LAW REFORM
COMMITTEE

Legal Liability of Health Service Providers

FINAL REPORT

MAY 1997

PARLIAMENT OF VICTORIA

LAW REFORM COMMITTEE

The Legal Liability of Health Service Providers

FINAL REPORT

Ordered to be Printed

Melbourne

Government Printer

May 1997

N° 45 Session 1996–97

COMMITTEE MEMBERSHIP

CHAIRMAN

Mr Victor Perton, MP

DEPUTY CHAIR

Mr Neil Cole, MP

MEMBERS

Mr Florian Andrighetto, MP

Hon Carlo Furletti, MLC

Hon Monica Gould, MLC

Mr Peter Loney, MP

Mr Noel Maughan, MP

Mr Alister Paterson, MP

Mr John Thwaites, MP

The Committee's address is —

Level 8, 35 Spring Street
MELBOURNE VICTORIA 3000

Telephone inquiries — (03) 9651 3644

Facsimile — (03) 9651 3674

Email — lawrefvc@vicnet.net.au

Internet— http://www.vicnet.net.au/~lawref

Committee Staff

EXECUTIVE OFFICER and DIRECTOR OF RESEARCH

Mr Douglas Trapnell

CONSULTANTS

Prof Greg Reinhardt

Dr Russell Smith

RESEARCH OFFICERS

Ms Padma Raman

Ms Rebecca Waechter

OFFICE MANAGERS

Mrs Rhonda MacMahon (until 18 October 1996)

Ms Lyn Petersen (from 2 December 1996)

CONTENTS

Committee Membership.......................... 3
Committee Staff..........4
Functions of the Committee..........10
Terms of Reference..........11
Chairman's Foreword..........12
List of Recommendations..........15

1 INTRODUCTION
Background to the Inquiry..........23
Terms and Concepts..........26
Framework of the Report..........29

2 LIABILITY, IMMUNITY AND INSURANCE
Introduction..........32
Liability in Negligence and The Bolam Principle..........33
The Bolam Principle..........34
Rogers v. Whitaker and the Bolam Principle in Australia..........35
Adequate Disclosure by a Health Service Provider: Post-Rogers..........38
Diagnosis and Treatment: Rogers and Beyond..........39
Woods v. Lowns and Procopis: A Move Back Towards Bolam?..........41
Is the Legal Standard of Care Adequate?..........43
Education on the Law of Negligence..........44
Good Samaritan Legislation..........45
The Position of Rescuers at Common Law..........46
Health Service Providers as Rescuers..........46
Good Samaritan Laws in other Jurisdictions..........50
Should Victoria Enact Good Samaritan Laws?..........51
Statutory Immunity of Screening Services..........52
Support for Statutory Immunity of Screening Services..........54
Opposition to Statutory Immunity of Screening Services..........57
Possible Models for Legislative Change..........58
Improving the Quality of Screening Services..........63
Compulsory Professional insurance..........64

Public Health Care 68
Linking Compulsory Professional Indemnity Insurance with Registration 69

3 COMPENSATION PAYMENTS: THE NEED FOR REFORM
Introduction 73
The Aim of Compensatory Damages 76
The Heads of Damage 77
The Once-and-for-all Rule and its Problems 80
The Extent to which Lump Sums are Used 83
Evidence of Under-Compensation 84
Evidence of Over-Compensation 88
Dissipation and Loss of Funds 91

4 COMPENSATION PAYMENTS: ALTERNATIVE APPROACHES
Introduction 95
New South Wales 96
Government Insurance Office Structured Settlements 96
Motor Accidents Act 1988 Structured Settlements and Interim Payments 97
Workers Compensation Act 1987 Structured Settlements and Interim Payments 100
Supreme Court Act 1970 and District Court Act 1973 Interim Damages 100
Dust Diseases Tribunal Act 1989 Provisional Damages 102
New South Wales Law Reform Commission's Proposal for Provisional Damages 103
South Australia 104
Supreme Court Act 1935 Interim and Periodical Payments 104
Western Australia 108
Periodical Payments 108
Victoria 110
Transport Accidents Periodical Payments and Structured Settlements 110
Workers' Compensation Periodical Payments and Structured Settlements 112
Structured Settlements by the Health Services Commissioner 115
Other Victorian Compensation Legislation 116
Criminal Injuries Compensation 116
United Kingdom 117
Court-Awarded Interim Damages 117
Court-Awarded Provisional Damages 120
Court-Awarded Periodical Payments 123
Structured Settlements 124
The United States 133
The Introduction of Structured Settlements 133
Taxation Treatment of Structured Settlements 134

Funding Arrangements 135
Legislative Regulation of Structured Settlements 135
The Current Structured Settlements Climate 136

5 COMPENSATION PAYMENTS: THE CASE FOR REFORM
Introduction 143
Written Submissions 144
Oral Evidence 146
Evidence Obtained in the United States 147
The Case for Reform 150
Certainty 150
Security 151
Reduced Liability 151
Avoidance of Dissipation 153
Flexibility 154
Sounder Financial Management 154
Encouraging Early Settlement 155
Freedom of Choice versus Paternalism 155
The Need for Legislation 156
Taxation 156
Administration 157
Reviewability 157

6 COMPENSATION PAYMENTS: THE CASE AGAINST REFORM
The Case for Retaining the Current System of Compensation 159
Finality in Litigation 160
The Effect of Lump Sum Compensation Upon the Plaintiff's Well-Being 161
Lump Sum Payments Secure Freedom of Choice for Plaintiffs 162
The Lump Sum Payment is an Accurate Measure of the Plaintiff's Loss 163
Increased Costs Associated with any Structured Arrangement 163
Taxation 164
Introduction 164
Why Lump Sum Damages are Non-Taxable 165
Statutory Interest is Taxable 165
Proposed Taxation Changes to Treatment of Lump Sum Payments 167
Taxation of Structured Settlements and other Structured Arrangements 168
Conclusion 171

7 COMPENSATION PAYMENTS: THE PREFERRED APPROACH
Introduction 173

The Adoption of Overseas Schemes 173
The Taxation of Compensation Payments 176
Overview of the Proposed Scheme 177
Court-Awarded Payments 177
Out-of-Court Settlements 181
Court-Awarded Compensation 183
County Court Proceedings 183
Interim Payments 183
Provisional Payments 189
The Itemisation of Awards of Compensation 193
The Payment of Compensation for Past Losses 194
The Payment of Compensation for Future Losses 196
Structured Judgments for Small and Medium Awards 197
Structured Judgments for Large Awards 199
Out-of-Court Structured Settlements 204
Legislative Controls 204
Settlements Covered 204
The Itemisation of Compromised Claims 205
The Settlement of Small and Medium Claims 206
The Settlement of Large Awards 206
The Application of the Reforms Proposed in this Report to other Compensation Payments 208

8 IMPROVING THE LITIGATION PROCESS
CASE MANAGEMENT OF LITIGATION 212
County Court of Victoria 212
Supreme Court of Victoria 214
United Kingdom Initiatives 215
Responses to Judicial Case Management 218
ALTERNATIVE DISPUTE RESOLUTION 223
Introduction 223
The Health Services Commissioner 224
The Existing Role of the Health Services Commissioner 225
How Complaints are Treated 226
Increasing the Role of the Health Services Commissioner 228
Alternative Mechanisms for Increasing the Role of the Health Services Commissioner 230
Conclusion 247

9 PROBLEMS OF RURAL MEDICINE ....

The Shortage of Doctors in Rural Communities 249
Medical Services in Eastern Victoria 254
Problems Attracting and Retaining Doctors 255
Reducing Disincentives 273
State Government Initiatives 274
Royal Australian College of General Practitioners 276
Australian Medical Association 276
Rural Doctors Association 277
Federal Government Initiatives 278

APPENDICES
Appendix A—List of Submissions 286
Appendix B—List of Witnesses 291
Appendix C—Glossary 293
Appendix D—Case Studies 295
Appendix E—Structured Settlement Agreement 298

PARLIAMENTARY COMMITTEES ACT 1968

4E. The functions of the Law Reform Committee are—

(a) to inquire into, consider and report to the Parliament where required or permitted so to do by or under this Act, on any proposal, matter or thing concerned with legal, constitutional or Parliamentary reform or with the administration of justice but excluding any proposal, matter or thing concerned with the joint standing orders of the Parliament or the standing orders of a House of the Parliament or the rules of practice of a House of the Parliament;

(b) to examine, report and make recommendations to the Parliament in respect of any proposal or matter relating to law reform in Victoria where required so to do by or under this Act, in accordance with the terms of reference under which the proposal or matter is referred to the Committee.

TERMS OF REFERENCE

Parliamentary Committees Act 1968

TERMS OF REFERENCE FOR AN
INQUIRY INTO THE LIABILITY OF THE
STATE OF VICTORIA AND HEALTH
SERVICE PROVIDERS

The Governor in Council, acting under section 4F(1) of the *Parliamentary Committees Act 1968* and on the recommendation of the Minister for Health, by this Order requires the Law Reform Committee to inquire into, consider and report to the Parliament on issues arising out of court-based compensation for people who have suffered injuries as a result of service provided by a health provider, in accordance with the following Terms of Reference:

1. The Government is concerned that the increasing cost of professional indemnity insurance could affect access to medical services.

2. The Parliamentary Law Reform Committee is requested to investigate options with respect to the following—

   a) the need to ensure medical services provided are of a high standard and that where standards are not maintained people have suitable redress;

   b) the reduction of any disincentives to the provision of health services by fears of inappropriate liability;

   c) the use of structured settlements to maximise the benefit to an injured person of any financial compensation ordered by a court; and

   d) alternatives to the current system of court-based compensation for people injured in the use of health services.

Dated 12 June 1996

Responsible Minister: ROB KNOWLES

Minister for Health

Victoria Government Gazette, G 24, 20 June 1996, pages 1568 & 1569

CHAIRMAN'S FOREWORD

I have great pleasure in presenting the Law Reform Committee's final report on its Inquiry into the Liability of the State of Victoria and Health Service Providers. The inquiry arose out of Government concern that the increasing cost of professional indemnity insurance could affect access to medical services, particularly in provincial and rural Victoria. The Committee was asked to investigate and report upon a number of specific issues; including, the use of structured settlements as an alternative to lump sum payments of compensation, and alternatives to the current system of court-based compensation.

The Committee has found this to have been a difficult and complex reference. The issues raised for consideration have involved not only difficult questions of law and questions concerning what is considered to be good medical practice, but also human factors; such as, the need to maintain good doctor-patient relationships and the effect of litigation on doctors' reputations.

It is clear to me that there is no simple solution to these complex issues. Striking a balance between the personal interests of health service providers, the protection of health service consumers and the public interest is most difficult, and has led to a myriad of solutions around the world. The Australian common law solution on the legal liability of medical practitioners is disapproved of by many doctors. On the evidence before the Committee, there is no public benefit in making a change to the common law. Further, the Committee could find no better formulation to balance the interests of doctors and patients.

Nonetheless, the Committee through its recommendations has sought to provide for clarification of the law relating to doctors and nurses as rescuers. The Committee found that there was a public benefit in altering the

evidentiary effect of false reports in screening tests. The introduction of compulsory professional indemnity insurance for statutorily registered health service providers is recommended also. A number of recommendations relating to matters of court procedure and the types of remedies available are made; including, the introduction of interim and provisional awards of damages and the payment of damages by way of structured judgments or settlements. A more extensive role for the Health Services Commissioner is advocated and a number of recommendations are directed towards addressing problems specific to the practice of medicine in provincial and rural Victoria.

The Committee has found that the perception of the medical profession concerning recent increases in the cost of professional indemnity insurance is not reflected in a significant increase in either the quantity of claims or their quantum. Rather, a number of high profile cases, particularly in New South Wales, has led to a widespread belief that there is a crisis in medical negligence litigation when, in fact, there is not. The Committee's view is that there is no real crisis in the level of insurance premiums that is impacting on service delivery, or is likely to impact in the near future. Present premium levels are not oppressive. Consequently, the Committee has recommended the introduction of structured settlements because of their benefit to those receiving compensation payments and not because of any nexus with lower insurance premiums.

I wish to thank all the members of the Committee for their contributions to this final report. I also wish to thank the many individuals and organisations which made written submissions and the expert witnesses who gave generously of their time to assist the Committee with its inquiry.

In presenting its report, the Committee acknowledges the great assistance it has received from Dr Russell Smith and Prof Greg Reinhardt who have acted as consultants on various aspects of this inquiry. I wish to thank the Director of Research, Mr Douglas Trapnell, who has worked tirelessly and thoroughly on this reference while managing all of the other functions of the Committee.

Rebecca Waechter and Padma Raman, the Committee's research officers, have worked diligently, thoughtfully and cheerfully during the project. Our former office manager, Rhonda MacMahon, and our present office manager, Lyn Petersen, have provided valuable support.

On a personal note, this is a reference in which many people have offered me their private views on the issues concerned. I have seen many examples of personal tragedy for doctors and patients. I have seen the issues at close range. I have been spurred to get the best out of this project. Given the constraints of the federal-state relationship and community attitudes to radical solutions such as no-fault liability, I believe that the Committee's report offers the best solutions available to Victoria.

I commend the report to the Parliament.

Victor Perton, MP

Chairman
21 May 1997

LIST OF RECOMMENDATIONS

Is the Legal Standard of Care Adequate?

Recommendation 1

The Australian common law standard of reasonable care in medical negligence cases is appropriate and should not be replaced by a statutory standard, other than in the limited ways recommended in this report.

Paragraphs 2.37–2.40

Should Victoria Enact Good Samaritan Laws?

Recommendation 2

The Victorian Government should enact legislation to provide a limited defence for medical practitioners and nurses who provide medical assistance at the scene of an accident or other emergency. The Queensland provisions contained in the Voluntary Aid in Emergency Act 1974 *should be used as a model in formulating the Victorian laws.*

Paragraphs 2.64–2.66

Statutory Immunity for Screening Services

Recommendation 3

The Wrongs Act 1958 *(Vic.) should be amended to provide that a false report arising out of a screening procedure does not of itself constitute a breach of a duty of care in negligence, although it may be relied upon as a material fact in determining whether there has been negligence:*

Paragraphs 2.67–2.107

Improving the Quality of Screening Services

Recommendation 4

The Cancer Act 1958 *(Vic.) should be amended to allow information on breast and cervical cancer to be forwarded to health service providers in screening programs.*

Paragraphs 2.108–2.109

Compulsory Professional Insurance

Recommendation 5

Statutorily recognised health service providers should be required to obtain compulsory professional indemnity insurance cover with respect to privately funded patients, in order to become and remain registered. The minimum level of cover should be specified by the appropriate registration board, in consultation with relevant professional associations. Run-off cover should be provided for those who are currently insured on a different basis to the mandatory requirement.

Paragraphs 2.110–2.134

The Taxation of Compensation Payments

Recommendation 6

The Victorian Government should ask the Commonwealth Government to amend the Income Tax Assessment Act 1936 *(Cwlth) to provide that payment of compensation, including by way of structured judgments and settlements, for personal injuries are non-taxable in the hands of the payee.*

Paragraphs 7.10–7.13

County Court Proceedings

Recommendation 7

Sub-section (1) of section 73 of the County Court Act 1958 *(Vic.) which provides that judgments and orders in civil proceedings are final, should not apply to claims for compensation for personal injuries suffered through the use of health services.*

Paragraphs 7.37–7.38

Interim Payments

Recommendation 8

The Supreme Court Act 1986 *(Vic.) and the* County Court Act 1958 *(Vic.) should be amended to permit the court to make an interim award of damages to a plaintiff in actions for damages for personal injuries arising out of the use of health services. The amendment should be along the lines of the provisions contained in Order 29, rule 11 of the Rules of the Supreme Court (Eng.) and section 76E of the* Supreme Court Act 1970 *(NSW).*

Paragraphs 7.39–7.40

Recommendation 9

The Victorian Government should ask the Commonwealth Government to amend the Social Security Act 1991 *(Cwlth) to permit interim payments of compensation for injuries suffered through the use of health services to be received by claimants without any requirement to pay any sum to the Health Insurance Commission, until the final assessment of damages takes place. The notification provisions of the Act should continue to apply to the payment of interim damages.*

Paragraphs 7.41–7.56

Provisional Payments

Recommendation 10

The Supreme Court Act 1986 *(Vic.) and the* County Court Act 1958 *(Vic.) should be amended to permit the court to make a provisional award of damages to a plaintiff in actions for damages for personal injuries arising out of the use of health services along the lines of the provisions contained in section 32A Supreme Court Act 1981 (Eng.) and section 11A* Dust Diseases Tribunal Act 1989 *(NSW). Payment of compensation for future non-pecuniary loss should be able to be paid provisionally in the circumstances where provisional damages may be awarded.*

Paragraphs 7.58–7.59 & 7.60–7.67

The Itemisation of Awards of Compensation

Recommendation 11

In assessing damages for personal injuries suffered through the use of health services, the court making an award or the parties agreeing to compromise an action, should allocate specific sums to the various heads of damage, and in particular should specify what sums are payable in respect of past losses and what sums are payable in respect of future pecuniary losses.

Paragraphs 7.68–7.70

The Payment of Compensation for Past Losses

Recommendation 12

The payment of compensation made in respect of past losses should be made by way of a lump sum.

Paragraphs 7.72–7.76

Recommendation 13

A list of recommended financial advisers should be compiled by appropriate court officers, and approved by the judges of the Supreme and County Court for

distribution to persons who receive large awards of damages, whether as a result of court judgments or negotiated settlements.

Paragraphs 7.77

Structured Judgments for Small and Medium Awards

Recommendation 14

Damages awarded for injuries caused through the use of health services should be paid by way of lump sum in all cases where the amount awarded in respect of future pecuniary losses is less than $50,000 (subject to indexation), but without affecting the ability of the court to award interim or provisional damages.

Paragraphs 7.82–7.83

Recommendation 15

Damages awarded for injuries caused through the use of health services may, at the discretion of the court, be paid by way of a structured judgment approved of by the court in all cases where the amount awarded in respect of future pecuniary losses is greater than $50,000 but less than $500,000 (subject to indexation), but without affecting the ability of the court to award interim or provisional damages.

Paragraph 7.84

Recommendation 16

Legislation should be enacted to provide a licensing system for bodies which are authorised to provide annuities for use in structured judgments. Minimum statutory requirements should be laid down. The office of the Senior Master of the Supreme Court and the Registrar of the County Court should be approved as bodies authorised to provide annuities for use in structured judgments.

Paragraphs 7.85–7.86

Structured Judgments for Large Awards

Recommendation 17

Except where exceptional circumstances are demonstrated, all awards of damages where the amount allowed for future pecuniary losses exceeds $500,000 (subject to indexation), arising from the use of health services, should be paid in accordance with a structured judgment approved by the court.

Paragraphs 7.87–7.102

Recommendation 18

The Administration and Probate Act 1958 *(Vic.) should be amended to permit the estate of a plaintiff who was a party to a structured judgment, to recover any sums*

payable in respect of loss of earning capacity which would have been paid to the plaintiff had he or she continued to live.

Paragraphs 7.103–7.104

The Itemisation of Compromised Claims

Recommendation 19

In agreeing to compromise a claim for damages for injuries suffered through the use of health services, the parties should be required to allocate specific sums to the various heads of damage, and in particular should specify what sums are payable in respect of past losses and what sums are payable in respect of future pecuniary losses.

Paragraphs 7.110–7.111

The Settlement of Large Awards

Recommendation 20

Except where exceptional circumstances are demonstrated, in all claims for compensation for injuries suffered through the use of health services where it is agreed between the parties that the amount of compensation awarded in respect of future pecuniary losses exceeds $500,000 (subject to indexation), the monies should be paid in accordance with a structured judgment, approved by the court and administered by the Senior Master of the Supreme Court or the Registrar of the County Court.

Paragraphs 7.114–7.117

Recommendation 21

The Administration and Probate Act 1958 *(Vic.) should be amended to permit the estate of a plaintiff who was a party to a structured settlement, to recover any sums payable in respect of loss of earning capacity which would have been paid to the plaintiff had he or she continued to live.*

Paragraph 7.118

The Application of the Reforms Proposed in this Report to other Compensation Payments

Recommendation 22

Consideration should be given to making payments of compensation for loss suffered other than in respect of personal injuries arising out of the use of health services, subject to the rules governing the payment of compensation recommended elsewhere in this report.

Paragraphs 7.120–7.122

Recommendation 23

Consideration should be given to making awards of compensation made pursuant to the provisions of the Accident Compensation Act 1985 *(Vic.), the* Transport Accidents Act 1987 *(Vic.) and payments made to claimants arising out of agreements conciliated by the office of the Health Services Commissioner, subject to the rules governing the payment of compensation recommended elsewhere in this report.*

Paragraphs 7.123–7.125

Recommendation 24

Consideration should be given to making payments of compensation made pursuant to the provisions of the Country Fire Authority Act 1958 *(Vic.), the* Education Act 1958 *(Vic.), the* Police Assistance Compensation Act 1968 *(Vic.), the* Victoria State Emergency Service Act 1987 *(Vic.), and the* Wrongs Act 1958 *(Vic.) subject to the rules governing the payment of compensation recommended elsewhere in this report.*

Paragraph 7.126

Case Management of Litigation

Recommendation 25

The continued use of case management measures by Victoria's courts should be encouraged.

Paragraphs 8.2–8.31

Alternative Dispute Resolution

Recommendation 26

A party to a claim for negligence arising out of the provision of health services should be able to choose conciliation before the Health Services Commissioner prior to the issue of proceedings as an alternative to court-run pre-trial conferences.

Paragraphs 8.110–8.113

Recommendation 27

The legislation governing the Office of the Health Services Commissioner should be amended to address the potential conflict between two of its main functions; namely resolving complaints to the satisfaction of the parties, and the Commissioner's responsibility for standards of health. This should be achieved by adopting the model which exists under New South Wales legislation.

Paragraphs 8.70–8.74

Recommendation 28

Despite a complaint being referred to the Medical Practitioner's Board, the Office of the Health Services Commissioner should still be able to provide conciliation services to the parties in the complaint.

Paragraphs 8.75–8.78

The Shortage of Doctors in Rural Communities

Recommendation 29

Consideration should be given to increasing the subsidy for general practitioners under the State Government's Continuing Medical Education Program. The program should be extended to cover other areas where continuing education would be particularly useful, such as paediatrics and the treatment of infectious disease.

Paragraphs 9.41–9.43

Recommendation 30

Medical professional colleges should review the delivery of continuing medical education so as not to create unnecessary barriers in credentialling, recertification and recruitment of rural doctors.

Paragraph 9.44

Recommendation 31

Federal and State Governments should provide financial incentives to rural practices which accept an assignment of medical students, so that they are not financially disadvantaged by the provision of this service.

Paragraph 45

Recommendation 32

The feasibility of extending teleconferencing services to assist rural practitioners should be investigated by the Federal and State Governments. These facilities can provide valuable peer support and access to specialist advice for rural doctors.

Paragraphs 9.46–9.48

Recommendation 33

Rural doctors should be encouraged to form an Australian College of Rural and Remote Medicine.

Paragraph 9.52

Problems in Obtaining Locums

Recommendation 34

Consideration should be given to providing a cost effective alternative to insurance which extends the basic indemnity cover of urban locums who provide coverage for rural doctors on recreation or other leave. This may be achieved by using a variation of the arrangement available to general practitioners engaging in rural practice in small communities, or by way of a subsidy.

Paragraph 9.69–9.71

Advanced Specialist Training Posts

Recommendation 35

Consideration should be given to addressing the need to provide employment opportunities for spouses of doctors who are willing to work in rural areas.

Paragraph 9.89

Recommendation 36

Consideration should be given to the provision of employment paths for those doctors who return to metropolitan areas after working in rural or remote areas for 5 to 10 years.

Paragraph 9.89

Recommendation 37

The difficulties facing medical practitioners in rural and remote areas should be further investigated in 1998. A detailed examination of the efficacy of each Federal and Victorian Government initiative and proposal should be undertaken.

Paragraphs 9.84–9.113

Recommendation 38

The admission of suitably qualified overseas doctors who wish to practice in rural Victoria should be facilitated by the Victorian Government and the Medical Board of Victoria.

Paragraph 9.110

Recommendation 39

Consideration should be given to providing greater incentives for Australian trained medical practitioners to work in rural areas.

Paragraphs 9.84–9.112

1 INTRODUCTION

Background to the Inquiry

1.1 In September 1995, the Law Reform Committee was given a reference by the Governor-in-Council to inquire into, consider and report to the Parliament on issues arising out of court-based compensation for people who have suffered injuries as a result of services provided by a health service provider.[1] The terms of reference for the Inquiry were amended in November, 1995.[2]

1.2 Four specific issues were identified as matters to which the Committee should direct its attention: the need to ensure that medical services provided are of a high standard and that where standards are not maintained people have suitable redress; the reduction of any disincentives to the provision of health services by fears of inappropriate liability; the use of structured settlements to maximise the benefit to an injured person of any financial compensation ordered by a court; and alternatives to the current system of court-based compensation for people injured in the use of health services.

1.3 Following receipt of the reference, the Committee heard oral evidence from a number of individuals and considered some written submissions prior to undertaking research for the preparation of its Issues Paper No. 1 which was published in January 1996.[3] Over thirty submissions were received prior to the initial closing date for receipt of submissions on the 18 March 1996.

1.4 On 5 March 1996 the Parliament was dissolved for the State election and the Committee's reference lapsed. Following the election a new Committee was appointed on 14 May 1996 consisting of two former members and seven new members, including a new Chairman. The Committee wishes

---

1 *Victoria Government Gazette*, G37, 21 Sep. 1995, p. 2719.

2 *Victoria Government Gazette*, G43, 2 Nov. 1995, p. 3082.

3 Parliament of Victoria, Law Reform Committee, *Legal Liability of Health Service Providers: Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996.

to record its appreciation for the substantial contributions made by its former members. Terms of reference for the current inquiry were published in the *Victoria Government Gazette* on 20 June 1996. They are in identical form to those as amended in November 1995.[4]

1.5 The Law Reform Committee is a joint investigatory Committee of the Victorian Parliament with a statutory power to conduct investigations into matters concerned with legal, constitutional and parliamentary reform or the administration of justice.[5] The Committee's membership, which includes lawyers and non-lawyers, is drawn from both Houses of the Victorian Parliament and all political parties are represented.

1.6 At the time of tendering this report, the Committee has received seventy-nine written submissions as well as having received evidence from a number of individuals and organisations in both Victoria, and the United States during a visit undertaken by delegates of the Committee in August/September 1996. The names of persons and organisations who made written submissions are listed in Appendix A to this report and the names of persons who gave oral evidence to the Committee are listed in Appendix B.

1.7 The issues embodied in the terms of reference are extremely wide in scope and raise fundamental questions as to the role which court-based compensation should play in ensuring that people who suffer injuries through medical misadventure are adequately and properly compensated. A number of other inquiries have considered and are considering similar issues. The most recent of these are the Commonwealth Department of Human Services and Health's Professional Indemnity Review[6] and the New South Wales Departments of Health and the Attorney-General, Joint Working Party on Medical Liability.[7]

---

4 *Victoria Government Gazette*, G 24, 20 Jun. 1996, pp. 1568–1569.

5 *Parliamentary Committees Act 1968* (Vic.), s. 4E.

6 Commonwealth Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: Final Report*, AGPS, Canberra, 1995 (hereafter cited as 'PIR Final Report').

7 T. Harris, 'GPs back law-suit curbs', *The Weekend Australian*, 4/5 Jan. 1997, p. 7.

1.8 The Victorian reference arose out of a number of specific concerns which were identified concerning the manner in which people receive compensation for medical misadventure in Victoria.

1.9 First, was the widespread perception that the amounts of money paid by health service providers to obtain professional indemnity cover have increased to such an extent for practitioners in some specialities, such as obstetrics and gynaecology, that practice in these specialities is becoming financially unviable. The situation of rural general practitioners who undertake obstetric services infrequently was cited as the area of major concern.

1.10 Secondly, extremely large awards of damages which have occasionally reached over five million dollars, are said to have exceeded the maximum amount payable by the mutual funds in respect of professional indemnity cover, thus leaving health service providers at risk of personal liability and those who have suffered injuries at risk of going uncompensated.[8]

1.11 Thirdly, concern has been expressed that the basis upon which liability in negligence is now determined by courts in Australia is inappropriate in situations where an adverse outcome is an expected, if unfortunate and rare, consequence of a procedure carried out in good faith and in a professional manner. The situation which arises in cervical screening is given as an example of this.

1.12 Fourthly, there is the problem of defensive medicine; namely, that doctors may be providing services in such a way as to ensure that the risk of professional liability is minimised, even if this entails the provision of services which may not be clinically necessary for patient care.

1.13 Finally, there is a view that it is inappropriate for a health user injured through medical misadventure to receive a substantial award of damages on the basis of an estimated life expectancy, where the individual in question

---

[8] See e.g., *Crossman, by his next friend Public Trustee v. Le Fevre and Port Adelaide Community Hospital Incorporated (in Provisional Liquidation)*, unreported, Supreme Court of SA, Matheson J, 22 Dec. 1991. See also, P. Nisselle, 'Legal claims and costs hit doctors and community' *The Age*, 18 Jul. 1995.

may die earlier than expected, thus providing his or her estate with a financial windfall. Similarly, it was considered to be unfair for individuals to be required to shoulder the financial burden of caring for a person injured through medical misadventure where their circumstances have altered from those predicted to occur at the time damages were assessed.

1.14 The issues raised during this inquiry are particularly important given the findings of a recent study into the incidence of adverse events (that is, unexpected injuries) arising out of the use of health services in Victorian hospitals. The study which was publicly released on the day before the Committee adopted its report, found that 62,949 patients experienced adverse events.[9] This represents a five percent error rate.[10] The total number of adverse events was 67,260.[11] Most of these events consisted of complications arising out of surgical or medical procedures.[12] Additionally, the study revealed that the death rate for persons experiencing an adverse event was 0.14 percent.[13] Ross Wilson, the Director of Quality Assurance at the Royal North Shore Hospital in Sydney, described the rate of adverse events identified by the Victorian study as being 'of sufficient magnitude to demand action'.[14] The Committee notes this is consistent with the findings of a study conducted in 1992.[15] In light of this recent study, the Committee believes that the recommendations in this report will be significant not only to those who suffer an adverse outcome while using health services, and to health service providers, but also to the general community.

Terms and Concepts

1.15 Various different forms of compensation payments exist and these are often inadequately differentiated in the literature on the topic. For the purposes of the following discussion, a glossary is provided in Appendix C to this report. Other terms and concepts are as follows.

---

9 D. O'Hara & N. Carson, 'Reporting of adverse events in hospitals in Victoria, 1994–1995' *Med. J. Aust.*, 1997, vol. 166, p. 461

10. ibid.

11 ibid.

12 ibid.

13 ibid., p. 463.

14 R Wilson, 'Editorials: Are we committed to improving the safety of health care?' *Med. J. Aust.*, 1997, vol. 166, p. 452.

15 The Quality in Australian Health Care Study. See R. M. Wilson, W. B. Runciman, R. W. Gibberd, et. al., 'The Quality in Australian Health Care Study', *Med. J. Aust.* 1995, vol. 163, pp. 458–471.

1.16 'Lump Sum Damages' embody the common law position that an individual who suffers loss should be compensated by a single monetary sum awarded once-and-for-all by the courts. The rationale for this rule will be examined in more detail in Chapter 2.

1.17 'Periodical Payments'[16] involve a statutory modification to the common law position in respect of compensation for future loss. Payments are made in accordance with a specified time schedule and are able to be modified according to the circumstances of the claimant. Periodical payments require an initial assessment of the claimant's circumstances at the time the assessment is made followed by a regular periodical re-assessment of the claimant's needs as time progresses. Such a system requires that the claimant return to court in order to have the amount of the periodical payment re-assessed at various times. Payments are, therefore, made on the basis of accurately determined needs rather than being based upon a prediction of future contingencies.

1.18 'Interim Payments' involve the payment of sums of money to claimants pending the final determination of a claim and assessment of damages by the courts or by way of out-of-court settlement. Such schemes are of particular use where protracted and complex litigation is involved and have the benefit of enabling the claimant's loss to be determined to a more precise extent over a longer period of time than had an assessment been made once-and-for-all at trial.

1.19 'Deferred Assessment of Damages' involves the postponement of the assessment of damages until certain aspects of the claimant's loss become clearer. In order to ensure that the claimant receives some financial support during the period of the postponement, such a system is best combined with interim payments. By deferring the assessment of damages, the court is well-placed to know the full extent of the claimant's loss, or at least is in a better position to make a realistic prediction of future losses.

---

[16] Throughout this report periodical will be used as an adjective in preference to periodic, the latter is generally the preferred term in the United States.

1.20 ‘Provisional Damages’ varies the concept of deferred assessment by requiring the court to make a final determination and assessment of damages, but giving the claimant an option of returning to court for a further assessment should specified events occur, which were unforeseen at the time the original assessment was made. Examples of such circumstances could include the development of a further medical condition or serious deterioration in an existing condition. Such a scheme ensures that claimants’ changed circumstances are not overlooked in the compensation process.

1.21 ‘Structured Judgements and Structured Settlements’ are alternative methods to a lump sum payment for delivering compensation to recipients. There are two types of arrangements commonly available. In the first, the extent of the defendant’s liability remains open with the claimant’s costs continuing to be met for as long as they arise, regardless of how they might vary from the costs that were estimated at the time of the trial or settlement. This is the kind of arrangement found in statutory compensation schemes such as workers’ compensation and no-fault motor vehicle accident schemes, save that some schemes place an upper limit on the benefits that are available. The second form of structured settlement operates by means of contractual arrangements which provide a combination of periodical payments and occasional lump sums. In it the defendant’s liability is determined and fixed at the time the arrangement is entered into with payments arranged through annuities and various insurance products. It is usual for past losses to be compensated by an initial lump sum payment with future losses to be compensated by a continuing regime of payments extending over the remainder of the claimant’s lifetime. The size and timing of the payments made are tailored to meet the needs of the claimant and provision may also be made for the claimant’s dependents in the event of the death of the claimant. This report will employ two terms to describe such arrangements: *structured settlements* will be used to describe arrangements made upon the compromise of an action through an out-of-court-settlement; while *structured judgments* will be used to describe situations in which a court order is made embodying the terms of a judgment for damages or an agreement or otherwise where a court structured judgment is ordered. This latter procedure would be most appropriate for claims involving minors and claimants with some other legal incapacity or intellectual disability where court approval is necessary.

Framework of the Report

1.22 Following this introductory chapter, Chapter 2 deals with three issues. The terms of reference require the Committee to investigate options for 'the reduction of disincentives to the provision of health services by fears of inappropriate liability'. This chapter examines three areas that were highlighted in the evidence and submissions relating to this term of reference. First, the scope and correctness of the Bolam principle and the High Court of Australia's decision in *Rogers v. Whitaker*[17] will be examined and any need for legislative reform will be discussed. Secondly, the chapter considers whether there is a public policy reason to statutorily limit the liability in negligence for medical practitioners who act as 'rescuers' and for those involved in public health screening programs. The chapter concludes by examining whether and which categories of health service providers should be required by law to have compulsory professional indemnity cover and the appropriate level of such cover.

1.23 Chapter 3 outlines the need for reform in relation to the payment of compensation by describing the aim of damages payments, the various types of compensation payments employed and how awards of damages are paid at present. The available evidence is then presented to indicate whether or not individuals are being adequately and fairly compensated through the receipt of a once-and-for-all lump sum payment of damages at present. In particular, two problems will be considered: under-compensation in which inadequate funds are provided to enable the claimant to live satisfactorily in view of the losses sustained; and over-compensation in which claimants may be provided with sums which turn out to be excessive, mainly in circumstances in which the claimant dies earlier than estimated on the basis of actuarial assessment. The further problem of claimants dissipating awards of damages resulting in their eventually becoming dependent upon government financial support will also be addressed.

1.24 Chapter 4 sets out the various alternative approaches to the payment of compensation which have been adopted throughout the common law world. These include:

---

17 (1992) 175 C.L.R. 479.

(a) a number of statutory schemes which control the manner in which damages are paid;

(b) periodical payments of compensation in which future losses are paid by varying instalments;

(c) interim awards of damages in which payments are made prior to the final trial and assessment of damages;

(d) deferred assessment of damages in which the assessment is postponed until the circumstances of the claimant's loss have become clearer;

(e) provisional damages in which a final assessment of damages may be reviewed should specific or unforeseen events take place; and finally structured settlements in which an initial sum or sums are paid to the claimant with the balance being used to fund a series of periodical payments made over a number of years. An example of each approach will be presented in the context of the jurisdiction in which it operates with three countries being chosen for consideration: Australia, the United Kingdom and the United States of America. These alternative approaches will be described both in terms of court-awarded payments and out-of-court settlements with the advantages and disadvantages of each being considered in order to provide a framework for the selection of the most desirable option for introduction in Victoria.

1.25 Chapter 5 provides a summary of the submissions received by the Committee relating to the payment of compensation issue and concludes with a review of the arguments in favour of introducing reform in this area, and some observations on the opposing arguments.

1.26 Chapter 6 sets out the arguments against reform of the system of payment of compensation. In addition, this chapter considers the taxation implications of the various reform options canvassed, particularly how the individual components of a structured settlement should be taxed, if at all. The questions of whether payments made in respect of non-economic loss should be tax-exempt, whether lump sum components of awards made in respect of past and future loss of earnings and earning capacity should be taxable, whether tax exemptions should be given in respect of monies placed into trust and managed by an approved manager, and whether any administrative costs associated with managing periodical payments should be deductible expenses will be considered.

1.27 Chapter 7 then presents details of the preferred approach for introduction in Victoria for the payment of compensation. Before examining the detail of the recommended approach, two preliminary matters will be considered: the first dealing with the question of whether overseas models for the payment of compensation should be adopted in Victoria, and the second examining the taxation of compensation payments. The recommended approach is then presented in two sections: the first describing various reforms to the award of damages made by a court, and the second dealing with out-of-court-settlements of a structured nature which may or may not require court approval. The chapter will conclude with a discussion of the application of the proposed reforms to other types of compensation payments such as non-personal injuries cases and cases relating to personal injuries suffered other than through the use of health services.

1.28 Chapter 8 discusses alternatives to the current system of court-based compensation for people injured in the use of health services as well as recent initiatives in the case management of court-based litigation.

1.29 Chapter 9 considers the problems encountered by health service providers—particularly medical practitioners—in provincial and rural areas of Victoria and examines the existing and proposed Commonwealth and State Government programs developed to deal with these problems.

2 LIABILITY, IMMUNITY AND INSURANCE

Introduction

2.1 The Committee's terms of reference require it to investigate options for 'the reduction of any disincentives to the provision of health services by fears of inappropriate liability'. During the present inquiry, the Committee has received submissions and evidence which bear upon three aspects of this issue. These are dealt with in this chapter.

2.2 The first matter concerns the perceived erosion of the so-called 'Bolam principle'[18] as it applies to the standard of care in negligence required of medical practitioners in Australia following the High Court decision in *Rogers v. Whitaker*.[19] The current status of the Bolam principle in Australian tort law, and the question whether there should be any statutory modification of the common law position, are considered. The need to adequately educate medical students and practitioners regarding the law of negligence is also addressed.

2.3 The Committee has received evidence that a number of medical practitioners do not stop to render assistance to persons in need of medical assistance in an emergency situation, because of fear that, if they make a mistake, they may be held liable in negligence. Thus, the unique position of medical practitioners and nurses as rescuers is raised for the Committee's consideration. Once again, questions of public policy play a crucial role in determining whether there should be a statutory limitation of liability in such cases.

2.4 The next issue considered in this chapter relates to the position of public health screening programs. The question here is whether there are

---

18 See *Bolam v. Friern Hospital Committee* [1957] 1 W.L.R. 582

19 (1992) 175 C.L.R. 479

grounds in public policy to limit the liability in negligence for those involved in such programs, where a false negative result is generated. A false negative result—that is, where the screening test fails to detect a condition or disease that it is designed to detect—may occur through negligent conduct, or simply as a result of random statistical probability. The concern expressed to the Committee is that those who conduct such programs may be held to be liable in negligence where there has been no negligent act, but merely an adverse outcome as a result of random statistical probability. This issue highlights the medical profession's concern that juries will not properly apply the law in cases where a plaintiff has suffered a significant injury as a result of a false negative result. This concern raises the questions whether there needs to be a statutory definition of negligence, a statutory immunity from claims in negligence and/or a statutory defence in such cases.

2.5 Finally, the chapter concludes by examining an issue which is very much related to questions of liability in negligence; namely, the need for compulsory professional indemnity insurance cover for health service providers and the extent and nature of such cover.

Liability in Negligence and the Bolam Principle

2.6 In order to establish negligence a plaintiff must prove on the balance of probabilities that the defendant owed him or her a duty of care; that the defendant did not meet the required standard of care; that the breach of the duty of care caused loss or damage to the plaintiff; and that the loss or damage was reasonably foreseeable.

2.7 The duty of care arises out of a relationship of proximity between the parties. Where health service providers are concerned, the treating of a patient by a doctor is enough to give rise to the duty of care. In the landmark decision of *Rogers v. Whitaker* the High Court of Australia held:[20]

> The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is 'a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement' (*Sidaway v. Governors of Bethlem Royal Hospital* (1985) A.C. 871, per Lord Diplock at p 893); it extends to the examination, diagnosis and

[20] ibid., 480.

> treatment of the patient and the provision of information in an appropriate case (*Gover v. South Australia* (1985) 39 S.A.S.R. 543, at 551).

2.8 While the duty of care is usually easily established in cases of negligence where there is a doctor-patient relationship, the standard of care owed and the content of the duty owed has been a more complicated question in law.

The Bolam Principle

2.9 In England the standard of care owed by health service providers, and how this standard is determined, was settled in the case of *Bolam v. Friern Hospital Committee*[21] (hereafter referred to as 'Bolam'). In Bolam, McNair J, in the course of his directions to the jury, laid down the test that applies to medical practitioners or other professionals, in these terms:[22]

> the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill, it is well-established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

2.10 In relation to the content of this standard of care and how a court determines whether there has been a breach of the required standard, McNair J said:[23]

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

This test has become known as 'the Bolam principle'.

2.11 The Bolam principle was succinctly expressed by Lord Scarman in *Sidaway v. Governors of Bethlem Royal Hospital*: [24]

> The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes a duty of care: but the standard of care is a matter of medical judgment.

---

21 [1957] 1 W.L.R. 582.

22 ibid, 586–7.

23 ibid.

24 [1985] A.C. 871, at 881.

2.12 English courts have invariably followed the Bolam principle and it has been applied to all aspects of medical practice including treatment, diagnosis and advice.[25]

Rogers v. Whitaker and the Bolam Principle in Australia

2.13 In Australia, however, there has been a long line of clear authority that has held that the Bolam principle was not the exclusive measure to be applied, especially in cases that involve an alleged failure to provide information or a warning.[26] In 1992, the High Court of Australia in *Rogers v. Whitaker*[27](hereafter referred to as 'Rogers') finally resolved that the Bolam principle does not apply in relation to the provision of information or warning and is of limited use in cases involving negligent diagnosis and treatment. It is important to note that Rogers did not make new law in Australia, but clarified existing law laid down by superior courts that had not accepted the Bolam principle.

2.14 The Bolam principle and the Australian High Court's rejection of the principle in *Rogers v. Whitaker*[28] has been the subject of much discussion.[29] There has been a perception amongst some practitioners and medical professional organisations that the departure from the Bolam principle results

---

25 In respect of treatment, the Bolam principle was adopted by the House of Lords in *Whitehorse v. Jordan* [1981] 1 W.L.R. 246; in relation to diagnosis in *Maynard v. West Midlands Regional Health Authority* [1984] 1 W.L.R. 634 and in relation to the provision of information, advice and warning (by majority) in *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871.

26 *F. v. R.* (1983) 33 S.A.S.R. 189; *Battersby v. Tottman* (1985) 37 S.A.S.R. 524; *Gover v. South Australia* (1985) 39 S.A.S.R. 543; *Albrighton v. Royal Prince Alfred Hospital* (1980) 2 N.S.W.L.R. 542; *Whitaker v. Rogers*, unreported, Supreme Court of NSW, Campbell, J., 3 Aug. 1990; *Rogers v. Whitaker* (1991) 23 N.S.W.L.R. 600; *E. v. Australian Red Cross* (1991) 99 A.L.R. 601.

27 (1992) 175 C.L.R. 479.

28 ibid.

29 See D. Chalmers & R. Schwartz, '*Rogers v. Whitaker* and informed consent in Australia: fair dinkum duty of disclosure, (1993) 1 *Med. L. Rev.* 139; B. Pincus, 'Consequences of medical advisers failure to warn', (1993) 31 (6) *Law. Soc. J.* 38; B. McSherry, 'Failing to advise and warn of inherent risks in medical treatment: when does negligence occur?', (1993) 1 *J.L.M.* 5; I. Dunn, 'What should doctor tell you?', (1993) 67 *L.I.J.* 268; B. Milstein, 'High Court rules on informed consent' (1992-93) 1 *A.H.L.B.* 37; Commentary, 'Negligent failure to disclose information: Rogers v Whitaker' (1993) 1 *Med. L. Rev.* 115; L. Skene, 'The standard of care in relation to a medical practitioner's duty of disclosure', (1993) 1 *T.L.J.* 103; M. Jones, '"Informed consent" in the High Court of Australia', (1994) 2 *Tort L. Rev.* 5; Hon. Justice Malcolm, 'The High Court and informed consent: the Bolam Principle abandoned', (1994) 2 *Tort L. Rev.* 81; S. Monks, 'The concept of informed consent in the United States, Canada, England and Australia: a comparative analysis' (1993) 17 *U.Q.L.J.* 222.

in an imposition of a standard of care that is too high.[30] However, the rejection of the Bolam principle has not changed the standard of care owed by doctors; rather, it has changed how that standard is determined.

2.15 In coming to their decision, the High Court in Rogers considered *Reibl v. Hughs*[31] (an important judgement of the Canadian Supreme Court) and the refusal of King CJ to follow Bolam in the South Australian case of *F. v. R.*[32] The majority judgement in Rogers contains the following passage:[33]

> In Australia it has been accepted that the standard of care to be observed by a person with some special skill is that of the ordinary skilled person exercising and professing to have that special skill. ...But that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade ... Even in the sphere of diagnosis and treatment, the heartland of the skilled practitioner, the Bolam principle has not always been applied ... Further, and more importantly, particularly in the field of non disclosure of risk and provision of advice and information, the Bolam principle has been discarded and, instead, the courts have adopted the principle that, **while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decisions about his life'. ... Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often decisive role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing treatment is the question of a different order**. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. (emphasis added)

2.16 Thus, it has been settled in Australia that whether or not the conduct in question meets the standard of care is to be determined by the court and not by the medical profession. However, it is important to emphasise that in coming to a decision as to whether the standard of care has been breached, evidence from medical practitioners can be highly persuasive and at times decisive in determining the issue.

2.17 It is also important to note that the outcome in medical negligence cases is often dependant on the facts in a particular case. In Rogers, Ms Whitaker had been almost completely blind in her right eye since a

---

[30] Submission nos. 11 & 17.

[31] (38) (1980) 114 D.L.R. (3d).

[32] (1983) 33 S.A.S.R. 189.

[33] *Rogers v. Whitaker* (1992) 175 C.L.R. 479, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ at pp. 489–90.

penetrating injury to it at the age of nine. In 1983, almost forty years after her initial injury, she decided to have an eye examination in preparation for a return to the paid workforce. She was referred to Dr Rogers, an ophthalmic surgeon, who advised her that an operation on her right eye would not only improve its appearance but would probably restore significant sight to that eye. The operation was carried out with the appropriate skill and care. However, the surgery did not restore sight in her right eye but she developed sympathetic ophthalmia in her left eye, which resulted in a loss of sight in her left eye. The evidence was that the risk of developing sympathetic ophthalmia was approximately one in 14,000, although the risk of occurrence was slightly greater, where there had been an earlier penetrating injury to the eye operated upon (as was the case here). Ms Whitaker had 'incessantly' asked questions about possible complications and had inquired as to whether something could have been put over her good eye during the operation.[34]

2.18 The High Court found that if the Bolam principle had been applied, the patient's questions regarding complications or risks would be of no consequence, because medical opinion would dictate whether the risk should have been disclosed.[35] The High Court preferred the approach adopted by King CJ in *F v. R*[36], where a woman became pregnant following a tubal ligation (a form of sterilisation) and brought an action in negligence alleging that the medical practitioner had failed to warn her of the failure rate of the procedure.[37] King CJ said that the amount of advice or information that a responsible doctor should disclose depends on a range of factors; including, 'the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances'.[38]

2.19 The High Court in Rogers agreed with these factors and said:[39]

---

34 ibid.

35 ibid, 489.

36 (1983) 33 S.A.S.R. 189

37 The failure rate was calculated to be less than 1% in this form of sterilisation.

38 *F. v. R.* (1983) 33 S.A.S.R. 189, 192-3.

39 *Rogers v. Whitaker* (1992) 175 C.L.R. 479, 489.

> The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. The duty is subject to the therapeutic privilege.

2.20 Taking into account all of the circumstances, the specific facts that influenced the High Court in Rogers were that the surgery was elective; Ms Whitaker had repeatedly asked questions regarding complications; the only serious risk was that of sympathetic ophthalmia and the doctor should have known of this risk; and the consequences of the realisation of the risk were extreme, while disclosure would have caused no harm, inconvenience or damage. These factors outweighed the fact that the risk was statistically remote.

2.21 Rogers does not set the precedent for medical practitioners to disclose every risk of one in 14,000, but, rather, requires medical practitioners to look at all the circumstances surrounding each patient in relation to the known risks and evaluate the effect of the realisation of the risk. Accordingly, health service providers need to look at disclosure from the perspective of the patient.

Adequate Disclosure by a Health Service Provider: Post-Rogers

2.22 Rogers has been followed and refined in several Australian cases. The information and advice given to a patient needs to be understandable to the patient. Giving a patient a pamphlet that relies on medical jargon to explain procedures may be insufficient.[40]

2.23 The New South Wales Supreme Court in *Karpati v. Spira*[41] recently held that when discussing risks with patients, subjective terms such as 'rare', 'unlikely' and 'likely' should not be used. Spender J said that 'where an explanation is to be given of serious risks, this should involve telling a patient

---

40 See *Shaw v. Langley*, unreported, Dist. Ct. Qld, Pratt DCJ, 24 Nov. 1993, No 485/91, which involved a failure to inform the patient of risks of a breast augmentation procedure; *Tekanawa v. Millican*, unreported, Dist. Ct. Qld, Botting DCJ, 11 Feb. 1994, No 1219/92, which related to the failure to inform the patient of risks of scarring.

41 unreported, Supreme Court of NSW, Spender AJ, 6 Jun. 1995, No 15853/92.

what that risk is in percentage terms if there is a known figure, or a band or range of figures'.[42]

2.24 In *Teik Huat Tai v. Saxon*[43], the Full Court of the Supreme Court of Western Australia upheld the trial judge's findings that the doctor had negligently failed to inform the patient of the risks associated with hysterectomy and vaginal repair. The patient developed a recto-vaginal fistula. The principles articulated in Rogers regarding the assessment of risk were applied by the Court The Court considered whether the risk of developing the fistula was material within the meaning of Rogers and held that the patient was an anxious person and the doctor should have been aware that the patient would attach significance to the risk.

2.25 In *Tekanawa v. Millican*[44] the Court held that where the surgery is purely elective or cosmetic, there is a higher standard of disclosure.

2.26 Another post-Rogers decision concerning the failure to warn is *Hribrar v. Wells*[45]. Here, a dental surgeon, who specialised in maxillo-facial surgery, performed an operation on Ms Wells to correct a malocclusion that caused her to grind her teeth. Ms Wells suffered a series of complications following the operation and she was warned of all the complications except the specific complication of nerve damage. The surgeon's counsel argued that damages should be restricted to the nerve damage and not the rest of the complications. However, the judge accepted Ms Wells statement that if she had been warned of the nerve damage she would not have had the operation. On appeal, the trial judge's findings were upheld but two of the three judges expressed reservations on the issue of causation. On the facts, causation did not have to be resolved but both judges expressed the view that on the grounds of policy and fairness, damages should be restricted to those that causally relate to the failure to warn about the particular risk.[46]

---

[42] ibid.

[43] unreported, Supreme Court of WA, Full Ct., 1 Feb. 1996, No 23/95.

[44] unreported, Dist. Ct. Qld, Botting DCJ, 11 Feb. 1994, No 1219/92.

[45] (1995) 64 S.A.S.R. 129.

[46] ibid, King CJ and Duggan J.

Diagnosis and Treatment: Rogers and Beyond

2.27 Rogers noted that the Bolam principle has not been followed in Australia even in the area of diagnosis and treatment.[47] Rogers drew a clear distinction between cases where there has been a failure to inform and cases that involve diagnosis and treatment:[48]

> There is a fundamental difference between, on the one hand diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it.

2.28 The High Court in Rogers went on to decide that in the area of diagnosis and treatment, professional opinion was more likely to play an influential or decisive role.[49] Rogers was a case that was fundamentally about advice and warning. In the area of treatment and diagnosis, the Rogers decision has been applied and further refined. In *Darley v. Shale*[50], for example, Wood J said that:[51]

> Evidence of a current practice is almost always of great value and may be decisive, yet when explored it may nevertheless turn out to be negligent.

Wood J held that in deciding between alternative forms of treatment which may be supported by conflicting bodies of expert opinion, either form of treatment will not necessarily automatically conform with the standard of reasonable care.

2.29 Another post-Rogers case concerning diagnosis and treatment, that has received much attention is that of *Burnett v. Kalokerinos*[52]. The case began as a case of alleged misdiagnosis of cervical cancer by the defendant, but the case ultimately progressed on a very narrow factual issue of whether the plaintiff's

---

47 *Albrighton v. Royal Prince Alfred Hospital* (1980) 2 N.S.W.L.R. 542; *E. v. Australian Red Cross* (1991) 99 A.L.R. 601.

48 *Rogers v. Whitaker* (1992) 175 C.L.R. 479, 489.

49 However, Gaudron J's judgment in Rogers indicates that even in the area of diagnosis and treatment, the nature of a particular risk or its foreseeability is not something that is purely within the area of medical expertise. Rather, these were questions that were often a matter of common sense. Gaudron J, accordingly found that there was no basis for limiting liability along the lines of Bolam even in the areas of diagnosis and treatment.

50 [1993] 4 *Med. L. Rev.* 161.

51 ibid. The case involved inappropriate treatment and was decided without the benefit of Rogers. However, in respect to diagnosis and treatment the principles are consistent with those expressed in Rogers.

52 Unreported, Supreme Court of NSW, Spender AJ, 22 Mar. 1995, No 1138 of 1993.

version of a particular consultation with the defendant was to be believed. The Defendant in this case practices in the small country town of Bingara. The plaintiff was a 35 year old mother of two children who had been a patient of the defendant for 12 months leading up to the important consultation in October 1991. After the defendant delivered her second child in June 1991, the plaintiff had complained of heavy intermenstrual bleeding. She made the same complaint to the defendant at the crucial October 1991 consultation when he organised for her to see a gynaecologist in Tamworth. The Plaintiff alleged that she returned after the consultation and told the defendant that she could not make the appointment at Tamworth for a range of reasons and would rather have seen a specialist in the closer town of Inverell. The defendant claimed that this second meeting never happened and conceded that if the plaintiff's version of events was believed, he should be found negligent.

2.30 The judge in Burnett[53] did believe the plaintiffs version of events and thus found the defendant guilty. The defendant appealed to the Court of Appeal, which held that the Doctors case did not warrant the major step of reversing a finding of fact by a trial judge.[54] However, the Court of Appeal did find contributory negligence on the part of Ms Burnett, because she failed to seek medical attention despite the fact that her bleeding continued. Damages were reduced by 20 percent. While some saw the case as a finding of negligence where a patient had refused to follow the doctor's advice, the case ultimately did turn on its unique facts, and the most that can be extracted from it is that a general practitioner may have to negotiate referrals to specialists with the patient.[55]

Woods v. Lowns and Procopis: A Move Back Towards Bolam

2.31 The recent case of *Woods v. Lowns and Procopis*[56] has been seen by some commentators as restricting the application of Rogers. The case is noteworthy

---

53 ibid.

54 *Kalokerinos v. Burnett*, unreported, NSW Court of Appeal, 1 Nov. 95, No 40243 of 1995.

55 For a discussion of this case see M. Bollen, 'Exposure of medical practitioners to liability' in *National Medico-Legal Congress Conference Proceedings*, Sydney, 26–27 February, 1996.

56 (1995) 36 N.S.W.L.R. 344.

not only for its implications for negligence, but also because of its findings in relation to emergency situations.

2.32 The plaintiff in this case was an eleven year old boy with a history of epilepsy. The plaintiff had been treated by the defendant Procopis, a paediatric neurologist, from 1979 to 1986. One morning in 1987, the plaintiff's mother went out for a walk and came back to find her son having a fit. She immediately sent her eighteen year old son to get an ambulance and sent her fourteen year old daughter to get a doctor. The daughter ran down to Dr Lowns's surgery, approximately 300 metres away, and told him that her brother was having a bad fit and asked him to help. The doctor declined to attend. When the daughter returned home, the ambulance officers were attempting to treat the boy and rushed the boy to another nearby surgery. The general practitioners there were unable to bring the fit to an end. The boy was then taken to a hospital where the fit was stopped, but by this time he had suffered serious brain damage and remained totally disabled.

2.33 The trial judge, Badgery-Parker J found that Procopis's failure to inform the parents about the use of rectal Valium in emergencies constituted a breach of his duty of care to the plaintiff. Badgery-Parker J also found that if the defendant Lowns had attended to the boy when asked, the appropriate treatment would have commenced seventeen to twenty minutes earlier and the plaintiff would have escaped brain damage.

The Standard of Care—Procopis v. Woods

2.34 On appeal, the majority of the Court of Appeal (Kirby P and Mahoney JA, with Cole JA dissenting) reversed the trial judge's findings that Dr Procopis had not satisfied the requisite standard of care. Dr Procopis argued that unlike Rogers, this case involved treatment rather than advice. However, Kirby P found that the Rogers principle was one of general application, but, nonetheless, he found that this case was better seen as one of advice rather than treatment. There had been substantial agreement amongst the expert evidence that Dr Procopis's advice conformed with the highest standard of medical practice in Australia. In reversing the trial judge's decision, Kirby P found that limited yet important use is to be made of normal medical practice.

Mahoney J noted that in clinical decisions of this kind the court would be reluctant to put aside the considered opinion of experts in the field.

Failure to Attend—Lowns v. Woods

2.35 The majority of the Court of Appeal (Kirby P and Cole JA, Mahoney JA dissenting) upheld the trial judge's decision that Dr Lowns had a duty to attend to the boy and had breached that duty. While this has been a controversial decision, it was based on the existence of sufficient proximity and a unique statutory provision that regulates the conduct of Doctors in New South Wales. Section 27(1)(h) of the *Medical Practitioners Act 1938* provides that a doctor is guilty of misconduct if he or she refuses to attend and treat a person in need of urgent attention. Mahoney J in his strong dissenting judgment, said that the doctor had no legal obligation towards the boy prior to this case. He felt that while there may have been moral and ethical obligations on the doctor, these were matters of professional misconduct and were not the issues in question in this case.

2.36 Having reviewed the law as it stands in Australia, it is clear that medical negligence cases do depend on the facts of a particular case. Legal liability is based on whether on the balance of probabilities, the health service provider has met his or her duty to take reasonable care. It is also evident that Australian courts in determining the appropriate standard of care in a given case, do pay heed (but are not governed by) professional opinion and practice. Professional opinion is more persuasive in areas of diagnosis and treatment.

Is the Legal Standard of Care Adequate?

2.37 The Committee has received some submissions that argue that there is a need to return to the Bolam principle in determining liability or that health service providers are judged on inappropriately high standards of care.[57] The Australian Dental Association Victorian Branch, for example, felt that the rejection of the Bolam principle by Australian courts eliminated 'what was once considered the ultimate sanction of peer review'.[58] They believed that the reinstatement of Bolam was important to restore and support the ability of health care providers to exercise their 'clinical discretion in the management of a clinical problem'.[59]

---

57 Submission nos. 11, 17, 33 & 44.

58 Submission no. 33.

59 ibid.

2.38 The Committee has received several submissions from legal and medical groups that suggest that there is no reason to change the common law standard.[60] The Australian Medical Association (Victorian Branch) (hereafter referred to as 'the AMA'), for example, submitted that the profession recognises that it is accountable to patients in line with Rogers, 'not by reference to a body of peer opinion but by reference to a reasonable person in the patient's position'.[61]

2.39 The AMA also highlighted that the definition of 'unprofessional conduct' in the *Medical Practice Act 1994* (Vic.) had changed in line with Rogers. 'Unprofessional conduct' is not only conduct that is of a lesser standard than is reasonably expected of a medical practitioner by his or her peers, but also includes conduct that is of a lesser standard than might be reasonably expected by the public.[62] The AMA also noted that since the introduction of the Health Services Commissioner, medical practitioners are 'far more accountable to their patients as consumers of health services'.[63]

2.40 In light of the submissions received, the Committee believes that the common law standard of care applied by Australian courts is appropriate and not too onerous on health service providers. The Committee believes that there may be instances where new defences to negligence may be needed for achieving public policy objectives. These areas are the subject of later discussion in the chapter.

Recommendation 1

The Australian common law standard of reasonable care in medical negligence cases is appropriate and should not be replaced by a statutory standard, other than in the limited ways recommended in this report.

Education on the Law of Negligence

2.41 As noted above, medical negligence cases are very much dependent on the facts of a particular case and are subject to the technicalities of the legal process. The Committee is concerned that medical negligence cases can be

---

60 Submission nos. 19, 20, 32, 35, 36, 48 & 76.
61 Submission no. 32.
62 ibid.
63 ibid.

easily misinterpreted unless one has a general understanding of the legal principles involved. The Committee is also concerned that a fear of litigation on the part of health service providers might lead to greater use of defensive medical practices. The extent to which medical practitioners engage in these practices reflects a fear which may be based on a lack of awareness of the law. The Committee believes that education is vital to overcome any misunderstandings regarding the risk of litigation and its probable outcome.

2.42 At Melbourne University the importance of medical ethics is taught as part of the subject 'Clinical Medicine and Surgery', and in fifth year, medical students are taught to understand the role of law, forensic medicine and ethical considerations of medicine practice. The topics covered include: medico-legal aspects of injuries and professional conduct.[64] At Monash University medical students in their sixth year of study are taught ethical issues relating to patient care in the subject 'Clinical Studies', and issues relating to the interaction of law and medicine in the subject, 'Public Health and Forensic Medicine'.[65] This latter subject includes presentations from the Medical Practice Board, medical defence organisations and the Health Services Commissioner.

2.43 The Committee has concluded that these subjects provide a valuable opportunity for medical students to understand a range of medico-legal issues and that they should be encouraged. The Committee is keen to ensure that medical students, as a part of their assessable course, should be educated concerning the legal definition of negligence, and its relationship to the duty of care, how conduct is assessed by the courts and the likelihood of litigation. Educating medical students about the nature of negligence should be carried out in a neutral context, rather than by medical defence organisations

Good Samaritan Legislation

2.44 In the medical field, a 'Good Samaritan' is a health care professional who volunteers to help someone in need of urgent medical attention in circumstances where a doctor-patient relationship does not exist. Typical

---

64 Melbourne University, Faculty of Medicine, Dentistry and Health Sciences, *Faculty Handbook* 1997, http://www.unimelb.edu.au/HB/Med/510/.

65 Monash University, *Medicine Handbook 1997*, http/www.monash.edu.au/pubs/handbooks /medicine/

cases include the scene of a motor vehicle collision and other like emergencies. The act must be done without the existence of any duty of care owed to the patient and without any expectation of reward or compensation.

2.45 During the course of this inquiry, the Committee has been told that the fear of malpractice suits causes medical practitioners to avoid offering medical attention to people at the scene of an accident or in an emergency.[66] However, there has been no reported Australian case where a health service provider has been held liable for providing assistance in good faith. Nonetheless, there may be good reasons of public policy which justify a statutory clarification of the common law.

The Position of Rescuers at Common Law

2.46 At common law, there is no general duty to rescue a person in peril, even where it is foreseeable that the consequences of failing to assist will be the death or injury of that person. While there is no general duty to rescue under the common law, the rescuer may owe a duty of care once a rescue attempt is under way. The duty owed at this stage is to ensure that the conduct of the rescuer does not increase the risk to those in peril or bring others into danger.[67]

2.47 While the rescuer must act reasonably, this requirement is not strictly interpreted; reasonableness is determined in the context of the emergency.[68] The actions of a rescuer are not viewed as completely voluntary and even if a rescuer is aware of the risk and consciously decides to continue, the risk has not been taken voluntarily in a legal sense. The justification for this principle is found in *Wagner v. International Railway Co.* where Cardozo J said:[69]

> Danger invites rescue. The cry of distress is the summons to relief. The law does not ignore the reactions of the mind in tracing conduct to its consequences… The risk of rescue, if only it be not wanton, is born of the occasion. The emergency begets the man. The wrongdoer may not have foreseen the coming of a deliverer. He is accountable as if he had.

---

66 Submission no. 29.

67 *Hargrave v. Goldman* (1963) 110 C.L.R. 40.

68 *Ward v. T. E. Hopkins & Sons Ltd* [1959]3 All E.R. 225. In Australia following *Sutherland Shire Council v. Heyman* (1985) 157 C.L.R. 424, the court will consider all the circumstances of the case which reveal knowledge of, or responsibility for, the danger in question. The court will then decide whether there was a breach of a duty of care to prevent the foreseeable injury based on whether the combination of factors is enough to establish a relationship of proximity.

69 *Wagner v. International Railway Co.*, 133 N.E. 437 (1921), Cardozo J at 437–38.

2.48 The unique position of rescuers in common law reflects a strong public policy commitment to condone heroic acts. Thus, redress is denied in these circumstances so as to encourage rescue.

Health Service Providers as Rescuers

2.49 At common law a health service provider has no legal obligation to give assistance at the scene of an emergency or accident, even where treatment, if administered, would be life-saving.[70] Unless a medical practitioner enters into a doctor-patient relationship, they are not obliged to render assistance to the world at large. However, this general proposition is subject to the following exceptions.

Health Service Providers in Emergency Departments

2.50 A positive duty to act arises where the doctor occupies a specific and protective role. An example of such a role is a medical practitioner working in an emergency department of a hospital. The duty does have limits. In *Barnett v. Chelsea & Kensington Hospital Management Committee*[71] Nield J found that although a medical practitioner working in a casualty department has a general obligation to examine all patients who come to the department, the doctor need not see every caller at the department.[72] It is important to note that the duty of care in an emergency department is qualified by the exigencies of hospital life; the governing principle being what was reasonable in all the circumstances.

2.51 In emergency situations, there is also a recognised exception to the requirement that medical treatment is to be preceded by consent. The common law recognises that a medical practitioner can conduct procedures that are reasonably necessary in the circumstances.[73] In this context an

---

[70] J. G. Fleming, *The Law of Torts*, 8th. edn, Law Book Co., Sydney, 1992, p.147.

[71] [1969] 1 Q.B. 428.

[72] At p. 436 Nield J held: 'If the receptionist, for example, discovers that the visitor is attending his own doctor and merely wants a second opinion, or if the caller has a small cut which the nurse can perfectly well dress herself, then the casualty officer need not be called'.

[73] *Collins v. Wilcock* [1984] 3 All E.R. 374. Wood J in *T. v. T.* [1988] Fam. 52, formulated this exception as a separate defence of medical necessity. Wood J held that in urgent situations, a health service provider would be justified in taking the steps that good medical practice required. ibid, 68.

emergency situation is one where treatment is necessary to save life or prevent serious permanent injury.[74]

Doctor's Behaviour Causes Injury

2.52 If the medical practitioner's actions cause or contribute to the injuries for which the person requires assistance, the subsequent failure to treat may amount to negligence.

Ethical Duty may have been breached

2.53 Medical practitioners may be subject to disciplinary proceedings for the breach of an ethical duty if they fail to attend or treat a person in an emergency. [75]

Lowns v. Woods Exception

2.54 If a doctor fails to respond to an urgent request for medical attention and the victim is not an existing patient, the doctor may be held negligent if: [76]

(a) the request for help is made in a professional context;

(b) there is physical proximity between the doctor and the victim;

(c) the doctor is aware of the need for urgent attention to a serious medical emergency (causal proximity exists); and

(d) circumstances are such that the doctor is appropriately qualified, equipped and available to provide treatment and is not at physical risk.

Duty May be Created by Statute

2.55 In New South Wales, the *Medical Practice Act 1992* places an ethical duty on medical practitioners to attend an emergency. Section 27(1) of the Act provides that 'professional misconduct' includes:

> refusing or failing, without reasonable cause, to attend within a reasonable time after being requested to do so, on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner.

2.56 As discussed above, this provision came into play in the case of *Woods v. Lowns*[77] where the trial judge (and the majority judges on the appeal) felt

---

74 *Walker v. Bradley*, unreported, Dist. Ct. NSW., Kirkham J, 15 Dec. 1993, No 1919 of 1989.

75 Section 6.3 of the Code of Ethics of the Australian Medical Association, quoted in *Halsbury's Laws of Australia*, chap. 3.

76 *Lowns v. Woods* [1996] Australian Torts Reports 63,151, ¶81-376.

that it was a clear statement of public policy that placed an obligation on medical practitioners in relation to those in need of urgent attention.

2.57 In Victoria the *Medical Practice Act 1994* governs the professional and ethical obligations of registered medical practitioners. Section 3 of the Act defines 'unprofessional conduct' very broadly, and includes:

> (a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered medical practitioner; or
>
> (b) professional conduct which is of a lesser standard than that which might reasonably be expected of a medical practitioner by her or his peers.

2.58 Given the definition of 'unprofessional conduct' in Victoria, there is the potential for the Board to interpret the definition so as to find that a medical practitioner has acted unprofessionally in failing to stop and render assistance to a person in need.[78] For example, a member of the public might claim that the public at large would expect a medical practitioner to stop and give assistance at the scene of an accident.

2.59 The Northern Territory has adopted a more novel and radical approach to creating a duty of care in these circumstances. Section 155 of the *Criminal Code* provides that:

> Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously fails to do so is guilty of a crime and is liable to imprisonment for 7 years.

2.60 This provision and the severe penalty attached to it is unique in Australian law and to the law of other common law countries.[79] In the Northern Territory case of *Salmon v. Chute*[80] the accused had been driving when a young child ran out on to the road. He swerved to avoid the child but the child was hit and thrown some distance away. The driver kept driving and the child died in hospital as a result of the injuries sustained during the

---

77 (1995) 36 N.S.W.L.R. 344; [1996] Australian Torts Reports 63,151, ¶81-376.

78 The AMA's Code of Ethics would carry weight in such proceedings but would be subject to interpretation by the Medical Practitioners Board.

79 It is interesting to note, however, that in countries based on Civil Law, since world war II, almost every new criminal code has contained a 'failure -to-rescue' offence. For a discussion of the history of such a provision see *Salmon v. Chute* (1994) 94 N.T.R. 1, per Kearney J.

80 (1994) 94 N.T.R. 1; *R. v. Salmon* 70 A. Crim. R. 536.

accident. The driver was convicted of a number of offences including one against section 155.

2.61 On appeal, Kearney J interpreted the elements of section 155. The phrase 'a person…being able' refers to a person who possesses both the physical and mental capacity to provide help to the victim. There must be a degree of physical proximity between the accused and the victim and the accused must know that the victim requires assistance or help. The words 'rescue, resuscitation … first aid or succour' are to be read in their context; they envisage a person either directly or indirectly assisting a victim. 'Person in urgent need' is to be read as a danger to life that requires immediate action and the duty under section 155 exists even if a person is doomed to die. To 'callously fail' involves a conscious and deliberate choice on the part of the accused to not provide aid or assistance and requires proof that the accused's failure would offend common standards of respect and kindness.[81]

Good Samaritan Laws in other Jurisdictions

2.62 The Northern Territory provision was described by the then Attorney-General of the Northern Territory in the Legislative Assembly as the 'Good Samaritan provision'. However, other jurisdictions around the world have introduced laws that prevent a person from suing a health care provider for injuries from a Good Samaritan act. Most states in the Unites States of America have some form of Good Samaritan legislation that prevents victims from suing their rescuer provided two conditions are satisfied. These conditions are that the rescue must be a voluntary act and the action must be a good faith effort to help.[82] The American Good Samaritan laws are said to be working with 'overwhelming success'.[83]

---

81 ibid.

82 States like Virginia (and Maryland to a lesser extent) have fairly broad Good Samaritan laws covering not only health professionals but also fire and rescue companies, volunteer sports program physicians, licensed engineers participating in rescue assistance, free health care centres, hospice volunteers, veterinary professionals rendering assistance without charge. There are other states like West Virginia, Pennsylvania, and the District of Columbia that have narrower provisions protecting health care providers who assist in emergencies.

83 Submission no. 29.

Queensland Provisions

2.63 The only Australian state that provides statutory protection from liability for health care providers who attempt to rescue is Queensland.[84] Section 3 of the *Voluntary Aid in Emergency Act 1973* (Qld) provides:

> **Protection of medical practitioners and nurses.** Liability at law shall not attach to a medical practitioner or nurse in respect of an act done or omitted in the course of rendering medical care, aid or assistance to an injured person in circumstances of emergency:
>
> (a) at or near the scene of the incident or other occurrence constituting the emergency;
>
> (b) while the injured person is being transported from the scene of the incident or other occurrence constituting the emergency to a hospital or other place at which adequate medical care is available.
>
> If:
>
> (c) the act is done or omitted in good faith and without gross negligence; and
>
> (d) the services are performed without fee or reward or expectation of fee or reward.

Should Victoria Enact Good Samaritan Laws?

2.64 The Committee received a submission that argued that enacting Good Samaritan Legislation was critical because:[85]

> there are a great many doctors and nurses who will not offer any level of medical attention to a person on the street (ie outside of their clinic, rooms or hospital) due to fear of malpractice suits. They fear the situation that exists when they do not have a contractual relationship and the normal protections for ordinary and unforeseen negligence. As a result, they do not offer help.

The Submission went on to give examples of situations where health service providers do not act in emergency situations because of fear of litigation.

2.65 The Committee's believes that it is necessary to act on such advice in the interests of the general public. Good Samaritan legislation may have the positive effect of avoiding situations like *Lowns v. Woods*[86] where the general

---

84 NSW provides limited protection to Ambulance Service workers under the *Ambulance Services Act*. Section 26 of this Act provides that:
An employee of the Ambulance Service or an honorary ambulance officer is not liable for any injury caused by the employee or officer in the carrying out, in good faith, of any of the employee's or officer's duties relating to:
(a) the provision of ambulance services (defined in section 3 as services relating to the work of rendering first aid too, and the transport of, sick and injured persons); or
(b) the protection of persons from injury or death, whether or not those persons are or were sick or injured.

85 Submission no. 29.

86 [1996] Aust Torts Reports 63,151.

practitioner did not believe he owed a duty to the boy. Such laws would hopefully provide the incentive for health service providers to give assistance in emergency situations without fear of litigation. While the Committee understands that there has not been a case in Australia where a health service provider has been found liable for providing assistance in good faith, it is hoped that Good Samaritan laws would dispel some of the myths concerning negligence actions and give effect to important social policy.

2.66 Having considered Good Samaritan laws in other jurisdictions, it is the Committee's view that the model used in Queensland is appropriate. The Committee believes it is appropriate in terms of limiting protection to situations where there has been no gross negligence and where the act has been done in good faith without expectation of reward. The Committee also believes the Queensland model is appropriate as the information on Good Samaritan legislation provided to the Committee was in the context of medical practitioners and nurses.[87] Extending the categories of health service providers who can claim protection under Good Samaritan laws is beyond the scope of the present inquiry, but, nonetheless, requires further investigation.

***Recommendation* 2**

The Victorian Government should enact legislation to provide a limited defence for medical practitioners and nurses who provide medical assistance at the scene of an accident or other emergency. The Queensland provisions contained in the* Voluntary Aid in Emergency Act 1974 *should be used as a model in formulating the Victorian laws.

Statutory Immunity of Screening Services

2.67 In Issues Paper No. 1 the Committee requested information on the extent to which compensation has been sought for injuries resulting from incorrect information arising from the use of screening services.[88] In the 1993/94 Annual Report of the Department of Health and Community Services considerable concern about this issue was voiced, with the Department stating that:[89]

---

87 ibid.

88 Parliament of Victoria, Law Reform Committee, *Legal Liability of Health Service Providers, Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996 (hereafter cited as 'Issues Paper No. 1'), para. 2.17.

89 Victoria. *Department of Health and Community Services, Annual Report 1993-94*, Department of Health and Community Services, Melbourne, 1994, pp. 128-129.

> This will be a topic of substantial debate in the course of the next year or two. Ultimately, it may prove necessary to consider legislation providing statutory immunity for screening programs of demonstrable and appropriate quality. Ignoring negligence, for which pursuit of action by common law should always be available, any screening program has a small but real statistical probability of both false negative results and false positive results (where the abnormality is thought to be present but does not ultimately prove to be so).

2.68 In raising this issue for discussion, the Committee asked whether or not some form of statutory immunity from suit should be provided for practitioners who carry out screening programs of demonstrable and appropriate quality which are performed without negligence.

2.69 Those groups who responded to this issue either argued that: an adverse outcome of itself would not be sufficient to satisfy the definition of negligence so that there was no need for statutory immunity; or alternatively, that statutory immunity for programs which comply with benchmark standards of quality, was necessary to remove the uncertainties about the standards applied by the courts and to recognise the special nature of screening services. It should be noted that the definition of negligence was discussed above in the section dealing with the basis of liability.

2.70 It is necessary to briefly consider the unique nature of screening services in order to provide a backdrop for the debate surrounding the possible introduction of statutory immunity. The nature of these services is discussed in three key submissions on this issue, from the Victorian Cytology Service, the Victorian Breast Screening Coordination Unit and the joint submission of the Departments of Human Services and Justice.[90]

2.71 The Victorian Cytology Service informed the Committee that although the aim of health care providers is quality for all, this may not mean a satisfactory outcome in all cases. Three reasons were given for this:

1. the nature of the disease;
2. inevitable and unpredictable imperfections in the process used; and
3. failure to perform to a reasonable standard of care.

---

90 Submission nos. 7, 54 & 60. See also submission no. 13.

2.72 The submission from the Cytology Service also indicated that the rate of squamous cervical cancer is very low for women who received a negative Pap smear report (2.5 cases per 100,000 women per year) compared to other women (25 to 45 cases per 100,000 women per year).[91]

2.73 The Victorian Breast Screening Coordination Unit described screening mammography as being such that the failure to diagnose will not of itself constitute negligence.[92] Moreover, it observed that screening mammography can be done without greater than usual risk of malpractice actions provided that appropriate imaging parameters are satisfied; there is reasonable interpretation; and there are adequate mechanisms to ensure an acceptable standard of care are in place.

2.74 In the joint submission of the Departments of Human Service and Justice, the Department of Human Services described the manner in which screening services operate. It noted that screening services are not focused on providing health care for the individual, but on reducing disability or death in the overall population.[93] Moreover, screening tests provide a result along a continuum, with a cut-off point being assigned to define an abnormal result. This means that if the cut-off point is set too low there will be an increase in false negative reports leading to an increase in the cost of providing services, because more women receive follow-up tests. Accordingly, the department observed that it would be more accurate to describe results in terms of the probability of disease, rather than providing a cut-off point for abnormal results.[94] It then advised that according to the Victorian Cytology Service the rate of false negative for cervical screening is 10 per cent.

Support for Statutory Immunity of Screening Services

2.75 The Department of Human Services recommended that there should be statutory immunity for screening services which comply with benchmark standards of quality.[95] Standards for screening service can be codified because services are not focused on providing health care for the individual but on reducing disability or death in the overall population.

---

91 Submission no. 7.
92 Submission no. 54.
93 Submission no. 60.
94 ibid.
95 ibid.

2.76 Specifying benchmark standards would remove uncertainties as to the standards which may be applied by the courts. These uncertainties lead to screening providers inappropriately overusing tests, which increases the costs of the service. The Department's submission states that:[96]

> It can be argued that the current principles of liability are based on the duty of care appropriate for diagnostic services focused on individual patients who have symptoms, rather than on the duty of care appropriate for population based screening services directed at people who are symptom free.

The Department believes that there is a risk of the service being involved in litigation each time there is a false negative result.

2.77 Among several medical groups there was support for the introduction of statutory immunity for screening programs carried out with a demonstrable and appropriate level of quality.[97] Notably, the Victorian Cytology Service recommended that liability for negligence should be avoided on the ground that the adverse outcome to a user of the service was due to a recognised error rate, provided that there are defined accountability measures to prevent substandard work.[98] Additionally, it is suggested that a case for negligence should not be established where 'resource limitations prevent addition of technology or expertise that is available but beyond the capacity of the funding agency to provide'. Moreover, negligence should only arise where there is 'a failure by the carer...to implement processes or procedures or safeguards that have been laid down by standard setting bodies or authorities as appropriate practice'.[99]

2.78 The Service also suggested that the lack of a defined reasonable standard of care has produced uncertainty and is detrimental to the parties. It recommended that a legislative standard should be applied to the outcome and the process, so that litigation should proceed only if the health service provider has not performed to one or more of these standards.

---

96 ibid.

97 Submission nos. 7, 11, 13, 17, 21, 35, 36, 38, 42, 55 & 77.

98 Submission no. 7.

99 ibid.

2.79 The uncertainty about the standard of reasonable care was seen by the Victorian Cytology Service as creating a fear of litigation. This fear is said to be 'ever–present' for providers in public health screening programs. The submission suggests that fear has led to a higher rate of smears being reported as either abnormal (with the increase relating to abnormalities of a trivial type) or unsatisfactory. These results are worrying for women and have led to more women being advised to have further treatment.[100] Similarly, the Medical Defence Association of Victoria emphasised that this fear has led to defensive practices. It warns that if malpractice litigation continues to increase there will be 'fundamental changes in the provision of medical services in vulnerable areas such that the community will have to accept the provision of medical services on a very different basis to that which it has hitherto enjoyed'.[101]

2.80 The Royal Australasian College of Surgeons recommended that statutory immunity should not be restricted to screening services, instead all procedures which are performed with demonstrable appropriate quality without negligence should be immune from suit.[102] This recommendation is based on the bell–shaped curve of outcomes which applies to screening, surgical results and results of other investigations.

2.81 The National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch) and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch) in a joint submission recommended that statutory immunity should be available to screening programs.[103] Alternatively, courts could adopt the approach that users of the service voluntarily assume the risk; a common law suit would then only be available for damage beyond the normal parameters of risk.

2.82 The Medical Protection Society suggested that if compulsory accreditation applied to all laboratories performing screening tests, with

---

100 Submission no. 7 provides figures on the increased rate of reporting.
101 Submission no. 77 .
102 Submission no. 17.
103 Submission no. 35.

quality control programs being required for accreditation, then statutory immunity could be given.[104] The Society also expressed concern that the law did not always recognise non-negligent errors. This approach was also taken by the Western Health Care Network, which suggested that statutory immunity might be reasonable if screening programs had to comply to statutory quality standards, with appropriate monitoring and feedback, backed up with arrangements for compensation when the system fails.[105] The Medical Defence Association of Victoria supported immunity for screening programs which comply with recognised levels of performance, based on there being an irreducible level of incorrect results.[106]

2.83 The Australian Council of Professions recommended that there should be statutory immunity for practitioners who carry out screening programs of demonstrable and appropriate quality which are performed without negligence and for practitioners whose treatment of patients is based on the results of these screening tests, even where negligence occurred during the performance of these tests.[107]

Opposition to Statutory Immunity of Screening Services

2.84 Many of the submissions received by the Committee opposed the establishment of a statutory defence for screening programs.[108] Notably, the Department of Justice observed that, based on the material presently available to it, there is adequate protection provided for screening service providers under the common law, provided the suggested risk management procedures are adopted.[109] The Department is unaware of litigation experience which justifies the concerns of screening service providers and there is no evidence that services have had difficulty in obtaining insurance. Moreover, there are strong reasons for not introducing statutory immunity. The common law is sufficiently flexible to cover this area, the individual's right to sue for

---

104 Submission no. 36.
105 Submission no. 38.
106 Submission no. 77
107 Submission no 11.
108 Submission nos. 19, 20, 60 (Dept. of Justice) & 62. Submission no. 62 recommended that no limitation should be placed on the ability of a patient to sue for true negligence. However, it also suggested that screening tests may become unavailable because of litigation.
109 Submission no. 60.

negligence is central to our legal system. The risks relating to screening services should be properly managed using quality assurance programs and benchmark standards.

2.85 Similarly, the Health Law Committee of the Australian Plaintiff Lawyers opposed such immunity based on it being unnecessary. [110] It described many providers as working under the myth that an adverse outcome equates with negligence.

2.86 This approach was also taken by Slater and Gordon, which observed that there is no liability unless negligence is proven and negligent conduct should not be excused because the procedure has a recognised error rate.[111] Furthermore, this submission stated that it is undesirable for compliance with a regulatory regime to be a statutory defence for negligence. The Courts should determine what constitutes negligence and not the executive.

2.87 The Law Institute of Victoria recommends that any changes in the manner in which legal liability is determined should be left to the evolutionary process of the common law.[112] The Victorian Bar Council was even more critical of any proposal to provide statutory immunity. In the Council's view, statutory immunity is unnecessary where a screening program performs without negligence. Moreover, it observed that where a program of appropriate quality performs negligently it is 'unthinkable that there should be statutory immunity'.[113] The submission went on to state that if a failure to diagnose is due to a recognised error rate in a diagnostic test, then this failure to diagnose could not constitute negligence.

2.88 The Victorian Breast Screening Coordination Unit opposed the introduction of statutory immunity for screening services.[114] However, to protect the future of the BreastScreen program, it emphasised that a distinction between screening and diagnostic practice must be acknowledged.

---

110 Submission no. 19.
111 Submission no. 20.
112 Submission no. 45.
113 Submission no. 48.
114 Submission no. 54.

2.89 Similarly, according to Ian Russell, a Surgeon and Oncologist, the fear of litigation has caused an over investigation of breast symptoms.[115] The right of persons to take legal action against the screening program should not be denied, but legal advisers should also be aware of the limitations of the program and its quality standards so that they can advise whether or not a legal action should proceed.[116]

Possible Models for Legislative Change

2.90 The Department of Human Services outlined three possible models to provide a degree of statutory protection from negligence actions for screening programs.[117]

(a) A statutory defence to a civil action.

(b) Statutory confirmation that a false report does not necessarily constitute a breach of a duty of care.

(c) A no fault compensation scheme for people who have suffered loss as a result of a false negative report.

Each of these models is considered below.

Statutory Defence to Civil Action

2.91 The Department of Human Services indicated that statutory immunity could be achieved by using the model which operates for transmission of HIV and Hepatitis C through blood and blood products, pursuant to sections 132 to 134 of the *Health Act 1958*.[118] The legislative provisions list the action to be taken in order to qualify for the defence and the behaviour which will lead to an exception to the defence.[119]

2.92 Such an approach is favoured by the Department because it would remove uncertainties about the standards which courts may apply and whether recognition will be given to the different nature of screening services compared to other services. It is claimed that:[120]

---

115 Submission no. 13.

116 ibid.

117 Submission no. 60 ; Letter from Dr Chris Brook, Director of Public Health Division, Department of Human Services to the Law Reform Committee, 10 April 1997.

118 Submission no. 60 .

119 *Health Act 1958* (Vic.), ss. 132 & 133.

120 Submission no. 60.

> A high profile legal action which is brought against a screening service alleging negligence because of mistaken diagnosis could severely undermine delivery of current screening services.

2.93 This model would, according to the Department, mean that[121]

> if a service meets benchmark criteria (based on "best practice"), and if health service consumers are well informed as to the inherent risks in the screening process, and provide informed consent, a defence against liability in medical negligence should exist at law'.

2.94 The standard of practice would be included in legislation. Where these standards were not met, a person would be entitled to claim. However, the legislation would also provide that 'in an action to which the defence applies, a certificate purporting to have been issued by the screening agency concerned stating that the test had been done in the approved manner shall be proof of the matters so stated'.[122] The Department has suggested that the criteria would consist of membership to the appropriate professional body, that there be periodic rescreening, and that a quality assurance procedure be implemented.[123]

2.95 The statutory defence would only apply where the process leading to the false negative rate is sound and 'there is no manifest error deemed to be negligent'.[124] The legislation could also provide the manner in which informed consent is to be obtained. For example, according to the Department of Human Services[125]

> approved standards could relate not only to the way in which services are provided, but also to the sort of information and advice which is provided by the screening agencies and the type of informed consent that is required from consumers of the screening services.

2.96 A number of other submissions to the Committee supported the introduction of a statutory defence, and outlined a possible standard to qualify for such a defence. For example, the Victorian Cytology Service

---

121 ibid.
122 The inclusion of such a provision is based on section 134 of the *Health Act 1958*(Vic.).
123 Dr Chris Brook, op cit, p. 2.
124 Submission no. 60.
125 Dr Chris Brook, op cit, p. 3.

recommended that in determining if the process standard had been complied a number of factors should be considered.[126]

1. Whether the screening facility was accredited and had an internal quality assurance system and had satisfactory results in the external quality assurance system.
2. Whether the employee was appropriately qualified and supervised, the volume of tests done by the employee within the range designated.
3. Whether the profile of screening results for that employee was within an acceptable range.

2.97 This approach was supported by the AMA.[127] Additionally, the Association suggested that events which constitute negligence should be distinguished from medical misadventure.

2.98 The Royal Australasian College of Surgeons recommended that the standard should be set so that 'a careful practitioner should be able to pass any test 100% of the time'.[128]

2.99 The Medical Defence Association of Victoria believes that there should be a statutory defence where an adverse outcome for a health service is due to a recognised error rate for that service.[129] Nonetheless, the submission recognises that it would be difficult to implement this defence, because there is a difference between adverse outcome resulting from a recognised error rate and the same outcome attributed to negligence by the practitioner. Codification of the procedure for obtaining informed consent was recommended, in order to provide immunity for a doctor who complies with the procedure.

Statutory Confirmation That a False Report does not Necessarily Constitute a Breach of a Duty of Care

2.100 The second model proposed by the Department of Human Services is that there should be legislative confirmation that a false negative or false positive result does not of itself constitute a breach of the provider's duty of

---

126 Submission no. 7.
127 Submission no. 32.
128 Submission no. 17.
129 Submission no. 77 .

care.[130] This approach would provide some reassurance for service providers who fear litigation, and would therefore be likely to reduce the incidence of defensive medicine. The Department notes that such a provision would not suggest that a person was prevented from relying on the false negative or false positive report to support their claim.[131]

2.101 The Committee has concluded that it is desirable to introduce a legislative provision which states that a false report does not of itself constitute a breach of a duty of care. To some extent, this provision should allay the fear among health service providers who administer screening services. The Committee is aware that such a provision would not change the current legal position. However, the introduction of the provision could be considered by a judge when instructing a jury.

No Fault Compensation Scheme for People Who Have Suffered Loss as a Result of a False Report

2.102 The Department of Human Services observed that it may be appropriate to have a no fault compensation scheme for persons who suffer loss as a result of false reports when using screening services. This observation is based upon the predictable and irreducible error rate inherent in the test.[132]

2.103 The submission from the Eleanor Shaw Centre for the Study of Medicine, Society and Law and the Baker Medical Research Institute observed that there is concern in the community that preventative disease screening programs are being put at risk by medical litigation.[133] These programs include: child immunisation programs, the conduct of Pap smear tests by general practitioners, and research and development, with useful drugs being withdrawn from the market because of unsubstantiated allegations made in legal proceedings. In this submission it is recommended that compensation for injuries should be seen as an 'opportunity and an obligation for support and caring', instead of viewing it as a form of punishment. Accordingly, the introduction of a no-fault (no punishment) compensation system is supported by these bodies. This approach was also taken by the Melbourne Division of

---

130 Dr Chris Brook, op cit, p.2.
131 ibid.
132 ibid.
133 Submission no. 8.

General Practice and the Anti-Cancer Council of Victoria, and suggested in the alternative by the Department of Human Services.[134]

2.104 The *Final Report* of the Commonwealth Department of Human Services and Health's Review of Professional Indemnity Arrangements for Health Care Professionals (PIR), Chaired by Ms Fiona Tito, identified considerable problems with the introduction of a no-fault compensation scheme. Notably, this scheme would result in a shift of costs for the community. It would also:[135]

> increase the proportion of the costs of negligence paid by the community and the injured person, and reduce the contribution to these costs currently met by those who were negligent. This in turn would reduce the overall resources available to meet the needs of those with disabilities, unless more tax resources were diverted to these costs. This does not seem equitable.

2.105 Additionally, the report pointed to difficulties relating to causation; the schemes 'ignore the real problems of causation and separating out who should be compensated differently from others with similar disabilities and why'.[136]

2.106 Based on these difficulties, the Committee does not believe that the introduction of a no fault compensation scheme would be viable at this stage. The provision of a no fault compensation scheme for people who have suffered loss as a result of a false report is therefore not recommended.

2.107 The Committee believes that the most appropriate way in which to resolve the difficulty facing those health service providers who provide screening services is to provide statutory confirmation of the fact that a false report does not necessarily constitute a breach of a duty of care.

Recommendation 3

The* Wrongs Act 1958 *(Vic.) should be amended to provide that a false report arising out of a screening procedure does not of itself constitute a breach of a

---

134 Submission nos. 26, 34 & 60. The submission from the Melbourne Division of General Practice was supported by several other submissions: 39, 40, 41, 43, 49, 50, 51 & 55. The Anti-Cancer Council stated that it supports the introduction of statutory immunity for screening programs, where there is a demonstrable level of quality and no negligence.

135 PIR Final Report, pp. 139–140.

136 ibid., p. 139.

duty of care in negligence, although it may be relied upon as a material fact in determining whether there has been negligence.

Improving the Quality of Screening Services

2.108 Under the *Cancer Act 1958* (Vic.) the exchange of information between the Victorian Cancer Registry and the screening registries is not included in the list of appropriate disclosures. This is because section 62(6) of the *Cancer Act*, as amended by section 7 of the *Cancer (Central Registers) Act 1989*, did not specify that data could be exchanged between these bodies. The Act only allows disclosures where the person identified consents, the disclosure is to the medical practitioner treating that person, or the disclosure is to allow an organisation which maintains a prescribed register to follow-up positive results from cancer tests or to send a reminder notice to a person who is due for a test. The Victorian Cytology Service has advised the Committee that this restriction places a 'serious limitation' on improving the quality of screening.[137] The Service believes that a full exchange of information should be allowed, using formalised and routine liaison pathways. Without this reform information concerning how screening can be improved is unavailable, trends in the rate of diagnosis cannot be predicted, and women with cancer which was diagnosed in the interval since their last screening test are caused additional stress by being sent a reminder notice for their next screening test.[138]

2.109 The Committee is concerned about this problem and believes that it should be addressed. At the time of preparing this report, there was a Bill before the Victorian Parliament to address this situation.[139] The Committee believes that the *Cancer Act 1958* (Vic.) should be amended to allow information on breast and cervical cancer to be forwarded to health service providers in screening programs.

Recommendation 4

The* Cancer Act 1958 *(Vic.) should be amended to allow information on breast and cervical cancer to be forwarded to health service providers in screening programs.

---

137 Submission no. 7.

138 ibid.

139 Miscellaneous Acts (Omnibus No. 3) Bill 1997 (Vic.), Part 5.

Compulsory Professional Insurance

2.110 The professional indemnity arrangements which apply to publicly funded and privately funded health care in Victoria were described in the Committee's Issues Paper No. 1.[140] A government-funded indemnity insurance policy applies for publicly funded health services. It operates on a claims made basis, with a maximum sum limit for individual cases which is reassessed annually. Claims above the limit are individually considered by the Victorian Department of Human Services.[141] The policy covers providers even where the claim is made after the provider has left the hospital, provided the event occurred while he or she was employed there.

2.111 Professional indemnity cover for privately funded health care is provided by medical defence organisations operating under a mutual funds arrangement. In Victoria the majority of doctors are represented by the Medical Defence Association of Victoria, which is a mutual fund.[142] Pursuant to the Association's constitution, the Council has a discretion to provide an indemnity to a member when requested.[143]

2.112 In considering the appropriate nature of professional indemnity cover, a distinction is made between cover on a claims incurred basis (where indemnity is provided for incidents which occur in the period of professional indemnity cover whenever the claim is made) and on a claims made basis (where cover is provided whenever the incident occurs, provided the claim is notified while the policy is still current). For cover on a claims made basis the practitioner will need to buy 'run-off cover' for when he or she ceases to practice, so that newly notified claims are covered.[144]

2.113 The Final Report of the Review of Professional Indemnity Arrangements for Health Care Providers (PIR) concluded that professional indemnity cover should be compulsory for all health care providers, not merely those who are registered.[145] Furthermore, this cover should be

---

140 Issues Paper No. 1, paras. 2.1–2.10.
141 Submission no. 60 .
142 Submission no. 77 .
143 ibid.
144 PIR Final Report, p.226.
145 ibid, p. 232.

contractually based rather than discretionary, and be on a claims incurred basis.[146]

2.114 In Issues Paper No. 1 the Committee sought responses from the public on whether or not there should be compulsory indemnity cover and what the minimum amount of cover should be for each profession or speciality.[147]

2.115 Among the submissions received by the Committee, most groups which addressed the issue of compulsory professional indemnity insurance favoured its introduction.[148] The Health Law Committee of the Australian Plaintiff Lawyers Association, Victorian Branch, advocated that the maintaining of adequate professional indemnity insurance should be a prerequisite to registration and the right to practice. The Association believes that other health care providers should also be required to have such insurance.[149] Similarly, the submissions of the Victorian Bar Council, Slater and Gordon, and the Institute of Legal Executives recommended that health care providers should be required to have professional indemnity cover, regardless of the nature of the service.[150]

2.116 Aged Care Victoria recommended that member organisations should only allow providers who have appropriate professional indemnity insurance to tend to patients.[151] It also suggested that the Commonwealth Government should increase the Standard Aggregate Module component of nursing home funding so that it covers the cost of professional medical malpractice insurance.

---

146 ibid, pp. 232 & 239.

147 Issues Paper No. 1 pp. 21& 23

148 Submission nos. 5, 7, 17, 19, 20, 22, 26, 28, 31, 33, 37, 48, 54 & 77. The Eastern Health Care Network suggested that individuals and groups should be required to carry personal insurance, especially medical officers in a high risk work place environment; see submission no. 42.

149 Submission no. 19.

150 Submission no. 20, 22 & 48.

151 Submission no. 26.

2.117 The Victorian Cytology Service asserted that professional indemnity cover should be compulsory for all providers, but it observed that such a requirement would still not address the need for retrospective cover. [152]

2.118 The Chiropractors and Osteopaths Registration Boards have expressed concern regarding the lack of mandatory professional indemnity insurance for members of the profession they regulate. In August 1996 they passed a resolution asking the Commonwealth and States, through the Australian Health Ministers Advisory Council, to develop an agreed strategy for 'making professional indemnity insurance (minimum policy of $5 million) compulsory for all Chiropractors and Osteopaths in Australia'. [153]

2.119 Additionally, some submissions pointed to the desirability of having professional indemnity cover. The Australian Council of Professions suggested that the proportion of members with cover, and the level of cover, should be assessed by the Committee.[154] The use of professional indemnity cover was supported by the Australian Association of Occupational Therapists who advised that therapists in private practice have taken out cover.[155] The Australian College of Midwives observed that affordable insurance is an essential requirement for midwives and that the College is investigating the possible provision of cover for all its members. The Royal College of Nursing recommended that insurance be made available through professional organisations or that nurses should be encouraged to fund their own personal professional indemnity scheme.[156]

---

152 Submission no. 7.

153 A. Didi, Secretary, Australasian Conference of Chiropractors and Osteopaths Registration Boards, letter to the Hon. Mr Rob Knowles, Minister for Health, 6 Jan. 1997.

154 Submission no. 11.

155 Submission no. 10. This submission also advised that the Australian Association of Occupational Therapists (Victorian Branch) would resist any changes to the professional indemnity system that would cause a large increase in practitioner contributions.

156 Submission nos. 10, 12 & 23. However, the Royal College of Nursing suggested that compulsory insurance may lead to increased litigation; see submission no. 23.

2.120 However, a number of groups opposed the introduction of compulsory professional indemnity insurance.[157] The National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch) and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch) in a joint submission informed the Committee that indemnity insurance is already a requirement for accreditation in Victorian hospitals, consequently, most practitioners have cover.[158] The joint submission contended that if cover were made compulsory then this would give the insurance organisations the power to decide who will practice, and may lead to a further rise in premiums. Accordingly, they recommended that patients could be advised to ask the doctor whether he or she is insured, instead of the introduction of compulsory professional indemnity insurance.

2.121 The Melbourne Division of General Practice opposed the introduction of compulsory indemnity cover, on the grounds that requiring medical defence premiums for registration would not be appropriate for general practitioners who are employed by a Victorian State hospital or are teaching full time.[159]

2.122 The AMA also opposed such a change. However, its initial reaction was different; it was prepared to consider compulsory professional indemnity insurance in respect of privately funded health care provided by its members, although the matter would first need to be debated by the Council, and members would need to be satisfied that the administration of such a regime could be effectively monitored; for example, by the Medical Practitioners Board.[160] This issue was then addressed in a supplementary submission provided to the Committee. The Victorian Branch Council, having debated the issue, resolved that it should be referred back to the Board of the AMA for determination. The Board opposed the adoption of a policy which was inconsistent with that of the Federal AMA, which favours universal but not mandatory professional indemnity cover. This view was also shared by the

---

[157] Submission nos. 32, 34 & 35.
[158] Submission no. 35.
[159] Submission no. 34.
[160] Submission no. 32A.

Medical Protection Society, which believed that definitional issues would be a problem.[161]

Public Health Care

2.123 The AMA suggested that doctors should not be required to have profession indemnity cover for public patients, because the existing arrangements are adequate.[162] The Victorian Department of Human Services provides cover for doctors in public hospitals treating public patients. The AMA's view was supported in a joint submission by the National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch) and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch).[163] With respect to publicly funded patients, the AMA also supported the present professional indemnity arrangements. Insurance under these arrangements is capped by the insurer.

2.124 However, the Victorian Bar Council and the Medical Practitioners Board of Victoria supported compulsory indemnity cover for publicly funded, as well as privately funded, health care.[164]

2.125 The Committee accepts that existing arrangements for public health care providers are adequate and that there is no need for compulsory professional indemnity insurance for public health care providers.

Linking Compulsory Professional Indemnity Insurance with Registration

2.126 Several groups who supported compulsory professional indemnity insurance have recognised the need to link such cover with registration. The Victorian Breast Screening Coordination Unit recommended that consideration should be given to introducing compulsory indemnity cover for all health professionals, with indemnity cover being a condition of registration or practice.[165] The Physiotherapists Registration Board of Victoria suggested that the failure to carry appropriate professional indemnity cover should constitute unprofessional conduct for the purposes of de-registration.[166] It was observed that the majority of physiotherapists in

---

161 Submission no. 36.
162 Submission no. 32. See also submission no. 34.
163 Submission no. 35.
164 Submission nos. 37 & 48.
165 Submission no. 54.
166 Submission no. 28.

private practice belong to the Australian Physiotherapy Association and they have indemnity cover. The Victorian Bar Council also recognised that there would be administrative difficulties in applying such a requirement to providers who are without statutory recognition or control.[167]

2.127 This approach is also consistent with the initial advice of the Victorian AMA which suggested that the Victorian medical community may be more likely to accept compulsory professional indemnity insurance if other health care providers were required to have adequate insurance as a condition of registration.

2.128 The Committee has concluded that compulsory insurance should apply to a broader group then just medical practitioners. All health service providers who are statutorily recognised should be required to have insurance. As a matter of practical reality, it would be difficult to control the insurance cover of health service providers, who are not recognised by a registration board. This difficulty was acknowledged by the PIR.[168] The PIR recommended that all persons who represent themselves as health care providers should be required to have professional indemnity cover, despite the resulting difficulties relating to administration and enforcement.[169] The Committee has considered these public policy arguments, but has concluded that its recommendation must be administratively workable. Accordingly, the requirement that there be compulsory insurance needs to be linked to registration.

2.129 Consequently, the following health service providers, being professions which are recognised by statute should be required to have compulsory insurance: chiropractors, chiropodists, dental technicians, dentists, medical practitioners, nurses, pharmacists, optometrists, osteopaths, physiotherapists, and psychologists.[170]

---

167 Submission no. 48.

168 PIR Final Report, pp 235 & 236.

169 ibid.

170 The relevant statutes are as follows: *Chiropodists Act 1968; Chiropractors Registration Act 1996; Dental Technicians Act 1972; Dentist Act 1972; Medical Practice Act 1994; Nurses Act 1993; Optometrists Registration Act 1996; Osteopaths Registration Act 1996; Pharmacists Act 1974; Physiotherapists Act 1978; and Psychologists Registration Act 1987.*

2.130 The Committee has considered the level of coverage which should be required under a system of mandatory professional indemnity insurance, and whether liability should be capped by statute. In some submissions it was suggested that there should be statutory capping of liability for those with professional indemnity cover.[171] For example, the Royal Australasian College of Surgeons suggested that if compensation were capped then professional indemnity cover could be made compulsory for publicly funded health care providers in each profession.[172] According to the Australian Council of Professions, if a statutory capping on liability is introduced then it should only be available to practitioners who have the appropriate professional indemnity cover.[173] The Council recommended that a capping system should have variable ceilings based on the category of injury or adverse event.[174]

2.131 According to Aged Care Victoria, the level of cover for medical practitioners should be set at $10 million. The Medical Defence Association of Victoria said that there should be cover of at least $7.5 million per event, subject to revision over time due to increased court awards (rather than CPI).[175] These figures are based on the possibility of a medical practitioner failing to diagnose a potentially fatal condition.

2.132 Other submission indicated that there should be no capping and that the level of cover should be sufficient to meet any award.[176] Unlimited occurrence based cover was supported by the Australian Dental Association (Victorian Branch).[177] Similarly, the Victorian Bar Council supported occurrence based cover, with the amount being unspecified. However, they suggested that a level of cover for $10 million should be sufficient to provide

---

171 Submission no. 11

172 Submission no. 17.

173 Submission no. 11.

174 ibid.

175 Submission no. 77.

176 Submission nos. 20, 28 & 35. The National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch) and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch) favours effective tort reform to ensure that the amount of damages is kept under reasonable control; rather than insurance being capped.

177 Submission no. 33

indemnity for the worst case scenario.[178] The Victorian Breast Screening Coordination Unit submitted that for radiographers, premiums should be based on their claims risk.[179]

2.133 The AMA was unable to assess whether indemnity by commercial insurers on a capped basis of around $5 million would provide sufficient protection for privately funded patients.[180] This was because doctors have not had standard commercial arrangements with insurers. Additionally, the submission states that 'it is hard to argue why there should be a difference for public patients and private patients in the "ceiling" on insurance cover'.[181]

2.134 The Committee believes that the minimum level and type of cover under a system of compulsory professional indemnity insurance should be specified by the appropriate registration board, in consultation with relevant professional associations. The Committee is aware of the need to prevent registered health service providers with insurance on a claims made basis from suffering financial loss as a result of the introduction of mandatory cover on a claims incurred basis. Accordingly, the necessary run-off cover should be included in any insurance contract.

Recommendation 5

Statutorily recognised health service providers should be required to obtain compulsory professional indemnity insurance cover with respect to privately funded patients, in order to become and remain registered. The minimum level of cover should be specified by the appropriate registration board, in consultation with relevant professional associations. Run-off cover should be provided for those who are currently insured on a different basis to the mandatory requirement.

---

178 Submission no. 48.
179 Submission no. 54.
180 Submission no. 32.
181 ibid.

3 Compensation Payments: the Need for Reform

Introduction

3.1 Chapters 3 to 7 of this report take up the issue that is referred to in paragraph 2(c) of the terms of reference, namely, the investigation of options with respect to the use of structured settlements to maximise the benefit to an injured person of any financial compensation ordered by a court.

3.2 As indicated in Chapter 2 of the Committee's Issues Paper No. 1[182] this question concerns the manner in which compensation is paid to people who have suffered injuries as a result of services provided by a health service provider. These Chapters of the report will consider whether awards of compensation should be made once-and-for-all, as is the current position, or whether damages should be awarded in some other manner such that they may be payable over a period of time in order to take into account an individual's changing circumstances.

3.3 Although it may be said that reforming the manner in which payments of compensation are made will not, of itself, solve all of the problems that led to the Committee receiving its reference, such reform may be able to curtail the rise in professional indemnity costs and result in individuals being more fairly and adequately compensated. In addition, fears expressed by many health service providers of incurring excessive liability may be reduced and health users may feel that they have received fair redress for the injuries they have suffered.

3.4 The problems associated with proposing and implementing reforms to the civil compensation system in the field of medical negligence should not be overlooked. Since the 1960s over a dozen Royal Commissions, inquiries, reports and reviews have taken place that have sought to reform civil

[182] Paras. 3.23 to 3.31, Issues 28 to 39 and B46 to B49.

compensation systems throughout the common law world. Many valuable recommendations have been proposed but few have been acted upon.[183] By focussing upon the specific issue concerning the manner in which compensation is paid, the present Committee hopes to be able to recommend a practical and workable solution to one important area of concern while maintaining the overall structure of the common law system of compensating individuals who have suffered injury through the use of health services. More far-reaching reforms such as the introduction of alternative systems of compensation may be the most effective way of solving the perceived problems associated with health service litigation but may be unlikely to be introduced in times of fiscal restraint and government downsizing.

3.5 The Committee is also keenly aware of some of the larger philosophical issues associated with reform in this area. The primary issue concerns the nature of compensation and who should be responsible for providing it. Various individuals and bodies may be involved in providing compensation for health users who suffer injuries through the use of health services: health users themselves, health service providers, professional indemnity organisations, members of the community through general taxation contributions, and government-funded social security organisations. At present losses are born by all of these bodies to varying degrees depending upon the nature and circumstances of the incidents that give rise to claims and, unfortunately, often to circumstances of chance. As will be discussed later, the taxation implications of reform in this area are of considerable importance, for an otherwise useful and efficient scheme devised for the payment of compensation may not be used by claimants if the existing taxation regime makes it financially unviable. In New South Wales, for example, the scheme of structured settlements provided for under the *Motor*

---

183 Parliament of Victoria, Law Reform Committee, *Legal Liability of Health Service Providers – Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996 (hereafter cited as 'Issues Paper No. 1'), paras. 1.34–1.42.

Accidents Act 1988 (NSW)[184] has not been used largely because payments made under the scheme are not exempt from taxation.[185]

3.6 Finally, the Committee takes the view that it is desirable to examine the question of how compensation is paid prior to embarking upon an inquiry into some of the more far-reaching matters referred to in the terms of reference, as questions of periodical payments and structured settlements, for example, have application to other alternative systems of compensation. No-fault schemes of compensation, for example, also require sums of money to be awarded to claimants and it would be appropriate for these to be paid to claimants by employing the most efficient and cost-effective means.

3.7 Although the terms of reference speak only of 'compensation ordered by a court', the question of how out-of-court settlement monies are to be paid will also be considered and whether or not this should be legislatively controlled. It is well-known that only a very small proportion of writs issued in civil negligence proceedings result in trial, with most actions being resolved by some form of compromise.[186] In addition, many other potential claims are settled without recourse to legal proceedings at all and are settled by some form of ex-gratia payment. Both court awards of damages and out-of-court settlements are, however, invariably paid by professional indemnity organisations and it is arguably just as important to deal with the issues arising out of these settlements as it is to deal with the issues arising out of court-awarded damages following trial.

3.8 The Committee is also aware of the many recent proposals that have sought to reform other aspects of civil proceedings and of the need for the current recommendations to be appropriate in the context of a modern civil justice system. The New South Wales Law Reform Commission, for example, has recently issued a report recommending the introduction of provisional

---

184 Section 81.

185 See NSW Law Reform Commission, *Provisional Damages*, Report No. 78, NSW Law Reform Commission, Sydney, 1995, para. 2.14.

186 See Issues Paper No. 1, paras. 2.13–2.15; H. Luntz,. *Assessment of Damages for Personal Injury and Death*, 3rd edn., Butterworths, Sydney, 1990, para. 1.2.9, n. 15.

damages in all cases of personal injuries in that State.[187] Reforming the manner in which compensation is paid in situations of liability for the provision of health services could, therefore, be used as a model for the payment of compensation in other areas of civil liability. Although the Committee is constrained by its current terms of reference, it is hoped that the present recommendations may be of use in suggesting wider reforms to the procedures by which compensation is paid in other areas of legal liability.

3.9 The present chapter examines the nature of the system by which damages are paid to individuals who have suffered injuries through the use of health services, and whether this system requires reform. After describing the aim of civil damages and the manner in which damages are assessed at present, the question of whether or not individuals are over-compensated or under-compensated will be addressed. Finally, consideration will be given to the research that has documented the manner in which individuals dispose of their compensation payments in order to determine whether they are dispersed appropriately and in accordance with the purposes for which they were awarded.

The Aim of Compensatory Damages

3.10 *Restitutio in integrum* (literally, restoration to the original position) is a principle that derives from the equitable remedy which sought to place parties in the position they occupied prior to entering into a transaction. It lies at the heart of the common law system of awarding damages. Its classic formulation was that of Lord Blackburn in the case of *Livingston v. Rawyards Coal Co.*:[188]

> in settling the sum of money to be given for . . . damages you should as nearly as possible get at that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation.

3.11 Of course, it may well be impossible to return an injured health user to exactly the same condition which he or she occupied prior to having sustained certain injuries such as the loss of a sense or some bodily disfigurement. A sum of money could not, for example, compensate exactly

---

187 NSW Law Reform Commission, loc. cit.

188 (1880) 5 App. Cas. 25, 39 (House of Lords).

the plaintiff in *Rogers v. Whitaker*[189], who suffered loss of sight in both eyes through the defendant having failed to warn her of the risks of the complication of sympathetic ophthalmia occurring following surgery. Accordingly, the courts have determined that damages for personal injury and death should be fair, but not perfect.[190] In the words of Dixon J in *Lee Transport Co. Ltd. v. Watson*:[191]

> No doubt it is right to remember that the purpose of damages for personal injuries is not to give a perfect compensation in money for physical suffering. Bodily injury and pain and suffering are not the subject of commercial dealing and cannot be calculated like some other forms of damage in terms of money.

As Professor Luntz notes, however, the consequences of a personal injury are both pecuniary (such as the need to incur medical expenses or the loss of earning capacity) and non-pecuniary (such as pain and suffering and loss of amenities).[192] In assessing damages in the context of injuries sustained through the provision of health services, some heads of damage may be capable of more precise quantification than others.

The Heads of Damage

3.12 The expression 'Heads of Damage' refers to the individual items of loss that a plaintiff in a personal injuries action may seek to recover. It is accepted practice now for courts to allocate specific sums for specific heads of damage. In the present context, damages may be given for non-pecuniary losses (pain and suffering, loss of amenities, loss of expectation of life and disfigurement), medical, hospital and nursing expenses, future care costs, alterations to premises, aids and appliances, loss of earnings and loss of earning capacity and various other losses. In assessing such losses, it is necessary to calculate sums actually lost at the date upon which the assessment takes place (the date of trial) and then to estimate losses that are likely to be sustained throughout the remainder of the claimant's life.

3.13 It is this latter estimation which gives rise to most of the difficulties in the process of assessing damages. Fortunately, the vast majority of tort claims arising out of the provision of health services relate to temporary disabilities in which there is either no, or no significant component relating to future

---

189 (1992) 175 C.L.R. 479 (High Court of Australia).
190 Luntz, op. cit., para. 1.1.5.
191 (1940) 64 C.L.R. 1, 13–14.
192 Luntz, op. cit., para. 1.1.4.

losses. Lump sum awards would, in such cases, provide an acceptable form of payment because the plaintiff would receive compensation for quantifiable losses actually sustained at the date of trial.

3.14 The problem of primary importance in the present context concerns the relatively small number of cases involving serious disabilities in which claimants seek financial support over substantial periods of time for loss of earning capacity and for on-going care costs. Awards of damages and settlements in these few cases account for the vast majority of the liabilities of the defence organisations. One recent Victorian settlement involving a permanently severely disabled young adult was said to have exceeded $6 million as compensation for injuries caused through a mistaken injection of a cancer drug into his spine.[193] In the case heard in South Australia in 1991, already referred to, damages of around $5 million were awarded to a severely brain-damaged infant who had suffered oxygen deprivation during a delivery managed by a midwife, which resulted in the child suffering spastic quadriplegia and cerebral palsy.[194]

3.15 Various factors may affect the reliability of a determination of damages for future loss. The New South Wales Law Reform Commission categorised these factors as being those that exist generally and those that are peculiar to the plaintiff's case.[195] General factors include: the effects of inflation; changes in levels of income taxation and rates of pay; and various vicissitudes of life, such as, early death, sustaining further injury, or being prevented from work by external causes. Factors peculiar to the plaintiff include changes in his or her life span and medical prognosis.

3.16 The future course of inflation, rates of taxation on the investment of a lump sum, wage levels and cost of care services are not taken into consideration in assessing damages at common law. Instead, the present day values are reduced by a fixed, so-called 'discount rate', which seeks to

---

193 *Sydney Morning Herald*, 6 May 1995, p. 8.

194 *Crossman, by his next friend Public Trustee v Le Fevre and Port Adelaide Community Hospital Incorporated (in Provisional Liquidation)*, unreported, SA Supreme Court, Matheson J, 22 Dec 1991

195 NSW Law Reform Commission, op. cit. paras. 2.1 to 2.4.

approximate long term real interest rates net of taxation (the rate by which the net return on invested funds exceeds the inflation rate). A discount rate of three per cent has generally been applied following the decision of the High Court of Australia in *Todorovic v. Waller*.[196]

3.17 Various States throughout Australia have altered the discount rate by legislation, increasing it to between five and seven per cent depending upon the type of claim involved.[197] This may have a substantial effect on the amount of compensation paid in individual cases with a higher discount rate resulting in a lower award of damages being recovered.[198] The Discussion Paper prepared for the Review of the Relationship Between Compensation and Health and Community Service Programs illustrated the effects of varying discount rates by comparing the amounts required to compensate a 25-year-old claimant for loss of earnings of $400 per week until the retirement age of 65. Using a three per cent discount rate this amounted to $468,800 while a seven per cent rate provided only $280,400.[199] There has been much criticism of the use of discount rates and it has been argued that rather than preventing over-compensation of plaintiffs, they may in fact result in plaintiffs being under-compensated owing to the problems associated with obtaining an adequate return on investments.[200]

3.18 Lord Scarman noted the difficulty of making long-term predictions of future loss in the case of *Lim v. Camden and Islington Area Health Authority*:[201]

> Knowledge of the future being denied to mankind, so much of the award as is to be attributed to future loss and suffering—in many cases the major part of the award—will almost surely be wrong. There is really only one certainty: the future will prove the award to be either too high or too low.

---

196 (1981) 150 C.L.R. 402, 409.

197 T. Brennan & J. Deeble,. *Compensation and Commonwealth Health and Community Service Programs: A Discussion Paper Prepared for the Review of the Relationship Between Compensation and Health and Community Services Programs*, AGPS, Canberra, 1993, Table 2.8, para. 2.50.

198 See Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: An Interim Report*, AGPS, Canberra, 1994 (hereafter cited as 'PIR Interim Report'), para. 4.141, n. 204.

199 Brennan and Deeble, op. cit., table 2.9, para. 2.51.

200 PIR Interim Report, op. cit., para. 4.142.

201 [1980] A.C. 174, 183.

The Once-and-for-all Rule and its Problems

3.19 Awards of damages are traditionally made on one occasion, in a lump sum, once-and-for-all with the one payment being made in complete and final discharge of the defendant's liability.

3.20 The so-called 'once-and-for-all rule' was first formulated in 1701 in the case of *Fitter v. Veal*[202] by Holt CJ who held that the plaintiff, who had recovered damages for battery in respect of the bruising and wounding of his head, could not recover further damages in respect of a surgical procedure that he had subsequently undergone for the removal of a piece of the bone from his skull.

3.21 The consequence of the rule is that where a claim for damages resulting from a particular act or omission of the defendant has been successfully litigated or compromised, the plaintiff is prevented from bringing an action in respect of any further manifestation of injury resulting from the same act or omission.[203] The rationale for the rule in the eighteenth century lay principally in the need for plaintiffs to be provided with a lump sum rather than ongoing payments in order to avoid the risk that the defendant would die, abscond or become insolvent. In modern times, when payments invariably come from insurance companies or mutual fund organisations, such a justification is less relevant because it is rare for such bodies to be wound up.

3.22 Various justifications exist for retaining the rule.[204] The first is the need for there to be finality to litigation (embodied in the maxim *interest reipublicae ut sit finis litium*) so the defendant knows the extent of his or her liability. Moreover, by allowing plaintiffs to return to court on more than one occasion, the courts would arguably become more congested, plaintiffs would suffer from compensation neurosis,[205] defendants and insurance companies would infringe the privacy of plaintiffs by seeking to produce evidence of an absence of injury, and defendants and insurance companies would not be able to close

---

202 (1701) 12 Mod. 542.

203 Luntz, op. cit., para. 1.2.1.

204 See Luntz, op. cit., paras. 1.2.18 to 1.2.28.

205 A recognised mental condition caused by the stress of unresolved litigation.

their books and assess the extent of their liability. As we shall see, in those jurisdictions where periodical payments are used, plaintiffs tend not to make wide use of them and, indeed, various organisations in the United States provide a service of converting periodical payments into lump sums. Finally, lump sum awards tend to compensate the carers and relatives of a plaintiff who dies, whereas periodical payments generally terminate on the death of the plaintiff.

3.23 There has been substantial criticism of the rule throughout the common law world, including Australia for many years now. In Victoria Professor Luntz gave a clear explanation of the problems in a dissenting opinion appended to the Report of the Chief Justice's Law Reform Committee on Damages by way of Periodical Payments, which was presented to the Full Committee on 14 March 1968. Although the Committee considered that the principle of periodical payments was desirable, it opposed its introduction on practical grounds. What follows is a summary of the arguments made by Professor Luntz.[206]

3.24 The principal difficulty that arises in assessing damages in personal injury actions, whether in relation to injuries sustained through the use of health services or not, is the need to ascertain what loss the plaintiff has suffered and will continue to suffer throughout the remainder of his or her lifetime. This entails reliance upon expert medical evidence as to the likely progression of an illness, such as brain damage leading to epilepsy or damage to a joint leading to osteoarthritis. Expert evidence will also be needed to estimate the plaintiff's life expectancy, that obviously cannot account for all of the contingencies of life such as a plaintiff dying through causes unrelated to the original injury. The whole process has been described as one of 'unending disputes between rival lawyers and doctors'.[207]

3.25 In order to provide greater certainty as to the loss actually suffered, plaintiffs are invariably advised by their legal advisers to delay issuing

---

206 See also Luntz, op. cit. paras. 1.2.10–1.2.17.

207 J. R. Valentine, 'Medical Litigation: Time for Change', *Australian Medicine*, 5 Aug. 1991, pp. 3–4.

proceedings until injuries have stabilised, even if this takes them to the maximum period permitted for the commencement of proceedings provided for in Statutes of Limitations. Such delay may lead to an exacerbation of any compensation neurosis and increase legal costs as plaintiffs continue to consult their advisers and have regular medico-legal examinations. The determination of liability may also be impeded through witnesses becoming unavailable or their memories of events fading. It is for this reason that suggestions have been made that proceedings be issued and liability determined as soon as practicable, with damages to be assessed at a later time and perhaps paid on a provisional basis.[208]

3.26 Lump sum awards of damages may also discourage plaintiffs from seeking and undergoing active rehabilitation as this would tend to reduce the award of damages to which they may be entitled. In one study of the influence of compensation on recovery from low-back pain, it was found that compensable patients who had received lump sums had poorer outcomes than both non-compensable patients and those who received compensation by periodical payments. Of the patients who claimed lump sum compensation, fifty per cent said they would not go through the claim procedure again under similar circumstances because of the stress and trauma it caused. The authors of the study concluded that the compensation system, particularly the lump sum system, acted against the long-term interests of the patient, while periodical payments may enable patients to return to employment sooner and with less stress.[209] Although periodical payments may also attract such consequences, the impetus to delay or avoid rehabilitation is likely to be less than where a lump sum award is involved.

3.27 In addition, unless interim or provisional awards of damages are made, a plaintiff may be unable to afford the cost of undertaking rehabilitation programmes. Structured settlements and periodical payments

---

208 See the suggestion of Winn LJ in *Hawkins v. New Mendip Engineering Ltd.* [1966] 1 W.L.R. 1341, 1347 (Court of Appeal); *Stevens v. William Nash Ltd.* [1966] 1 W.L.R. 1550, 1554-5 (Court of Appeal).

209 C. G. Greenough & R. D. Fraser, 'The Effects of Compensation on Recovery from Low-Back Injury', cited in the PIR Interim Report, op. cit., para. 4.158, no. 223.

would ensure that the plaintiff has adequate funds available to meet such disbursements as and when they arrive.

3.28 As Professor Luntz notes,[210] the longer the delay before any money can be received, the greater will be the pressure on seriously injured persons to accept inadequate offers of settlement. Hence, the practice of some insurance companies of making late payments into court shortly before trial or settling at the door of the court.

3.29 As will be discussed below, lump sum awards of damages and out-of-court settlements at present do not attract income taxation where they are unapportioned into income and non-income components, thus depriving the Crown of revenue and giving the plaintiff an unmerited bonus.[211] Compensation that is paid periodically, however, is generally taxable in the hands of the plaintiff as income.

3.30 Although the use of discount rates (referred to above) is intended to counter variations in the rate of inflation as it affects a lump sum award of damages, it is clearly difficult for a court to be certain that a lump sum will, in fact, be adequate to meet the plaintiff's needs, particularly in times of escalating inflation. Periodical payments may be indexed to keep pace with changes in inflation, thereby ensuring that plaintiffs are neither under- nor over-compensated through such influences.

The Extent to which Lump Sums are Used

3.31 Research undertaken for the Commonwealth Department of Human Services and Health's Professional Indemnity Review found that over 65,000 people receive a lump sum payment of compensation for personal injury each year in Australia in respect of all types of claim, not just medical negligence. It also found that of these, 3,300 receive money for future income and of these fewer than 500 receive money for future care needs. However, these 3,300 people, which represent fewer than five per cent of recipients of lump sums, receive more than half of the total money paid in lump sums. Approximately

---

210 Luntz, op. cit., para. 1.2.13.

211 See K. Chalmers & J. Evans, 'Pain but no Gain? Capital Gains and Compensation Receipts', (1996) 70 A.L.J. 617–37.

$1,474 million is paid in lump sums each year in Australia of which at least half and probably more is paid for future care and income requirements.[212]

Evidence of Under-Compensation

3.32 In addition to the problems already outlined concerning the prediction of the needs and circumstances of the plaintiff at the time the assessment of damages takes place, there are a number of reasons why a lump sum award of damages may be inadequate to cover the income, medical and care needs of the plaintiff. These were characterised in a Discussion Paper prepared for the Commonwealth Department of Human Services and Health's Professional Indemnity Review as follows. A lump sum may be inadequate owing to a reduction in the award of damages to take account of contributory negligence; the fact that the plaintiff may have negotiated an inadequate settlement for a variety of reasons; and the fact that the plaintiff's ability to rely upon government-funded programmes may have reduced the original calculation of the award of damages.[213]

3.33 A number of studies have documented the extent to which plaintiffs have received awards of damages that are inadequate to meet their on-going needs; some anecdotal and others empirical.

3.34 An early study commissioned by the New South Wales Law Reform Commission in 1983 examined 263 compensation recipients with injuries arising from motor vehicle, work and general accidents who were interviewed an average of six years after having received their payments. It was found that approximately fifty per cent of all recipients had an income lower than average weekly earnings at the time of the interview; approximately fifty per cent were in receipt of social security benefits; and a substantial majority of the recipients regarded the amount they received as inadequate. Almost seventy per cent of those interviewed reported continuing

---

212 See Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: Final Report*, AGPS, Canberra, 1995, (hereafter cited as 'PIR Final Report'), para. 7.96.

213 Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Structured Settlements as Payment of Compensation for Personal Injury: A Discussion Paper*, para. 2.2.

injury-related expenses six years after receiving their payments that were not predicted at the time of settlement.[214]

3.35 More recently, Neave and Howell of the University of Adelaide Law School interviewed 227 people in 1992 who had received common law damages nine years prior to being interviewed after having been injured in road accidents in South Australia.[215] In order to identify cases where under-compensation had occurred, evidence was obtained concerning the extent to which the subjects were satisfied with the damages they had received, were reliant upon social security, living in poverty or otherwise experiencing financial insecurity.

3.36 It was found that 18.5 per cent were reliant upon social security for reasons related to the accident; 16.3 per cent were living in families which were below the poverty line (compared with 12.3 per cent of the general population); 11.6 per cent were living below the poverty line after housing costs were taken into account (compared with 10.6 per cent of the general population); 21.8 per cent were rated by interviewers as financially insecure because of the accident; 60.4 per cent were originally satisfied with the amount of compensation they received but by the time of the interview, some eight to nine years after settlement, only 24.0 per cent were satisfied; and 52.6 per cent said that their compensation was insufficient to cover their accident-related losses.[216]

3.37 Neave and Howell also found no evidence that those subjects who had not followed financial advice regarding the investment of their settlement monies were less financially secure that those who followed such advice. The authors concluded that the current financial insecurity of the 21.8 per cent determined to be financially insecure would not have been improved by

---

214 C. Bass, 'Lump Sum Accident Compensation', (1983) 1 *Human Resources* 59, 165–7 and see the other studies cited by Luntz, op. cit., para. 1.2.16, n. 28; and the NSW Law Reform Commission, *Accident Compensation: Traffic Accident Case Studies*, Research Paper 1, .NSW Law Reform Commission, Sydney, 1984.

215 M. Neave & L. Howell, *The Adequacy of Common Law Damages*, University of Adelaide, Adelaide, 1992, discussed in PIR Interim Report, op. cit., paras. 4.143–4.149.

216 Neave and Howell, op. cit., pp. 51 & 85.

better financial advice. Instead, it was found that the subjects' current financial situation was largely determined by their degree of injury and that the compensation awarded was inadequate to provide for their needs. The authors noted:[217]

> Virtually all the injured people in the study who had on-going medical costs were now claiming on Medicare, and people with private health insurance were also being reimbursed for accident-related medical treatment. Severely injured people were receiving other subsidised Government services such as domiciliary care.

3.38 The study of Neave and Howell concluded that injured people are not well-served by lump sum awards and that problems of under and over-compensation could only be prevented by the introduction of a statutory scheme providing indexed periodical payments for economic loss.[218]

3.39 As part of the Commonwealth's Professional Indemnity Review, a study was undertaken by researchers at the Centre for Socio-Legal Studies at La Trobe University in Melbourne in 1992.[219] Twenty-four people who had sustained a health/medical care injury participated in the study, eleven of whom had received compensation varying from less than $10,000 to more than $100,000. All eleven claimants received lump sum awards, although those who were minors had the fund administered by the court.

3.40 A number of problems were identified with lump sum awards including inadequate provision being made for changing levels of need and costs, difficulties with investments and trying to generate a sufficient stream of income to meet current needs while sustaining capital for longer term needs. Some of those interviewed, however, considered that replacing lump sum awards would result in a loss of independence by being required to make constant applications for further funds as the need arose.[220]

3.41 The study specifically examined the question of whether the compensation received was adequate. All of the families of injured children

---

217 ibid., p. 147.

218 ibid., p. 87.

219 Commonwealth of Australia, Department of Health, Housing and Community Services, Review of Professional Indemnity Arrangements for Health Care Professionals, *The Health/Medical Care Injury Case Study Project*, AGPS, Canberra, 1993.

220 ibid., p. 81.

who were interviewed felt that the money they had received in compensation was inadequate to meet their child's on-going needs and that they would be required to provide financial support themselves. The lump sum settlement was thus considered to bring temporary relief only. In particular, many of those interviewed were initially pleased with the lump sum but soon discovered that there were subtle forms of hidden costs that had not been anticipated. Of the four people interviewed who had received relatively small lump sums, all expressed dissatisfaction with the amount that did not adequately cover even their quantifiable economic losses. In addition, most of those interviewed considered that a monetary sum could not adequately compensate for the emotional and psychological losses involved.[221]

3.42 Various studies conducted in other countries have also documented the problem of under-compensation. The Disability Management Research Group of the Rehabilitation Studies Unit at the University of Edinburgh, conducted a follow-up study of recipients of compensation payments for personal injuries arising out of motor vehicle accidents and medical negligence in 1993. 152 claim files were examined and 83 claimants interviewed who had, on average, had their accident ten years prior to the study and who had received compensation payments of more than £150,000 in 1987 and 1988. It was found that in most cases family members were the primary carers, with only seven of these persons receiving payment for their services and with four others whose contributions to care were augmented by part-time assistance. The study also identified the problem of the costs of care increasing beyond those anticipated at the time the award was made. The care costs of one person with quadriplegia who required twenty-four hour attention doubled in the space of five years that resulted in the claimant's family having to assume greater responsibility for the management of the care provided.[222]

---

221 ibid., pp. 49–54.

222 P. Cornes,. *Coping With Catastrophic Injury*, University of Edinburgh, Edinburgh, 1993, cited in the PIR Structured Settlements Discussion Paper, op. cit., para. 2.13.

3.43 A large study was undertaken for the English Law Commission in 1994 of the experience of the tort system of 761 individuals who had suffered injuries through work and road accidents as well as some medical accidents and public liability cases occurring between 1967 and 1991. Data relating to a wide range of matters were canvassed including the manner in which respondents used their damages and the adequacy of awards.[223]

3.44 All but nine per cent of the respondents in the Law Commission's study received compensation by way of out-of-court settlements, some receiving interim awards, and a few provisional awards. The majority of accident victims had been satisfied with their settlement at the time of the settlement, although levels of satisfaction subsequently declined.[224] A comparison of current earnings with earnings at the time of the accident for all of those respondents in work at that time revealed that, on average, compensated accident victims were £169 per week worse off at the time of the interview than at the time of the accident.

3.45 The study also found that the most common source of alternative financial assistance for those who had suffered loss of earnings and/or extra expenses was state benefits.

3.46 Two in five of the respondents to the Law Commission's study said that their damages had not been sufficient to cover past losses with the most frequently cited loss that had been under-compensated being loss of earnings. Respondents who had received between £50,000 and £99,999 were most likely to say that their standard of living was now worse off than at the time of the accident. About half of the respondents thought that their standard of living in ten years' time would be lower than they had enjoyed before the accident.[225]

---

223 England and Wales, Law Commission, *Personal Injury Compensation: How Much is Enough? A Study of the Compensation Experiences of Victims of Personal Injury*, Law Com. No. 225, HMSO, London, 1994.

224 ibid. p. 256.

225 ibid., p. 260.

3.47 In its submission to the present inquiry Slater and Gordon, a firm of solicitors with extensive experience in conducting personal injury litigation in Victoria, concluded that under-compensation of plaintiffs with serious injuries is a far more common problem than over-compensation.[226]

Evidence of Over-Compensation

3.48 Although there is less evidence of plaintiffs being over-compensated than under-compensated through receipt of lump sum awards of damages, some examples do exist. These principally relate to situations in which victims of injuries die earlier than was anticipated by actuarial assessment at the time the lump sum award was made. The overcompensation is received by the next of kin of the deceased rather than the plaintiff in question. This may be appropriate where relatives have provided care and support.[227]

3.49 One possible reason for which plaintiffs who receive lump sums may be over-compensated relates to the problem of so-called 'double dipping'. This is thought to have greater significance for the recipients of lump sum awards than for those who receive settlement monies periodically. The PIR Interim Report described the problem as follows:[228]

> For some claimants, an additional incentive to receive compensation in a lump sum is the possibility of accessing income support and health and community services provided by the Commonwealth and State Governments. An obvious advantage accrues to claimants who obtain a financial settlement providing for the full cost of these items and then obtains free or subsidised access through government programs. . . Particularly in relation to Medicare, this "double-dipping" has historically been more readily achieved by claimants who receive lump sum rather than periodical payments.

3.50 In order to reduce the extent to which this problem occurs, the Department of Social Security precludes the recipient of lump sum awards of compensation that contain a component for economic loss, from receiving income support for a certain period of time that is determined according to the size of the payment received. Recipients of periodical payments of compensation are also subject to a preclusion period in relation to the receipt of social security income support. The calculation operates as follows. Where a lump sum compensation payment is received, the Department of Social

---

226 Submission no. 20.

227 See *Kars v. Kars*, unreported, High Court of Australia, 10 Dec. 1996.

228 PIR Interim Report op. cit., para. 4.161.

Security examines it to determine whether it includes any component for lost earnings or lost capacity to earn. If the economic loss component has not been specified, it is deemed to be fifty per cent of the award. The plaintiff is then precluded from claiming income support payments for a period equivalent to the number of weeks represented by the economic loss component divided by the average weekly earnings of all persons in the household. Recipients of periodical payments or lump sums with no economic loss component are subject to an ordinary income and assets test in relation to income support claims.[229]

3.51 Not all publicly-funded health and community service programmes deal with the issue of double dipping although one significant area has now been partially resolved through the introduction of the *Health and Other Services (Compensation) Act 1995* (Cwlth) that commenced operation on 1 February 1996. This Act establishes machinery for the Health Insurance Commission to recover benefits paid by Medicare where an injured person, or his or her estate, recovers compensation in a claim where compensation is payable for medical and like expenses. It requires these types of claims to be notified to the Health Insurance Commission and provides a process whereby the amount repayable is fixed.[230]

3.52 Although it may be inappropriate to describe 'double dipping' as over-compensation, owing to the fact that the original lump sum may be inadequate in the first instance to cover on-going costs of plaintiffs, there is evidence to suggest that the preclusion periods imposed by the Department of Social Security have not been complied with by claimants for income support. The evidence is derived from a study undertaken for the Commonwealth Department of Human Services and Health's Professional Indemnity Review in which 2,818 Department of Social Security records relating to compensation recipients who had claimed income support with more than one month of the preclusion period remaining, were examined. The study found that 1,361 or

---

229 PIR Structured Settlements Discussion Paper, op. cit., paras. 4.22– 4.26.

230 See (1996) Law Institute Journal 49–53; M. Handcock, 'Health and Other Services (Compensation) Act 1995: Effective from 1 February 1996', (1996) 23(3) Brief 30–32.

forty-eight per cent of claimants sought income support between six months and two years before the end of their preclusion period. The remaining 687 or twenty-four per cent of claimants, had more than two years of their preclusion period remaining.[231] The Department of Social Security explained the problem in its submission to the present inquiry as follows:[232]

> Despite extensive outreach and information activity to publicise the social security implications of compensation lump sums, the Department continues to see many cases of hardship and distress where a lump sum has been spent unwisely within a short period of time. The person then turns to the Department for income support and is told that no payments can be made, sometimes for many years into the future. The person is left with the prospect of selling whatever assets he or she has, in order to survive until the end of the period.

3.53 Generally, however, there is little direct evidence of the extent to which over-compensation exists. In a Discussion Paper prepared for the Commonwealth Review of the Relationship Between Compensation and Health and Community Services programs, it was stated that, anecdotally, there are numerous cases in which hundreds of thousands, if not millions of dollars provided for future care are inherited by the injured person's heirs, although there was found to be no adequate data to support the view. The authors of the Discussion Paper concluded that lump sum awards are a very inefficient and inaccurate method of awarding compensation.[233]

Dissipation and Loss of Funds

3.54 The final problem arising out of lump sum awards of damages is that plaintiffs, other than those with a legal incapacity such as infants and persons of unsound mind, are free to do what they wish with their lump sums. As Gibbs J said in the case of *Cullen v. Trappell*:[234]

> It is trite law that the court has no concern with the use to which the plaintiff may put the amount paid to him in satisfaction of his verdict. He may invest it in gilt-edged securities, or hazard it in an investment which may yield a capital gain, or squander it on luxuries, and it does not matter to the court whether he may possibly, or does actually, use it in any of these ways

3.55 Sometimes, plaintiffs who receive lump sum awards of damages fall prey to fraudsters who persuade them to invest in worthless or highly

---

231 PIR Structured Settlements Discussion Paper, op. cit., para. 2.7.

232 Submission no. 6.

233 Brennan & Deeble, op. cit., para. 5.15.

234 (1980) 146 C.L.R. 1, 14–15.

speculative enterprises. Similarly, plaintiffs may be unskilled in the management of a lump sum and simply not know how best to preserve it through careful investment. By paying awards periodically, the likelihood of such loss or victimisation is reduced, although an initial lump sum which may be used as part of a structured settlement may be dissipated or stolen unless designated for a specific purpose.

3.56 In terms of social policy and the allocation of scarce government social security and public health care funds, it is important for awards of damages not to be dissipated by plaintiffs such that they subsequently need to rely upon government services to meet their needs which should have been satisfied by the award of damages. It is also arguable that because funds for the payment of damages are generally provided by insurance, the state has an obligation to ensure that they are used to meet the needs for which they were created. Such an argument is particularly relevant in relation to publicly-funded health care in which the government takes out professional indemnity cover, although less so for private health care where mutual fund subscriptions are paid by individual health service providers.

3.57 Professor Luntz provides a number of illustrations of plaintiffs who have dissipated awards of damages through neglect or victimisation.[235] In one case in 1967, a 21-year-old woman was awarded $29,000 in a lump sum that after medical and legal costs were deducted left $26,727. A number of young men preyed upon her and the entire sum was used within five months. In another case, a quadriplegic was awarded $222,000 which was lost in a car radio business owing to the dishonesty of a partner. In 1983, four quadriplegics invested their settlement monies (one amounting to $630,000) with a reputable trustee company which subsequently went into liquidation after funds were used for its own purposes.

3.58 Other plaintiffs may be required to use their awards of damages to discharge debts that have been incurred since the date of the injury, or to purchase furniture, appliances, motor vehicles or to pay off house mortgages.

---

[235] Luntz, op. cit., para. 1.2.16, n. 27.

Neave and Howell in the study cited above, for example, found that 32 per cent of claimants had used their compensation payments to invest in the family home, 32 per cent had made other investments, 17 per cent had purchased luxury items, while 3 per cent had repaid debts.[236] Such expenditure may be justifiable if it ensures that plaintiffs are less likely to rely on government support in the future, although this may not necessarily be the case.

3.59 The study undertaken for the English Law Commission referred to above provided many insights into the manner in which accident victims make use of their settlement monies and awards of damages.[237] The study found, however, that claims of plaintiffs dissipating awards of damages were exaggerated, particularly for those who had received large awards. The Law Commission also found that victims of personal injury were concerned to preserve capital in order to cover future health care and care assistance costs, at least during the period of up to ten years after the date of the injury.

3.60 Although there was evidence of considerable prudence exercised by respondents in the management of settlement monies, one in five respondents were unhappy with the choices they had made and with the interest rate received from investments. Of those respondents who reported having spent all of their settlement monies, most did so in order to cover past expenses or in order to purchase a house, some, however, regretting the fact that they had not saved their settlement monies.[238]

3.61 Among settlements received within three years of the date of the interview, nearly three in four of those with the smallest settlements had spent over half or all of their damages. Those with larger awards were, however, more prudent.[239]

3.62 Relying upon the results of this study, the Law Commission concluded that there is a risk that plaintiffs may dissipate their compensation awards,

---

236 Neave & Howell, op. cit., p. 98.
237 England and Wales, Law Commission, loc. cit.
238 ibid., p. 259.
239 ibid.

although the fear is not one of dissipation through profligacy but of gradual dissipation due to inflation, unexpected needs and the fact that the award was inadequate in the first place.[240]

3.63 To conclude, it is apparent from the research referred to above that lump sum awards of compensation made once-and-for-all fail to meet the ongoing needs of those injured through negligence. In order to focus and summarise the problems, the Committee reproduces in Appendix D, a number of case studies in which the experiences of individuals who have received lump sum awards of compensation in Australia are described. Two examples are based upon the circumstances of actual claimants in appeals made to the Administrative Appeals Tribunal. Although these case studies do not involve injuries sustained through the use of health services, the issues raised are of equal relevance to such claimants. Both are reproduced from the Professional Indemnity Review's *Structured Settlements Discussion Paper*.[241] In addition, the Committee reproduces one case study referred to in the PIR *Health / Medical Care Injury Case Study Project*.

---

240 England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages*, Law Com No. 224, HMSO, London, 1994, para. 3.18.

241 PIR Structured Settlements Discussion Paper, op. cit., pp. 2 & 22.

4 COMPENSATION PAYMENTS: ALTERNATIVE APPROACHES

Introduction

4.1 Having examined whether the system of lump sum compensation made once-and-for-all is in need of reform, it now remains to consider the various alternative approaches which have been adopted in various jurisdictions and to assess the extent to which they are able to remedy the deficiencies which have been observed in the existing system.

4.2 This chapter will review the approaches adopted in those jurisdictions which have the greatest relevance to the situation as it exists in Victoria: in Australia, New South Wales, South Australia and Western Australia will be considered followed by an examination of the approaches taken in the United Kingdom and the United States of America. Consideration will not be given to the various Canadian provinces as their approaches generally follow those which operate in the United States. Similarly, consideration will not be given to the systems which operate in various Continental European countries where the use of periodical payments of compensation are said to have first developed. The various statutory compensation schemes which operate in Victoria will also be considered.

4.3 Examples will be drawn from these jurisdictions for each of the various types of alternative approaches outlined in the introductory chapter, where they exist: statutory compensation schemes; periodical payments; interim awards; deferred assessment of damages; provisional damages; and structured settlements.

4.4 Each of the approaches in each of the jurisdictions will be examined from the point of view of court-awarded payments of compensation as well as out-of-court settlements. The advantages and disadvantages of each of the

various approaches will also be considered in order to provide a framework for the selection of the most desirable option for introduction in Victoria.

New South Wales

4.5 The alternative approaches to the payment of damages in New South Wales have recently been reviewed by the Law Reform Commission of that State, and the present discussion draws heavily upon this research.[242] The specific provisions of each compensation scheme are set out in the loose-leaf service entitled: 'Personal Injury Law Manual NSW'.[243]

Government Insurance Office Structured Settlements

4.6 The use of structured settlements in Australia was first undertaken by the New South Wales Government Insurance Office (GIO) in respect of motor vehicle accident claims. The scheme originally provided for defendants to contract to fund all of the claimant's future care needs as they arise and to make direct payment of these to the service provider. Damages for loss of earning capacity continued to be paid by way of lump sum. The extent of compensation paid for future care costs reflected the claimant's changing needs but, unless covered by re-insurance, the defendant's future liability was uncertain. This uncertainty made the scheme unattractive to insurers.[244] The first such arrangement took place on 28 May 1982 and by 1989, a further fifteen arrangements had been entered into. The agreements provided for payment of a lump sum to cover the past expenses of the claimant, past and future loss of earning capacity and similar economic loss, non-pecuniary loss, interest and costs. The GIO then undertook to meet the reasonable cost of all future medical treatment, domestic, nursing and institutional care and equipment which was reasonably and causally related to the injuries. Such settlements did not make provision for periodical payments in respect of loss

---

242 NSW Law Reform Commission, *Provisional Damages*, Report No. 78, NSW Law Reform Commission, Sydney, 1995, pp. 17–28.

243 T. J. Goudkamp & A. S Morrison, *Personal Injury Law Manual NSW*' Law Book Co. Ltd., Sydney, 1995.

244 Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: An Interim Report*, AGPS, Canberra, 1994 (hereafter cited as 'PIR Interim Report'), para. 4.181.

of earning capacity and were not indexed for inflation, nor for any change in the residual earning capacity of the claimant.[245]

Motor Accidents Act 1988 Structured Settlements and Interim Payments

4.7 Compulsory third party insurance in New South Wales was until 1987 provided on a monopoly basis by the GIO. This unrestricted common law scheme was found to be extremely costly to maintain and so legislation was introduced to establish a new scheme called 'Transcover', which operated from 1 July 1987. The Transcover system offered statutory benefits for income replacement, a focus on rehabilitation, and statutory benefits for permanent impairment and pain and suffering, in addition to meeting all hospital and medical expenses. The scheme was originally fault-based but was expected to be later converted into a no-fault scheme.

4.8 Following a change of government, a new scheme was established pursuant to the *Motor Accidents Act 1988* (NSW) with effect from 1 July 1989. This scheme was a modified common law system which aimed to provide a fair and affordable system of compensation for motor accident victims with an emphasis on rehabilitation and active claims management.[246]

4.9 In 1995, amendments were made to the Act which limited the availability of damages to persons injured in motor vehicle accidents in New South Wales.[247] The legislation sought to address the needs of severely injured claimants, maintain premiums at an affordable level, limit payments for non-economic loss in cases of minor injuries, and enable payments to be made by way of structured settlements and interim payments. These reforms, in so far as they reduce payments made in respect of non-economic loss and certain other matters, have been the subject of severe criticism.[248]

4.10 Section 81(2) of the *Motor Accidents Act 1988* allows the court to approve a structured settlement with respect to future economic loss and

---

245 H. Luntz,. *Assessment of Damages for Personal Injury and Death*, 3rd edn., Butterworths, Sydney, 1990, para. 11.5.5.

246 J. Walsh & J. Skinner, *Report on Medical Professional Indemnity Arrangements for Health Care Professionals for the Review of Professional Indemnity Arrangements for Health Care Professionals*, AGPS, Canberra, 1994, para. 6.2.3.

247 *Motor Accidents Amendment Act 1995* (NSW),.

248 R. Burbidge,. 'Proposed Amendments to the Motor Accidents Act 1988 (NSW),', (1996) *Univ. of NSW Law Rev.*, pp. 465–9.

impairment of earning capacity for plaintiffs injured in motor vehicle accidents. Non-economic loss continues to be awarded by way of lump sum. Section 81 has not been used since it came into force, arguably owing to the requirement that both the plaintiff and the defendant's insurer (or the Nominal Defendant) agree to the arrangement.[249]

4.11 Sub-section (2) of section 81 provides that the court may order that payment be made in accordance with such arrangements as the court determines or approves while sub-section (3) lists factors to be taken into account in making the order. These include the plaintiff's ability to manage and invest a lump sum, the need to ensure that payment is made only for such expenses that the plaintiff is truly entitled to, so that some method of verification is provided for, the views of the insurer, and such other matters as the court thinks fit. In respect of claims for impairment of earning capacity, the court may direct the purchase of an annuity[250] and periodical payments for impairment of earning capacity may not be made at more frequent intervals than twelve months.[251] Any party to the arrangements may apply for their variation or termination at any time.[252]

4.12 The *Motor Accidents Act 1988* also provides for interim payments where liability has been admitted or determined (wholly or in part). Section 45 of the Act requires insurers in such cases to make interim payments for such hospital, medical, pharmaceutical and certain rehabilitation and respite care expenses as may be incurred by the claimant. Such claims must be reasonable and necessary, properly verified and relate to the injury caused.[253] A court order is not necessarily required in order for interim payments to be made where liability has been admitted. The purpose of section 45 is to ensure that

---

249 Section 81(1). See: NSW Law Reform Commission, op. cit., para. 3.4; Luntz, op. cit., para 1.3.11.

250 *Motor Accidents Act 1988* (NSW), s. 81(4).

251 *Motor Accidents Act 1988* (NSW), s. 81(6).

252 *Motor Accidents Act 1988* (NSW), s. 81(7).

253 *Motor Accidents Act 1988* (NSW), s. 45(2A).

insurers endeavour to resolve claims as expeditiously as possible[254] thus ensuring the maximum opportunity for the rehabilitation of the claimant.[255]

4.13 In December 1996, the New South Wales Parliamentary Standing Committee on Law and Justice tabled an interim report on its Inquiry into the Motor Accidents Scheme.[256] Part of the interim report considered the current operation of those sections of the *Motor Accidents Act 1988*, referred to above, which enable structured settlements to be made.

4.14 The Inquiry found that section 81 of the *Motor Accidents Act 1988* had rarely, if ever been used, mainly owing to the fact that insurers were reluctant to make use of structured settlements where the parties could apply to the court at some future date to vary the terms of the award.[257] The other principal disincentive to the use of structured settlements under section 81 relates to the unfavourable taxation treatment of periodical payments as opposed to lump sum awards.[258]

---

254 *Motor Accidents Act 1988* (NSW), s. 45(1).

255 NSW Law Reform Commission, op. cit., para. 3.5.

256 NSW Legislative Council, Standing Committee on Law and Justice, *Interim Report on the Inquiry into the Motor Accidents Scheme: Compulsory Third Party Insurance*, Report No. 3, Government Printer, Sydney, 1996.

257 ibid., para. 10.1.2.

258 ibid., para. 10.2.2.

4.15 The Inquiry heard evidence to the effect that the Federal government may be proposing to introduce taxation reforms which would make all awards of compensation for personal injuries taxable in the hands of the claimant, regardless of how they are paid. After considering the likely effects which such a taxation reform would have in terms of re-distributing losses from the Commonwealth to the States, the Inquiry expressed its grave concern about such taxation reform proposals.[259] The Inquiry was strongly supportive of the proposition that payments of compensation made pursuant to a structured settlement be non-taxable in order to improve the position of claimants and to reduce the reliance which claimants place upon Commonwealth-funded social security programmes if their lump sum awards have been dissipated.[260]

4.16 The inquiry concluded that when the non-taxable status of structured settlements is achieved, they should be introduced as a voluntary mechanism for the whole or part of a compensation payment. It would then be possible to repeal section 81 of the *Motor Accidents Act 1988*.[261]

Workers Compensation Act 1987 Structured Settlements and Interim Payments

4.17 Structured settlements are available under section 151Q of the *Workers Compensation Act 1987* (NSW). Damages for future economic loss may be awarded in the form of a structured settlement in circumstances similar to those contained in the *Motor Accidents Act 1988*. Both parties to the claim must consent to the terms of the settlement.[262]

4.18 Although the previous provision permitting structured settlements was subject to much criticism, its provisions were used occasionally, although in view of the fact that the consent of both parties is required under the amended section 151Q(1), it is unlikely that it would be used regularly for reasons similar to those discussed above concerning motor vehicle claims.[263]

---

[259] ibid., para. 10.2.8.
[260] ibid., para. 10.2.8, recommendation 41.
[261] ibid., para. 10.3.3, recommendations 42 & 44.
[262] *Workers Compensation Act 1987* (NSW), s. 151Q(1). This requirement was introduced by the *Workers Compensation Legislation Amendment Act 1995* (NSW).
[263] NSW Law Reform Commission, op. cit., para. 3.7.

4.19 Section 112 of the *Workers Compensation Act 1987* also permits interim awards to be made where it is clear that some compensation will be payable under the Act, but the actual amount has not been ascertained because of various specified disputes between employers and insurers and employers and employees.[264]

4.20 In addition, under the *Workers Compensation (Dust Diseases) Act 1942* (NSW), the Workers' Compensation (Dust Diseases) Board may, pending its final determination as to the amount of compensation to be paid, make an interim award of compensation not exceeding the least compensation to which the claimant is, in the opinion of the Board, entitled.[265] The Board has power to terminate interim awards or to deduct any interim payments already made when making a final determination.[266]

Supreme Court Act 1970 and District Court Act 1973 Interim Damages

4.21 Both the Supreme Court and District Court in New South Wales have power to make interim awards of damages in any action for damages.[267] The following discussion will focus on the provisions set out in the Supreme Court Act which were introduced in 1991 in order to assist financially disadvantaged plaintiffs and in order to encourage the settlement of actions. Similar issues arise with respect to the power of the District Court to make interim awards of damages.

4.22 A wide statutory discretion is given to the Supreme Court to award interim payments at any stage of proceedings in any action, other than in cases involving death or injury arising out of motor vehicle accidents where Part 6 of the *Motor Accidents Act 1988* applies.[268] Orders may only be made if the defendant has admitted liability, or if the plaintiff has obtained judgment against the defendant for damages to be assessed, or where the court is satisfied that, if the action proceeds to trial, the plaintiff would obtain judgment for substantial damages against the defendant.[269] The court may

---

264 ibid., para. 3.6, n. 12.

265 *Workers Compensation (Dust Diseases) Act 1942* (NSW), s. 8B(1).

266 *Workers Compensation (Dust Diseases) Act 1942* (NSW), ss. 8B(2) & (3).

267 *Supreme Court Act 1970* (NSW), s. 76E & *District Court Act 1973* (NSW), s. 58.

268 See s. 76H *Supreme Court Act 1970* (NSW),.

269 *Supreme Court Act 1970* (NSW), s. 76E(3).

not, however, award more than a reasonable proportion of the damages which in the opinion of the court are likely to be recovered by the plaintiff,[270] taking into consideration contributory negligence or cross claims.[271] In addition, interim awards may not be made if the defendant is uninsured in respect of the risk giving rise to the plaintiff's claim, the defendant is not a public authority, or the defendant would, having regard to the defendant's means and resources, suffer undue hardship if such a payment were to be made.[272]

4.23 The determination of these threshold questions has given rise to some difficulties of interpretation. In determining that the plaintiff would obtain judgment for substantial damages, it has been held that something more than a prima facie case needs to be shown, although the plaintiff need not adduce evidence beyond reasonable doubt.[273] It has also been held that although the plaintiff need not adduce evidence of need, hardship or other prejudice, such evidence may be taken into account by the court in exercising its discretion in favour of making an interim award.[274] Section 76E does not deal with the question of proceedings which have been taken against more than one defendant. In such cases it appears that an interim award may be directed against any one or more of the defendants.[275]

4.24 The fact that a defendant makes one or more interim payments is not of itself an admission of liability by the defendant[276] and the court is given a wide discretion regarding the terms and conditions of the payment, including the variation or discontinuance of the payment on application of either party.[277]

---

270 *Supreme Court Act 1970* (NSW), s. 76E(5).
271 *Supreme Court Act 1970* (NSW), s. 76E(6).
272 *Supreme Court Act 1970* (NSW), s. 76E(4).
273 *Frellsen v. Crosswood Pty Ltd* (1992) 15 MVR 343 relying upon various English authorities: see NSW Law Reform Commission, op. cit., para. 3.15.
274 ibid., p. 348.
275 ibid., p. 348.
276 *Supreme Court Act 1970* (NSW), s. 76F(1).
277 *Supreme Court Act 1970* (NSW), s. 76G.

4.25 The court has power to postpone the final assessment of damages until the plaintiff's condition stabilises[278] and although this power may solve the problem of predicting the course of the plaintiff's condition in the future with certainty, such a procedure would tend to delay final resolution of the litigation which may be counter-productive in terms of the plaintiff's effective rehabilitation.

Dust Diseases Tribunal Act 1989 Provisional Damages

4.26 Since 1 August 1995, section 11A of the *Dust Diseases Tribunal Act 1989* (NSW) permits the Dust Diseases Tribunal to make an award of provisional damages in relation to proceedings by persons who are suffering or have suffered from dust-related conditions. Where it is proved or admitted that there is a chance that the claimant will, as a result of the relevant breach of duty, develop another dust-related condition, the Tribunal may award damages assessed on the assumption that the injured person will not develop another dust-related condition, and award further damages at a future date if the injured person does develop another dust-related condition.

4.27 Pursuant to the *Dust Diseases Tribunal Rules* (NSW), the plaintiff must plead a claim for provisional damages at the time of issuing proceedings.[279] The Tribunal is given a wide discretion to order provisional damages in accordance with the legislation, although only one application may be made in respect of each dust-related condition.[280] To date, however, the Tribunal has not made any awards of provisional damages.

New South Wales Law Reform Commission's Proposal for Provisional Damages

4.28 In September 1996, the New South Wales Law Reform Commission recommended that provisional damages should be made available in personal injury cases heard in the Supreme Court or District Court in that State.[281] The model preferred was that reflected in the *Dust Diseases Tribunal Act 1989* and *the Supreme Court Act 1981* (England and Wales).

4.29 It was recommended that one application for further damages should be permitted subject to the judge at that application granting a further right to the plaintiff to return to court on the occurrence of further specified

---

278 See the authorities cited by the NSW Law Reform Commission, op. cit., para. 3.13.
279 Rule 5(3).
280 Rule 5(8)(c).
281 NSW Law Reform Commission, loc. cit.

deterioration arising from the same injury. It was also recommended that the court be able to specify the period within which the plaintiff could apply under an award for provisional damages and where no period was set by the court or where the plaintiff died before the end of the period set by the court, the right to apply for a further award would terminate on the plaintiff's death. Where the plaintiff died before a claim for further damages had been made, the plaintiff's estate could pursue the claim and the damages recovered would not be affected by the restrictions on the recoverability of heads of damages specified in the *Law Reform (Miscellaneous Provisions) Act 1944* (NSW).[282] Finally, it was recommended that an award of provisional damages should not preclude a dependant's claim under the *Compensation to Relatives Act 1897* (NSW) for death attributable to the specified disease or deterioration in the plaintiff's condition. The assessment of damages in such a claim should take into account, as the justice of the case may require, any pecuniary loss already awarded to the deceased in respect of the period after his or her death.

4.30 These recommendations go some way to solving the problem of under-compensation of plaintiffs through subsequent deterioration in their condition, and clarify the rules which exist in New South Wales at present which make the achievement of such an object possible through reliance upon the power of the court to determine questions of liability and damages separately,[283] to adjourn proceedings pending the assessment of damages,[284] and to award interim damages.[285]

4.31 The Commission considered that the broader questions associated with the introduction of periodical payments and structured settlements (see below) should be examined separately.[286]

---

282 Sub-section (2) of section 2.

283 *Supreme Court Rules* (NSW), Pt. 31, r. 2.

284 *Supreme Court Rules* (NSW), Pt. 34, r. 4.

285 *Supreme Court Act 1970* (NSW), Pt. 5, Div. 2; see NSW Law Reform Commission, op. cit., para. 5.2.

286 ibid., para. 5.3.

4.32 To summarise the situation in New South Wales, it appears that the once-and-for-all rule has been eroded in a number of ways and in relation to a number of statutory compensation schemes. Structured settlements and interim and provisional damages are available in certain circumstances although these have not tended to be used by litigants. The reasons for their lack of use include the possibility that payments other than by way of lump sums may be subject to taxation, and the fear on the part of defendants and insurers that on-going payments will be reviewed in the future, thus making precise quantification of their liability impossible. These two central issues of taxation and reviewability will need to be addressed before similar reforms could be effectively introduced in Victoria.

South Australia

Supreme Court Act 1935 Interim and Periodical Payments

4.33 In South Australia legislation was introduced over twenty years ago to enable the final assessment of damages to be postposed and payments made in the interim. The provision was intended to enable liability to be determined promptly while events were still fresh in the memory of witnesses and without having to wait until the plaintiff's condition stabilised sufficiently to enable damages to be assessed finally. During the period of the postponement, interim payments could be made to support the plaintiff and to permit the plaintiff's debts to hospitals, doctors and other creditors to be cleared. Such interim payments could take the form of a lump sum, weekly payments or whatever was considered to be the most suitable form in the circumstances.[287]

4.34 Section 30B(1) of the *Supreme Court Act 1935* (SA) provides that the court may enter a declaratory judgment finally determining liability and postpone the assessment of damages in all actions before the court. Although section 30B is not limited to any particular type of action, it has most often been used in personal injury claims.[288]

---

287 NSW Law Reform Commission, op. cit., paras. 4.3 & 4.10.

288 ibid., para. 4.7.

4.35 Once liability has been determined, the court may make orders that the party held liable make such payment or payments on account of the damages to be assessed as to the court seems just; and make periodical payments to the plaintiff on account of the damages to be assessed during a stated period or until further assessed.[289] There is no onus on either party to satisfy the court that such an order should or should not be made and the court will decide for itself in the exercise of its discretion what is the best course to take.

4.36 Providing the court with the power to make an interim award of its own motion can clearly be beneficial in certain cases. In *Revesz v. Orchard*,[290] for example, a seriously disabled plaintiff who had suffered brain damage, initially applied for the assessment of damages to be postponed but subsequently requested a final assessment. Hogarth J determined that it would be preferable for the assessment to be postponed as he considered that the plaintiff's mental condition was such that it would not be safe to place him in control of a large sum of money. The judge also considered that further evidence would become available at a later hearing which would assist in the final assessment of damages.[291]

---

289 *Supreme Court Act 1935* (SA), s. 30B(2).
290 [1969] S.A.S.R. 336.
291 Luntz, op. cit., para. 1.3.7.

4.37 In exercising the wide discretion provided, the court is required to consider all of the circumstances including the nature and extent of the plaintiff's injuries and the seriousness of any possible developments in the plaintiff's condition in the future. In addition the court may consider the unknown effect of uncertain labour conditions,[292] the outcome of an examination on the plaintiff's earning capacity,[293] the failure to produce evidence which ought to have been tendered in respect of the extent of damages,[294] the inability of the plaintiff presently to manage a lump sum award[295] and the uncertainty of future costs.[296]

4.38 Periodical payments ordered by the court may be varied, upwards or downwards, or terminated by the court on the application of any party to the action (s. 30B(6)). Any party may apply for a final assessment of damages at any time. If the plaintiff's condition has stabilised, the judge must proceed to a final assessment of damages. Even if stabilisation has not occurred but four years have elapsed since the making of the declaratory judgment, the court may not refuse to make a final assessment if either party applies for one, unless special circumstances exist by reason of which such an assessment ought not be made.[297] In *Haye v. Braggins*,[298] for example, a final assessment was not made for six years, while in *Beasley v. Marshall*[299] the final assessment was not made for seven years which was considered by the court even then to be too soon.

4.39 Where the final assessment is made, credit must be given for all amounts paid and judgment entered for the balance.[300] Subsection (9) of section 30B deals with the situation where the plaintiff dies prior to the final assessment being made. In making the final assessment, the court is to base its

---

292 *Forst v. Graves* (1967) 52 L.S.J.S. 464.

293 *Preston v. Mercantile Mutual Insurance Co. Ltd.* (1970) 55 L.S.J.S. 566.

294 *Revesz v. Orchard* (1969) 54 L.S.J.S. 611.

295 ibid.

296 *Walker v. Tugend* (1981) 28 S.A.S.R. 194; see, generally, M. J. Tilbury, *Civil Remedies: Principles of Civil Remedies*, vol. 1, Butterworths, Sydney, 1990, para. 3027.

297 *Supreme Court Act 1935* (SA), s. 30B(6) & see Luntz, op. cit., para. 1.3.8.

298 (1994) 175 L.S.J.S. 346.

299 *Beasley v. Marshall* (1985) 124 L.S.J.S. 458.

300 *Supreme Court Act 1935* (SA), s. 30B(5).

calculation on the value of money at that final date, rather than an earlier date.[301]

4.40 Clearly, where there is evidence that the plaintiff suffers from some form of compensation neurosis, the court would decline to exercise its discretion to award periodical payments. In *Yelland v. Nominal Defendant*,[302] King CJ refused the plaintiff's request for a declaratory order and interim assessment of damages because the plaintiff had allowed a pre-occupation with her injuries to dominate her life and it was highly desirable that the litigation be finalised. Similarly, in *Polidori v. Staker*,[303] the court determined that it would not be in the plaintiff's best interests to go on receiving guaranteed periodical payments.[304]

4.41 The interim award of damages is designed to cover out-of-pocket expenses and loss of earning capacity to the date of the hearing. It may also be used to award a proportion of future pecuniary loss, although not of an amount disproportionate in relation to what the plaintiff may finally receive, such as would embarrass the judge when making the final assessment.[305]

4.42 Interim payments may not be made in respect of non-pecuniary loss except in certain specified circumstances.[306] First, where serious and continuing illness or disability results from the injury, such as in cases of psychological illness.[307] Secondly, where the damages for the pecuniary loss are less than the actual loss, such as where they have been reduced because of contributory negligence or counter-claims made by the defendant. Thirdly, where the judge is of the opinion that there are special circumstances, such as where a plaintiff has sustained an initially non-serious injury which is very likely to become serious at some time in the future.[308]

---

301 Luntz, op. cit., para. 1.3.9.
302 *Yelland v. Nominal Defendant* (1980) 89 L.S.J.S. 223.
303 *Polidori v. Staker* (1973) 6 S.A.S.R. 273, 276.
304 Luntz, op. cit., para. 1.2.22.
305 ibid., para. 1.3.6, n. 12.
306 *Supreme Court Act 1935* (SA), s. 30B(2)(b).
307 *Angelopoulos v. Angelopoulos* (1978) 80 L.S.J.S. 409.
308 *Nathan v. Vos* [1970] S.A.S.R. 455.

4.43 Section 30B has apparently been used most often in cases involving substantial future medical expenses.[309] A South Australian judge, Sangster J, believes that the section has not been used as much as it could owing to the fact that parties to litigation often do not wish to incur the costs of a future hearing for the assessment of damages, when it is hoped that the whole action would be settled at one time.[310]

4.44 The model employed in South Australia, then, is one in which an extensive discretion is given to the judge to determine the types of cases in which the final assessment of damages ought to be postponed and an interim award made. Clearly, one of the central problems with the lump sum, once-and-for-all rule is that it is not able to deal with unforeseen circumstances which take place in the plaintiff's future. By allowing a court to consider all of the available evidence when and as it arises, the South Australian model may seem preferable.

Western Australia

Periodical Payments

4.45 Sub-section (4) of section 16 of the *Motor Vehicle (Third Party Insurance) Act 1943* (WA) permits courts in proceedings for compensation arising out of death or personal injury sustained in motor vehicle accidents to award damages in a lump sum, by periodical payments or a combination of both. It is usual for a lump sum to be paid in respect of pecuniary loss to the date of the assessment and pain and suffering both past and future, with periodical payments given in order to compensate loss of future earning capacity and future medical expenses.

4.46 No guidance is given in the legislation as to the circumstances in which periodical payments are to be used and the court is given a wide discretion in determining the terms and conditions upon which compensation is to be paid. The provision has seldom been used, however, one possible reason being the rule that where neither party agrees to periodical payments, the court must

---

309 NSW Law Reform Commission, op. cit., para. 4.5.

310 Luntz, op. cit., para. 1.3.5.

make a lump sum award.[311] Prior to 1985, some thirty-three awards were made using the powers provided for in section 16.[312]

4.47 The court also has power at any time either of its own motion or on an application by any party to the action, to review the determination or to vary, reduce, increase or suspend periodical payments, or to order that a lump sum be given. The court may also order that any periodical payments may be redeemed by payment of a lump sum.[313] Where only a lump sum has been awarded, it may not be reviewed by the court, thus preserving the once-and-for-all rule in this case. Where periodical payments and a lump sum are awarded, only the periodical payment element may be reviewed subsequently. The legislation does not, however, specify the conditions which would warrant a review of previous orders, although the court in the case of *Musca v. Colombini*[314] described a number of factors to be taken into account. Wolff CJ held that periodical payments could be increased if changes in economic conditions occurred or if the economic position of the defendant improved. If, however, the plaintiff's earning capacity increased, then periodical payments should be reduced, but not if the plaintiff's financial circumstances improved fortuitously such as by receipt of a legacy.[315] Virtue J also considered that periodical payments could increase in order to take account of the effects of inflation.[316] The Full Court considered that if periodical payments were subject to income taxation, they could be increased to take account of this.[317]

4.48 A serious omission from the Western Australian legislation is that no provision is made for situations in which a plaintiff who has received a periodical award of damages dies. In cases where a lump sum only has been awarded, the plaintiff's estate would inherit any part of the lump sum remaining at the date of the plaintiff's death. Where periodical payments are

---

311 *Hall v. Fare* [1973] W.A.R. 156, 160.
312 Luntz, op. cit., para. 1.3.2.
313 *Motor Vehicle (Third Party Insurance) Act 1943* (WA), s. 16(4)(b).
314 *Musca v. Colombini* [1970] W.A.R. 33.
315 ibid., pp. 33–4.
316 ibid., p. 37.
317 See Luntz, op. cit., para. 1.3.4.

made, however, the payments cease upon the death of the plaintiff, thus depriving the plaintiff's estate of that part of the lump sum notionally set aside for the plaintiff's earnings, less the cost of maintaining the plaintiff during the period by which the plaintiff's life was expected to be shortened. Of the thirty-three cases in which the section had been used before 1985, seven plaintiffs had died before 30 June 1982, although most of these cases involved periodical payments in respect of hospital and nursing care only. Professor Luntz believes that this problem could be overcome by enabling the court to make an order requiring periodical payments to continue after the death of the plaintiff, reduced by a suitable amount to reflect the reduced cost of maintenance and medical expenses. Alternatively, the dependants could be given an independent right of action following the death of the plaintiff, notwithstanding that payments had been made during the lifetime of the deceased plaintiff.[318]

Victoria

Transport Accidents Periodical Payments and Structured Settlements

4.49 Victoria was the first Australian jurisdiction to establish a no-fault motor vehicle accident scheme with the introduction of the *Motor Accidents Act 1973* (Vic.). This scheme was replaced by an extended scheme which came into operation on 1 January 1987 pursuant to the *Transport Accident Act 1986* (Vic.). The current scheme is administered by the Transport Accident Commission which collects revenue from motorists and various other sources and pays compensation out of the Transport Accident Fund to injured claimants.

4.50 The operation of this complex legislative compensation scheme is provided in the loose-leaf service entitled: *Accident Compensation Victoria*.[319] Summaries are provided by Luntz and Hambly,[320] with more recent developments being noted by Lombard.[321]

---

318 Luntz, op. cit., para. 1.3.3.

319 M. O'Loghlen & B. R. Wright, *Accident Compensation Victoria*, Butterworths, Sydney, 1996.

320 H. Luntz, & D. Hambly, *Torts: Cases and Commentary*, 4th edn., Butterworths, Sydney, 1995, paras. 19.3.1–19.3.19.

321 M. Lombard, 'Restructuring the Transport Accident Commission' (1994) 68 *Law Institute Journal* 1184–5; M. J. Lombard, 'The Myths of Transport Accident Law' (1995) 69 *Law Institute Journal* 444–7.

4.51 The Act permits compensation to be paid to persons injured as a result of a transport accident regardless of fault. Various categories of persons are, however, excluded from the scheme, or have their benefits reduced, the most important of which relate to certain categories of drunken drivers.[322]

4.52 Compensation is payable under the Act for various expenses including medical, hospital, nursing, rehabilitation and home care services in most cases.[323] These benefits continue to be payable after a common law action has been taken and accordingly cannot form part of any common law claim.[324] Loss of earnings for the first eighteen months after the date of the accident are compensated under the Act by way of weekly payments, the amount of which is calculated on the basis of a proportion of pre-accident earnings but subject to various restrictions.[325] The maximum payable for a claimant with dependents is $664.

4.53 Where loss of earnings extend beyond eighteen months, and the claimant is at least ten per cent impaired, impairment benefits are payable under section 46A of the Act. These are paid in accordance with formulae set out in sections 47 and 48 which provide for lump sum, interim and periodical payments to be made depending upon the degree of impairment and the age of the claimant. Persons aged twenty-five or below receive a full annuity, while persons aged more than seventy-five receive no annuity. Those between these ages receive a proportionally reduced annuity. Both lump sums and annuity payments are indexed.[326] The maximum amount payable at present under sub-section (2) of section 47 is $66,250 while the maximum payable under sub-section (1) of section 48 is $154,540.

4.54 Common law proceedings are able to be taken in respect of certain injuries. Losses for which payments are made under sections 44 and 45 of the Act are excluded from common law claims. The maximum amount payable for pecuniary loss is at present $734,570 which is available after a threshold of

---

322 *Transport Accident Act 1986* (Vic.), ss. 39 & 40.
323 *Transport Accident Act 1986* (Vic.), s. 60(1).
324 *Transport Accident Act 1986* (Vic.), s. 93.
325 *Transport Accident Act 1986* (Vic.), ss. 44 & 45.
326 *Transport Accident Act 1986* (Vic.), s. 61(2).

$32,640 has been reached. The maximum payable for pain and suffering at common law is $326,470 after the same threshold has been reached. Claims made in respect of death under the *Wrongs Act 1958* (Vic.) have a ceiling of $534,750. All these amounts are indexed. Although the maximum amount for pain and suffering may be attained relatively often, few claims approach the ceiling for pecuniary loss owing to the operation of the 6% discount rate.[327]

4.55 Thus, the no-fault scheme for transport accident injuries in Victoria permits recurrent payments to be made to claimants in certain circumstances. In those limited circumstances in which common law proceedings may also be taken, courts are required to award lump sums once-and-for-all.

4.56 Victoria has had some experience of structured settlements made in respect of injuries sustained in transport accidents. Even prior to May 1989, the Transport Accident Commission had entered into two structured settlements. One case involved an 18-year-old quadriplegic who was provided with a lump sum, an indexed weekly benefit, an indexed amount to cover voluntary nursing and assistance and hospital and medical expenses. The other case involved a plaintiff who had suffered severe brain damage, who was provided with payments to cover continuing hospital and medical expenses in addition to a lump sum.[328] The Transport Accidents Commission continues to experiment with the use of structured settlements instead of lump sum awards and the provisions of the current legislation make this possible to a limited degree and in accordance with strict controls, although subject to the restrictions which taxation law currently entails.[329]

Workers' Compensation Periodical Payments and Structured Settlements

4.57 In Victoria, the *Accident Compensation Act 1985* allows workers to claim compensation pursuant to a no-fault scheme called 'Workcover' for certain injuries and diseases acquired in the workplace. The operation of this equally complex legislative scheme is set out also in O'Loghlen and Wright's work.[330] To be eligible for compensation, injuries must have arisen out of or in the course of employment or employment must have been a significant

---

[327] Lombard, op. cit., 1995, p. 447.
[328] Luntz, op. cit., para. 11.5.5.
[329] Brennan & Deeble, op. cit., paras. 2.50, 2.55 & 5.17.
[330] O'Loghlen & Wright, loc. cit.

contributing factor in aggravating a previous condition. Compensation may also be claimed where employment was a contributing factor in creating a disease or in aggravating a pre-existing disease.

4.58 In certain restricted circumstances designed to prevent double compensation, workers who are seriously injured as a result of the negligence of their employers or fellow employees are able to seek common law damages.[331] These are limited to a maximum amount of $739,690 in respect of pecuniary loss[332] if a threshold of $32,860 has been reached,[333] and a maximum of $333,420 in respect of pain and suffering[334] where a threshold of $32,860 has been reached.[335] These amounts are subject to indexation in accordance with section 100.[336]

4.59 Where an injured person is eligible for workers' compensation, a weekly benefit is paid as compensation for loss of earnings and earning capacity. In the short term, 95% of pre-injury earnings may be paid up to a maximum of $664 per week, less an amount which the worker could earn if able to obtain employment with the injury, provided that he or she makes every reasonable effort to engage in rehabilitation and return to suitable employment.[337] After twenty-six weeks, in cases of serious injury, 90% of pre-injury earnings will be paid up to a maximum of $664 per week less any current earnings, while in cases of total incapacity, 70% of pre-injury earnings will be paid, again up to a maximum of $664 per week.[338] In cases of partial incapacity, 60% of pre-injury earnings will be paid to a maximum of $398 per week, less an amount which the worker could earn if able to obtain employment with the injury, provided that he or she makes every reasonable effort to engage in rehabilitation and return to suitable employment. Benefits cease to be payable after 104 weeks except in cases of serious injury or total

---

331 *Accident Compensation Act 1985* (Vic.), s. 135.
332 *Accident Compensation Act 1985* (Vic.), s. 135A(7)(a)(ii).
333 *Accident Compensation Act 1985* (Vic.), s. 135A(7)(A)(i).
334 *Accident Compensation Act 1985* (Vic.), s. 135A(7)(b)(ii).
335 *Accident Compensation Act 1985* (Vic.), s. 135A(7)(b)(i).
336 See O'Loghlen & Wright, op. cit., pp. 1736.7 & 2141.12.
337 *Accident Compensation Act 1985* (Vic.), s. 93A.
338 *Accident Compensation Act 1985* (Vic.), s. 93B.

and permanent incapacity in which case the entitlement continues until retirement age.[339]

4.60 Claimants are also able to recover the cost of reasonable medical and hospital costs, although these cease one year after the claimant returns to work, except in the case of claimants suffering from serious disabilities or total incapacity in which case there are no limitations. Benefits paid under the scheme, however, cannot be claimed in common law proceedings. Claimants may also receive benefits which will enable them to participate in approved rehabilitation programmes.

4.61 Section 115 of the Act also enables claimants to redeem on-going payments by converting them into a lump sum in certain circumstances, in which case payments for rehabilitation services cease. Redemption is possible where the claimant is aged fifty-five or older, is totally and permanently incapacitated or seriously injured, and has been receiving payments for at least two years, or in certain prescribed circumstances. This is one of the few instances in which a statutory system of periodical payments is able to be commuted to a lump sum.

4.62 The maximum amount payable by way of lump sum for impairment disability, injuries or maims is $102,460[340] while the maximum payable for pain and suffering is $55,040.[341] Compensation for pain and suffering is payable in a lump sum but only for claimants who receive at least $11,000 under the Table of Maims.[342] In November 1996 amendments were proposed to the *Accident Compensation Act 1985* (Vic.) to permit payments made in respect of claims under the Table of Maims and pain and suffering to be paid by instalments over a period of five years if they exceeded $5,000. The

---

339 O'Loghlen & Wright, op. cit., pp. 1678–89; see also Brennan & Deeble, op. cit., p. 9, Table 2.2; D. Denby, 'Workcare Revisited', (1992) 66 *Law Institute Journal* 1074–5.

340 *Accident Compensation Act 1985* (Vic.), s. 98.

341 *Accident Compensation Act 1985* (Vic.), s. 98A.

342 *Accident Compensation Act 1985* (Vic.), s. 98; see O'Loghlen & Wright, op. cit., pp. 1705.4–1706.

proposals were not, however, taken up in the *Accident Compensation (Further Amendments) Act 1996* (Vic.).[343]

4.63 The comparable provisions relating to workers' compensation for the other Australian jurisdictions are reviewed by Brennan and Deeble.[344]

Structured Settlements by the Health Services Commissioner

4.64 In Victoria the office of the Health Services Commissioner provides an alternative avenue for resolving disputes between health service providers and users. The *Health Services (Conciliation and Review) Act 1987* (Vic.) enables users of health services to have complaints about health services resolved through the process of conciliation.

4.65 During the period 1 January 1993 to 30 June 1994, the last year in respect of which statistics are available, 1,959 complaints were received which, with the 913 carried over from the previous year, totalled 2,872. Ninety-seven (7.9%) of those complaints were resolved by the health service provider and the user reaching an agreement.[345]

4.66 Conciliated agreements may take any form which is acceptable to the parties and this may, presumably, include the payment of a lump sum, periodical payments, the provision of services, or even the provision of some item needed by the complainant such as a household appliance. The outcome of conciliations, are, however, strictly confidential and disclosure is not permitted under the Act.[346] As a result, little is known of the form in which payments are made and whether or not structured arrangements and periodical payments are used at present.

4.67 General information is, however, known of the nature of some of the complaints made to the Commissioner and it seems that these occasionally involve incidents in which health users have sustained serious injury. In 1994, for example, almost 100 complaints were classified as being sufficiently

343 See O'Loghlen & Wright, loc. cit., *Bulletins* of Nov. 1996 & Jan. 1997.

344 Brennan & Deeble, op. cit., paras. 2.4–2.18.

345 Victoria, Health Services Commissioner, *Annual Report 1993–1994*, Health Services Commissioner, Melbourne, 1994, p. 23.

346 *Health Services (Conciliation and Review) Act 1987* (Vic.), ss. 20(15) & 32.

serious to warrant Registration Boards taking action.[347] One case involved a baby born prematurely with brain damage owing to the mother's antenatal bilirubin levels not being adequately monitored. Although it was found that the delay in diagnosis would have made no difference to the outcome of the case,[348] the possibility exists that serious complaints involving substantial amounts of compensation could be conciliated by the Commissioner's office.

4.68 The question thus arises as to whether legislation should specify whether such payments may be made periodically or in accordance with a structured arrangement.

Other Victorian Compensation Legislation

4.69 A number of other Victorian Acts permit compensation to be paid and the question arises as to whether these should be amended to permit payments to be made periodically or in accordance with structured arrangements. The Acts include the *Country Fire Authority Act 1958* (Vic.), the *Education Act 1958* (Vic.), the *Police Assistance Compensation Act 1968* (Vic.), the *Victorian State Emergency Service Act 1987* (Vic.), the *Wrongs Act 1958* (Vic.), and the *Criminal Injuries Compensation Act 1983* (Vic.).[349] Although the scope of these Acts extends beyond the current terms of reference, it is perhaps appropriate to consider the question of Criminal Injuries Compensation in more depth.

Criminal Injuries Compensation

4.70 Each jurisdiction in Australia has legislation establishing compensatory schemes for the payment of lump sum awards for people injured as a result of criminal conduct. In paying compensation under these schemes, the components of the award are not dissected in order to avoid delay and to ensure that the proceedings are conducted informally. There is also the need to ensure that such payments are non-taxable in the hands of the claimant.

4.71 Although criminal conduct could result in permanent and serious disability, such as where brain damage is caused during an assault or shooting, the various schemes have relatively low ceilings placed on

347 Victoria, Health Services Commissioner, op. cit., p. 34.
348 ibid., p. 45.
349 See O'Loghlen & Wright, op. cit.

compensation which may be awarded. These vary from a maximum of $10,000 in Tasmania to $71,310 in Queensland.[350]

4.72 In Victoria, a maximum of $50,000 is payable for compensation,[351] with a maximum of $20,000 being payable in respect of pain and suffering.[352] Section 23 of the Act provides that payments made in respect of the death of a victim are to be made in a lump sum.[353] The Tribunal is, however, provided with a wide discretion to authorise the making of advance payments at such times and of such amounts as the Tribunal determines in respect of injuries suffered by victims pending the final lump sum award.[354]

4.73 The Tribunal in Victoria is also given a wide discretion as to the manner in which compensation is payable, which, in effect, permits it to employ structured arrangements.[355] Orders for compensation may also be varied upon application made within six years of the date of the injury where fresh evidence exists or where circumstances alter.[356] This provision in effect abrogates the once-and-for-all rule in respect of such payments of compensation. Where offenders are ordered to make payments to refund the amount of compensation and costs ordered to be paid to victims, the Tribunal may require refunds to be paid in a lump sum or periodically.[357]

4.74 Although only relatively small amounts of compensation are able to be awarded, the Victorian legislation, at least, has seen fit to provide the Tribunal with a wide discretion in determining how payments are to be made. Where appropriate, structured awards of compensation may be made, other than in cases of compensation for death, with payments being administered by the office of the Tribunal and paid out of a Consolidated Fund.[358]

---

350 See Brennan & Deeble, op. cit., para. 2.25.

351 *Criminal Injuries Compensation Act 1993* (Vic.), s. 18A; Criminal Injuries Compensation Regulations 1984 (Vic.), r. 20.

352 Section 18 & r. 19.

353 Section 23(1)(a).

354 Sections 23(1)(b), 23(3).

355 Section 24.

356 Section 25.

357 Section 27(2).

358 Section 30.

United Kingdom

Court-Awarded Interim Damages

4.75 In 1968, the Winn Committee on Personal Injuries Litigation recommended the introduction of the power to make interim payments to plaintiffs out of moneys paid into court by defendants.[359] The proposal was recommended in order to enhance the settlement of cases, to facilitate future negotiations between the parties, to strengthen the bargaining position of the plaintiff and to relieve hardship suffered by plaintiffs.

4.76 Order 29, Rules 9 to 18 of the Rules of the Supreme Court, now permit courts to make interim awards of damages in any case other than those relating to claims arising out of motor vehicle collisions where the Motor Insurers Bureau has jurisdiction and also has the power to make interim awards.

4.77 Order 29 Rule 11(1) specifies the matters to be taken into consideration in making an order for interim damages. Similar requirements to those specified in sub-sections (5) and (6) of section 76E of the *Supreme Court Act 1970* (NSW) are stated: the defendant must have admitted liability or the plaintiff must have obtained a judgment for damages to be assessed, or the plaintiff must be likely to obtain substantial damages if the action proceeds to trial;[360] and the defendant must be insured, be a public authority or with means and resources sufficient to make the interim payment.[361] Generally, the court is given a wide discretion to make such interim payments it thinks just, but not exceeding a reasonable proportion of the damages which in the opinion of the court are likely to be recovered by the plaintiff after taking into account any relevant contributory negligence, set-offs, cross-claims or counter-claims.

4.78 Similar provisions apply in the County Court Rules.[362]

4.79 Application may be made at any time after the period allowed for the defendant to acknowledge service of the writ,[363] and while the needs of the

---

359 United Kingdom, Committee on Personal Injuries Litigation, *Report*, (Lord Justice Winn, Chairman), HMSO, London, 1968, Cmnd 3691, p. 38.

360 Rules of the Supreme Court, Order 29, rule 11(1).

361 Rules of the Supreme Court, Order 29, rule 11(2).

362 County Court Rules, Order 13, rule 12.

plaintiff are a relevant consideration, the court may take into account other factors in deciding to make an award.[364] It has been argued that the requirement for the plaintiff to demonstrate some need through the production of supporting evidence has resulted in the provisions being under-utilised, although obviously caution is needed in order to ensure that interim awards do not exceed the sum which the plaintiff will ultimately obtain when damages are finally assessed.[365]

4.80 The Law Commission found considerable support for the view that plaintiffs ought not be required to demonstrate need in order for an interim award of damages to be allowed. One fear which has been expressed by insurers, is that interim awards may be used to fund the litigation, rather than to pay for rehabilitative or care costs. On balance, however, the Law Commission determined not to amend the existing practice whereby need is not required to be demonstrated in order for an interim award to be made.[366]

4.81 In Britain the problem of so-called 'double-dipping', or making use of government-funded benefits while at the same time receiving damages in respect of the same heads of loss, has been found to exist, as it does in Australia.[367] The Law Commission considered evidence that a government scheme, similar to what which exists in Australia, which was introduced to solve this problem, may have the effect of using up a claimant's interim awards of damages. Although periodical payments and payments made under a structured settlement are exempt from the operation of the Compensation Recovery Scheme, interim payments are not exempt. The Law Commission received substantial support for the view that interim payments ought not be subject to the Compensation Recovery Scheme but

---

363 Rules of the Supreme Court, Order 29, rule 10.

364 *Stringman (a minor) v. McArdle* .[1994] 1 W.L.R. 1653.

365 England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages: A Consultation Paper*, Law Com. No. 125, HMSO, London, 1992 (hereafter cited as 'Law Commission Consultation Paper'), paras. 4.2–4.7.

366 England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages*, Report, Law Com. No. 224, HMSO, London, 1994 (hereafter cited as 'Law Commission Report'), paras. 4.2–4.8. See now: Social Security (Recoveryof Payments) Act 1997 (c. 27) (UK).

367 See previous discussion in Chapter 3.

unfortunately, the Law Commission was unable to deal with the problem owing to the limited scope of the inquiry being undertaken.[368]

4.82 In Australia, since the introduction of the *Health and Other Services (Compensation) Act 1995* (Cwlth), it may be necessary in order to avoid similar problems to provide an exemption in respect of the notification and recovery provisions of the Act for interim payments of compensation. Such an exemption would not permit double dipping to take place in the long term, however, as the notification and recovery provisions could be made to apply to the final award of damages only.

4.83 The Law Commission also addressed the question of whether interim awards of damages should be payable in respect of claims made by plaintiffs injured in motor vehicle accidents where the defendant was an uninsured driver. The Commission formed the view that interim payments should be available in such cases and recommended that the Rules be amended accordingly.[369]

4.84 One further complex question concerned the situation which arises where there are multiple defendants but where the plaintiff is unable to say which is liable at the time the application for interim payments are made. The existing law in England is that in such situations an order for interim payments cannot be made.[370] Although this rule may cause hardship in some cases, the Law Commission believed that the law could not be amended so as to avoid the problem without imposing undue hardship on defendants who will not ultimately be found liable.[371] Interim damages may, however, be awarded if the court is satisfied as to the liability of the individual defendant against whom the order is made.

---

368 Law Commission Report, op. cit., paras. 4.9–4.12.

369 ibid., paras. 4.13–4.17.

370 *Breeze v. McKennon* (1985) 32 Build. L.R. 41 (CA) & *Ricci Burns v. Toole* [1989] 1 W.L.R. 993 (CA).

371 Law Commission Report, op. cit., paras. 4.19–4.23.

4.85 Generally, the Law Commission found that the use of the interim payments regime worked well, save for the issues referred to above and some criticism of delay in obtaining orders.[372]

Court-Awarded Provisional Damages

4.86 Section 32A of the Supreme Court Act 1981 (Eng. and Wales) permits provisional damages to be awarded in personal injury actions in certain circumstances. There must be an admission or proof of a chance that the injured person will develop a serious disease or serious deterioration in his or her condition as a result of the act or omission which gave rise to the cause of action.[373] In such cases, the court may award damages on the assumption that the disease or serious deterioration in the condition will not develop, and then award further damages at a future date if the disease or deterioration in the condition actually does develop.[374] These provisions also apply in County Court proceedings.[375]

4.87 The procedures for the award of provisional damages thus modify the once-and-for-all rule to a limited extent only. They do not permit plaintiffs to apply for further damages where there is an uncertain prognosis but only where there is a specific chance that a deterioration in the condition will occur.

4.88 Since the procedures commenced operation on 1 July 1985, they have occasionally been used, although the precise circumstances in which they may be awarded are not fully resolved.[376] In *Willson v. Ministry of Defence*,[377] the court specified various factors which should be considered in deciding whether provisional damages should be awarded. A number of Practice Directions have also been issued to guide courts.[378]

4.89 Some of the problems which the English Law Commission found with the award of provisional damages include the additional expenses associated with applications for further reviews, the financial uncertainty which exists

---

372 Law Commission Report' op. cit., para. 4.18.
373 Supreme Court Act 1981 (Eng. & Wales), s. 32A(1).
374 Supreme Court Act 1981 (Eng. & Wales), s. 32A(2).
375 County Court Rules (Eng. & Wales), Order 22, rule 6A.
376 See NSW Law Reform Commission, op. cit., pp. 36–40.
377 *Willson v. Ministry of Defence* [1991] 1 All E.R. 638, 641J–642A.
378 [1985] 1 W.L.R. 961 amended by [1995] 1 W.L.R. 507.

for the defendant in not knowing the full extent of the liability, the fact that the defendant may go bankrupt, and the lack of guidance on the circumstances regarding any deterioration in the plaintiff's condition necessary for a further award to be made.

4.90 The Law Commission examined a number of suggestions for reforming the operation of awards of provisional damages but made only one principal recommendation for alteration of the existing practice.

4.91 It was considered that the existing rules in England and Wales were too restrictive in limiting applications for further damages to one occasion in respect of each disease or type of deterioration specified in the order for provisional damages.[379] It was recommended that this be amended to provide that more than one application may be made where the disease or deterioration so specified occurs in more than one position on the plaintiff's body provided that the possible positions are specified at the time of making the order.[380] Thus, a plaintiff who specified at the time the order was made that arthritis may develop in any limb, would be permitted to claim further damages if arthritis did so develop. If only one limb was specified then further damages would only be available if arthritis developed in the limb so specified. This recommendation was not, however, taken up in the recent Damages Act 1996 (Eng.).[381]

4.92 The Law Commission decided after having reviewed the arguments for and against certain other proposed reforms that the existing rules be retained without alteration. Accordingly, claims for provisional damages would only be available where a plaintiff's condition deteriorated following a specified event rather than gradually;[382] claims for provisional damages would not be available where medical uncertainty existed as to the prognosis in relation to an already existing condition;[383] situations in which a plaintiff's existing medical condition would result in death were adequately regulated

---

379 Order 37, rule 10(6).

380 Law Commission Report, op. cit., paras. 5.21–5.23.

381 Damages Act 1996 (Eng.)(c. 48) Royal assent 24 Jul. 1996.

382 Law Commission Report, op. cit., paras. 5.6 to 5.8.

383 ibid., paras. 5.9 to 5.12.

by the existing rules;[384] time limits for further applications ought not be specified, but rather left to the discretion of the courts;[385] and the court's discretion should not be further restricted.[386]

4.93 The Law Commission also considered in some detail the rules which govern situations in which a plaintiff who has been awarded provisional damages dies before reapplying to the court. The question which arises is whether the plaintiff's estate in such situations should be able to claim damages for loss of the plaintiff's earning capacity or loss of earnings during the lost years (that is, the years following the plaintiff's death). Had the plaintiff lived and made a further application to the court, substantial further damages could, in some cases, have been awarded with respect to these heads of damage. The Law Commission recommended that the plaintiff's estate should be entitled to damages for the lost years in certain circumstances.[387]

4.94 Section 3 of the Damages Act 1996 (Eng.) now provides that an award of provisional damages shall not bar an action under the Fatal Accidents Act 1976 (Eng.),[388] and that such part, if any, of the provisional damages and any further damages awarded to the claimant before his or her death as was intended to compensate for pecuniary loss which in the event falls after the date of death, shall be taken into account in assessing the amount of any loss of support suffered by the person or persons for whose benefit an action is brought under the Fatal Accidents Act 1976 (Eng.).[389] The Act also provides that no award of further damages made in respect of the deceased after the date of death shall include any amount for loss of income in respect of any period after death.[390]

---

384 ibid., paras. 5.13 to 5.16.
385 ibid., paras. 5.17 to 5.19.
386 ibid., para. 5.20.
387 ibid., paras. 5.24 to 5.38.
388 Damages Act 1996 (Eng.), s. 3(2).
389 Damages Act 1996 (Eng.), s. 3(3).
390 Damages Act 1996 (Eng.), s. 3(4).

Court-Awarded Periodical Payments

4.95 In the United Kingdom, in 1978, a majority of members of the Pearson Commission recommended that periodical payments should be available, although a minority strongly opposed the idea.[391]

4.96 The majority recommended a scheme of periodical payments for cases of death or serious or lasting injury. Under the proposed scheme, courts would be required to order periodical payments unless the plaintiff could show that a lump sum award would be more appropriate. Plaintiffs could apply for the commutation of a periodical payment order to a lump sum and the courts would have a discretion to make such an order. Periodical payments would be subject to review on the application of either party but only if there were changes in the plaintiff's pecuniary loss as a result of changes to the medical condition. Periodical payments would be administered by insurers at least monthly and payments would be revalued annually in line with movements in average earnings. Where proceedings were settled out-of-court, however, parties would be free to receive settlement monies by way of lump sum or periodical payment.[392]

4.97 Those who opposed the idea did so principally on the grounds that it would be cumbersome to operate and result in increased use of the courts. Although the Law Commission in its recent consideration of structured settlements, decided not to examine the use of periodical payments as these were an integral part of structured settlements, the legislation which has appeared now provides for their use. Sub-section (1) of section 2 of the Damages Act 1996 (Eng.) provides that 'a court awarding damages in an action for personal injury may, with the consent of the parties, make an order under which the damages are wholly or partly to take the form of periodical payments'. This provision was introduced to enable structured settlements to be used and is made in addition to the power of courts to make periodical

---

391 United Kingdom, Royal Commission on Civil Liability and Compensation for Personal Injury, *Report*, (Lord Pearson, Chairman), vol. 1, HMSO, London, 1978, Cmnd 7054, paras. 555–614 (majority) & paras. 615–630 (minority).

392 Law Commission Report, op. cit., para. 3.113.

payments as part of interim or provisional awards of damages as set out above.[393]

Structured Settlements

The Current Practice

4.98 In the United Kingdom, structured settlements are now established practice in personal injury litigation and recently introduced legislation has formalised their legality and operation.[394] By July 1993, over two hundred structured settlements had been used.[395] Although they were originally introduced without the need for legislative reform, their introduction was impeded because of the taxation implications; namely that periodical payments were regarded by the Inland Revenue as taxable in the hands of the plaintiff. Thus, there was little motivation to structure settlements rather than make lump sum awards.

4.99 In mid-1987, however, the Inland Revenue and the Association of British Insurers produced model documentation under which periodical payments would be treated as non-taxable capital sums. The model agreements do not stipulate the existence of an annuity but it is well-established practice for the insurer to use this mechanism to fund on-going payments to the claimant.

4.100 Four model agreements were approved by the Inland Revenue for non-taxable structured settlements.[396] The 'Basic Terms' agreement allows the periodical payment part of the settlement to cease after a pre-set period and to consist of a series of pre-set amounts. Such an agreement is appropriate where the claimant expects to receive a retirement pension at a certain age. The 'Indexed Terms' agreement links the payments in a Basic Terms agreement to the Retail Price Index in order to make them inflation proof. The 'Terms for Life' agreement allows pre-set payments to continue until the claimant's death but with the option to make this subject to a pre-set minimum number

---

393 Damages Act 1996 (Eng.), ss. 2(2) & 2(3).

394 Damages Act 1996 (Eng.), (c.48).

395 See R. Lewis, *Structured Settlements: The Law and Practice*, Sweet & Maxwell, London, 1993, p. ix & paras. 4.15–4.27 in which the history of structured settlements in the United Kingdom is described.

396 ibid., pp. 284–95.

of payments being received. Finally, the 'Indexed Terms for Life' agreement is an inflation-proofed Terms for Life agreement in which payments are increased in proportion with increases in the Retail Price Index. Provided these standard forms of agreement are used, the Inland Revenue has given them clearance as being non-taxable. Other forms of agreement may be used, although these would require advance clearance by the Inland Revenue.[397]

4.101 The taxation of awards of damages made by periodical payments has now been legislatively clarified with Parliament making it clear that periodical payments made pursuant to specified structured settlements and court-awarded arrangements are not, for the purposes of income tax, to be regarded as income in the hands of the recipient or any person who receives the payments on behalf of the recipient, or any trustee who receives payments on trust for the benefit of the recipient.[398] A similar taxation exemption is now also provided in respect of annuities paid under the Criminal Injuries Compensation Scheme.[399]

4.102 Prior to the introduction of the Finance Act 1996 (Eng.), structured settlements took place by the insurer purchasing an annuity for a tax-deductible premium and receiving payments which match the ongoing obligations of the claimant. The insurer had the liability to make payments to the claimant, and funded that liability with a separate annuity agreement with a life insurance company. In practice, the insurer commonly arranged for a life insurer to act as its paying agent so that it could use the life insurance company's systems for administration of ongoing payments, rather than having to establish its own. The life insurance company had to deduct tax from the payments it made to the defendant's insurer pursuant to the life policy and was unable to make payments direct to the plaintiff.[400] The need for this discontinuity between the annuity contract and the structured settlement agreement was necessary in order for the payments to be of a

---

397 Law Commission Consultation Paper, op. cit., para. 3.10; Lewis, op. cit., pp. 284–6.

398 Finance Act 1996 (Eng.), sch. 26, inserting s. 329AA into the Taxes Act 1988 (Eng.).

399 Finance Act 1996 (Eng.), sch. 26, inserting s. 329AB into the Taxes Act 1988 (Eng.).

400 Income and Corporation Taxes Act 1988 (Eng.), s. 349.

capital and not an income nature; thus ensuring that they were not taxable in the hands of the plaintiff.[401] The effect of section 329AA of the Taxes Act 1988 (Eng.) (as amended by the Finance Act 1996 (Eng.)), is that periodical payments will not now be taxable.

4.103 The defendant's insurer must 'gross-up' (that is, proportionally increase the gross amount) the payments it makes to the plaintiff in order to cover the deduction previously made to the life insurance company. The defendant's insurer is then able to recover the cost of grossing-up as a deduction from profits for the purposes of company tax, or by claiming repayment from the Inland Revenue. This model is different from that which operates in the United States where periodical payments may be made direct by the life insurance company as agent for the defendant's insurer without deducting tax provided that the payments are non-transferable, non-commutable and non-assignable.[402]

4.104 In the United Kingdom, the use of structured settlements has become accepted by reason of the fact that insurance companies are able to maximise their profit by investing appropriate sums which will guarantee the continuation of payments to the plaintiff as they are required, but taking into account the contingencies of the future. A structured settlements package is usually established by agreement between the plaintiff, the defendant's insurer and the life insurance company with the assistance of intermediaries with forensic accounting expertise and knowledge of life markets.[403]

Plaintiffs' Experiences of Structured Settlements

4.105 Evidence of the manner in which structured settlements are used in the United Kingdom is provided in the Law Commission's study of the compensation experiences of personal injury victims.[404] A sample of cases of claimants who had received structured settlements was selected from

---

[401] See PIR Structured Settlements Discussion Paper, op. cit., pp. 24–5, Attachment A; Law Commission Consultation Paper, op. cit., para. 3.12.

[402] Law Commission Consultation Paper, op. cit., para 3.13.

[403] ibid., para. 3.13.

[404] England and Wales, Law Commission, *Personal Injury Compensation: How Much is Enough? A Study of the Compensation Experiences of Victims of Personal Injury*, Report, Law Com. No. 225, HMSO, London, 1994, ch. 12, pp. 231–4.

insurance company files and interviews were conducted with nine individuals who had received between £95,000 to £1,000,000.

4.106 In all but one of the cases, the settlement comprised an initial lump sum and an annuity, the one exception being a claimant who refused any lump sum on the basis that he did not want the responsibility of administering it.[405] Most claimants accepted structured settlements in order to provide a secure source of income and to conclude the legal proceedings. There was some evidence of claimants being forced to accept structured settlements on the basis of information and calculations provided by legal and financial advisers without fully understanding the calculations involved or the type of settlement used.[406]

4.107 The study found general agreement amongst those interviewed that structured settlements were preferable to lump sum awards of compensation. Those interviewed, of course, had not received a lump sum payment. The main reasons for preferring a structured settlement were the desire to have some financial security and peace of mind as well as the possibility that one could plan financially for the future. Those interviewed were also relieved at having the responsibility for investing their money taken off their shoulders. The Law Commission noted, however, that others interviewed who had received a lump sum, liked the freedom of choice and sense of control which a lump sum provided.[407]

4.108 A number of those interviewed, however, expressed concern as to the amount of the settlement and the fact that it was unable to meet their loss of earnings and extra expenses which arose from their injuries. This problem relates to the accuracy of the calculations made and the predicted costs involved in care, rather than the nature of the settlement itself. Others interviewed expressed concern with the size of the lump sum component of

---

[405] ibid., para. 12.1.
[406] ibid., para. 12.1.
[407] ibid., para. 12.2.

the settlement which was often inadequate to purchase a home or start a business.[408]

4.109 Various legal and procedural issues have arisen concerning the use of structured settlements in the United Kingdom and these were dealt with by the Law Commission in its Final Report. Some of the issues relate to matters which have relevance particularly to the situation in the United Kingdom and these will not be addressed here. The following, however, are of importance in suggesting reforms in Victoria.

Court Imposed Structured Settlements

4.110 One of the most difficult questions to resolve is whether courts should be empowered to impose a structured settlement where one or more of the parties is against the idea. A wide range of options exist in giving courts such a power, ranging from a general power to impose structured awards in any case in which the court deems it to be just, to more specific powers which permit courts to impose structured awards which relate only to particular heads of damage, such a loss of future earning capacity. Alternatively, the discretion could be taken away from courts entirely and a mandatory requirement introduced which requires all cases of particular types or all awards relating to particular heads of damage to be structured.

4.111 The Law Commission considered these matters in great detail and concluded that the voluntary system of structured settlements which exists in England and Wales should be maintained and that a mandatory system of imposing structured settlements or a system in which courts are given a discretionary power to impose structured settlements against the wishes of the parties should not be introduced at present.[409] The legislation which has appeared follows this recommendation and provides that periodical payments and structured settlements may be made only with the consent of the parties.[410]

4.112 In support of the view that the courts should be given a power to impose a structured settlement, it was argued that the principle of *restitution in integrum* only requires that plaintiffs be compensated, not that they be compensated in a particular way. Because many individuals do not have

---

408 ibid., para. 12.3.

409 Law Commission Report, op. cit., paras. 3.37–3.53.

410 Damages Act 1996 (Eng.), ss. 2 & 5.

financial freedom of choice prior to suffering an injury, the award of a lump sum is not required to return them to that position after suffering an injury. In fact, awarding damages in a structured format may achieve *restitution in integrum* more effectively than had a lump sum been awarded. Secondly, the state has a real interest in ensuring that plaintiffs who receive compensation do not subsequently become a burden on government-funded social security and health care. By giving the courts a power to impose structured settlements in certain cases, this problem may be averted.

4.113 In opposition to the argument that the courts should be given a power to impose structured settlements, it was argued that to give the courts a power to impose a particular form of settlement would involve an exercise in paternalism on the part of the state which would go against the doctrine of freedom of contract in which parties are able to determine their contractual arrangements as they see fit. It was argued that plaintiffs should be able to spend their damages awards without state interference.[411] Secondly, a number of practical difficulties were identified which would make the exercise of such a power unworkable. These included questions relating to the determination of the scope of the court's power; whether it would interfere with the bargaining positions of the parties in reaching a settlement; whether it would affect the discount negotiated by life insurers for agreeing to finance the arrangement; and whether it would prevent the parties from reaching workable settlements generally. Thirdly, questions of cost and delay may arise by reason of the parties to an imposed structure seeking to have it reviewed on appeal. Because a structured settlement involves so many components, it would be likely that the parties would seek to appeal against the court's decision relating to each, such as the amount of the initial lump sum, provision for further lump sums, the amount of the annuity, cost of living adjustments and so on. The court would also need expert forensic assistance in structuring an award if this were contrary to the parties' wishes. Appeals could be taken as a matter of course which would delay the commencement of payments, add further legal costs, and congest the courts further. The right of appeal could, of course, be removed, although this would be a radical reform resulting in the possibility of injustice being suffered.

---

[411] ibid., para. 3.38.

Structured Court-Awarded Damages

4.114 Although accounting for only a very small proportion of claims for damages for personal injuries, cases which proceed to trial and judgment by a court were also examined by the Law Commission as being the subject of structured judgments for the payment of compensation.[412] The Law Commission's recommendations have been taken up in the Damages Act 1996 (Eng.) which now clarifies the power of a court to make an order for the periodical payment of damages with the consent of the parties such that it receives the same taxation treatment as a structured out-of-court settlement.[413]

4.115 The Law Commission also considered the power of courts to make structured periodical or interim awards of damages. In England and Wales at the time the Law Commission considered the matter, both provisional awards of damages and interim payments could not be structured so as to obtain taxation relief. The Law Commission recommended that it should be possible to structure interim and provisional awards of damages where both parties consent in order to deal with the small number of cases where such awards are made.[414] Again, these recommendations have been followed in the Damages Act 1996 (Eng.)[415] and the Finance Act 1996 (Eng.).[416]

Structured Motor Insurers' Bureau Payments

4.116 In England and Wales the Motor Insurers' Bureau is a guarantee fund set up by all motor insurers in order to compensate the victims of uninsured and untraceable motorists who cause injury negligently. The Bureau meets damages awarded for personal injuries, damage to property, costs and interest. The Law Commission's recommendation allowing the Bureau to make use of structured arrangements for the payment of compensation and to take advantage of the taxation concessions which were recommended for other personal injuries cases has been legislatively approved.[417]

---

412 ibid., paras. 3.77–3.84.
413 ibid., paras. 3.77–3.78; Damages Act 1996 (Eng.), s. 2 & Finance Act 1996 (Eng.), sch. 26.
414 Law Commission Report, op. cit., para. 3.84.
415 Damages Act 1996 (Eng.), s. 2(2).
416 Finance Act 1996 (Eng.), sch. 26 inserting s. 329AA(7) into the Taxes Act 1988 (Eng.).
417 Law Commission Report, op. cit., paras. 3.86–3.96.

Structured Criminal Injuries Compensation Payments

4.117 The Law Commission also considered whether criminal injuries compensation payments made by the Criminal Injuries Compensation Authority could be structured. Although structuring such payments was considered to be desirable, in view of the current laws and practice governing the establishment of the newly introduced Criminal Injuries Compensation Scheme, it was considered to be better to wait some time before seeking reforms to the scheme to enable structured settlements to be used.[418] The Finance Act 1996 (Eng.) has, however, clarified the taxation liability of payments made under the scheme, confirming their capital nature.[419]

Assignment of Liability

4.118 In England and Wales, structured settlements take place by the defendant's insurer making payments to the plaintiff rather than the life insurer making payments direct to the plaintiff. This is required in order to ensure that the payments are not taxable in the hands of the plaintiff. The Law Commission recommended that legislation be introduced which would enable defendants' insurers to purchase an annuity from life insurance companies in discharge of their liability and for life insurance companies then to make payments direct to plaintiffs. This would enable defendants' insurers to close their books on claims.[420] The amendments to the Taxes Act 1988 (Eng.) have given effect to these recommendations.[421]

Security

4.119 In order for a structured settlements regime to be accepted, it is necessary for the companies which provide the funds to be secure and able to meet future obligations to make payments to plaintiffs. The Law Commission noted in its Consultation Paper the possibility of insurance companies failing and the various methods by which plaintiffs could be protected in such circumstances.[422] Lewis in his work on 'Structured Settlements' also discusses the security issues associated with structured settlements and recounts instances in Britain and the United States where large insurance companies have failed.[423]

---

418 ibid., paras. 3.101–3.105.
419 Finance Act 1996 (Eng.), sch. 26, inserting s. 329AB into the Taxes Act 1988 (Eng.).
420 Law Commission Report, op. cit., paras. 3.61–3.62.
421 Taxes Act 1988 (Eng.), s. 329AA.
422 Law Commission Consultation Paper, op. cit., paras. 3.61–3.64.
423 Lewis, op. cit., pp. 229–34.

4.120 The Law Commission noted that plaintiffs who have invested lump sum payments may also face the risk of loss of investments due to insolvency but that they have some control over the security of their funds.[424] In the case of structured settlements it is essential that payments made under a settlement be secure in order to prevent plaintiffs falling back on the state in the event of companies becoming insolvent. The Damages Act 1996 (Eng.) now extends the protections provided for the holders of annuities under the Policyholders Protection Act 1975 (Eng.) to the recipients of periodical payments made pursuant to structured settlements and provides that the full amount of the liability will be protected in the event of the liquidation of an insurer.[425] In the case of public sector structured settlements, the Damages Act 1996 (Eng.) permits the Crown to guarantee the payments made under the structured settlement or court order.[426]

Review of Structured Settlements

4.121 The Law Commission considered in some detail the question of whether structured settlements should be capable of review by the parties where the financial circumstances of the plaintiff altered.[427]

4.122 The arguments in favour of allowing a review mirror those already canvassed in support of the use of periodical payments and interim and provisional awards of damages, namely that it is unfair for a claimant to suffer financial hardship where events, unforeseen at the time compensation is agreed to, result in the amount awarded being insufficient to meet the claimant's on-going needs.

4.123 The arguments against allowing review of structured settlements relate to the need for insurers to be able to close their books and be able to calculate the exact extent of their liability, the possibility of rehabilitation being impeded, and the possibility that settlements could be negotiated with less precision and care in view of the possibility of subsequent amendment. In

---

424 Law Commission Report, op. cit., para. 3.67.

425 Damages Act 1996 (Eng.), s. 4.

426 Damages Act 1996 (Eng.), s. 6.

427 ibid., paras. 3.146–3.154.

England and Wales, there is also the problem that any taxation concessions may not apply if a settlement is re-opened.

4.124 The Law Commission took the view that settlements should not be able to be reviewed by the payment of further sums, although it should be possible to re-negotiate the payment of amounts already agreed in order to take account of the plaintiff's changing circumstances. Re-negotiation without making further additional payments happens at present and does not make the settlement taxable. There is also the possibility for interim and provisional damages to be awarded in appropriate circumstances.

4.125 The Law Commission also considered the question of whether structured settlements should be able to be reviewed by a court on the application of one or more parties. In view of the fact that the Law Commission was opposed to introducing reforms which would enable the courts to impose structured settlements without the consent of the parties, it was also opposed to allowing structured settlements which had been entered into by the parties to be reviewed by the courts.[428] Where changes in the claimant's circumstances were likely to arise, these could be dealt with by the use of provisional or interim structured arrangements. These recommendations were affirmed by Parliament and review of settlements was not provided for in the Damages Act 1996 (Eng.).

The United States

The Introduction of Structured Settlements

4.126 In the United States, various statutes permit awards of compensation to be paid periodically including alimony and child support, workers' compensation, no-fault motor vehicle compensation schemes and Federal vaccination injury schemes. At common law, however, courts in the United States were originally required to award damages once-and-for-all in a lump sum.

4.127 Departures from the common law rule developed in the United States in the late 1950s and became more popular during the 1960s following

---

428 ibid., para. 3.85.

litigation involving the drug Thalidomide.[429] The severely deformed children who sought compensation from the makers of Thalidomide created a need for a system of paying damages which would provide them with an assured income throughout the remainder of their lives. Victims were compensated with a pension which was increased by two per cent per annum.

4.128 Although originally limited to catastrophic injury cases, such as the Thalidomide litigation, structured settlements have been used more recently in a wide range of personal injury litigation, particularly that relating to health care where defendants and their insurers have found that costs are able to be contained more effectively with structured settlements than with lump sum payments. These settlements have also been used in large-scale product liability litigation such as that involving the Ford Pinto in the early 1980s.[430]

Taxation Treatment of Structured Settlements

4.129 The principal impetus for reform came, as in the United Kingdom, when the United States Inland Revenue Service issued taxation rulings in the mid-1970s which stated that income from a structured settlement would be tax free in the hands of the plaintiff.[431]

4.130 Legislation now provides for amounts of damages on account of personal injury to be excluded from assessable income, whether they are paid as lump sums or as periodical payments.[432] Also excluded are amounts received under workers' compensation acts and benefits under health and accident insurance policies. The exclusion is restricted in so far as the receipt relates to amounts paid out for medical expenses for which a tax deduction is available. Generally, however, lump sums and periodical payments are treated the same for tax purposes making the use of structured settlements popular.

---

429 Lewis, op. cit., para. 4.02.

430 E.g. *Grimshaw v. Ford Motor Co.* 119 Cal. App. 3d. 757, 791–2 (1981) in which internal Ford engineering studies concluded that the cost of paying victims for injuries and death would be less expensive than installing a device that could prevent petrol from escaping from vehicles in collisions. US$127 million punitive damages were awarded. See G. M. Gold, (ed.), *Evaluating and Settling Personal Injury Claims*, John Wiley & Sons, New York, 1991, para. 4.1.

431 e.g. Inland Revenue Service Ruling 79-220; see Lewis, op. cit., para. 4.04.

432 Internal Revenue Code, § 104(a)(2).

Funding Arrangements

4.131 Structured settlements or court determined periodical damages awards terminate the liability of the defendant and create a new contractual liability for making periodical payments to the claimant. Various financial alternatives exist in the United States to enable such arrangements to take place. One funding arrangement is known as a qualified assignment of the obligation to pay damages. In such arrangements, the defendant or its insurer settles a claim by promising to make periodical payments in the future and then transfers this obligation to an assignment company. The defendant's liability is thereupon extinguished. The assignment company then purchases an annuity from a life insurance company which pays the annuity to the plaintiff.[433]

4.132 An alternative funding arrangement involves the use of annuities. In exchange for the release from liability, the defendant or its insurer promises to make periodical payments to the claimant. The claimant is thus an unsecured creditor of the defendant. The defendant or the defendant's insurer then purchases an annuity for a lump sum and makes payments to the claimant.[434]

4.133 Finally, trusts, security bonds, re-insurance and various other arrangements have been used in recent years in the United States to finance periodical payments and structured settlements.[435]

Legislative Regulation of Structured Settlements

4.134 By 1980, some fourteen states had adopted some form of periodical payments legislation which enabled awards of future damages to be paid by instalments, mainly in relation to medical malpractice and product liability claims.

4.135 Periodical payment of judgments legislation is directed primarily at court-awarded payments of compensation although parties to an out-of-court settlement may agree for some or all of the provisions contained in a legislative scheme to apply to the payment of damages by way of settlement. Parties to an out-of-court settlement do not, however, have to pay heed to legislative periodical payments schemes.

---

433 D. W. Hindert, J. J. Dehner & P. J. Hindert, *Structured Settlements and Periodic Payment Judgments*, Law Journal Seminars Press, New York, 1996, Chapter 3.

434 ibid. para. 3.05.

435 ibid. paras. 3.07–3.10.

4.136 In 1980, the National Conference of Commissioners on Uniform State Laws approved a model periodical payment of judgments act, known as the 'Model Act', which was adopted by South Dakota for medical malpractice claims.[436] The Model Act was not used more widely by other states owing to certain features regarding financing and taxation of the payments. In 1990, however, a revised and simplified Uniform Periodic Payment of Judgments Act was introduced which has been used to varying degrees in a number of states, not without some controversy, however.

4.137 In late 1994, the Supreme Court of Arizona decided that Arizona's adoption of the Uniform Act[437] was unconstitutional as it constituted a form of damage limitation prohibited by the Arizona Constitution which stated that 'no law shall be enacted in this State limiting the amount of damages to be recovered for causing the death or injury of any person'.[438] The significance of this decision is, however, largely confined to the specific circumstances of Arizona's Constitution.

The Uniform Act

4.138 The nature and operation of the Uniform Periodic Payment of Judgments Act is described extensively in Hindert, Dehner and Hindert's *Structured Settlements and Periodic Payment Judgments*[439] and the Committee has been greatly assisted by speaking with two of the authors while receiving evidence in the United States, Messrs. Patrick Hindert and Joseph Dehner.

4.139 The Uniform Act applies only to claims for 'bodily injury' which is defined as 'bodily harm, sickness, disease, or emotional or mental distress sustained by an individual, including death resulting from any of those conditions at any time'.[440]

4.140 Any person bringing a claim for compensation for bodily injury, whether in a representative capacity or in his or her own behalf, may be a claimant and elect for the provisions of the Act to apply to the claim.

---

436 S.D. Comp. L. §§ 21-3A-1 to 21-3A-13 effective from 1 Jul. 1987.

437 Ariz. Rev. Stat. Ann. §§ 12-581-591.

438 Article 2, § 31; see *Smith v. Superior Court*, unreported, Arizona Supreme Court, 29 Dec. 1994, No. CV-92-0069-PR.

439 Hindert et al., op. cit., Chapter 9.

440 Uniform Periodic Payment of Judgments Act, § 1(1).

4.141 A claimant is unable to elect for the Act to apply where the claim is for future damages for economic loss, without reduction to present value, which does not exceed US $100,000 or where the court finds good cause not to try the case under the provisions of the Act.[441] 'Good cause' exists only where the time over which payments would be made is too short, or the amount of damages is too small in relation to the time over which the payments would be made, or where the defendant is unable to fund a periodical payment judgment.[442]

4.142 The jury or other trier of fact is required, under the Act, to make a finding relating to various heads of damage. Past damages and future non-economic loss may not be structured and the trier of fact is to determine separate sums for these heads which will be awarded as a lump sum. Future economic loss must be separately determined in respect of medical expenses and other economic loss,[443] and future economic damages must not be reduced to present value.[444] The trier of fact may determine that future medical expenses will continue for the duration of the claimant's life without specifying a number of years.[445] The trier of fact also has the option of including an allowance for inflation in determining an amount for annual future economic loss, or rendering a separate finding of the inflation rate or rates to be applied to annual losses.[446]

4.143 Having determined these factual matters, it is then for the judge to determine the form in which the judgment will be given and how the damages will be paid. The National Conference of Commissioners who drafted the Uniform Act specified eight steps in converting a jury verdict into periodical payments.

4.144 First, the court must apply any rules of law which would increase or decrease the judgment other than set-offs (amounts claimed by the defendant)

---

441 Uniform Periodic Payment of Judgments Act, § 2(c).
442 Uniform Periodic Payment of Judgments Act, § 3(a).
443 Uniform Periodic Payment of Judgments Act, § 4(a)(3).
444 Uniform Periodic Payment of Judgments Act, § 4(b).
445 Uniform Periodic Payment of Judgments Act, § 4(e).
446 Uniform Periodic Payment of Judgments Act, § 5(b) & (c).

and credits where they exist. Secondly, the court must account for any set-off or credit which will reduce the award. Thirdly, the court must account for any periodical payment set-off or credit, namely the periodical payments made under the structured portion of the settlement. Fourthly, legal costs and expenses are then determined. Fifthly, funds for paying legal costs and expenses are identified in accordance with various rules of priority. Sixthly, if part of the award for future economic loss is to be paid as a lump sum, this is to be identified and taken into account in determining the amount remaining for periodical payments. Seventhly, all lump sums for punitive damages, pre-judgment interest, past damages, future non-economic loss and lump sum components of future economic loss are determined and future periodical payments of economic loss calculated for the number of years the jury has determined they should be paid. Periodical payments are to be paid annually on the first day of the month unless the court determines otherwise.[447] Interest is only to accrue on periodical payments from the day the payment is due.[448]

4.145 Finally, the court must describe the funding plan to be used which is a 'qualified funding plan' specified in the Act and approved by the court. Various funding arrangements are specified in the Act to ensure consistency and security of payments depending upon the nature of the entity making the payments. If approved, the defendant, the defendant's liability insurer, as assignee from the defendant, or a re-insurer may make periodical payments as long as the insurer is one specified on a list of qualified insurers approved by the Insurance Commissioner. Essentially, a qualified insurer must be a large company with over US$100 million of capital and surplus and highly-rated by two of the nationally recognised rating organisations.[449] Where there are multiple defendants, funding may be provided by one who may then seek contribution or indemnity from the others.[450] If the defendant (or its insurer)

---

447 Uniform Periodic Payment of Judgments Act, § 6.
448 Uniform Periodic Payment of Judgments Act, § 8.
449 See Hindert et al., op. cit., para. 9.02[6], [11] & 9.03[6].
450 Uniform Periodic Payment of Judgments Act, § 10.

is unable to fund the periodical payments, the claimant may elect for damages to be paid in a lump sum.[451]

4.146 Where the claimant dies, periodical payments made in respect of medical expenses terminate.[452] Periodical payments for other future economic loss, such as loss of earning capacity, may continue after the claimant's death and be paid to the claimant's estate, depending upon the nature of the claim and the number of claimants.[453]

4.147 A judgment under the Uniform Act is satisfied once all lump sums have been paid and a qualified funding plan is funded.[454] Thereafter, the claimant's rights are determined by the terms of the funding plan rather than the judgment.

4.148 The Uniform Act also limits the assignability of periodical payments to ensure that the payments serve the purposes for which they were made. Periodical payments may, however, be assigned to meet legal costs and expenses, medical care or spousal or child support.[455] Similarly, the Act generally exempts periodical payments from garnishment, attachment, execution, and any other process or claim.[456]

State Legislation

4.149 Over thirty states have some form of periodical payments legislation, the more recent versions of which apply to areas of tort law other than medical malpractice and product liability.[457] There is, however, little uniformity in the legislative schemes which operate in different states with the principal differences relating to the following matters.[458]

4.150 First, differences exist in the various state statutes in terms of the nature of the injuries covered, threshold amounts, the heads of damage which

---

451 Uniform Periodic Payment of Judgments Act, § 9(a).
452 Uniform Periodic Payment of Judgments Act, § 13(a).
453 Uniform Periodic Payment of Judgments Act, § 13.
454 Uniform Periodic Payment of Judgments Act, § 16.
455 Uniform Periodic Payment of Judgments Act, § 14.
456 Uniform Periodic Payment of Judgments Act, § 15.
457 PIR Structured Settlements Discussion Paper, op. cit., p. 25, Attachment A; Law Commission Consultation Paper, op. cit., para. 3.4.
458 Hindert et al., op. cit., Chapter 10.

may be paid periodically, and how the legislative schemes relate to common law actions.[459]

4.151 Second, legislation in various states differs with respect to the role which the parties, judge and jury have in determining whether periodical payments will be used. California, for example, has a requirement which makes it mandatory for periodical payments to be used when requested by either party. Other states give the judge a discretion as to when periodical payments should be used. In all states the judge and not the jury, is given the task of drafting the agreement for periodical payments including the frequency and amounts of payments, their duration, contingencies which affect the amount and duration of payments, measures to lessen the risk of the debtor becoming insolvent, and modifying the payment schedule. The jury retains, however, the task of determining the dollar amounts of loss.[460]

4.152 Third, states differ with respect to the details to be included in a periodical payment judgment although it is usual to include the name of the recipient(s), the amount and timing of the payments, the number of payments and period of time over which they are to be paid, contingencies which may affect payments and reversionary or beneficial interests. Questions of review and adjustment of judgments, inheritance of awards, and the payment of legal fees differ between states.[461]

---

459 ibid., para. 10.02.

460 ibid., para. 10.03.

461 ibid., paras. 10.04–10.05.

4.153 Hindert et al. make the following observations on the future of legislative attempts to regulate structured settlements in the United States:[462]

> The future of the Uniform Act will depend on the ability of its sponsors to convince legislatures and the courts that it is not a one-sided effort by potential defendants to limit their losses and to deprive needy plaintiffs of their rightful awards. Instead, it must be, and appears to be, a step forward in making more certain that compensation pays losses as and when incurred.

The Current Structured Settlements Climate

4.154 The structured settlements industry has grown considerably in the United States as insurers have realised the savings which may be made through the use of such arrangements. By 1992, it was estimated that structured settlements were used in over 10,000 cases a year including one-third of all cases valued at US $150,000 or more and in one-half of all million dollar settlements.[463] Over thirty life insurance companies offer annuities for use in structured settlements and there is now a National Structured Settlements Trade Association with membership comprising more than seventy-five companies and over 500 individuals. Thus, a major new industry has developed in the United States consisting of consultants, brokers, and finance companies. The individuals involved in the structured settlements industry vary considerably in training, skills and ability, although they tend to be licensed life insurance agents who earn commissions on the annuities they place, usually around four per cent. They also undertake cost-benefit analyses, evaluation of damages, assistance in negotiating settlements, expert testimony, verdict analysis and the preparation of documentation.[464]

4.155 Structured settlements in the United States are negotiated in an extremely adversarial manner with substantial profits being able to be realised through adept negotiation. Lewis,[465] for example, argues that up to fifty-per cent savings are able to be made by insurers in negotiating favourable terms for annuities. This has led to wide-scale advertising of structured settlements which has now extended to the Internet where litigants

---

[462] ibid., para 9.03[9].

[463] Lewis, op. cit., para. 4.04.

[464] P. J. Hindert, 'Periodic Payments and the Defense of Damages', paper presented at the International Association of Defense Counsel's Annual Meeting in 1994, Colorado Springs, Colorado 15 Jul. 1994.

[465] Lewis, op. cit., para. 4.06.

and their advisers are able to locate a wide range of promotional material from companies which offer structured settlements.[466]

[466] See e.g., Turk Settlements Company http://www.structuredsettlements.com/what.htm; Henderson Structured Settlements Inc.http://www.eidos.ca/henderson/ssol.htm; Prosperity Partners Inc. http://www.note.com/note/pp/cvt_sett.htm, and others which convert periodical payments into lump sums, e.g. Stone Street Capital http://www.stonestreet.com/index.htm.

5 COMPENSATION PAYMENTS: THE CASE FOR REFORM

Introduction

5.1 This chapter examines the arguments in favour of introducing reforms to the manner in which compensation is paid. Chapter 3 described in some detail the problems which exist with the current system of paying compensation by way of once-and-for-all lump sums while Chapter 4 reviewed a number of approaches which have been taken in other jurisdictions to address these difficulties. It now remains to consider precisely, how changes to the way in which compensation payments are made may improve upon the situation as it exists in Victoria at present, and which of the various reform models would most effectively solve the difficulties which led to the Committee receiving its reference. Arguments opposing the introduction of reform, including issues surrounding taxation reform, will be dealt with in a subsequent chapter.

5.2 At the outset, it is appropriate to recall that a wide variety of alternative approaches to the payment of compensation may be used. It is important to distinguish these in balancing the advantages and disadvantages of each. It is initially necessary to distinguish between court-awarded payments of compensation and out-of-court settlements. These two outcomes of claims may further be broken down into court-awarded payments which follow a full hearing of a claim and those which merely approve an out-of-court settlement (such as is necessary where an infant's claim is involved). Out-of-court settlements may also be broken down into those which follow the issue of legal proceedings and those which take place prior to the issue of legal proceedings. Chapter 7 of this report will consider the extent to which reforms are needed in relation to each of these various ways in which a claim may be resolved and payment of compensation made.

5.3 It should also be recalled that reforms to the manner in which compensation is paid may be directed at each or all of the various heads of damage. Lump sums may, for example, continue to be the favoured manner of paying compensation for non-economic and past economic loss while periodical payments may be preferable for the payment of future economic loss. Some of the arguments which favour periodical payments may be of greater relevance for some heads of damage than others and in reviewing the following arguments consideration needs to be given to the fact that some, but by no means all, of a claimant's award of compensation ought to continue to be paid by a lump sum. If alternative approaches are adopted to the payment of future economic loss only, then the question arises as to whether such reforms should be restricted by a monetary limit. This question will be addressed in Chapter 7 when considering the manner in which reforms should be introduced in Victoria.

Written Submissions

5.4 Between 8 January 1996 and 25 November 1996, the Committee received sixty-five submissions in writing. These came from a range of government and private organisations involved in providing health care, as well as individual medical practitioners, legal practitioners and health care users. Both urban and rural organisations were represented.

5.5 One half of the written submissions referred to the manner in which compensation payments are made and the use of structured settlements and periodical payment of court awards. Of these, sixty-four per cent (21) supported the use of structured settlements generally without qualification, some expressing very strong support. A further thirty per cent (10) favoured the use of structured settlements in certain circumstances or under certain conditions only, while only two submissions (6%) were generally opposed to the idea.

5.6 Those expressing opposition included the Australian Plaintiff Lawyers Association[467] which preferred the payment of compensation to be in a lump sum, once-and-for-all for the reasons traditionally associated with support of lump sum awards; namely, the need for finality of litigation and the administrative difficulties associated with arranging structured settlements

---

[467] Submission no. 19.

and periodical awards. The Association also believed there to be no evidence of over- or under-compensation arising out of the existing system.

5.7 The other submission which opposed the use of structured settlements was made jointly by the National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch) and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch).[468] These organisations were strongly of the view that those injured through the use of health services, particularly cerebrally affected neonates, should be cared for by government-funded health and social security programmes, rather than damages awarded through tort litigation. The organisations believed that on-going costs associated with caring for disabled persons should be funded at a pre-determined level by government and should be open to all regardless of fault or cause.

5.8 Of those who offered qualified support for the use of structured settlements, the following arguments were advanced.

5.9 The Medical Defence Association of Victoria was opposed to the introduction of periodical payments for the settlement of medical negligence claims as it took the view that the costs associated with setting up and supervising a satisfactory system would far outweigh any benefits that may flow. The Association did, however, generally support the use of structured settlements once the taxation issues have been resolved.[469]

5.10 The Victorian Bar Council considered that the abandonment of lump sum awards in favour of structured alternatives should only be contemplated if the structured alternative provides adequate security for the recipient and is practicable in the trial context. In particular, the Bar Council considered that structured settlements would be very difficult for juries to come to grips with and the taxation issue would also need to be resolved.[470]

---

468 Submission no. 35.
469 Submission no. 58.
470 Submission no. 48.

5.11 The firm of solicitors, Slater and Gordon, expressed general support for the use of structured settlements, while noting a number of concerns about the manner in which they would be administered. Their submission stated:[471]

> As a result of our experience with statutory compensation schemes, we do not believe it is appropriate for plaintiffs or their relatives to be required to engage in time-consuming, stressful and frustrating ongoing dealings with insurers in order to obtain payment of medical expenses. For this reason, we do not support periodical payments (in the sense of weekly or monthly income support payments), or the making of orders for the payment of reasonable medical and like expenses, with the possibility of disputes concerning the reasonableness of each service.

5.12 The Institute of Legal Executives (Victoria) also noted potential problems of administration submitting that 'anecdotal evidence suggests that public administrators charge higher fees, and are less responsive to enquires, than other administrators'.[472]

Oral Evidence

5.13 The Committee has also been fortunate in having had a number of individuals appear before it to offer information and opinion. Those who appeared and gave evidence concerning the manner in which compensation payments are made included representatives from the Department of Health and Community Services, the Medical Protection Society, Corrs Chambers Westgarth, solicitors and the National Cervical Screening Program. The following arguments were advanced.

5.14 Dr Chris Brook, Director of the Public Health Division of the Department of Health and Community Services, described the context in which the inquiry was established and the need for structured settlements to be considered as a reform option.[473] Dr Paul Nisselle, Australasian Secretary of the Medical Protection Society, noted the need for taxation reforms to be implemented before structured settlements could be adopted in Victoria.[474]

5.15 On 27 November 1995, the Committee heard from Messrs Bryan Gurry and Ben Burke of Corrs Chambers Westgarth, solicitors. An outline of the activities of the Professional Risk Management Group of California and its affiliated organisation, Merrett Health Risk Management Group of the United

---

[471] Submission no. 20.
[472] Submission no. 22.
[473] *Minutes of Evidence*, 23 Oct. 1995.
[474] *Minutes of Evidence*, 23 Oct. 1995.

Kingdom, was provided and an explanation given of how structured settlements could be used in conjunction with a managed care approach for severely injured persons. It was submitted that structured settlements could be introduced in Victoria without the need for taxation law reform on a similar basis to that which was used in Britain, although a ruling from the Commissioner of Taxation would be desirable to clarify the taxation position of the recipients of periodical payments made pursuant to a structured settlement.[475]

5.16 Finally, on 23 February 1996, the Committee heard evidence from Mr Robin Boyce, formerly a Senior Officer with the Commonwealth Department of Human Services and Health's Professional Indemnity Review, who described the work carried out by the Review to do with structured settlements and how they could be used to improve the position of both claimants and insurers in an appropriate taxation environment.[476]

Evidence Obtained in the United States

5.17 The Committee was also fortunate in having received oral submissions from a number of key individuals involved in the structured settlements and periodical payment judgments field in the United States.

5.18 A small delegation comprising the Committee's Chairman, Mr Victor Perton, MP, and the Director of Research, Mr Douglas Trapnell, attended meetings in San Francisco. They were joined in Washington and New York by Committee members Mr Florian Andrighetto, MP and Mr Alistair Paterson, MP. The Committee is particularly grateful to Mr Patrick Hindert, Chairman and Chief Executive Officer of Benefit Designs Inc. and his assistant Ms Jane Ferguson for arranging and coordinating these meetings, from which the Committee greatly benefited.

5.19 Three meetings were held. At the first meeting in San Francisco, on 16 August 1996, evidence was received from the Hon. W. Jackson Willoughby, a Judge of the California Municipal Court and one of the Commissioners involved in the drafting of the Periodic Payment of Judgments Act, Mr S.

---

475 *Minutes of Evidence*, 27 Nov. 1995.

476 *Minutes of Evidence*, 23 Feb. 1996.

Thomas Todd, an Attorney at Law and adviser to the Commissioners on the Uniform Periodic Payment of Judgments Act, and Mr Hindert. The speakers provided an introduction to the use of structured settlements in the United States and outlined the provisions of the Uniform Periodic Payment of Judgments Act. The general context of tort law reform in the United States and the problem of medical malpractice litigation was also canvassed with particular reference being give to the compensation of infants severely injured at the time of birth. Discussion also centred around the need to provide adequate financing for companies which offer structured settlements and how payments may adequately be secured. The difficult problem of reviewing structured judgments was also raised and justifications explained for the position which occurs in most jurisdictions where structured settlements cannot be re-negotiated if the claimant's circumstances change.

5.20 The second meeting took place in Washington on 3 September 1996 at the offices of Hogan and Harston, Attorneys. Those present were Mr Randy Dyer, Executive Vice President of the National Structured Settlements Trade Association, Mr Douglas Bennett, a partner in the Washington firm of 'Public Strategies', John S. Stanton and William W. Lett of Hogan and Harston, Ms Ferguson and Mr Hindert The Washington meeting was principally concerned with examining the process of taxation reform which led to the United States Internal Revenue Code being amended to permit plaintiffs to receive compensation payments paid by means of structured settlements without incurring personal tax liability. Ms Ferguson described the taxation treatment of compensation payments in both the context of the United States as well as Australia and indicated what would be required to have similar reforms take place in Australia to those which occurred in the United States. Some of the practical problems associated with using structured settlements were also canvassed including the questions of whether arrangements should be mandatory and what should happen in the event of insurance companies becoming insolvent.

5.21 The final meeting took place in New York on 5 September 1996. Those present were Professor Roger Henderson of the University of Arizona Law School, Ms Larraine Gerelick, Director of Claims for Columbia Health Care Indemnity Inc., Mr Joseph Dehner, an Attorney at Law from Ohio, Mr Robert W. Waeger, Deputy Director of the Medical Professional Liability Department of the Pennsylvania Catastrophe Loss Fund, Ms Ferguson and Mr Hindert. The meeting was concerned with exploring the practical issues associated with adopting structured settlements in Victoria. After providing some general background material to the context of medical malpractice liability in the United States, the tort reforms adopted in the States of Ohio, Colombia and Pennsylvania were outlined. Reference was also made to other states which have periodical payment of judgements legislation such as Maryland and Wisconsin which have their own particular approaches.

5.22 The overall picture which emerged from these consultations was that the Uniform Periodic Payment of Judgments Act provides a comprehensive and detailed formula for the operation of structured settlements in the United States. Although the Act has not been adopted in its entirety in any jurisdiction to date, certain features have been relied upon in individual states. Examination of the Uniform Act provides a list of the essential issues which need to be addressed if similar legislation were to be introduced in Victoria, although some, such as the manner in which Attorneys' fees are paid, are not relevant to the situation in Victoria.

5.23 The benefits which can be obtained from adopting structured settlements were also canvassed in great detail and although quantitative evidence was not provided, other than an estimated forty per cent savings for insurers,[477] other benefits were clearly apparent such as providing fairer and more appropriate compensation for claimants while containing costs for health care providers and their insurers.

---

477 Evidence received in San Francisco on 16 Aug. 1996 and New York on 5 Sep. 1996. Precise figures were not available to justify this assumed saving.

5.24 One final, and important, area addressed in the meetings related to the need for an appropriately organised financial industry to exist to provide products to enable structured settlements to be workable. Insurers and those who provide re-insurance of liabilities need to be large and secure enough to ensure that on-going payments will be met over many years into the future. Judges and lawyers also need to be fully trained in the use and operation of structured settlements and periodical payments. As one of the American lawyers said:[478]

> Structured settlements have probably been one of the biggest factors in enabling us to predict losses and to pay them out in a more reasonable fashion. It has been a help to the defence and the insurance industry . . . in this state because of the tax benefits to the plaintiff. I think society benefits because it prevents the plaintiff from having a windfall which gets spent very quickly. It pays compensation as the plaintiff would have received it in a normal course of life and it is very hard to argue against the benefits of the periodical payments system. I think it has been very successful.

The Case for Reform

5.25 On the basis of the evidence received by the Committee, it is now possible to review the arguments in favour of reforming the current once-and-for-all system of lump sum compensation for the victims of injuries sustained through the use of health care services. Seven principal arguments should be considered.

Certainty

5.26 Payments of compensation made periodically or in accordance with some structured arrangement, clearly permit greater certainty to be present in determining the claimant's needs at various times in the future. In some systems, payments may be made for the remainder of the claimant's life, thus avoiding the need to rely upon actuarial tables or expert medical evidence in order to estimate the anticipated date of the claimant's death.

5.27 Where payments are linked to an index for inflation such as the Consumer Price Index, it is no longer necessary to estimate an appropriate rate of inflation for use in calculating a lump sum award of compensation for future economic loss. Not all structured settlement schemes make use of

---

478 Evidence received in New York on 5 Sep. 1996.

indexed payments and we have seen that structured settlements made in accordance with the provisions of the Uniform Periodic Payment of Judgments Act in the United States permit the tribunal of fact to make a determination of the rate of inflation applicable when calculating the structured award or to take inflation into account when determining loss.[479]

5.28 In addition, as Professor Luntz notes, where compensation for medical expenses is made periodically as and when the need arises, the problem of inflation will be overcome,[480] although in schemes which have an open-ended liability in respect of future medical expenses, the defendant or the defendant's insurer will be unable to know precisely the extent of the liability at the time the settlement is entered into.

Security

5.29 Where claimants have been seriously injured and need on-going care for the remainder of their lives, periodical payments represent security in terms of ensuring that income will be available throughout their lives for the payment of care and support costs. A regular, guaranteed flow of payments will provide claimants with security which they may be unable to achieve through the investment of a lump sum. Of course, structured arrangements which provide initial lump sums for the purchase of equipment, housing or home modifications would be appropriate when linked with subsequent on-going payments.

5.30 Safeguards are needed, of course, to ensure that the entity responsible for making on-going payments is solvent and will not encounter financial difficulties.[481] In the United States, examples have been given of large insurance companies having been wound up leaving the recipients of periodical payments without support. Adequate levels of security must, therefore be provided to ensure that only the largest and most reliable

---

479 Uniform Periodic Payment of Judgments Act, § 5; see D. W. Hindert, J. J. Dehner & P. J. Hindert, *Structured Settlements and Periodic Payment Judgments*, Law Journal Seminars Press, New York, 1996, para. 9.02[3].

480 H. Luntz,. *Assessment of Damages for Personal Injury and Death*, 3rd edn., Butterworths, Sydney, 1990, para. 11.5.2.

481 Victorian Bar Council, Submission no. 48.

institutions are responsible for the payment of compensation payments made on a periodical basis, whether as self insurers, insurers, or re-insurers.[482]

Reduced Liability

5.31 From the insurer's perspective, structured settlements which incorporate a periodical payment regime have been found to be preferable to lump sum awards in terms of reducing overall liability. This may arise owing to the insurer not having to pay compensation for future medical expenses and loss of earnings after the date of the claimant's death, unlike the case with a lump sum where compensation is based on an estimated life-span only. In addition, in Britain, it has been found that the taxation savings which accrue to the plaintiff are able to be used by insurers to negotiate substantial discounts when entering into structured arrangements.[483] In addition, insurers have indicated that they are able to cover their liabilities at a lower cost by not having to find a lump sum in advance,[484] although this would not be applicable where insurers purchase annuities or engage in re-insurance of structured settlements in which case the insurer would be required to pay out the full amount of the structured liability at the time of entering into the re-insurance arrangement.

5.32 In the submission made to the Committee from Benefit Designs International Inc.,[485] it was argued that, based on the United States experience, the adoption of periodical payment judgments and structured settlements would reduce the amounts of money paid in satisfaction of court awards of damages and settlement of claims. Cost savings were said to arise because of taxation planning benefits, reduction in liability through the purchase of annuities and because claims may be resolved more promptly. Depending upon the extent to which structured settlements are employed, it was argued that they may also have the effect of reducing the cost of professional indemnity contributions.

---

482 See Hindert et al., op. cit., para. 3.05[10].

483 England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages: A Consultation Paper*, Law Com No. 125, HMSO, London, 1992 (hereafter cited as 'Law Commission Consultation Paper'), para. 3.18.

484 Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: Final Report*, AGPS, Canberra, 1995, (hereafter cited as 'PIR Final Report'), para. 7.89.

485 Submission no. 18.

5.33 The Medical Protection Society, however, in its submission to the Committee considered that the introduction of structured settlements could, in the long term, be more expensive than lump sum awards. The Society, nonetheless, was willing to support their introduction for other reasons.[486] Similarly, the Victorian Bar Council considered that the introduction of structured settlements could increase the liability of defendants due to discounts for present payment and the vicissitudes of life not being available for periodical payments and the possibility that payments would be taxable in the hands of the plaintiff, thus resulting in awards having to be increased to account for this. Accordingly, the Bar Council concluded that professional indemnity contributions would be significantly greater were structured settlements to be employed.[487] The Medical Defence Association of Victoria also believed that structured settlements would not reduce the cost of claims to any significant degree, as the greatest proportion of costs are incurred with respect to the large number of very small claims dealt with, which would be inappropriate for structuring.[488]

Avoidance of Dissipation

5.34 One of the principal benefits of structured settlements and periodical payments of compensation is that they can reduce the likelihood that recipients of compensation will dissipate their compensation payments and not use them for the purposes for which they were awarded, such as the payment of on-going medical and nursing costs. If claimants receive payments periodically, there is an increased likelihood they will have sufficient compensation payments available to meet their requirements throughout the remainder of their lives, thus avoiding the possibility that they will need to rely upon government-funded social security. There is also the advantage that so-called 'double dipping' will be avoided, namely that the recipients of compensation will make use of government-funded services when they have already been provided with compensation payments intended to cover exactly the same needs.[489] Accordingly, a structured settlement could be said to achieve *restitutio in integrum* to a far greater extent than does a lump sum award made once-and-for-all.

---

486 Submission no. 36.
487 Submission no. 48.
488 Submission no. 58.
489 See PIR Final Report, op. cit., paras. 7.89 & 7.94.

5.35 The adoption of periodical payments and structured settlements does not, however, eradicate the problem of dissipation of awards and double-dipping as the recipients of periodical payments will still be in receipt of sums of money which may be used in any way. However, smaller sums are paid in a structured arrangement than in the case of a lump sum award, and this reduces the likelihood that the bulk of compensation payments will be used for purposes other than those for which they were intended. The payment of on-going medical and care costs as and when they arise would reduce the problem further, although insurers would be unlikely to enter into such arrangements in view of the difficulties associated with determining their liability at the date of the settlement. The English Law Commission, however, found that parents and carers who had the responsibility of caring for the needs of injured children and relatives, were very careful in determining how funds were spent.[490]

Flexibility

5.36 Settlements which incorporate a mixture of lump sums and periodical payments are a much more flexible vehicle for the payment of compensation than a lump sum in that the structured arrangements are able to be tailored individually to suit the needs of the claimant. Structured settlements may, therefore be closely linked to the changing needs and circumstances of the claimant such as when the individual's health significantly improves or deteriorates. Although the question of reviewing structured arrangements has been raised by many commentators,[491] there is always the possibility of restructuring settlements where circumstances change without altering the total extent of the insurer's liability.[492]

Sounder Financial Management

5.37 Although there is some evidence that the recipients of lump sum awards are able to manage their funds effectively,[493] there is clear evidence

---

490 England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages*, Report, Law Com. No. 224, HMSO, London, 1994 (hereafter cited as 'Law Commission Report'), paras. 4.2–4.8. See now: Social Security (Recovery of Payments) Act 1997 (c. 27) (UK),.para. 3.21.

491 Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: An Interim Report*, AGPS, Canberra, 1994 (hereafter cited as 'PIR Interim Report'), para. 4.169.

492 See Law Commission Report, op. cit., paras. 3.146–3.154.

493 England and Wales, Law Commission, *Personal Injury Compensation: How Much is Enough? A Study of the Compensation Experiences of Victims of Personal Injury*, Report, Law

that few recipients of lump sums seek out and make use of appropriate financial advice concerning the investment and management of their funds.[494] By paying a proportion of compensation monies periodically, claimants are given some formal structure for the receipt of their funds and are less likely to engage in incorrect investment and spending decisions. The interim report of the Professional Indemnity Review also noted that the receipt of periodical payments will mean that the claimant does not have the responsibility and worry of closely managing what may, in any event, be an inadequate lump sum, so as to achieve the highest possible future income.[495]

Encouraging Early Settlement

5.38 Finally, it has been argued that the use of structured settlements encourages the early and effective settlement of claims as the process of preparing a settlement will reduce the number of factual issues upon which the parties are unable to agree.[496] Negotiating the terms of a structured settlement is said to be less difficult in a case involving substantial sums than negotiating a lump sum as the parameters of negotiation are pre-determined (such as under the provisions of the Uniform Periodic Payment of Judgments Act of the United States).

Freedom of Choice versus Paternalism

5.39 One of the primary arguments which has been raised against the restriction of lump sum payments of compensation is that such restriction would erode the freedom of choice which litigants have to dispose of their settlement monies when and how they see fit. Requiring plaintiffs to receive payments periodically in out-of-court settlements is said to inhibit freedom of contract. Similarly, allowing courts to determine when and how damages are to be paid to claimants is said to amount to an unwarranted act of judicial paternalism.

5.40 There is also some evidence that recipients of compensation for personal injuries prefer to receive a lump sum as this conceptually is seen to

---

Com. No. 225, HMSO, London, 1994 (hereafter cited as 'Law Commission, Personal Injury Compensation'), pp. 258–9.

494 Commonwealth of Australia, Department of Health, Housing and Community Services, Review of Professional Indemnity Arrangements for Health Care Professionals, *The Health/Medical Care Injury Case Study Project*, AGPS, Canberra, 1993, .pp. 49–54.

495 PIR Interim Report, op. cit., para. 4.169.

496 Law Commission Report, op. cit., para. 3.10.

be paid in due satisfaction for their injury and their patience in waiting for the determination of their claim.

5.41 Against these views, it can be said that claimants who say that they prefer a lump sum award are not, in fact, making an informed decision with a full understanding of the alternatives available to them and the financial implications of a lump sum award. It is has been found that claimants who initially favoured a lump sum, changed their mind after a number of years when the funds remaining proved to be inadequate to meet their needs.[497]

5.42 Further, it can be argued that the community has an interest in ensuring that recipients of compensation do not dissipate their awards as this would result in their falling back on government-funded support. Accordingly, some paternalism on the part of the State may be needed to ensure that limited social security funds are available to meet the needs of those who have not received financial support from other avenues, such as professional indemnity insurance.

The Need for Legislation

5.43 Some have argued that the introduction of structured settlements and periodical payment of judgments is too difficult as it would require substantial amendment to both State and Federal legislation. Although legislative amendment may be desirable, particularly in order to clarify the taxation treatment of periodical payments, some reforms may be achievable without the need for legislation.

5.44 In the United Kingdom, for example, structured settlements were able to be introduced following an agreement entered into with the Inland Revenue which clarified those circumstances in which periodic payments would not be subject to income taxation.

Taxation

5.45 In Australia, some forms of structured settlements could be introduced under the existing taxation regime, or, indeed, if all personal injury payments were made taxable, by the recipients of payments suffering the burden increased taxation in return for the receipt of increased compensation

---

[497] Law Commission, Personal Injury Compensation, loc. cit.

entitlements. By inflating payments of compensation to take account of the taxation liability, recipients of compensation would not be worse off. This would, however, alter the revenue balance which exists between the States and the Commonwealth at present. Ideally, the question of how compensation payments are to be taxed should be legislatively resolved.[498]

5.46 At present, legislation would be needed to permit courts to award compensation periodically, although as we have seen, very few cases are concluded by a court award. The vast majority of claims are settled out-of-court and, depending upon the outcome of the taxation issue, these could be structured in any way agreeable to the parties.

Administration

5.47 Critics of structured settlements have referred to the absence of organisations willing to act as brokers, intermediaries and insurers willing to take on the administration and management of structured arrangements. It is said that the administration of periodical payments is costly and time consuming making them unattractive to insurance companies.[499]

5.48 There are also said to be no companies in Australia willing to offer structured arrangements to plaintiffs.[500]

5.49 In both the United Kingdom and the United States, these problems were also seen to be present when structured settlements were first introduced, although now in both these countries the industry has developed rapidly and a wide range of financial products are available.[501] Interest has already been expressed by a number of companies in offering structured settlements in Australia for motor vehicle compensation claimants and the Committee has heard that similar interest has been shown in the health care professional indemnity market.

5.50 These are, however, commercial rather than law reform issues. As long as the questions of security and accountability of organisations which offer

---

498 NSW Legislative Council, Standing Committee on Law and Justice, *Interim Report on the Inquiry into the Motor Accidents Scheme: Compulsory Third Party Insurance*, Report No. 3, Government Printer, Sydney, 1996, para. 10.2.7.

499 See Submission no. 19.

500 NSW Legislative Council, Standing Committee on Law and Justice, op. cit., para. 10.2.3.

501 See Hindert et al., op. cit., para. 1.03.

structured settlements are dealt with, there seem to be no reasons why structured settlements should not be introduced in the expectation that the financial industry will move into this field as and when the need arises.

Reviewability

5.51 A further difficulty relates to the problem of structured settlements being unable to be reviewed in some jurisdictions and, accordingly, unable to take account of changing circumstances in the claimant's life. This, it will be recalled, was one of the main problems with lump sum awards.

5.52 Structured settlements do, however, have greater flexibility and are able to predict with greater certainty than a lump sum award, the needs of claimants throughout their lifetime. The question which arises, however, is whether or not the structured arrangement should be able to be reviewed where the claimants' circumstances alter significantly from those relied upon at the time the agreement was entered into.

5.53 Insurers are said to be reluctant to enter into structured arrangements where this will not permit them to close their books and assess the full extent of their liability once-and-for-all. Where an insurer purchases an annuity, however, the extent of the liability of the insurer will be known and the responsibility for payments passed onto the life insurance company from which the annuity has been obtained.

5.54 The Law Commission considered various options to deal with this problem.[502] First, was the use of a contingency fund out of which additional unexpected claims by the plaintiff could be met. Secondly, the Law Commission examined the possibility of permitting the unexpended benefits of the original settlement to be restructured in such a way that an unexpected contingency could be accounted for without increasing the overall liability of the insurer. Finally, the Law Commission examined the possibility that further funds could be paid to the claimant, upon application to the court. In view of the taxation problems associated with allowing reviewable structured settlements and the general lack of enthusiasm for the idea by the insurance industry, the Law Commission decided against allowing provision for review

---

[502] Law Commission Report, op. cit., paras. 3.146–3.154.

by way of introducing new funds. It did, however, endorse review by way of simple restructuring of agreements where no new funds would be provided.

5.55 The Professional Indemnity Review also considered the question of reviewability of structured settlements and noted a number of practical and legal difficulties involved. These included the fact that the extent of an insurer's liability would be open-ended and the administrative problems associated with negotiating changes in agreements.[503] In a small selection of appropriate cases, however, it is likely that such problems would not be insurmountable.

---

[503] PIR Interim Report, op. cit., para. 4.185.

6 COMPENSATION PAYMENTS: THE CASE AGAINST REFORM

6.1 This chapter reviews the arguments against the introduction of reforms to the manner in which compensation is paid to persons injured through the use of health services in Victoria. It identifies the non-taxability of lump sum payments as the principal reason for the retention of the current system for paying compensation. It will look at the relevance of taxation to the calculation of damages. It examines the likely tax treatment of payments made under the various reform options put forward in this report. It will examine the extent to which it may be necessary for the Federal Government to amend the *Income Tax Amendment Act 1936* (Cwlth) to ensure fair and adequate compensation for persons injured through the use of health services.

The Case for Retaining the Current System of Compensation

6.2 A summary of the reasons for retention of the once-and-for-all rule is given in Chapter 3 of this report.[504] It is proposed to deal more fully here with the arguments for retention. Several of the arguments were identified in the Law Reform Committee's Issue Paper No. 1.[505] It will be noted that many of the arguments favouring lump sum payments over periodic payments are in fact countered by the recommendations made in this report.

[504] See para. 3.22. Reference is made to H. Luntz,. *Assessment of Damages for Personal Injury and Death*, 3rd edn., Butterworths, Sydney, 1990, paras. 1.2.18–1.2.28. Further summaries of the reasons for retention of the once-and-for-all-rule are to be found in England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages: A Consultation Paper*, Law Com No. 125, HMSO, London, 1992, paras. 2.3–2.4 and the NSW Law Reform Commission, *Accident Compensation: Traffic Accident Case Studies*, Research Paper 1, .NSW Law Reform Commission, Sydney, 1984, paras. 3.11 & 3.12 referred to in D. Booth,. 'Lump Sum Verdicts and Compensation for Future Care', paper presented to the Australian Insurance Law Association Conference on 'Structured Settlements Better Ways of Compensating Catastrophic Injuries', Sydney, Jul., 1994, pp. 3–5. And see also R. Lewis, *Structured Settlements – The Law and Practice*, Sweet & Maxwell, London, 1993, ch. 7.

[505] Parliament of Victoria, Law Reform Committee, *Legal Liability of Health Service Providers: Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996, para. 2.25.

Finality in Litigation

6.3 There is a need for finality to litigation. The Report of the Chief Justice's Law Reform Commission on Damages by way of Periodical Payments presented on 14 March, 1968 stated that as[506]

> a matter of expediency there is obviously much to be said for the application of the (once-and-for-all) principle. If actions could be continually re-opened after judgment there would be no end to litigation and the clutter in the courts would become intolerable.

6.4 There can be little doubt that the Courts (and those responsible for the resources of the Courts) have a legitimate interest in ensuring that any claim for compensation is dealt with in the most expeditious and cost effective way. That argument is even more pressing today than in 1968. Any option for reform which increases the work of the Courts in relation to the award of compensation is to be discouraged. This will include any option relating to the award of interim damages, as this necessarily contemplates the consideration by the Courts of compensation on at least two occasions. It carries with it costs incurred by both parties in respect of two or more hearings. This is not to be confused with the splitting of trials to allow liability to be determined separately from the amount of damages which can be quite advantageous in many cases.[507]

6.5 The case for finality in litigation is put succinctly in the Law Commission Consultation Paper. It will be noted that some matters referred

---

[506] Victoria, Chief Justice's Law Reform Committee, *Report on Damages by way of Periodical Payment*, Melbourne, 14 Mar. 1968, p. 2. The impact upon the business of the Court is made event more forcefully at p. 7 as the main factor in favour of lump sum damages. This was rejected by Professor Luntz in his dissenting report annexed to the majority report; greater certainty in the award of damages might discourage litigation (at p. 4 of the dissenting report).

[507] In England and Wales, as the result of the report of the Winn Committee on Personal Injuries Litigation the Rules of the High Court were amended to allow personal injuries cases to be split and to allow interim payments to plaintiffs.(See United Kingdom, *Report of the Committee on Personal Injuries Litigation*, Cmnd 3691, HMSO, London, 1968). The Rules of the Supreme and County Courts of Victoria allow liability and damage to be heard at different times where it is just and convenient to do so: see Supreme Court Rules Order 47.04. And see generally paras. 4.75–4.85 on the question of interim damages in the United Kingdom.

to may be subsumed under other factors which warrant the retention of lump sum awards. The Commission said:[508]

> The fact that lump sum awards bring finality to litigation has already been mentioned. Such finality creates a degree of certainty where there has been uncertainty and allows all parties involved to look to the future instead of the past. The plaintiff can devote full energy to rehabilitation and the defendant (usually an insurer) can close the file and accurately assess all costs. Premiums can be adjusted and policy cover altered if necessary, such decisions informing the public of the true costs of risk-spreading. The administrative resources of the justice system are released for the use of the parties next in line. The lump sum payment is simple and does not need to be policed because there is no need for the plaintiff to be monitored. All cost and expense associated with the dispute cease. The plaintiff is also protected from the possibility of the defendant later becoming insolvent. The state, the public, insurers and individual plaintiffs and defendants have a legitimate interest in such certainty and finality of litigation.

The Effect of Lump Sum Compensation upon the Plaintiff's Well-Being

6.6 The effect of a lump sum payment upon the plaintiff's well-being is referred to in the passage from the Law Commission Consultation Paper referred to in paragraph 6.5. Professor Luntz reviews the literature on the objection to periodical payments based on ‘compensation neurosis’ and the argument that receipt of lump sum compensation is likely to assist the plaintiff's rehabilitation.[509] He notes that there are few studies that actually determine what happens after settlement. It should be emphasised, however, that there is evidence, referred to in Professor Luntz's work, which supports a correlation between lump sum compensation and the rehabilitation of the plaintiff.[510]

6.7 The receipt of a lump sum payment enables a plaintiff to undertake a change in lifestyle. This is a matter referred to in the New South Wales Legislative Council's Standing Committee on Law and Justice's Interim Report on the *Inquiry into the Motor Accidents Scheme: Compulsory Third Party Insurance*, Report No. 3.[511] For example, the plaintiff can discharge his or her mortgage or set up in business. The plaintiff might wish to move to another country to take advantage of educational or business opportunities there.[512] ‘Financial autonomy could be seen as having a psychological effect in helping

---

508 Law Commission Consultation Paper, op. cit., para. 2.3.

509 Luntz, op. cit., paras. 1.2.21 & 1.2.22.

510 ibid.

511 op. cit., p. 153.

512 This is a particular example given in the Law Commission Consultation Paper, op. cit., para. 3.21.

restore the confidence of accident victims who perceive and experience a loss of control over their lives.'[513] This is something which the plaintiff may not obtain through periodic payments.

Lump Sum Payments Secure Freedom of Choice for Plaintiffs

6.8 The fact that a plaintiff should be entitled to complete freedom of choice in relation to the means by which he or she is compensated for personal injury is allied to the question of ability to use the payment of compensation as he or she wishes discussed in paragraph 6.7. The matter is discussed by Professor Luntz. He notes that a plaintiff's preference for lump sum compensation is effectively limited by the social security legislation. No longer can a plaintiff use a lump sum payment to acquire a house and other assets, or discharge a mortgage and then apply for social security payments.[514] The *Social Security Act 1991* (Cwlth) imposes a preclusion period, that is, a period after the award of compensation within which an injured person is precluded from receiving social security benefits. Indeed, recent changes to that Act which apply to compensation received on or after 20 March, 1997, effectively extend the preclusion period.[515] The plaintiff's freedom of choice is thus effectively limited. The plaintiff cannot expend the lump sum and draw social security.

6.9 Freedom of choice carries with it the notion that the plaintiff should be at liberty to invest compensation as he or she thinks fit. It has been noted that while 'this view recognises that a skilful investor could do extremely well, it accepts and indeed attaches importance to the idea that a person should also be quite free to be unskilful, negligent or even a non-investor'.[516]

6.10 Reference has been made in this report to the study of the English Law Commission in relation to the compensation experiences of victims of personal injury.[517] Importantly, for present purposes, the Commission was able to conclude that respondents to the survey had shown great prudence in the management of settlements; there was a strong preference for lump sum payments; the majority (60%) of victims showed a preference for freedom of

---

513 ibid., para. 2.5.
514 Luntz, op. cit., para. 1.2.24.
515 See `Lump Sum Compensation Payments to Change' (1997) 35 *Law Society Journal* 22.
516 Law Commission Consultation Paper, op. cit., para. 2.4.
517 See paras. 3.43–3.46.

choice.[518] It is appreciated that this study may be of limited value in the context of the present report, however, it appears to provide the only empirical evidence in relation to the question of freedom of choice and investment of compensation. Again, the effect of the social security legislation on the ability of the recipient to dissipate lump sum compensation should not be underestimated. Clearly a lawyer will be negligent for failure to advise a client of the consequences of dissipation of a lump sum compensation payment.

The Lump Sum Payment is an Accurate Measure of the Plaintiff's Loss

6.11 No means for measuring a plaintiff's loss can be entirely accurate as there is necessarily a degree of forecasting involved in any process adopted for measuring loss. In calculating a lump sum the Court takes account of future contingencies notwithstanding the difficulty of doing so.[519] The Court needs to establish the present value of future loss. The approach of the Court involves assumptions as to investment of damages and the plaintiff's life expectancy. There is nothing to suggest that any structured arrangement will give rise to greater accuracy in securing the plaintiff's economic future.[520] It is fair to say, however, that such an arrangement can perhaps take better account of economic factors and life expectancy.[521]

Increased Costs Associated with any Structured Arrangement

6.12 At present any costs associated with investment of lump sum compensation are met by the plaintiff and would be deductible as outgoings against investment income under s 51(1) of the *Income Tax Assessment Act 1936* . It is the plaintiff who will be responsible for costs associated with investment and who will bear those costs.

---

518 England and Wales, Law Commission, *Personal Injury Compensation: How Much is Enough? A Study of the Compensation Experiences of Victims of Personal Injury*, Report, Law Com. No. 225, HMSO, London, 1994, para. 10.17.

519 In Luntz, op. cit., para. 1.2.10 there is a discussion of the difficulty of assessing future contingencies. Professor Luntz points out that one of the difficulties is determining how long a seriously injured plaintiff will live (*Skelton v. Collins* (1966) 115 C.L.R. 94) and see his dissenting opinion annexed to the Report of the Chief Justice's Law Reform Committee on Damages by Way of Periodical Payment, op. cit., p. 4.

520 See the Chief Justice's Law Reform Committee Report, op. cit., p. 4: 'Whether [the] award is by way of lump sum or periodic payment the future is equally obscure and the award of a periodic payment is not calculated to do either plaintiff or defendant greater justice or injustice.'

521 The point is made in the Law Commission Consultation Paper, op. cit., para. 3.19.

6.13 In the case of a structured arrangement, neither the United Kingdom model whereby the defendant's insurer purchases an annuity from a life insurer,[522] nor a model based upon investment of moneys by a Court officer are free of cost, direct or indirect. In the former case there will be administrative costs associated with the ongoing implementation of the arrangement, for example, accounting costs and costs associated with fulfilling obligations to the Tax Office. In the latter case there will clearly be some real cost associated with the investment of moneys resulting from the use of Court resources. Questions will arise as to who should bear these costs. Obviously, the simpler the arrangement the less costly the administration associated with it.

Taxation

Introduction

6.14 Obviously the most important argument in favour of retention of lump sum compensation is the non-taxability of such compensation as a receipt on capital account[523] and the likelihood that any periodic payment of taxation will attract an income tax liability except where clearly a payment of capital. This appears to be the conclusion reached by Coopers & Lybrand in their report to the Review of Professional Indemnity Arrangements for Health Care Professionals (PIR).[524]

6.15 It is important initially to consider the relevance of taxation to the calculation of damages. The plaintiff's loss of earnings are to be assessed net of tax. Australian Courts apply the decision of the House of Lords in *British Transport Commission v. Gourley*;[525] damages are to be reduced for both future and past loss of earnings after allowance for taxation on the lost earnings.[526] The principle is given statutory effect in Victoria by the *Wrongs Act 1958* (Vic.) s. 28A.

---

522 See para. 6.35 below.

523 The rationale for non-taxability will be discussed in para. 6.17 below.

524 Commonwealth Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Report on Taxation Treatment of Compensation Payments*, AGPS, Canberra, 1995, (hereafter cited as 'the Coopers & Lybrand report'), paras. 1.2 & 4.4.7.

525 [1956] A.C. 185.

526 *Cullen v. Trapnell* (1980) 146 C.L.R. 1.

6.16 It can be concluded that the calculation of damages for lost earnings on a net tax basis combined with the treatment of lump sum compensation as a receipt on capital account effectively deprives the Revenue of taxation. The Revenue gains nothing from the notional deduction of tax from lost earnings in the calculation of damages.

Why Lump Sum Damages are Non-Taxable

6.17 Professor Luntz examines the reasons why damages for personal injuries are non-taxable.[527] First, they do not constitute an 'indemnity' within the meaning of that word in section 26(j) of the *Income Tax Assessment Act 1936* (hereafter referred to as 'the Act'). That section seeks to impose a liability to taxation on an amount received by way of insurance or indemnity in respect of income which would have been assessable. Secondly, they do not represent income at least to the extent that they represent loss of earning capacity, a capital item, and the fact that they are calculated by reference to loss of earnings does not destroy their character as capital.[528] Thirdly, and perhaps most significantly, the fact that they are awarded as a lump sum, that is, it is difficult to extricate compensation for losses on revenue account from those on capital account, is such as to make the whole payment non-taxable.[529] This appears to be settled law in Australia. In the United Kingdom apportionment is considered appropriate.[530]

Statutory Interest is Taxable

6.18 In all Australian jurisdictions there is statutory provision for the award of interest on moneys recovered by a plaintiff for the pre-judgment period. The recent decision of the Federal Court in *Whitaker v. Commissioner of Taxation*[531] establishes that statutory interest awarded on a judgment for damages for personal injury is assessable income under section 25(1) of the Act even though the statutory damages could not be regarded as an item separate and discrete from the judgment.[532] *Whitaker*[533] was a case involving a

---

527 Luntz, op. cit., para. 5.7.4. He notes the statement of Gibbs J in *Atlas Tiles v. Briers* (1978) 144 C.L.R. 202, 223: 'The Commissioner will not attempt to assess tax on awards of damages for personal injuries. He is never likely to do so while the law remains as it is.'

528 See R. W. Parsons, *Income Taxation in Australia*, The Law Book Company, Sydney, 1985, para. 2.542.

529 *McLaurin v. DCT* (1961) 104 C.L.R. 381; *Allsop v. FCT* (1965) 113 C.L.R. 341. And see Parsons, op. cit., para. 2.558.

530 See *Tilley v. Wales* [1943] A.C. 386.

531 (1996) 96 A.T.C. 4,823, Hill J.

532 See the recent discussion by B. Pape, 'Taxation of S. 94 "Interest"',(1997) 35 *Law Society Journal* 55. *Whitaker* concerned interest under section 94 of the *Supreme Court Act 1970*

New South Wales judgment for personal injuries.[534] In New South Wales the general form of judgment makes no separate provision for statutory interest; it simply forms part of the award of damages generally.[535] It might be argued from this that *Whitaker*[536] was wrongly decided on the basis that the statutory interest cannot be dissected from the judgment of which it forms part. It should be noted that, in Victoria, the general forms of judgment at trial also appear to contemplate one judgment for damages.[537] In the United Kingdom interest on damages for personal injuries is not assessable as income.[538]

6.19 An appeal has been filed in respect of the decision in *Whitaker*.[539] The appeal was argued before the Full Federal Court on 19 February, 1997. Judgment has been reserved. The Full Court's judgment may throw some broader light upon the question of what, if any, part or parts of a lump sum compensation payment for personal injuries are assessable to income tax. If the appeal by the taxpayer is successful then the principle in *British Transport Commission v. Gourley*[540] may apply so that net statutory interest only is brought to account in calculating a plaintiff's damages.[541]

6.20 Damages for personal injury do not attract a liability for capital gains tax: see section 160ZB(1) of the Act.

6.21 In conclusion, the recipient of a lump sum payment of damages for personal injuries will receive that sum free of tax save for a liability to tax in respect of statutory interest awarded by the Court, if the decision in *Whitaker*[542]is upheld.

(NSW). The author expresses the view that if such interest, that is interest on damages from the date of accrual of the cause of action (in Victoria from the date of commencement of proceedings: see section 60 of the *Supreme Court Act 1986* (Vic.)), is assessable then loss of past income should be assessable to taxation (at p. 57).

533 ibid.

534 The original judgment was the subject of an appeal to the High Court on the liability of medical practitioners: see *Rogers v. Whitaker* (1992) 175 C.L.R. 479.

535 See B. Pape, op. cit., p. 55.

536 (1996) 96 A.T.C. 4,823.

537 See e.g., Form 60E (Judgment at Trial by a Jury) in the Supreme Court scheduled to the General Rules of Procedure in Civil Proceedings 1996.

538 See Income and Corporation Taxes Act 1988 (UK) s. 329.

539 (1996) 96 A.T.C. 4,823.

540 [1956] A.C. 185.

541 This is the view expressed by B. Pape, op. cit., p. 56.

542 (1996) 96 A.T.C. 4,823.

Proposed Taxation Changes to Treatment of Lump Sum Payments

6.22 On 23 July, 1996, the Australian Tax Office released Pre-Ruling Consultative Document No 10 ('the PCD') on the topic 'Income tax: how are compensation or damages payments for personal wrong and injury treated under sub-section 25(1) and paragraphs 26(e) and 26(j) of the *Income Tax Assessment Act 1936* (Cth.)?' The PCD replaces a Draft Tax Ruling TR 94/D20 issued in May, 1994.

6.23 The PCD states that the document is designed to initiate discussion and consultation and to obtain comments. It states that PCDs are not statements of the views of the Tax Office. Nonetheless, in paragraph 6.1 of the PCD it is stated that the Tax Office does have a view in relation to amounts received in respect of loss of earning capacity, interest (including pre-judgment interest) and dissected and undissected lump sums, paid as a single sum or by instalments. Paragraph 8.2 is said to express the current view of the Tax Office. That paragraph is to be read with the Appendices to the PCD.

6.24 Whilst it is by no means clear from the document what might be the precise views of the Tax Office in relation to lump sum payments having regard to the status of the document and the ambiguity of language in it, it would appear that the Tax Office will seek to dissect lump sum payments previously regarded as capital payments on the basis that income and capital items could not be dissected or apportioned, and to bring to account so much of the payment as represents economic loss, as opposed to loss of earning capacity, loss of amenity of life and loss of expectation of life, which will continue to be regarded as received on capital account.[543]

6.25 The effect of any Ruling which exposes some element of a lump sum compensation payment for personal injuries to tax will be for plaintiffs to 'gross up' their claim to take account of any liability to income tax. The direct effect of this will be to increase the compensation burden for insurers, with increases in premium, and, in the particular context of professional indemnity in health care, will increase the cost of health care to the States which operate the public health system.

---

[543] So as to overcome the decisions in *McLaurin v. FCT* (1961) 104 C.L.R. 381 and *Allsop v. FCT* (1965) 113 C.L.R. 341.

6.26 Enquiry made of the Tax Office has revealed that it proposes to publish an Issues Paper in June or July, 1997. This will be available publicly and will set out issues raised in submissions received by the Tax Office. It would appear that ultimately a series of Rulings will be issued dealing with a range of matters relating to the award of compensation. It is not possible to predict the nature and scope of those rulings.

Taxation of Structured Settlements and other Structured Arrangements

The Work of the Professional Indemnity Review

6.27 Reference has been made to the Coopers & Lybrand report commissioned by the Commonwealth Department of Human Services and Health's Review of Professional Indemnity Arrangements for Health Care Professionals ('the PIR').[544] In Chapter 4 of that report, Coopers & Lybrand examine the current tax regime in relation to compensation payments. They examine the legislation and the Tax Office Rulings and determinations. Their analysis supports the view that an undissected lump sum payment by way of compensation for personal injuries is non-taxable, whereas the receipt of periodic compensation payments will normally be assessable except to the extent that the payments are in respect of a capital item such as loss of earning capacity.[545] That view is largely based upon Draft Taxation Ruling TR 94/D20. That Ruling has been withdrawn by the PCD.[546]

6.28 The PIR concluded in its Final Report, having referred to the Coopers & Lybrand report, that the complexity and uncertainty as to whether periodic payments might attract a liability to taxation provided a significant disincentive to the use of structured settlements.[547] The PIR suggested that there be a clear ruling given by the Tax Office covering the tax treatment and characteristics of structured settlement products as a first step to their broader use.[548]

---

544 Para 6.14, above.

545 See the Coopers & Lybrand report, para. 4.4.7.

546 See para 6.22 of this report.

547 Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: Final Report*, AGPS, Canberra, 1995 (hereafter cited as 'the PIR Final Report'), para. 7.99

548 ibid. And see Recommendation 105 in the PIR Final Report.

6.29 The PIR Final Report was published prior to the release of the PCD.[549] The PCD leaves completely open the treatment of amounts received pursuant to structured settlement arrangements, but poses such questions as whether a periodic payment made directly by an insurer as compared to an annuity purchased by an insurer should receive different treatment[550] and whether an allowance made to preserve the value of the compensation payment, for example, where payments are indexed for inflation, is to be treated as capital or income.[551]

6.30 Clearly a broad exemption from taxation of payments received under a structured settlement or other structured arrangement will encourage an injured person to adopt such arrangement.[552] Significantly, the Standing Committee on Law and Justice of the New South Wales Legislative Council has also recommended that the New South Wales Government state its support to the Commonwealth Government for the non-taxable status of structured settlements. [553] Any component of a periodic payment which is in respect of non-pecuniary loss should clearly be tax exempt, as should any part of the payment which represents future loss of earning capacity. This will ensure similar treatment to that presently afforded to lump sum payments.[554]

6.31 There must exist some doubt that the question of taxation of compensation payments for personal injury can be resolved by any Ruling of the Tax Office. Legislation would appear to be the only solution, although one cannot be confident that the Commonwealth Government will act to exempt all compensation for personal injury from taxation. Any Commonwealth Government attempt to impose a greater taxation burden upon the receipt of

---

549 See para 6.22 of this report.

550 This raises questions as to the United Kingdom experience in relation to structured settlements discussed below.

551 See para. 6.2 of the PCD.

552 Coopers & Lybrand report, para. 5.5.3. The authors of the report put forward a number of options to secure tax relief and state that they regard an exemption by way of rebate as an alternative to specific exemption from tax: see para. 5.4.2.

553 op. cit., p. 152

554 Of course, in the case of undissected lump sum payments, no part of the lump sum will be taxable.

compensation will almost certainly lead to larger settlements and awards of compensation.

6.32 If compensation payments received under a structured settlement or other structured arrangement are taxable in the hands of the plaintiff, then any costs associated with managing periodical payments should and would be deductible as expenses incurred in deriving income under s. 51(1) of the *Income Tax Assessment Act 1936*.

6.33 In the case of moneys invested through the Senior Master of the Supreme Court or the Registrar of the County Court, all beneficiaries are regarded as persons presently entitled for the purpose of s. 99A of the *Income Tax Assessment Act 1936* , that is, as persons liable to tax. Provided that income generated on money invested by the Court exceeds the tax threshold of $5,400.00, the Master or Registrar will deduct tax at the relevant marginal rate and forward this to the Commissioner of Taxation. The Master or Registrar would not be responsible for remitting tax on compensation payments made pursuant to a structured settlement or other structured arrangement in the absence of some withholding tax provision.

6.34 It remains to say something of the United Kingdom approach to the structured settlement and to the tax treatment of periodic compensation payments made under structured settlements there.[555]

---

[555] For a complete discussion of structured settlements in the United Kingdom see R., Lewis, op. cit., *passim*.

6.35 In the United Kingdom the defendant's insurer remains liable to the plaintiff under the structured settlement. The insurer will purchase an annuity from a life insurance company. The life insurance company will deduct tax from the payments which it makes to the defendant's insurer. The defendant's insurer is obliged to pay the gross amount of compensation payable under the structured settlement to the plaintiff, but is ultimately able to claim the 'top up' as a deduction against tax. Any payment by the life insurance company to the plaintiff direct would attract a liability to tax in the plaintiff.[556] It should be noted, however, that recent legislation in the United Kingdom has the effect of enabling a payment to be made by the life insurance company to the defendant's insurer so that the insurer incurs no liability to tax.[557] The United Kingdom Parliament has made provision for the award of damages by way of periodic payment with the consent of the parties.[558] It has also made provision to secure the plaintiff's entitlements in the event of insolvency.[559]

6.36 Current uncertainty as to the tax treatment of structured settlements in Australia make it difficult to predict whether the United Kingdom model would ensure that payments received by a plaintiff were received as capital.

Conclusion

6.37 Until such time as there is a degree of certainty as to the tax treatment of payments made under structured settlement arrangements, they cannot be attractive to persons injured as the result of services provided by a health service provider. An injured plaintiff will inevitably opt for lump sum compensation. The current consultative process of the Tax Office in relation to the treatment of compensation payments would not appear to contemplate

---

556 The United Kingdom model is explained in a discussion paper prepared by D. Colenbrander entitled 'Tax Implications of Introducing the UK Structured Settlements Model into Australia', 26 October, 1995. See also the Case study prepared by D. Guenther based upon the Colenbrander paper entitled 'Case Study: The Application of structured Settlements using the UK Model'.

557 Finance Act 1996 (UK), ch. 8, sch. 26. This obviates a cash flow problem which arises where the insurer is bound to top up the plaintiff's claim and then wait until it is entitled to claim the top up by way of deduction.

558 Damages Act 1996 (UK).

559 ibid.

legislation which will make payments of compensation for personal injuries tax-exempt. The inevitable result would appear to be the continuation of lump sum compensation.

7 Compensation Payments: the Preferred Approach

Introduction

7.1 This chapter considers the nature of the reforms which could be introduced in Victoria to improve the manner in which compensation is paid to individuals who are injured through the use of health services. It will examine the issues in a number of sections. Two preliminary matters will be examined first. An assessment will initially be made of the relevance of schemes which regulate the manner in which compensation is paid in other countries, in order to determine whether Victoria should adopt schemes which operate in other countries in full or in part. This will be followed by consideration of the question of the taxation of compensation payments.

7.2 A brief overview of the reform proposals will then be presented. This will be followed by an examination of how compensation for specific heads of damage should be paid starting with past losses and then considering future losses. The particular problem of compensation of future pecuniary losses will then be examined in depth. The issues and proposed reforms will be presented separately in respect of court-awarded damages and out-of-court settlements. Finally, consideration will be given to the extent to which the reforms recommended should be applicable to the payment of compensation in contexts other than relating to injuries suffered through the use of health services.

The Adoption of Overseas Schemes

7.3 Victoria's tort-based compensation system has its roots in English common law, as do the systems which operate in the United States and Canada. Victoria also shares many of the characteristics which relate to the payment of compensation in both the United Kingdom and the United States. Some aspects of taxation law and government-funded compensation schemes raise essentially similar issues. Persons injured through the use of health services in Victoria also seek compensation for many of the same reasons as in other countries.

7.4 There are, however, some important differences between the situation as it exists in Victoria and certain overseas jurisdictions. First, the size of the problem is considerably smaller in Victoria, as compared with the United States or the United Kingdom. In Victoria, relatively small numbers of cases of medical negligence are litigated annually. It has been estimated that no more than twenty-five medical negligence cases go to verdict each year in Australia, accounting for less than two per cent of all claims issued.[560] At 30 June 1993, the Medical Defence Association of Victoria, for example, had a liability of only $14,544,000 in respect of outstanding claims.[561] Of the 65,000 people who receive lump sum compensation in Australia in respect of all types of claim, not just health care, fewer than 3,300 receive money for loss of future income and of these, fewer than 500 receive compensation for future care needs.[562] Thus, the adoption of a system such as that which exists in the United States Uniform Periodic Payment of Judgments Act, designed to deal with substantially larger numbers of cases, may not be necessary in a jurisdiction such as Victoria.

7.5 Secondly, the health insurance systems which operate in Victoria raise issues of a different nature from those which apply in both the United Kingdom and the United States. Structured Settlements have been made possible in both these countries largely through governments deciding that periodical payments are to be non-taxable in certain circumstances. It would require the adoption of a similar perspective by the federal government to permit a structured settlement regime to operate effectively throughout Australia.

---

560 P. Henderson, 'Medical Negligence: The Plaintiff's Perspective', (1996) 70(8) *Law Institute Journal* 24, 27.

561 J. Walsh & J. Skinner, *Report on Medical Professional Indemnity Arrangements for Health Care Professionals for the Review of Professional Indemnity Arrangements for Health Care Professionals*, AGPS, Canberra, 1994 para. 6.2.3.

562 See Commonwealth of Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: Final Report*, AGPS, Canberra, 1995, (hereafter cited as 'PIR Final Report'), para. 7.96.

7.6 Thirdly, it has taken over twenty years for the structured settlements industry to develop in the United States including the establishment of government approved insurance companies and approved brokers and intermediaries. The judiciary and the legal profession in the United States have also been educated as to the benefits of structured settlements and the appropriate circumstances in which they should be used. In the United Kingdom, these developments are only starting to occur, and other jurisdictions in Australia have had only limited experience of structuring settlements and periodical payment of compensation in the limited circumstances in which they are available. This provides an opportunity for Victoria to be innovative in offering a workable solution to a complex problem, but also carries the danger that too radical a reform package may be challenged by the various legal and medical professional organisations involved.

7.7 Fourthly, the legal profession in the United States is remunerated in a manner different from that which operates in Victoria. A number of the characteristics of structured settlements have been devised with the allocation of legal costs in mind, and particularly the payment of contingency fees. It would not, therefore, be appropriate to adopt the Uniform Periodic Payment of Judgments Act in its entirety in Victoria.

7.8 Fifthly, the professional indemnity arrangements which exist in Australia and the United Kingdom in respect of the provision of private health services are different from those which exist in the United States. In the United States, indemnity is provided through insurance whereas in Australia and the United Kingdom mutual funds and medical defence organisations provide professional indemnity for health care providers who are outside the public health care system. In the United Kingdom the mutual funds and defence organisations operate in such a way as to make structured settlements unattractive for taxation reasons and the same may occur in Australia unless the taxation office makes the taxation treatment of structured settlements and

periodical payments offered by these organisations as attractive as for insurers which operate in the public health care sector.[563]

7.9 Finally, the nature of government-funded health care and private health insurance varies considerably between the countries examined. This has profound implications where payments fail to compensate claimants adequately. Without government-funded support, individuals who find themselves without adequate compensation to meet their needs may be required to fall back on the charity of their relatives and friends, or, as sometimes occurs, to realise their assets or to live in deprived conditions.

The Taxation of Compensation Payments

7.10 One of the principal impediments to the establishment of a compensation regime other than on a once-and-for-all lump sum basis, is the liability of payments of compensation to taxation. We have seen that there is a possibility that periodical payments of compensation and payments made pursuant to structured settlements may not be subject to taxation if paid in certain ways. At present the position is unclear, which is why the Professional Indemnity Review called for a definitive ruling on the matter from the Australian Taxation Office.[564]

7.11 We have also seen that there would be considerable fiscal benefits if the government were to declare all compensation payments, howsoever paid, to be non-taxable. This is the position which has been achieved in the United States, whilst in the United Kingdom, payments made in accordance with approved structured judgments are also non-taxable. The benefits to the Commonwealth government arise out of savings in the payment of income support to claimants who dissipate or lose their lump sum payments and are required to make use of government-funded support. By making compensation payments periodically, there is less likelihood that payments will be used other than for the purposes for which they were intended as compensation.

---

563 See England and Wales, Law Commission, *Structured Settlements and Interim and Provisional Damages*, Law Com No. 224, HMSO, London, 1994, (hereafter cited as 'Law Commission Report'), para. 3.54.

564 PIR Final Report, op. cit., para. 7.99.

7.12 If payments of compensation remain taxable, this may have the effect of increasing awards of compensation to take into account the increased liability for taxation. This would mean, in the health care context, that those liable for the payment of compensation would suffer an increased liability. In the case of publicly-funded health care, the state government would incur an increased liability in respect of its professional liability insurance payments which would need to be increased to cover the additional sums paid in respect of taxation. In the case of privately-funded health care, individual practitioners would incur an increased liability in respect of their professional indemnity contributions paid to the mutual funds which would need to increase contributions to take account of the additional sums paid in respect of taxation.

7.13 The Committee is of the opinion that compensation payments made in respect of future loss of earning capacity and future care costs are capital in nature and, as such, should not be taxable, regardless of the manner in which they are paid, whether by lump sum, periodical payments, or some combination of both. The benefits to the community in declaring this to be the law would be far-reaching and would tend to assist claimants, health care practitioners, insurers, mutual funds, state and territory governments, and even the Federal Government. The Committee believes that the *Income Tax Assessment Act 1936* (Cwlth) should be amended accordingly.

Recommendation 6

The Victorian Government should ask the Commonwealth Government to amend the* Income Tax Assessment Act 1936 *(Cwlth) to provide that payment of compensation, including by way of structured judgments and settlements, for personal injuries are non-taxable in the hands of the payee.

Overview of the Proposed Scheme

Court-Awarded Payments

7.14 The Committee has sought to devise a scheme for the payment of compensation for individuals injured through the use of health services which is appropriate to the specific concerns of Victorians. Accordingly, although the systems which operate in various overseas jurisdictions have provided valuable insights, the Committee believes that no single scheme already in

operation meets all of the requirements which led to the establishment of the current inquiry.

7.15 The Committee wishes to alter the current system of court-based compensation as little as possible and, accordingly, makes no recommendations for changing the manner in which compensation is paid in respect of past losses which are quantifiable at the date of assessment.[565]

7.16 In certain circumstances, payments of compensation may need to be made prior to a final assessment taking place, and the Committee believes that the courts should be able to award interim payments in certain limited circumstances.

7.17 In addition, where a claimant's injuries have clearly not stabilised, it would be appropriate for courts to be able to award provisional payments of compensation, with a limited right for plaintiffs to apply to the court for a further award of damages should specified changes take place in their condition. It should be possible for payments made in respect of both future pecuniary loss as well as future non-pecuniary loss to be paid provisionally.

7.18 Apart from those situations in which interim or provisional damages may be awarded, damages for injuries suffered through the use of health services should be paid by way of a lump sum in all cases and in respect of all heads of damage where the amount assessed in respect of future pecuniary losses does not exceed $50,000, a sum which should be subject to indexed review.

7.19 In cases where the amount assessed in respect of future pecuniary losses exceeds $50,000 but does not exceed $500,000,[566] the court should be provided with a discretion to approve payments in accordance with a structured judgment in terms approved by the court. Structured judgments would entail the payment of one or more lump sums in combination with periodical payments for the remainder of the claimant's life or for a certain agreed period. Annuities would be provided by an approved body or, alternatively, the parties could elect for the structured judgment to be

---

565 This view was supported by Slater and Gordon, solicitors, in submission .no. 20.

566 These figures should be subject to indexed review.

administered by the Senior Master of the Supreme Court (or the Registrar of the County Court) with money being paid into the Common Fund of the court. Sums paid could, subject to negotiation, be indexed.

7.20 In cases where damages payable in respect of future pecuniary losses exceed $500,000,[567] however, courts would be required to make an order incorporating a structured judgment unless one or both of the parties were able to establish circumstances which would make this inappropriate or unfair. The Committee believes that such mandatory orders requiring the use of structured judgments should be restricted to claims involving the most serious injuries only and has determined the sum of $500,000 as being reflective of this. The court would also be given a discretion in certain other cases to order the use of structured judgments (see below).

7.21 The Committee favours the definition of structured judgments for the payment of damages proposed by the English Law Commission, with appropriate modifications.[568] Thus, a 'structured judgment' for the purposes of the law of Victoria should be defined as an agreed arrangement for the payment of damages for personal injuries suffered through the use of health services, on terms whereby the damages are to consist partly of periodical payments and partly of one or more lump sums, and the person to whom the payments are to be made is to receive them as the annuitant under one or more annuities purchased for the person's benefit. Periodical payments may be for the life of the claimant or for a specified period. There may be a specified number of payments or a minimum number of payments. The amounts of the periodical payments (which need not be at a uniform rate or payable at uniform intervals) may be: specified in the agreement, with or without the provision for increases of specified amounts or percentages; or subject to adjustment in a specified manner so as to preserve their real value; or a combination of both methods. It would be a requirement that the annuity

---

567 This figure should also be subject to indexed review.

568 Law Commission Report, op. cit., p. 112.

or annuities are provided by a body approved for the purpose of providing such payments by the law of Victoria.

7.22 In Victoria until the financial industry develops appropriate and secure products relating to structured judgments, the Committee believes that in cases involving more than $500,000 for future pecuniary losses, the funds should be administered by the Supreme or County Court in a manner similar to the present 'Common Fund' of the Supreme Court.[569] The Senior Master (or the Registrar of the County Court) would have responsibility for administering the receipt and payment of monies into and out of the fund.

7.23 In all cases in which compensation for future pecuniary losses exceeds $500,000, the defendant or the defendant's insurer would be required to pay money into the Common Fund which would then be administered by the Senior Master. Defendants could discharge their liability for the payment of compensation immediately by contracting with an insurer to pay an appropriate sum into the Common Fund, which would then be paid by the Senior Master to claimants over time in accordance with an agreed structured judgment which would incorporate indexed review where this was agreed between the parties. Structured judgments could be prepared independently of the court but would require the approval of the Senior Master. Structured judgments relating to claimants with a legal incapacity would need to be approved by the court as at present is the case under the Rules of the Supreme Court.

7.24 It should be compulsory for all awards of compensation in cases of personal injuries sustained through the use of health services to be prepared in such a way as to itemise the individual components of compensation being awarded including, particularly, any amount provided in respect of future loss of earning capacity. It should be an offence to make such calculations in a way which artificially distorts the amount attributable for future loss of

---

[569] This approach was favoured by the Australian Plaintiff Lawyers Association in submission no. 19.

earning capacity to as to keep this amount below the specified thresholds. This would hopefully ensure that the legislation could not be circumvented.

7.25 The Senior Master would be required to invest funds in secure investments as currently occurs with the Supreme Court Common Fund.

7.26 In cases where the claimant dies earlier than predicted, payments from the Common Fund would continue to be paid to the claimant's estate in accordance with the structured judgment, but only in respect of compensation for future loss of earning capacity, not future non-pecuniary loss or future medical and other expenses. The Senior Master would be given a discretion to convert continuing payments under the arrangement into a lump sum for the benefit of the deceased claimant's estate. Moneys remaining in the Common Fund in respect of the deceased's future non-pecuniary loss and future medical and other expenses would be repaid to the defendant or insurer which made the initial payment into the Fund.

7.27 All sums paid out of the Common Fund would be non-taxable in the hands of the recipient and would be exempt from attachment of earnings.

7.28 Legal costs would be settled at the time of payment into the Common Fund.

7.29 The Senior Master would also have jurisdiction to hear applications for further payments made in circumstances in which a provisional order for damages was made. In such rare cases, the defendant or its insurer would be required to pay additional sums into the Fund.

7.30 To summarise, the scheme recommended by the Committee entails the following elements: lump sum payments made in all cases in respect of past losses; interim awards in certain cases; provisional awards in certain cases; lump sum awards in cases where compensation for future pecuniary losses is less than $50,000; discretionary structured awards in cases where compensation for future pecuniary losses is greater than $50,000 but less than $500,000; mandatory structured awards in cases where future pecuniary losses exceed $500,000 with payments to be administered by the court. The threshold amounts would be subject to indexed review.

Out-of-Court Settlements

7.31 The Committee has formed the view that certain out-of-court settlements ought to be regulated by legislation. Parties to an out-of-court settlement should be at liberty to use structured judgments and periodical payments whenever they see fit, except in the following circumstances.

7.32 Where settlements of claims for compensation for injuries suffered through the use of health services (whether court proceedings have been issued or not) include compensation in respect of future pecuniary losses of greater than $50,000 but less than $500,000, the parties to the settlement should be able to elect that the agreed settlement monies be paid into court and administered by the Senior Master of the Supreme Court or the Registrar of the County Court in accordance with the terms of the structured settlement agreement.

7.33 In all cases in which claims for compensation arising out of injuries suffered through the use of health services (whether court proceedings have been issued or not) are settled for an amount which includes compensation for future pecuniary losses in excess of $500,000, the use of a structured settlement should be compulsory and in accordance with the same rules as those which will govern the mandatory use of structured awards ordered by a court (see above).

7.34 The Committee believes that the definition of structured judgments referred to above in the context of court-awarded damages, should, with appropriate adaptations, be used in the context of out-of-court settlements and other compromised claims for compensation. As with the payment of structured judgments, it would be a requirement that the annuity or annuities are provided by a body approved for the purpose of providing such payments by the law of Victoria. Until the financial industry develops appropriate and secure products relating to structured settlements, the Committee believes that in cases involving more than $500,000 for future pecuniary losses, the funds should be administered by the Supreme or County Court in a manner similar to the present 'Common Fund' of the Supreme Court.

7.35 As with court awards, it should be compulsory for all out-of-court settlements involving personal injuries sustained through the use of health services to be prepared in such a way as to itemise the individual components of compensation being awarded including any amount provided in respect of future loss of earning capacity. It should be an offence to prepare such a settlement in a way which artificially distorts the amount attributable for future loss of earning capacity to as to keep this amount below the specified threshold. This, again, should ensure that the legislation is not circumvented.

7.36 Having briefly described the essential features of the scheme recommended by the Committee, it now remains to describe in detail the issues which arise and the arguments for and against each aspect of the proposals.

Court-Awarded Compensation

County Court Proceedings

7.37 Although most cases involving serious injuries arising out of the use of health services in which substantial claims for compensation are made, will be conducted in the Supreme Court, the County Court may also hear such claims as there is no monetary limit applicable to personal injuries claims.[570]

7.38 Sub-section (1) of section 73 of the *County Court Act 1958* provides that judgments and orders in civil proceedings are final. This embodiment of the once-and-for-all rule, may be inconsistent with the various reforms proposed in this report and, accordingly, the Committee considers that this provision should be repealed in so far as it applies to actions for compensation for personal injuries suffered through the use of health services.

Recommendation 7

Sub-section (1) of section 73 of the **County Court Act 1958** ***(Vic.) which provides that judgments and orders in civil proceedings are final, should not apply to claims for compensation for personal injuries suffered through the use of health services.***

---

570 *County Court Act 1958* (Vic.), s. 37.

Interim Payments

7.39 In Chapter 4 a number of legislative schemes were outlined which permit the interim payment of damages in certain circumstances. The Committee believes there to be good reasons for enabling a scheme for the interim payment of compensation to operate in Victoria in all cases involving personal injuries suffered through the use of health services, and, indeed, as outlined below, in other cases as well.

7.40 The Committee recommends that the legislative scheme which operates in New South Wales pursuant to section 76E *Supreme Court Act 1970* (NSW) should be adopted as the model for introduction in Victoria, subject to a number of modifications to take account of the problems which have arisen in applying the New South Wales scheme, as well problems which have arisen in the comparable schemes in South Australia and the United Kingdom (see Chapter 4).

Recommendation 8

The* Supreme Court Act 1986 *(Vic.) and the* County Court Act 1958 *(Vic.) should be amended to permit the court to make an interim award of damages to a plaintiff in actions for damages for personal injuries arising out of the use of health services. The amendment should be along the lines of the provisions contained in Order 29, rule 11 of the Rules of the Supreme Court (Eng.) and section 76E of the* Supreme Court Act 1970 *(NSW).

7.41 In implementing this recommendation, it will be necessary to confine the availability of interim damages as closely as possible. The relevant issues have been discussed in Chapter 4, above, and may be summarised as follows.

7.42 Interim damages should only be available where there is a definite likelihood that the plaintiff will recover substantial damages, as it would be inappropriate for an amount of damages awarded on an interim basis to exceed the final amount of damages recovered by the plaintiff. The Committee believes that the model adopted in New South Wales[571] and England[572] adequately deals with this issue, by restricting interim awards to situations in which:

(a) the defendant has admitted liability; or

---

571 *Supreme Court Act 1970* (NSW), s. 76E(3).

572 Rules of the Supreme Court (Eng.), Order 29, rule 11(1).

(b) the plaintiff has obtained judgment against the defendant for damages to be assessed; or

(c) if the court is satisfied that, if the action proceeds to trial, the plaintiff would obtain judgment for substantial damages.

Consideration may also need to be given to specifying the standard of proof applicable in determining the likelihood of the plaintiff recovering substantial damages.

7.43 The question of whether interim awards of damages should be available in situations in which there are multiple defendants also needs to be examined. In New South Wales the legislation is silent on this matter and interim awards may, apparently, be directed against any defendant.[573] In England interim awards may be made in actions in which there are multiple defendants, although the court must be satisfied that the plaintiff would recover substantial damages against the particular defendant against whom the order is made. If the question of liability is unclear, an order should not be made.[574] It may be useful for this aspect to be clarified in any legislation which may be enacted in Victoria. In addition, it may be prudent to specify the standard of proof applicable in determining that the plaintiff will recover substantial damages against the particular defendant in question.

7.44 It is important for courts not to require defendants to pay interim damages of an amount which would exceed the sum which they ultimately will be required to pay to the plaintiff upon final determination of the action. The Committee believes that the court should be given a wide discretion in determining the sum to be awarded by way of interim payments.[575] The restrictions specified in the English and New South Wales models, which provide that interim awards should not exceed a reasonable proportion of the damages which, in the opinion of the court, are likely to be recovered by the plaintiff—after taking into account any relevant contributory negligence and

---

573 See NSW Law Reform Commission, *Provisional Damages*, Report No. 78, NSW Law Reform Commission, Sydney, 1995, para. 3.15.

574 *Breeze v. McKennon* (1985) 32 Build. L. R. 41 (CA) & *Ricci Burns v. Toole* [1989] 1 W.L.R. 993 (CA).

575 Such as exists in *Supreme Court Act 1935* (SA), s. 30B(2).

any set-off, counterclaim, or cross-claim on which the defendant may be entitled to rely–seem appropriate.[576]

7.45 In both New South Wales[577] and England[578] interim damages may only be awarded where the defendant has adequate financial standing. The rules provide that the defendant must be a person who is insured in respect of the risk giving rise to the plaintiff's claim, or be a public authority, or be a person whose means and resources are such as to enable the defendant to make the interim payment (without suffering undue hardship).[579] The Committee believes that the provisions specified in New South Wales should be followed in Victoria. In addition, it may be appropriate to provide the court with power to require the defendant to give security for the payment of interim damages. The amount specified as security should be determined in the discretion of the court but should be sufficient to cover the amount of the entire interim award. This could be paid into the Common Fund to be administered on such terms as the Senior Master of the court deems fit.

7.46 Clearly, the fact that a defendant has made interim payments should not, of itself, amount to an admission of liability by the defendant. The Committee believes that this should be provided for in legislation, as occurs in New South Wales.[580]

7.47 The Committee also believes that the court should be given a wide discretion as to the manner in which interim payments should be made. It may be appropriate to specify in legislation certain powers of the court, including:

(a) the power to make payments by way of lump sums or periodical payments or both;[581]

---

576 Rules of the Supreme Court, Order 29, rule 11(1) and *Supreme Court Act 1970* (NSW), ss. 76E(5) and (6).

577 *Supreme Court Act 1970* (NSW), s. 76E(4).

578 Rules of the Supreme Court, Order 29, rule 11(2).

579 The words in parentheses are in the NSW legislation only: s. 76E(4)(c).

580 *Supreme Court Act 1970* (NSW), s. 76F(1).

581 As in Rules of the Supreme Court (Eng.), Order 29, rule 13(3) and see also Damages Act 1996 (Eng.), s. 2(2).

(b) the power to order the repayment of all or part of interim payments with or without interest;[582]

(c) the power to vary or discontinue payments;[583] and

(d) the power to require payment by other parties to the proceedings of all or part of any interim payment that the defendant may be entitled to recover from that party.[584]

7.48 Courts should, in the opinion of the Committee, be able to make an order for the payment of interim damages at any time after the period allowed for the defendant to acknowledge service of the writ by entering an appearance.[585]

7.49 When damages are finally assessed, credit should be given in the final assessment for all sums paid as interim damages and the final judgment should state the full amount of the damages awarded, the total of all sums already paid as interim damages, and the amount of any damages remaining payable, with judgment being entered for the last-named sum. In addition, any order for the payment of interim damages should be able to be enforced as a judgment of the court which makes the order.

7.50 One further difficult issue concerns the situation which may arise where a plaintiff, who has received an award of interim damages, dies prior to the final assessment taking place. The Committee believes that in such cases the plaintiff's executor or administrator should be entitled to recover such damages, other than damages for future medical and like expenses, as the plaintiff would have been entitled to, had death not occurred. In calculating the damages due to the plaintiff's estate, credit should be given in the final assessment for all sums paid as interim damages, and the final judgment should state the full amount of damages awarded, the total of all sums already paid as interim damages, and the amount of any damages remaining payable, with judgment being entered for this last-named sum.

---

582 As in *Supreme Court Act 1970* (NSW), s. 76G(2)(a).

583 As in *Supreme Court Act 1970* (NSW), s. 76G(2)(b).

584 As in *Supreme Court Act 1970* (NSW), s. 76G(2)(c).

585 As in Rules of the Supreme Court, Order 29, rule 10 and see also *Supreme Court Act 1970* (NSW), s. 76E(2).

7.51 The Committee, did not form the view that it should be necessary for the plaintiff to produce evidence of need, hardship or other prejudice as a pre-condition to the making of an interim award, although a court would be entitled to take such evidence into account in the exercise of its discretion.

7.52 In New South Wales no restriction is placed on the time at which the final assessment of damages is to take place. The court may adjourn proceedings once liability has been determined (or at any other time) and make an interim award of damages until the final assessment of damages takes place. The ability to postpone the assessment of damages derives from the court's inherent power to adjourn proceedings at any time.[586] A similar outcome may be achieved in South Australia by reason of the court's power to enter a declaratory judgment, with the assessment of damages postponed.[587] In South Australia, however, the parties are permitted to apply to have a final assessment of damages made at any time, and the court is required to make a final assessment if the plaintiff's condition has stabilised or if four years has expired since making the declaratory judgment.[588] In the United Kingdom no time limits are placed on the power to make a final assessment of damages.

7.53 The Committee believes that it is preferable to allow the court a wide discretion in determining the appropriate time for making a final assessment of damages. The parties ought to be able to apply for a final assessment at any time but the court should be given power to decline to make a final assessment depending upon the circumstances.

7.54 In Victoria the General Rules of Procedure in Civil Proceedings 1996 permit the court to adjourn a trial,[589] or to enter judgment with damages to be assessed.[590] In such cases, damages are assessed by a Master of the court.[591] These rules could be used to permit judgment to be entered where liability is

---

586 Supreme Court Rules 1970 (NSW), Part 34, r. 3.

587 *Supreme Court Act 1935* (SA), s. 30B.

588 *Supreme Court Act 1935* (SA), s. 30B(6).

589 General Rules of Procedure in Civil Proceedings 1996 (Vic), r. 49.03.

590 ibid., Order 51 (see G. Nash, *Victorian Courts*, Law Book Co. Ltd., Sydney, 1996, para. 13.14490).

591 ibid., r. 51.01.

admitted or determined, and the assessment of damages postponed. The recommended provisions relating to interim damages could then be used to pay specified sums to the plaintiff pending the final assessment of damages by a Master. The Committee believes that these rules adequately deal with the contemplated procedure regarding postponement and the use of interim damages and makes no recommendation for an amendment to the Rules in this regard.

7.55 In the United Kingdom a problem arose in respect of the payment of interim damages where the Compensation Recovery Scheme operates. This scheme permits the Department of Social Security to recoup benefits in certain circumstances so as to avoid the problem of 'double dipping'.[592] The problem concerned the fact that the Department of Social Security would require the repayment of benefits even where damages had not finally been assessed and interim payments were being made. This had the effect of swallowing up the interim payments. The Law Commission examined this problem and considered that it would be appropriate to exempt interim payments from the recoupment scheme. In view of the limited terms of reference, a formal recommendation was not made.[593]

7.56 In Australia it would be appropriate to amend the *Social Security Act 1991* (Cwlth) to prevent the recovery provisions from applying to interim awards of damages.[594] It would be appropriate for the Health Insurance Commission to be notified of the fact of interim payments being made, but not permitted to recover any sums until a final assessment of damages was made.

Recommendation 9

The Victorian Government should ask the Commonwealth Government to amend the* Social Security Act 1991 *(Cwlth) to permit interim payments of compensation for injuries suffered through the use of health services to be received by claimants without any requirement to pay any sum to the Health

---

592 See Chapter 4.

593 Law Commission Report, op. cit., para. 4.9.

594 See L. Hastwell, & J. Richardson, 'Compensation Awards: The Social Security Implications', (1996) 70(4) *Law Institute Journal* 59–61.

Insurance Commission, until the final assessment of damages takes place. The notification provisions of the Act should continue to apply to the payment of interim damages.

7.57 The Committee believes that these recommendations would ensure that in those cases where a claimant's condition has yet to stabilise, or where the claimant requires funds in order to assist in meeting the costs of medical treatment or rehabilitation programs, the claimant would be assisted financially, but without prejudicing the position of the defendant.

Provisional Payments

7.58 The problem of under-compensation of claimants has been addressed to some extent in the United Kingdom by legislation which permits the court to award provisional damages.[595] The general scheme has been taken up in the *Dust Diseases Tribunal Act 1989* (NSW) and the New South Wales Law Reform Commission has recommended that it be made available in all personal injuries actions heard in the Supreme and Districts Courts of New South Wales.[596]

7.59 The Committee believes that, in certain circumstances, it would be beneficial for courts in Victoria to be given a power to award provisional damages along the lines of the United Kingdom model, but subject to modifications to take account of the recommendations of the English Law Commission and the New South Wales Law Reform Commission.[597]

Recommendation 10

The* Supreme Court Act 1986 *(Vic.) and the* County Court Act 1958 *(Vic.) should be amended to permit the court to make a provisional award of damages to a plaintiff in actions for damages for personal injuries arising out of the use of health services along the lines of the provisions contained in section 32A Supreme Court Act 1981 (Eng.) and section 11A* Dust Diseases Tribunal Act 1989 *(NSW). Payment of compensation for future non-pecuniary loss should be able to be paid provisionally in the circumstances where provisional damages may be awarded.

7.60 The Committee believes that the award of provisional damages should be restricted to circumstances in which there is proved or admitted to be a chance, that at some definite or indefinite time in the future, the plaintiff will,

595 Supreme Court Act 1981 (Eng.), s. 32A.
596 NSW Law Reform Commission, op. cit., recommendation 1, p. 50.
597 See Law Commission Report, op. cit.; NSW Law Reform Commission, op. cit.

as a result of the act or omission which gave rise to the cause of action, develop some serious disease or suffer some serious deterioration in his or her physical or mental condition. Provisional damages should then be able to be awarded on the assumption that the plaintiff will not develop the specified serious disease or suffer the specified serious deterioration in his or her condition, and further damages should be able to be awarded at a future date if the plaintiff, in fact, develops the serious disease or suffers the serious deterioration in his or her condition.

7.61 In order to restrict the circumstances in which claims for provisional damages are made, the Committee has formed the view that plaintiffs should be required to plead a claim for provisional damages in their Statement of Claim and to specify the condition or conditions in respect of which they seek to claim further damages.[598] On making an order for provisional damages, the court should specify the condition or conditions in respect of which the award of further damages may be made.

7.62 The Committee believes that some of the options for reform of the award of provisional damages which were considered, but rejected, by the English Law Commission, should also not be taken up in Victoria. Accordingly, claims for provisional damages should only be available where a plaintiff's condition deteriorates following a specified event rather than gradually[599] and claims for provisional damages should not be available where medical uncertainty exists as to the prognosis in relation to an already existing condition.[600]

7.63 There are a number of other specific issues which need to be examined in specifying the circumstances in which such a scheme could operate in Victoria. The first issue concerns the number of applications which a plaintiff should be entitled to make for further damages. In both New South Wales and England the view has generally been taken that only one application should be able to be made in respect of each specified condition. The *Dust*

598 As in Dust Diseases Tribunal Rules 1990 (NSW), r. 5(3).
599 Law Commission Report, op. cit., paras. 5.6– 5.8.
600 ibid., paras. 5.9–5.12.

Diseases Tribunal Rules 1990 (NSW) permit only one application to be made in respect of each condition,[601] while in England the Law Commission has recommended allowing more than one application to be made, where the disease or deterioration so specified occurs in more than one position on the body of the plaintiff, provided that the possible positions are specified at the time of making the order.[602] The Committee believes that the recommended English approach provides an acceptable restriction on the operation of the rule, although it may be appropriate to provide the court with a discretion to permit further claims for damages to be made where exceptional circumstances exist in relation to the development of further serious diseases or further serious deterioration in the plaintiff's physical or mental condition.

7.64 The second major issue concerns the time within which a plaintiff may apply for further damages, following the award of provisional damages. In the United Kingdom time limits for further applications are not specified, but rather left to the discretion of the court.[603] In New South Wales the Law Reform Commission recommended that the court should be able to specify a period within which further applications should be made. If no period were set by the court, or if the plaintiff died before the end of the specified period, then the right to apply would terminate on the plaintiff's death.[604] The Committee believes this approach to be preferable to that in the United Kingdom, where time limits are entirely discretionary.

7.65 A third issue relates to the situation which arises where a plaintiff who has been awarded provisional damages dies before an application for further damages has been made. We have seen that section 3 of the Damages Act 1996 (Eng.) now provides that an award of provisional damages shall not bar an action under the Fatal Accidents Act 1976 (Eng.).[605] It also provides that such part, if any, of the provisional damages, and any further damages awarded to the claimant before his or her death, as was intended to compensate for

---

601 Dust Diseases Tribunal Rules 1990 (NSW), r. 5(8)(c).
602 Law Commission Report, op. cit., paras. 5.21–5.23.
603 ibid., paras. 5.17–5.19.
604 NSW Law Reform Commission, op. cit., recommendations 6 & 7, pp. 53–4.
605 Damages Act 1996 (Eng.), s. 3(2).

pecuniary loss which in the event falls after the date of death, shall be taken into account in assessing the amount of any loss of support suffered by the person or persons for whose benefit an action is brought under the Fatal Accidents Act 1976 (Eng.).[606] The Act further provides that no award of further damages made in respect of the deceased after the date of death shall include any amount for loss of income in respect of any period after death.[607] Similar provisions were recommended by the New South Wales Law Reform Commission.[608]

7.66 The Committee believes that similar principles should govern the operation of any award of provisional damages in Victoria where a plaintiff dies before a claim for further damages is made. Accordingly, the plaintiff's estate should be able to pursue the claim for further damages pursuant to section 29 of the *Administration and Probate Act 1958* (Vic.), and any damages awarded to the plaintiff should not bar an action relating to the death of the plaintiff under Part III of the *Wrongs Act 1958* (Vic.). However, any of the damages intended to compensate for future pecuniary loss should be taken into account by the court when assessing any loss in relation to such a claim, where it is just to do so.

7.67 Finally, the Committee believes that a court should be entitled to order that provisional damages be paid by way of lump sums or periodical payments or any combination of the two.

The Itemisation of Awards of Compensation

7.68 As we have seen, it is accepted practice in Australia for damages to be calculated by allocating specific sums to the different heads of damage. Although this practice entails the risk of overlap between some heads, it is useful in ensuring that all items of loss have been taken into account.[609]

7.69 We have also seen how some litigants have sought to obtain undifferentiated awards of compensation in order to ensure that they are

---

606 Damages Act 1996 (Eng.), s. 3(3).

607 Damages Act 1996 (Eng.), s. 3(4).

608 NSW Law Reform Commission, op. cit., recommendations 8 & 9, pp. 54–5.

609 See H. Luntz,. *Assessment of Damages for Personal Injury and Death*, 3rd edn., Butterworths, Sydney, 1990, para. 1.5.5.

treated as capital for income taxation purposes. If the Committee's recommendation regarding the taxation of compensation payments is taken up, this will no longer be a factor motivating claimant's to request undifferentiated awards of damages. The recommendations described below regarding the use of structured judgments, require that itemised awards of compensation be made, at least in order to determine whether compensation for future pecuniary loss exceeds various specified thresholds. It will also be necessary to ascertain the amount allocated for past losses as these are to be paid in a lump sum.

7.70 Although it may not be necessary for itemisation of damages to be legislatively required, the Committee feels that this would clarify matters, both in relation to court-awarded damages and to out-of-court settlements where these exceed the specified thresholds.

Recommendation 11

In assessing damages for personal injuries suffered through the use of health services, the court making an award or the parties agreeing to compromise an action, should allocate specific sums to the various heads of damage, and in particular should specify what sums are payable in respect of past losses and what sums are payable in respect of future pecuniary losses.

7.71 The Committee is concerned that the operation of the recommended scheme could be circumvented if damages are itemised in such a way as to artificially distort the amount payable in respect of future pecuniary losses, by making it less than the specified thresholds. Accordingly, it should be an offence to intentionally itemise amounts payable as compensation for injuries suffered through the use of health services in such a way as to reduce the amount allocated for future pecuniary losses to less than the specified threshold amounts, while increasing other sums allocated for other heads of damage.

The Payment of Compensation for Past Losses

7.72 Not all claimants for compensation seek payments in respect of such future losses. Occasionally, the claimant's injuries will have resolved by the time the assessment is made, permitting the claimant to resume work without suffering an on-going loss of earning capacity. In such cases claims may be

limited to non-pecuniary loss, such as for pain and suffering or disfigurement, in addition to pecuniary losses incurred prior to the date of assessment of damages. Compensation for such claims may, nonetheless, be substantial. In Victoria, for example, the maximum amount payable for pain and suffering in common law proceedings taken in respect of transport accidents is $326,470 while a maximum of $333,420 is payable in respect of pain and suffering in common law proceedings taken in respect of work-related injuries.

7.73 Claimants who receive such large sums may make use of them in appropriate or inappropriate ways; they may invest the money or dissipate it quickly. Throughout the common law world, however, it has been concluded that the manner of payment of compensation for such intangible losses as pain and suffering should not be controlled legislatively and that injured claimants should be entitled to use such sums as they see fit.

7.74 In the United States, for example, the Uniform Periodic Payment of Judgments Act provides that past and future non-pecuniary losses be quantified and paid in a lump sum.[610]

7.75 Although a paternalistic regime may be willing to consider making the payment of compensation for all past losses, including past non-pecuniary losses, subject to regulation, it is generally accepted that this is undesirable and unnecessary. The Committee takes the same view believing that claimants should be entitled to receive a proportion of their compensation in respect of past losses in a lump sum. This would provide them with an initial sum to spend as they see fit. A proportion may be used to settle debts, to purchase household goods, motor vehicles or other items to improve one's life-style. Some or all may be invested. It would be for the injured person to decide how and when such compensation is to be spent.

Recommendation 12

The payment of compensation made in respect of past losses should be made by way of a lump sum.

7.76 The Committee believes that this fundamental principle should be embodied in legislation.

---

610 Uniform Periodic Payment of Judgments Act (US), § 7(g).

7.77 The Committee further believes, however, that where lump sum payments are made in respect of past losses, recipients may need access to proper financial counselling to assist in managing what may occasionally amount to substantial sums. Financial counselling should be made available both to the recipients of court-awarded payments of compensation and to those who receive payments following out-of-court settlements.

Recommendation 13

A list of recommended financial advisers should be compiled by appropriate court officers, and approved by the judges of the Supreme and County Court for distribution to persons who receive large awards of damages, whether as a result of court judgments or negotiated settlements.

The Payment of Compensation for Future Losses

7.78 The primary problem which gave rise to the present inquiry into the manner in which compensation is paid to individuals injured through the use of health services concerned compensation for future loss, and particularly future pecuniary loss such as loss of earning capacity.

Future Non-Pecuniary Losses

7.79 A problem which has not been resolved in those jurisdictions which require all non-pecuniary damages to be paid once-and-for-all, concerns the possibility that a claimant's medical condition will change in the future, drastically altering the extent of non-pecuniary losses suffered.

7.80 Compensation for disfigurement and pain and suffering in respect of the loss of a limb may be capable of reasonably precise determination at the date of the trial or the date upon which compensation is assessed initially and there is unlikely to be any change made to the claimant's condition which would warrant a revised assessment. Where an assessment is made in respect of future pain and suffering arising out of other conditions yet to manifest themselves, however, the assessment may be far from accurate. A claimant, for example, who has to undergo various surgical procedures which are causally related to the original negligent act but not predicted at the time the original assessment takes place, may be greatly under-compensated in respect of future pain and suffering. Similarly, if a new treatment is discovered which

cures a previously incurable and painful condition, the award of compensation for future pain and suffering may be excessive.

7.81 Accordingly, payment for future non-pecuniary losses should not be paid once-and-for-all in a lump sum but paid in such a way as to ensure that appropriate adjustments may be made for changes which occur in the claimant's condition in the future. Claimants should not, however, be free to return to court for re-assessment of their non-pecuniary loss whenever they believe they are deserving of additional compensation. Such a system would be intolerable and unattractive to insurers. Instead, in certain specific circumstances, to be described below, awards of compensation for future non-pecuniary loss should be paid provisionally on the understanding that if a specific change occurs in the claimant's condition in the future, the claimant would be entitled to an additional award of compensation in respect of future non-pecuniary loss.

Structured Judgments for Small and Medium Awards

7.82 The Committee canvassed the possibility of the use of structured judgments with those who gave oral evidence and heard opinions as to the monetary limits which should apply in determining whether structured judgments should be invoked. In the United States, Ohio has a threshold of US $25,000 in respect of future medical expenses while Ohio specifies US $200,000 beyond which the payment of damages is to be regulated.[611] The Committee received written and oral submissions which varied greatly with respect to the minimum amount of compensation beyond which structured settlements should be used. Most submissions on this issue were between $50,000 and $100,000, although some were for larger sums including one of $1 million.[612]

7.83 The Committee has formed the view that compensation for injuries suffered through the use of health services should be paid by way of lump sums in all cases where the amount awarded in respect of future losses is less than $50,000. In cases below this threshold, the entire award of damages

---

611 Evidence of Ms Larraine Gerelick, New York, 5 Sep. 1996.

612 Australian Medical Association submission no. 32 $1 million. Mr B. Burke referred to $50,000 and B. Gurry $100,000 in their evidence to the Committee, 27 Nov. 1995. These figures presumably related to the total award of compensation. Submission no. 18 also referred to sums of between $50,000 and $100,000 as the minimum permitted for the use of structured judgments. Submission no. 20 by Slater and Gordon, solicitors, referred to the figure of $500,000 for total compensation.

should be paid by way of lump sum, other than in those situations in which interim or provisional damages may be payable. The specified threshold figure of $50,000 should be indexed in a manner similar to the indexation which occurs in the *Transport Accident Act 1986* (Vic.) and the *Accident Compensation Act 1985* (Vic.).[613]

Recommendation 14

Damages awarded for injuries caused through the use of health services should be paid by way of lump sum in all cases where the amount awarded in respect of future pecuniary losses is less than $50,000 (subject to indexation), but without affecting the ability of the court to award interim or provisional damages.

7.84 In those cases where the amount awarded in respect of future pecuniary losses exceeds $50,000 but does not exceed $500,000, the parties should be able to elect that such damages be paid in accordance with a structured judgment provided that this is approved of by the court. Again the maximum threshold amount of $500,000 should be indexed.

Recommendation 15

Damages awarded for injuries caused through the use of health services may, at the discretion of the court, be paid by way of a structured judgment approved of by the court in all cases where the amount awarded in respect of future pecuniary losses is greater than $50,000 but less than $500,000 (subject to indexation), but without affecting the ability of the court to award interim or provisional damages.

7.85 It will be necessary for appropriate arrangements to be made to approve organisations which may be authorised to provide annuities for structured judgments. A system of authorisation such as exists for institutions offering life insurance may be appropriate.

Recommendation 16

Legislation should be enacted to provide a licensing system for bodies which are authorised to provide annuities for use in structured judgments. Minimum statutory requirements should be laid down. The office of the Senior Master of the Supreme Court and the Registrar of the County Court should be approved as bodies authorised to provide annuities for use in structured judgments.

---

[613] See M. O'Loghlen & B. R. Wright, *Accident Compensation Victoria*, Butterworths, Sydney, 1996, pp. 1736.7 & 2141.12.

7.86 Where moneys have been paid into court to be administered by the Senior Master in accordance with the terms of a structured judgment ordered by a court or a structured settlement arising out of the compromise of an action, the Senior Master will be required to deal with the funds in accordance with the rules governing Funds in Court.[614] In order to clarify the position, Order 79 should be amended to permit the Senior Master of the Supreme Court and the Registrar of the County Count to pay moneys out of the Common Fund for the benefit of plaintiffs (and or their estates) in accordance with the terms and conditions of structured judgments, in any case approved by the respective courts.

Structured Judgments for Large Awards

7.87 In order to prevent claimant's dissipating large awards of compensation for future pecuniary losses, the Committee has determined that it be mandatory for damages in such cases to be paid in accordance with structured judgments approved by the court. Until statutorily licensed commercial bodies are able to provide appropriate products, such awards should be administered by the Senior Master of the Supreme Court or the Registrar of the County Court. It is likely that very few cases would be involved each year, and the existing administration of the Common Funds would be adequate to deal with such cases. Similar administrative arrangements should apply in respect of County Court proceedings where the same threshold has been reached.

7.88 This proposal for the mandatory use of structured judgments is contrary to the position which applies in other Australian jurisdictions which make use of periodical payments and the United Kingdom, although some jurisdictions in the United States have a mandatory requirement that structured settlements be used.

---

614 General Rules of Procedure in Civil Proceedings 1996, Order 79.

7.89 The Committee believes that a limited mandatory requirement is appropriate in cases involving very large awards of damages in order to ensure that awards are not dissipated resulting in claimants suffering hardship and being forced to rely upon government-funded benefits. In many cases which satisfy the monetary threshold, funds already need to be paid into court owing to the claimant being a minor or incapacitated.

7.90 In certain cases, however, the parties should be at liberty to apply to the court to have damages paid as a lump sum, although the Committee believes that this would occur in exceptional circumstances only.

Recommendation 17

Except where exceptional circumstances are demonstrated, all awards of damages where the amount allowed for future pecuniary losses exceeds $500,000 (subject to indexation), arising from the use of health services, should be paid in accordance with a structured judgment approved by the court.

7.91 In exercising the discretion to award a lump sum instead of a structured judgment, the court may have regard to a number of matters including:

(a) the age and physical and mental condition of the plaintiff;

(b) the ability of the plaintiff to manage a lump sum award of damages;

(c) the circumstances of the plaintiff relating to the need for a lump sum payment;

(d) the possibility that the plaintiff may, in the future, become dependent upon government-funded income support;

(e) the views of the defendant and the defendant's insurer, if any.

7.92 In the United States, the Uniform Periodic Payment of judgments Act requires that the trier of fact make determinations relating to certain findings of fact where a structured settlement is to be employed. Separate sums must be determined in respect of past losses and future non-pecuniary losses, as these must be paid by way of a lump sum. Separate findings must be made in

respect of future medical expenses and other future pecuniary losses. The trier of fact is also required to determine the period during which the claimant is expected to live or else specify that payments are to continue for life. The trier of fact is also obliged to determine an allowance for inflation in respect of annual future pecuniary loss or else specify an inflation rate or rates to be applied.[615]

7.93 The Committee takes the view that these matters should be left to the judge to determine based upon evidence tendered in the proceedings. In approving a structured judgment, the judge should specify these elements and describe how they should be adjusted over time, if necessary.

7.94 The Committee believes that the parties, with the agreement of the court, should be at liberty to determine the amount of periodical payments to be used in a structured judgment, at what time they should commence or cease, their frequency and the circumstances in which they should be paid. One of the principal benefits of structured judgments is their flexibility and this should be retained to the greatest extent possible.

7.95 Unlike the United States, legal costs should continue to be payable in accordance with existing Victorian rules. The complex provisions in the Uniform Periodic Payment of Judgments Act concerning the quantification and allocation of attorneys' fees are not of concern in Victoria.[616]

7.96 In cases where claimants suffer from a legal incapacity such as, for example, mental impairment or infancy, the same provisions should continue to apply as apply at present. Accordingly, payments of damages for the benefit of such persons should be paid into the Common Fund and administered by the Senior Master of the court.[617] It should, however, be possible for the court to approve the use of structured judgments for such claimants as long as the existing requirements are fulfilled. Thus, there is a need to amend Order 79 of the General Rules of Procedure in Civil

---

615 D. W. Hindert, J. J. Dehner & P. J. Hindert, *Structured Settlements and Periodic Payment Judgments*, Law Journal Seminars Press, New York, 1996, para. 9.02[3].

616 ibid., para. 9.02[4].

617 *Supreme Court Act 1986* (Vic.), s. 60A; General Rules of Procedure in Civil Proceedings 1996, Order 79.

Proceedings to authorise the Senior Master of the Supreme Court and the Registrar of the County Court to make use of approved structured judgments in paying sums of money held in court for the benefit of persons under a disability.

7.97 The Committee considered at length the question of how best to ensure the security of structured judgments and determined that approved organisations should only be able to offer annuities. We have seen that in the United States a similar requirement exists to guard against the possibility of insurers becoming insolvent, which unfortunately has eventuated prior to the introduction of controls.

7.98 In the largest cases involving the most serious injuries, the Committee has taken the view that the only way in which a secure structured judgment can be offered is through the use of the existing procedures governing the Supreme Court Common Fund administered by the Senior Master of the court.[618] Interest payable to the Senior Master would help to off-set any additional administrative costs associated with the increased number of cases to be dealt with, although in the short term this would not be likely to be excessive.

7.99 In order to ensure that moneys paid to claimants periodically pursuant to an approved structured judgment, or by way of interim or provisional periodical payments are used for the purposes for which they are awarded, the court rules would need to be altered to provide an exemption from such payments being the subject of an attachment of earnings order or other court execution. This would be similar to the exemption which exists in the United States Uniform Periodic Payment of Judgments Act.[619] Accordingly, there is a need to amend Order 72 of the General Rules of Procedure in Civil Proceedings 1996 (Vic.) to exempt from attachment of earnings orders or other court execution, payments of compensation made pursuant to an interim award of damages, provisional award of damages or an approved structured

---

618 ibid., Order 79.

619 Uniform Periodic Payment of Judgments Act (US), § 15; see Hindert *et. al.*, op. cit., para. 9.02[9].

judgment, made in relation to a claim for compensation arising out of injuries suffered through the use of health services.

7.100 Once payment has been made into court in accordance with these recommendations, the defendant’s liability should be discharged. Payments may, of course, be made by the defendant’s insurer in which case the receipt into the Common Fund would be a sufficient discharge of liability.

7.101 The Committee has received a number of submissions affirming the need for there to be finality to litigation and for awards of compensation not to be reviewable should the circumstances of the claimant change. The Committee has taken these submissions into account and has determined that structured judgments should not be able to be reviewed in the sense of the defendant or its insurer being required to contribute further funds in satisfaction of additional liability.

7.102 The only circumstances in which additional funds would be required arise in those limited cases in which the Committee has recommended that provisional damages be awarded. The Committee believes this to be a highly restricted detraction from the once-and-for-all rule and necessary to alleviate hardship on the part of plaintiffs. In addition, the limited circumstances in which interim awards of compensation may be made are not, in the Committee’s view, excessive and would not impinge greatly on the ability of insurers to manage their finances with certainty.

7.103 The Committee also believes that the recommendations described above adequately deal with the situation in which a claimant dies earlier than originally anticipated. In such cases, interim payments could continue to be paid in respect of loss of earning capacity during the lost years, but not in respect of continuing medical expenses of other pecuniary or non-pecuniary loss. The final assessment of provisional awards of damages would permit compensation to be payable to the estate of the deceased claimant, but only in respect of future loss of earning capacity, with the amount paid provisionally being taken into account. Structured judgments would ensure that payments terminate for pecuniary losses other than loss of earning capacity which would be recoverable by the plaintiff’s estate.

Recommendation 18

The* Administration and Probate Act 1958 *(Vic.) should be amended to permit the estate of a plaintiff who was a party to a structured judgment, to recover any sums payable in respect of loss of earning capacity which would have been paid to the plaintiff had he or she continued to live.

7.104 Where defendants have paid money into court in accordance with the terms of a structured judgment or structured settlement, and the plaintiff dies prior to the date upon which payments made in respect of future non-pecuniary loss and future medical and like expenses are to terminate, the Senior Master should be given power to repay such sums to the defendant or its insurer. Accordingly, there is a need to amend the General Rules of Procedure in Civil Proceedings 1996 (Vic.) to provide for such payments. However, no repayment should be made in these circumstances in respect of other compensation paid for future pecuniary loss, such as loss of future earnings.

7.105 The Committee believes that any disputes as to the payment of moneys out of the Common Fund should be dealt with in accordance with existing provisions of Order 79 of the General Rules of Procedure in Civil Proceedings.[620] Any dispute as to the manner in which a structured judgment has been prepared should be subject to appeal in the same way as any other order of a court. The Committee believes, however, that it would be appropriate to clarify these appellate powers in legislation. Consequently, the *Supreme Court Act 1981* (Vic.) and the *County Court Act 1958* (Vic.) should be amended to permit the parties to a structured judgment to appeal against:

(a) any determination of the sums of money specified in each component of the structured judgment;

(b) any determination of the sums of money allocated for lump sum and periodical payments in the structured judgment; or

(c) the court's exercise of its discretion to require a structured judgment to be used or not to be used.[621]

---

[620] General Rules of Procedure in Civil Proceedings 1996, rule 79.06.

[621] See Law Commission Report, op. cit., para. 3.49.

Out-of-Court Structured Settlements

7.106 Having considered the manner in which compensation payments should be made where proceedings go to trial, the Committee will now examine the question of out-of-court settlements which, as we have seen, is how the vast bulk of claims are finalised.

Legislative Controls

7.107 Although it has been argued that Parliament should not interfere with the freedom of litigants to settle proceedings by way of contractual arrangements in any manner they wish, we have seen that the consequence of complete freedom has resulted in plaintiffs receiving inadequate or excessive compensation with the government being required to provide support when settlement monies have been exhausted. Accordingly, the Committee believes that the state has a duty to intervene in the manner in which out-of-court settlement monies are paid, although not the manner in which settlements are negotiated.

Settlements Covered

7.108 Claims for compensation for injuries suffered through the use of health services may be compromised at various stages in the litigation process. Some may be settled 'at the door of the court', after all of the interlocutory procedures of litigation have been completed, while others may be settled after a factual determination has been made, but prior to damages being assessed. Still other claims may be settled immediately following the issue of proceedings, while others may be settled prior to legal proceedings being issued. The latter may occur in claims conciliated by the office of the Health Services Commissioner.

7.109 The Committee believes that the reforms recommended in this report should apply to all cases in which a health user has sought financial compensation for injuries suffered through the use of health services, whether or not legal proceedings have been commenced. Because so few claims go to trial before the courts, any benefits which may arise in reducing professional indemnity costs, would need to relate to all claims for compensation, whether proceedings have been issued or not.

The Itemisation of Compromised Claims

7.110 In discussing the reforms which should apply to court-awarded damages, it was recommended that the court in making an award of

compensation and the parties in agreeing to compromise an action, should allocate specific sums to the various heads of damage. In particular, they should specify what sums are payable in respect of past losses and what sums are payable in respect of future pecuniary losses. In view of the recommendations to be made regarding out-of-court settlements, the Committee believes that similar itemisation of compensation should occur when actions are compromised. This will be necessary in order to determine when mandatory obligations are applicable.

Recommendation 19

In agreeing to compromise a claim for damages for injuries suffered through the use of health services, the parties should be required to allocate specific sums to the various heads of damage, and in particular should specify what sums are payable in respect of past losses and what sums are payable in respect of future pecuniary losses.

7.111 As is the case with structured judgments, the Committee is concerned that the operation of the recommended scheme could be circumvented if damages are itemised in such a way as to artificially distort the amount payable in respect of future pecuniary losses, by making it less than the specified thresholds. Accordingly, in structuring a settlement it should be an offence to intentionally itemise amounts payable as compensation for injuries suffered through the use of health services in such a way as to reduce the amount allocated for future pecuniary losses to less than the specified threshold amounts, while increasing other sums allocated for other heads of damage.

The Settlement of Small and Medium Claims

7.112 The Committee believes that the parties involved in claims for compensation for injuries suffered through the use of health services in which less than $500,000 is agreed to be paid in respect of future pecuniary losses, should be free to settle their claims and pay compensation in any way they see fit. The threshold sum of $500,000 should be subject to indexation as described above.

7.113 If appropriate reforms to the taxation system are made, the use of periodical payments and structured settlements may become popular. In these relatively small claims, however, the Committee feels that structured settlements should not be regulated legislatively, other than providing that

the parties may agree for moneys to be paid into court and administered by the Senior Master of the Supreme Court or Registrar of the County Court in cases where compensation for future pecuniary losses is more than $50,000 and less than $500,000.

The Settlement of Large Awards

7.114 As has been recommended with respect to court-awarded damages, the Committee believes that it should be mandatory for compromised claims made in large cases involving payments of compensation for future pecuniary losses in excess of $500,000, to be paid in accordance with structured judgments approved by the court and administered by the Senior Master of the Supreme Court or the Registrar of the County Court, until such time as licensed commercial providers become available.

7.115 In certain cases, however, the parties should be at liberty to apply to the court to have damages paid as a lump sum, although the Committee believes that this would occur only in exceptional circumstances. In exercising the discretion to award a lump sum instead of a structured judgment, the court may have regard to a number of matters including:

(a) the age and physical and mental condition of the plaintiff;

(b) the ability of the plaintiff to manage a lump sum award of damages;

(c) the circumstances of the plaintiff relating to the need for a lump sum payment;

(d) the possibility that the plaintiff may, in the future, become dependent upon government-funded income support;

(e) the views of the defendant and the defendant's insurer, if any.

Recommendation 20

Except where exceptional circumstances are demonstrated, in all claims for compensation for injuries suffered through the use of health services where it is agreed between the parties that the amount of compensation awarded in respect of future pecuniary losses exceeds $500,000 (subject to indexation), the monies should be paid in accordance with a structured judgment, approved by the court and administered by the Senior Master of the Supreme Court or the Registrar of the County Court.

7.116 The conclusions of the Committee referred to above regarding the need for flexibility in determining the components of a structured judgment, the payment of legal costs, the payment of compensation for claimants under a legal disability, and the exemption of payments made under a structured judgment for attachment of earnings and other court execution, should also apply in respect of out-of-court structured settlements.

7.117 Once payment has been made into court in accordance with these recommendations, the defendant's liability should be discharged. Payments may, of course be made by the defendant's insurer in which case the receipt into the Common Fund would be a sufficient discharge of liability.

7.118 The Committee also believes that the recommendations described above with respect to the situation which occurs where a claimant who is the subject of a structured judgment dies, should apply with respect to out-of-court structured settlements. In such cases, interim payments could continue to be paid in respect of loss of earning capacity during the lost years, but not in respect of continuing medical expenses or other pecuniary or non-pecuniary loss. The final assessment of provisional awards of damages would permit compensation to be payable to the estate of the deceased claimant, but only in respect of future loss of earning capacity, with the amount paid provisionally being taken into account. Structured settlements would ensure that payments terminate for pecuniary losses, other than loss of earning capacity, which would be recoverable by the plaintiff's estate.

Recommendation 21

The* Administration and Probate Act 1958 *(Vic.) should be amended to permit the estate of a plaintiff who was a party to a structured settlement, to recover any sums payable in respect of loss of earning capacity which would have been paid to the plaintiff had he or she continued to live.

7.119 The Committee believes that any disputes as to the payment of moneys out of the Common Fund should be dealt with in accordance with existing provisions of Order 79 of the General Rules of Procedure in Civil Proceedings.[622] Any dispute as to the manner in which a structured settlement has been prepared should be subject to appeal in the same way as

---

622 General Rules of Procedure in Civil Proceedings 1996, rule 79.06.

any other order of a court. The Committee believes, however, that it would be appropriate to clarify these appellate powers in legislation.[623]

The Application of the Reforms Proposed in this Report to other Compensation Payments

7.120 The preamble to the terms of reference of the present inquiry require the Committee to 'inquire into, consider and report to the Parliament on issues arising out of court-based compensation for people who have suffered injuries as a result of service provided by a health provider'. Paragraph 2(c) of the terms of reference requires the Committee to investigate options with respect to 'the use of structured settlements to maximise the benefit to an injured person of any financial compensation ordered by a court'. Arguably, paragraph 2(c) should be constrained by the words contained in the preamble, thus restricting the present inquiry to compensation for injuries suffered through the use of health services.

7.121 The issue which arises is whether the reforms recommended in this report, which deal with the manner in which compensation is provided to injured health service users, should be made applicable to the payment of compensation to the victims of other personal injuries and, indeed, those who have suffered other types of loss in non-personal injuries proceedings. Although many of the arguments which have been canvassed in the preceding chapters apply just as well to personal injuries cases other than those arising out of the use of health services and to non-personal injuries cases, the present terms of reference prevent the Committee from recommending reforms in these broader contexts.

7.122 We have seen that in various jurisdictions, courts are empowered to make interim, provisional and periodic awards of compensation in certain circumstances, even where claims arising out of personal injuries are not involved. There are many circumstances in which Victorian courts would benefit from being provided with a power to make such awards in non-personal injuries cases. The English Law Commission, however, decided not to extend the availability of structured settlements to non-personal injuries cases, because personal injuries claims have a particular relationship to the

---

623 See Law Commission Report, op. cit., para. 3.49.

payment of government-funded social security payments.[624] Nonetheless, the Committee believes that it would be appropriate to consider the wider application of the reforms proposed.

Recommendation 22

Consideration should be given to making payments of compensation for loss suffered other than in respect of personal injuries arising out of the use of health services, subject to the rules governing the payment of compensation recommended elsewhere in this report.

7.123 We have seen that some of the statutory no-fault compensation schemes which operate in Victoria for compensating those injured through work-related accidents, transport accidents and criminal conduct, permit compensation to be paid periodically in various circumstances. Some of these schemes permit substantial sums of compensation to be paid for future pecuniary loss, and in such cases it would be appropriate for the same procedures to operate as those recommended for health service injuries. In the United States, for example, moves are being made to enable workers' compensation awards to be structured in a manner similar to that available under the Uniform Periodic Payments of Judgments Act.[625] The *Motor Accidents Act 1988* (NSW) and the *Workers Compensation Act 1987* (NSW) similarly allow courts to approve structured settlements with respect to future pecuniary loss and impairment of earning capacity for individuals injured as a result of motor vehicle and work-related accidents. In certain circumstances interim awards of compensation may also be made.

7.124 Likewise, we have seen that substantial sums may be paid to claimants arising out of agreements conciliated by the office of the Health Services Commissioner in Victoria. If part of these awards are made to compensate future pecuniary loss, then arguably the reforms recommended in the present report should also be applicable. This is particularly important as claimants who enter into conciliated agreements are prevented from seeking compensation in respect of the same injuries from the courts, and thus, if their

---

624 Law Commission Report, op. cit., para. 3.44.

625 Evidence of Mr P. J. Hindert, San Francisco, 16 Aug. 1996.

conciliated settlement monies are dissipated, they may fall back on government-funded programmes for financial assistance.

7.125 However, the *Criminal Injuries Compensation Act 1993* (Vic.), as we have seen, already permits compensation to be paid in a wide range of differing forms and, presumably, structured judgments could be offered under the existing regime. In view of the relatively small maximum amount of $50,000 involved, it would not be appropriate for payments of compensation made under this legislation to comply with the proposed recommendations

Recommendation 23

Consideration should be given to making awards of compensation made pursuant to the provisions of the* Accident Compensation Act 1985 *(Vic.), the* Transport Accidents Act 1987 *(Vic.) and payments made to claimants arising out of agreements conciliated by the office of the Health Services Commissioner, subject to the rules governing the payment of compensation recommended elsewhere in this report.

7.126 Finally, we have seen that compensation payments may be paid to claimants in accordance with the provisions of a number of other Acts which operate in Victoria. In order to achieve consistency and to enable the benefits of the reforms recommended in this report to be made available in other contexts, the Committee believes that investigations should be conducted with respect to the manner in which compensation is paid pursuant to these other Acts.

Recommendation 24

Consideration should be given to making payments of compensation made pursuant to the provisions of the* Country Fire Authority Act 1958 *(Vic.), the* Education Act 1958 *(Vic.), the* Police Assistance Compensation Act 1968 *(Vic.), the* Victoria State Emergency Service Act 1987 *(Vic.), and the* Wrongs Act 1958 *(Vic.) subject to the rules governing the payment of compensation recommended elsewhere in this report.

8 IMPROVING THE LITIGATION PROCESS

8.1 The terms of reference for the present inquiry require the Committee to investigate 'alternatives to the current system of court-based compensation for people injured in the use of health services'. However, before discussing alternatives to the system of court-based compensation, the manner in which the system is currently operating must to be considered, in order to determine the extent to which alternatives are needed. Recently, there have been considerable improvements in the courts' management of cases. These initiatives have gone some way towards reducing delays in bringing cases to court and thus, the case for introducing an alternative system may be weakened.

CASE MANAGEMENT OF LITIGATION

County Court of Victoria

8.2 All common law jurisdictions have experienced problems relating to the cost of proceedings, due to extensive discovery and interrogation, and delays in the process. This includes delays in getting cases to trial. The difficulties facing courts in dealing with these issues were discussed at a recent conference in Brisbane on Civil Litigation Reform.[626] At the conference, the initiatives taken by the Victorian County Court in relation to case management were outlined by Judge David Jones. They received considerable praise and were generally regarded as leading the way in reforming the civil litigation process.

8.3 The County Court aims to have cases heard within a year of their being issued and the defence being filed.[627] To assist in achieving this goal there is judicial case management of matters from the issuing of proceedings until

---

[626] Litigation Reform Commission Conference, *Civil Justice Reform – Streamlining the Process*, Brisbane, 6–8 Mar. 1996.

[627] Prue Innes, 'Judicial case management cuts delays', 1996 70(1) *Law Institute Journal*, p. 12.

settlement or the trial of the case.[628] In relation to medical negligence cases, this includes the following three key measures:[629]

(a) The introduction of a Damages List, which is controlled by the judge in charge of the list.

(b) The holding of directions hearings.

(c) The encouragement of the use of alternative dispute resolution (ADR) mechanisms. Court annexed mediation has been found to be particularly useful, with it being successful in around 65 per cent of cases.[630] Mediation is the 'intervention of a third party attempting to resolve a conflict between two others'.[631] This mechanism is used where the court orders, or where the parties consent. Other ADR mechanisms may also be used, including information conferences.

8.4 The Law Institute of Victoria in its submission to the Committee observed that costs, delays and inefficiencies in the civil trial process have been reduced through the use of court-based mediation and major changes to the County Court Rules.[632] It pointed to the following changes in particular:

(a) The County Court is now the major trial court for malpractice cases.

(b) Discovery of documents and services of interrogatories are **only** permitted if ordered by the court.

(c) If the defendant has filed an appearance then a directions hearing is held, and the court may take steps to secure admissions or agreements by the parties.

Additionally, a Practice Note is being prepared by the Chief Judge of the County Court on how to regulate the management of medical misadventure cases.

8.5 During the Civil Litigation Reform conference, an expansion of existing court-based ADR was recommended by Judge Jones, who suggested that in

---

[628] Victoria, County Court of Victoria, *Annual Report 1 July 1994 to 30 June 1995*, p. 10.
[629] ibid., p. 9.
[630] P. Innes, op. cit., p. 13.
[631] D. M. Walker, *The Oxford Companion to Law*, Clarendon Press, Oxford, 1980, p. 831.
[632] Submission no. 45. See also the County Court (Chapter I Amendment No. 24) Rules 1995.

future the independent expert evaluation system could be used for many personal injury cases, especially where the case is not complex.[633] The system was developed by the Victorian Workcover Authority (VWA) to deal with common law Workcover cases, and has lead to settlements in approximately 93 per cent of cases.[634] There is some support for the broader use of this system in Victoria. According to Judge Jones 'a group of common law barristers in Victoria have indicated that they are prepared to carry out evaluation in non VWA personal injury cases along similar lines'.[635] This alternative to adjudication is used only where the parties consent. It involves the case being assessed by an experienced barrister, with he or she considering submissions and medical evidence from the parties. The assessment provides both parties with 'a realist figure that can form the basis for negotiations'.[636]

8.6 On 15 November 1996 the County Court issued a *Circuit Practice Note* to assist practitioners in understanding the methods which are used by the court to expedite the resolution of cases. The Practice Note refers to the use of video conferencing to allow call over of the civil lists in a number of provincial centres.[637] During the call over of cases in the directions list, the Judge in Charge may order that mediation or other forms of ADR be used.[638]

Supreme Court of Victoria

8.7 The Supreme Court is also placing increasing emphasis on call overs and the use of mediation. As a result, the waiting time for cases is now approximately eight months.[639] The use of court annexed mediation was developed under the 'Portals' Mediation Initiative, which is outlined in the Court's Annual Report for 1995.[640] Under this scheme there is a list of

---

633 Judge D. A. T. Jones, Alternative Adjudication—Independent Expert Evaluation, paper presented to the Litigation Reform Commission Conference, *Civil Justice Reform—Streamlining the Process*, Brisbane, 6–8 Mar. 1996, p. 3.

634 P. Innes, op. cit., p. 13.

635 ibid.

636 ibid.

637 Chief Judge Chambers, County Court, Melbourne, *Circuit Practice Note*, 15 Nov. 1996, pp. 7–11.

638 ibid, p. 9.

639 Submission no. 60.

640 Victoria, *Supreme Court of Victoria Annual Report 1995*, p. 7.

approved mediators, and judges seek to identify appropriate matters for referral to mediation.

8.8 The Supreme Court has also extended its use of judicial case management. According to the Chief Justice, Hon. Mr Justice John H. Phillips, in June 1996 it was decided that judicial case management should extend to all areas of civil work, with a litigation support group being established to assist in the management.[641] In the past, case management had only applied to cases which were within a specialist list.[642] A Practice Note issued in November 1996 outlines this extension of case management and the reasons for it. The main reason for the change was to increase efficiency:[643]

> Hitherto, cases outside the specialist lists have not been subjected to management and parties have been left to bring them to a conclusion as the parties have seen fit. It is now generally accepted in Australia and in other common law systems that such an approach does not always lead to the most efficient and economical disposition of individual matters or the most efficient application of the necessarily scarce resources of the judicial system.
>
> All litigation is expensive. All proceedings should be brought to an end as soon as that can be done, consistently with the need for each party to have a reasonable opportunity for considering its position and preparing and presenting its case. The new proposal is framed with those considerations in mind.

This reasoning applies equally to the Court's use of case management in medical negligence cases.

8.9 The Practice Note also provides that all pre-trial proceedings and particulars relating to a case should be completed within 18 weeks of the first directions hearing.[644]

United Kingdom Initiatives

8.10 In March 1994 Lord Woolf began a review into the rules and procedures of the civil courts in England and Wales, with the aim of suggesting improvements which would reduce the cost of litigation and improve access to justice, reduce the complexity of the rules and modernise

---

641 P. Innes, 'New Procedures for Supreme Court', 1996 70(1) *Law Institute Journal*, p. 15.

642 Victoria, Supreme Court of Victoria, *Annual Report 1995*, p. 6.

643 Supreme Court of Victoria, *Practice Note No. 1 of 1996*, p. 2.

644 Annexure to Practice Note No. 1 of 1996, 'Civil Case Management—Targets and Draft Directions', p. 1.

terminology, and remove unnecessary distinctions of practice and procedure.[645]

8.11 Lord Woolf's final report on *Access to Justice* was published in July 1996. The review recommended substantial changes to the civil justice system, but rejected the application to medical negligence cases of proposed fast-track and multi track systems, which were recommended for other types of tort cases.

8.12 Among the changes recommended was a shift in responsibility for the management of civil litigation away from litigants and their counsel to the Courts. Judges would be able to allocate cases to the appropriate track for judicial case management and trial. Cases would generally be dealt with according to one of the following systems of management:[646]

> *(a) Small Claims Jurisdiction*
>
> Small claims would usually be dealt with in a single hearing. Complex cases, even if not exceptional, could be transferred by the District Court judge. It was also suggested that the small claims jurisdiction should be expanded, other than in cases of personal injury, to cover matters not exceeding £3,000. This change was implemented on 8 January 1996.[647]
>
> *(b) Fast Track*
>
> Cases where the amount claimed is greater than £3,000 but does not exceed £10,000 would be heard by a fast track which has a strictly limited procedure. No oral evidence may be received from experts and the trial must last not more than three hours. In these cases the amount of discovery would be restricted to 'standard discovery', for example, to the documents on which a party relies.
>
> *(c) Multi-Track*
>
> In cases involving more than £10,000 a case management conference would be held early in the case and a pre-trial review

---

645 United Kingdom, Lord Woolf, *Access to Justice—Interim Report to the Lord Chancellor on the Civil Justice System in England and Wales*, HMSO, London, 1995, p. i.

646 ibid., pp. 21 & 35–36.

647 'Lord Woolf's Final Report on Access to Justice—Media Guide', 26 Jul. 1996 (hereafter cited as 'Woolf Media Guide'), p. 3.

> conducted just before the trial. During these procedures, information would be made available as to the likely costs which would be incurred by each party should the case proceed to trial. The counsel and solicitor who are to appear at the trial must attend both the conference and the review. Discovery would be limited to 'standard discovery' at the first stage, with the extent of extra discovery being determined by the judge.

The Final Report recommended that these last two categories should be generally adopted, although it would be up to judges to determine which procedure best suited particular cases.[648]

8.13 However, there are a number of problems with applying the fast-track system to medical negligence cases. Lord Woolf acknowledged that the procedure would be unsuitable.[649] These cases tend to deal with fairly complex issues of causation, even where the amount sought by the plaintiff is under £10,000. This difficulty was demonstrated in the Medical Protection Society's (MPS) submission to Lord Woolf's inquiry, which concluded that these cases were unsuitable for this system.[650] The Society stated that: [651]

> There is very little correlation between the value of a claim and its medical complexity. Increasingly, issues of cause and effect (causation) are a major issue in medical negligence claims. Whilst a negligent error may have occurred there is frequently considerable argument as to the consequences of the error. Such extremely high value claims (for example, the so-called brain-damage cases) may have relatively simple issues of liability and causation. *On the other hand, some relatively low value claims may raise highly complex issues of causation*. [emphasis added]

8.14 According to the MPS, the procedure is also unsuitable because the practitioner's reputation is involved in these cases.[652]

> It matters little to the doctor's perception about the impact of an allegation of negligence whether the claim is of high or of low financial value. He or she will be jealous of professional reputation and integrity irrespective of price.

---

648 United Kingdom, Lord Woolf, *Access to Justice – Final Report to the Lord Chancellor on the Civil Justice System in England and Wales*, HMSO, London, 1996 (hereafter cited as 'Woolf Final Report'), pp. 2 & 69–71; Woolf Media Guide, p. 9.

649 Woolf Final Report, p. 192.

650 ibid., p. 7.

651 Medical Protection Society, 'Access to Justice: Comments of the Medical Protection Society on the recommendations in the interim report on the Civil Justice system in England and Wales', p. 2. See attachment to Submission no. 36.

652 ibid.

The Society is concerned that if low value claims are forced down a fast track procedure, subject to rigid timetabling with limited experts and a three hour hearing, the result is likely to be a 'quick fix' at the expense of grave injustice to all concerned, but especially to the doctor or dentist.

8.15 Accordingly, Lord Woolf suggested that 'the Court Service should facilitate a pilot study of other options for litigating smaller claims on a modest budget: a modified fast track, a best practice approach or a streamlined multi-track procedure'.[653]

Responses to Judicial Case Management

8.16 The case management measures introduced in Victoria have been well received by Government departments and the legal profession. The changes to the civil litigation process were described by the Departments of Human Services and Justice in their joint submission to the Committee as 'succeeding in reducing cost and delay for all types of civil matters'.[654] Further, the submission suggested that 'there is no apparent reason to distinguish personal injuries litigation from other types of litigation, all of which are being case managed in an increasingly effective manner'.[655]

8.17 There was considerable support in the submissions to the present inquiry for the use of mediation. Indeed, many of the submissions indicated that there should be greater use made of alternative dispute resolution, such as mediation.[656] Notably, the Melbourne Division of General Practice recommended that mediation be used as the main form of dispute resolution.[657] Further, it was suggested that independent scientific experts should advise mediators and mediators should be trained in aspects of health service issues and in successful dispute resolution. They should be able to propose settlement terms, with compensation being assessed for losses or previous temporary impairment and loss of income suffered and the effects of continuing impairment. Mediation should be subject to appeal to the

---

653 Woolf Media Guide, p. 14. See also Woolf Final Report, p. 196.

654 Submission no. 60.

655 ibid.

656 Submission nos. 29 & 32. Submission no. 29 recommended, however, that conciliation and mediation services should not be allowed to be controlled by lawyers, because they seek confrontation and their fees are costly.

657 Submission no. 34. See also submission nos. 39, 40, 41, 43, 49, 50 & 51 which supported the submission from the Melbourne Division of General Practice.

Victorian Supreme Court. The Inner Eastern Melbourne Division of General Practice also recommended that the mediation system should be improved. This would 'address the need for improved and advanced communication skills of doctors [and] overcome communication breakdown problems'.[658]

8.18 The Australian Medical Association (Victorian Branch) supported the case management initiatives introduced by the County Court, because they 'would see a greater utilisation of alternative dispute resolution or mediation processes in the court process'.[659]

8.19 The Law Institute specifically endorsed the use of mediation in the Supreme, County and Magistrate Courts as providing a 'speedy, low-cost alternative to litigation':[660]

> In late 1995 the Chief Justice instigated the use of mediation in all three levels of the Court system…This followed the successful use of mediation in Supreme Court "Offensives" to tackle backlogs in civil cases in 1992–1993 and 1995 respectively. The mediation programme included in the Spring Offensive 1992 is reported by the Supreme Court to have assisted in settlement in just over 50% of the Court's civil list of cases awaiting trial (see Bartlett, C., "Mediation in the Spring Offensive 1992", (1993) 67 *LIJ* 232). In the Autumn Offensive 1995, a settlement rate of 79.65 per cent was obtained in those cases sent to mediation.

8.20 The submission goes on to state that these changes should be considered by the Committee, especially in light of the failure of the Professional Indemnity Review to give this issue sufficient weight:[661]

> Although ADR is canvassed in both the Issues Paper and in the Interim Report of the Professional Indemnity Review, the incorporation of a mediation programme within court procedures is by and large overlooked. This is regrettable and surprising given that mediation is a confidential process (and therefore is an answer to those who are concerned about details of cases being published in the media) and has also been described by the Chief Justice as "an economical, speedy and trauma-free method of dispute resolution".

8.21 The Law Institute also gave its support to the case management measures used in the County Court. It recommends that 'the Law Reform Committee note the significance of these improvements to the civil trial

---

658 Submission no. 52.
659 Submission no. 32.
660 Submission no. 45.
661 ibid.

process' and 'evaluate the effect of these changes within the context of its inquiry'.[662]

8.22 The Australian Plaintiff Lawyer's Association supported the moves by the courts to reduce delays and inefficiencies in the trial process; namely, through case management and mediation. In its submission, it wrote:[663]

> APLA endorses any move to reduce delays and inefficiencies in the trial process. Such moves have already been taken by the Supreme Court with the event of a Major Torts List and directions hearing being conducted by the Listings Master, and in the County Court with the advent of the Damages List. Both lists are controlled by Judges whose charter, inter alia, is to have cases proceed with speed by eliminating known delays in the use of various traditional interlocutory steps and limiting the use to which such traditional interlocutory steps are put where the same may be regarded as unnecessary having regard to the peculiarities of the particular case. Mediation is invariably ordered at an early stage conducted by a mutually appointed independent mediator, supplied with materials from both parties, who requires both parties to negotiate the case realistically. Failing successful mediation, the case is invariably listed for trial without further delay.

Accordingly, its submission recommended that the trial process should not be changed.

8.23 The Victorian Bar holds a similar view and it points to the work of trial management committees in this area. These committees are comprised of experienced trial judges, barristers and solicitors.[664]

8.24 The Medical Defence Association of Victoria believes that the court initiatives to reduce costs will be effective, especially that of mediation. Considerable support is given to the initiatives taken by the County Court:[665]

> The Medical Defence Association of Victoria is aware of the active steps being taken by all levels of courts in Victoria to reduce the cost, delay and other inefficiencies in civil actions for damages for injuries. Important work is being carried out in the County Court in which the majority of claims against medical practitioners are commenced.
>
> The court programs are in their infancy. However, there are early indications that the programs being introduced by the courts are leading to significant improvements in the litigation process. The Medical Defence Association of Victoria considers these court initiatives are to be encouraged and also recognises that for them to realise their full potential, the Government must be prepared to commit resources to the process.

---

662 ibid.

663 Submission no. 19.

664 Submission no. 48.

665 Dr D. R. V. Dickens, President of the Medical Defence Association of Victoria, letter dated 22 Apr. 1997.

8.25 Similarly, the Medical Protection Society recognised the moves, especially in the County Court, to accelerate the court processes, although the experience in South Australia was preferred.[666]

8.26 However, concern regarding the success of these measures was expressed in the submission of the solicitors Slater and Gordon, which advised the Committee that 'none of the numerous inquiries into the costs of the legal system has produced recommendations which in our view are likely to substantially decrease the cost of legal proceedings'.[667] Further in response to the issue of how legal costs could be reduced while still ensuring acceptable standards in the provision of legal services, they observed that:[668]

> Changes made to Rules of Court for the purpose of increasing efficiency of the legal system often result in increased legal costs. For example, the recent change to the County Court Rules to require litigants to obtain leave for discovery and interrogatories could be expected to cost each party an additional $1,000.00. Similarly, the costs of an unsuccessful mediation can add up to $5,000.00 to the cost of a proceeding. Court imposed requirements for witness statements, written outlines of argument, and written submissions, further add to legal costs. It is precisely because of these characteristics of the legal system that an adequately funded system of civil legal aid is essential to ensure access to justice for plaintiffs in medical negligence cases.

8.27 Other ways to improve the litigation process were suggested in some submissions. Notably, in a joint submission, the National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists recommended three ways of reducing legal costs: solicitors working on medical negligence cases should have specialist training and some specialist experience in the field, the number of witness should be limited, and proceedings should be streamlined.[669] The Western Health Care Network also advocated the use of streamlining to improve efficiency, it suggested that specialised courts should be used for medical negligence matters.[670] As already discussed, Lord Woolf in his final report on *Access to Justice* provided a model for the streamlining of proceedings.

---

[666] Submission no. 36.
[667] Submission no. 20.
[668] ibid.
[669] Submission no. 35.
[670] Submission no. 38.

However, problems were found in applying the fast track system to medical negligence matters.

8.28 The Committee commends the improvements in case management noted above. They have had a significant impact on the efficiency of the civil justice system by improving the way people injured through medical negligence can achieve suitable redress, and have reduced delays in bringing proceedings to a conclusion and the cost of those proceedings. The work of the courts in this area was recognised by those submissions which dealt with this topic. While, the Committee recognises that the increased use of judicial case management has resulted in a greater workload for judges, the Committee has concluded that these efforts should be further encouraged.

8.29 The Committee remains concerned about the spiralling cost of litigation and inordinate delays in civil litigation. These issues need to be further addressed to ensure that where standards are not maintained people have suitable redress in the courts, if they so desire.

8.30 At the federal level consideration is being given to this issue. On 29 November 1995, the Law Reform Commission of Australia (ALRC) was given terms of reference which require it to review the adversarial system of litigation, with particular reference to civil litigation procedures before courts exercising federal jurisdiction.[671] The inquiry is extensive in nature. It includes, among other matters, examining procedures and case management schemes used by courts and tribunals, mechanisms for identifying the issues in dispute, and the use of court-based and community alternative dispute resolution schemes. The commission will not produce preliminary recommendations until 30 September 1997, with the final report to be produced a year later.

8.31 The ALRC's review arose out of concerns that the litigation system was excessively adversarial in nature, with this being seen as having a damaging

---

[671] Australian Law Reform Commission, *Review of the Adversarial System of Litigation: An Introduction to the Inquiry*, Background Paper, ALRC, Sydney, 1996, attachment: 'Terms of Reference, Dated 29 Nov. 1995, Attorney-General, Michael Lavarch'.

effect.[672] It should be noted that the ALRC's inquiry is not intended to look at the situation in the States, other than for the purpose of comparison.[673] The Committee believes that these issues should be closely monitored and if thought necessary, examined in Victoria.

Recommendation 25

The continued use of case management measures by Victoria's courts should be encouraged.

ALTERNATIVE DISPUTE RESOLUTION

Introduction

8.32 The Committee has been specifically requested to investigate alternatives to the current court-based system of compensation for people injured in the use of health services.[674] There has been considerable work done in this area in recent times. An extensive review of the alternative dispute resolution (ADR) mechanisms in various countries has already been carried out by the Commonwealth Department of Human Services and Health's Review of Professional Indemnity Arrangements for Health Care Professionals (PIR) and this information is contained it its 1991 Interim Report.[675]

8.33 The PIR supported greater use of alternative dispute resolution for a number of reasons.[676] It can sometimes preserve the doctor-patient relationship. There is less difficulty with complainants obtaining expert advice and they do not have to be able to afford a lawyer. The atmosphere is relatively informal, which may assist the injured person who lacks the stamina required to pursue litigation through to the end. The system of awarding costs against the unsuccessful litigant does not apply in alternative dispute resolution.

---

672 ibid, p. 1.

673 ibid, pp. 1 & 5.

674 Victoria Government Gazette, G37, 21 Sep. 1995, p. 2719; amended Victoria Government Gazette, G 43, 2 Nov. 1995, p. 3082.

675 Commonwealth Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity Care: An Interim Report*, AGPS, Canberra, 1994, (hereafter cited as 'PIR Interim Report') pp. 90–96.

676 Mr R. Boyce, Assistant Director of the National Cervical Screening Program (formerly Senior Officer with the Review of Professional Indemnity Arrangements for Health Care Professionals), *Minutes of Evidence*, 23 Feb. 1996, pp. 96–97.

8.34 The desirability of using ADR mechanisms was also recognised in the recent report by Lord Woolf on the civil justice system in England and Wales. He recommended encouraging the use of these mechanisms where the claim relates to medical negligence, particularly where the claim is relatively small.[677]

8.35 Suggestions for the use of alternative dispute resolution in resolving claims against health service providers were outlined in several submissions. The submission of the Institute of Legal Executives suggested that there should be a medical ombudsman, with power to refer complaints to appropriate organisations and tribunals.[678] The Health Services Commissioner already carries out this function to some extent. The submission argues that alternative dispute through the Health Services Commissioner or otherwise could be employed to assist the parties in identifying the issues. The Elearnor Shaw Centre for the Study of Medicine recommended that the legal liability system should be linked to a dispute resolution process which looks at conciliation and mediation separately from the issue of compensation.[679] The need for such a system was founded on the fact that many instances of litigation arise from the desire to have a perceived wrong rectified or to come to terms with a betrayal of trust. The submission also stated that medical education should emphasise the need for practitioners to communicate well with their patients. This educative role could be performed by the professional organisations and the medical and lay media.

8.36 The Committee's inquiry has focussed on three models of alternative dispute resolution; compulsory conciliation (by extending the role of the Health Services Commissioner (HSC)), preliminary screening and arbitration panels. In the Committee's Issues Paper, responses were sought from the community on the desirability and feasibility of the introduction of

---

677 Woolf Final Report, p. 195.
678 Submission no. 22.
679 Submission no. 8.

preliminary screening and arbitration panels, in the context of discussing the nature of the Health Services Commissioner's role.[680]

The Health Services Commissioner

8.37 The Health Services Commissioner (HSC) provides a framework that could be adapted to provide for compulsory conciliation or the carrying out of the screening function. Before discussing whether or not such functions should be assigned to the HSC, it is necessary to outline its existing roles and functions. The HSC is an independent statutory authority which was created to investigate, conciliate and resolve disputes between patients and doctors, hospitals and other health service providers.

8.38 The HSC was established in 1988 by the *Health Services (Conciliation and Review) Act 1987*. The decision to establish the HSC followed a recommendation of the Victorian Parliament's Social Development Committee in its final report on *Complaints Procedures Against Health Services*(1984). The Committee's recommendation was made after it concluded that going before the courts with a complaint 'takes time, money and conviction, it is rarely used by those consumers who need it most, that is, the frail, aged, sick, intellectually handicapped, consumers in lower socio-economic groups, and non-English speakers'.[681]

The Existing Role of the Health Services Commissioner

8.39 Under the Act, the HSC has three main functions:

(a) It endeavours to resolve disputes by providing an independent, accessible and impartial alternative to the courts. The conciliation of complaints is confidential and privileged.

(b) The HSC also seeks to help health service providers to improve their quality of health care. Feedback is able to be provided for quality improvement by the processing of complaints.

---

[680] Parliament of Victoria, Law Reform Committee, *Legal Liability of Health Service Providers – Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996, pp. 43–47.

[681] Parliament of Victoria, Social Development Committee, *Interim Report upon Complaints Procedures Against Health Services*, Vic. Government Printer, Melbourne, 1983, p. 51; Parliament of Victoria, Social Development Committee, *Final Report upon Complaints Procedures Against Health Services*, Vic. Government Printer, Melbourne, 1984, pp. 31–33.

(c) The HSC promotes the eight guiding principles for the quality of care which are found in the preamble to the Act. According to the HSC, these principles are used in deciding if a complaint is about a service that has been provided or withheld, reasonably or unreasonably.[682]

8.40 Where the complaint involves a 'significant standards issue' it may be formally investigated by the Commissioner or referred to a professional registration board or other agency. In relation to these formal investigations, the Commissioner has the power to compel attendance and call for evidence and documents. The Commissioner tends to only use these powers when the complaint is likely to contain matters of public interest. Where the Commissioner decides the complaint is justified he or she must decide what action should be taken to remedy it.

8.41 Additionally, the HSC is a central base for data collection on complaints. Pilot studies during 1993 and 1994/95 have considered improving the collection, management and use of information relating to complaints.[683]

8.42 The Commissioner has the power to consult with various bodies. It liases with branches of the Victorian Department of Human Services and the Commonwealth Department of Health and Family Services in relation to health services provided directly by these Departments. Matters may be referred by the HSC to the relevant registration board, the Guardianship Board, the Office of the Public Advocate, the Ombudsman and the Coroner.

---

682 Ms V. McCutcheon, Acting Health Services Commissioner, *Minutes of Evidence*, 12 Feb. 1996, p. 37. See also submission no. 2.

683 Submission no. 60.

8.43 Complaints about the HSC may be made to the Ombudsman. However, given the manner in which conciliation is conducted it is difficult to review, because the confidentiality requirements mean that the Ombudsman lacks access to what occurred during the process, he or she only has access to the outcome.

8.44 General advice and constructive oversight of the operations of the HSC is carried out by the Health Services Review Council. It consists of three representatives from each of the following groups: providers, users and persons without an affiliation with any professional association for users or providers. Additionally, the Commissioner reports annually to Parliament.

How Complaints are Treated

8.45 The HSC receives complaints from users of health services and complaints made on their behalf, for example, when a person is not capable of complaining. Where complaints are against the public sector, the Department and the individual organisations are respondents to the complaint.[684] Before the HSC accepts a complaint it must be within its jurisdiction and not be trivial, vexatious or frivolous.[685] Jurisdiction is acquired once the complaint is referred to the HSC or if it receives a referral from Parliament or a minister to conduct a general inquiry.

8.46 The HSC encourages complainants to write to the provider in order to try and resolve the complaint themselves. Most complaints handled by the HSC are minor. They tend to be dealt with by listening and identifying the complaint (70 per cent of complaints are handled by the HSC in this way), the remaining complaints are handled by an investigator identifying the issues with the provider, perhaps with other opinions being obtained, and then advising the complainant.[686] Only a very small number of complaints are formally investigated. This will happen if the complaint is very serious or the information could not otherwise be obtained.[687] In cases where there is a formal investigation the Commissioner can decide if the complaint is justified. The investigation is confidential, but is not covered by the privilege provision.

---

684 Ms V. McCutcheon, op. cit., p.38.

685 Ms Newby, Health Services Commissioner, *Minutes of Evidence*, 12 Feb. 1996, p. 40.

686 Ms V. McCutcheon, op. cit., p.39.

687 ibid.

8.47 Of those complaints which are not initially resolved, approximately six to ten per cent of complaints are referred for conciliation. In these cases a financial settlement is sought by the complainant or there appears to be some negligence.[688]

8.48 Conciliation is a consensual process which involves a neutral umpire who points out the parties' options. The conciliator is not involved in the HSC's preliminary assessment of the complaint. He or she may discuss matters with the parties independently or jointly, perhaps indicating to the parties the strengths and weaknesses of their position and possible solutions. The conciliator applies the same principles as are used in negligence cases, there must be a breach of the duty of care, expert medical opinions are obtained, and there must be causation.[689]

8.49 To assist in the HSC's function, it was suggested by the National Association of Specialist Obstetricians and Gynaecologists in their joint submission and the Royal College of Obstetricians and Gynaecologists that the Commissioner should be given access to lists of experts prepared by the Royal Colleges.[690]

8.50 Lawyers are not present during negotiations, unless the consent of the Commissioner has first been obtained. It is only when a conciliated complaint is about to be concluded which involves an agreement for compensation that complainants are advised by the HSC to consult with a lawyer for advise on the quantum of compensation.[691] Because they have a neutral role, conciliators do not advise complainants whether the offer is a fair one.[692]

8.51 The vast majority of complaints to the HSC do not result in financial compensation being paid. As at February 1996, there had been 1100 cases where conciliation was used, of these only 10 per cent have lead to a financial

---

688 ibid.

689 Mr Jackson, Conciliator, Office of the Health Services Commissioner, *Minutes of Evidence*, 12 Feb. 1996, pp. 45–46.

690 Submission no. 35.

691 Mr Jackson, op. cit., p. 47.

692 ibid.

pay-out.[693] This figure reflects the HSC's approach to conciliation. According to the Medical Defence Association of Victoria, the HSC not only provides a useful forum of communication between patient and practitioner, but also has only sought to have compensation paid where an entitlement can be established based on negligence.[694]

Increasing the Role of the Health Services Commissioner

8.52 The main reason for expanding the role of the HSC is the high success rate in dealing with complaints which have come before it. There is the potential for additional savings in cost and time in dealing with complaints if the HSC is further utilised. Other benefits of using the HSC include; the possibility of preserving the patient/doctor relationship, the informal environment of the proceedings and access to expert conciliators.

8.53 Although most of the complaints handled by the HSC are minor, there is the potential for it to deal with more serious cases. Recently, there has been a growth in the number of serious medical negligence complaints being handled. According to the 1995/1996 Annual Report, there were 503 substantial complaints in 1995/96 compared to 470 in 1994/95 (a 7% increase) and 235 serious complaints in 1995/96 compared to 192 in 1994/1995 (a 22% increase).[695] This growth reflects the HSC's strategy of concentrating its resources on dealing with serious complaints.

8.54 The HSC plays an important role in encouraging communication between the parties. Among the submissions, support was given for the referral of all complaints to the hospital at first instance where the complaint originated,[696] or for all claimants undergoing substantial pre-trial counselling.[697] This first measure is promoted by the HSC, with complainants being encouraged to write to the health service provider. The Eastern Health Care Network indicated that the 'alternative conciliation scheme conducted by the HSC has worked successfully in a number of instances'.[698]

---

693 Mr Jackson, op. cit., p. 45.
694 Submission no. 77, p.10.
695 Victoria, *Annual Report for the Office of the Health Services Commissioner 1995–1996*, pp. 10–11.
696 Submission no. 42.
697 Submission no. 35.
698 Submission no. 42.

8.55 The HSC's conciliation program appears to have been very successful. The parties very rarely withdraw from conciliation before reaching a settlement, and most people (more than 90 per cent) do not go elsewhere after conciliation.[699] Moreover, the HSC indicates that conciliation is not being used as a delaying tactic by medical defence organisations, despite the potential for this to occur.[700]

8.56 The Law Institute of Victoria in pointing out the difficulties with the introduction of screening panels and the like, supported the conciliation role played by the HSC:[701]

> Most cases concerning adverse patient outcomes involve the unravelling of "who said what to whom and when was it said". The issues are factual, are usually based on recollection and do not lend themselves to informal panel hearings. There are not many disputed claims for damages which turn on a technical medical issue. *It is difficult to ascertain what savings would flow from the use of a panel as distinct from the normal dispute resolution options already available—namely, mediation, the conciliation service provided by the Health Services Commissioner, and the traditional pre-trial negotiations and informal conferences*. [emphasis added]

8.57 Accordingly, the Committee has concluded that the HSC provides a suitable redress for people when standards are not maintained, and that it reduces the provider's fear of litigation by educating and providing information to him or her on better practice through compliance with the guiding principles. The HSC's services are particularly useful in relation to small claims, but not restricted to them. These factors mean that consideration should be given to how the services of the HSC can be expanded. Three alternatives were canvassed by the Committee in Issues Paper No. 1: compulsory conciliation, screening panels and arbitration.

Alternative Mechanisms for Increasing the Role of the Health Services Commissioner

Compulsory Conciliation

Support for Compulsory Conciliation

8.58 In the submissions to the Committee and evidence received there was considerable support for either the introduction of compulsory conciliation

---

[699] Mr Jackson, op. cit., p. 44.

[700] Ms Punshon, Conciliator, Office of the Health Services Commissioner, *Minutes of Evidence*, 12 Feb. 1996, p. 54.

[701] Submission no 45.

prior to issuing of proceedings for claim of negligence, or an expansion of the HSC's conciliation services. The introduction of compulsory conciliation was supported by the HSC, with it being seen as a natural extension of its role.[702] The Medical Protection Society also favoured an expansion of the conciliation services provided by the HSC, rather than the introduction of arbitration or a Health Services Compensation Tribunal.[703] The Society advises that 'there is increasing confidence on behalf of the health care providers in the conciliation processes and services provided by the Health Services Commissioner'.[704]

8.59 The use of conciliation was praised also by the Australian Dental Association,[705] the Women's and Children's Health Care Network[706] and the Victorian Nurse Executives Association.[707] The National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists said in their joint submission that they would like to see the use of the tort system become secondary to that of the HSC.[708] They recommended that initial conciliation by the HSC should be free of charge. Plaintiffs who go to higher levels in the conciliation process should pay a deposit and legal aid may be necessary at this further stage of arbitration.[709] The benefits of using the conciliation services of the HSC were described in their submission.[710]

> Liability is arrived at by consensus, and theoretically both parties should be satisfied with the result. This is the opposite outcome to the adversarial system where there are "winners" and "losers". We strongly support this mechanism of settling disputes, as it has so far been applied by the Health Services Commissioner in the State of Victoria. We see this mechanism as being able to make reasonable settlements and as a very useful tool in the settlements of disputes between doctors and their patients.

8.60 Compulsory conciliation by the HSC was supported by several individual practitioners. The HSC is generally viewed as having worked well. Its work has the potential to be very useful in relation to rural practitioners. Dr Macfarlane, a general practitioner from Bairnsdale observed that the HSC

---

702 Ms Newby, op. cit., p. 66.
703 Submission no. 36.
704 ibid.
705 Submission no. 33.
706 Submission no. 5.
707 Submission no. 31.
708 Submission no. 35.
709 ibid.
710 ibid.

provides an opportunity to resolve misunderstandings between patients and doctors, especially where these arise from 'a lack of appreciation of city versus country and trans-cultural problems'.[711] The HSC is particularly useful because it provides a forum for communication, and an expansion of its role would, according to Dr Peter Ryan, an Associate Professor of Medicine at Monash University, reduce the problems caused by the current litigious environment.[712]

8.61 To encourage conciliation among the parties, it was suggested by some groups that the availability of legal aid should be conditional upon the parties having first attempted conciliation.[713]

Opposition to Compulsory Conciliation

8.62 Some opposition to expanding the role of the HSC to include compulsory conciliation was expressed. It was suggested that the conciliation role of the HSC should be refined further before considering its expansion.[714] While the Victorian Breast Screening Coordination Unit expressed support for an expanded role for alternative dispute resolution, including the allocation of additional resources to the HSC for this purpose, the Unit 'would be most concerned about any moves to make alternative mechanisms compulsory, if the effect were to deny a plaintiff access to the tort system'.[715]

8.63 The Victorian Bar Council expressed the view that:[716]

> The role of the Health Services Commissioner should not be complicated or compromised by the Health Services Commissioner having any role in tortious litigation.

It should be noted that this response does not directly deal with the issue of expanding the conciliation function of the HSC. The solicitors Slater and Gordon also opposed the introduction of compulsory conciliation, and any increase in the HSC's role in relation to conciliation. In their opinion:[717]

---

711 Dr Macfarlane, Bairnsdale, *Minutes of Evidence*, 8 Nov. 1996, p. 14.

712 Submission no. 74. The introduction of compulsory alternative dispute resolution was also supported by some submissions, see e.g., submission no. 30.

713 Submission nos. 5 & 35.

714 Submission no. 42.

715 Submission no. 54.

716 Submission no. 48.

717 Submission no .20.

> Screening panels would serve no useful purpose, would almost certainly be biased in favour of defendants, would add to the cost of litigation, and would unfairly force plaintiffs to disclose their evidence prior to the issue of proceedings. These problems can be observed when complaints are made to the Health Services Commissioner. In our experience, complainants have been encouraged to provide confidential material to prospective defendants, without being warned of the disadvantages of doing so if the matter cannot be resolved by the Commissioner. Health service providers, in contrast, are not so naive.

8.64 Although the issue of compulsory conciliation was not expressly raised in the Committee's issues paper, a number of related issues were discussed. Accordingly, there was an opportunity to express an opinion on extending the conciliation role of the HSC. Those who chose to do so, tended to favour this approach. Against this background, there was limited opposition to compulsory conciliation.

8.65 The Committee believes that there are other similar areas which might merit the introduction of conciliation or an increase in its use, for example, an action relating to a legal professional. In such a case there is an existing relationship which may be able to be preserved, and the existence confidential information concerning the plaintiff.

Changes which would need to be Made for the Health Services Commissioner's Conciliation Services to be Expanded

8.66 If the role of the HSC were to be extended, three matters would need to be addressed:

(a) The adequacy of funding to the HSC.

(b) The potential conflict between the HSC's conciliation role and the Commissioner's responsibility for standards of health care.

(c) The fact that when a matter is referred to a professional registration board for investigation, the HSC's ability to conciliate the complaint is lost, despite the wishes of the complainant.

8.67 The HSC has indicated that there are insufficient funds to educate the community about its existing role.[718] An expansion of the HSC's role would place an even greater burden on the HSC's resources. The Committee heard evidence to the effect that if the HSC took over the role of compulsory

[718] Ms Newby, op. cit., p. 49.

conciliator there would need to be not only legislative change, but also an increase in funding.[719] The joint submission from the National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists recommended that additional funding should be provided to the HSC.[720] Similarly, the Medical Protection Society stressed that the conciliation service provided by the Victorian office should be expanded, and given adequate resources and publicity.[721]

8.68 However, the recent Resourcing Review by the Department of Human Services suggested that the funding problems could be addressed by management changes.[722] Its recommendations included reducing staff caseloads, setting benchmarks for the fast closure of complaints, and staff restructuring.[723] The HSC welcomed the proposal to streamline cases, with those that need limited handling being identified quickly, as distinct from those which should be referred.[724] However, they thought that the use of benchmarks would be problematic:[725]

> HSC is concerned however that the proposed benchmarks may not be achievable. Complex complaints, made by people in a highly charged emotional situation, require careful and detailed analysis of numbers of records and interviews with senior medical persons. The outcome must be based on attempting a resolution rather than a focus on rapid closure.

8.69 Although the recommendations contained in the review may address the funding problems to some extent, an increase in funding will be necessary if the HSC's role is to be increased, in which case there is likely to a corresponding reduction in expenditure for Hospitals, Courts and the Human Services Department. This may mean that there is no net increase in government expenditure, arising from an expansion of the HSC's role.

8.70 It would be necessary also to deal with the potential conflict between the function of the HSC in resolving complaints to the satisfaction of the

---

719 Ms McCutcheon, op. cit., p. 66.
720 Submission no. 35.
721 Submission no. 36.
722 Victoria, *Office of the Health Services Commissioner, Annual Report for 1995–1996*, p. 6.
723 ibid.
724 ibid., pp. 6–7.
725 ibid., p. 7.

parties, and the Commissioner's responsibility for standards of health care. The conflict arises from the fact that once a compliant goes to conciliation its impact in the wider health system is lost. According to the former Health Services Commissioner, Ms Newby, the Victorian legislation provides no guidance on how to deal with this conflict.[726] Several of the other Australian jurisdictions have addressed this issue; including, New South Wales, Queensland and the Australian Capital Territory. The Committee believes that the adoption of one of these mechanisms is necessary in Victoria if the HSC's role as a conciliation body is to be expanded.

8.71 New South Wales provides a useful model. Under section 56 of the *Health Care Complaints Act 1993* (NSW) the Commissioner is able to investigate a complaint that has been subject to conciliation, where the conciliator's report recommends that it be investigated, or new material becomes available which would cause the Commissioner to refer the complaint for investigation. Additionally, section 55 requires the Health Conciliation Registry to report to registration authorities generally on the complaints that have been conciliated in the last six months. The report will include reference to general issues arising out of complaints, which are relevant to professional or educational standards of the profession. The registration authority is only able to use the report to provide general information to health practitioners concerning professional and educational standards.

8.72 In Queensland the *Health Rights Commission Act 1991* (Qld) provides that the Commissioner is to decide whether or not to conciliate a complaint, as distinct from investigating or referring the matter to a registration board. In so doing, he or she is to take into account the public interest. The Act also states that 'the Commissioner may decide not to take action on a health service complaint if it has been conciliated and the conciliator recommends that the Commissioner should not take action'.[727] Accordingly, the Commissioner has a discretion as to whether or not further action is taken after conciliation. To

---

[726] Ms Newby, op. cit., p. 52.

[727] *Health Rights Commission Act 1991* (Qld), s.75(9).

assist in exercising this discretion, the Commissioner receives a report from the conciliator as to any issues involving the public interest. Before conciliation starts, the Commissioner will have identified and informed the conciliator of any issues raised by the complaint which he or she considers involves the public interest.[728] Confidentiality is preserved for the parties under section 85 of the Act, which prevents anything said during conciliation from being admissible before a court or tribunal or being used as a ground for investigation or inquiry by the Commissioner.

8.73 In the Australian Capital Territory section 40 of the *Health Complaints Act 1993* (ACT) allows the Commissioner to investigate a complaint, even if the process of conciliation is complete, provided it appears to him or her that there are significant issues of public safety or public interest or a significant question as to the practice of the provider.

8.74 Accordingly, the Committee believes that the *Health Services (Conciliation and Review) Act 1987* (Vic.) should be amended to provide:

(a) the Commissioner with a discretion to take action, even where the matter has been settled through conciliation;

(b) conciliators with the ability to report to the Commissioner on whether the matter involves public interest concerns or significant standards issues; and

(c) for the establishment of the Health Council Registry, which receives information on general issues of professional or educational standards arising out of conciliated matters, so that it can report to health providers on this general information.

8.75 The HSC's ability to deal with a complaint is lost once it has been referred to the Medical Practitioner's Board, unless it is asked deal with the complaint by the board.[729] The HSC has an obligation to refer matters which are not suitable for conciliation to the board. Where the Board and the

---

728 *Health Rights Commission Act 1991* (Qld), s.79.

729 *Health Services (Conciliation and Review) Act 1987*, s.23(4): 'The Commissioner must stop dealing with a complaint about a registered provider which the Commissioner has referred to the appropriate registration board unless the board asks the Commissioner to continue dealing with the matter, or unless the Minister has referred the matter to the Commissioner for inquiry.'

Commissioner agree that the complaint is suitable for conciliation, the complaint is dealt with by the HSC.[730]

8.76 The HSC ceases to deal with a matter that has gone to the Medical Practitioner's Board in order to avoid duplication.[731] Moreover, the HSC's work was intended to compliment, not replace, that of other bodies, including registration boards. During his second reading speech on the bill, Mr Roper observed:[732]

> The office will not duplicate the functions of professional registration boards in relation to complaints regarding the professional conduct of their members.
>
> The relationship between registration boards and the commissioner will be one at "arms length" so that their respective roles are distinct.

Before the Bill was debated there were concerns that establishing the HSC would result in a double jeopardy situation for health service providers.[733]

8.77 However, the way in which the legislation is operating has meant that it may need to be amended. According to the former Health Services Commissioner, Ms Newby, discussions with the board have revealed its preference to deal with certain types of behaviour. This in turn may create a difficulty for complainants who will lose the option of having the matter dealt with by conciliation. She advised that:[734]

> We may be faced with a complainant who, firstly, wants compensation and will not get it from the board and, secondly, may feel totally intimidated and unable to cope with the full panoply of a tribunal hearing such as those run by the board.

8.78 This problem appears not to have been envisaged by the drafters of the legislation. The Committee believes that the relationship between the HSC and the registration boards needs to be clarified. It should be such that the two systems operate in tandem. In so recommending, the Committee is not advocating that the operations of the board be circumvented. The Committee has concluded that it is desirable to address these three problem areas even if a greater role is not assigned to the HSC. This should be done in order to facilitate the efficient operation of the HSC.

---

730 *Health Services (Conciliation and Review) Act 1987*, s.24(5).
731 Victoria, *Parliamentary Debates Assembly*, , p. 500.
732 ibid., 26 Feb. 1987, p. 165.
733 ibid., 17 Mar. 1987, p.498.
734 Ms Newby, op. cit., p. 53.

Preliminary Screening of Claims

8.79 Screening panels are employed in a number of jurisdictions in the United States.[735] These panels determine the merits of the case before it can go to trial, by so doing, they encourage early settlement. The panel does not prevent a plaintiff taking the matter to court, but where an adverse finding is given, it may be used as evidence in the trial.

8.80 The distinction between conciliation (including compulsory conciliation) and the use of screening panels is that the former creates an environment where the parties are able to freely exchange information in order to reach a solution which they find acceptable, whereas this feature does not exist in relation to the use of screening panels. The importance of the confidentiality of conciliation proceedings in encouraging discussion between the parties was recognised by the Professional Indemnity Review:[736]

> Conciliation should allow for informal discussion, exchange of information (including independent legal and medical advice), to help reach a voluntary agreement or settlement. All proceedings should be confidential and legally privileged and consumers allowed the support of an advocate.

8.81 Similarly, according to the HSC, it is the fact that information cannot be used in a court hearing or formal investigation which 'encourages providers to be more open and honest in providing explanations and expressing opinions'.[737] This in turn means that conciliation can be used as a suitable means for redress where standards are not maintained by health service providers.

8.82 A screening panel may be comprised of people with a range of experience; such as, a member of the judiciary, a lawyer, a health professional from the relevant speciality and a lay person. The panel conducts a fairly informal hearing.

Support for Screening Panels

---

735 See discussion provided in Law Reform Committee, *Legal Liability of Health Service Providers – Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996, pp. 43–44.

736 Commonwealth Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity Care: An Interim Report*, AGPS, Canberra, 1994, p. 7.58.

737 Victoria, *Office of the Health Services Commissioner Annual Report for 1995/96*, p. 15.

8.83 Several submission supported pre-trial screening of claims. Notably, the Royal Australasian College of Surgeons and several other groups pointed to the benefits of using screening panels of experts; these include, a reduction in delays, cost and an improvement in access to justice.[738] The College would, however, only support this change if appropriate legal representation and guidance were provided.

8.84 However, among the submissions which supported the pre-trial screening there was some difference in opinion as to who should sit on the panel. The Australian Council of Professionals recommended that the panel should be constituted of experts and up-to-date generalists within the professions, without there being assistance from government-appointed lawyers or lay persons.[739] The Australian Dental Association recognised the potential of screening, but stressed that it must be by way of peer review at a very high level.[740]

8.85 Some submissions indicated that pre-trial screening should be carried out by the HSC.[741] According to the National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists in a joint submission, all claims should be screened to determine if they are frivolous, vexatious or trivial. At first instance this should be done by the plaintiff's lawyer as part of their professional code, and then by the Health Services Commissioner, with an appeal available to the court.[742] They also recommended that before preliminary screening by the HSC could occur, at least six months should have passed and the complaint should be made within six years. If the plaintiff fails to prosecute a claim, then

---

738 Submission nos. 17, 31 & 38.

739 Submission no. 11. The use of an appropriate medical panel or tribunal was also supported by submission no. 13. The submission suggested that one option was for there to be a tribunal comprised of a medical panel (made up of 10 or 12 medical practitioners and one or two legal representatives). Individual cases would then be considered by three members of the panel.

740 Submission no. 33.

741 Submission nos. 13 & 35.

742 Submission no. 35.

the case should close. If the defendant does not appear before the HSC, then the plaintiff should be able to go to court.[743]

8.86 If cases are allowed to proceed to the civil court despite the finding of the expert panel that there was no evidence of negligence, then its finding should be admissible as evidence in court, according to the Australian Council of Professionals.[744] Where the action is found to be frivolous, it should be dismissed.[745] Further, the Australian Council of Professionals indicated that the system should operate in the following manner:[746]

> No case is allowed to proceed to a court unless (a) mediation has failed or been rejected by either party, and (b) an out-of-court settlement has not been reached, and (c) the expert review panel has been unable to conclude that no negligence occurred.

8.87 A number of other groups seem to be willing to consider the use of such a body, for example, the Medical Defence Association of Victoria suggested that the use of panels to screen compensation claims as to liability and quantum of damages prior to the issue of proceedings should be further investigated:[747]

> The concept would appear to have merit, although how it would be implemented and to what extent it would impact upon litigation against medical practitioners is difficult to say. The concept is worthy of investigation.

The Association therefore recommended that the screening panels as used in the United States should be considered in Victoria.[748]

Opposition to Screening Panels

8.88 There was considerable opposition to the introduction of screening panels. The Departments of Justice indicated that the existing cost penalty structures are effective so that it is unnecessary to create panels to filter claims.[749] The use of screening panels was opposed by the Victorian Bar Council on the grounds that they would create a 'further bureaucratic,

---

743 ibid.
744 Submission no. 11.
745 ibid.
746 ibid.
747 Submission no. 77, p. 18.
748 ibid.
749 Submission no. 60.

expensive and unnecessary hurdle to access to justice'.[750] The Law Institute of Victoria thought that it would be difficult to ascertain what savings would result from the use of a panel, as distinct from the existing forms of ADR.[751]

8.89 Strong opposition to preliminary screening was expressed in the submission from Slater and Gordon.[752] They stressed that filtering of cases occurs already due to the legal costs of litigation. In the case of 'no win no fee' arrangements, solicitors would not accept frivolous or unmeritorious work for which they would not be paid. Further, screening panels would increase the cost of litigation, unfairly require plaintiffs to disclose evidence before the issue of proceedings, and probably act in favour of the defendant.

8.90 The Australian Medical Association (Victorian Branch) believes that there is no need to screen claims as to liability and quantum prior to the issue of proceedings. Hopeless cases are already weeded out and abandoned and most lawyers act in a way which is responsible and effectively fetters these cases.[753] However, the Association does advocate the use of the following two initiatives:[754]

> 1. It is true that some doctors always appear as witnesses for one side or another. In an effort to halt this practice the AMA has sought the use of **accredited** experts or an independent panel of experts meeting before each case to provide expert medical opinion on a consensus basis or at least to define the matters in issue.
> 2. The AMA (Victorian Branch) Ltd. is aware of initiatives in the NSW Supreme Court dealing with the litigation arising from **Chelmsford** whereby psychiatrists have been appointed amicus curiae (a friend of the court) to assist the judge in each of those cases on the expert psychiatric evidence required. [Original emphasis]

8.91 The Committee considers that the arguments against the introduction of a screening panel (or the provision of such a function by the HSC) are compelling and that their introduction is not appropriate.

---

750 Submission no. 48.

751 Submission no. 45.

752 Submission no. 20. Similarly, the Australian Plaintiff Lawyer's Association argued that a health user should not have to establish a case in order to obtain leave of a court before proceeding. A burden of showing a prima facie case would be easily satisfied and a higher burden would be unfair: submission no. 19.

753 Submission no. 32.

754 ibid.

Arbitration

8.92 Arbitration involves the 'submission of a dispute to the decision of a person other than a court of competent jurisdiction'.[755] As the Victorian Bar Council observed, parties can already use voluntary arbitration:[756]

> There is nothing to prevent parties opting for voluntary arbitration of civil claims if they so desire. There is no need for compulsory arbitration.

8.93 It should be noted that the arbitration systems which are currently used in thirteen jurisdictions in the United States operate only after the agreement of the parties to the procedure.[757]

Support for Arbitration Panels

8.94 There is some support for such a system in Victoria among those making submissions. Significantly, the Medical Defence Association of Victoria supported the use of a system of arbitration, provided that it is not a substitute to common law proceedings, and is used only if agreed to by the parties.[758] However, the Association indicated that if arbitration were to be generally preferred over court-based proceedings, there would then be delays in the system.[759]

> Arbitration, as an alternative to common law proceedings may be effective in terms of reducing delay and access to justice, provided parties can expeditiously access arbitration. If arbitration were to become the preferred course to common law proceedings, then presumably the demands on the arbitration system would lead to delays which in time would replicate the delays in the courts. The Medical Defence Association of Victoria believes that arbitration is unlikely to significantly reduce costs as cases being determined by arbitration will require the same preparation as cases proceeding to mediation or trial.

8.95 According to the Medical Defence Association, if this system is to be adopted then a number of actions would need to be taken:[760]

(a) Arbitration should be resorted to prior to the issuing of a common law writ.

(b) Arbitrators need to be recognised as being suitably qualified.

---

755 D. Walker, *The Oxford Companion to Law*, Clarendon Press, Oxford, 1980, p. 73.

756 Submission no. 48.

757 See discussion provided in Law Reform Committee, *Legal Liability of Health Service Provider – Issues Paper No. 1*, Law Reform Committee, Melbourne, 1996, p. 45.

758 Submission no. 77, p. 18.

759 ibid.

760 ibid.

(c) The cost of arbitration would presumably be met equally by each party, pending the arbitrator's decision and any costs order.

(d) No distinction should be made between legal aid for preliminary screening, arbitration and common law proceedings.

(e) Judgment should be entered against a party who fails to prosecute or to appear, once the parties have agreed to arbitration.

(f) The arbitrator would need the power to compel production of evidence.

(g) Reasons for the arbitration panel's decision should be provided.

(h) There should be an appeal mechanism.

8.96 The use of expert panels of arbitrators, in preference to court proceedings, was supported by some groups. For example, the Western Health Care Network stated that 'if arbitration can live up to the spiel it would certainly be an attractive option'.[761]

8.97 In Victoria, the HSC provides an 'embryonic screening and arbitration system'. The latter is under its formal powers of investigation.[762] The HSC has identified two problems with it operating as an arbitration system, assuming that it was desirable for it to operate in this way. First, its formal powers to make a determination would have to be further developed. Secondly, the screening and investigation role would need to be kept separate in order to comply with the rules of natural justice.[763]

8.98 Ms Newby, the then Health Services Commissioner, went on to suggest that there is probably a case for replacing the court system with an arbitration and conciliation system through a health complaints authority.[764] She regarded conciliation and arbitration as being suitable for obstetrics

---

761 See e.g., submission no. 38.
762 Ms Newby, op. cit., p. 56–57.
763 ibid., p. 57.
764 Ms Newby, op. cit., p. 58.

cases.[765] This view was taken based on the success of the system in Norway, where a patient compensation tribunal operates alongside the court system, plaintiffs can request that cases go to court.[766] She indicted that the tribunal was preferred in Norway because it was cheaper and quicker and the National Health Service—which provides 85% of health care—had a policy of using it.

8.99 However, the Committee was advised by the Royal Australasian College of Surgeons that the HSC is probably not the appropriate forum to provide a selected panel that is an alternative to court-based compensation, even though such a panel may be appropriate:[767]

> A panel of experts would seem a good idea to determine liability and quantum of damages prior to the issuing of proceedings, but this would need to be with appropriate legal representation and guidance. The [Victorian State Committee of the Royal Australasian College of Surgeons] believes that it could be effective in terms of reducing delay, cost, access to justice entitlement to compensation and adequacy of compensation. Such a body could be set up by Government.

Opposition to Arbitration

8.100 There is considerable opposition among those making submissions to the introduction of compulsory arbitration. Notably, the Law Institute thought that it would be difficult to identify savings from the use of a panel, as distinct from the existing dispute resolution options, including mediation, conciliation by the HSC and court-based pre-trial negotiations.[768] The Bar Council referred to the existence of voluntary arbitration of claims, where desired, so that there is no need for compulsory arbitration. Further, it advised that:[769]

> It should be recognised that the Supreme Court and County Court in Victoria have established rigorous procedures involving mediation and pre trial conferencing of claims.

8.101 The Departments of Human Services and Justice in their joint submission also gave support for the current system, where there is court-

---

765 ibid., p. 59.
766 ibid.
767 Submission no. 17.
768 Submission no. 45.
769 Submission no. 48.

based mediation and other forms of ADR.[770] The replacing of common law proceedings by arbitration was seen as being undesirable, and therefore opposed.[771] Further, they suggested that arbitration systems may work against the claimant unless they are fully supported by advocates with expertise in the field:[772]

> The use of arbitration, and devises such as screening panels and preliminary screening processes may all serve to improve the relevance, timeliness and ultimate quality of decision-making. However, the development of decision-making procedures to secure just outcomes must take account [of] the relative capacities of participants to fully represent and protect their interests.
>
> For many individuals and families, the shock, grief, and dislocation of sudden-onset disability may reduce their capacity to balance complex trade-off decisions. In this context, arbitration systems may actually work against the claimant unless they are fully and effectively supported by advocates with specific expertise in the field. Similarly, the arbitrators require expertise in this field, and should be suitably qualified people.

8.102 The Medical Defence Association of Victoria —which supported arbitration as an alternative to court proceedings, but opposed it being used as a substitute for such proceedings—also observed that there was a need for arbitrators to be experienced. They advised that where arbitrators are experienced, arbitration should not impact on the entitlement to, or adequacy of, compensation.[773]

8.103 The Australian Medical Association (Victorian Branch) and the Australian Dental Association (Victorian Branch) opposed the use of a system of arbitration.[774] The Australian Medical Association's opposition was based on the fact that 'a system of arbitration would still be called upon to determine negligence which it is submitted is a **legal** issue to be determined by a **court**'. [original emphasis]

8.104 The evidence received from the Gippsland Law Association indicated that allowing the HSC to have the power to seek a resolution would work

---

770 Submission no. 60.
771 ibid.
772 ibid.
773 Submission no. 77, p. 19.
774 Submission nos. 32 & 33.

well for minor cases, but not for big cases.[775] Further, such a system could see more relatively trivial cases being pursued.

8.105 Additionally, several of the submissions to the Committee suggested that a system of arbitration would not provide a cheaper and quicker alternative to court proceedings. According to Slater and Gordon, private arbitration is not a means of reducing costs, and if arbitrators were given court-like powers—in an attempt to make the process more accountable—then cost, formality and delay would increase.[776] Furthermore, the submission from Slater and Gordon expressed the following concern about the use of medical practitioners as arbitrators:[777]

> We do not believe that medical practitioners would be appropriate arbitrators. It is notorious that in the building industry, standard form contracts drawn by builders are used to force compulsory arbitration on consumers, it is therefore not surprising that the process in the building industry is not viewed as being impartial and lacking integrity. In our opinion, medical arbitration would result in a similar bias against patients.

8.106 The National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists in a joint submission warned that the setting up of another system of arbitration could mean setting up a complete tribunal or court.[778]

8.107 The submission from the Medical Defence Association of Victoria also indicated that if arbitration were the preferred course, it would be unlikely to significantly reduce the costs of cases, because these cases will require the same level of preparation as cases going to mediation or trial.[779]

8.108 Similarly, the Victorian Bar Council observed that a system of arbitration of claims or preliminary screening would not be effective as an alternative to the issue of proceedings in terms of reducing delay and the cost

---

775 Mr Murphy, Executive of Gippsland Law Association, *Minutes of Evidence*, 8 Nov. 1996, p. 23.

776 Submission no. 20.

777 ibid.

778 Submission no. 35.

779 Submission no. 77, p. 19.

of access to justice.[780] In relation to the need to reduce delays and costs, it stressed that:[781]

> Rigorous court based monitoring of litigation is reducing delay and the cost. Arbitration of claims requires similar evidence to that required in the normal litigation process and is unnecessary.

8.109 The Committee accepts that the introduction of a system of arbitration would be undesirable for the above reasons. Moreover, the 'embryonic' arbitration system of the HSC should not be expanded. This recommendation is made because of the problems inherent in separating the screening role and the arbitration role. Unless their separation can be guaranteed, there is the potential that rules of natural justice will not be complied with. The arguments raised against pre-trial screening are also highly persuasive.

Conclusion

8.110 The Committee believes that the role of the HSC should be expanded. Conciliation on a wider basis would probably be more successful than the pre-trial conferences now being held in the courts. These conferences are held in all civil actions before the action is listed for trial and attendance is compulsory.[782] The settlement rate arising from these conferences has decreased dramatically: 51% of personal injury causes were settled during these conferences in 1992/93 compared to only 37% of these cases in 1994/95.[783] It is likely that this trend will continue. The annual report of the County Court has indicated that the trend relates not only to the efficacy of the conferences but to an increased use of ADR mechanisms:[784]

> Its diminution in effectiveness during the last two years along with the general adoption of Court annexed ADR, particularly in the form of mediation and (in appropriate cases) independent evaluation in respect of personal injury matters, has, subsequent to the year of the report, led to its demise.

8.111 The Committee has therefore concluded that parties should be able to choose conciliation before the Health Services Commissioner prior to the issue of proceedings as an alternative to court-run pre-trial conferences. In those cases where pre-trial conferences result in settlement—that is 37% of personal

---

780 Submission no. 48.
781 ibid.
782 Victoria, *County Court Annual Report 1995*, p. 12.
783 ibid.
784 ibid.

injury cases—considerable savings to the court system would have been made through resolving cases earlier by conciliation prior to the issuing of proceedings. Further, the use of conciliation prior to the issuing of proceedings should reduce the costs for parties, and there is a potential for resolution to be reached in a larger number of cases, given the current success of conciliation by the HSC.

8.112 Parties who are unable to resolve their claims through conciliation by the HSC and who issue court proceedings, should be able to opt out of the pre-trial conference stage once litigation has been commenced. Such a system would allow pre-trial conferences to become voluntary for those who have gone through a process of conciliation before the HSC.

8.113 The Committee believes that the benefits resulting from increased use of conciliation by the HSC are attractive, and outweigh the concern that the HSC could be used as a delaying tactic by medical defence organisations. This has not occurred under the present system. The cost of proceedings where a case goes to court is, therefore, unlikely to increase significantly.

8.114 Before the HSC's role as a conciliator could be expanded, the problems discussed in paragraphs 8.66–8.77 would need to be addressed. The failure to address these issues would prevent the HSC from effectively carrying out this new function. Furthermore, while extending the functions of the HSC is likely to be cost neutral overall, the HSC would need an increase in funding and other resources for it to undertake this extended function.

Recommendation 26

A party to a claim for negligence arising out of the provision of health services should be able to choose conciliation before the Health Services Commissioner prior to the issue of proceedings as an alternative to court-run pre-trial conferences.

Recommendation 27

The legislation governing the Office of the Health Services Commissioner should be amended to address the potential conflict between two of its main functions; namely resolving complaints to the satisfaction of the parties, and the Commissioner's responsibility for standards of health. This should be

achieved by adopting the model which exists under New South Wales legislation.

Recommendation 28

Despite a complaint being referred to the Medical Practitioner's Board, the Office of the Health Services Commissioner should still be able to provide conciliation services to the parties in the complaint.

9 PROBLEMS OF RURAL MEDICINE

The Shortage of Doctors in Rural Communities

9.1 The Committee was informed that this inquiry was partially motivated by the concerns of rural doctors regarding a dramatic increase in their private indemnity premiums, especially for those who practice obstetrics. As a result, a number of practitioners have threatened to withdraw the provision of obstetric services.[785] In order to obtain first hand evidence regarding this problem, the Committee held a number of public hearings in rural Victoria. It became apparent that the problems faced by rural doctors are much more varied and complex than simply the cost of obtaining profession indemnity insurance.

9.2 Consequently, there is a need to consider conditions generally experienced by doctors working in rural areas. According to the Rural Doctors Association of Victoria:[786]

> It is impossible for example to consider the matter of Medical Indemnity in rural Obstetrics without examining the discipline as a whole: there is a decline in both GP and Specialist Obstetricians, and a complex set of factors threatening to produce, or actually producing, a decline in obstetric standards.

9.3 The Committee is mindful that its recommendations have the potential to affect the provision of medical services in rural Victoria. Consequently, this chapter examines the nature of the problems facing rural practitioners, together with existing and proposed Federal and State measures designed to address these problems. In undertaking this task, the Committee has first considered the extent of medical services in Eastern Victoria, and the problems experienced in attracting and retaining doctors in rural communities.

---

785 Dr C. Brook, Director of the Public Health Division, Department of Health and Community Services, *Minutes of Evidence*, 23 Oct. 1995, pp. 4 & 5.

786 Submission no. 44.

9.4 The first part of this chapter considers the difficulties experienced by specialists and general practitioners practising obstetrics and gynaecology in rural areas. The main problems for practitioners in these areas are then discussed individually. These problems consist of: the lack of opportunity to take holidays and the scarcity of time for continuing education; reduced access to education and the isolation of practitioners from peer support; difficulties in obtaining locums; and more generally, the fear of litigation and the application of standards by the courts which many rural practitioners believe do not represent reasonable general practice. Prior to the introduction of the professional indemnity arrangement by the Department of Human Services, the cost of professional indemnity insurance was also a main problem for general practitioners engaging in obstetrics. The adequacy of this arrangement in addressing this issue is assessed. The Committee will then be in a position to assess the extent to which measures are needed to reduce disincentives for the provision of health services in rural communities.

9.5 The second part of this chapter discusses the current programs, and proposed initiatives, which have been designed to provide support to general practitioners and specialists in rural areas. These initiatives have been introduced by the State and Federal Governments. The responses of the Royal Australian College of General Practitioners, the Australian Medical Association and the Rural Doctors Association are also considered.

9.6 In conducting its inquiry, the Committee has consulted widely and received considerable evidence concerning a shortage of doctors in Victorian rural areas. It has received evidence from practitioners from several major provincial centres, large towns and rural areas, including: Bairnsdale, Geelong, Traralgon, Sale, Mildura, Charlton, Sea Lake, Birchip and Natimuk.[787] Many of the practitioners who gave evidence or who made submissions to the Committee came from areas where there is a shortage of

---

787 The Rural Doctors Association of Victoria, in their submission to the Committee have defined the geographical distribution of Victorian Rural General Practice using the following classifications: Major provincial centres, Large towns without continuous complete 24 hour specialist coverage, Rural practice, an Remote rural practice. See Submission no. 44.

doctors. This shortage makes it difficult for them to attend conferences and the like. The fact that these practitioners took time away from their work to assist the Committee is an indication of the seriousness of their concerns and their commitment to improving the situation.

9.7 Submissions and evidence dealing with the problems of rural medicine were also received from various key organisations, including the Departments of Human Services and Justice, the Victorian Division of the Australian Medical Association, the Rural Doctors Association of Victoria, the East Gippsland Division of General Practice and several bush nursing hospitals. This evidence clarified the situation in country areas, including the nature of the difficulties facing rural doctors.

9.8 The Rural Doctors Association in its submission described the decline in numbers of general practitioners and specialists obstetricians in rural areas, together with the factors which threaten to reduce obstetric standards.[788] It pointed to the closing of maternity units and the fact that the rural Bush Nursing obstetric system has nearly disappeared. This has occurred despite small rural maternity units being extremely safe places in which to deliver. The Association claimed that these closures have threatened the safety and accessibility of obstetric services in rural Victoria. The shortage of practitioners is particularly disturbing because the average retention time of general practitioners in rural practice is only seven years.[789]

9.9 The reduction in the number of general practitioners has a high social, as well as financial, cost for rural communities. As the Central Highlands Division of General Practice observed: [790]

> The reduction in the number of GPs willing to practice in the more litigious / high risk medical fields in rural communities and the consequent loss of local services altogether, will be a high cost both financially and socially to the community.

---

788 ibid.

789 ibid. R. Strasser, *Rural General Practice in Victoria*, 1992. The Rural Doctors Association included in its submission a geographical distribution of general practitioners in rural Victoria and a spread sheet of rural medical locations.

790 Submission no. 41.

9.10 A six month study by the National Farmers Federation on services in rural communities found that maintaining doctors or attracting doctors is a major concern. The study identified the loss of a community's general practitioner as a major cause of fear for a community.[791] It also found that there is a shortage of dentists in rural communities.[792] Further, the study pointed to a shortage of 500 rural doctors in Australia.[793] The Federation considered this to be particularly disturbing because if a doctor leaves a town, many other services decline. The study examined services in six country towns in Australia, one of which was Tempy in Victoria.[794] After considering the study, the National Farmers Federation Council released a discussion paper and made the following key recommendations:[795]

1. Priority should be given to research into health care status and the needs of rural Australians.
2. A formal agreement should be developed between Commonwealth and State Governments on the delivery of health care in rural areas.
3. Divisions of rural health should be established in government organisations and an office of rural communities should be created by State governments to advise on policy development. There should also be a national peak body which liaises with Commonwealth Government organisations.
4. The workforce incentive programs and workforce infra-structure programs should be reviewed. Incentive schemes should be developed to encourage recruitment and retention of practitioners.
5. The use of technology in treatment and training should be extended.

---

791 D. McKenzie, 'Poor health services, bank closures hurt rural dwellers', *The Australian*, 23 Jan. 1997, p. 3.

792 ibid.

793 Gael Jennings Program, Radio Station 3LO, 30 Jan. 1997, Mediatrack, Press Radio & TV Monitoring.

794 D. McKenzie, op. cit., p. 3.

795 National Farmers Federation, *Trends in the Delivery of Rural Health, Education and Banking Services*, Discussion Paper, Vol. 11, February 1997, pp. 22–23.

9.11 According to the Rural Doctors Association of Victoria there is a need for emergency services in towns without hospitals.[796] The tendency towards the centralisation of services has reduced the number of resident surgeons, so that towns have a reduced capacity to handle emergencies. The Rural Doctors Association submitted that there needs to be first line management of emergencies, rather than immediate transfer of patients:[797]

> In particular it is stressed that the urban dogma of immediate transfer to major trauma centres is not applicable to rural regions. Initial treatment and stabilisation are vital.
>
> Only by providing a safety net of well trained and strategically placed rural GPs will the rural public have access to first line management of emergencies. The progressive reduction of the hospital network is a real worry. Simply relying on ambulance and paramedical services is not the answer.

9.12 This problem was also highlighted by several practitioners who gave evidence to the Committee. For example, according to Dr John Horton of Birchip, rural health services have been reduced by the closure of small country hospitals and downgrading of acute facilities to nursing homes.[798] This trend is particularly worrying, because acute facilities need to be readily available in order to lessen the likelihood of serious and permanent injuries, and the consequent possibility of compensation or litigation. The downgrading of acute facilities will also result in skilled doctors not being attracted to an area.[799]

9.13 Some commentators have suggested that an indication of the extent of the shortage of doctors in country areas can be obtained by comparing the percentage of doctors working in country areas to the size of the population they serve.[800] According to the Rural Doctors Association of Victoria, in 1994 there were 432 doctors servicing a rural population (which does not include

---

796 Submission no. 44. The Victorian Bush Nursing Association also indicated that rationalisation of private hospital beds in rural Victoria will lead to a decline in infrastructure supporting health services: See submission no 73.

797 Submission no. 44.

798 Submission no. 71.

799 ibid.

800 Submission no. 75. Attachment: 'Crisis in Rural Obstetrics' on 30 October 1995. In this submission it was stated that: 20% of Australian doctors care for 30% of the population, that is, country people.

Fringe Metropolitan areas and base hospitals) of 575,395, that is, one doctor per 1,331 people.[801] Eighty per cent of medical practitioners in Victoria work in Melbourne, according to the 1991 census data (that is, 7,980 practitioners). This figure can be extrapolated to provide an estimated for 1994. The total number of registered medial practitioners for Victoria in 1994 was 14,524 practitioners, 80% of this figure is 11,619. Consequently, the estimated number of medical practitioners working in Metropolitan Melbourne for 1994 is 11,619 practitioners. This works out to be 275 people per doctor, based on a population of 3,197,815 for the Melbourne Metropolitan area.[802]

Medical Services in Eastern Victoria

9.14 The Committee was informed that the shortage of medical practitioners in Eastern Victoria is at an unacceptably low level. The extent to which services have been reduced in Gippsland was described by Dr Geoff Macfarlane, a general practitioner from Bairnsdale, who said that a general practitioner has stopped performing plastic surgery in Maffra, because of the cost of the $24,000 per year insurance premium.[803] In Bairnsdale one general practitioner has ceased obstetrics and three general practitioners have ceased anaesthetics. In Orbost there are only four doctors, and at least three doctors are required to handle an obstetric emergency.

9.15 According to Dr Macfarlane, hospital services in Eastern Victoria are as follows: in Bairnsdale there is a 100 bed general practitioner hospital with one physician and two surgeons.[804] Maffra, Omeo and Orbost each have a general practitioner hospital. In Sale there are specialists with some general practitioner support, but only three general practitioners who do obstetrics to any extent.

9.16 The Committee was told by Dr R. McKimm, of Sale, that in effect he is the only resident specialist obstetrician between Sale and the New South Wales border, and that he has contemplated leaving Sale.[805] Recently, Dr Peter Goss, from Sale, indicated that Sale has lost a couple of general

---

801 Submission no. 44. The manner in which the figures have been calculated is described at section 3.2 of the submission.

802 Assistance in calculating these figures was obtained from Ms B. Lesman, Research Officer, Parliamentary Library, Victoria. See Medical Board of Victoria, *Annual Report for 1993/94*, p. 13; Australian Bureau of Statistics, Catalogue no. 4346.0, p. 10.

803 Submission no. 75. Dr G. Macfarlane, Bairnsdale, *Minutes of Evidence*, 8 Nov. 1996, p. 4.

804 Submission no. 75.

805 Dr R. McKimm, Sale, *Minutes of Evidence*, 8 Nov. 1996, p. 33.

practitioner obstetricians. Doctors are also leaving the Latrobe Valley: they have lost physicians, obstetricians and ear nose and throat surgeons.[806]

9.17 Medical centres provide full time services in Heyfield, Lakes Entrance and Mallacoota.[807] However, in Lakes Entrance there is no doctor available from 1200 hours Sunday to 0800 hours Monday.[808]

9.18 The Natimuk Bush Nursing Hospital advised the Committee that there is no permanent medical practitioner in Natimuk; there is only a part time practitioner with a small clinic one day per week (with no after-hours service).[809] The Bush Nursing Hospital is small; it has a two bed hospital, 20 bed nursing home, and 20 bed hostel. A district nurse and child day care centre are funded by a Health and Community Care program. A doctor from Horsham visits the nursing home and hostel on a regular weekly basis and residents are transported to Wimmera Base Hospital in emergencies. The hospital was still trying to attract a suitable medical practitioner late in November 1996 after its doctor left the district early in 1994. An application for specific registration on an 'area of need' basis had been made, so that an overseas trained practitioner can be appointed prior to sitting the Medical Board's examinations.

Problems Attracting and Retaining Doctors

9.19 The difficulties facing rural general practitioners mean that they require certain special attributes, including a 'high degree of basic competency and ability to respond to the particular needs of their local area'.[810] As one rural doctor observed, they tend to enjoy the totality and continuity of patient care and the challenge of often working beyond their current skills. Thus, these practitioners tend to be practical, mature and stable with wide-ranging intellects.[811]

9.20 A number of studies have considered the difficulties faced by rural communities in attracting and retaining practitioners. For example, the Ministerial Review of Medical Staffing in Victoria's Public Hospital System in 1995 (the Lochtenberg report) noted the difficulty in recruiting specialists,

---

806 Dr Peter Goss of Sale speaking on the Gael Jennings Program, op. cit.
807 Submission no, 75.
808 ibid.
809 Submission no. 63.
810 Rural Doctors Association of Victoria, Submission no. 44.
811 Dr G. Macfarlane, op. cit., p. 3.

registrars and Honorary Medical Officers to rural base hospitals, and in maintaining sufficient general practitioners in rural centres.[812] Moreover, the Baume report found that viable population thresholds are necessary in order for general practitioners to maintain their skills.[813]

9.21 Several submissions pointed to a number of factors as contributing to the shortage of doctors in rural areas. According to Dr Peter Radford, two main factors contribute to the shortage of doctors in rural Australia.[814] First, very large work loads are endured by a few individual doctors. Secondly, the rural doctor must, in a practical sense, be able to handle all problems up to a certain level, yet matters are becoming more complex and the courts demand an increasing level of skill. It was suggested that these factors, together with the increase in the cost of medical indemnity insurance, will lead to a greater shortfall in rural doctors and fewer general practitioners being willing to perform certain procedures.

9.22 The reluctance of doctors to practice in the country is also attributed to resident-house doctors perceiving country practice to be too demanding and difficult because of the workload. According to Dr Macfarlane, only three percent of students want to practice in the country.[815] He said that the current financial incentives are not enough and that trainees should go to the country.[816] The President of the Royal Doctors Association, Dr Sam Lees, similarly observed that the difficulties in the recruitment and retention of rural practitioners result from them being overworked and experiencing professional, social and family isolation.[817]

---

812 B. Lochtenberg, *Ministerial Review of the Medical Staffing in Victoria's Public Hospital System—Final Report*, June 1995. See also Submission no. 44.

813 R. Baume, *A Cutting Edge: Australia's Surgical Workforce*, AGPS, Canberra, 1995. Cited in submission no. 44.

814 Submission no. 3.

815 Dr G. Macfarlane, op. cit, p. 7.

816 ibid.

817 Submission no. 72.

9.23 The Committee heard evidence from Dr McKimm that the main reasons for doctors wanting to leave the area are difficulties with hospital administration and difficulties relating to the work environment.[818]

9.24 Concern about the lack of doctors willing to work in rural areas was also expressed by the Hopetoun Bush Nursing Hospital. Its submission indicated that neighbouring districts have had difficulty in replacing doctors who leave.[819]

9.25 It is clear that a number of rural communities have had to obtain an overseas doctor because of their inability to attract local doctors. In these cases the communities have expended a great deal of time and money seeking the overseas doctor.

9.26 In order for the overseas doctor to practise, permission is required from the medical Practitioners Board. The Committee has received complaints that in at least one case the Medical Practitioners Board has withdrawn its permission for an overseas doctor to practise in a particular town, without adequate warning to the local community. Following a request from the Health Minister, the Board reassessed the case and permitted the overseas doctor to practise for a further period.

9.27 Given the difficulties faced by rural communities in attracting local doctors, it is important that the Medical Practitioners Board adequately consult with local communities prior to making decisions which could affect the provision of medical services in those communities. It is also important that the Medical Practitioners Board understand the difficulties encountered by rural communities, and ensure that its decisions do not unnecessarily disadvantage those communities.

Difficulties for Specialists and General Practitioners Practising Obstetrics and Gynaecology

9.28 The Committee has concluded that it is the cumulative effect of many factors which makes it difficult to retain general practitioner obstetricians and specialists in rural areas. These factors include: the difficulties in sustaining a

---

818 Dr R. McKimm, op. cit., p. 33.

819 Submission no. 67.

single doctor obstetric service; the lack of a hospital or facilities to support these practitioners in some rural areas; insufficient back-up from specialists for general practitioners; a heavy workload and an inadequate level of remuneration; the cost of professional indemnity insurance; problems relating to hospital administration encountered by some specialists; and the rationalisation and amalgamation of hospitals.

9.29 Attracting general practitioners with obstetric qualifications and specialists to rural communities is particularly difficult. The Rural Doctors Association of Victoria observed that this situation is a reflection of the difficulties associated with sustaining a single doctor obstetric service.[820] Moreover, the Association indicated that the strain on doctors is increased by the concentration of obstetrics in larger rural centres and the diminishing numbers of ageing general practitioner obstetricians. According to Dr Macfarlane, the seriousness of the shortage of country doctors is such that:[821]

> In rural Australia we are short of 500 people who have my sort of background and skills. We are training about 20 a year. The average age of rural doctors is climbing around 14 months a year.

9.30 The Committee heard that despite the vacancies for specialist obstetricians, there may not be facilities to support practitioners in these areas. According to Dr McKimm:[822]

> Of the 35 vacancies for specialist obstetricians in provincial centres in Australia, 15 are in Victoria. That does not necessarily mean there are hospitals and facilities that are able to support them; that is what the need is.

9.31 The reason for this is that a city with a sufficient population is necessary in order to sustain at least one specialist.[823] However, a sustainable practice needs to have two specialists in order to provide peer support, locum relief, weekend relief and to attract trainees. This situation means that general practice services in outlying hospitals are supported by specialists in provincial hospitals in larger centres.[824]

---

820 Submission no. 44.
821 Dr G. Macfarlane, op. cit., p.7.
822 Dr R. McKimm, op. cit., p.34.
823 ibid, p. 41.
824 ibid, p.42.

9.32 Accordingly, several general practitioners have expressed concern about the lack of sufficient back-up from specialist obstetricians.[825] This adds to the high degree of stress and burn out associated with the long periods of being on call.[826] Several specialists referred to the problems caused by being on call for long periods of time. The Committee was told that heavy workloads may reduce the level of patient care, because of tiredness and the lack of opportunity to update knowledge.[827] An illustration of the difficulties for rural specialists was given by Dr McKimm, an obstetrician and gynaecologist, who observed that when he is in Bairnsdale or Melbourne and there is a crisis in Sale, he has to return quickly or deal with things at a distance. He went on to say that:[828]

> I vicariously share responsibility for a wide geographic area with other doctors practising in my field in circumstances where I do not always feel I can assess what is going on as accurately as I would like.

9.33 The Committee heard that in Geelong there has been a dramatic decrease in the number of general practitioners who do obstetrics. Ten years ago there were approximately 40 general practitioner obstetricians, compared to just three in 1997.[829] This decrease appears to be linked to the cost of premiums and the additional burdens arising from an obstetric practice. One practitioner, Dr Paul Davey, said:[830]

> I was a general practitioner–obstetrician up until June 1996, delivering in the vicinity of 30–40 babies a year. I stopped obstetrics due to increasing medical indemnity premiums. My colleagues not doing obstetrics were paying $5,000 per annum less and I decided, reluctantly, that it was not financially viable to continue doing obstetrics, especially with the additional stresses this causes to family and personal life.

---

825 Dr Peter Goss, loc. cit.
826 ibid.
827 Submission no. 68.
828 Dr R. McKimm, op. cit., p. 33.
829 Submission no. 77.
830 ibid.

9.34 Similarly, a practitioner in Traralgon told the Committee that the following reasons have lead to practitioners not providing obstetrics or anaesthetics services in country areas:[831]

1. Even if the additional qualification were obtained the hospital would still need specialist cover.
2. There is the possibility that a more experienced person would not be available to deal with cases which become difficult.
3. Remuneration for general practitioners with obstetric qualifications is poor and there is an additional medical indemnity charge.
4. Practicing obstetrics places additional burdens on one's family and practice.

9.35 Concern about the level of remuneration for rural doctors was expressed in several submissions to the Committee.[832] The Committee received evidence that a practitioner specialist working in obstetrics can earn the same amount of money in the city without working so hard.[833] This is because of their large private practice component and the way the practice is structured.[834]

9.36 In the East Gippsland Division of General Practice there has been a reduction of services in obstetrics, anaesthetics, plastic surgery and minor surgery. This is attributed to:[835]

1. indemnity costs;
2. the increased workload caused by doctor shortage;
3. increasing time for education and decreasing time for recreation; and
4. the decreased availability of urban locums who can work in the country because many have only basic indemnity cover.

---

831 Submission no. 61.

832 See e.g., submission no. 64.

833 Dr R. McKimm, op. cit., p.35.

834 ibid. However, according to Dr McKimm, the implementation of the Lochtenberg findings may address some of these issues.

835 Submission no. 75.

9.37 Concern was expressed by Dr Macfarlane that the burden on general practitioners who practice obstetrics may become greater because nurses and midwives increasingly want to take over cases. The doctor is then placed in a difficult situation where he or she has to make a decision as to whether there is about to be a disaster, without time to prepare and without having had the opportunity to become familiar with the case.[836]

9.38 Problems for specialists partially originate from their dependency on a small number of hospitals (or a central hospital) for resources with which to practice.[837] They may experience difficulties with management because the hospitals have limited resources and may not be prepared to divert resources to support obstetric and gynaecological practices. Dr Macfarlane suggested that the reluctance to work in Sale (or come to Sale) would be reduced if there were a private hospital resource. It would provide an alternative resource for practice and mean that there would be a greater incentive for the public hospital administration to communicate effectively.

9.39 According to Dr McKimm, in Bairnsdale an agreement was reached between practitioners and the hospital administration for a modified scale of fees for service, in order to address concerns relating to complicated obstetric cases. The scale is complexity-based rather than procedural based. He has unsuccessfully sought to introduce this model into Sale. The reason for favouring this type of agreement over the existing one, is that the fee-for-service system has failed to attract another practitioner and does not recognise the procedural aspects of work, such as providing clinical support and advice, teaching and establishing community networks.[838]

9.40 The Charlton Bush Nursing Hospital stated that the following factors impact on the availability of doctors for hospitals in its area:[839]

1. The role of Government in regulating private hospitals.
2. The threat of rationalisations and amalgamations of hospitals.

---

836 Dr G. Macfarlane, op. cit., p. 11–12.
837 Dr R. McKimm, op. cit., p. 35.
838 ibid, p. 45.
839 Submission no. 66.

3. The potential for small agencies to be disadvantaged by the new funding scheme for nursing home/hostel residents and the transfer of funding responsibility for aged care to the States.

The hospital has found it difficult to attract doctors who have the required skills. This is evidenced by the fact that it took 4½ years of advertising to find a replacement for a doctor who had retired.[840]

Availability of Continuing Education and Holidays

9.41 Rural general practitioners have to maintain certification in many areas; for example, almost three weeks a year is required out of practice time in order to maintain certification for anaesthetics.[841] Consequently, the ongoing requirements of certification mean that a total of three months is spent on study every three years.[842] This level of study is said to result in a contraction of services.[843]

9.42 Dr Macfarlane advocated the use of financial incentives for professional development in order to assist in providing practitioners with an opportunity to fulfil their educational requirements. This issue has been addressed to a limited extent by the introduction of a subsidy for general practitioners under the Continuing Medical Education Program.[844] According to Dr Macfarlane, the subsidy is a 'meagre' one because:[845]

> It only provides one week per triennium, pays too little for a locum in a small practice ($40 per day) and the doctor, hospital and DHS [Department of Human Services] contribute one third each; it ignores ongoing practice costs.

9.43 The program also ignores the need for continuing education in a number of areas, including paediatrics and infectious disease. Further, practitioners may find it difficult to attend program sessions.[846]

9.44 The Rural Doctors Association has suggested that if stringent standards are inflexibly applied then there will be problems for rural doctors

---

840 ibid.

841 Dr G. Macfarlane, op. cit., p. 3.

842 ibid.

843 ibid.

844 Victoria, Department of Human Services, Acute Health Division, *Continuing Medical Education Program for Rural General Practitioners, Information Kit*, 092AU96.

845 Dr G. Macfarlane, op. cit., p. 3.

846 ibid, p. 6.

in relation to credentialling, recertification and recruitment.[847] For this reason it is recommended that colleges should review their standards to ensure appropriate standards for rural practitioners.

9.45 Moreover, Dr Macfarlane recommended that there should be financial incentives for a rural practice which takes on an assignment of medical students.[848] These assignments last for a period of 13 weeks. A reward for teaching these students is sought because an assignment costs the practice around $180 to $200 in lost fees per day.[849]

9.46 It was also observed by Dr Macfarlane, that the colleges are formalising the manner in which skills are to be maintained.[850] Skills and standards are maintained by post graduate education from visiting specialists and satellite broadcasts. Other measures used to maintain skills are: college conferences, weekend study conferences in Melbourne, E-mail and the internet, and weekly care discussion groups. As one practitioner observed, the use of telephone-conferencing and news groups may go some way towards addressing the problem of professional isolation.[851] The potential for telemedicine to be used to assist rural practitioners was also considered recently by Peter Yellowlees and Craig Kennedy, who wrote:[852]

> Interestingly, the experience that we have had in rural service provision via telemedicine indicates that professional support and supervision services for isolated practitioners are more valuable than the provision of direct clinical 'second opinions' or other services.
>
> As 'burnout' is a major factor behind the exodus of general practitioners from rural areas, we believe that a properly organised research trial is warranted to examine whether the use of telemedicine to provide personal and professional support would help to resolve this problem.

9.47 An example of the manner in which video conferencing can be used to assist rural doctors is provided by the Video Conferencing Project established in 1995 by the Royal Children's Hospital Mental Health Service in Melbourne,

---

847 Submission no. 44.
848 Dr G. Macfarlane, op. cit., p. 9.
849 ibid.
850 Submission no. 75.
851 Dr Peter Goss, loc. cit..
852 P. Yellowlees & C. Kennedy, 'Health Care, Telemedicine: here to stay' (1997) 166 *Medical Journal of Australia* p. 264.

together with the Child and Adolescent Mental Health Service in Bendigo, Mildura and Warrnambool.[853] The manager of this project identified the primary benefits for rural communities as being to allow rural doctors to have access to specialist child and adolescent psychiatric expertise.[854]

9.48 However, Yellowlees and Kennedy questioned the adequacy of resolution in video conferencing for certain tasks; namely, resolution might be sufficient for diagnosis where an interview is held, but not where an x-ray is evaluated.[855]

Recommendation 29

Consideration should be given to increasing the subsidy for general practitioners under the State Government's Continuing Medical Education Program. The program should be extended to cover other areas where continuing education would be particularly useful, such as paediatrics and the treatment of infectious disease.

Recommendation 30

Medical professional colleges should review the delivery of continuing medical education so as not to create unnecessary barriers in the credentialling, recertification and recruitment of rural doctors.

Recommendation 31

Federal and State Governments should provide financial incentives to rural practices which accept an assignment of medical students, so that they are not financially disadvantaged by the provision of this service.

Recommendation 32

The feasibility of extending teleconferencing services to assist rural practitioners should be investigated by the Federal and State Governments. These facilities can provide valuable peer support and access to specialist advice for rural doctors.

Reduced Access to Education and Isolation From Professional Peers

9.49 The Institute of Legal Executives suggested that rural providers would be less reluctant to deliver services, such as screening tests, if they had access

853 ibid, p. 265. See insert entitled: 'Telemedicine: triumphing over the tyranny of distance'.
854 ibid.
855 P. Yellowlees & C. Kennedy, loc. cit.

to ongoing training.[856] Moreover, it recommended that employers should be actively discouraged from imposing conditions on providers which lead to stress, fatigue and personal danger.

9.50 The Melbourne Division of General Practice observed that medical services may be provided in locations and at times when other services are not available, and communication is difficult.[857]

9.51 The Rural Doctors Association of Victoria suggests that there should be an improvement in the long term postgraduate training of rural practitioners.[858] Further, it said that rural doctors in Australia should form the Australian College of Rural and Remote Medicine.[859] The Association also believes that instead of Specialist Colleges having a direct input into accreditation, this should be done by rurally based working medical personnel, acting under accepted guidelines. The Association is currently compiling guidelines for rural work.

9.52 The Committee accepts the submission of the Rural Doctors Association that a College of Rural and Remote Medicine should be established. The Committee further believes that state and Federal Governments should give their support to such an initiate.

9.53 The Rural Doctors Association also believes that rural general practitioners should be able to obtain a diploma of anaesthetics, given the levels of practice of anaesthetics in small towns.[860] The Association is committed to the proper training of GP anaesthetists and the ongoing review and development of standards, accreditation criteria and quality assurance. The model currently being considered is that GP anaesthetists should be checked and approved of by an accredited supervisory specialist anaesthetist.

Recommendation 33

Rural doctors should be encouraged to form an Australian College of Rural and Remote Medicine.

---

856 Submission no. 22.
857 Submission no. 34.
858 Submission no. 44.
859 ibid.
860 ibid.

Cost of Professional Indemnity Arrangements

9.54 Many groups and practitioners have described the rising cost of professional indemnity premiums as being a factor contributing to general practitioners ceasing to practise obstetrics. They suggested that if this disincentive were removed then a further reduction in the number of rural general practitioners providing obstetric services may be avoided. The Commonwealth Department of Human Services attributed the rising cost of premiums offered by the medical defence organisations to demutualisation, under-funding in the past, and the increased size of settlements.[861] Further, it advised that the claims experience for obstetric misadventure is high and that one group of rural general practitioners have threatened to withdraw services.[862]

9.55 This problem has been addressed to some degree by the Victorian Government's insurance options, discussed below. Nevertheless, it is important to outline the situation which the introduction of these options was designed to alleviate.

9.56 According to the Rural Doctors Association of Victoria attitudes to the issue of medial indemnity are crucial in maintaining general practitioners in the rural work force.[863] This is apparent from the attitudes of several practitioners. For example, Dr McKimm informed the Committee that paying $15,000 for indemnity cover was a major disincentive to obstetric practice. This is because ceasing to practice obstetrics would halve the premium.[864] The Australian College of Midwives also suggested that maternity services in rural areas have been reduced due to the high cost of indemnity insurance for general practitioners practising obstetrics.[865]

9.57 The Committee also heard that the cost of premiums affects training and recruitment to obstetrics and gynaecology. The rise in costs is progressive, so that it may reach a point where a particular form of

[861] Submission no. 60.
[862] ibid.
[863] Submission no. 44.
[864] Dr R. McKimm, op. cit., p. 40–41.
[865] Submission no. 12.

professional activity is no longer financially viable. Thus, concern is largely based upon the future cost of premiums.[866]

9.58 Additionally, there is a perception that if doctors have to pay high premiums there is the possibility of a huge payout and that they are likely to face litigation.[867]

9.59 The Western Health Care Network observed that, because of the high cost of premiums, it is not financially viable for a general practitioner or a specialist to practise procedural obstetrics if only a few deliveries are done a year.[868] This is a particular concern in country areas. This observation is consistent with that of the Rural Doctors Association of Victoria. In its submission to the Committee, the Association observed that in relation to private hospitals, the Victorian Rural Divisions Coordinating Unit in 1995 found that 28 confinements per year would need to be conducted in order for doctors with full indemnity to break-even financially.[869]

9.60 Dr B. Dowty, a consultant physician in Mildura, observed that it is difficult for country physicians not to have procedural professional indemnity, because they would usually be the only physician there.[870] The cost of professional indemnity for procedural physicians was $7,000 in 1996/97 compared to $3,900 for non-procedural physicians. The additional cost for a practice which is mainly consultative may contribute to the physician moving to a metropolitan area or to a physician deciding not to come to the country.

9.61 A number of solutions were suggested in the submissions to the Committee. For example, the Medical Protection Society suggested that a solution to the rural crisis would be to re-mutualise general practice subscriptions so that all general practitioners paid the same subscription, regardless of the type of work.[871] The Rural Doctors Association of Victoria

---

866 Dr R. McKimm, op. cit., p. 47.
867 ibid, p. 40.
868 Submission no. 38.
869 Submission no. 44.
870 Submission no. 68.
871 Submission no. 36.

supported the recommendations of the Tito Report, that indemnity rises be curbed and that there be an Australian Health Ministers' Advisory Council on Rural General Practice.[872] On the issue of indemnities, the Association advised that it supports the New South Wales 'Rural Doctors Settlement Package', which provides special rates of pay and on-call allowance at selected hospitals.[873] In New South Wales rural doctors have a settlement package which pays a quarterly lump sum to general practitioners practising obstetrics and increased fees for conducting obstetrics.

9.62 According to Dr Janet Watterson, a general practitioner who practices obstetrics and anaesthetics in Sale, each year there has been a huge increase in premiums, without an increase in the payment for services.[874] This situation was described by her as being untenable.[875] She observed that the public hospital had sought to address the situation by negotiating for larger fees for obstetric procedures, at the cost of withdrawing other services. The submission recommends that the problem be resolved by an entire restructuring of the medical compensation system.

Insurance Options Provided by the Department of Human Services

9.63 Arising out of these concerns, the Victorian Department of Human Services has provided a cost effective insurance alternative to general practitioners engaged in rural obstetric practice in small communities.[876] The Department is able to obtain a cost effective coverage for these doctors at a marginal rate far lower than the mutual funds, but this is restricted on the basis of absolute risk and applies to a limited number of general practitioners. This approach may be contrasted with that taken in New South Wales, South Australia and Western Australia, where a subsidy is offered. Such an approach was opposed by the Department because the State has no control over the practice of the doctors.

---

872 Submission no. 44.
873 ibid.
874 Submission no. 62.
875 ibid.
876 Submission no. 60.

9.64 Consequently, the Department has offered two insurance options to procedural general practitioners in designated Victorian Public and Bush Nursing Hospitals:[877]

1. The first option provides cover for general practitioners engaging in obstetrics at a cost of $3,500. Procedural general practitioners who are not engaging in obstetrics pay $2,500.
2. The second option requires that doctors take additional private cover for their private non-procedural work ($1,800), but cover is provided for all obstetric, anaesthetic and procedural care to public and private patients of designated hospitals, that is, the designated Bush Nursing Hospitals. Procedural general practitioners not doing obstetrics pay $2,000 and those doing obstetrics pay $3,200.

These figures will be adjusted according to the Consumer Price Index, the adjustment is expected to be no greater than five per cent over the next three years. The options are available for three years, or in the case of individual subscription, 12 months.

9.65 Both of these options include run-off cover, together with an undertaking from the Minister for Health that the run-off coverage is guaranteed in the event of a change in the insurance arrangements.[878] The inclusion of this feature addresses the concern raised by the Australian Medical Association, referred to by the Tito Inquiry.[879] Moreover, the Government's approach is consistent with that recommended by the Tito Inquiry.[880]

9.66 Dr Macfarlane told the Committee that nearly all procedural doctors in East Gippsland have accepted the premium of $2,500 or $3,500 which was offered under the arrangement with the Department of Human Services,

---

877 ibid.

878 ibid.

879 Commonwealth Department of Human services and Health, Review of the Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care, A Final Report*, AGPS, Canberra, 1995 (hereafter cited as 'PIR Final Report'), p. 291.

880 ibid, see recommendation 159.

instead of the high premiums offered by the medical defence organisations.[881] He concluded that this has alleviated the crisis in rural obstetrics to some extent but 'a strong disinclination toward obstetrics remains because of the adversarial nature of litigation'.[882] To illustrate this situation the submission refers to the fact that 90 per cent of cerebral palsy is unpreventable and no one's fault, yet multimillion dollar awards in damages continue to be made.

9.67 Consequently, it is generally accepted that the introduction of the new arrangement has meant that the cost of medical indemnity is no longer the main concern for doctors in East Gippsland.[883] Their major concern now is the shortage of doctors.[884] The arrangement does not address the other underlying causes of the shortage of practitioners in rural communities. This task remains a matter to be addressed by the Federal and State Government programs which are discussed below.

9.68 The Committee has found that there is evidence of a widespread fear of litigation among doctors generally. However, there is no evidence of a significant increase in medical negligence litigation. The shortage of doctors in some areas of practice has not been shown to be a consequence of any rise in the cost of obtaining professional indemnity insurance. Rather, the Committee has received extensive evidence to the effect that the shortage of doctors in rural areas, for example, is due to other social and economic factors.

Problems in Obtaining Locums

9.69 According to the East Gippsland Division of General Practice, there has been a decrease in the availability of urban locums who can work in country areas.[885] This is because many urban locums only have basic indemnity cover. This lack of locum cover means that rural doctors are under increased pressure because of the need to provide a seven day per week 24 hour service, resulting in long working hours and sleep loss. Not surprisingly, the Rural

---

881 Submission no. 75.
882 ibid.
883 Dr G. Macfarlane, op. cit., p. 6; submission no. 72.
884 Dr G. Macfarlane, op. cit., p. 6.
885 Submission no. 75. See paragraph 9.36 above.

Doctors Association of Victoria indicated that there needs to be more than one person per area with an anaesthetic, emergency and obstetric capacity.[886]

9.70 The difficulty in obtaining locums means that a greater burden is placed on the regions doctors. According to the Charlton Bush Nursing Hospital, doctors in their region work cooperatively to assist each other during emergencies or on weekends for certain procedures.[887] As most towns have only one practitioner, it can be inconvenient to drag him or her away from the community or hospital. The hospital suggested that the inconvenience will increase when fewer practitioners are willing to perform certain procedures.

9.71 The Committee believes that this situation needs to be adequately addressed and that the existing professional indemnity arrangements provide disincentives to urban locums who may be otherwise willing to provide coverage to country areas, when needed. Accordingly, the Committee believes that the State Government should consider introducing measures to complement the locum grants which are available under the Federal Government's Rural Incentives Program, which is discussed below.

Recommendation 34

Consideration should be given to providing a cost effective alternative to insurance which extends the basic indemnity cover of urban locums who provide coverage for rural doctors on recreation or other leave. This may be achieved by using a variation of the arrangement available to general practitioners engaging in rural practice in small communities, or by way of a subsidy.

Fear of litigation

9.72 The Rural Doctors Association of Victoria observed that general practitioner rural educators believe that there is a growing fear of litigation, which deters people from entering rural practice. However, the Association ruled out the use of special malpractice arrangements:[888]

---

[886] Submission no. 44.

[887] Submission no. 66.

[888] Submission no. 44.

> Special malpractice arrangements for rural practitioners are not feasible, but rural General Practitioners, working with continual stress and sleep-loss, are naturally aggrieved that their self-sacrifice is potentially their downfall.

9.73 The Association believes that the publicity given to cases, even if no adverse findings result, causes serious damage to careers and leads to relocation of the practice. Relocation to another rural town can be difficult.[889] Additionally, in their submission they raise the fear that a doctor may be liable for referring a patient to a distant specialist if an accident occurs because of the distance involved.

9.74 Several rural practitioners also suggested that the shortage of rural doctors is partly due to the fear of litigation.[890] According to Dr Janet Watterson of Sale, there is a perception that rural doctors will be asked to do difficult procedures.[891] Further, she believes that the fear of litigation has lead to the practice of defensive medicine.

9.75 Similarly, according to the Charlton Bush Nursing Hospital, young doctors are not prepared to perform obstetric or emergency surgical procedures, apparently for fear of litigation.[892]

9.76 Dr John Harrison, an ear nose and throat surgeon from Mildura, suggested that there is a fear of widespread litigation.[893] He described the litigation crisis in the United States and suggested that a similar situation in Australia should be avoided by discouraging the development of a perception of risk free litigation with 'chances of riches or revenge'. To prevent this perception, he recommended that there should be 'individual or personal responsibility on the plaintiff's side'.[894]

---

889 ibid,
890 See e.g., submission no. 62.
891 ibid.
892 Submission no. 66.
893 Submission no. 65.
894 ibid.

9.77 However, fear of litigation is not universally felt among rural practitioners. Dr John Horton, a practitioner from Birchip, informed the Committee that litigation is less likely for rural practitioners than for practitioners working in larger centres.[895] Moreover, Dr Sam Lees of Wycheproof was unaware of a doctor having left because of litigation or the fear of litigation.[896]

Changing Attitudes

9.78 Some submissions indicated that the there is a need to encourage doctors to understand that medical negligence actions are a hazard of work. Such a change in attitude should be complemented by lawyers recognising that medicine is not a science of absolutes, but rather one of probabilities.[897]

9.79 Another practitioner suggested that the public should be educated about what should be realistically expected, and insurers should only settle medical negligence claims where it is clearly appropriate to do so.[898] By so doing, it was thought that the incidence of litigation would be reduced.[899]

How should standards for rural practitioners be assessed?

9.80 The Rural Doctors Association is concerned that the Courts are judging rural outcomes against the best metropolitan standards.[900] This view is contained in several of the submissions from rural practitioners. Notably, Dr Cheong, of the Royal Australian College of general practitioners, described as unfair the use of specialist expert witnesses to determine reasonable practice. He suggested that they are unable to represent, or understand, reasonable 'general practice'.[901]

9.81 For the same reason, Dr Macfarlane was critical of the use of senior specialist opinion in court to measure medical performance.[902] He indicated that expert witnesses need to be from the relevant specialist area—for example, rural medicine—so that they are familiar with the problems in that

---

895 Submission no. 71.
896 Submission no. 72.
897 Dr G. Macfarlane, op. cit., p. 8.
898 Submission no. 68.
899 ibid.
900 Submission no. 44.
901 Submission no. 46.
902 Submission no. 75.

area.[903] Furthermore, he recommended that medical legal experts should be formally certified and qualified.

9.82 In some submissions concern was expressed regarding the competence of rural practitioners being assessed on the same basis as city practitioners, despite the pressures of professional isolation experienced by the former.[904] According to Dr Peter Radford, these problems could be partly addressed by allowing a practitioner to be judged by his or her peers.[905] A judge cannot clearly envisage the conditions under which a rural doctor works, such as the lack of access to technology. Furthermore, in assessing risks and benefits of investigations, account must be taken of the risks and cost of travel.

9.83 The Melbourne Division of General Practice suggested that the accepted practice in law is that specialist practice is the standard by which general practitioners are judged. Accordingly, the Division recommended that general practitioner standards of care should be judged by their peers, and not by specialist consultants.[906] This approach is consistent with that taken by the Northern Division of General Practice, which recommended that Courts, when considering a general practitioner's standard of care, give ample opportunity for that case to be judged by other general practitioners with appropriate skills, expertise and knowledge of the standards of care within General Practice.[907]

Reducing Disincentives

9.84 Governments and medical organisations have implemented a number of measures designed to reduce the disincentives which have lead to a shortage of rural doctors. Several of these programs are outlined below.

---

903 ibid.
904 Dr R. McKimm, op. cit., p. 37.
905 Submission no. 3.
906 Submission no. 34.
907 Submission no. 40.

State Government Initiatives

9.85 In the 1995/96 Annual Report for the Department of Human Services, the Department identified as one of its key challenges, the need to 'improve self–sufficiency and access to specialist services in rural areas'.[908] During that year, the following two committees looked at this issue: the Rural Health Advisory Group and the Small Rural Hospitals Implementation Task Force. According to the annual report, the task force carried out the following function:[909]

> The Small Rural Hospitals Task Force continued to assist small rural hospitals with fewer than 30 acute beds to redevelop service profiles that are more responsive to the needs of the community. This often involves the redirection of resources from bed–based services to continuing and primary care services.

9.86 Recently, a number of other measures have been implemented by the State Government. In December 1995 the Government funded 50 extra specialist training positions.[910] This was followed in March 1996 by a package of measures designed to address the shortage of doctors in rural communities.[911] These measures included spending an additional $3 million on support and training for medical practitioners in rural areas and providing up to $8,000 for each rural doctor to attend relevant conferences or seminars. The Government also established a co-ordinating Unit for Rural Health Education, which seeks to 'encourage and assist young rural people to take up health professions; to provide ongoing support to existing practitioners; and to generate greater interest in rural practice among health professionals'.[912]

9.87 As discussed above, the Government has obtained an insurance arrangement which reduces the indemnity costs for general practitioners practising obstetrics in rural areas.[913]

---

908 Victoria, Department of Human Services, *Annual Report 1995/96*, p. 12.

909 ibid., p. 4.

910 Hon. M. Tehan, Office of the Health Minister, 'Lawrence must act on country doctor shortage', *News Release*, 7 Dec. 1995, p. 2.

911 Hon. M. Tehan, Office of the Health Minister, 'Labor plays catch–up politics for rural voters', *News Release*, 19 Mar. 1996, p. 1.

912 ibid.

913 See the discussion at paragraphs 9.54 to 9.58.

9.88 The Minister for Health, Hon. Rob Knowles MP, recently summarised the Government initiatives aimed at addressing the shortage of doctors in rural areas.[914] He referred to the following five major initiatives:[915]

1. The introduction of a continuing education program.
2. The introduction of medical assistance in covering the cost of medical indemnity insurance, particularly for general practitioners providing obstetrics and surgical procedures.
3. The introduction of a specialist medical grant for regionally based hospitals. The grant recognises that the costs of employing specialists (or the cost of delivering these services) is higher for regionally based hospitals than for metropolitan hospitals. The costs of delivering specialist services at base hospitals, like Sale, is about 20 to 25 per cent higher than it is in metropolitan hospitals.
4. The establishment of a medical work force council. One of its first tasks is to consider other initiatives for addressing the issue of the shortage of doctors in rural areas.
5. The development of a range of new joint pilot studies relating to the development of multi purpose services, between the State and the Commonwealth Governments. The State Government is in the process of selecting a number of smaller hospitals to participate under a new funding mechanism called 'Health Streams' which looks at combining the funding from a range of programs into a single program and gives the health service greater flexibility as to how it structures services.

9.89 The Minister stressed that these initiatives would take time to make an impact. However, he indicated that several issues remain to be dealt with; namely, how should the State Government assist with:[916]

- employment for the spouses; and
- employment paths for those prepared to go to area for 5 to 10 years but then want to return to metropolitan areas for the education of their children.

---

914 Gael Jennings Program, op. cit..
915 ibid.
916 ibid.

Royal Australian College of General Practitioners

9.90 The Royal Australian College of General Practitioners (RACGP)has established a Rural Training Stream, whereby registrars can obtain a fellowship of the RACGP and a graduate diploma in Rural General Practice.[917] For the Rural Training Program the regular training program is combined with educational and training needs which are specific to the need of rural practitioners.[918] The College also has a rural faculty which represents the interests of rural practitioners within the College and provides advice on academic and training requirements for rural practitioners.[919]

Australian Medical Association

9.91 According to the Vice President of the Australian Medical Association (Victorian Branch), Anthony Dixon, the vast number of babies born in country Victoria are delivered by general practitioners.[920] He also indicated that the medical profession welcomes programs which are designed to help general practitioners and to encourage them to stay in rural areas. Nonetheless, in order to address the shortage of doctors, it is necessary to adopt a three stage process:[921]

1. In the short term, there is a need to encourage doctors to consider coming to rural areas and to then consider staying there.
2. In the middle term, there is a need to encourage under-graduate medical students to consider working to rural areas.
3. In the long term, it is necessary to encourage students from rural secondary schools to consider entering medical school. He suggested that students who come from the country have a seven fold chance of returning once they have finished their training. Around 30 per cent of Victorians live outside greater Melbourne or Geelong, but in 1997 only 19 per cent of the intake of medical school students entering Monash University came from the country. For Melbourne University the figure was even lower, approximately 15.3 per cent.

---

917 Royal Australian College of General Practitioners, *Training Program Handbook, 1997*, p. 5.

918 ibid.

919 ibid.

920 Gael Jennings Program, op. cit..

921 ibid.

9.92 In order to encourage rural secondary school students to pursue a health professional career, Monash University has produced a promotional booklet and video and organised residential workshops with other universities for twenty rural secondary school students in years 11 and 12, during April 1997.[922]

Rural Health Campaign

9.93 On the 27 January 1997, the Australian Medical Association announced that a new rural health campaign would be introduced.[923] The campaign will consist of three key strategies:[924]

1. consultation with rural communities, politicians and groups;
2. developing a position statement, which includes recommendations to the Federal Government;
3. establishing health promotion initiatives.

9.94 The Federal President of the Australian Medical Association, Dr Keith Woollard, outlined the direction which the campaign would take, by suggesting that:[925]

> The Rural Incentives Program, which has been running since 1992, needs to be overhauled to ensure the incentives are better targeted and have a broader appeal. There is also a need to encourage students from rural areas to study medicine, as they are more likely to return to the bush on completion of their training. We also need to address cutbacks to health services and problems caused by high premiums for medical indemnity.

Rural Doctors Association

9.95 The submission from the President of the Royal Doctors Association of Victoria, Dr Sam Lees, recommends that the following measures be implemented to address the shortage of rural practitioners:[926]

1. entry into general practice should be controlled;
2. there should be proper training, and accreditation;

---

922 Monash University, Centre for Research in Health, Education and Social Sciences, Gippsland Campus, *Secondary School Project*, http://www.monash.edu.au/informatics/ruralhealth/projects/Schools.htm

923 Australian Medical Association, ‘AMA goes to bat for the bush’, *Media Release*, 27 Jan. 1997.

924 ibid.

925 ibid.

926 Submission no. 72.

3. standards should be assessed by general practitioner peers; and

4. counselling should be introduced for doctors who are sued or threatened with litigation.

9.96 The Association informed the Committee that in relation to the area of adverse outcomes and malpractice, any changes made to the present system should be across the board, and that rural doctors should not be treated as a special case.[927]

9.97 It also indicated that further studies should be taken to compare the safety of rural obstetrics with obstetrics in the urban sector.[928] The results of a recent trial project on hospital quality control at Wimmera Base Hospital provide an indication of the safety of rural hospitals.[929] It found that:[930]

> Of 15,912 discharges, 1,465 records screened positive, yielding 155 adverse outcomes (1% discharges), of which 88 were minor and 67 required further action. Resultant changes to hospital policy resulted in a fall from 69 detected adverse patient occurrences in the first year of the project to 33 in the third.

9.98 The Committee was informed that the Rural Doctors Association is concerned about the deregulation of midwifery and the removal of the requirement that midwives practice under the supervision of a medical practitioner.[931] Additionally, the Association recommended that the Government should regulate for the continuous rostering of midwives until the mother goes home, and that a system of accreditation appropriate for the needs of rural hospitals should be provided.

Federal Government Initiatives

9.99 Various strategies have been implemented by the Federal Government to remedy the shortage of doctors in rural areas. The breadth of these initiatives reflects the fact that there is no single way to address the problem, and that it should be tackled at a number of levels. This approach is apparent from the following comment made by the Commonwealth Department of Health and Family Services:[932]

---

927 Submission no. 44.

928 ibid.

929 ibid.

930 ibid.

931 ibid.

932 Commonwealth Department of Health and Family Services, Office of Rural Health, State Financing Branch, '1996–1997 Federal Budget—Rural Health Initiatives', Feb. 1997, p. 1.

> Noting that no single strategy alone will address the problems of service access and availability in rural Australia, the Government will work to integrate a range of measures to strengthen rural and remote health services and establish an infrastructure for the support of health care workers.

The main strategies are outlined below.

Review of General Practice Training

9.100 On the 22 January 1997 the Federal Health Minister announced that there would be a review of general practice training, in order to, among other things, 'advise on practical support for rural vocational training and ways to better meet the community needs of country people'.[933] The review, which is chaired by Dr Bryce Phillips, will issue a report by September 1997.

9.101 This review appears to reflect the fact that, despite the various Government initiatives to address the shortage of practitioners, the percentages of general practitioners and specialists in rural communities has not increased. According to the combined departmental and Health Insurance Commission data there was little change in the percentages of rural practitioners from 1991 to 1996. Between 1991/92 and 1996/96 the percentage of general practitioners in rural communities varied between 21.4% and 22.2%.[934] For specialists the percentage varied between 12.4% in 1991/92 and 12.8% in 1995/96.[935]

Rural Incentives Program

9.102 The Rural Incentive Program was established in 1992 to improve access to general practice services for rural and remote communities, to assist in the delivery of high quality services by supporting appropriate training and to encourage practitioners to relocate to (or stay in) areas of need. The program receives $15 million a year in funding. According to the Commonwealth Department of Human Services and Health, the following rural or remote Victorian communities have difficulty attracting general practitioners: Charlton, Donald, Jeparit, Kaniva, Lakes Entrance, Leongatha, Lismore,

---

[933] Hon. Dr M. Wooldridge, 'Review of General Practice Training', *Media Release*, 22 Jan. 1997, MW1/97, p. 1.

[934] Source: Combined departmental and Health Insurance Commission data. Cited in Commonwealth, Department of Health and Family Services, *Annual Report 1995/96*, p. 67.

[935] ibid.

Manangatang, Murota, Ouyen, Rainbow, Robinvale, Sea Lake and Yarrawonga.[936] The program provides five types of grants:[937]

1. Relocation grants— a single incentive grant of $20,000 to general practitioners who relocate (or $30,000 for general practitioner couples).
2. Training grants— a maximum grant of $87,000 is available to rural general practitioners (including those who relocate to rural areas) for training to improve skills in areas which are necessary for rural general practice.
3. Remote area grants— a maximum grant of $50,000 per annum is available for general practitioners in selected 'isolated and difficult areas where the economic base of the practice may be marginal and there are increased professional difficulties'.
4. Continuing and medical education/locum grants— these grants encourage general practitioners to maintain their skills in relevant areas and to obtain recreation leave.
5. Rural undergraduate support grants— a series of grants to medical schools to improve the teaching of the rural component of their course and to allow students to gain a better understanding of rural practice.

9.103 In addition to the measures under the Rural Incentives Program, the Government indicated that a funding package of $20 million per annum during 1996–1997 would be provided to rural areas and hospitals to encourage doctors to practice in rural and remote areas.[938] There is also a Rural Health Support, Education and Training Program designed to improve recruitment and retention rates of health service providers in rural areas, by providing training opportunities and support.[939] The program will receive $5.9 million in funding during 1996/97.

---

936 Commonwealth Department of Human Services and Health, General Practice Branch, *General Practice*, Fact Sheet No. 5a, Feb. 1996, p. 1.

937 Commonwealth Department of Human Services and Health, General Practice Branch, *The General Practice Rural Incentives Program*, Fact Sheet No. 5, Feb. 1996, p. 1.

938 Office of Rural Health, State Financing Branch, Commonwealth Department of Health and Family Services, *1996–1997 Federal Budget – Rural Health Initiatives*, Feb. 1997, p. 1.

939 ibid, p. 3.

Establishment of Departments of Rural Health

9.104 Under the Government's Rural Medicine Workforce Crisis Strategy, $3 million will be spent in 1996/97 to establish university departments of rural health.[940] There will eventually be six of these departments. Initially, rural health units will be set up in Mt Isa (Queensland) and Broken Hill (New South Wales) with links to the University of Queensland and the James Cook University, and the University of Sydney and the University of New South Wales.[941] Additionally, the Committee notes that Australia's first professional chair of Rural Health was recently established at the Bendigo Campus of La Trobe University's.[942]

John Flynn Scholarship Scheme

9.105 The John Flynn Scholarship Scheme provides for additional undergraduate medical student placements to rural general practices or Aboriginal medical centres.[943] In 1996/97, $370,000 will be spent on the scheme.[944] According to the Department of Health and Family Services, placements are made during the vacation period for a two week period each year over four years. The scholarship generally starts in the second year of study. Each year 105 scholarships are made available through the ten medical schools in Australia. The number of scholarships to each school is assigned based on its size. Students receive a scholarship of $2,500 per annum for four years.[945]

Locum Services for Specialists

9.106 According to the 1996/97 budget, over the next four years $1 million will be directed towards providing locum services for specialists in rural

---

940 ibid.

941 ibid.

942 Victoria, Office of the Minister for Tertiary Education and Training, 'Bendigo to get first university rural health chair', *New Release*, 23 Apr. 1997.

943 Personal telephone conversation with Ms J. Grieve, Commonwealth Department. of Health and Family Services, General Practice Branch, 5 Mar. 1997.

944 Office of Rural Health, State Financing Branch, Commonwealth Department of Health and Family Services, '1996–1997 Federal Budget — Rural Health Initiatives', February 1997, p. 2.

945 Personal Conversation (telephone) with Jodie Grieve, GP Branch, Commonwealth Department of Health and Family Services, 5 March 1997.

communities. During 1996/97, $150,000 will be spent.[946] This funding will assist specialists to take leave or to pursue continuing education.

Health Jobs Australia

9.107 A pilot medical vacancy information data system was established recently to list current medial vacancies in Australia, including vacancies in rural and remote areas.[947] The project has been funded to the extent of $580,000, with $304,000 being provided in 1996/97. Vacancy information for health professionals can be accessed by the internet.[948] This service includes information about the location of the position, employer, job category and the existing medical services and the type of classification assigned to the areas, for example, Lakes Entrance is described as a non-metropolitan small rural area.

Training Places in Rural Hospitals

Restrictions on Access to Medicare Provider Numbers

9.108 Access to Medicare provider numbers is denied to doctors first registered on or after 1 November 1996 who are not eligible for recognition as a general practitioner or specialist (that is, those doctors without a post graduate qualification), as well as to overseas trained doctors for a period of ten years.[949]

9.109 Two measures have been adopted by the Government to assist the situation in rural Victoria:

1. Privileged entry is available into the General Practice Training Program to doctors who have approved clinical assistantships in rural areas for a specified period, provided they meet with the College's minimum standards for a place in the program.[950]
2. The Government has legislated to provide access to temporary Medicare provider numbers to persons who would otherwise be denied access. Access is restricted, in that they must work in an

---

946 Office of Rural Health, State Financing Branch, Commonwealth Department of Health and Family Services, '1996–1997 Federal Budget — Rural Health Initiatives', February 1997, p. 2.

947 ibid, p. 3.

948 Under the following internet address: http://www.hcsaust.com.au/hja/home.html.

949 *Health Insurance Act 1973* (Cwlth), ss. 19AA & 19AB.

950 Australia, Department of Health and Family Services, 'Doctors not able to provide services for which Medicare benefits are payable', Information Sheet

approved placement, such as an approved rural locum practice.[951]

These measures are designed to 'enable doctors (otherwise not eligible to access Medicare) to do rural locum through a structure that provides adequate supervision, quality assurance and backup arrangements while allowing Medicare billing'.[952]

9.110 Support for the recognition of overseas trained doctors who wish to practice in rural areas is contained in several of the submissions. It was suggested that consideration should be given to the question: Why are overseas trained doctors not recognised in Victoria?[953] Further, to enable rural areas to attract practitioners, the following recommendations were made by the Natimuk Bush Nursing Hospital:[954]

1. Medicare Provider Numbers should be allocated to rural areas, with a possible limitation on the extent of numbers available in the major metropolitan cities of Melbourne and Geelong.
2. Restrictions on overseas qualified doctors who wish to practice in rural Victoria should be eased.
3. Rural doctors should be assisted in taking annual leave, sick leave or study leave, by the provision of locums.
4. Rural medicine be given due recognition as requiring specific help in order that Australian qualified doctors be made to realise that the rural population requires 'Centres of Excellence' other than those offered by the capital cities within the states of Australia. It was observed that larger rural cities can provide care equivalent to that offered by city hospitals, within reason.
5. The Rural Incentives Scheme should include incentives for the spouses of medical practitioners who relocate to the country.

---

951 *Health Insurance Act 1973* (Cwlth), ss. 19AA & 19AB. Australia, Department of Health and Family Services, 'The new section 19AA of the Health Insurance Act; the new section 19AB of the Health Insurance Act; doctors not able to provide services for which Medicare benefits are payable', Information Sheet & 'Approved placements for rural locums', Information Sheet, February 1997.

952 ibid.

953 Submission no. 29.

954 Submission no. 63.

Advanced Specialist Training Posts

9.111 In the 1996/97 the Government assigned $1.945 million to the Advanced Specialist Training Post Initiative in Rural Areas.[955] The purpose of the initiative is to establish training positions in major rural centres, so that access to specialists services is improved.[956]

9.112 The Committee is concerned about the continuing difficulties facing rural practitioners and the shortage of practitioners, especially those with general practitioner obstetric and specialist qualifications. Accordingly, the Committee concludes that the various educational and financial initiatives designed to address the shortage of rural doctors should be extended and encouraged. Further, the Committee eagerly awaits the findings of the Review of General Practice Training and the Review of the Rural Incentives Program, as well as the outcome of the Australian Medical Association's Rural Health Campaign. These studies should provide a detailed evaluation of the problems facing rural medicine. Such an evaluation is required in order to adequately address the concerns which have been so strongly voiced in several submissions to this Committee.

9.113 Additionally, the Committee believes that there is a need for a more integrated approach between the responses of the State and the Commonwealth Governments, so that the proposed and existing programs can complement each other. This approach is particularly important because each of the problems facing rural practitioners needs to be addressed, and the efficacy of one initiative in doing so will impact on the operation of other initiatives.

Recommendation 35

Consideration should be given to addressing the need to provide employment opportunities for spouses of doctors who are willing to work in rural areas.

Recommendation 36

---

[955] Australia, Department of Health and Family Services, Office of Rural Health, State Financing Branch, *1996-97 Federal Budget – Rural Health Initiatives*, February 1997, p. 3.

[956] ibid.

Consideration should be given to the provision of employment paths for those doctors who return to metropolitan areas after working in rural or remote areas for 5 to 10 years.

Recommendation 37

The difficulties facing medical practitioners in rural and remote areas should be further investigated in 1998. A detailed examination of the efficacy of each Federal and Victorian Government initiative and proposal should be undertaken.

Recommendation 38

The admission of suitably qualified overseas doctors who wish to practice in rural Victoria should be facilitated by the Victorian Government and the Medical Board of Victoria.

Recommendation 39

Consideration should be given to providing greater incentives for Australian trained medical practitioners to work in rural areas.

APPENDIX A LIST OF SUBMISSIONS

No.	*Date of Submission*	*Name*	*Affiliation*
1	2 January 1996	Dr P. Nisselle	The Medical Protection Society
2	12 February 1996	Ms V. McCutcheon	Acting Health Services Commissioner
3	26 February 1996	Ms E. Golombek and Ms D. Hellier	Cancer Care Nursing Agency
4	4 March 1996	Dr P. Radford	medical practitioner
5	8 March 1996	Mr I. Davies	Women's & Children's Health Care Network, Royal Women's Hospital
6	12 March 1996	Mr R. G. Elmes	Department of Social Security
7	15 March 1996	Dr G. Medley & Dr H. Mitchell	Victorian Cytology Service
8	12 February 1996	Dr P. Komesaroff	Baker Medical Research Institute
9	17 March 1996	Mr A. Proudfoot	The Public Policy Assessment Society Inc.
10	12 March 1996	Ms L. Ford	Australian Association of Occupational Therapists - Victoria
11	5 March 1996	Dr J. Southwick	Australian Council of Professions Ltd.
12	13 March 1996	Ms M. Reid	Australian College of Midwives Incorporated Victorian Branch
13	13 March 1996	Mr I. S. Russell	surgeon & oncologist
14	18 March 1996	Corrs Chambers Westgarth	solicitors
15	15 March 1996	Mr D. Guenther	Motor Accidents Authority of New South Wales

No.	*Date of Submission*	*Name*	*Affiliation*
16	13 March 1996	Dr P. S. Allen	Monash Medical Centre
17	18 March 1996	Mr J. R. Cocks	Royal Australasian College of Surgeons Victorian State Committee
18	18 March 1996	Ms J. Ferguson	Benefit Designs International, Inc
19	15 March 1996	Mr R. Pearce	Australian Plaintiff Lawyers Association, Victorian Branch
20	19 March 1996	Slater & Gordon	solicitors
21	18 March 1996	Dr M. Martin	The Royal Australasian College of Radiologists, Victorian Branch
22	18 March 1996	Ms R. Curnow	The Institute of Legal Executives (Victoria)
23	20 March 1996	Ms E. C. Percival	Royal College of Nursing, Australia
24	21 March 1996	Mr K. J. Thompson	Chiropodists Registration Board of Victoria
25	20 March 1996	Dr M. Cass	Quality Assurance Network
26	21 March 1996	Mr P. Bunworth	Aged Care Victoria Inc.
27	18 March 1996	Dr D. Smith	The Australian Council on Healthcare Standards
28	20 March 1996	Mr C. G. Roberts	Physiotherapists Registration Board of Victoria
29	26 March 1996	Mr A. T. Kenos	citizen
30	26 March 1996	Dr C. Sotiropoulos	medical practitioner
31	29 March 1996	Ms J. E. Gibson	Victorian Nurse Executives Association Inc.
32	29 March 1996	Dr E. R. Mason	Australian Medical Association (Victorian Branch) Limited

No.	Date of Submission	Name	Affiliation
32A	11 July 1996	Ms E. Kennedy	Australian Medical Association (Victorian Branch) Limited.
33	29 March 1996	Mr G. Pearson	Australian Dental Association
34	1 April 1996	Dr G. Santoro & Dr B. Freeman & Dr R. Martyres & Ms S. Francisco	Melbourne Division of General Practice Inc.
35	2 April 1996	Dr M. O'Connor & Dr P. Dobson & Dr M. Sedgley & Dr. C. Maxwell	The National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch)
36	2 April 1996	Dr P. Nisselle	The Medical Protection Society
37	4 April 1996	Dr K. J. Breen	Medical Practitioners Board of Victoria
38	16 April 1996	Dr C. R. Joyner	Western Health Care Network
39	22 April 1996	Ms A. Peek	Dandenong District Division of General Practice
40	18 April 1996	Dr D. Barbaro	The Northern Division of General Practice - Melbourne
41	24 April 1996	Dr S. Morrow	Central Highlands Division of General Practice Ltd.
42	22 April 1996	Mr V. J. Davies	Eastern Health Care Network
43	24 April 1996	Dr V. Vizec	Western Melbourne Division of General Practice
44	28 April 1996	Dr M. L. Moynihan	Rural Doctors Association of Victoria

No.	*Date of Submission*	*Name*	*Affiliation*
45	30 April 1996	Mr J. Symes	Law Institute of Victoria
46	30 April 1996	Dr I. R. Cheong	The Royal Australian College of General Practitioners
47	29 April 1996	Mr L. R. Lewis & Mr D. K. Brown & Mr M. V. Sheehan	Pharmaceutical Defence Limited
48	28 May 1996	Ms E. Wentworth	Victorian Bar Council
49	9 May 1996	Dr R. Currie	North East Valley Division of General Practice Ltd.
50	6 May 1996	Ms M. Shearer	Whitehorse Division of General Practice
51	14 May 1996	Ms A. Stephens	East Gippsland Division of General Practice
52	23 May 1996	Dr L. Hall	Inner Eastern Melbourne Division of General Practice
53	23 May 1996	Dr V. C. Amerena	The Dental Board of Victoria
54	27 May 1996	Ms O. Stagoll	Victorian Breast Screening Coordination Unit Inc.
55	3 June 1996	Dr R. Burton	Anti-Cancer Council of Victoria
56	9 July 1996	confidential	
57	12 July 1996	confidential	
58	16 July 1996	confidential	
59	1 August 1996	Ms P. Williams	Pollyanne Williams Risk Management Consultant
60	6 November 1996	Mr W. J. McCann	Department of Human Services and Department of Justice
61	1 November 1996	Dr A. C. Richards	medical practitioner
62	10 November 1996	Dr J. Watterson	medical practitioner
63	22 November 1996	Mr R. Lane	Natimuk Bush Nursing Hospital Inc.
64	28 November 1996	Mr K. Chambers	surgeon

No.	*Date of Submission*	*Name*	*Affiliation*
65	28 November 1996	Mr J. N. Harrison	surgeon
66	29 November 1996	Mr S. Barker	Charlton Bush Nursing Hospital Inc.
67	25 November 1996	Mr N. Bush	Hopetoun Bush Nursing Hospital
68	27 November 1996	Dr D. J. Dowty	medical practitioner
69	28 November 1996	Ms M. R. Ryan	nurse practitioner
70	28 November 1996	confidential	
71	29 November 1996	Dr J. Horton	medical practitioner
72	29 November 1996	Dr S. J .B. Lees	medical practitioner
73	29 November 1996	Victorian Bush Nursing Association	
74	5 November 1996	Professor P. Ryan	Monash University Department of Medicine, Alfred Hospital
75	8 November 1996	Dr C. G. Macfarlane	medical practitioner
76	8 November 1996	Mr P. Murphy	Gippsland Law Association
77	18 July 1996	Dr D. R. V. Dickens	Medical Defence Association of Victoria
78	29 January 1997	Dr P. Davey	medical practitioner

Hearings held during the 52nd Parliament

No.	*Date of Hearing*	*Witness*	*Affiliation*
1	27 November 1995 Melbourne	Mr B. Gurry } Mr B. Burke }	Corrs Chambers Westgarth, Solicitors
2	12 February 1996 Melbourne	Ms L. Newby	Health Services Commissioner of Victoria
		Ms V. McCutcheon	Acting Health Services Commissioner of Victoria
		Ms T. Punshon } Mr K. Jackson }	Conciliators, Office of the Health Services Commissioner of Victoria
3	23 February 1996 Melbourne	Dr M. Dorsch	Director, National Cervical Screening Program
		Mr R. Boyce	Assistant Director, National Cervical Screening Program (formerly senior officer with the Review of Professional Indemnity Arrangements of Health Care Professionals)

Hearings held during the 53rd Parliament

No.	*Date of Hearing*	*Name*	*Affiliation*
1	8 November 1996 Public Hearing Bairnsdale	Dr G. Macfarlane	Rural Doctors Association of Victoria East Gippsland Division of General Practice
2		Mr P. Murphy	Gippsland Law Association
3		Mr E. Timmins	citizen
4		Dr R. J. McKimm	Specialist Obstetrician, Sale
5	28 November 1996 Public Hearing Mildura	Dr P. Talbot	Executive Director, Medical, Mildura Base Hospital
6		Mr J. Harrison	Ear, Nose & Throat Surgeon
7		Dr B. Dowty	General Physician
8		Mr K. Chambers	General Surgeon
9	29 November 1996 Public Hearing Charlton	Mr S. Barker } Mrs N. Wright }	Chief Executive Officer Board Member Charlton Bush Nursing Hospital
10		Mr D. C. Wayne	Chief Executive Officer Sea Lake and District Health Service
11		Dr J. Horton	General Practitioner, Birchip
12		Mr R. Lane	Manager, Natimuk Bush Nursing Hospital
13		Dr S. J. B. Lees	General Practitioner, Wycheproof
14	29 January 1997 Public Hearing, Geelong	Dr P. Davey	General Practitioner
15		Dr R. Fawcett	Acting Director, Medical Services, Geelong Hospital

'Defensive practice' means an act or omission of a health service provider which is intended to minimise the incidence of professional liability even though this may entail the provision of health services which may not be clinically necessary for patient care.

'Health service provider' means an individual member of a profession recognised by statute, including: doctors, dentists, dental technicians, nurses, pharmacists, chiropractors, osteopaths, chiropodists, optometrists, physiotherapists and psychologists.

'Health service' means a professional service provided by a health service provider for private or public patients.

'Injury sustained in the use of health services' refers to any physical or mental injury or adverse outcome sustained by a patient in the course of receiving a health service which may give rise to legal liability.

'Profession' means medicine, dentistry, dental technology, nursing, pharmacy, chiropractic, osteopathy, chiropody, optometry, physiotherapy, psychology.

'Professional indemnity insurance' includes mutual fund arrangements.

'Specialty' means each special area of practice within a profession, including: anaesthesia, dermatology, diagnostic radiology, emergency medicine, general practice, internal medicine, medical administration, obstetrics and gynaecology, occupational medicine, ophthalmology, otolaryngology, orthodontics, orthopaedics, paediatrics, pathology, psychiatry, public health

medicine, radiation oncology, radiology, rehabilitation medicine, surgery and other recognised specialties within each profession.

'Structured Settlements' are contractual arrangements which provide a combination of periodic payments and occasional lump sums, where the timing and size of the payments are tailored to meet the needs of the recipients. They may also make provision for the claimant's dependants in the event of the death of the claimant. Structured settlements are an alternative method to a single lump sum payment for delivering compensation to the recipient.

APPENDIX D CASE STUDIES

Work-Related Back Injury (Periodical Payments and Lump Sum of $300,000)

This case involved a woman who sustained a permanent back injury whilst at work.

Following the accident she received periodical compensation payments for approximately six years, and then received a lump sum compensation payment of $300,000. After costs, the net amount received by her was $219,000.

Her husband, a carpenter, had not worked for a number of years, and had been diagnosed as having employment-related asbestosis. In three-and-a-quarter years following the compensation settlement, the couple provided their children with a total of $48,000 as loans to purchase vehicles, and although there were oral agreements to repay this money, the children were unable to do so. The couple also spent money buying and selling a number of cars, incurring a net loss of $22,742. Expenditure on household equipment, such as television, radio, microwave etc totalled $12,844. The balance of $30,000 was spent on other living expenses for which the couple could not account. The couple were then in considerable financial hardship.

The compensation settlement meant that the couple were precluded from receiving social security payments for some fifteen months. The woman had been unsuccessful in obtaining employment with her previous employer, and had difficulty coping with her part-time employment from which she received $70 per week. Her husband did not expect to be able to return to the work force.

Their assets consisted of a car, furnishings and household items, and the husband's carpenter's tools. The couple owed six months' rent and had been

issued with a notice of termination from the Housing Department house they had lived in for twenty-five years.

In addition to her back problems, the stress of the financial circumstances exacerbated the woman's health problems and she developed depression, insomnia and an itching skin complaint.[957]

Motor Vehicle Accident—Related Paraplegia (Lump Sum of $800,000)

This case involved a man who became a paraplegic as a result of a motor vehicle accident.

Following twelve months of hospital and rehabilitation treatment, he attempted employment as a telephonist, but was unable to cope after three months. He then applied for and was granted, a social security invalid pension.

Three-and-a-half years after the accident, he received a lump sum damages payment of $800,000. Because of this lump sum compensation, his invalid pension was cancelled, and he was precluded from receiving social security payments for nine years. He paid $77,734 for legal, medical and associated expenses and then purchased a unit and had it modified for wheelchair access at a cost of $406,660, including $22,000 spent on furnishings. In a little over two years following the receipt of the compensation monies, he spent $142,496 on drugs, alcohol, 'friends' and other items 'too numerous to itemise'. He had also spent $45,000 on the purchase of a car, boat and trailer (now wrecked), $45,000 on the repayment of loans to family members, and invested $90,000 in two business ventures, but this money was subsequently lost following their failure. Approximately $45,000 of the monies remain unaccounted for.

Having spent all of his money, he was required to rely on his parents for support. The only property of any value that he had left was the unit in which

---

957 Australia, Department of Human Services and Health, Review of Professional Indemnity Arrangements for Health Care Professionals, *Structured Settlements as Payment of Compensation for Personal Injury: A Discussion Paper*, AGPS, Canberra, 1995, p. 2.

he resided, estimated to be worth $250,000. The unit was not readily saleable because of the special modifications made to facilitate wheelchair access.[958]

Negligent Breast Surgery (Lump Sum Settlement < $50,000)

This case involved a woman who underwent a bilateral subcutaneous mastectomy performed by her general practitioner for unspecified breast disease. Several attempts at breast reconstruction with the insertion of breast implants failed resulting in the need for further surgery by a plastic surgeon who reconstructed her breasts without implants. She suffered pain, scarring, mood swings, migraine, loss of earnings and severe emotional stress over a ten year period.

After eight years, her claim was settled out-of-court for less than $50,000. She made the following observations on how she used her lump sum award.

> If you have a large amount of money you can blow it in one big hit. Some people do that. If an indexed income had been offered to us instead of a lump sum we would have accepted that. All we did was pay off a few of the debts we owed. We left it in the bank for a year to get the interest. Then my husband got retrenched which was a shock. We only had a little runabout and this was the last chance we would get to get a new car so we bought one with $20,000. We paid for a new fridge and other things we needed around the house and we got a fernery built so that I had a little hobby. After you have paid for your solicitor, I gave about two and a half thousand to [the solicitor], a car, etc. there is not much left. I loaned about two thousand to my son to do some things. I did go around asking for advice from the banks, about what to do with it. To be quite honest they didn't seem to be the least bit interested. I had to explain it for tax.[959]

---

958 ibid. p. 22.

959 Australia, Department of Health, Housing, Local Government and Community Services, Review of Professional Indemnity Arrangements for Health Care Professionals, *The Health/Medical Care Injury Case Study Project*, AGPS, Canberra, 1993, pp. 49 & 87.

APPENDIX E STRUCTURED SETTLEMENT AGREEMENT

Field v. Herefordshire Health Authority(31 October 1991)

Field v. Herefordshire Health Authority was the first English medical negligence case involving a Health Authority to use a structured settlement agreement.
The case concerned a young girl who had been injured as a result of the negligent use of forceps at her birth in 1984. She suffered brain damage causing extensive and permanent paralysis which requires continuous artificial respiration. She can speak only a few words to her parents who provide her with constant care. She communicates with the help of a computer and attends a school with special facilities. Her life expectancy is extremely uncertain, but she may live into her thirties.
In June 1991, the judge gave provisional approval to a conventional award of damages agreed at £1.7 million. The case was adjourned in order for a structured settlement to be arranged. Approval was obtained from the Treasury, the Department of Health and the Court of Protection.

On 31 October 1991, the court approved the following settlement which cost the defendants £1.6 million, about £100,000 less than the agreed sum which would have been paid apart from the structured settlement. The settlement was paid over four months later which resulted in a total saving to the insurer, including interest, of £200,000. The periodical payments were arranged by purchasing annuities from two life insurance companies. Had a lump sum been awarded, it was estimated that it would have been exhausted after 23 years.[960]

[960] R. Lewis, *Structured Settlements: The Law and Practice*, Sweet and Maxwell, London, 1993, para. 16.13 & pp. 316–323.

The Settlement Agreement

Parties: Rebecca Jayne Field (A Minor by Mrs Yvonne Lesley Field, her Next Friend) ('The Claimant')

Herefordshire Health Authority ('The Defendant')

WHEREAS:

(1) The Claimant has made a claim against the Defendant arising out of an incident on 11 November 1984 from which the Claimant suffered personal injuries ('the Claim').

(2) The Claimant is a patient and a minor and brings the Claim by her Next Friend.

(3) It is agreed, subject to the approval of the High Court of justice, that the Claim shall be settled for £1,700,000 (One million, seven hundred thousand pounds).

(4) The High Court of justice has approved the Agreement recited at (2) above.

(5) The Court of Protection has authorised the Next friend to sign this Agreement in the name and on behalf of the Claimant.

AGREED:

1. By way of settlement of the Claim the Defendant shall pay or procure to be paid to, or for the benefit of the Claimant, the sum of £1,700,000 (One million, seven hundred thousand pounds) and the Claimant shall accept such sum in full and final settlement of the Claim, which is discharged.

2. Subject to the compliance by the Next Friend with Clause 3 to the satisfaction of the Defendant, the debt of £1,700,000 (One million, seven hundred thousand pounds) arising under Clause 1 shall be discharged by payments by the Defendant to, or for the benefit of the Claimant as follows:

   (a) The sums of £50,000 (Fifty thousand pounds) which have already been paid to the Claimant;

   (b) The further sum of £507,587 (Five hundred and seven thousand five hundred and eighty seven pounds) to be paid forthwith;

   (c) The further sums as specified in the attached Schedule.

3.1 The Next Friend, acting on behalf of the Claimant, shall forthwith take all necessary steps to discontinue any proceedings which have begun or threatened against the Defendant in connection with the Claim.

3.2 Neither the Claimant nor the Next Friend shall institute any proceedings against the Defendant in connection with the Claim.

DATED:

SIGNED: (1) (the Claimant, acting by the Next friend)

(2) (for the Defendant)

THE SCHEDULE

Item	Amount	Date of Payment
1.	£4,916.66	At the end of each calendar month the first payment to be made on or before the last day of November 1991
2.	£1,276.25	At the end of each calendar month the first payment to be made on or before the last day of November 1996
3.	£2,714.83	At the end of each calendar month the first payment to be made on or before the last day of November 2001
4.	£50,000	At the end of every five years the first payment to be made on or before the last day of November 1996

Amounts payable under this Schedule shall be made as follows:

Item 1

(a) After one year's payments have been made and at the end of every 12 (twelve) months thereafter the amount will be increased at the rate of 5% (five per cent) per annum compound.

(b) A minimum of 120 (one hundred and twenty) payments hall be made under this Schedule, regardless of the date of death of the Claimant, but subject to this no amounts shall be payable after the date of death of the Claimant.

Item 2

(a) After one year's payments have been made and at the end of every 12 (twelve) months thereafter the amount will be increased at the rate of 5% (five per cent) per annum compound.

(b) A minimum of 120 (one hundred and twenty) payments hall be made under this Schedule, regardless of the date of death of the Claimant, but subject to this no amounts shall be payable after the date of death of the Claimant.

Item 3

(a) After one year's payments have been made and at the end of every 12 (twelve) months thereafter the amount will be increased at the rate of 5% (five per cent) per annum compound.

(b) A minimum of 60 (sixty) payments hall be made under this Schedule, regardless of the date of death of the Claimant, but subject to this no amounts shall be payable after the date of death of the Claimant.

Item 4

(a) The amount of £50,000 is as expressed in cash terms as at the time of this Agreement. Each payment to be made will be this sum as increased or decreased in proportion to the increase or decrease in proportion to the increase or decrease in the General Index of Retail Prices (All Items) for the 5 (five) years ending 3 (three) months prior to the date of alteration. In respect of the first payment to be made after the year 2024 and for all subsequent payments to be made, payments will continue to increase or decrease similarly, provided that at the time in the opinion of the Defendant suitable British Government Index Linked Stocks still exist to support the continuation of such increases or decreases. Should the Defendant deem on any subsequent anniversary that suitable Stocks no longer exist the increase due then and in each subsequent year would be 7% of the amount of the annuity payable immediately prior to the date of increase.

(b) There is no minimum number of payments and the amount shall cease to be payable after the death of the Claimant.