EXPLANATORY MEMORANDUM TO

THE PERSONAL INJURIES (NHS CHARGES) (GENERAL) REGULATIONS AND ROAD TRAFFIC (NHS CHARGES) (AMENDMENT) REGULATIONS 2006 NO. 3388

and

THE PERSONAL INJURIES (NHS CHARGES) (REVIEWS AND APPEALS) AND ROAD TRAFFIC (NHS CHARGES) (REVIEWS AND APPEALS) (AMENDMENT) REGULATIONS 2006 NO. 3398

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Description

2.1 The Personal Injuries (NHS Charges) (General) Regulations and Road Traffic (NHS Charges) (Amendment) Regulations 2006 ("the General Regulations") make provision concerning the operational procedures and requirements that will govern how NHS charges will be recovered from persons who pay compensation in cases where an injured person receives NHS hospital treatment or ambulance services. This instrument sets out how the scheme for the recovery of charges (provided for in Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act")) is to deal with applications for certificates, reduction of the amount of NHS charges in cases of contributory negligence, information to be provided, payments to hospitals and ambulance trusts and the liability of insurers. It also deals with the application of the scheme in respect of various types of payments such as structured settlements, interim payments etc, and provides for payments exempted from the scheme. Regulation 12 removes a definition included in error in the Road Traffic (NHS Charges) Amendment Regulations 2005 (see the Third Report of Session 2005-06 of the Joint Committee on Statutory Instruments).

2.2 The Personal Injuries (NHS Charges) (Reviews and Appeals) and Road Traffic (NHS Charges) (Reviews and Appeals) (Amendment) Regulations 2006 ("the Reviews and Appeals Regulations") make provision for the circumstances in which a certificate of NHS charges issued by virtue of provisions in Part 3 of the 2003 Act may be reviewed. It also provides the procedural rules and requirements for bringing appeals against such certificates and against decisions not to grant a waiver under s157(4) of the 2003 Act. Regulation 10 corrects a drafting error in the Road Traffic (NHS Charges) Reviews and Appeals) Regulations 1999 by removing an incorrect cross reference to section 9 of the Road Traffic (NHS Charges) Act 1999 (see the Seventeenth Report of Session 1998-99 of the Joint Committee on Statutory Instruments).

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 Regulation 12 of the General Regulations removes a definition included in error in the Road Traffic (NHS Charges) Amendment Regulations 2005. This is in response to

comments made by the Joint Committee on Statutory Instruments in its Third Report of Session 2005-06.

3.2 Regulation 10 of the Reviews and Appeals Regulations corrects a drafting error in the Road Traffic (NHS Charges) Reviews and Appeals) Regulations 1999 by removing an incorrect cross reference to section 9 of the Road Traffic (NHS Charges) Act 1999. This is in response to comments made by the Joint Committee on Statutory Instruments in its Seventeenth Report of Session 1998-99.

4. Legislative Background

4.1 Part 3 of the 2003 Act provides the legislative framework for the NHS Injury Costs Recovery (ICR) Scheme that will come into force on 29th January 2007.

4.2 These instruments regulate the operational procedures for the collection of NHS charges under the ICR Scheme, and the procedures for the review and appeals against collection of NHS charges under the ICR Scheme. They are part of a group of three instruments (see paragraph 7.5 below) which between them make provision for the general operation of the ICR Scheme, the amounts to be recoverable under the scheme and other matters linked to those amounts, and the arrangements for reviews and appeals.

4.3 Section 195(3) of the 2003 Act requires the Secretary of State to consult the National Assembly for Wales before making any regulations under Part 3 of that Act. The National Assembly for Wales' Health Minister was specifically invited to participate in the consultation on the draft regulations that took place at the end of 2004, and did so. Assembly officials have been kept fully informed of progress since then.

4.4 The Secretary of State is also required to consult with the Council on Tribunals in relation to the Reviews and Appeals Regulations, and this has been carried out.

5. Extent

5.1 This instrument extends to England and Wales.

6. European Convention on Human Rights

6.1 As the instruments are subject to negative resolution procedure and do not amend primary legislation, no statement is required.

7. Policy background

7.1 For more than 70 years, hospitals have been able to recover the costs of treating the victims of road traffic accidents where the injured person has made a successful claim for personal injury compensation. The arrangements for this were streamlined and modernised through the provisions of the Road Traffic (NHS Charges) Act 1999.

7.2 The Law Commission for England and Wales consulted in 1996 on whether this recovery should take place not just following road traffic accidents but in all cases where people claim and receive personal injury compensation. More than three quarters of the people who responded to the consultation agreed with the Commission's view that the NHS should be able to recover its costs from the liable

party. The NHS, and therefore the taxpayer, should not have to pay for the treatment of such patients. Rather, those causing injury to others should pay the full cost of their actions, including costs of NHS treatment.

7.3 The Department of Health undertook a full public consultation exercise with all interested parties on how such an expanded scheme might operate in the Autumn of 2002 (see paragraph 3.2 of the Regulatory Impact Assessment (RIA) which accompanies the instrument for more detail). The responses in the main supported the scheme and proposals for its administration. There were some concerns, however, about whether the Employers' Liability Compulsory Insurance (ELCI) market was sufficiently robust to cope with the expansion. Virtually all employers are required by law to hold ELCI, and at the time of the consultation there were considerable concerns following a period of sudden and significant increases in premiums, leading insurers and more importantly employers to fear an imminent collapse of the ELCI market.

7.4 Following on from that consultation the necessary legislative framework was put in place as Part 3 of the 2003 Act. However, in response to the concerns expressed during consultation, the Government committed to not implementing the expanded scheme until a study of the ELCI market, carried out by the Department for Work and Pensions during 2003, was published. The study's final report, issued in December 2003, recommended that implementation of the ICR Scheme should be postponed for a year, and this recommendation was accepted.

7.5 A further public consultation was undertaken at the end of 2004 covering in detail the draft regulations that will govern the ICR Scheme (see paragraph 3.5 of the RIA for more detail). There are three sets of Regulations:

- The Personal Injuries (NHS Charges) (Amounts) Regulations 2006;
- The Personal Injuries (NHS Charges) (General) Regulations and Road Traffic (NHS Charges) (Amendment) Regulations 2006;
- The Personal Injuries (NHS Charges) (Reviews and Appeals) Regulations and Road Traffic (NHS Charges) (Reviews and Appeals) (Amendment) Regulations 2006.

7.6 The Personal Injuries (NHS Charges) Amounts) Regulations 2006 are subject to the affirmative resolution procedure. They were laid separately in draft on 8 November 2006 in order to ensure sufficient time for the necessary Parliamentary processes to be completed.

7.7 The consultation raised further concerns about the planned timing for introducing the ICR Scheme, as the ELCI market was still considered fragile. After further discussions with the Department for Work and Pensions, which was developing a programme of work to implement the recommendations of its earlier study, Ministers agreed to a further postponement of implementation of the ICR Scheme from April 2005 to October 2006.

7.8 One of the key messages to come out of the consultation on the draft regulations was that the Department of Health needed to look again at how the ICR scheme would deal with the issue of contributory negligence. In order to allow contributory negligence to be taken into account in a much wider range of cases primary legislation was required to amend the 2003 Act. This was achieved by section 73 of the Health Act 2006 amending section 153 of the 2003 Act. Due to uncertainties as to when the Health Bill

would receive Royal Assent, and concerns about being able to ensure that the ICR scheme was implemented in its entirety if Royal Assent were delayed, it was decided to have one further postponement of the implementation of the ICR scheme to 29th January 2007.

7.9 The operation of the ICR scheme will mirror the existing road traffic recovery scheme where possible but with several key differences. The ICR scheme is not restricted to personal injury claims following motor accidents but will apply to all payments of personal injury compensation other than those payments which are specifically exempted either in Schedule 10 of the 2003 Act or in Regulation 11 of the General Regulations. It will also introduce for the first time the recovery of ambulance services for each case where the injured person has been transported to or between hospitals for treatment of the injury for which compensation has been paid. Taking into account contributory negligence[1] is also a new feature in the ICR Scheme. Compensators can have contributory negligence taken into account for ICR scheme purposes in all cases where it is a factor in primary compensation claims and they are able to provide specified supporting evidence. The ICR Scheme also introduces a new right to apply for a waiver of the requirement that compensators must pay NHS charges deemed due before they can appeal against the level of those charges, where payment would cause exceptional financial hardship.

8. Impact

8.1 A Regulatory Impact Assessment is attached to this memorandum.

8.2 The impact on the public sector will be a small rise in insurance premiums, suggested in the RIA (see paragraph 5.36) to be in the region of 2%.

9. Contact

9.1 Mr Martin Campbell at the Department of Health Tel: 0113 254 5174 or e-mail: martin.campbell@dh.gsi.gov.uk can answer any queries regarding this instrument.

[1] Contributory negligence is where the injured person accepts, or is found to have, an element of responsibility for the injury in question. In such cases, the compensation payment is usually reduced by a proportion which reflects that element of personal responsibility.

NHS INJURY COSTS RECOVERY SCHEME
REGULATORY IMPACT ASSESSMENT

1. Title of Proposal

1.1 The NHS Injury Costs Recovery (ICR) Scheme. The legislative framework for the scheme is set out in Part 3 of the Health and Social Care (Community Health and Standards) Act 2003.

2. Purpose and intended effect of the measure

Objective

2.1 The Government's aim is to establish a scheme so that those deemed responsible (through the payment of personal injury compensation) for causing injury to others, are also required to make a payment contributing to the costs of any NHS hospital treatment required by the injured person.

2.2 The key objective is to maximise funds available to NHS trust hospitals by allowing the recovery of the costs of treatment in cases where the treatment is required as a result of a third party's failures or negligence. The legislation stipulates that all monies recovered through the ICR Scheme must be used to provide goods and services for the benefit of patients or, where appropriate, for the purposes of NHS ambulance services.

2.3 The Government also expects that the existence of such a scheme will help to encourage people to be more aware of their responsibilities and to take active steps to reduce the risk of causing injury to third parties, as well as reducing the cost to the taxpayer of subsidising the wrongdoer by meeting part of the costs of his or her wrongdoing.

Background

2.4 The total cost to the NHS in treating personal injury cases other than road traffic accidents is estimated to be in the region of £170million to £190million.

2.5 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person where that person has made a successful personal injury compensation claim against a third party. This builds on the existing scheme introduced by the Road Traffic (NHS Charges) Act 1999 ("the RTA scheme"), which allows costs to be recovered in road traffic accident cases only. Both the existing RTA scheme and the extended ICR scheme apply only to NHS treatment provided in NHS hospitals. The ICR scheme will also allow the recovery of the costs of ambulance services to take the injured person to an NHS hospital (not covered by the RTA scheme). The costs of treatment provided in the primary care sector, eg by General Practitioners, is not recoverable under either scheme.

2.6 The current RTA scheme is operated by the Department for Work and Pension's (DWP) Compensation Recovery Unit (CRU) on behalf of the Secretary of State for Health (for England and Wales) and the Scottish Ministers (for Scotland). In 2004/05, the scheme recovered more than £115million, money which is returned direct to the NHS trusts that provided treatment to the road traffic accident victims. Motor insurers are legally obliged to inform the CRU every time a qualifying claim is made. The CRU use the information to establish what, if any, NHS charges may be payable, using a simple tariff system[2]. A certificate showing the amount payable is issued to the insurer (usually known as the compensator in this context), and this must be paid to the CRU in the event that the primary compensation claim is successful. The CRU will then forward the amount recovered to the NHS trust that provided treatment to the injured person.

[2] This tariff system means, of course, that frequently the amounts recovered do not match exactly the costs of providing treatment in any specific case. The tariffs represent average treatment costs and are not intended to provide exact reimbursement. As the intention is that the tariff arrangements will apply in the ICR scheme, compensators will in fact rarely have to pay the full costs of hospital treatment.

2.7 The Law Commission for England and Wales consulted in 1996 on whether this process of recovery should take place not just following road traffic accidents but in all cases where people claim and receive personal injury compensation for injuries which require treatment by the NHS. More than three quarters of the people who responded to the consultation agreed with the Commission's view that the NHS should be able to recover its costs from the liable party in any case where personal injury compensation is paid.

Rationale for Government intervention

2.8 Had the Government not taken any action following the outcome of the Law Commission consultation, the following risks would have remained in place:

- the NHS continuing to bear the cost of treating injuries that have been caused by the wrongdoers, with the resultant loss of between £170m and £190m that could otherwise be used to improve patient services, e.g. by reducing waiting times;
- the taxpayer would therefore be subsidising those liable for causing injury to others;
- unjust enrichment of those liable for causing injury to others;
- reduced incentives for employers/public authorities, etc., to have effective health and safety measures in place.

Who will be affected?

2.9 The expanded ICR scheme will subsume the existing RTA scheme, so all those affected by the RTA scheme, i.e. motor insurers, will be equally affected by the ICR scheme. In addition to motor insurance, there are three other main areas of liability that could result in successful compensation claims leading to a subsequent liability to pay ICR scheme charges. These are employer's liability, public liability and product liability. **Table 1** below uses information supplied by the CRU on the number of claims by liability. Figures are not known for product liability but any such claims are likely to be small. In addition a small number of clinical negligence claims may also attract ICR scheme charges (see paragraph 5.20 below).

2.10 The person paying compensation or buying insurance against paying compensation is affected. The provisions are not restricted to payments made as the result of compulsory insurance but even so the majority of payments are likely to come through insurance companies which will therefore incur additional administration even if the actual costs are passed on to those buying insurance. However, in cases where there is no insurance cover, then the individual making the payment in the primary compensation claim will also be liable for ICR scheme charges.

2.11 Industries with the highest risk of non-fatal injuries at work are: construction, transport and communications and manufacturing. Occupations in transport and construction along with food, drink and tobacco operatives are the 'riskiest' occupations in terms of reportable injury relative to all other occupations.

Table 1: Accident Claims 2003/04 and 2004/05 by Liability

	Accident Claims	
	2003/04	2004/05
Employer	**79,286**	**77,765**
Public	**91,177**	**86,966**
Clinical Negligence	7,109	7,196
Other	1,881	2,194
Liability not known	2,993	2,269
TOTAL	**182,446**	**176,390**

Source: Compensation Recovery Unit

2.12 The cost to the NHS of treating personal injury cases other than RTA cases is estimated at £170-£190 million. This figure has been calculated using data supplied by the Health and Safety Executive (2004/05 numbers of accidents at work); the Department of Health's Hospital Episode Statistics (HES) data (2004/05 average length of stay) and the RTA scheme tariff.

3. Consultation

3.1 **The Law Commission for England and Wales consulted in 1996** on whether the recovery of NHS costs should take place not just following road traffic accidents but in all cases where people claim and receive personal injury compensation. More than three quarters of the people who responded agreed with the Law Commission's view that the NHS should be able to recover its costs from the liable party.

3.2 **The Department of Health undertook a consultation exercise on how such a scheme might operate in the Autumn of 2002** and received 64 replies. The Department also sought the views of other Government Departments through the establishment of an Interdepartmental Working Group. The majority of responses to the consultation supported the need for the expanded scheme and the proposals for its administration. The Trade Union Congress and Health and Safety Executive supported the scheme due to the incentive for employers to improve the health and safety of their employees.

3.3 Concerns were raised by businesses, organisations representing businesses and insurance companies about the timing of introducing these charges because of the problems being experienced in the Employers' Liability Compulsory Insurance (ELCI) market, mainly the high rise in premiums and difficulties in obtaining insurance being experienced at that time in a number of sectors.

3.4 Following on from that consultation the necessary legislative framework was put in place as Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act"). However, the Government responded to the concerns raised during the consultation by giving guarantees at the time the Bill was introduced in Parliament that the ICR scheme would not be implemented until the final outcome was published of a study into the state of the ELCI market, being conducted by the Department for Work and Pensions during 2003. The study's final report was published in early December, only a few days after the 2003 Act received Royal Assent. One of its recommendations was that implementation of the ICR scheme should be postponed for a year to give the measures being proposed to stabilise the ELCI market time to be implemented and take effect. This recommendation was accepted.

3.5 **A further consultation was undertaken between September and December 2004** which set out in detail the draft Regulations that would govern the new scheme. There were 71 replies received in total. One major concern raised in the consultation concerned the proposals for applying a reduction in ICR scheme charges where the payment settling the primary compensation claim had been reduced to take account of contributory negligence[3]. The provisions of the 2003 Act were felt to be too restrictive and likely to provide a perverse incentive to compensators to use the courts or mediation services in order to obtain a ruling on contributory negligence that would be acceptable for ICR scheme purposes. This would have undermined Government policy of trying to reduce the number of claims going to court and encouraging the use of alternative dispute resolution techniques.

3.6 In response to these concerns, the Government re-examined how contributory negligence would be taken into account and agreed to amend the 2003 Act to allow contributory negligence to be taken into account by a wide range of alternative dispute resolution mechanisms. The necessary amendment is contained in section 73 of the Health Act 2006.

3.7 The other key concern expressed during the consultation on the Regulations was that the ELCI market was still considered to be too fragile to cope with the then proposed implementation date of April 2005. After further discussions with the DWP, Ministers agreed to a further postponement to October 2006. However, as the (then) Health Bill progressed through Parliament, uncertainties as to when it would achieve Royal Assent led to concerns about ensuring that it would be possible to implement the ICR scheme in its entirety from the outset. Ministers therefore agreed to one further postponement to 29th January 2007.

[3] Contributory negligence is where the injured person acknowledges, or is deemed to have, some responsibility for the injury. For example, an injury may have been caused as a result of an equipment failure, but may have been exacerbated because the injured person failed to use appropriate safety gear. In such cases a reduction in the compensation payment can be agreed or imposed by the court to recognise the element of the injured person's own responsibility.

4. Options

4.1 Three options were identified and considered:

Option 1

Do nothing.

Option 2

Introduce, through legislation, the expansion of the existing RTA scheme to include the recovery of NHS charges following payment of personal injury compensation where insurance is mandatory, i.e. ELCI cases only.

Option 3

Introduce, through legislation, the expansion of the existing RTA scheme to include the recovery of NHS charges in all cases where personal injury compensation is paid.

5. Cost and Benefits Analysis

Option 1

5.1 The do nothing approach does not address the issue raised by the Law Commission that by providing healthcare free of charge the NHS in effect discharges part of a wrongdoer's liability, and will have less funds available for improving services to the majority of patients whose injuries/illness is not the result of the failure of a third party. The taxpayer would still ultimately bear the cost of wrongdoing. However, doing nothing would answer the concerns of businesses and insurers about insurance premium increases.

Option 2

5.2 **Benefits** – expanding the current scheme to include only ELCI cases would partly address the view that the wrongdoer should pay the full costs of their liability. It would also enable the NHS to recover the cost of treating persons injured in the course of employment. In addition it might act as an incentive to employers to improve their health and safety practices in order to minimise claims.

5.3 **Costs** – this option would limit the scheme to recovering monies only in employment injury cases. It would do nothing to address the costs to the NHS in relation to more than 86,000 public liability accidents taking place each year, nor to clinical negligence or product liability cases. Employers would be faced with increased insurance premiums that other sectors would not have to bear. As well as being inequitable for businesses, this may have an adverse effect as excluded sectors could interpret this as an indication that their liability does not extend to treatment of injuries.

Option 3 (recommended)

5.4 **Benefits** – this option meets concerns expressed by the Law Commission that those who are liable for injuries should not be subsidised by the taxpayer. It also reinforces the duty to prevent accidents happening. Accident victims are not asked to pay for their own treatment through their taxes. Money that is raised would be returned directly to the hospitals providing treatment and could therefore be used to provide better hospital services for all GB residents.

5.5 **Costs** – this option would result in increased costs to the person paying compensation or buying insurance against paying compensation. This option is not restricted to compensation payments paid through insurance, but even so, it is envisaged that the majority of payments will come through insurance companies and that actual costs including administration will be passed on to those buying insurance. There will be additional administration costs incurred by the CRU but economies of scale suggest that this should be minimal in comparison to the potential recoveries.

Issues of equity and fairness

5.6 It is only fair that the cost burden of treating injured persons is transferred from the taxpayer to the wrongdoer.

5.7 Historically, insurers have not tended to take health and safety records into account when setting premiums. This could create a situation of inequity as employers, public bodies, etc., who take positive action to improve the health and safety of employees and service users would in effect be subsidising those that do not or are negligent. However, this is a situation that existed before the ICR scheme was first proposed, and is not a result of it. Moreover, one strand of the work undertaken by the DWP following its study into the state of the ELCI market has been to work with insurers to develop methodologies to allow them to take more and better account of matters such as health and safety records when setting premiums. For example, in September 2003 the Association of British Insurers (ABI) introduced its "Making the Market Work" scheme, which provides guidance to trade associations on the kind of best practice that insurers would want to see in health and safety schemes, and assesses trade association schemes against that best practice so that its members can have consistent information about them when setting premiums. It is therefore likely that over time, the insurance market will evolve so that this potential inequity is minimised.

5.8 Racial equality issues have been considered in relation to this policy. However, the ICR scheme is expected to have no racial equality impact, either positive or negative.

Contributory Negligence

5.9 A further issue to be considered in terms of equity and fairness is how, in any expanded scheme, contributory negligence should be taken into account. The Law Commission recommended that the liable party should only pay NHS costs in proportion to their liability. In response to that recommendation the 2003 Act provides that where there is a specific quantified finding of contributory negligence through one of several court or mediation based processes the NHS charges should be reduced in direct proportion to the injured person's liability. Thus, if the injured person is deemed to be 20% responsible for the injury suffered and the compensation payment is consequently reduced by 20%, then the NHS charges payable under the ICR scheme must also be reduced by 20%.

5.10 As indicated in paragraphs 3.5 – 3.6 above, further consultation on the draft regulations for the expanded scheme identified a need to further widen the scope for contributory negligence to be taken into account, so that a wide range of alternative dispute resolution mechanisms can be used, rather than only mediation or court based procedures. In making the necessary amendment to the legislation to allow for this (see paragraph 3.7 above) it was acknowledged that it will ultimately mean a reduction in the amount of money recovered in such cases once the ICR scheme is in place (although it is impossible to quantify this because no data is collected on numbers of personal injury claims settled out of court where contributory negligence is a factor in the settlement calculation). However, it also means that compensators will be treated fairly and equitably, as well as supporting the Government's drive to encourage use of alternative dispute resolution mechanisms in civil claims, rather than court processes.

<u>Quantifying and Valuing the Benefits</u>

<u>Option 1</u>

5.11 The do nothing option would have no benefit to the taxpayer or the NHS but would relieve the liable party of the full costs of his or her actions. Insurance premiums would not be increased to cover insurers' additional costs.

<u>Option 2</u>

5.12 Introducing primary legislation to include ELCI claims only would see employers meeting NHS costs of around £114m as illustrated below.

5.13 The Health and Safety Executive (HSE) have provided statistics on the number of accidents at work, as shown in **table 2**. In 2004/05 the number of fatal and major accidents involving

employees and self-employed were 31,679. The HSE defines fatalities as deaths occurring up to one year from the accident date.

Table 2: The Number of Accidents at Work 2004/05

	Employees Number of Injuries	**Self-employed Number of Injuries**
Fatal	169	51
Major/non-fatal	30,213	1246
Over 3 day (3 or more days off work)	120,346	1135
Total	**150,728**	**2,432**

Source: Health and Safety Executive 2004/05

5.14 It is assumed that both the fatal and major accidents will require an inpatient admission, and that the patient will have been taken to hospital by ambulance. For the remaining 46,086 accidents for which employers are liable (77,765 claims – 31,679) it is assumed that half are treated as outpatients (23,043) without the need for ambulance services and half either by GPs or with no NHS care needed. By implication, the remaining 72,983 accidents (150,728 number of accidents recorded by HSE less number of employers' liability claims 77,765) are assumed not to require any NHS input. Please note these assumptions are made for illustrative purposes only.

5.15 The Department of Health's Episode Statistics (HES) data shows that for the accidents to employees in the 16-64 working age group the average length of stay in hospitals was 5 days. This data relates to England only.

5.16 The data collected above can then be used to give an indication of the revenue that could be collected from ELCI claims cases. Like the RTA scheme, the ICR scheme will apply to the costs of providing NHS hospital treatment, not primary care. The intention therefore is that the current tariffs used in the RTA scheme (£620 per inpatient day and £505 for outpatient), will be migrated to the ICR scheme and can therefore be applied to the data. In addition, the expanded ICR scheme also makes provision for the cost of NHS ambulance services to be recovered. Again, the intention is to use a simple flat rate tariff based on average journey costs. This has been calculated as £159. **Table 3** sets out the figures in detail.

Table 3: Potential Revenue Generation from ELCI cases

Service Provided	**Tariff (a)**	**No of Cases (b)**	**Length of stay (c)**	**Recovery Amounts (a) x (b) x (c)**
Cost per In-Patient day	£620	31,679	5	£98.205m
Outpatients	£505	23,043	1	£11.636m
Ambulance Costs	£159	31,679	1	£5.037m
TOTAL				**£114.878m**

Option 3

5.17 Introducing primary legislation to include all cases where people claim and receive personal injury compensation for injuries which require treatment by the NHS supports the basic argument that those causing injury to others should be liable to pay the full cost of their actions. This option would include employer, public and product liability, and some clinical negligence cases. Whilst public liability insurance is not mandatory, it is relatively common amongst reputable providers of services to the public.

5.18 Public liability claims will apply to all age ranges. HES data shows that the average length of stay for accidents would be 6.7 days for all ranges because the over 65 age group tend to have long lengths of stay.

5.19 It is likely that the number of incidents causing fatality or major injuries would be less in public liability than in workplace accidents. Tables 4 and 5 provide estimates of income generation using different assumptions. It is assumed that the percentage of outpatient cases would be the same as for employer's liability. As before, the tables also assume that ambulance journeys would only be required for inpatient stays. It should be noted that the figures below are for illustrative purposes only.

Table 4

Assuming 20% in-patient, of the remaining cases (86,966 -17,393) 30% would require out-patient treatment and 70% would be treated by a GP or have no NHS involvement.

Service Provided	Tariff (a)	No of Cases (b)	Length of stay (c)	Recovery Amounts (a) x (b) x (c)
In-patient	£620	17,393	6.7	£72.250m
Out-patient	£505	20,872	1	£12.941m
Ambulance	£159	17,393	1	£2.765m
Total				**£87.956m**

Table 5

Assuming 15% in-patient, of the remaining cases (86,966-13,045) 30% would require out-patient treatment and 70% would be treated by a GP or have no NHS involvement.

Service Provided	Tariff (a)	No of Cases (b)	Length of stay (c)	Recovery Amounts (a) x (b) x (c)
In-patient	£620	13,045	6.7	£54.189
Out-patient	£505	22,176	1	£11.198m
Ambulance	£159	13,045	1	£2.074m
Total				**£67.460m**

5.20 Using the assumptions set out in paragraph 5.18 above and illustrated in Tables 4 and 5 the income generated under public liability could be between £67m and £88m. Taking an average would result in costs to public liability of **£77.5m.**

5.21 There is little information held on product liability and the number of claims are expected to be minimal. Similarly, only a very few clinical negligence cases are expected to fall within the scope of the ICR scheme. The 2003 Act makes provision to exclude from the scheme cases where remedial treatment is provided by the same NHS trust as makes the compensation payment in the clinical negligence claim, since to do otherwise would result in trusts in effect making injury costs recovery payments to themselves. The scheme will come into play, however, in the very few cases where remedial treatment is provided by a different NHS trust.

5.22 The estimated total benefits to be gained from option 3 are in the region of **£192.378m** (£114.878m from employers' liability claims and £77.5m from public liability claims). This is over and above the funds already being recovered under the RTA scheme (over £115m in 2004/05), which will continue under the ICR scheme.

Compliance costs for business

Option 1

5.22 This option, the do nothing approach, has no associated costs for those who cause accidents or their insurers. The cost of NHS hospital care would continue to be met by the taxpayer, including businesses.

Option 2

5.23 This option, to expand the scheme to include only ELCI claims, results in increased insurance premiums for businesses, and some increased administration costs for insurers. There would be no additional costs in relation to public/product liability claims.

Option 3

5.24 This option, to expand the scheme to include all successful personal injury claims, would result in business bearing the cost of their wrongdoing by the payment of NHS charges or by purchasing insurance against the risk of liability. Premiums for all relevant insurance cover would be likely to increase, and insurers will incur additional administrative costs.

Business sectors affected

5.25 Any business with potential liabilities towards third parties, whether as an employer, a producer of goods or transacting business in a public place – in other words, essentially, all businesses - will be affected, including charities and voluntary organisations.

5.26 Insurance companies providing cover in these areas would also be affected by the administrative costs and by the need to apportion costs amongst holders of policies. (See paragraphs 5.31 – 5.36 below.)

Compliance costs of Option 3 for a typical business

5.27 The costs would either be the direct costs of paying any NHS charges if the incident is not covered by an insurance policy, or the increases in insurance premiums where cover is taken out. Where the charges are paid directly, the level of charge will be different in each case depending on the type of treatment provided, up to the maximum of £37,100 (using road traffic recovery scheme tariffs – in that scheme the maximum is reached in only a small minority of cases). Where the charges are paid through an insurance policy, the increases in premiums will be likely to reflect at least the increased costs to insurers.

5.28 Businesses are unlikely to incur significant additional administration costs, since there will be few additional procedures or information requirements for the ICR scheme that they are not already having to comply with in relation to the primary compensation claim. ELCI cover is, in all but a few specific circumstances, mandatory, so that virtually all employers' liability cases will be covered by insurance. Whilst public liability insurance is not mandatory, those organisations with significant liabilities in this respect do generally take out appropriate cover. In the vast majority of cases, therefore, the insurers will liaise with the CRU. In the rare event that the incident is not covered by some form of insurance then there may be additional administrative costs in dealing direct with the CRU, which is expected to administer the scheme on behalf of the Secretary of State for Health, just as it currently does for the RTA scheme. However, it is impossible to make any meaningful assessment of what such costs might be because no statistics are held on the number of claims made which are not covered by insurance.

5.29 Some respondents to the consultation suggested that increased ELCI insurance premiums might encourage less scrupulous employers to operate without any insurance. In fact, it will be in an employer's best interests to take out ELCI insurance. The extended scheme will not be reliant on insurance cover as the existing RTA scheme is. Without insurance, as well as having committed an offence for which they could be prosecuted, employers against whom an employee makes a successful personal injury claim will find themselves personally liable for both the compensation payment and any ICR scheme charges that become due. It many cases it is likely that these could amount to more than the insurance premium would have done. Thus, it can equally reasonably be argued that the introduction of the ICR scheme will provide an added incentive to employers to take out appropriate insurance. Nevertheless, there will always be a proportion of "cowboy" businesses that choose to operate outside the law, regardless of the cost of insurance. There is no evidence to suggest that the ICR scheme of itself will change that behaviour one way or the other.

5.30 Similarly, it has been suggested that some businesses may choose to contest claims through the courts, rather than reaching settlement through alternative dispute resolution mechanisms, to try and minimise NHS charges, thus incurring additional legal costs. However, having an upper ceiling of charges as is currently the case in the RTA scheme (set at £37,100 for

2006/07) is likely to deter compensators from doing this – in the vast majority of cases, the cost of fighting a claim in court would be higher than the actual NHS charges. Moreover, having an upper ceiling provides compensators with an element of certainty in terms of financial planning – knowing that their liability to pay NHS charges cannot exceed that upper limit.

Compliance costs for insurers

5.31 Insurance companies will be exposed to claims made against them in their own right in the same way as any other business. However, they also incur costs in processing claims for NHS charges purposes.

5.32 Insurers already have a legal obligation to notify the CRU of all personal injury compensation claims, not just road traffic accident cases, because the CRU also deal with benefits recovery. However, there will be additional costs of processing recovery scheme cases for all personal injury claims and not just road traffic cases.

5.33 The additional costs for insurers will comprise:

(i) the need to identify the hospital providing treatment either in ELCI cases (option 2) or in all cases (option 3) when notifying claims to CRU;
(ii) alterations to IT and any forms to capture the additional data;
(iii) any retraining of staffing required.

Of these (i) is a recurring cost, whereas (ii) and (iii) should be one-off costs.

5.34 **Table 6** below sets out estimates, for illustrative purposes only, of costs to insurers for each of the three options. These estimates use data and assumptions as follows:

- information obtained in 1998 as part of the regulatory appraisal accompanying the Road Traffic (NHS Charges) Act 1999 which suggested that the work involved in identifying an NHS hospital added approximately 30 minutes to the handling time of an insurance claim;
- the numbers of employers' and public liability claims as set out in table 1, of which employers' liability represents roughly 47% of the total;
- estimated recoverable costs as set out in table 3 and paragraph 5.20;
- data from the Office of National Statistics that gross average weekly earnings in 2005 were £431, or £10.79 an hour (= £5.40 per half hour);
- data from the Association of British Insurers' document *UK insurance – Key Facts 2005* that in 2004 UK net general insurance premiums covering insurance other than property and motor amounted to £12.5billion[4].

Table 6

Illustrative estimates of costs to insurers

	Option 1	Option 2	Option 3
Annual additional administration hours	None	38,883	82,365
Annual additional administration costs	None	£418,376	£443,124
Additional administration costs as percentage of premiums collected	N/A	0.0071%	0.0035%
Recoverable costs as percentage of premiums collected	N/A	1.94%	1.54%

5.35 Experience gained in the implementation and operation of the RTA scheme suggests that the one-off costs for IT and staff training are unlikely to be high as insurers will already have

[4] This figure will include employers' liability and public liability cover, but the ABI does not break it down further to specify these separately. It may also include other types of commercial insurance such as product liability, but this too is not separately identified (although it is likely to be small). A crude calculation to match the proportion of claims for the purposes of option 2 suggests that employers' liability might represent £5.9billion (47% of total).

administrative processes in place for providing information to the CRU. Similarly, insurers will already have mechanisms in place for making payments to the CRU in relation to benefits recovery cases. The ICR scheme will just be an extension of those existing processes. Similarly, training and other administrative costs are not expected to be significant.

5.36 Using these estimates, it can be supposed that, if these costs were spread equally across the industry, option 2 might result in an increase in premiums of around 2%, while option 3 would be a little less at just over 1.5%.

Costs to Local Authorities and Government

5.37 Local Authorities and Government will be subject to the same provisions as other businesses and will be required to pay NHS costs in relevant cases.

5.38 Currently, the Departments of Health in England, Scotland and Wales pay the Compensation Recovery Unit £1.9m to recover in excess of £115million per year from the road traffic recovery scheme. There will be some additional costs for the Departments of Health in extending the recovery scheme from road traffic to all personal injury claims. The CRU has estimated that the costs are likely to increase to approximately £2.4million to implement option 3. This would represent less than 1% of the total income expected to be recovered, (including recoveries of existing scheme of £115million. The increased costs to implement option 2 would be significantly less, given that ELCI claims represent less than half of those received by the CRU. Allowing for the fact that some changes will be needed whichever option is being considered, for illustrative purposes it can be estimated that an increase in costs of around £250,000 might be required (ie around half of what would be required for option 3).

Costs to charities/the voluntary sector

5.39 The impact of these proposals on charities and voluntary organisations would be the same as for businesses where the organisation employs staff or has interactions with the public (eg high street charity shops). See paragraphs 5.28 – 5.29 above.

Costs to individuals

5.40 Unlike the RTA scheme, the ICR scheme will not be restricted solely to those cases covered by insurance. Nor is liability limited to businesses and public authorities. It is therefore possible that an individual who causes injuries to a third party and is subsequently successfully sued for personal injury compensation could also find themselves liable to pay ICR scheme charges if the injured person received NHS hospital treatment for their injuries. Where the compensation claim is covered by personal insurance the ICR scheme charges will also be covered, but if the individual makes the compensation payment directly, then they will also be personally liable for the ICR scheme charges up to the maximum amount of £37,100 (again using RTA scheme tariffs). Data identifying how often these “personal” compensation payments are made is not available – very often they will be the result of an entirely informal arrangement that does not come to the attention of any of the authorities - but it seems likely that in the majority of cases there will be an insurance policy in place.

6. Impact on Small Firms

6.1 The vast majority of businesses in the United Kingdom employ fewer than 50 people and are therefore classed as small businesses. More than two thirds of these small businesses are sole proprietorships and partnerships comprising only the self employed owner manager(s) and companies comprising only an employee director. It is worth noting, therefore, that sole trader businesses and those where the employees are all members of the same family are exempt from the requirement to take out ELCI. Thus many will not be affected at all by the introduction of the ICR scheme.

6.2 Nevertheless, where a small business is run on a tight margin the impact of any increase in either compulsory or voluntary insurance premiums will be unwelcome. However, the small business attracts responsibilities for the safety and well-being of people in just the same way as any other business and should be encouraged both to both risks wherever possible and to make sensible provision for meeting the costs of any accidents should they occur.

6.3 If insurers do not develop premium setting arrangements that better reflect businesses health and safety records then there is a risk that an across the board increase in premiums may have a disproportionate effect on small businesses. Small businesses would have less influence on insurers to discount premiums. (But see paragraph 5.7 above.) However, there is little concrete evidence to support disproportionate effect arguments one way or the other.

6.4 The Small Business Service (SBS) was a member of the Department of Health's Interdepartmental Working Group during the development of proposals for the injury costs recovery scheme. The SBS has stated that it was satisfied with the opportunities that it had been given to influence the development of the policy.

Social Impacts

6.5 The extent to which insurance companies pass on the extra costs to consumers is considered a second-round effect. As such, the effect is difficult to estimate and is likely to be speculative and therefore, the costs have not been quantified.

6.6 Consumers should benefit from the policy, as businesses will strive to improve their health and safety record in order to minimise the risk of incurring injury costs.

Health Impacts

6.7 In line with Cabinet Office guidelines, a health impact assessment has been considered. This policy is expected to contribute towards improvements in health and safety and as such is considered to be likely to have a positive impact on health and social care services by reducing the demand on primary care, hospital care and the need for medicines. Therefore a full Health Impact Assessment is not considered to be necessary.

Environmental Impacts

6.8 There are no significant environmental impacts.

7. Competition Assessment

7.1 The market mostly affected by this policy is insurance. Insurance companies that compete against one another to sell the same or similar insurance cover for motor, public, product and employer liability will be affected the most. In 2004, 1,167 companies were authorised to carry out insurance business in the UK, 870 for general business only (such as motor, commercial and household), 237 for long term business (such as life insurance and pensions) and 60 for both. The market is therefore highly competitive. However, the competition filter test showed that the preferred option was likely to have only minimal effect on competition in this sector.

7.2 The ABI has a membership of 94% of the insurance market. According to their website, the top five companies by class in 2004 held the market share shown in **table 7**. Although the percentages of market share are high, each of the companies are insurance groups containing many smaller insurers.

Table 7

Insurance Class	**Market Share held by 5 largest companies in 2004**
Private Motor Insurers	66.66%
Commercial Motor Insurers	73.63%
Accident Insurers	63.63%
Liability Insurers	62.86%

Source: ABI

7.3 None of the options considered will alter the number or size of insurance firms in the market, or consequently change market shares. It is likely that any need to raise premiums as a result of the expansion of the NHS injury cost recovery scheme will be across the industry (with the exception of morotr insurance, where NHS cost recovery already applies). The preferred option will not result

in higher set up costs or ongoing costs for new firms nor should it result in any technological changes.

7.4 As indicated in table 6 above, it is estimated that the preferred option, option 3, would result in premium increases of just over 1.5% if spread equally across the insurance industry. It is likely that insurance companies will pass these increases on to their clients, but the amount is not considered significant enough to affect competition.

8. Enforcement, Sanctions and Monitoring

8.1 The legal framework for option 3, the option chosen by Government, is set out in Part 3 of the 2003 Act. As with the existing RTA scheme, the ICR scheme will be enforced primarily through regulations. However, whereas there are two sets of Regulations that govern the RTA scheme, the ICR scheme is expected to have three sets of supporting Statutory Instruments:

- the Personal Injuries (NHS Charges) (Amounts) Regulations;
- the Personal Injuries (NHS Charges) (General) and Road Traffic (NHS Charges) (Amendment) Regulations;
- the Personal Injuries (NHS Charges) (Reviews and Appeals) and Road Traffic (NHS Charges) (Reviews and Appeals) (Amendment)Regulations.

A full public consultation on drafts of these Regulations was carried out during the latter part of 2004.

8.2 Under the RTA scheme, liability to pay NHS charges is limited almost exclusively to insurers, because the 1999 Act tied liability to compensation payments made through insurance. There will be greater scope under the expanded scheme for involvement of compensators who are not insurers because that link between compensation and insurance will no longer be exclusive. In practice, the vast majority of claims will still be covered by insurance and insurers are already very aware of their legal obligations to advise the CRU of any personal injury claim they deal with. The CRU already has long-standing and effective compliance-checking mechanisms in place to ensure that insurers meet their obligations in this respect, and it is expected that these will continue to be applied in relation to the ICR scheme.

8.3 However, it is inevitable that there will be some cases where the claim is not covered by insurance, and any compensation payment is paid directly by the individual responsible for causing the injury. Awareness of the ICR scheme legislation and their obligation to pay NHS charges may be low among this group but even here most people involved in dealing with a claim will have someone representing them – a solicitor or claims management company, for example. All these bodies are fully aware of their and their clients' obligations under the law. In the unlikely event of a claim for compensation being handled personally by an injured party and the wrongdoer without any specialist support, it may be that the case never comes to the Compensation Recovery Unit's attention but the risk of non-compliance is low.

8.4 In the event that a compensator fails to pay NHS charges for which they have been deemed liable, the 2003 Act includes provisions enabling the CRU to pursue payments through the courts if necessary.

8.5 It is already the case that the CRU provides regular monitoring information to the Departments of Health concerning compliance with the RTA scheme and its actions in cases of non-compliance. It is expected that similar arrangements will apply in respect of the ICR scheme.

9. Implementation and delivery plan

9.1 The intention is that the ICR scheme will come into effect on 29th January 2007. Due to the repeated postponements of implementation, considerable work in preparation for successful delivery of the scheme has already been undertaken. For example, the electronic data transfer system used by the CRU to communicate with NHS trusts in respect of the RTA scheme has already been updated and re-designed to accommodate the additional requirements of the ICR scheme. NHS trusts were involved in the testing of these changes to the electronic

system and have had input to the guidance which accompanies it to assess whether it is user-friendly and fit for purpose.

9.2 The key to successful delivery of the ICR scheme will be communication:

- to NHS trusts to ensure they understand the changes to the scheme, and to the electronic system, and can operate it seamlessly;
- to NHS ambulance trusts, who will benefit from NHS costs recovery for the first time when the ICR scheme is introduced, explaining the scheme and establishing mechanisms for them to receive recovered charges;
- to insurers explaining the changes and ensuring they understand their additional legal obligations.

A communications strategy has been developed and will ensure that these requirements are met in plenty of time for all key stakeholders to make any necessary adjustments. Communications will be co-ordinated by the Department of Health to ensure consistency with the CRU.

9.3 A risk register has been compiled to identify all potential issues, assess their risk and possible impact. All risks have been assigned owners, have an action plan and key milestones. The policy manager in the Department of Health is responsible for co-ordinating the register and ensuring that all risks are being managed proportionately to the level of risk.

9.4 NHS Trusts receive regular updates informing them of latest developments in preparing for the ICR scheme. Open days at the CRU's offices are planned where NHS trusts and ambulance trusts will be invited to attend to develop an understanding of how the scheme will operate.

9.5 Trusts will not see an immediate increase in the number of forms they are being asked to complete via the electronic system, therefore an increase in the resources required will be gradual. Cases relating to road traffic accidents will continue unchanged, but recoveries for all other types of injuries will only be effected for accidents/injuries occurring on or after 29th January 2007. It may be weeks or months after the incident before the injured person makes a compensation claim, at which point the CRU will be informed of the claim and can begin the process of establishing whether ICR scheme charges may be due. Once the claim is made, personal injury cases take on average 18 months to settle and NHS charges cannot be recovered unless and until compensation is paid. Because of this it took some three years for the RTA scheme to fully bed in and it is expected that the ICR scheme will follow the same incremental delivery pattern.

9.6 Insurers, similarly, will see an incremental increase in administration as more qualifying personal injury claims come in. They will also see gradually increasing costs as more qualifying claims are settled and ICR scheme charges become due.

10. Post-implementation review

10.1 Implementation of the ICR scheme will be carefully monitored from the outset. Its success in terms of achieving policy objectives will be reviewed by the Department of Health not less than 2 years after implementation. As indicated in paragraph 9.5 it is likely to be at least that long, possibly longer, before the ICR scheme is fully embedded so that success can be reasonably assessed.

10.2 The review will need to consider not just whether the policy objectives have been met, but also whether the various impacts – on the NHS, insurers and businesses – have been as expected, and that compliance levels are acceptable.

11. Summary and Recommendation

11.1 **Table 8** below summarises the costs and benefits of the three options considered.

Table 8

Option	Total benefits per annum: economic, environmental, social	Total cost per annum: - economic, environmental

		social **- policy and administrative**
1	None	£170m - £190m lost to NHS in costs of treating injuries for which others are responsible.
2	Approx. £230m recovered for NHS trust hospitals (£114.8m ELCI + £115m RTA).	Approx. 2% increase in insurance premiums for businesses, ie equalling the increased costs for insurers; approx. £418,376 additional administration costs for insurers; approx. £250,000 increase in costs paid to the CRU by Departments of Health.
3	Approx. £307m recovered for NHS trust hospitals (£192.3m ELCI/public liability etc + £115 RTA).	Approx. 1.5% increase in insurance premiums for businesses, ie equalling the increased costs for insurers; approx. £443,124 additional administration costs for insurers; approx. £500,000 increase in costs paid to the CRU by Departments of Health.

11.2 The fundamental principle behind this policy is that the NHS, and therefore the taxpayer, should not have to subsidise those responsible for causing injury to others. Over the last six years the RTA scheme has demonstrated that it is possible to design and operate a scheme to recover costs relating to road traffic accident injuries, and the Law Commission established not only that there was no logical bar to extending that scheme to cover all personal injury compensation cases, but also that there was general public support for doing so.

11.3 Further consultation on the mechanics of an extended scheme resulted in the Government deciding to proceed. Option 3 was chosen as the one to take forward, and that is the option recommended.

12. Ministerial Declaration

'I have read the Regulatory Impact Assessment and I am satisfied that the benefits justify the costs'.

Signed by the Lord Warner

Lord Warner

Date: 12th December 2006