EXPLANATORY MEMORANDUM TO

THE PERSONAL INJURIES (NHS CHARGES) (GENERAL) AND (AMOUNTS) AMENDMENT REGULATIONS 2009

2009 No. 316

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

This memorandum contains information for the Joint Committee on Statutory Instruments.

2. Purpose of the instrument

2.1 The purpose of the instrument is to increase the charges ("NHS charges") recovered from persons who pay compensation ("compensators") in cases where an injured person receives National Health Service hospital treatment or ambulance services. The increase in charges relates to an uplift for Hospital and Community Health Service (HCHS) annual inflation.

2.2 The instrument also seeks to remedy the issue of "dual charging" which although only affecting a handful of cases per year, means that some compensators are currently paying twice for the same episode of hospital treatment for some patients.

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

3.1 This instrument increases the amount of NHS charges recoverable by virtue of regulations made under Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act"), and the Committee's attention is drawn to the information in paragraph 7 as to how the increases have been calculated.

3.2 This instrument also seeks to remedy an unintentional overlap in legislation pertaining to the 2003 Act and the NHS (Charges to Overseas Visitors) Regulations 1989 ("the 1989 Regulations"), which can result in two sets of charges being levied for the same hospital treatment for some patients. The Committee's attention is drawn to the information in paragraph 10 as to the causes and impact of this overlap and the intended amendments to address it.

4. Legislative Context

4.1 The NHS has been able to recover the cost of treating victims of road traffic accidents for more than 70 years. The arrangements for this were streamlined and modernised though the provisions of the Road Traffic (NHS Charges) Act 1999.

4.2 The Law Commission for England and Wales consulted in 1996 on whether the process of recovery of treatment costs should take place in all cases where

people claim and receive personal injury compensation for injuries that require NHS hospital treatment. The majority of respondents were in favour.

4.3 Part 3 of the 2003 Act therefore made provision for the establishment of such an extended scheme, known as the NHS Injury Costs Recovery (ICR) Scheme. The Regulations governing the operation of the expanded scheme came into force on 29 January 2007. There are three sets of Regulations:

- Personal Injuries (NHS Charges) (General) and Road Traffic (NHS Charges) (Amendment) Regulations 2006;
- Personal Injuries (NHS Charges) (Reviews and Appeals) and Road Traffic (NHS Charges) (Reviews and Appeals) (Amendment) Regulations 2006;
- Personal Injuries (NHS Charges) (Amounts) Regulations 2007.

4.4 The amounts recoverable under the ICR scheme are specified in regulation 2 of the Personal Injuries (NHS Charges) (Amounts) Regulations 2007 ("the principal Regulations"). This instrument increases the amounts recoverable under the Principal Regulations in respect of incidents occurring on or after 1st April 2009.

4.5 Powers stemming from the *NHS Act 2006* (previously the *NHS Act 1977*) enable the Secretary of State to provide for charges to be made and recovered in respect of services under the *NHS Act 2006* which are provided in respect of certain persons who are not ordinarily resident in the UK. The 1989 Regulations, as amended, were made using these powers.

4.6 The 1989 Regulations place a duty on NHS bodies including NHS trusts to make and recover charges for services forming part of the health service, provided in respect of persons who are not ordinarily resident in the UK unless the person or treatment is exempt from charges under one of a number of exemption categories.

4.7 This instrument makes changes to the Principal Regulations to reduce the amount of NHS charges recoverable under the ICR scheme in cases where the injured person has been charged under the 1989 Regulations and been compensated for those charges.

4.8 The Personal Injuries (NHS Charges) (General) and Road Traffic (NHS Charges) (Amendment) Regulations 2006 ("the 2006 Regulations"), amongst other things, provide for certain information relating to the injured person to be provided to the Secretary of State by certain classes of persons within set timeframes.

4.9 This instrument makes consequential changes to the 2006 Regulations to make provision for the supply of information to the Secretary of State relating to the making of charges in respect of the injured person under the 1989 Regulations and to the inclusion of those charges in the compensation payment to the injured person.

4.10 These amendments will apply to the determination of charges on or after 1st April 2009 and to reviews and appeals relating to such determinations.

5. Territorial Extent and Application

5.1 This instrument applies to England and Wales. The National Assembly for Wales has been consulted as required by section 195(3) of the 2003 Act.

6. European Convention on Human Rights

6.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy Background

Increase in Charges

7.1 The Department of Health undertook a full consultation in summer 2006 on all the draft Regulations governing operation of the ICR scheme. This included seeking agreement to continue the practice established under the old Road Traffic Act recovery scheme of automatically uprating the level of charges on 1st April every year in line with Hospital and Community Health Service (HCHS) inflation. The majority of respondents agreed the proposal.

7.2 The principal Regulations make provision, amongst other things, for the calculation of NHS charges under the ICR scheme. Regulation 2 provides for a simple set of tariffs; a single one-off payment where hospital treatment is provided without admission (out-patient treatment) of £547, a daily rate for each day or part day of admission to hospital, excluding the day of discharge (in-patient treatment), of £672, and £165 per ambulance journey. The maximum amount that can be recovered in relation to any one injury (the cap on charges) is set at £40,179.

7.3 HCHS inflation is based on expenditure specific to the hospital sector and is calculated by combining the indices for NHS pay and price inflation using a 64/36 weighting. The latest estimate for HCHS inflation is 3.4% for 2008/09.

7.4 Consequently, the charges for treatment or services in respect of injuries occurring on or after 1 April 2009 will increase as follows:

Hospital treatment without admission (out-patient) from £547 to £566;
Admission to hospital (in-patient) from £672 to £695;
Ambulance journey from £165 to £171;
Maximum amount that can be recovered in relation to any one injury (the cap on charges) £40,179 to £41,545 .

7.5 We estimate that the increase in the tariffs will provide additional income to NHS hospitals of £5.4 million per year (based on the difference between the current charge and the proposed charge applied to the latest (2008) in/outpatient road traffic accident settlement claims data). As this cash increase is in line with HCHS inflation, it will simply maintain the real term value of current income.

Removal of Dual Charging

7.6 The separate provisions of the principal Regulations and the 1989 Regulations, as set out in paragraph 4 mean that the cost of treatment provided to a person who is not ordinarily resident in the UK and who is involved in a personal injury claim could be levied twice, although this affects only a small number of cases each year.

7.7 This was not the intention when the principal Regulations were introduced and the intention is to remedy this. The local administrators of the two systems do not have discretion not to levy the respective charges. The Secretary of State has the discretion not to demand payment of the levied NHS charges on a case-by-case basis but this is not a sustainable administrative process.

7.8 The intention is therefore to amend the principal Regulations to make provision for NHS charges to be reduced where a charge has been made in respect of the injured person under the 1989 Regulations and the injured person has been compensated for that charge. As a result no NHS charge will be levied in respect of the NHS treatment for which compensation has been paid. Where ambulance services have been used to transport the injured person, then NHS charges will still apply for those services as these are not recovered under the 1989 Regulations.

7.9 Consequential changes are necessary to the information requirements under the 2006 Regulations to enable the administrators of the ICR to obtain information from the injured person or the hospital concerned in relation to the making of charges under the 1989 Regulations and from the compensator in relation to the inclusion of those charges in the compensation payment.

7.10 The amendments will apply to NHS charges levied on or after 1 April 2009.

8. Consultation

8.1 It was not necessary to consult on the instrument. There was a positive response to the Law Commission's consultation in 1996 which included the proposal to uprate the level of charges in line with Hospital and Community Health Services (HCHS) inflation each year. The support for this practice to continue was also confirmed in the outcome of the Department of Health's public consultation in 2006 on the draft Regulations governing the ICR scheme.

8.2 The amendments to remove the dual charging anomaly are not deemed to be of major interest.

9. Guidance

9.1 It is not considered necessary to issue guidance on the amendments proposed by the Regulations. The uplift in the tariff is a routine event that does not require any additional explanation. The amendments to remove the dual charging anomaly, including the amendments relating to the supply of information, are relatively straightforward and do not require any additional explanation either.

9.2. We propose to write separately to the Association of British Insurers and the Motor Insurance Bureau who are already aware of the likely scale of increases. Removal of the dual charging anomaly will also be welcomed and will help to maintain or improve industry goodwill and support for the main intent of the ICR scheme.

10. Impact

10.1 A full Impact Assessment (IA) has not been prepared for this instrument, as the impact on business, charities or voluntary bodies is negligible.

10.2 An Equality Impact Assessment (EqIA) has been attached although the changes have neither a positive nor a negative impact as it does not help or penalise any specific group or community.

10.3 The bulk of the NHS charges is covered by insurance, and will be paid by insurers in addition to the personal compensation payment which the injured person will have secured. It is possible that insurers will choose to pass the increased costs on to their customers through increased insurance premiums.

10.4 As the expanded ICR scheme only came into effect on 29th January 2007, and cases have a settlement lag of a year or more, the data on non-motor liability cases settled is not yet reliable enough to be meaningful in the calculation of the impact on employer and public liability insurance premiums. Thus, estimates of the impact of the increases are in relation to motor claims, as under the old Road Traffic Act recovery scheme. On that basis, if we assume the additional costs identified above are spread evenly among all holders of compulsory motor insurance, then the cost per average policy could be expected to rise by 0.05% or around 29p per policy. These figures are calculated using 2009/10 estimates for net motor premiums of £11.0bn and average annual expenditure per household buying motor insurance of £588 based on information provided by the Association of British Insurers.

10.5 In 2007/08, the Compensation Recovery Unit (CRU, part of the DWP) received a total of £2.4m to administer the scheme on behalf of the Secretary of State for Health (for England and Wales) and the Scottish Ministers (for Scotland). During the same period, the CRU recovered over £137m for NHS hospitals. This tariff increase does not increase the cost of administering the scheme as a facility to increase the level of charges has already been built into the IT system. There are therefore no additional costs to the Exchequer arising from the tariff increase.

10.6 The latest available data on the number of dual charging incidences identifies only eight cases in total in 2008/09. However, of those cases, five accepted the overlap in the legislation and paid in full but three challenged the legitimacy of the charge. The total value of all cases was just over £50k.

11 Regulating Small Business

11.1 This instrument applies to small business but has a minimal impact on business including small firms employing up to 20 people as explained in paragraph 10.1 to 10.4 above.

12. Monitoring & Review

12. The change in the tariff is an agreed annual event that seeks to maintain the levels of funds recovered in real terms. The tariff is reviewed and adjusted annually using the latest available data. It is expected that there will be no further incidences of dual charging as a result of the amendments to the Principal Regulations.

13. Contact

For any queries regarding the instrument, please contact:
Karl Payne at the Department of Health Tel: 0113 2545380 or e-mail:
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Equality Impact Assessment (EqIA) Screening

Title and short description

Amendments to existing regulations relating to the operation of the NHS Injury Costs Recovery (ICR) Scheme.

The Injury Cost Recovery Scheme recovers the cost of NHS hospital treatment that has resulted from a personal injury for which an insurer has paid personal injury compensation. The charge is based on set tariffs for ambulance journeys, initial (single day) treatment and hospital in-stay duration. It is triggered by mandatory notification by the insurer and administered for DH by the Compensation Recovery Unit (CRU) in Dept of Work & Pensions

The first proposed amendment increases each of the unit repayment tariffs in line with NHS pay & price inflation to be applicable for the 2009/10 financial year.

The second proposed amendment removes a current anomaly whereby recovery charges are levied in instances where the insured patient is an overseas visitor who was not eligible for free NHS treatment and so has already been charged and paid for their treatment. This situation occurs currently due to overlapping legislation. The amendment will specifically remove the requirement to levy an ICR charge where the hospital has already received payment under the 1989 overseas visitors regulations.

Negative impact

Could your policy have a significant negative impact on equality in relation to:

- disability
- ethnicity
- gender
- sexual orientation
- age
- religion or belief
- human rights

Charges under the Injury Cost Recovery Scheme are levied in all instances where an insurer settles a personal injury claim. Insurers are required by statute to notify CRU of every such instance where NHS treatment has been provided. The charges are based on a set of tariffs linked to the type and duration of services provided. There is no discretion on the part of administrators of the scheme to increase, decrease or cancel that charge. Neither the insurers nor CRU administrators can therefore knowingly discriminate against any group or community.

The ICR scheme is already operational. The amendment seeks only to increase tariffs to maintain the real terms value of cost recovery. The principle of charging, and maintaining real terms annual value, was confirmed by public consultation in 1996

Overall, around £140m annually is recovered annually through the scheme. However, this is paid directly by the compensator (insurer). There is no financial cost to the individual either directly or through a reduced personal compensation payment.

Insurers are most likely to treat the cost as an overhead and may spread the cost evenly among all holders of compulsory motor insurance, then the cost per average policy could be expected to rise by 0.05% or around 29p per policy..

CRU have identified only 8 instances of double charging in 2008/09 which accounts for just over £50k from total recoveries of around £150m.

- Will the policy present any **problems or barriers** to any community or group? Yes/**No** *See above*
- Will any group of people be **excluded** as a result of your policy? Yes/**No**
- Does the policy have the potential to **worsen** existing discrimination and inequality? Yes/**No**
- Will the policy have a negative effect on **community relations**? Yes/**No**

Positive impact

- Could the policy have a significant positive impact on equality by reducing inequalities that already exist? How will it meet our duty to:

1. Promote **equality of opportunity**?

2. Eliminate **discrimination**?

3. Eliminate **harassment**?

4. Promote **good community relations**?

5. Promote **positive attitudes** towards disabled people?

6. Encourage the **participation** of disabled people?

7. Consider **more favourable treatment** of disabled people?

8. Promote and protect **human rights**?

See previous notes on negative impact.

The proposed amendment removes the requirement to levy ICR charges where the insured patient is an overseas visitor who was not eligible for free NHS treatment and so has already been charged and paid for their treatment.

The impact will affect only cases involving overseas visitors. However, there is no direct benefit (in this instance the avoidance of charges) to the individuals or their collective race/ethnic groups because:

- the charge is levied on the compensator (insurance company)
- the number of actual instances is extremely small (8 cases in 2008/09)

Evidence

- What is the evidence for your answers above?:

The tariff increase is based on the standard HCHS inflation calculation.

The incidences of dual recovery are from the analysis of CRU database

- What does any **available research** say? Please consider quantitative, qualitative, national and international evidence, results of any consultations you might have carried out, etc

The public consultation carried out in 1996 prior to the ICR scheme expanding from road traffic accidents to all personal injuries received positive majority support. The same consultation also supported the proposal to uplift tariffs annually to maintain their real terms value. No equalities issues were raised in responses to the consultation.

- What **additional research or data** is required to fill any gaps in your understanding of the potential or known effects of the policy?

The inflation calculation is reviewed every year. Any over-or under adjustment in the current year will be compensated – no equalities impact.

CRU will monitor to ensure that there are no further instances of double charging, although this should result automatically from the regulation amendment.

- Have you considered commissioning new data or research?

None required

Screening assessment

In light of the above, do you consider that your policy requires a full impact assessment?

Adverse impact is unlikely but positive impact is also unlikely.

Next steps

- Explain what **other measures** might be necessary to ensure that your policy promotes equality and eliminates discrimination, e.g. flagging up the need for those implementing it locally to publish their own EqIAs.

- Note how you will **monitor** the situation as policy development proceeds and the policy is implemented. Identify any **further research** that may be required.

No further action will be required

Approved by Richard Murray, DH Director of Financial Planning & Allocations , Jan 2009