



## **Recovery of NHS Treatment Costs**

### **Introduction**

At the end of January, the latest requirement upon Compensators to pay for a benefit traditionally borne by National Insurance funding took effect. It is now necessary for a Compensator facing a claim under Public or Employers' Liability covers (and direct funding of the risks, where such may arise) to meet the cost of NHS treatment - up to a specified limit – that is given to an individual who later pursues a compensation claim for the injury.

The change is one which had been mooted for several years. It was first raised within the Health & Social Care (Community Health and Standards) Act 2003, at which point it was expected to be introduced from 1<sup>st</sup> April 2005. In practice, the effective date was the 29<sup>th</sup> of January 2007. Disease claims are, thankfully, exempted. Although not a retrospective requirement, it does mean that for accidents happening on or after this date the Compensator faces an additional financial liability. It becomes incumbent upon the Compensator to seek a Certificate of NHS Charges, which is valid at the point of settlement and to pay over the amount shown when damages are provided to the claimant. The level of charges are intended to reflect 'average' treatment costs; so on occasions the figure levied for simple treatment will offset the charge for complex intensive care, the true cost of which exceed the average.

### **History of repayment**

#### **Motor accident treatment costs**

There has been a long history of Insurers being responsible to repay certain treatment costs in the Motor Insurance sector. From 1934 (as required by provisions enacted within the original Road Traffic Act of 1930), and before the establishment of the National Health Service; doctors or hospitals providing emergency treatment were able to recover the cost from motorists and/or their Insurers. The charge for emergency treatment was levied upon the user of the vehicle, irrespective of blame. The hospital treatment charge used the proviso of a payment (even without admission of liability) to the injured party by the Insurer. Whilst the requirement was to repay the hospital directly, it would only apply to known treatment; thus it became incumbent upon the hospital to register their interest in the claim with a motorist's Insurer and to take steps to monitor progress of the claim toward conclusion to receive their payment.



In this field, it had been identified that the effectiveness and indeed efficiency of the process was sporadic. It was suggested that some hospitals had a shambolic system of recovery where the sums recouped fell short of the costs, and the expense of administering the process then eroded the amounts that were repaid. In effect, there was a haemorrhage of money from the NHS system, which was, ostensibly, benefiting the Motor Insurance industry. The response of the then Government was to instruct an investigation by the Law Commission, which resulted in the publication of Consultation Paper No 144, *Medical, Nursing and Other Expenses (1996)*. The findings concluded that a more effective, centralized, system was needed. However, for the first time, the suggestion of recovery of such costs from all tortfeasors was also mooted. In 1997, the new government's first Budget announced their intention to recover the costs of treatment centrally, even before the Law Commission had made its findings known. However this was only for situations where an existing right of recovery was present, in effect for Motor Insurance. The provision was enacted the Road Traffic Act (NHS Charges) 1999; and in force for payments made from April that year.

The change in the law resulted in a centralized recovery process, administered by the Compensation Recovery Unit (CRU) of the Department of Social Security (now known as the Department for Work and Pensions). It was already the responsibility of a Compensator to register a claim with the CRU for the purposes of benefits recovery (which will be discussed further below), so the documentation used was amended to include a request for a certificate of treatment costs. The amount of treatment costs to be discharged was due from a Compensator within 14 days.

An interesting anomaly is that the provision to recovery the monies is achieved through the 'vehicle' of the Road Traffic Act, so those vehicle not requiring compulsory cover under the Road Traffic Act 1988 such as Crown vehicles are not required to pay. Conversely it was expected that the Motor Insurers' Bureau (MIB), a compensatory fund for uninsured and untraced motorists financed by all insurers transacting Motor business in the UK, and previously exempt from reimbursement to hospitals, were categorized as making 'payments' of a type captured by the new Act. On a more generous note, the MIB were not subject to the retrospective provision on existing claims. However as they were historically exempt, I suspect it was of little comfort.

### **Social Security Benefits**

The principle of recovery of centrally funded entitlements was also raised by the introduction of the benefit 'clawback' procedures in 1989 by Section 22 of the Social Security Act. In basic terms, it became a requirement of a Compensator to notify any accident, injury or disease claims, which they were handling to the newly established



CRU. In the event that a payment was to be made, then the Compensator was accountable for benefits advanced to the claimant; generally by offsetting the amount advanced against a claim for loss of earnings and paying such an amount separately to the Department of Social Security (DSS) via the CRU.

Prior to this, the law on the area dated back to 1948 and Section 2(1) of the Law Reform (Personal Injuries) Act. The position was a curious one for Insurers, in that some benefits like Statutory Sick Pay (SSP) could not be taken into account, whereas such as Sickness Benefit was partly deductible. The result was that claimants would generally achieve a gain from an earnings loss claim, although SSP was paid for a limited period, and the 50% deduction for other benefits applied for only 5 years from the date of accident. (The same five-year period was to be adopted for the cut-off date for repayment under the 1989 Act.). The logic offered for this unusual scenario was that the benefit payment was funded by National Insurance contributions made partly by the claimant, who should obtain any surplus in consideration of their earlier payment. I consider that this is analogous to the effecting of a private Insurance scheme, where the Courts have declined to take any Policy proceeds into account when quantifying a wage loss.

From 1<sup>st</sup> January 1990, the newly termed ‘Compensator’ was obliged to pay back benefits advanced. There was an exemption for ‘small payments’; up to £2,500, net of costs. There were teething problems; for instance the Act did not define whether the small payment threshold was solely for the injury element of the claim, although it was clearly its intention to be so. There was also something of a loophole where contentious cases (featuring issues on liability or perhaps medical causation) with substantial benefit payments, in excess of £40,000 on occasions, could be disposed of by a payment below the small claims threshold avoiding costly litigation; but at the same time not triggering the recoupment provisions. As a result of practical experience the CRU’s suspicion was that underreporting of claims, where a Compensator took the view that such were of minimal value and therefore did not merit notification, was prevalent. Obviously this was not what the scheme was intended to allow and further changes were necessary.

The change came in 1997 with the Social Security (Recovery of Benefits) Act 1997, which removed the small claims provision, thereby making all claims reportable to the CRU. Therefore, it was necessary to seek a certificate of benefits, even when the chances of any actual benefit payment to the claimant were remote. Another influence on the scheme was the manner in which SSP was funded. This moved from full payment by the DSS, to payment in conjunction with the employer and finally full employer funding. Most injury claims will not involve benefits advanced by the DSS/DWP and an employer cannot reclaim the SSP. Often there is no repayment due, but as the Compensator is accountable to repay any relevant benefit it is essential to check as a claimant is unlikely to refund any over payment. This imposed a heavier burden in terms of the administration cost of claims.



Although something of an aside, experienced claims handlers will have encountered the practical problem of having to discharge a benefit certificate where it is obvious that the sums advanced have no connection to the incident claimed for. Naturally, a shrewd claimant will seek the maximum amount of benefit available to them at any time so payment long after they have recovered from the known affects can arise. Often attempts to have a benefit payment reviewed are not successful, so a Compensator has to pay the full amount to be entitled to register an appeal and are not able to recover the costs of the procedure, nor any interest on any eventual recovery even when then are fully vindicated in their challenge.

### **Subrogation**

Where an individual has taken out their own medical insurance that covers them for the costs of treatment for accidental injury, then a compensator will face a claim through the legal personality of the injured party to recover their outlay. This is the right of subrogation under the Policy being exercised and is distinct from the process of centrally funded treatment; benefits or service costs being recouped.

### **The Money Side**

The DWP website ([www.dwp.gov.uk](http://www.dwp.gov.uk)) is perhaps the simplest route to determine what the financial liability to pay for NHS Treatment. The CRU have been involved in the recovery of charges since 1999, although that has been solely on motor claims and perhaps unlikely to be encountered by the CILA membership too often. The changes from 29<sup>th</sup> January extend the recovery process for accident/injury claims; there are a few exceptions but not of great relevance to this article.

There are three categories of charging:

1. Ambulance use - a standard charge of £159 per person, per journey. Multiple journeys or multiple casualties will see a commensurate charge. Additional transfer between hospitals after initial admission will incur a further charge. Charges from ambulance use are subject to the overall capped amount.
2. Outpatient treatment - £505 per person. So a short visit to an Accident & Emergency Department will incur this charge. Similarly subsequent visits for such as Fracture Clinic review will be captured in this category.
3. In-patient treatment - £620 per day or part day.



The current ceiling is £37,100 for all charges, but these figures will be subject to annual review.

Objectively, an accident resulting in injury will involve a visit to hospital. Perhaps for some claimants it is seen as a means of validating their later claim, in the same way as reporting a theft of property to the Police. We can therefore expect that the new procedures will add £505 or more to each injury claim where the recovery entitlement has been provided. This additional cost is one to be borne by a compensator, so must be provided for in the reserve allocated to future claims and therefore will increase the cost of Employers' and Public liability claims. Logically, this will impact on the level of premium charged by Insurers; and inevitably passed to the Policyholder by way of higher costs to them. Perhaps the current 'soft' market will absorb the increase in the short-term.

From the government's standpoint, the recovery of NHS charges represents a revenue stream to the Trusts, although the more cynical may suggest that it offers a means by which the amount borne by the state will be reduced as the Trusts will likely receive the same aggregate amount. How much will be recouped can only be forecast, and with uncertain accuracy. Using the limited statistics available, such a registration of claims to the CRU it seems that the bulk of claims intimated are in the motor sector. In 2004/5 these accounted for 53% of the total, but this proportion increased to 68% on 2005/6 when the overall number of claims intimated (or at least registered) fell by 80,000 from the previous year. So, the numerical majority of claims are already being catered for in the existing recovery process. Although somewhat subjectively, I consider it is also likely that the chances of serious injury are greater in a motor accident than in industry; therefore there may be a higher cost of treatment per event from motor accidents. In 1998, the Regulatory Appraisal of Road Traffic (NHS Charges) Bill indicated that the full cost of treatment from road accidents was of the order of £145 million. This would translate to £184 million at current values. Applying the earlier percentages (from the 2005/6 year) to this figure, then we arrive at an additional £92 million revenue to the Trusts providing treatment in Employers' and Public Liability cases.

The adage about proving anything one wishes with statistics may well hold good for this exercise; but it does appear that the financial limits now prevailing will generate considerably more than a simple extrapolation of the 1998 figures and provide a further example of disproportionate 'claims inflation'. If we take £184 million as notionally representing the cost of annual motor accident related treatment, and apply the latest available claimant numbers from the CRU records, then a sum in the region of £400 per claim would be expected. Instead, as indicated above; a more likely cost per capita would be £664 (ambulance, plus A & E outpatient charges) which is 66% higher. Adopting such a hypothesis to the EL/PL figure, the revenue could prove closer to £153 million.



My research for this article has revealed some interesting illustrations of the way in which the amount levied upon motorists for recovery treatment charges under the original Road Traffic Act has escalated; and the extent to which increases have accelerated in recent years is clearly evident. Whilst recognising that the information is sourced from the motor field, I consider it is of value; as clearly the type of insurance that is actually funding the repayment of treatment has become academic in light of the recent changes.

Set out below is a table illustrating some selected historical figures. What is surprising is the negative variance between the 2003 limits and those currently used; the logical conclusion would be that the increases have not kept up with the Retail Price index, but objectively such may be an inappropriate basis to utilise for the inflationary trends in the health sector. On the other hand, we can expect a revision of the charges at an early opportunity and one that seeks to reconcile the negative variance demonstrated. As the Regulations provide for review of the charges, the mechanism by which such can be implemented already exists and the possibility of small incremental increases may escape the attentions of the insurance lobby until it is too late.

SELECTED DATES FOR RTA TREATMENT COSTS LIMITS

DATE	RPI	OUT	CDV	VARIANCE	IN	CDV	VARIANCE
Apr-80	66.11	£125.00	£386.48	£118.52	£1,250	£3,864.80	£33,235.20
Apr-97	156.3	£295	£385.78	£119.22	£3,000	£3,923.22	£33,176.78
Jul-97	157.5	£354	£459.41	£45.59	£10,000	£12,999.16	£24,100.84
Apr-03	181.2	£452	£509.87	-£4.87	£33,000	£37,225.17	-£125.17
Apr-07	204.4	£505	£505		£37,100	£37,100	

**KEY**

- RPI - RETAIL PRICE INDEX
- OUT - LIMIT OF OUTPATIENT TREATMENT COSTS REPAYABLE
- IN - LIMIT OF INPATIENT TREATMENT COSTS REPAYABLE
- CDV - CURRENT DAY VALUE



## **Practical Problems**

It will be a requirement upon the Compensator to obtain a certificate of NHS charges valid at the point of payment. It remains to be seen how efficient the flow of information through the CRU will be, but as they are already equipped to deal with providing such information on motor claims, only the volume will have changed.

There may be ongoing treatment, weeks or even months after the event where the level of charges will increase and updated certificates may incorporate unexpected, deferred charges.

The application of the principle of contributory negligence will cause some difficulty. The Road Traffic Act had stipulated that the criteria which triggered liability to pay back the cost of treatment was any form of compensatory payment made by an Insurer; so even where there was a substantial reduction for contributory negligence the charges were repaid in full. It seems like a similar practical outcome will arise where EL/PL payments are concerned, as the Act expects there to have been a judgement by a Court upon liability or a formal agreement reached between the parties as to the apportionment.

Although the vast majority of claims are concluded without any Court hearings, extra-judicial negotiations may be prolonged or frustrated by disputes over apportionment of liability. Longer negotiations increase fees and could jeopardise the Pre Action Protocol periods on occasions.

In instances where the level of settlement impacts on the entitlement to be paid costs or the level of costs, the extra amount of treatment charges introduced by the changes will distort the 'gross' value of the case and lead to higher legal charges for dealing with exactly the same scenario.

## **Future Developments**

There remain areas where the potential to recover costs incurred by a public body in fulfilling its legal obligation have not been formalised. Such is not restricted to providing treatment or paying benefit; take the scenario of rescue costs to a climber who has chosen to scale a dangerous mountain in atrocious weather conditions, should they not run the financial risk of the expenditure of rescue? The Courts seem willing to extend the duty of care owed towards individual rescuers, so would the cost borne by an organisation such as a Mountain Rescue Team or the RAF who supplied a helicopter still be categorised as an economic loss?



Move on to the example of a self-inflicted injury; should a mentally ill person bear the financial cost of treating themselves after self-harm? Any liability cover they hold would not help as they are party to the contract and breach no duty of care for failure to protect themselves. If they are unlikely to be able to pay, should they be treated at all? The proverbial ‘can of worms’ would be opened on this area. Perhaps it could be argued that they were in receipt of previous treatment from a Health Authority that had not effectively cured them, when it was recognised that therapy in response to their condition should have a good prospect of success. There could be a counterclaim made in response to attempts to recover, on the grounds of clinical negligence. This would involve a circuitry of claim, but doubtless greater cost; defending a counterclaim may expend more in terms of resources than would be generated by the recovery.

These examples have been selected somewhat mischievously, but do illustrate the difficulties that may arise. A greater concern must be in circumstances where such as a Local Authority are bound to provide care to an injured person indefinitely; in light of the recent changes they may be encouraged as to their prospects of recovering the costs. If this were to develop, the Insurance industry as a whole would wish to mount a challenge to the proposition as it could see a ‘floodgates’ type situation, and imponderables such as:

- the appropriate rate to repay
- the care period
- lump sum payment based on multiplier/multiplicand approach
- instalment type settlements
- open-ended claims, which could only be finalised once a person passes away

## **Conclusions**

The recent alteration to the law making Employers’ and Public Liability Insurers responsible to repay the costs of treatment by NHS Trusts to accident claimants reflects the trend of shifting the financial onus to fund services or benefits from the central funds of government to an individual tortfeasor and pursued through the vehicle of the tort (delict in Scotland) system. The mechanism to make such recoveries has been in place in the Motor Insurance sector since the introduction of compulsory third party liability insurance for motorists. Whilst clearly there will be an increase in cost to each individual claim, it is expected that this will be borne by those paying the premiums rather than those taxpayers. For an Insurer, this may seem inequitable but in some ways they are acting as a conduit for transfer of monies between their portfolio of Policyholders and the state, rather than the monies being collected through taxation/levy upon those policyholder as private individuals or forming part of corporate entities. What is unlikely to happen is that those paying the higher premiums can benefit from a reduction in tax; so



it could be said to represent another ‘stealth’ tax introduced by the government. Objectively, their counter argument may be that the failure to include all accident claimants within the recovery procedures was a longstanding loophole that they are entitled to remove. However when the powers to recovery were enacted to the 1930 RTA, no NHS existed and for over 50 years there has been collateral funding for motor accident related treatment.

We may be disappointed by this latest development, but realistically it is one that the Insurance market will have to face pragmatically. The ability to recover such charges has existed for many years in the motor sector, and the trend of extending the process may continue in other areas. When conditions are so ‘soft’ it is not even possible to demonstrate a clear consequence to premium levels, but undoubtedly there will be an increase in claims costs in the liability market in the future.

If there is a warning to be taken from this move; we must collectively, as compensators and compensators’ representatives, resist any further steps towards more nebulous prospective recovery entitlements which have not been formalized or enacted, to avoid potentially open-ended and unworkable situations that could lead to a paralysis on the compensation system as a whole.

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