Supplementary written evidence submitted by the Department of Health and Social Care (NLR 0072)

This supplementary evidence includes amendments to the Department's written evidence to the Committee. The amendments relate to evidence on international comparisons, and specifically to the data in Table A within *Section 1: The cost and impact of clinical negligence*, and consequential amendments to related paragraphs.

These amendments are to:

- Paragraphs 16-19 on international comparisons
- Table A: **Clinical negligence claims and costs data across jurisdictions**
- Paragraphs 28-30 on learning from other countries on systems for compensation.

Following these amendments is a summary of sources for the data in Table A.

Response to the Committee's questions – amended

Section 1: The cost and impact of clinical negligence

International comparisons

16. Systems for managing clinical negligence claims vary internationally. We have looked at a limited set of other countries to understand if they have faced similar issues with rising clinical negligence costs. Using available data from previous years, Table A below provides a breakdown of claims and costs data between various countries of interest. Making direct comparisons between countries is difficult due to factors including differences in healthcare systems, state provision of services, legal systems, coverage of claims data between organisations and various inclusions and exclusions between the different data sources. For example, the data in the table may not cover all the claims and all the costs included in data for England, which comes from NHS Resolution. Countries vary in the extent to which their indemnity or insurance cover, and hence the proportion of their claims shown in available data, is centralised to one organisation. Schemes and their data also vary in which types of cost they include or exclude, such as legal costs or how compensation interacts with state services. For these reasons, the table should be viewed as illustrative.

17. This snapshot shows the overall cost of claims against the NHS being significantly higher than in some other countries. While Scotland, Australia and Canada have tort law systems more comparable to this country, Sweden, Denmark and New Zealand have adopted compensation schemes. Tort law systems can be seen as more adversarial, with claims negotiated between claimant and defendant solicitors. If there is no agreement on liability and/or the amount of compensation to be awarded, they will ultimately go to trial in the courts. In comparison, compensation schemes are more inquisitorial with claims generally taken to an administrative body which decides on eligibility and compensation, with much-reduced use of the courts and legal representation.

Table A: Clinical negligence claims and costs data across jurisdictions

See data sources and points to note below

System	Country	Population (2018, million)	Claims / 100,000 (2018/19)	Cost per capita (£) (2018/19)	% of GDP (2018/19)	% of Health Spend (2018/19)
Tort law	England	56	19	42.1	0.1%	2%
	Wales (2017 data)	3.1	14	29.2	0.1%	1%
	Scotland	5.4	9	6.9	0.02%	0.3%
	Canada	37	2	4.1	0.01%	0.1%
	Australia	25	26	6.8	0.02%	0.2%
'Avoidable harm' compensation scheme	Sweden	10	167	5.0	0.01%	0.8%
	Denmark	6	183	-	-	-
'No-fault' compensation scheme	New Zealand	4.9	332	18.7	0.1%	1%

18. Sweden, Denmark and New Zealand also have a wider eligibility for compensation. While in this country it needs to be established that the claimant was injured as a result of negligent medical treatment, Sweden and Denmark have 'avoidable harm' systems meaning that once the injury is established to have been caused by a decision, act or omission of the heath care provider, the core test is whether the injury was preventable. In the New Zealand 'no-fault' scheme, there is no need to prove a breach of duty of care by the healthcare provider, just that the injury occurred during treatment. Consequently, a higher proportion of harmed patients are eligible for compensation in these countries than here, seen by the higher claims per 100,000 people rates set out in Table A.

19. However, neither the Government's own enquiries nor the published literature have yet yielded a full explanation as to why per-capita spending on claims in this country appears significantly higher than in all of these other countries. While cost of claims per capita in England was £42.1 in 2018-19, for the same year in Scotland this was £6.9, in Sweden it was £5 and New Zealand it was £18.7. Although some of these data sources contain a lower proportion of the country's claims (such as Australia and Canada) or exclude certain costs (such as Sweden and New Zealand) compared to England, we do not think these differences alone would account for the large variation observed. We welcome evidence from stakeholders to help explain these differences.

Learning from other countries on systems for compensation

28. Systems of compensation in other parts of the world provide learning opportunities on addressing the rising cost of clinical negligence claims, patient safety and claimant experience. Some stakeholders believe the adoption of an 'avoidable harm' or no-fault' compensation scheme as exists in some Nordic nations and New Zealand could lead to improvements in these areas.

29. While it is possible to construct an argument that adopting an 'avoidable harm' or 'no-fault' compensation scheme could bring about some benefit in terms of patient safety (e.g. through removing a disincentive to disclosure) or claimant experience, we cannot say this with any certainty, considering the limited evidence available and the inevitable difficulties in translating findings across different health systems. Some of these benefits are being achieved in this country through different means. We are also not aware of direct evidence that fear of the current claims process is discouraging NHS staff from disclosing incidents.

30. There is also uncertainty over how many additional claims may be brought if these alternative schemes were introduced. The schemes in Sweden, Denmark and New Zealand were established to increase access to compensation and, as set out in Table A, have all experienced higher claim volumes: some 9 to 17 times those of England. Adopting these alternative schemes, particularly a no-fault scheme, could potentially lead to an increase in costs for the NHS. We welcome further evidence from stakeholders as part of this inquiry process on these and other compensation approaches used in different countries.

Data sources and points to note for Table A

England: NHSR Resolution Annual Report and Accounts 2018/19, sources covers NHS Resolution schemes only and excludes schemes for GPs as these were launched in April 2019.

Wales: Volumes - internal data from Wales; Costs: Written Assembly Question 02 July 2018, source covers state indemnity schemes only and excludes schemes for GPs as these were launched in April 2019.

Scotland: Clinical Negligence Other Risk Scheme (CNORIS) 2018/19 Annual Report, source covers CNORIS scheme only.

Canada: Canadian Medical Protective Association Annual Report 2018/19; source covers estimated 90% of doctors only and exclude legal costs.

Australia: Australian Prudential Regulation Authority Official reporting portal; source covers private providers of indemnity only, excludes claims arising from public hospitals and public services.

Sweden: LoF Annual Report 2019 (for 2018 calendar year), medical care and personal assistance costs are covered entirely by Swedish social security system and not by LoF.

Denmark: Patienterstatningen website – claim volumes in 2018. Source covers public healthcare only.

New Zealand: Accident Compensation Corporation (ACC) Treatment Safety Report 2020, excludes legal costs. ACC pays for some, but not necessarily all medical treatment and capped amounts for loss of income, and impairment payments for lifelong injuries, if entitled.

<u>Other data sources</u>

- **Claim volume and cost figures** are from sources as outlined above.
- **Population and GDP estimates for UK countries** are sourced from ONS.
- **Population and GDP estimates for non-UK countries** are sourced from the World Bank and exchange rates from OECD.
- **Health spend** estimates are sourced from individual countries' government accounts.

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