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Economic Aspects of Medical Negligence in the Context of the National Health Service in Britain

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INTRODUCTION

It is conceivable that the United Kingdom (U.K.) will come to rely and spend heavily on litigation in cases of harm to patients from health services, resembling the experience of the United States (U.S.). That could not have been said with any conviction until the 1980s, or even later. How do recent changes to the National Health Service (NHS) affect an economic analysis of issues associated with medical negligence litigation? An embryonic quasi market in health services in Britain as well as an increase in business practices previously regarded as distinctive of the private sector make an inquiry based on conventional notions of an idealized market more relevant than before. There has been a longstanding expectation that litigation will be more prominent in the U.S. than in the U.K., partly because health services in the U.K. are less market orientated than they are in the U.S. That expectation now deserves more scrutiny than it received when the NHS was undeniably a monolithic, bureaucratic, public-sector organisation. Are the conclusions suggested by a standard economic analysis of the health services market in the U.K. as it was during the 1980s confirmed or invalidated by what has happened since then?

One theme that undoubtedly remains important, as ever, is that of relevant empirical evidence that is both reliable and readily available. Such evidence relating to the issue of medical litigation in the U.K. has been sparse indeed, both for individual decision makers and for any who would attempt a disinterested

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analysis of overall resource allocation.[1] There are some grounds for hope that recent changes will prompt improvements in this regard,[2] although doubts persist about their extent. Exclusive, rather than shared, access to information may seem all the more valuable in an increasingly fragmented health service system.

This article begins by outlining a standard economic analysis of medical malpractice litigation as it was in the U.K. before 1990. It then identifies key changes to the NHS since 1990 and places them in the context of an experiment in quasi markets. The standard economic analysis is then reconsidered given the changes in health services, and some tentative predictions are suggested. This particular comparison over time is offered as one contribution to the search for more efficient, responsive, and equitable resource allocation for health care in Britain and North America.

I. An Economic Analysis of Medical Litigation

A conventional economic analysis of medical negligence litigation focuses on overall objectives for resource allocation, especially efficiency, and the role of material incentives (alongside others) in shaping decisions and their outcomes. Economists commonly define improvements in efficiency in any particular context as changes in resource allocation that enable at least one individual to feel better off without necessarily leaving anyone else feeling worse off. For example, cutting the cost of providing particular health services (thus enabling resources to be used in other valuable ways) would qualify as an improvement in efficiency only if the value of benefits, as perceived by the individuals receiving the service, is not also cut by so great an extent; similarly, increases in the value of benefits from a service would qualify only if costs (alternative benefits foregone) did not rise by so great an extent. Additional cuts in costs or increases in benefit might be supported on other grounds, such as equity or fairness in some form, but not on grounds of efficiency according to this definition. Such an analysis, using a textbook market for comparative purposes and applied to the system of medical

1. As identified by Robert Dingwall *et al.* throughout their book Medical Negligence: A Review and Bibliography (Oxford: Centre for Socio-Legal Studies, 1991). For an example, see page 11.

2. For example, since the Crown indemnity reforms of 1990, local health authorities must now routinely report some relevant data to the Department of Health.

negligence litigation as it operated in the U.K. during the 1980s, reveals at least three characteristics.

First, there was no relationship between the professional indemnity insurance premiums actually paid by individual doctors (given various government subsidies) and their experience of negligence claims against them. Doctors, though far outnumbered by nurses and other categories of employees within the NHS, clearly exert a leading influence on resource allocation decisions and their outcomes. A closer relationship between insurance rates and negligence claims could efficiently deter substandard practice if this were coupled with an appropriate version of the courts' current test of weighing an individual doctor's practice against standards to be expected of relevant peers. Litigation itself would then deter only substandard and negligent practice within any service and would not discourage doctors from performing services where the risk of genuine medical error or accident is high. Doctors would have better information about the costs incurred by patients who suffer harm and would have a material incentive to take those costs into account when making practice decisions.

Second, the analysis suggests that court awards during the 1980s did not accurately reflect the expected losses that patients might face as a consequence of medical negligence. The availability of remedies and government payments to patients who suffered injury limited the awards. Both the first and second characteristics reduced the short-term impact of any doctor's medical negligence on their own pockets. According to the standard economic analysis, this impaired the information carried by price, which might otherwise lead health service providers and administrators to maintain an optimal overall balance in allocating resources, weighing the need to provide medical services against the need to avoid medical error and harm to patients.

Third, such an economic inquiry would also question the costs associated with the system of medical negligence litigation, apart from any sums paid as compensation, particularly the costs that confront those individuals contemplating whether or not to prepare a claim. At least some of these other costs are known in shorthand as "transaction costs." They could be high enough to deter entry into the market for relevant legal services, hence impairing the information about the true costs of medical harm that might otherwise be conveyed by market price. The eco-

nomic inquiry would also recognise, however, that the causes of those transaction costs may contribute to the deterrence of medical error.[3] For example, any attempt to relate indemnity premia closely to the claims prospects of individual doctors or health care organisations, which might optimally deter error by those individuals by confronting them with cost consequences of any error, would itself incur costs in establishing the appropriate levels of premia. The collection of data required to relate indemnity premiums to the size or frequency of claims with any precision, as advocated by economists, would incur one more set of costs to be weighed against the benefits expected from the exercise. At some point the costs of achieving more precision are likely to outweigh the expected benefits.

That list of characteristics in the economic assessment might be supplemented by considering whether there can be compatibility in the market between medical negligence litigation and existing arrangements for allocating resources with regard to other causes of injury or disability. These arrangements include essentially no-fault assumptions and social welfare payments.[4] The analysis of compatibility also involves the problem of constraints considered immovable in one aspect of the health services market that may impinge on the efficiency of resource allocation elsewhere and overall in the market.[5]

Popular commitment or rhetoric expressing notions of fairness, which have always been associated with the NHS, would stir somewhat, in this particular context, the conventionally muted attention to questions of equity in an economic analysis, by comparison with those of efficiency. The aspiration may be that all individuals in equal need of health care should receive equally adequate care if it is technically possible to provide it; greater need should imply more care. Problems arise in reaching a consensus on the precise understanding of equity and reconciling in practice any such formulation with the constraint of scarce resources. Economists might suggest that any equitable objective adopted might be achieved more cost effectively if the message sent by court awards for medical negligence cases were

3. *See, e.g.,* Roger Bowles & Philip Jones, *Medical Negligence and Resource Allocation in the NHS*, 24 SOC. POL. & ADMIN. 39, 47-48 (1990).

4. Dingwall *et al.*, *supra* note 1, at 75-76 (clearly regretting that commentators have tended to reflect separate agendas for each of these matters).

5. For a discussion of relevant types of these possible problems, see Stephen Williams, *Second Best: The Soft Underbelly of Deterrence Theory in Tort*, 106 HARV. L. REV. 932 (1993).

not suppressed and distorted by the manner in which those awards are made. Court decisions about whether to make an award in a particular case, or how much it is to be, have been affected by considering what other welfare benefits are available to the patient in his or her current circumstances and what form these alternatives take (universal or means test, flat rate or variable rate, statutory or discretionary, etc.). Consequently, court awards typically do not reflect the full expected cost of the incident that gave rise to the claim.

Of course, even mainstream versions of economic analysis could be applied with a different emphasis. For example, formal study of the negotiating and contracting behaviour of various economic actors has become increasingly popular since the 1980s. There is plenty of scope for this analysis in the complex relationships between patients and agents, including health service and legal professionals, employed to act on their behalf. The transmission and assimilation of information relevant for decision making remain key themes in that type of study.

In summary, mainstream economists in the 1980s would have highlighted divergences between the practice of medicine at that time and a textbook market for medical services. Many strands in the implied criticism of current practice refer to nonmarket or noncompetitive elements in resource allocation as they affected health services in the U.K. at that time. The spectre of high transaction costs, however, requires even conventionally trained market economists to make some heretical adjustments to the system, such as government subsidies to improve patient access to competent legal advice or alternatives to litigation such as some form of no-fault scheme.

Economic assessment of medical litigation in the 1980s was rare and limited. The health service context was one where public ownership, finance, and provision combined to mightily outweigh the private sector, with bureaucratic resource allocation still largely dominating market allocation for health services and compensation for injury. The apparently greater prominence in the United States of medical malpractice litigation and its cost has always been ascribed in part to the differently mixed health economies and the different legal systems in the two countries.[6] However, the resource allocation mechanisms for delivering health services (and other welfare services) in the U.K. have be-

6. *See* MARGARET BRAZIER, MEDICINE, PATIENTS AND THE LAW 116 (2d ed. 1992).

gun to change and have done so more dramatically since 1990. Increasingly, the health service system in the U.K. is shaped by quasi-market forces rather than by bureaucracies.

II. Changes to the NHS for the 1990s

In 1990, Parliament formally announced two changes to the NHS. In January of that year, a new form of Crown indemnity regarding the work of doctors and dentists within the NHS established that the organisation, not the practitioners, would be liable for any court-awarded compensation payments for medical negligence. This replaced the curious dual liability that had existed for doctors but never for other NHS employees (a legacy of the political origins of the NHS). June of 1990 saw the passing of the National Health Service and Community Care Act, which confirmed a government intention to establish distinct responsibilities for purchasing and providing NHS services on behalf of patients.[7] Both of these announcements, but most clearly the purchaser-provider initiative, can be recognised as continuing the encouragement and development through the 1980s of business practices previously more associated with the private sector, where cost sensitivity, if not price sensitivity, played an increasingly important role. Parallel developments took place throughout much of the existing public-sector community, including the education and central government services communities.

It would have surprised no one that these initiatives took place under strong leadership by Conservative rather than Labour governments. Prime Minister Thatcher's decision to restrain radical reforms of this kind to the extent she did merely affirms that the NHS inspires more popular and political resistance to the further encroachment of a market-orientated allocation of resources than do other public-sector institutions.

One consequence of the changes that emerged is the increased recognition in the U.K. that a standard economic approach might be relevant to the analysis of medical negligence litigation or the NHS itself. The long-term popular experience of a health service system well insulated from the influence of market prices negotiated between individual buyers and sellers, apparently by the collective choice of the nation, did not square

7. An outline of these and allied reforms was expressed in a British Department of Health, Working for Patients (White Paper) (CM555, London: HMSO, Jan. 1989).

with the use of textbook markets as a benchmark against which current practices or plausible reforms were to be explained and assessed. Markets had apparently been rejected on various grounds as the main vehicle for allocating health care resources. Emphasis on the role of litigation (and hence market price) in providing information relevant to the optimum allocation of resources, as distinct from its incentive and burdens, might also have sounded strange to people in Britain. By 1991, however, the semblance of a sizeable quasi market[8] in NHS services was emerging, and even those resisting or sceptical about its development had to recognise it as such.

III. The Purchaser-Provider Innovations

Since 1991, in accordance with the ideas outlined in *Working for Patients*,[9] the Department of Health has designated a number of applicants from among existing NHS hospitals and units as independent NHS Trust providers of services. By April 1994, there will almost certainly be about four hundred such Trusts in England, encompassing approximately ninety-five percent of all English hospitals. These Trusts, many but not all of them general acute-services hospitals, face different and generally less restrictive government constraints, when compared with traditional providers, on how they are to uphold NHS principles and policies. In particular, they are accountable to central, rather than local, NHS bureaucracies. Providers that remain subject to local NHS administration or management, by choice or because ineligible for Trust status, found themselves potentially in competition with the Trusts as well as a growing array of institutions newly designated as purchasers of NHS services.

Routine purchase of most NHS services had not been a feature of the health care institution prior to 1991. Any reference to a purchasing function within the NHS had been confined to the acquisition of inputs from which NHS services were generated, not to the services themselves. Since 1991, responsibilities for explicitly purchasing access to services on behalf of defined patient populations were assigned to all District Health Authori-

8. A term apparently first used in a comparable context in Oliver Williamson, Markets and Hierarchies: Analysis and Antitrust Implications 8 (1975).

9. British Department of Health, *supra*, note 7.

ties (DHAs)[10] and offered to some General Practices (GPs), the family doctor service. Both the GPs and the DHAs are types of organisations that had provided, administered, or managed some such services until then and would continue to do so. These purchasers are allocated limited public funds on a prospective basis, in various ways, so that they can negotiate contracts with providers within or beyond the NHS. The dual responsibilities of DHAs as purchasers and providers of contracted services currently imply unusual formal divisions within these organisations. However, these apparent anomalies will be reduced if, as expected, more providers successively attain the status of independent NHS Trust.

Together, these new arrangements became known, imprecisely, as the internal market. The term stresses the contracts and prices that were to be established for NHS services between different NHS institutions. In some ways, the reforms facilitated the integration of the private and NHS sectors in health care, although the private sector remains comparatively limited, as do prospects for direct competition between purchasers, or providers, of both sectors. Individual patients or their private agents still largely face a market price of zero at the point of use for NHS services purchased on their behalf by DHAs or GPs. Some user charges, which were set administratively rather than emerging as market prices, have become more prominent since 1990, continuing trends familiar in the 1980s. However, health care services are still to be financed mainly by prospective allocation from general taxes, channelled through the NHS. The superficial prominence of greater attempts by local NHS managers to generate supplementary revenue through private enterprise yields small sums when compared with these enormous public inflows. Distributions of any surplus revenue as profit within NHS organisations remains formally forbidden: it is instead to be directed to improve local health services for patients.

Trusts and directly managed NHS providers are to derive their income mainly by contracting with NHS purchasers, with each other, or with the private sector. The amount of public funding for purchasers is intended to be determined largely on the basis of capitation (resident population in the case of local

10. There were about 165 DHAs in England by April 1993, following some restructuring, each of them having a revenue budget for the year 1993/94 of between £35 million and £350 million. THE INSTITUTE OF HEALTH SERVICE MANAGEMENT, THE HOSPITALS AND HEALTH SERVICES YEARBOOK, § 2, at 1-2 (1993).

DHAs; practice lists for GPs), weighted by such factors as the age of the population, the incidence of ill health, and the local cost of providing health care. Some public payments linked to particular items of service will also be offered, although in practice, to date, past levels of expenditure have still been used to determine present and future funding.

Fund-holding GPs, as they are known, get their public funds from a slice of the allocations channelled to local health authorities, who are to fund the GPs before using the money for other purposes. The share of health authority allocations devoted to fund-holding GPs is destined to grow as more GPs are designated as fund holders. DHAs remain responsible for a large proportion of purchases on behalf of fund-holding GPs, generally for the more essential and costly items. Thus, the exposure of fund holders to possible failure and exhaustion of their resources, with smaller organisations especially at risk, is reduced. DHAs also continue to purchase all services they deem necessary for patients of those GPs that have not become fund holders, as yet a clear majority.

Since 1984, the central government has influenced important precursors, in terms of business orientation, to the 1990 reforms. These included the introduction of a general management function to the NHS, specific budget responsibilities, and influential appointees from the private sector. There was also a series of initiatives (such as requirements that private contractors be allowed to supply particular NHS inputs) that forced NHS decision makers to seek "value for money" and to to so in particular ways; these initiatives were designed to influence any who were unaware of the possibility of contracting with private suppliers or who were unwilling to vigorously pursue such possibilities. By 1991, commentators were convinced of a shift in cultural balance within the health care system from a professional orientation to a businesslike one, which was followed by the introduction of structures that encouraged a new contract culture to develop. Previously, reliance had been placed to a greater extent on professional trust.[11]

It would be a great exaggeration to claim that the purchaser-provider reforms of 1990 have resulted in a health care system where resource allocation is dominated by the influence of market prices negotiated between many individual buyers and sellers. The reforms themselves have done comparatively little to

11. *See, e.g.*, IAN HOLLIDAY, THE NHS TRANSFORMED 15-23 (1992).

shake the NHS monolith, and genuine pressure to compete to make services available to patients remains limited. NHS purchasers and providers, such as individual big-city hospitals (especially in London and Birmingham) have begun to test the possibility of exit from the market, a development that coincides with another aspect of health policy, a shift in balance from hospital to community care.

The impact of the quasi market on the market presence of other existing types of health care institutions or individual types of service is not yet clear. The latter will depend heavily on the quality of information newly generated regarding patient need, cost, and quality of service. DHAs are virtually local monopsony[12] purchasers of services on behalf of up to a million captive patients, a potential influence on the market that is compounded where DHAs have formed purchasing consortia among themselves in the name of economy or better planning. The relationship between DHAs and NHS providers individually or as a whole is virtually that of a bilateral monopoly, especially in a local context. These restrictions on a purchaser's ability to choose services compound restrictions on the patients, who must rely on the purchaser to act as an agent on their behalf. In addition, large start-up costs for hospitals (sunk costs) seem to offer incumbent NHS providers a market advantage over potential new entrants, at least for a wide range of general acute services. There is as yet no market in the ownership or management of existing NHS institutions.

The formal delineation of separate purchasers and providers for the first time, together with tighter budgetary discipline, might be expected to increase explicit market-sensitive information. Contract price (asked, offered, or agreed) is one such type of information. It, in turn, encourages the search for more details regarding cost, volume, or quality of services. The expected benefits of acquiring extra information, however, will be weighed against its expected costs. Similarly, the usefulness of explicit performance indicators in planning will be judged partly by whether they are sensitive enough to the fundamental aims of decision makers. Where aims are unclear, intangible, or in conflict, as in the NHS, investment in explicit indicators may be restricted or misdirected. Individual players in the internal market will be tempted to focus on their own private benefits and

12. A monopsony is a market situation where one buyer exists for services provided by a number of sellers.

costs of extra information, which will diminish their willingness to disseminate the information widely and increase attempts to free-ride by using data produced by others. Health care is not so perfect a market that reliance on privately generated information is guaranteed to yield efficient or equitable overall resource allocation. Rather, the quasi market in the U.K. is complex, motivated by nonprofit objectives and populated by individuals who vary radically in their opportunities to process relevant personal or technical information.

Incentives to generate and disseminate good, market-related information systematically, including details on quality that would interest patients, may thus be diminished, especially considering the high costs of doing so within strictly limited budgets and given the limited information bases from before 1991. The development of comparative medical audits as a contribution towards quality assurance was included as a commitment in the White Paper, *Working for Patients*.[13] How enthusiastically it progresses among cost-constrained health authorities or professional associations and how readily it influences the allocation of resources is open to doubt. New but weak substitutes for the patient's power to exit from the market or voice concerns include the institution by government of the Patient's Charter of limited guarantees concerning waiting times and other aspects of health services. Where competitive pressures are weak but budgetary constraints are strict, as seems to be the case with DHA purchasers, the interests of individuals currently seeking services may suffer when compared with those of the NHS, its professionals, or other taxpayers.

Incentives to pursue patient concerns including questions of quality could be a little stronger among fund-holding GPs, whose practice lists, containing as few as 7,000 patients, may attract capitation payments. The ability of patients to transfer between GPs has been made formally easier in recent years. GPs may now advertise to some extent and in fact are obliged to display certain information about the services they offer. The relatively small size of GP resources, when compared with those of DHAs and some providers, suggests that GPs suffer a competitive disadvantage in the quasi market. To date, however, some DHAs have committed many of their resources early in the financial year to block contracts that allow them access to services on a scale that proves eventually to be more than is

13. BRITISH DEPARTMENT OF HEALTH, *supra*, note 7.

needed. Fund-holding GPs have necessarily managed resources on a smaller scale and specified their contract requirements more conservatively. As a consequence, some of them have been able to buy access to limited numbers of hospital places for their patients towards the end of the financial year at a time when DHAs no longer have the uncommitted resources left to do so.

Optimists for market allocation claim that markets, unlike bureaucracies, have in-built mechanisms that enable them to adjust efficiently to changes in their context. It may be that the quasi market in health services in the U.K. will undergo a similar adjustment, but it is still too soon to judge. For example, we can confidently expect that DHA activities will be further displaced by the new fund holders and Trusts. However, the outcomes will depend partly on the structures put in place at the outset and whether definitions of respective rights and responsibilities are clear. Medical litigation is regarded as one possible way to define and enforce relevant rights in the name of market efficiency. It is not clear that the initial purchaser-provider reforms will have much overall impact on medical negligence litigation as a deterrent against poor standards of service, although tighter budgetary discipline within the NHS may tend to increase the patient's need to have ready access to an effective system.

IV. Changes to Crown Indemnity

The change in relationships between health service organisations that arose as a result of the purchaser-provider innovations affects the distribution of responsibilities established by the almost contemporaneous reform of Crown indemnity in respect of liability for medical error in the delivery of NHS services. Under the revised liability scheme, only the NHS is liable for medical errors; under the former scheme the physician faced potential liability as well. The Department of Health adopted this change from among a range of alternatives designed to meet Department concerns about the escalating costs of subsidising doctors' professional indemnity subscriptions to the medical defence organisations (MDOs). In the late 1980s, the NHS had borne much of the burden of these subscriptions (actually the general taxpayer) either by direct subsidy or through the effect the rates had on the formulae used to decide the levels of doctors' remuneration. Claims that the administrative costs of litigation be successfully contained by simply reallocating liability

from doctors (and MDOs) to health service organisations were treated sceptically beyond the Department.[14] However, the indemnity reforms clearly could be seen as consistent with the more general shift from a predominantly professional or clinician culture to one in which businesslike management might hold increased sway. Litigation costs could change if responsibilities were exercised according to a different balance of priorities rather than by the elimination of any particular category of transaction costs.

The trend in MDO subscription rates before and after the shift in liablity illustrates the large effect doctors' personal liability had on their subscription rate when compared with other services provided by these organisations. The main rate for 1988 reached over £1000 per individual in cash terms, following several large annual percentage increases.[15] In 1990, by contrast, rates dropped to £160 or less (although the amount of non-NHS work undertaken by a doctor would raise the sum payable).[16]

In effect, the Crown indemnity reforms removed most MDO subscriptions for NHS doctors as a set of price information that might influence the allocation of resources between providing medical services and avoiding medical error. However, they did little to alter directly the relative burdens of liability between doctors and the NHS, given the pre-existing NHS subsidies. The value of MDO subscriptions as price information was likely to be limited in practice. The Department of Health, if not the MDOs, continued to resist higher rates for those doctors expected to give rise to higher levels of litigation. There were fears of greater problems, including cost, in recruiting and retaining doctors for high-risk specialties, which could be seen as a threat to the broad aspiration that NHS services be comprehensive. Any vagaries of the existing system of negligence litigation in applying the test of individual practice against the standards expected of relevant peers would reinforce the fears among those who tend to be risk averse.

The Crown indemnity reforms have also rendered the NHS as a whole effectively subject to self-insurance. The NHS is prevented from seeking contributions from individual doctors or

14. *See, e.g.*, Margaret Brazier, *NHS Indemnity: The Implications for Medical Litigation*, PROF. NEGL., June 1990, at 88.

15. *See* Paul Fenn & Robert Dingwall, *Medical Negligence and Crown Indemnity in* HEALTH CARE U.K. 1989 39, 41 (Anthony Harrison & John Gretton eds., 1989).

16. *See* Brazier, *supra* note 14, at 90.

other employees for costs arising from its own liability for incidents occurring on its premises, although contributions can be sought from family doctors and others involved in non-NHS work. Therefore, the NHS has a greater incentive to manage the risks of error and litigation actively, which includes persuading individual doctors to comply with the strategies developed by budget-constrained managers.

Formal responsibility within the NHS for dealing with particular claims of negligence has been decentralized since 1990. It now rests largely with individual local provider units, either Trusts or the so-called directly managed units attached to DHAs, in which the relevant incident took place. Furthermore, those units managed by a DHA are instructed to make liability payments from the budget of the clinical specialties involved.[17] More localised responsibility and stricter financial controls suggest that the role of disciplinary procedures and of medical audit will assume a potentially greater prominence, depending on how strong the traditionally powerful professional defence of clinical autonomy remains. A compromise on autonomy could increase or expose the temptation to adjust one's clinical practice specifically to temper fear of litigation. The prospect for the medical profession is one of patients bringing claims against them, even though they are covered by NHS indemnity, and NHS business managers strictly controlling their activities. That might seem to them a nightmare combination of the pain of litigation with an inquisitorial no-fault scheme, which they had striven for years to avoid.

There is speculation, without much tangible evidence as yet, that doctors in the U.K., anticipating that the costs of litigation will escalate, are practising "defensive medicine"—that is, they practice in a way that restricts exposure to litigation rather than one that promotes the net benefits to patients when the two aims conflict. The issue is complicated by uncertainty about distinctions between "defensive medicine" and properly careful medicine, especially if actual practice is subject to more open scrutiny than has been the case without explicit agreement about what constitutes the limits of appropriate practice. Individual doctors may sense a greater difficulty in adhering to what the profession regards as established standards. Their professional influence on the allocation of resources for health care

17. *See* Jean Trainor, *Good Housekeeping*, HEALTH SERV. J., Apr. 9, 1992, at 14, 16.

may be challenged by the business managers of NHS providers or agents representing patients and other interests.

The small size of individual NHS provider units, and even DHAs, makes possibly wild swings in negligence claims from time to time particularly difficult to manage effectively. The institution of loans from the Department of Health (for Trusts) and from DHAs (for other NHS units) only mildly serves to shift the risks from individual providers. The loans bear interest, and applications can be made only in particular cases (some a legacy from pre-1990 arrangements) and only after the provider has exhausted a fixed amount of their current budget to meet the cost of negligence liability. A group of Trusts (or other providers), all with similar prospects, then, would see attractions in pooling the resources set aside by each of them to meet the cost of claims,[18] evening out unpredictable swings in payments. The transaction costs of arranging the pools and the loss of deterrent to individual error could be considerable, however, unless the mutual pool is managed with the sophistication, if not the profit objective, of a commercial insurance fund.[19] The expert contribution of the three sizeable, experienced medical defence organisations to managing risks associated with medical negligence litigation, substantially in cooperation with NHS authorities, has been weakened by the decline of most indemnity subscriptions for individual doctors in 1990. By comparison, any contribution of MDOs, if employed as agencies on a piecemeal basis by the smaller, less experienced constituent parts of the NHS empire, would be compromised or amended by the new, fragmented approach and, possibly, by the newly contractual nature of the relationship between them as organisations with different agendas.

As Trusts, which are managed independently of DHAs, increase in number, they will complicate further the efficient management of liability across the NHS as a whole. The small size of Trusts and their short history to date means that even if NHS regulations permitted them to seek commercial insurance for medical negligence litigation, it may not be affordable given the unpredictability of claims against them. The Trusts could, instead, oblige the doctors they employ to pay their own indemnity subscriptions to MDOs, echoing NHS arrangements prior

18. *Id.*

19. *See* Roger Bowles & Philip Jones, *Better Safe than Sorry*, HEALTH SERV. J., Mar. 21, 1991, at 18-19.

to 1990. That, though, might raise the cost of employing Trust doctors to a rate higher than that of their rival non-Trust providers. If left largely self-insured, Trusts may be persuaded to avoid providing health care services where risks of litigation seem high, leaving these services to be performed by other providers or not at all, to the possible detriment of patients.

The response of NHS providers to their potential liability under the reformed Crown indemnity will be complicated by their equally new relationships with purchasers. The willingness of GPs to act with their patients to bring claims for negligence against a doctor, and hence against a provider, will depend partly on the generosity of their capitation payment rates and the competitiveness of the internal market. The fewer their feasible alternative sources of contract services, the greater their need will be, as agents for the patient, to resort to litigation as a possible sanction against poor quality; however, they will also need to preserve a working relationship with the particular provider. The strongly adversarial nature of the legal system in England may be unhelpful in this regard. In addition, it should be noted that disputes arising from contracts between NHS purchasers and NHS providers are, for the present, to be settled within the health service and are not subject to contract law. Underlying this all, perhaps, is the fact that there remains no direct financial relation between NHS patient and NHS purchasing agent, let alone between patient and doctor or provider.

The willingness of DHAs to ally themselves with individual patients for purposes of negligence litigation seems still more in doubt, even if the administrative structures or "Chinese walls" that separate their roles as purchasers and as managers of some NHS providers are preserved effectively. Both of these roles will diminish as GPs continue to become fund holders and as more parts of the NHS become independent Trusts, leaving the authorities with less influence on the market. They are likely, nevertheless, to remain remote from individual patients when compared with GPs and perhaps even with hospital doctors. Though newly charged with the responsibility to identify the health care needs of their resident population, on which they base their purchasing requirements and strategy, their incentives to do so could be threatened substantially by the cost of acquiring and disseminating that information assiduously and sensitively on behalf of such a large and remote set of people. In the

initial stages of the purchaser-provider reforms, more systematic effort clearly went into establishing the contracting system, without which the market could not operate at all, than into an information-generating process on behalf of patients.

Any help that purchasers offer to patients considering medical negligence litigation could well have some impact on outcomes, including court awards, by offsetting slightly the formidable constraints on most potential plaintiffs' access and influence. (This will be so particularly until individual providers have acquired more of the expertise required to avoid or to win cases.) The postreform semi-detachment of doctors' MDOs from the management of incidents involving the NHS could shift the imbalance of effective representation a little in favour of the patient. The health authority's limited expertise in preparing a case would raise the expected cost of pursuing it successfully through the courts, thereby increasing the chance for an agreed settlement, especially if the explicit defence of a doctor's reputation is less of a priority for the health authorities than for the MDOs. There remains, however, the large problem of providers having more information about the quality of services than do patients, especially on technical matters. Even strong purchasers facing smaller providers may be able to redress the imbalance, but only if they are willing and able to spend considerable amounts of money and resources on contract specification and monitoring.

V. The Influence of Welfare and Legal Systems

Changes in the eligibility of patients for various subsidies affect trends in court awards, prior settlements, and transaction costs more so than do the NHS innovations since 1990 and their resulting implications for the law and the market for legal expertise. The practical ability of the legal system to address liability for injury provides information that may serve to increase the predictability of events, thus reducing the overall cost of health services. The distribution of health care costs and the cost of the legal system, which restrain them, may be modified by subsidy.

Central government continues its earnest scrutiny of welfare payments generally, including legal aid for plaintiffs, with a view toward containing public expenditure as a proportion of national income while existing commitments increase. A generalised attempt to curb widespread eligibilities in order to preserve levels of subsidy for those with greatest financial need would especially affect the legal aid scheme, to which many people

wishing to pursue a claim currently apply. The more varied and extensive welfare payments available in the U.K. have been offered as one reason why awards for negligence tend to be lower than in the U.S.[20] The expected financial loss to patients in the U.K. as a result of negligence may be genuinely lower than it is in the States. If so, then courts in the U.K. may substitute higher awards in place of any reductions in these government subsidies. Any erosion of access to free NHS services, which would result in additional costs to patients who seek remedial care for a negligently caused injury, might also be assimilated within the level of awards made. The alacrity with which judges will encourage such adjustments as these might depend on whether the undue deference allegedly given to the interests of doctors as professionals, compared with that given patients,[21] continues now that the impact of litigation on doctors has been somewhat deflected by NHS liability.

The undoubted influence of government subsidies could be dangerous if those with influence in or on the NHS believe that their own participation in the recent institutional changes has little effect on the quality of services provided. The belief could further encourage the traditional U.K. demand that subsidies to patients be prioritised indefinitely, without specifying what alternative uses of resources would thereby be foregone (the opportunity costs). The necessary search for improvements in the efficient delivery of high-quality services within the NHS might be neglected as well.

VI. A Tentative Conclusion

One conclusion suggested by this article is that it would be a mistake to dwell exclusively on the recent structural or cultural changes to the NHS, relevant though they are, in attempting to predict prospects for litigation. This is in part because sizeable, complex, and often controversial innovations within the quasi-market experiment continue to challenge a popularly cherished institution in what is still a very mixed economy of health. Pressures on public sector budgets in general will be relentless. The pressures may be attributable to an increasingly dependent population or to the continuation of governmental attempts to reduce the share of public expenditure in national income, but it seems certain that they will substantially affect reliance and

20. *See, e.g.*, Dingwall, *supra* note 1, at 32.
21. A view confidently expressed in Brazier, *supra* note 6, at 71-72.

spending on potential or actual litigation. One gloomy possibility facing individuals is that as alternative remedies are restricted, requiring them to rely increasingly on access to litigation to deter and compensate for medical harm, access to adequate legal services will become financially further out of reach.

VII. A Final Note About Information

The panoply of changes to the NHS since 1990 put a premium on good information relevant to the increasingly distinctive and constrained choices faced by players in the health service quasi market. We can expect various piecemeal efforts throughout the quasi market or on its fringes to acquire and use such information. We can also expect some defensiveness in supplying and disseminating it. Much of the relevant effort can be regarded as an investment in research output, where outcomes, if any, benefit future rather than current patients. These expected benefits are vulnerable to being ignored or underrepresented if decision making and budgets are closely tied to a proliferation of separate current stakeholders, even if many of them are NHS organisations. There is a broad interest in efficiently and equitably balancing the provision of services that promote good health with the avoidance of occasional error or malpractice that results in harm to patients. In the U.K., this balancing seems to require renewed attention to the availability of explicit information from those whose responsibilities span wider than an individual purchaser or provider budget.