*
[49] It must be understood that where the State is the employer of the tortious doctor, it will be vicariously liable in law for the actions of the doctor. Refusing to step into the breach will involve relying on the immunity of the State and refusing to meet a

healthcare workers, then the liabilities based on the 100% compensation principle would simply be too high for the small populations to sustain.

14.4 Not only should there be an overall cap on damages considered but each head should have a cap considered. For example, in some parts of Australia, damages for lost earnings and earning capacity are capped typically at multiple or two or three times the average weekly earnings so awards are reduced by way of a formula not susceptible to judicial manipulation. This would seem sensible on Islands where the population of some high net worth individuals could mean that the lost earnings element of a claim could be a sum that would be utterly unreasonable to expect the median member of the community to support. Any individual earning above the average may well already have appropriate insurance provision for lost earnings should they be unable to work.

15 Removing Care as a Recoverable Head of Loss

15.1 The most important single reason why compensation costs so much in England is because the common law has driven itself into a cul-de-sac from which there is no logical escape following a series of decisions over the last 40 years. Until 1976 no baby had recovered compensation for a birth injury. Indeed, there was no certainty that compensation could be recovered for an injury sustained before birth and so an Act was passed in 1976[50] to make the position clear.

15.2 Since then the courts have confused the issues of the right of the parents to enjoy a semblance of family life with the right of the child to proper care. This has resulted not only in prodigious additional support being provided for parents to enable them to look after their children at home, but to that support being sustained when the victims grow up, passing the age when they would normally leave home. Today these claims routinely include the costs of running a one-patient institution. It is recognised that the parents rarely are capable or inclined to manage the arrangement and so it includes the costs of case managers who will supervise the institution after the parents have retired and indeed died. The fiscal consequences are increased because with advances in medical care and nutrition[51], the life expectancy of the individuals,

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judgment. In England the doctrine of State immunity was overturned in England in the 1970's: we are not aware of any comparable jurisprudence on the Channel Islands.

[50] Congenital Disabilities (Civil Liability) Act 1976

[51] It is routine for these children to be fitted with Percutaneous endoscopic gastrostomy (PEG) feeding tubes, which were first described in 1980 for use in children.

who may be profoundly brain damaged, has increased from a few years to ranges much closer to the rest of the population.

15.3 The provision of this level of care in such a setting is massively expensive. It is common for these people to have problems with continence, convulsions and sleeping, so that they may need occasional 1:1 or even 2:1 care such as turning at night. Where they are adults and will need manual handling, two carers are required often for 24 hours a day to cater for events that may occur less than once a week. There is usually a claim for a hydrotherapy pool. The accommodation claim will include the cost of a bungalow designed for disabled living and large enough to contain staff and the equipment the patient will perhaps only need occasionally. The cost of this support may be up to 10 times what it would cost to provide that care in a proper setting designed for the purpose of catering for a group of people with similar problems, which is the way in which most such care is delivered to people who do not have defendants to sue. There are also intrinsic problems with one-patient institutions because they can never have the supervisory structure necessary to ensure that the residents receive care that is consistent and of high quality.

15.4 The tort law system is not well designed to cater for the cost of providing care. Since the tortfeasor and the victim are separated on the day of judgment the needs will only be assessed by the courts once, on the day when compensation is awarded. Since the English courts are also committed to the proposition that the victim must be awarded 100% compensation, even though they have only proved their entitlement to compensation and their need for specific item on the balance of probabilities, there is an inevitable tendency to err on the side of generosity.

15.5 To rectify this problem we need to provide proper State care for profoundly damaged people in State financed care homes of appropriate size, in exchange for which the State should by primary legislation deprive people of the right to recover the costs of such care. Since many people so afflicted by disability will have no claims in tort, there will be a positive benefit to the disabled population – it is the mark of a civilised society that it cares for its most vulnerable members.[52] The needs of this group of people cannot be disputed; the mistake is in choosing to allocate the response to this need through the tort system, which increases the cost of those who are successful whilst excluding those who cannot sue an identifiable defendant. If someone were to suggest that ITU

[52] Widely attributed to Mahatma Gandhi

care should be allocated by the courts and provided in the home the folly would be evident and it is difficult to explain how we have strayed so far from the path of reasonable assessment and provision in the case of those who need intensive care of a different sort.

15.6 In England the Law Reform (Personal Injures) Act 1948 s2(4) requires the court to ignore the possibility of avoiding an expense by making use of State care, even though there is no requirement upon a successful claimant not to use it. There is no reason why the Channel Islands should not enact the opposite assumption or as a matter of policy decree that it will not endorse the one-patient institutions that we have in England with the care provided by workers commanding high salaries. The States could remove care and case management as a recoverable head of loss and in exchange it could arrange for all those in need to receive care provided through the independent sector or by purchasing whatever may be appropriate from NHS providers.

16 State Indemnity for Doctors and their Estates

16.1 Prior to 2004, all hospital consultants in Ireland were indemnified by MDOs[53]. Due to the commercial insurers no longer being willing to insure the obstetricians, the State developed a Clinical Indemnity Scheme for State claims while private work continued to be indemnified by MDOs. In 2004, one MDO withdrew its cover for Irish obstetric consultants. It argued that from 1977 until 2001, it took only €25 million in subscriptions from Irish obstetrician members but paid over €75 million in obstetric claims from those years, spending over €50 million of money subscribed by non-obstetrician members[54]. Then in 2015, another MDO that largely covered all private consultants told the government[55] that between 2009 and 2014 the cost of indemnity per member had increased by over 95% and that as of 2015 there were no obstetricians working in whole-time private practice because it was not affordable. In order to mitigate the spiraling costs for private doctors and the subsequent pressure on the State system, the Irish government introduced a system of caps whereby the government covers any claim against a private consultant for incidents in private hospitals (so easing the burden on the State) above a certain ceiling and so reducing the risk to the insurer and the premiums charged. The system

[53] http://www.oireachtas.ie/parliament/media/JCHC-Report-on-The-Cost-of-Medical-Indemnity-Insurance.pdf
[54] The Irish Times, MDU cannot carry a state responsibility Thu, Feb 10, 2005, *Dr Michael Saunders is chief executive of the Medical Defence Union.*
[55] As part of the Joint Committee on Health and Children Report on the Costs of Medical Indemnity Insurance

is far from perfect, but it is an example of how systems based on MDOs can fail leaving a gap in healthcare and significant liabilities at the feet of the taxpayer.

16.2 Another example was seen shortly before 2000 where many Australian MDOs were forced to increase premiums for private doctors due to spiralling clinical negligence costs and the long tail of claims. The exponential rise, particularly for obstetricians, reduced the availability of some types of services, as is being replicated with private obstetrics and neurosurgery in England today. In 2001, an insurance group collapsed and the Australian government stepped in to stabilise the medical indemnity market requiring medical indemnity to be provided as insurance product (as opposed to discretionary indemnity); it introduced the Premium Support Scheme providing government subsidies towards the cost of the premiums; it introduced a High Cost Claims Scheme where the government reimburses medical indemnity insurers 50% of the insurance pay-out over a threshold; it introduced the Run Off Cover Scheme providing that eligible doctors receive secure, free medical indemnity cover when they stop practising; and introduced the Exceptional Claims Scheme which covers doctors for 100% of the cost of private practice claims that are above the limit of their medical indemnity contracts of insurance so that doctors are not personally liable for very high claims. These initiatives helped to stabilise the medical indemnity market and stopped doctors closing down high-risk areas of their private practice and forcing the State to shoulder the cost of care.

16.3 A change in system requires involvement from all sectors, but allowing the Islands healthcare systems to be based on the discretion on MDOs without limiting the value of claims is simply not fair to patients and doctors and is not sustainable. By having doctors indemnified on an individual basis prevents any learning from mistakes or development of expertise with the Islands as to the managing of claims. We understand that within both Islands there is now a single governance framework and single complaints system but with each doctor managing his/her own claim with an indemnifier we cannot see that there is any ability for learning from negligence claims.

16.4 From 1 April 2003 CNST independent sector providers of NHS care have been able to join the CNST. This is surely an acknowledgment that State provided healthcare is a necessity, that in some areas private providers are better placed to provide the care and yet State patients should not lose their avenue for redress under CNST. A similar system could be envisaged in Guernsey

where the majority of secondary care is provided by MSG, a LLP separate but commissioned by the State.

17 Conclusion

17.1 As healthcare has become more effective it has become safer and more predictable. Inevitably society has become less tolerant of failure in that context. Negligence does not equate to incompetence, doctors are human and therefore fallible; even more commonly, the systems in which they work can be seen to have let down the patients who were entitled to rely upon them to do better. It cannot be right that when an accident causes injury to a patient the compensation claimed by the patient is allowed to cripple a health service. Society needs to bolster the healthcare system and allow lessons to be learnt from mistakes. There is a dearth of information available as to the level of clinical negligence claims across the Islands but the evidence available is that the current system is unsustainable and the Islands lack the arrangements that disguise the unaffordability of the situation in England.

17.2 There are other softer disadvantages of the present pattern of events, including the risk that doctors practice “defensive medicine” because they fear the legal consequences of making errors[56]. Defensive medicine leads to unnecessary interventions and the avoidance of treating high risk patients. It may also lead to a lack of candour and increased costs. It would be reasonable to postulate that doctors in the Islands are already performing defensive medicine in the knowledge that their job security is based on the discretion of a MDO that has already called time on at least one colleague.

17.3 There is a precious window of opportunity for the Channel Islands to change their arrangements before there is a crisis precipitated by an insupportable claim being presented by a profoundly damaged patient who is the victim of tort. This event will personalise the issue and make it much harder to adopt an approach based on a civilised recognition of the need to provide reasonably for all disadvantaged people, whether they be the victims of tort or not. The Islands have an enormous advantage in being able to deal with this as a theoretical problem. It is in the context of this change that fundamental tort reform may be seen as fair and acceptable. If the States act now, they will avoid having to tell an injured patient that the compensation they expect under

[56] https://www.medicalprotection.org/docs/default-source/sab-docs/5892-striking-a-balance-policy-paper-web.pdf

the current legal framework simply does not exist as well as telling people that they are losing something that they believe is precious.

17.4 If it is recognised that the English pattern is unsustainable and may be transferred to the Islands suddenly and without warning, it will be seen that the Islands are living on the slopes of a volcano. When it erupts it will do so without warning and the States will find that they do not have the devices that have been developed in England to insulate us from a reality that is unaffordable. Once there is an identifiable claimant who is to be deprived of compensation the argument will be intensely emotional, with vested interests amongst the legal fraternity prepared to stand up for a status quo that has many disadvantages apart from being unaffordable.

17.5 One key disadvantage is that those disabled individuals without defendants to sue are excluded from the largesse and that the quality of care provided at home to the few successful claimants is intrinsically less reliable and consistent. Arguably the proper model of care involves residential care homes, appropriately financed and equipped to meet the needs of the residents which include those injured through negligence.

17.6 Just as the populations accept that island life limits the availability for certain treatments, so too should they accept that they cannot expect to receive pay-outs equalling or greater than the current value in England, which is already unaffordable. One MDO carried out a recent survey of their UK members with 73% of the public and 86% of healthcare professionals supporting changes to the legal system to tackle the issue. The surveyed population agreed that how society pays for clinical negligence is just one of many difficult decisions that are needed when considering healthcare spending[57].

17.7 There is a window of opportunity to legislate for an affordable and sustainable personal injury claims system in the Channel Islands[58]. By being proactive, the Islands would be supporting the recruitment and retention of high quality healthcare professionals and guaranteeing the provision of healthcare services. The Islands would be guarding their budgets against unaffordable damages bills and would be seen as vanguards of reform. However, should the opportunity not be taken then the Islands are at risk of losing the fiscally productive populations and businesses that rely on the healthcare services (most notably the obstetric departments).

[57] https://www.medicalprotection.org/docs/default-source/sab-docs/5892-striking-a-balance-policy-paper-web.pdf

[58] Of course, any limit to a compensation scheme will impact other personal injury insurers and may encourage other businesses to relocate to the Islands where liability is more predictable and affordable than many other jurisdictions.

17.8 Before any legislative reform is undertaken appropriate consultation and reports should be commissioned, but it is our view that such measures are overdue. We think it is only time that similar measures are legislated for in England, but the Channel Islands lack the arrangements that enable the English the luxury of being able to kick the can down the road if our politicians so choose. The fact that the problem is still largely theoretical does not alter the fundamental message of this advice: this is a crisis you will waste at your peril.

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BMA

The Cost of Professional Medical Indemnity within the Channel Islands – A Crisis and a Window of Opportunity

- There is a window of opportunity to protect the provision of healthcare in the Channel Islands
- In England, birth injury claims are now regularly pleaded at upwards of £20 million and a GP meningitis case has settled at around £15 million
- The English government is currently bank-rolling these claims provided they are the result of NHS care but there is increasing momentum to legislate
- The reality is more acute in the Channel Islands where the value of claims will at least reflect those in England but where doctors are indemnified by commercial insurers who will have a cap on the amount of damages they will pay, or by mutual organisations who have a limited amount of funds to protect their members
- Doctors cannot practise medicine without indemnity arrangements in place yet their availability is impacted as a result of the escalating number and cost of claims in England. As a result some specialists in England are being driven out of private practice even though they have no shortage of patients
- If a high value claim is made in the Channel Islands and is not managed by the doctor's indemnifier then either the patient will not recover their damages in full or the States will need to find £millions to compensate the patient
- There is a need to legislate in the Channel Islands before such a claim is made
- If this opportunity to reform the system is not taken, then the Islands not only risk losing their health services and the populations who rely on them, but will also risk needing to find £millions in damages to settle valid claims

HEMPSONS

COMMENTARY ON THE STATES OF JERSEY DRAFT DAMAGES (JERSEY) LAW 201-

PREPARED FOR THE JERSEY SCRUTINY COMMITTEE ON BEHALF OF THE JERSEY PRIMARY CARE BODY (JPCB)

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Introduction

1 The essence of this draft law is that it is as it says an attempt to:

'bring Jersey into line with the British Isles.'[1]

The problem is that the present clinical negligence system in England has been recognised as being unsustainable by most commentators including NHS Resolution, the body set up to handle the English claims by the UK government.[2] Since that happened NHS Resolution's 2017-18 Annual Report has revealed that the provision for future liabilities has grown by a further £12 billion in one year to £77 billion,[3] more than three times the provision in 2015. The only reason the English system stays airborne is because it has the unshakeable backing of a government that is able to allow future liabilities to accumulate until it is unable to raise money by selling gilts. If the English system had continued to depend upon the credit of the Medical Defence Organisations (MDOs), as it did until 1990 and as yours still does, it would have been proved insolvent before that happened in Australia in 2002 unless there had been a radical change in the remuneration of doctors. This has been largely because of the cost of obstetric claims which have increased from about £1million maximum in 1990 to about £40m now. At the moment the English figures only cover hospital cases, but the state is about to extend cover to general practitioners because it has recognised that these cases are unaffordable at the rates the MDOs would have to charge GPs.

2 That is why we say, with the greatest respect to the Law Officers of Jersey, that the proposals put forward are not fit for purpose. They set out to emulate an English system that can only be financed by a government prepared to run a national debt and it is neither reasonable nor practical to expect such a burden to be carried by two hundred doctors in Jersey or their indemnifiers. Were the States to accept that they are vicariously liable for the doctors (when the Medical Defence Organisations ("MDOs") are forced to step away) then you would be adopting a system that we are struggling to escape in England. In the rest of this paper we will examine this proposition, explain some of the implications and comment on a few details of the proposals.

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[1] See Official Commentary introducing Draft Law, Page 9

[2] See NHS Resolution, aka Litigation Authority 2016-17 annual report, quoted in our first paper at paragraph 11.1.

[3] For comparison, the estimated cost for replacing the Trident fleet is £41bn, while the discounted provision for Nuclear Decommissioning over 120 years is £234bn. Another comparison can be seen if you divide the provisions by the English population (54.8m) you come to £1,405, multiply that by the 100,000 people on Jersey you come to a very rough and ready assuming all thing being equal estimate that the total provisions for Jersey should be £140.5m,

The official briefing to the draft Law repeats several of propositions that are part of the English common law that has been recognised to be unsustainable. Some of these have been criticised in our previous papers and we will confine ourselves to commenting on those on which the proposal depends.

The Significance of Discount Rates

3 As you know, to every stream of annual expense or loss of earnings – the multiplicand – a multiplier is applied to produce a lump sum. To present you with the forensic consequences for the indemnifiers according to the Ogden Tables here is an outline summary of the available options. To provide for a fixed term multiplier according to the Ogden Table 28, which we mostly use and is on the UK Government website, you get the following figures.[4]

4

Term	-2%	-1%	0%	0.5%	1%	2%	2.5%	3%	4.5%	5%
10	11.1	10.5	10	9.8	7.5	9.1	8.9	8.7	7.9	7.7
20	24.6	22.2	20	19	18.1	16.5	15.8	15.1	13.6	13
30	41.2	35	30	27.9	26	22.6	21.2	19.9	16.3	15.4
40	61	49	40	36.3	33	28	25	23	18.8	17.6
50	86	65	50	44.3	44	32	29	26	20.2	18.7
60	117	82	60	51.9	45	35	31	28	21.1	19.4
70	154	101	70	59.1	50	38	33	30	21.7	19.8
80	200	123	80	66	55	40	35	31	22.1	20.1

Table 1: Multipliers applicable to a fixed period according to discount rates ranging from -2% to +5%

5 Until *Wells v Wells*[5] in 1998, we used the 4.5% Discount Table which never produced a multiplier above 18, because a Judicial Discount of around 10% was applied for longer terms to reflect the reality that:

5.1 The impact of dying 10 years earlier was much greater than the impact of surviving 10 years longer, according to the tables; and

[4] We have added the 4.5% and 5% figures that appeared in previous editions, because these are now omitted from the published version. We have also rounded figures un and down for the sake of clarity.

[5] [1998] 3 W.L.R. 329

5.2 The probability of unexpected longevity was limited by the laws of nature. Someone with an expected life of 60 years could die tomorrow, but they could not live for 120 years because of the limitations applying to our species.

6 You will note that in respect of shorter periods the choice of discount rate is less significant, but in respect of longer periods the choice of a lower rate can be astonishing. You will see that reducing the rate from 5% to -2% increases the multiplier by 90% on the 20 year table: to do the same thing for 80 years increases the figure by 900%. The 2.5% discount rate, which prevailed in England between 2001 and 2017 had produced devastating results, exemplified by the case of *Robshaw*[6] where a total of £14.5 million was awarded in 2015 in a case where the life expectancy was 50 years from trial. Table 1 shows that this could give rise to a multiplier of anywhere between 18.7 and 86, depending on the discount rate chosen.

7 The official commentary on the draft Damages (Jersey) Law does recognise in places that the law cannot attempt to follow the guidance of actuaries in a mannequin fashion. For example, the last paragraph on page 13 decrees that if a negative discount rate would be required for full compensation this would represent

> **'a severely negative economic prognosis for the Island. This would be a compelling reason to deviate from 'full compensation'.'**

Since the conclusion of the end of page 9 of the supporting report for the draft Law is intended to bring Jersey into line with the British Isles, it is hard to reconcile these two propositions when England has a statutory rate at present of -0.75%: it seems you have already recognised that there is such a compelling reason to deviate from the English system, although whether the proposal intends to adhere to the artificial and unaffordable concept of full compensation as well is less clear – it seems not when there is a recession.

8 More importantly for your purposes, this statement is pregnant with an assertion that the rates chosen are affordable. The basis of this assertion is not described, and we say it is wrong. It is also misconceived because the problem is much more specific. Long before the Island's economic prognosis is impacted in a severely negative fashion, you will suffer devastating social changes as a result of the inability of the 200 doctors and their indemnifiers to pick up the bill in the case of medical negligence. The MDOs with whom your doctors are mostly insured are mutual funds made up of other

[6] *Robshaw v United Lincolnshire Hospitals NHS Trust* [2015] EWHC 923

doctors[7] and they cannot sustain claims of over £10m other than as rare cases that can be reinsured on a catastrophe basis.

Prevalence and Uptake of Litigation

9 One of the most surprising things about this problem is the extent to which people vary in their propensity to claim and the speed with which this propensity can change. In 1975, we settled the first cerebral palsy claim brought as a result of a birth injury. No-one had previously brought such a claim against a doctor in England and there were doubts about whether a duty could be owed to an unborn child. Now we know there are about 700 such injured livebirths every year according to the Each Baby Counts programme of the RCOG, pointing to an incidence of about 1:1,000 livebirths so that you can expect to have one such birth every year or so. Not all of them can point to a claim, indeed some make a more or less complete recovery; Each Baby Counts includes every case where a baby is delivered in such poor condition that they need cooling in a Neonatal Intensive Care Unit. However, until recently the NHSLA as it then was, was settling about 120 each year and claims are now being made in a rapidly increasing proportion of the 700 deliveries a year as a result of changes in practice by the NHS, following the introduction of the statutory Duty of Candour and the Redress Scheme by NHS Resolution. You should anticipate that claims will be made as a matter of routine in future.

A Hypothetical Example

10 We do understand that the Scrutiny Committee will need an example of the sort of case we are describing and so we attach a copy of those we are most concerned about.[8] We handle these routinely – last year there were about 30 received by this firm alone. The number is going up because there are about 700 such livebirths every year according to the Each Baby Counts programme of the RCOG and claims are being made in a rapidly increasing proportion of them as a result of changes in practice by the NHS, following the introduction of the statutory Duty of Candour and the Redress Scheme by NHS Resolution. You will see from the judgement that the various arguments in each case are complex and detailed and so we have simplified them for your purposes.

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[7] There are commercial insurers offering rival products, but for various technical reasons these do not offer practical alternatives as we have explained elsewhere.

[8] *Robshaw v United Lincolnshire Hospitals NHS Trust [2015] EWHC 923*

11 Many heads of damage are not affected by the discount rate. By way of illustration, we use the example of cerebral palsy claim resulting from birth injury which will include::

11.1 A conventional award for the injury itself, called Pain suffering and loss of amenity. This varies with severity and degree of insight and distress experienced by the Claimant, but typically about £300,000.

11.2 Care and equipment to date. This varies with the age of the claimant and the amount of care needed, but a typical figure may be £1,000,000.

11.3 Accommodation: there is usually a claim for a new and adapted house. Typically, a Defendant pays £500,000 up front to adapt.

We may take a figure of £3 million for present purposes, although it is often a lot more.

12 The Variables

12.1 The multiplicand for the cost of care is the biggest single variable. Again it is not a simple figure because all these claimants need much less money when they are children and we usually agree them in stages: it would not be unusual to agree on £75,000 whilst the claimant is a child, £100,000 between 14 and 18 and £300,000 in the adult epoch and we are using those figures for our worked example.

12.2 There are other claims for the case manager, the various therapies, and transport, equipment replacement, holidays and the annual cost of the capital sum invested in buying the house. For this example, we are going to say that is all £100,000 per annum.

There is a loss of earnings claim, typically £40,000 a year between the ages of 21 and 65.

13 We are going to assume a life expectancy of 50 years from settlement at age 12, as in *Robshaw*. Because we do not presently have tables for 1.8% as proposed by the draft law, we have used the midway point between the1.5% and 2% tables. We hasten to make clear that this is simply an illustrative hypothetical to help the Committee to understand the impact of what we are discussing.

SUMMARY TABLE OF HYPOTHETICAL CASE

	Discount Rate	0.5%	1.8%	2.5%	4.5%	5%
1	*Unaffected*		3,000	3,000	3,000	3,000
2	Care to age 14	149		145	140	140
3	Care 14-18	398		363	329	322
4	Care 18-62		8,340	6,942	4,380	4,243
5	Other continuing		3,300	2,872	1,976	1,826
6	Loss of earnings		944	826	500	460
7	Total		16,131	14,184	10,325	9,991

Table 2: Summary Table of a hypothetical birth injury case showing effect of the proposed discount rates as against rates based on higher rates. All figures are in '000s.

It will be apparent that the 5% table still leaves a massive award. This is why we say that fixing the discount rate can only be part of the solution. But it will make it clear to the doctors and their indemnifiers that the island of Jersey does understand the problem and will be prepared to work to find a practical solution that is fair to both sides.

100% Compensation

14 The definition of compensation, *restitutio integrum,* is to put the Claimant as nearly as money can in the same position as he would have been if the tortious event had not occurred. This has been revealed to be at best meaningless in the context of personal injury. A poor person who suffers the tortious loss of his legs is not restored the position in which he would have been by receiving a large sum of compensation. A poor person with two legs is not in the same position as a comparatively rich person with no legs. The conundrum has not been resolved nor is the hiatus diminished by making him an even richer person with no legs. Money does not and cannot put the victim in a position that remotely equates to the situation before the tort and whilst the formulation sounded attractive at when it was first uttered, the years that have lent it such weight of judicial authority have also revealed its weakness. Forty years ago, Lord Denning in his dissenting judgment in the Court of Appeal in *Lim Poh Choo* argued that the total of the damages awarded was excessive and called for a radical reappraisal of the law. His view of the acceptable principle was:

> **"... fair compensation must mean that she is to be kept in as much comfort and tended with as much care as compassion for her so rightfully demands: and that she should not want for anything that money can buy. But I see no justification in**

law or in morals in awarding to her large sums of money in addition to those needed to keep her in comfort.[9]'

15 It is said that you should pay 100% of the quantified damage. This is far more than Lord Denning's comfort money, and it ends up being an artificial exercise because the damage is quantified on the basis of what it would be reasonable for the Claimant to spend on mitigating their loss, where there is no expectation that they will necessarily spend the money in that fashion. Where the liability is uncertain a discounted liability is often agreed – the Defendant agrees to pay 70% of the total to reflect the risk of not winning. The court quantifies the claim on the same basis, knowing the Defendant will only pay 70%: both parties acknowledge that the money identified for a specific purpose, such as a hydrotherapy pool at home, will never be spent because there is not enough of it.

16 Incidentally, in the House of Lords, Lord Denning's view was criticised on the grounds that any medical practitioner could purchase unlimited indemnity for the modest figure of £100 a year. Forty years on we know of one obstetrician who is paying over £500,000 and the Medical Defence Union has decided not to cover spinal surgeons at all.

17 Further in practice, the Courts have taken the view that Claimants are assumed to invest in very low risk investments, again an artificial assumption. This is on the basis that any investment involves some risk and the Claimant who must take the risk should also keep the profit. We suggest that this is simply a rhetorical device to increase damages because the need to take a risk with money to make it work is part of the change in circumstances that happens to everyone in receipt of substantial capital. It is one of the changes that happens when a victim becomes a rich man and the solution to that change is not to make him even richer.

18 The judiciary who have been the unwilling authors of this impractical system have included some of its most thoughtful critics. Most recently Lord Sumption, the author of the common law contemporary orthodoxy in his Guernsey Court of Appeal judgement in *Helmot v Simon*[10] and who is now a highly influential member of the UK Supreme Court. He questioned the whole process of tort compensation for personal

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[9] *[1979] Q.B. 196* , 216
[10] [2012] UKPC 5

injuries in his widely acclaimed lecture to the Personal Injury Bar Association.[11] Whilst he doubted if his views would find ready acceptance, he did predict that the principle of paying a full indemnity, the 100% rule, would be replaced by a statutory measure of damages with a view to achieving a better balance between public and private interests.

Compromise is Necessary

19 The States of Jersey cannot fail to recognise that it is faced with threat to modern medical practice on the Island as a result of the level of claims that are being made. We laid out the components of the problem in our paper of 28 February 2018 and since then it has become apparent that there are several catastrophic injury claims pending on the Island and your commercial and MDO indemnifiers must now be taking cognisance of the implications of those cases for the future arrangements that they make with your doctors. There has been a question mark over the Channel Islands ever since *Helmot v Simon* showed that Guernsey could take the lead in a new inflationary surge.

20 You have just had the shock of a pair of claims that were originally asserted to be worth £238 million. Even if these are finally resolved at slightly lower figures, doctors and their indemnifiers are being forced to make plans for a future in which such claims are going to be part of the landscape. Our first report described how you were sitting on a volcano: since then it has erupted more vigorously than we predicted and it seems to be clear that you must confront the situation boldly, demonstrating a determination to restore the confidence of your doctors and their indemnifiers. You have, it seems to us, no option but to recognise that a compromise must be struck that is affordable, and slavishly trying to follow an English model that has proved to be broken and based on a different approach to incurring liabilities will not meet the challenge that you face. You need to make a clear declaration to the medical profession and the insurance market that Jersey is heading in a radically different direction and setting a realistic discount rate must be but the first step.

21 In Australia, they were faced with a similar threat to medical practice in 2002 when one indemnifier collapsed, and another withdrew from the market. The result was that they

[11] https://www.supremecourt.uk/docs/speech-171116.pdf last accessed 6 November 2018 'Abolishing Personal Injuries Law – A project'

set up the Ipp Committee[12] and introduced a number of arrangements that we described at paragraph 16.2 of our first paper. As far as the discount rate is concerned all the Australian states have tackled the problem differently and some have come up with different rates for injuries sustained in different ways and some have adopted different rates for loss of earnings and for meeting the costs of care. But most of them have adopted a discount rate of either 5% or 6%.

22 The BIICL paper referenced by the draft Damages (Jersey) Law narrative contains an article by Professor Mark Lunney that we commend to you and it identifies a crucial compromise:

> **'The discount rate in Australia seems to be set by reaching a compromise between a discount that accurately reflects the real rate of return a tort Claimant might obtain if investing in reasonably safe investment and one that takes into account that the fact that too low a rate of return might have adverse consequences on the provision and cost of liability insurance.'[13]**

23 You today are faced with a mandatory need to strike such a compromise. You have to recognise that the English common law system is unsustainable and that unlike England you are not putting your national debt behind your system. This in turn means you are not free to kick the can down the road as we in England are doing, because doctors and indemnifiers are being forced today to take decisions about how they are going to provide for unsustainable demands. In those circumstances, the law has to strike a contract between the medical profession and the victims of the mistakes they will inevitably make as the human practitioners of a fallible art in an environment that is increasingly intolerant of any practice that appears sub-optimal when viewed with the benefit of hindsight. If that contract is unreasonable you will damage and ultimately forfeit that medical service. To tell your doctors that they must risk bankruptcy in order to practice their art is almost as unreasonable as the Code of Hammurabi, which decreed that the doctor who blinded his patient should be deprived of his own sight.

What Rate should you choose?

24 On page 4, your briefing quotes with approval Lord Oliver who in *Hodgson v Trapp*[14] in 1988 tried to describe the philosophy of the common law of compensation. We repeat what Lord Sumption said in his lecture, the fact that Lord Oliver sought to

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[12] https://static.treasury.gov.au/uploads/sites/1/2017/06/R2002-001_Law_Neg_Final.pdf last accessed 6 November 2018

[13] BIICL *'Briefing Note on the Discount Rate applying to Quantum in Personal Injury Cases: Comparative Perspectives'* p.19

[14] [1988] 3 W.L.R. 1281

describe the purpose of the law does not imply that he agreed with it. However, the circumstances then were different in the following respects:

24.1 The discount rate used in *Hodgson v Trapp* was 4.5% and this was the rate used in the case of *Dr Lim Poh Choo*, which as the supporting report to the draft legislation correctly notes on page 5 resulted in substantial over-compensation;

24.2 At the time the inflation rates in England were widely thought to be out of control so that investments had to keep up with an anticipated annual devaluation of her fund in real terms of 5-10%; and

24.3 the marginal rate of income tax in England was 83% plus a 15% surcharge on unearned income so that returns from investments such as Dr Lim Poh Choo's fortune was forced to use were taxed at 98%. Her advisers were no doubt forced to deal with such confiscatory headwinds by investing for growth rather than income.

25 What the case of *Lim Poh Choo* and the others handled during that era shows is that professional investors are able to cut their cloth according to the needs of the situation. Your official briefing acknowledges that history reveals she was over-compensated, since her fund had grown from £229,000 to £1.3 million at the time of her death, despite an unforeseen inflation in her cost of care. In our first paper we quoted the Parable of the Talents[15] and we suggest that the law should recognise only that it has to provide a reasonable sum in compensation of the wrong that has been done and leave it to the investors to protect the interests of the victim of tort as best they can. History shows that the competently advised rich man with no legs will have financial options open to him that were not available to his bipedal self before his accident. The background to the draft Law acknowledges that:

> **'As courts err on the side of the claimant in making lump sum orders, there is frequently a considerable amount of money left at the time claimant [sic] dies.'[16]'**

26 Finally, by way of preamble, we note that in Jersey you do not have the anachronistic section 2(4) of the English Law Reform Act 1948[17] which requires the courts to ignore the possibility of avoiding an expense by making use of public provision. In England

1. [15] Paragraph 12.1 and Matthew 25: 14-30
2. [16] Page 7
3. [17] *In an action for damages for personal injuries (including any such action arising out of a contract), there shall be disregarded, in determining the reasonableness of any expenses, the possibility of avoiding those expenses or part of them by taking advantage of facilities available under [the National Health Service Act 2006 or the National Health Service (Wales) Act 2006] or the [National Health Service (Scotland) Act 1978], or of any corresponding facilities in Northern Ireland.*

the tax payer pours funds into a private system rather than supporting the betterment of the public systems in place, which would benefit all patients with a comparable level of need.

27 It is also worth highlighting that civil claims are determined on the balance of probability. Therefore, we allow children with cerebral palsy who do not have a perceived tortfeasor to be dependent on the States whereas a child who has a 51% chance of success has a claim for damages only limited by the imagination of his experts and the technology available. Whether society should accept one child living in adverse conditions and another in a one patient institution simply because they lie on different sides of a 50% line set by the profession[18] is not a purely philosophical point. As Lord Sumption put it in his lecture:

> **'…negligence is not morally culpable. It is a normal feature of human behaviour… I can imagine a moral case for imposing an absolute liability on those who cause physical damage to others, simply on the grounds that they are the agents of some invasion of the victim's physical integrity. That was the basis of the more limited and now largely redundant tort of trespass to the person. I can also imagine a moral case for imposing liability on those who intentionally or recklessly cause physical damage to others. But liability for negligence does not depend upon a person's mere infliction of damage, nor on his state of mind. It depends upon his falling below some objective standard of conduct to which he has not usually assented, but which the law imposes upon him. It seems to me that the only possible justification for the law doing that is its social utility. Yet the arbitrary results and incomplete coverage of a fault-based system, combined with its prodigious costs and unwelcome side-effects, seriously undermine the social utility of the law of tort as a way of dealing with personal injury.'[19]**

28 It seems to us that the States of Jersey should now follow the Australian example and recognise that a compromise has to be struck when setting the discount rate. That the notion of 100% compensation is based on a delusion and that you have to consider what can best be done for the community. You have to strike a reasonable compromise that will be clearly practical for the medical profession to deliver and allow them to remain. We suggest that this points to a discount rate of 4.5%, reflecting the practice followed by the UK courts until 1998 and close to the 5%-6% used in Australia. We do not think this will be enough, but it is an essential part of any readily available solution.

29 Finally, the draft Act is curious in choosing a split rate. It suggests that the discount rate should be 0.5% up to and including 20 years and 1.8% if the period is more than

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[18] Expert witnesses advising both sides

[19] https://www.supremecourt.uk/docs/speech-171116.pdf last accessed 6 November 2018 'Abolishing Personal Injuries Law – A project'

20 years. This reflects advice that returns over a longer period are likely to be higher, even though they are more uncertain, and so a higher discount rate is used which in effect reduces the lump sum paid. However, the way it is struck means that the fund for a victim with a life expectancy of 20 years will receive a multiplier of 19.13 whereas someone who has to provide for a longer period of 22 years will actually receive somewhere between 17.30 (1.5%) and 16.51 (2%). That cannot be sensible on any footing.

30 It may be that the draughtsman intends that every longer epoch shall be divided, so that the first 20 years shall be calculated at 0.5% (giving a multiplier of 19.03) and a second calculation for the period from 21 years to the end of the person's life or working life as the case may be to be assessed on the 1.8% table. That would not be the way actuaries look at things, because the uncertainty and greater earning potential both apply to the whole epoch from the day of judgement, but we cannot tell. If so, it would be vulnerable to the objection that it would be much more expensive and more cumbersome to calculate.

Periodic Payments Order

31 For the reasons given in our second paper attached to our commentary on the Terms of Reference, a periodic payments order will be thoroughly unsuitable for medical cases in the States of Jersey. In short, the reasons are:

31.1 The MDO's who pay almost all of these damages cannot fund them. This is partly because they are not regarded in law regarded as being "*reasonably secure"* because they are not fully regulated insurance companies.

31.2 The PPO works in England largely because it is a tax avoidance device for Claimant's: whereas the stream of income that a Claimant earns from their invested capital is subject to tax, a stream of payments paid by a tortfeasor is tax free, like any other payment of damages. Unfortunately, the money that the MDO or the insurer invests to earn that stream of income is taxed in their hands before the damages are paid. Thus, the tortfeasor ends up paying much of the tax that the recipient has avoided. It works in England for public sector payers only because the Treasury were persuaded to agree to it at the time of Lord Woolf's reforms to civil litigation in the mid-1990s when the figures were much smaller.

The net effect of this is that when a PPO is demanded in England from an MDO it has to be *"bought off"* and the demand is but a device to increase damages.

32 Where insurance companies pay PPOs what they do is to buy a matching annuity in the market place and since the life offices who pay annuities always act on the most conservative means available, they will in effect match the stream with index-linked gilts and at present the price will be a negative rate of interest, not far off the rate of -1.56% presently used by HM Treasury for calculating long-term provisions. Insofar as they are unconvinced by the evidence that inflation in Jersey will not coincide with that in England the rates may be even higher.

33 In the case of our hypothetical case in Table 2, a PPO would be valued by HM Treasury using the -1.56% Table. We do not have access to this, but using the -1.5% Table, the total multiplier increases to 74.7 years, and net present value of the case on Table 2 would be £34.6 million if it were costed at a flat rate. That is of course a figure that exists only on the Balance Sheet of HM Treasury, but on the assumption that no-one else can borrow money as cheaply as the government, one would expect a commercial insurer to have to pay more to acquire a matching index-linked annuity.

34 The PPO also works in England only because it is politically convenient as a means of postponing a current liability even if it costs more. This philosophy of fiscal management has been called into question in England as with, for example, the recent Budget announcement that there will be no more private finance initiative (PFI) schemes to finance new hospitals and schools. At the moment, the net cost of PPOs for which NHS Resolution has to make provision is increasing significantly every year, which is seen by our political masters as a preferable alternative to settling sector liabilities as and when they fall due. That is not the fiscal policy that is being followed on the States of Jersey where so far from having a national debt you actually have a positive fund.

35 The draft Law rejects the idea that Jersey should be assumed to have a different level of future inflation, but it does not deal with the mechanism by which the court can order that the sum shall be increased annually. In England we use one of a variety of specific indices which provide for index-linked inflation and we expect that is what is proposed. But the bureaucracy necessary to maintain this and to keep in touch with recipients so as to be aware when they die will be disproportionately expensive on a small scale.

36 Another novel feature of your proposed scheme is that it will permit Claimants to return to demand an upward revision of their award at any time. This strikes us as alarming,

bringing with it the prospect that that the paying party can never close the book or quantify their liability with any certainty. It would be much harder to sell as a liability in the life office market place in London[20]. Nor would we like to try to justify such an unquantifiable liability to the people in HM Treasury and the National Audit Office who approve the NHS accounts every year: it is a fundamental principle that we quantify every liability. One of the major objections raised on both sides to the original PPO was that it ended the parting of victim and tortfeasor on the day of judgment which had been an essential feature of the common law. This was only to the extent of having to make an annual payment, and so to keep to in touch to the extent necessary to make those payments and to be aware of the victim's death so that the stream could cease promptly. The proposal that the Claimant could come back to seek a revision whenever things went badly is a recipe for endless further litigation, an unquantifiable further liability and an escalating insurance bill. The care costs in one cerebral palsy case are often upwards of £250,000 per annum. There would of course be no practical provision for the paying party to return to court whenever it seemed that the needs had diminished, or the recipient seemed to be saving rather than spending. Like Dr Lim Poh Choo.

European Convention of Human Rights

37 The guideline on the draft Damages (Jersey) Law suggests at the top of page 12 of its supporting report that a human right to a fair determination of a claim would be infringed if the law was changed whilst the claim was in progress. If this were to suggest that any change in the law that reduced the value of an award once the claim had been made would infringe someone's legal rights, then we respectfully disagree. Taken literally that would suggest that any change in the law that reduced the level of damages by increasing the discount rate could not be applied to cases currently in progress. In fact, such changes regularly happen, just as the annual Budget varies the wealth of various claims that may be brought by individuals and are routinely accepted as part of the warp and weft of the law.

38 The reference in the footnote on that page to *Zielinski v. France (1999) 31 EHRR 19* was to the principle that the legislature should not interfere with the rights of the parties on a case-specific basis. What *Zielinski* prohibited was the interference by the

[20] We hasten to add we have done no market testing and speak here from first principles. In theory you can sell anything in the London market, but to find the price for such a novel and open-ended liability you would have to find someone who was prepared to think creatively and we could not do it on the basis of a couple of phone calls.

legislature to influence the judicial determination of an individual or group dispute. There the State had introduced a new law with five years retrospective effect that reduced the salaries of staff working for a health and social affairs department. Conflicting decisions were given by local Courts and rather than waiting for the Court of Appeal to deal with the matter the Government introduced an amendment to an Act disposing of the dispute. That is quite different from the situation which arises when the law of the land is changed in a fashion that may reduce compensation payable as a result of a tort to all claimants.

General Observations

39 The comment on page 4 of the supporting report to the draft legislation notes that working years can be predicted with reasonable accuracy in respect of lost earnings but that this is not the case for life expectancy or future care costs seems to over-simplify the situation in an era where people are routinely working beyond conventional retirement age and yet employment is less secure.

40 On page 5 of the supporting report, your officials refer to the cost of care as the head of loss that makes up the multiplicand. We observe that when determining the lump sum award, it is more than the 'cost of care' that determines the amount and it is only the future loss element of a lump sum that requires the discount rate and a multiplier/multiplicand approach. Those having never seen a Schedule of Loss for personal injury claims should be aware that the cost of care is often shifted to a PPO while the lump sum consists of past losses (which incur interest but no discount for obvious reasons), a figure for general damages mainly made up of a figure for 'pain, suffering and loss of amenity' (again incurring interest), and future damages which is where the discount rate is applied. In the list of heads of future loss you will often see claims for occupational therapy, physiotherapy, speech and language therapy, deputyship costs, educational psychology, orthopaedics assistive technology, wheelchairs, vehicles and invariably in cerebral palsy claims, a new house with adaptations to house the carers, all the equipment and the (always disputed) hydrotherapy pool.

Conclusion

41 In this paper we have only commented on the discount rate and its current aim to achieve 100% compensation which is the business of this committee. We think that Jersey needs to take effective measures to reassure the insurance market that the Channel Islands are a sensible place to do business, countering the impression given by *Helmot v Simon* and the publicised *Plaintiff 2* and *Plaintiff 3* cases litigated earlier this year. A 4.5% discount rate will be a sensible start, but effective law reform will need to go further. In England we recognised that matters were out of control when *Robshaw* was awarded £14.5 million in 2014: that is a sum that the MDOs simply cannot provide as indemnity for one doctor other than as a non-recurring catastrophe for which there may be reinsurance. There needs to be a broadly-based attack on the concept of the one-patient institution and a battery of measures such as those used in Australia. However, the present debate about the discount rate provides an occasion when you are forced to send a clear signal to the market and the medical profession that the Island of Jersey either is, or is not, prepared to do something effective to address an unsustainable situation.

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DRAFT DAMAGES (JERSEY) LAW 201-

COMMENTARY ON THE TERMS OF REFERENCE ON BEHALF OF THE JERSEY PRIMARY CARE BODY (JPCB)

9 November 2018

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1 What changes are being proposed to compensation payments in personal injury cases in Jersey?

You have the draft Act. In essence, this proposes:

1.1 That there should be a statutory personal injury discount rate (PIDR) of 0.5% to be applied in respect of periods of 20 years or less and a statutory PIDR of 1.8% to be applied where the period is greater than 20 years. There should also be an elaborate system whereby the rate can be changed but it is not permitted to fall below 0%.

1.2 There is to be an exemption to tax for income derived from sums awarded in respect of personal injury damages.

1.3 Claimants with Periodical Payment Orders ("PPOs") are to be allowed to return to court if their needs increase.

1.4 Provisions in relation to legal actions already commenced in respect of the European Convention of Human Rights Article 6 which we think are superfluous.

2 Why are the changes contained in the draft Damages Law necessary?

Please see our attached papers:

2.1 *'Commentary on the draft Law'* dated 8 November 2018

2.2 *'Executive Summary'* and *'Briefing paper on Professional Indemnity within the Channel Islands: A Crisis and a Window of Opportunity'* dated 28 February 2018

2.3 *'Unsustainable Insurance Premiums and an Unsustainable Healthcare System - the Impact of the Potential Personal Injury Award re: Plaintiffs 2 and 3'* July 2018

2.4 *'The Jersey Indemnity Crisis 2018, Second Note on the Cases of Plaintiffs 2 and 3 and a Possible Remedy'* July 2018

3 What problems (potential and actual) are there for doctors in obtaining medical indemnity insurance in Jersey (and Guernsey)?

The potential problems take four parts:

3.1 Doctors in Jersey are paying higher professional indemnity rates than their counterparts in the UK by virtue of the fact that they practise in Jersey. JPCB has spent the last two years negotiating with professional indemnifiers who cite the Guernsey case of *Simon v Helmot* [1] as a reason why doctors are required to pay more for their insurance.

3.2 The indemnifiers may withdraw altogether from the market, or sectors of it if Jersey is considered a high risk jurisdiction for clinical negligence claims. The MDU has for example withdrawn from providing cover for spinal surgery in England. We suspect that once the judgment and details of the current Plaintiff 2 and Plaintiff 3 case has been fully digested, your doctors will find it much harder to get indemnity. Certainly, once the obstetric cases that we understand exist and come to trial there will be a rapid reconsideration of positions. It may well be that this legislative process is being closely scrutinised, but we do not know.

3.3 The doctors will face a rapid increase in their indemnity subscriptions. That seems inescapable, but we are not privy to those discussions. We are aware of obstetricians who are paying £4,000 per baby that they deliver in London.

3.4 Doctors with a poor claims record will be driven out of practice. That is already happening, we know of one orthopaedic surgeon in the Channel Islands who has been lost as a result of this.

3.5 The MDOs may exercise their discretion in a fashion that leaves the doctor and a patient without support. We can say no more, but there is no doubt that the discretion is unfettered.

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[1] *Simon v Helmot [2012] UKPC5*

3a What is the wider context that any such problems are set against?

3.6 There is a widespread crisis in all common law jurisdictions concerning the level of personal injury damages. The only country which has faced up to it is Australia which reached a crisis in 2002. The UK would have reached a very similar crisis at about the same time or sooner, had it not been for the existence of a statutory clinical negligence scheme for NHS Trusts which is underwritten by the State and has been able to accumulate liabilities steadily ever since. These now total £77 billion according to HM Treasury, this increased by £12 billion last year alone.

3b What would be the impact on members of the public accessing healthcare in Jersey and Guernsey if concerns around doctors' indemnity insurance are not resolved?

3.7 Very simply, parts of the medical profession will be driven out of business and the rest will be significantly impacted by unsustainable insurance/indemnity. The cost of medical care will increase as remaining doctors practise defensive medicine. Doctors may refer more patients off island with associated costs. In time, the indemnity issue will impact on the recruitment of doctors to Jersey generally.

3.8 Doctors purchase indemnity either from the medical defence organisations or from commercial insurance companies. The first is subject to discretion, the doctor's only right is for their request considered by the MDO Board. However, it is our advice to members of the medical profession that it is much better because the commercial sort of indemnity offers illusory benefits. because it only covers claims made during the subsequent 12 months, whereas

3.8.1 claims can be made over 20 years after the event in relation to obstetric mismanagement, for example; and

3.8.2 the doctor has a duty of utmost good faith to notify their insurer of any circumstance that may give rise to a claim; and

3.8.3 the insurer has an unfettered right to increase the premium,

so the doctor can have no confidence that they will be able to afford the premium necessary to have insurance in place at the time when the claim is made. This ignores the problem of claims made after the doctor has retired,

which will only be covered if the doctor holds "*run-off cover"* to meet historic claims made after a period of indemnity.

3.9 The reality of the matter is that the level of claims in some areas of medicine are simply unaffordable by either system. This is most extreme in obstetrics. In England we are spending £2.6 billion per annum on the obstetric service through commissioners buying services from acute hospitals. Out of that £2.6 billion the service has to find £1.1 billion in respect of indemnity payments each year. However, that is only a part of the picture because of the amount of money that has to be earmarked by the Treasury in respect of claims incurred but not reported, claims made but unsettled and periodic payment orders agreed. Over the last 5 years the provision for obstetric damages in England has increased by more than £40 billion. That is a sum that is utterly beyond the resources of the medical profession and Medical Defence Organisations (MDOs) responsible for the liability. It has to be understood that insurance for expenditure that is predictable if unusual[2] is no more than a way of smoothing out expenditure over a period of years. An insurer is not a charity and this is a scale of liabilities that simply cannot be provided for by any mechanism that society is prepared to finance.

3.10 What tends to happen when the system is stretched unreasonably is not that the medical profession disappears completely. Rather those who are free to choose to go first will leave and you will end up with a residual workforce who are likely to be less mobile either because they are less attractive to other employers or more foolhardy. The knock-on consequences both financially in respect of claims and broader in attractiveness of the Island for mobile populations is obvious and ultimately devastating for the economy of a community that demands modern healthcare.

3c Will the draft Damages Law resolve the problems identified, either partly or fully?

3.11 No, for the reasons we have described in our paper of 8 November 2018.

3.12 In essence, the draft Law is an attempt to replicate the system which has been recognised to be unsustainable in England, even with the backing of HM Treasury which has accumulated liabilities of £77bn for hospital negligence

[2] The incidence of obstetric brain damage according to the RCOG's Each Baby Counts is about 1:1,000

claims alone. That would be a surprising choice for a community that prides itself on its prudence, and the lack of any sort of national debt.

3.13 However, you are proposing to introduce our system without the backing of anyone prepared to accumulate liabilities on that scale. That is not so much unwise as impractical.

3.14 An impractical system can continue only so long as no-one notices.

4 What impact will the draft Damages Law have on recipients of damages awards.

4.1 It is an inadequate attempt to reduce damages and if defendants prove insolvent, the recipients will get little or nothing.

5 What will be the impact of introducing a statutory discount rate for damages awards?

5.1 Any statutory rate is an attempt to control or deviate from the market price if money. It implicitly recognises that the state has to strike a compromise between the interests of claim ants and those of society. The impact depends on the level at which a statutory discount rate for damages is set.

5.2 If the States choose to continue to follow the advice of the actuaries to try to replicate 100% return, then you will be diverting a disproportionate set of resources to the victims of tort, and we have explained our prediction that this will be unsustainable by the medical profession (who currently indemnify claims in Jersey) in the foreseeable future.

5.3 If you do what we advise that you should do (a version of what has been happening in Australia for the last 15 years) you will be recognising that you have to find a sharply different compromise. In Australia, they have struck that balance variously by adopting a presumed discount rate of 5% in respect of some sums, and 6% in respect of others. From deference to tradition only, we do not advise you to go so far, and we advise that you should introduce a presumed discount rate of 4.5% which was the rate that applied in all English

claims between when these discount tables were first produced to the courts in the 1980s and 1998 when the House of Lords decided *Wells v Wells*.

5.4 However, we do not suggest that that will be a sufficient remedy for the problems revealed by the well publicised personal injury cases heard earlier this year where two claimants sought over £200 million. We have identified some measures being followed in Australia and we do have a number of other suggestions, but they are beyond the scope of the business of your committee. Fixing the discount rate is a necessary part of the solution, but it will not be enough on its own.

5a What rates have been set with regards to damages awards up until now?

5.5 The answer is that these have been limited only by human imagination. At present, we know that you have been urged under the common law in Jersey to use a rate of -2% or more and in some states in Australia, they are using a rate of 6%. Those are the two extremes of which we are aware that are presently under realistic debate.

5.6 However, in English common law up until 1998 we also used to use what was called the 'judicial discount'. In these cases, it has always been recognised that the risk of the Claimant dying early is roughly balanced by the risk of them living unexpectedly long; the risk of them needing to retire early is balanced by the chance that they will continue to work past retirement. However, the extent of these deviations is not so balanced because of the limits of human life-span. If you look at the 4.5% discount table, you will see that there is a far greater impact on the multiplier if the period is shortened than there is if it is extended. On the 4.5% table, the multiplier for 20 years is 13.3. If the period is shortened by 5 years to 15, it falls by 2.32 to 10.98. By contrast, if it is increased by 5 years, the multiplier only increases by 1.86. This is because the longer the period, the greater the contribution made by the work that the money has done whilst invested.

5.7 Accordingly, the courts used to reduce the multiplier by 1 or 2 in respect of longer periods to reflect the impact of uncertainty. That is why it was rare for the courts to adopt a multiplier of greater than 18 even when they had to provide

for a very long case. That was a matter of common law practice that was never embodied in statutory law.

6 What will be the impact of putting into statute the power of the court to make periodical payment orders for damages awards?

6.1 We think these will have minimal impact in medical cases at least in Jersey, for a number of reasons. First, because most of your claims are covered by the medical defence organisations who are unable to use PPOs. We have explained this at some length in our accompanying commentary on the proposal but suffice to say for your purposes that the MDOs will not be doing it and therefore they will not be applying to any medical cases.

6.2 Nor are they popular with insurers in practice, who have to pay over the odds to buy a matched index-linked annuity that will enable them to close the file. Further the novel proposal in the draft Law that Claimants should be able to return to court if their needs increase will in practice be quite enough to chase any insurer away.

6.3 PPOs are only suitable where the indemnifier is the state. They have proved popular in England with Claimants because they provide certainty and an exemption from taxation for their income. They have proved attractive to HM Treasury because of the primary concern to postpone any expenditure that is not bolted down. Since Jersey does not run a national debt and your levels of taxation have hitherto been low, there will be less attraction for both sides.

6.4 PPOs require a supporting bureaucracy which can calculate the annual inflation of the annuity in accordance with a relevant index, check the recipient is still alive and pay the money every year. Such a system may be considered disproportionately expensive given the very small number of potential recipients on the island.

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