Clinical Indemnity: Private Practice Under Threat

17 May 2024

The Medical & Dental Consultants Association (MDCA) commissioned Mazars to conduct research on the clinical indemnity environment in which its members operate and to advance proposals to address the issues they face. This report is a snapshot of that research.

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Executive Summary

Rising Indemnity Costs Threaten Private Practice:

The cost of medical indemnity cover for private consultants in Ireland is rising. The pace of this increase has accelerated in recent years, leading to indemnity costs now representing a large proportion of the cost of running a private practice. If the price of indemnity continues on this trajectory, it will jeopardise the viability of the entire private healthcare sector.

Consequences of a Decline in Private Sector Activity:

A significant number of private consultants are considering leaving the profession due to rising indemnity costs. Private practice represents a substantial element of the healthcare system. Given the level of care provided by private practitioners, a large exodus of these practitioners would have highly significant effects on the provision of healthcare in Ireland. The overall supply of healthcare services would see a substantial downward shift, further lengthening waiting lists and impacting patient care.

Actions Recommended:

There are several potential options to address the issue of clinical indemnity approaching unviable levels. Chief amongst these are:

1. Reduce the indemnity level threshold beyond which the State Claims Agency provides cover (‘reduce the caps’)

2. Implement (‘commence’) the Pre- Action Protocols already legislated in the Legal services Regulation Act 2015

3. Clarify the indemnity remit of the State Claims Agency versus the Medical Defence Organisations in the context of State-commissioned care of public/uninsured patients by private practitioners

4. Consider extending the remit of the Personal Injuries Resolution Board to medical negligence.

Background

Private Health Sector

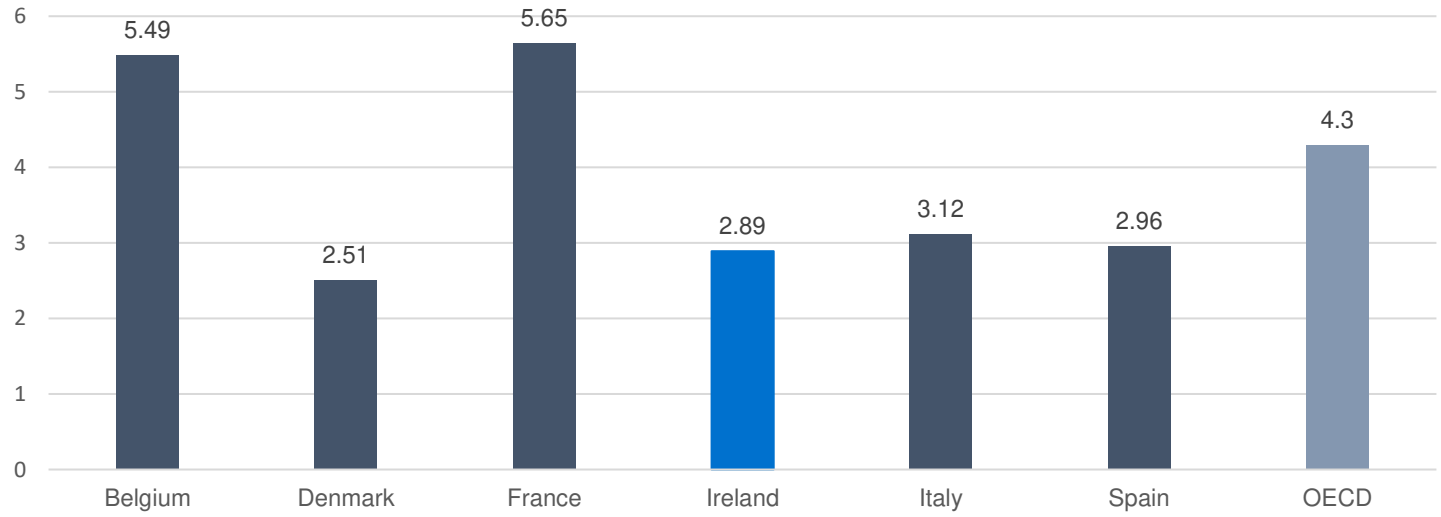
Ireland has a large private health sector – over 47 per cent of the population have private health insurance.[1] As of 2022, there were a total of 86 hospitals in Ireland, approximately three quarters of which were publicly administered, with the remainder being privately administered. Within the Health Service Executive (HSE), i.e. the public health service, there are approx. 4,152 HSE-funded approved consultant posts.[2]

Although there is limited data available on the proportion of private and public consultant doctors throughout the health service, the complexity of available consultancy contracts is itself an indication of how closely the public and private systems are intertwined.

There are contracts which permit public practice only, however, there are a range of contracts which allow doctors to undertake private work upon fulfilling the hours of public work contracted. These contracts allow consultants to treat private patients in public hospitals, and occasionally allow consultants to spend time in private facilities as well as public facilities.[2] This type of agreement is representative of the majority of consultants – in 2018, 83 per cent of medical consultants were employed on contracts that permitted them to engage in private practice.[3] Therefore, it is difficult to categorise these consultants as public or private since there is no record of the proportion of a consultant's work is public/private. These are referred to as dual practice consultants.

Despite this overlap between public and private healthcare, low levels of resources are emphasised in the OECD 'Health at a Glance' report in 2023, which identified Ireland as having one of the lowest inpatient bed per 1,000 inhabitants' rates among peer countries.[4] This is shown in Figure 1 below.

Figure 1: Hospital Beds per 1,000 Inhabitants



Source: OECD Health Statistics

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Background

Private Health Sector

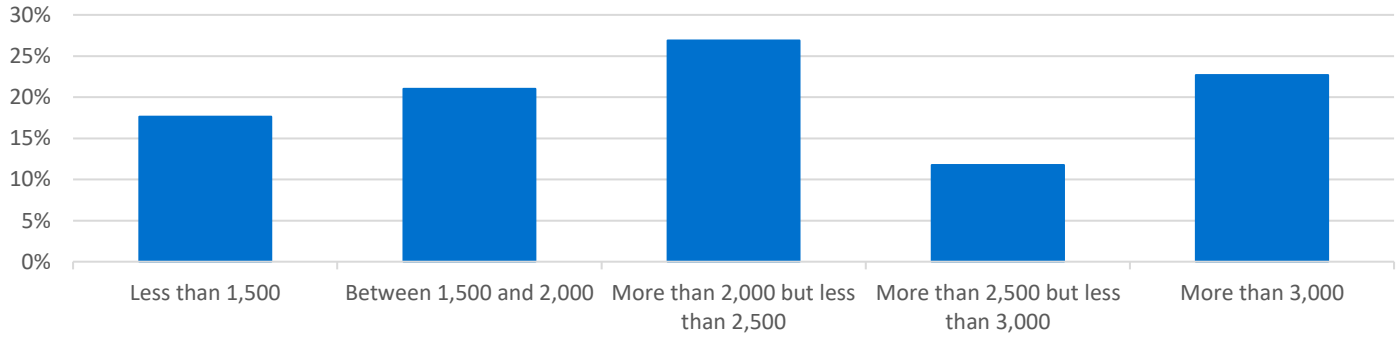
The Economic & Social Research Institute (ESRI) has also estimated a bed capacity deficit of 1,000 inpatient beds in public acute hospitals.[5] These shortfalls in the public system are contributing to long waiting times which have created a reliance on the private sector for care. There are now several arrangements between the State and the private sector, for example The National Treatment Purchase Fund (NTPF), the 'Safety Net Agreements' and local public/private hospital agreements, whereby the State commissions care for public/uninsured patients by private practitioners in private facilities. The NTPF, perhaps the best known of these, has seen its budget increase significantly in recent years, pointing to the reliance of the public system on private care.

The Private Hospitals Association (PHA) has also stated that they:[6]

- Provide 1 in every 6 hospital beds in the country
- Care for around 400,000 patients every year
- Carry out over 250,000 surgical procedures per annum
- Undertake ~50% of all heart surgeries and ~65% of all spinal surgeries conducted each year
- Complete around 3,000,000 diagnostic tests per annum

Additionally, a survey conducted by Mazars of the membership of the Medical and Dental Consultants Association (MDCA) shows that 80 per cent of the MDCA membership individually care for over 1,500 patients per year. If the proportions caring for the given number of patients are taken from Figure 2, it is estimated that over 250,000 patients are cared for by MDCA members per year. This estimate illustrates activity from MDCA members only, whereas the above PHA estimates include work done by all private consultants. The data on number of patients cared for by MDCA members is illustrated in below.

Figure 2: Number of Patients Cared for by MDCA Members Annually*



Source: Mazars/MDCA Survey 2024 * *n*=119

The data from both the Mazars/MDCA survey and the PHA refer to private-only practice, i.e., they do not include the onsite private activity of dual practice consultants, who, as mentioned, represent the majority of practicing consultants. Hence, these figures are likely underestimates of the overall private sector's role in the Irish healthcare system

Background

Clinical Indemnity

Context

This complex overlap of public and private healthcare has caused complications to arise when it comes to clinical indemnity. Clinical indemnity refers to an insurance plan to financially safeguard medical practitioners against legal costs and claims for compensation by patients in the event of a legal case.

The Clinical Indemnity Scheme (CIS) is a government scheme which sees the assumption of responsibility by the State for the indemnification and management of clinical negligence claims arising from the diagnosis, treatment and care of patients. This scheme is managed by the State Claims Agency (SCA) on behalf of the State. It was introduced in the early 2000s as a result of both withdrawal of commercial insurers offering coverage to obstetricians/gynaecologists and the inability for many to provide cover at affordable rates. This was largely due to increased court awards and costs at the time.[7]

Coverage

The Clinical Indemnity Scheme (CIS) covers claims against the HSE and voluntary/State authorities, including claims against a range of categories of staff. Regarding consultants, cover is provided in respect of their public practice, as well as their private practice in a public hospital. The scheme does not apply to private work carried out by consultants in private hospitals/enterprises. However, there are individual indemnity thresholds beyond which the State provides cover. This measure was introduced in 2004 to avoid increases in indemnity cover for private consultants that would have rendered private practice unviable, establishing the principle of the State supporting private care as a component of the overall healthcare system. These caps are linked to the Consumer Price Index (CPI) hence they increase with inflation. Currently the limits are as follows:

- For Consultant obstetricians, neurosurgeons, and orthopaedic surgeons undertaking spinal surgery the limit is €664,141.44 per claim, with an annual aggregate limit of €1,992,424.36 per consultant.
- For all other specialties the limit is €1,328,282.92 per claim with no aggregate limit.

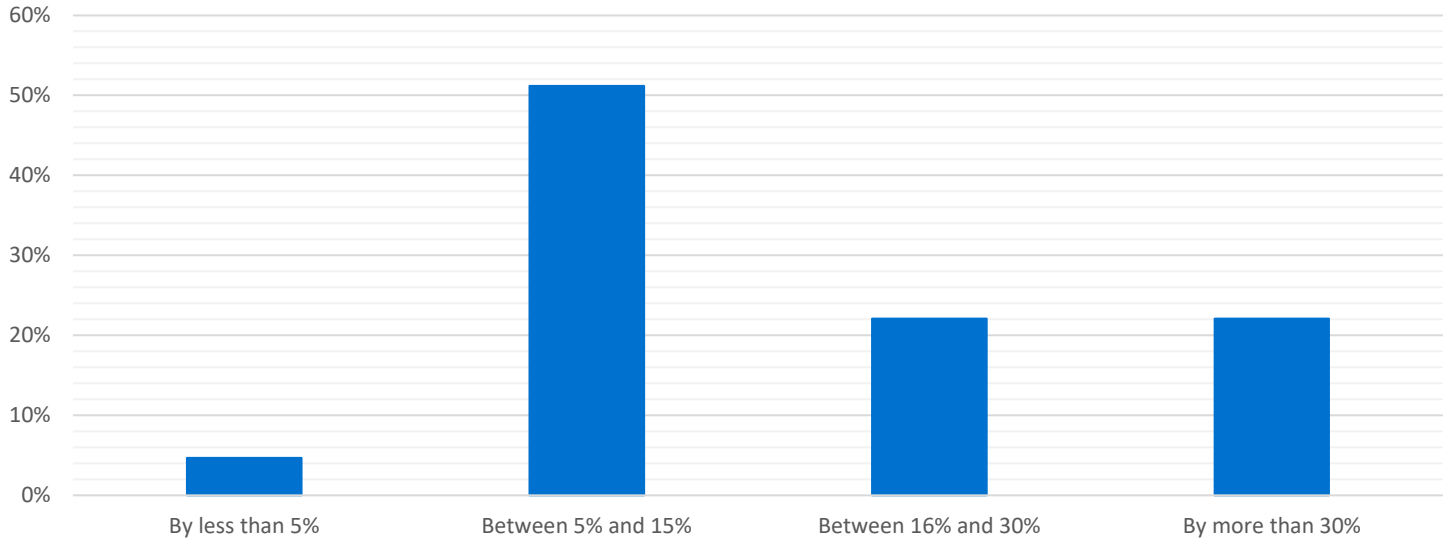
Below these caps, private consultants must obtain private indemnity cover, as required by law under the Medical Practitioner's (Amendment) Act 2017. This market is facing significant issues – see below.

Indemnity Market Problems

Indemnity Price Increases

The cost of clinical indemnity for private practitioners has become a major issue in recent years. For example, in 2018, the Irish Hospital Consultants Association (IHCA) indicated that the average cost increases in 2016/17 and 2017/18 were in the order of 4.5 per cent per year with increases of up to 10 per cent impacting some consultants and specialities in private practice.[8] More recently, in the Mazars/MDCA survey conducted in 2024, over 80 per cent of members reported increases in their clinical indemnity premiums. A fifth of members reported increases of 16-30 per cent over the past three years, and another fifth of members saw increases more than 30 per cent over the same period The proportions of members experiencing different levels of increases is shown in Figure 3.

Figure 3: Percentage Increase in the Price of Clinical Indemnity*



Source: Mazars/MDCA Survey 2024 * *n*=86

This survey data, when compared to the IHCA data from 2018, indicates that the increases in indemnity premia have been more severe in recent years. These increases have seen indemnity costs become a substantial share of the overall cost of practice. Over a fifth of MDCA members reported that clinical indemnity represents over 30 per cent of their overall costs.

The cost of clinical indemnity is largely driven by the estimated financial risk involved in a consultant's practice, but other factors are also considered, such as the type of cover, number of customers, level of legal fees and awards, and the type of consultancy practice. The type of practice has a large bearing as it is an indicator of risk. Hence the cost of indemnity can differ significantly between practices considered low risk, such as dermatology, and those considered high risk, such as spinal surgeries.[9]

Indemnity Market Problems

Indemnity Cost Increases

There are two main reasons put forward to explain the recent increases in the cost of medical indemnity. The first is that the introduction of the CIS saw a large reduction in those seeking private indemnity cover given that the State began providing cover for public practices, i.e. the demand for private indemnity cover decreased substantially. It is likely that this would motivate private insurers to increase premia to recover (some of) the loss of revenue from the decrease in clients.

The second factor often cited is the increased level of legal fees and length of time of legal proceedings, as well the escalating value of awards/settlements in cases of medical negligence. This can present a large cost to the State and private practitioners. This is discussed in more detail below, however, in summary, it is clear that higher legal fees and awards increase the cost of claims and hence, increase the level of premia for indemnity.

These factors were the main reasons provided by insurers to respondents in the Mazars/MDCA survey, with cost of claims, increases in awards/damages, and legal costs being cited by the majority.

New Sláintecare Contract

The recently launched Sláintecare consultant contract aims to incentivise consultants to dedicate more time to the public health service through guaranteed minimum public service hours, activity-based pay structures, and potential limitations on private practice.

If uptake of the Sláintecare contract is high, the proportion of private care within the overall health system will likely reduce to some extent as consultants would likely provide a larger share of care within the public system. This could lead to higher indemnity costs as the pool of those seeking private indemnity shrinks further. However, if uptake is low, or if the new contract terms are not sufficiently attractive to many consultants, they may leave the public sector. This would likely see indemnity costs stabilise or decrease due to a larger pool of consultants seeking private indemnity. At present therefore, the long-term impact of the new Sláintecare contract remains unclear.

Whatever the outcome, some stakeholders consulted as part of the research underpinning this report were of the view that there will always be a need for some level of private care supported by sustainable indemnity cover, as evidenced by the activity of the NTPF and the ‘safety net agreements’ operationalised during the pandemic.

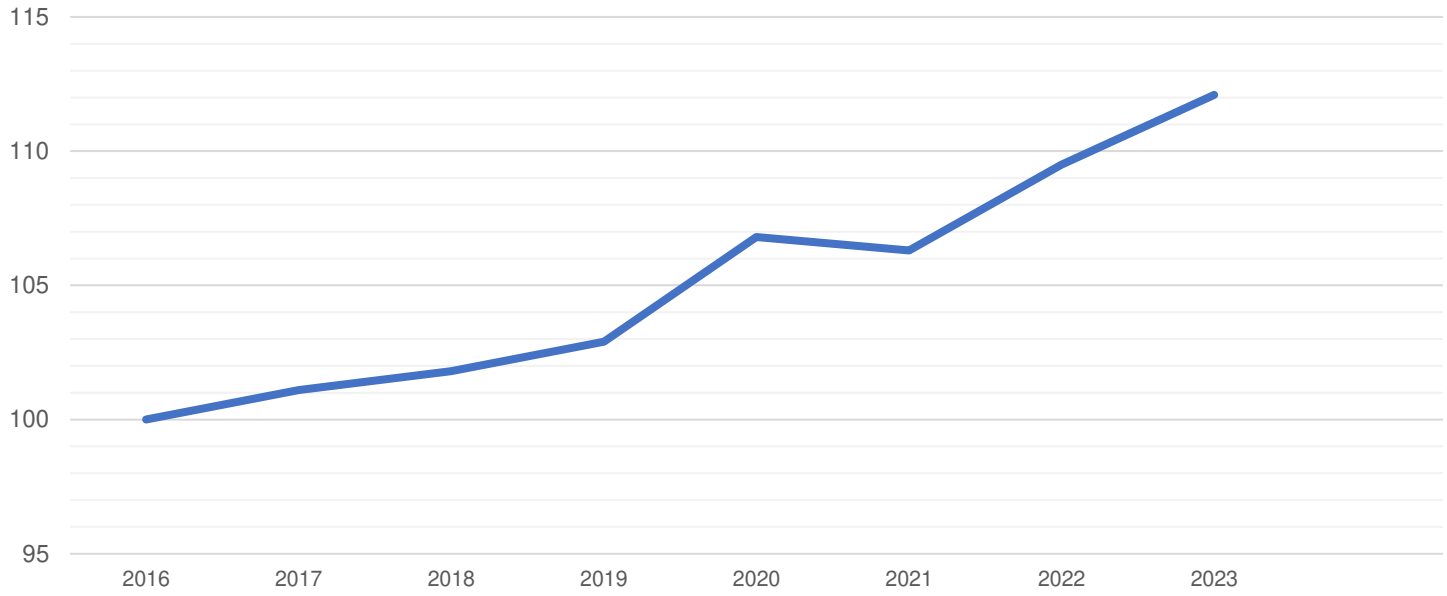
Indemnity Market Problems

Legal Costs

High legal costs have been flagged as an issue in Ireland for many years. Given that medical negligence cases are often complex and long, legal costs are a substantial factor regarding clinical indemnity cover and indeed are a key factor in the increasing cost of clinical indemnity.

In a report produced by the Review of the Administration of Civil Justice in 2020, it was concluded that Ireland ranks amongst the highest-cost jurisdictions internationally for civil litigation. It placed Ireland as one of three Western European jurisdictions with particularly high litigation costs in relation to the value of the case and the fourth highest cost in Europe/US/Canada/Japan for resolving claims (as a percentage of GDP).[10] Although there is little or no data on legal costs in Ireland, below is the trend in professional services (specifically legal, accounting, public relations and business management consultancy) in recent years.

Figure 4: Service Producer Price Index (SPPI) (Base 2016 Q1 = 100) – Legal, Accounting, Public Relations, and Business Management Consultancy



Source: Central Statistics Office (CSO)

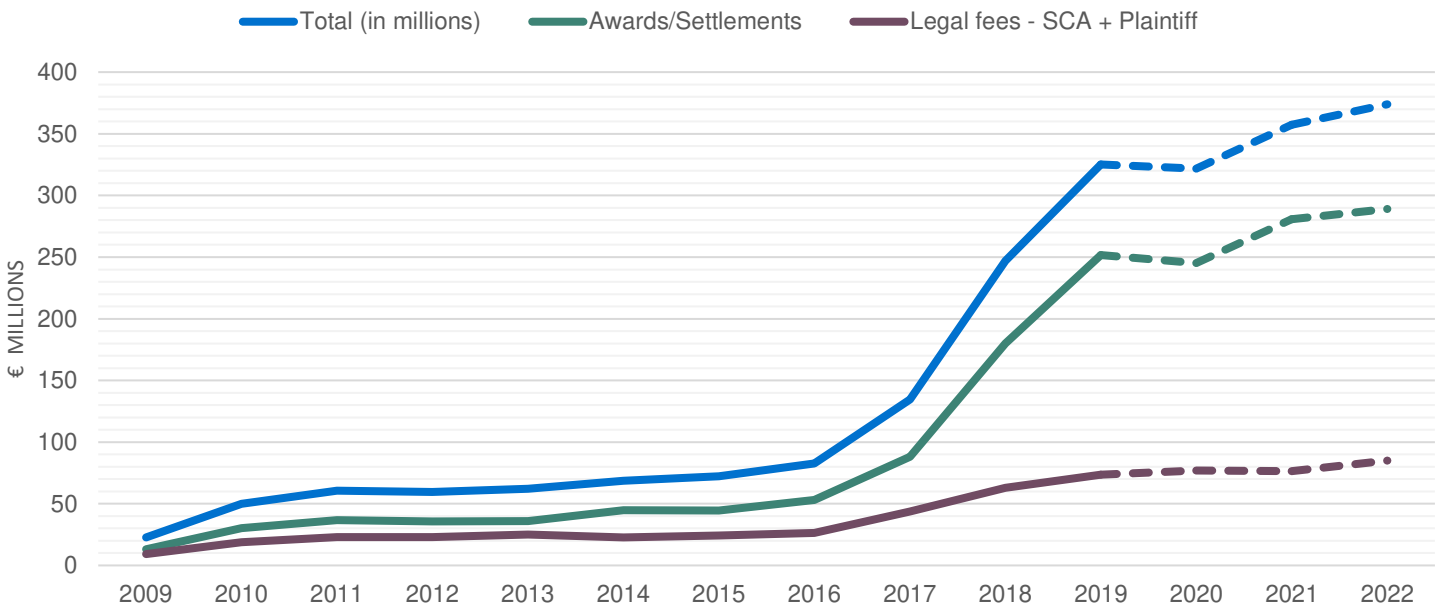
While the degree to which legal fees alone are contributing to this trend is not specified in the data, it is clear that the price of these professional services has increased since 2015.

Indemnity Market Problems

Legal Costs

The SCA also provides data on the cost of its clinical negligence cases, which is a strong indicator of costs for legal services also. Figure 5 shows a significant increase in the level of clinical negligence claims, with the total cost rising from €13.15 million in 2009 to €374 million in 2022. Clearly, this is a sizeable increase in 13 years. As shown in Figure 5, awards and settlements account for a large proportion of the cost of clinical claims, however, legal fees for clinical claims increased by €8.4 million from 2021 to 2022, according to the SCA data.

Figure 5: SCA Cost of Resolving/Managing Clinical Claims (€ million) (Claims Ongoing 2019-2022 - - -)



Source: State Claims Agency (SCA)

The duration of cases has also increased significantly. This partly explains the rising legal costs. According to the Office of the Comptroller & Auditor General, the average time needed to finalise a clinical negligence claim rose from 4.26 years to 4.97 years between 2012 and 2021. This represents a 17 per cent increase. It was also acknowledged that surgery-related claims took, on average, 5.25 years to process, which is an increase of 59 per cent since 2012.[11]

Notwithstanding the above, it remains difficult to distinguish the main driver of the increase in legal costs, be it the increase of the average damages awarded, a higher level of professional fees, the duration of cases, or other factors. It is not unreasonable, however, to conclude that it is a combination of these issues.

Indemnity Market Problems

Possible Impact Market Problems

Given that the increases in the costs of clinical indemnity have intensified in recent years, as well the substantial proportion of total practice costs that these indemnity costs now represent, it is important to consider the impact these issues may have if they continue unaddressed.

When asked about the rising costs of clinical indemnity in the Mazars/MDCA survey, 39 per cent of respondents said they would consider stopping their activity as a private consultant. Of those that said they would consider ceasing practice, 48 per cent said they would consider retiring and 33 per cent said they would consider moving to another country to practice. It seems a matter of some concern that an important component of overall healthcare capability, as already described, is considering exiting the system due to indemnity costs.

Another area many respondents alluded to was the issue of fairness and competitiveness in the healthcare market, with an equitable insurance/indemnity agreement and enforcement of contract provisions throughout the healthcare sector key elements of this. These areas are not covered by this report but may merit further work in the future.

Proposed Reforms

Adjustment of State Caps on Clinical Indemnity

Given the continually escalating prices of indemnity for private practitioners, it is proposed that the medical indemnity caps provided by the State be reduced to put downward pressure on the price of private indemnity cover. The reduced caps would see less risk be placed on private practitioners, which will then lead to lower indemnity prices.

This was proposed in 2015 in a report published by the Joint Committee on Health and Children. The report recommended that the Department of Health consider reducing the medical indemnity lower cap to €250,000 and the higher cap to €500,000.[12] It also recommended an investigation into the possibility of the SCA providing indemnity on a commercial basis.

Similar recommendations were made by the Irish Hospital Consultants Association (IHCA) and Private Hospital Association (PHA) in 2018 in a submission to a review of the management of clinical negligence claims. They also recommended that the indemnity caps be lowered and the possible provision of indemnity by the SCA on a commercial basis,[13] or in the case of the PHA, an extension of the CIS to private practitioners.[14] As of yet, these recommendations have not been implemented.

Tort Reform

Given the importance of rising legal costs and settlements/awards in the pricing of clinical indemnity, it is clear from the evidence examined in this paper (and elsewhere) that tort reform is required. There have been some reforms in the past such as the introduction of a mediation process. This is a process in which an independent and neutral mediator assists the disputing parties in resolving the dispute in a collaborative and consensual manner. This was introduced in 2004 and expanded in the Mediation Act (2017) with the intention of supporting faster resolution of disputes. Another reform that has been legislated for but is yet to be implemented is the creation of Open Disclosure. This was passed as part of the Patient Safety (Notable Incidents and Open Disclosure) Act (2023) and it mandates the disclosure of a range of incidents resulting in death. It is anticipated that this will reduce the number of medical negligence cases brought before the courts.

While these developments mark progress when it comes to tort reform, there are other recommendations which have not been implemented to date but would seem to provide 'low hanging fruit' in terms of reducing medical negligence claims and thus indemnity costs.

One such recommendation is the introduction of Pre-Action Protocols. This refers to a series of steps to be taken before a claim can be litigated. This was legislated for in the Legal Services Regulation Act (2015) but has not since been commenced. Experience from other jurisdictions suggests that Pre-Action Protocols would reduce the length of cases, and thus reduce legal costs, as it promotes early exchange of information and viewpoints before a legal claim is made. It has been noted that Pre-Action Protocols would likely trigger mediation also, the benefits of which are well documented, having particular regard to reducing costs and delays associated with the resolution of disputes.[13]

Ambiguity of Cover for State-commissioned Care of Public Patients by Private Consultants in Private Facilities

There are an increasing number of arrangements whereby the State commissions (or previously commissioned) care for public/uninsured patients from private hospitals/private practitioners. These include, inter alia:

- The National Treatment Purchase Fund (NTPF)
- The Safety Net Agreements
- Special/local agreements between public and private hospitals across the country
- The National Framework Arrangement

Information from MDCA members, the Private Hospitals Association, the State Claims Agency and Medical Defence Organisations such as the Medical Protection Society suggests that there is substantial ambiguity regarding cover (SCA v MDOs) in some , if not all, of the above scenarios. Anecdotal evidence indicates in at least some of these scenarios there is substantial back and forth between the SCA and MDOs to establish who is responsible for indemnity. This likely adds to the time and effort required to resolve claims and, therefore, potentially feeds into premia increases. There is also a potential additional issue whereby responsibility is incorrectly attributed to an MDO instead of the SCA, thereby likely contributing to increased costs and premia. It seems reasonable to conclude that establishing absolute clarity up front regarding responsibility for indemnity (SCA or MDO) in these situations would reduce unnecessary red tape and exert downward pressure on MDO indemnity premia.

Extension of Remit for the Personal Injuries Resolution Board

Much of the Government's action plan on insurance reform has been based on increasing the role of the Personal Injuries Resolution Board (PIRB) in settling claims without recourse to court action. Since its inception, medical negligence has been excluded from the Board's terms of reference. Given the evidence presented in this paper, now would be a good time for the Government to review that exclusion and consider directing injury claims arising from medical incidents through the PIRB. The potential for associated reductions in clinical indemnity premia appear worthy of such consideration.

Conclusion

Actions to Address the Challenges of Indemnity Cover

Due to the many constraints in the public healthcare system in Ireland, there is a reliance on private healthcare to fill the gaps that the public system cannot fill. However, private practitioners are currently facing significant pressure from the rising cost of clinical indemnity. This could see the size of the private healthcare sector decline if these costs were to make private practice unviable. Without a substantial increase in the capacity of the public sector, this would have damaging effects on the health and treatment of the Irish population.

There are several potential options to address the issue of clinical indemnity approaching unviable levels. Chief amongst these are:

1. Reduce the indemnity level threshold beyond which the State Claims Agency provides cover ('reduce the caps')

2. Implement ('commence') the Pre- Action Protocols already legislated in the Legal services Regulation Act 2015

3. Clarify the indemnity remit of the State Claims Agency versus the Medical Defence Organisations in the context of State-commissioned care of public/uninsured patients by private practitioners

4. Consider extending the remit of the Personal Injuries Resolution Board to medical negligence.

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Mazars

Consulting

Block 3 Harcourt Centre,

Harcourt Road,

Dublin 2,

D02 A339

Ireland

www.mazars.ie