



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Mercher, 16 Ionawr 2013
Wednesday, 16 January 2013

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol

Committee members in attendance

Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur (yn dirprwyo ar ran Mick Antoniw) Labour (substitute for Mick Antoniw)
Jenny Rathbone	Llafur (yn dirprwyo ar ran Vaughan Gething) Labour (substitute for Vaughan Gething)

Eraill yn bresennol

Others in attendance

Dominic Clayden	Cyfarwyddwr Hawliadau Prydain ac Iwerddon, Aviva UK and Ireland Claims Director, Aviva
Simon Cradick	Partner, Morgan Cole PAC, yn cynrychioli Fforwm y Cyfreithwyr Yswiriant Partner, Morgan Cole LLP, representing the Forum of Insurance Lawyers
Faye Glasspool	Cyfarwyddwr Etifeddiaeth y DU, RSA Director UK Legacy, RSA
Michael Imperato	Cydgysylltydd APIL Wales APIL Wales Co-ordinator
Simon Jones	Pennaeth Polisi a Materion Cyhoeddus, Cymru, Gofal Canser Marie Curie Head of Policy and Public Affairs, Wales, Marie Curie Cancer Care
Nick Starling	Cyfarwyddwr Yswiriant Cyffredinol, Cymdeithas Yswirwyr Prydain Director of General Insurance, Association of British Insurers

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol

National Assembly for Wales officials in attendance

Steve George	Clerc Clerc
Gwyn Griffiths	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Olga Lewis	Dirprwy Glerc Deputy Clerk
Robin Wilkinson	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 9.07 a.m.
The meeting began at 9.07 a.m.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da a chroeso i chi i gyd i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Croeso i bob aelod o'r pwyllgor, a diolch yn enwedig i Gwyn Price a Jenny Rathbone am ddod i'n helpu y bore yma.

Mark Drakeford: Good morning and welcome to the Health and Social Care Committee. I welcome every member of the committee, and thank in particular Gwyn Price and Jenny Rathbone for coming to help us this morning.

9.07 a.m.

Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Cyfnod 1—Sesiwn Dystiolaeth 4 Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Stage 1— Evidence Session 4

[2] **Mark Drakeford:** Am yr awr gyntaf, mae gennym dystion o Gymdeithas Yswirwyr Prydain. Hoffwn groesawu Nick Starling, Dominic Clayden a Fay Glasspool, y mae pob un ohonynt yn cynrychioli'r gymdeithas. Rwyf am ofyn i un ohonoch—Mr Starling, siŵr o fod—i wneud sylwadau agoriadol byr. Ar ôl y datganiad hwnnw, byddaf yn troi at aelodau'r pwyllgor i ofyn cwestiynau. Rydym yn gwneud pethau'n hollol ddwyieithog, yn Gymraeg a Saesneg. Nid oes rhaid i neb gyffwrdd y microffonau—maent yn dod ymlaen wrth i bobl ddechrau siarad.

Mark Drakeford: For the first hour, we have witnesses from the Association of British Insurers. I welcome Nick Starling, Dominic Clayden and Fay Glasspool, all of whom represent the association. I will ask one of you—probably Mr Starling—to make some brief opening remarks. After that statement, I will turn to members of the committee to ask questions. We do everything completely bilingually, in English and Welsh. You do not have to touch the microphones—they will come on when you begin to speak.

[3] We will go straight into the opening part of this first session. Mr Starling, I think that you might be going to offer us a few opening remarks.

[4] **Mr Starling:** Good morning, and thank you very much for inviting us here today to give this evidence. The first thing I want to say is that the insurance industry and members of the Association of British Insurers are absolutely committed to helping sufferers of asbestos-related diseases, for which our members pay out something like £200 million a year in compensation claims. We fully understand the motivations behind this Bill, but we do not believe that it is necessary.

[5] First of all, it is not necessary because we are taking forward with the UK Government and other Governments a package of proposals to help people with asbestos-related diseases, especially the most serious disease, mesothelioma. This is being carefully developed in conjunction with UK Government departments and others to ensure that there is medical research, asbestos awareness campaigns and compensation for people who cannot trace an insurer or an employer. This is something that will be put on a sustainable footing over the next 40 years. We have also brought some further material on that that we can give to

committee members.

[6] We think that the Bill is likely to place a significant administrative burden on health bodies. When this was looked at a few years ago by the Law Commission and the Ministry of Justice, they considered that disease claims should be excluded from getting health-related costs because of the complexity of issues of diagnosis; issues around comorbidities and complications like that. It is acknowledged that you can claim for the medical-related costs of road traffic accidents and other accidents, but these are much more straightforward to calculate and they can be factored into premiums as well. We believe that a robust, regulatory impact assessment of the Bill has not been produced and we think that it is going to place a financial burden on Welsh public bodies. We estimate that around 60% of asbestos-related cases are picked up by insurers, but the other cases would be picked up by other bodies, such as schools, local authorities and NHS bodies. In the case of insurers that are in run-off and have gone out of business, they will be picked up by the Financial Services Compensation Scheme and therefore by premium payers.

[7] Finally, we think that the Bill imposes a retrospective cost on compensators. When the premiums were collected, they were collected on the basis that there would be liability payments, not medical costs. This was not anticipated at the time that the policies were being written. You cannot recover the costs in the way that you can with road traffic accidents in the next year's premium because these are premiums that were taken 10, 20, 30, 40 years ago. So, this retrospective cost on insurers is going to be met through increased costs on Welsh businesses.

[8] **Mark Drakeford:** Thank you very much for that. We will turn straight now to any member of the committee who wishes to ask the first question. We will take a question from Gwyn first, and then Darren.

[9] **Gwyn R. Price:** Good morning to you. Could you expand on your suggestion that the Bill might be in contravention to the United Nations Convention on Human Rights?

[10] **Mr Clayden:** It is probably best if I pick that up. Under article 1, protocol 1 of the convention, individuals and, it seems clear from the case law, corporate bodies are entitled to quiet enjoyment of their property. Clearly, when you get into decisions of interference with that, it is a balancing exercise between the right to enjoy your property and rights within society. There is a material question over taking property, namely money, away from insurers and indeed other bodies, in a situation where, as it looks on the face of the Bill, it is going into general taxation, or indeed any other mechanism, and of whether that balance is a proportionate response. That is a material problem and it is very questionable.

[11] **Gwyn R. Price:** So, from your point of view and the insurance side of it, it is the money factor in relation to that.

[12] **Mr Clayden:** That is the case. This is not a situation where anybody at the time the premiums were calculated envisaged the tidal wave of terrible consequences that was occurring. It is not as if the money is sitting there. It would involve additional liabilities being placed on insurance companies and other bodies now, and it is a matter of asking whether that is a proportionate and reasonable balance of the interested parties in broader society.

[13] **William Graham:** Thank you for your evidence. The Forum of Insurance Lawyers is quoted as saying that,

[14] 'It is possible that compensators will seek to identify Welsh claimants and expedite settlement of their claims to minimise exposure to recovery of NHS charges. Such behaviour would obviously benefit the individuals to the possible of detriment of non-Welsh claimants.'

[15] How do you react to that?

[16] **Ms Glasspool:** Within the package of reforms that we are putting together at the moment is a pre-action protocol for mesothelioma victims regardless of jurisdictions, which would aim to expedite settlement for all sufferers regardless of where they are based.

[17] **William Graham:** So, you would not place a great deal of credence on that statement.

[18] **Ms Glasspool:** No.

9.15 a.m.

[19] **Darren Millar:** I want to explore the other action that is taking place on a UK basis, if I may. Earlier, you referred to the issue of claimants not being able to trace their employer or insurer at the time that they were exposed to asbestos. You suggested that you were in the process of coming to an arrangement whereby the insurance industry would be able to fund the compensation claims of those people who are currently outside the scope of compensation or do not have access to it because of traceability issues. Will you expand on that a bit more? How confident are you that those arrangements will be put in place?

[20] **Mr Starling:** We have reached these arrangements in discussion with the UK Government; I think that the announcement was made in June or July of last year. As with all Government announcements that depend on legislation, the Government is cautious about what it can promise. However, we believe that the Government is committed to bringing forward this set of measures and we believe that they are the sort of measures that would command widespread support. We are, therefore, working on the basis that legislation will be introduced this year and put into effect by 2014. It is intended to be a robust mechanism. First of all, it needs to ensure that, wherever possible, a compensator can be traced, so we are strengthening the arrangements for tracing to ensure that every avenue is explored to identify either the insurer, employer, local authority or whatever where the liability lies. It needs to ensure that only the cases where it is absolutely clear that no-one can be traced fall into the scheme. The scheme will be funded by a levy on all employers' liability insurance going forward. It will include everyone from the date of announcement who is unable to trace any insurer. We have put a lot of work into this, and we are putting a lot of work into it now, and we are confident that it will go ahead.

[21] **Ms Glasspool:** To give some context to that, we think that the scheme will benefit an extra 200 to 300 people a year through access to compensation.

[22] **Darren Millar:** Is there a timescale for traceability? We know that mesothelioma is a swiftly progressing disease. Is there a timescale by which tracing is deemed not to be possible? People would then, therefore, have access to compensation.

[23] **Mr Clayden:** We are working through the detail on that. I am the claims director at Aviva, and it falls to me to deal with all sorts of terrible injuries that people suffer in road traffic accidents, accidents at work and so on. I think that everybody recognises just how terrible mesothelioma is. I have sat with people who have it. We are all acutely aware of how devastating it is. We have to work through the detail, because it is a balancing act. We do not want to let insurers off the hook, frankly, by having a position where one can say, 'Sorry, we cannot trace the employer' and it all goes into the scheme for untraceable insurers. We need to make it very robust. If you issued a policy, you should step up to the plate and take your liability; that is the basis for this. However, we are dealing with a situation where, in reality, there are claims from exposures that may have occurred in the 1950s and 1960s. It is not a

matter of people hiding policies or anything else—policies may just not exist. The other feature is that not everybody had insurance. The scheme picks up not just where there is an insurance policy and the insurer genuinely cannot be found, but where there was no insurance.

[24] **Darren Millar:** I do not have an issue with that; it sounds great, in a perfect world. The difficulty is that there needs to be a timescale attached to the traceability issues so that the search is not prolonged and so it does not go on for 20 years, so that there can be access to compensation for those people who are suffering.

[25] **Ms Glasspool:** The Employers' Liability Tracing Office is the body that administers the system on which all of the policies have to be recorded. At the moment, there are 8 million records on that system. Under this package of reforms, we are making it compulsory for all insurers to put their details on that. Currently, 150 insurance firms have logged their details. It is a fairly straightforward system: you go in and put the employer information on it, and you see whether there is a match with a policy or not. So, it is a fairly quick process.

[26] **Mr Clayden:** I think that the other bit to draw out—and the point you make is a very fair one—is that interim payments are also very important. The reality, with regard to individual cases, is that everyone is different, but—and I apologise if this comes across as dispassionate or callous, because it is not mean to be—it is about how we get money to people when they are alive. Then, there is a separate period relating to what the situation is for the family and other people afterwards. So there is an issue, which we are conscious of and are trying to work through, with regard to how to ensure that there is an immediacy to this. It may not involve all of the settlement, and closure is important for people while they are alive, but it is about getting money to them fast.

[27] **Darren Millar:** I have one final question on this. Do you think that, if this legislation were on the statute books in Wales and this scheme was in operation, the cost implications of the scheme for the insurance industry might put other arrangements that you are progressing with the UK Government at risk?

[28] **Mr Starling:** No, I do not think that they would put them at risk. Sorry for the pause before responding there; it took me a while to work out the implications of that. The scheme that has been proposed here just adds extra costs. We acknowledge that there are extra costs coming from the scheme that is being proposed for the whole of the UK. That will be in the form of extra costs on premiums, going forward. However, we think that those are proportionate. The costs for this Bill will be additional, but I do not think that they would conflict with what we are developing across the UK.

[29] **Ms Glasspool:** We would have to look at how we deal with the extra costs, because we do not have them in our reserves. They are not what we expected to pay out, because they are new costs. Therefore, we do not currently have accountability for those additional moneys.

[30] **Mr Clayden:** A point that I would like to make on that is that this is an issue that is going to be with us for the next 30 or 40 years. We do not know how it is going to develop. We are dealing with what we know now and what we have to deal with now. It would have a dampening effect on any ability or desire to do anything in the future. It is fair to say that part of the reason why insurance companies have engaged in the process of looking for a solution is because of the nature of the disease with which we are dealing. We have looked at the costing and said, 'Yes, this feels right.' This Bill was not part of that contemplation, so it does feel like an extra burden is being imposed, which feels a little bit unfair when we are stepping up to the plate, it is fair to say.

[31] **Darren Millar:** I have one more question, if I may, Chair. What proportion of public sector employers in Wales, do you think, would be affected by these compensation arrangements? Asbestos is being ripped out of Bronglais and Glan Clwyd hospitals at the moment.

[32] **Ms Glasspool:** It is difficult to give an absolute figure on that. We think that, under your proposals, probably 40% would not come from an insurer and would fall to local government bodies or pre-privatised industry, such as steelworks, et cetera. When we looked at the impact assessment, it was not clear that it had necessarily been taken into account that, whereas you get some moneys back, you have to pay a lot of moneys out as a compensator, not just as an administrator of the scheme.

[33] **Mr Starling:** In terms of current exposure—you mentioned people who are currently removing asbestos—there would be the absolute expectation that there would be full protective equipment and so forth to ensure that there is no negligent or dangerous exposure.

[34] **Darren Millar:** Okay. Thank you.

[35] **Mark Drakeford:** I am slightly anxious about the time, but, before we leave this issue, I wish to go back and put one point to you to see what your response to it would be. While the discussion that we have just had about the compensation scheme has been very interesting and very laudable, no doubt, what has it to do with this Bill? This is not a Bill about compensation; it is a Bill about the recovery of medical costs. Where is the connection between what we have been exploring and the Bill that this committee is considering?

[36] **Ms Glasspool:** The connection is probably the motivation. As I understand it, the motivation behind the Bill is to use that money to specifically help asbestos sufferers, and the motivation behind our mesothelioma reforms is exactly the same.

[37] **Mr Starling:** To clarify, part of our reforms that are still under discussion is to enable some of the money that is raised to be used for ongoing research. The insurance industry has already put some money into research led by the British Lung Foundation, which has already had some quite major benefits, for example, in setting up a mesothelioma tissue bank, which has not happened before. Part of this scheme will be to channel money into ongoing research. I am trying to avoid the cliché, but mesothelioma has been a bit of a cinderella in cancer research, and there are some promising avenues around gene therapy and so forth. The great win for everyone would be if we could develop something that drastically minimises the symptoms or even stops it from being a fatal disease. That is why we think that what we are proposing is potentially so important and significant. It could well achieve the sort of things that you would like to achieve via this Bill.

[38] **Mark Drakeford:** Thank you very much. I will go to Jenny next—sorry, Rebecca, you have a question on this point, do you?

[39] **Rebecca Evans:** Yes. On the use of recovered moneys, I would like to explore how you think that the moneys would be best used. You mentioned research, but, in your paper, you say that

[40] ‘the proposed solution of returning the recovered charges back to Welsh Ministers rather than to the health bodies does not guarantee help to asbestos-related claimants and creates further complexity’.

[41] I cannot see how, by returning the moneys to the health boards, you would be furthering research. Do you have any views on how the moneys could be best spent?

[42] **Mr Clayden:** To be honest, I am not clear from the Bill what the intention is and what the mechanism is. One of the features is that it returns the money to general taxation. I think that there is a separate issue in terms of legislative competence in that area, which it may be useful to touch upon. In terms of the overall issue of where money is best spent, dealing with people who are not getting compensation presently should be, and is, a priority. I think that money for research more generally is best channelled through a centralised UK-wide pool. The charities and research bodies work on a national and international basis. On an annualised basis, I wonder whether the money from this Bill would make a massive difference. It is better off being funded centrally.

[43] **Jenny Rathbone:** My understanding is that it would not go into general taxation; it would go to the Welsh Government, which is responsible for funding the NHS in Wales. However, I wanted to pick up on the point that Nick Starling made in his opening remarks, which is that it would increase the burden on health bodies. Why do you think that is? You have already referred to the fact that there have been huge advances in medicine over the last 50 years, and we now systematically look for the cause of and type of malignancy in order to define precisely what treatment is best. That is done in all cases now, as far as I am aware. Therefore, I am not clear why having this scheme in place would place an additional burden on the NHS, because all the medical information that would be required to identify that this person had an asbestos-related disease would be gathered in any case as part of good practice in dealing with the patient.

[44] **Mr Clayden:** There is an issue around causation, of course. The other feature is that, given the nature of people who have mesothelioma and die from it, there are comorbidity issues. So, there may be other conditions for which somebody is being treated. That is a pretty regular occurrence, given the age of the people involved, so you have the issue of what is attributable to the mesothelioma and what may be linked to other medical conditions that they suffer from. There will be a question as to how much it is. The mechanisms for tracking what the charges are would inevitably be under scrutiny.

9.30 a.m.

[45] I will explain this in terms of a related issue that may give some insight as to where this might go. That issue is bridge strikes, which might appear slightly unrelated, but I will get there. Very regularly, cars hit bridges over which railways go. There has to be an inspection of the bridge and repairs carried out, and the relevant bodies will present a bill to motor insurers. These things regularly go through the court process. I have been involved in cases that go to the Court of Appeal, where those charges have been challenged and the records scrutinised. All of that occurs. There is an issue of what is recoverable and then there is the question of how much. So, scrutiny and challenge of that is, frankly, inevitable, and that creates an additional burden, from a clinical point of view, of having to make decisions on attribution between different causation and treatment and how much.

[46] **Jenny Rathbone:** Yes, but this Bill is quite narrow in its definition of the cases that would be involved. Mesothelioma is terminal. So, if the person also had diabetes, that would be unfortunate, but it would not be the primary cause of death. That would be the mesothelioma.

[47] **Mr Clayden:** There would be a review, I suspect, in every case of the breakdown of costs that were being sought. The assessment that we have made is that this will add approximately £25,000 or £26,000 to every case. The reality is that that would come under scrutiny. I would be surprised if it just went through on the nod.

[48] **Jenny Rathbone:** Fair enough, but that would, presumably, be part of the compensation scheme, because it would be a cost to the NHS. Therefore, it would be part of

the payout.

[49] **Mr Clayden:** I do not believe that it would be, no. You would get into the challenges of the bridge strike cases of what is in and what is out.

[50] **Ms Glasspool:** It is quite difficult. In relation to the current scheme, where we recover under injury, it was decided specifically to exclude disease because of various complexities. I had a car accident a couple of years ago and I broke my leg. There was a specific incident, an ambulance came to take me to the hospital, my leg was put in plaster, I spent a night in hospital and I was out the following day. So, it was very clear when I had the injury and the treatment that I had was very frontloaded after that one-off incident. However, it is not that clear with disease, and because of the age of the patient, as Dominic said, they often have other conditions. So, it is about working out the treatment that was attributable to that disease and the date of diagnosis. If you look at lung cancer as a result of asbestos, you will see that you often have contributory negligence factors and other conditions to take into account, which makes it very different from an accident claim. That is why, from my understanding, disease was excluded under the current scheme.

[51] **Mr Starling:** There is also the point at which compensation is paid. If we are successful in speeding up the compensation, it is inevitable that a lot of the medical treatment will be after that compensation is paid. So, the point at which you start and stop counting is another issue.

[52] **Jenny Rathbone:** That is true, but, nevertheless, it would certainly include the cost of diagnosing and identifying exactly which type of asbestos-related disease the patient was suffering from. It is a bit like the advances in DNA science. It will presumably be possible to identify that a piece of asbestos lodged in a person's body can be matched to the type of asbestos that was used in the school where they worked or whatever the circumstances may be.

[53] **Mr Clayden:** I do not believe that that would be the case, to be honest.

[54] **Jenny Rathbone:** I do not see why not, given the level of detail within medical science.

[55] **Mr Clayden:** I do not foresee that at present. The reality is that this is a dose-related risk. It is one fibre, and people may have many hundreds of thousands, or even millions, of fibres in their lungs, so how do you work out which one it is? The other feature is from a clinical point of view. My understanding is that, increasingly, biopsies of the lung while people are alive are regarded as not necessarily the best thing to do, because they may cause the spread of the cancer, or accelerate it. So, the only actual diagnostic tool is on a post-mortem basis. Again, you would get into debates over whether that is a treatment cost or not. Unfortunately, what was not totally clear-cut, certainly when I went through this, is what is proposed to be in and what is not on a practical level.

[56] **Mark Drakeford:** I want to be clear about at what point some of these issues become an issue for this Bill. The Bill is not about establishing liability or compensation. All of that happens, and triggers the mechanism in this Bill. Some of the things that we have just rehearsed are things that are going to have to be thrashed out whether the Bill is there or not. The Bill is to do with the recovery of costs. Mr Clayden, if I understand you rightly, you say that there will be a lot of argy-bargy about which of these costs is really associated with an asbestos causation of disease. A disease may have many causalities; there may be other things involved. Is that where you think the complication will come into this?

[57] **Mr Clayden:** I do not believe that disease will have many causations. If somebody

has a medical condition, it may not simply be an asbestos-related condition; they may have other ongoing conditions—diabetes or all manner of things—because we are dealing with things that tend to happen later in life.

[58] **Mark Drakeford:** So, separating the costs that the NHS is incurring because of asbestos and the costs that the NHS is incurring because it is treating that same person for a range of other things is where the complexity would come into this. Okay. Thank you.

[59] Turning to your bridge analogy, the Bill suggests a tariff-based approach and, unlike your bridge analogy, it would not be a matter of going through each item on the bill and arguing whether it was a legitimate cost or not. The Bill states that in order to be more straightforward and simple in compensation, a tariff-based scheme would operate. Am I right in thinking that some of those things would not be so complex?

[60] **Mr Clayden:** That gets into article 1 protocol 1, as to whether or not a tariff is a proportionate response in terms of how it is calculated. The amount would have to be understood against a base level of what costs would be incurred, and that could be reviewed on a regular basis.

[61] **Mark Drakeford:** I see how you could take that line of argument. However, assuming that the mechanism that the Bill establishes is established, and there is a tariff, would that reduce some of the level of complexity, compared with the bridge compensation analogy that you offered?

[62] **Mr Clayden:** I suspect that there would be challenges, because tariffs are also sought in bridge-strike cases. That has been part of the litigation.

[63] **Mark Drakeford:** We will go to William next for his substantive question, and then across to Rebecca and Elin.

[64] **William Graham:** On administration, what assessment have you done to the role of the compensation recovery unit? Do you think that that is the best way in which to proceed, assuming that the Bill goes ahead?

[65] **Ms Glasspool:** The administration cost of recovering the money needs to be looked at in more detail by whoever co-ordinates that. The CRU currently administers the injury codes on behalf of the Department for Work and Pensions, and that works well. I am not sure as to how this would apply in identifying the various health bodies that have had touch points with the asbestos victims. The explanatory memorandum states that that is one of the reasons why the money would be kept centrally, because giving it back to relevant health bodies, as currently happens, would be quite difficult. So, the cost would be more than anticipated for the CRU to co-ordinate that.

[66] Also, as currently happens, if I had an injury—such as the one with my broken leg—and I made a claim, I would automatically write to the CRU for a certificate detailing my hospital treatment. It would then write to the hospital to see what the charges were, and then it would use the tariff to pay it back. I am trying to work out how we would make sure that everything there would be captured under this scheme and whether we would have to check, for every asbestos claim, whether it was subject to Welsh, English or Scottish treatment, and how the administration would work.

[67] **William Graham:** One thing that always exercises committees here is the difference between what is actually on the face of the Bill and what is subsequently left for regulation or further legislation. Do you have any comments on that?

[68] **Mr Starling:** Do you mean in terms of the Bill, on the face of it, being quite straightforward but the subsequent legislation being quite complex?

[69] **William Graham:** Quite. There is always the worry that we do get to test the items in the Bill today, but we do not get the chance to test the regulation.

[70] **Mr Starling:** I think that the complexity will come out of the sorts of things that Dominic Clayden has talked about, which is how, exactly, you set up a tariff system—if you are going to do so—and how you allocate the costs. That is where any sort of secondary legislation would introduce complexity, but I do not think that it would introduce any additional complexity on top of what is on the face of the Bill.

[71] **Mark Drakeford:** The first question that Mr Graham asked you was put to the Member in charge last week. I think that he said to us that he thought that it was quite straightforward; so, I just want to check this with you. I think that he said to us that it would not matter where the disease had been caused—England, Scotland or anywhere else—but the costs involved are costs that are incurred by the Welsh NHS. Do you not see the Bill as being clear on that or should we consider that as an issue?

[72] **Ms Glasspool:** I think that it needs a bit more investigation. It would be worth looking at the recommendations under the Law Commission report, and the Northern Ireland report, as to why disease was excluded, because the cost to recover would outweigh the benefit.

[73] **Mark Drakeford:** I now call on Rebecca.

[74] Awn at Elin ar ôl Rebecca. We will move on to Elin after Rebecca.

[75] **Rebecca Evans:** As an association, do you have a general opposition to the principle that the NHS should be able to recover costs from someone who is responsible for incurring those costs?

[76] **Mr Starling:** We do not have a general opposition. I think that we said in our statement that we accept that that principle is acceptable. There are two caveats to add to that. First, it needs to represent value for money, which comes to the point about complexity. So, where it is straightforward in terms of injuries we think that it is acceptable. What is absolutely key for our members is that you have to be able to write into your premiums what the anticipated costs are. If someone turns around and says that, in going forward, a particular sort of insurance has to cover a particular sort of cost, which it did not cover before, our members can sit down and say, 'Right; we will calculate that cost in our premiums, and calculate it going forward'. The issue is that the premiums were set many decades ago on the basis that it would just be liability that is paid. What has been introduced here is an extra cost. The principle here is not so much the issue of whether the costs should be paid by the liable partner but the issue of retrospectivity, where a retrospective cost is imposed.

[77] **Rebecca Evans:** With regard to the situation or the system around road traffic accidents and recovering costs to the NHS as a result, are there lessons that the committee should learn from that particular system? Do you see any particular problems with it?

[78] **Mr Clayden:** I do not think that there are any particular problems in terms of the mechanism in terms of recovery. It does add burdens, and if you asked the NHS, I think that it would tell you that it has sometimes struggled in terms of getting the paperwork in the right places to get that process to work. The point that I would re-emphasise is the one that Mr Starling makes, which is that that is a forward-looking view of the world. I would reiterate the point that we believe that what is unfair in the proposal is that this is a retrospective burden,

which is being sought suddenly to put on insurers.

[79] **Mr Starling:** Perhaps I could add a supplementary point to that. These costs do not disappear; someone pays. If you are talking about road traffic accidents, you would find that that was a shift of payment by the taxpayer—to a shift to payment by the premium payer who, quite often, is the same person. So, somewhere in the system, people are paying for it. I think that it is important to remember that. They are not absorbed by insurance companies. They are paid eventually by someone.

[80] **Rebecca Evans:** So, you would not be placing past liabilities on future customers.

[81] **Mr Clayden:** I think that there would be a question of how that is dealt with, and perhaps it would be useful to explain how we would have to reserve. I have heard mention on occasions that it would not be much every year. However, that is simply not the case. Given the way that we are required by law to hold money, we have to hold the total amount that would be incurred all the way into the future; so it creates a lump sum or one-off hit to insurers.

9.45 a.m.

[82] So, we have to go, 'We think this will cost each individual company x amount of pounds every year projected forward into the future' and then there is an actuarial calculation discounting against investment return, balanced against inflation. However, there is a one-off hit; it is not the case that it will not cost you a lot every year in the grand scheme of things—there is a perception that insurers have deep pockets. It would create that one-off hit, and the market would have to work out whether the insurers involved had to take it as an individual pressure or whether it would be reflected in prices. It is a complex market dynamic as to where that would land, but it certainly would be a one-off hit in the multiple millions for insurers.

[83] **Mark Drakeford:** Jenny, is there anything that you want to ask on this?

[84] **Jenny Rathbone:** We keep on coming back to this point. You are in the risk business. When you give a person or a business a quote or insure them against possible risks, your actuaries do all the analysis about possible risks, which might include things that have not yet been envisaged. I am struggling to understand how you do not recognise that the costs of asbestos-related diseases, which may not have been envisaged in the 1960s, are, nevertheless, part of the risk business that you are in.

[85] **Mr Clayden:** The position is that we have to hold reserves against the known risks that we have. What we are not allowed to do is to say, 'All sorts of things may happen; therefore, we will hold that in reserves'. We would be subject to revenue scrutiny for holding back profits and not paying tax on them. You could say with your tongue in cheek that if you wanted to do that, it would be an easy mechanism for insurance companies to avoid paying tax. We are required to hold reserves against the known liabilities that we have. So, I will be clear: there are not reserves set aside to deal with this issue.

[86] **Jenny Rathbone:** But it is possible to make a special charge against reserves.

[87] **Mr Clayden:** But the money has to come from somewhere. We would have to—

[88] **Jenny Rathbone:** Indeed, it has to come from somewhere. I agree with you.

[89] **Mr Clayden:** So, we would have to put that in as a one-off hit.

[90] **Elin Jones:** On this principle of the retrospective implications of this legislation, do you have any examples of where other legislation has broken this principle? Is there any other legislation that you can think of that has put insurers in this position of retrospectively having to pay against something that their premiums did not reflect?

[91] **Mr Clayden:** The only other case that I am aware of is a challenge that was mounted in Scotland against pleural plaques compensation, which went all the way to the Supreme Court. The Supreme Court held that the balancing position between compensating people for pleural plaques and insurers was a reasonable decision by the legislators. One of the difficulties, which would be subject to a potentially different challenge in this instance, is that it is not a question of providing compensation for an individual, but of whether the money should go into the central taxation pot. You would get into a debate over what should be paid out of general taxation and what should be specific, and that would be a separate area of consideration in this proposed legislation.

[92] **Ms Glasspool:** It is important to stress that it is not just insurers; we think that about 40% would be a retrospective cost that local authorities would have to incur now.

[93] **Elin Jones:** On the general principle of this kind of legislation, do you have any concern at all that, if this legislation was enacted, it could set a precedent for other legislation that might come along on other industrial injuries or industry-related diseases? This is specific to asbestos, but there are other diseases out there that could fall into a similar category.

[94] **Mr Starling:** The short answer is, 'Yes, that could clearly happen'.

[95] **Mark Drakeford:** I will look to see whether Members have any further questions in a moment, but I have just three quick points that I need to put to you myself. First of all, I wonder whether you could help us in relation to the precedent or otherwise of motor accidents. What was the effect on premiums of that change in the law?

[96] **Mr Clayden:** The short answer is that I cannot be specific. What I can be clear on is that it was included in prices going forward. The claims cost rose, and the claims cost is the driver of the premium.

[97] **Mark Drakeford:** It has been put to us that, if you analyse premiums post 1999, you will find that there is no evidence of their being raised to take account of the new road traffic accident liabilities that were created.

[98] **Mr Clayden:** I am somebody who helps set the reserve and pricing for our company, and I can absolutely assure you that we take into account all the costs that we pay out in claims, including the liability for road traffic claims. That is included in the premium that everybody pays, absolutely. It cannot go anywhere else.

[99] **Mark Drakeford:** My second question is in relation to the Law Commission. In your written evidence, and a couple of times this morning, you have referred to its views on the distinction between the recovery of costs involving accidents and the recovery of costs in relation to diseases. I apologise if you have not had a chance to see the letter that the Law Commission wrote to us. Although it is in the public domain, it may not have come to your attention. I want to put to you what the Law Commission said to us in correspondence. We asked it about the point that you were making in your evidence, and it said:

[100] 'A search of our archive catalogue has shown that there are no files relating to this project extending beyond 2001. We were therefore at a bit of a loss as to what report the ABI was referring to.'

[101] It goes on to say that it contacted you, and it was established that you were referring to a Northern Ireland Department of Health consultation, but it then says:

[102] ‘As far as we are aware the Law Commission has never expressed a firm view on whether the NHS cost recoupment scheme should extend to industrial diseases’.

[103] **Mr Starling:** We will have to write to you about that, Chair, because we are not familiar with this letter.

[104] **Mark Drakeford:** We will make sure that the letter is specifically drawn to your attention. When I saw its letter to us, I felt that it was not quite as definitive as your evidence seemed to suggest, in saying that the recoupment of NHS costs was something that the Law Commission was specifically recommending against.

[105] The third and final point from me: in your written evidence, but not in your oral evidence today, you say quite a lot about the issue of scope and competence. I want to be clear that competence is not a matter for this committee—it is a matter for the Presiding Officer, and she has made her determination. However, she did write to us setting out the issues that she had weighed up and, as a result, we have said that we will ask relevant witnesses about the issue of competence, so that the Presiding Officer can consider the evidence that you put on the record. Here is an opportunity for you to take a few moments, if you would like to, to rehearse the arguments orally that you have put to us on paper on that point.

[106] **Mr Clayden:** Inevitably, it can be only a short conversation. It is certainly our belief that there is a material question as to whether this falls within legislative competence. It is clear that health and health services do fall within competence, but revenue-raising, in our view, does not. Part of this involves specific, detailed arguments around section 15, et cetera. However, the reality is that if something has big ears and a trunk and is grey, it is an elephant and, by any other name, this is an area of revenue-raising. The draft Bill is not clear, first, in respect of any return of money directly to the hospitals concerned or even what would happen if it went beyond that point. I come back to the question: what is the actual purpose here? It is revenue-raising, and in terms of competency, our and my view is that that would place it outside.

[107] **Mark Drakeford:** Thank you very much; I just wanted to make sure there was an opportunity for you to get that on the record as part of this morning’s proceedings. I have three people with one very brief question each to round off the session. Gwyn is first, then Darren, then Jenny.

[108] **Gwyn R. Price:** Following on from that, would you support the Bill if it was made clearer how the recovered money would be used to support victims of asbestos-related diseases?

[109] **Mr Clayden:** In summary, from the broader conversations that we have had about what is going on at the UK level, we would not support this Bill generally. We would urge you to reconsider it.

[110] **Darren Millar:** I have just one question, and it is on the additional costs. You have said that those who pay premiums would effectively end up paying for the cost of the scheme. Which premiums payers would those be? Would they be specifically Welsh employers, English employers, Scottish employers, et cetera? Would they be UK-wide premiums? Or would they just be Welsh premiums? Is there an additional cost for Welsh businesses?

[111] **Mr Clayden:** I think that there is a question as to whether it could be passed on. The

reality is that we live in a competitive market, so if there is a company that has a historical book and another that does not have one, could the company include it in its price? It may not be recoverable; it may just be that the reality of the situation is that it is a retrospective, unforeseen hit that companies have to take.

[112] The feature that it does draw into, though, in terms of the people who set prices in an insurance company, in the broader weighing up of the risks associated with insuring people in Wales—we touched briefly on our concerns about extension to other areas—is that it would generally put a doubt in people’s minds in terms of what it would be to insure somebody in Wales; that is, ‘Are we going to get anything else coming out in the future, and what does that mean?’ There is an additional risk. It is a problem.

[113] **Jenny Rathbone:** If this Bill goes ahead, do you think that it will make organisations more aware of the potential risks of asbestos, and therefore more mindful of the risks to their employees, with less likelihood of claims as a consequence?

[114] **Mr Starling:** I declare an interest here as a former policy director for the Health and Safety Executive.

[115] We very much hope that the risks of asbestos are much better understood now so that people are not being exposed to it. Of course, the only risks around asbestos now are to do with maintenance, where people are unaware of its presence, or removal. We do not have the massive risks that occur with using it as a primary material. We therefore very much hope and expect that, in the future, these risks will be better understood, but we are not complacent about that. One of the things that we did with the British Lung Foundation was around awareness campaigns. There is a general concern that people think that asbestos is a problem of the past and that we do not need to worry about it, but that is not the case.

[116] One of the purposes of insurance is to help with risk management, and in this case, where it talks about exposure that occurred a long time ago, it is a relevant question, but less relevant to this particular issue.

[117] **Jenny Rathbone:** So, a heightened awareness among Welsh companies might actually reduce their insurance costs.

[118] **Mr Starling:** Most of the exposure to asbestos now is via specialist companies that have particular arrangements to deal with asbestos. I do not think that it is more general.

[119] **Jenny Rathbone:** Once people have understood the problems, yes, that is the case. However, there are still risks to do with schools not being aware that asbestos is leaking and not dealing with it in a timely fashion, for example.

[120] **Mr Clayden:** I would hope that that awareness is already there. It is certainly a conversation that we would have with customers all the time.

[121] **Mark Drakeford:** Thank you very much indeed. We are right at the end of our time with you this morning. We have had a pretty comprehensive run through the major issues, but we have just a couple of moments left at the end. So, if there are any points that you feel have not emerged with the clarity that they ought to have or with the strength needed that you think it is important that we, as a committee, are clearly aware of, there is just a moment, now at the end, if you want to put any final thoughts to us.

[122] **Mr Starling:** May we just make a subsidiary point about the Law Commission?

[123] **Mark Drakeford:** Certainly.

[124] **Ms Glasspool:** Sorry, but I have just looked back over my notes. In 2002, the UK Department of Health consulted on whether to extend the recovery of costs to disease, but concluded that there were too many practical issues that outweighed the benefit. That view was shared by the Northern Ireland department of health in 2003. We will write to you on that point.

10.00 a.m.

[125] **Mark Drakeford:** Thank you for that.

[126] **Ms Glasspool:** The other point to make clear is that an average damages compensation payment for a mesothelioma victim is around £200,000, and an element of that is care that we would pay for. It is important to understand what these additional moneys would be used for in addition to the care that we would already pay for in compensation.

[127] **Mr Starling:** We will distribute to Members a leaflet that we have prepared on the UK scheme that we talked about earlier.

[128] **Mark Drakeford:** That is very helpful; we would be glad to have a copy of that. Diolch yn fawr iawn i chi i gyd. Thank you very much for coming to help us with our enquiries this morning.

[129] **Elin Jones:** Chair, do we have a copy of the Law Commission letter in the papers?

[130] **Mark Drakeford:** Yes, I think we distributed it separately earlier on as a paper to note.

[131] **Elin Jones:** Do you think that we could have a note about the consultation that the Department of Health did in 2002 on co-morbidity—or perhaps not on co-morbidity, but on extending to disease—

[132] **Mark Drakeford:** It is on the distinction between accidents and disease, is it not?

[133] **Elin Jones:** Yes.

[134] **Mark Drakeford:** Yes. Robin is familiar with this distinction and will get a copy of that for Members.

10.02 a.m.

**Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Cyfnod
1—Sesiwn Dystiolaeth 5
Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Stage 1—
Evidence Session 5**

[135] **Mark Drakeford:** Bore da a **Mark Drakeford:** Good morning and
chroeso. Diolch yn fawr am ymuno â ni y welcome. Thank you very much for joining
bore yma. Croesawaf ein tyst nesaf, Mr us this morning. I welcome our next witness,
Simon Cradick, sy'n cynrychioli fforwm y Mr Simon Cradick, who is representing the
cyfreithwyr yswiriant yng Nghymru. Diolch forum of insurance litigators in Wales. Thank
am ddod i'n helpu y bore yma. you for coming to help us this morning.

[136] Mr Cradick, I will offer you a couple of moments at the beginning to make any

introductory remarks that you would like to offer us. We will then go straight into questions from Members. We have only half an hour for this session, so I apologise in advance if I do not manage to call absolutely everybody. However, we want to make the most of your time with us, so we will go straight into your opening remarks.

[137] **Mr Cradick:** I have not prepared any opening remarks, Chair. I am a partner in the firm of Morgan Cole. I am based in Cardiff and am a member of a special interest group that is part of the forum of insurance litigators that deals with industrial disease claims. A large part of my case load, my work and expertise, is in industrial diseases, particularly with regard to asbestos. FOIL received an invitation to make a submission and felt that it would be improper not to do so and, for reasons of geographical proximity, I appear before you today. In practical circumstances, it is as a practitioner that I appear.

[138] **Mark Drakeford:** It is very helpful for us to have a view from the front line in that way.

[139] **William Graham:** Thank you for your evidence, first of all. You note that you foresee a number of practical difficulties in terms of disease claims generally. Can you help us with that? For example, you say in your paper that

[140] ‘the profile of health services costs for disease cases may be weighted towards the period after compensation has been paid and will therefore not be recovered...many of the costs are likely to occur within the primary care sector and...are not proposed for recovery.’

[141] **Mr Cradick:** In 2003, when the UK Parliament extended the scheme with regard to road traffic accident recovery to employers’ liability and public liability claims, there was a consultation where considerable consideration was given to whether that extension should include industrial disease claims. I have not done exhaustive research into that consultation and what its conclusions were, but the conclusion was that it would be impractical to incorporate industrial disease claims for a number of reasons. With regard to a couple of those, I am not ashamed to say that I found something from the Scottish Parliament and copied and pasted it in.

[142] In reading through the explanatory notes, I was a little surprised that there was not an analysis of what those reasons were in 2003 for not including disease claims and why, with regard to these provisions contemplated here, those reasons would not apply—whether they were no longer valid, or whether they would not apply in particular to asbestos-related disease.

[143] The issue in terms of recovery is highly relevant when you are looking at mesothelioma claims. It is a point that has been raised in the paper submitted by FOIL, and it is probably the most important point that it makes. There is a driver throughout the insurance industry, which is pushed down on us as practitioners, to settle these claims at the earliest possible juncture. As time has gone on, diagnosis has become better, the symptoms are better recognised and diagnosis is made at an earlier stage. The average life expectancy is 12 to 18 months. Most hospitals and most consultants will immediately refer someone who has been diagnosed for legal advice, possibly to a recommended firm of lawyers. Claims are therefore made at a very early stage. The insurers are now geared up to deal with these claims very promptly. Investigation tends to be because the claims are so old that it tends to be very difficult; there is now a database of companies and businesses, and a general knowledge of where and when you would expect there to be exposure to airborne asbestos fibres.

[144] So, claims are being settled at a very early juncture. In the last two years, my personal case load in terms of mesothelioma claims has reduced significantly because insurers are settling these claims at an early stage, prior to litigation. The Bill, as I read it and as I think it

must be interpreted, is to recover NHS charges incurred up to the date upon which the settlement is achieved. It did not appear to me in the explanatory notes that consideration has been given to when that settlement might be achieved, and what element and percentage of the costs will have been incurred at that point.

[145] On the costs, again, I have not done any personal research and I have not been able to look at the breakdown of the costs that have been employed. However, the natural history of the disease is that the victim is in—I hesitate to use the words ‘reasonable health’, but does not suffer initially; it is in the last two or three months, the terminal stages, where the major healthcare kicks in, after the cycles of chemotherapy and radiotherapy. It is at that point where there is significant in-patient care. It does seem, therefore, that if claims are settled, as they are, at an early stage, the majority of the charges would fall outside the scheme as it stands, because those charges would be post the date of settlement and date of compensation payment.

[146] **William Graham:** Could you just guide us with your professional opinion? Is it your evidence that you think that these claims will reduce, because they will be settled earlier?

[147] **Mr Cradick:** Litigated claims, yes. Undoubtedly. That is not entirely for altruistic reasons—it is because the insurers do not want to pay me and my colleagues on the claimants’ side; they do not want pay lawyers. So, the earlier they settle, they exclude legal costs of their own, and they will reduce the costs recovered by the claim. So, there is undoubtedly a driver to settle all these very early.

[148] **Mark Drakeford:** It is an important point for the committee, so I am going to raise it one last time with you. Last week, we heard evidence that suggested the opposite: that because the settlement of a compensation claim will trigger another set of costs for the insurer, because they will now have to pick up medical costs as well, they will fight those claims even harder and cases will become more drawn out and will be more difficult to settle. You are saying to us from a practitioner’s point of view that you think the driver will be in the opposite direction: to settle early in order to minimise the medical costs.

[149] **Mr Cradick:** It is an issue of cost-benefit analysis, depending upon the amount of money and the exposure that would come from the NHS charges. If you take a ballpark figure from the explanatory notes—I do not know whether there is any justification for this figure—of £24,000 and say that 25% of those costs are incurred prior to settlement and 75% apply to the last two or three months, then, the compensator is going to look at that and say, ‘Well, the earlier I settle, the more I save’. That is in terms of mesothelioma. Mesothelioma is unique among injury claims in the UK at present in that you do not have to prove, on the balance of probability, that the compensator was the cause of the injury; you merely have to establish that they increased the risk of the disease developing. It is quite a technical point, but it is, at present, the only case where, even if you cannot prove, on the balance of probability, that the compensator was liable, you can still succeed in the claim. That means that those type of claims are settled; liability is very easy to establish, so those claims are settled. Asbestosis—diffuse pleural thickening—is a different kettle of fish.

[150] **Gwyn R. Price:** Do you think the estimated costs associated with implementing the Bill are realistic and reasonable?

[151] **Mr Cradick:** I cannot comment on that. I have not done any research. Clearly, some research has been done into it, but I cannot comment.

[152] **Mark Drakeford:** Jenny, did you want to go next?

[153] **Jenny Rathbone:** No, I think I will pause.

[154] **Mark Drakeford:** I will call Darren in that case.

[155] **Darren Millar:** I want to explore this in a bit more detail. I was expecting you to come to the committee today and say that this is great and very good news for your industry, given the potential long drawn-out legal processes that might arise as a result of claims being disputed and negotiated et cetera. You do not seem to be saying that, however. Can you tell us precisely what the position of FOIL actually is? Do you support the need for a Bill in this area or not?

[156] **Mr Cradick:** I query the question and the reference to need. FOIL, and I personally, do not see why there needs to be a Bill in Wales as opposed to the UK. Wales is no different from any other part of the UK in terms of this. So, in terms of the need, I would say that I do not see that. If you are looking at desirability, that is a slightly different question. Our view is that, when it comes to mesothelioma claims, if the average cost of a mesothelioma claim is probably £150,000 and you add 10% for NHS charges, it is not going to change the major driver. I do not see that, in respect of mesothelioma claims, you are going to have any change in behaviour, and, for the reasons I have explained, there may be a driver to settle at an earlier stage. They may even identify Welsh claims in order to expedite them because they would be cheaper to settle at an earlier stage than their English counterparts.

[157] There are major differences with regard to lung cancer and asbestosis, where diagnosis and the attribution of asbestos-related disease are much more difficult. Mesothelioma has been in front of the House of Lords and the Supreme Court on three occasions. A massive amount of medical evidence has been produced before the court; that has been done, but lung cancer has not. There has been no equivalent litigation on lung cancer.

10.15 a.m.

[158] **Darren Millar:** So, on other asbestos-related diseases, which is what the Bill is trying to capture, you think that it would much more difficult to extend this to lung cancer, asbestosis—

[159] **Mr Cradick:** I think that you will have bigger issues in terms of causation and attribution. At the moment, lung cancer is almost invariably associated with smokers. It is believed that asbestos exposure and smoking act synergistically to increase the risk multiplicatively: in other words, 5% and 5% probably mean more than 10%. However, that has not been explored in front of the courts. Reliance is placed on some research that was published in Helsinki by a fairly small group of consultants a few years ago, but that has never been tested in front of the courts. If there were to be an explosion in lung cancer claims, this may well be an area that would likely be fully tested to establish exactly what had to be done to prove culpability of asbestos exposure as opposed to non-industrial causes. That is a difficult one, but, if I am honest, the liability that might be imposed by these regulations would not be a major trigger for that because we are talking about a fairly small number when you look at the issue nationally.

[160] **Mark Drakeford:** I would like to put a couple of questions to you. Last week, when the movers of the Bill were here, they said that they had made a number of decisions on the basis that they had resolved issues in a way that would contribute to administrative simplicity and efficiency. They told us at least four different things last week. The first was that they had decided that the Bill would only recover costs incurred in a hospital setting and would not cover costs in a primary or community setting. Secondly, they told us that they would stop the clock at the point when the compensation issue had been resolved. The third point was that they would have a tariff-based scheme, so it would not be a matter of having to explore the

specifics of every case, and the fourth was that they would use the compensation recovery unit of the Department for Work and Pensions as the way to run it. Their rationale for all of that was that it would make the consequences of the Bill easier to administer. From your experience on the ground, do those claims stand up to examination?

[161] **Mr Cradick:** The first two points do. Use of the compensation recovery unit would be far simpler for practitioners because the mechanism is there; I assume that it would operate in tandem with the existing regime. You would need to change the reporting mechanism slightly in that the comments would need to report that there had been treatment in a Welsh hospital, which means that there would have to be a request to the claimant to identify that. I do not know whether a separate certificate would be issued or a conjoined one, but, if it were a disease, then it would have to be a separate one because they do not issue conjoined ones in such cases. However, that would seem sensible.

[162] I am unclear what a tariff payment might mean. There is a big difference between a road traffic accident and an accident claim because by the time the claim is settled, with the best will in the world, 90%, if not 100%, of the treatment has been included. If there is long, ongoing treatment, it has probably hit a cap, so you know that you have a liquidated figure and you know what the figure will be. It is unclear at what point a settlement is reached in a mesothelioma claim where there is ongoing settlement—it is unclear at what point in the treatment it will settle and, therefore, I am unclear as to how a tariff would operate. If it is on a daily, in-patient and out-patient basis, then that could be calculated.

[163] **Mark Drakeford:** That was the example that the movers gave to us last week. You would count up the number of in-patient hospital days that someone had had, but you would not look in each case at how much the cost was; there would be a fixed price per night, which you would add up and that is how you would get the figure.

[164] **Mr Cradick:** That would be in line with the existing regime, and would work. However, as I say, there would be a question mark as to how many in-patient days would have been encountered at that point if claims were settled within six or nine months of diagnosis.

[165] **Mark Drakeford:** I am not sure whether you will be able to help me with my second question, but one theme that emerged a little last week and was certainly put to us by our last set of witnesses is that there is a distinction to be made between the private sector companies having insurance and the public sector. There is some debate as to what proportion of the costs that would be generated by the Bill would fall on public sector organisations. Those organisations may not have insurance to cover these sorts of costs. Do members of the Forum of Insurance Lawyers represent public authorities in these sorts of cases? If so, is there anything from that experience that you could suggest to us as being relevant?

[166] **Mr Cradick:** From the point of view of local authorities, it has never been compulsory to have employers' liability insurance. I would say that most had it. However, the great majority have their historic liabilities with Municipal Mutual Insurance, as it was, which was a mutual. As a result of legacy liabilities, principally of mesothelioma, the mutual is running out of money, so the local authorities will not have full insurance cover going forward. That fund will gradually diminish and local authorities will be bearing more of those liabilities themselves. There are other Government bodies—trusts and so on—that were exempted from employers' liability cover. There are certainly large private organisations with inherited liabilities where they will not be able to trace the employers' liability cover; they will, therefore, be uninsured.

[167] **Mark Drakeford:** From the public sector's point of view, there is a set of issues here that the Bill throws up that they would have to deal with.

[168] **Mr Cradick:** Yes. When the Scottish Parliament looked at the implication of pleural plaques, there was some research on what the liabilities would have been. It might be worth while looking at that.

[169] **Darren Millar:** As regards public sector liability, if a library were built and you had individual members of the public attending that library on a daily basis and being exposed to asbestos in it, those people would not be employees of the local authority that provided the library. However, they would be exposed as a result of the risk at which the local authority had put them if it was aware of the risks and so on.

[170] **Mr Cradick:** You are opening a can of worms there. [*Laughter.*]

[171] **Darren Millar:** Exactly. I am just trying to establish where the blame game goes and whether compensation is currently available to people who are exposed in that way under the existing arrangements. If this Bill goes ahead, would it be appropriate to extend the scope to allow for the recovery of medical costs from individual local authorities or other public bodies?

[172] **Mr Cradick:** There are two, if not three, points there. First, is there scope for compensation? Yes; through public liability claims.

[173] **Darren Millar:** Are many claims made? I suspect that there are very few at present.

[174] **Mr Cradick:** Yes.

[175] **Darren Millar:** Are there lots?

[176] **Mr Cradick:** Public liability claims are not as frequent as employers' liability claims, as you might imagine. However, the local authorities will certainly have liabilities from schools, for example, which is fairly topical. A case that hit the Supreme Court in the last two years involved a woman who sadly developed mesothelioma. The only exposure that she could identify was while she was at school. Repairs had been carried out at the school, and it turned out that ceiling tiles had contained asbestos fibres. The level of exposure was minute, and probably did not double the background risk—there is an ever-present background risk from airborne asbestos fibres. However, it was enough for her to prove it, because she had increased the risk of mesothelioma, so the claim succeeded against the local authority.

[177] Insurance arrangements for public liability claims are very different. It is now very difficult to get insurance for public liability claims, and has been for several years, as they are usually excluded from public liability policies. So, a lot of local authorities, public bodies and companies do not have—and, going forward, will find it difficult to get—public liability insurance for mesothelioma claims. There is another issue relating to a legal point, which I will not bore you with. The policies are written differently. It does not matter if you had a public liability policy at the date on which the exposure occurred, because the wording of the public liability policy means that it is triggered when the injury occurs, which is not the same wording as an employer's liability policy. Depending on which line of thinking you accept, the injury occurs either five years before diagnosis, which is when the tumour gains a blood supply, or 10 years before diagnosis, which is when the cell first mutates. There is a nice argument waiting to be had in the legal sphere as to which is which.

[178] **Darren Millar:** I wish to clarify this point. Do you think it would be appropriate for the Bill to be extended to allow for public liability?

[179] **Mr Cradick:** Why would it be extended?

[180] **Darren Miller:** I am just thinking—

[181] **Mr Cradick:** Is not the Bill, as it is—

[182] **Darren Millar:** As far as I understand it, it is just—

[183] **Mr Cradick:** It is about employers.

[184] **Darren Millar:** It is all employers, is it? Regarding the impact of public liability insurance claims, I do not know how many public liability insurance claims there are in Wales relating to asbestos-related diseases, or the scale of the potential impact of that on the public sector.

[185] **Mr Cradick:** They are much rarer.

[186] **Darren Millar:** I see. How many have you seen at your practice?

[187] **Mr Cradick:** I cannot quote any statistics; anything that I suggest would be unreliable. It generally tends to be in cases where there is no exposure during employment that one tends to look back for other possible sources, and that is when the public liability aspect kicks in. However, there is no doubt that, going forward, there will be scope for cases where people have no exposure in employment, so they will start looking back to schools, public bodies, and so forth, to see if they can establish something. I already have one claim where there is absolutely no evidence that the person was exposed at school, but she asserts the circumstances that there was asbestos there. We are trying to find out whether, 30 years ago, there was asbestos at the school. It is extremely difficult.

[188] **Mark Drakeford:** We have time to squeeze in a question from Rebecca.

[189] **Rebecca Evans:** In your evidence, you say that one practical difficulty is the fact that the profile of NHS costs may be weighted towards the period after compensation has been paid, and therefore will not be recovered. You have also spoken about that earlier today. To put this in context, could you give us a sense, based on your experience as a practitioner, of how long cases tend to take in order to reach compensation, and at what point in the progression of this disease does this take place? I know that it is difficult, but maybe you could give us a picture of that.

[190] **Mr Cradick:** I can only speak as a practitioner dealing with litigated cases. If there is a litigated case, it has proceeded some way down the line. Alternatively, it may be that the solicitors have been instructed late in the day, and the claimant is nearing the terminal stages of the disease, and so they issue proceedings straight away. Indeed, in those circumstances, there is still a drive to have a settlement as instantly as possible. In the usual, run-of-the-mill claims where diagnosis is made at an early stage, consultation with solicitors is conducted at an early stage and the incompetence is identified. I do not have any statistics that I can quote, though your previous witness might have been able to provide some if he was from the Association of British Insurers, but I would imagine that claims are settled in six to nine months in those cases. That would, on average, be well before the terminal stages of the disease, which is where the vast majority of costs are likely to be incurred. I cannot give a breakdown, and I do not know whether that research has been done. However, that is where the in-patient care comes in.

[191] **Mark Drakeford:** I have one final question to ask, though I do not know whether you will be able to help us with it immediately. The Bill provides a list of what it defines as asbestos-related diseases. If you have had a chance to look at that list, would you say that it is

adequate?

10.30 a.m.

[192] **Mr Cradick:** Yes. There are only four principal related diseases: mesothelioma; lung cancer in the presence of significant asbestos exposure; asbestosis, although, clinically, you cannot diagnose asbestosis other than by reference to history—it is clinically indistinguishable from idiopathic pulmonary fibrosis; and diffuse pleural thickening. Pleural plaques is a fifth, but it is symptomatic, and it is not actionable other than in Scotland.

[193] **Mark Drakeford:** Therefore, do you think that the Bill is satisfactory from that point of view?

[194] **Mr Cradick:** Yes. There may be other very rare diseases, but I have never come across them.

[195] **Mark Drakeford:** Diolch yn fawr. **Mark Drakeford:** Thank you very much. Mae'r dystiolaeth wedi bod yn ddefnyddiol The evidence has been very helpful to us. iawn i ni.

[196] **Mr Cradick:** Croeso. Gobeithio bod **Mr Cradick:** You are welcome. I hope that it hyn wedi bod o help. has been helpful.

[197] **Mark Drakeford:** Ydy. Diolch yn **Mark Drakeford:** Yes. Thank you very fawr. much.

[198] **Elin Jones:** Chair, one issue that has emerged from both sets of evidence is the issue of the public sector. The previous evidence said that about as much as 40% of the cases may well fall within the public sector. I am not sure whether that is an issue in terms of our own scrutiny, but the evidence sessions will draw that out, so will the public sector be coming in?

[199] **Mark Drakeford:** I think that it is an issue for us, because the point that is being made to us is that, in the end, it will represent a circulation of public money, where money is taken out of one public sector pocket to be put back into another, and incurring costs along the way to do it. It is a legitimate question for us at Stage 1. Written evidence has come in over the last few days—which is in the pack—from the Welsh Local Government Association. It rehearses this issue as its main point. The clerk has contacted the WLGA and asked it whether it might be able to do some more work on some of the things that it has stated, and then come in to provide oral evidence. We have identified a slot in a couple of weeks' time when that could happen. For me, it depends on whether or not it is able to provide more specific detail and quantification of some of the points it makes in its written evidence. It has promised to do some work in the next couple of days to see how much it could obtain for us in the next two weeks. We will then make a judgment as to whether or not it is worth having the WLGA in. Given that this has emerged as an issue, it would probably be worth having one session where we focus on that specifically.

[200] **Darren Millar:** We have been concentrating on other employers.

[201] **Elin Jones:** Yes, and it will equally be an issue for the Minister, because the NHS is a large employer, and asbestos is an issue for hospitals.

[202] **Mark Drakeford:** Yes. According to some witnesses that we have heard from, the NHS could find itself having to find money from one hand in order to give it directly back to itself with the other. It is a point that we ought to pursue, if we can. We will do it in that way, if that is acceptable.

[203] **Elin Jones:** Yes.

[204] **Mark Drakeford:** I apologise to those who were not called to ask questions; I will go to you first in the next session if there is anything that you want to ask of our next witness.

[205] **Jenny Rathbone:** It is difficult for me, because I have not heard the evidence from people who are in favour of the Bill and, therefore, I have fewer burning questions to ask.

[206] **Mark Drakeford:** The next sets of witnesses are, from their written evidence, broadly in favour of the Bill, so I anticipate that we will hear some of the things that we heard last week.

10.34 a.m.

**Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Cyfnod
1—Sesiwn Dystiolaeth 6
Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Stage 1—
Evidence Session 6**

[207] **Mark Drakeford:** Bore da a chroeso i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Diolch yn fawr iawn am ddod i'n helpu y bore yma. Dyma'r chweched sesiwn dystiolaeth ar y Bil. Hoffwn groesawu ein tyst nesaf, sef Michael Imperato, sy'n cynrychioli Cymdeithas Cyfreithwyr Niwed Personol Cymru. Diolch am ddod y bore yma, Mike. Fel arfer, rydym yn gofyn a oes gennych unrhyw sylwadau agoriadol byr yr hoffech eu gwneud, cyn droi at Aelodau'r pwyllgor i ofyn cwestiynau.

Mark Drakeford: Good morning and welcome to the Health and Social Care Committee. Thank you very much for coming to help us this morning. This is the sixth evidence session on the Bill. I would like to welcome our next witness, who is Michael Imperato, who is representing the Association of Personal Injury Lawyers Wales. Thank you for coming this morning, Mike. As usual, we ask whether you have any brief opening remarks that you would like to make, before turning to Members for questions.

[208] Thank you for being with us this morning. We will take a couple of minutes at the beginning if there are any points that you want to make as an introductory set of remarks and then we will go straight to questions from Members.

[209] **Mr Imperato:** I just want to clarify that I am appearing on behalf of the Association of Personal Injury Lawyers, which covers all of England, Wales, Scotland and Northern Ireland. We act for claimants. So, my views are couched on that basis. I would like to make that very clear to everybody. I am a lawyer in Cardiff for a firm called NewLaw Solicitors and I have been involved in claimant personal injury work for over 20 years. Among the basket of cases that I deal with are asbestos-related disease cases.

[210] **Mark Drakeford:** Excellent, thank you. Gwyn Price wants to ask the first question.

[211] **Gwyn R. Price:** Do you feel that the list of what the Bill defines as asbestos-related diseases is adequate?

[212] **Mr Imperato:** Yes. One of the things that the Bill is seeking to achieve is simplicity. I do not have a problem with what the list lays out at this time.

[213] **William Graham:** How could the Bill change the nature or volume of work that you

expect to carry out?

[214] **Mr Imperato:** I would not expect the Bill to make a great impact on the practitioner. Do not forget that the Bill only really kicks in when dealing with a successful, settled case. The vast majority of cases are settled rather than taken to court. Only 1% or 2% would ever go all the way to a court hearing. So, the vast majority are settled. The claim would be a good claim in the first place, and it would therefore be successful. In that respect, I cannot see that I would see any major difference in terms of my case or file load. Certainly, that was the case when similar legislation first came in to deal with road traffic accident cases and was then extended in 2003. That, frankly, passed me by as a claimant lawyer. I did not notice at all anything different because the claimant is not so concerned with the mechanism of the repayment issue. That is something that, as far as I am concerned, is wholly for the defendant to sort out. So, as I said, the 2003 Act passed me by; I noticed no difference either in the volume of cases or in the defendants' attitude to how the cases were being run. That is my experience and I see no reason why this would be any different.

[215] **William Graham:** Thank you for that answer. A previous witness suggested that the number of cases, generally, is likely to decline. Would you accept that to be the case?

[216] **Mr Imperato:** It all depends what kind of medical survey you read. The general view is that the graph of asbestos-related cases will probably increase for another few years. Several years ago, the graph was going to peak in 2015, but another report stated that it was going to peak in 2016. It is a bit of a moving feast at the moment. However, a point will come when the exposure of cases will diminish, because, gradually, the employers started to fulfil their statutory duties and stopped exposing people to asbestos. So, yes, things have improved and there will be a diminishing pool of cases. However, I think that the view is that we possibly have not yet reached the peak.

[217] **Mark Drakeford:** I am going to go next to Elin, Rebecca, Darren and Jenny.

[218] **Elin Jones:** We have heard evidence this morning that the profile of medical costs is higher post-settlement of compensation than pre-settlement of compensation. Therefore, it falls outside the scope of recovery. Do you have any view on whether it is sensible for this legislation to exclude the majority of the medical costs from recovery?

[219] **Mr Imperato:** I do not necessarily accept that the majority of costs are bound to be excluded. I do not think that that is necessarily right. The Bill is trying to be a simple mechanism. You want a settlement, and at settlement the liability of the defendant—the defending insurer—effectively freezes and it will pay the treatment costs up until that date. That is the simplest way forward. If it turns out that the vast majority of care costs occur after that point, is it worth having the Bill? Is the Bill serving its purpose? The class of cases where the costs are going to be most significant are the mesothelioma cases. The costs in those cases will be higher, because that is where the most hospital treatment occurs. Sadly, if you are diagnosed with mesothelioma, you will probably die in 12 months' time. It is a death sentence. By the time you approach your solicitor and work out that you can make a claim and the claim gets up and running and the case moves towards settlement, it will be the end of you. As a solicitor, one is always trying to deal with a case as quickly as possible, because you have a person on your hands who is dying.

[220] Cases involving mesothelioma are high-value cases—in the region of £100,000 to £200,000, or maybe more, when you take into account the person's terrible suffering. The injury alone would be £50,000 to £75,000 in damages, and then there is the pension, care of the wife, and other expenses. So, you are talking about big-value claims. Insurance companies do not write you a cheque for £100,000 after the first claim letter that you, as a claimant lawyer, send to them. They will haggle and argue about it. Unfortunately, cases do

not settle right at the beginning. Indeed, normally, in my experience, many months go by.

[221] Therefore, in my view, a large chunk of the medical cost will be caught in any event. If the case settles before the mesothelioma sufferer dies, there will be an element of postdating in relation to the claim. There will certainly be a large chunk, because the first thing that happens is that the sufferer will be sent to a consultant and they will have chemotherapy, scans and biopsies and what have you—that is all early on. It is very much a front-loaded treatment. After a few months, you are just waiting for the chap or lady to die, frankly.

[222] **Elin Jones:** Do you have a view on whether the passing of this legislation would have an effect on the speed of settling cases in Wales? We have had slightly conflicting evidence on this. We had interesting evidence from the witness before you that seemed to suggest that because the recovery of costs would only be eligible pre-settlement there would be an incentive to settle earlier in Wales, because less costs would have been incurred with the NHS. Do you have a view about the likely effect of this legislation on the speed of settlement?

[223] **Mr Imperato:** I can see that argument. I do not think that the impact of this legislation would necessarily slow things down to the detriment of the people of Wales. There is an argument that it might speed things up. You could also argue that, for every legal case, defendants should settle early to save costs. They never do, because, frankly, some of them are messing about, some are incompetent, and some just want to drag it out in the hope that the claimant will get battle weary and settle for one of the first couple of offers that are made.

[224] You could apply that to every personal injury case that has ever been. However, it is in the interest of defendants, when they realise that they are not going to win, to settle instantly. However, that does not necessarily happen in practice. There is always stuff going on with cases, which means that they seem to have a life of their own. So, you could maybe apply that argument. There is previous legislation of this type in England, as I mentioned earlier, but I never saw an impact of any sort on the way in which I ran cases against defendants.

[225] **Rebecca Evans:** I want to raise the question of the speed of cases as well. We have had evidence suggesting that if there were a different system operating in Wales and England, insurers would search out Welsh cases and try to settle those first, because it would be cheaper for them. Do you think that there is any validity in that argument?

10.45 a.m.

[226] **Mr Imperato:** I think that you overestimate the insurance industry, frankly.

[227] **Mark Drakeford:** Do you mean that it would not have the capacity to do that?

[228] **Mr Imperato:** Insurers are more concerned with arguing about liability in the first place. Then they will argue about whether this chap's mesothelioma is such that the defendants will have to pay him for the injury itself—be that £50,000, £60,000 or £70,000. You get arguments about that. Frankly, I think that it is immoral to be arguing about that, but they will do so. You then have arguments about whether this man is poor—I keep referring to this 'man'; of course, it could be a woman, but I am afraid that in my experience, it is mostly men involved. The next argument might be about the amount of care that the man's wife has to give him in his home and all this sort of thing. Insurers tend to get bogged down in those types of arguments. They do not take such a strategic view, as you might suggest.

[229] **Darren Millar:** I want to ask about the average length of time that it takes to settle a claim from diagnosis. You seem to suggest that the discussions go on for many months once a claim is lodged. Are they almost always settled prior to death?

[230] **Mr Imperato:** That is a very good question. The answer is that there is a strange, legal anomaly—and we are talking about mesothelioma cases—that sometimes, the claim can be worth more if the person dies rather than lives, for various reasons to do with fatal accident laws. So, sometimes, there is a difficult discussion about whether the claimant wants his case to be settled quickly, because he is worth more dead than alive. You have to have that discussion, which is one of the most difficult that a practitioner has to have with somebody.

[231] Generally, people want to see their cases settled before they die. One of the cases that I found most affecting concerned a chap who lived in Swansea who installed boilers in schools and so on. We could not find the insurance company, so I advertised in Swansea's *South Wales Evening Post* and on BBC Radio Wales et cetera, but I could not find it. He seemed to be coping quite well and looked relatively well with his mesothelioma. Then, I finally got a break and I found the insurance company, so I went all the way down to Swansea to see him—I know it is not far, but I simply went to see him. I had not seen him for a month or two and he had deteriorated rapidly and was suddenly as thin as a rake and could not walk around. I told him that I had found the insurance company and that his wife was going to get a settlement. In fact, the defendant's solicitor was the chap that you have just seen, Simon Cradick. Off the top of my head, I think the settlement was between £150,000 and £200,000. So, I was so pleased. That chap died knowing that his widow would be looked after. So, generally, you really want to settle these cases for the sake of the peace of mind of the person who is dying.

[232] So, given that it is normally a 12-month time frame from diagnosis to death, you are trying to settle the claim in a matter of months.

[233] **Darren Millar:** How many months, on average?

[234] **Mr Imperato:** It is probably something like six months, maybe a bit more. It depends on the value of the claim. Simple cases of pension loss, for example, can be run through very quickly. But, if you have somebody with quite complicated pension arrangements, there can be a bit of an argument over the loss of that pension, as it might be tens and tens of thousands of pounds. That is the difference. Insurance companies are not charities. They want to save every £5,000, £10,000 or £15,000 that they can. So, they do not pay out just on a whim, they say, 'You've got to prove it; if you're saying this case is worth £200,000 and we say it is worth £150,000, then convince us it is worth £200,000'.

[235] **Darren Millar:** This is an interesting point, Chair, because if the profile of NHS costs is that they are weighted towards the end, and at the very beginning of the treatment for somebody who has had this diagnosis, and if it takes six months, then the recovery of costs is not going to be the average cost, which is laid out in the explanatory memorandum; it is going to be about half that cost. Therefore, the recovery overall to the Welsh NHS will be much less, will it not?

[236] **Mark Drakeford:** I think that we need to put that point to them because they may have taken that into account. The point that they have made to us is that they are stopping the clock at the point when the compensation is settled. It is a deliberate decision on their part, for simplicity. However, it is a very good point that you make. We would need to check with them whether they have then factored into the figures that they present in the explanatory memorandum the impact that that would have on the level of costs that can be recovered.

[237] **Mr Imperato:** Perhaps I could clarify that I did say that the big costs are probably

frontloaded in these things. When someone is two or three months away from death, you are just waiting for them to die. You cannot do anything.

[238] **Darren Millar:** The reason why we question that is because the evidence that we received earlier was that it is end-loaded in terms of the cost profile.

[239] **Mr Imperato:** If you went into a hospice or something, that would be it, but in my experience, most people want to die at home.

[240] **Mark Drakeford:** Hospice costs are recoverable through the compensation mechanism in any case.

[241] **Mr Imperato:** Yes.

[242] **Darren Millar:** It is the in-patient cost that is here.

[243] **Jenny Rathbone:** In terms of your initial description about the amount of money that you are seeking for your clients, I assume that some of the palliative care, which is what the end costs are, is included in that level of compensation. It is part of looking after the wife and all of those sorts of issues, is it not? If, as you say, most of the costs for the NHS are frontloaded because it is all about the diagnosis costs, which are the expensive and sexy end of the NHS, why is the insurance industry making such a song and dance about this? It seems that the actual cost involved, compared with the £150,000 or the £200,000 costs for the injury to the individual in the first place, is small beer in their terms, is it not?

[244] **Mr Imperato:** I think so. As I said, the insurance industry does not have a charitable status. The companies are determined to reduce costs at all levels. They also see what Wales is doing as opening the door in England. That is their agenda. Their concern is to stop anything that might open the door to England passing similar legislation. I agree, Jenny; my view is that, typically in a claim, you claim the gratuitous care provided by the person's family in looking after them and, of course, that gratuitous care rises as the guy starts to die. From personal experience, this is what happens: I would probably see the client every few weeks. They do not want to see me every week. I would go to visit them every couple of weeks. The first time that you see the chap, he has a bit of a cough, he is not moving around a lot, but he is pottering around the house and you see him in his chair in the living room. You will be joking away with him, and he is in reasonable spirits. In a way, because I see him every few weeks, I get a snapshot of the decline. It then gets to the stage where he is as thin as someone who has come out of a concentration camp in the second world war; he cannot move nor do anything. He is in bed and has to be turned over by his wife, he is incontinent, he does not recognise you, he cannot speak to you, and he is going to die. It is the worst thing. This is what we are dealing with here. In those last couple of months, they do not want to die in hospital; it is on the family. It is the gratuitous care that the family are giving him that you claim for. By then, he is past treatment in hospital by a long way.

[245] **Jenny Rathbone:** Given what you said earlier about the way in which the incidence of claims is likely to peak—there was some discussion about when that will actually be, but it sounds like it is not that far off, in 2015 or 2016, perhaps—what impact, if any, is this Bill, if passed, likely to have on the way in which insurance companies assess premiums for companies or institutions?

[246] **Mr Imperato:** I do not think that it will have any impact on insurance companies. If they are assessing premiums now, going forward—as you say, Jenny—it is a declining thing. The insurance companies carry out a risk assessment—a risk analysis—which includes many things. There are many things that insurance companies have to insure you for now that might or might not happen, or that might happen in many years to come. It is impossible to predict

the landscape of the legal world in years to come. So, there will be some things on which the insurance companies might lose, but there will be things on which they might win. For example, you used to be able to claim compensation for pleural plaques in England and Wales as an asbestos-related illness, but now you cannot. You can in Scotland and Northern Ireland, but not in Wales and England, so they had a saving there that they were not expecting when they wrote those policies 30 years ago. In April, claimant lawyers will not be able to claim an uplift success fee on personal injury cases from the defendant, so they will have a huge windfall in April. There are winners and losers, so let us not get too worried or sympathetic about the insurance companies' premiums, because it is a far more complicated system and they factor in a myriad of things. They will win on some things and lose on others.

[247] **Mark Drakeford:** May I pursue that, because our morning started off with an interesting question from Gwyn Price to the insurers about the suggestion in their evidence that the Bill trespassed on their human rights? I may be misrepresenting them, because I am not absolutely sure that I followed the argument, but I think that they were saying that the human rights issue was because they were being asked to pick up a cost that they could not possibly have anticipated when policies were sold and premiums were set, so this was now unfair—I think that they used that word a couple of times—to the industry, because it was not a liability that they could have been expected to cover. Is that an argument that we ought to take seriously?

[248] **Mr Imperato:** No, you must wholly dismiss that argument, because it has already been run by the insurance industry. I have referred to the Scottish Parliament passing a Bill to recover damages for pleural plaques. Pleural plaques is an asbestos-related disease that does not cause overt, obvious symptoms, but it is a marker that there is a chance that you might develop asbestosis or mesothelioma—people always think the worst, they think, 'Oh my God, I have a death sentence', but only a small percentage develops mesothelioma from pleural plaques. You used to be able to recover a modest value for those claims. The House of Lords rejected those cases and changed the law a few years ago, but in Scotland they produced legislation that turned it back. In Scotland and Northern Ireland, you can now recover modest damages for pleural plaques. The insurance industry challenged the power of the Scottish Parliament to do that—I have the judgment in front of me—running that exact argument. When I saw that in the ABI's submission to the committee, with the greatest respect to the ABI, I thought that it was rather strange that it did not go on to say that it ran that exact argument in the case that went to the Supreme Court two years ago and that argument was kicked out. If you would like, I can summarise the human rights argument that it ran and lost on, but, basically it was a non-runner. It had its chance and lost.

[249] **Mark Drakeford:** Elin wants to follow this up.

[250] **Elin Jones:** I am not here to defend the ABI, but it offered in its verbal evidence to us a reference to that Supreme Court judgment and recognised that it had unsuccessfully challenged the principle of retrospectivity in the Supreme Court. May I ask a different question?

[251] **Mark Drakeford:** Of course.

[252] **Elin Jones:** We have had evidence this morning, again from the ABI, that around 40% of claims are against the public sector. Do you recognise that percentage in terms of the likely impact of this legislation, namely that around 40% of it could fall on the public sector and its insurers, or possibly parts of it that may not be insured?

[253] **Mr Imperato:** The issue is not the percentage of claims against the public sector; it is the percentage of claims with an insurance company behind them that is really the issue here. Many public sector organisations had commercial insurance to cover them, so, in a way, it did

not matter to me as a claimant whether I was suing the old British Steel or a power-generating company; they have insurance behind them, so it does not make any difference.

11.00 a.m.

[254] **Elin Jones:** I understand that point. Do you recognise that around 40% to 60% of cases are against public sector bodies, recognising that a lot of the public sector could have insurance as well?

[255] **Mr Imperato:** I am not going to say that it is 40%, but I recognise that a significant number of cases are against public sector bodies. I have run a lot of cases against the Ministry of Defence on behalf of dockyard workers, so if you count the MoD in there, the figure goes up again.

[256] **Mark Drakeford:** Thank you. There is one very last question under the wire from Rebecca.

[257] **Rebecca Evans:** The Bill aims to recover costs to the NHS in Wales, regardless of where exposure to asbestos took place. Do you envisage any difficulty in reclaiming costs if, for example, exposure took place in Scotland?

[258] **Mr Imperato:** If the exposure took place in Scotland but the person is treated in Wales, I do not envisage any difficulty in reclaiming costs. However, an issue for the Welsh Government to deal with is to make sure that if this Bill passes, there is an education programme. That is a factor that you have to take into account—it is all very well having this power of recovery, but defendants' organisations have to be made aware of their responsibilities to deal with it. The issue is that a claimant might have a solicitor who is not based in Wales—they might be based in England or further afield—so it must be ensured that there is an education process about the fact that we have this power in Wales and that people know about it.

[259] **Mark Drakeford:** Just for the sake of the record and in case I inadvertently misled anyone earlier, the Bill proposes that the costs recovered are costs incurred by the Welsh NHS. Those costs could be incurred in England; you could send a patient for treatment across the border. So, it is not about where the treatment takes place—it is about the fact that those costs are incurred by the Welsh NHS. That has come up a couple of times during the morning.

[260] Mike, diolch yn fawr iawn i chi. Thank you very much indeed for a very interesting session. I may well ask the clerk to contact you so that we have details of that Scottish human rights case, in case we want to explore it in more detail. Thank you for drawing it to our attention. Diolch yn fawr.

[261] I propose that we break for five minutes. It is not on the agenda, but I think that we all deserve at least one cup of coffee during the morning.

[262] Gofynnaf i chi fod yn ôl yma am 11.10 a.m. I ask you to be back here at 11.10 a.m.

*Gohiriwyd y cyfarfod rhwng 11.03 a.m. a 11.14 a.m.
The meeting adjourned between 11.03 a.m. and 11.14 a.m.*

**Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Cyfnod
1—Sesiwn Dystiolaeth 7**
**Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Stage 1—
Evidence Session 7**

[263] **Mark Drakeford:** Hoffwn groesawu ein tyst nesaf, sef Simon Jones o Ofal Canser Marie Curie. Diolch yn fawr am ddod i'n helpu y bore yma. Fel arfer, gofynnaf ichi a oes gennych ddatganiad agoriadol byr. Ar ôl y datganiad agoriadol, trown at aelodau'r pwyllgor, a fydd yn gofyn cwestiynau.

Mark Drakeford: I would like to welcome our next witness, Simon Jones from Marie Curie Cancer Care. Thank you very much for coming to help us this morning. As I usually do, I will ask you whether you have a short opening statement. Following the opening statement, we will turn to committee members, who will ask questions.

11.15 a.m.

[264] If you have any brief opening points, you can make those to us now. Then we will go into questions. We have only got half an hour, so we will try to move it along.

[265] **Mr Jones:** My name is Simon Jones and I am the head of policy and public affairs for Marie Curie, and have been for about seven months now. I have a background in health going back further than that. I will keep my opening remarks brief. It might help to give an outline of what Marie Curie does. It provides end-of-life care and palliative care in two different settings. One is a hospice setting, very much for in-patients. There is a widely held misconception that people come into a hospice and it is the last place that they will ever go. They often come in and go out, but obviously people do die in hospices. Linked to that, the community nursing service is about providing support and care for people in their own homes. Some of that is provided by experienced nurses, but a lot of it is provided by senior healthcare assistants who sit with people overnight. You might come on to those issues in your questioning.

[266] I have prepared a note, which I think has been distributed to you all. It gives you some idea of the numbers, which are small, and I can add to that now. I have the statistics for our hospice for the same period, so perhaps during questions I will add to those so that you have some idea.

[267] We are supportive of this Bill. We think it has lots to offer. I am sure there will be some questions around our view of what it might offer and deliver. If I may, I will ask for the opportunity to mention something I have discovered in my research, which is that there is some interesting case law in respect of recovering costs for hospices running back to 2010, which might have an impact on your thinking. Certainly, there is one comment by a legal company in England that suggests that this case law might get the Government—one assumes it is the Westminster Government that is being referred to—to look at the issue of recovering costs in the context of a cash-strapped NHS. If I may, I will take you through some of those issues in questions. I will stop there.

[268] **Mark Drakeford:** I am sure that there will be a chance to explore all of those points. Who would like to kick off? William?

[269] **William Graham:** Thank you for your evidence. How do you think the mechanism for recovering costs could be sorted out? The Government needs to identify those costs if they are allowed, and presumably part of that would be that we would at least want the fund to be explained by the Minister, perhaps on an annual basis, or every now and again.

[270] **Mr Jones:** If I understand you correctly, the first part of your question is about how we would calculate the costs, and the second bit is about how they might be recovered. There is a complication there in that a percentage of the resources that we use to provide care comes from charitable sources rather than NHS sources. As far as I can see, that is not something that is explicitly referred to in the Bill, but is something that might need to be considered in the future. As to how we calculate the costs, we know how much a nurse shift costs. We know how much a senior healthcare assistant costs overnight—the cost to the charity is £20 an hour, and in addition there would be whatever we secure through the NHS contract. We know how much a bed day costs. Our calculation for the hospice in Penarth is £450 per bed day. This would inevitably follow an Act: we would need to develop systems that enable us to track patients with specific diagnoses. You can see in my paper that C32, C34 and C45 are the international codes for diagnosis for some particular diseases that are related to asbestos, although not exclusively. So, we would need to put in place tracking systems to enable us to make a robust estimate of those costs. The actual costs themselves we work out all the time in terms of our contracting with the NHS. We are in that commissioning process. That is something that is done and is known.

[271] The other reason for needing to put in specific systems is that people will fall in and out of different services. They might spend four days in the hospice, then receive the community nursing service, then some overnight care, so there is an inevitability about a mix and match of services. I do not need to point this out to you, but we only deal with that very sad part of care that is right at the end of life, and, for these patients, listening to some of the evidence earlier, there has obviously been quite a long care pathway to get to the point at which they would receive our services.

[272] In respect of how the resources recovered might be used, I would not go so far as to say it is a point of principle, but we would be looking at perhaps campaigning as a charity for those resources to support what one might describe as ‘the add-on services’—that is, the additional things that people do not get. They might be community-based services, rather than the core health services that there would be an expectation—and, one would hope, an understanding—to be in place.

[273] Thinking about this—I will go into it very briefly; we might explore this a bit more in questions—as well as for community-based services, we feel that this could be used specifically for research. It is an area, particularly around mesothelioma, where more research is needed, and these moneys might be used for that.

[274] As a charity, Mesothelioma UK was set up by Macmillan and is now independent. It does not really have a footprint in Wales, but it provides an important advocacy service and a help and advice service. You may therefore want to look at supporting that sort of activity.

[275] I suppose the bottom line—it is in the note I submitted—is that it is honestly unsustainable to ring-fence money in an Act, but perhaps putting something in there that requires the Minister to declare how much has been recovered formally and how that has been spent, along with the rationale behind decision making, would then allow organisations such as ours and, indeed, patients and their families, to scrutinise how it has been used.

[276] **Darren Millar:** You mention that the cost base for organisations such as yours is often different from the cost base for the NHS as a whole. Of course, the explanatory memorandum to the Bill sets out the schedule of standard tariffs that might be introduced. Do you think that it is fair to apply a standard tariff to the sorts of costs that might be recoverable under the scheme as a result of the care that you are providing, given that your cost base is so different?

[277] **Mr Jones:** I would not necessarily think it unfair. That is perhaps ducking the issue a

little bit, but, as a rule of thumb, that tariff base identified in the explanatory memorandum is as good a place as any to start, and as good a place as any to be. There may be winners and there may be losers but, over time, that would probably even itself out.

[278] I think that palliative care would need to be interrogated. I could see reference to the palliative care having been included in the costings that, I think, the finance directors of Cwm Taf and Aneurin Bevan LHBs did—I seem to recall that it was some of the finance directors from some of the finance teams at the local health boards. However, were they including the charitable resources element of the care? They may well have just been, for obvious reasons, looking at the NHS contracts with Marie Curie, St David's hospice, George Thomas hospice or whoever it might be and calculating that in the cost. That does not cover the entirety of the cost of the care given to that particular individual, but that does then bring into sharp focus whether this Bill, and then the Act, could go far enough to recover charitable costs, as opposed to where it stands at the moment, which is NHS costs, and that being in the context of my organisation and that percentage of the cost of care for an individual that is related to an NHS contract and the NHS pound.

[279] **Darren Millar:** Just to explore this a little further, in many parts of Wales, the NHS will make a contribution towards hospices. Sometimes, it is a very unscientific contribution: an arbitrary amount that has been fixed for the past five or even 10 years, rather than a service level agreement-type approach. To what extent do you think that complicates the recovery of costs that the NHS might incur? That is, costs that the NHS might be able to glean back, as it were.

[280] **Mr Jones:** Rather than complicate the calculation of the costs, a hospice would say, for example, 'This individual patient has spent this amount of time with us; this is our cost per day and this is our cost per community nurse shift, therefore, the cost of caring for this person while in our responsibility was X'. One assumes that they could then say—this is what happened in this case law—that the total percentage of the NHS contribution to their totality of costs is 40%. So you could apply that to the individual cost of the individual patient. What would be a moveable feast, for exactly the reasons you have described, is that for one hospice or one provider of palliative care, the percentage of NHS contribution might be 30% and for another it might 45%. So, there would be that variable, but you could establish a calculation if you wanted to reach just the NHS figure that would be, to any decent, reasonable human being, sensible.

[281] **Rebecca Evans:** Under the current proposals, moneys recovered will go to Welsh Ministers in the hope that they will disperse them for the benefit of people affected by asbestos. Do you think that that is the most appropriate place for the money to go? We have had other suggestions, for example, that the health board that incurred the cost should receive the money back. Are you satisfied with the proposal as it stands?

[282] **Mr Jones:** It would inevitably depend on which seat you were sitting in. If you were a health board that was in an industrial area of south Wales that might have a higher incidence, for obvious reasons, of asbestos-related cases, and therefore incurring greater care costs, you might reasonably make an argument that the money coming back might be directed in your favour. Equally, we have an NHS Wales that has an NHS Wales budget, and the point that I make in the paper and which I reiterated this morning, is that, if there were something that required the Minister to be open and transparent about the way in which he or she spent that money that was recovered, it would enable scrutiny and challenge and that could come from within the NHS or from without the NHS. The figure itself—I think the estimate was £2 million—is not an inconsiderable amount of money, but, equally, when that is spread around the entirety of NHS Wales, one assumes that one would want to avoid a bun fight over a reasonably small amount of money, rather than the Minister being required in an open way coming up with some imaginative ways of using the money.

[283] However, at the end of the day, a person—in our case, it would be the person who has died—has given up their life and as a consequence this money has come in. Therefore, I think that there should be something around ensuring that the way the money is used satisfies the desires of that person and the family of that person. I am sure they would far rather the money not have to be recovered at all, because they would have far rather not have had the illness. It is very difficult to look at trying to direct this money and I think we would argue that there is sound reason around it coming to the Minister. However—and I will not labour the point—how that money is then used, and the argument around using that money, needs to be open and transparent.

[284] **Rebecca Evans:** On a different point, we have had evidence from Tenovus that an unintended consequence of the Bill could be that asbestos victims find it harder to make a compensation claim, as insurers and employers will defend claims far more vigorously. What do you make of that?

[285] **Mr Jones:** I do not think that is necessarily within my competence to respond. What little I got from your previous piece of evidence suggested that insurance companies, regardless of the circumstances, will fight tooth and nail in every circumstance to reduce their liability and I would not really go beyond that. I do not see any particular reason why it would be the case.

[286] **Jenny Rathbone:** Thank you for your very clear list of costs involving caring for somebody at the end-of-life stage. Is it your reading of the Bill that the costs of providing that level of care in a Marie Curie home might be recoverable from the insurance industry even though primary care costs are specifically excluded? So, if someone opts to go into a hospice, there is a claim, but, if someone opts to stay at home to be looked after at the end of their life, then there will not be a claim for that, although you could argue that it was wrapped up in the general claim.

11.30 a.m.

[287] **Mr Jones:** As I understand it, from looking at the explanatory memorandum, the calculation and then at the tariff, that takes into account the entirety of the individual's care pathway, which would or would not include attendances at a GP surgery, would it?

[288] **Mark Drakeford:** It would not, because it excludes primary care costs.

[289] **Mr Jones:** So, it only covers secondary care. That would raise an issue, because you can access our services via your GP. A GP can refer to our community nursing service or it can be accessed via a district nurse, employed by a local health board, which would obviously be secondary care access in the main.

[290] **Jenny Rathbone:** That would be primary care, would it not? Anyway, we could debate that.

[291] **Mr Jones:** Yes, we could debate that. An awful lot of people are referred to palliative care directly from secondary care as a result of discharge from hospital into secondary care, so you might then argue that they are on the secondary care pathway. All of our contracts are with local health boards. Our contracts are not with GP practices. We negotiate our contracts to provide a service with a local health board and a certain amount of money comes into the hospice from the palliative care implementation group, which is an NHS Wales group. So, we do not contract with a GP to provide a service, although a number of our services sit alongside and support GPs in caring for an individual.

[292] **Jenny Rathbone:** So, given that you have different referrers, some in primary and some in secondary care, it needs to be clarified in the detail of the Bill as to what would be the status of palliative care in a hospice in the sense of whether it is a recoverable cost.

[293] **Mr Jones:** In the context of, at the moment, it only being the NHS element of those costs, rather than—

[294] **Jenny Rathbone:** Indeed, but then you can see that the money recovered could potentially lead to a grant to hospices to provide add-on costs, but that would be up to the Government.

[295] **Mr Jones:** It could come back to provide additional services and you could do a direct piece of maths around what extra services could be provided as a result—whether community nurse hours, shifts, healthcare assistance overnight, or days in a hospice bed. However, the bottom line is that our contracts are with NHS local health boards and we would argue that it is a community-based service rather than a primary-care based service.

[296] **Jenny Rathbone:** That is clear, but that needs to be clarified in the Bill, because some of your referrals are from secondary care and could be argued to be a better way of providing care than providing it in a hospital, but some of them are referred from primary care.

[297] **Mr Jones:** I cannot think of a circumstance, however, where someone has reached a palliative stage in their illness and would not be in a secondary-care setting or had not been in a secondary-care setting, as well as being supported in a primary-care setting, for obvious reasons.

[298] **Mark Drakeford:** That is an important point for us to take up with the proposer of the Bill, is it not? If there is an ambiguity here, we need to see how those promoting the Bill think that it is resolved by it.

[299] **Jenny Rathbone:** We have heard mixed evidence this morning about whether this Bill would speed up the enthusiasm of insurers to settle in order to avoid additional costs or whether it would cause them to dig their feet in and defer settlement—the costs would be determined depending on the date of settlement and on what state the patient was in on the date of settlement.

[300] **Mr Jones:** Sadly, in terms of our service, the totality of the cost could not be determined until the patient had died. I do not know whether that means that the NHS then needs to wait until what is, in many of these cases, the inevitable end of the care pathway, which is death, before you can recover the costs or it has to—that is tricky.

[301] **Mark Drakeford:** The Bill sets out a mechanism, and states that there is a prior claim for compensation that has to be resolved. It will allow any secondary care costs that were incurred up to that point to be recovered, but the clock stops at that point; you cannot recover any costs beyond that point. The proposers of the Bill say that that provides administrative certainty and simplicity for the insurance industry and everyone else; although it is not a perfect solution, this overrides the fact that, as you say, you could not identify all of the relevant costs at that point. Is that a fair compromise?

[302] **Mr Jones:** I listened to the previous evidence on wanting the compensation to be awarded, as far as possible, at the point at which somebody has the opportunity to take advantage of it. The scenario that you have set out regarding the way in which the Bill would work raises important questions about the scale of the NHS costs that were incurred and how they will be recovered. There is a sense of inevitability, in that the more that a disease

develops and gets closer to a terminal stage, the greater the element of NHS intervention, for obvious reasons, to the point at which you reach end-stage palliative care. At that stage, you are in a hospice receiving round-the-clock care or being cared for by loved ones at home and receiving community support from the NHS or a charitable organisation like ours. If you reach a cut-off point, you might have covered an element of secondary care. As you pointed out, all of the primary care would not be taken into account, but you may well miss a degree of the NHS costs, which could be the greater element.

[303] **Elin Jones:** I am not sure whether I have understood this fully. So, at the moment, the NHS is not commissioning end-of-life care for an asbestos-related disease.

[304] **Mr Jones:** It does not do so specifically, no.

[305] **Elin Jones:** That care is not provided, but if a person is in one of your hospices or receiving a service, the funding for that care does not specifically follow that patient. You are not commissioned to provide individual care for an individual patient. The funding that you receive from the NHS is a block payment, so it does not follow the individual. In the recovery of costs, it would be problematic for somebody—the NHS or an insurance company—to finally decide what the extent of the cost to the NHS had been.

[306] **Mr Jones:** It comes back to Darren's point that, often, where we are is a result of an interesting contractual commissioning journey. In the Cardiff and Vale University Local Health Board area, for example, we are commissioned to provide the greater bulk of our beds in Penarth. That is based on epidemiological evidence on the number of beds that would be likely to be used at any given time, because you know how many people are dying and what they are dying from. There is a direct relationship with the number of patients, but not a specific patient. I am trying to think of any circumstances in which money follows a specific patient in Wales, and I cannot, off the top of my head. In the Betsi Cadwaladr University Local Health Board area, for example, we are commissioned to provide a community nursing service that includes senior healthcare assistants sitting in overnight. We would be commissioned to provide x number of shifts per annum. We could, in fact, provide a lot more than that because of the demand, but it is not a case of 'Mr Jones needs this, and here is the money to fund it'.

[307] Having said that, in response to the second half of your question, what we can easily do is calculate the exact costs of a particular episode of care, whatever the nature of that care.

[308] **Elin Jones:** You can then provide that information to the NHS for it to be able to recover the cost in cases of asbestos-related diseases.

[309] **Mr Jones:** We can do that. If this legislation came in, we would need to put systems in place that pick up the specifics around this matter even more than we are able to do at the moment. We would have to apply the calculation that I talked about earlier regarding what percentage of the cost is for the NHS and what percentage is charitable. In every pound that we spend on care, an element will come from the NHS and an element will come from charitable resources—and the rule of thumb for Marie Curie is 50-50.

[310] **Darren Millar:** I would like to ask something on this. The difficulty with this relates to situations where you are commissioned to provide a specific service for an NHS provider, such as Betsi Cadwaladr health board, and situations where you are given a contribution towards your general funds. When you have a contribution to your general funds, it is relatively easy: you look at the percentage of that, compared with the rest of your income for the rest of the year, and you can say, 'Well, x per cent was NHS cost'. That can be 10%, 30%, 50% or whatever it might be. However, when you are commissioned to deliver a specific service, you have a more difficult juggling act in trying to calculate the cost percentage. You

mentioned community nursing in the Betsi Cadwaladr area. It may be funding up to 80% of your community nursing in any one year, and it could be 20% in the next, depending on the volume of work that you do, et cetera. However, it would be inappropriate to apply a blanket percentage across all of your services. Do you see what I mean?

[311] **Mr Jones:** I do, but I do not think that it is so complicated, in the sense that we do not receive core funding, full stop. The palliative care implementation group is slightly different, as funding comes from the centre. Our funding is all directly related to service-level agreements and to the number of patients that we would be expected to support and treat in a given period, which is usually a year.

[312] **Darren Millar:** Do you work out these percentages on an all-Wales basis or on a local health board basis?

[313] **Mr Jones:** We could do what was required. We could reach a figure—as, indeed, the tariff does—that is felt to be a reasonable, defensible figure. Alternatively, we could reach a figure for Betsi Cadwaladr, for Cardiff and Vale or for the hospice. In relation to the contract that we get, we know how much the institution costs to run. Therefore, it becomes easy to, first, calculate how much it costs per bed per day, and, secondly, how much of that is covered by the NHS and how much is covered by charitable funds. So, we can break that down by service.

[314] **Darren Millar:** Or by area.

[315] **Mr Jones:** Yes.

[316] **Darren Millar:** Or by type or prevalence of disease.

[317] **Mr Jones:** Yes.

[318] **Darren Millar:** There are many methods, and that is the point that I am making. Therefore, would it not be fair to have some sort of tariff system in place?

[319] **Mark Drakeford:** Simon, what we have done this morning, very usefully, is draw out a number of issues that we will need to explore with the proposer of the Bill when he comes back next week, I think, regarding how these costs are calculated for the future.

[320] **Mr Jones:** If I may, I would like to make one point, so that it is in your records. You might want to look at this point, as might the people supporting you. I wish to refer to a specific 2010 case in the Queen's Bench Division of the High Court: *Drake and others v. Foster Wheeler Limited*. The judge extended the gratuitous support that you can receive if you provide personal care to hospice-provided care, in relation to the charitable element of the money. So, there is case law around this particular area. It has not been used very much, and I have not been able to get any evidence on unsuccessful claims. However, case law exists around recovering hospice costs.

[321] **Mark Drakeford:** The committee will need a note for next week, if possible, to help us frame our questions around these points. Thank you very much indeed for your help and for raising some very interesting points for us, certainly for next week.

11.44 a.m.

Papurau i'w Nodi
Papers to Note

[322] **Mark Drakeford:** Byddwn yn bwrw ymlaen yn syth gydag eitem 6 ar yr agenda. Mae un papur i'w nodi yn unig: cofnodion y cyfarfod a gynhaliwyd ar 10 Ionawr. A yw pawb yn fodlon â'r cofnodion? Gwelaf fod pawb yn fodlon. Felly, symudwn ymlaen at eitem 7.

Mark Drakeford: We will press ahead immediately to item 6 on the agenda. There is one paper to note: the minutes of the meeting held on 10 January. Is everyone content with the minutes? I see that everyone is content. Therefore we move on to item 7.

11.44 a.m.

**Cynnig dan Reol Sefydlog Rhif 17.42(ix) i Benderfynu Atal y Cyhoedd o'r
Cyfarfod**
**Motion under Standing Order No. 17.42(ix) to Resolve to Exclude the Public
from the Meeting**

[323] **Mark Drakeford:** Cynigiaf fod

Mark Drakeford: I move that

y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod, yn unol â Rheol Sefydlog Rhif 17.42(ix).

the committee resolves to exclude the public from the remainder of the meeting, in accordance with Standing Order No. 17.42(ix).

[324] Gwelaf fod Aelodau'n fodlon.

I see that Members are content.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.44 a.m.
The public part of the meeting ended at 11.44 a.m.