ENDING FAULT IN ACCIDENT COMPENSATION: ISSUES AND LESSONS FROM MEDICAL MISADVENTURE

*Brian Easton**

This paper suggests that emphasising prevention and rehabilitation are the key directions that the ACC system should move in the future. Compensation should be phased out in favour of rehabilitation as the primary means of remediation. Additionally the author recommends removing inequity in the system by phasing out accidents as the basis for entitlement and replacing it with an entitlement regime based on injury outcomes. This discussion is located within the context of the treatment of medical misadventure under the ACC system.

I INTRODUCTION: THE WOODHOUSE VISION

There seems to be common agreement that the treatment of medical misadventure should conform to the Woodhouse Principles and there should be no notion of fault in its coverage. I shall not labour this point, but it is worthwhile to remind ourselves of these Principles and how the 1966 Commission rejected fault as being relevant. Their primary Principles were:[1]

> Prevention, Rehabilitation, and Compensation – Injury arising from accident demands an attack on three fronts. The most important is obviously prevention. Next in importance is the obligation to rehabilitate the injured. Thirdly, there is a duty to compensate them for their losses. The second and third of these matters can be handled together, but the priorities between them need to be reversed. No compensation procedure can ever be allowed to take charge of the efforts being made to restore a man to health and gainful employment.

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* Economic And Social Trust On New Zealand, 18 Talavera Terrace, Wellington <http://www.eastonbh.ac.nz> (last accessed 15 November 2004).

1 New Zealand Royal Commission of Inquiry into Compensation for Personal Injury *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (Government Printer, Wellington, 1967) para 2 ["*Woodhouse Report*"].

It added that: "Safety – This needs no elaboration. Any modern compensation scheme must have a branch concerned solely with safety... ."[2] And then the Report set down Five General Principles for rehabilitation and compensation:[3]

(1) Community Responsibility;

(2) Comprehensive Entitlement;

(3) Complete Rehabilitation;

(4) Real Compensation; and

(5) Administrative Efficiency.

Note that the Woodhouse Commission did not recommend the abandonment of the fault approach when it established its basic principles. Rather the abandonment derived from its application of those principles, for it found that:[4]

> (2) The fault principle cannot logically be used to justify the common law remedy and is erratic and capricious in operation. ...
>
> (5) The common law remedy falls far short of the five requirements outlined in the report.

II THE GAINS FROM NO-FAULT MEDICAL MISADVENTURE

There are three significant gains when medical error is no longer recognised in the scheme:

(1) Speedier decisions and lower compliance costs, because the health professionals will be less defensive and the assessment less complicated.

(2) The opportunity for more effective preventative programmes, again arising out of health professionals being less defensive.

(3) Fewer vexatious claims, because the Accident Compensation System would no longer be seen as a disciplinary body.

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2 *Woodhouse Report*, above n 1, para 3.

3 *Woodhouse Report*, above n 1, para 4.

4 *Woodhouse Report*, above n 1, para 171.

Depending on the criterion of medical misadventure used, the apparent cost of the scheme may rise. But those costs are transfers. The gains just mentioned involve genuine reductions in compliance costs, therefore there are gains to the economy as a whole.

III SOME PROBLEMS THE NEW SCHEME WILL FACE

A Compliance Costs

The medical fault system generates compliance costs.[5] The system needs to continually review, measure and, where possible, reduce compliance costs, as well as speeding up its decisions.

For instance, current procedures require the same investigative procedure irrespective of the cost of remediation. In some cases the cost of remediation is a fraction of the cost of assessment. In my submission to the Review of Medical Misadventure,[6] I suggested a procedure involving a prima facie finding, which gives the Authority the discretion to approve the undertaking of rehabilitation without further investigation, where the costs of remediation are small. However, it would not cover compensation – that is the payments of monies – but only rehabilitation, in order to reduce "gold-digging".

Time is a compliance cost. Remediation takes time. In the case of medical misadventure – in its widest sense – the professionalism of the health system will mean that rehabilitation will be addressed immediately if possible. However, especially given the fracturing of funding and institutions, this will not always happen, and the injured may have to go through an ACC assessment. The challenge is to reduce the effect of this fracturing and provide institutions with incentives to provide practical remediation as early as possible.

B Wither Prevention?

There is potential for considerable gains in the prevention of misadventure. However because of institutional fragmentation – between ACC, the professional bodies, and the health providers – the potential of the ending of medical failure may not be realised.

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5 Recall that the Woodhouse Commission was able to offer a better deal at less cost by eliminating compliance costs imposed by litigation.

6 Brian Easton "Submission to the Review of Medical Misadventure 2003" available at <http://www.eastonbh.ac.nz> (last accessed 17 December 2004).

C What to do about Incompetent Health Professionals?

One simple step for promoting prevention would be to encourage the expert advisors to recommend measures to reduce the repetition of misadventure in the cases they review. But should they go as far as identifying potentially unsafe health professionals?

There is a finely balanced argument here. Taking the system right out of the identification of incompetent health professionals enables ACC to focus on its fundamental objectives, encourages cooperation by those involved in the case being investigated, and prevents a fault principle slipping back in. Moreover, past experience suggests that all the unsafe professionals are already known to the relevant authorities.

On the other hand, dealing with unsafe professionals is an effective form of prevention. Even more fundamentally, it would hardly be ethical for an expert advisor to identify an unsafe professional and not to make some effective comment on her or him.

Practically, consider a subsequent public enquiry into some medical misadventure, which involved an advisor having to say that in the expert's opinion a health professional was incompetent, but the expert had not mentioned that judgement in the report, or if it was mentioned, ACC had not acted on this judgement. Politics suggests this practical consideration may be decisive. How then to maintain all the benefits of the scheme? The issue becomes one of defining an appropriate threshold.

D The Line Between Entitlement and No-Entitlement

The line between medical misadventure which gives an entitlement to rehabilitation and compensation has still to be agreed. I want to make two points here.

The first is about informed consent. If an event is so rare that it was not mentioned when informed consent to the medical intervention was given, then it is surely medical misadventure. Of course there are many rare events which are mentioned when informed consent is being given, but which are medical misadventure. And sometimes the putative patient may not be advised of outcomes when informed consent is being given, which are common enough not to amount to medical misadventure. So how does informed consent relate to the definition of medical misadventure? In particular, if the patient was not advised of a possible outcome, no matter how common, are they more likely to be entitled to remediation?

The second issue is an historic one, identified at the very beginning by the Woodhouse Report. This is the inequity of the situation where sickness is treated differently from accident, even where the

outcome for the patient is the same. A similar problem applies to sickness and medical misadventure. In my paper to last year's ACC seminar,[7] I pointed out that the inequity arose because the Woodhouse proposals were funded from the reductions in compliance costs of the discarded common law system (premised on fault), but there were no such gains if the system were extended to sickness. Thus, removal of the inequity would raise a substantial fiscal cost, one which thus far the nation has been unwilling to pay. Where the medical misadventure definition is drawn will contribute to increasing or reducing this inequity, but it will not eliminate it (and it will generate compliance costs).

The problem is that the entitlement is input driven rather than outcome driven. It depends upon the path to the injury, not the destination. That generates the inequity, so let us go back and consider why the different paths for the same outcome have arisen.

IV WHY SHOULD THERE BE COMPENSATION?

The origins of the path which leads to compensation are deeply associated with the notion of fault. Compensation was justified because:

(1) it would seem inequitable that the person who caused the accident and the resulting damage should be no worse off, while the victim has to bear the damage; and

(2) it provided a market incentive to discourage individuals from causing accidents.

Thus monetary compensation is a living fossil in the New Zealand no-fault system, left over from the fault-based path, even though there is no practical implication for a person who is at fault (except sanctions under criminal law).

V FOCUSSING ON REHABILITATION

The Woodhouse Report defined rehabilitation as:[8]

> The restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable. It is a total process which begins with the earliest treatment of the injury or disease. It does not end until everything has been done to achieve maximum social and economic independence. The aim is that this should be achieved in a minimum of time.

One of the reasons for the focus on compensation was that in the past there were few possibilities for rehabilitation other than compensation. Had there been the possibility of effective rehabilitation in the

7 Brian Easton "The Historical Context of the Woodhouse Commission" (2003) 34 VUWLR 207.

8 *Woodhouse Report*, above n 1, para 354.

nineteenth century, the remediation provisions of tort law would have been rather different. As effective rehabilitation became a practical possibility, the Woodhouse Commission prioritised it over compensation.[9]

To go a step further, if there is quality rehabilitation is any compensation necessary at all? Of course the rehabilitation may include cash payments, but it involves a more comprehensive notion.

Suppose an individual's remediation was primarily rehabilitation with monetary compensation only where rehabilitation by itself was inadequate. Would the re-oriented scheme cost more or less? Any answer involves not only considering the relative costs of the two approaches, but is also dependent upon the relative effectiveness of rehabilitation strategies, which may be getting more successful with time.

VI A VISION FOR A FUTURE DIRECTION?

Crucially for the inequity between the two paths, rehabilitation is likely to be increasingly applied in the case of sickness without ACC cover. Victims will not get compensation, but compensation becomes increasingly irrelevant when there is effective rehabilitation.

Therefore, a way forward to reduce the inequity is:

(1) To accelerate the shift of remediation from compensation to rehabilitation for ACC cover.[10] It is important that this shift is not driven by the goal of reducing costs, even if this was the outcome in the long run. The big social gains would be better remediation and less inequity.

(2) To accelerate the convergence on non-ACC rehabilitation towards the level of ACC rehabilitation.

A careful reading of the Woodhouse Report suggests that were it to reconvene, the Commission would be sympathetic to such a strategy, which has become more feasible in the intervening years. In essence this is not a proposal for radical overnight change but a direction for evolution. But if evolutionary, the proposal represents a new direction – extending the original Woodhouse vision.

This paper, can be summarised by suggesting that the direction of evolution should be:

(1) Emphasising prevention;

(2) Emphasising rehabilitation and phasing out compensation; and

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9 *Woodhouse Report*, above n 1, para 2.

10 It was mentioned in the ACC conference that this possibility is well underway. Whereas once over 60 per cent of ACC expenditure was on compensation, it is now about 30 per cent.

(3) Phasing out accident as the basis of entitlement and phasing in the injury income, by providing better rehabilitation to all victims.

The end point might be the replacement of the "Accident Compensation Corporation" by the "Injury Prevention and Rehabilitation Corporation".