

Clinical negligence in the UK: Would it be safe to throw the baby out with the bath water?

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1. Introduction

The clinical negligence system is the means by which patients who can be proved to have received unsatisfactory (i.e. negligent) medical care can receive compensation. Debate about the way in which the UK (and others) achieve this, and whether suitable alternatives are available, has never been far away from this understandably sensitive topic. Current policy debate illustrates the perceived causes for concern. In the past three months, the National Audit Office [6], a major public inquiry [5] and the Department of Health [2] have all criticised and identified areas for reform. Thus, the government describes clinical negligence in the UK as “slow and bureaucratic” and contributing, via its adversarial arrangements, to a “‘cover-up’ culture”. The Kennedy Report suggests that such litigation-induced paranoia contributed to a lack of transparency in the Bristol heart inquiry. The NAO’s research indicated that cases opened in 1999/00 took, on average, five and a half years to settle, and that 44% of the cases it sampled produced legal costs greater than the damages paid. Costs are “spiralling” [2] to £400 million in 1999/00. The case against the present system is clear cut.

Or is it? Based on information such as that above, the government has promised a White Paper in 2001 aimed at reform of the clinical negligence system in the UK. It will first institute a programme of research into the present system and its alternatives.

Undoubtedly, there is much to be said for such research and for reviewing the policy options some twenty years after this last happened. However, it is likely that an open-minded review of the options will reveal a less one-sided case than the above precis implies. For example, evidence for the cost-effectiveness of alternative systems of compensation for 'medical injuries' is ambiguous; the extent to which such alternatives help deter future malpractice is dubious; the costs of the current system may not be quite so drastic as some 'headline figures' would suggest; and it is arguable that some measure of improvement could be achieved through more general reform of the legal system as opposed to reforming the basis for compensation in medical cases *per se*. As [1, p. 389] remarks: "In practice, the choice is between imperfect alternatives on the basis of less than complete empirical evidence."

The paper is structured as follows. The next section provides a brief description of the economic rationale for a system of clinical negligence. This is followed by an account of the way in which the present system in the UK operates. Section 4 then discusses the performance of the current system and Section 5 looks at the no-fault option for reform. Section 6 concludes the paper.

2. The economic role of negligence rules

Tort liability (where wronged parties may claim damages after establishing others' negligence) serves two functions: it provides compensation ('insurance') and, by linking this to the source of the damages, it provides deterrence of future negligent behaviour. However, it is widely accepted that, if compensation is the objective of the system, then tort is not the most cost-effective way of achieving this: other methods of insurance (public or private) can compensate patients quicker and at lower administrative cost. Accordingly, the (economic) arguments for using a negligence-based rule lie in its deterrence effects: its ability to induce parties to engage in costly measures to take care.

In any system involving costs and benefits of taking care, it is possible to define an efficient standard of care. This minimises the total social costs of the activity in question

(in this case, providing medical treatment); in particular, equating the marginal unit of prevention costs with the marginal unit of ‘harm’ saved. In principle, a variety of standards of care (such as ‘strict liability’ and ‘negligence’) can achieve this goal but only under specified conditions. These involve all relevant actors (patients, doctors, courts, insurers) having full information about the consequences of their actions and the behaviour of others. It is the difficulty of fulfilling these conditions that can make liability an inefficient basis for providing compensation. For example, in the case of negligence, if the courts cannot set a standard of care and interpret it in a predictable way, poorly informed patients will bring some weak cases while ignoring other strong ones. Depending on the balance of these possibilities, clinicians may invest too much in care (‘defensive medicine’) or too little.

These observations create a problem for assessing the clinical negligence system: it has not been possible to estimate the extent and costs of the deterrence benefits of negligence. It is also difficult to estimate the extent of defensive medicine, for reasons of data availability and because this concept is correctly defined relative to the (unobservable) efficient level of care. This means that the net benefits of operating a negligence system cannot be directly computed. After a series of papers, [1] concludes that positive net benefits are “possible but not assured.” (p. 412). Evidence also suggests that negligence rules are successful in screening amongst cases. Typically, those where a Trust deems itself to be liable for the damages caused have a higher probability of producing a payout to the patient and, also, of settling early. This suggests that the system does not work with the degree of randomness of which it is sometimes accused.

3. The current system of clinical negligence in the UK

To succeed in a clinical negligence claim, a patient must demonstrate s/he was owed a duty of care that was breached; that the breach clearly led to the damages claimed; and that the damages claimed are, indeed, accurate. Effectively, the patient must prove *liability* (based on negligence) on the part of the defendant and *quantum*. This will involve solicitors, perhaps barristers and the courts and might require protracted, costly

legal proceedings: hence the criticisms laid out above. Lord Woolf's 1996 reforms of civil procedure in England and Wales noted that clinical negligence cases might suffer especially from these problems because of the complex and lengthy nature of the causes and paths of illness.

The institutions designed to administer this system have changed over the last decade or so. Prior to 1990, clinicians were individually liable for the consequences of their negligence, and therefore patients frequently cited both the hospital and the clinician when bringing a claim. The hospital, as part of the NHS, would meet the cost out of its budget, while the clinician would meet the cost from one of several medical practitioners' risk pools to which he or she subscribed. After 1990, the NHS assumed responsibility for clinicians' negligence in the course of NHS work, so that patients now claim against the hospital in question. One rationale for this change was that hospitals are better placed than individual clinicians to institute risk management policies, although, for such policies to be successful, the hospital must resolve the principal-agent problem that may arise between itself and its employees. NHS hospital Trusts now have a certain amount of financial autonomy, and can in principle pass on some of this risk from medical accidents to Primary Care Trusts (PCTs) who commission treatment.

The NHS Litigation Authority (NHSLA) was established in 1995 to administer cases by overseeing the Clinical Negligence Scheme for Trusts (CNST) and, since 1996, the Existing Liabilities Scheme (ELS). The CNST is a form of pooling arrangement amongst Trusts. It meets claims in return for 'premium' income. As with other insurance, Trusts can influence their premiums by choosing an excess, below which they meet all the costs of a claim. They pay 20% of costs above the excess up to a pre-specified threshold. Premiums are also related to the risk management standards attained by the Trust, as assessed by the NHSLA (66% of Trusts are at Level 1, with Level 3 the highest.) The ELS covered liabilities for pre-1995 incidents with estimated settlement costs (included damage payout) above £10,000.

Other public bodies also play an important role in the clinical negligence scheme, in particular the Lord Chancellor's Department and the Legal Services Commission. These operate, respectively, the system of civil procedure within which claims take place, and the legal aid scheme, which funded 7,375 claims in 1999/00.

4. The cost of the UK's clinical negligence system

Using NHSLA data and its own survey evidence, the NAO estimates a total of 23,000 open claims at 31st March, 2000. To track changes in the frequency of new claims over time, [3] analyses the totality of claims arising within the Oxfordshire Health Authority over the period 1974 -1998. They find that the rate of claims per thousand finished consultant episodes increased from 0.46 in 1990 to 0.81 in 1998. However, when a 30% increase in hospital activity over the period is borne in mind, this amounts to an annual growth rate of 7%. As the authors remark, this is a "substantial rate of growth but not the uncontrolled explosion sometimes alluded to in the wider media." (p. 1567). Much of the media coverage has, in fact, focused on the estimates of *outstanding* clinical negligence liabilities – that is, the claims against the NHS that have yet to be paid. For example, NHS accounts made a provision for future clinical negligence liabilities of £2.6 billion in 1999/00, while the NHSLA's estimate (based only on larger cases) was £4.3 billion. However, these estimates are by their nature speculative, and may to some extent be based on 'worst case scenarios'. Moreover, because litigation can be an extremely lengthy process, these estimates can relate to claims that are settled over many years, even decades, into the future.

An alternative strategy for calculating the cost of claims begins with existing data on recent claims and seeks to estimate the *cash cost* (i.e. money actually paid out) in a given financial year. Apart from providing a more suitable basis for assessing the cost of the system, this has the benefit of relying on 'hard data'. [3] performs such an analysis, based on detailed case-level information from Trusts within Oxfordshire Health Authority. They estimate a figure for cash paid by the NHS in 1998 of £84 million (£61

million in damages; £23 million in defence costs). Whilst several sizeable future claims and some recent legal developments may mean this figure is relatively low (for example, House of Lords' decision in 1998 is likely to increase damages on child cases by 25-40%), it still represents a significant reduction compared to the figures above.

Two conclusions can, perhaps, be gleaned from this discussion. First, it is not clear that the clinical negligence system the UK is as expensive as some figures suggest. Not only is a range of estimates available here; we might also add that *none* of the present estimates nets off any deterrence benefits or includes any additional costs of defensive medicine. Second, the alterations to the system that took place in the mid-90s have made it difficult to gather data on the cash cost of the system: the division of responsibilities amongst various public bodies has meant that data are housed in different places.

5. The 'no-fault' alternative

A variety of reform proposals have surfaced as a replacement to tort law. Rather than evaluate all of these, the current paper considers the principal suggestion: a move to 'no-fault' compensation for medical injuries (see [1] and [7] for surveys). This would allow compensation to patients without the need to establish negligence on the part of the Trust and is one of the solutions to be considered by the recently established Working Party preparing the government's clinical negligence White Paper [2]. The perceived benefits of such a move include

- Removing the need for adversarial legal procedure to establish fault. This, in turn, would lower the costs of the system, reduce delay and improve patients' claims experience.
- Encouraging a culture of openness in the NHS. This would be fostered by clinicians and other NHS staff being more willing to raise concerns and admit to errors if relieved from the fear of high-profile litigation.
- Encouraging the use of other (non-financial) remedies. Studies indicate that patients often do not require financial compensation, so much as an explanation,

apology and reassurance that faulty care systems have been reformed. The tort system is specifically not designed to provide these.

Let us consider each of these in turn.

Legal procedure and costs

We have seen that 44% of clinical negligence cases incur legal costs above the damages they recover. This seems unsatisfactory. The situation is similar elsewhere: [1] reports that up to 40 cents per dollar of clinician insurance premiums in the US ultimately goes to lawyers. In contrast, figures for Sweden and New Zealand (who have both introduced variants of no-fault schemes) appear much lower; e.g. less than 10% of total expenditure in New Zealand's case. However, such figures can be misleading. In New Zealand, for example, this result was been achieved by effectively "rubber-stamping" claims and paying with only limited investigation. The hidden social cost of this, in terms of reduced deterrence and increased accidents is unknown. The low budget cost in Sweden has been achieved by a 'collateral offset rule' (where the damages paid are offset against compensation available from other sources), relatively low awards given the generosity of the Swedish social security system, and with tight criteria for offering compensation. Of course, costs will be influenced by the volume of claims that would be made.

Unfortunately, there is no reliable evidence on the possible elasticity of claims behaviour in the UK; recent work [8] suggests that roughly 10% of patients admitted to two London acute hospitals suffered an adverse event, with a half of these be 'preventable'. The claims we currently observe may, thus, represent only the 'tip of the iceberg' in this respect and a change to the basis of claiming could encourage claims that, presently, would not succeed. It would be important to gain some estimate of what is 'below the water' before adopting the no-fault principle and deciding on its precise arrangements.

No-fault schemes do not dispense with the need for evidence, adjudication and (possibly) representation because it is necessary for the patient to establish the extent of the claim and that it arose through some aspect of medical treatment. In New Zealand, a relaxed definition of the circumstances eligible for compensation led to a fast increase in claims

and, in 1992, to tighter eligibility criteria (based on *fault*). Thus, the criterion of “medical misadventure” was replaced by “personal injury resulting from medical error or medical mishap”, with “medical error” being defined in terms of failure to observe a “standard of care and skill reasonably to be expected in the circumstances”; a clear move towards the criteria applied in tort. Hence, no-fault compensation may still generate (potentially) costly, protracted, adversarial legal disputes.

Even if this were not the case, it is unclear that no-fault schemes would eradicate delay. As [4] shows, considerable delay is due to the parties waiting to see how injuries evolve. In complex medical cases, this can take several years. In their study, the Trust’s mean estimate of damages increased from £40,000 to £140,000 as cases lengthened from two to six years. Any serious attempt to eradicate delay would, it appears, have to allow for ‘top-up’ payments over time or establish ‘intervention type’ as the basis for payment. These would neither remove uncertainty, nor enhance fairness.

It is finally worth noting that, if matters of legal procedure are contributing to problems with clinical negligence, the appropriate response may be reform within the legal system rather than wholesale withdrawal from it. Lord Woolf’s pre-action protocols have so far received only limited evaluation but measures such as this could help contain the worst excesses of cost. Contingency fees may also provide an effective way of keeping costs below damages.

Culture of openness

Is it necessarily the case that clinicians (and other NHS staff) will feel more obliged to highlight errors in a world where they are not held responsible for their actions? This would imply that they are not worried about their reputations and the opinions of their peers if they have caused damage; that the system for determining eligibility under no-fault compensation would not engage them in lengthy, high-profile negotiations; and that their employers would not, at some point, decide that sanctions were appropriate. None of these seems especially convincing and it might be argued that failure to sanction a (repeat) ‘offender’ was a substantial denial of patients’ interests. Tragedies like that at

the Bristol Royal Infirmary [5] also highlight breakdowns in the NHS's willingness to listen to, and support, "whistle-blowers" and it may be that actions here would make valuable changes to openness within the NHS.

Appropriate compensation

A body of survey evidence suggests that many negligence claimants feel 'forced' into seeking financial redress for the harm they have suffered. Many say they initiated their claim in order to receive an explanation of (and, if appropriate, apology for) their situation. They are also interested to know what remedial measures have been taken to prevent similar events in the future. It is difficult for the NHS to accommodate such preferences against a background where litigation is possible for fear of prejudicing any subsequent case. It might be argued that a no-fault scheme dilutes this problem (assuming claimants are able to achieve satisfactory 'closure' by seeing remedial measures in action, if necessary) by reducing the need to rely on admissions of error by the Trust.

Undeniably, it is important to bear such evidence in mind when looking to compensate medical injuries. However, we have seen that a no-fault scheme is unlikely to remove completely a Trust's concern about implicating itself. It is also true that for some claimants, 'blame' is an important motivation and it is unclear how we should weight these two competing sets of preferences.

6. Conclusions

The most appropriate method of compensating patients (or their families) for damage suffered during medical care will always arouse passionate debate. Patient health is, rightly, a sensitive topic and must be balanced against the inevitable probabilities of harm involved in some (indeed, all) medical interventions; clinicians need some freedom to perform delicate tasks. At the same time, there are many demands on public expenditure and it is right to question apparently expensive programmes to see whether goals can be achieved more effectively. This complex web of issues has been explored in a variety of

countries (producing equally varied answers) and is now the subject of policy scrutiny in the UK.

In this paper, we have suggested several factors that should not be overlooked when considering policy reform in this area. Perhaps two are especially important. First, while an ideal world would allow cost-benefit analyses of the existing scheme and reform options, a combination of data availability, measurement difficulty and institutional variety make this impossible (in the UK and elsewhere). We can, however, observe that the costs of the existing system in the UK may not be as large as some estimates suggest, and that alternative schemes tend not to work as cheaply as might originally be envisaged. Second, the key economic benefit of a fault-based compensation system is its deterrence effects. Undeniably, our inability to quantify this makes it hard to factor into any debate but this should not mean that it is ignored. Schemes that are not based on fault need to address the issue of how deterrence will be achieved or, if not, what the consequences might be. Clinical governance schemes are sometimes suggested as a solution to this problem but need suitable evaluation (including methods to quantify deterrence). Ultimately, it is hard to disagree with the NAO's [6] assessment of the importance of deterrence and accountability: the "key issue" is "providing a financial incentive to Trusts to reduce incidents involving negligence (this is absent if they do not pay for them)." (para. 17).

A number of reforms may be available within the framework of tort and these must also be evaluated. We have indicated that reforms to the legal system should be considered (and evaluated) here. However, as the government has made clear [2], a number of others will be considered as part of its White Paper review. These include fixed tariffs for injuries (once fault has been established), the use of structured settlements as opposed to the payment of a lump-sum on completion of the case, and greater use of mediation along-side the current tort system. ([1] discusses other reform options.)

It is clear that the system in the UK merits scrutiny, evaluation and (no doubt) some measure of reform. We have seen, however, that Danzon [1, p. 389] characterises reform

in this area as choosing amongst imperfect alternatives with limited empirical information. We hope that the present paper explains this position and, in so doing, shows why economic efficiency should be borne in mind when making policy choices in this important area.

References

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