Protecting themselves against claims for medical malpractice is a major cost for doctors and dentists. For almost a century the market for medical malpractice cover has been dominated by a tiny oligopoly. But, as society becomes more litigious and the scale of awards escalates, there are signs the established players may be beginning to lose their grip on the market.

There are around 34,000 registered general practitioners practising in mainland U.K., roughly 22,000 general dental practitioners, and around 200,000 other registered healthcare professionals, most of them employed by the NHS. Every one of them runs the risk of facing a law suit from an aggrieved (former) patient or their representatives.

GPs, GDPs and all those working outside the NHS are required by the Good Practice Guidelines of their respective registering bodies to have “adequate and appropriate” arrangements in place to provide financial compensation to any patients who may claim against them.

Exactly what “appropriate and adequate” means in this context is currently a topic of hot debate. The guidelines on what constitutes an acceptable limit are effectively set by private sector employers, the NHS and Primary Care Trusts, with some input from the regulatory bodies.

The view taken generally represents a compromise between what is available, what is affordable, and what is deemed adequate for the specific activities undertaken. In practice, this tends to equate to a minimum aggregate limit of £5million to £10million. GPs and dentists aside, everyone working within the NHS is protected by the government backed NHS Litigation Authority (NHSLA). Beyond the remit of the NHSLA, the market is dominated by three long-established defence bodies:

- The Medical Defence Union (MDU), which includes the Dental Defence Union (DDU)
- The Medical Protection Society (MPS), which includes Dental Protection Limited (DPL)
- The Medical Doctors and Dental Union of Scotland (MDDUS).

MDU and MPS dominate the sector, with a market share of around 40 percent each. The role of the conventional insurance sector is restricted largely to risks that fall outside the acceptance criteria of the defence bodies and to specialist affinity arrangements catering for the needs of particular niche groups within the medical professions.
Mainstream insurance providers have historically been cautious about entering the medical malpractice arena based on concerns about the scale of payouts they could face. These concerns have been judiciously encouraged by the incumbent providers, who have always guarded their claims data jealously—other than to highlight the largest of compensation payments made.

But more intensive analysis of the available statistics is increasingly persuading insurance companies that the rates charged by the defence bodies are not only adequate, but could actually by bettered quite substantially without over-exposing insurers to risk.

With the apparent possibility of government shifting responsibility for protecting NHS employees to the private sector, commercial insurers are now keen to establish a toehold in what could be an expanding market for the future.

As new market entrants come on to the scene, some well thought out but others offering onerous exclusions and limited cover, the question for the vast majority of medical practitioners still protected by one of the established defence bodies, is whether they are better off where they are or whether it would be worth considering their alternatives.

MDU, MPS and MDDUS are all mutuals and provide indemnity as a membership benefit. They also offer other benefits such as assistance with disciplinary and employment matters, and providing legal and medico-legal helplines. But none of them offers any other form of insurance beyond medical malpractice cover.

MPS and MDDUS have always offered discretionary cover with no contract of insurance and MDU has recently returned to 100% mutual discretionary cover. This is an interesting development as for the past twelve years MDU had been backed by two major insurers, SCOR and Hannover. Until April of 2013, MDU had publicly stated that insurance backed indemnity had considerable advantages over discretionary mutuality. From the point of view of assuring patients’ ability to obtain adequate compensation, the more secure, tangible and transparent contractual (insurance-based) indemnity looks the better option.

One of the major concerns with mutuals is the reserving policy for claims which may have been incurred but not reported. In paragraph 17 of the Notes to the financial statements of the MPS Annual Report, the organisation states:

"Incidents that could potentially lead to claims that have occurred prior to the end of the financial year, but that have not been reported to MPS by the year end are known as Incurred But Not Reported (IBNR) claims. IBNR claims do not constitute a liability and are therefore not recognised in the financial statements because recognition is dependent on the (MPS) Council exercising its discretion . . . . Having considered how discretion is exercised by MPS, the Council concludes that there cannot be a valid expectation that all requests for assistance will be met in full and that it is not appropriate to make provision for potential claims that have not been reported by 31st December".

In other words, MPS is putting aside no money for any incidents or claims that may arise during the year because it can use discretion to refuse to pay any claim. Insurers have a contractual responsibility to meet valid claims and cannot exercise discretion to decide not to do so.

One of the alternative indemnity schemes is Medica Insure arranged by Lockton for a major hospital group. This scheme seeks to be highly selective around the consultants that it insures, avoiding high risk groups and focusing on individual risk underwriting rather than the type of work/income band favoured by the mutual defence bodies.

Meanwhile the General Medical Council and the EU have been drawn into the argument and have set a number of studies and consultations in motion with a view to determining the extent to which each approach conforms with the “appropriate and adequate” definition.

Current concerns over patient protection have recently focused on the necessity of ensuring “appropriate and adequate” indemnity. The established discretionary providers offer protection with no upper limit on an occurrence basis—i.e. members are covered for costs of compensating any instance of negligence or malpractice, so long as cover was in place at the time—even if the claim is not made for many years after the event.

Any medical professional transferring from cover arranged on a claims-made basis—i.e., where they must hold cover at the time when the claim is brought, rather than when the incident occurred—will need to arrange retroactive or run-off cover with the new insurer to protect them against claims yet to materialise that relate to a period during which they were with a previous insurer. But for most medical practitioners this issue will obviously not arise.

The MDU has been in existence for almost 125 years, the MPS for 117 years. Given their long histories and market dominance, they clearly have a strong hold on the sector. But this very dominance has also perhaps made them somewhat complacent and dated in their approach. Their limited range of insurance products, sometimes underwhelming service and lack of transparency could well leave them vulnerable to competition from a new wave of medical malpractice insurers.

Changing demographics and regulatory concerns over the traditional defence associations’ security could also help to shift the balance toward mainstream insurance alternatives. The greater certainty provided by true insurance contracts, combined with the greater security offered by major insurance providers could well prove the decisive factors in the longer term.