New Zealand is unique in a number of respects, and one which is of interest to the international medical community is our no-fault accident compensation legislation.

Prior to 1974, New Zealand had a regime similar to most other countries. Citizens who suffered the tort of injury caused by the action or negligence of some other person or company could sue for damages, and receive financial compensation for the injury. Amounts awarded in New Zealand never reached the dizzy heights seen in some places, but were assessed as compensation for pain, suffering, loss of function and loss of income. Employers were required to insure against injury to their employees; motor vehicle owners were required to carry third-party personal insurance (paid at time of vehicle registration), and public bodies and corporations generally insured against the possibility of damages awarded against them because of some injury traceable to their actions or inactions.

Some of the undesirable features of this tort-based workers compensation scheme included the propensity of some workers who had suffered an injury at sport or recreation at the weekend to limp along to work on Monday morning, and suffer an “accident” at work, and claim compensation for the injury. Another was the secondary gain from exaggerating the effects of compensatable injury.

The 1966 Royal Commission on Worker’s Compensation, chaired by the Rt Hon Sir Owen Woodhouse, proposed what amounted to sweeping reforms. Its implementation was the 1972 Accident Compensation Act which came into force in 1974 and which, with some tinkering, has been with us ever since. Initially there was an Accident Compensation Commission, and the scheme became universally known as “ACC.” The legal structure was later changed to a Corporation without disturbance of the acronym.

The Woodhouse Commission proposed five general principles:
• community responsibility;
• comprehensive entitlement;
• complete rehabilitation;
• real compensation;
• administrative efficiency.

Writing retrospectively in 1999 after 25 years of its operation, Sir Owen enlarged on some of the underlying rationale for the proposals that led to the ACC scheme. As he describes it, the pre-existing system of compensation was expensive in legal costs, slow in operation with many claims taking 5 years or more to be determined, and capricious in that similar injuries suffered under similar circumstances might produce vastly different financial outcomes. The outcome was a scheme that then seemed, and still does seem to many outsiders, radical. The right to sue for damages for the tort of negligence causing injury was removed, and in return injury would be compensated regardless of fault, including fault of the injured.

One of the early cases causing public outrage was the compensation of an inexpert safe-blower who misjudged the explosion and injured his hands. The acceptance of his claim was inevitable—consider the inequity that might result if those breaking the law were to be refused compensation: Suppose, for example, the case of a man driving the wrong way down a one-way street (and so in commission of an illegal act), and a workman on an adjacent high-rise building site dropping an untethered tool on his car and causing serious injury. He would be unable to sue, since that right...
was abolished by the ACC legislation, but by virtue of a relatively minor transgression, denied relief.

One of the most radical aspects of the proposal was that ACC would be principally funded by levies on employers, but injuries occurring outside the workplace would also be covered. Sir Owen explains this aspect of the scheme by showing that in the case of an employer carrying workman’s insurance and paying premiums for that insurance, the cost of those premiums is loaded onto the products of the enterprise and therefore constitutes a tax on all of us. This was viewed as an aspect of community responsibility for injury at work that should then be extended to injury in other circumstances. The outcome was a proposal that the community should compensate for injury, regardless of the location and circumstances of the injury.

Writing in Health Affairs journal, Harkness Fellow Dr Marie Bismark and Health and Disability Commissioner Ron Paterson state that four main factors have contributed to the system’s affordability. First, New Zealanders benefit from a strong social security system. Injured patients, like everyone else, receive free hospital care and subsidized pharmaceuticals. (Yet per capita health spending was only US$1,886 in 2003, compared with US$5,635 in the United States.) Thus, New Zealand’s public health and welfare systems cover many of the damages that would be at issue in a U.S. medical malpractice claim, leaving the ACC with a much smaller compensation burden. Second, compensation awards are generally lower and more consistent than under a malpractice equivalent. Third, the New Zealand experience suggests that even under such a system (which includes a legal duty of open disclosure), most entitled patients never seek compensation, and many may be unaware that they have even suffered an adverse event. And finally, the New Zealand system does not incur large legal and administrative costs. The system has been very cost-effective, with administrative costs absorbing only 10% of the ACC’s expenditures compared with 50–60% among malpractice systems in other countries.

One of the anomalies in the first 30 years of the scheme was its handling of complications and undesirable outcomes of medical treatment. If the provider of care were at fault, then this was an injury and was compensated. If it were a rare occurrence, for which the provider was not at fault (expected in fewer than 1% of cases) then it was a medical mishap, and compensated. If it did not meet either of these criteria, then it was not compensated. This always seemed anomalous in a no-fault scheme.

A review carried out in 2003 found that the requirement to establish fault impacted on health professionals by creating an overly blaming culture (rather than a culture of learning from mistakes) — by focusing too much on the actions of individual health professionals, and by making health professionals uneasy about participating in the medical misadventure claims process for fear of the repercussions, particularly from inter-agency reporting. The consequences of this included less focus on the patient’s injury, less focus on the prevention of similar injuries, confusion over the Corporation’s role, and opportunities to learn (and therefore improve) safety being limited.

The New Zealand Medical Association (NZMA) had advocated for, and strongly supported, the amendment that came into force in April 2005 redefining all such occurrences as “treatment injury,” and compensating regardless of perceived fault. That provides a much more equitable outcome for patients, and helps to avoid the adversarial situation that could previously arise where a patient was required to assert negligence on the part of the doctor in order to receive compensation.

There has, however, been some resiling from the original principles. The initial position was that the full costs of the accident would be met. The level of funding for care has been restricted, and most patients now find that they must make a co-payment for many items of assessment and treatment. There is a reasonable argument to make that this is not in keeping with the social contract inherent in the scheme, in that the right to gain compensation for costs has been removed and these costs should be met in full.

It remains an anomaly that in New Zealand accident, but not illness, is compensated. In the Woodhouse report, the principle of community

Separate and independent processes are available for responding to patients’ non-monetary interests (such as the desire for an apology, an explanation, or corrective action to prevent harm to future patients). In particular, the Health and Disability Commissioner resolves complaints by advocacy, investigation, or mediation.

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It remains an anomaly that in New Zealand accident, but not illness, is compensated. In the Woodhouse report, the principle of community
responsibility is stated thus:

*Just as modern society benefits from productive work of its citizens, so should society accept responsibility for those willing to work but prevented from doing so by physical incapacity.*

It is by no means clear why this should apply to accident but not to illness. There may be “contributory negligence” in both circumstances, and there is an inherent randomness in both circumstances. For example, ACC will pay compensation to someone who cannot work due to having organs damaged in a car crash, but the same level of compensation may not be available if they suffer organ damage through illness. This is a nettle that has apparently been too daunting for successive governments to grasp.

However, the deficiencies of New Zealand’s ACC system are small compared to its advantages (see Table 1). One of those will have been brought home to New Zealand doctors by the collapse in 2004 of the Australian medical indemnity system, brought down by huge claims and huge settlements. Because such claims cannot be made in New Zealand, our medical indemnity subscriptions are considerably lower than those of most comparable countries. This does not make New Zealand doctors more careless, although it may make us less risk-averse and more willing to deal with uncertainty of outcome. That is one of the strengths of our medical system—New Zealand doctors are still prepared to exercise clinical judgement, whereas it seems that our colleagues in some other jurisdictions have had much of that beaten out of them.

### Table 1 Facts and statistics about Accident Compensation Commission (ACC)

<table>
<thead>
<tr>
<th>According to the ACC, the scheme:</th>
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<tr>
<td>• provides cover for injuries, no matter who is at fault</td>
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<tr>
<td>• eliminates the slow, costly and wasteful process of using the courts for each injury</td>
</tr>
<tr>
<td>• reduces personal, physical and emotional suffering by providing timely care and rehabilitation</td>
</tr>
<tr>
<td>• minimises personal financial loss by paying weekly earnings compensation to injured people who are off work</td>
</tr>
<tr>
<td>• focuses on reducing the causes of these problems—the circumstances that lead to accidents at work, at home, on the road and elsewhere.</td>
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In 2005/2006 more than 1.2 million people had injuries treated by their local GP and paid for by ACC, with ACC paying for over 2.3 million visits. ACC funded NZ$24.3 million in dental treatments and $154.5 million in hospital treatments. ACC funded 2.6 million physiotherapist visits, 2.4 million visits to other treatment providers and 250,000 rehabilitation services. Rehabilitation rates are high: 66% of people return to work after 3 months, 84% after 6 months and 93% after a year. Injury prevention is a primary focus of ACC’s work, with campaigns focused on safety at work, at home, on the road and playing sports.

(Source: ACC website—www.acc.co.nz)

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### References