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Ken Oliphant

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COMPENSATION, IDEOLOGY AND PATIENT SAFETY
IN NEW ZEALAND'S NO-FAULT SYSTEM

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Ken Oliphant[♦]

Abstract

As the idea of no-fault compensation for medical injuries attracts increasing attention in Europe, the experience of the New Zealand Accident Compensation Scheme offers an educational case history. This paper traces the different phases of the Scheme's approach to compensating medical injuries, and considers the rival ideologies underlying the divergent approaches adopted and what they say about the methods that consecutive governments have employed in order to secure patient safety.

[♦] Director, Institute for European Tort Law, Austrian Academy of Sciences; Professor of Tort Law, University of Bristol. This paper was delivered in summary form at an international workshop in Pisa on 5-6 June 2009 on the topic 'Medical liability and medical accidents compensation. From the blame game to individual rights protection in the provision of medical services.' I am grateful to Colm McGrath for his assistance in the preparation of this paper, and to the two anonymous referees for their helpful comments.

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1. Introduction

New Zealand's no-fault accident compensation scheme, established 1974, offers an educational 'case history' for those who would wish to investigate alternatives to the compensation of medical injuries by way of tort liability. A state-administered fund provides a range of compensation and other benefits for those suffering personal injury in defined circumstances. Where there is cover under the scheme, no claim for compensatory damages in tort is allowed. This paper focuses on the class of covered injury previously designated 'medical misadventure' and now called 'treatment injury', highlighting the crucial stages of development of the scheme's handling of such injuries and the ideologies underpinning successive legislative reforms, in particular relating to the basis and nature of the state's perceived responsibility to pay compensation, and the strategies adopted by the state to prevent medical injuries and ensure patient safety.

Three stages of development may be identified. First, in the scheme's early years (1974-1992), the concept of 'medical misadventure' was left largely undefined by the legislature, and its meaning had to be ascertained on a case-by-case basis by the courts. An informal distinction emerged in practice between two categories of misadventure: 'medical error' and

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‘medical mishap’. The general trend in these years was expansive, reflecting a somewhat blurred vision of the scheme as underpinned by considerations of social solidarity. Insofar as patient safety was concerned, there was a touching if rather uncritical belief that the bar on tort actions for compensatory damages would encourage greater openness on the part of medical practitioners and so contribute to injury prevention.

Secondly, in the middle years of the scheme (1992-2005), ‘medical misadventure’ was restrictively defined to counter the expansionary tendencies of the previous years, which were alleged to have contributed to a ‘costs blow-out’ which nearly drove the scheme into bankruptcy. (Whether this in fact happened is critically evaluated below.) In this period, an insurance-based approach prevailed, underpinning both the individual’s entitlement to compensation and the dominant strategy of injury prevention.

Lastly, in the scheme’s most recent history (2005-present), the category of ‘medical misadventure’ was abolished and replaced with the new category of ‘treatment injury’. The previous approach was felt to be confusing and arbitrary, and undesirably to retain a focus on fault as a precondition to the payment of compensation, at least in some cases. This stage of the scheme’s history sees a shift away from the insurance-based approach based on individual responsibility, and a return to ideas of community responsibility – but this time the emphasis is on the community’s *causal* responsibility for medical injuries, rather than obligations of social solidarity as such. As far as patient safety is concerned, a systems-based approach now prevails, based on collective action rather than individual responsibility. As statistical information is now emerging about the operation of the ‘treatment injury’ regime, it would seem to be desirable to see what conclusions can be drawn by way of evaluation of its success in achieving the twin goals of compensation and patient safety.

2. Key elements of New Zealand's no-fault scheme¹

New Zealand's no-fault accident compensation scheme, commonly known as 'ACC' after the statutory body – the Accident Compensation Corporation – that administers it,² was established on 1 April 1974. But it was no April Fool's Day joke. ACC now receives about 1.8 million claims a year, and accepts liability in almost 1.6 million of them. A very high percentage (over 90 %) of accepted claims entail nothing more than the payment of medical treatment costs, but every year some 120,000 claims result in the payment of compensation or the delivery of rehabilitation entitlements. These may be added to the over 200,000 ongoing compensation or entitlement claims brought forward from previous years.

The key elements of the scheme may be summarised as follows:

- (1) The scheme is a statutory scheme. In the 35 years since its inception, it has undergone numerous legislative amendments, but retains broadly its original form. ACC is currently governed by the Injury Prevention, Rehabilitation, and Compensation Act 2001.

- (2) The scheme is founded on five guiding principles: Community responsibility; Comprehensive entitlement; Complete rehabilitation; Real compensation; and Administrative efficiency.³

¹ For general overviews, see G. Palmer, *Compensation for Incapacity: a Study of Law and Social Change in New Zealand and Australia* (Oxford University Press 1979); T.G. Ison, *Accident Compensation: A Commentary on the New Zealand Scheme* (Croom Helm 1980); G. Palmer, 'New Zealand's Accident Compensation Scheme: 20 Years on' (1994) 44 U. Toronto L.J. 223; I. Campbell, *Compensation for Personal Injury in New Zealand: Its Rise and Fall* (Auckland University Press 1995); S. Todd, 'Privatization of Accident Compensation: Policy and Politics in New Zealand' (2000) 39 Washburn L.J. 404, and K. Oliphant, 'Accident Compensation in New Zealand: An Overview', in G. Schamps (ed.), *Évolution des droits du patient, indemnisation sans faute des dommages liés aux soins de santé: le droit médical en mouvement* (Bruylant 2008), as well as two special issues of the Victoria University of Wellington Law Review, vol. 34 no. 2, *Looking Back at Accident Compensation: Finding Lessons for the Future* (2003) and vol. 35 no. 4, *The Future of Accident Compensation*, ed. G. McLay (2004). Additional information is available from the Accident Compensation Corporation (ACC) website <http://www.acc.co.nz>.

² The body has undergone a number of name changes over the years, but for convenience I shall refer to it as 'ACC' throughout.

³ Royal Commission of Inquiry into Compensation for Personal Injury (Chairman: Mr Justice Woodhouse), *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (Government Printer 1967), para. 55.

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- (3) The scheme is a no-fault scheme, as expressed in the principle of ‘comprehensive entitlement’: ‘all injured persons should receive compensation... on the same uniform method of assessment, regardless of the causes that gave rise to their injuries.’⁴
- (4) Compensation is provided for personal injury falling within one of 12 categories of injury covered by the scheme. In the scheme’s early years (to 1992) a unitary concept of ‘personal injury by accident’ was employed, but this was perceived to be too blunt an instrument, and was therefore replaced by the approach of identifying specified categories of personal injury. The most important categories in the current legislation include personal injury caused by ‘an accident’ and work-related diseases, infections and processes. There are specific exclusions from the scheme in respect of illnesses and infections – unless they fall within one of the specified categories – and the consequences of ageing.⁵
- (5) The scheme is exclusive. A statutory bar applies to proceedings (in tort or otherwise) for compensatory damages in respect of personal injury covered by the Act. New Zealanders have therefore given up their right to compensation from other sources in return for the benefits available under ACC.
- (6) The scheme provides ‘real’ but not ‘full’ compensation. This includes, where appropriate, weekly compensation, paid at 80 percent of pre-accident earnings, up to a fixed maximum of approximately 2.5 times average weekly income for those in paid employment, lump sum compensation for non-economic loss of up to NZ \$ 100,000 (approximately EUR 50,000), paid in respect of permanent impairment of 10 % or greater, and, in the event of death, a funeral grant, survivor’s grant and weekly compensation to surviving dependants. Medical treatment fees are paid directly by ACC. A range of social and vocational rehabilitation entitlements is also available.

⁴ Ibid.

⁵ Injury Prevention, Rehabilitation, and Compensation Act 2001, secs. 20-21. The most recently added category of covered injury is work-related mental injury: s. 21B.

(7) The scheme is funded by levies on employers, the self-employed, motor vehicle licence-holders, and, since 1992, by employees ('earners') too. A proportion of excise on petrol also goes to ACC. The scheme is run as a number of separate accounts, with (for example) the Employers' Account paying for work-related injuries, the Motor Vehicle Account bearing the cost of motor accidents on public roads, and (since 1992) the Earners' Account paying for other non-work injuries suffered by people in paid employment.

3. Compensation for medical injuries under the scheme⁶

It has always been accepted that some adverse outcomes of medical treatment are covered by ACC, and explicit legislative provision for 'medical misadventure' was made very early in the scheme's history. Not until 1992, however, was a statutory definition of medical misadventure provided. This section considers the main stages of the development of the medical misadventure concept in the ACC, before addressing the replacement of that concept with a new concept of 'treatment injury' in 2005.

(a) The early years (1974-1992): 'medical misadventure' at large⁷

At the scheme's inception in 1974, the governing statute made no reference to 'medical misadventure' or any equivalent concept. But it was acknowledged that at least some adverse outcomes of medical treatment fell within the initial entitlement criterion, 'personal injury by accident', and entitled the victim to compensation without the need to prove fault. Within a year, an amending statute gave further guidance as to the meaning of 'personal injury by accident', introducing specific exclusions in respect of injury caused exclusively by heart

⁶ This section draws on the author's previous analysis in K. Oliphant, 'Defining 'Medical Misadventure': Lessons from New Zealand' (1996) 4 Med. L.R. 1 and K. Oliphant, 'Beyond Misadventure: Compensation for Medical Injuries in New Zealand' (2007) 15 Med. L. R. 357. For an excellent recent overview in German, see P. Butler, 'Medical Misadventure', in H.-J. Ahrens et al., *Medizin und Haftung: Festschrift für Erwin Deutsch zum 80. Geburtstag* (Springer 2009).

⁷ For further detail and analysis, see Oliphant (fn. 6, 1996), 4–23, and Oliphant (fn. 6, 2007), 359–362.

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attacks, disease, infection or the ageing process, and adding an express reference to ‘medical, surgical, dental or first-aid misadventure’ as an illustrative category of personal injury by accident. Medical misadventure was not itself defined in the statute, but an informal definition soon emerged in practice, embracing two distinct categories of misadventure: ‘medical error’, where there was incorrect treatment, and ‘medical mishap’, where the patient suffered a rare adverse treatment outcome. This classification was subsequently adopted by the courts.⁸ The general trend in these years was towards an expansive conception of medical misadventure. In particular, it appeared that the threshold of ‘rarity’ employed to determine whether there was ‘medical mishap’ was progressively lowered so as to allow increasing access to accident compensation entitlements.

In the opinion of the (right-wing) National Government elected in 1990, these developments fitted into a pattern of excessively generous court decisions on the meaning of personal injury by accident, which had the effect of extending the boundaries of the scheme to cover situations not anticipated at the time of its inception.⁹ This expansion was seen as a major contributory cause of grave financial difficulties – a ‘costs crisis’ – experienced by ACC in the mid- to late-1980s.¹⁰ As a result of compensation expenditure rising more rapidly than levy income, ACC began to draw heavily on its accumulated reserves, and at the end of 1986 these had become so depleted that reserves meant to be sufficient for 4 or 5 years were on course to be exhausted within a matter of months. In effect, ACC was on the brink of insolvency. An urgent response was required, and the Government acted by imposing huge levy increases almost overnight. On average, levy rates for employers went up by 192 %; in some cases, they exceeded 500 %. Inevitably, this provoked a barrage of criticism, and much debate about the viability of the scheme.

In retrospect, it seems that the main problem was not the scheme’s expanding boundaries, reflecting the broad interpretation given to the key concept of personal injury by accident, and to medical misadventure as a constituent element of personal injury by accident, but the

⁸ See, e.g., *ACC v. Auckland Hospital Board* [1980] 2 N.Z.L.R. 748

⁹ See W.F. Birch, *Accident Compensation: A Fairer Scheme* (Office of the Minister of Labour 1991).

¹⁰ For further detail and analysis, see Oliphant (fn. 1), paras. 18-20.

failure to make due anticipatory provision for the scheme's coming to maturity.¹¹ In any scheme of this nature, expenditure rises from an initially low base as, with each passing year, more and more ongoing claims are accepted, until eventually a plateau of maturity is reached at which the number of new ongoing claims accepted is matched by the number of existing ongoing claims that are closed. Ignoring this crucial fact, ACC had in fact reduced levy rates in the early 1980s, even though the scheme's plateau of maturity had yet to be attained.

Notwithstanding the availability of evidence about the real causes of the 'costs crisis', the National Government elected in 1990 resolved to reform ACC so as to reverse 'cost creep' (the progressive increase in scheme costs) and to distribute ACC costs more equitably by reducing the burden on employers, on whom the costs were thought to fall disproportionately. The result was the Accident Rehabilitation and Compensation Insurance Act 1992.

(b) The middle years (1992-2005): 'medical misadventure' defined¹²

The Accident Rehabilitation and Compensation Insurance Act 1992 established a wholly new legislative framework for accident compensation, implementing a new insurance-based approach. Its main provision was the breaking up of the previously unitary concept of personal injury by accident into a set of specific categories of 'covered' personal injury. The Government's explicit aim was to 'eliminate unintended extensions to the scheme'.¹³ Amongst the new categories of covered injury was personal injury amounting to medical misadventure, which was itself given further definition. Taking the two branches of medical misadventure – medical error and medical mishap – which had emerged from ACC's prior practice, and judicial analysis of the previous legislation, the new Act added a further level of detailed specification.

¹¹ Law Commission (New Zealand), *Personal Injury: Prevention and Recovery*, Report No. 4 (Wellington 1988), para. 16.

¹² See Oliphant (fn. 6, 1996), 23-28 and Oliphant (fn. 6, 2007), 362-369.

¹³ Birch (fn. 9), 31.

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The definition of ‘medical error’ reflected the law of tort’s conception of negligence: ‘the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances’.¹⁴ It was expressly stated that it covered not only positive malpractice but also negligent failures to diagnose or treat.¹⁵

The definition of ‘medical mishap’ had two elements: rarity and severity. The rarity test required that ‘the adverse consequence [sc. of treatment] would not occur in more than 1 percent of cases where that treatment is given’.¹⁶ It was evidently intended to prevent any further watering down of the concept of mishap by strictly stipulating the degree of rarity required. The severity test required that the result of the treatment should be death, extended hospitalisation or lasting and significant disability. It was evidently intended to eliminate claims arising from less serious injuries. Though the rarity test reflected, albeit inexactly, the previous understanding of medical mishap, the severity test was something new and lacked any source in the judicial analyses of medical mishap prior to 1992.

Another innovation introduced by the Act was the creation of a new ACC Medical Misadventure Account to channel funds needed for the resolution of medical misadventure claims. An ulterior goal was the introduction of experience-rated premiums for registered health practitioners, but ACC has not exercised its statutory power to make registered health practitioners liable to pay an ACC levy, and funds for the Account have so far been raised out of contributions from the Earners’ and Non-Earners’ Accounts, the latter funded by direct Government payment.

In a series of studies published by ACC in 2002 and 2003, it was reported that ACC received approximately 2,100 claims of medical misadventure a year, the majority of which were rejected.¹⁷ Amongst accepted claims, the balance was heavily in favour of medical error (86 % of accepted claims) as opposed to medical mishap (14 % of accepted claims).¹⁸ In the context of the ACC scheme as a whole, medical misadventure claims were numerically of

¹⁴ Accident Rehabilitation and Compensation Insurance Act 1992, s. 5(1).

¹⁵ Accident Rehabilitation and Compensation Insurance Act 1992, s. 5(7).

¹⁶ Accident Rehabilitation and Compensation Insurance Act 1992, s. 5(2).

¹⁷ ACC, ACC Background Paper: Medical Misadventure Claimant Profile (ACC 2003), 2.

¹⁸ *Ibid.*, 6.

little significance, constituting approximately 0.14 % of all claims received and 0.05 % of all claims accepted. But the cost of medical misadventure claims was disproportionately high: in 2004-2005, expenditure on the ACC Medical Misadventure Account was 2.1 % of total ACC expenditure, a figure almost 40 times that one would expect from the mere numerical representation of accepted medical misadventure claims. A major factor was that, where only 1 in 15 of all ACC claims was then an entitlement claim, i.e. for compensation or rehabilitation assistance, as opposed to the provision of medical treatment alone, more than half of medical misadventure claims fell into that category.¹⁹ These cost considerations are a large part of the reason why ACC compensation for medical injuries has generated so much debate.

(c) Recent history (2005-present): 'treatment injury'²⁰

In May 2003, ACC and the New Zealand Government (since 2000 under Labour control) published a Consultation Document proposing reform of the ACC medical misadventure provisions in the light of a variety of concerns.²¹ It was felt, first, that the criteria for defining medical mishap were confusing and arbitrary. Some victims of severe adverse outcomes of medical treatment received no compensation because their condition was not a rare consequence of the treatment they received. Conversely, victims of rare adverse outcomes of medical treatment might have their claim rejected because their condition was insufficiently severe. Secondly, the definition of medical error in terms of a registered health practitioner's failure to meet the expected standard of care was thought to contradict the general entitlement to compensation under the scheme on a no-fault basis. This contributed to 'an overly blaming culture rather than a culture of learning from mistakes', and a focus on individual acts rather than the entire treatment environment.²² From the perspective of patient safety, the focus on fault limited opportunities to learn, thereby inhibiting improvements. The requirement of fault also led to delays in the assessment of medical error

¹⁹ Oliphant (fn. 6, 2007), 365-368. Currently, about 1 in 12 of all ACC claims is an entitlement claim.

²⁰ See Oliphant (fn. 6, 2007), 369-387.

²¹ ACC/Department of Labour, Review of ACC Medical Misadventure: Consultation Document (ACC 2003).

²² *Ibid.*, 11.

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claims, which impacted negatively on the patient's rehabilitation and recovery, and contributed disproportionately to the costs of the scheme.

The chosen reform option was to replace the existing concept of medical misadventure – by now enshrined in the consolidating legislation of 2001²³ – with a new concept of 'treatment injury'. Fault no longer plays a role. As one judge has observed, it was 'Parliament's intention to move away from a definition that involved any need to enquire into responsibility for an injury.'²⁴ The constituent elements of the former concept of medical mishap – rarity and severity – have also been discarded. Following the reform, s. 32 of the 2001 Act now reads (so far as is material):

- (1) Treatment injury means personal injury that is—
- (a) suffered by a person—
 - (i) seeking treatment from 1 or more registered health professionals; or
 - (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
 - (iii) referred to in subsection (7); and
 - (b) caused by treatment; and
 - (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—
 - (i) seeking treatment from 1 or more registered health professionals; or
 - (i) the person's underlying health condition at the time of the treatment; and
 - (ii) the clinical knowledge at the time of the treatment.
- (2) Treatment injury does not include the following kinds of personal injury:
- (a) personal injury that is wholly or substantially caused by a person's underlying health condition;
 - (b) personal injury that is solely attributable to a resource allocation decision;
 - (c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment...

(Section 32(7) extends the entitlement to compensation to various persons to whom a person seeking or receiving treatment passes an infection that is a treatment injury.)

²³ Injury Prevention, Rehabilitation, and Compensation Act 2001.

²⁴ *Accident Compensation Corporation v McEnteer* [2008] NZHC 1877 at [17], per Dobson J. It seems likely that fault will continue to play some (perhaps tacit) role in judicial application of the treatment injury provisions in practice: see Oliphant (fn. 6, 2007), 384-5, and further S. Todd (ed.), *The Law of Torts in New Zealand*, 5th edn. (Brookers 2009), para. 2.4.04(1)(b).

The main definition (s. 37(1)) has both a positive and a negative aspect. Positively, the injury must be caused by (medical) treatment; negatively, it must not be a necessary part of the treatment (e.g. a surgical incision) or its ordinary consequence (e.g. an expected side effect). The two negative elements are expressed disjunctively, so the claimant must prove that neither applies.²⁵ But that is not the full picture, for the further specific exclusions in s. 37(2) must also be noted. Of these, the most fundamental is the first. A treatment injury must be caused by the treatment and not (wholly or substantially) by the patient's underlying health. The Act leaves a number of questions unanswered.²⁶ In particular, we may ask at what point of the spectrum of probabilities does a foreseeable adverse consequence of treatment become 'ordinary'? Is it enough that the consequence was 'not unlikely', or does it have to be 'more likely than not'? Further, when both the treatment and the patient's underlying health are contributory causes of the injury, on what basis is it to be determined that it was the underlying condition, and not the treatment that acted as the trigger, that was the 'substantial' cause? Final determination of these issues must await judicial decision in appropriate cases.

The practical effect of the reform has been to cause, first, a very steep rise in the number of medical misadventure / treatment injury claims: from 1,434 in 2004/2005, the last year of the medical misadventure regime, to 2,846 (2005/2006), 3,964 (2006/2007) and 5,073 (2007/2008) in the first three years of the treatment injury regime. (It is possible that some potential claimants in 2004/2005 deferred claiming pending the introduction of the new regime.) In the same period, the total number of ACC claims rose much more modestly: from 1,523,946 (2004/2005) to 1,604,359 (2005/2006), 1,685,995 (2006/2007) and 1,755,899 (2007/2008).²⁷ The reform has also significantly reduced the proportion of medical misadventure / treatment injury claims declined by ACC: from 57.4 % (2004/2005) to 33.1 % (2005/2006), 35.9 % (2006/2007) and 30.4 % (2007/2008). It may be noted that, both before and after the treatment injury reform, the decline rate here is radically higher than that

²⁵ *Accident Compensation Corporation v McEnteer* [2008] NZHC 1877.

²⁶ See Oliphant (fn. 6, 2007), 382-385.

²⁷ Source: *ACC Annual Report 2006*, 56, *ACC Annual Report 2007*, 26, and *ACC Annual Report 2008*, 12.

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for ACC claims in general, which has hovered at between 1.1 % and 1.3 % for the last four years.²⁸

As may be expected, expenditure on the ACC Medical Misadventure / Treatment Injury account has also risen: from NZ \$ 48,633,000 (2004/2005) to NZ \$ 56,532,000 (2005/2006), NZ \$ 69,186,000 (2006/2007) and NZ \$ 86,317,000 (2007/2008).²⁹ Again, this compares with more limited rises for ACC as a whole: from NZ \$ 2,268 million (2004/2005) to NZ \$ 2,495 million (2005/2006), NZ \$ 2,807 million (2006/2007) and NZ \$ 3,149 million (2007/2008).³⁰ From these figures, it can be calculated that, in 2004/2005, expenditure on medical misadventure was about 2.1 % of all ACC expenditure; in 2007/2008, expenditure on treatment injury was about 2.7 % of all ACC expenditure. In a four year period, expenditure on medical misadventure / treatment injury has risen by about 77 %, whereas overall ACC expenditure has risen by about 39 %.

These rises far exceed Treasury predictions at the time of the treatment injury reform, which estimated an annual consequential increase in ACC costs of NZ\$ 8.7 million (excluding transitional costs).³¹ Though the first year of treatment injury saw an increase in costs of roughly the predicted level, subsequent years have seen continuing and markedly higher increases.

Following a change of Government in 2008, with National replacing Labour in power, the new Minister for ACC announced that significant changes were required to avoid 'huge increases' in ACC levies.³² The treatment injury reform has been identified as one of three major causes for the increases in cost (along with increased use of physiotherapy in

²⁸ Source: ACC Injury Statistics 2008, URL: <http://www.acc.co.nz/about-acc/statistics/acc-injury-statistics-2008/index.htm> (last accessed 26 May 2009), Section 1, 'Declines by Account'.

²⁹ Source: *ACC Annual Report 2006*, 97, *ACC Annual Report 2007*, 93, and *ACC Annual Report 2008*, 90. The headings used in the financial statements changed with effect from 2008. In the earlier reports, I have used the figure for 'total expenditure'. In Annual Report 2008, I have added 'claims handling costs', 'net operating costs' and 'injury prevention costs' to the figure for 'total claims paid' for the purposes of this comparison. At time of submission, the New Zealand Dollar: Euro exchange rate was approximately 1:0.5.

³⁰ Source: *ACC Annual Report 2006*, 97, *ACC Annual Report 2007*, 93, and *ACC Annual Report 2008*, 90. Again, I have had to adapt the figures in Annual Report 2008.

³¹ Oliphant (fn. XX, 2007), 378.

³² Nick Smith MP, Press Release: 'Changes needed to contain ACC costs' (4 March 2009). URL: <http://www.beehive.govt.nz/release/changes+needed+contain+acc+costs> (last accessed 25 May 2009).

rehabilitation and a package of reforms in 2007 which, inter alia, extended cover to victims of mental injury arising from workplace traumatic events).³³ However, it has also been reported that the extension in cover resulting from the change from medical misadventure to treatment injury has been less important in driving up costs than the decision, in line with general ACC policy, to change from a pay-as-you-go to a fully-funded system, which means that the ACC Treatment Injury Account must have income sufficient to pay not just the current year costs of new accepted claims, but also all their expected costs in future years.³⁴

4. Analysis

Putting aside questions of finance for the time being, We may now consider the rival ideologies underlying the two regimes of compensation for (respectively) medical misadventure and treatment injury, and what they say about the methods that consecutive governments have employed in order to secure patient safety. As I have argued elsewhere, it is my view that the reform evidences a paradigm shift in attitudes to injury prevention, the role of ACC and the state's responsibility for personal injury by consolidating a move away from an insurance model of injury prevention which highlighted individual responsibility, to a systems approach based on open disclosure and learning, reflecting collective or community responsibility.³⁵

(a) Private law, insurance and systems approaches to injury prevention

In 1974, New Zealand turned away from the private law test of fault as the criterion for entitlement to compensation for personal injury because it was believed that fault not only impeded the achievement of compensation goals – it was, in effect, a form of lottery – but also served no useful role in injury prevention: ‘the claim that the prospect of damages has a

³³ Anonymous, ‘Questions and Answers’, undated (but accompanying the Minister’s press release (fn. XX) of 4 March 2009. URL: http://www.beehive.govt.nz/sites/all/files/QA_ACC_costs.pdf (last accessed 25 May 2009).

³⁴ M. Mills, ‘Ministerial Inquiry into Disclosure of Funding Shortfall in ACC Non-earners’ Account (Martin Jenkins, February 2009), 13 ff.

³⁵ Oliphant (fn. XX, 2007), 387-391.

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financial implication loses all its force against a background of compulsory insurance by means of which these losses are so widely shared.³⁶ On the contrary, it was thought that ACC itself could make an important contribution to the promotion of safety because it would have accurate details of all accidents that occurred and a direct interest in controlling the cost of accidents.³⁷ However, in the early years of the ACC scheme, there was little success in collecting statistical data about accidents, and the scheme's purported concern with safety was in practice 'submerged' under its compensatory function.³⁸

In 1992, the recently elected National Government adopted a radically different approach to injury prevention based on insurance. It employed a number of insurance techniques to address problems of moral hazard arising when individuals are insulated from the full economic effects of the losses they suffer, including *risk segmentation* (e.g. by breaking up the previously unitary concept of personal injury by accident, and assigning different categories of covered injury, including medical misadventure, to new ACC accounts), the *alignment of risk and premium* (e.g. making provision for registered health professionals to fund the Medical Misadventure Account through their premiums (though such premiums were never actually levied)), and the *experience rating of premiums* (applied to employers with regard to work injuries, and contemplated – though never implemented – for registered health practitioners).³⁹ The highpoint of the insurance-based approach came in 1999 with the transfer of responsibility for compensating work injuries from ACC itself to private insurers.

On replacing National in power in 2000, the incoming Labour Government immediately reversed the partial privatization of the ACC scheme. In fact, the privatization experiment lasted only one year. Labour's own commitment to injury prevention, signalled clearly in the title of the consolidating statute it introduced in 2001 (the Injury Prevention, Rehabilitation and Compensation Act), was qualitatively different from that of its predecessor in government. It considered that the incentivizing of individual behaviour that underpinned many of the insurance techniques employed by National actually served to undermine the

³⁶ Woodhouse (fn. 3), para. 90.

³⁷ Ibid., para. 319.

³⁸ Law Commission (fn. 11), xi.

³⁹ Oliphant (fn. XX, 2007), 388-389.

development of systems and the collective action necessary to reduce the incidence and cost of personal injury. Labour's systems-based approach found its fullest expression in the treatment injury reform of 2005. The abolition of the fault-based category of medical error reflected the belief that a preoccupation with individual responsibility could impede the goal of patient safety. The new concept of treatment injury was intended to help the compilation of data about the ways in which treatment itself could cause personal injury, and, by removing the stigma attaching to a doctor found guilty of fault (even if no liability in damages followed), contribute to the development of a learning culture.⁴⁰ ACC now provides the Ministry of Health and district health boards with non-individualized claims data, and is required to report details of treatment injury, and any other relevant information, to the authority responsible for patient safety where there is a risk of harm to the public.⁴¹ This evidently encompasses the reporting of data about the performance and competence of individual health practitioners. Whether the requirement goes far enough, and whether it is right to preclude the disclosure of details about individual practitioners except where there is a risk of harm to the public, has been doubted in view of the desirability of having complete and accessible details about individual treatment outcomes even before safety fears are raised.⁴²

(b) Individual and community responsibility

The differences of approach to patient safety discussed above reflect deeper underlying visions of the nature of responsibility for injuries in modern society, and the shifting balance between individual and community responsibility – and indeed between different conceptions of community responsibility – as foundation stones for the ACC scheme.

⁴⁰ *Ibid.*, 389-390.

⁴¹ Injury Prevention, Rehabilitation, and Compensation Act 2001, ss. 282 and 284.

⁴² Oliphant (fn. XX, 2007), 390.

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As noted above, one of the five fundamental principles explicitly underpinning the ACC scheme is community responsibility, expressed thus in the official report upon which the scheme is based:⁴³

in the national interest, and as a matter of national obligation, the community must protect all citizens (including the self employed) and the housewives who sustain them from the burden of sudden individual losses when their ability to contribute to the general welfare by their work has been interrupted by physical incapacity...

I have noted elsewhere⁴⁴ that it is, in fact, possible to discern two distinct theories of community responsibility in the report, one based on social solidarity, the other on causality ('Since we all persist in following community activities, which year by year exact a predictable and inevitable price in bodily injury, so we should all share in sustaining those who become the random but statistically necessary victims'⁴⁵). In the scheme's early years, the tension between the two theories was scarcely addressed. The hope prevailed that compensation entitlements might ultimately be extended to victims of incapacity of every kind, including the sick and the infirm, not merely the victims of accidents.⁴⁶ That suggests a responsibility based on social solidarity. But the restriction of compensation to personal injury by accident (even if only provisional) seemed to fit uncomfortably with the social solidarity rationale.

In 1992, legislative reform of ACC produced a sharp move away from community responsibility in whatever form. The insurance-based approach to injury prevention of the then National Government rested on an underlying commitment to individual responsibility. This was manifested in the targeting of economic incentives on the individual to address the moral hazard problems that arise from, as regards the person causing the injury, the bar against actions for compensatory damages at private law, and, secondly, as regards the victim of the injury, the entitlement to compensation payments and rehabilitation in the event of an accident. In the medical context, this mindset led naturally to adoption of the category of medical error (i.e. fault) because the individual health practitioner was

⁴³ Woodhouse (fn. 3), para. 55.

⁴⁴ K. Oliphant, 'Beyond Woodhouse: Devising New Principles for Determining ACC Boundary Issues' (2004) 35 VUWLR 915.

⁴⁵ Woodhouse (fn. 3), para. 56.

⁴⁶ Ibid., para. 290.

thought to be best placed to ensure patient safety, and to be susceptible to the deterrent effect of experience-rated ACC premiums based on the reporting of errors (though, as noted, the envisaged premium was never in fact introduced).⁴⁷

On coming into power in 2000, Labour set about restoring the emphasis on the fundamental ACC principle of community responsibility, most notably by re-establishing the ACC monopoly in the provision of compensation for covered injuries. In contrast with the early years of the scheme, however, the focus can be seen to have been now on the version of that principle that highlighted community *causal* responsibility rather than social solidarity. The boundaries of ACC's responsibility for injury may be considered to reflect a distinction between incapacities caused by human interaction and incapacities whose origin is 'natural'.⁴⁸ Broadly speaking, the dividing line was between injuries and disease. The treatment injury reform of 2005 cemented this analysis: ACC cover extends to personal injuries resulting from the treatment (human cause) but not to personal injuries caused – wholly or substantially – by the claimant's underlying health condition (natural cause). The reform thus elevated a specific understanding of community responsibility, based on causality, into the touchstone of the ACC scheme's field of application to the adverse outcomes of medical treatment.⁴⁹

5. Conclusion

The idea of no-fault compensation for medical injuries has attracted increasing attention in Europe in recent years. The first schemes, explicitly based on the insurance model, were introduced in Sweden in 1975 (patient insurance) and 1978 (pharmaceutical insurance).⁵⁰ Other Nordic countries followed: Finland introduced statutory patient insurance in 1987,

⁴⁷ Oliphant (fn. 6, 2007), 388-9.

⁴⁸ Cf. R. Gaskins, 'Tort Reform in the Welfare State: The New Zealand Accident Compensation Act' (1980) 18 *Osgoode Hall Law Journal* 238.

⁴⁹ Oliphant (fn. 6, 2007), 391.

⁵⁰ See C. Oldertz, 'Security Insurance, Patient Insurance, and Pharmaceutical Insurance in Sweden' (1986) 34 *American Journal of Comparative Law* 635; L. Wendel, 'Compensation in the Swedish Health Care Sector', in J. Dute/M. Faure/H. Koziol (eds), *No-Fault Compensation in the Health Care Sector* (Springer 2004). Patient insurance was initially voluntary, but it was made compulsory under the Patient Insurance Act 1996. Pharmaceutical insurance remains voluntary.

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Norway in 1988, and Denmark in 1992.⁵¹ In France, an Act of 2002 established a no-fault compensation scheme for medical accidents, iatrogenic diseases and nosocomial infections, guaranteeing compensation for the victim on the basis of national solidarity, though without displacing the civil liability of the health practitioner or institution, which may be enforced by the body responsible for administering the scheme.⁵² A similar dual system, but with civil liability limited to intentional fault and gross negligence, was enacted in Belgian law in 2007, though it did not enter into force on the intended date and has now been postponed sine die.⁵³ In the United Kingdom, there have been a number of calls for the introduction of no-fault compensation for medical injuries over the years,⁵⁴ but the adopted reform – the NHS Redress Act 2006 – is rather limited in scope, and amounts in effect to little more than a formalised settlement procedure for relatively low-value (up to £20,000) tort claims against the public healthcare system.⁵⁵ No doubt similar debates about compensation for medical injuries have been conducted in other countries too.

For those considering no-fault compensation for medical injuries in Europe, the New Zealand experience provides a number of valuable lessons: first, as to the need for clarity about such a scheme's underlying ideology and the purposes that it is intended to serve; second, as to the variety of ways in which no-fault compensation regimes can plausibly be said to contribute to the goal of patient safety, even in the absence of a concurrent system of liability in private law; third, as to the impact on compensation costs of different definitions of covered injuries; fourth, as to the discontinuities and disruptions that can result from changes of Government if compensation is allowed to become a political football.

⁵¹ See M. Mikkonen, 'Compensation in the Finnish Health Care Sector', in J. Dute/M. Faure/H. Koziol (eds) (fn. 50); L. Fallberg, 'Patients Rights in the Nordic Countries' (2000) 7 *European Journal of Health Law* 123, 129-130.

⁵² See P. Brun, 'France', in H. Koziol/B. Steininger (eds), *European Tort Law 2002* (Springer 2003), 179 ff; D. Martin, 'Le Dispositif Français d'Indemnisation des Victimes d'Accidents Médicaux, par la Voie du Règlement Amiable', in G. Schamps (ed.) (fn. XX).

⁵³ See I. Durant, 'Belgium', in H. Koziol/B. Steininger (eds), *European Tort Law 2007* (Springer 2008), 182 ff; idem, in H. Koziol/B. Steininger (eds), *European Tort Law 2008* (Springer 2009), 147.

⁵⁴ See Oliphant (fn. 6, 1996) 1 f.

⁵⁵ See K. Oliphant, 'England and Wales', in H. Koziol/B. Steininger (eds), *European Tort Law 2006* (Springer 2007), 154 f.

Those already inclined to favour no-fault compensation for medical injuries will see the New Zealand experience as a success that demonstrates the potential of no-fault regimes, rapidly and at reasonable cost, to deliver substantial compensation and other assistance to a far wider class of victims than would be able to sue successfully in private law.

Those already prejudiced against the idea of no-fault, on the contrary, will see the New Zealand experience as a salutary warning that such schemes require ever increasing levels of public investment, in amounts that would be regarded as unacceptable in most modern societies, and, further, that the confusion that surrounds the supposed role of no-fault in contributing to the promotion of patient safety itself militates against removal of existing private law incentives.

That these divergent views are possible demonstrates the limitations of the available statistical data by which ACC's performance might be assessed. In the medical context, though more patients are now compensated for their injuries than ever before, it remains an open question whether introducing no-fault in place of liability in private law has had a positive or negative effect on patient safety, or no effect at all.