(9) In the past drivers have not been obliged to insure against the results of their own negligence on the highway.
(10) Owners of vehicles, who alone have provided funds for the compulsory insurance scheme, should not be required to make increased payments to the scheme proposed. The time has arrived to require individual drivers to make some direct contribution to a fund which will provide them with considerable personal advantage.
(11) We recommend that an annual levy of $1.50 be charged in respect of all driving licences, and that this sum should be collected by local authorities on behalf of the compensation fund.
(12) Finally we recommend that the levies proposed in respect of earnings and in respect of the owners and drivers of motor vehicles should be pegged. To the extent that additional funds might be needed in the future these in our view should be provided from general taxation.

REPORT OF THE ROYAL COMMISSION ON COMPENSATION FOR PERSONAL INJURY

A Medical Viewpoint

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During the sitting of the Commission and since its report appeared in December 1967 a variety of opinion ranging from high praise to pungent criticism of the recommendations has been voiced by different sections of the community. This has probably stemmed from two, often conflicting, influences—their attitude to the social welfare of the community as a whole and the way in which they would personally be affected by the recommendations.

To support the adverse opinions of the Report by different parties there has of course been specific criticism, much unfortunately petty and related to apparently unimportant detail. The writer would not suggest that the Report offers no room for criticism, but would suggest that at this time concentration should be primarily on the general social intent and the desirability and economic feasability of the recommended scheme, and that we should not lose sight of the primary objective in a mass of detail.

For example, it appears from perusal of the Manual of International Classification of Diseases that there could well be difficult medical problems in ascertaining the causation of some of the medical conditions described in the Manual which is used by the Commission as a basis of medical classification. Of course there will be difficult medical problems associated with any compensation scheme. Can coronary occlusion be considered an accidental injury following strenuous exertion?—has a painful back resulted from injury or pre-existing

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arthritis?—and so on. The Commission has suggested that this Manual be used for the basis for definition of an accident, but it felt that certain sections would need to be excepted and no doubt such adjustments as are necessary can be made to reduce problems to a minimum. They certainly would be reduced by removing the need to distinguish between occupational accidents and those of other origin.

So far as medical opinion of the Report is concerned, relatively little comment has been made, but what there is appears favourable, as in the Editorial to the *New Zealand Medical Journal* of February 1968. The profession clearly has two particular interests in any compensation scheme—the effects of medico-social legislation on the community as a whole and the part which the profession must personally play in the implementation of the scheme. Overall the recommendation of the Commission would seem to place a greater responsibility on the profession, but at the same time to remove some of its responsibilities from the generally unwelcome glare of the courtroom back to the consulting room.

The medical and associated professions probably see in the lives of their patients and families more of the defects in the present compensation scheme than do most people and the two greatest defects are probably the distressingly low ceiling of compensation payments and the limitation of such payments to a maximum of six years. Temporary short term disability can create problems, but most people do manage to get by one way or another. Long term disability however can cause serious financial and social hardship, particularly at the present day when so many families have credit and hire-purchase commitments. In this respect the above average wage earner, having accepted greater commitments, may be harder hit than any. That such situations are not even commoner is due to the benevolent employer who may make up a man's wages, and to the various benefit schemes, out-of-court settlements and so on. That these should be accepted as a substitute for adequate compensation payments is in principle wrong.

It must be admitted that determination of the ideal level of compensation payment is a difficult problem. If it be high enough to avoid any unreasonable hardship to the recipient and his family, may it be so high that little financial incentive to return to work remains? Undoubtedly this may happen, but would be obviated to a considerable extent by the recommendation of the Commission that during the initial period of work absence a lower rate of compensation should be paid. Also of undoubted value in this respect is the lump sum payment for a permanent disability in the right cases. However, acceptance of a lump sum payment must not be considered a final settlement. Should the condition deteriorate or the unexpected happen, it is essential that provision be made for reconsideration of the case.

To this question of return to work and rehabilitation the Commission devotes considerable space in its Report and there is no doubting its importance. The value of intensive rehabilitation has been often demonstrated—in England for example, in a series of cases following operation on the knee joint those who went to a special Rehabilitation Centre returned to work in an average of 18 days, those who did not in an average of 31 days. This example is perhaps exceptional in the degree of success achieved, but does show what can be done in certain cases in certain circumstances. We do have rehabilitation services in New Zealand, but not to the same extent as many other countries. Our

relatively small and scattered population does not provide the concentration of suitable patients necessary to make special centres a workable and economic proposition whilst our employment situation has not exerted the same pressure to achieve rapid and complete rehabilitation. Although we can point out individual cases which could have been better rehabilitated, we really do not know how great is the need for further rehabilitation services in this country, only that it does exist. Apart from Training Centres, at present operated by the Disabled Servicemen's Re-establishment League, it seems doubtful to the writer whether special Rehabilitation Centres are the best answer to the New Zealand problem. Rather should intensified rehabilitation be an integral function of all our hospitals on both an in-patient and out-patient basis and in conjunction with the family doctor. The total delay in return to work following injury of the 'glamour' cases who might be treated in a special Rehabilitation Centre is probably small compared with that of the everyday humdrum cases who may never even be admitted to hospital.

In many ways the problem of rehabilitation and the services it requires is quite separate from the problem of compensation and it could and should be developed even with our present compensation scheme. Nevertheless the two have a certain interdependency. The more effective and rapid the rehabilitation the less the financial drain on the compensation fund and conversely the more protracted the compensation proceedings and the more reason the patient has for making the most of his injury the less effective and the slower will be the rehabilitation. In this respect the Commission has been particularly critical of Common Law litigation.

We know that about 60 such cases come to trial each year, that the average time between the accident and filing of the suit is 13 months, with another 6 months on the average before the trial is held and that some 500 claims altogether are settled each year. We do not know just how many of these patients might otherwise have been able to return to work sooner, nor how many others, with thoughts of Common Law proceedings which never proceeded, were similarly affected. It is certainly a widespread popular opinion—probably to an extent true and probably to an extent acted upon—that to return to work whilst a claim is pending will lessen the chances of success and the amount of the claim which may be granted. Undoubtedly this does retard rehabilitation in a number of cases, but just how many and by what length of time we cannot say.

Of the many other arguments for and against Common Law proceedings the medical profession is of course particularly interested in the question of medical evidence. Just as in any other profession, conflicting and divergent opinions do occur. In compensation cases this may be a genuine difference in interpretation of the same facts or it may be that certain facts have been disclosed to one doctor only and not to the other. Much more so than in years past, the public is aware and does accept that medical opinion is not always unanimous, but nevertheless the profession can never be entirely happy that their differences, which may be the lifeblood of progress within the profession, should be the centrepiece of courtroom proceedings.

In our present compensation scheme, or in whatever scheme might be accepted to replace it, clearly medical opinion is and must be one of the keystones around which it functions and it is essential that we consider carefully how this may be best and most fairly obtained and

presented. In the early stages, corresponding presumably to the period of low-rate compensation envisaged in the Commission's recommendations, on the grounds of practicability, economy and trust there appears no acceptable alternative to the opinion of the patient's own medical attendant. Presumably beyond this stage where large sums of money may be involved—long term disability, death, permanent disability or the granting of lump sum compensation—something more will be demanded as a safeguard both to the scheme and to the patient. Here there are two really quite different situations.

The first is concerned purely with general medical principles and is typified by two apparently similar cases quoted in the Commission's Report which produced two entirely different decisions. An individual employed on strenuous manual work collapses and dies from coronorary occlusion—is this a fatal accident related to his work or death due to disease quite unrelated to his occupation? This, it seems to the writer, is not a decision which can be made on an individual basis in a court of law or elsewhere. A ruling on this and similar situations should be determined on the basis of all available medical knowledge by a panel of medical experts on a national basis and applied uniformly by incorporation in the legislation or other means.

In the second situation the individual patient himself is the basis of our assessment. When the disability is purely objective—loss of a limb, reduced visual acuity, loss of hearing or restricted joint movement for example—no great difficulty should occur. If we accept a uniform system of assessment, as that published in detail by the American Medical Association, applying various formulae to accurate clinical findings to measure 'whole man' incapacity, then any number of doctors assessing the same patient should arrive at virtually the same answer. When however the disability is entirely or partially one of subjective symptoms, for example, post-traumatic headache or a painful shoulder out of all proportion to objective findings, some divergence of opinion is inevitable. Here we can only hope to find the fairest answer, perhaps giving a small benefit of doubt to the patient, but must accept that from time to time an injustice will be done in one direction or the other. There can be no escape from this fact.

The fairest answer can only be the majority opinion of medical experts in the particular field. Clearly every patient cannot be examined by every expert and in practice we must be satisfied with something less. If we take a hypothetical case with one of the conditions mentioned where overall medical opinion might be divided 80% to 20%, the odds are 4 to 1 that the opinion of any single expert would represent that of the majority and about 9 to 1 that the opinion of a panel of three experts would represent the majority view. Perhaps the best answer would be the assessment of minor cases by a single expert with the patient's right of appeal to a panel and the assessment of major cases always by a panel of three.

It may be argued that under such a system dissenting expert opinion could exist but not be considered at all, whereas under the adversary principle of Common Law the loser, be he defendant or plaintiff, has at least had the right of having any opinion in his favour being heard by the Court. Just how the Court can be expected to decide between two conflicting medical opinions it is impossible to understand. Although one may represent the majority and the other the minority of opinion, the Court's decision would on the face of things appear to be an even

chance and often influenced by factors quite unrelated to the point in question.

Having dwelt at length, because of its real difficulty in solution, on this problem of conflicting expert opinion, it should however be stressed that in the vast majority of cases medical opinion will be unanimous, or virtually so, and no such problem will arise.

The comments to this point have been concerned primarily with worker's compensation, but the Commission does envisage its proposals having a considerably wider coverage. Virtually all that has been said is probably equally applicable to compensation for traffic accident injuries. So far as the self-employed are concerned it may be assumed that inclusion in such a scheme would offer injury insurance cover on better terms than at present available through private insurance. The family problems and hardships which may arise from injury to the housewife, disabled at home or undergoing treatment in hospital, are probably appreciated by the medical profession more than anyone and any step to alleviate this situation is certainly in the right direction. The only doubt of the writer would be whether financial compensation is necessarily the best answer in these circumstances—at times it may be, at other times home-help paid by the compensation fund might better ensure the purpose of compensation.

In conclusion it seems to the writer speaking from the medical point of view, that the general philosophy of the Commission's recommendations appears sound, humanitarian and a clear advance on existing legislation. Anomalies and injustices, medical and otherwise, must inevitably occur, but probably less frequently than at present and it is essential that pre-occupation on this aspect does not cloud our judgment of the proposals as a whole. Finally if such a scheme as envisaged is introduced, it is to be hoped that it will be only the forerunner of an overall scheme to cover both accidental injury and sickness for all sections of the population. Basically it is extremely difficult to distinguish between the man accidentally infected with the tubercle bacillus and the man accidentally injured by a motor car—that different values should be placed upon their disabilities seems wrong.

REPORT OF THE ROYAL COMMISSION ON COMPENSATION FOR PERSONAL INJURY

A Private Insurance Viewpoint*

INTRODUCTORY

In December 1967 the Royal Commission of Inquiry published its report under the title of "Compensation for Personal Injury in New Zealand". The Insurance Council of New Zealand and the Non-Tariff Insurance Association of New Zealand had made joint submissions to the Royal Commission on behalf of the insurance industry, and on publication of the Report the Industry's Workers Compensation Committee subjected it to a close scrutiny.

* This article is contributed by the New Zealand Insurance Council