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No-Fault Compensation In New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety

Injury compensation systems meet patients' financial needs only and must be complemented by other forms of accountability.

by Marie Bismark and Ron Paterson

ABSTRACT: In 1974 New Zealand jettisoned a tort-based system for compensating medical injuries in favor of a government-funded compensation system. Although the system retained some residual fault elements, it essentially barred medical malpractice litigation. Reforms in 2005 expanded eligibility for compensation to all "treatment injuries," creating a true no-fault compensation system. Compared with a medical malpractice system, the New Zealand system offers more-timely compensation to a greater number of injured patients and more-effective processes for complaint resolution and provider accountability. The unfinished business lies in realizing its full potential for improving patient safety. [*Health Affairs* 25, no. 1 (2006): 278–283]

In 1974 New Zealand adopted a government-funded system for compensating people with personal injuries (operated by the Accident Compensation Corporation, or ACC), replacing its former tort-based system. A generation of New Zealanders has now grown up knowing the ACC as the primary method of dealing with personal injury claims, including medical injuries, and avoidance of litigation is widely regarded as a social gain.[1] Reforms in 2005 removed the final fault element from the compensation criteria for medical injuries, making it a true no-fault system.

Contextual differences in health funding, social security, and community values limit generalization of the New Zealand experience to other countries. Nevertheless, this system merits close consideration for its efforts to compensate injured patients quickly and equitably, while offering accountability mechanisms focused on ensuring safer care rather than assigning individual blame. Exhibit 1 lists some of the features of the New Zealand system in comparison with the U.S. system.

■ **The trouble with torts.** The failings of the U.S. tort-based medical malpractice system have been well described. Most injured patients do not qualify for compensation, because their injuries were not negligently caused. And even negligently injured patients, especially those who are poor or elderly, are unlikely to sue and receive compensation.[2] Yet,

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EXHIBIT 1
Comparison Of The United States Medical Malpractice And The New Zealand No-Fault Systems

	United States	New Zealand
Eligibility for compensation	Negligence	Treatment injury (post 1 July 2005)
Expert advisers	Appointed by parties	Appointed by ACC
Decisionmaker	Lay jury	Administrative panel
Time to resolve a claim	Years	Weeks to months
Administrative costs	High (>50%)	Low (<10%)
Average payment	High	Low (average payment < US$30,000)
Physician indemnity insurance costs	High	Very low (< US$1,000, regardless of specialty)
Links to quality improvement processes	Theoretical deterrent effect	Claims analysis informs efforts to improve patient safety

SOURCE: Authors' analysis.
NOTE: ACC is Accident Compensation Corporation.

paradoxically, most lawsuits arise out of appropriate care.[3] This creates confusing signals about quality of care, and although some doctors adopt a defensive mode of practice, there is little evidence of a true deterrent effect.[4]

■ **Thirty years of government-funded compensation.** New Zealand's compensation system arose not in response to concerns about medical malpractice but through farsighted workers' compensation reforms. A Royal Commission, established in 1967, concluded that accident victims needed a secure source of financial support when deprived of their capacity to work. Skeptical of the ability of a liability-based system to provide such support, the commission recommended no-fault compensation for personal injury.[5] At around the same time, the United States, Australia, and the United Kingdom also debated the merits of no-fault compensation, but the idea of a comprehensive approach to injury by accident failed to gain traction.[6]

In the New Zealand system, injured patients receive government-funded compensation through the ACC. In exchange, they give up the right to sue for damages arising out of any personal injury covered by the accident compensation legislation. This prohibition applies even when a person chooses not to lodge a claim or is not entitled to compensation.[7] It remains possible to bring actions for exemplary damages, but the courts have found that not even gross negligence warrants such damages unless there is some element of conscious or reckless conduct.[8]

■ **"Medical error" and "medical mishap."** Historically, health care–related injuries have made up 0.05 percent of all claims made to the ACC, with around 2,000 such claims received in an average year from a population of four million. Under the original legislation, personal injury by accident included "medical, surgical, dental or first aid misadventure," without further definition. At the time, claims against health professionals were uncommon, and for several years doctors remained uncertain about the extent to which the specter of liability had been removed.[9]

In 1992, the concepts of *medical error* and *medical mishap* were formally introduced into the ACC legislation. *Medical error* was defined as the failure to observe a reasonable standard of care and skill—civil negligence by another name. Before 2002 medical error could not be attributed to an organization; this focus on individual error, combined with the threat of disciplinary action, hindered open communication and delayed compensation, as doctors sought to challenge error findings.

The second category, *medical mishap,* was defined as a rare (occurring in less than 1 percent

of cases) and severe (disability or prolonged hospitalization) adverse consequence of properly given treatment. The *mishap* concept allowed recovery for non-negligent injuries and accounted for the majority of accepted claims. Yet the definition was a clumsy one, with the rarity and severity criteria criticized for being confusing and arbitrary.[10] Here is an example of a medical mishap compensation claim:

> A young woman underwent laparoscopic surgery to confirm a diagnosis of endometriosis. Post-operatively, she was readmitted with abdominal pain and found to have peritonitis associated with a bowel perforation. She required a temporary colostomy and spent three weeks in critical care.
>
> The ACC's independent expert advised that the complication was a rare and severe consequence of treatment properly given and met the definition of *medical mishap*. The woman was awarded a compensation package worth around US$28,000 (for pharmaceuticals, home help, and lost earnings). Under the new 2005 compensation criteria, this injury would be compensated as a form of "treatment injury."

■ **2005 reforms.** Criticisms of the compensation criteria—particularly the inconsistency between *medical error* and the no-fault basis of the wider ACC system—prompted an interagency review in 2002. The review found overwhelming support for new coverage criteria and almost no suggestion of returning to a right to sue—a reflection on the extent to which the ACC system is embedded in New Zealand culture and support for the proposition that "even an imperfect administrative compensation system [is] an improvement over the...medical malpractice system."[11]

Consequently, on 1 July 2005, *medical mishap* and *medical error* were replaced with a new concept of *treatment injury*.[12] This change broadened coverage to include all personal injuries suffered while receiving treatment from health professionals. A causal link between treatment and injury is still required. Injuries that are a necessary part or ordinary consequence of treatment (such as chemotherapy hair loss) are not covered. Clarification of what constitutes "a necessary part" will be critical. As before, there is no coverage where the injury is solely the result of resource allocation decisions.

A key objective of the change is to encourage health professionals to assist injured patients to make claims earlier, thereby facilitating timely provision of ACC assistance. Claimants are informed about the availability of independent processes for resolving concerns about the quality of care, and the ACC is required to report any "risk of harm to the public" to the responsible authority. A new Patient Safety team analyzes claims data and works with the health sector and researchers to help improve patient safety.

■ **Claims process.** The ACC system is one of the simplest in the world for patients to navigate, and although the eligibility criteria have changed, the decision-making process remains much the same. Claims are decided in the ACC's national claims unit, based on information provided by patients and their providers, and advice from independent clinical advisers. Straightforward claims can be processed in weeks, with a statutory requirement for decisions to be made within nine months. Historically, the ACC has accepted around 40 percent of all claims. Dissatisfied claimants may request a review of the decision, and if this fails, they have a right of court appeal.

The ACC is financed through general taxation and an employer levy. A fixed award schedule means that claimants with similar disabilities receive similar compensation. Entitlements fall into four categories.[13] (1) *Treatment and rehabilitation* includes the cost of pharmaceuticals, disability aids, child care, home modifications, and vocational retraining. Most treatment costs are already covered by New Zealand's universal health care system. (2) *Compensation for loss of earnings* includes weekly compensation of 80 percent of the claimant's earnings at the time of injury, up to a set maximum. (High earners can purchase additional first-party income protection insurance.) Weekly compensation was the most important driver of compensation costs during 1992–2003.[14] (3) *Lump-sum compensation*—a one-time payment of up to US$70,000 to compensate for permanent impairment resulting from

an injury—is paid in addition to any other ACC entitlements. (4) *Support for dependents* takes the form of a funeral grant and a survivor's grant paid to surviving spouses and children under age eighteen.

■ **Affordability.** No-fault systems have the potential to compensate many more patients than malpractice litigation can, but depending on compensation criteria, level of awards, and social context, this need not result in greatly increased costs.[15] Accurately estimating the long-term costs of the New Zealand system is difficult, with uncertainty about future claim rates, changes in life expectancy, and innovations in health care. To date, compensation for medical injuries has cost around US$29 million per year. As in the United States, the most costly claims involve neurological injury to infants: fewer than 7 percent of claims yet more than 16 percent of spending.[16]

The ACC expects that following the 2005 reforms, the number of compensation claims will go up by 50 percent, and many more claims will be successful. However, most of the new claims will involve minor, temporary injuries, which were previously ineligible for compensation. The reforms are expected to cost an additional US$5 million a year.

Four main factors have contributed to the system's affordability. First, New Zealanders benefit from a strong social security system. Injured patients, like everyone else, receive free hospital care and subsidized pharmaceuticals. (Yet per capita health spending was only US$1,886 in 2003, compared with US$5,635 in the United States.)[17] Thus, New Zealand's public health and welfare systems cover many of the damages that would be at issue in a U.S. medical malpractice claim, leaving the ACC with a much smaller compensation burden.

Second, compensation awards are generally lower and more consistent than under a malpractice equivalent. As described above, economic losses are compensated according to a fixed schedule, and compensation for noneconomic losses is available only for permanent disabilities.

Third, the New Zealand experience suggests that even under such a system (which includes a legal duty of open disclosure), most entitled patients never seek compensation, and many may be unaware that they have even suffered an adverse event. Peter Davis and colleagues have estimated that the ratio of potentially compensable events to successful claims is around thirty to one.[18] Further work is under way to understand the extent of under-claiming and the characteristics of patients who do not claim.

And finally, the New Zealand system does not incur large legal and administrative costs. The system has been very cost-effective, with administrative costs absorbing only 10 percent of the ACC's expenditures compared with 50–60 percent among malpractice systems in other countries.[19]

■ **Accountability.** Many U.S. commentators have expressed concern that a "no-fault" compensation system equates to a "no-accountability" medico-legal system. For example, Robert Wachter and Kaveh Shojania speculate that "Americans' passion for individual accountability would…torpedo a system that could not assign fault (and with it the duty of compensation) on truly blameworthy errors."[20] Between 1972 and 1994 such criticisms had some legitimate foundation, because the abolition of the right to sue did leave a lacuna in systems of medical accountability. However, in the late 1980s a major inquiry at a leading teaching hospital forced New Zealand to consider this accountability function and recommended the establishment of a Health and Disability Commissioner to restore balance to the system.[21]

The commissioner promotes patients' rights and provides accountability where care has not been provided with reasonable care and skill.[22] As the following case study shows, complaints are resolved using patient advocacy, mediation, or investigation, as appropriate. The actions of organizations and individuals are considered, and the commissioner acts as a gatekeeper to disciplinary proceedings in serious cases. Complaints are used as a "window of opportunity" to improve health services, and lessons learned through complaint investigations are widely disseminated.[23]

> A general practitioner referred his patient for mammography of a breast lump and told her he would contact her if there were any problem. Thirteen weeks later (after two phone calls from his patient), the doctor obtained the mammography report and told his patient the results were abnormal. The patient complained to the commissioner, who found that the doctor had failed to provide care of an appropriate standard. The commissioner recommended that the medical center implement a system for follow-up of test results.
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> In light of this and other cases that involved physicians' failure to follow up test results adequately, the commissioner drew attention to the topic in a medical journal. This led to debate by general practitioners and the development and implementation of pilot guidelines for improving follow-up of test results.

■ **Unresolved concerns.** Despite the recent reforms, four major concerns about the ACC system remain unresolved. First, many observers believe that levels of ACC compensation are inadequate, particularly in comparison with tort jurisdictions. This is especially a problem for patients—usually women and the elderly—who are not in paid employment at the time of the injury and thus are unable to claim earnings-related compensation.[24]

Second, compensating treatment injuries, while excluding most other illnesses from the ACC system, is bound to produce tensions, because ACC assistance is generally higher than that received from the health and welfare systems. This is particularly troubling in the area of birth abnormalities, such as cerebral palsy, in which babies with similar needs could be eligible for very different kinds of support.

Third, the ACC system has been criticized for its duplication of processes following an adverse event.[25] In response, the ACC has strengthened interagency relationships with police, coroners, the health and disability commissioner, and other regulatory bodies, to reduce unnecessary overlap.

Finally, although the system is structured to support efforts to improve patient safety, the potential gains are still a long way from being fully realized. After thirty years of the ACC and nine years of independent complaint resolution, New Zealand hospitals appear no safer (or more dangerous) than those in other Western countries. The adverse-event rate of 12.9 percent stands midway between the levels recorded in two countries with shared medical traditions in training and practice: Australia (16.6 percent) and the United Kingdom (10.8 percent).[26] Although the recent reforms are expected to bolster efforts to create a culture of learning, the task of making health care safer is daunting and will not be achieved through medico-legal reform alone.

■ **Concluding remarks.** In the 1970s the U.S. Department of Health, Education, and Welfare sponsored a study of New Zealand's proposed no-fault system. Arthur Bernstein, the study's author, reported that "the most effective remedies for the ills of our tort reparation system [may]be disclosed by demonstration, in an attractive, usually tranquil, and very civilized little country half-a-world away. ...The developments 'down under' thus merit our most careful and continuing observation."[27]

Some thirty years later, with the rise of systems thinking about the causes of adverse events, the tort system is looking increasingly anachronistic. Although the New Zealand system has not delivered a perfect solution to the problem of medical injury, it remains popular, and there is no enthusiasm among the public or health care providers for a return to tort law as an alternative. The ACC does not deliver the windfalls of a "forensic lottery," but it offers injured patients reasonable assistance, quickly, and without rancor. The unfinished business lies in realizing the system's full potential for enhancing patient safety.

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NOTES

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