

50 years on from the Woodhouse Report

workers' health in New Zealand's ACC scheme

Abstract

It has been 50 years since the Woodhouse Report was published, resulting in the creation of the first ACC scheme for New Zealand. Work and the working environment have changed a great deal in this time, as have scientific understandings of the relationship between work and health. The Accident Compensation Act 2001, as it stands, is struggling to provide fair and equitable compensation to New Zealand workers, with significant gaps in cover, inequalities in the treatment of different occupations and a detrimental flow-on effect for worker health and safety. This article outlines some of the key areas of legal reform required to ensure that the ACC scheme can meet the needs of New Zealand working people in the future and help improve work health and safety.

Keywords ACC, compensation, stress, mental illness, cardiovascular disease, gender, health and safety, law reform

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It has now been 50 years since the publication of the report of the Royal Commission of Inquiry into Personal Injury in New Zealand, commonly referred to as the Woodhouse Report, after the commission's chair, the then Justice Woodhouse. The anniversary has been met with various calls for reform, including improving the transparency and fairness of the scheme, and even extending it to provide comprehensive social insurance for all incapacities (Palmer, 2018; Forster, Barraclough and Mijatov, 2017). This article focuses only on the workers' compensation functions performed by the ACC scheme, as these unique functions, and the connection to work health and safety, are too often neglected.

The royal commission was originally set up to inquire into New Zealand's workers' compensation regime and make recommendations for improvement. The Woodhouse Report went far further than that, proposing the adoption of something radically different: an accident compensation scheme, with compensation for work-related injuries to be incorporated within it. The ACC scheme extended cover to New Zealanders who suffered 'accidents' outside of work, such as in vehicle collisions or in the home, and has become a key

feature of the country's social and legal landscape.

The decision to incorporate work-related injuries into an accident-focused scheme was not without costs to those core workers' compensation functions and to work health and safety in the years that followed. For example, the cover of chronic work-related health problems in New Zealand is poor compared to that in comparable jurisdictions, with some of the largest causes of work-related incapacity excluded, significant gender inequalities in cover, gaps in data collection and negative consequences for work health and safety. While these issues have been discussed in greater detail elsewhere,¹ this article provides an overview of the problems in most urgent need of reform.

The original 'accident' compromise

Woodhouse and fellow reformers had grander visions in the 1960s than just compensation for accidents. Reformers wanted a comprehensive social insurance scheme that would provide cover to incapacities of any kind, covering 'all the hazards of modern living' including all diseases (Royal Commission of Inquiry into Personal Injury in New Zealand, 1967, p.3). This ambitious vision was thought too radical for the government of the day and the proposal was confined to 'accidents'. The first Accident Compensation Act 1972 was drafted to reflect this narrower focus, and intended to be a temporary measure until political fortunes changed. The Labour Party opposition at the time had expressed an intention to 'introduce not only the letter of the Woodhouse report but also the spirit of the concept behind' it (Faulkner, 1972). In 1989 an attempt was made to extend ACC cover to all sickness and disease, following an officials committee report (Officials Committee, 1986) and a report by the New Zealand Law Commission, headed by Sir Owen Woodhouse (New Zealand Law Commission, 1988). However, these proposals were scrapped by the incoming National government in 1990, which favoured a shift towards a private insurance model (Birch, 1991).

The 1972 Act contained another political compromise, the inclusion of 'occupational disease'. Occupational

diseases did not fit the rationale for the new scheme as they were not accidents, but they had been covered under the previous workers' compensation regime. To exclude them from cover would deprive workers of an existing entitlement, breach ILO conventions and result in resistance to the proposal by organised labour, which had fought for the cover of those diseases over many decades and generally opposed the Woodhouse Report (MacMillan, 1983). The 1972 Act imported the occupational diseases provisions, as they stood, from the Workers Compensation Act 1956, and described them as an 'extension of cover', making their status as

include acute incidents of poisoning or choking, burns and some cases of exposure to radiation or extremes of temperature (ss25(b), (c)). The definition of accident focuses on acute physical injury, being an immediate or sudden impact on the body from something external.

Where a worker has an injury that falls within the definition of 'accident' they have cover. If the worker's health problems fall outside the definition, there are separate sections with a range of different legal tests which apply, reflecting the retention of the original compromise. ACC provides cover for certain listed 'occupational' conditions in the occupational diseases schedule, and

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an exception to the 'accident' focus of the legislation clear (Accident Compensation Act 1972, ss65–7). While the ACC legislation has been re-enacted and amended many times since the 1970s, subsequent iterations of the legislation retained this 'accident plus exceptions' structure and the problems that come with it, including the current Accident Compensation Act 2001.

Current cover of work-related health problems

The current legislation revolves around the definition of 'accident' in section 25. An accident is defined as 'a specific event or a series of events, other than a gradual process' that involves the 'application of a force (including gravity), or resistance, external to the human body', or 'involves the sudden movement of the body to avoid a force (including gravity), or resistance, external to the body', or 'involves a twisting movement of the body' (s25(1)(a)). This definition covers the majority of work-related slips, trips and falls, many lifting and manual handling injuries, machinery-, tool- and plant-related injuries, and physical assaults. An accident can also

for some gradual process injuries, diseases or infections under section 30, the problems with each discussed in greater detail elsewhere. There are two final, narrow categories of cover provided in sections 21B and 28, which relate to single incident trauma, and heart attack and stroke. This may sound like good coverage, until you take a closer look at what work-related health conditions are being excluded and who this affects.

Exclusion of work stress-related illness

A fuller analysis of the gaps in the cover of chronic work-related illness is provided in other papers by the author (see Duncan, 2016, 2017, 2018, 2019), but one of the most significant gaps is work stress-related illness. Although section 30 provides cover for 'gradual process, disease or infection', it excludes any conditions related to 'non-physical stress' (s30(5)(a)). There have now been at least 70 years of research into stress-related illnesses and the links between work stress and the development of chronic diseases (Väänänen, Murray and Kuokkanen, 2014; Sapolsky, 2004), yet work stress-related health conditions are excluded from cover.

In relation to mental illnesses, ACC cover is limited to conditions that arise 'because of a physical injury' (26(1)(c)), those caused by certain criminal acts (schedule 3 lists sexual offences) and those covered in section 21B. Section 21B, introduced in 2008, covers a narrow range of traumatic exposure – for example, a transport driver suffering post-traumatic stress disorder after a person commits suicide by stepping in front of their vehicle. To obtain cover the worker must experience, see or hear an event directly or be 'in close

currently no cover for the health consequences of workplace bullying or harassment, despite the growing recognition of the size and impact of this in New Zealand workplaces (Bentley et al., 2009). There is also no cover for illnesses resulting from workload pressure, burnout or care fatigue. Looking internationally, the largest numbers of work-related mental illness claims are for work stress-related illnesses and bullying (Safe Work Australia, 2016). ACC offers little cover to the potentially large and growing number of

(see Wieclaw et al., 2006; Rodwell and Demir, 2012; Brouwers and Tomic, 2000). These hazards are associated with increased rates of chronic stress-related illnesses, including mental illnesses such as depression and anxiety, which are excluded from the ACC scheme. If we map the health risks associated with these jobs against the cover available, the health conditions most likely to affect workers in female-dominated occupations are the most likely to be excluded, leaving these workers with less of a safety net than workers in other occupations.

The lack of recognition of the health effects of a work-stress and the exclusion of most work-related mental health problems runs contrary to decades of research, the practices in comparable jurisdictions and the recent urgings of international bodies (OECD, 2018). It potentially also has an effect on people's perceptions of the 'realness' of mental health problems and the importance of work-stress as a hazard.

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physical proximity to the event at the time it occurs'. The event is required to be a single identifiable event and be 'an event that could reasonably be expected to cause mental injury to people generally' (s21B(2), (5)).

For example, in the case of *KB v ACC* (2013) a claim was made by a police officer attending a particularly distressing suicide and having to counsel the family, which she alleged caused her condition. The court declined cover, finding that 'the appellant has experienced a significant number of events in the course of her work' and an event 'must be one that is in effect a one-off event, and which results in the more or less immediate onset of the factors involved in the medical condition of post-traumatic stress disorder'.² While there has been some hope expressed following the decision in *MC v ACC* (2016),³ the meaning of words can only be strained so far, and the drafting of section 21B excludes the vast majority of work-related mental health problems.

In the case of *OCS Ltd v TW* (2013) the court declined a claim made for a mental health problem resulting from a pattern of bullying and harassment that culminated in an incident of minor assault.⁴ There is

workers affected by these conditions.

Workers in female-dominated occupations

Particularly noteworthy are the impacts of this exclusion on female-dominated occupations. The legal treatment of workers in female-dominated occupations under the ACC scheme has been covered in greater detail elsewhere. To summarise, New Zealand's labour market remains highly segregated by gender, meaning that male and female workers tend to perform different types of work (Statistics New Zealand, 2015, 2019). Different types of work mean exposure to different types of hazards, and result in different patterns of work-related health problems (Eng et al., 2011).

Looking at the international research, and the data available from workers' compensation schemes in other jurisdictions (the lack of New Zealand data is discussed further below), the work that women typically perform, like teaching, caregiving, healthcare and administration, tends to be associated with exposure to psychosocial hazards such as bullying, harassment, occupational violence, workload stress and fatiguing care demands

The importance of worker mental health

The recent report of the Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, highlighted the costs associated with poor mental health:

The economic costs of mental illness are substantial. Recent estimates for OECD countries are that mental illness reduces gross domestic product (GDP) by approximately 5%, through disability leading to unemployment, work absenteeism and reduced productivity, and the additional costs of physical healthcare among people with mental health problems. (Government Inquiry into Mental Health and Addiction, 2018, p.97)

While much is made of the positive impact of work on mental well-being, stressful work can also be a significant cause and exacerbator of poor mental health (Chandala and Zhang, 2018). Mental health problems frequently involve a range of complex and interrelated causal factors, with work forming a significant component of many people's mental health problems. Most New Zealanders spend more time working than doing anything

else, and tackling New Zealand's mental health crisis requires acknowledging the role of work.

Work-stress has been linked with a wide range of mental health problems, including depression and anxiety, internationally and in New Zealand (Rantala et al., 2018; Melchior et al., 2007). Work intensification, increasingly rapid organisational restructures, hyper-connectivity and precarity have all been linked to increased stress levels and poorer mental and physical health (Crawford and LePine, 2010; Maslach and Leiter, 2008; Wajcman and Rose, 2011; MacCormick, Dery and Kolb, 2012; Green, 2004; Korunka and Kubicek, 2017; New Zealand Council of Trade Unions, 2013). Recognising this body of evidence and the costs of inaction, other countries include stress-related illnesses within their workers' compensation schemes, allowing for greater resulting data on costs and consequences.

Out of step with the rest of the world, section 30(5) of the Accident Compensation Act contains a blanket exclusion for any health problems resulting from 'non-physical stress' and a legislated separation between mind and body. The problems with retaining mind/body dualism in law are particularly evident in the treatment of chronic pain cases such as *Teen v ACC and Telecom Ltd* (2002) and *Meikle v ACC* (2008),⁵ where ACC regards the pain as mental (Duncan, 2016). Science has long since abandoned the strict separation of mind and body, increasingly recognising that the human body seldom confines its functions to neatly isolatable and convenient categories (Sapolsky, 2017). An earlier version of the *Diagnostic and Statistical Manual of Mental Disorders* (1994) even concluded that the 'term mental disorder unfortunately implies a distinction between "mental" and "physical" disorders that is a reductionist anachronism of mind/body dualism', retained in the title only 'because we have not found an appropriate substitute' (American Psychological Association, 1994). There is no basis in science, nor good social policy, for drawing a hard line between mind and body.

Stress-related heart disease and stroke

Another area where the ACC legislation has fallen behind medical thinking is in its

cover of 'cardiovascular or cerebrovascular episode[s]' (heart attacks and strokes). Cover is only provided if 'the episode is caused by physical effort or physical strain, in performing his or her employment, that is abnormal in application or excessive in intensity for the person' (s28(3)). Essentially, cover is only available where the heart attack or stroke is 'caused by' some unusual physical exertion on the part of a worker in performing an unusually physical task in their ordinarily sedentary work. For example, in *Estate of Wei v*

not likely, on review of the medical evidence, be considered the 'cause'. It would be extremely unlikely for a worker to have a heart attack in the circumstances set out in section 28(3) without pre-existing heart disease or a pre-existing structural defect, meaning the section, as drafted, offers little assistance to workers in the contemporary workplace.

The consequences of exclusion

While cost arguments and floodgate fears are often levelled in response to calls to

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ACC (2004), Wei died of a heart attack after being assaulted while working in his electronics shop. The judge considered that although the 'physical effort in the struggle during the assault' may meet the requirements, it could not be said to have 'caused' the cardiovascular episode, meaning Wei's estate could not obtain compensation. The medical evidence revealed underlying asymptomatic heart disease. The court recognised that the additional physiological stress may have triggered the heart attack, but this did not amount to cause. Although stress was a factor here, the judge held that 'physiological stress' did not meet the definition of 'physical stress'.⁶

This case highlights the risks of drafting for specific medical conditions at a given point in time, a consequence of the accident plus exceptions structure of the ACC legislation. Heart attacks were, in the early part of the 20th century, considered by policymakers to be caused by physical exertion and thus 'accidents'. Nowadays, heart attacks are viewed as acute events caused by a blockage in blood vessels to the heart in cases of cardiovascular disease. As in the case of Wei, the physical exertion would at best be considered to operate as a trigger to an inevitable event, and would

widen the scope of ACC cover (Birch, 1991), the costs of exclusion are being borne by the individuals and families affected, businesses, and the wider society and economy. Employees who are unable to access ACC cover are either using sick leave, turning up to work unwell (with the associated costs and productivity impacts), leaving the workplace or labour market entirely, or suing through the personal grievance system.

The Holidays Act 1993 provides for five days' sick leave per year (section 65(2)), which is unlikely to be filling the gaps, although the worker may have a more generous contractual entitlement and a supportive employer granting what has colloquially been called 'stress leave'. If the worker is an employee they may be able to sue their employer, either taking a personal grievance for unjustifiable disadvantage or bringing a claim for breach of statutory duty or breach of an implied term of contract. To succeed the employee would need to prove the fault of the employer in failing to provide them with safe and healthy work and provide the necessary evidence of causation and incapacity. The New Zealand Court of Appeal in the leading case of *AG v Gilbert* (2002) has described this as posing 'formidable

obstacles' to most employees.⁷ An employee would also have to bear the costs and stress of legal action, something unlikely to be appealing to someone with a stress-related illness and no income. Even if they win, the amounts in compensation awarded are unlikely to be high, or equivalent to that provided with ACC cover (Duncan, 2018).

Legal action is not without costs for the employer either. Employers are exposed to litigation risk in relation to work stress-related illnesses in a way they are not normally, and may not be prepared for, with few affordable or easily accessible resources to help small employers prevent

benefits (efficient and predictable costs, avoiding legal action, healthier workers, etc.) are likely to outweigh these.

There are also social costs of exclusion. Employees without sufficient sick leave entitlements, insurance cover or a successful legal case have only family or the benefit system to fall back on. A New Zealand study looking at the impacts of the differences between ACC cover and a benefit, involving people with a similar level of impairment, concluded that the WINZ (Work and Income) group (no ACC cover) had 'considerably poorer socio-economic outcomes', did not return to

resources and guidance for employers.

The report of the Royal Commission into the Pike River Coal Mine Tragedy (Royal Commission on the Pike River Coal Mine Tragedy, 2012) and report of the Independent Taskforce on Workplace Health and Safety (2013) both highlighted workplace health, including conditions resulting from exposure to psychosocial hazards, as an issue in need of urgent attention. WorkSafe New Zealand has issued *Healthy Work: WorkSafe's strategic plan for work-related health 2016 to 2026*. This document acknowledges New Zealand's failure 'to adequately address work-related health risks and the harm associated with them', which they recognise are having an 'even greater impact' on the country than 'that from acute work-related injuries' (WorkSafe New Zealand, 2016, p.6). One of the additional benefits of extending ACC cover to a wider range of work-related health conditions would be better data on those conditions, which would help regulators to develop a better health and safety response.

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or defend against such claims. On a practical level, many employers struggle to manage employee stress-related health issues, including health and safety monitoring and risk assessment, evaluating impairment and impact of illness on performance, and cases of alleged bullying and harassment. Complexities also arise for employers in return-to-work planning, making the reasonable accommodations required under the Human Rights Act 1993, and navigating the related privacy rights and disclosure obligations.

Extending ACC cover to a wider range of work-related health problems would allow both employers and employees to avoid many of these costs and practical issues, with employees able to access treatment and compensation and be managed back to work through the usual ACC processes. Extending cover would likely be a particular gain for organisations in industries where stress-related health problems are a significant issue, such as transport, health, education, finance, and public and professional services. While ACC levies may rise in these sectors in response to an expansion of cover, the

work as early, and were the 'most vulnerable for decline into poverty and ill health' (McAllister et al., 2013). While there is no New Zealand data on how many individuals are being affected by exclusion from ACC cover each year, looking to international rates, the numbers and the associated costs are potentially considerable.

A negative impact on health and safety

The lack of ACC cover for significant chronic work-related health problems also has a negative flow-on effect for work health and safety. New Zealand's workplace injury and illness data is mostly derived from ACC administrative data, meaning that where there is no cover for a particular condition, there is no resulting data on that condition. If work stress-related conditions are not showing up in the official workplace injury and illness data, they are not visible as a 'problem' to policymakers and regulators. The lack of data makes it difficult to understand the size and specifics of the issues, who is affected, and the costs associated. It is also more difficult to develop monitoring or enforcement responses, or to develop

What might reform look like?

Calls for reform of the scheme have ranged from specific amendment, to the complete reimagining of the health and welfare system. Specific legislative models with alternative drafting to fit in either an amended ACC scheme or a comprehensive social insurance scheme have been proposed and explained in greater detail elsewhere. Whatever model is selected, reform needs to begin with a clearer set of principles underpinning compensation. One of the lessons from ACC's peculiar history is the need to focus on better cover, not just more cover. The ACC scheme has always struggled to find a principled basis for the determination of the boundary lines of cover. This stems from the original political compromise to confine the scheme to accident. An accident, in plain meaning, is 'an unexpected event with negative consequences' or something 'happening by chance or accident; not planned [or] unexpected'. If the scheme cannot (or there is no political will to) compensate all such consequences, then a question as to which accidents should be compensated naturally arises. The scheme contains an inherent rationing problem

that pure workers' compensation regimes do not (Duncan, 2017). As Geoffrey Palmer identified as early as 1976, the ACC scheme has developed a 'cut and fill approach', of small-scale ad hoc amendment, with amenders failing 'to see the forest for the trees' (Palmer, 1977, p.8).

Preventing work-related health problems is better than just compensating them, and the ACC scheme plays an important role in improving work health and safety. While, as Woodhouse argued, all incapacities may be equally deserving, this does not mean that they are caused by the same factors, or can be prevented by the same response. If prevention is truly a goal of the scheme, then the workers' compensation provisions need to be designed to perform those functions, and towards the goals of improved work health and safety. Just adding a new section for chronic work-related mental health conditions or removing section 30(5) repeats the same pattern which has caused

the problems in the first place. As discussed elsewhere, the problems with the current cover of work-related health conditions are much wider, with stress-related illnesses only symptomatic of a fundamental tension within the scheme (Duncan, 2016).

Work has also changed a lot since the Woodhouse Report was written in 1967. Greater pressure is being placed on the scheme by changes in the nature of work and medical thinking on the relationships between an individual's work and health. Work will continue to change, with the types of health problems facing New Zealand workers and the causal relationships between work and health becoming more complex and interrelated. As argued in other papers, the best response to increasing factual complexity in the relationships between work and health is clarity in legal principle (Duncan, 2019). Reforms to the workers' compensation functions of the ACC scheme need to start with a clear set of principles, recognising

the different context of work-related health problems, the rights of workers to compensation, the links between compensation and prevention activities, and the role of the ACC scheme in improving work health and safety. Fifty years on from the Woodhouse Report, it's time for policymakers to stop plugging the holes in a compromised scheme and think about the bigger picture of what we are compensating and why, designing a scheme better able to meet the needs of New Zealand working people harmed through work, as well as outside of it.

- 1 This article draws on research towards a PhD in law at Victoria University of Wellington and contained in a series of publications. For a more in-depth treatment of some of the historical, wider chronic health issues, gender issues and coverage of cardiovascular diseases and depression see Duncan, 2016, 2017, 2018, 2019.
- 2 *KB v ACC* [2013] NZACC 41, paras [24] and [25].
- 3 *MC v ACC* [2016] NZACC 264.
- 4 *OCS Ltd v TW* [2013] NZACC 177.
- 5 *Teen v ACC and Telecom Ltd* [2002] NZACC 244; *Meikle v ACC* (2008)[2008] NZACC 158.
- 6 *Estate of Wei v ACC* [2004] NZACC 338.
- 7 *AG v Gilbert* [2002] 2 NZLR 342, para [87].

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