

The Costs of Medical Negligence

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Editor

The United Kingdom House of Commons Committee of Public Accounts¹ published a report on the costs of medical negligence on January 30, 2026. Its findings reflect the similar challenges being faced in many healthcare services.

The rising costs of claims in England continue to divert vital resources away from the frontline services. Settlement costs have tripled since 2006-7, and the UK government has £60 billion of liabilities on the balance sheet. Annual settlements have increased to £3.6 billion in 2024-5. Globally, treating cases where harm was avoidable costs developed countries 8.7% of their health expenditure each year.

The recent increases have been driven mainly by a small number of very high value cases in obstetrics with an average cost of £11.2 million per claim. The Report states that the Department of Health has not taken sufficient measures to tackle the problem.

Preventing harm is clearly the most effective way to protect patients and reduce the widespread impact of negligence. With so many lives and so much money at stake, there needs to be a meaningful change that can be acted on swiftly. Without change, the system will continue to be a barrier to acknowledging mistakes and learning from them. More needs to be done to tackle the underlying causes of harm. Patients often pursue legal action to get answers and accountability due to a confusing and under-responsive complaints system. The UK's National Health Services (NHS) is drowning in more than 1500 recommendations, and there is a need to concentrate and implement the key ones that will improve outcomes. A total of 2.4 million patient safety incidents are reported annually. Seventy per cent cause no harm. On the other hand, 0.5% of patient safety incidents cause severe harm or death. There appears to have been little improvement in the frequency of harm over the past 5-10 years. Learning from past incidents is fundamental to improving patient safety.

The Report states that there are too little data on the factors behind medical litigation. Behind every serious case, there is a tragic incident of patient harm. The extensive information routinely collected is not reviewed at a national level. More investment in data analytics is required. It is stated that NHS England has a plethora of data and no information. There should be a clear system of accountability for patient safety, learning from mistakes, and the sharing and implementation of what works.

There are concerns that in far too many cases, the legal costs to settle a case are disproportionate to the amount of compensation awarded to the patient. This is particularly

the case for lower value claims below £25,000 where the legal costs are almost 4 times the damages quantum.

There are concerns that the amounts of damages are inflated unnecessarily due to a historic legal requirement to assume that treatment and care will be provided privately. It is not known the extent that claimants will go on to use publicly funded services. This has the potential to amount to an element of double-counting and change is overdue. It is estimated that this factor may add up to £1 million to high- cost claims where 60% of the damages relate to future care.

In 2024-5, the cost of settling claims involving brain injury at birth was £1.554 million with the total costs for paediatric failings being £325 million. The settlements have to include compensation for lifelong health and social effects, future lost earnings, and any necessary adaptations to accommodation. There may be court rulings on additional innovative or novel treatments.

NHS Resolution is the administration scheme that negotiates the settlement of claims. At present, it settles 120-130 brain injury cases involving children each year. Previously, it took up to 11 years to resolve a claim. NHS Resolution has speeded up the process using an early notification system. It provides timely support for families, and it makes every effort to settle cases without resort to the courts. This is important in the reduction of legal costs which stand at 19% of the total settled claims. NHS Resolution has increased the proportion of cases resolved without litigation from 66% in 2006-7 to 83% in 2024-5.

There were a number of submissions including those from the Royal College of Obstetricians and Gynaecologists. It stated that every mother or baby injury or death is a tragedy. Prevention requires investment and support for maternity services. Half of all women having a baby do so with a medical intervention such as a caesarean section or an instrumental delivery. It is driven by being older, a higher BMI, gestational diabetes, and pre-existing medical conditions. The more complexity, the more likely that women will need obstetric-led care. There needs to be a shift from a blame culture to a true and constructive learning one. The three key factors that need sustained attention are funding, workforce, and estates. There are real risks when funding is diverted from maternity to other services. Estates need investment. As many as 43% of maternity and neonatal estates do not meet basic standards. This is unsatisfactory for patients and puts additional strain on staff. It leads to delays in the undertaking of medical procedures. The Avoiding Brain Injury in Childhood (ABC) is designed to reduce the risks associated with two key circumstances, the management of the impacted fetal head at caesarean section, and the recognition and response to the baby who is deteriorating during the labour.

The Royal College of Ophthalmologists also made a detailed submission. It stated that since 2006, there has been a 218% increase in the number of claims opened, compared with 166%

across all specialties. The payout in 2024-5 was £28 million. It is pointed out that one of the challenging issues is the increase in the fragmentation of care with many services, particularly cataract surgery, now being delivered across both NHS and independent sector providers. It is recommended that there should be good communication between providers in relation to sharing images and patient information. The most common causes of litigation are failure/delay in treatment and failure in follow-up arrangements. The importance of timely reviews for patients is stressed.

The British Medical Association in its submission states that the current system of compensating patients is not fit for purpose, is grossly expensive, adversarial, and promotes individual blame instead of collective learning. There is no evidence that the standards of doctors' care have deteriorated but rather there has been an increased number of claims and higher awards. It is often suggested that clinical negligence claims play a role in ensuring patient safety. However, this is neither the purpose or the effect of medical negligence, the single factor being patient compensation. The current adversarial system needs to be reformed. There should be a gradual move to a no-blame culture scheme, starting with one specialty as a pilot initiative in order to refine how best to roll it out.

The findings in this report on medical negligence reflect not only what happens in the UK, but also in other countries. The Department of Health report on the rising costs of health-related claims (2024), chaired by Dr. Rhona Mahony, reached many of the same conclusions². It identified six strategic priorities, which aim to reduce the requirement for litigation in healthcare, and to improve the litigation process for those taking this path: (1) care for infants born with Neonatal Encephalopathy; (2) the prevention of adverse events; (3) a timely response when harm occurs; (4) learning from adverse events, capturing data, and promoting key research; (5) faster and more efficient resolution of claims; and (6) standardised approach to mass claims.

Three themes emerge. First, the avoidance of medical error and an emphasis on a safety culture for all healthcare staff. Second, appropriate medical care and compensation for patients who have suffered an avoidable medical injury. Third, a national adverse event data collection system and a responsive learning network that benefits all staff.

References:

1. The House of Commons Committee of Public Accounts. Costs of Clinical Negligence. 64th Report of Session 2024-26. Published 30th Jan 2026.
2. Report and Implementation Plan of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims. Department of Health. Published 19th Sept 2024.