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TREATMENT INJURY IN NEW ZEALAND

STEPHEN TODD*

INTRODUCTION

This article discusses medical malpractice and compensation in New Zealand, but there is not much in it about liability. The reason is that in New Zealand, a statutory accident compensation scheme makes provision for the payment of compensation to the victims of personal injury that is suffered in ways that are covered by the scheme. One of these ways is personal injury caused by medical treatment, and in nearly all cases the victims will receive compensation pursuant to the statutory scheme rather than common law damages. If the circumstances are such that the scheme applies, then actions for damages are barred. Only in rare cases falling outside the ambit of the scheme might there be scope for suing the doctor or other person responsible for causing the injury, or his or her employer, and in this way recovering such damages.

Although the focus of the article is on compensation for medical injuries, the initial part of the article is broader in that it places the discussion in the context of the accident compensation scheme in New Zealand as a whole. This part gives a brief overview of the nature of the scheme, its relationship with rules of liability at common law, the benefits it provides, and how it is funded and administered. Then the main part of the article looks at the provisions in the scheme for compensation for the victims of medical injury. It includes discussion of the extent of the statutory cover, problems of causation, how the relevant provisions have operated in practice, and the costs that have been incurred in administering the scheme and delivering the benefits. It covers as well some consideration of the alternative ways in which a doctor or other professional person may be held accountable for the consequences of wrongful conduct notwithstanding the bar on suing. In the final Part there is an evaluation of the scheme as a whole and, more specifically, of the cover it provides in medical cases.¹

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I. THE NEW ZEALAND ACCIDENT COMPENSATION SCHEME

A. *The Woodhouse Report*

The reasons for the introduction of the New Zealand accident compensation scheme, and its fundamental design, are found in the Report of the Royal Commission inquiring into personal injury law in New Zealand (usually known as the Woodhouse Report after the name of its Chairman, the Honorable Justice Woodhouse).² The Royal Commission was charged with investigating and reporting “upon the law relating to compensation and claims for damages for incapacity or death arising out of accidents (including diseases) suffered by” employees.³ Accordingly, it examined the remedies for injured employees at common law and under the workers’ compensation legislation⁴ in order to determine whether change was needed and, if it was, to consider what form it might take.⁵

Having made its inquiries, the Commission was convinced that both the action for damages and the workers’ compensation system fell clearly short of providing a satisfactory system of compensation. First, the common law process could be seen to cause serious injustice and to perpetuate a number of anomalies. The key objections were that the fault theory had developed into a legal fiction, for the economic consequences of negligent conduct were spread via insurance over the whole community; the risks of litigation—the difficulties of proof, the ability of advocates, the reactions of juries, and mere chance itself—turned the system into a lottery; and the tort system was cumbersome, inefficient and extravagant in operation to the point that the cost of administration absorbed more than forty percent of the total amount of money flowing into the system.⁶ As for the workers’ compensation scheme, this scheme worked upon a limited principle, was formal in procedure, was meager in its awards, and was ineffective in the field of prevention of accidents and the physical or vocational restoration of the injured.⁷ These last two areas, it was said, “should be at the forefront of any general scheme of compensation.”⁸

1. The descriptions of the history of the scheme and of some of its core provisions and the cases interpreting them that follow in this article are based partly upon the accounts in STEPHEN TODD, *THE LAW OF TORTS IN NEW ZEALAND* ch. 2, ¶ 2.2 (5th ed. 2009).

2. ROYAL COMM’N OF INQUIRY, *COMPENSATION FOR PERSONAL INJURY IN NEW ZEALAND* 19–28 (1967) [hereinafter *WOODHOUSE REPORT*].

3. *Id.* at 11.

4. Workers’ Compensation Act 1956.

5. *WOODHOUSE REPORT*, *supra* note 2, at 19.

6. *Id.* at 49–50, 52.

7. *Id.* at 97.

8. *Id.*

The Commission concluded that both the action for damages and workers' compensation fell clearly short of providing a satisfactory system of compensation. It recognized that an overall solution might be the integration of a comprehensive scheme of accident compensation into the social security framework covering both accidents and illness.⁹ There would be great advantage in doing this, for it would give an organic structure and unity to the whole process. However, integration was not feasible if compensation would then have to take the form of the same flat rate payments for all, which would be unacceptable and unjust. The only way in which a comprehensive system could operate equitably was by linking benefits to earning capacity and by taking into account permanent physical disability. The Commission thought that the next move might be in this direction, but did not itself pursue the matter.¹⁰ It was seen as unwise to attempt one massive leap when two considered steps might be taken, but the experience gained by taking the first step would assist in moving towards a comprehensive plan.

As for the first considered step, the Commission recommended that there should be a comprehensive system of accident prevention, rehabilitation and compensation which would avoid the disadvantages of the existing processes, meet the requirements of "community responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency," and satisfy the requirement of financial affordability.¹¹ The object should be compensation for all injuries, irrespective of fault and regardless of cause. In due course Parliament acted on these recommendations, but the second step has never been taken. So New Zealand has developed two different systems for compensating incapacity, depending on the cause of the incapacity in question, with markedly less generous benefits being available under the social security scheme than those which apply in the case of accident compensation. The distinction has returned periodically to haunt the operation of the accident scheme and remains in full force today.

B. Implementation

The Woodhouse proposals were enacted in the Accident Compensation Act 1972.¹² In its original form the proposed scheme covered only employees injured at work and victims of motor accidents. However, be-

9. *Id.* at 179-80.

10. *See id.* at 181.

11. *Id.* at 107.

12. Accident Compensation Act 1972.

fore it came into force there was a change of government, and the new administration substantially widened its ambit so that it provided for compensation for all accident victims suffering personal injury by accident.¹³ At the same time, the Act barred the right to sue or to claim workers' compensation for those covered by the scheme, following Woodhouse's view that these remedies became irrelevant.¹⁴ So the legislation denied access to the courts in return for the perceived advantages of the statutory scheme. The exchange has sometimes been spoken of as a "social charter," "social contract," or "social compact."¹⁵

The purposes of the 1972 Act were to promote safety, to promote the rehabilitation of persons who suffered personal injury by accident covered by the scheme, and to make provision for the compensation of those persons or their dependants.¹⁶ Where coverage existed it was compulsory. No one could opt out and seek damages instead.¹⁷ Victims of injury were entitled to weekly compensation for loss of earnings at the rate of eighty percent of the claimant's earnings prior to the accident, up to a prescribed maximum figure, lump sums for loss of bodily function, pain and suffering and loss of amenity, again with prescribed maximum figures, medical expenses and other incidental costs, and death benefits.¹⁸ Payments were funded by levies payable by employers, the self-employed and motor vehicle owners, and also out of general taxation.¹⁹ The scheme was administered by the Accident Compensation Commission, with functions which included the making of payments to those entitled and the taking of various steps to promote safety and rehabilitation.²⁰ Other features included the processes for making a claim, limits on entitlements, dispute resolution, incentives to safety and issues of economic deterrence, the basis for calculating the levies, and further matters of management and administration.²¹

We will consider certain of these features to the scheme in some detail when we turn to examine its operation in the particular field of medical injuries.

13. *Id.* § 54.

14. *Id.* § 5.

15. *Brightwell v. Accident Comp. Corp.* [1985] 1 NZLR 132 (CA) 139-40; *Queenstown Lakes Dist. Council v. Palmer* [1999] 1 NZLR 549 (CA) 555.

16. *Id.* § 4.

17. Accident Compensation Act § 5.

18. *Id.* § 103.

19. *Id.* §§ 71-74.

20. *Id.* §§ 6, 16.

21. *Id.* §§ 15-20.

C. Developments to 2010

Since the passing of the 1972 Act there have been four reenactments of the accident compensation scheme as a whole—in the Accident Compensation Act 1982,²² the Accident Rehabilitation and Compensation Insurance Act 1992,²³ the Accident Insurance Act 1998,²⁴ and the Injury Prevention, Rehabilitation, and Compensation Act 2001.²⁵ We need to look briefly at the aims of each of these enactments.

The Accident Compensation Act 1982 left coverage untouched, made some minor changes to entitlements, turned the Accident Compensation Commission into the Accident Compensation Corporation (ACC) with a board of directors, and, most significantly, placed the funding of the scheme explicitly on a pay-as-you-go basis.²⁶

Under pay-as-you-go funding, levies for the year pay all of that year's costs, including both new and old claims. They do not cover the continuing costs of claims extending into future years. Under full funding, levies must meet all the costs of claims made during the year. They do not include past claims, but do include the continuing cost of claims for the full duration of an injury. At its inception the scheme was not fully funded, but because there were no old claims payments in were substantially greater than out-goings. This partial funding in the early years meant that substantial reserves were accumulated, leading to pressure from employers to reduce the cost of accident compensation. The government of the day took heed and made substantial cuts in the levies. As a result, the reserves were depleted very rapidly, and this contributed to the scheme's growing financial instability. The government once again intervened, by imposing huge levy increases (in some cases exceeding five hundred percent) and by asking the Law Commission to review how the scheme was operating and to make recommendations accordingly.

The Law Commission's 1988 Report denied that the scheme was facing a financial crisis and, far from recommending cuts, it strongly supported expanding the scheme so as to bring sickness and non-accidental incapacity under its umbrella.²⁷ The Commission considered that the demarcation between injury and illness was clearly anomalous and that it

22. Accident Compensation Act 1982.

23. Accident Rehabilitation and Compensation Insurance Act 1992.

24. Accident Insurance Act 1998.

25. Injury Prevention, Rehabilitation, and Compensation Act 2001.

26. Accident Compensation Act 1982.

27. NEW ZEALAND LAW COMMISSION, REPORT NO. 4 PERSONAL INJURY: PREVENTION AND RECOVERY (Government Printer, Wellington 1988) [hereinafter 1988 REPORT].

ought to disappear, sooner rather than later. It thought that this could be done in stages, by accepting congenital incapacities already supported by the social welfare system, by later taking in higher level disabilities and finally including others less serious.²⁸ On the other hand, lump sum payments were seen as illogical in relation to the income maintenance purposes of the injury scheme, and for sickness they would become incongruous.²⁹ Serious lost physical capacity and any economic loss were better met by periodic payments. Lump sums should, therefore, be abolished.

The Commission was satisfied that their scheme would not lead to an explosion in costs and could be funded by levies, investment income and taxation, much as already happened. While the costs of the scheme had been rapidly going up, by far the largest area of increase was in the amounts payable to those who claimed in earlier years who were still in receipt of payments from the Corporation. The cost of claims in the first year had increased only by small amounts. In 1987 the whole of the real increase in spending was for earlier years.³⁰ So the scheme was doing what it was intended to do—compensating the seriously incapacitated without a limit of time. The Labour government accepted the Commission's recommendations and tabled a Bill creating a comprehensive income maintenance and rehabilitation scheme available to all persons who suffered incapacity, regardless of cause. However, shortly afterwards, the government lost power in the election of 1990, and the Bill accordingly lapsed. The incoming National government then came to the conclusion that the existing scheme was too expensive and abruptly changed direction.

Following the election the new Minister of Labour issued a Policy Statement reviewing the state of the scheme.³¹ This condemned the funding base for the scheme as unfair, because employers were funding nearly seventy percent of the total costs while work accidents accounted for only about forty percent of those costs, and earners paid nothing towards the cost of non-work injuries.³² And more critically, the review maintained that the increasing numbers of people receiving compensation, higher benefits, and the expansive interpretation by the courts of "personal injury by accident" in delimiting coverage had caused costs to run out of control.³³ It was proposed to solve these difficulties by a reform of the scheme that widened

28. *Id.*

29. *Id.*

30. *Id.*

31. DEP'T OF LABOUR, ACCIDENT COMPENSATION—A FAIRER SCHEME, (Government Printer, Wellington 1991).

32. *Id.*

33. *Id.*

and reallocated its funding base, reduced its costs and removed some of the judicial extensions to its coverage.

The Accident Rehabilitation and Compensation Insurance Act 1992 was intended to meet these concerns and achieve these objectives.³⁴ As regards funding, pay-as-you-go was retained, but substantial changes were made to existing sources of funding and new sources were introduced.³⁵ In particular, employers met only the cost of providing coverage for injury sustained in the course of employment (except where a motor vehicle was involved), and all earners paid a levy to meet the cost of coverage for accidental injury.³⁶ As regards benefits, there was a new "work capacity" test aimed at moving accident compensation claimants who could not find work onto the unemployment benefit; rehabilitation assistance was available only in restricted circumstances; lump sum payments for loss of faculty and pain and suffering were abolished and replaced by an "independence allowance" set at low levels; and entitlement to compensation ended when a claimant became entitled to superannuation payments.³⁷ Further savings were sought to be made by reining in the ability of the judges to give an expansive interpretation to the provisions governing the ambit of the scheme.³⁸ The bases for cover formerly all fell within the broad concept of "personal injury by accident," but now they were treated as separate categories and made subject to a series of detailed definitions.³⁹ Judicial discretion in determining their limits was largely removed.

The next significant development came with the passing of the Accident Insurance Act 1998.⁴⁰ This left cover and benefits as they were but privatized the delivery of the statutory benefits for the victims of accidents at work.⁴¹ The monopoly control exercised by the Accident Compensation Corporation was removed and employers were obliged to insure with a private insurance company or a new state-owned enterprise set up to compete with the private companies.⁴² A regulatory regime aimed to make sure

34. Accident Rehabilitation and Compensation Insurance Act 1992.

35. *Id.* at pt. VII.

36. *Id.* §§ 100, 113.

37. *Id.* §§ 37–44.

38. *Id.* § 3.

39. Cover as presently provided continues to be based on the 1992 categories, but with some amendment. See text accompanying notes 65–71.

40. Accident Insurance Act 1998. For evaluations see Stephen Todd, *Privatization of Accident Compensation: Policy and Politics in New Zealand*, 39 WASHBURN L.J. 404, 474–87 (2000).

41. Accident Insurance Act 1998.

42. Accident Insurance Act 1998 § 169.

that persons with cover received their entitlements.⁴³ The purpose behind the reform was to facilitate freedom of choice, promote a greater emphasis on safety and rehabilitation, and encourage the efficient management of claims.⁴⁴ The government view was that a publicly-administered scheme lacked sufficient incentives to safety and efficiency. The introduction of private enterprise would reduce the overall costs of injury, by an increased focus on prevention and rehabilitation and on the monitoring of workplace safety performance. Further, pay-as-you-go funding restricted the ability of the Corporation to reward innovation in injury prevention, as employers paid premiums that related largely to injuries that had already occurred. So henceforth the scheme was to be financed on a fully funded basis.

Whether these hopes for efficiency and accident prevention would have been fulfilled cannot be known, for the new privatized regime was in force for just one year. A new Labour government was elected at the end of 1999, and one of its first acts was to restore the public monopoly. It saw no necessary or sufficient connection between the issues of paying victims and reducing accidents. It also rejected the view that the ACC operated inefficiently. On the contrary, there was no duplication in the provision of services and administrative costs were very low.⁴⁵ However, full funding was thought to be desirable and this was retained in the new legislation that the government introduced shortly afterwards.

This legislation—the Injury Prevention, Rehabilitation, and Compensation Act 2001—once again left the provisions for coverage largely undisturbed.⁴⁶ Entitlements also were not much changed, the significant exception being the reintroduction of lump sum compensation for impaired amenity (but not for pain and suffering).⁴⁷ So in core respects the previously existing law continued. The new developments in the 2001 Act were primarily in the field of accident prevention, and to this end it introduced new processes and strategies aimed at reducing the incidence of injury and promoting safety and security. However, provision for cover for medical

43. *Id.* § 168.

44. *Id.* at pmbl.

45. In the election in November 2008 the National Party regained power, and one of its policies is to reintroduce private insurance covering accident compensation liabilities. INCREASING CHOICE IN WORKPLACE ACCIDENT COMPENSATION (June, 2011), (available at <http://dol.govt.nz/consultation/increasing-choice/increasing-choice.pdf>) has made a number of proposals. These include extending the Accredited Employers Programme (as to which see *infra* text accompanying note 286), allowing choice of workplace insurance cover in competition with the ACC, subjecting insurers to prudential regulation, and appointing a market regulator to monitor and enforce employer and insurer compliance with legal requirements.

46. Injury Prevention, Rehabilitation, and Compensation Act 2001 pt. 2.

47. *Id.* § 69.

accidents was extended by amendment in 2005,⁴⁸ in a way which will be explained below and which has had very significant practical consequences. A further amendment in 2008 extended cover to include work-related mental injury.⁴⁹ Finally, in 2010, the name of the 2001 Act was changed to the Accident Compensation Act 2001,⁵⁰ thus returning to the original, and surely appropriate, title.

D. Relationship with the Common Law

From the inception of the accident compensation scheme there has been a bar on suing in New Zealand for damages for personal injuries or death. The bar is presently found in section 317(1) of the 2001 Act, which simplifies the original wording in the 1972 and 1982 Acts. It provides: "No person may bring proceedings independently of this Act, whether under any rule of law or any enactment, in any court in New Zealand, for damages arising directly or indirectly out of—(a) personal injury covered by this Act; or (b) personal injury covered by the former Acts."⁵¹

The bar cannot be avoided by failure to make a claim or a purported denial or surrender of rights under any of the Acts or a lack of entitlement to any particular benefit.⁵² A similar bar applies in the case of personal injury caused by a work-related gradual process, disease, or infection.⁵³

The scope of the statutory bar was examined by the Court of Appeal in *Queenstown Lakes District Council v. Palmer*.⁵⁴ In this case the plaintiff sought damages for the shock and mental injury that he suffered after witnessing the death of his wife in a rafting accident which was caused, he alleged, by the negligence of the defendant.⁵⁵ It was argued that this was a claim for damages "arising . . . 'indirectly' out of a personal injury covered by the Act," that is, the death of Mrs. Palmer, but Thomas J, delivering the judgment of the court, was satisfied that the common law action was not barred.⁵⁶ Section 14(1) of the 1992 Act (the predecessor to section 317(1) of the 2001 Act) did not apply, because the proceedings brought by Mr.

48. Injury Prevention, Rehabilitation, and Compensation Amendment Act (No 2) 2005 § 13.

49. Injury Prevention, Rehabilitation, and Compensation Amendment Act 2008 § 9.

50. Accident Compensation Amendment Act 2010 § 5.

51. Accident Compensation Act 2001 § 317(1). For the earlier bars, see Accident Compensation Act 1972 § 5(1); Accident Compensation Act 1982 § 27(1); Accident Rehabilitation and Compensation Insurance Act 1992 § 14(1); Accident Insurance Act 1998 § 394(1).

52. Accident Compensation Act 2001 § 317(7).

53. *Id.* § 318(1)–(2). Oddly there are no similar anti-avoidance provisions as in section 317(7), but these are implicit in the bar itself and are in fact unnecessary.

54. [1999] 1 NZLR 549 (CA).

55. *Id.*

56. *Id.*

Palmer did not arise indirectly out of Mrs. Palmer's death.⁵⁷ The critical words in section 14(1) were "personal injury covered by this Act," and the relevant personal injury had to be personal injury for which damages were sought.⁵⁸ Yet Mr. Palmer was not seeking damages for his wife's death. The relevant injuries for which he was seeking damages were the mental injuries which he himself suffered as a result of the alleged breach of a duty of care owed to him by the defendants. Mrs. Palmer's death was simply part of the sequence of events which provided the factual basis for his claim.

Thomas J was satisfied that the legislative history and the policy behind the legislation, and indeed common sense, supported this view.⁵⁹ Persons covered under the Act were denied access to the courts at common law in return for the perceived advantages of the statutory scheme. The legislation reflected this policy from the outset. The purpose of the provision barring common law claims was to prevent persons who suffered personal injury being compensated twice over, once under the statute and then at common law, not to prevent them recovering any compensation at all. So the application of the Act and the corresponding scope for common law proceedings would automatically adjust as and when the scope of the cover provided by the Act was extended or contracted.⁶⁰ To the extent that the statutory cover was extended, the right to sue at common law would be removed; to the extent that the cover was withdrawn or contracted, the right to sue at common law would be revived. Any other view would lead to fundamental injustice, depriving a person in Mr. Palmer's position both of compensation and of damages.

The bar on suing does not extend to any proceedings relating to any damage to property, or any express term of any contract or agreement,⁶¹ or any personal grievance arising out of a contract of employment.⁶² However, there can be no award of compensation in such proceedings for personal injury covered by the scheme,⁶³ nor indeed in any other kinds of proceedings, such as a criminal prosecution.⁶⁴

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *E.g., Brittain v. Telecom Corporation of New Zealand Ltd* [2001] 2 NZLR 201 (CA) (confirming that proceedings for a benefit founded on an insurance contract providing for additional payments in the event of injury are not barred).

62. Accident Compensation Act 2001 § 317(2).

63. *Id.* § 317(3).

64. Sentencing Act 2002 § 32(5) provides that a court making a sentence of reparation "must not order the making of reparation in respect of . . . loss or damage . . . for which the court believes that a

E. Cover

1. Categories of Cover

The provisions for cover under the accident compensation scheme over the years have become increasingly detailed, and presently they are divided up under twelve specific heads of claim. However, cutting through this prolixity, the various bases for cover fall broadly into four core categories. These are personal injury caused by an accident;⁶⁵ personal injury by way of medical treatment;⁶⁶ personal injury caused by employment-related disease or infection;⁶⁷ and personal injury by way of mental injury suffered as a consequence of physical injury,⁶⁸ by the victims of certain specified sexual offences,⁶⁹ or which is work-related.⁷⁰ The victim in any of these cases can make a claim for compensation to the Accident Compensation Corporation pursuant to a simple administrative process.⁷¹

2. Personal Injury

In every case the cover provided under the Act depends on the claimant having suffered “personal injury.” This is defined as meaning death; physical injuries; mental injury suffered because of the claimant’s physical injury, or caused by certain criminal acts, or which is work-related; or damage (other than wear or tear) to dentures or prostheses.⁷² Personal injury does not include personal injury caused wholly or substantially by a gradual process, disease, or infection unless it is work-related, caused by treatment, is consequential on another, covered, personal injury, or is consequential on another treatment injury.⁷³ Nor does it include a heart attack or stroke unless this constitutes a treatment injury or is work-related.⁷⁴

person has entitlements under the Accident Compensation Act 2001.” In *Davies v. Police* [2009] 3 NZLR 189 (SC) paras. [2], [24]–[25], [34], [37] the Supreme Court held that the inquiry should be into whether there was cover for the type of loss for which there were entitlements under the Act, not into the sums actually payable. Accordingly, a criminal court could not make a reparation order to compensate a victim for the difference between her full loss of income and the eighty percent loss for which she was compensated under the 2001 Act.

65. Accident Compensation Act 2001, § 20(2)(a).

66. *Id.* § 20(2)(b)–(d), (f)–(i).

67. *Id.* § 20(2)(e), (j).

68. *Id.* § 26(1)(c).

69. *Id.* §§ 21, 26(1)(d), sched. 3.

70. *Id.* §§ 21B, 26(1)(d).

71. *Id.* § 48.

72. *Id.* § 26(1).

73. *Id.* § 26(2).

74. *Id.* § 26(3).

It is clear that the reference to “physical injuries” in the definition is intended to be all-embracing. The definition specifically states that such injuries include “a strain or a sprain,” but otherwise the concept is not further defined.⁷⁵ Seemingly it should be understood as meaning any condition involving harm to the human body, including harm by sickness or disease, that is more than merely trifling or fleeting.⁷⁶ Mental injury, by contrast, is statutorily defined, this being a “clinically significant behavioural, cognitive, or psychological dysfunction.”⁷⁷

3. Residual Actions for Damages

It is apparent at least that “physical injuries” has a very broad meaning. But there may still be certain forms of injury which do not qualify under the statutory definition and which may be actionable at common law. A clear example is mental injury in secondary victim cases. Further, assuming that some form of personal injury, as defined, has been suffered, it may fall outside the particular categories which are covered for compensation and, again, may be potentially actionable. The most significant examples probably are personal injury which is not caused by an “accident,”⁷⁸ and injury by disease or by heart attack or stroke which is not otherwise covered as having been caused by treatment or as being work-related. In these and certain other cases a common law action can still be maintained where the harm is alleged to have been caused by tortious conduct by another.

The ambit of cover in each of the four core categories is defined by the Act in close detail. Our concern is with the provisions governing injury caused by medical treatment, and we will be looking at these in Part II below.⁷⁹

75. *Id.* § 26(1)(b).

76. TODD, *supra* note 1, at para 2.4.01. This suggestion was approved in *Falwasser v. Attorney-General*. [2010] NZHC 410 para [90]. It was held in this case that a plaintiff suffered physical injuries from exposure to pepper spray, and that his common law claim against the police accordingly was barred. *Id.* at para [91].

77. Accident Compensation Act 2001 § 27. The definition is based upon the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*.

78. The core meaning of “accident” (defined at length in section 25(1)) is “a specific event” involving “the application of a force . . . or resistance external to the human body.” Accident Compensation Act 2001 § 25(1). It does not cover, for example, seeing or hearing about injury to another, or a child suffering from foetal alcohol syndrome due to her mother having drunk alcohol during the pregnancy, *Winikerei v. ARCIC* 27/7/05, Fogarty J, HC Wellington CIV-1999-485-000008, or a child suffering from cerebral palsy caused by an antenatal force external to the foetus but occurring within the mother, *Sam v. ACC* [2009] 1 NZLR 132 (HC) at para [43], or a person inhaling smoke, *Simm v. ACC* [2006] NZHC 1634 (HC) at paras [1]–[3].

79. For discussion of the other categories, see TODD, *supra* note 1, at para 2.4.02 (personal injury by an accident), para 2.4.03 (mental injury), para 2.4.05 (work-related disease, heart attacks and strokes).

A further possible basis for an action is where the plaintiff seeks to recover exemplary, rather than compensatory, damages. Quite early on, in *Donselaar v. Donselaar*, the Court of Appeal decided that actions for exemplary damages could still be maintained.⁸⁰ Richardson J explained that proceedings for exemplary damages were not “proceedings for damages arising directly or indirectly out of” a person’s injury or death, where the statutory bar applied, because exemplary damages did not arise out of the plaintiff’s injury and were not directed to the plaintiff’s loss.⁸¹ In its contemporaneous decision in *Taylor v. Beere*, the Court of Appeal confirmed that exemplary or punitive damages were intended to punish and deter a defendant guilty of outrageous or contumelious conduct.⁸² Recently, in *Couch v. Attorney-General*, the New Zealand Supreme Court limited the remedy by deciding that it should be available only in cases of advertent or reckless wrongdoing.⁸³ Negligence, even where gross, would not suffice.

F. Claimants

All persons who suffer personal injury in New Zealand are entitled to claim,⁸⁴ although non-residents are eligible only for limited benefits.⁸⁵ The scheme also applies to persons ordinarily resident in New Zealand who suffer death, physical injuries and consequential mental injuries or personal injury as a result of medical treatment while outside New Zealand, and the injury is one for which there would be cover if the personal injury had occurred within New Zealand.⁸⁶

G. Benefits

Where there is cover there is a right to compensation. The statutory entitlements available to victims of personal injury are treatment and rehabilitation, earnings-related compensation, lump sum compensation for permanent impairment, and death benefits.⁸⁷

80. [1982] 1 NZLR 97 (CA) 98, 107.

81. *Id.* at 109.

82. [1982] 1 NZLR 81 (CA) 84–86.

83. [2010] 3 NZLR 149 (SC) at para [1].

84. Accident Compensation Act 2001 § 20. There is an exception in section 23, concerning accidents on ships or aircraft coming to, travelling around or leaving New Zealand. *Id.* § 23.

85. In particular, non-residents do not qualify for earnings-related compensation, because they must be persons receiving income as defined in the Income Tax Act 1994. See the definition of “employee” in section 6. *Id.* § 6.

86. *Id.* § 22. Special provision is made for injury by work-related disease where this is suffered outside New Zealand. *Id.* § 24.

87. *Id.* § 69.

The Corporation is liable to pay the cost of necessary and appropriate medical treatment and of social or vocational rehabilitation.⁸⁸ The purpose of social rehabilitation is to assist in restoring a claimant's independence to the maximum extent practicable, and it can cover such benefits as aids and appliances, home help, child care, modifications to the home, assistance with transport and training for independent living.⁸⁹ Vocational rehabilitation is available to persons covered by the Act who are entitled to weekly compensation.⁹⁰ It seeks to help a claimant maintain or obtain employment or regain or acquire vocational independence.⁹¹

Earnings-related compensation has always been, and remains, a key benefit.⁹² It is payable to claimants who were earners at the time of the personal injury and who are unable, because of their injury, to engage in their employment.⁹³ There are special provisions dealing with, *inter alios*, earners not in permanent employment, the self-employed, low earners and potential earners.⁹⁴ The amount payable is eighty percent of the claimant's weekly earnings, as calculated in accordance with detailed statutory formulae.⁹⁵ All calculations are subject to a maximum weekly payment of NZ\$1,341.31, which is adjustable in relation to movements in average weekly earnings.⁹⁶

Lump sums may be awarded to compensate for permanent impairment, but not for pain and suffering.⁹⁷ There is a minimum impairment threshold of ten percent and the minimum payment is NZ\$2,500.⁹⁸ The maximum sum, which is payable for impairment of eighty percent or more, is set at NZ\$100,000.⁹⁹ These figures are adjusted annually in line with the Consumer Price Index.¹⁰⁰ The amount payable in any particular case is calibrated so that more seriously injured claimants receive proportionately more than less seriously injured claimants.

88. *Id.* §§ 69(1)(a), 75–96, sched. 1, pt. 1.

89. *Id.* §§ 79, 81(1).

90. *Id.* § 85.

91. *Id.* § 80(1).

92. *Id.* §§ 69(1)(b)–(c), 100–06, sched. 1, pt. 2.

93. *Id.* § 103.

94. *Id.* at sched. 1, pt. 2, cls. 35–38, 42, 47.

95. *Id.* sched. 1, pt. 2, cl. 32.

96. *Id.* sched. 1, pt. 2, cl. 46.

97. *Id.* § 69(1)(d), sched. 1, pt. 3, cl. 54.

98. *Id.* sched. 1, pt. 3, cl. 56(3).

99. *Id.* sched. 1, pt. 3, cl. 56(4).

100. *Id.* §§ 116, sched. 1, pt. 3, cl. 56(5).

Where death ensues, the Act makes provision for the payment of benefits to the deceased's dependants.¹⁰¹ These include funeral grants, certain survivors' grants, and weekly compensation for loss of dependency.¹⁰²

A claimant who qualifies for compensation may be disentitled to relief, fully or partially, on a number of grounds. They include: the claimant wilfully inflicting injury on himself or herself or committing suicide;¹⁰³ the claimant seeking compensation as a spouse or dependant in circumstances where he or she has been convicted of the murder of the deceased person;¹⁰⁴ the claimant being in prison;¹⁰⁵ and the claimant being injured in the course of committing a criminal offence punishable by a maximum term of imprisonment of at least two years, unless the Minister responsible for the scheme is satisfied that there are exceptional circumstances exempting the claimant from the operation of this provision.¹⁰⁶ These ultimately are penal provisions, preventing payment of what would otherwise be perfectly valid claims, for reasons of public policy.

H. Claims Process

The Act sets out a simple process for making a claim. All that is necessary is that a person should lodge a claim for cover and/or a specified entitlement.¹⁰⁷ On receiving it the Corporation must decide whether it accepts that cover exists, and if satisfied that it does, provide information about relevant entitlements and facilitate access to those entitlements.¹⁰⁸ There is a one year time limit for making a claim, the start of the period running from the date of the personal injury, but the Corporation must not decline a late claim unless its lateness prejudices the Corporation's ability to make decisions about the claim.¹⁰⁹ The Corporation must make reasonable decisions in a timely manner, give notice in writing of any decision, give reasons if the decision is adverse to the claimant, and provide information about review and appeal rights.¹¹⁰ A dissatisfied claimant may apply for a review of any of the Corporation's decisions, including a decision

101. *Id.* § 69(1)(e).

102. *Id.* § 69(1)(e), sched. 1, pt. 4, cls. 64–66, 70–71.

103. *Id.* § 119.

104. *Id.* § 120.

105. *Id.* § 121.

106. *Id.* §§ 122.

107. *Id.* § 48.

108. *Id.* § 50.

109. *Id.* § 53.

110. *Id.* §§ 54–64.

under a Code of Claimants' Rights.¹¹¹ An independent reviewer conducts the review hearing in accordance with detailed rules of procedure.¹¹² An appeal lies to the District Court,¹¹³ and further appeals on matters of law may be taken, with leave, to the High Court¹¹⁴ and thence to the Court of Appeal.¹¹⁵

I. Funding

The funding for accident compensation comes from levies on activities where accidents tend to occur and also from general taxation.¹¹⁶ The levies originally were payable by employers, the self-employed and motor vehicle owners, and over the years new sources of funding have been added. Today the levies fund four accounts: the Work Account (for work-related injuries of employees, private domestic workers and self-employed persons); the Motor Vehicle Account (for motor vehicle injuries); the Earners' Account (for earners' non-work injuries); and the Treatment Injury Account (for injuries caused by treatment).¹¹⁷ In addition there is the Non-Earners' Account (for injuries to non-earners other than motor vehicle injuries or treatment injuries), funded out of general taxation.¹¹⁸

As was earlier explained, the levies in the 1980s and 1990s were calculated on a pay-as-you-go basis. However, since the Accident Insurance Act of 1998 all of the accounts save for the Non-Earners' Account have been required to be fully funded.¹¹⁹ The premiums for each account must cover all the costs of claims made in any particular year, including all future costs.¹²⁰ Formerly a separate Residual Claims Account funded the continuing cost of past claims which were unfunded on a pay-as-you-go basis, but in 2010 this account was folded into the Work Account.¹²¹ These outstanding residual liabilities are required to be fully funded by 31 March 2019.¹²²

111. *Id.* § 134.

112. *See id.* pt. 5.

113. *Id.* § 149.

114. *Id.* § 162.

115. *Id.* § 163.

116. *Id.* pt. 6.

117. *Id.* § 392.

118. *Id.* § 392(1)(c).

119. Accident Insurance Act 1998 §§ 282-307.

120. Accident Compensation Act 2001 § 169.

121. *Id.* § 21.

122. *Id.* § 169.

The levies funding the Work Account are collected from employers, private domestic workers and the self-employed, those for the Motor Vehicle Account from vehicle registrations and from the sale of petrol, and those for the Earners' Account directly from employees' earnings.¹²³ In the case of the Treatment Account, a statutory power to impose levies on registered health professionals and organizations that provide treatment under the Act has never been implemented. Rather, the Account is funded from the Earners' and Non-Earners' Accounts according to the mix of earner and non-earner clients.¹²⁴

J. Administration

The Accident Compensation Corporation (ACC) is responsible for administering the accident compensation scheme.¹²⁵ The Corporation is a Crown entity,¹²⁶ and is managed by a Board appointed by the Minister.¹²⁷ The duties of the Corporation are, *inter alia*, to determine cover, provide entitlements, manage the Accounts, collect levies, and administer dispute resolution procedures.¹²⁸ Its functions include carrying out these duties, promoting "measures to reduce the incidence and severity of personal injury," and managing "assets, liabilities and risks in relation to the Accounts."¹²⁹ The Corporation must comply with the Minister's directions relating to the policy of the Government in relation to its functions, duties and powers.¹³⁰ An annual "service agreement" sets out the quality and quantity of services provided by the Corporation, including its desired outcomes and objectives in performing its functions, duties and powers.¹³¹ An Annual Report provided to Parliament gives an overview of its performance over the past year and its plans for the future.¹³²

123. *Id.* §§ 167(2), 213, 218.

124. *Id.* § 228(2).

125. *Id.* § 3.

126. *Id.* § 259(4).

127. *Id.* § 267. "The Minister" means "the Minister of the Crown who . . . is . . . responsible for the administration of [the] Act. *Id.* § 6.

128. *Id.* § 165.

129. *Id.* § 262.

130. *Id.* § 270.

131. *Id.* § 271.

132. *See, e.g.,* ACCIDENT COMP. CORP., ANNUAL REPORT (2010), available at <http://www.acc.co.nz/search-results/index.htm?ssUserText=annual+report+2010> [hereinafter 2010 REPORT].

II. MEDICAL INJURIES

As originally enacted, the accident compensation legislation provided cover for "personal injury by accident" without specific reference to adverse outcomes of medical treatment.¹³³ Then shortly after its introduction the Act was amended, by adding "medical, surgical, dental or first aid misadventure" as an illustrative category but without any further definition. So, within the one general concept, the courts had a largely unfettered discretion in deciding quite where the parameters of the scheme ought to be set. And they took advantage of this statutory flexibility, by emphasizing that a generous approach was in keeping with the policy of the Act of providing comprehensive cover for all those suffering personal injury in New Zealand, "wherever, whenever, and however occurring."¹³⁴ More particularly, we can see this kind of approach being taken in the cases considering the meaning of medical misadventure.

Early decisions show the courts developing a two-limb test, by asking whether there had been either medical negligence or medical mishap.¹³⁵ As regards negligence, the Court of Appeal in *Green v. Matheson* accepted that this was medical misadventure, which included insufficient or wrong treatment, failure to inform, misdiagnosis, misrepresentation (innocent or fraudulent) or administrative shortcomings.¹³⁶ If the plaintiff's claim was mishandled, it was her misfortune or ill-luck, and this fell squarely within the idea of misadventure.¹³⁷ As regards mishap, this was a quite unforeseeable adverse consequence of treatment which had been properly administered and which did not involve negligence.¹³⁸

In *Childs v. Hillock* the two-limb approach was confirmed in the Court of Appeal.¹³⁹ Hardie Boys J considered that it achieved a proper balance between recognizing (i) that the patient's misfortune or mishap could be the result of negligence, or other non-culpable error in treatment, or an unintended consequence of correct treatment, and (ii) that not every medical intervention is successful and that many are attended by risk.¹⁴⁰ So his Honour accepted the need to differentiate between medical patients who were covered for compensation and patients who were simply receiving

133. Accident Compensation Act 1972 § 4(b).

134. *ACC v. Mitchell* [1992] 2 NZLR 436 (CA) 438-39.

135. See *ACC v. Auckland Hosp. Bd.* [1980] 2 NZLR 748 (HC) 751; *Bridgeman v. ACC* [1993] NZAR 199 (HC).

136. [1989] 3 NZLR 564 (CA) 572-73.

137. *Id.* at 573.

138. See *Auckland Hosp. Bd.*, *supra* note 135, at 751.

139. [1994] 2 NZLR 65, 72 (CA).

140. *Id.*

medical treatment because they were ill.¹⁴¹ Some unexpected or “accident-like” event was required so that the case was removed from the category of sickness or disease, which was not covered, to medical misadventure, which was.¹⁴² Indeed, the legislature then followed the lead taken by the courts, by providing in the 1992 Act that medical misadventure meant personal injury caused by medical error or medical mishap.¹⁴³ “Medical error” was defined as meaning medical negligence, and “medical mishap” as meaning an adverse consequence of properly administered treatment that was “rare” and “severe.”¹⁴⁴ These further requirements were defined in their turn in close detail.¹⁴⁵

The provisions introduced in 1992 were carried over into the Accident Insurance Act 1998 and then the Injury Prevention, Rehabilitation and Compensation Act 2001.¹⁴⁶ Shortly afterwards, however, a review undertaken by the ACC jointly with the Department of Labour expressed dissatisfaction with the very concept of medical misadventure as defined in the statute.¹⁴⁷ In particular, the need to prove a medical error was seen as quite anomalous in the context of a no fault compensation scheme. It perpetuated a blaming culture and meant that the scheme was required to resolve the same kinds of difficulties that arose under the tort system that it replaced. This in turn led to considerable cost in investigating claims and delay in deciding them. The medical mishap provisions also were criticized, being seen as confusing and arbitrary. They often bore little relationship to the circumstances of the patient, resulting in claimants unfairly missing out on cover.

Following a consultation process the review recommended that the concept of medical misadventure be abandoned and that instead there

141. *Id.*

142. *Id.*

143. Accident Rehabilitation and Compensation Insurance Act 1992 § 5(1).

144. *Id.* More specifically, the Act stated that “medical error” meant the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances. *Id.* It was not medical error solely because desired results were not achieved, or subsequent events showed that different decisions might have produced better results, or the failure in question consisted of a delay or failure attributable to the resource allocation decisions of the organization. *Id.*

145. *Id.* § 5. An adverse consequence was “rare” only if the probability was that it would not occur in more than one percent of cases in which that treatment was given. *Id.* § 5(2). There was no medical mishap where an adverse consequence was rare in the ordinary course but was not rare for that particular person, and the greater risk was known to the person prior to the treatment. *Id.* § 5(3). The consequence was “severe” only if it resulted in the patient dying, or being hospitalized as an inpatient for more than fourteen days, or suffering significant restriction or lack of ability lasting more than twenty-eight days in total. *Id.* § 5(4).

146. Accident Insurance Act 1998 §§ 34–37; Injury Prevention, Rehabilitation and Compensation Act 2001 §§ 32–34.

147. ACCIDENT COMP. CORP., REVIEW OF ACC MEDICAL MISADVENTURE: CONSULTATION DOCUMENT (2003).

should be cover for unintended injuries in the treatment process. This would include all adverse medical events, whether or not preventable, provided they were unintended or, on another formulation, outside the expected and likely range of consequences of treatment. This recommendation formed the basis for the amendments to the scheme in 2005,¹⁴⁸ introducing the concept of “treatment injury.”¹⁴⁹ Their primary aim was to move away from any need by a claimant to prove fault by a registered health professional in order to qualify for compensation. The hope was that professionals would be more willing to cooperate in the claims process and that there would be a partnership between ACC and the health sector that encouraged a climate of learning and also protected public safety.

A. Cover

The extent of coverage for medical injury now is defined in six overlapping heads of claim. These are: personal injury that is treatment injury suffered by the person;¹⁵⁰ personal injury that is a secondary infection passed on by a victim of treatment injury to his or her spouse or child or to any other third party, whether directly or through his or her spouse;¹⁵¹ personal injury caused by treatment for personal injury for which the person has cover;¹⁵² personal injury caused by gradual process, disease, or infection that is treatment injury suffered by the person;¹⁵³ personal injury caused by a gradual process, disease or infection consequential on treatment given to the person for personal injury for which the person has cover;¹⁵⁴ and personal injury that is a cardiovascular or cerebrovascular episode that is treatment injury suffered by the person.¹⁵⁵

Subparagraphs (b), (c), (f) and (i) are the exclusive determinants of cover for personal injury that is suffered by way of some form of “treatment injury,” which is defined as meaning, *inter alia*, personal injury suffered by a person seeking or receiving treatment from a registered health

148. Injury Prevention, Rehabilitation, and Compensation Amendment Act (No 2) 2005, § 13.

149. See Ken Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 MED. L. REV. 357 (2007) [hereinafter Oliphant (2007)].

150. Accident Compensation Act 2001 § 20(2)(b).

151. *Id.* §§ 20(2)(c), 32(7).

152. *Id.* § 20(2)(d).

153. *Id.* § 20(2)(f).

154. *Id.* § 20(2)(h).

155. *Id.* § 20(2)(i).

professional.¹⁵⁶ Until 1992 it was possible to mount alternative arguments, that what had occurred either was medical misadventure or was personal injury by accident in the ordinary sense. However, the Act provides now that an “accident” does not include an occurrence which is treatment given “by or at the direction of a registered health professional.”¹⁵⁷ So coverage for personal injury by an accident and for medical treatment does not overlap.

However, the Act provides separate coverage under paragraph (d) for personal injury that is a consequence of treatment for another “personal injury for which the person has cover,” and under paragraph (h) for “personal injury caused by a gradual process, disease, or infection consequential on treatment given to the person for personal injury for which the person has cover.”¹⁵⁸ It is not clear why these provisions have been included, for in each case there must be an initial personal injury for which a person has cover under another head. If treatment for personal injury is given by a registered health professional, at least as a general rule it appears that the provisions for treatment injury and for the consequences of treatment will cover the same ground.¹⁵⁹ We do not need to take this question any further and will turn to the provisions governing treatment injury, looking first at relevant principles of causation and then at the meaning of this newly-introduced concept.

B. Treatment Injury

1. Proof of Cause

In order for there to be cover for a treatment injury, the personal injury must be “caused by” the medical treatment.¹⁶⁰ In the context of litigation the ordinary rules of proof, invoking the so-called “but for” test, require that a plaintiff prove on the balance of probabilities that the defendant’s conduct was a cause of his or her loss. But sometimes the cause may not be capable of such proof, perhaps because of the particular circumstances in which an accident or event happened or because of the limits to scientific

156. *Id.* §§ 20(2), 32(1)(a). “Registered health professional” means, inter alia, “a chiropractor, clinical dental technician, dental technician, dentist, medical laboratory technologist, medical radiation technologist, midwife, nurse, occupational therapist, optometrist, pharmacist, physiotherapist, podiatrist, or registered medical practitioner.” *Id.* § 6(1).

157. *Id.* § 25(2)(a).

158. *Id.* § 20(2)(d), (h).

159. *See Childs v. Hillock* [1993] NZAR 249 (not discussed on appeal at [1994] 2 NZLR 65 (CA)).

160. Accident Compensation Act 2001 § 32(1)(b).

understanding in the particular field. In such cases it is perfectly possible for the courts to hold the plaintiff to the normal requirements, so that if the necessary evidence cannot be adduced the action fails. But this strict approach can have harsh consequences, and in certain special cases the courts have been persuaded to modify the ordinary rules. In an outstanding example, the House of Lords in England has developed a doctrine of risk, pursuant to which a plaintiff can succeed if he or she can prove that the defendant caused or increased the risk of an outcome, as opposed to proving that the defendant caused the outcome itself.¹⁶¹ The question we must now consider is whether this or other similar modifications to the ordinary principles of causation can apply in New Zealand in the context of a claim for accident compensation.

a. Atkinson and Ambros

The clear answer, as laid down in the decision of the Court of Appeal in *Atkinson v. Accident Rehabilitation Compensation and Insurance Corporation*, is that modifications of this kind cannot apply to disputes about cover for accident compensation.¹⁶² A child received negligent medical treatment in the course of surgery shortly after birth, leading to hypoxia.¹⁶³ The child later was found to be suffering from brain damage, and a claim for accident compensation was made on his behalf.¹⁶⁴ The claim failed, on the ground that the hypoxia could not be causatively linked to the brain damage.¹⁶⁵ Richardson P, delivering the judgment of the court, recognized that it may have contributed to the damage, but it was not proved that it had contributed.¹⁶⁶ The statute focused on outcomes, not on risk of injury or potential for injury. To accept a lesser statutory test of increased risk or to adopt a reversed onus approach would be inconsistent with the statutory language and scheme.¹⁶⁷ Public policy considerations had led to common law modifications of this kind in relation to causation, but the public policy of the accident compensation scheme had to be drawn from its statutory provisions and these were outcomes-focused.¹⁶⁸ “Risk or potentiality of

161. See Lara Khoury, *Causation and Risk in the Highest Courts of Canada, England and France*, 124 L. Q. REV. 103, 110–13 (2008); M H Tse, *Tests for Factual Causation: Unravelling the Mystery of Material Contribution, Contribution to Risk, the Robust and Pragmatic Approach and the Inference of Causation*, 16 TORTS L.J. 249 (2008).

162. [2002] 1 NZLR 374 (CA) paras [19]–[26].

163. *Id.* at para [22].

164. *Id.* at para [2].

165. *Id.* at paras [22]–[26].

166. *Id.*

167. *Id.* at para [24].

168. *Id.* at para [25].

injury [was] not enough to attract cover.”¹⁶⁹ And that conclusion “may well have been seen as part of the policy package” governing the scheme as a whole.¹⁷⁰

The view taken in *Atkinson* came under challenge in *ACC v. Ambros*, where the Court of Appeal returned to the causation question and gave it extended consideration.¹⁷¹ Mrs. Ambros died of a heart attack which was secondary to a rare condition called spontaneous coronary artery dissection (SCAD).¹⁷² She had just given birth to her first child, and SCAD was commonly associated with pregnancy and childbirth.¹⁷³ The question at issue was whether her death was caused by medical error in failing to diagnose her condition and, accordingly, was covered under the Accident Insurance Act 1998.¹⁷⁴ The High Court upheld the claim,¹⁷⁵ and the Accident Compensation Corporation appealed from that decision.

Glazebrook J, delivering the judgment of the court, noted that the 1998 Act was passed against a background of the causation principles set out in *Atkinson*, and was satisfied both that it had to be seen as legislative acceptance of those principles and also that the case was correctly decided.¹⁷⁶ “In ordinary usage, one would not normally say that an injury was caused by medical error when that injury was highly likely to have occurred without the error.”¹⁷⁷ *Atkinson* also was consistent with English authority, and in particular with *Wilsher v. Essex Area Health Authority*, where the House of Lords declined to hold that causing an increase in the risk of harm by contributing one of several possible causes could be treated as causing the harm.¹⁷⁸ Accordingly, as the High Court test did not accord with *Atkinson*, and there were no grounds for reviewing that decision, the appeal should be allowed.¹⁷⁹

Glazebrook J then turned to consider an alternative causal test put forward by counsel appearing as amicus curiae, that where a personal injury is alleged to arise from a failure of medical diagnosis and/or treatment,

169. *Id.*

170. *Id.*

171. [2008] 1 NZLR 340 at paras [8]–[9]. The description of this case is based upon a section of my article, Stephen Todd, *The Court of Appeal, Accident Compensation and Tort Litigation* in *THE PERMANENT NEW ZEALAND COURT OF APPEAL: A CELEBRATION OF 50 YEARS* (Rick Bigwood, ed., 2009).

172. [2008] 1 NZLR 340 at para [1].

173. *Id.*

174. *Id.* at paras [2]–[3].

175. *Ambros v. ACC* (unreported) High Court, Auckland, CIV 2004-404-3261, 21 March 2005).

176. [2008] 1 NZLR 340 at paras [17]–[18].

177. *Id.* at para [18].

178. *Id.* at para [19]; *Wilsher v. Essex Area Health Auth.* [1998] A.C. 1074 (H.L.) 1090–92.

179. *Id.* at para [21].

and (a) is the very injury which the diagnosis and/or treatment was intended to prevent, and (b) is part of the medical event in respect of which the diagnosis and/or treatment was given, then, prima facie, the injury has been caused by the failure of the diagnosis and/or treatment.¹⁸⁰ In her Honour's opinion, whether this modification of ordinary principle ought to be accepted required examination of the manner in which courts in other jurisdictions had dealt with difficulties of proof and uncertainty in the evidence.¹⁸¹

There were a number of situations where dissatisfaction with the result of the traditional test of causation had led to calls for modification to the "but for" test. One of these was the principle laid down in *McGhee v. National Coal Board*¹⁸² and applied in *Fairchild v. Glenhaven Funeral Services Ltd.*¹⁸³ and *Barker v. Corus UK Ltd.*,¹⁸⁴ that where there was one noxious agent rather than multiple agents, a material contribution to the risk posed by that agent was equivalent to a material contribution to the damage.¹⁸⁵ However, the principle was contrary to *Atkinson* and was not applicable in New Zealand. Another was the possibility of claiming damages for the loss of a chance of avoiding a bad outcome, but *Hotson v. East Berkshire Area Health Authority*¹⁸⁶ declined to extend the relevant principles to a claim of medical negligence in failing to diagnose an injury. Rather, it affirmed the traditional test, asking if a failure to diagnose or treat was on the balance of probabilities a cause of the harm.¹⁸⁷ Applying *Hotson* in New Zealand, a claimant might not receive accident compensation cover if an injury had two possible causes, and it was more likely that the injury was caused by an event which did not attract cover as opposed to other events which did. Furthermore in *Gregg v. Scott*,¹⁸⁸ decided after *Fairchild*, the House of Lords still maintained the rule in *Hotson*. Loss of chance analysis had had a mixed reception in other common law jurisdictions,¹⁸⁹ but whatever the developments elsewhere, the analysis was in-

180. *Id.* at para [9].

181. *Id.* at paras [79]–[84].

182. [1973] 1 W.L.R. 1 (H.L.) 4–5.

183. [2003] 1 A.C. 32 (H.L.) 68.

184. [2006] 2 A.C. 572 (H.L.) 593–94.

185. For later discussion of the principle, see *Sienkiewicz v. Greif (UK) Ltd* [2011] 2 WLR 523 (S.C.).

186. [1987] 1 A.C. 750 (H.L.) 760–63.

187. *Id.*

188. [2005] 2 A.C. 176 (H.L.) 234..

189. *Ambros*, [2008] 1 NZLR 340 paras [44]–[45], where Glazebrook J noted that the analysis was rejected by the Supreme Court of Canada in *Laferrière v. Lawson*, (1991), 78 D.L.R. 4th 609, 657(h)–

compatible with the accident compensation regime. Either there was cover or there was not. There was no ability to discount compensation, and no conceptual need to do so where a wrongdoer was not himself or herself liable for the injury. Applying *Atkinson*, any risk needed to be realized in the occurrence of personal injury which was proved to have been caused by the risk factor involved. So if an omission to treat caused an identifiable added injury, cover would be available for that injury.

Turning to informed consent cases, Glazebrook J noted that in both *Chappel v. Hart*¹⁹⁰ and *Chester v. Afshar*¹⁹¹ a surgeon who had failed to warn of a risk was held liable in circumstances where an explanation would on the balance of probabilities have caused delay, but the same treatment would have been likely to have been undertaken at a later date with a similar risk of injury. The decisions were primarily based on a policy choice to impose liability in order to ensure that the duty to obtain informed consent was respected by medical practitioners, which policy had little relevance to a no fault accident compensation regime. Another view, which could be seen as being in accordance with the *Atkinson* test, was that the claims were attributable to the materialization of the risk and not to the exposure to the risk.¹⁹² So the “but for” test could be seen as met if the chances of the risk materializing on the later occasion were slight. Yet her Honour declined to endorse that approach, noting Lord Hoffmann’s view that the argument was similar to saying that a win at the casino was caused by going there on Tuesday because the chances were slight that there would have been a win had the punter gone there on Wednesday.¹⁹³

Glazebrook J accordingly determined that none of these developments applied in the context of the accident compensation scheme.¹⁹⁴ Even so, there were a number of ways in which the courts had otherwise dealt with difficulties of proof and uncertainty. These included a shifting of the evidential burden of proof, the drawing of inferences of cause in circumstances where science could not determine the matter, showing a statistical link between particular events and an injury, and establishing proximity between an alleged cause and its alleged effect. Taking these factors into

658(a), that differing views were expressed in the High Court of Australia in *Naxakis v. West General Hospital* (1999) 197 CLR 269, and that a number of decisions in state jurisdictions in Australia had accepted it. See also *Tabet v. Gett* (2010) 240 CLR 537.

190. (1998) 195 CLR 232, 285 (H.C.A.).

191. [2005] 1 A.C. 134 (H.L.) 140–42.

192. See CLERK AND LINDSELL ON TORTS paras. 2–15 (Anthony Dugdale & Michael A. Jones, eds. 19th ed. 2006).

193. *Ambros* [2008] 1 NZLR 340 at paras [48]–[52]; Lord Hoffmann, *Causation*, 121 L. Q. REV. 592, 602 (2005).

194. *Ambros*, [2008] 1 NZLR 340 at paras [51]–[52].

account, her Honour was satisfied that a combination of some very limited statistics, the proximity between the omissions and Mrs. Ambros' death and the increased monitoring had her condition been diagnosed sufficed to make the question of causation arguable.¹⁹⁵ So the matter was referred back to the High Court for determination.¹⁹⁶

b. Modification of Ordinary Rules?

Ambros considered, and declined to apply, three different routes pursuant to which an ordinary approach to causation might be modified. First, there is the risk principle articulated by the House of Lords in *McGhee*, *Fairchild*, and *Barker*, holding that in defined circumstances it may be sufficient to prove that the defendant caused an increased risk of a damaging outcome, as opposed to the outcome itself. A core control on this principle is the so-called single agency rule, applied in *Wilsher*, holding that the principle cannot apply where there are multiple possible causal agents. Yet the claims in *Fairchild* were not obviously more deserving than the claim in *Wilsher*, and the causal uncertainty was no less acute. The House of Lords seemingly settled on proof of a risk posed by a single agent for essentially pragmatic reasons, to provide a remedy in deserving cases and to have a workable rule that does not undermine the application of ordinary rules of causation in other cases. However, even accepting the single agency rule, at common law it remains uncertain whether or when the risk principle can apply outside mesothelioma cases.¹⁹⁷ Acceptance of the principle only in some limited circumstances is likely to lead to inconsistency in the law, although it may be that this is a price worth paying in order to allow compensation in particularly deserving cases.

Second, there is the idea of a lost chance. The concept of risk describes the probability of a negative outcome. Its "mirror image" is the loss of the chance of a positive outcome.¹⁹⁸ Sometimes the courts redefine the nature of the plaintiff's loss. They award damages not for an outcome but for the loss of a chance of a better outcome, whether in actions founded upon statute, for breach of contract, or for tort. The recovery of damages in such a case does not depend on proof that the benefit of the chance could be assessed as being more likely than not. Rather, the question is whether the chance that was lost was "real" or "substantial," as opposed to the loss

195. *Id.* at paras [53]–[78].

196. *Id.* at paras [113], [115].

197. In the UK the recovery of damages in mesothelioma cases is now governed by section 3 of Compensation Act 2006, reversing the rule of proportionate liability introduced by the House of Lords in the *Barker* decision. Compensation Act, 2006, c. 29, § 3 (U.K.).

198. JOHN G. FLEMING, THE LAW OF TORTS 229 (9th ed. 1998), 229.

of a mere speculative possibility.¹⁹⁹ So when exactly can claims properly be framed as being for the loss of a chance? The decisions show that in cases involving hypothetical physical injury the chance principle is not applied and the plaintiff must adduce proof on the balance of probabilities that he or she would have avoided the adverse physical outcome in question. In particular, *Hotson*²⁰⁰ and *Gregg*²⁰¹ in the UK, *Laferrière v. Lawson*²⁰² in Canada and *Tabet v. Gett*²⁰³ in Australia decline to apply a chance analysis to negligent omissions to provide medical treatment or advice. By contrast, in cases involving hypothetical financial damage, many decisions show that the plaintiff need prove only that he or she lost a substantial chance of avoiding that outcome.²⁰⁴ A possible justification for the distinction, to which *Gregg* lends some support,²⁰⁵ lies in the distinction between deterministic events in the natural world and indeterministic events involving the unfathomable actions of human agents.²⁰⁶ Speaking very broadly, uncertainty about the cause of harm may be the result of lack of knowledge, not random unpredictability of outcome, in which case the cause may be classified as deterministic and is for the plaintiff to prove. Harshly perhaps, an analysis of this kind puts the risk of losing due to scientific uncertainty on the plaintiff. Only inherent uncertainty can be the subject of a lost chance.

Third, there are the decisions of the High Court of Australia in *Chappel* and of the House of Lords in *Chester*. On one view, the decisions were primarily based on a policy choice to impose liability in order to ensure that the duty to obtain informed consent was respected by medical practitioners. On another, the claims were attributable to the materialization of the risk and not to the exposure to the risk. So the “but for” test could be seen as met if the chances of the risk materializing on the later occasion were slight. Yet we have seen that the latter argument is not convincing, for the reasons explained by Lord Hoffmann and endorsed by Glazebrook J in *Ambros*. So the decisions stand as significant departures from orthodox

199. *Davies v. Taylor*, [1974] A.C. 207 (H.L.) 216; *Benton v. Miller & Poulgrain* [2005] 1 NZLR 66 (C.A.) at paras [57]–[58].

200. *Hotson v. E. Berkshire Area Health Auth.*, [1987] 1 A.C. 750 (H.L.) 760–61.

201. *Gregg v. Scott* [2005] 2 A.C. 176 (H.L.) 187–90.

202. [1991] 1 S.C.R. 541, 608.

203. (2010) 240 CLR 537, paras [150]–[52].

204. See, e.g., *Sellars v. Adelaide Petroleum NL* (1994) 179 CLR 332, 355–56; *White v. Jones* [1995] 2 A.C. 207 (H.L.) 234; *Jackson v. Royal Bank of Scotland* [2005] 1 W.L.R. 377 (H.L.) 387–88; *Benton v. Miller & Poulgrain* [2005] 1 NZLR 66 (C.A.), at paras [78]–[86].

205. [2005] 2 A.C. 176 (H.L.), at paras [79], [220].

206. See generally Helen Reece, *Losses of Chances in the Law*, 59 MOD. L. REV. 188, 192–94 (1996).

principles of causation. One commentator has observed that *Chester* not only opens the door to full recovery in almost all cases involving the breach of the medical duty to inform, but could easily be extended to all instances of professionally rendered advice.²⁰⁷ While there is no sign as yet of this happening, we remain in the dark about when exactly policy will justify departing from a subjective test of causation in cases where the plaintiff has relied on another to give skilled advice.

None of the principles considered above could operate to modify the need to prove the cause of Mrs. Ambros' death. The question was whether Mrs. Ambros died as a result of her underlying condition or of medical error in failing to diagnose that condition. The increased risk arose out of separate agencies, only one of which was covered for compensation.²⁰⁸ So the case was similar in principle to the decision in *Wilsher* and the risk principle could not apply. The damage could not be analyzed in terms of a lost chance of a better outcome either, for we have seen that the chance principle has not been applied in medical cases involving physical harm. As for the special rule about informed consent, this obviously was not relevant to the particular facts in issue. So the case had to be determined on the basis of ordinary principles governing proof of cause.

The question remains whether any of the modifying principles *ought* to be imported into an inquiry into the cause of an injury for the purpose of cover for accident compensation. Glazebrook J thought not, and this very arguably is the better view. If a risk principle were to be introduced into the scheme, the same difficulty would arise in deciding what kinds of risks ought to justify compensation. While this question perhaps could be resolved pragmatically, it is certainly doubtful whether a step of this kind ought to be taken at all. There is no special justification for modifying the ordinary rules of causation in the context of a no fault, non-liability based, compensation system. The compensation scheme must have defined boundaries, and proof on the balance of probabilities that a victim's injury comes within them is the appropriate test. Parliament having set these boundaries, they cannot be expanded simply because the concept of accident compensation is seen as deserving of support or a particular victim has needs which, without cover, cannot easily be met. Why include a person exposed by medical treatment to a small risk of disease in circumstances where the treatment probably did not cause the disease, yet exclude a per-

207. Lara Khoury, *Chester v. Afshar: Stepping Further Away from Causation?*, 2005 SING. J. LEGAL STUD. 246, 258–59 (2005).

208. However, if there is an injury and a finite set of possible causes all within the definition of "accident" then there is proof that the injury was caused by accident. *Sam v. ACC* [2009] 1 NZLR 132 (HC) paras [20], [46].

son suffering from the same harm who has not been exposed to that risk? A victim who cannot prove that “but for” medical treatment he or she would not have contracted a disease must be in the same position as all other victims of the disease. Again, it is hard to see that compensation for loss of a chance of a better medical outcome ought to have a place in the scheme. To repeat Glazebrook’s J observation, there is no ability to discount compensation, and no conceptual need to do so where liability is not in issue. Indeed, the concept has in any event been rejected at common law, this primarily because of its very significant implications. In *Gregg*, Lord Hoffmann thought that the wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in the law as to amount to a legislative act.²⁰⁹ It would have enormous consequences for insurance companies and the health service. In similar vein, Lord Phillips and Baroness Hale both emphasized that the change would introduce very great and unwarranted complexity into the law.²¹⁰ Seemingly it would do something similar to the accident compensation scheme. As for the informed consent principle, the policy in *Chappel* and *Chester* of imposing liability in order to encourage medical practitioners to obtain their patients’ informed consent to treatment is hardly relevant to a no fault scheme. So once again we can support *Ambros* in deciding that these cases should not apply.

2. Nature of Treatment Injury

“Treatment injury” means personal injury suffered by a person seeking or receiving treatment from a registered health professional that is caused by treatment and that is not a necessary part or ordinary consequence of the treatment, taking into account all the circumstances including the person’s underlying health condition and the clinical knowledge at the time of the treatment.²¹¹ It does not include: (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; or (c) personal injury that is a result of a person unreasonably withholding or delaying consent to undergo treatment.²¹² The fact that treatment did not achieve a desired result does not of itself constitute treatment injury.²¹³ There is no cover in certain cases, considered below, where

209. *Gregg v. Scott* [2005] 2 A.C. 176 (H.L.) 198–99.

210. *Id.* at 210, 234.

211. Accident Compensation Act 2001 § 32(1).

212. *Id.* § 32(2).

213. *Id.* § 32(3).

personal injury is suffered in the course of a clinical trial.²¹⁴ Where treatment results in an infection suffered by a patient, cover extends to secondary victims of that infection in certain cases.²¹⁵

“Treatment” (for the purpose of deciding whether or when treatment injury has occurred) is given a wide definition. It includes: (a) the giving of treatment; (b) a diagnosis of a condition; (c) a decision on the treatment to be provided (including a decision not to provide treatment); (d) failure or delay in providing treatment; (e) obtaining or failing to obtain a person’s consent to treatment; (f) the provision of prophylaxis; (g) the failure of any equipment used as part of the treatment process; and (h) the application of any support systems used by the organisation responsible for providing the treatment.²¹⁶

Formerly, in order to establish medical misadventure, a claimant had to establish that there had been a “mishap” or “error,” as defined. The definition of “treatment injury” abandons any reference to either concept, yet both are necessarily relevant in determining whether a treatment injury has occurred. First, as regards mishap, there is no cover for personal injury that is a necessary part or ordinary consequence of treatment. The only example given in the explanatory note to the Bill introducing the new provisions was a surgical incision during an operation. That may be clear, but the answers to many other questions are not. Treatment very frequently will pose a risk of recognized but unwanted side effects. Are these an “ordinary consequence” of treatment? Of course, the risks of treatment can vary enormously, from those that are certain or virtually certain to those that are vanishingly small. At some point a court must be able to say that they were not “necessary” or “ordinary.”²¹⁷

ACC takes the view that known complications are not necessarily excluded, as the ordinary consequence criterion is interpreted to refer to inju-

214. *Id.* § 32.

215. *Id.* § 32(7).

216. *Id.* § 33(1).

217. The relevant question here is whether the injury can be seen as a necessary part or ordinary consequence at the time when the treatment commenced rather than when the nature of the claimant’s condition became apparent during the course of treatment. In *McEnteer v. ACC* [2010] NZCA 126 the claimant had suffered an aneurysm which ruptured during surgery and which had to be clipped temporarily for longer than normal, resulting in brain damage. It was argued for the claimant that while the surgeon knew a temporary clipping was needed, so cover for that was excluded, he was not to know that the aneurysm would rupture needing a longer clipping, and that this was therefore an unanticipated development causing injury for which there was cover. *Id.* at [13]. The Court of Appeal rejected the argument, holding that it would require an abstracted expectation of an average outcome based on hypothetical treatment and would open up much scope for debate for no discernable reason. *Id.* at paras [18]–[19].

ries which are “expected” or “usual.”²¹⁸ But how this threshold might be represented in percentage terms is hard to say. There must indeed be a risk of “category creep,” whereby increasingly probable consequences are accepted as treatment injuries.²¹⁹ Without a doubt the threshold for coverage has shifted, from consequences that were “rare” in the determination of whether there had been medical misadventure to those now that are not necessary or ordinary. But the courts still must determine whether there has been some kind of mishap justifying coverage. In this respect the law has reverted from detailed definition back to judicial discretion.

Second, as regards error, let us take the requirement that the personal injury should not be wholly or substantially caused by a person’s underlying health condition. Where there is a failure to treat and the patient’s condition gets worse, or treatment does not alleviate a condition, how do we determine whether the continuing injury is caused by the treatment or by the underlying condition? It may be that we need to make an inquiry into the causal potency of the underlying treatment relative to that of treatment.²²⁰ Perhaps a claimant must establish on the balance of probabilities that treatment, or different treatment, would have improved the patient’s condition or prevented it from getting worse. The Corporation is no longer required to find fault, but the requirement that the claimant show that the health professional should have treated or should have treated differently is likely to involve the claimant needing to show that the health professional was negligent in making his or her decisions about treatment. Furthermore, the Act provides that it is not of itself treatment injury because desired results are not achieved. So the scheme is not intended to underwrite a lack of success in medical treatment. But when might there be treatment injury when desired results are not obtained? An obvious answer is when the wrong treatment is given. In addition, “treatment” is defined as including, *inter alia*, a decision not to provide treatment, a failure to provide treatment or to provide treatment in a timely manner, failing to obtain a person’s consent to undergo treatment, and the failure of any equipment, device, or tool used as part of the treatment process. While negligence is not formally required, all of these points suggest that it necessarily reappears in deciding whether treatment injury can be shown to exist.

218. ACCIDENT COMP. CORP., TREATMENT INJURY PROFILE 3 (Sept. 2010) (kindly provided to the author by Dylan Tapp, Clinical Analyst, ACC) [hereinafter ACC TREATMENT INJURY PROFILE].

219. Oliphant (2007), *supra* note 149, at 383.

220. *Id.* at 384.

3. Treatment Injury in Operation

Evidence of the continuing significance of mishap and error can be found when we consider the figures showing how claims for medical misadventure used to be handled and how treatment injury has operated in practice in the five years since its introduction. Prior to 2005 the difficulties facing claimants seeking to prove that they had suffered medical misadventure led to frequent disagreement as between claimant and the ACC, both in determining whether the closely defined requirements for “mishap” were satisfied and also in resolving contested issues of negligent error. Fewer than three thousand medical misadventure claims were made annually, and only forty percent were accepted as being entitled to cover.²²¹ Of these, eighty-six percent were based on medical mishap and fourteen percent on medical error.²²² They comprised only a small percentage of all injuries accepted under the accident compensation scheme and took much longer than the average to resolve.²²³ But the picture now is very different.

The most significant change is a dramatic increase in the number of claims lodged with ACC. There were 1,434 medical injury claims in 2004–05, 2,846 in 2005–06, 3,964 in 2006–07, 5,073 in 2007–08, 5,472 in 2008–09 and then a small drop to 5,210 in 2009–10.²²⁴ In June 2010 the total number of treatment injury claims reached 31,103, and the overall acceptance rate climbed to sixty-six percent.²²⁵ By comparison, the total number of ACC claims made over the same period has risen only slowly, and the most recent figures show a small decrease. There were 1,523,946 claims in 2004–05; 1,604,359 in 2005–06; 1,685,995 in 2006–07; 1,755,899 in

221. ACCIDENT COMP. CORP., CLAIMANT PROFILE: MEDICAL MISADVENTURE CLAIMANTS (Feb. 2003).

222. *Id.* at 3.

223. In 2002 medical misadventure claims comprised only 0.05% of all accepted injuries. See WELLINGTON DEPT. OF LABOUR & ACC, ACC BACKGROUND PAPER: A COMPREHENSIVE STUDY OF THE COST OF ACCEPTED MEDICAL MISADVENTURE CLAIMS 4 (Mar. 2003).

224. ACCIDENT COMP. CORP., ANNUAL REPORT 56 (2006), available at <http://www.acc.co.nz/publications/index.htm?ssUserText=annual+report> [hereinafter 2006 REPORT]; ACCIDENT COMP. CORP., ANNUAL REPORT 26 (2007), available at <http://www.acc.co.nz/publications/index.htm?ssUserText=annual+report> [hereinafter 2007 REPORT]; ACCIDENT COMP. CORP., ANNUAL REPORT 12 (2008), available at <http://www.acc.co.nz/publications/index.htm?ssUserText=annual+report> [hereinafter 2008 REPORT]; ACCIDENT COMP. CORP., ANNUAL REPORT 2009, 48, available at <http://www.acc.co.nz/search-results/index.htm?ssUserText=annual+report+2009> [hereinafter 2009 REPORT]; 2010 REPORT, *supra* note 132, at 9. Oliphant (2007), *supra* note 149, at 385–86 notes that that most of the rise in the number of claims in 2005–06 as compared to 2004–05 could be attributed to treatment-only claims. This strongly suggested that the abandonment of the “severity” threshold in the definition of medical mishap had led to a pronounced increase in the number of claims for minor treatment injury. The rise in account expenditure was not considered likely to be commensurate, but, as will be seen, this may have been too sanguine a view.

225. Figures supplied in ACC TREATMENT INJURY PROFILE, *supra* note 218.

2007–08; 1,752,452 in 2008–09; and 1,662,347 in 2009–10.²²⁶ So treatment injury claims constitute only a very small percentage of the total number of claims for accident compensation, but that percentage has risen a little over the five year period.

There also has been a doubling of the acceptance rate. While ACC still declines many more claims for treatment injury than claims under the other accounts, the disparity has been reduced in recent years. In 2004–05, the last year of the medical misadventure regime, 70.6% of claims were declined, whereas in 2008–09, under the treatment injury regime, the figure was 35.5%.²²⁷ The most common reasons for declining a claim were that no physical injury could be identified (16%), there was no causal link between treatment and the injury (9%), the injury was an ordinary consequence of treatment (4%), and the injury was wholly or substantially caused by the underlying health condition (4%).²²⁸ If we make a comparison with all claims once again, the overall percentage of declined claims in 2004–05 was 3.9% and in 2008–09 it was 2.5%.²²⁹ It seems likely that this latter small drop is attributable or mainly attributable to the substantial drop in declined claims for treatment injury.

The median time taken to determine the question of cover has dropped dramatically. Whereas the average time taken to determine a misadventure claim was approximately five months, in 2009 it was thirty-seven days.²³⁰ Some decisions are taken very quickly, while others still can take up to nine months. Commonly accepted injuries include wound infection, allergic reaction, hematoma and bruising claims, nerve damage, dental damage, skin damage or injury or tear, and pressure ulcers. The top ten treatment injuries are generally high volume, low cost claims, although in aggregate they entail substantial cost.

A number of observations can be made about these developments. First, the data collected by ACC concerns (necessarily) the “adverse events” providing the foundation for claims for treatment injury, bearing out the point that mishap and error are inherent in that concept. ACC is an accident scheme, not an illness scheme, and an accident-like event remains necessary in order for there to be cover for a medical injury. Second, before

226. 2006 REPORT, *supra* note 224, at 56; 2007 REPORT, *supra* note 224, at 26; 2008 REPORT, *supra* note 224, at 12; 2009 REPORT, *supra* note 224, at 48; 2010 REPORT, *supra* note 132, at 9.

227. ACCIDENT COMP. CORP., ACC INJURY STATISTICS 2008/2009 9 (2010), http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/reports_results/wpc088561.pdf.

228. Figures supplied in ACC TREATMENT INJURY PROFILE, *supra* note 218, at 4.

229. ACCIDENT COMP. CORP., ACC INJURY STATISTICS 2008/2009 8 (2010), http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/reports_results/wpc088561.pdf.

230. Figures supplied in ACC TREATMENT INJURY PROFILE, *supra* note 218, at 4.

2005 most medical misadventure claims were for a “rare” and “severe” medical mishap. In the new definition there must still be a mishap of some kind, but now it is an injury that is not a necessary part or ordinary consequence of treatment, is not caused by the patient’s underlying health condition, and is not simply a failure to achieve the desired result of the treatment. It seems highly likely—perhaps certain—that the very substantial increase in claims noted above is due to the lowering of the threshold for what qualifies as a mishap. The concept, albeit unexpressed, is implicit in the notion of treatment injury. Third, negligent error remains highly significant in establishing such injury. We do not know with any confidence whether instances of negligence have gone up or down or stayed the same, as ACC no longer makes findings of error,²³¹ but for reasons already stated every case of negligent treatment will constitute treatment injury. ACC does provide statistics about adverse event notifications,²³² and the most common of these concern delays in giving treatment or failures to diagnose or to treat, and mistakes in the administration, dispensing and prescribing of medicines.

The task of defining what is and what is not covered for accident compensation in the context of medical treatment is bound to be difficult and probably cannot be resolved in an entirely satisfactory fashion. Medical injury frequently lies near the dividing line between accident and illness. For as long as the accident compensation scheme provides cover for accidents but not for illness (save for occupational disease), it will remain necessary to search for an unexpected accident or event which can separate a medical injury from ordinary treatment of an illness or disease.

4. Costs

In light of the escalating number of claims, it is not surprising that ACC’s accounts show a dramatic increase in the costs of compensation for treatment injury. Annual expenditure on the account, including the continuing costs of the former medical misadventure account, has risen from \$48.6m in 2004–05 to \$56.5m in 2005–06, \$69.2m in 2006–07, \$86.3m in

231. However, there is some evidence that the number of public hospital errors that caused or could have caused major harm to patients has recently increased. The Health Quality and Safety Commission has reported that in 2009–10 there were 374 patients involved in a “serious” or “sentinel” event (as to which see *infra* text accompanying note 246), of whom 127 died, whereas in 2008–9 there were 308 such events including ninety-two deaths. Martin Johnston, *Hospital Errors Causing Serious Harm Climb*, N.Z. HERALD (Nov. 17, 2010, 2:04 PM), http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10688172. The chairman of the Commission’s interim board has suggested that the rise is probably the result of better reporting by the staff involved. *Id.*

232. See *infra* on reporting of medical risks.

2007–08, \$109.8m in 2008–09, and then down a little to \$106m in 2009–10.²³³ This spectacular increase has far exceeded the Treasury estimates of the costs of the 2005 reform. Replacing medical misadventure with treatment injury was predicted to result in an annual increase of \$8.7m, with transitional costs amounting to a one-off \$12m.²³⁴

Expenditure on the ACC scheme as a whole over the same period also has risen, but not so quickly. Total expenditure was \$2.2 billion in 2004–05, \$2.5 billion in 2005–06, \$2.8 billion in 2006–07, \$3.1 billion in 2007–08, \$3.5 billion in 2008–09, and just under \$3.3 billion in 2009–10.²³⁵

Until recently the escalating costs of the treatment injury account were not matched by an equivalent rise in funding. The net annual deficit rose from \$103.5 million in 2004–05 to \$598.6 million in 2008–09, but then a small surplus of \$4.7m was recorded in 2009–10, while the account deficit rose from \$332.5 million in 2004–05 to \$1.4 billion in 2009–10.²³⁶ At the same time ACC's outstanding claims liabilities have grown from \$9.4 billion in 2004–05 to \$23.8 billion in 2008–09 and \$24.4 billion in 2009–10.²³⁷

The above figures indicate that notwithstanding some recent improvement the accident compensation scheme is facing severe financial problems. Some commentators would dispute this conclusion. While certain increased costs are the consequence of expanded cover and entitlements,²³⁸ most, it is said, flow from the requirement introduced in 1998

233. ACCIDENT COMP. CORP., ANNUAL REPORT 100 (2005), available at <http://www.acc.co.nz/publications/index.htm?ssUserText=annual+report> [hereinafter 2005 REPORT]; 2006 REPORT, *supra* note 224, at 97; 2007 REPORT, *supra* note 224, at 93; 2008 REPORT, *supra* note 224, at 90; 2009 REPORT, *supra* note 219, at 79; 2010 REPORT, *supra* note 132, at 57. Ken Oliphant, *Compensation, Ideology and Patient Safety in New Zealand's No Fault System*, 3 OPINIO JURIS IN COMPARATIONE, 1, 12 n. 29 (2009) [hereinafter Oliphant (2009)] notes that up to and including the 2007 Report, a figure was given for "total expenditure" whereas in 2008, a comparable figure required the aggregation of the figures for "total claims paid," "claims handling costs," "net operating costs," and "injury prevention costs." I have followed this example for 2009 and 2010.

234. Ruth Dyson, Cabinet Social Development Committee, Medical Misadventure Review—Conclusions and Recommendations 2004, ¶¶ 14, 38, 66–71.

235. 2005 REPORT, *supra* note 233, at 92; 2006 REPORT, *supra* note 224, at 88; 2007 REPORT, *supra* note 224, at 83; 2008 REPORT, *supra* note 224, at 80; 2009 REPORT, *supra* note 219, at 71; 2010 REPORT, *supra* note 132, at 47. The figures for 2008, 2009 and 2010 are an aggregation of "total claims paid," "claims handling costs," "net operating costs," "injury prevention costs," and "levy collection costs,"

236. 2005 REPORT, *supra* note 233, at 100; 2006 REPORT, *supra* note 224, at 97; 2007 REPORT, *supra* note 224, at 93; 2008 REPORT, *supra* note 224, at 90; 2009 REPORT, *supra* note 219, at 79; 2010 REPORT, *supra* note 132, at 57.

237. 2009 REPORT, *supra* note 224, at 3; 2010 REPORT, *supra* note 132, at 29.

238. Geoff Cumming, *Truth the Casualty of Crisis Management*, N.Z. HERALD (Mar. 14, 2009), http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10561589 (stating that these extra costs accounted for \$537 million of ACC's total liability of \$21.8 billion in the 2009 financial year).

that the scheme be fully funded, initially by 2014 and now by 2019.²³⁹ This requirement is seen as unnecessary and driven by a political ideology favouring eventual privatisation of the scheme.²⁴⁰ This, however, is not the view of the New Zealand Government. The Minister for ACC stated in the 2009 Report that the growth in ACC's liabilities should have been recognized and addressed some years earlier and was unsustainable. The annual report disclosed financial difficulties in all of ACC's accounts, driven by years of significant increases in costs and increasing numbers of claims. The underlying cause had been a shift from ACC being a public insurance scheme to it becoming an extension of the welfare state. So the Government had embarked upon a programme of reform aimed at strengthening ACC's governance, improving rehabilitation and promoting injury prevention, and embarking on a substantial stocktake taking a long-term view on how the scheme's performance could deliver better value for money.²⁴¹ Indeed, recent figures show that ACC's liabilities have stabilized and that there was a surplus of about \$2.5 billion in 2009-10.²⁴²

C. Professional Accountability

The accident compensation regime can provide compensation for the victims of medical injury. But such victims may wish to achieve various objectives apart from compensation, in particular to find out how their injury happened, to help prevent it happening again, to receive an acknowledgment of responsibility and to hold a negligent professional accountable for his or her conduct. These kinds of objectives can be met to a greater or lesser extent in a number of different ways. In addition, if a medical injury is not covered for accident compensation, there may remain the option of bringing a civil action for damages.

1. Reporting of Medical Risks

Before 2005, the ACC had a responsibility to report all findings of medical error to the relevant professional body and to the Health and Disability Commissioner. However, the requirement was seen as a reason why health professionals were reluctant to co-operate in the claims process,

239. See *supra* note 122 and accompanying text.

240. See Joanna Manning, *Access to Justice for New Zealand Health Consumers* 17 (Mar. 24, 2010) (unpublished paper) available at <http://www.hdc.org.nz/education/hdc-medico-legal-conference-2010-a-decade-of-change> (summarizing arguments from the Retirement Policy and Research Centre).

241. 2009 REPORT, *supra* note 224, at 3.

242. 2010 REPORT, *supra* note 132, at 2.

fearing the possible repercussions.²⁴³ So when the new treatment injury provisions abandoned the need to prove error, the reporting requirements were changed as well. A reporting obligation now arises if the Corporation believes, from information collected in the course of processing claims for treatment injury, that there is risk of harm to the public, in which case “the Corporation must report the risk, and any other relevant information, to the authority responsible for patient safety in relation to the treatment that caused the personal injury.”²⁴⁴ In this respect, then, public safety concerns must prevail when balanced against the objectives underlying the 2005 changes of encouraging co-operation and promoting a shift away from a blaming culture.

The ACC has well-developed processes for assessing risk and notifying the appropriate persons or bodies. Its Treatment Injury Centre considers the potential for risk of harm to the public using information collected when assessing cover, and events posing sufficiently serious risks are considered and assessed by an internal ACC panel.²⁴⁵ All “sentinel” events—events during treatment resulting in unanticipated death or major permanent loss of function—are notified to the Director General of Health, together with all “serious” events—those with the potential for causing death or major permanent loss of function—in cases where there is a high or moderate likelihood of recurrence.²⁴⁶ The Director-General then decides whether the notification is disseminated to the treating facility, and also determines the response that is needed to improve safety. In rare cases the ACC will notify a registration authority if it has expert clinical advice that there are serious competence concerns. If there is a serious and immediate risk of harm to the public notifications can be made very quickly.²⁴⁷

The change in the statutory requirements for cover, and in particular the removal of the formal requirements that there should be a finding of error or mishap, has had the consequence that ACC does not now collect detailed information about the causes of medical injuries. Accordingly, the onus has shifted to the notified authorities to make their own investigations into any issue of culpability.

243. Summary of ACC Medical Misadventure Consultation, August 2003, p 1.

244. Accident Compensation Act 2001 § 284. It is likely that the ACC will also report to a newly instituted National Health Safety and Quality Commission, which will act as a central agency for adverse data event collection and promotion of patient safety. An interim board was set up in June 2010, with the new Commission planned to be up and running in 2011.

245. ACC TREATMENT INJURY PROFILE, *supra* note 218.

246. *Id.*

247. *Id.* at 7.

Over the period from July 2005 to June 2010 ACC made 1,661 notifications of its belief that there was a risk of harm to the public.²⁴⁸ Easily the most common reason was delay and failure to treat in relation to the diagnosis and management of cancer and, less commonly, to visual problems, birth asphyxia, and testicular torsion. Other common reasons were wrong medication administration in relation to the person, drug, dose, route, and time; bile duct injuries and bowel perforations involving, inter alia, identifiable technical issues with surgical technique, premature failure of hip, and knee prostheses; and cerebrovascular accidents and hypoxic brain injury relating to coronary artery bypass graft, angiograms, cardiac valve surgery, and insertion of cardiac catheters.²⁴⁹

2. Complaints

A *Code of ACC Claimants' Rights* seeks to meet the reasonable expectations of claimants seeking accident compensation in their dealings with the Corporation. It provides, inter alia, a procedure for the lodging and dealing with complaints about breaches of the Code and the consequences and remedies for breach.²⁵⁰

A regime for making complaints about medical treatment is provided by the Health and Disability Commissioner Act 1994.²⁵¹ The Act lays down a procedure for making complaints to the Health and Disability Commissioner in respect of breaches of the Code. The Commissioner may investigate a complaint, deliver an opinion and make recommendations for remedial action. There is no power to award damages. Serious cases may be referred to the Director of Proceedings, who can institute disciplinary proceedings or civil proceedings in a Human Rights Review Tribunal.²⁵² The Tribunal has the power to award damages to compensate for pecuniary loss and expense, loss of any benefit, and humiliation, loss of dignity and injury to feelings, and to punish for any action that was in flagrant disregard of the rights of the aggrieved person.²⁵³ Compensatory damages for

248. *Id.*

249. *Id.*

250. Health and Disability Commissioner Act 1994 §§ 39–47.

251. *Id.*; see generally Manning, *supra* note 240.

252. Health and Disability Commissioner Act 1994 §§ 45(2)(f), 49(1)(a).

253. *Id.* at §§ 52, 54, 57. In *Marks v. Dir. of Health and Disability Proceedings* [2009] 3 NZLR 108 (C.A.) at para [62] the Court of Appeal held that an “aggrieved person” was a consumer whose rights under the Code had allegedly been infringed and that the parents of a suicide victim seeking to bring an action against their son’s psychiatrist did not qualify. Manning criticizes the decision and recommends its reversal on the grounds that this would give a wider group the opportunity to bring proceedings and would promote accountability and improvements in the quality of services. Manning, *supra* note 240, at 6–7.

personal injury covered by the Accident Compensation Act 2001 are excluded.²⁵⁴ So proceedings before the Tribunal are likely to be brought only by consumers seeking exemplary damages or who have suffered no physical injury.

3. Actions for Damages

A medical professional also may be held accountable by way of a civil action for damages. Yet in light of the cover for treatment injury, there is very limited scope for bringing such an action in a medical context. Obviously any common law liability will depend on proof of negligence, yet negligence by a registered health professional, including negligence in relation to treatment, diagnosis, failing to treat, giving advice and obtaining consent to treatment, normally gives rise to coverage for treatment injury. Conversely, if conduct is not negligent and there is no cover, there is no scope for a common law action either. Even so, there remains the possibility of actionable negligence in exceptional cases where there is no cover, perhaps because there is a special statutory exclusion, or there is no "personal injury" as defined in the statute.

a. Clinical Trials

An exception to cover arises out of certain special rules applying to clinical trials.²⁵⁵ Persons who suffer injury as a result of treatment given as part of a clinical trial who have not agreed in writing to participate in the trial are covered, as are persons who suffer such injury in the course of a trial certified by an accredited ethics committee as not being principally for the benefit of the manufacturer or distributor of the medicine being trialled. But if a person has agreed in writing to participate in a trial which is certified only as being for the benefit of the manufacturer or distributor, injury suffered by the participant is not covered. So a common law remedy founded on negligence by a sponsoring company or an investigator might be available.²⁵⁶

254. Accident Compensation Act 2001 § 52(2).

255. Accident Compensation Act 2001 § 32(4)-(6); Nicola Peart & Andrew Moore, *Compensation for Injuries Suffered by Participants in Commercially Sponsored Clinical Trials in New Zealand*, 5 MED. L. REV. 1 (1997).

256. The practice of ethics committees in certifying a trial is to ensure that adequate compensation is available in the event of injury, by requiring the company concerned to abide by the New Zealand Researched Medicines Industry Guidelines on Clinical Trials. These provide for payment for "more serious injury of an enduring and disabling nature" irrespective of proof of negligence, but state that compensation may be abated to the extent that injury has arisen through a significant departure from the agreed trial protocol, or the wrongful act of a third party, or contributory negligence by the patient. The amount of any compensation "should be appropriate to the nature, severity and persistence of the in-

The justification for this exception to cover is obscure. Seemingly it is founded upon the participant's consent to any risk, but consent is not a bar to compensation in other contexts. A drunken driver and his passenger arguably consent to the risk of injury in a collision, yet both can make claims for compensation.

b. Stillbirths

Whether a stillbirth is a personal injury to the mother can be disputed. In *Harrild v. Director of Proceedings*²⁵⁷ a majority in the Court of Appeal held that a mother had suffered personal injury on account of the death of the foetus in consequence of negligence by her doctor. Elias CJ was not attracted by the stark choice of treating the unborn child either as the same as the mother or as distinct. She considered that where severance of the physical link between mother and unborn child occurs through the death of the child as a result of medical error, then physical injury is suffered by the mother.²⁵⁸ Keith and McGrath JJ thought similarly.²⁵⁹ Blanchard and Glazebrook JJ, by contrast, considered that on the majority view a mother and foetus are treated as a single entity, which ignores biological reality.²⁶⁰ This perhaps is the more convincing view, but unless the question comes to be reconsidered by the Supreme Court, there is cover for a negligently caused stillbirth and there can be no action for damages.

c. Pregnancy and Unwanted Births

Cases involving pregnancy and unwanted births also require special consideration. The question arose in *Accident Comp. Corp. v. D.*²⁶¹ where the Court of Appeal, in a majority decision, determined that unwanted pregnancy was not a "personal injury" under the 2001 Act because it was not a "physical injury."²⁶² In Arnold and Ellen France JJ's view, these phrases suggested a need for harm or damage, and the denial of cover also fitted better with the consistent exclusion of various gradual processes un-

jury." The Preamble contemplates that adherence to the guidelines is without legal commitment, and certainly the question whether or how they might be legally enforceable by a patient is unclear. *Guidelines on Clinical Trials Compensation for Injury Resulting from Participation in an Industry-Sponsored Clinical Trial*, RESEARCHED MEDICINES INDUSTRY (Aug. 2008), <http://www.medicinesnz.co.nz/assets/Uploads/compensation-guidelines-0808-final.pdf>.

257. [2003] 3 NZLR 289 (C.A.) at paras [22], [42], [135].

258. *Id.* at para [21].

259. *Id.* at paras [42], [135].

260. *Id.* at paras [66]–[69].

261. [2008] NZCA 576 (C.A.) at para [54]; affirmed in *Allenby v. Hannam* [2011] NZCA 251 (C.A.).

262. *Id.*

der the differing accident compensation regimes.²⁶³ While the common law illustrated that pregnancy could be described as an injury, the starting point was the statutory scheme, which did not give cover in the case at hand. Their Honours accepted that there was something odd about the fact that an unwanted pregnancy would be the only result of medical misadventure for which cover was not available. But there were inevitable oddities in a non-exhaustive scheme that had to draw the line somewhere. And there might in most cases be good public policy reasons for not regarding a pregnancy and the delivery of a baby as physical injuries. It was for the legislature to determine where the balance lay.

d. Informed Consent Cases

We have seen that in *Accident Comp. Corp. v. Ambros* Glazebrook J considered that the informed consent cases apparently relaxing the requirement of proof of cause of an injury should not be imported into the accident compensation regime.²⁶⁴ Accordingly, a failure to warn of a small risk of medical treatment, which risk later eventuates, is not covered for compensation and to this extent might be actionable in damages. However, the occurrence of the adverse event following a failure to warn is likely nonetheless to amount to treatment injury, on the basis that this is not a necessary part or ordinary consequence of the treatment, with cover accordingly.

e. Mental Injury

A patient suffering mental injury as a consequence of physical injury caused by medical negligence is covered for compensation.²⁶⁵ However, cover does not extend to mental injury suffered by a secondary victim. An example is where a husband suffered “reactive depression” as a result of being unable to continue sexual relations with his wife after she was injured due to medical misadventure.²⁶⁶ So an action for damages could lie in this kind of case.

f. Miscellaneous

There arguably is no personal injury where surgery leads to no physical or mental health problems, but, due to the doctor’s negligence, it does

263. *Id.* at para [55].

264. [2008] 1 NZLR 340 (C.A.) at para [51].

265. Accident Compensation Act 2001, § 26(1)(c).

266. *ACC v. F* [1991] 1 NZLR 234 (HC) 240.

not produce the desired results.²⁶⁷ Again, a doctor can be liable in battery for wrongful physical contact not causing actual injury. Mental injury to a patient caused by professional misconduct is actionable as well.²⁶⁸

g. Exemplary Damages

The option of a claim for exemplary damages remains. In *A v. Bottrill*²⁶⁹ the Privy Council upheld the availability of exemplary damages in a bad case of medical negligence, but the decision was overruled in *Couch v. Attorney-General*,²⁷⁰ where the Supreme Court required that there be advertent or reckless wrongdoing. The test is likely to be difficult to satisfy, certainly in a medical context.

CONCLUSION

Let us now attempt to evaluate New Zealand's scheme, with particular reference to the way in which it operates in the field of medical injury. We will consider whether it provides adequate compensation, has defensible boundaries, is administratively efficient, and operates as an incentive or a disincentive to safety-conscious behavior.

A. Adequate Compensation?

The statutory scheme in operation in New Zealand arguably performs well in its core function of providing a source of compensation for the victims of accidents. The statutory benefits, in particular earnings-related compensation, are reasonably generous and compare favorably with flat rate social security payments. Inevitably there will be winners and losers by comparison with common law damages. In *Queenstown Lakes*²⁷¹ Thomas J remarked on the notion of a social contract and a trade-off between the loss of common law rights and the gaining of accident compensation benefits, and said also that damages and compensation were never intended to correspond. Uncertainty of recovery at common law was exchanged for a no-fault scheme which included provision for rehabilitation as well as ongoing earnings-related compensation. Disparity between the two would always exist. So some injury victims will or might in some sense be worse off, but

267. Kate Tokeley, *Accident Compensation and Cosmetic Surgery*, 1998 N.Z. L. J. 5, 5–6 (1998) (discussing the question in relation to wrong-sized breast implants).

268. *L v. Robinson* [2000] 3 NZLR 499 (HC) at para [1], [44].

269. [2003] 1 AC 449 (PC).

270. [2010] 3 NZLR 149 (SC); see *supra* note 83.

271. [1999] 1 NZLR 549 (CA) 557.

most will benefit from the scheme. And, of course, the key advantage of accident compensation is that it is available for nearly all injury victims, not just those who can establish the liability of another to pay compensation.

B. Defensible Boundaries?

There is no accident compensation simply for disease or illness, unless work-related. In *Queenstown Lakes*, Thomas J drew attention to this point as well, commenting that difficulties would necessarily arise out of the line between injuries arising from accidents and other injuries and conditions which were not attributable to accidents.²⁷² These difficulties are acute in the case of alleged medical injury by way of sickness or illness, for treatment is given (or is not given when it should be) to patients who are already sick or ill. As we have seen, the solution has been to allow claims for injury caused by unexpected mishaps or wrongful treatment or failure to treat. The line between such compensable treatment injury and the non-compensable condition requiring the treatment is bound to be hard to draw.

Ultimately any compensation scheme has to set boundaries. The boundaries to the accident compensation scheme as they presently exist are founded very broadly on a distinction between human and natural causes. These may be hard to defend, but there is no natural limit upon which all can agree. A line has to be drawn somewhere, and wherever it is it will create difficulties and anomalies in relation to cases which are excluded. So if illness were to be included, it would still be necessary to define the qualifying circumstances, and some borderline cases would be excluded. And there is practical value in the accident/illness divide. Most cases giving rise to the question whether another was liable for the injury are covered, the difficulties created by tort litigation are largely avoided, and victims by and large receive adequate compensation. More generally, if illness and disease were to be covered there would be major financial implications, the scheme would transmute into part of the social security system, and payments inevitably would at least be substantially reduced.²⁷³

272. *Id.*

273. Social security payments in New Zealand are made pursuant to the provisions of the Social Security Act 1964 § 1A. These may supplement accident compensation entitlements, particularly in cases where the claimant is a non-earner whose entitlement is limited to a lump sum. Where there is no accident compensation cover, a person's only source of income may be a social security benefit. The relationship between accident compensation and social security is governed by the Accident Compensation Act 2001 and the Social Security Act 1964, which seek to prevent double payments and which make provision for transfers or reimbursements of money between the ACC and the Work and Income Service of the Ministry of Social Development. Accident Compensation Act 2001, §§ 252–53; Social Security Act 1964 §§ 71, 71A. The social security scheme makes provision for three main types of

Of course, accepting the need to show some kind of “accidental” event, the question remains quite how to define that event. The 2005 amendments lowered the bar in medical injury cases and made the qualifying conditions much easier to satisfy. The predictable result has been the striking increase in the number of treatment injury claims over the last five years. The reforms of 2005 have been said to cement the distinction between incapacities caused by human interaction and incapacities which are natural,²⁷⁴ which no doubt is true in that we must still distinguish between the treatment (human cause) and the underlying condition (natural cause). But the reform might equally be seen as weakening the distinction, in allowing many more claims for injuries which are attributable to unexpected developments and events which are neither especially rare nor, it may be, easily separable from the underlying condition. At all events the reform widens the idea of an accident in this context and extends cover to more people suffering harm in the course of medical treatment. This is at the cost of rather greater uncertainty as to the extent of cover, coupled with the need for an increase in funding for the treatment account.

C. *Administratively Efficient?*

This brings us to consider the whole question of costs and funding. A major advantage of an event-based compensation scheme is that claims can be made quickly and processed efficiently. The cost of delivering the statutory benefits avoids the very substantial costs associated with the need to prove liability before compensation can be paid. The costs of administering the scheme are relatively low and have remained stable over the last five years. In 2009, the scheme’s operating costs amounted to 13.4% of claims paid, levy collection costs were 1.6% of total revenue, and investment costs were 0.34% of investment assets.²⁷⁵ A comparison between the administrative costs in the work account and those of similar Australian schemes shows that in 2006–07 ACC spent 19.7% of total scheme expenditure on

benefit for incapacitated persons. The invalid’s benefit is payable to New Zealand residents over the age of 18 who are totally blind or permanently or severely restricted in their capacity for work (but excluding self-inflicted conditions). Social Security Act 1964 § 40. An emergency benefit is payable on grounds of hardship where a person cannot qualify for any other benefit and by reason of disability cannot earn a sufficient livelihood. *Id.* § 61. Survivors’ benefits or domestic purposes benefits are payable in certain circumstances to wives or husbands or those who had been in a relationship in the nature of marriage on the death of the other in respect of the costs of bringing up dependent children, and an orphan’s benefit is payable to the principal caregiver of a child whose parents are both dead. *Id.* §§ 21, 27B, 28. Further supplementary allowances and grants, such as the disability allowance and the child disability allowance are available. *Id.* §§ 39A, 69C.

274. Oliphant (2009), *supra* note 233, at 17.

275. 2009 REPORT, *supra* note 224, at 21 (total operating costs include both “operating costs/claims paid” and “injury prevention costs/claims paid”).

claims management and other administration, whereas the Australian average was 25.2%.²⁷⁶ Comparisons with the costs of litigation are revealing. An estimate of the cost of tort litigation in the UK concluded that about fifty-five pence of the insurance pound was paid out to injured victims, and about forty-five pence was swallowed up in administration.²⁷⁷

Critics might argue that administrative efficiency can be bought at too high a cost. They might say, *inter alia*, that removing a right to sue for injury and substituting a right to make a claim from a compulsorily funded statutory body, irrespective of the claimant's or anyone else's responsibility for the injury, is likely to encourage malingering and to lead to bureaucratic inertia and ever-increasing costs. Perhaps there is some evidence in support of this kind of thesis in the seemingly relentless rise in the costs of accident compensation that we have already noted. But at least some of the increase is due to widening provisions for cover and entitlements, and it is in any event impossible to come to a considered conclusion without good evidence about all the causes of the increase. We can say only that some element of abuse is endemic in all compensation systems, that steps are being taken to control costs and improve ACC's finances, and that better performance is perfectly achievable.

D. Disincentive to Safety-Conscious Behavior?

Possibly a stronger argument, and certainly one that attracts articulate support, is that a compensation scheme of this kind removes a deterrent to injury-producing activity and operates as a disincentive to safety conscious behavior. This raises large questions which cannot be addressed adequately here. However, we might note that the Woodhouse Report did not see proof of fault as useful in injury prevention,²⁷⁸ and the New Zealand Law Commission concluded that the alleged deterrent role of tort was not significant.²⁷⁹ Let us, briefly, consider the evidence.

A number of studies starting back in the 1960s show that the value of tort liability as a deterrent to unsafe conduct or as an incentive to take care is certainly unproven and is likely to be negligible.²⁸⁰ Evidence provided

276. *Id.*

277. P CANE, *ATYIAH'S ACCIDENTS, COMPENSATION AND THE LAW* 397 (7th ed., 2006) (commenting that no other compensation system is anything like as expensive).

278. WOODHOUSE REPORT, *supra* note 2, at para 319.

279. 1988 REPORT, *supra* note 27, at para 81.

280. *See, e.g.*, TERENCE GEORGE ISON, *THE FORENSIC LOTTERY: A CRITIQUE ON TORT LIABILITY AS A SYSTEM OF PERSONAL INJURY COMPENSATION* (1967); ELI P. BERNZWEIG, *BY ACCIDENT NOT DESIGN: THE CASE FOR COMPREHENSIVE INJURY REPARATIONS* (1980); STEPHEN D. SUGARMAN, *DOING AWAY WITH PERSONAL INJURY LAW: NEW COMPENSATION MECHANISMS FOR VICTIMS*,

by some more recent studies confirms this conclusion. For example, Tess and Armstrong, comparing empirical evidence on fault, no-fault and hybrid schemes across a number of dimensions, including availability of benefits, costs of the scheme and prevention incentives, saw no-fault schemes as coming out ahead.²⁸¹ As regards prevention of accidents in particular, their conclusion was that fault, no-fault and blended systems appeared to perform similarly and, importantly, that there were far more important drivers of safety improvements than the threat of tort.²⁸² In the specific field of medical malpractice the consensus is similar. So Mello and Brennan, in a US study, considered that evidence of a deterrent effect was limited and vulnerable to methodological criticism.²⁸³ The data did not support the notion that the malpractice system sent a strong deterrent system to providers. Sloan and Chepke, in like vein, stated that it was difficult to find good evidence that negligence liability deterred medical errors.²⁸⁴ As regards the New Zealand scheme in particular, Oliphant concluded that it remained an open question whether introducing no-fault in place of liability in private law had had a positive or negative effect on patient safety, or no effect at all.²⁸⁵

At best, evidence about the deterrent impact of imposing tort liability for causing injury is equivocal, and certainly a link with lower accident rates is not easily shown. Indeed it is strongly arguable that holding people accountable for their conduct can be achieved in other, more effective, ways. We have seen that there are a number of alternative methods of achieving accountability by medical professionals operating in New Zealand.

CONSUMERS, AND BUSINESS (1989); Don Dewees & Michael Trebilcock, *The Efficacy of the Tort System and Its Alternatives: A Review of the Empirical Evidence*, 30 OSGOODE HALL L. J. 57 (1992). Compare Gary T. Schwarz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, (relying on anecdotal evidence to conclude that tort law might still be "somewhat successful" in achieving its stated deterrence goals). In Stephen Todd, *Privatization of Accident Compensation: Policy and Politics in New Zealand* 39 WASHBURN L. J. 404, 478–82 (2000) I attempted to review the literature on this topic, and found it was difficult to come to any clear conclusion. For a recent and helpful review, see Harold Luntz, *Torts and Insurance: The Effect on Deterrence*, in *TORTS IN COMMERCIAL LAW* (Simone Degeling & James Edelman eds.) (forthcoming 2011).

281. Kirsten Armstrong & Daniel Tess, Institute of Actuaries of Australia, *Fault Versus No Fault—Reviewing the International Evidence* (Nov. 9–12, 2008), http://www.actuaries.asn.au/library/GIS08_3d_Paper_Tess,Armstrong_Fault%20versus%20No%20Fault%20-%20reviewing%20the%20international%20evidence.pdf.

282. *Id.* at 27.

283. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (2002).

284. Frank Sloan & Lindsey Chepke, *THE LAW AND ECONOMICS OF PUBLIC HEALTH* (2007).

285. Oliphant (2009), *supra* note 233, at 19.

A further point deserving note is that market incentives aimed at reducing accidents can of course operate within the accident compensation scheme. The ACC Accredited Employers Programme (AEP) gives employers significant discounts on their ACC levies in exchange for taking responsibility for their employees' work injury claims. Recent proposals to extend the scheme include reducing barriers on participation by providing a greater range of risk-sharing arrangements, reducing compliance costs faced by employers by providing more flexibility in meeting financial entry requirements, and offering other risk-sharing arrangements to small employers outside the AEP.²⁸⁶ The ACC Workplace Safety Management Practices Programme and the Workplace Safety Discount Programme also provide levy discounts for businesses showing sound health and safety practices. Until recently there was no general discount on levies, analogous to an insurance no-claims discount, for businesses showing a good safety record.²⁸⁷ Historically the work levy has been based on injury rates across industry categories, without any differentiation according to a particular business's safety record. However, in April 2011 ACC introduced a system of experience rating, under which a business's work levy can be modified based on its claims history.²⁸⁸ So experience rating seeks to reward those businesses with safer workplaces and to encourage a focus on improving workplace safety.

A further proposed reform, as already noted,²⁸⁹ will allow private insurers to provide insurance cover in respect of accident compensation entitlements in competition with the ACC. The aim of the proposal is to improve safety, rehabilitation and efficiency in the workplace. The document asks a number of questions about the proposed changes, and feedback from interested persons has been invited.

²⁸⁶. INCREASING CHOICE IN WORKPLACE ACCIDENT COMPENSATION (June, 2011), *supra* note 45.

²⁸⁷. Whether this should be attempted has been debated. The Law Commission in its 1988 Report drew attention to the uncertainties involved and also to possible inequities. Small firms might be subject to statistically random fluctuations in accident rates, which might occur despite taking all proper precautions. See 1988 REPORT, *supra* note 27, at para 140–49. Subsequent studies show inconclusive results.

²⁸⁸. EXPERIENCE RATING – MAKING ACC WORK LEVIES FAIRER FOR INDIVIDUAL BUSINESSES (2011) (available at <http://www.acc.co.nz/for-business/experience-rating/index.htm?IdcService>).

²⁸⁹. INCREASING CHOICE IN WORKPLACE ACCIDENT COMPENSATION (June, 2011), *supra*, note 45.

E. Overview

One's assessment of the accident compensation scheme may turn very much on personal disposition concerning the legislative imposition of a compulsory, state-controlled, scheme, funded by levies in the nature of taxation, in a field which traditionally has been the preserve of private action and initiative. If one is happy with the idea, or at least can live with it, one can attempt to judge the scheme on its results, unhampered by ideological conviction.²⁹⁰

In summary, the compensation is reasonably generous and is available with the minimum of formality; the boundaries are defensible, with the result that, broadly speaking, medical injury outside the ordinary consequences of treatment and not attributable to a patient's pre-existing condition is compensable; the scheme operates quite efficiently, so for the most part available resources are used to meet the needs of qualifying claimants rather than for administrative purposes; there is little evidence that barring tort claims has compromised safety standards; the need in some cases to hold individuals accountable for wrongdoing can be met by the use of a detailed statutory process for the making of complaints; the level of funding needed to meet the costs of the scheme can be achieved by levies which compare favorably with the costs of alternatives, such as by insurance against tort liability; and while there certainly have been escalating costs, these are explicable at least partly by the change from pay-as-you-go to full funding, and seemingly they are reasonably manageable.

The accident compensation scheme has survived many challenges, some financial, some operational, some ideological, and no doubt these will continue. All difficulties will not simply disappear. However, by comparison with the tort system it has been and continues to be a distinct success.

290. For a variety of reviews of the first thirty years, see *Looking Back at Accident Compensation: Finding Lessons for the Future*, 34 VICT. U. WELLINGTON L. REV. 189, 467 (2003) (containing the papers delivered at a conference at Victoria University of Wellington in August 2002); *The Future of Accident Compensation*, 35 VICT. U. WELLINGTON L. REV. 775-974 (2004) (containing the papers delivered at a second conference in December 2003); see also *Accident Compensation Symposium*, 2008 N.Z. L. REV. 3, 140 (containing papers paying tribute to Sir Owen Woodhouse on the 40th anniversary of the day the Woodhouse Report was presented to Parliament). For an overview see *Accident Compensation Corporation New Zealand: Scheme Review* (2008), a report commissioned by the ACC by Price Waterhouse Coopers, Sydney, which concluded that the implementation of the Woodhouse Principles via the ACC scheme had afforded New Zealand's society and economy four decades of added economic and social value.