Australian Government

Productivity Commission

Disability Care and Support

Productivity Commission Inquiry Report

Volume 2

No. 54, 31 July 2011

17 Insurance arrangements for injury

Key points

- There are a range of state and territory arrangements for insuring people for catastrophic injury, with coverage varying depending on the type of accident, its location and exact circumstances. There is little rationale for the striking differences across schemes.
  - Only about half of people injured catastrophically will have access to some form of insurance — usually compulsory third party motor vehicle cover.
  - The other half rely on generally inadequate taxpayer-funded health and disability services — in most cases, for the rest of their life.
- Existing fault-based insurance arrangements for catastrophic injury do not meet people's care costs efficiently. Legal costs can be substantial, and for the fraction of claims compensable through insurance, monies recovered often fall well short of meeting people's lifetime needs. Fault-based systems are also problematic because:
  - court outcomes are uncertain, people's future needs are unpredictable and poorly captured by a once-and-for-all lump sum, compensation is often delayed, and there is a risk that lump sums are mismanaged
  - adversarial processes and delay may hamper effective recovery and health outcomes
  - in the presence of insurance, especially with little focus on risk-rating for some causes of injury, the common law does not provide incentives for prudent behaviour by motorists and other parties.
- While no-fault arrangements reduce people's freedom to the extent (some) common law rights are removed, they are likely to produce generally superior outcomes compared with fault-based common law systems. They:
  - provide consistent coverage across injured parties according to injury related needs
  - provide much more predictable and coordinated care and support over a person's lifetime
  - do not adversely affect people's incentives to improve their functioning following an injury
  - are likely to be more efficient
  - currently perform no worse at deterring excessively risky behaviour, as despite the appearance of the common law, it is the insurer that pays. And although no-fault arrangements would probably not meet all people's desire for 'punishment' of an at-fault party, there is no clear evidence that the common law achieves this either.

17.1 Introduction

There are many accidents resulting in injury each year in Australia, with over 50 000 for transport accidents alone (Henley and Harrison 2009, p. 2). Some injuries are 'catastrophic', resulting in substantial and permanent disability. For example, this could include delayed diagnosis of meningitis resulting in severe brain damage, quadriplegia from falling off a ladder, and an acquired brain injury from a motor vehicle accident or criminal assault.

Various inconsistent and ostensibly arbitrarily different arrangements have evolved in each state and territory to provide insurance cover for people catastrophically injured. Systems broadly align with the cause of injury and, in terms of long term support for people with catastrophic injury, include:

- workers' compensation schemes throughout Australia
- no-fault third-party motor vehicle insurance arrangements in the Northern Territory, Victoria, Tasmania and New South Wales and fault-based arrangements in other states[1] and the ACT
- limited provision for people suffering disability because of violent crime (a rising source of catastrophic injury)
- fault-based medical indemnity and public liability insurance.

There is little rationale for the striking differences between schemes. The practical consequence for people acquiring disability is that the amount, nature and timeliness of support depends on the type of accident, its exact circumstances and location. This can have very lasting impacts for people with catastrophic injury.

- In many cases, people rely on the common law to claim compensation, which will only succeed if they can identify a negligent and solvent first party as the cause of the accident ('fault-based' arrangements). How much compensation they get depends on the presence of insurance, the circumstances of the accident, the quality and cost of their legal representation, judicial interpretation of liability, the brinkmanship of the out of court settlement process, and the process for assessing damages. If a person is unable to pursue a common law claim, they must rely on publicly-funded health and disability services, which are often comparatively inadequate.

[1] All of these except the Northern Territory provide no-fault benefits alongside access to limited common law damages.

- However, in some instances, no-fault insurance is available to cover at least their lifetime care and support needs, regardless of whether they can identify an at-fault first party (defendant) as responsible for causing the accident and, hence, liable to pay. Table 17.1 sets out the key characteristics of fault versus no-fault arrangements.
- Sometimes there are hybrid systems, in which people obtain the benefits of no-fault insurance for one type of claim (long-term care costs), but can pursue other types of claims (income loss and compensation for 'pain and suffering') through the common law where an at-fault first party is involved.

As an illustration of the inconsistencies across the state schemes, a person catastrophically injured in a car accident on the southern side of Boundary Street in Tweed Heads (NSW) would be guaranteed high quality lifetime support, regardless of whether there was an at-fault first party. Had the accident occurred on the same road just a few metres to the north (Queensland) then, in the absence of an at-fault first party, the person would have to rely on often inadequate publicly-funded services. The difference reflects that NSW has a no-fault motor vehicle accident scheme and Queensland a fault-based arrangement.

Fault-based systems only apply where there is an identifiable solvent party that can be found liable.[2] Improving support for people with no legal recourse will inevitably require an extension in coverage through some form of no-fault scheme — whether that be the social welfare system, as a de-facto no-fault system, or a specifically legislated no-fault scheme. The choice, therefore, is not necessarily whether to maintain the fault-based common law *or* supplant it with a pure no-fault approach, although at one extreme there would be the option of replacing the common law entirely. Rather, at this stage, it is likely the more relevant question for policy is how both fault and no-fault arrangements would best fit together.

This chapter considers the strengths and weaknesses of common law versus no-fault insurance arrangements, particularly in relation to catastrophic injuries. Chapter 18 looks at the actual design and implementation of more coherent insurance arrangements for people catastrophically injured in accidents.

This chapter does not address the policy responses to injuries or other harms from product failure (product liability). The body of law in this area is different from accidents covered in this chapter, in that strict liability is the usual standard for liability, claims are infrequent, actions often take the form of class actions, there are often very complex facts that need to be contested, and the defendant parties are typically corporations (sometimes domiciled abroad).

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2 Although, some statutory CTP schemes have a nominal defendant 'insurer' to cover accidents where the party at-fault is uninsured or unidentifiable.

Table 17.1 **Fault versus no-fault schemes**

Fault based systems (common law)	*No-fault systems*
Eligibility	
Based on the tort law of negligence, determines whether or not the defendant first party is liable to pay. This requires that the defendant owed the injured party (plaintiff) a duty of care, that the injury arose from a breach of the duty of care and that the injury is sufficiently proximate to the breach. Contributory negligence by the plaintiff will reduce the amount of damages awarded.	100 per cent coverage of catastrophically injured parties within causes of injury covered by a scheme (eg motor vehicle accidents, workers' compensation, potentially expanding out to all causes of injury) Achieve broader coverage by restricting the ability of an injured person to engage civil court action. This limits legal process costs.
How is the level of need determined?	
Claims are assessed against heads of damage in an adversarial setting. Medico-legal reports and expert opinion help to inform the reasonableness of claims, but there is no structured process or consistency across individuals. Settlements amounts take into account the probability of success, hence reducing the likelihood of full compensation.	Administrative processes implemented through an objective and consistent assessment tool to identify functional needs and supports.
What is the form or nature of compensation?	
Fixed lump sum payment or the option of a structured settlement, though structured settlements are almost never taken-up voluntarily. In some instances, a court appoints a trustee to administer funds. This occurs for children beneficiaries or those with a 'legal' disability such that decisions about the use of funds are subject to oversight to ensure use of funds is reasonable and affordable.	Legislation and policy guidelines determine: ▪ service needs as they arise (medical, social and vocational rehabilitation; personal care; assistive technologies and early interventions) ▪ periodical payment of income benefits (usually based on a percentage of pre-accident earnings subject to caps) ▪ statutory lump sum for permanent impairment.
Who bears the risk of future uncertainty?	
The injured party bears the risk that a once-and-for-all (discounted) lump sum will meet injury-related needs for their lifetime. If funds are insufficient or mismanaged, social welfare and health and disability services are relied on.	The scheme bears the risk, taking responsibility to meet all injury-related needs (subject to legislated conditions) for the life of the injured person, which is held as a contingent liability.

Options for scheme design are plentiful

In designing injury insurance schemes, governments can choose between mixtures of:

- fault-based arrangements, no-fault insurance and public provision of supports (and whether these operate exclusively or allow hybrids)
- coverage across the various 'heads of damage', predominantly long term care and support needs, income support, and pain and suffering
- coverage of catastrophic versus less severe injuries.

Existing schemes involve varying combinations of the above features. For example, in NSW, third-party motor vehicle insurance covers lifetime care and support for catastrophic injuries, replacing common law claims for damages covering these costs, but retains the right for people with catastrophic injuries to pursue other heads of damage (for income and pain and suffering). In contrast, in Victoria, insurance arrangements cover all severities of motor vehicle injuries (not just catastrophic ones) providing no-fault lifetime care and support, income support and a statutory lump sum based on the level of permanent impairment; but also permits people to pursue the possibility of extra compensation through common law avenues.[3]

While injury insurance arrangements are of policy relevance in their own right, they can also provide lessons for the NDIS more broadly — and most particularly about governance. Those lessons are mainly addressed in chapter 9.

17.2 What is catastrophic injury?

A key focus of insurance for personal injury is on people who face particularly high and enduring costs from an accident. There are over 20 000 people with a 'catastrophic-level' injury in Australia, with up to 1 000 being injured each year. These injuries are mostly experienced by young men aged less than 30 years old,[4] and usually entails a period of initial acute care and intensive medical and social rehabilitation to return to some level of independence. In most cases, the consequences of the injury will have a broader and permanent impact on a person's life and functioning, and typically affect their family.

The fullness of recovery and scope for effective medical treatments varies across individuals, injury types and over time as more advanced treatments develop. While there is a concentration of costs and an emphasis on hospital and rehabilitation services during the initial recovery period, the principal ongoing service need is for lifetime care and support, mainly personal care services (figure 17.1).

Around half of all catastrophic injuries are the result of motor vehicle accidents, 8 per cent are work related, 11 per cent arise from medical incidents, with the remaining 32 per cent classed as general injuries, typically associated with sport and recreation activities, criminal assault and catastrophic falls (Walsh et al. 2005). While falls, sport and recreation activities account for a significant number of injury

3 The preservation of common law rights was not the intention of the original proposal, but a result of compromise amendments made to the Act in the Victorian upper house (Field 2008, p. 92)

4 For example, around 44 per cent of participants in the NSW LTCS scheme were injured between age 16 and 30 years, and 72 per cent of adult participants are male (NSW LTCSA 2009, pp. 12,14).

statistics, these do not usually cause major trauma.[5] Criminal injuries are an increasing source of serious and catastrophic injury in Australia.

There are complex boundaries in the classification and definition of catastrophic injury, as compared with disease. While 'disease' is generally differentiated from injury (Langley and Brenner 2004), workcover schemes will include some occupational diseases, such as malignant mesothelioma related to workplace contact with asbestos. For the purposes of this chapter, a 'catastrophic' injury refers to a level of personal injury broadly consistent with existing definitions and assessments used by the Victorian Transport Accident Commission (TAC) major injury unit, the NSW Lifetime Care and Support Authority (LTCSA) and the New Zealand Accident Compensation Corporation's (ACC) National Serious Injury Service.[6]

In particular, as the criteria for eligibility, a catastrophic injury would need to be defined according to the type and severity of injury.

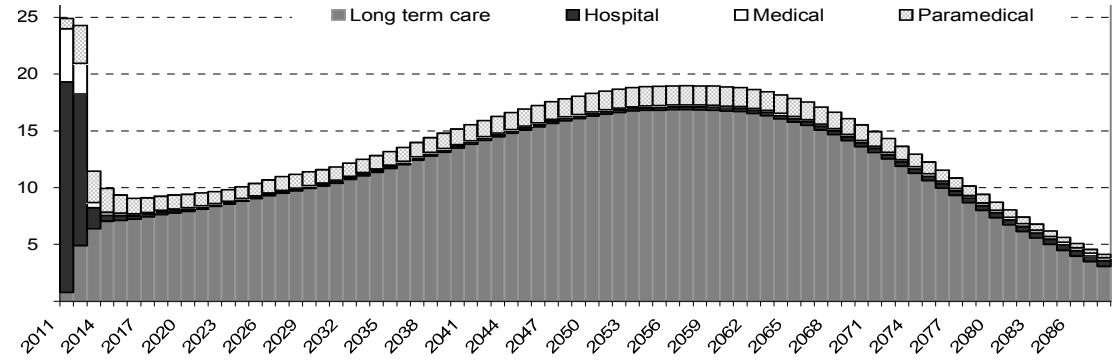
- Severe brain injury and spinal cord injury are the most common types of serious or catastrophic injury, but multiple amputations, severe burns and permanent blindness can also be 'catastrophic' and give rise to a similar need for treatment, rehabilitation and lifetime care and support.
- The severity of the injury would be based on a range of relevant clinically-verified measures, such as:
  - length of Post Traumatic Amnesia (for example, greater than seven days)
  - Neurological Spinal Chord Injury level or score on the ASIA impairment scale
  - amputations of the upper and/or lower extremities at or above the fingers and or adjacent to or above the knees
  - full thickness burns to greater than 40 per cent of the body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment
  - legal blindness — field of vision less than 20 degrees in diameter
  - Functional Index Measure (for example, 5 or less, or 2 less than the age norm).

5 Exceptions are falls by old people, which sometimes involve serious disability. These would typically be covered by the aged care system since the risks of such falls often reflect the natural process of ageing.

6 The Tasmanian Motor Accidents Insurance Board (MAIB) distinguishes catastrophic injury based on a 'requirement for daily care', in which case, disability and medical benefits are not subject to a limit of $400,000, but should not exceed expenses for attendant care and other services otherwise incurred within purpose-built group accommodation (Schedule 1, Motor Accidents (Liabilities and Compensation) Regulations 2010). Catastrophic injuries with daily care liabilities account for around two-thirds of total claim provisions (MAIB 2009).

Figure 17.1 **How do lifetime care and support costs accrue?**

Projected community support payments for major injury TAC clients, 2011 accident year, $ million



Data source: TAC estimates.

On average, a successful award under the common law for the lifetime care associated with a catastrophic level injury is around $1 to $2 million. Amounts tend to vary across claim types — averaging $1.1 million for a successful motor vehicle claim, $1.67 million for a medical negligence claim and $1.4 million for a general injury claim (Walsh et al. 2005). (To reflect current values, and adjusting for wage inflation in awards and superimposed inflation, it would be realistic to inflate these awards by around 30 per cent.) These common law awards are upper estimates of the funds that actually go to injured parties, as certain legal charges not recoverable from the defendant party are taken out of the final award. As discussed in section 17.10, these can be significant.

Average participant lifetime care and support expenses (including attendant care, hospital, medical and social rehabilitation, home and vehicle modifications and equipment) under the no-fault Lifetime Care and Support scheme covering catastrophic transport accidents in NSW is projected to be around $1.41 million (derived from LTCSA 2009a). Under the Victorian TAC scheme, the average lifetime care cost for major injury clients (equivalent to catastrophic) is around $1 million.

The value of benefits provided will be significantly higher than this in many cases, principally reflecting the costs of personal care projected over a lifetime. Some of the more expensive common law claims occur for severe birth injury, with liability estimates of such cases as high as $20 million under a no-fault system (including payments for income and level of permanent impairment; ACC 2009, p. 32). For high level quadriplegia, the average lifetime care cost of TAC clients is around $5.6 million, whereas the equivalent cost for paraplegia is $870,000.

17.3 Criteria to assess injury insurance arrangements

There are many possible criteria against which to judge no-fault versus fault-based insurance arrangements for addressing catastrophic injury across Australia:

i. the certainty, timeliness and quality of care and support throughout a person's life (section 17.4)

ii. coverage of people acquiring a disability through a catastrophic injury (section 17.5)

iii. recovery and health outcomes (section 17.6)

iv. the freedom of parties to choose whether they want to litigate and, if successful, how to spend the proceeds (section 17.7)

v. people's desire to achieve justice when someone caused them a loss (section 17.8)

vi. the impact on people's incentives to take care to avoid injuring others (section 17.9)

vii. costs and the efficiency of achieving objectives (section 17.10)

viii. the desire by people to get compensation for loss of earnings and pain and suffering (chapter 18; appendix I).

There are inevitably tradeoffs between these criteria. Consequently, no insurance arrangement is perfect, and choosing the 'best' requires some judgment as to the appropriate balance. In addition, as a practical reality, litigation arrangements for compensation are often subject to statutory limits and other rules (with such constraints growing after 2002 to secure the affordability of insurance systems — see box 17.1).

Unless governments were to wind back these constraints, the comparison between alternatives is therefore between no-fault regimes and constrained common law arrangements. As Field (2008, p. 97) observed, the common law is 'a pale imitation of its former self', and hence, the goals of affordability and cost effectiveness apply to common law regimes as equally as they do to no-fault systems.

The subsequent sections weigh up how various insurance options fare against the above criteria. The particular issue of insurance benefits for loss of earnings and pain and suffering is addressed in chapter 18 (and appendix I).

Box 17.1 **2002 reforms to tort liability insurance laws in Australia**

Since early 2002, Australian state and territory governments undertook a process of reform to instil greater predictability, manage cost increases and secure the availability of various classes of insurance. The context for these reforms was influenced by:

- a hardening (increase in the price) of premiums
- the collapse of HIH (from insufficient attention to pricing risk and the full and relative costs of capital), and the near collapse of Australia's largest medical defence organisation (UMP/AMIL)
- a range of international and domestic factors affecting returns to investment and the cost of re-insurance
- an increase in compensation payments for personal injury (awards for personal injury had increased at an average rate of 10 per cent per annum, well outstripping inflation which averaged 2.5 per cent over the same period)
- changes in the courts willingness to extend liability for negligence
- increasingly litigious community attitudes

Insurance products affected included public liability insurance and professional and medical indemnity insurance.

Complementary tort law reforms were enacted by state, territory and Australian governments to reflect constitutional division of powers. State and territory governments hold constitutional power over the law of negligence, administration of the courts system, and for insurance that does not cross state boundaries. The Australian Government has powers to protect consumers and give effect to prudential standards.

Tort law reforms broadly included those relating to:

- establishing liability, contributory negligence, foreseeability, causation and remoteness of damage, standard of care for professionals, and mental harm (must be a recognised psychiatric illness and harm must be foreseeable to a normal person)
- thresholds and caps on damages, to remove smaller claims (mainly for general damages) from the legal system and set limits on particular heads of damages on larger claims. There were also concerns in some states and territories about the proportion of payouts absorbed in legal costs, and some measures were applied to improve disclosure and ensure a larger portion of recovered damages went to the injured parties
- claim procedures, through time limits, methods for making and resolving claims (including pre-litigation procedures, advertising, court procedures and legal costs).

Source: Australian Government (2004).

17.4 Certainty, timeliness and quality of lifetime care and support

As noted earlier, most catastrophic injuries involve lifelong disability, and hence, the need for lifelong care and support. In some cases, the common law can deliver adequate payouts that cover all of these costs. However, compensation outcomes from litigation typically fall well short of meeting people's lifetime needs. This reflects that:

- court outcomes are uncertain and, by far, most people settle out of court
- people's future needs are unpredictable, so that damages awarded at a given time may underestimate or overestimate people's future needs
- compensation is often delayed and, particularly if liability is disputed, access to early treatments and appropriate discharge from hospital to medical and social rehabilitation can be delayed and poorly coordinated
- assumptions about discount rates play an important role in determining lump sum compensation, especially for payouts intended to last many decades, and while it is generally agreed that rates applied are too high, agreement is lacking about the 'right' discount rate
- lump sums may not be managed appropriately to meet long term needs, and there are inherent difficulties in managing preclusion periods for access to safety-net services, especially when it may be unrealistic to refuse essential care and support needs.

Court outcomes are uncertain

Judicial interpretation of liability, particularly judicial assessment and application of the principles of contributory negligence, proximity, causality and foreseeable risk, is unpredictable. Many see the 'lottery' nature of the common law as one of its key weaknesses, generating dissatisfaction among both claimants and defendants (sub. 1; sub. 3; sub. 605; sub. DR958; sub. DR767; sub. DR997; sub. DR728). The high rate of out-of-court settlements, in part, indicates an aversion of both sides to the inherent risks of going to trial, with settlement amounts broadly approximating the expected risks and benefits of a court hearing.

Inconsistencies in judicial reasoning and interpretation of the individual circumstances of a case are frequently made evident through appeal processes, in which decisions are overturned between different levels of the judicial hierarchy based on different reasoning and interpretations of how legal precedent should be applied (box 17.2). Though, in part, variations in judicial reasoning, especially by

judges at different levels, can reflect test cases or areas where the common law is not settled.[7]

Box 17.2 **A case of inconsistent judicial reasoning**

Nagle v Rottnest Island Authority [1993]

In 1977, a man became a quadriplegic after diving from a partially submerged ledge striking his head against a fully submerged rock. He sought damages from the Authority on the basis that it should have warned people not to dive from what seemed an obvious diving platform. In this case, the judicial reasoning behind the decisions of the trial judge, full court appeal judges and high court judges was inconsistent. In particular:

- There was inconsistent opinion about whether or not a duty of care was owed by the defendant, including whether or not the submerged rocks were a hidden or obvious risk.
- There were inconsistent views about the scope of the duty of care, and hence, whether or not there was a breach. In particular, the various views about the standard of care expected reflected different interpretations about the foreseeability of the accident and its circumstances and the proximity of the relationship between the defendant and the plaintiff.
- There was disagreement as to what extent the defendant failed to warn of the danger. (Would a general sign, a more specific sign or a fence have met the standard of care expected? To what extent did no history of accidents shape the standard of care expected?).
- Following the different interpretations of the expected standard of care, there were also inconsistent views about whether the defendant's failure to provide a suitable standard of care (e.g. warning signs or a fence) constituted causation, and hence whether the existence of such precautions would have prevented the injury. While the plaintiff was aware of the presence of rocks, there was a difference of opinion between judges about whether a warning would have added to his state of knowledge and prevented the plaintiff's actions.

Ultimately, the High Court determined that a warning sign should have been erected and found in favour of the plaintiff (some 16 years after the accident).

Source: http://www.austlii.edu.au/au/cases/cth/high_ct/1993/76.html.

7 This is an important feature of the common law, adding to its value and flexibility to remain relevant over time. Moreover, there is the similar argument that legislation is not always certain, with the design of statutes subject to change in parliament and administrative decisions applying the legislation subject to appeal.

The calculation of damages also lacks clarity in some areas, such as accounting for gratuitous care, with the law in Australia not settled about the way particular heads of damages are quantified, with different case histories and methodological approaches holding precedent across jurisdictions.

These judicial risks are a key motivation behind the use of mediation between the injured party and insurers to reach early settlement and avoid a court hearing.

Assessing damages is an exercise in predicting the future

Common law damages for personal injury are based on an estimate of incurred and predicted future costs directly related to the injury. Damages are assessed at a single point in time and, with few exceptions, the amount awarded is unable to be altered regardless of how wrong a prediction may prove to be. Even the best efforts of legal practitioners and the use of experts will involve errors due to the inherent uncertainties in predicting future outcomes and the cost of meeting needs related to an injury. As a result, it is likely that damages based on 'sophisticated guesses' by the courts and negotiating parties will prove inadequate to cover the full costs of injury. Alternatively, it might transpire that the damages awarded are surplus to actual injury related expenses and losses. Either way, such inaccuracies incur a cost.

As critiqued in the influential High Court decision of *Todorovic v Waller [1981]*, in cases where:

> … the medical prognosis is that the full manifestations of a plaintiff's injury will not be apparent for some years after trial. The once-and-for-all lump sum award is in those situations a seemingly inadequate form of compensation, because the task of translating the assumptions as to the future into the money figure to be awarded to a plaintiff as a single sum, is incapable of being performed with accuracy. (Aicken J, 150 CLR 403 at 457, in NSW Law Reform Commission 1992)

In particular, reflecting that damages are only recoverable for the additional costs associated with an injury, various assumptions are required about the situation of a person had they not been injured, compared with the situation of the person following the injury. This involves considerable speculation and potential inaccuracy about:

- the extent of recovery and resulting disability after the injury has stabilised
- life expectancy
- the availability of gratuitous care
- formal care needs and associated cost over the lifetime of the injured party
- the impact of the disability on the person's lifetime earning capacity

- the future risk of a complication related to the injury (for example, the risk of epilepsy following brain damage)
- future advancements in medical science, surgeries and assistive technologies.

To take account of these risks and uncertainties, in practice, damages are calculated by weighting the sum of money payable in the event that a risk materialises by the probability of that risk occurring — an expected value. For some general risks there is an adjustment (usually a reduction) for 'contingencies', such as to account for the possibility of future unemployment, sickness or death.

To some extent, postponing the trial, settlement or final assessment of damages until more facts emerge, increases the capacity to predict future outcomes and reduces potential errors. However, delaying legal proceedings is one of the primary sources of dissatisfaction from the public and professionals with the tort system (and a major source of legal costs). It can hamper incentives to rehabilitate (appendix J) and can limit early access to treatments, slow-stream rehabilitation and a transition to independence. (Arrangements such as signed agreements with government departments responsible for disability services or disbursement funding through law firms or the first party's insurer can mitigate some of the delays in access to rehabilitation and other disability-related services, with costs reimbursed once settlement is reached or a judgment made. However, people whose claim for common law damages has unresolved liability issues will generally not have access to appropriate care and support beyond the initial acute care setting).

Some scope to vary damages awarded after trial can occur in a very small proportion of cases through appeal mechanisms. However, the facts covered at the date of the appeal must be relevant to the appeal, and the legal costs of revisiting a case can be high, hence eroding the potential gains from correcting damages.

In addition, there are instances where the uncertainties associated with the calculation of damages can be reduced through the subsequent adjustment of damages years after liability and an initial determination was awarded. This can occur only under restricted circumstances and these provisions are rarely used in practice. As an illustration, under section 30B of the *South Australian Supreme Court Act 1935*, a court has the power to make an interim assessment of damages (excluding non-economic loss, unless the plaintiff's contributory negligence prevents recovery of the full amount of their economic loss) and adjourn the final assessment until the medical condition of a plaintiff has stabilized, or four years has expired since declaratory judgment was entered. The interim order may be varied on the application of either party.

In summary, common law regimes are not always effective at assessing the lifetime care and support needs of people with catastrophic injury, as compensation is determined at a snapshot in time even though needs (and costs) span many years or even decades into the future. No-fault schemes have greater flexibility to respond to changes in participants' needs, as well as the availability of new technologies and relative price changes that affect cost-benefit decisions about the type of care and supports that it would be reasonable to fund. In contrast, assumptions about the cost of meeting future needs, including predictions about the availability and cost of future technologies and supports, are embedded in common law damages. This issue has been raised by lawyer groups arguing for an extension of no-fault coverage under the NSW LTCS scheme:

> … lump sum compensation for future medical expenses is a poor mechanism for meeting future treatment needs of amputees. Expansion of the LTCS scheme to cover above knee and dominant hand amputees would enhance the future functionality of a small yet badly injured set of accident victims. (Australian Lawyers Alliance 2011, p. 2)

Delays

Early resolution of successful claims and rejection of those lacking merit has been a central focus of reforms to legal processes and claims management. Avoiding reliance on courts (as a generally acknowledged slow, complex and costly way of dealing with disputes (box 17.3)) has seen a policy focus on 'pre-action protocols'. Specific reforms have led to requirements for pre-litigation disclosure, case conferencing prior to the commencement of proceedings, exchange of offers, active use of cost orders to encourage early acceptance of reasonable offers and use of scale or fixed cost models for charging. The most obvious benefits of early resolution and reduced delays include:

- increased efficiency through a reduction in legal transactions costs
- shorter and less stressful litigation process for claimants and earlier attempts to mitigate permanent injury and other injury-related losses.
- early investigation of the facts (mutual evidence disclosure and third-party subpoenas), before recollections become 'murky'.

The main mechanism for early resolution of claims is out-of-court settlement. While not disputing the range of benefits listed above, several problems remain with settlement processes. In particular, faults in negotiation processes and the lack of a structured process for systematically assessing liability and damages mean that full compensation is unlikely to be achieved in most circumstances.

Box 17.3 **Some examples of litigation delay**

- A plaintiff was injured in a motor vehicle accident while on a working holiday in South Australia and suffered severe brain damage. He received a 30 per cent reduction in damages due to contributory negligence. The court assessed damages at $761 022, 14 years after the accident. A subsequent appeal led to an increase in damages to $856 922, though representation of the plaintiff by the Public Trustee was taxed at $361 000. Disputes continued through the courts regarding these costs and interest awarded. Twenty three years after the accident, the case was still not resolved, with collective costs most likely far exceeding the damages (Luntz 2007).
- *Agar v Hyde [2000]*: Two men were injured playing rugby in 1986 and 1987, aged 19 and 18 respectively. The judgement was handed down against the plaintiffs 13 and 14 years after the date of their injuries.
- *Vairy v Wyong Shire Council [2005]*: Over 12 years elapsed between the accident in 1993 and a final decision being made against the plaintiff on appeal to the High Court of Australia in 2005. The quantum of damages was agreed between the parties prior to 2002 when the case was first heard in the NSW Supreme Court, but resolution of the case required the courts to assess liability.
- Medical indemnity claims can be particularly difficult to resolve, with nearly 60 percent of claims not finalised 2 years from the date of claim commencement, and 15 per cent of claims still not finalised more than 5 years after the claim was initiated (ACCC 2009b). These delays are in addition to the time that elapses between the date of the medical incident and when a claim is commenced — frequently over a decade. The Productivity Commission has heard many examples of protracted claims, especially for birth related injuries, such as a claim not being commenced until 20 years after the birth and the case then continuing for several years on issues including the life expectancy and future care needs of the now adult concerned.

It has been suggested by some participants that removing the common law cause of action associated with future care, and instead providing benefits in a statutory no-fault setting, would have the important benefit of reducing litigation delays. The basis for this argument is that although liability is determined relatively quickly in a proportion of cases, assessing the quantum of damages is held-up because of uncertainties associated with calculating a person's future care needs. Medical and rehabilitation costs already incurred, lost income and future capacity for paid employment are all suggested to be more readily identifiable at an early stage. For example, Avant Mutual Group, Australia's largest medical indemnity insurer, suggested that in their experience of litigating major civil claims:

> … the most significant head of damage is future care costs. By eliminating this head of damage we would expect major civil claims litigation to be resolved more quickly, less expensively and with less stress for those involved. (sub. 550, p. 2)

On average, over the four year period from 2006-07 to 2010-11, the time between a motor vehicle accident occurring to the resolution of a common law claim for compensation under section 93 of the Victorian Transport Accident Compensation Act was 4 years and 4 months. Many TAC claims take significantly longer to resolve, with the top 10 percentile of claims averaging around 7.5 years following the date of the accident. Based on beneficiaries whose funds are administered by Victoria's Senior Masters' Office, the time between the accident and resolution of the claims was 6 years on average, and nearly 9 years for medical negligence claims.

A significant period of time generally elapses between the date of the accident to when the application to commence a common law claim is received — on average, around 2.5 years for TAC claims. This initial delay, at least in part, reflects the unavoidable problem of medical stabilisation, particularly in cases of brain injury where a person's injuries and extent of recovery can take years to become apparent. But, in some instances, the length of time before a writ is issued may also reflect a departure between a medical practitioner's and solicitor's opinion about how long it takes for an injury to stabilise. As stated by plaintiff lawyer, Burt:

> Some lawyers adopt a wait and see approach by advising new clients that "nothing can be done until the eighteen month anniversary". …in cases involving relatively minor injuries or injuries that you recognise as being unlikely to produce any significant disability, this may be an appropriate course to adopt. However, over the years in my own practice, I have acted for numerous people with "winning cases" who have come to me after receiving this type of advice. (2002, p. 1.1)

If it is true that many solicitors overestimate the time taken for the seriousness of an injury to be established (Luntz 2002, p. 23), to the extent that this prolongs the time before compensation is received, this could be of concern. Medical reports can help to crystallise knowledge about the state of an injured person's condition, but these are also attributed as a source of delay, with a general reluctance of medical practitioners to participate, hence giving rise to a specific medico-legal industry with links to insurers and law firms. Moreover, there may be reasons why lawyers deliberately delay obtaining advice from medical experts:

> It is important that medical experts not be retained until all of the information has been gathered for the simple reason that the history provided by your client to that doctor would appear in the medical report. If the history is inaccurate then this will in itself be sufficient to raise credit as an issue at trial. … supporting documents given to the doctor might have to be provided to TAC. (Burt 2002, p. 1.6)

To reduce the delay between when an accident occurs and when legal proceedings are initiated, many schemes variously impose statutory limitation periods, after which a common law claim is ineligible except in a small range of circumstances. A statutory limitation period is not applied under the Victorian TAC scheme, which

may account for the significant time period before a common law claim is commenced following an accident.

The Claims Assessment and Resolution Service (CARS) in NSW seeks to address legal delays by providing a structured, early opportunity for resolution. Other than in special circumstances, there is no access to courts until the matter has first been to CARS — a process which some lawyer groups have criticised as being 'extremely cumbersome, bureaucratic and slow' (Goudkamp 2005). In general, frustrations with such pre-litigation requirements are confined to complex cases that are unlikely to reach early settlement through procedures lacking the full force of a court's authority.

Even so, the introduction of CARS and a range of other changes (including removal of damages for pain and suffering for whiplash injury and implementation of clinical practice guidelines for injury management), has reduced NSW legal and investigation costs as a proportion of claims. In particular, the Cabinet Office of NSW claimed that following the reforms:

- legal costs fell by around two-thirds
- investigations costs approximately halved
- the proportion of total payments actually paid to claimants increased from 80 to 86 per cent, though return to the claimant is only 61 per cent of total premiums. (2005, p. 32).

The outcomes from CARS highlights that it may be possible to address drawbacks of standard common law processes through specific intervention. However, alternative measures for redress and care and support of injured people would intrinsically avoid such delays and inefficiencies.

Application of a discount rate

Injured people often need care and support over many subsequent years (and in cases of catastrophic injury, for the rest of a person's life). The typical practice of courts awarding damages is to do so by providing a once-only lump sum. This includes damages for a range of losses, including losses expected to accrue into the future, such as the costs of care for the rest of a person's life. To account for the financial return a lump sum can yield to a beneficiary from receiving the money in advance of when many expenses are actually incurred, courts apply a 'discount' rate to the stream of expected future costs. Apart from an assumed rate of investment return, the discount rate applied also takes account of expected inflation and tax provisions.

The discount rate is a key driver of the adequacy of a lump sum, and indeed, whether or not the principle of indemnity — the payment of a benefit not greater or less than, but equivalent to the value of the losses actually suffered — is achieved. In the event that the discount rate applied is based on incorrect assumptions and set too high, the practical consequences for the ability of a beneficiary to fund even just their lifetime care costs depends on:

- the amount of damages awarded for other heads of damages (income and pain and suffering) and whether there is scope to 'redirect' these damages towards meeting future care costs
- whether there is a reduction for contributory negligence, such that the total amount of the lump sum may not be sufficient to meet lifetime care costs, and especially if the reduction for contributory negligence is high
- the period over which the discount rate is applied, with a discount rate applied over a large number of years having a marked effect on the amount the lump sum is reduced (table I.2). Catastrophic injuries are generally permanent and care and support needs long lived, hence people with these injuries are generally most affected.

Not surprisingly, significant contention surrounds what rate is appropriate, and some prominent High Court decisions have influenced the rate applied and basis for application. The High Court established a discount rate of three per cent in *Todorovic v Waller [1981]*, arguing that such a rate allows for inflation, wages, prices and taxes on the invested sum awarded. Despite this decision, there is considerable variability in the discount rate applied to lump sum damages, both across jurisdictions and individual schemes (table 17.2). Although the 'correct' discount rate varies over time, the fact that real discount rates vary so markedly, both by jurisdiction and the cause of accident, means that an equivalent future stream of care and support costs will generate quite different lump sum compensation amounts (appendix I).

The Law Council of Australia commented that discount rates applied to compensation awards should be lower, mainly to enable people that opt to receive a lump sum payment to buy-in to a scheme if they wish to (sub. DR948, p. 22). The issue of a discount rate that is set 'too high' is uniquely a feature of lump sum damages. While it can significantly affect the prospects of a person being able to finance their lifetime care costs, it is not a feature of no-fault systems as such investment risks are borne by the scheme itself.

Table 17.2 **Statutory discount rates**

Before and after reforms to civil liability insurance laws in each jurisdiction

Jurisdiction	*Professional and public liability under civil liability laws*		*Workers' compensation*	*Transport accidents*
	before	*after*		
New South Wales	3	5	5	5
Victoria	3	5	6	6
Queensland	3	5	5	5
Western Australia	6	6	6	6
South Australia	3	5	n.a	5
Tasmania	7	5	3	5
Australian Capital Territory	3	3	3	3[a]
Northern Territory	5	5	n.a	6

n.a NT does not have common law settlement for workers' compensation **a** a rate of 5 per cent is under consideration by the Legislative Assembly, as proposed in the Road Transport (Third Party Insurance) Amendment Bill 2011, presented 17-02-11.

Source: Australian Government (2004, p. 93); Cumpston (2008); Plover and Sarjeant (2010. p. 3).

Management of fixed lump sums by beneficiaries

Lump sum payments have the advantage that a recipient can make their own choices about investment strategies and the desired liquidity of the funds. Beneficiaries taking responsibility for managing their lump sums themselves can also avoid some of the difficulties in getting cost-effective annuities (Cameron 2007).

More importantly, a recipient has the flexibility to consume their money in a way that best meets their preferences. Arguments underpinning this principle align with the value of self-directed funding (chapter 6). However, there are some important differences, including:

- the difficulty that many people may have in managing large amounts of money. Most recipients of lump sum damages lack experience in managing such large sums of money, and while financial advice can assist decisions, it is not a requirement. As stated by Luntz (2002), the dissipation of awards is not always because the recipient chooses to spend it unwisely, but because they are inadequately equipped to invest it safely, or they are unlucky, often due to the financial climate and especially in the early years if capital growth is minimal (pp. 25–6)
- exposure by vulnerable people to fraud by others, which may completely exhaust their lifetime disability funding. Cumpston (2002) describes the case of Tomislav Papic, who lost $5 million of a $6 million settlement to theft
- people may face pressures to give money to relatives or make short-sighted decisions, such as gambling the money away. For example:

  - in *Cockburn & ORS v GIO Finance Ltd*, the father took control of his quadriplegic son's settlement of $1.49 million and dissipated it in his own failed business ventures ([2001] NSWCA 177)
  - decisions of the Administrative Appeals Tribunal of Australia relating to the enforcement of a preclusion period for access to social security pensions benefits and allowances, found that misuse of lump sum compensation for personal injury was frequently linked to gambling and drinking problems and illicit drug use, taking extensive holidays; and payments and repayments to friends and family (O'Neill, AATA 619, 21 August 2009; Page, AATA 370, 21 May 2009)
  - previous surveys of how plaintiffs spend their money have revealed that lump sums are commonly spent quickly, discharging debts that have accumulated between the accident and the resolution of the claim on purchases of motor vehicles and household appliances, and occasionally paying the mortgage on a house (NSW Law Reform Commission 1984). While not all are necessarily inappropriate expenditures, it does mean that the capital sum remaining to generate a return and draw-on for ongoing expenses is less likely to be sufficient.
- in the same way that assessing damages under the common law is an exercise in predicting the future, so is an injured person's predicament in choosing how to responsibly spend their lump sum for the duration of their remaining life. Even trustees of people with disability, who must scrutinise expenditures not knowing exactly how long the money must last or what a person's future health status might be, struggle with this predicament
- the concern that people have weakened incentives for prudent financial management given a capacity for recourse to publicly-funded care and support.

The consequence of these problems (compounded by the difficulties in predicting the costs of lifetime care, and statutory limits on damages and discount rates) mean that lump sum amounts are often not adequate to meet long-term care and support costs. The report by the NSW Law Reform Commission found that:

> … in some cases the compensation was dissipated within three years of the award. These studies also found inaccuracy in the lump sum award where inadequate allowance was made for the effects of inflation on the cost of items and services including wheelchairs, pharmaceuticals and home nursing. Other inaccuracies were found in the failure to assess accurately the physical capabilities of the victim and his or her likely lifestyle and employment prospects. (1992, chapter 2.6)

Some participants have similarly recognised problems with the management of lump sums. For instance, the Tasmanian Government said:

> There is also justified concern that large lump sum settlements are often misused or are grossly inadequate for long term support. (sub. 600, p. 6)

Similarly, the Australian Orthotic Prosthetic Association observed:

> This lump sum settlement in many instances is used not for ongoing lifetime prosthetic care. Often amputees mismanage these funds and then become reliant upon the government community programs for their long-term care. Victoria and NT have systems by which settlements do not include major lump sum payments for lifetime care, but instead provide ongoing lifetime care, support and funding. This model appears to make a great deal of sense. (sub. 237, p. 3)

In many ways, lump sums are a peculiarity of history (Veitch 1982). One of the major historical motivations for their existence was a concern that the defendant might become insolvent if they had an ongoing liability. But this is now unlikely given that regulated insurers are typically the source of the financing, and lifetime care schemes are typically government guaranteed. It is somewhat odd that losses, such as monthly wage and costs of care that regularly have to be met, are compensated through one large payment intended to last an indefinite lifetime.

Structured settlements have not been taken up

While structured settlements suffer many of the same problems associated with lump sums, they have the important benefit of reducing:

- mismanagement of lump sum amounts and encouraging the spending of damages for the purposes intended in the settlement. This, in turn, reduces the risk that an injured person will have to later rely on taxpayer funded services.[8]
- risks to the injured party from uncertainty over life expectancy (life insurance companies are better able to handle this risk).

Since legislative amendments to remove tax impediments and facilitate court-ordered structured settlements, there appears to be only one instance of these tax-exempted, CPI-indexed lifetime annuities being taken up in Australia.[9] The main difficulty

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8 While structured settlements primarily provide periodical payments for life, they can also be 'structured' to individual needs to provide an upfront lump sum, such as to enable career and lifestyle changes, and preserve a contingency lump sum to meet unexpected future needs, such as from the loss of a gratuitous carer or change in health status. To the extent that previous structured settlements in the UK capture people's preferences, on average, only about half of the award was used to arrange a periodic payment, with the remainder used for interim payments, discharging debts, paying for immediate purchases and towards a contingency fund (Lewis 2006, p. 427).

9 The Commission understands that there has previously been an instance of the NSW government offering structured settlements, though this only operated from the mid-1980's and ceased for any new participants in 1992. For people catastrophically injured through no-fault of

appears to be that the prices of annuities are unattractive for insurance companies to purchase on behalf of beneficiaries, especially in the context of the currently high[10] discount rates used to determine lump sums (Cameron 2007). To this end, a lower discount rate in the UK is consistent with a much higher rate of structured settlements than Australia, but there are a range of other factors that, ultimately, result in low rates of take-up both in Australia and the UK[11]. Apart from the high cost of purchasing annuities, other factors affecting the true costs of defendant insurers providing structured settlements include interactions with re-insurance and difficulties in setting reserves and complying with regulations to ensure solvency.

- The market is thin and there is little competition in the market for providing annuities for tort claimants. Although the US has in excess of 15 annuity providers, outside of the US, the demand from insurers for such annuity products is weak. As such, the life market is suggested to be volatile and have a high rate of churn in market participants (Lewis 2006). A thin insurance market is inherently problematic, due to the limited ability to pool the risks associated with inevitable differences between the actual and predicted life expectancies and total claim cost.
- It is suggested that insurers hold insufficient information about the impact of injury on life expectancy, which results in the use of conservative estimates and, in turn, less competitive annuities.
- Given necessary prudential requirements, public bodies are better placed than private insurers to self-fund annuities or periodical payments. Moreover, public bodies are generally not subject to the same financial services regulations that raise the cost of providing annuities. For example, in the UK, providers of annuities are required to closely match their assets with the index-linked nature of their liabilities, which inevitably requires relatively high priced, index-linked government issued gilts to be purchased.

Although accepting a greater risk, people holding lump sums could usually get a better financial return in the absence of structured payments. Cameron (2007) gives an example where despite the tax exemption available for structured settlements, a stream of annuity payments was estimated to total $2.9 million, while a conventional investment (with a 7.3 per cent return and annual withdrawals equal to the annuity and indexed at 3 per cent) was estimated to reach a capital value of

their own, this scheme provided an advance lump sum payment and a guarantee to pay lifetime care and support expenses upon receipt of invoices (including for domestic and nursing care, reasonable hospital and medical costs and necessary equipment).

10 The 'correct' discount rate will vary over time with changes in inflation and investment returns.

11 In the UK, less than 10 per cent of 500 claims exceeding £100 000 involved a structured settlement (Lord Chancellor's Department, Courts Bill: RIS (November 2002) Table 1).

$4.8 million. The difference between the two sources of income reflects the sensitivity to the investment rate of return, as the guaranteed (risk-free) stream of income provided through the purchased annuity generally assumes a lower average return than may be achievable in practice through conventional investments.

Reflecting these issues, and a general desire to expand the use of structured settlements (and more recently in the UK periodical payment orders), there have been calls, especially in the UK, for governments to intervene (Association of Personal Injury Lawyers 2004). In the context of this inquiry, however, many of the issues around structured settlements would be resolved by no-fault arrangements.

Avoiding double compensation is difficult and costly to administer

Double compensation can occur in any instance when a person has access to a lump sum payment to cover some or all of their care and support costs and might also seek to access taxpayer-funded services. The need for processes to avoid this situation were widely acknowledged by lawyers. For example, KM Splatt and Associates suggested that compensation recovery 'remits millions to government coffers':

> Under the common law, the taxpayer is recompensed by the torfeasor's insurer thus saving the Australian taxpayer huge amounts of money. The Productivity Commission was very remiss in not analyzing this very important fact. (sub. DR 647, p. 3)

There should be no delusion, however, that recovery of compensation for taxpayer-funded care and support services provided for 'compensable injury' represents a gift or subsidy to Australian taxpayers. Rather, in the absence of recovering such costs, taxpayers would be billed twice, since insurance for catastrophic injury is mostly made compulsory and funded by the broader public through various public insurance frameworks.[12]

State and territory governments variously impose measures to avoid double compensation — typically, lump sum preclusion periods and compensation recovery arrangements. These measures aim to prevent the costs of compensable injury from being shifted to taxpayers and, in turn, restrict an injured person from accessing both financial compensation *and* social welfare services and supports without contributing towards the value of these services. Rather than precluding people who obtain compensation altogether, such arrangements exist because a lump sum compensation payout, which is most frequently obtained as a negotiated settlement, typically:

[12] To this end, funds for compensation are akin to tax and the issue becomes the efficiency of alternative funding sources (including the effectiveness of risk rating insurance).

> …does not specify what has been awarded or the amount awarded may not seem sufficient to support the person. In addition, the individual may be in need of urgent services even though it may be some years before their compensation claim can be resolved. (DHS Victoria 2000, p. 2)

In practice, however, there are inherent difficulties in managing preclusion periods for access to safety-net services, especially when it may be unrealistic to refuse essential care and support needs in the not uncommon event that a person's lump sum was insufficient or prematurely exhausted. This complicates attempts by government agencies and service providers to ensure consistent application of rules and guidelines affecting compensable parties who seek taxpayer-funded services and supports. In most jurisdictions, the Commission has been told there is significant need for discretion and fine judgement in the application of the rules.

To the extent that consistent, fair and appropriate outcomes are pursued, considerable administrative effort and costs are incurred. Participants raised this concern, including Professor Richard Madden, who cited the substantial administration costs, doubt and worry that surrounds existing arrangements for recovering the cost of Medicare services as a reason not to fund compensation of Medicare services at all (sub. DR997, p. 5).[13]

Specific problems include:

- the administrative cost of recovering money (on a full cost recovery basis) for the services consumed
- the administrative burden of assessing compensable status and determining the amount of compensation provided for specific uses and allowing for contributory negligence (which, by definition, will mean that full compensation is not received and limits the capacity of a person to self-fund their treatment, care and support needs)
  - most compensation is received through settlement, which frustrates attempts to calculate the amount that a compensated client should reasonably be expected to pay for the taxpayer-funded services and supports they seek to access. In particular, unless there is a court judgement or another form of independent assessment, such as by a tribunal or arbitrator, there is unlikely to be sufficient information to know how much money was awarded under each

[13] In the context of fault-based arrangements, this proposal may have practical merit, but it is relevant that funding of health and rehabilitation services in no-fault systems can play an important role in encouraging investment in these facilities that may otherwise be underfunded. Moreover, funding such health system expenses from premiums reflects the full 'external costs' of accidents and encourages efficient levels of risk reduction.

head of damage — for example, compensation for medical treatment and future care and support costs, as compared to income losses and pain and suffering

- recovering the cost of taxpayer-funded services generally requires the terms of the out-of-court settlement to state that at least some of the settlement is to be used for care and support. If, for example, attendant care costs are not specifically documented in the settlement, there is no basis to recover the value of taxpayer-funded services consumed for this purpose. To this end, there may be some strategic incentives for a settlement to not itemise costs covered by the settlement
- various assumptions are made to get around this paucity of information, such as the 50 per cent rule applied by the Commonwealth Government, but the inaccuracy of 'rules of thumb' may result in unfairness, undue hardship, or in some instances, over or double compensation. To some extent, this is remedied through appeals processes to review administrative decisions where special circumstances might be evident to warrant an exemption from the usual rules[14].

An underlying premise of the approach suggested by the Law Council of Australia (sub. DR948, p. 14-15) and the Australian Lawyers Alliance (sub. DR843) and Law Institute of Victoria (sub. DR1024, p. 1) is that lump sum preclusion and compensation recovery provides an effective and efficient means of avoiding double compensation. In particular, if lump sum compensation is to be made available as an opt-in arrangement alongside significantly improved access to services and supports under a new no-fault lifetime care arrangement (as has been advocated by the above groups), preclusion arrangements and compensation recovery would have to provide a reasonably workable, fair and efficient process.

But, comments from the Law Council of Australia about the process to recover the cost of Medicare services consumed by compensable parties, are less than encouraging:

> The Law Council remains concerned at the relatively high recovery cost under the scheme. It is noted that the last time the efficiency of the scheme was reviewed in 2001, it was reported that Medicare Australia expended nearly 50 per cent of amounts recovered administering the scheme each year. (Submission to the Community Affairs Legislation Committee, Inquiry into the Health and Other Services (Compensation) Amendment Bill 2006).

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14 Special circumstances might include unexpected and unforseen medical expenses, with the prospect of financial hardship in the near future and the absence of any other avenues for support (including from friends or family); clinical evidence of an addiction or other condition outside of the person's control; incorrect or insufficient advice about the duration and operation of a person's preclusion period; expenditure of compensation funds due to fraud by another person; or evidence of excessive legal costs, such that the *gross* amount of the lump sum significantly misrepresents the amount of compensation actually available to the injured person.

The Commission has been unable to establish the exact costs of compensation recovery systems, including at the state level. That said, parties involved in the process (and from a variety of jurisdictions) have informed us that there are significant, unavoidable administrative complexities and high costs associated with case-by-case decisions about access to taxpayer-funded disability services. This reflects the paucity of information about the types of costs that the compensation amount was negotiated to cover and the need to take into account the individuals circumstances.

The experience of the Victorian Senior Master's Office in seeking to secure adequate care and support for their 'compensated' clients has required their intensive involvement to advocate for their clients' needs. This has sometimes also required the involvement of the Office of the Public Advocate and various case managers. Senior officers from the department responsible for making decisions about the compensable status of clients are also required. This level of involvement results in a heavily bureaucratic process

In the Commission's assessment, there is no obvious way to achieve significantly more efficient and effective management of a compensable person's access to taxpayer-funded services and supports. This does not mean that some improvements could not be made — for example, it may be possible to pursue greater consistency between the principles and processes that determine damages for compensation and those determining needs-based access to taxpayer-funded systems. However, there are inherent obstacles to securing a sufficiently robust and operable system that reconciles the amount of compensation awarded with the level of need for care and supports. Moreover, to the extent that this could cost effectively be achieved, such as by a court specifying a complex 'budget for life' and the insurer providing periodical payments, the compensation system would, in effect, resemble a periodic payment scheme, most of which are no-fault.

How do no-fault systems fare?

Whether or not no-fault systems meet a person's lifetime needs better than common law damages depends on their generosity, the assessment arrangements used and case management of injured people.

Under Australasian no-fault systems for compensation, rehabilitation and lifetime care and support, an insurer holds a 'claim' to ongoing care and support and other benefits as a contingent liability. This means that a catastrophically-injured person will generally have lifelong contact with the scheme and, to the extent possible, a particular person or group of people coordinating a variety of support needs. In

addition, the risks associated with unforeseen costs that arise into the future in relation to an injury is managed by the scheme, rather than being borne by the individual (that is, no-fault insurance schemes provide intertemporal insurance).

The schemes manage the provision of supports through an objective assessment process, in accordance with the relevant legislation and policy guidelines governing access to benefits and the levels of support available. Even if the actual function is contracted out, the scheme will generally oversee claims management and various assessment-related functions; determination of claims for medical treatment rehabilitation services (including social and vocational rehabilitation services) lifetime care and support; home modifications; aids and appliances; and any other supports enabled under the legislation. Overlaying this is an appeals process for reviewing the way in which a scheme meets the care and support needs of individuals with catastrophic injuries.

In theory, the problem of managing a lump sum under fault-based insurance arrangements is replicated in a fully-funded lifetime scheme. That is, a person's annual support needs must be sustainably financed from returns on a portfolio of assets — the pool of funds put aside to meet each participant's estimated (net present value of) lifetime liabilities. However, pooled funding, a strong governance and prudential framework, including full funding of liabilities, supervision of investments and (bounded) discretion to set premium levies addresses many of the problems besetting fault-based systems, including:

- uncertain court outcomes ('the lottery') and future care needs
- delays and lost opportunities for early interventions
- the impact of any errors in the discount rate
- lump sum mismanagement and problems in managing a compensable person's access to taxpayer-funded services and supports.

While lump sums might once have had the practical advantage of managing the insolvency risk of the insurer or party liable to pay damages, Australia's no-fault systems are typically government underwritten, so insolvency is not a genuine concern.

In addition, lifetime care schemes can encourage the development of a service network, including systems to provide best practice models of rehabilitation. For catastrophic injury, initial acute and sub-acute care is not significantly different across compensated and non-compensated clients. However, the difference can be pronounced for the transition to rehabilitation, access to specialist rehabilitation units and transitioning back into the community. When the Victorian TAC commenced operation in 1987, the TAC responded to the severe shortage of

rehabilitation facilities by building and operating their own facility for many years. This is no longer required, as sufficient capacity now exists due to the increased number of clients and attached funds (TAC funds 80 per cent of clients using the main brain injury rehabilitation unit in Victoria).

Despite the range of advantages associated with no-fault systems discussed above, some participants have criticised the financial sustainability of no-fault systems, including the associated consequences for guaranteeing participants' continuing care needs (subs. 375, 392 and 409). In particular, the previous unsustainable growth in liabilities of the New Zealand accident compensation scheme is sometimes held up as a characteristic of no-fault systems more generally. As stated by Mark Blumer:

> The most significant feature of the ACC's situation at the end of 2008-09 is that its financial position has become unsustainable … If this is allowed to continue the Scheme's very existence could be under threat. … Those who depend on the scheme may find the supply of their care needs cut back, or whoever is funding the scheme may have to put in extra money. I would not trade a right to care for that situation. (2010)

Similarly, Maurice Blackburn, Slater and Gordon and Shine Lawyers cite the affordability of no-fault approaches as a concern, drawing on the New Zealand scheme as an example of:

> … a system that is perceived to be equitable at conception, but comes at a high cost, [and hence] may quickly develop inequities through reductions in rights and benefits aimed at mitigating costs … (sub. 392, p. i).

These claims, however, appear overstated to the extent that they fail to recognise the underlying reasons why problems in the New Zealand scheme emerged, which can, in fact, equally be applied to both fault and no-fault schemes. (For example, concern over financial sustainability motivated the suite of tort law reforms in Australia, which limited access to damages.) Moreover, the New Zealand ACC has undergone recent changes that have substantially reduced unfunded liabilities. In addition, various reviews of the scheme have shown the scheme operates with lower costs than most fault-based systems and is generally associated with better outcomes (PwC 2008). The Victorian TAC, another long established scheme, does not appear to have financial problems.

To the extent that the financial state of the New Zealand scheme, as made public following the change of Government in 2008, illustrates a potential vulnerability of no-fault systems, the unfunded growth in liabilities only affirms the need for a sound governance framework. It does not specifically demonstrate financial sustainability as an inherent weakness of no-fault systems. While mainly in relation to the NDIS but also relevant to no-fault systems for accidental injury, chapter 9 presents a

framework for good scheme governance which is informed by the New Zealand experience, including the need for appropriate and clear:

- limits on political interference that might otherwise jeopardise a scheme's integrity
- legislation defining scheme boundaries, reducing any unfunded creep in scheme coverage or inconsistent decisions about the reasonableness of benefits
- performance metrics to provide a discipline on costs, administration expenses and drive efficiencies in delivery of care and support
- effective monitoring by a government department concerned about the financial sustainability of the scheme.

Associated with these potential, albeit avoidable, concerns about the desirability of no-fault systems is the tension that Australian governments have been seen to impose legislative restrictions on the ability to obtain compensation through the common law, and yet might soon seek to take legal rights away more completely. On the one hand, statutory limitations on the common law have been motivated to ensure that compensation remains comprehensive and prioritised to those most in need, particularly those with catastrophic injuries and lifelong needs for care and support. On the other hand, people whose injuries fall below the set thresholds have undoubtedly lost.

The removal of, at least some, common law rights within a no-fault system is offset to the extent that injured people are instead promised access to lifetime care and support (and perhaps other forms of assistance also, depending on the scope of the scheme and the extent that common law rights are removed). An important distinction, however, is that a statutory no-fault system manages access to benefits through a statutory authority rather than judicial processes. The Commission has heard three main concerns about the role of a statutory body and the administration of statutory benefit rules in no-fault systems:

- while a no-fault system overcomes the 'lottery' nature of the common law damages, a proportion of those successful in obtaining compensation under the fault based compensation system would fare worse under a no-fault system
- more so than under a fault-based system that has fewer levers available to governments to intervene in the way benefits are allocated, administrators of a no-fault system may be perceived as susceptible to direction from government to either restrict benefits or alter scheme coverage
- there is a belief that no-fault schemes inevitably grow into a fully fledged bureaucracy, with high costs and low productivity. Albeit that the experience of no-fault schemes has usually been lower claim management expenses and a relatively higher proportion of premiums paid as claimant benefits (PwC 2008), any scheme should strive to avoid potential inefficiencies and a lumbering

bureaucratic structure. This highlights the importance of sound governance and accountability, including robust cost controls and performance metrics.

Another concern raised by some participants about no-fault systems is the failure of such regimes to consider the individual situation of the person with a disability. For example, Maurice Blackburn, Slater and Gordon and Shine Lawyers said that an important function of the common law is that it:

> … provides flexibility in delivering alternative compensation levels to people with different impacts from the same disability, and can therefore address heterogeneous needs and preferences. (sub. 392, p. ii)

They went on to cite the specific example of dealing with cases of disfigurement, suggesting that statutory benefits under no-fault regimes are too inflexible to adequately deal with instances where the type of impairment and the associated loss experienced does not necessarily align with functional impairment loss (as is typically used to determine the amount of compensation under a no-fault system) (sub. 392, p. 16).

The Commission agrees that addressing individual circumstances is important to achieving good outcomes for people with disability; indeed, a statutory scheme that is too rigid could result in perverse outcomes. For example, a person whose face is disfigured might benefit from plastic surgery, especially if the absence of such an intervention would prevent them from having the confidence to leave their home and participate in the community, including in gainful employment. Similarly, the psychological effects of a physical injury, which can be devastating to a person's life and identity, should be addressed in complement to other treatments and interventions. To this end, existing no-fault systems attempt to take account of an individual's situation through:

- needs assessment, which can be undertaken as individual circumstances change (chapter 7)
- identifying features central to the person's pre-accident lifestyle, including by tailoring supports to former participation goals. As occurs under the Victorian TAC, this might include, for example, the provision of a more highly specialised wheelchair to enable sport to be played by a former athlete who had experienced a spinal injury
- the establishment and enhancement of mechanisms to enable greater control by individuals as to how resources could best meet their participation goals, health and wellbeing, including through self-directed funding approaches, client satisfaction surveys and monitoring of client outcomes.

The Commission has been careful in this report to design an NDIS that supports the practical realisation of self-directed funding approaches (chapter 8). In coordination

with the experiences of the NDIS, there is also a role for self-directed funding models in lifetime care schemes for accidental injury, as has been a central theme of many participants' advice. For example, as stated by Maurice and Blackburn, Slater and Gordon and Shine Lawyers who emphasised the importance of choice:

> People with a disability should have the option to receive care through a consumer directed care model *and* the option to relinquish care responsibility to a designated case manager. (sub. 392, p. ii)

The practical task to allay concerns about removing common law rights for long term care and support among some groups within the community should not be underestimated. Despite numerable past official inquiries and reviews investigating the issue and broadly reaching similar conclusions about a no-fault system of statutory benefits as the best way to proceed[15], governments have shied from implementing such changes on most occasions. Incremental change may address this to some extent, and may also be appropriate to ensure that any new system is up and running before taking on functions broader than the important task of ensuring comprehensive lifetime care and support for the most severely injured is realistically considered. These issues are explored in chapter 18.

17.5 Coverage of people acquiring a disability through a catastrophic injury

By definition, full common law compensation for the losses associated with catastrophic injury only applies where an at-fault (provably negligent) first party (defendant) can be identified, damages are assessed accurately and there is no contributory negligence to reduce the amount of compensation the defendant is liable to pay.[16]

A person acquiring a catastrophic injury but unable to establish another solvent party's legal liability for the injury would generally[17] not gain access to compensation under a fault-based common law system. This includes cases where:

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15 Official inquiries include: the 1967 New Zealand Royal Commission of Inquiry into Compensation for Personal Injury; the 1974 Australian National Rehabilitation and Compensation Committee of Inquiry; the 1981 New South Wales Law Reform Commission Inquiry into Compensation for Personal Injury and Death from Motor Vehicle Accidents; the 1986 Victorian Government Statement on Transport Accident Reform; and the 2004 Productivity Commission report on National Workers' Compensation and Occupational Health and Safety Frameworks.

16 Contributory negligence is the failure of the injured person to take reasonable care for their own safety, with a per cent reduction based on the relative contribution the plaintiff made to their own injury.

17 There are some statutory exceptions, which provide access to common law damages in circumstances where a legally not at-fault first party is defined as at-fault for the purposes of ensuring insurance cover for the injured third party. For example, in NSW, the *Motor Accidents*

- the accident was purely a matter of chance without any other party's involvement. For example, a driver, their passengers or a pedestrian might sustain motor vehicle injuries from chance or blameless events outside the control of the driver — a car tyre blowing out, the driver suffering a heart attack or stroke, an oil slick on the road, an unexplained mechanical failure or an unavoidable collision with an animal darting across the vehicle's path. In accidents more generally, a person may fall off a ladder after a strong unexpected gust of wind, or a swimmer may acquire a brain injury when submerged by a freak wave. Bad luck is common
- a person may make a mistake that anyone might make, but which results in their own catastrophic injury
- another person causes the accident but has nevertheless taken 'reasonable' care. For example, someone causing an accident that was blameless or inevitable (such as because they sneezed, had a heart attack or were bitten by an insect whilst driving) would be unlikely to be found negligent[18]
- the injury arose out of a single vehicle accident and the injured driver was themself at fault, or alternatively, an accident took place in a person's own home or private property, such as from falling off a ladder, falling from a horse, or rolling a four-wheel motor bike on a rural property.[19]

Consequently, the scope of cases that are non-compensable under the common law is very wide. Australia-wide, only about half of catastrophic injuries are compensated through insurance, with the supports required for the remainder covered through (generally inadequate) taxpayer-funded health and disability services. The proportion varies significantly across jurisdictions and depends crucially on whether a fault or no-fault insurance system is in place.

Compensation Amendment Act 2006 extended no-fault cover to pedestrians and passengers who were injured as a result of 'blameless or inevitable' accidents. Such accidents seeking common law damages are now processed in the same way as fault-based claims, although the driver of the vehicle (still technically defined as at-fault) will remain ineligible to claim. The legislative amendment also provided no-fault cover of children's medical expenses and rehabilitation costs, and since April 2010, 'at-fault' motor vehicle injuries are entitled to a maximum of $5,000 for reasonable and necessary medical expenses and/or lost earnings.

18 A recent case decided by the High Court epitomises the limits to negligence. *Sydney Water Corporation v Maria Turano & Anor* [2009] HCA 42 concerned a claim against Sydney Water for the death of a driver and injury of other occupants of a car that was hit by a tree during a storm. The plaintiff's case rested on the argument that Sydney Water was negligent because a leaking water main (laid in 1981, ten years prior to the accident) had damaged the tree's roots, making it susceptible to collapse. The High Court dismissed any liability because Sydney Water could not have reasonably foreseen the risk of an accident.

19 The Victorian TAC covers accidents involving off-road vehicles on a no-fault basis, which are also required to purchase insurance.

Motor vehicle accidents

Across Australia, it has been estimated that compulsory third party (CTP) insurance arrangements cover around two-thirds of motor vehicle accidents resulting in a catastrophic injury (Walsh et al. 2005). However, since then, NSW has established a no-fault lifetime care scheme for catastrophic motor vehicle injuries, which would mean that closer to 80 per cent of such injuries would now be covered. No-fault cover (which extends to 100 per cent of these injuries) is available in NSW, Victoria, Tasmania, and to a more limited extent in the Northern Territory. Coverage is patchy in other jurisdictions, due to fault-based access to benefits and the potential for damages to be reduced through contributory negligence. Limited cover for at-fault drivers (in the form of a lump sum payment) can be purchased from some insurers as an additional feature of CTP cover, but these are subject to caps and various other restrictions and exclude cover for motor bikes.

Workplace accidents

Workers compensation arrangements provide no-fault cover in all Australian jurisdictions, and hence, extend at least some no-fault benefits to 100 per cent of injured parties, but in some jurisdictions, care and support costs are not adequately provided for catastrophic injuries (chapter 18). Residual common law rights for some heads of damage are available in all jurisdictions, except South Australia and the Northern Territory.

Medical accidents

Estimates show that catastrophic medical incidents attract some form of compensation in about 50 per cent of cases across Australia (based on a comparison with New Zealand that operates a no-fault system for covering these injures) (Walsh et al. 2005). Access to benefits is managed entirely through litigation, though most claims are settled out of court. Cases are often not finalised for many years following the incident, or the initial discovery, that gave rise to the initiation of a claim.

General accidents in the community or at home

Cover for general injury, through either public liability insurance or private legal liability insurance (as tends to be included in home and contents general insurance policies), provides access to compensation for about 20 per cent of general injury claims. These claims are managed through the adversarial system, though recent tort law changes have limited the extent that people with less serious injuries can claim and the level of damages available.

Criminal injuries

Each jurisdiction has a taxpayer-funded criminal injury compensation scheme, recognising that the offender may not always be (sufficiently) solvent to pay damages, such as can be accessed under the crimes act in various jurisdictions.[20] These are usually last resort schemes however, and albeit that they ensure broad coverage across affected individuals, they do not provide adequate levels of compensation for severe physical injury, including permanent disfigurement and loss of function experienced from violent crime. Rather, as stated by the Victorian Victims of Crime Assistance Act 1996, for example, the purpose of providing financial assistance to victims of crime is:

> … as a symbolic expression by the State of the community's sympathy and condolence for, and recognition of, significant adverse effects experienced or suffered by them as victims of crime … (section 1.2. b)

Across jurisdictions, caps on the total amount of compensation are applied between $25 000 to $75 000, though the availability of this level of financial assistance would require evidence of significant costs incurred related to the injury.[21] This means that for catastrophic injury, victims of crime are not covered for their future (most likely lifelong) care needs. This can negatively affect the extent of rehabilitation and recovery and long term prosects for community participation. As recounted by one participant whose daughter was brutally injured in 2002:

> … when she was bashed by her then ex boy friend. She was left with a severe brain injury, and we were told that she would not improve and the only option offered to us, which we believe was due to the fact that Anj was a victim of crime with no compensation, was an aged nursing home in Benalla. The physios in intensive care said she needed botox and plastering, this was not done. The lack of these procedures has had a enormous effect on her wellbeing and rehabilitation. If these things had been done early Anj would not have had to suffer years of pain and suffering as she has had to due to the fact she didn't have the funding. (sub. 535, p.1)

Similarly, the Commission has heard of an instance of a person now in their twenties residing in a nursing home having been physically abused and severely brain damaged by their parents as a 6-week-old child. But apart from a trivial amount of compensation awarded through victims of crime assistance, this person relies on evidently inadequate support from the disability and health systems.

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[20] Or in some instances from a government department if it is proven the department breached their duty of care.

[21] Within these limits, benefits claimable span across medical expenses, loss of amenities and expectation of life, physical injury, mental and nervous shock, and loss of income.

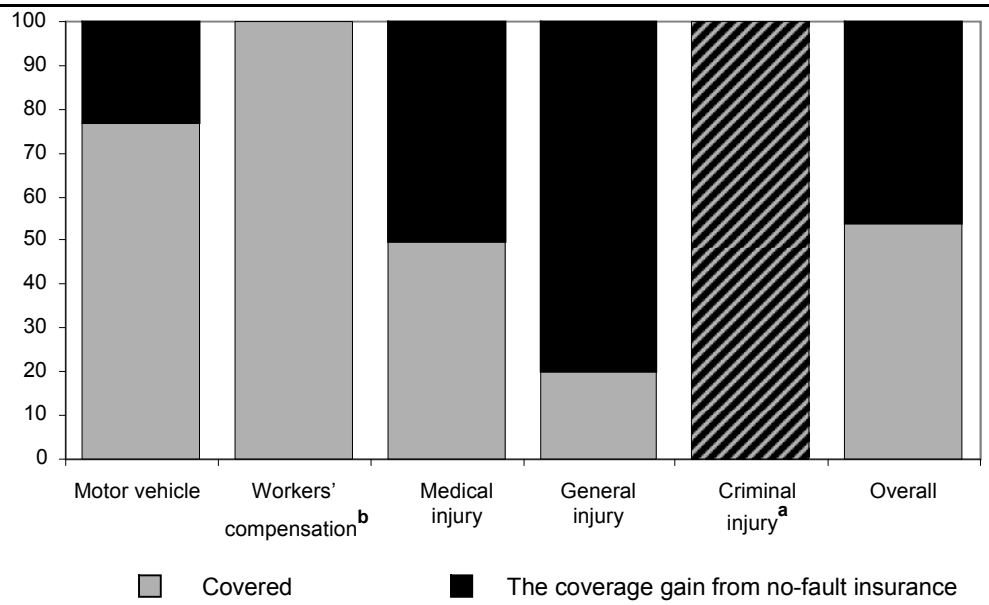
In summary

Current coverage across the broad range of circumstances in which catastrophic accidents occur — from motor vehicle use, playing sport and various recreational activities, medical treatment and criminal assault — is patently inadequate. A person could acquire an identical disability from an accident in any of these contexts, and as such, there is a good rationale for equal insurance and access to care and supports.

The introduction of universal no-fault arrangements for catastrophic injury, by definition, would provide complete coverage, with the minimum gains shown in figure 17.2. (They are a minimum because some schemes offering 100 per cent coverage provide significantly capped benefits, such as for criminal injury.)

Figure 17.2 **Deficiencies in cover by source of injury**

Per cent of people whose lifetime care and support needs are (not) covered



a Although a 'symbolic' level of cover extends to 100 per cent of catastrophic criminal injuries, cover for this category is represented differently to show the potential for significantly improved *depth* of cover under a new no-fault arrangement. **b** Although 100 per cent cover is shown for workers' compensation, in some jurisdictions this is not the case, with only fault based benefits available beyond a certain period and reduction of the lump sum for contributory negligence.

Data source: Walsh et al. (2005), updated.

17.6 Impacts on recovery and health outcomes

A key goal of all insurance systems (common law, no-fault or social insurance) is to improve a person's health and functioning following an injury.

There are several conceptual grounds where adversarial fault-based systems could reduce the scope for such improvements (and might sometimes exacerbate problems):

- the size of a person's award for compensation (and that of his or her lawyer) under the common law is dependent on the severity of the injury. The usual strong incentives for people to maximise recovery is undermined by an awareness that the greater the recovery, the lower the potential level of compensation. In effect, the prospect of injury-related compensation is like a tax on recovery. It would not be surprising for such a tax to have an effect. This interpretation does not require the person to 'manufacture' their disability (though that will sometimes happen)
- litigation processes take time, are stressful, and accentuate a person's preoccupation with the disabling aspects of an injury (psychosocial factors play a significant role in recovery.)
- no-fault insurance schemes directly seek to achieve better health and functioning by explicitly managing cases and consumption of services and supports to get better outcomes as fast as possible. At a broader level, no-fault schemes regularly survey their clients, are developing tools to measure and better understand how to improve client outcomes and progress. These are not the priority concerns of fault-based systems.

Generally, these theoretical concerns are supported by empirical evidence. A recent review undertaken for the Australian Centre for Military and Veteran's Health (Pietrzak et al. 2009) concluded that:

> The search of literature showed that evidence associating compensation with a worse disability outcome appears irrefutable. Hundreds of papers included in three meta-analyses and all the individual papers from the updated search showed adverse effect of compensation on health and RTW outcomes. (p. 6)

The Australasian Faculty of Occupational Medicine and The Royal Australasian College of Physicians (2001) also concluded:

> Although most people who have compensable injuries recover well, a greater percentage of these people have poorer health outcomes than do those with similar but non-compensable injuries. There is sufficient good quality evidence to show this to be true, and significant agreement among practitioners in all relevant fields (medical, legal, insurance, government oversight bodies) to support the evidence and to suggest that a complex interaction of factors is responsible for this.

Professor Richard Madden suggests that common law processes for medical injury has the perverse effect of preventing disclosure of errors and risks in the health system, hindering efforts to improve safety and quality (sub. 466, p. 2). Similarly, a key objective of the 2005 legislation establishing a no-fault system for medical injury in New Zealand was to move away from reporting medical error decisions to foster instead improved quality, safety and learning initiatives, including through:

> … sharing information on issues where there is a risk of harm to the public. … disclosure of harm as a first step in facilitating claims, strategies to reduce barriers to claims… [and] addressing competence and performance issues as internal organisational responsibilities. (Malcolm and Barnett 2004, p. 21)

Not all agree about the potential for common law processes to lead to adverse health outcomes. In particular, one up-to-date 'review of reviews' does not support the above contentions (Spearing and Connelly 2010). This study was also raised by the Law Council of Australia as the basis for their claim that:

> … arguments that litigation impedes recovery are not supported by any conclusive evidence. (sub. 375, p. 12)

Given the apparent meticulous approach of the Spearing and Connelly study, it should be considered carefully in the debate. The authors sifted through the various systematic reviews in the compensation literature. Many reviews were eliminated from consideration on the grounds of their coverage.[22] Of the remaining 11 systematic reviews, 9 of them concluded that access to compensation had negative impacts on health outcomes (compared to the counterfactual). One study made no judgment either way because of the nature of the studies it considered. The remaining study (Scholten-Peeters et al. 2003 referred to as SP from now on) found no robust negative effect of litigation on health outcomes (following whiplash injuries). Spearing and Connelly eliminated all bar the latter study because of various defects in the quality of the other reviews, and on the basis of that study, concluded that:

> Until consistent, high quality evidence is available, calls to change scheme design or to otherwise alter the balance between the cost and availability of injury compensation on the basis that compensation is 'bad for health', should be viewed with caution. (p. 9)

[22] Spearing and Connelly did not include in their meta study reviews examining compensation effects for some groups relevant to the Commission's analysis, including reviews that considered effects on children, professional negligence or where the injury was from an unknown cause. Reviews not in the English language were also omitted.

However:

- it is not clear why the penalty for a defect in quality is a weight of zero when making judgments about impacts. Therefore the other reviews arguably also have *some* relevance to judgments about the impacts of compensation
- a more recent study into whiplash (Centre for Automotive Safety Research (CASR) 2006, p. 10) considered that SP had not given credence to an important study finding a robust link between litigation and adverse outcomes. Moreover CASR's own research on South Australian whiplash injuries did find such a link (p. 74)
- the burden of proof used by SP (and also adopted by Spearing and Connelly) was a requirement to prove beyond reasonable doubt that litigation arrangements were bad for health. For example, using SP's criteria, a study suggesting that litigation had 1.9 times the likelihood of retarding recovery, but which was not statistically significant at the 0.05 level would be seen as strong evidence of no impact. However, in many other contexts where a risk of harm is present on conceptual grounds, the onus of proof is reversed. In that case, the requirement would be to demonstrate that litigation had no adverse effect, especially in the light of the subjective concerns raised by many clinicians.
  - The heart of the issue is that the *policy* interpretation of impacts and their statistical significance should be against the background of the implications of false positives and negatives, rather than focusing alone on reducing the likelihood of false positives (McCloskey 1985; McCloskey and Ziliak 1996).

As discussed in appendix J, the evidence on the impacts of litigation on health and wellbeing outcomes of those experiencing major injury is weakened by methodological limitations. However, the weight of the evidence suggests adverse impacts of litigation. Certainly, there is no evidence that litigation produces *better* health and functioning outcomes than no-fault schemes, despite being more expensive on a case-by-case basis (as discussed below).

As an addendum, a related question is the net wellbeing impacts of common law versus no-fault systems for people other than the injured parties. There is little evidence on this score, but if litigation is stressful for the person with an injury, it is likely also to be so for their support network. Equally, in some cases, the defendant may also suffer significantly from an adversarial approach — even if ultimately found not to have been at fault (for example, as shown by the testimony of a general practitioner facing a writ for case of cerebral palsy for a birth that occurred 20 years previously — Kerr 2004).

17.7 People's freedom

No-fault systems usually extinguish people's common law rights for at least one head of damage (predominantly lifetime care and support). In Australasia, New Zealand is unique in extinguishing virtually all common law rights for all accidents. Where a scheme extinguishes common law rights, it means that third party insurers (such as the NSW LTCS Authority or the Victorian TAC) determine the amounts and nature of supports. In contrast, access to the (unconstrained) common law allows people to:

- attempt to get larger compensation payouts
- obtain a lump sum payment, which they can choose to spend as they wish. Lump sum payments are the ultimate form of 'self-directed funding' (see chapter 6). However, it should be noted that lump sum settlements and court awards may be held by a third party in trust (for children and some adults with diminished decision making abilities).

Accordingly, extinguishing common law claims diminishes freedom of choice, which is often highly valued by people and can enable them to allocate resources to the spending areas that match their preferences and heterogeneous needs (Maurice Blackburn, Slater and Gordon and Shine lawyers, sub. 392, p. ii). The Law Council of Australia was very concerned by any move to constrain common law rights:

> It is also not appropriate to deprive disabled people of choice, by compulsorily requiring them to enter into a prescriptive scheme for life, where all decisions are subject to the approval of the scheme's managing authority (as is the case under the NSW Lifetime Care and Support Scheme …). (sub. 375, p. 5)

Similarly, personal injury lawyer, Mark Blumer, recently commented in a public presentation about the proposal for an NDIS that because no-fault compensation systems take away people's enforceable (common law) rights, they must include a review mechanism that maintains practically enforceable rights regarding whether or not a particular treatment, rehabilitation or type of care is needed. Similarly, the Australian Lawyers Alliance suggested that the review mechanism under the NSW LTCS scheme suffered a 'natural justice problem' and that:

> Any scheme introduced as a result of this [Productivity Commission] inquiry should allow for an appropriate and properly funded way for decisions of the care-funding authority to be tested in a transparent way. (sub. 305, p. 10)

The tendency of individuals to object to what may be viewed as paternalistic features of no-fault systems will vary, often depending on the particular event that gave rise to their injuries. For example, the psychological trauma (pain and suffering) faced by victims of criminal violence or assault may call for an appropriate balance between:

- a victim spending their compensation in a way that is meaningful and enables them to 'feel' compensated and empowered. As summarised in Hull's reading speech about the purpose of special financial assistance to Victorian victims of crime as to:

  > …acknowledge a victim's suffering — not dictate to victims how they should spend their award. The victim is in the best position to decide for themselves how best to use their money. If they see fit to spend it on paying off their mortgage or gas and electricity bills, going on a family holiday, buying a red coat, or even setting up a fund to assist in the search for an alleged offender, then it is a matter for them and not government. (Victorian Hansard, 26 May 2000, p. 1912)

- allocating it in a way that encourages it to last over time (which could continue to remind them of the traumatic event) or be put towards more sensible, albeit less meaningful, uses. (This issue is taken up in chapter 18 and appendix I.)

There are a number of counterarguments to the issues raised about the reduced freedom implied by the removal of common law rights. First, while freedom of choice has value, it has to be weighed up against any costs of fault-based systems and any advantages for the wellbeing of people through alternative insurance arrangements.[23] Freedom of choice per se, is not a sufficient basis for maintaining all common law rights.

Second, the Commission envisages a greater role for self-directed funding in the proposed new arrangements for the disability system and injury schemes, so the capacity to choose among supports need not be missing in a no-fault system.

Finally, as already discussed, it is not practical to remove a person's right to taxpayer-funded supports if a person has exhausted their lump sum secured through litigation. In that case, successful litigants can free-ride on taxpayer-funded supports. Taxes are coercive mechanisms — people cannot choose to be taxed or not. So the freedom of choice exercised through the common law can entail loss of freedom for other people forced to subsidise it.

Consequently, from a practical perspective, it is difficult to support the notion that fault-based systems provide people with more meaningful or widened choices compared with no-fault systems.

[23] Notably, compulsory third party insurance (which underpins both fault and no-fault systems) also reduces freedom, as people cannot elect to self-insure. That reduction in freedom is justified by the fact that many people negligently harmed by a self-insured party would not get adequate compensation because the defendant's liability would be limited through bankruptcy provisions.

17.8 The value of 'justice'

Is it 'just' to compensate victims only?

Many in the community might regard the common law as appropriately one-sided in its compensation arrangements, with justice being served by no compensation for the at-fault driver.

However, consider the most negligent of cases, say a highly intoxicated young man, driving an unregistered vehicle at speed who severely injures both himself and the innocent party. Most people would regard it as repugnant to leave the at-fault young man without any support (surgery, rehabilitation, a wheelchair), accepting the legitimacy of meeting some basic level of need for services. Under current fault based arrangements, a generally inadequate level of support would be provided through the general disability system and the social welfare system, with the gap in injury-related needs filled by family, charity and other informal arrangements. So ultimately, the at-fault party would 'get by', albeit mainly relying on taxpayer-funded health and disability services and transferring a significant proportion of their injury-related costs to other parties providing informal supports.[24]

No-fault arrangement could have provision to differentiate between people's access to scheme benefits in a way that could incorporate some common law attributes (if judged appropriate). For example:

- on the one hand, access to a particular scheme benefit could be limited to only those people whose injury was caused by the clear culpability or egregious actions of another person
- on the other hand, access to some benefits could be denied if there is evidence of deliberate recklessness in causing your own injury.

That said, it is reasonable to expect the community would have limited appetite to restrict access to benefits for many instances of catastrophic injury — perhaps, only to restrict benefits made available in lieu of a person's 'pain and suffering'. Nevertheless, the relevant point is that the common law would not be the only way of achieving such an end, *if* it were regarded as desirable.

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[24] No-fault motor vehicle accident schemes variously exclude or reduce payments (for impairment and income benefits) and restrict access to some services to drivers who are convicted of culpable driving under the relevant legislation, were driving under the influence of alcohol or other drugs, were uninsured, or not in possession of a licence.

The principle of collective responsibility for the costs of injury has a long pedigree in attempts to integrate personal injury law with social welfare principles, and was strongly advocated in the Woodhouse Report (1967). This report continues to guide the remit and operating principles of the Accident Compensation Corporation in New Zealand, and recognised that injuries caused by accidents are often the result of a complex series of events, involving multiple causes and agents, and that personal choices are socially embedded. In particular, Woodhouse argued a parallel responsibility for accidents is shared between:

> … groups, networks, organisations, corporations and government agencies ... Their success depends on social coordination, not just assertions of personal choices. (Report of the royal Commission of Inquiry [Woodhouse report] 1967)

This recognises, for example, that a person may make a small 'mistake' that anyone might make (say a momentary slip in attention), but which results in the injury of another party. International empirical evidence suggests that it is common for 'good' drivers to make such mistakes, with the most common cause of accidents being carelessness and lack of attention, rather than reckless or deliberately aggressive driving (Pearson Royal Commission Report 1978). And such accidents are common, with nearly one in five individuals reporting having been involved in a road crash in some capacity over the last three years (DITR 2010, p. 81).

Accordingly, looked at more closely, the common law does not appear to generally achieve a just discrimination between an at-fault and innocent party, in many cases because 'fault' lacks a moral dimension. That is, many injuries caused by a person deemed to be negligent (under the common law) are not always easily categorised into the 'victim/perpetrator' model.

The 'retributive' function of the common law

People suffering negligent injury from another party often want to punish that party through financial penalties — 'making them pay'. In *theory*, the common law provides one avenue to do that by imposing a financial penalty on that party. As stated by the Australian Lawyers Alliance:

> If tort law becomes incapable of recognising important wrongs, and hence incapable of righting them, victims will be left with a sense of grievance and the public will be left with a feeling that justice is not what it should be.' (sub. 305, p. 16) … It is considered apt that a wrong doer be liable to "correct the wrong" and not the public purse. (sub. DR843, p. 4)

In practice, however, the capacity of the common law to 'right wrongs' is limited because of the role of the insurer. Indeed, the factors that generally reduce the capacity of the common law to create incentives for care also undermine the

capacity of the common law to provide an avenue for retribution. And, the mechanisms that could effectively be used for retribution — criminal charges, de-registration of professionals, loss of licence — are available whether or not a common law fault–based system is in place. Moreover, as noted above, many cases involving common law negligence are the result of everyday common mistakes that anyone can make.

It appears the Law Council of Australia also acknowledge the limitations of the common law for this purpose. They even contest that the retributive function of the common law is relevant to its modern justification at all, stating that it is:

> … incorrect to identify 'retribution' as a central justification for the common law. … the focus, therefore, is on what is required to restore the plaintiff to their pre accident disposition, rather than what reparations would amount to an appropriate punishment for the defendant. (sub. DR948, p. 19)

On the other side of the coin, however, some cases of negligence cross criminal boundaries, and this is where victims' and society's desire for compensation as a form of retributive justice are likely to be greatest. To address this, some no-fault systems retain exemplary damages — intended to punish the defendant by requiring them to pay compensation to the plaintiff over and above the amount of compensation necessary. For example, these are available alongside New Zealand's no-fault accident scheme. However, exemplary and aggravated damages (collectively termed punitive damages) are no longer universally available in Australia following the suite of reforms commenced in 2002 to abolish these damages in personal injury cases (Australian Government 2004, p. 97).

In summary, neither fault-based or no-fault systems address people's desire for retributive justice, and so this cannot be used as a criterion for weighing up alternative insurance arrangements.

17.9 Providing incentives for people to avoid injuries

While many injuries are the result of pure accident, many could be prevented if people changed their behaviours. Poor occupational and health standards, substance abuse, dangerous driving, weak adherence to professional standards, faulty products and generally engaging in risky behaviours can cause injury to a person and to others. To the extent that a risk is observable and able to be changed, the goal of policy is to reduce the costs of people's risky behaviours. For instance, although age and gender are statistical risk factors in causing road accidents, people cannot alter these specific characteristics. Even still, it may be possible to modify behaviour, such as decisions about vehicle type, including by discouraging the use of high

powered motorbikes and heavily modified performance vehicles, having zero tolerance of alcohol consumption and requiring appropriate training.

People are less likely to take account of the full costs of their risky behaviour when they are unaware or misinformed about the capacity to cause injury, and especially if the costs of injury are borne by others. Policy attempts to correct people's incentives to take care, avoid risks and hence reduce injury. What level of policy intervention is appropriate however, depends on how direct costs and benefits accrue from incremental changes in levels of safety, vis-à-vis the costs and benefits of some risk taking. (Achieving zero risk would be very costly and undesirable.)

There are many policy approaches to increasing safety and reducing the likelihood of accidents, such as regulation; guidelines, protocols and standards; raising awareness; changing technologies; 'naming and shaming'; fines, criminal prosecutions for breaches of laws and — relevant to this chapter — the deterrent effects of civil litigation. In that vein, the Law Council of Australia has emphasised the importance of civil litigation as a deterrent:

> … common law compensation systems perform an important regulatory role, deterring or discouraging negligent behaviour by requiring responsibility and restitution. (sub. 375, p. 11)

The deterrent effects of litigation may arise in several ways.

The direct monetary effect

People causing injury to others may have to pay compensation — creating direct monetary incentives to avoid negligence. However, this argument has little relevance to common law cases involving serious injuries, since in most instances the party at fault is covered by insurance.

In theory, strong monetary deterrence against negligence would apply to cases in which an at-fault party is not insured. In that instance, the person would be liable to pay compensation personally. For example, this would arise in cases involving criminal injury or a negligent party driving an unregistered vehicle. (In the latter case, such people have significantly higher odds of being in an accident resulting in injury). However, in most instances of injury caused by a person (as compared with a corporation), such people have no capacity to pay compensation anyway ('judgment proof'), and so the apparent deterrence effect is absent.[25]

[25] As an illustration, the Queensland Nominal Defendant provides personal injury insurance to people injured by uninsured (or unidentified) drivers. In 2009–10, the value of such claims and associated settlement costs were nearly $30 million, of which it recovered around $650,000

The reality is that the effective capacity to seek common law damages in personal injury goes hand in hand with the existence of insurance (Justice Kirby 2000), which in turn, blunts the deterrence effects claimed for the common law (especially when there is limited application of experience rating — see below (Harris 1991).

The insured still have some incentives to be careful

Even where people insure against the majority of the monetary risks of civil litigation, insurers structure their policies to address moral hazard and ensure parties still have (at least some) incentives to take due care. In particular, insurers have strong fiscal incentives to manage moral hazard to protect their financial viability from growth in claims and costs.

In the event of an accident in which a policyholder is at-fault and a common law claim against them is successful, they:

- may have to do certain things such as put in place risk mitigation strategies before being able to get insurance cover (for instance, workers' compensation insurance goes hand-in-hand with compliance with OHS standards; and medical indemnity insurers finance clinical risk management programs).
- will still have to pay a front-end deductible to their insurer
- may face higher risk-rated premiums in the future if they fall into a higher risk category (experience rating). In some cases, no insurer will cover them, and where insurance is mandatory (workers compensation, CTP and in some jurisdictions medical indemnity), this will often disqualify them from legally undertaking the activity that leads to the risks. For instance, a high-risk medical practitioner may not be covered to perform certain procedures, usually triggered by an unusually high number of claims against a practitioner.

Of these, experience rating, and risk rating more generally, has the potential to have a significant effect on excessively risk-taking behaviours. As stated by one participant about insurance for WorkCover and public liability:

> Tortfeasors have significantly higher premiums for years to come. This is very effective in helping to ensure a safer public and work environments as there are consequences for negligent tortfeasors. (KM Splatt and Associates DR647, p. 3)

Some have criticised no-fault systems for paying weak attention to moral hazard. For example, Howell et al. (2002) argued that New Zealand's no-fault accident compensation scheme has resulted in higher than optimal levels of workplace

from the uninsured parties, or around 2 per cent of the total costs (Motor Accident Insurance Commission 2010, pp. 6, 59).

accidents than in systems where common law rights persist. The evidence for that contention is not strong, but to the extent it may be true, their argument primarily rests on the deficiencies of risk rating of the workers compensation fund, and not an intrinsic deficiency in no-fault schemes. No-fault schemes can apply risk rating, and they typically do so to some extent, or at least equivalently to fault based regimes.

A *potentially* important difference relevant to experience rating between common law and no-fault systems is the nature of the information insurers are able to access about the inherent riskiness of a particular driver (or class of drivers). Under fault-based systems, court judgments or settlements reveal the extent of negligence and its costs for the injured party. No-fault arrangements make no judgment about culpability for the purpose of meeting people's care and support needs, but nothing would prevent them from doing so in setting CTP premiums. In that instance, they would need to rely on information from police reports about the extent of fault, and the number and severity of past accident claims. Dionne (2001) describes how experience rating has successfully been applied in Quebec's no-fault motor vehicle accident scheme.

If fault based systems were better able to determine accurately the relative riskiness of drivers than any process that a no-fault system *could* use, then risk rating would be more effective at deterrence under a common law than a no-fault system. However, as discussed above, courts and settlements (which reflect the expected probability of success in the negotiated lump sum) are not a reliable basis for determining the appropriate level of compensation and the extent of fault. As such, it is doubtful, even in this theoretical world, that the common law would possess superior information for setting risk rated premiums.

In any case, there are several practical reasons, some of them regulatory, why the impact of risk rating on moral hazard should not be exaggerated, regardless of whether a common law or no-fault system is present.

- In many instances, risk rating reflects the higher probabilities of accidents for broad groups of people with characteristics that they cannot change (like their age or gender). Deterrence primarily only works if it relates to a risky trait that people can change, although it may work to the extent that it eliminates supply or consumption of a target group. For example, if a fully risk rated premium were applied to young male drivers, it is possible this group would defer the purchase of a vehicle or switch to a safer, lower performance vehicle to the extent that this would lower their CTP premium.
- There are transaction costs of setting risk-rated premiums that limit their effectiveness in reducing negligent behaviours. Many individual characteristics that might be highly relevant to risk are often not observable ex ante (such as drink or aggressive driving, or passive adherence to OHS standards in a workplace).

- Government often place statutory limits on the potential for premiums to vary in accordance with efficient risk-rating — especially if there is a negative impact on low income groups or the supply of certain activities (box 17.4). In the case of medical indemnity, the Australian Government subsidises the insurance system to ensure premiums are not too high for certain groups of clinicians. Given these regulatory and budget measures, insurers do not set fully risk-rated premiums.[26] In particular, the capacity for an insurer to deter reckless driving through a bonus/malus[27] is typically bounded.
- In the motor vehicle area, the price effects of risk-rating and the imperfect monitoring of unregistered vehicles encourages the riskiest people with the most limited resources to (illegally) opt out of compulsory third party insurance.

This does not mean that risk rating is unworkable. There may well be advantages in some forms of experience rating (such as higher premiums and larger excesses for drivers with past costly claims for which they were at fault), and relaxation of some of the government rules that limit the potential to vary premiums accordingly.

However, as already alluded, experience rating need not be the exclusive domain of common law insurance systems (administrative processes already in place mean that no-fault insurance systems have a similar capacity to apply experience rating if sought). Potentially, this is a useful feature of no-fault systems, especially given the significant costs of establishing a person's culpability for causing an accident under the common law.

Given the above arguments, it is unlikely that fault-based systems address ex ante moral hazard better than no-fault systems. In some ways fault-based systems may even perform worse, such as in the presence of the high discount rates in some jurisdictions, which systematically reduces the likelihood of full compensation and efficient risk-rating by insurers. Moreover, given the lump sum nature of compensation paid out to injured people under the common law, it is possible that there is a higher risk that people seeking common law compensation exaggerate the severity of their injuries, with the costs that imposes (a form of 'ex post moral hazard').

[26] In New Zealand, the situation is even more striking than in Australia. Even after partial adjustments for risk, premiums for the highest engine capacity motorcycles are only around one tenth of the actuarially fair amount (Office of the Minister for the ACC 2010).

[27] A bonus is a reduction in the premium otherwise payable to reflect good driving behaviour and claims history, whereas a malus imposes a penalty, or higher premium, for evidence of bad behaviour.

Box 17.4 **Risk rating in compulsory third party insurance**

Reviews of CTP premiums and compensation schemes frequently state the importance of capacity to pay when setting premiums. As a result, the flexibility of insurers offering CTP motor insurance is tightly controlled. Insurers' discretion to adjust premiums by offering a bonus or imposing a malus is limited in some jurisdictions according to specific regulations creating a maximum premium[28], or by prohibiting zone or age differentiation, such as in Queensland.

Although the compensation models adopted across jurisdictions range across modified common law schemes to government monopoly no-fault cover, premium charges are quite similar across jurisdictions when expressed as a percentage of AWE. If annual premiums start to track above 40 to 50 per cent of average weekly earnings, governments typically respond by placing additional restrictions on judicial access (through civil liability laws or other statutory provisions) or reducing entitlements (Cutter 2007). As stated in a comparison of CTP schemes across Australia:

> Clearly the compensation model in each jurisdiction is tailored to achieve an affordable CTP premium. In some cases clear interventions (eg. MACA 1999) have been introduced in order to achieve this. (Cutter 2007)

The main implication of governments seeking to create affordable and stable premiums is that insurers are unable to charge an actuarially-based 'fully funded' premium. Despite insurers' attempts to sort risk types according to a number of categories (age, experience, driving and accident record and vehicle type), this is only partially successful at sorting drivers into homogenous groups. Consequently, insurers take care to market strategically and price relative to their competitors in such a way that reduces bad risks and attracts good risks:

> The bonus/malus limitations mean that insurers are not able to charge 'sound' rates for every risk. Better risks are written via a mixture of pricing and marketing strategies, and ensuring that prices relative to competitors are where they need to be, i.e. higher than competitors for the worst risks and lower than competitors for the best risks. … The interaction with competitors is more important than technical rating …(Konstantinidis et al. 2007).

The key underwriting risk factor used by CTP motor insurers is age, and in particular, drivers under 25 years, who on average, generate a loss in excess of 100 per cent, even at the maximum allowable malus (Konstantinidis et al. 2007). Hence, CTP insurers seek to avoid such risks by charging a price for young drivers that is higher than competitors. In a non-market situation, where there is a monopoly provider (such as the government), there is no discretion to sort risks and deter less profitable drivers, but this is overcome to the extent that the single provider can deliver better risk-returns on other drivers.

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[28] For example, in NSW, if an insurer's filed base premium is set close to the reference base rate, there is greater scope to impose a penalty for malus. A premium discount is limited to 15 per cent, or 25 per cent for over 55 year olds (the MAA Premiums Determination Guidelines, Section 24 of the *Motor Accidents Compensation Act 1999).*

Other measures are more likely to provide effective deterrence

In summary, there are three main reasons why fault-based systems are unlikely to strongly deter negligence compared with no-fault systems:

- people at fault who are not covered by insurance rarely have a capacity to pay compensation, significantly weakening any deterrent effects of the common law in personal injury for such people (who often tend to have the highest risks)
- by pooling risks, insurance reduces the extent to which an at-fault party bears the financial consequences of his or her action
- risk-rated insurance (including the use of experience rating) could theoretically provide incentives for care, but risk rating tends to be blunt and could, in any case, be applied in no-fault systems.

Moreover, as noted earlier, the common law is only one tool in the armoury of policy measures that can encourage better injury mitigation, with the other tools being generally more efficient (as the Commission noted in its review of workers' compensation and occupational health and safety arrangements in Australia — PC 2004).

Recognising the muted capacity of common law deterrence in the context of compulsory third party insurance, some have suggested that the common law is not well equipped to deal with the broader concept of 'accident prevention', which requires:

> …careful attention to environmental design, public education, group interaction, organisational cultures and political coordination. Any modern policy of accident prevention that does not consider these strategies will miss the important health and safety challenges of the coming century. (Gaskins 2000)

That said, the common law is likely to have some deterrence effects in some cases. As Justice Kirby (2000) has noted in respect of medical malpractice suits:

> The allegation of professional negligence is not only potentially costly. It is also personally insulting. It is emotionally hurtful. It tends to attract media coverage. It gets known around the profession. It is damaging to one's ego and practice. Defending it is distracting and time-consuming.

The question is whether the size of that effect is sufficient to outweigh the costs of the common law fault-based systems. Given the costs described later (section 17.10), and the prospect of relatively weak deterrent effects, the answer is probably no. This was also the conclusion of Cane:

> There is a significant body of empirical research about the deterrent efficacy of the tort system, which can perhaps be summarised by saying that tort law has more deterrent effect in some contexts than others, but in no context does it deter as effectively as economic theory of tort law would suggest. … because there is considerable doubt about the deterrent efficacy of tort law, and given the availability of much cheaper

> compensation mechanisms, the conclusion that tort law is not worth what it costs is an attractive one … (2007, pp. 55–56, 69)

Given such doubts about the deterrent effect of fault-based compensation systems, the Australian Medical Association (sub. 568, p. 10) argues against the use of high premiums and claim costs as a discipline on practitioners. They cite a range of professional safeguards (including the national registration mandatory reporting regime and the health complaints system) as superior alternatives.

In any case, the policy choice is not only between two options — common law rights on the one hand, and a no-fault system with no common law rights on the other. In the Australasian context, only New Zealand has completely barred the gate to common law rights in injury cases. Most Australian insurance systems are hybrids.

17.10 Efficiency and costs

All insurance systems entail costs beyond those of providing care and support and other forms of compensation to the injured party. In no-fault systems, claim numbers are higher because people at fault (or unable to find the fault of another party) also make claims, and staff also perform roles, such as coordinating care and support, not usually undertaken by insurers in (pure) fault-based systems. On the other hand, in fault-based systems, the insurers must meet the usual costs of any insurance business (claims management, financial management and so on), but also face costs associated with their own legal expenses (and any obligations to pay external legal costs).

Such costs are not necessarily wasteful, as at least some administrative 'inputs' are required to secure care and support for an injured person. However, an important policy question is the competing cost-effectiveness of fault-based versus no-fault systems. If one system can deliver equal or better services at lower costs, then the increment in costs in the other scheme *can* be seen as 'waste' in the sense that it diverts resources that could be used to help injured parties better (or to lower insurance imposts on people).

These issues are discussed below.

Administrative costs

The available evidence from no-fault systems suggests relatively low administrative costs. For example, the ratio of administrative costs to premium income in NSW Lifetime Care and Support scheme was around 3 per cent in 2009-10 (LTCSA NSW

2010b, p. 22).[29] It was significantly higher for the Victorian TAC scheme, which covers all types of motor vehicle accidents and some residual common law rights, at 14.1 per cent of TAC premium income in 2007-08 (TAC 2009a p. 45).[30] Administrative costs were 9.9 per cent of premium income in the New Zealand scheme (ACC 2010d, pp. 18, 47). In the Tasmanian CTP scheme, general and administrative expenses were around 4 per cent of net premium income (MAIB 2010, p. 22, p. 26).[31]

The various components of administration expense items should be interpreted carefully, however, as higher 'costs' may not necessarily represent wastage depending on what the expense is incurred for and whether the outcome is achieved. For example, while no-fault systems administering long-term weekly payments face an additional administrative burden above fault-based systems that mainly pay lump sums, weekly payment of benefits has the advantage of preventing mismanagement of lump sums. Similarly, sometimes injury management and return to work research is included in scheme administration expenses.

A further cost pressure on fault-based systems are reinsurance costs and costs of capital. Under (pure) no-fault systems, there are more claims, but these are more predictable than the fewer but sometimes larger claims under common law fault-based arrangements (for example, see Walsh et al. 2005, p. 39).

There is some evidence that fault-based systems have somewhat higher ratios of administrative costs to premiums, *before* counting any costs associated with explicit and implicit claims for legal and other litigation costs (Cutter 2007; WRMC 2009, p. 33). That raises the question of the size of those litigation costs since they are instrumental in determining the relative cost-effectiveness of the competing schemes.

What affects the size of litigation costs?

The magnitude of litigation costs reflects many influences, including:

- the role of mediation, which reduces costs compared to a court hearing, since the major influence on total costs is the stage of settlement

[29] Administrative costs include all personnel costs, operating expenses, consultancy, depreciation and various other costs. The low proportion of administration expenses in premium income reflects the immaturity of the scheme, with many participants not yet living in the community and requiring coordination services.

[30] The ratio is higher in 2008-09, but affected by the one-off costs of the re-location of the TAC, and therefore not representative.

[31] additional costs were associated with accident prevention, but these are not intrinsic to the normal insurance function of the Board.

- the duration of litigation. Some cases take several decades to resolve. Given that billable hour is the dominant method for charging, each additional six months a case takes to resolve was estimated to raise costs by 7 per cent (Williams and Williams 1994)
- the complexity, novelty or difficulty of cases, which often need expert testimony); facts and expert evidence are often relied upon heavily to establish the circumstances of an accident and the legal liability of another party
- statutory limits on litigation (or its costs). Civil liability laws were changed in each jurisdiction in 2002, which among other changes, limited access to damages and the amount of damages awarded (Chu 2007). These changes are likely to have increased the costs of navigating a successful case through the now tighter legal structure:

  > … what the statistics [on the number and value of claims] do not show is whether the costs of each litigated claim has increased through more rigorous preparation — my sense is legal costs have increased. (Chambers 2007)

- the negotiating muscle of the consumer, and in particular, differences between the plaintiff who consumes personal injury legal services at most once in their life, compared with the insurer (defendant), who repeatedly consumes these services and usually maintains in-house expertise.
  - Plaintiff law firms often engage a cost consultant with specialist expertise in providing costing advice and preparing an itemised bill of costs for the law firm. Estimates available to the Commission indicate that the use of cost consultants is highest for medical negligence claims (80 per cent of claims) versus only about 50 per cent for non-medical negligence claims.
  - The Senior Masters' Office in Victoria negotiates solicitor-client costs to achieve sizable savings for their client beneficiaries in most instances. Information available to the Commission shows a 15.5 per saving on these costs is achieved on average. This reflects the extensive experience of the Senior Masters' Office in dealing with plaintiff lawyers on behalf of their trustees and a detailed understanding of what constitutes reasonable fees and charges.

Some estimates of legal costs

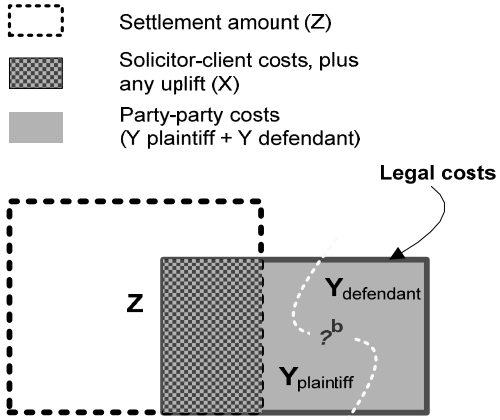
While it is straightforward to identify the factors influencing litigation costs (including fees, disbursements and charges), enumeration of them is hamstrung by a paucity of systematic, publicly available information on legal fees and charges.

Given the distribution of who ultimately bears legal costs — between plaintiffs and their solicitors, insurers (defendants) and, in turn, premium payers — the visibility of legal process costs varies but is generally poor.

Figure 17.3 is a stylised representation of how common law insurance allocates resources between the settlement awarded to a successful plaintiff ('Z') and legal processes including:

- party-party costs 'Y' (box 17.5), which are incurred separately by the defendant's insurer and the plaintiff
  - if a plaintiff is successful, they do not generally bear any party-party costs, with these costs ultimately borne by premium payers (which, if lower, could otherwise enable reduced premiums or increased benefits to injured parties)
  - if a plaintiff is not successful, they may be liable to pay the defendant's costs *and* some of their own disbursements.
- solicitor-client costs 'X' (box 17.6), including any uplift. These costs are taken directly from the plaintiff's settlement.[32]

Figure 17.3 **How do 'legal costs' relate to the settlement amount?**[a]



[a] This is a stylised representation informed by personal communication with the Victorian Senior Masters' Office. [b] The split between plaintiff:defendant party-party costs varies. For motor vehicle cases, estimates of the average ratio range from 80:20 to 60:40. For medical negligence, it is understood a defendant's party-party costs often exceed those of the plaintiff.

[32] Although the Commission understands that if a matter reaches court, or if there is a request to have costs assessed by the court, the plaintiff may be able to recover uplift fees from the other side. This relies on the presence of a contractual agreement about uplift between a plaintiff and their legal representation.

Box 17.5 **Party-party costs**

Party-party costs are the costs of litigation that a court can order to be paid by one party to the other party. Party-party costs are sometimes calculated on the basis of the Supreme Court Scale, or a fixed costs model and may be subject to scrutiny if reviewed by a taxing officer of the District Court or a Supreme Court Cost Assessor.

Whether legal fees and charges are claimable as party-party costs generally depends on the cost item being assessed as 'necessary' and 'proper' to attain justice — reasonable charges for work reasonably undertaken. This will vary depending on the circumstances of the proceeding, and a cost may be dismissed if the legal practitioner has not used the most economic alternative (not necessarily the most convenient) to attain justice under the circumstances. As the stage of litigation proceeds, costs allowable generally increase.

In the event that a plaintiff is not successful, or an Offer of Compromise is refused and at the resolution of the case it transpires that such an offer was reasonable, there is the prospect that the plaintiff (or in some instances, the plaintiff lawyer) may have to pay (at least a portion of) the defendant's costs. Similarly, if compensation is not awarded to the injured party, it is likely the plaintiff lawyer will be 'out-of-pocket' by a significant portion of their fees otherwise payable in the event of a successful resolution. In the long term, such losses are recouped through the profits from litigating successful cases.

In attempting to evaluate the size and nature of solicitor-client fees and charges, the Commission was presented with numerous informed judgements but, in general, estimates were not substantiated by rigorous evidence. Overseas estimates can be informative, but are not necessarily detailed to inform policy judgements in an Australian setting (box 17.7). The Commission was able to source some detailed estimates drawn from around 130 cases settled over the period 2009 to 2010 (see table 17.3).

While not necessarily providing numerical estimates, some participants argued that the costs of litigation were very significant. For example, commenting on the inefficiency of the common law in managing access to benefits, the Medical Indemnity Protection Society suggests that the requirement to find legal negligence involves:

> … an inefficient and time consuming process that dissipates resources which in our view could be better applied to outcomes rather than process. (sub. 282, p. 3)

While this view is intuitively reasonable, it is important to assess the actual evidence about the magnitude of the inefficiency. There is some evidence on the issue, but estimates of litigation costs are generally partial in nature. For instance:

- Avant Mutual (sub no. 550) suggested that the party-party legal costs in a cerebral palsy claim would lie between $625 000 and $800 000 out of compensation package lying between $8.9 and $12.3 million, depending on the circumstances of the case. This is around 7 per cent of the compensation amount but this ignores solicitor-client costs (including any uplift fees).

- In Queensland, legal and investigation costs of plaintiffs and defendants for CTP insurance amounted to between 15 and 18 per cent of the claim payments on finalised claims on motor vehicle accidents from 2002—2010 (Motor Accident Insurance Commission, 2010, p. 28).[33] In the ACT, legal costs are slightly higher than Queensland, and equivalent to 19 per cent of premium revenues.
- The ABS estimated that legal fees for personal injuries in Australia were around $1.2 billion in 2007-08, comprising around $410 million for motor vehicle injuries, $350 million for workers' compensation and $450 million for other injury claims (ABS 2009). Fees associated with 'no-win, no-fee' arrangements accounted for about 50 per cent of the total personal injury fees (assuming that 'no-win, no-fee' arrangements predominantly relate to personal injury litigation). These estimates relate only to legal fees from businesses whose activity is mainly legal services. It would ignore legal costs in insurers or other businesses whose major function was not legal.

Box 17.6 **Solicitor-client costs and uplift fees**

Solicitor-client costs are payed to the plaintiff lawyer out of the award or settlement amount. Overall, there is almost no up-to-date and systematic knowledge in the public domain about these fees and charges. This is because in Australia, cost agreements (which also outline 'no-win no-fee' arrangements and 'uplift' amounts) are generally not disclosed outside of the confidential client-lawyers relationship, except if they are assessed by the court, or in the event of a dispute about costs, such as to the Office of the Legal Services Commissioner.

It is common in personal injury matters for the plaintiff to retain a lawyer on a no-win, no-fee basis, which in the event of a loss, waives considerable fees. A written 'conditional cost agreement' outlines how costs are to be re-paid, which may or may not include 'uplift' — success-based fee arrangements charged as a percentage of the total legal costs (see appendix I).

Based on anecdotal information, the Commission understands that somewhere between 30 to 70 per cent of personal injury claims have a no-win, no-fee agreement associated with the claim, which are believed to generate between 15 and 50 per cent of the legal costs associated with a case. From the more comprehensive information the Commission was able to access however, it appears that around 70 per cent of cases have an 'uplift' applied, and given that not all conditional fee agreements will include an uplift, this suggests the prevalence of no-win, no-fee exceeds the upper end of most participant's expectations. In addition, the Commission found that, on average, across all claims (including those with and without an uplift applied), around 28 per cent of solicitor-client costs are accounted for by uplift fees.

[33] Finalised claims covered a range of heads of damage (economic loss, general damages, and care and support). Claims for care, aids and appliances, and home and vehicle modifications were about 9 per cent of the total costs — or 40 to 50 per cent less than total litigation costs.

As mentioned, the Commission was able to obtain comprehensive detail on average solicitor-client costs and (the plaintiff's) party-party legal costs from the Victorian Senior Masters' Office (SMO). This source of evidence covered all common law systems for securing compensation in Victoria — TAC motor accident claims, workers' compensation claims, medical negligence claims and public liability (general injury) cases. The client group of the Senior Master's Office that legal cost information were derived from (table 17.3) predominantly have catastrophic-level injuries[34], and while the estimates appear broadly consistent with a priori assumptions, information on defendant legal costs were not included in the dataset. For this reason, estimates of total legal costs assume the party-party costs of the plaintiff and defendant insurer are approximately equal. Based on other evidence available to the Commission, this appears to be a sufficiently robust assumption.

Table 17.3 **Estimates of legal costs**[a]

Based on 2009 and 2010 settlements

	Solicitor-client costs	*Party-party costs (plaintiff only)*	*Settlement amount awarded*	*Ratio of solicitor-client costs*	*Total legal costs as a per cent of*	
	(X)	*(Y_p)*	*(Z)*	*X/Y_p*[b]	*the plaintiff's net payment $(X+2Y_p)/(Z-X)$*[c]	*total claim cost $(X+2Y_p)/(Z+2Y_p)$*[d]
Compensation	*$ average*	*$ average*	*$ average*	*ratio*	*per cent*	*per cent*
0-250k	24020	34939	145023	0.69	77.60	43.69
>250k-500k	41656	44643	380357	0.93	38.66	27.88
>500k-750k	32048	36938	610682	0.87	18.31	15.47
>750k-1m	73989	96159	918418	0.77	31.54	23.98
>1m	151705	184384	3035502	0.82	18.05	15.29
Cause of injury						
Med. negligence	142224	177348	2614805	0.80	20.10	16.73
Motor	32664	40317	424465	0.81	28.92	22.43
Work	56961	46264	359445	1.23	49.42	33.07
General	52688	83454	568312	0.63	42.59	29.87
TOTAL	56916	70718	839325	0.80	25.35	20.22

a To calculate total legal costs, we have assumed the party-party costs of the plaintiff and defendant are approximately similar. Estimates do not include legal costs associated with 'unsuccessful' cases. **b** ratio of solicitor-client costs to a plaintiff's party-party costs. **c** total legal costs as a per cent of 'in-the-hand' compensation available to the plaintiff to meet injury related losses. **d** total legal costs as a per cent of the 'claim costs' drawn from insurance premiums.

Source: Senior Masters' Office of Victoria.

34 Even though some settlements may appear low (less than $250 000), this is likely to reflect a person's age rather than a less serious injury. The data were de-identified and provided to the Commission as totals and averages for different groups of clients.

Perhaps a more salient finding underlying the estimate in table 17.3 that legal costs comprise about 20 per cent of claims costs is:

- the extent to which legal costs comprise a larger proportion of the claimant's in-hand settlement when compensation is relatively low (over 75 per cent) or, alternatively, the extent to which legal costs are less significant for above average settlement amounts (18 per cent for settlements over $1 million)
- the very wide distribution in how plaintiffs fare, as measured by the spread in solicitor fees and charges paid by individuals in obtaining compensation.

In particular, looking at the proportion of solicitor-client costs taken out of each beneficiary's award, the coefficient of variation — or degree of dispersion from the average — is very large. The large spread in individual outcomes is observed even when calculated within different bands of compensation, and further supports the notion that common law compensation processes can be something of a 'lottery'. For example:

- for settlements of less than $250 000, the standard deviation was over 70 per cent of the average proportion (17 per cent) that solicitor-client costs compose of the injured person's in-hand settlement
- for settlements of greater than $1 million, the standard deviation was 57 per cent of the average proportion (5.2 per cent) that solicitor-client costs compose of the injured person's in-hand settlement
- overall, the standard deviation was 91 per cent of the average proportion (11 per cent) that solicitor-client costs compose of the injured person's in-hand settlement.

These estimates suggest a very wide variation in how individuals fare in terms of the performance and remuneration of their legal representation. To some extent, this may reflect differences in liability risks (and the associated cost of 'success-based fees' (box 17.6)). However, the size of legal costs are just one uncertainty at the end of a line of uncertainties (including the initial uncertainty about whether or not another party can be liable, and hence, whether compensation is payable at all) that individuals face when the risk of acquiring a catastrophic injury is realised.

Box 17.7 **Some overseas estimates of legal costs**

Overseas studies provide some evidence about the magnitude of litigation costs. These are potentially relevant to the Australian context, though estimates can be sensitive to the nature of the tort system in a country.

- In the United Kingdom, the Jackson review of civil litigation costs (2004) found that medico-legal costs represent a very high share of total costs in some classes of personal injury. For example, data provided by the Medical Protection Society (MPS) indicated that the ratio of legal and medical costs to overall costs (which includes payouts to plaintiffs) varied from around 50-66 per cent depending on the size of the claims (appendix 22 of the review). Notably claims dealt with by the MPS outside the UK showed a nearly identical cost structure, suggesting these data may be relevant to Australia.
- In the United States, there is (dated) evidence that only 50 percent of total malpractice costs go to patients (Thorpe 2004) and that average litigation expenses associated with aircraft accidents were just under 30 per cent of total payouts (Luu 1995).
- Data from the United States suggests tort costs in 2008 were US$255 billion or 1.8 per cent of GDP (Towers Perrin 2009). Of this, personal tort cases (mainly motor vehicle injuries) represented US $94 billion. Medical malpractice was a major component of the remaining tort costs. These tort costs included legal costs, administrative expenditures of insurers, and benefits paid to plaintiffs. Administrative costs are features of any insurance system, not just ones relating to the liabilities of common law actions. Moreover, benefits paid to plaintiffs are not litigation costs, but transfers from one party to another. In past studies, these benefits accounted for about 45 per cent of the total costs (Chimerine and Eisenbrey 2005). In that case, litigation costs would be around 30 per cent of the total tort 'costs' identified by Towers Perrin.

The implications of costs

Putting aside other heads of damage, insurance premiums to finance claims for lifetime care and support must cover four basic costs:

(i) the costs of lifetime supports for an injured person. Two influences affect the relative size of these costs in a fault versus no-fault system. The most important is coverage. For any given insured population, the total value of these costs is lower in a fault-based system than a no-fault one, simply because far fewer people are able to make claims in the former. A second influence is the average claim, which will depend on the distribution of injury costs for at-fault and 'innocent' injured parties, and the extent of scheme generosity for a person with a given injury rating

(ii) any costs associated with coordination of care and support. These costs will typically be zero for a fault-based system, but may partly be picked up as costs in the health care and disability sector more generally

(iii) the standard administrative costs of any insurer (including reinsurance, claims management, depreciation and so on). These costs are similar for both fault and no-fault systems.

(iv) any litigation costs (whether explicit in party-party form or implicit as a share of the compensation payouts). These are zero in pure no-fault systems and significant in fault-based systems.

Table 17.4 sets out the implications for efficiency of a fault-based system that has low coverage, some legal process costs, but no care coordination costs compared with a no-fault system that covers all claims and has some coordination costs, but that has no litigation costs.

The table is illustrative, but the parameters underlying it are consistent with some of the estimates of costs provided to the Commission. There are several ways of conceptualising the inefficiency in this illustration:

- The first is the total cost per claimant associated with providing identical lifetime supports (item 14/item 2). Using this metric, the no-fault system can provide the same support and care services for 19 per cent lower costs than a fault system (item 19). This is an underestimate of the real cost differential between the two systems since the impact of the same value of support and care expenses on the quality of life of the injured person is likely to be greater under the no-fault option given that it allocates resources to coordination (item 10).
- The second is the reduction in support and care services under a fault-based system (item 20) that would lead to a cost per claimant identical to the no-fault system. The no-fault system can deliver nearly 33 per cent more services than the fault-based system for the same price (item 21). (And for the same reasons given above, this will underestimate the real service advantage of the no-fault system.)

While table 17.4 uses indicative numbers, even significant departures from the key underlying assumptions still suggest that a no-fault system is likely to be more efficient than a common law fault-based system.

Table 17.4 **Illustration of the impacts of legal process costs on efficiency**

N	*Cost category*		*At fault*	*No-fault*
(1)	Costs of lifetime care and supports per injured person ($m)[a]		2.0	2.0
(2)	People claiming (number)		200.0	400.0
(3)	Total lifetime support costs ($m)	(1)*(2)	400.0	800.0
(4)	Solicitor-client fees as a share of settlement/judgment amount (%)[b]		11.0	-
(5)	Solicitor-client fees, including any uplift ($m)	(4)/(100-(4))*(3)	49.4	-
(6)	Total value of settlement/damages award ($m)	(3)+(5)	449.4	800.0
(7)	Ratio of party-party costs to value of awards[b]		0.17	-
(8)	Party-party costs $m	(6)*(7)	76.4	-
(9)	Ratio of care coordination costs to support costs		-	0.05
(10)	Care coordination ($m)	(3)*(9)	-	40.0
(11)	Ratio of administrative/operating costs to value of claims		0.12	0.12
(12)	Administration and operating costs ($m)	(11)*(6)	53.9	96.0
(13)	Total legal process costs ($m)	(5)+(8)	125.8	-
(14)	Total costs ($m)	(3)+(10)+(12)+(13)	579.8	936.0
(15)	Legal/medico costs as a share of total costs (%)	(13)/(14)*100	21.7	-
(16)	Insurance policies (million)		14.0	14.0
(17)	Premium needed to recover costs ($)	(14)/(16)	41.4	66.9
(18)	Total costs per claimant ($m)	(14)/(2)	2.90	2.34
(19)	Premium cost advantage (%)		..	19.3
(20)	Support provision associated with same premiums ($m)		1.51	2.0
(21)	Service level gain (%)		..	32.7

a In order to make 'like for like' comparisons, it has been assumed that the average injury costs of a person that cannot ascribe fault to a third party are identical to the average for a person that can identify an at-fault party. **b** based on SMO data as used in table 17.3.

Source: Commission calculations.

17.11 The performance of common law systems of fault-based compensation

The Commission identified a range of criteria against which to judge the performance of fault-based versus no-fault systems. Information about some aspects of the two systems is incomplete (especially in relation to costs). However, a no-fault system:

- provides much more predictable care and support over a person's lifetime, especially for people needing such supports over the longer run. In particular, no-fault insurance schemes explicitly focus on the health, functioning and participation outcomes of their clients on a life-time basis, including through care coordination, ongoing case management and monitoring client outcomes through systematic information management
- provides consistent coverage of all parties acquiring a disability through an injury, regardless of the circumstances of how the accident occurred, and

recognises that most apparently at-fault parties have merely made commonplace miscalculations, rather than acted maliciously. In the event of clear recklessness, a series of disciplinary mechanisms exist, or could be augmented, to punish perpetrators, potentially extending to punitive court actions or even criminal sanctions

- does not adversely affect people's incentives to improve their functioning following an injury
- does entail reduced capacity for choice to the extent that the right to common law actions are extinguished, though it would be possible for some common law rights to co-exist with a no-fault system
- will probably not meet all people's desire for 'punishment' of an at-fault party. However, the common law does not achieve a different outcome because at-fault parties are insured, and as noted above, much apparent negligence has no moral aspect. (While the potential for reputational damage from allegations of professional negligence would provide some deterrence, as noted by Kirby (2000), in practice, it is not clear that this increases broader safety due to poor disclosure of errors to enable future prevention and systemic changes.) Even still, there are still other avenues, including police charges, loss of licence, complaints about professionals and registering of professions, such as occurs for health practitioners
- probably has an equivalent capacity to deter excessive risk by using risk (and experience) rating in providing insurance cover (and neither system is a particularly powerful force for reducing injury rates against a background of insurance, other policies addressing excessive risk taking and people's own desire to avoid injury to others)
- is likely to be more efficient (that is, more care and support for each premium dollar).

Overall, no-fault systems are likely to produce generally superior outcomes compared with fault-based systems. This assessment is consistent with the findings and recommendations of past official inquiries and reports that have investigated the matter. These include: the 1967 New Zealand Royal Commission of Inquiry into Compensation for Personal Injury; the 1974 Australian National Rehabilitation and Compensation Committee of Inquiry; the 1981 New South Wales Law Reform Commission Inquiry into Compensation for Personal Injury and Death from Motor Vehicle Accidents; the 1986 Victorian Government Statement on Transport Accident Reform; and the 2004 Productivity Commission report on National Workers' Compensation and Occupational Health and Safety Frameworks

That said, there are many questions about how to design a no-fault injury scheme and to determine its exact boundaries and pathway to implementation. Those are the concerns of the next chapter. The design of any new no-fault arrangement, including its interaction with residual common law entitlements, will be key, not only to ensure complete coverage, but also to ensure improved participant outcomes.