THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: GUlw:1131099

6 May 2016

CTP Review
State Insurance Regulatory Authority
Level 25, 580 George Street
SYDNEY NSW 2000

By email: ctp_review@sira.nsw.gov.au

Dear Sir/Madam,

Review of the NSW Motor Accidents Compulsory Third Party Scheme ("CTP Scheme")

Thank you for the opportunity to comment on the Government's options for reform of the NSW CTP Scheme as outlined in its Options Paper, released on 11 March 2016. The Law Society was also pleased to be represented at the Roundtable meeting of stakeholders on 23 March 2016 and at subsequent Working Group meetings.

1. Background

A review designed to improve the scheme for the benefit of road users can be commended. However, the Law Society believes it is important to keep clearly in mind while considering options for reform, and the Government's identified objectives, the fact that the main objective of the scheme is to provide benefits and support in relation to compensable injuries sustained in motor vehicle accidents.

A fair CTP scheme is one in which injured road users receive compensation which puts them financially in as close a position as possible to their pre-injury position. Fair compensation will include enabling injured road users to obtain the medical treatment required for recovery, and the sums necessary to replace loss of earnings.

The current NSW scheme is generally a fair scheme and the Options Paper acknowledges that the benefits provided under it are considerably higher than in most other Australian jurisdictions. This is something about which the NSW Government should be proud.

While the Law Society accepts that there is scope for improvements to the scheme, in particular to address the substantial increase in legally represented small claims, it submits that it is also a fundamentally sound scheme.

The Law Society broadly accepts the four identified objectives of the Government's reform, which are to:

- Increase the proportion of premiums received by injured motorists
- Reduce the time taken to resolve a claim

- Reduce opportunities for claim fraud and exaggeration
- Reduce the cost of green slip premiums.

We note that the Government has attached competitiveness amongst insurers to the objective of affordability on the basis that this helps to ensure motorists do not pay more than they should.

Each of the recommendations made by the Law Society seeks to address some or all of these objectives. It should be noted that there will be some internal conflicts in these objectives and some compromises will be necessary. For example, the more thorough investigations that are proposed to address the objective of reducing fraud and exaggerated claims may increase the time taken to resolve claims.

The existing policy goals for the Government are that the scheme should be affordable, sustainable and efficient. The Law Society notes that the Independent Review of Insurer Profit within the NSW CTP scheme dated October 2015 concluded that

> Broadly the Scheme continues to meet its original policy goals of affordability, sustainability and efficiency[1].

We believe the objectives set out in the Options Paper can be better achieved by modifying the current fair and sound scheme, rather than embarking on a wholesale redesign of CTP insurance with all the risks that entails. There is some uncertainty around the final direct and indirect impacts of any change in a motor accident compensation scheme[2].

The Law Society submits that once the identified issues relating to scheme integrity set out on page 8 of the Issues Paper are dealt with, there remains a scheme which has proven stable and predictable with respect to moderate and severe injuries. This can be seen from the Review of Selected Performance Indicators of the NSW CTP Scheme 2014 published by SIRA in November 2015 where it was stated that

> The proportion of claims arising from moderate and serious severity injuries has remained relatively stable in recent years[3].

The importance of such stability cannot be overstated.

The Law Society also notes that the Independent Review of Insurer Profit determined that premiums today are comparable to those of 14 years ago in real terms.[4] The same report drew attention to the fact that superimposed inflation has remained benign since 2010.

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[1] J Mathews, *Report of the Independent Review of Insurer Profit within the NSW Compulsory Third Party Scheme*, October 2015, p.i.

[2] N Allsop, H Dalal, P McCarthy, *To fault or not to fault that is the question?*, Institute of Actuaries Australia, 12th Accident Compensation seminar, 2009, p.5.

[3] SIRA, *Review of Selected Performance Indicators of the NSW CTP Scheme 2014*, November 2015, para 4.3.1.8, and SIRA, *Deterring fraudulent and exaggerated claims in the NSW CTP insurance scheme* 2016, p.9.

[4] J Mathews, *Report of the Independent Review of Insurer Profit within the NSW Compulsory Third Party Scheme*, October 2015, p.iv.

The Law Society accepts that the CTP scheme should be reviewed, refreshed and amended to meet new developments and challenges but that does not mean the scheme should be changed dramatically just because it has not undergone dramatic change for a while.

2. The Current Scheme

The current NSW scheme, although primarily a fault-based common law system, already has significant additional "no fault" benefits and provisions which have been added since the introduction of the scheme in 1988. It is already a "hybrid" scheme. Injured motorists who can establish fault receive lump sum damages to compensate for past and future medical treatment expenses, rehabilitation expenses and domestic assistance, past and future economic loss due to loss of earnings or the deprivation or impairment of earning capacity, and for some, exceeding a prescribed impairment threshold, non-economic loss. Payments with respect to non-economic loss are capped as are the sums recoverable for past and future weekly wage loss.

An important feature of common law damages is that the final lump sum determined by settlement or award, is tailored particularly to the injured individual. The economic impact of an injured back to a builder's labourer will be different to the impact such an injury would have to a lawyer and this is reflected in the damages awarded under the current scheme.

In addition to the availability of such common law damages there are certain benefits available via an Accident Notification Form ("ANF"). This system provides benefits of up to $5,000 irrespective of fault, which include medical benefits and economic loss in some circumstances. The ANF system is designed to facilitate the prompt medical treatment of injured road users which is so important to an early recovery.

An important additional "no fault" component of the current NSW scheme is the scheme administered by the Lifetime Care and Support Authority. A substantial proportion of premiums payable by motorists goes to support this scheme, which provides payment for the treatment and care needs of the most catastrophically injured. Benefits available under this scheme are available to all persons injured in motor vehicle accidents, regardless of fault.

The NSW scheme also subsidises public hospital and ambulance costs, again on a no fault basis. This is funded from a levy on each green slip.

There are also some important exceptions to the requirement of establishing fault. The blameless accident provisions in Division 1 of Part 1.2 of the *Motor Accidents Compensation Act 1999* ("the Act") enable an injured person to bring a claim in circumstances where the driver who caused the accident is technically not 'at fault'. There are also special provisions for children under 16 years who are entitled to claim treatment, rehabilitation and care costs regardless of fault.

The current scheme also provides for the interim payment of damages for economic loss for persons who face financial hardship, for example, employed persons unable to work.

Once determined, the lump sum recovered under the current scheme will reflect the claimant's actual and future losses in addition to providing certainty, finality and choice about how the sum is best utilised.

We have a scheme in NSW which is providing fair benefits for all persons injured in a motor accident caused by the fault of another driver. We also provide a safety net of benefits to a range of other individuals including children, those who are catastrophically injured, those who are injured as a result of blameless accidents or those who receive no fault ANF benefits. The benefits available in other Australian states are far more limited, and comparisons of CTP premiums in other states are therefore not useful.

It should also be noted that schemes in some other states such as Victoria are government underwritten and are in deficit. For instance, for the last two financial years, the Victorian TAC scheme was in deficit to the tune of $108 million and $186 million, respectively[5]. This is despite the fact that investment returns over the last two financial years have been good at 14.7% and 11.7%, respectively[6].

3. Scheme Integrity

The Law Society notes that there has been a significant increase in legally represented small claims recently. In order to address the issue quickly, the Law Society reached a consensus position with the Bar Association and the Australian Lawyers Alliance which we believed would provide immediate premium relief. The intention behind the proposal, set out below and discussed at the Roundtable meeting on 23 March 2016, was that it could be implemented as an interim and urgent measure pending the broader scheme reform that we recommend in this submission. The Law Society's proposal for scheme redesign at section 4 below provides a long term solution.

In our joint letter to the Minister, we suggested that the *Motor Accidents Compensation Regulation 2015* ("Regulation") could be amended as follows:

<u>Children's claims</u>

(a) Where a claim is exempted solely on the basis of a lack of capacity related to the age of a claimant and where the ultimate settlement or judgment in the matter is $25,000 or less, then:

 (i) The maximum recoverable as party/party professional costs shall not be more than $5,500 inclusive of GST; and

 (ii) No additional professional fees may be charged on a contracted out basis

 unless the court otherwise orders.

(a) Where a claim is exempted solely on the basis of lack of capacity related to the age of a claimant and where the ultimate settlement or judgment in the matter is less than $50,000, but greater than $25,000 then:

 (i) The maximum recoverable as party/party professional costs shall not be more than $11,000 inclusive of GST; and

 (ii) No additional professional fees may be charged on a contracted out basis

 unless the court otherwise orders.

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[5] TAC 2015 Annual Report, p.29.

[6] TAC 2015 Annual Report, p.45.

(a) Where a claim to which (a) or (b) above applies is the second or other subsequent claim brought on behalf of an occupant of the same vehicle involved in an accident, then the maximum recoverable as party/party professional costs shall not be more than $5,500 inclusive of GST and no additional professional fees may be charged on a contracted out basis, unless the court otherwise orders.

<u>Small Claims</u>

As a short term measure to contain the legal fees payable in small claims, we proposed that the Regulation be amended to provide that where the total damages recovered by way of settlement, award or judgment is less than $50,000 the legal practitioners acting in the matter may not contract out of the regulated legal fees in relation to professional costs.

The intention was that for claims settled or awards made over $50,000 scheduled costs would only be available for the first $50,000 and solicitor/client costs would only be available in relation to sums above this figure and only on that portion of the damages award which exceeds the sum of $50,000.

We note that the issues of scheme integrity, fraud and claims exaggeration are being dealt with by the Government's newly implemented Fraud Taskforce and its various working groups. The Law Society agrees that the problem of insurance fraud must be addressed and is pleased to be part of the initiatives designed to reduce its incidence.

4. Scheme Redesign

The Law Society recommends expansion of the current Accident Notification Form (ANF) system and no fault benefits. The Law Society accepts that it may be desirable for some limited benefits to cover early medical treatment and loss of income to be available to all road users irrespective of fault for a limited period. This would improve the timeliness of benefits. As no costs are payable by insurers on "ANF only" claims, the claims resolution rate would be increased and costs in small claims would be driven down.

The proposal suggested is as follows:

(a) <u>ANF claims or "No fault benefits" ("NFBs")</u>

Preliminary proposal

(i) Expand the no fault ANF to $25,000.

(ii) Insurers to pay medical expenses as incurred for the first 12 months post – ANF lodgement.

(iii) Insurers to pay weekly benefits (on a fortnightly basis) as medically justified for the first 12 months post-ANF lodgement.

(iv) No legal fees recoverable.

(v) Creation of a low cost, low document dispute resolution system to provide immediate resolution of disputes over reasonable and necessary treatment and levels of wage payment.

(vi) Wages to be paid at the rate of ordinary time earnings. No lost overtime claimable under the ANF. For the unemployed (even those temporarily so) no weekly payments, with reliance on the social security system.

(vii) Insurers to use information provided with the ANF to make necessary liability investigations, requesting more information if required. Insurers to issue a Section 81 Notice within six months based on the ANF and additional requested information.

(viii) Period for lodging an ANF extended up to three months.

(ix) Period for lodging a full claim form extended from six months to twelve months.

(x) Insurer to have the capacity to settle all compensable rights with ANF payments and appropriate future allowances without the need for a full claim form to be lodged.

(xi) Lodging of a claim form is not to result in cessation of ANF benefits.

Further proposal: alternate to ANF

As an alternative to using the existing ANF system, and to improve scheme timeliness, the ANF regime be reclassified as a no-fault benefits (NFB) regime in which NFBs (both loss of earnings and medical treatment expenses) are payable during the first 12 months post-accident on a no fault basis up to a cap of $25,000. Weekly payments would be payable on a two monthly or quarterly basis during this 12 month period using the existing provisions of section 84A (which allows for interim payment of damages in cases of financial hardship) but reversing the onus of proof so that there is a presumption in favour of the claimant that such financial hardship exists.

Any disputes regarding these interim NFB weekly payments would be referrable to a CARS assessor on an expedited basis. Under this NFB regime a claim form would not be necessary as the NFB benefits would only first require completion of an abbreviated claim form and the transition process between ANF and claim form would not apply as ANFs become superfluous.

This NFB regime, using the provisions of section 84A, has an obvious advantage over a fortnightly payment of weekly benefits in that the insurer would not be required to pay tax on the interim payment. It would be received as a net payment by the injured person whereas a fortnightly benefit would require payments to be made regularly by the insurer to the Australian Tax Office.

(b) <u>Fault based claims</u>

(i) Normal lodgement of claim form for a fault-based claim to recover benefits beyond the prescribed ANF amounts.

(ii) Capacity to claim losses previously incurred not covered by the ANF such as loss of overtime.

(iii) As noted above, no legal costs in respect of payments recovered through the ANF.

For non-exempt matters:

(iv) If total damages / settlement is $50,000 or less (net of ANF payments), recovery of legal costs is limited to regulated costs (and there is no contracting out).

(v) If total damages / settlement exceeds $50,000 (net of ANF payments), recovery of legal costs is limited to regulated costs for the first $50,000 (net of ANF payments) and thereafter contracting out is permitted.

By way of example, where a claimant recovers $90,000 in total and had been paid $15,000 by way of ANF payments, $90,000 - $15,000 (ANF) = $75,000. Regulated costs would apply to the first $50,000; contracted out fees would apply to $25,000.

The above proposal is a multi-faceted approach to small claims which:

- Creates a disincentive for lawyers to be involved with small cases on behalf of those who might otherwise not bring a clam.
- Significantly improves scheme timeliness by bringing forward payments for lost wages during the first 12 months.
- Extends the no fault benefit at the bottom end of the scheme to provide a better social welfare safety net.

The Government has made reference to recent proposals in the United Kingdom designed to address increased frequency of claims for minor injuries such as whiplash. The Law Society notes that its scheme redesign proposal above provides by comparison, greater cost restrictions on the legal profession.

5. Benefits Reform

The Law Society reiterates that the purpose of the scheme is to provide fair compensation to victims of motor vehicle accidents, and notes the Government's aim, which is to return a higher proportion of premium to the injured. We therefore suggest modifications with respect to one head of damage, namely care.

<u>Care</u>

The Options Paper notes that the costs of care have increased at very high rates since 2000 and accounted for $42 per policy in 2014, compared to $18 per policy in 2004, according to the scheme actuary.

The Law Society also acknowledges that the growth in the cost of care is a substantial driver in the costs associated with minor injury claims and that changes are required to ensure that the objects of the scheme are achieved.

The cost of care is allowed on two bases, namely: gratuitous care and paid care.

Gratuitous care has been allowed as a separate head of damage since the High Court case of *Griffiths v Kerkemeyer* (1977) 139 CLR 161. That case established that claimants needing nursing and domestic services, which are provided gratuitously by family members or others as a result of their injury, may recover damages for those services.

The damages are awarded without reference to the actual costs of the claimant of having the domestic services provided, or to the income foregone by the provider of the care. *Griffiths v Kerkemeyer* damages are determined purely by reference to the cost of providing those services generally in the market.

There have been restrictions and caps that have been imposed on the recovery of *Griffiths v Kerkemeyer* damages in motor accidents. The restrictions are set out in section 141B of the Act. Gratuitous care can only be allowed where care has been provided for at least six hours per week and for at least six consecutive months.

Restrictions have also been placed on the hourly rate at which damages for gratuitous care can be awarded. The rate is fixed by reference to the average weekly total earnings of all employees in New South Wales, currently $29.44 per hour (section 141B(4) of the Act). This is a substantially lower rate than the costs of commercial care.

There are a number of potential options for further restrictions on the awarding of damages for gratuitous care. These could include:

- Increasing the hours per week above 6 hours
- Increasing the duration that care is required for above 6 consecutive months
- Reducing the hourly rate at which care is allowed
- Restricting the type of claimant who can recover damages for gratuitous care
- Abolishing it.

The Law Society's view is that it would be undesirable to abolish gratuitous care in its entirety as this would have a particularly severe effect on young and elderly people and persons from cultural backgrounds where care by family members is preferred to that provided by commercial providers. We submit that the objects of the Act could be best achieved by:

- Preserving the current restrictions that gratuitous care must be provided for at least six hours per week and six months before it can be allowed; and
- Providing that future gratuitous care can only be awarded to claimants who have an entitlement to receive non-economic loss.

Linking an entitlement to gratuitous care to non-economic loss entitlement is an effective, albeit arbitrary, way to limit the requirements for gratuitous care to the most seriously injured motorists. The advantage of using the non-economic loss threshold is that it is well known and will not lead to a proliferation of threshold disputes. There would be some deserving claimants who would be denied the opportunity to recover damages for gratuitous care, but on balance the certainty which this level provides is desirable.

The Law Society does not support the abolition of damages for past gratuitous care. This is not the most significant cost driver. Any damages for past gratuitous care have to be proven in respect of both the threshold requirements and on the basis that the care is reasonable and necessary.

With respect to paid care the Law Society maintains that continuing to allow for recovery of past paid care is reasonable. This care has actually been incurred by the claimant and the claimant can prove the expenditure.

The Law Society does not support restrictions on the ability to recover damages for future paid care. If savings are required, this could be achieved by regulating a cap on the maximum rate per hour at which paid care can be allowed. The Law Society's view is that a cap at the same rate applicable for gratuitous care would be reasonable (currently $29.44 per hour).

Loss of earnings

The Law Society does not recommend any reduction in the current cap on weekly loss of earnings given that there are very few claimants who are affected by such a cap. This category of benefit is not a premium driver, and any scheme savings by making such reductions would be negligible.

The Law Society also submits that it is entirely inappropriate to ration access to loss of earnings by way of the non-economic loss impairment threshold as was proposed during the 2013 reform process. The assessment of impairment under the AMA Guides does not equate to disability or incapacity and, as discussed later, a person with a manual job may well fall comfortably below the impairment threshold yet have a significant restriction placed on their employability into the future. If the Government wishes to curtail access to economic loss in respect of so-called 'minor severity' injury claims then this should be done on a case by case basis depending on the extent to which the claimant's injuries may impact on their employment prospects.

Non-economic loss

There is no evidence to suggest that excessive amounts are being paid out for this head of damage or that this head of damage is costly to the scheme.

The Law Society does not recommend a reduction in the current maximum cap of $511,000 with respect to non-economic loss. This is the sum that someone who has suffered a gross brain injury or quadriplegia receives to compensate for pain and suffering, and in this context is not excessive. The Law Society also notes that the Options Paper states that the Government wants to increase the proportion of benefits being provided to the seriously injured.

Medical benefits

The Options Paper raises the prospect of an excess on medical payments. The Law Society does not support this because:

- medical expenses, while a significant cost, are a relatively stable cost in the CTP Scheme;
- enabling claimants to obtain prompt treatment from the health professionals of their choice is vital;
- any disincentive to early treatment should be discouraged;
- in many cases claimants will make a contribution towards medical expenses where liability has not been admitted, and increasing that contribution is not desirable; and

- imposing an excess has the potential to further complicate an already complicated scheme.

6. Claims Processes

The Law Society puts forward several recommendations below that we submit will substantially improve scheme processes, leading to improvements in timeliness and costs savings and thereby achieving several of the Government's objectives. We have raised many of these issues before, some in response to previous reviews of the exercise of the functions of the former Motor Accidents Authority by the Legislative Council's Standing Committee on Law and Justice.

6.1 Blockages Created by Medical Assessment Service ("MAS")

If one of the objectives of reform is to improve timeliness, then the MAS process needs urgent remedial attention. The Law Society submits that the MAS represents a considerable blockage to preventing a person injured in a motor vehicle accident resolving their claim in a timely fashion. This delay results from a combination of factors, namely:

1. Stabilisation of injuries – MAS is unable to assess injuries until stabilisation of injuries arising from the accident has occurred. In the absence of stabilisation, permanency of the whole person impairment cannot be determined;

2. The purpose of MAS is to determine disagreements between the claimant and an insurer about such matters as the degree of permanent impairment of the injured person as a result of the injury caused by the motor accident. This requires medically trained Assessors to apply legal concepts;

3. There are no limitations on the number of applications that can be made for further assessment under section 62, provided the gateway in section 62(1A) is met;

4. A party may seek a review of a MAS Certificate and reasons pursuant to section 63 with that review not bringing any finality to the medical dispute. In this case it remains open to either party to seek a further assessment under section 62, or to apply for judicial review of any decision of MAS in the administrative law division of the Supreme Court.

The issue of causation has been at the forefront of disputes before MAS since at least 2006. The binding nature of a MAS Assessor's determination on issues of causation has been considered in:

(a) *Pham v Shui* [2006] NSWCA 373;
(b) *Brown v Lewis* [2006] NSWCA 87; and
(c) *Motor Accidents Authority of NSW v Mills* [2010] NSWCA 82.

The effect of these decisions is that a Certificate issued for the purposes of assessing whole person impairment is not binding on the parties as to any other issues in dispute. So, while causation is a necessary determination under section 58(1)(d) in the assessment of whole person impairment, it is not binding in relation to damages for economic loss, care and treatment expenses.

The extent to which determinations of causation have created blockages in the MAS process is evident in the various reported decisions relating to the claimant Adam

De Gelder. An example of the delay created by the MAS process in that matter can be seen in the most recent decision of Justice Gleeson in *Rodger v De Gelder* [2015] NSWCA 211 where at paragraphs 24 to 28, the following summary is provided:

> 24. In October 2011 Mr De Gelder commenced proceedings in the District Court against Mr Rodger. The insurer of Mr Rodger's vehicle was Insurance Australia Limited trading as NRMA Insurance. Mr Rodger, by his Insurer, admitted breach of duty of care but put in issue causation of the thoracic spine fractures and other claimed injuries. A hearing before Levy DCJ commenced on 21 May 2012 and the proceedings continued until 17 August 2012.
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> 25. On 15 October 2012 Judge Levy made interim findings, including findings as to causation of the fractures to Mr De Gelder's thoracic spine which were consistent with the earlier medical assessments (the injury was caused by the motor accident) but inconsistent with the medical assessment current at the time. His Honour referred the medical dispute back to the Motor Accidents Medical Assessment Service (MAS) for further assessment: s 62(1)(b).
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> 26. On 18 December 2012 a medical assessor (Dr Harrington) certified Mr De Gelder's impairment at 20% as a result of cervical spine and thoracic spine injuries caused by the motor accident. On 7 December 2012 Mr Rodger applied to the proper officer of the Authority for a review. That application was granted.
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> 27. On 21 May 2013 a review panel certified Mr De Gelder's impairment at 25%. Mr Rodger sought judicial review of that decision in the Supreme Court. Subsequently on 4 October 2013, Mr De Gelder consented to the orders sought. As a consequence the certificate issued by the review panel was quashed and the matter remitted to the MAS to be determined according to law.
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> 28. On 4 February 2014 the panel, being a differently constituted review panel, certified Mr De Gelder's impairment as a result of injury caused by the motor accident as 0%.

While the Court proceedings in Mr De Gelder's claim were not commenced until more than 6 years after the date of accident, and there were earlier MAS disputes (with the original application under section 61 and two subsequent applications for further assessment), his Honour's summary of what occurred between October 2011 and February 2014 demonstrates the delay and inefficiency that the current medical assessment procedure creates.

The proceedings before the Court of Appeal arose from a Summons filed by Mr De Gelder for judicial review of the Review Panel Certificate dated 4 February 2014 and the Court of Appeal judgment was not handed down until 23 July 2015, almost 10 years after the date of accident.

Unfortunately, Mr De Gelder is not alone in having experienced such delays with the medical assessment procedures.

By way of further example, in a claim involving an accident on 1 April 2008, a MAS Application for assessment of a whole person impairment dispute came before MAS in early 2012 (MAS reference: 2012/02/0429). A Certificate was initially issued on 14 May 2012. This was subject to a Review Application by the Claimant with a Review Panel Certificate issuing on 14 November 2012.

In 2014, the claimant made an Application for Further Assessment (MAS reference: 2014/04/1299) with the claimant being assessed on 15 October 2014 and a Certificate issuing on 4 November 2014. This Certificate was subject to an Application for Review lodged by the Insurer and the claimant was assessed by a newly convened Review Panel who issued a Review Certificate on 2 June 2015.

A further issue then arose with regard to causation of an infectious disease and on 13 November 2015 a further Certificate issued regarding causation of that condition.

On 21 January 2016 an Application for Review of the decision regarding the infectious disease was lodged by the claimant. The Proper Officer determined on 24 March 2016 that the Application should be dismissed, it not meeting the threshold in section 62(1A). It is now more than eight years since the date of this accident and almost four years since the initial MAS Application was lodged.

One of the other difficulties with the MAS process is that MAS Assessors are required to apply both a medical and a legal test of causation. A number of recent Supreme Court cases demonstrate the difficulties MAS Assessors and Review Panels have experienced in wrestling with causation:

(i) *Bugat v Fox* (2014) NSWSC 888,
(ii) *Owen v Motor Accidents Authority of NSW* (2012) NSWSC 560,
(iii) *Peet v NRMA Insurance Limited* (2015) NSWSC 558.

<u>Enhancements to MAS</u>

The case studies outlined above support the need for reform to meet the objectives of the NSW CTP scheme. The following enhancements to the medical assessment procedure need to be considered:

1. Removing causation as a medical assessment matter under section 58 to be determined by MAS;

2. Allowing Claims Assessors to determine what injuries are caused by an accident – drawing on the impairment assessed for each alleged injury by the MAS assessor, a Claims Assessor determines the entitlement to damages for non-economic loss;

3. Restricting each party to one Application for Further Assessment before lodgement of a CARS Application for general assessment. Any subsequent Application on one or more further occasions may only be made by a Claims Assessor or by a court but only if he/she is satisfied that all additional information about the injury that he/she considers relevant has been provided.

<u>Achieving the objectives</u>

In making this proposal for enhancements to MAS, the Law Society has closely considered the objectives of this reform process. The enhancements meet the objectives by:

1. Ensuring more seriously injured claimants are properly compensated through a consistency in the assessment of damages – all injuries caused by the accident are taken into account in assessing each head of damage. This is an outcome not always available under the current medical assessment procedure. For

example, Mr De Gelder's fractures to the thoracic spine (20% whole person impairment) were assessed by Levy DCJ as causally related to the accident but Mr De Gelder had no entitlement to damages for non-economic loss due to a MAS Assessor certifying otherwise;

2. Significantly reducing the time it takes to resolve a claim – where a Claims Assessor is left to determine causation for all heads of damage, the medical assessment procedure is less susceptible to disputes. (In the two case studies above, the life of each claim would likely have been reduced by several years had causation of injury for the entitlement to damages for non-economic loss not been in the hands of the MAS Assessor); and

3. Reduce the cost of premiums. (Claims costs in multiple MAS disputes are significant. A large head of damage is at stake and the current medical assessment procedure traverses into issues of legal causation beyond the expertise of medically trained experts.)

6.2 Pre-filing Requirements

The Law Society recommends that Part 4.4 Division 1A (sections 89A to 89F inclusive) and section 91 of the Act be repealed. The provisions add an unnecessary layer of protocols to be navigated before an Application for General Assessment can be filed. The time consuming provisions slow down the claims process and add unavoidable costs.

These pre-filing requirements involve:

(i) Participation in a mandatory settlement conference as soon as practicable after the insurer makes an offer of settlement. This requirement can be avoided if a claims assessor is satisfied that the party lodging the Application for General Assessment is ready and willing to participate in a settlement conference but the other party has refused or failed to participate despite having had a reasonable opportunity to do so (section 89A).

(ii) Mandatory exchange of documents upon which each party intends to rely prior to the mandatory settlement conference. Any documents not so exchanged cannot be considered at the subsequent assessment hearing unless a claims assessor admits the document after having been satisfied that the probative value of the document substantially outweighs any prejudicial effect it may have on the other party (section 89B).

(iii) In the event the claim fails to resolve at a mandatory settlement conference, each party must make an offer of settlement within 14 days after the conclusion of the conference. Such a settlement offer is to include a schedule of damages sufficient to explain the calculation of damages. After the expiration of 14 days, a party who has made the mandatory offer of settlement may refer the claim for general assessment if a claims assessor is satisfied that the other party has refused or failed to make its mandatory offer (section 89C). If there has been an exchange of offers within 14 days of the mandatory settlement conference, then the claim may not be referred for assessment until 28 days after each party to the claim has made the mandatory offer of settlement pursuant to section 89C (section 91(1)).

(iv) A claims assessor may impose a costs penalty on a party if satisfied that there has been a failure by a party without reasonable excuse to participate in a

settlement conference or exchange documents which were subsequently admitted (section 89D).

Some of the difficulties created by these quite rigid pre-filing requirements include the following:

(i) The relative inflexibility of the pre-filing requirements do not take into account the fact that no one claim or injury is the same. Complications in the claimant's case, such as the need for surgery or further surgery, a deterioration of the medical condition, a change in employment circumstances, occur unexpectedly and more often than not require further medical or other evidence to update the situation. Often it is also necessary for a party to obtain evidence to respond to documents exchanged prior to the mandatory settlement conference.

(ii) The potential loss to the claimant of the important entitlement to apply for a re-hearing of a claims assessor's award if stabilisation of the medical condition occurs close to the approach of the three year time limit or a solicitor receives instructions to act for a claimant close to the approach of the three year time limit. The lodgement of a CARS Application for General Assessment suspends the limitation period (section 109). The additional requirements outlined above increase the risk that the claimant will not be able to "stop the clock" in time in such factual scenarios.

(iii) Insurers disputing that a settlement conference is a section 89A compliant settlement conference and delaying the CARS assessment process.

(iv) Protracted disputes at CARS as to whether there has been compliance with sections 89A-89E sufficient to entitle the claimant to lodge the CARS Application.

(v) Most importantly, in the event the claim is not settled at the mandatory settlement conference, the parties are faced with repeating and updating much of the legal work performed in preparation under the pre-filing requirements when completing the CARS Application for General Assessment. This is neither time nor cost effective.

These pre-filing requirements could be removed in preference for a less formal dispute resolution process which could be presided over by CARS assessors or mediators who could effectively case manage the claim. A compulsory conference following the appointment of the Claims Assessor would ensure all documents on which a party relies are available before settlement is discussed and appropriate cost penalties could then apply if the matter did not resolve.

6.3 Open disclosure

The adoption of a mandated open disclosure model as currently exists in Queensland, may go a long way to achieving at least two of the Minister's key objectives, reducing the time it takes to resolve a claim, and reducing opportunities for claims fraud and exaggeration.

A positive feature of the Queensland CTP scheme is its transparency provisions found in sections 45 and 47 of the *Motor Accident Insurance Act* 1994 (Qld). These provisions appear to have been effective in building trust between the parties and reducing or eliminating friction points, thereby contributing to the expeditious resolution of claims.

Adopting similar open disclosure provisions as exist in Queensland would address the current challenges faced by insurers and claimants in promptly receiving all relevant medical reports, allied medical reports such as physiotherapy and occupational therapy reports, statements and forensic reports. In addition, a mandated disclosure requirement would contribute substantially to dissuading the making of exaggerated and/or fraudulent claims.

The open disclosure model contemplates a climate of open exchange of ALL relevant documents and information in relation to a claim as and when the documents and information become available to the parties during the life cycle of the claim. An open disclosure environment is one where there are *no games* and *no secrets,* but rather the full exchange of relevant information between the parties to enable a genuine claim to be processed more quickly and more cost effectively.

Opportunities for friction points to be created would reduce dramatically if an open disclosure model was to be adopted in the current scheme design, as both the claimant and the insurer would be required to openly disclose ALL documents and information in relation to a claim during the life of the claim, not just selective documents and information they traditionally would have disclosed to the other party.

An overriding objective in the CTP scheme design must be to facilitate the fair and right compensation being paid to the injured person in a timely fashion – that is, more of the premium dollar going to the injured person and less going to insurer profits and legal costs.

In an open disclosure environment, there would be no need for the current pre-filing procedures at CARS (Division 1A). These procedures have been demonstrated to create friction points, thereby increasing disputes and incurring legal costs. It appears that the operation of Division 1A may have (albeit unintentionally) resulted in an increase in disputes which in turn tends to increase the insurers' claims handling costs and the claimants' solicitor/client legal costs not recoverable from the insurer.

There are difficulties in navigating the current claims process. An open disclosure model is likely to be simpler and quicker than the current system and more manageable by self-represented claimants, thereby reducing the need to seek legal assistance especially in the smaller claims.

Such a change is a radical departure from the current scheme design but one that could be introduced quickly, and one which has the ability to transform dramatically the dynamics at play in the current scheme design. Adopting an open disclosure model is likely to have a significant impact on cost, timeliness and efficiency as demonstrated by the operation of the Queensland model.

Reducing the time it takes to resolve a claim

The present NSW CTP scheme currently empowers the insurer and the claimant to be selective when exchanging relevant information and documents. If a claimant elects not to rely on a particular piece of relevant information and/or document, then the claimant simply does not provide it to the insurer, eg treating medical practitioners' reports and clinical notes which may not be supportive of a claimant's position. Likewise, if an insurer elects not to rely on a particular piece of relevant information and/or document, then the insurer does not provide it to the claimant, eg liability evidence obtained by the insurer which may neutralise a liability issue, or medico legal reports which are supportive of the claimant's position.

Such non-disclosure, or selective disclosure, has the capacity to create friction points during the life of the claim which may take time and effort to address and resolve, thereby adversely impacting the life cycle of the claim, increasing claims handling costs, requiring claims assessor involvement to assess a claim and increasing the parties' legal costs. In addition, non-disclosure or selective disclosure by one party to the dispute may unfairly impact the other party.

The MAAS dispute resolution model is inquisitorial by design, not adversarial. The occurrence of friction points in the life of the claim tends to *convert* an inquisitorial model into an adversarial model, thereby delaying the life of the claim and increasing claims handling costs and legal costs. This all impacts on the proportion of the premium dollar being paid to the injured person.

The adoption of an open disclosure model has the capacity to reduce the life of the claim. There should be fewer disputes to resolve because there is an ongoing obligation to disclose ALL relevant material as and when the material becomes available.

An open disclosure model benefits injured claimants by encouraging early rehabilitation, a speedy and fair resolution of their claim by requiring full and timely disclosure of documents and information during the life cycle of the claim, and the ability to identify the real issues in a claim as they arise, thereby reducing or eliminating friction points and facilitating a timely resolution of the claim.

Reducing opportunities for claims fraud and exaggeration

It cannot be assumed that the mere occurrence of a motor vehicle accident means that a person must have suffered personal injury as a result of a motor vehicle accident (one of the assumptions of the claims harvesting model). An open disclosure model may go a long way to dissuade persons from making a CTP claim if in fact they did not suffer any injury as a result of a motor vehicle accident or, alternatively, only very minimal injury which has resolved.

An open disclosure model would adversely impact the ability of a claimant to act fraudulently or exaggerate injuries and disabilities. A claimant would be required to fully disclose the circumstances of the accident, any injuries and disabilities caused by the accident and ALL information and documents referable to, for example, a claim for past and/or future loss of earning capacity or a claim for past and/or future care.

6.4 Late Claims

Under section 72 of the Act, a claim must be made within six months of the date of the accident. The great majority of claims are made in this period. However, the current system in place for dealing with late claims is protracted and costly and should be reformed.

Currently, failure to submit a Personal Injury Claim Form within six months requires the claimant to provide a full and satisfactory explanation in the first instance for the delay in making the claim. Invariably, the insurer will reject that the explanation is full and/or satisfactory. To proceed with the claim, the claimant is then required to make a CARS 5A Application for Special Assessment to have an assessor determine if the explanation for making the late claim is full and satisfactory.

At the conclusion of the CARS special assessment hearing, a decision is made as to whether the explanation for the delay in making the claim is considered to be full and satisfactory. This decision is not presently binding on the parties. In circumstances where liability has been accepted, to date, the principal claims assessor ('PCA') will not exempt the matter from CARS. Accordingly, the matter will proceed to a general assessment hearing if it is unable to be resolved earlier. The process, from the lodgement of the explanation for the delay in making the claim, to the determination of a special assessment as to whether the explanation is full and satisfactory, takes between three to six months. Further, the claimant cannot ordinarily lodge the Application for General Assessment at CARS until this special assessment is concluded because of section 73(3) of the Act.

Once a general assessment hearing has been concluded, and a determination has been made as to a claimant's entitlement to compensation, that decision is unenforceable and a claimant is unable to recover the compensation which has been awarded to them by an assessor without pursuing separate District Court proceedings. This is an expensive process which most claimants would find difficult to fund. If a claimant accepts the amount of damages, but the insurer does not pay the amount of damages, the only avenue available to the claimant is to commence District Court proceedings. The costs penalties in section 151 of the Act only apply if the claimant does not accept the amount of damages for liability under a claim.

Insurers currently lose the great majority of late claims disputes and it is the Law Society's recommendation that the late claim dispute process should be removed, together with the right for insurers to reject claims lodged within three years. Alternatively, the Law Society recommends that late claim determinations of Claims Assessors be binding on the insurer.

At the very least, the time period within which a claimant is required to submit a claim pursuant to section 72 should be extended to 12 months. We submit that such an amendment would significantly reduce the number of late claims made, thereby reducing legal costs and the administrative costs of insurers and SIRA.

6.5 Streamline Workers Compensation paybacks

There is currently an anomalous situation where an injured accident victim's substantive rights will be determined in a CARS assessment while there is a simultaneous litigated court dispute between a workers compensation insurer seeking recovery of payments and a CTP insurer defending the action. While such claims under section 151Z of the *Workers Compensation Act 1987* have been significantly reduced due to changes in entitlements since the workers compensation legislative reforms in 2012, there is still unnecessary disputation. A bulk billing agreement between the workers compensation and CTP insurers would result in a scheme benefit.

7. Option 3 in the Government's Options Paper

The Law Society notes that the Government's Option 3 encompasses a wide range of variations and mentions the possibility of an increase to the threshold of the current no fault ANF. This is one of the Law Society's recommendations, discussed above in section 4. In the alternative we draw to your attention the NFB proposal outlined above.

The Victorian scheme is mentioned in the Options Paper. That state's scheme provides certain defined benefits for all injured road users but these benefits go

nowhere near providing full and fair compensation. There is a substantial gap, for example, between the weekly payments available for loss of earnings and an injured person's actual pre-accident earnings, and these payments only continue for a limited period. This means many claimants are left without any benefits after a certain period unless they can demonstrate a sufficiently serious injury to enable them to access limited common law damages.

While the Law Society recognises the philosophy behind wanting to extend compensation to all injured road users, we submit that this should not be at the expense of innocent victims. The money for newly covered injured road users must come from somewhere and this inevitably will mean a reduction in compensation available. The Issues Paper discusses the concept of fairness. The Law Society maintains it is not fair that accident victims should surrender benefits to subsidise payments to the negligent drivers who caused their injuries. Notions of personal responsibility must have some relevance here.

A defined benefits scheme such as that operating in Victoria would mean substantially reduced compensation for a large number of accident victims with significant injuries affecting their ability to work. Many people, even those assessed under 10% WPI, have real injuries which are likely to impact on their capacity to earn until retirement age and not just for an arbitrary period of say three or five years. For instance, a person who works as a builder's labourer may only achieve an impairment rating of 5% or 10% due to a disc injury yet may effectively not be able to work into the future taking into account the highly physical nature of the work involved and noting that many such workers have limited alternative work choices. The Law Society submits that the majority of the population cannot afford a shortfall in the compensation available to replace income and that many injured people would be at risk of losing their homes if payments are insufficient to cover their mortgage and living expenses.

The Law Society also submits that many road users cannot afford, or will not qualify for, income protection insurance to protect against such a shortfall should they be unable to continue working. This type of insurance is extremely expensive.

We submit any improvements in the timeliness of benefits would be erased by the substantial reduction in benefits available under such defined benefit schemes.

The Options Paper suggests that defined benefits would improve affordability. However, the Law Society notes the 2010 report by the RAND Institute for Civil Justice which found that dissatisfaction with no fault schemes (and all US states retain some common law) had grown in the United States because the anticipated premium cost reductions never materialized, primarily due to substantially higher medical costs with no fault schemes[7]. Several US states repealed no fault laws and realized premium cost reductions. Medical treatment costs were higher in no fault states which did not control these costs as effectively and where a higher proportion of these costs were borne by the first party auto insurer[8]. The RAND report ultimately concluded that medical costs are typically substantially higher within a no-fault jurisdiction because injured persons are more likely to visit medical providers and more likely to visit more often and the cost of medical care has also become more expensive with time in those jurisdictions[9].

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[7] JM Anderson, P Heaton and SJ Caroll, *The US experience with no fault automobile insurance: a retrospective*, RAND Corporation, 2010, p.xiv.

[8] Ibid pp.119, 136.

[9] Ibid p.xiv.

Tables 5.8, 5.9 and 5.10 from the RAND paper are attached for your consideration. Table 5.10, in particular, is a cause for serious concern in that it demonstrates that over a 20 year period between 1987 and 2007, the cost of medical care in no-fault states, compared to tort states, was between 42% to 51% higher. The conclusion reached by the authors of the RAND report was as follows:

> We analysed several data sources and concluded that the perception that no-fault generally had higher compensation costs then other regimes was largely accurate. Per-policy costs are highest in no fault states, and these states have also experienced more dramatic cost growth over time[10].

It has also been suggested that moving from a fault based scheme to a no fault scheme would most likely result in an increase in the scheme costs above and beyond the claims volume. A review of Australian schemes in 2009 revealed that persons injured in at fault vehicles have a higher rate of hospitalisation, higher utilisation of scheme benefits, and higher injury severity and hence related claim costs[11].

The Law Society takes issue with the suggestion in the Options Paper that moving from a third party scheme to a first party scheme would improve the way that the insurers would deal with the injured customer's claim. Of course, the adoption of a first party scheme, instead of a third party scheme, would have obvious advantages to an insurer who wished to market its other insurance products such as total and permanent disability lump sums or income protection or life insurance to a customer. However, recent consumer experience with Comminsure in this area of life insurance/income protection and/or TPD claims is less than optimal and causes one to question whether first party insurance is necessarily desirable. The focus should be on adopting measures to reduce the 19% profit generated by insurers over the course of the present scheme rather than on gifting further opportunities to insurers to expand profit margins in other areas.

The Law Society reiterates that the Victorian scheme is Government underwritten and running at a deficit ($108 million for 2014 and $186 million for 2015) and submits that such a scheme would not work efficiently in New South Wales with private insurers whose objective is to make a profit.

The Law Society submits that such a model would not be attractive to all private insurers and may drive some insurers out of the market. This would, of course, reduce competition and be counter to one of the Government's aims.

Implementation of a "defined benefits" model would involve a risk laden overhaul of an existing sound scheme. The Law Society submits that the NSW scheme's historic stability and predictability can be regained quickly with the suggested reforms detailed in this submission.

8. Option 4 in the Government's Options Paper

The Law Society's critique of a Victorian type model applies equally to the type of scheme discussed at Option 4. This is a New Zealand type scheme which, like the

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[10] Ibid p.135.

[11] N Allsop, H Dalal, P McCarthy, *To fault or not to fault that is the question?*, Seminar Paper, Institute of Actuaries Australia, 2009 p.12.

Victorian model, is government underwritten. The Law Society is not aware of such a model anywhere in this part of the world, which is privately underwritten.

While the Accident Compensation Corporation (ACC) in New Zealand had a budgetary surplus for the 2015 year, the ACC 2015 Financial Condition Report makes it clear that this largely reflected strong investment returns[12]. In fact, this Report predicts that over the next three years the New Zealand no-fault system will operate at a significant deficit which is expected to be $261 million for the 2016/2017 year[13].

Clearly, all the same issues with respect to the inadequate compensation provided by such defined benefit schemes to the innocent accident victims apply. In addition, common law benefits are not available to even the most seriously injured as there is a total abolition of third party rights.

The Options Paper suggests that a no fault model as described in Option 4 might reduce disputation between the parties as there would be no arguments over fault. We point out that there will inevitably be a substantially larger number of persons who come within such a scheme. It is also important to note that the issue of fault is only one of the many types of disputes that arise about liability. There are still disputes in no fault systems, for example, about causation or current weekly wage rates or whether treatment is reasonable or necessary or related to the injuries caused by the accident. The current NSW workers compensation scheme demonstrates that disputes of these types still exist under a no fault scheme.

The Law Society accepts that changes can be made under the current scheme to improve the timeliness of claim assessment. However, disputes about quantum are dealt with once, at the end of the claim, whereas under a statutory benefits scheme there can be multiple disputes during the life of the claim.

Philosophically the Society takes issue with the payment of benefits under a no-fault system by way of a drip feed process. Experience of the workers compensation system in NSW has taught us how soul destroying it can be to an injured worker whose ongoing entitlement to benefits, limited as they may be, is subject to constant supervision and revision by an insurer. The worker whose autonomy may have already been constrained by the work injury then finds that their remaining decision-making independence is further limited by a third party. Access to meaningful lump sum compensation provides a positive psychological impact for an injured person who is able to regain some of the autonomy removed by reason of an injury. Actuaries have an entrenched aversion to lump sum compensation and are not qualified to assess these benefits or comment on the adverse social impact of a "bare bones" defined benefits system.

The Law Society notes that there is some evidence that the combination of pure no fault insurance together with flat rate premiums as found in New Zealand or the Northern Territory has a detrimental effect on the safety of roads by lowering the level of care taken by motorists[14].

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[12] Accident Compensation Corporation, *Financial Condition Report*, 2015 p.2.5.1.

[13] Ibid p.2.4.5.

[14] K E Winkler, *Effects of No-Fault Auto Insurance on Safety Incentives*, School of Economics and Finance, Victoria University of Wellington, 2015 p.32.

9. Policy Considerations

Turning to the questions on policy considerations posed in the Options Paper, we comment as follows:

1. **Should there be a support or a safety net for anyone injured on the roads by vehicles that are not part of the insurance system (like bicycles) even if that increases the overall cost of CTP?**

The Law Society submits that the finite resources generated by the premium dollar would be better utilised towards fairly compensating those actually injured by the use or operation of a motor vehicle as was the original intent of the scheme. This is all the more so in circumstances where the Government has already extended the ambit of the no-fault provisions to date and where the Government has foreshadowed the real possibility of extending the no-fault coverage to further persons injured as a result of the use or operation of a motor vehicle.

2. **Is it better to make a claim against your insurer as opposed to the insurer of the at-fault driver? If so, why?**

(a) For the reasons stated above, the Law Society opposes any argument that there is any benefit to be gained by a claim being lodged on a *"first party"* basis rather than on a *"third party"* basis. There are any number of persons injured as a result of the use or operation of a motor vehicle who would not be suing their own insurer under a first party system and this would include pedestrians, bicycle riders and passengers in motor vehicles. It is submitted that it is unrealistic to suggest insurer behaviour will be altered to any extent by dealing with its own customer rather than third parties. Whatever small premiums the insurer may hope to receive from the continuing relationship with a satisfied third party customer into the future would be far outweighed by the commercial advantage of the insurer taking a hard line with an injured customer during the course of a compensation claim.

(b) It is possible that certain insurers will use the first party compensation system as a way to market more lucrative insurance products such as income protection or life insurance. This type of insurance is expensive and not available to many members of the community, particularly those with pre-existing medical conditions. This could create the socially undesirable situation of only those who are already wealthy and without significant pre-existing medical conditions being able to protect themselves properly against the potentially disastrous impact of even a moderate injury.

3. **Should Government retain competitive private underwriting, or give consideration to a return to public underwriting delivery?**

The Law Society's belief is that, provided the recommendations contained in the *"Report of the Independent Review of Insurer Profit within the NSW Compulsory Third Party Scheme"* are adopted to restrain insurer profit, then NSW should continue to adopt a private underwriting model. The Law Society accepts that a level of profit of 19% as detailed in the Issues Paper is excessive and must be curtailed by more stringent controls. If these premium reforms do not achieve the desired object of reducing the level of actual insurer profit, then the Law Society accepts that the Government should seriously contemplate a return to public underwriting where profit margins are unlikely to be inflated by any commercial imperatives that currently drive private insurers. Further, if contrary to the Law Society's submission, the Government

chooses to adopt a largely defined benefits system then experience elsewhere strongly suggests that public underwriting is the best alternative.

4. **How should Government best deal with fault (including injuries without another party to sue), illegal acts and contributory negligence in any reform?**

(a) The Law Society repeats that, whilst there are some limitations on fault as the driving factor behind a motor accident system, the reality is that it is fairer than a system where all, or most, injured persons are subject to *"bare bones"* defined benefits. The Law Society also repeats its position that it is grossly unfair for those whose injuries have been caused by the fault of another to have their benefits significantly reduced because of the desire to provide coverage for those who have caused the motor accident. This offends notions of personal responsibility.

(b) In any event, New South Wales already has a hybrid system which is composed of many no-fault aspects such as the Lifetime Care system, the no-fault benefits for children and the blameless accident and ANF provisions. This already provides a safety net of sorts to many members of the community who have been injured through their own fault. The Law Society accepts that it is appropriate for this safety net to be somewhat extended as postulated above given the imperfections and limitations of the current $5,000 ANF system and, as suggested, this ANF system could be reformulated as a no-fault benefit (NFB). An ANF will be unnecessary if the lodging of an abbreviated form of claim form can be the touchstone to the commencement of these NFB payments. The Law Society submits that its proposals provide an appropriate safety net and an appropriate balance between a tort scheme and a no-fault scheme. Research which examined the New Zealand scheme has concluded that the most appropriate compensation scheme is one that combines both regimes - no-fault insurance with the right to sue. This report concluded that such a hybrid scheme would provide "certainty of compensation and a cost effective way of managing moral hazard behaviour"[15].

(c) With respect to illegal accidents, the Law Society submits that this is already dealt with in a reasonable manner by the current common law system. Effectively those involved with joint illegal enterprises are excluded from third party insurance by a line of cases including *Gala v Preston* (1991) 172 CLR 243. One would also need to define what is meant by "illegal acts". Presumably not all persons who are injured as a result of a motor accident will be entitled to claim defined benefits if they are responsible for a criminal offence. This then becomes a friction point of such a system in that disputes will inevitably arise as to whether the conduct of a particular injured person reached the required standard of illegality or otherwise. It may lead to a perverse situation where an insurer would have a direct interest in the police pursuing an injured person for a criminal offence thus absolving the insurer of financial responsibility.

(d) In relation to the question of contributory negligence, the Law Society's view is, again, that the current common law system adequately balances the respective culpability of the injured person compared to the insured driver. This is the case even within the newly created "blameless accident" provisions, which is demonstrated by the NSW Court of Appeal decision in *Davis v Swift* (2014) 69

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[15] B Howell, J Kavanagh and L Marriott, *No fault Public Liability Insurance – Evidence from New Zealand*, 2002 p.147.

MVR 375. Regrettably there must always be an element of subjectivity involved with the balancing act between the responsibility of the injured party and the insured driver. The only appropriate means by which to undertake this task is by way of an analysis of the circumstances of each particular case.

(e) However, the Law Society believes that there is evidence that some insurers make unrealistic allegations of contributory negligence on the part of the injured party. To this end, we submit that further guidelines may need to be considered by SIRA with a view to providing clear guidance to insurers, and claimants on the type of conduct which will ordinarily result in a particular range of contributory negligence findings. These guidelines should not necessarily be legally binding, noting that often there will be discretionary considerations that will still need to be taken into account in the circumstances of a particular accident. Such circumstances may include the question of causation (whether any negligence on the part of the injured party contributed in any way to their injuries). For example, it is not mandatory for a taxi driver to wear a seatbelt so an automatic contributory negligence finding that may ordinarily apply to the wearing of a seatbelt would not and should not apply to such a driver.

5. **What changes to the CTP Scheme should increase competition?**

(a) The Law Society accepts that one of the reasons actual insurer profits have been so high over a number of years is that the system is a long-tail scheme with some elements of uncertainty and complexity. For this reason, the Law Society submits that simplifying the current third party system and improving efficiencies, would have a beneficial impact on third party insurers looking to enter the motor accident field. Once both the timeliness of claims is improved in the ways suggested above and the current system becomes more efficient, many of the barriers blocking new insurer entrants will be removed.

(b) The Law Society also accepts that many of the measures recommended in the *"Report of the Independent Review of Insurer Profit within the NSW Compulsory Third Party Scheme"* should go some way to promoting competition amongst insurers and maintaining affordability for poor risks.

(c) In line with what has been stated above, the Law Society also submits that any scheme falling under Option 4 as outlined in the Options Paper, is likely to stifle competition. We say this because of the novel nature of a *"defined benefits only"* scheme within a private underwriting system. The only no-fault systems that have been adopted in this part of the world with regard to motor accident insurance have done so in a public monopoly environment. One wonders whether the dire financial predictions that have been made at various times during the New Zealand no-fault experience would have been tolerated by private insurers. The likelihood is that if the financial downturns experienced from time to time under such no-fault schemes were to be replicated in a private underwriting environment, then many insurers would simply desert the system.

(d) The introduction of a no-fault system will inevitably involve significant administrative costs, particularly in the early stages when the whole systems of an insurer need to be re-formulated. This was the problem faced by GIO during the NSW Transcover period of the mid-980s. These extra administrative costs (particularly involved in dealing with extra at fault persons) may be successfully borne by insurers with large slices of the market, but economies of scale are likely to dissuade smaller insurers from either entering or remaining within the reformed system.

The other specific questions posed in the Options Paper have been answered within the body of the submission provided above. However, it would be remiss of the Law Society if it did not comment on what it believes to be the most important features in any scheme reform. In this respect the Law Society's ardent belief is that any motor accident scheme should be efficient and sustainable and deliver fair measures of compensation to victims of motor accidents. Any new scheme should deal with each claim on its individual merits taking into account the individual circumstances of the injured person without resort to arbitrary impairment thresholds which were never intended to measure employment capacity.

10. Conclusions

The Law Society has made recommendations which address all the Government's stated objectives in review of the scheme.

The Law Society's proposal in relation to scheme redesign, which has been the subject of collaborative meetings with insurers, is designed to extend some benefits to all injured road users, regardless of fault. It will also address the objective of a more timely delivery of certain benefits. The associated changes to the structure of legal costs will address the increase in legally represented minor severity claims, of such concern to the Government and insurers.

The Law Society believes that the various process changes suggested, if implemented, would effect significant improvements to scheme efficiency, timeliness of benefits delivery and ultimately affordability.

We are confident the Government's objectives can be achieved with implementation of our recommendations, without replacing a fundamentally sound and fair scheme, and all the risks involved in such an overhaul.

The Law Society is grateful for the opportunity to contribute to this review of the NSW CTP Scheme. Should you have any questions or require further information, please contact Leonora Wilson, the Policy Lawyer for the Injury Compensation Committee on 9926 0323 or email: Leonora.Wilson@lawsociety.com.au.

Yours sincerely

Gary Ulman
President

Table 5.8
Percentage of Victims Utilizing Particular Medical Services, by Insurance Regime and Year

		Liability System			
Type of Treatment	Year	Tort	No-Fault	Mandatory Add-On	Optional Add-On
ER visit	1987	32.4	47.2**	43.9**	38.5**
	1992	35.1	44.7**	38.3	38.3**
	1997	44.4	47.5**	43.7	43.7
	2002	44.9	46.9**	39.3**	45.5
	2007	47.1	48.7	41.9**	48.8*
Overnight hospital stay	1987	8.95	10.3**	9.64	9.56*
	1992	6.53	7.21**	5.87	6.84
	1997	5.35	5.57	5.88	5.22
	2002	5.44	6.34**	5.15	5.18
	2007	4.52	5.09**	4.06	4.64
Visit to chiropractor	1987	13.3	15.4**	14.5	10.2**
	1992	21.4	25.8**	19.1*	17.5**
	1997	30.6	33.8**	32.0	25.4**
	2002	32.7	34.3*	26.6**	27.9**
	2007	31.5	37.3**	28.4*	30.3
Visit to physical therapist	1987	7.18	6.95	10.5**	10.3**
	1992	12.3	13.0	16.5**	17.3**
	1997	15.7	21.3**	25.4**	22.0**
	2002	16.0	27.1**	26.0**	20.5**
	2007	13.4	22.9**	27.6**	18.0**
Visit to dentist	1987	1.09	1.34**	0.880	1.28**
	1992	1.85	2.24*	1.99	1.71
	1997	1.58	1.88**	1.45	1.54

Table 5.8—Continued

		Liability System			
Type of Treatment	Year	Tort	No-Fault	Mandatory Add-On	Optional Add-On
Visit to dentist (continued)	2002	1.11	1.84**	1.05	1.13
	2007	n.a.	n.a.	n.a.	n.a.
Visit to psychotherapist	1987	0.716	0.816*	0.822	0.691
	1992	1.19	2.02**	1.01	1.33
	1997	0.567	1.82**	0.840	0.566
	2002	0.494	2.61**	0.542	0.526
	2007	0.351	1.23**	0.335	0.327
None	1987	3.06	2.47**	2.77**	2.98*
	1992	3.09	1.78**	2.75	3.06
	1997	7.39	5.63**	6.44**	7.40
	2002	10.3	8.50**	11.9*	11.0*
	2007	9.78	6.69**	7.61**	9.09*

SOURCE: Authors' calculations from IRC closed-claim data (All-Industry Research Advisory Council, 1989b; IRC, 1993, 2003, 2008b).

* = statistically significantly different from the value for tort states at the 5% level.

** = statistically significantly different from the value for tort states at the 1% level.

with greater likelihoods of an accident victim visiting almost every category of health-care provider in almost every year for which we have data.[47]

Trends in claimed ER use differ substantially across systems. In all years, claimed ER use is more common in no-fault states than in tort states. An increasing share of patients has accessed the emergency

[47] We also conducted this analysis without controlling for accident, injury, vehicle, and driver characteristics and obtained generally similar results, although, for some types of treatment, such as emergency room (ER) utilization, differences across regimes were even more pronounced. This suggests not only that otherwise-similar individuals consume more treatment in no-fault states but also that no-fault states have more of the types of people who consume certain types of costly treatment.

Table 5.9
Average Number of Claimed Visits Among Those Using a Particular Provider Type, by Insurance Regime and Year

		Liability System			
Number of Visits	Year	Tort	No-Fault	Mandatory Add-On	Optional Add-On
Osteopath	1992	9.57	10.1	8.19	8.78
	1997	9.40	10.2	11.1	8.62
	2002	6.70	8.70*	4.95	7.81
	2007	6.45	6.06	7.89	7.00
Chiropractor	1992	23.8	34.1**	23.0	23.2
	1997	21.8	32.9**	22.1	20.8**
	2002	20.6	29.1**	23.5**	19.3**
	2007	18.8	27.5**	23.5**	19.8*
Physical therapist	1992	18.1	22.9**	21.6*	16.6**
	1997	15.0	21.9**	16.8*	14.3
	2002	13.7	22.5**	15.2	12.8*
	2007	13.2	21.3**	15.8*	13.4
Dentist	1992	8.92	8.12	10.7	7.56
	1997	3.15	4.87**	3.64	3.50
	2002	2.92	4.31**	3.85	2.94
	2007	n.a.	n.a.	n.a.	n.a.
Psychotherapist	1992	11.1	11.3	8.43	13.7
	1997	8.78	11.7**	9.37	6.78
	2002	7.62	7.99	3.83	8.17
	2007	8.00	8.49	4.11*	6.20

SOURCE: Authors' calculations from IRC closed-claim data (All-Industry Research Advisory Council, 1989b; IRC, 1993, 2003, 2008b).

* = statistically significantly different from the value for tort states at the 5% level.

** = statistically significantly different from the value for tort states at the 1% level.

Table 5.10
Cost of Medical Care in States with Other Insurance Regimes, Relative to Tort States

Survey Year	Median Cost of Care in Tort States ($)	Cost of Care Relative to Tort States (%)		
		No-Fault States	Mandatory Add-On States	Optional Add-On States
1987	972	5.86	−10.50	−11.44
1992	1,758	25.76	−12.92	−5.91
1997	1,414	51.06	−11.19	6.75
2002	1,584	50.43	−14.92	3.35
2007	1,936	42.90	−6.17	−3.50

SOURCE: Authors' calculations from IRC closed-claim data (All-Industry Research Advisory Council, 1989b; IRC, 1993, 2003, 2008b).

NOTE: All relative differences except those in mandatory–add-on states in 2007 are statistically significant at the 5% level (see shading). Dollar costs are expressed in year 2000 dollars.

was some relative cost growth in optional–add-on states, growth was much smaller in these states, and there is no evidence of growth in mandatory–add-on states. This evidence of high medical cost inflation reaffirms the patterns in Figure 4.1 in Chapter Four, which showed a growing premium-cost gap between no-fault states and states with other insurance systems between 1987 and 2002. An important distinction, however, is that the analysis in Table 5.10 demonstrates that this differential growth persists even after accounting for interstate differences in auto injuries and victims' demographic characteristics. Rising costs under no-fault were not a matter simply of increased utilization of treatment but also of rising charges for the same treatment.

Does this medical inflation primarily reflect trends in the larger no-fault states? To explore this hypothesis, we differentiate the larger

source of payments that was not constrained by health-insurance scrutiny, no-fault may have provided an opportunity for doctors to enrich themselves—or to subsidize below-cost care for uninsured patients.