Nuffield Foundation

Funding clinical negligence cases

Access to justice at reasonable cost?

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About the Nuffield Foundation

The Nuffield Foundation is an endowed charitable trust that aims to improve social well-being in the widest sense. It funds research and innovation in education and social policy and also works to build capacity in education, science and social science research.

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Foreword from the Nuffield Foundation

Since the late 1990s, successive governments have made changes to how clinical negligence claims are funded, with the aim of reducing legal aid expenditure. The cost of claims has been transferred from the government to lawyers operating on conditional fee arrangements (commonly known as 'no win no fee'). These lawyers then recover those costs from the NHS on cases that they win.

There have been concerns that these changes might act as a barrier to justice because lawyers would be too cautious to take cases, or conversely that they would lead to a surge in 'ambulance-chasing'. New evidence presented in this briefing paper shows that neither of these things have happened, although there have been changes to the number, type, and outcomes of clinical negligence claims, as well as to the types of claimants.

For example, although middle income groups were more likely to make a claim in 2013 than in 2001 due to the increased availability of conditional fee arrangements, those from the lowest income groups were less likely to do so, possibly as a result of the rundown of legal aid for clinical negligence cases. In particular, the authors suggest that conditional fee arrangements (as the main alternative to legal aid) put an emphasis on informed access to legal services rather than a means test, and this may have had an impact on the proportion of those on low incomes pursuing claims, while at the same time opening up new opportunities for those on middle incomes.

The authors also highlight a group of high value claims involving serious injury, usually to infants, which are no longer eligible for legal aid following the implementation of the *Legal Aid Sentencing and Punishment of Offenders Act 2012*. The evidence indicates reluctance on the part of lawyers and insurers to consider such high risk, high value claims, and this is an area that needs greater scrutiny.

The findings presented in this briefing paper are from a research project led by Professor Paul Fenn at the University of Nottingham and funded by the Nuffield Foundation. In addition to presenting an evaluation of the impact of changes to the funding of clinical negligence claims, Professor Fenn's innovative study also establishes an approach which could be used to provide further monitoring and evaluation in the future.

Teresa Williams
Director of Social Research and Policy

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Executive Summary

How are clinical negligence claims funded?

In England and Wales, the vast majority of new clinical negligence claims made by patients against doctors, nurses and others are now funded on a so-called 'no win, no fee' basis (i.e. conditional fee arrangements, or CFAs), where a lawyer agrees to waive his or her fee if the claim is lost, in exchange for an enhanced fee if the claim is won. Other funding routes can be used, including legal aid and legal expenses insurance, but these are now much less common, and may be restricted in their availability. The predominance of CFAs is a relatively recent phenomenon, and compares with the situation some 10 to 15 years ago when the main avenue open to patients was legal aid. This shift is partly due to a reduction in the proportion of individuals eligible for civil legal aid (50% in 2000 to 29% in 2007)[1] and partly to the progressive adoption by lawyers of the new funding opportunities represented by CFAs with increased information about risks, and improved availability of insurance against adverse costs.

The research presented in this report examines the use of four ways to fund clinical negligence claims:

1. **Self-funding:** The claimant meets all the costs of the case if it is unsuccessful (both side's legal fees and expenses). This means the claimant carries all the risk of paying these costs.

2. **Legal aid:** The State (via the Legal Services Commission[2]) meets the majority of the claimant's fees and expenses in an unsuccessful case. However, the State does not accept any liability for adverse costs arising from legal aid cases (a form of 'one-way cost-shifting').

3. **Before the event insurance (BTE):** The losing claimant's legal fees, expenses and adverse costs are met by a legal expenses insurance policy, either purchased explicitly for protection against one day being involved in a legal claim, or as an add-on to other insurance.

4. **Conditional fee arrangement (CFA):** The claimant's lawyer does not seek payment of his fees from the claimant if the case is lost. To compensate the lawyer for accepting this risk, he or she is also entitled to a percentage markup on the fees recovered from the defendant in a successful case (this markup is known as the 'success fee').

Aim of study

This study compares changes in the number and types of claim, the types of claimants, and the outcomes of claims that have occurred as a consequence of the shift in funding opportunities for clinical negligence claims in England and Wales over the last 15 years.

1. Hansard HC Written Answers cols 779W–780W, 20 February 2008. This fall in eligibility arose from a combination of income growth and reforms to civil legal aid (*A new focus for civil legal aid*, LSC, 2004).
2. The Legal Services Commission was replaced by the Legal Aid Agency following the *Legal Aid Sentencing and Punishment of Offenders Act 2012*. We refer to the LSC throughout the paper as it was responsible for administering Legal Aid for clinical negligence claims throughout the time period we cover.

Methods

To address these questions we analysed three sources of data.

1. **The Compensation Recovery Unit (CRU) dataset**, which records information on the population of all claims for compensation in England and Wales over the last decade, with information about the nature of each claim and its outcome (e.g. closed without payment, settled etc.).

2. **The Ipsos MORI dataset**. A questionnaire was designed and a survey administered by Ipsos MORI to provide data on the incidence of adverse events relating to healthcare, and whether a legal claim was pursued. In addition, demographic information was obtained on respondents' age, sex, region, level of qualification, social class, and household income. This survey was compared with a previous survey undertaken in 2001 in order to explore the extent of any changes to the incidence of adverse events or the rate of claiming.

3. **The NHS Litigation Authority (NHSLA) dataset,** consisting of all claims made against NHS acute hospital trusts and settled between April 2008 and April 2013, including those outstanding at April 1st 2013 (a total of 53,377 claims). This dataset includes information of the type of funding used by the claimant, and allows us to explore differences in outcomes across funding types.

Main findings

1. Our findings from analysis of CRU data suggest that the level of claiming in 2013 was not very different from the level of claiming in 2001. However, while the number of closed clinical negligence claims fell steadily between 2001 and 2009, since then it has risen substantially, with the number of newly opened claims approximately doubling between 2009 and 2013. This increase correlates with the emergence of CFA-funding as the predominant route by which patients bring clinical negligence claims against the NHS, and with a corresponding increase in the annual expenditure on claim payments by the NHSLA.

2. The CRU data also suggests that the success rate in clinical negligence (i.e. the proportion of claims that get paid) grew significantly between 2001 and 2009, perhaps reflecting the greater caution used by CFA lawyers when considering case merits. However, there are signs that this increase in the success rate has stopped (and may have been reversed) since 2009, corresponding to the period in which the frequency of claiming has been rising.

3. There is evidence from the Ipsos MORI surveys that the frequency of claiming by social grade/income group has changed since 2001. While middle income groups were relatively less likely to claim in 2001, by 2013 the situation had reversed and the middle income/ social grades were those with the highest frequency of claims after experiencing an adverse event. There were no other significant changes in the socio-demographic pattern of claiming.

4. Drawing on NHSLA data, we found that CFA-funded claims were generally of lower value (i.e. average damages paid), shorter in duration, and incurred lower costs than legal aid cases, presumably reflecting the greater complexity of legally aided claims relating to children. However, legal costs represented a greater proportion of total costs for CFA-funded claims than for other funding types. This is because of the addition of a success fee to compensate for the cost of losing claims; a cost that is borne by the taxpayer or the BTE policyholder in other types of funding.

5. Most of the very high value (>£1m) claims were in the cerebral palsy/birth-related brain damage category. Most of these claims were funded through legal aid during our period of observation, and most continue to be eligible for legal aid. However, we found that a number of high value claims appeared to involve an event taking place more than eight weeks after birth, and these claims are no longer eligible for legal aid since the implementation of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012*. We are unsure whether this group of claims would be considered suitable for CFA funding, and there is consequently a potential access to justice issue in respect of these claims.

Implications

In this paper we have collated data from several sources in order to understand better the implications of the major shift of responsibility for the funding of clinical negligence claims that has taken place over the last 15 years. A snapshot of clinical negligence experience in 2001 would have revealed a situation in which the majority of patients with valid claims against doctors or hospitals were unable to fund their legal expenses because they were not eligible for (means-tested) legal aid, but were not sufficiently wealthy to pay lawyers from their own resources. Our own data from a population survey carried out in 2001 shows evidence consistent with that picture, with low rates of claiming by those in the middle social grades and/or middle income quintiles. The subsequent rundown of legal aid funding for clinical negligence, and its gradual replacement by CFA funding, raised fears at the time that there would either be a severe problem of access to justice due to excessive caution by CFA lawyers, or a feast of ambulance-chasing inspired by fee deregulation and the introduction of success fees, leading to an explosion of claims. In fact, our findings suggest that neither has been the case.

While the type of patients bringing claims, and the nature of those claims, does appear to have changed with the revolution in funding, we also explored whether the outcomes of the claims differ across funding types. We might expect this to happen, either as a consequence of differences in the application of the 'merit test', or as a consequence of CFA lawyers behaving differently in comparison to legal aid lawyers when negotiating over settlements, and thus influencing the delay to settlement, the costs incurred, and the final amount agreed. It is of course difficult to separate these two sources of outcome differentials (i.e. case selection or behaviour), but our data seem to suggest that LSC-funded claims currently have higher damages, costs and durations than CFA-funded claims.

In conclusion, this paper has provided much needed evidence on a fundamental change in the arrangements for access to justice for NHS patients. Our review of the evidence suggests that to date, the transition has seen some significant changes to the composition of both claimants and claims, but there is no presumption that these changes have all been for the worse. For example, while it appears that the withdrawal of legal aid may have reduced the propensity for lower income groups to make claims, the growth of CFAs have made new options available to those in middle income groups, and overall, the success rate of these claims has increased. In recent years, however, it seems that this greater access to CFA lawyers has resulted in an increase in the number of claims brought against the NHS, possibly accompanied by a less cautious approach to risk assessment by claimants' solicitors. Moreover, over our period of analysis, the NHS has increasingly had to face the cost of success fees payable to CFA lawyers (reflecting the claimant's risk of losing), a burden borne previously by the taxpayer under legal aid, and in future by the claimant. The future is clearly one in which the role for legal aid is limited to a small, but very high value, subset of adverse events. For the remaining claims, the role for alternative risk-sharing agreements between patients and lawyers is the predominant model now and in the foreseeable future and a clear issue is the extent to which these can provide access to justice in the higher cost, riskier claims that legal aid has previously funded.

Introduction

This briefing paper should be considered in the context of increasing policy concern in the UK over both the quality of healthcare provided and the cost of compensating clinical negligence claims. The two issues are intertwined. On the one hand, the diversion of funds from the provision of core healthcare services to pay damages to successful litigants could be seen as a factor inhibiting the development of better treatment and care options. On the other hand, the threat of litigation is undeniably an incentive for healthcare providers to manage clinical risk in such a way as to minimise medical errors. For a long time, the principle that injured patients are entitled to pursue claims, and that these claims provide a public good, was implicit in the availability of legal aid funding for eligible claimants. However, with the progressive withdrawal of legal aid, it is natural to ask whether the balance between 'access to justice' and 'reasonable cost' is being maintained.

After a period of relative stability, the incidence and cost of clinical negligence has been rising in recent years. In 2012/13, 10,129 new claims of clinical negligence against NHS bodies were received by the NHS Litigation Authority (NHSLA), up from 6,652 (new and potential) claims in 2009/10.[3] In terms of the financial cost to the NHS, £1,259 million was paid in connection with clinical negligence claims during 2012/13, compared with £787 million in 2009/10. Out of these total payments, the NHSLA paid out £205 million on claimants' legal costs in 2012/13, representing a significant diversion of resources from patient care. Traditionally, patients have had their legal costs financed through legal aid, but a sequence of policy developments over the last decade has caused a significant shift in access to funding from public to private sources.

During the 1980s and 1990s the increasing public expenditure burden of legal aid as a main means of funding civil claims meant that large parts of the civil justice system were no longer eligible for state support. In order to maintain access to justice, it was necessary to induce lawyers to take on the risks previously borne by government (i.e. the risk of losing cases and thus being unable to recover costs from the defendant). This was made possible by permitting the use of outcome-based fees such as conditional fee arrangements (CFAs). In return for waiving their fees in the event of losing a case, these allowed lawyers to charge for bearing this risk by means of a 'success fee' – a percentage uplift on normal hourly fees if the case was won. At the same time, in order to induce claimants to take on the risk of having to pay the defendants' costs in the event they lost, an insurance product known as 'After the Event' (ATE) insurance was developed. In return for a premium, ATE insurance would cover the successful defendant's costs if the case was lost. Legal aid was not withdrawn from clinical negligence claims at that time, partly because of concerns that the risk of high cost cases could not be absorbed by solicitors or the relatively immature ATE market, but as ATE products grew with an understanding of these risks the new arrangements were increasingly made available to those who were not eligible for, or were unable to obtain, legal aid. As a result, the most recent data from the NHSLA reveal that CFAs are now the leading source of patient finance, with more claims supported (at least in part) by CFAs than by either legal aid or privately purchased "Before the Event" (BTE) legal expense insurance (which, unlike ATE insurance, but like other insurance policies, is purchased *before* any possible medical treatment to cover any legal expenses should they arise). Partly encouraged by this, legal aid funding was finally removed from most clinical negligence claims, by the *Legal Aid and Sentencing and Punishment of Offenders Act 2012*.[4]

3. This paper does not cover research on claims against GPs, whose arrangements for negligence and claims are separate from other elements of the NHS. Recent evidence suggests that similar trends to the ones reported by the NHSLA are apparent here, though the overall cost of these claims is small by comparison. More broadly, the latest figures from the Compensation Recovery Unit (which include claims against private healthcare providers as well as the NHS) show an increase in all clinical negligence claims from 13,517 in 2011/12 to 16,006 in 2012/13.

4. The only exceptions are claims concerning neurological injuries (such as brain injury) to children which result in severe disability. However, to be eligible for legal aid, the potential negligence must have occurred during pregnancy, childbirth or in the eight weeks following.

Methods

We examined the use of four ways to fund clinical negligence claims. In each case, these funding methods specify who pays the costs borne by the claimant when his or her case is unsuccessful. Loosely speaking, these costs are the claimant's lawyer's legal fees and the expenses incurred in pursuing the case, as well as the defendant's fees and expenses (since the legal rule for allocating legal costs in England and Wales requires the loser to pay the winner's costs). The costs that the loser pays on behalf of the winner are sometimes known as the 'adverse costs'.

SELF-FUNDED: The claimant meets all the costs of the case if it is unsuccessful (both side's legal fees and expenses). This means that the claimant carries all the risk of paying these costs.

LEGAL AID: The State (via the Legal Services Commission until 2012 and subsequently by the Legal Aid Agency) meets the majority of the claimant's fees and expenses in an unsuccessful case; funding them from a mixture of taxation and contributions required from successful claimants. In order to qualify for legal aid, the claimant must demonstrate that the case is of sufficient quality (the 'merit' test) and that he or she has insufficient funds to meet the costs otherwise (the 'means' test). In this case, the State bears the risk surrounding the fees and expenses of an unsuccessful case. However, the State does not accept any liability for adverse costs arising from legal aid cases (a form of 'one-way cost-shifting').

BEFORE-THE-EVENT INSURANCE (BTE): The losing claimant's legal fees, expenses and adverse costs are met by a legal expenses insurance policy, either purchased explicitly for protection against one day being involved in a legal claim, or as an add-on to other insurance. This insurance is often called 'before-the-event' insurance (BTE) because it is purchased *before* the incident that initiated the claim. The insurer bears the risk as to the claimant's fees and expenses (possibly passing some of this onto the lawyer it hires to run the case) as well as the adverse costs.

CONDITIONAL FEE ARRANGEMENT (CFA): The claimant's lawyer does not seek payment of his fees from the claimant if the case is lost. To compensate the lawyer for accepting this risk, he or she is also entitled to a percentage markup on the fees recovered from the defendant in a successful case (this markup is known as the 'success fee'). For the period covered by our data, a losing defendant paid the successful claimant lawyer's success fee. In order to protect the claimant against adverse costs, he or she can purchase an insurance policy – known as an 'after-the-event' policy (ATE) because it is purchased *after* the incident that initiated the claim. During our data period, the ATE premium was also recoverable from the defendant if the case was successful. In this situation, the claimant's lawyer bears the risk of his or her own costs if the claim is lost and the ATE provider bears the adverse cost risk, but in each case it is the defendant who ultimately pays the cost of this insurance.

Given the different allocation of risks and incentives implied by the use of, respectively, legal aid, CFAs and BTE insurance [see box], there are sound theoretical reasons why they may be associated with different types of claims and may have different impacts on the legal process and its outcomes. What is not clear, however, is the extent to which these alternative funding mechanisms are *actually* affecting the types of claims being brought and the types of patient bringing them. Moreover, there is little evidence on the effect of alternative funding mechanisms on the costs and outcomes of clinical negligence claims.[5] These are important issues: they may affect access to justice and the volume of clinical negligence litigation to which the NHS is exposed.

The replacement of legal aid by CFAs as the main means for funding clinical negligence cases amounts effectively to the privatisation of their funding and raises a number of important questions. By and large, these relate to (a) the possible behavioural incentives that lawyers, hospitals and patients will face when considering whether to bring, and fight, a clinical negligence case in a different funding environment; and (b) the future viability of various funding arrangements and, therefore, of access to clinical negligence compensation. The Lord Chancellor argues that CFAs are now sufficiently mature that they can be a reliable means of funding, yet it is often claimed that clinical negligence cases are an unusual kind of personal injury claim since they can involve high risk (in terms of success, damages, costs and delay) – which could render them problematic for the sharing of risk implied by CFAs. Such cases also raise

5. In fact, there is relatively limited evidence on the performance of CFAs and ATE across legal services (see Fenn and Rickman, 2010a, b). Fenn, Gray, Rickman and Carrier/Mansur (2002/2006) examine the conceptual and empirical role of CFAs, legal aid and BTE insurance across personal injury litigation, while Moorhead and Cumming (2008) examine the role of contingency fees in employment claims. Yet data limitations have prevented more recent work. As shown below, one of the key contributions of the current proposal is to assemble data for addressing the role of various funding mechanisms in clinical negligence.

important public policy issues in relation to the performance of the NHS in terms of quality of care and public expenditure. In this briefing paper we seek to compare the performance of legal aid, CFAs and legal expenses insurance in clinical negligence cases in order to assess the likely effects of the recent reforms. In particular, we explore how legal aid, CFAs and legal expenses insurance have affected:

- the type of claimant willing and able to bring claims against the NHS;
- the types of claim that may be brought;
- the litigation process followed; and
- the outcomes of these cases.

To address these questions we analysed three sources of data.

The Compensation Recovery Unit[6] (CRU) dataset: This is unique in recording information on the *population* of all claims for compensation in England and Wales over the last decade, with information about the nature of each claim and its outcome (e.g. closed without payment, settled etc). It is therefore ideally suited to analysing overall trends in litigation over time and as policies (such as those towards litigation funding) have changed. The full dataset is not publicly available, but we were able to obtain data from CRU in response to our FOI request in relation to the number of clinical negligence claims, and the proportion of those which were successful in obtaining damages for all years up to 2013.

The Ipsos MORI dataset: As part of a previous programme of research in 2001, we undertook a general population survey to obtain quantitative information on the frequency and severity of any illness, injury or impairment that individuals perceived themselves to have experienced as a result of medical treatment or care they had received. In order to revisit this with a view to obtaining comparative data, Ipsos MORI designed a questionnaire and administered a survey to provide data on the incidence of adverse events relating to healthcare, and whether a legal claim was pursued. In addition, demographic information was obtained on respondents' age, sex, region, level of qualification, social class, and household income. The questionnaire was administered by Ipsos MORI in face-to-face interviews to a randomly selected sample of adults in ten waves at weekly intervals between 4th January 2013 and 28th March 2013, with a two-week pause after the first two weeks to make preliminary checks of the questionnaire design and results. Between 1,914 and 2,029 individuals were interviewed in each wave, giving a total sample size of 19,746. We were able to compare these survey results with our previous 2001 survey with a view to ascertaining the extent to which the frequency of claims in response to perceived harm, and the characteristics of claimants, has changed over the past ten years, during which time the use of legal aid has declined and the use of CFAs has increased. Many of the questions in the 2013 questionnaire were identical to those used in our 2001 survey, but the sample size was substantially larger and two further questions were added to the survey, asking respondents about their understanding of the funding arrangements used in relation to their particular claim. This comparison allowed us to address questions about the role of legal funding in securing access to justice for NHS patients.[7]

The NHSLA dataset: This was made available to us by the NHSLA and consists of all claims made against NHS acute hospital trusts, under several different compensation schemes operated by the Authority – the Clinical Negligence Scheme for Trusts (CNST), the Extended Liability Scheme (ELS), and the ex-Regional Health Authority (RHA) scheme. As a consequence, the combined dataset consists of claims in respect of incidents arising since 1995 (the CNST) as well as claims originating from incidents before that date (ELS, RHA). We have access to all clinical negligence claims settled between April 2008 and April 2013, including those outstanding at April 1st 2013 (a total of 53,377 claims). The information on each of these claims includes:

- Dates at which the incident occurred, the claim notified, and the outcome (dropped, settled, trial etc.) recorded.
- Outcomes in terms of damages paid and claimant costs paid.
- The type of claimant funding (legal aid, CFA, self-funded, BTE insurance).

6. The Compensation Recovery Unit is a UK government agency within the Department of Work and Pensions that recovers social security benefits in certain compensation cases and NHS costs in certain injury cases.

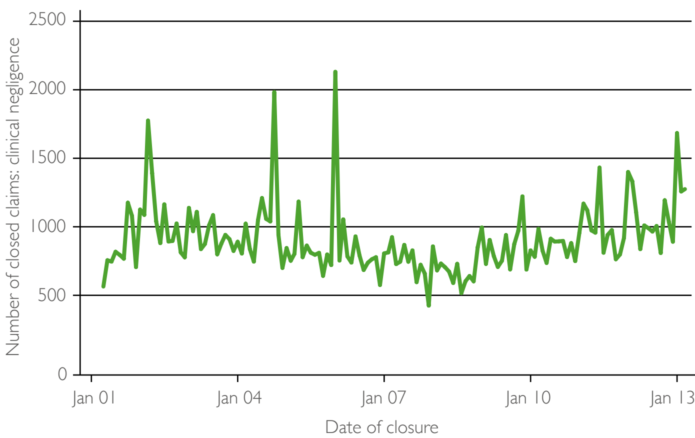
7. We should emphasise that what we have undertaken is different from existing surveys of legal need. For example, the English and Welsh Civil and Social Justice Survey (see Pleasance et al, 2010) and the MoJ's Baseline Survey to Assess the Impact of Legal Services Reform (see Finch et al, 2010) both conduct general surveys of legal need in the population. Our survey focused more specifically on the sources of problems with medical treatment or care, and therefore generated sufficiently large numbers to explore statistically issues of usage and funding in clinical negligence, with the year 2001 as a benchmark.

Results

Claim frequency and funding sources

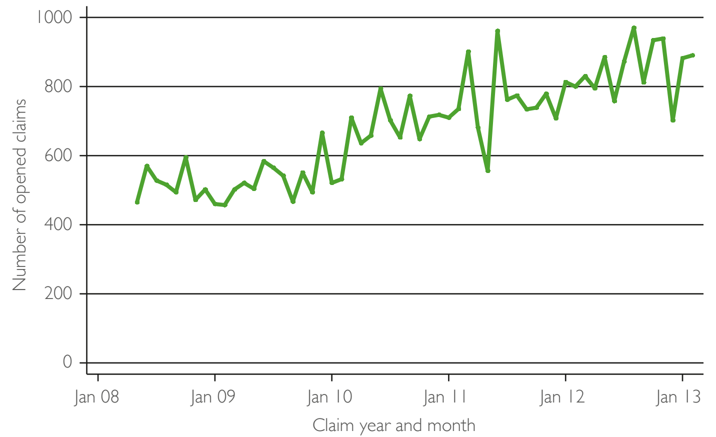
Analysis of the CRU dataset has identified trends in the numbers of completed clinical negligence claims from 2001 to 2013. The number of closed claims fell from relatively high levels in 2001/2 to a low point around 2008/9, with a subsequent increase up to 2013. As a consequence of this pattern, the number of clinical negligence claims closing in 2013 was not very different from the number closing in 2001/2. The perception that we are currently in an era of historically high litigation rates against healthcare providers is not borne out by this evidence, although it does seem to be true that recent experience (over the last five years or so) is one of increasing numbers of completed claims [Figure 1].

Figure 1: Trends in numbers of completed clinical negligence claims, 2001 to 2013 (CRU data)



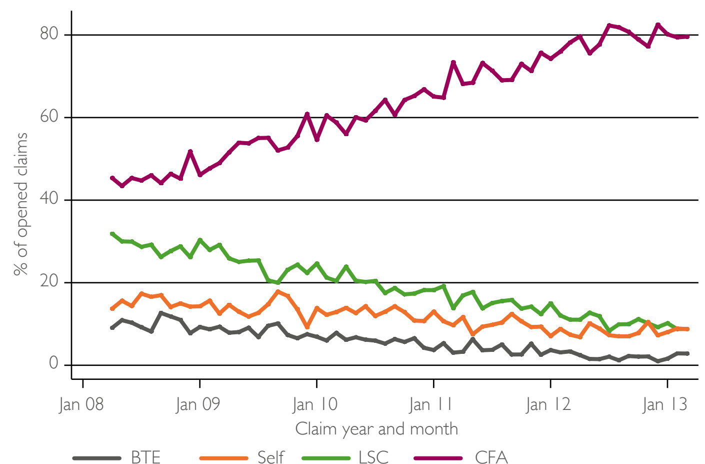
It is important to bear in mind that, due to the long durations of clinical negligence claims, the claims which are closing in any one year often have their origins some way into the past, and therefore trends in closed claims as shown in Figure 1 may not be a good reflection of what is happening contemporaneously. However, analysis of the NHSLA dataset since 2008 shows that the number of new clinical negligence claims being brought against the NHS has also been rising strongly since 2009 [Figure 2].

Figure 2: Trends in numbers of new clinical negligence claims, 2008 to 2013 (NHSLA data)



Of course, although such trends in claims are sometimes cited in critical media comments, it is difficult to evaluate them without having a benchmark for measuring the 'appropriate' level of claiming: for example, it is possible that higher claim rates are a reflection of improved access to the legal system amongst patients, or higher levels of awareness of opportunities to make legitimate claims. The available sources of funding for such claims is likely to play an important role here and it is possible to identify trends in the sources of funding used to support new clinical negligence claims, including legal aid (LSC), CFAs, and legal expenses insurance (BTE) as well as those claims self-funded by patients [Figure 3].

Figure 3. Trends in sources of funding of new clinical negligence claims, 2008 to 2013 (NHSLA data)



At the start of the period of observation, in 2008, CFA funding had just taken over from legal aid (then administered by the Legal Services Commission, LSC) as the most frequent source of funding for clinical negligence claims, although it was at that stage still used by fewer than half of all claimants. About a third of all claims were supported by the LSC at this time, with self-funded claims and BTE funding representing around 15% and 10% of the total respectively. The most obvious trend is a clear switch over the last decade from all funding methods towards CFA funding as the main source of funds for those bringing claims against the NHS, with the substitution away from legal aid being the most notable. With the recent withdrawal of legal aid from all but the most severe obstetric claims, this trend has culminated in a situation where, for those without BTE insurance to cover clinical negligence claims (the vast majority) the ability to bring a claim for clinical negligence now depends chiefly on the willingness of lawyers to offer a CFA after reviewing the merits of the case. This represents a fundamental shift in the funding arrangements available to patients, and the remainder of this report explores the possible consequences of that development in terms of the type of claims/claimants and the outcomes obtained.

Claim success rates by source of funding

To begin with, we examined the proportion of closed clinical negligence claims where a payment of damages was made to the patient. This is a measure of 'success' from the patient's perspective, and changes in the average success rate may reflect a change in the type of claims being brought. That is, a rise in the average success rate could be due to lawyers agreeing to take on less 'risky' claims (and vice versa).[8] Inspection of the trends over time in the success rates for clinical negligence claims using data from CRU has confirmed some interesting changes [Figure 4].

In particular, it does seem that the success rate in clinical negligence (i.e. the proportion of claims that get paid) is significantly higher now than it was ten years ago. Between 2001 and 2010 the proportion of successful claims went up from around 45% to around 70%, a very substantial change. Interestingly this period coincides with the major shift in funding that is the focus of this paper – from legal aid to CFA funding. Arguably, the evidence supports a view that lawyers (and ATE insurers) taking on cases on a CFA basis, and who are therefore exposed to a potential loss, are more cautious about taking on risky claims than was the case with the Legal Services Commission (using associated merit tests).[9] To explore this further, we use data from the NHSLA on the proportion of claims paid between 2008 and 2013 [Figure 5].

Figure 4: Proportion of clinical negligence claims that get paid (success rate), 2001 to 2013 (CRU data)

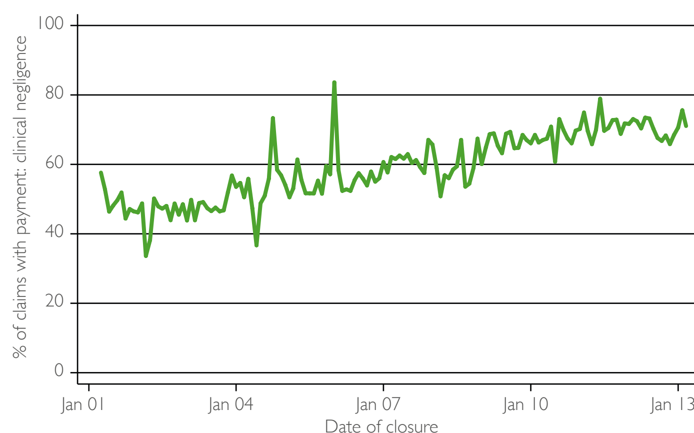
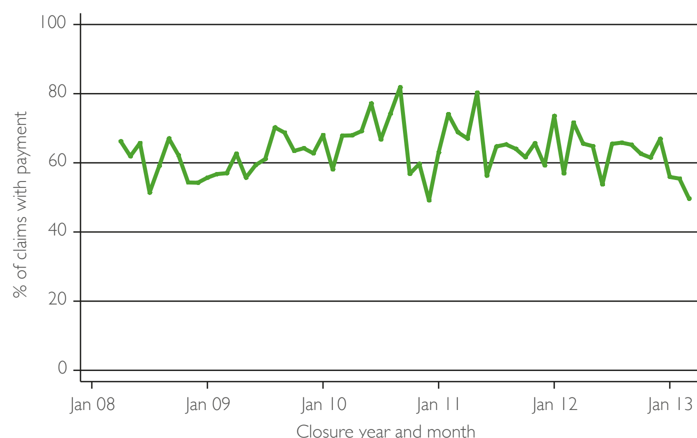


Figure 5: Proportion of clinical negligence claims that get paid (success rate), 2008 to 2013 (NHSLA data)

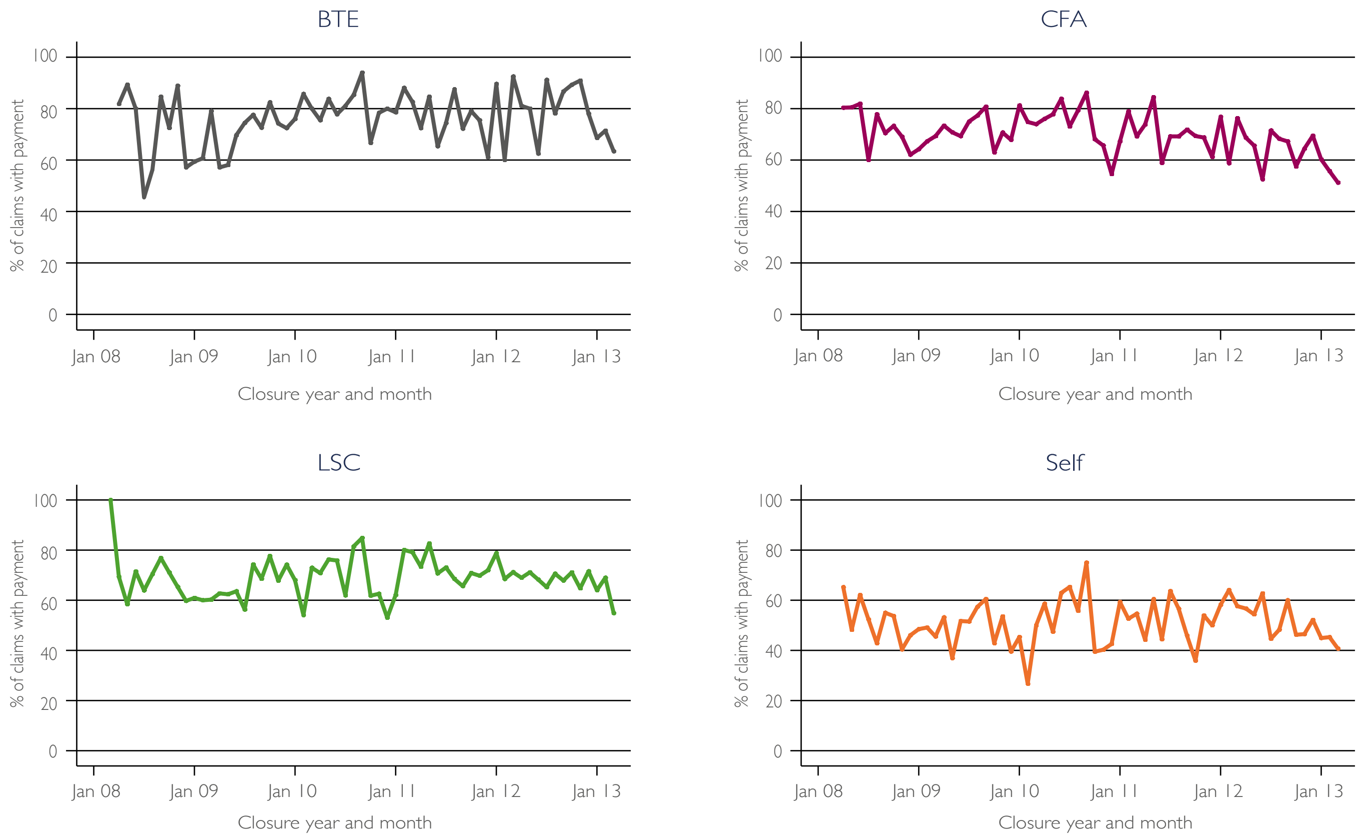


The time path of monthly success rates for claims closed by the NHSLA shows a lot of volatility from one month to another which makes it difficult to discern trends, but there is a hint that the long term rise in success rates shown by the CRU data above has come to an end, and, indeed, from 2010 may actually have been reversed to some extent. A breakdown of the success rates by sources of funding is shown in Figure 6.

8. On the other hand, it could also be consistent with defendants conceding claims of a given strength more readily, although this seems less likely.

9. Another possibility could be that claimants' lawyers have strong incentives to 'work hard' under CFAs because their fees are at risk. The shift towards CFAs that we have already charted might then explain the higher success rates in the Figure. This interpretation is slightly less convincing in the light of the two Figures that follow, since they suggest a recent drop in success rates, despite the continued rise in the proportion of CFA-funded clinical negligence claims, and this would then be inconsistent with the explanation just given.

Figure 6: Proportion of clinical negligence claims that get paid (success rate) by source of funding, 2008 to 2013 (NHSLA data)



While this Figure only shows the picture from 2008 onwards, it does seem to confirm that the success rate on legal aid claims has been generally lower than on CFA claims, although the difference has virtually disappeared from around 2010. It looks possible that CFA lawyers, having been cautious when building up a clinical negligence portfolio from the late 1990s onwards, have recently been prepared to accept more of the riskier cases.[10] Of course, an alternative interpretation might be that the recent past has seen new entrants into the clinical negligence sector of the CFA market, and they do not have the experience needed to assess risk in this complex area of litigation.[11]

Characteristics of patients making claims

Another perspective on the changes discussed above would be to explore the nature of the claimants themselves. Is it the case that the changes in funding, and associated increases in the likelihood of success, are correlated with changes in the types of patients who are bringing claims? This is difficult to establish on an ongoing basis, without detailed data on the characteristics of claimants, but, as explained earlier, we have access to two identical surveys of the population in which questions were asked about the responses made by patients after experiencing adverse events.

Table 1 shows the comparative data from these two surveys in relation to a question about legal claims in response to adverse medical events. For each survey, the table shows the breakdown of the numbers and percentages of people who reported an adverse event by their response to that question. The main message we take from this comparison is that there seems to have been relatively little change between 2001 (10.5%) and 2013 (10.7%) in the proportion of people experiencing adverse events who subsequently pursued a legal claim for damages.

However, we are also interested in whether the *type* of people pursuing compensation has changed in the wake of the changes in funding opportunities. In our initial 2001 Ipsos MORI survey there was some evidence of a relationship between social background and the likelihood of pursuing clinical negligence claims for financial compensation, a period during which the main source

10. Other possible explanations include changes in the behaviour of defendants in relation to their settlement strategies.
11. This explanation would also be consistent with the increase in the frequency of new clinical negligence claims from around 2009.

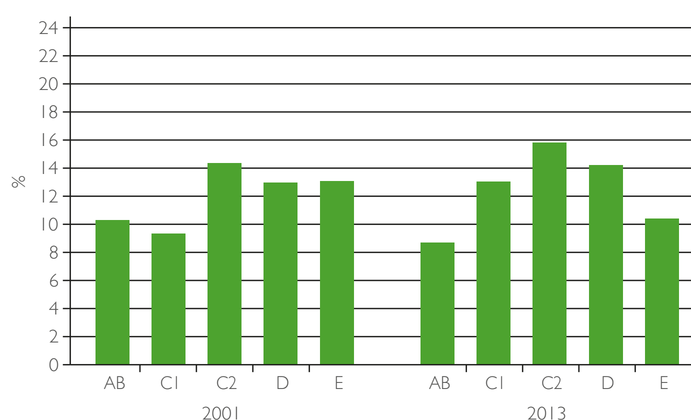
TABLE 1: BREAKDOWN OF RESPONSES TO QUESTION ABOUT LEGAL CLAIMS FOLLOWING ADVERSE EVENTS, 2001 AND 2013 (IPSOS MORI DATA)

	2001		2013	
	Frequency	Percent	Frequency	Percent
Did you pursue a legal claim for financial compensation, and if not, reasons:				
Yes	41	10.5	53	10.7
No, I didn't want financial compensation	149	38.1	219	44.0
No, it didn't occur to me	77	19.8	74	14.9
No, I didn't know how to go about it	10	2.6	17	3.5
No, I thought it would be too costly	8	2.1	8	1.6
No, I thought it would be too time-consuming	24	6.2	39	7.8
No, I was worried about the strength of my case	15	3.9	18	3.7
No need	0	0.00	8	1.6
No, recent incident/have not got around it	0	0.00	8	1.5
No, other reasons	62	15.9	35	7.1
Other*	3	0.7	17	3.4
Total	391	100	497	100

*=Other, Nothing, Can't remember, Refused, No answer, Don't know

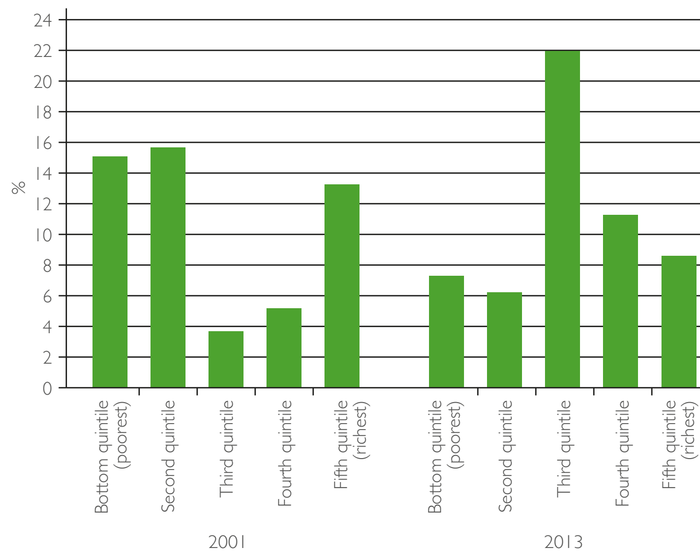
of funding available to patients was legal aid (subject to associated 'means' and 'merit' tests). As Figure 7 shows, in 2001 the proportion pursuing a legal claim in consequence of experiencing illness, injury or disability was between 9–10% in social grades AB and C1, but rose to 13–15% in social grades C2, D and E. As far as the latest data from 2013 is concerned, Figure 7 shows that the social grades most likely to claim were those in the middle: grades C1, C2 and D. This could reflect the reversal in funding opportunities between the two survey dates, with legal aid predominant in 2001 and CFAs predominant in 2013. The means test required in 2001 for legal aid would have favoured those in the lower social grades, whereas CFAs did not employ the means test. Lawyers are now free to target the high volume, middle income groups and assess their claims in terms of case strength and value. Moreover, the reduced availability of legal aid and the switch to CFA funding puts an emphasis on informed access to legal services, and this may have had an impact on the proportion of the lowest social grades pursuing claims.

Figure 7: Proportion of survey respondents pursuing a legal claim in consequence of experiencing illness, injury or disability, by social grade, 2001 and 2013 (Ipsos MORI data)



This pattern can perhaps be seen more clearly in Figure 8, where the same comparison of claim rates is made between the two survey dates, this time focussing on the variation across relative income groups. In 2001, we found that the highest propensity to claim was in the two poorest and the richest quintiles of the income distribution; by contrast, in 2013, it was the middle quintiles with the highest claim rates.

Figure 8: Proportion of survey respondents pursuing a legal claim in consequence of experiencing illness, injury or disability, by income quintile, 2001 and 2013 (Ipsos MORI data)



A reasonable inference from these findings is that the legal aid 'means' test was working as intended during the earlier period – it was providing support to those sections of society who were unlikely to have recourse to other means in order to bring a claim of negligence. The corollary of this, however, is that the level of claiming amongst the middle income groups was relatively low, and the subsequent growth of CFA funding over the following decade may have gone some way to filling that gap.

Of course, it is possible that the changes we have observed in Figures 7 and 8 are the result of some other demographic developments correlated with social grade and/or income. Table 2 shows how the characteristics of respondents reporting adverse events varied between the two dates in respect of their age, gender and the severity of the consequences. The table shows what percentage of the total in each group responded to their adverse event by making a legal claim. Taking into account the low sample sizes in some cells of the table, there does not seem to be any convincing evidence that the socio-demographic characteristics of those who make clinical negligence claims has altered significantly since 2001, with the possible exception of the income/social grade effects discussed above.

TABLE 2: CHARACTERISTICS OF RESPONDENTS REPORTING ADVERSE EVENTS BY AGE, GENDER AND SEVERITY OF CONSEQUENCES, AND PROPORTIONS OF THESE MAKING A LEGAL CLAIM, 2001 AND 2013 (IPSOS MORI DATA)

	2001				2013			
	No	Yes	Total	%	No	Yes	Total	%
Gender								
Men	159	19	178	10.67%	188	32	220	14.55%
Women	189	26	215	12.09%	257	23	280	8.21%
Age								
15–24	53	7	60	11.67%	39	8	47	17.02%
25–34	68	7	75	9.33%	45	12	57	21.05%
35–44	73	17	90	18.89%	66	14	80	17.50%
45–54	61	6	67	8.96%	69	5	74	6.76%
55–64	44	4	48	8.33%	82	10	92	10.87%
65+	49	4	53	7.55%	144	6	150	4.00%
Severity								
No time off	230	21	251	8.37%	321	26	347	7.49%
Week off	27	1	28	3.57%	24	3	27	11.11%
Month off	37	7	44	15.91%	29	4	33	12.12%
Year off	38	9	47	19.15%	47	12	59	20.34%
Retired	26	7	33	21.21%	42	10	52	19.23%

TABLE 3: PROBIT REGRESSION RESULTS, LIKELIHOOD OF PURSUING A LEGAL CLAIM IN CONSEQUENCE OF AN ADVERSE EVENT, BY YEAR, GENDER, AGE, SEVERITY OF CONSEQUENCES AND INCOME QUINTILE, 2001 AND 2013 (IPSOS MORI DATA)[12]

	Coefficient	P>T
Year		
2001	0	
2013	1.014923	0.225
Sex		
Men	0	
Women	0.250971	0.247
Year*Sex		
2013#Women	-0.49467	0.106
Age		
15–24	0	
25–34	-0.17515	0.675
35–44	0.373389	0.345
45–54	-0.39518	0.365
55–64	-0.40559	0.431
65+	-0.06972	0.889
Year*Age		
2013#25-34	0.251949	0.667
2013#35-44	-0.51598	0.326
2013#45-54	-0.30769	0.59
2013#55-64	-0.07464	0.908
2013#65+	-0.88853	0.169
Income Quintile		
Bottom quintile	0	
Second quintile	-0.06657	0.83
Third quintile	-0.68667	0.136
Fourth quintile	-0.37971	0.433
Fifth quintile	0.244737	0.666
Year*Income Quintile		
2013#Second quintile	-0.077	0.866
2013#Third quintile	1.435884	0.01
2013#Fourth quintile	0.548243	0.371
2013#Fifth quintile	-0.07698	0.912
Social Grade		
AB	0	
C1	0.66922	0.163
C2	0.547536	0.32
D	1.151007	0.039
E	1.05502	0.068
Year*Social Grade		
2013#C1	-0.88727	0.136
2013#C2	-0.36197	0.586
2013#D	-1.03739	0.148
2013#E	-0.74952	0.319
Severity		
No time off	0	
Week off	-0.09195	0.859
Month off	0.522669	0.153
Year off	0.751732	0.012
Retired	0.704389	0.061
Year*Severity		
2013#week off	0.328515	0.615
2013#month off	-0.68919	0.299
2013#year off	0.017649	0.966
2013#retired	-0.12856	0.794
Constant	-2.22372	0.001

To explore these hypotheses further, we pooled the two survey samples together and used multivariate analysis in the form of a probit regression approach, where the dependent variable is a binary variable taking the value 1 if a claim was pursued, and 0 otherwise, and restricting the pooled sample to those who reported an adverse event. The independent variables were those discussed above: variables measuring social grade and relative income, controlling for gender, age and severity of the consequences arising from the event. Each of these variables were interacted with an indicator variable for the survey year. In other words, we allowed for the possibility that claiming behaviour had changed in all socio-economic groups between 2001 and 2013. The results are shown in Table 3.

The main effects (i.e. without the interactions with the year indicator) reveal that the propensity to claim given experience of an adverse event is higher for social grades D and E, and for those who had to take over a year off work following the adverse event. No other factors were

12. Coefficients indicate the strength of each variable on the likelihood of pursuing a claim. For each variable, one value is chosen as the reference value, for which the coefficient is set to zero; the coefficients on all other values are interpreted relative to that reference value. The column headed P>t shows the probability that the coefficient can be rejected as insignificant (a rejection probability less than 0.05 is typically required for confidence). Interactions of each variable with year=2013 shows the effect of changes compared with 2001.

significant. As far as the interactions were concerned, while very few of these are significant, there is confirmation that respondents in the middle income range (i.e. the third quintile) are significantly more likely to claim in 2013 than they were in 2001.

Claim outcomes under different sources of funding

The final set of empirical analyses explore the consequences of alternative funding mechanisms for clinical negligence claims using the NHSLA claims-level data. In particular we assess the impact of funding choices on outcomes such as the timing of settlement or abandonment, the amounts of settlement, and the legal costs involved.

Table 4 below shows the mean outcomes for 5,659 paid claims closed during the most recent financial year available (2012/3). The mean outcomes vary considerably across funding sources, with costs, damages and delay being much higher for LSC-funded claims than others. This is of course to be expected, as the set of claims eligible for legal aid were likely to include very much more complex ones than the average clinical negligence claim. The dominant source of funding in that year was, as we have seen, a lawyer working on a CFA basis. Claims funded through that route resulted in mean settlements of under £80,000, and were settled in less than two years on average. Self-funded claims were of relatively low value and settled more quickly than CFA claims, whereas BTE-funded claims outcomes were somewhere between LSC-funded claims and CFAs in terms of outcomes.

TABLE 4: OUTCOMES OF PAID CLAIMS BY FUNDING SOURCE, 2012/13 (NHSLA DATA)

Source of funding	Claimant legal costs [N]	Damages [N]	Days to closure [N]
BTE	39360 [331]	146358 [331]	922 [331]
CFA	39359 [3302]	78867 [3302]	670 [3302]
LSC	72934 [1058]	772730 [1058]	1579 [1058]
Self Funded	15016 [416]	35030 [416]	553 [416]
Other/ Unknown	17138 [552]	47733 [552]	647 [552]
Total	41679 [5659]	206279 [5659]	844 [5659]

As far as the claimant's legal costs are concerned, any comparison across funding sources would not be helpful unless it takes into account variations in case value. A very simple way of doing this is to look at the ratio of the claimant's legal costs to total payments by the NHSLA. Table 5 compares the means of these ratios across funding types, again for claims closed with payment in the financial year 2012/13.

TABLE 5: CLAIMANT LEGAL COSTS AS A RATIO OF TOTAL PAYMENTS, BY SOURCE OF FUNDING, 2012/13 (NHSLA DATA)

Source of funding	Claimant legal costs as % of total paid[13] [N]
BTE	40.79% [331]
CFA	53.39% [3302]
LSC	36.08% [1058]
Self Funded	22.04% [416]
Other/Unknown	41.49% [552]
Total	45.95% [5659]

The striking factor from inspection of this table is the clear difference between the proportion of costs in CFA-funded claim payments (53.39%) and the proportion in LSC claims (36.08%) or BTE claims (40.79%).[14] The reason for this must in part be due to the differences in the way that the cost of losing cases is borne. In LSC-funded claims, the costs of losing claims are borne by the LSC itself, and, therefore ultimately by the taxpayer. In BTE-funded claims, some of the costs of losing claims are borne by the insurer, and, therefore ultimately by the policyholder. In each case they are not reflected in the costs paid to the claimants' lawyers, whereas for CFA-funded claims an additional amount is required from the defendant in successful cases in order to compensate the CFA lawyer for the costs of losing cases. This is the "success fee", and it is a consequence of the transfer of risk away from the taxpayer onto the claimant's lawyer. It is also clear from the earlier discussion of Table 3 that CFA claims are of lower value on average by comparison with both LSC and BTE-funded claims and this may contribute to the higher proportion of costs in CFA claims (because costs tend to increase less than proportionately with damages).

13. Figures in this column were calculated using the ratio of costs to payments (i.e. costs + damages) for each claim in the database.
14. Clearly, the proportion of costs on self-funded claims were far lower than others.

Figure 9a: Mean duration of paid claims (days), by source of funding, 2008–2013 (NHSLA data)

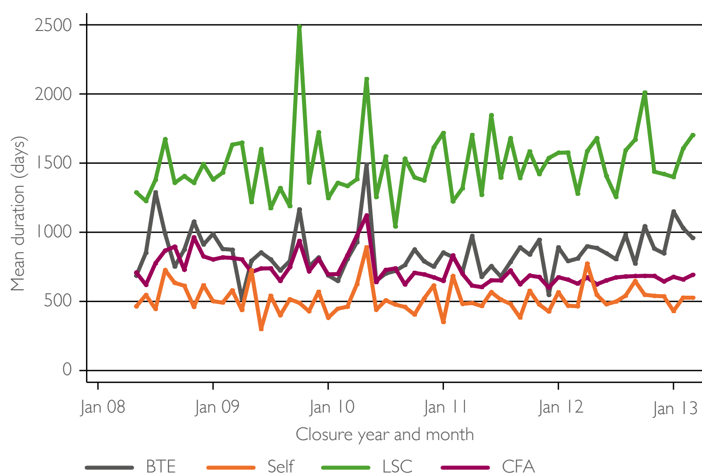


Figure 9b: Mean damages paid (£'000s), by source of funding, 2008–2013 (NHSLA data)

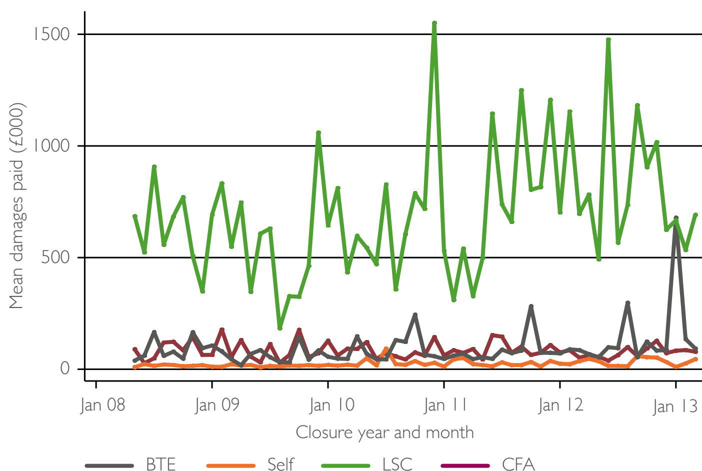


Figure 9c: Mean claimant costs (£'000s), by source of funding, 2008–2013 (NHSLA data)

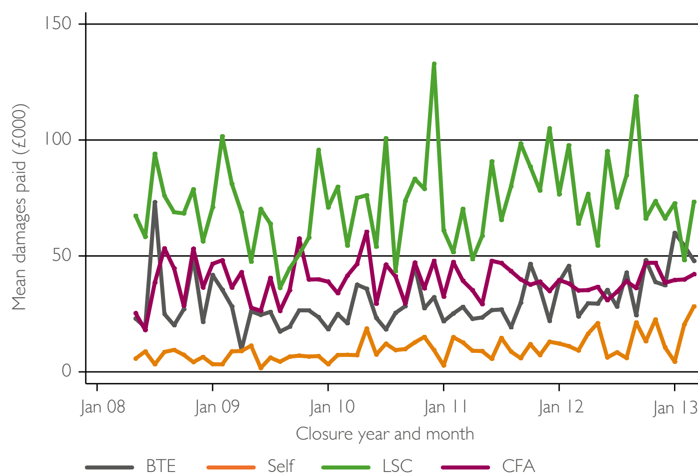
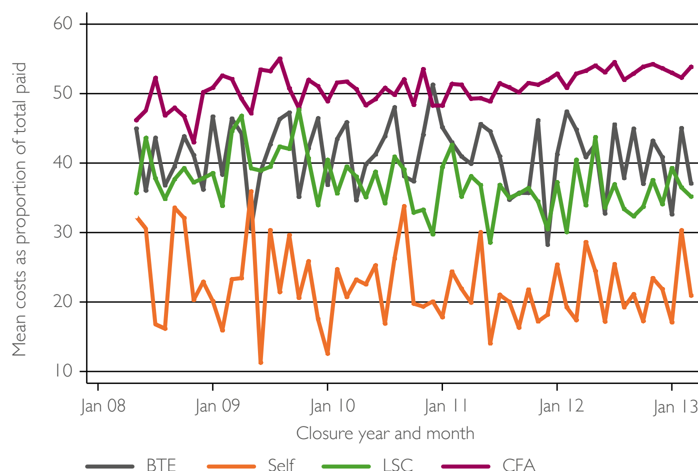


Figure 9d: Costs as a proportion of total payments, by source of funding, 2008–2013 (NHSLA data)

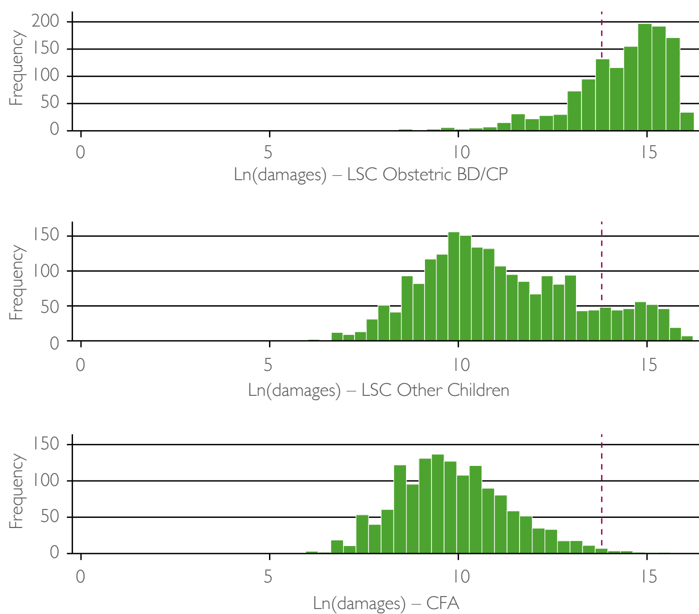


We also explored whether the differences in outcomes across funding sources were stable over time. Figures 9a–d plot the time paths of monthly means for duration to closure, damages and costs, as well as the ratio of costs to total payments. It does appear to be the case that the differences observed between the funding sources has not shifted much since 2008. In particular the differences between the outcomes of LSC-funded and CFA-funded claims remains significant: the former has much higher mean damages, as well as higher costs and delays to settlement.

The findings presented in this briefing paper document the implications for claim outcomes of the unprecedented shift in the funding of clinical negligence claims over the last 15 years. Our period of analysis extended to the threshold of a new regime which has the potential for still further changes in outcomes, triggered by the withdrawal of legal aid from all clinical negligence claims, with the exception of those concerning neurological injuries (such as brain injury) to children which result in severe disability. However, for these exceptions to be eligible for legal aid, the potential negligence must have occurred during pregnancy, childbirth or in the eight weeks following. This raises a question about the availability of funding for claims concerning injuries to children outside those limits. Arguably, such claims could be equally complex and uncertain, and with similar potential for very high damages. During the development of CFA funding for clinical negligence claims to date, our evidence seems to indicate a reluctance on the part of the lawyers and insurers evaluating them to consider such high risk, high value claims. Figure 10 shows the extent to which this may be an issue to be resolved. The figure shows the distribution of damages paid on "obstetrics" and "other children" claims settled by the NHSLA and funded by the LSC in 2012/13, by comparison with the distribution of damages paid on CFA-funded claims. The damages are converted to log form for

ease of comparison, and the red line in each chart indicates damages of £1 million (also to aid comparison). There appears to be a small but not insignificant sub-population of 'other children' cases (those to the right of the red line in the middle panel) which are characterised by the same levels of loss as the birth-related brain damage cases, but which no longer qualify for legal aid following the 2012 changes. As the bottom panel of the figure shows, CFA lawyers do not appear to have been willing to take on such high value cases (there are virtually no cases to the right of the red line in the bottom panel), and the question to be resolved is whether they will do so in future.

Figure 10: Distribution of damages paid on "obstetrics" and "other children" claims settled by the NHSLA and funded by the LSC, by comparison with the distribution of damages paid on CFA-funded claims, 2012/13 (NHSLA data)



Discussion

In this briefing paper we have collated data from several sources in order to understand better the implications of the major shift of responsibility for the funding of clinical negligence claims that has taken place over the last 15 years. A snapshot of clinical negligence experience in 2001 would have revealed a situation in which the majority of patients with valid claims against doctors or hospitals were unable to fund their legal expenses because they were not eligible for (means-tested) legal aid, but were not sufficiently wealthy to pay lawyers from their own resources. Our own data from a population survey carried out in 2001 shows evidence consistent with that picture, with low rates of claiming by those in the middle social grades and/or middle income quintiles. The subsequent rundown of LSC funding for clinical negligence, and its gradual replacement by CFA funding, raised fears at the time that there would *either* be a severe problem of access to justice due to excessive caution by CFA lawyers, *or* a feast of ambulance-chasing inspired by fee deregulation and the introduction of success fees, leading to an explosion of claims. In fact, our findings suggest that neither has been the case. The average monthly frequency of clinical negligence claims in 2013 is not much different to the frequency in 2001 (although we have noted that this is a consequence of falling claim rates from 2001 to 2008 followed by a significant rise in claim rates after 2009). What has changed is the socio-economic composition of the claimants. In 2013 the population survey snapshot reveals a higher rate of claiming from those in the middle social grades, and the middle income quintiles. One inference that might be drawn from this is that the switch from legal aid to CFA funding, and the consequent reduced importance of the means test in determining which valid claims get funded, has opened up possibilities that were not previously available to those on middle incomes. At the same time, it appears that the demise of legal aid has reduced the propensity to claim for those in the lower income groups (although it should be noted that virtually all claims by children, included birth-related injury claims, would still pass the means test requirement for legal aid).

Although the means test has declined as a factor influencing the type of claimant, the 'merit test', or its equivalent in terms of risk assessment by CFA lawyers (and ATE insurers), remains an important feature of clinical negligence claims. We do not have direct evidence of how this process has changed, if at all, but we do have data on the average proportion of claims that are successful (i.e. obtain a payment of damages), which should in principle reflect the average case strength of claims. Evidence from CRU suggests that the percentage of successful claims rose significantly between 2001 and 2010, perhaps reflecting a more cautious approach to risk assessment by CFA lawyers and ATE insurers during that period. However, since 2010 there is some suggestion in the data that the success rate for CFA-funded claims has fallen somewhat, and this has coincided with an increase in the frequency of clinical negligence claims, reversing the previous trend. It has been suggested to us that this development may be attributed to the entry of non-specialist law firms into the clinical negligence market, and this remains an important area for future research – both in terms of potential effects on clinical negligence claim handling and the reasons that might be attracting firms to enter the clinical negligence market.

While the type of patients bringing claims, and the nature of those claims, does appear to have changed with the revolution in funding, we also explored whether the

outcomes of the claims differ across funding types. We might expect this to happen, either as a consequence of differences in the application of the 'merit test', or as a consequence of CFA lawyers behaving differently in comparison to legal aid lawyers when negotiating over settlements, and thus influencing the delay to settlement, the costs incurred, and the final amount agreed. It is of course difficult to separate these two sources of outcome differentials (i.e. case selection or behaviour), but our data do seem to suggest that LSC-funded claims currently have higher damages, costs and durations than CFA-funded claims. This continuing difference is likely to have been influenced heavily by the preponderance of children claimants amongst those funded by the LSC, and consequently the presence of a significant number of very high value, high cost birth-related injury claims. While there is no technical or legal reason why such claims could not be funded on a CFA basis, the risk of very high losses on losing claims will have been a considerable deterrent. Indeed, it is presumably for this reason that the government has decided to retain legal aid for cases involving cerebral palsy and other birth-related injuries.

For the remaining, non-birth-related injuries, the choice is now between self-funding, using a pre-existing legal expense insurance policy (for which take-up has been low) or persuading a lawyer to take the claim on a CFA basis. The claimant's legal costs under this last option will include a success fee to compensate the lawyer for the risk of losing the case, and therefore a higher proportion of legal costs to total payments. As we have pointed out, this means that the transfer of risk from the taxpayer-funded LSC to the private legal services sector implies an increase in the costs to be borne by the main defendant in clinical negligence cases – ironically, the NHS, which is also a public sector body.

As pointed out at the start of this paper, one reason behind the capacity for CFA lawyers to take on an ever greater proportion of the risky clinical negligence claims has arguably been the increasing maturity of the ATE insurance market, which (for the lifespan of the data we have analysed) has provided protection against the adverse cost risk, at a price which could be recovered from the losing defendant. This is an essential ingredient of CFAs for claimants who would otherwise risk sizeable costs in the event of defeat. However, as well as removing most clinical negligence claims from the scope of legal aid, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) also introduced measures that may affect the ATE market: it has made ATE premiums non-recoverable from a losing defendant (so the claimant must pay them regardless of outcome) and introduced one-way cost-shifting (so that losing claimants are less likely to be asked to pay the defendant's costs). Both these will have uncertain consequences which are yet to be resolved. At the same time, it is possible that new business structures (ABSs) involving a combination of insurance, finance and legal services will grow large enough to fund these risky cases themselves. Alternatively, the post-LASPO market may see the emergence of Damage Based Agreements (DBAs), US-style 'contingency fees' where the lawyer is paid a pre-specified fraction of damages won on a case. While the DBA model introduced by LASPO has some technical problems when compared with CFAs,[15] the ability to defray risk by earning a suitable fraction of high damage outcomes may help some firms (perhaps well capitalised ones) to pursue the large complex claims that are the 'problem areas' for funding clinical negligence claims.

In conclusion, this briefing paper presents much needed evidence on a fundamental change in the arrangements for access to justice for NHS patients. Our review of the evidence suggests that the transition to date has been achieved with some significant changes to the composition of both claimants and claims, but there is no presumption that these changes have all been for the worse. For example, it appears that the withdrawal of legal aid may have reduced the propensity for lower income groups to make claims, but the growth of CFAs have made new options available to those in middle income groups, and overall, the success rate of these claims has increased. In recent years, however, it seems that this greater access to CFA lawyers has resulted in an increase in the number of claims brought against the NHS, possibly accompanied by a less cautious approach to risk assessment by claimant solicitors. Moreover, over our period of analysis, the NHS has increasingly had to face the cost of success fees payable to CFA lawyers (reflecting the claimant's risk of losing), a burden borne previously by the taxpayer under legal aid, and in future by the successful claimant herself. The future is clearly one in which the role for legal aid is limited to a small, but very high value, subset of adverse events. For the remaining claims, the role for alternative risk-sharing agreements between patients and lawyers is the predominant model now and in the foreseeable future and a clear issue is the extent to which these can provide access to justice in the higher cost, riskier claims that legal aid has previously funded. We hope that the results reported here can provide benchmark data against which the longer term effects of the LASPO reforms on clinical negligence litigation can be assessed, and further research pursued. As part of this project, we have explored ways of simulating the effects of recent policy changes using behavioural assumptions derived from our results, and we believe this would also provide a fruitful direction for future research.

15. See P. Fenn and N. Rickman, "Balance of Funds", *Litigation Funding*, August 2014, pp 10–12.

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