

Access to justice for New Zealand health consumers

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Joanna Manning
Associate Professor
Faculty of Law
The University of Auckland

The impetus for establishing the accident compensation regime in New Zealand in 1972 had nothing whatever to do with the modern patient safety agenda of wanting to dispose of medical negligence cases.¹ The overriding purpose was to give accident victims, especially workers and motor accident victims, a secure means of compensation. Later, when the system for the accountability of health professionals received intense scrutiny from the late 1980s, principally as a result of the *Cartwright Report*, the “given” of an accident compensation system enabled New Zealand to construct a unique, just, sensible and balanced system for prevention, accountability and compensation in cases of adverse events in the health system. The complaints regime, in place by 1996, has been undergoing refinements and improvements since.

We have various agencies which make up our system — a no-fault accident compensation regime, a complaints system under the jurisdiction of the Health and Disability Commissioner, a disciplinary regime which deals with a small minority of serious cases involving registered health practitioners, and a statutory tribunal that deals with an even smaller volume of complaints and which can make modest damages awards. Exemplary damages claims in court remain a rare possibility.

Today we have a system which is the envy of world leaders in the field of patient safety and medical error,² who struggle with the modest goal of introducing reforms to or alongside the

¹ There were very few medical negligence actions at the time, see P Butler, (2004) 35 VUWLR 811, p 815 n 25. The Woodhouse Report, on which the scheme was based, scarcely considered the medical negligence action as a category of the tort action at all, see New Zealand 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), paras 171 & 289(c).

² D Studdert & T Brennan, “No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention,” (2001) 286 JAMA 217; I Kennedy et al, *Learning From Bristol: The Bristol Royal Infirmary Inquiry* (July 2001) ch 26, para 35; C Vincent, “Compensation as a Duty of Care: The Case for ‘No-fault’” (2003) 12 Qual & Saf in Health Care 240, p 241. See also Professor Alan Merry and Dr Mary Seddon, leading New Zealand exponents of the system analysis, who describe the HDC as “world leading” for its focus on “addressing aspects of the system which contribute to patient harm, rather than only seeking to identify individual scapegoats when things go wrong.” A Merry & M Seddon, “Quality Improvement in healthcare in New Zealand: Part 2: Are our patients safe – and what are we doing about it?” (2006) 119 NZMJ 2086.

tort action to make it perform more adequately as a mechanism for compensating patients, doing justice between the parties, and preventing accidents in the health system. Ours is not a “no-blame” system, but I would characterise it as one of “low” blame. I consider that this is generally appropriate, because most practitioners are well intentioned and want to benefit their patients. Their mistakes, though they can devastate, even destroy lives, are for the most part unintentional. There is an important distinction between the complaints regime in the health and disability field and the criminal justice system.

Patients’ Motivations for Medico-Legal Action

The title of this paper is “Access to justice for health consumers.” What constitutes “justice” for health (and I include disability services) consumers who have suffered an adverse event? This audience will be familiar with the consistent insights offered from multiple studies across different jurisdictions as to why patients and families bring medical malpractice or other legal action after an adverse event. Patients who bring claims against doctors do not all share the same or a single motivation. A range of reasons motivates decisions to claim, although they fall into broad categories. Bismark and Dauer classified these motivations as falling into four categories:³

- *Communication*, including the desire to find out what happened to the patient and why, particularly strong where they have perceptions of being misled or of a lack of candour about what happened; wanting an acknowledgement of responsibility, including apology;
- *Correction*, such as a system change or a review of an individual practitioner’s competence to ensure that a similar incident does not happen to others in the future;
- *Accountability* and *sanction*, being a desire to see erring practitioners punished, face professional discipline or otherwise called to account; and
- *Restoration*, such as financial compensation for financial, physical and noneconomic losses, and to provide for the future care of the injured person.

These four “categories of accountability” mirror the three (often incompatible) objectives of tort law: compensation; corrective justice; and deterrence.⁴ Not all patients seek all of these outcomes; they may be interested primarily in one. Further, the studies suggest that where compensation is a reason for taking action, it may not be the exclusive or even the dominant motivation.⁵

³ See M Bismark & E Dauer, “Motivations for Medico-Legal Action: Lessons from New Zealand” (2006) 27 *Jo of Leg Med* 55 and M Bismark et al, “Accountability Sought by Patients following Adverse Events from Medical Care” (2006) 175 *CMAJ* 889, p 890.

⁴ For the tort action’s performance on these four fronts, see J. Manning, “New Zealand’s remedial response to adverse events in healthcare,” (2008) 16 *Torts Law Journal* 120-155.

⁵ For example, Bismark’s study of New Zealand patients found that of patients or relatives who complained to the Health and Disability Commissioner after an adverse event, only a quarter (25.6 percent) also made a claim for monetary compensation. Those who complained to the Commissioner were primarily interested in correction (approx 50 percent) and in securing an explanation of the events that led to their injury (40 percent), see M Bismark et al, “Accountability Sought by Patients following Adverse Events from Medical Care” (2006) 175 *CMAJ* 889, p 891. See also G Hickson, “Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries” (1992) 267 *JAMA* 1359, 1361 (families filed suit because they needed the money

No system can fulfil all of these objectives or interests to the maximum extent in a single case. It is inevitable that in individual cases one motivation or objective is frequently inconsistent with one or more of the others. They are in tension. One objective must be given priority over another or the others, and the extent to which all can be achieved is a matter of balance. In “tort” countries, these motivations are addressed primarily in a single remedy, the medical negligence action for damages. In such an action, compensation is limited by the overriding need to find a defendant at fault, and deterrence is seldom explicitly pursued by a court, but is rather assumed to have been addressed (if at all) as a sort of by-product or consequence of the action.⁶

In New Zealand we have two separate tracks or pathways designed to redress patients’ interests. The compensation role has been met by a state-funded compensation scheme since 1974. (It may also go some way towards meeting a patient’s communication interest).⁷ The other motivations are designed to be fulfilled principally by an independent complaints regime (the Health and Disability Commissioner), supplemented by professional discipline, a Human Rights Review Tribunal (HRRT), and residual claims for exemplary damages. New Zealand has managed to reduce the tension between compensation and accountability, by separating the compensation system from the complaints and disciplinary regimes, and removing fault-finding from the Treatment Injury head of accident compensation cover. Tensions between the objectives still occur, for example between fault-finding (in terms of Code breaches) in HDC investigations into complaints and contributing to the safety agenda. But I would claim that our system offers much better opportunities to maximise attainment of each objective and finding the optimal balance.

in only 24% of cases); C Vincent et al, “Why do People Sue Doctors A Study of Patients and Relatives Taking Legal Action” (1994) 343 *The Lancet* 1609 (explanation and apology referred to by plaintiffs in medical negligence litigation as wanted twice as often as compensation); G Hickson, “Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries” (1992) 267 *JAMA* 1359 (compensation the reason for malpractice suit in only 24% of cases).

⁶ In fact, what evidence there is suggests that the deterrent signal due to malpractice litigation is weak, see M Mello & T Brennan, “Deterrence of Medical Errors: Theory and Evidence” (2002) 80 *Tex L Rev* 1595, pp 1615-1623. See also, D Studdert et al, “Defensive Medicine among High-Risk Specialties in a Volatile Malpractice Market” (2005) 293 *JAMA* 2609; D Studdert et al, “Medical Malpractice,” (2004) 359 *NEJM* 283, and M Mello et al, “Who pays for medical errors? An analysis of adverse event costs, the medical liability system, and incentives for patient safety improvement,” (2007) 4 *JELS* 835.

⁷ ACC is obliged to give notice of its decisions in writing with reasons, see s 64(4) of the Accident Compensation Act 2001. (Note: the Injury Prevention, Rehabilitation and Compensation Act 2001 was renamed the Accident Compensation Act 2001 as from 3 March 2010, by the Accident Compensation Amendment Act 2010, s 5). In practice this means that, when ACC determines a Treatment Injury claim, the claimant receives a letter, indicating: what information ACC considered in determining the claim, whether the claim has been accepted or declined, brief reasons for the decision, and information about review rights. In complicated claims where ACC has sought external clinical advice and the claim has been assessed by the Complex Claims Panel, the claimant would generally also receive a copy of the external clinical advisor’s report. Information provided March 2010 by R Taylor, Team Manager, Reporting Team, ACC Treatment Injury Centre.

In considering health consumers' access to justice, I will be making some comments about addressing patient's remedial interests in terms of communication and accountability. I shall concentrate on the HDC, as the primary vehicle for meeting these interests. In the second part, I shall consider the restoration and compensation interest and accident compensation.

One point I wish to make is that when we consider changes to our system, whether it be to make changes to the HDC regime to increase access to justice for consumers and their families, or to tighten up access to accident compensation cover or compensation, we need to consider the impact any such changes might have on the system as a whole — how the compensation regime interacts with the complaints regime, for example, and vice versa. In addition, having developed such a sensible and good system, we need to be alert to threats to it. I believe the system could well be placed under significant strain resulting from planned changes to the compensation regime.

The HDC's complaints regime

Before considering possible changes to enhance access to justice for consumers, a brief description of the complaints regime is necessary. When a complainant makes a complaint, the Commissioner has a variety of dispute resolution mechanisms available, both formal and less formal. No further action will be taken on some complaints, such as where the Commissioner considers that is “unnecessary or inappropriate,” or where the Commissioner is satisfied that there is already an adequate remedy.⁸ Less serious complaints may be dealt with by the alternative disputes resolution procedures provided for in the Act (patient advocacy and mediation),⁹ or by referring the complaint back to the provider to resolve with the complainant in appropriate cases.¹⁰ The Commissioner can also refer a complaint to other agencies, such a practitioner's registration authority for a competence or fitness to practice review, a confidential process the aim of which is primarily rehabilitative.¹¹ A minority of complaints are formally investigated by the HDC, as opposed to being resolved through low-level means (advocacy, mediation) or referred to other agencies. These are complaints involving potentially major breaches of the Code of Rights, such as allegations of sexual impropriety and of significant lapses in that resulted in death or significant disability. At the conclusion of the investigation the Commissioner almost invariably¹² delivers a formal “opinion,”¹³ which includes any attribution of culpability to the provider in the form of a finding of breach of the Code of Rights. Sanctions for breach, in the form of

⁸ See Health and Disability Commissioner Act 1994 (HDCA), s 38.

⁹ The Commissioner may refer the complaint to an advocate for the purpose of attempting to resolve the complaint between the parties by agreement, see HDCA, s 42; the Commissioner may decide it appropriate for the complaint to be referred to mediation in an endeavour to resolve the matter by agreement between the parties, see s 61.

¹⁰ See HDCA, s 34(1)(d). Complaints that are able to be referred to the provider to resolve are limited to those that do not “raise questions about the health and safety of members of the public”.

¹¹ See HDCA, s 34(1)(a).

¹² Occasionally the Commissioner will conclude an investigation less formally through a letter to the parties, particularly if no breach of the Code is found.

¹³ So-called because it is the term used in the Act, see s 45.

recommendations, are almost always non-punitive. The Commissioner has no power to order damages for Code breaches, though he is able to recommend reimbursement of fees.

After finding a provider in breach of the Code, the Commissioner can decide to refer a provider to a separate prosecutorial officer, the Director of Proceedings (DP), with an independent discretion to consider whether to institute further proceedings, either professional discipline for registered practitioners or civil proceedings in the Human Rights Review Tribunal (HRRT), or both.¹⁴ The DP can initiate civil proceedings before the HRRT against a provider referred by the Commissioner.¹⁵ It determines afresh whether the provider has breached the Code of Rights. This avenue is particularly relevant for non-registered providers, for whom it is the only alternative for further action, as there is no disciplinary tribunal with jurisdiction over them. It is also a possibility for organisations (such as DHBs) for the same reason. Unlike the Commissioner, the HRRT does have a power to award compensatory and exemplary damages for breaches of rights in the Code.¹⁶ In practice, that jurisdiction is seldom exercised, because the Tribunal cannot award damages (other than exemplary damages) where a complainant or other aggrieved person has suffered personal injury covered by the accident compensation scheme.¹⁷

The Office interprets its statutory purpose (“fair, simple, speedy, and efficient resolution”) as to resolve complaints at the lowest level consistent with fairness and its protective function. There is a tension here, and a balance to be struck: resolution by advocacy or mediation may not be appropriate for serious cases or for complaints apparently raising public health and safety or significant competence concerns, or allegations of sexual impropriety, which are more likely to be investigated and may result in referral to the DP. Ultimately, rights promotion and protection is the Act’s principal purpose, and the statutory injunction is to achieve “fair,” as well as “simple, speedy, and efficient” resolution.¹⁸

Unrestricted or less restricted access to the Human Rights Review Tribunal? Access to investigations?

Under the Health and Disability Commissioner Act 1994 (HDCA) there is currently quite restricted access by complainants and the aggrieved person¹⁹ to the HRRT. It is to be

¹⁴ The statute permits, and it is not unheard of for the DP to pursue both disciplinary charges and civil action before the HRRT in respect of the same health practitioner, after an HDC investigation, see HDCA, s 45(2)(f) and s 49(1)(a).

¹⁵ For a discussion of the HRRT jurisdiction by the former Director of Proceedings, see T Baker, “Human Rights Review Tribunal: The role of the tribunal in upholding the rights of consumers of health and disability services in New Zealand,” (2009) 16 JLM 85.

¹⁶ See HDCA, s. 57(1). The maximum amount of an award is \$200,000.

¹⁷ See HDCA, s. 52(2).

¹⁸ See long title and s 6 of the Health and Disability Commissioner Act 1994.

¹⁹ When used separately from references to “the complainant” in the HDCA, the term “aggrieved person” refers to the consumer in respect of whom a Code breach is alleged or has been found, but who has not made a complaint to the HDC, as distinct from those complaints where the complainant and the consumer are the same person. The HDC refers to these as “third party complaints”.

remembered that the Tribunal is the only body that can make a damages award upon a finding of breach of the Code. That restricted access arises for three reasons: because of the interpretation of s 57(1)(c) of the Act by the Court of Appeal in *Marks v Director of Health and Disability Proceedings*;²⁰ because of the effect of s 52(2) of the HDCA; and thirdly, because of the “gatekeeper” role the Commissioner has been assigned under the Act in respect of access to the HRRT (and the disciplinary process before the HPDT, for that matter).

I shall take the *Marks* and the s 52(2) restrictions together. The current position is as follows: where the Commissioner makes a “breach” finding after an investigation and decides not to refer a provider to the Director of Proceedings (DP), or the DP declines to take further action after a Commissioner referral the DP, s 51 of the Act permits “the aggrieved person” to bring civil proceedings before the HRRT. The remedies the HRRT may grant include damages awarded to “the aggrieved person” for *inter alia* “humiliation, loss of dignity, and injury to feelings” (s 57(1)(c)). The term “aggrieved person” is not defined in the Act. The DP’s understanding was that the term included complainants in third party claims, such as family members of the consumer, and there was some judicial support for the interpretation.²¹ In 2009 in *Marks* the Court of Appeal reversed a more liberal decision of the High Court consistent with the DP’s understanding and practice, and held that the term “aggrieved person” is limited to consumers who have rights under the Code (with two exceptions).²² The DP had brought a civil action before the HRRT on behalf of the parents of a man who had died of self-inflicted injuries, seeking a declaration of a breach of the Code by a consultant psychiatrist when providing care to their son. Damages of \$40,000 were sought for their injured feelings. The Court held that the parents were not “aggrieved persons” under the Act, which term was confined to consumers whose Code rights are alleged to have been breached.

The effect is that proceedings before the HRRT can only be brought by or on behalf of consumers in respect of whom the Commissioner has made a “breach” finding, and damages awards can be made only to or for the benefit of them. In general, family members and other third parties cannot bring an action before the HRRT in their own right.

Marks has the unfortunate consequence of restricting the already tightly restricted access to the HRRT by complainants and consumers still further. Consumers’ access is in practice restricted already by the effect of the HDCA’s self-contained bar provision (s 52(2)),²³ since

²⁰ [2009] 3 NZLR 108 (CA).

²¹ See *Director of Proceedings v O’Neil* [2001] NZAR 59 (HC), where the Court awarded damages to both parents of a deceased baby as “aggrieved persons”, when only the mother had been a consumer of midwifery services.

²² These were: first, that the fathers of babies in obstetric cases may be “derivative consumers in their own right and thus aggrieved persons under the Act” (*Marks*, para [61]); and that executors and administrators could claim on behalf of deceased consumers, but not in their own right (para [69]).

²³ Section 52(2) provides that where a person has suffered personal injury within the meaning of the applicable accident compensation legislation, no damages (other than punitive damages) arising directly or indirectly out of that personal injury may be sought by or on behalf of that person in any HRRT proceedings under s 50 or s 51, or awarded to or for the benefit of that person in any such proceedings.

most consumers, in the serious cases considered for referral or referred to the DP, will have suffered personal injury covered by the ACC scheme, and so no damages award can be made (except for an award of punitive damages).²⁴ HRRT proceedings are realistically only available to consumers who have suffered no physical injury. So, while consumers with accident compensation cover could take HRRT proceedings after a “breach” finding, there is little point and usually nothing further to gain, balanced against the cost and effort, in them doing so. The Court of Appeal itself suggested in *Marks*, despite its restrictive interpretation, that the overall statutory consumer rights protection and promotion purpose of the Act could well be enhanced by allowing secondary victims, particularly family members and those with a close association with the consumer, to have direct access to the HRRT and to be eligible for awards of damages, given the effect of s 52(2):²⁵

“The Act therefore may have contemplated that allowing a group with a close association to health consumers, as well as health consumers themselves, to claim damages could promote and protect the rights of health consumers, by giving a wider group an incentive to bring health professionals to account for breaches of the Code.”

In the 2009 *Review* of the Act and Code the Commissioner agreed that the effect of *Marks* makes access to the HRRT overly restrictive and supported its legislative reversal. He recommended doing so by the simple means of substituting the term “aggrieved person” with the phrase “the complainant (if any) or the aggrieved person (if not the complainant)”, where it appears in sections 50 to 58. This would leave the *Marks* definition of “aggrieved person” in force, but allow complainants in third party complaints, who are not the “aggrieved person” in the restricted *Marks* sense, access to the Tribunal and damages awards. He considered that the change would promote accountability and quality improvement, and would not lead to a flood of claims.²⁶ Such a change would import the judicial definition of “complainant” under the HRA into the HDC regime. In *A-G v Human Rights Review Tribunal & CPAG* Miller J held that the term “complainant” is to be given its natural and ordinary meaning, distinct from “the aggrieved person”, as meaning someone who has complained to the Commission under the Act.²⁷

But would this change go far enough? Assuming now that *Marks* is reversed, I come to the Commissioner’s role as “gatekeeper” of access to the HRRT. A Commissioner investigation is a prerequisite to HRRT proceedings. It is the only route by which complainants and consumers can access HRRT proceedings and seek damages awards. Further, HRRT proceedings brought by the aggrieved person are conditional on: a “breach” finding after the investigation in respect of the provider(s); and either no Commissioner referral of the provider(s) to the DP; or (where the Commissioner has made a referral), the DP has declined to take such proceedings. If the Commissioner decides to take no action on a complaint, or declines to undertake an investigation, or makes a “no-breach” finding after an investigation, neither the consumer nor the DP is able access the HRRT and (potentially) damages.

²⁴ Neither the DP nor any consumers have brought proceedings seeking punitive damages only in cases caught by s 52(2).

²⁵ [2009] 3 NZLR 108 (CA), para 13.

²⁶ See the *Report*, p. 11.

²⁷ HC Wellington, CIV 2006-485-1713, 6 November 2006, Miller J, paras [56]-[57].

We can compare this with the procedures for the complaints regimes under both the Privacy Act 1993 (PA) and Human Rights Act 1993 (HRA), the other two jurisdictions which access the HRRT. Of the three, the HRA is the most liberal in terms of complainant/aggrieved person's access to the HRRT, and the HDCA is the most restrictive.

The complaints procedure under the PA is most similar to that under the HDCA, except that the statutory emphasis is even more firmly on the conciliation of complaints. The Privacy Commissioner is enjoined to encourage the settlement of complaints by agreement and secure assurances against the repetition of "interferences with privacy."²⁸ As under the HDCA, HRRT proceedings can only be brought, either by the Director of Human Rights Proceedings or the aggrieved person personally, *after* a Privacy Commissioner investigation, no matter how brief. The reason is because the Privacy Act encourages alternative dispute resolution as provided by the Commissioner's investigations and procedures. If the Privacy Commissioner decides to take no action on a complaint,²⁹ a complainant cannot then bring proceedings. After an investigation, the Commissioner forms an "opinion" whether an "interference with the privacy an individual" has occurred, in which case s/he must again attempt to secure a settlement and assurance against repetition. Only if unable to do so, or a term of a settlement or assurance has not been complied with, can the Privacy Commissioner refer the matter to the Director of Human Rights Proceedings for the purpose of the latter deciding whether to institute proceedings before the HRRT. The "aggrieved individual" can bring proceedings personally before the HRRT only if:³⁰

- (1) The Privacy Commissioner decides that the complaint has no substance i.e. that there has been no interference with privacy;³¹
- (2) The Commissioner decides there has been an interference with privacy but decides not to refer it to the Director;
- (3) The Commissioner has referred it to the Director, and s/he agrees to the individual bringing proceedings; or
- (4) The Commissioner has referred an interference with privacy to the Director, but the Director decides not to take proceedings.

The striking difference is that under the PA regime an aggrieved person can bring HRRT proceedings after a Privacy Commissioner opinion that the complaint has "no substance" (no 1 above), whereas under the HDCA an aggrieved person has no right to bring HRRT proceedings personally after a Commissioner "no-breach" opinion.

The HRA is much less directive of the parties to a complaint than either the PA or the HDCA. Under the HRA there is virtually unrestricted access by *both parties* to the HRRT. As

²⁸ An "interference with privacy" is defined in s 66 as breach of an Information Privacy Principle (IPP) *plus* an adverse consequence to the complainant (such as emotional harm). The exception to this is IPP 6 (access), where the breach of that principle alone is enough to amount to an "interference with privacy."

²⁹ See s 71 of the Privacy Act 1993. The grounds are the same as under s 38 HDCA.

³⁰ See s 83 of the Privacy Act 1993. The Privacy Act procedure also presumably suffers from the *Marks* interpretation, and would require amendment to ensure that complainants, as well as the victims of an interference with privacy, could bring HRRT proceedings and receive damages awards under s 88(1)(c).

³¹ Most complainant-initiated proceedings result from situations where the Privacy Commissioner has found that there is no interference with privacy.

Miller J noted in the *CPAG* case, the legislative history of the HRA indicates that the Legislature has attached greater importance over time to “private enforcement” through HRRT proceedings,³² compared to the PA or the HDCA. Where a complaint has been made, there is a general right for the complainant, the person aggrieved (if not the complainant), and the person against whom the complaint is made (as well as the Commission) to bring proceedings before the HRRT for breach of Part 1A or Part 2 of the HRA. In particular:³³

- (1) The complainant or aggrieved person has the right to bring HRRT proceedings where the Human Rights Commission declines to take action on a complaint (s 80(4)). Neither can do so under the HDC process;
- (2) Where the Commission has attempted to facilitate the resolution of a complaint between the parties by providing dispute resolution services, and no settlement³⁴ is reached, either party may take HRRT proceedings. There is no such ability after advocacy or mediation, for example, under the HDC procedures;
- (3) Either party can bring HRRT proceedings to enforce a settlement;
- (4) A party can decline to participate in the HRC’s dispute resolution services and bring HRRT proceedings instead, though that party is in jeopardy of having the Director of Human Rights Proceedings reject their application for legal representation, and the Director or HRRT are able to refer the proceedings back to the Commission for an attempt at resolution by settlement.

In addition, since the 2001 Amendment the Director of Human Rights Proceedings only ever provides *representation* to the complainant, aggrieved person, or group of persons before the HRRT and only *on their request* (s 90(1)(c)), although s/he is not obliged to do so. HRRT proceedings do not lie at the suit of the Director, who can never be a plaintiff, unlike under the PA or HDCA. The complainant or aggrieved person is free to take proceedings themselves (albeit at their own cost). Under the HDC process, it is the other way around; the DP must first decline or fail to take proceedings in his or her own right as plaintiff, before the aggrieved person can do so (s 51(b)) (unless there is a “breach” finding and no DP referral). Overall, the process of a complaint is much more within the control of the complainant or aggrieved person under the HRA, whereas under the HDCA, the process is very much more controlled by the Commissioner.

What might be the reason(s) for these differences in access to the HRRT in these three closely related statutes, passed within a year of each other? Are there principled justifications? And relatedly, should access to the HRRT under the HDCA be more generous, as it is under the HRA (and even the PA), or at least less restricted than it is now? All three pieces of legislation seek to encourage complaints to be resolved early by conciliatory means and agreement, though to different degrees. Perhaps the key difference is that the function of the HRC does not include conducting investigations of complaints. There is no equivalent to an HDC or PA investigation under the HRA. In so far as a complaint is made, the functions of the HRC are restricted to providing information and offering services designed to facilitate

³² See *A-G v Human Rights Review Tribunal & CPAG* HC Wellington, CIV 2006-485-1713, 6 November 2006, Miller J, para [47]. See also for example, s 80 of the HRA, which states that the HRC may only take action on a complaint if the complainant or aggrieved person informs it that s/he wishes to proceed with the complaint.

³³ See s 91 and s 92D of the Human Rights Act 1993.

³⁴ Settlement is defined in s 83(3) as agreement of the parties concerned on actions to settle the matter and a satisfactory assurance by the person to whom the complaint relates against repetition of the conduct.

resolution by settlement.³⁵ Given that there is no possibility of a complaint being investigated by the HRC, there is arguably good reason for the parties to have greater access to the HRRT for an authoritative determination of their rights. That interest can be met under the other two complaints regimes by a Commissioner investigation. Reasons for the inconsistency between the PA and the HDCA are less clear, however. Perhaps an argument could be advanced that civil proceedings before the HRRT are the only way an aggrieved person of an “interference with privacy” can access any form of compensation and so access should be more generous, whereas the compensation interest is served for many HDC consumers through the separate process of an accident compensation claim.

A cynic might suggest that the generosity of party-initiated access to the HRRT may be in inverse proportion to the extent that the Legislature contemplated that the public might utilise it. Under the HRA parties always have the option to take these matters to the Human Rights Review Tribunal with or without the assistance of the Office of Human Rights Proceedings, but the figures demonstrate that they rarely do. Similarly under the Privacy Act, the numbers of complainant-initiated proceedings before the HRRT are still manageable,³⁶ whereas there may have been a legislative concern that too liberal access might result in a flood of cases to the HRRT from the HDC regime.

Where a complainant makes a complaint, and the Commissioner decides to take no action or further action under s 38(1), or to refer it back to the provider for resolution directly with the complainant under s 34(1)(d), should a dissatisfied complainant or consumer be able to access the HRRT directly? Most DHBs have developed good complaint processes and are getting better at investigating complaints, so an increasing number of complaints about DHBs that come to HDC in the first instance are being referred back to them to resolve themselves, working with the consumer.³⁷ An example is a case where there has been an adverse event in a public hospital; either a patient complaint to the DHB, or to the HDC and a referral back to the DHB; and the DHB has convened an independent panel to conduct an investigation and write a written report, in which findings identifying sub-standard care and systemic deficiencies have been made and changes recommended to try to prevent a recurrence. In the event of an HDC complaint the Commissioner may well consider that there is insufficient to be gained by repeating an investigative process. A “no further action” decision may well be made.

³⁵ The Complaints Division’s ability to conduct an investigation was removed by the 2001 Amendment, and replaced with an HRC with the more restricted functions of providing information to the public who have questions about discrimination and facilitating the resolution of disputes about compliance with Parts 1A or Part 2 by the parties concerned, in the most efficient, informal and cost-effective manner possible, see s 76(1) of the HRA.

³⁶ There was, however, an unusually high number of new proceedings in 2009, when 25 complainants personally filed new cases in the Tribunal, to add to the Director’s four. Complainants filed 12 cases on their own account in the Tribunal in 2008; and 18 in 2007. Figures sourced from Privacy Commissioner Annual Reports for years ended 30 June 2009, 2008 and 2007. The party complained about cannot bring proceedings under the PA.

³⁷ Information provided by HDC. The DHB has to work with the consumer to resolve the complaint and report back the outcome to the HDC, see s 35(c).

If access were extended to such a case, one could perhaps stop there, the justification being that the consumer has not had some kind of HDC process in these situations, and HRRT proceedings are an appropriate substitute. But, if access to the HRRT was opened up in these situations, a convincing argument could be mounted that it should follow that the right to take HRRT proceedings should be extended also to dissatisfied complainants/consumers: where the Commissioner has agreed to take action on a complaint but has declined to conduct an investigation under s 40 (currently, the majority of complaints); and where the complaint has been investigated and a “no breach” finding made (as under the PA). If the latter were accepted, fair and even-handed treatment could well dictate that providers dissatisfied with “breach” findings should be given the right of access to the HRRT.³⁸ This has been resisted to date because of its potential to become a sort of *de facto* appeal mechanism, all of which would seriously threaten the early and less formal resolution focus of the Act.³⁹

Despite the current inconsistency, I do not, however, advocate replicating the unrestricted access to the HRRT under the Human Rights Act for HDC complaints. Instead, I support investigating ways of strengthening complainants’ and consumers’ access to investigations under the HDC procedure. I am personally less concerned about restricted access to the HRRT by complainants and consumers than restricted access to HDC investigations. As between HDC investigations and HRRT proceedings, I favour investigations for access reasons – they do not involve a transfer of costs from the HDC to the parties (in cases where the DP has declined to take the proceedings) — and as being more in keeping with the statutory focus of less formal, less legal, lower-level resolution.

The HDC has been open about the trend in recent years for it to undertake fewer investigations (in terms of absolute numbers and as proportion of investigations of complaints received) — down from 538 of 1,338 (40% of complaints resolved) in Commissioner Paterson’s first full year of office, to 7, 8 and 8% in 2007, 2008, and 2009 respectively).⁴⁰ This is not been attributable to steadily increasing complaint volumes over the decade, because complaint numbers were about the same in 2001 as in 2009.⁴¹ It has instead been driven by two factors. First, investigations are the most formal and “legal” of the HDC’s resolution processes, and as such are relatively time-consuming and resource-intensive. Commissioner Paterson appears to have given priority during his term to reducing

³⁸ I note that, however, under the Privacy Act 1993 the person against whom the complaint is made cannot bring HRRT proceedings if dissatisfied with a Commissioner “opinion” that the complaint has substance.

³⁹ The Cull Report recommended extending access to the HRRT where the Commissioner had made a “breach” finding after investigation, and not referred the provider(s) to the DP, but did not consider or recommend that proceedings could be brought in “no-breach” cases or by providers after “breach” findings, see H Cull, *Review of Processes concerning Adverse Medical Events* (March 2001). The recommendation was implemented by amendment to s 51 in the Health and disability Commissioner Amendment Act 2003.

⁴⁰ The number of investigations completed each year for the last 10 years are: 538 investigations concluded of 1,338 complaints resolved during the year in the year ended 30 June 2001 (40%); 234 of 1,299 in 2002 (18%); 345 of 1,338 in 2003 (26%); 178 of 1,162 in 2004 (15%); 172 of 1,158 in 2005 (15%); 116 of 1,110 in 2006 (10%); 89 of 1,273 in 2007 (7%); 100 of 1,295 in 2008 (8%); and 112 of 1,378 in 2009 (8%).

⁴¹ 1,397 new complaints were received during the years ended 2001 and 1,360 in 2009. There were 1,211 in 2002; 1,159 in 2003, 1,142 in 2004, 1,124 in 2005, 1,076 in 2006, 1,289 in 2007, 1,292 in 2008.

both the backlog of “old” investigations and the average time taken to resolve complaints,⁴² through a policy of reserving investigations for increasingly serious cases. The second reason is a conviction, based on the Office’s experience, that “early resolution is usually considered in the best interests of both complainant and provider, [and so] fewer cases are concluded by formal investigation.”⁴³

Thus “only the most serious matters” of the following kind are likely to be investigated:⁴⁴

... potentially significant breaches of ethical boundaries, and major lapses in standards of care that have resulted in death or severe disability. Public safety concerns, the need for accountability, and the potential for the findings to lead to significant improvement in health and disability services, are also reasons why a complaint may be formally investigated.

An investigation can also be useful, where the provider has shown little insight into their failings and that changes are needed.

It is this second assumption – that early and less formal resolution is usually in the best interests of both complainant and provider — which may be open to question. It is hard for an outsider to measure the extent to which complainants and consumers themselves agree with this assessment of their best interests. The HDC cited complainant dissatisfaction about being denied an investigation as one reason for lower levels of satisfaction by complainants with the process than providers in the 2009 satisfaction survey.⁴⁵

The most valuable resource the HDC has are its complainants, because they are the means by which potentially unsafe practitioners can be identified and something done to rehabilitate them, or in the worst cases to stop them practising to protect the public. The system needs to be consumer-friendly, and provide no disincentive to them to make an initial complaint. The fact that the system is free, efficient, confidential, largely lawyer-free and relatively informal are important advantages over the civil damages action.

I suspect that if I or a family member had an adverse medical event resulting in death or serious injury and I had serious concerns about the standard of care, I would not be satisfied unless there was a thorough investigation, followed by an official, written Health and Disability Commissioner’s report that stated what happened, what went wrong and why, who was involved and adjudged responsible (if that were thought the case), that incorporated an expert clinical opinion if appropriate, and what remedial action was to be taken. It would be a serious document kept in our important papers for current and future generations that would be part of my family’s ongoing story.

⁴² There were over 600 open files, including over 400 investigations, when the second Commissioner, Ron Paterson, assumed office in March 2000, see R Paterson, “Moving on from HDC”, NZ Doctor, March 2010. The average time taken to resolve complaints has decreased from an average of 44 weeks in June 2000, with 37% of complaint files still open after a year, compared to the situation in 2009 where 87% of HDC complaints are resolved within 6 months and 96% within 12 months, most within a few weeks, see HDC Annual Reports 2001 and 2009.

⁴³ See Annual Report 2006, p 1.

⁴⁴ 2009 Annual Report, p 6; see also 2008 Annual Report, p 5.

⁴⁵ HDC, Annual Report for the year ended 30 June 2009, p 7.

And so I consider that Ronald Young J's characterisation in a recent judicial review case of a Commissioner "breach" opinion as "just that, an opinion not directly affecting the legal rights or liabilities of the health care provider"⁴⁶ while arguably legally accurate,⁴⁷ misses something essential about the significance of a Commissioner decision. The Judge did admittedly go on to accept that "health care providers do treat any negative opinion by the Commissioner as significant ... given the high standing of the Commissioner and the understandable desire of the health care providers to guard their reputations closely."⁴⁸ But this leaves out altogether the significance of the Commissioner's opinion *to complainants and consumers* in addressing their remedial interests. It is the official standing and the high status of the Commissioner that counts; the fact that it is an official adjudication by the Commissioner, who holds this statutory, government-appointed, independent, consumer protection office, that imbues the decision with special legitimacy and significance, in addressing the remedial interests of patients, particularly that of accountability.

In summary, apart from reversing *Marks*, I am so far unpersuaded of the case for opening up access to the HRRT to match access under the HRA or even the PA. Nor am I advocating a statutory right to an investigation, even in the sorts of serious cases I have described. That would be too inflexible, and I do agree that it is a question of balance. One way forward may be to consider developing and consulting on a policy, stating guidelines structuring the Commissioner's discretion in s 40(1) as to when an investigation is undertaken, in similar fashion to the Commissioner's Naming Policy and Guidance about Open Disclosure Policy.⁴⁹ Such a policy would be transparent; complainants would know what to expect, and could address themselves to the relevant criteria in their communications with the Commissioner; and they could seek review by the Ombudsman in terms of the criteria if dissatisfied.

Some will no doubt consider this suggestion too modest. In any event, however, it seems a good point in the process of evolution of the HDC to consider these issues, so that there can be debate and collaboration over what are quite difficult issues.

Restoration and compensation: accident compensation

More than thirty-five years ago New Zealand passed legislation replacing the negligence action for damages for personal injury with a state-run, no-fault accident compensation scheme. Underlying the scheme is a social contract between the people and the government in early 1970s. In exchange for cover and access to statutory entitlements under the scheme, the people agreed to surrender their right to sue for personal injury covered by the scheme

⁴⁶ See *S v Health and Disability Commissioner* HC Wellington, CIV 2009-485-2146, 8 February 2010, Ronald Young J, para [35].

⁴⁷ Ronald Young J refers to the Commissioner's "opinion" because of the reference to the Commissioner's "opinion" in a number of places in s 45 of the Act. He concluded that the Commissioner has "no authority to take any action affecting health care providers' rights or liabilities" (para [33]), because "any action for a breach of the Code are referred to others to enforce" (para [30]).

⁴⁸ *Ibid*, para [34]. Emphasis added.

⁴⁹ See HDC, *Naming Policy* (1 July 2008); HDC, *Guidance on Open Disclosure Policies* (December 2009).

and access to court-ordered damages awards.⁵⁰ This included patients injured or who died as a result of Medical Misadventure, as the head of cover was first called.

A fundamental problem that has beset the scheme since 1974 is that it has not been politically sacrosanct, despite appeals to the underlying social contract. Instead, as a government scheme financed through levies and taxation,⁵¹ it has been vulnerable to changing ideologies and political interference. A fundamental problem has been to achieve bipartisan consensus about levy-setting and entitlements. How to solve this key challenge remains elusive.

And so, in 1992, as part of moves aimed at reducing costs by restricting cover and eligibility for compensation, Medical Misadventure was defined as meaning personal injury resulting from either “medical error” or “medical mishap.”⁵² The definition of Medical Error essentially incorporated the “fault” concept from common law negligence.⁵³ Non-negligent errors in the course of treatment were only covered if they met the stringent requirements of Medical Mishap.⁵⁴ The legislation also significantly reduced compensation levels, notably

⁵⁰ The Accident Compensation Act 2001, s 4 referred to “the social contract” for the first time in its purpose section, as follows: “The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury ...” The purpose of this reference was to reaffirm the original five guiding principles of the Woodhouse Report, see New Zealand 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) (the Woodhouse Report). Even before, the courts had recognised the social contract, see *Queenstown Lakes District Council v. Palmer* [1999] 1 NZLR 549 (CA), p 555; *Brightwell v ACC* [1985] 1 NZLR 132 (CA), pp 134 per Cooke J.

⁵¹ The Treatment Injury Scheme is funded by ACC levies, a proportion paid by New Zealanders in paid employment (approx 55 % of Treatment Injury costs) and by a proportion of the levy paid by the government out of taxation for those not in paid employment (45% of costs), see *ACC Background Paper: Comparison of International schemes that Compensate for Medical Injury* (Wellington: Department of Labour & Accident Compensation Corporation, August 2003), p 8. The Act allows for funds to be derived from a levy paid by registered health professionals and organisations (s 230), but this provision has never been applied.

⁵² See Accident Rehabilitation and Compensation Insurance Act 1992, s 5(1).

⁵³ Defined as “the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances”, see Accident Rehabilitation and Compensation Insurance Act 1992, s 5(1); Accident Insurance Act 1998, s 36(1); Accident Compensation Act 2001, s 33(1).

⁵⁴ It covered adverse consequences of medical treatment *properly* (as opposed to negligently) given, which met extremely stringent statutory tests for “rarity” and “severity.” An adverse consequence of treatment was “rare” “only if the probability is that the adverse consequence would not occur in more than one percent of cases where that treatment is given.” Limited flexibility was introduced in 2001, when a new provision allowed a different rarity level to be specified in regulations in relation to a particular kind or kinds of treatment, see the former Injury Prevention, Rehabilitation and Compensation Act 2001, s 34(4). Adverse consequences of treatment were “severe”, only if they resulted in death, hospitalisation as an inpatient for 14 days, or significant disability,

abolishing lump sum compensation for permanent physical impairment and for pain and suffering.⁵⁵ Dissatisfaction at the “leaner and meaner” scheme generally, especially the abolition of lump sums, but also the more restricted nature of Medical Misadventure, stimulated a substantial increase in common law cases in personal injury, in particular for exemplary damages, during the mid to late 1990s.⁵⁶ Some plaintiffs sought damages to supplement what they perceived as inadequate compensation entitlements. Quite some number of these were in medical cases.⁵⁷

Even though Medical Misadventure claims comprised a very small percentage of all injuries accepted under the ACC scheme,⁵⁸ they caused disproportionate difficulty and took considerably longer on average to resolve.⁵⁹ It was a problematic head of cover and attracted considerable criticism. The move to Treatment Injury in 2005 removed the need to prove fault on behalf of a registered health professional for the purposes of cover and repealed the unfairly restrictive concept of Medical Mishap. The move was widely supported by both patients’ and health professionals groups, and was undoubtedly positive. Henceforth, cover extended broadly to personal injury suffered by a person seeking or receiving treatment from or at the direction of a registered health professional(s), which is caused by that treatment.⁶⁰ All adverse medical events resulting in physical injury, preventable and unpreventable, are potentially covered. The philosophy underlying the new Treatment Injury provisions is the internationally influential “system” approach to medical accidents, with its patient safety

which lasted more than 28 days, or the claimant qualified for an independence allowance. See Accident Rehabilitation and Compensation Insurance Act 1992, s 5(1) and (2).

⁵⁵ In favour of a modest independence allowance, see Accident Rehabilitation and Compensation Insurance Act 1992, s 54.

⁵⁶ See J Miller, “Trends in Personal Injury Litigation: The 1990s” (2003) 34 VUWLR 407 and A Duffy, “The Common Law Response to the Accident Compensation Scheme” (2003) 34 VUWLR 367.

⁵⁷ See for example, the litigation brought by Patient A against Dr Bottrill, culminating in *A v Bottrill* [2003] 1 AC 449 (PC); also *Ellison v L* [1998] 1 NZLR 416; *Harris v McIntosh* [2001] 3 NZLR 721; *Brownlie v Good Health Wanganui Ltd* [2005] NZAR 289 (10 December 1998); *van Soest v Residual Health Management Unit* [2000] 1 NZLR 79; *Owen v Residual Health Management Unit* [2000] 3 NZLR 475.

⁵⁸ As at December 2002 Medical Misadventure comprised only 0.05% of all injuries accepted under the scheme, at a total cost of \$128 million, see *ACC Background Paper: A Comprehensive Study of the Cost of Accepted Medical Misadventure Claims* (Wellington: Department of Labour & Accident Compensation Corporation, March 2003) p 4.

⁵⁹ The legislation classified them as “complicated claims,” which required ACC to adopt special administrative procedures. Health professionals had statutory consultation and appeal rights. Medical Misadventure claims took on average five months to determine, longer than decisions on other complicated claims.

⁶⁰ See Accident Compensation Act 2001, s 32(1)(a) and (b). It is still necessary to prove that the personal injury was caused by treatment and not “wholly or substantially” by the patient’s underlying health condition, see s 32(1)(b) and 32(2)(a), and cover for Treatment Injury does not extend to personal injury that is a “necessary part, or ordinary consequence” of the treatment, see s 32(1)(c).

focus.⁶¹ The 2001 legislation had also restored lump sum entitlements for permanent physical impairment. These changes took quite some pressure out of this head of cover. The interests of claimant patients and health practitioners were now more aligned, so the barriers were lowered for the latter to support patients' claims.⁶² Claims rates increased substantially straight after the reform⁶³ and the trend has continued.⁶⁴ The time taken to resolve claims decreased vastly,⁶⁵ and the acceptance rate of claims went up markedly.⁶⁶ The trend for increased personal injuries litigation appears to have tailed off noticeably since the 1990s under the more generous scheme.⁶⁷

⁶¹ The Government brought a leading proponent of the approach, James Reason, to New Zealand to provide advice during the government review. Applied to Medical Misadventure, the reasoning is that the process of finding fault for Medical Error was punitive and resulted in an overly blaming culture, promoting secrecy about error, thereby frustrating injured patients' claims for compensation and inhibiting improvements in patient safety.

⁶² The mandatory reporting provision (s 284), requiring ACC to report cases of Medical Error to the relevant professional body and the Health and Disability Commissioner, had the effect of pitting the claimant's interests against those of the health professional. Health professionals typically sought legal advice before providing responses, were reluctant to co-operate in the claims process, and were inclined to review Medical Error decisions, see *ACC Background Paper: Comparison of International schemes that Compensate for Medical Injury* (Wellington: Department of Labour & Accident Compensation Corporation, August 2003), p 13.

⁶³ There was approximately a 42 percent increase in the total number of claims received for Treatment Injury in 2006, its first full year of operation, compared to those received for the last full year of the Medical Misadventure scheme (2004), see letter 9 July 2007 from ACC to author.

⁶⁴ The number of new Treatment Injury claims have increased each year since the reform in 2005. For example, there were 1,434 (0.1%) new Medical Misadventure claims registered in the 2004/5 year (of 1,523,946 total new ACC claims) (the last full year of Medical Misadventure), compared to 5,472 (0.3%) new Treatment Injury claims registered in 2008/9 (of 1,752,452 total new ACC claims). Information sourced from ACC Annual Reports.

⁶⁵ The median decision time decreasing from on average 5 months for Medical Misadventure claims to 13 days with Treatment injury claims, see letter 9 July 2007 from ACC to author.

⁶⁶ From an average acceptance rate of 38% for Medical Misadventure over period from April 1992 to June 2005 to approx 64% on average for Treatment Injury between 1 July 2005 to 30 June 2007, see letter 9 July 2007 from ACC to author.

⁶⁷ Others explanations are also the existence of the complaints regime as an avenue for airing grievances in the health field, and that exemplary damages claims were strongly discouraged by the Court of Appeal in a line of decision, see *Ellison v L* [1998] 1 NZLR 416; *Daniels v Thompson* [1998] 3 NZLR 22; *Bottrill v A* [2001] 3 NZLR 622 (CA), reversed in *A v Bottrill* [2003] 1 AC 449 (PC); *S v A-G* [2003] 3 NZLR 450. But see, *Couch v A-G* [2008] 3 NZLR 262 (SC) (reserved on threshold for exemplary damages).

Now, in what feels like history repeating itself, the incoming National government announced in 2009 that the scheme was in financial crisis, citing a “\$1 billion hole” in the non-earners’ account and claiming that ACC was “effectively insolvent.”⁶⁸ This is a controversial claim.⁶⁹ Some have argued that the “blowout” in ACC’s finances, and the pressure to respond with levy increases and cuts in entitlements, is fabricated. While some of the increased costs are the result of expanded cover and entitlements under the previous government,⁷⁰ they argue the financial “crisis” is created largely by the statutory requirement since 1998 that the scheme be fully funded by 2014;⁷¹ that full funding is unnecessary and the scheme can be satisfactorily financed on a pay-as-you-go basis (PAYG) with a pragmatic level of reserves; and that the real driver of full funding is a political and ideological agenda (as a prelude to privatisation of ACC).⁷²

In any event, the National government has embarked on a number of initiatives to control ACC’s costs. Unpinning the government’s approach is a change in its view of the role of ACC “from welfare agency” (or, as Woodhouse described it, “a Government scheme of *social* insurance”)⁷³ to “injury risk manager”.⁷⁴ ACC has itself undertaken various initiatives to reduce costs, such as terminating the physiotherapy contract that allowed free physiotherapy visits and replacing it with a co-charging scheme,⁷⁵ tightening up on ACC-

⁶⁸ See “Government fears \$1 b ACC budget problem could worsen”, NZ Herald, 4 December 2009; “National plans big ACC shake-up after blow-out”, NZ Herald, 4 March 2009; “PM confirms ACC board sacking”, NZ Herald, 9 March 2009; N Smith, “ACC’s \$4.8 billion loss unsustainable”, press release, 9 October 2009. Hansard, 4 March 2009.

⁶⁹ See G Cumming, “Truth the casualty of crisis management”, NZ Herald, 14 March 2009.

⁷⁰ Additions to the scope of the scheme since 2004 accounted for \$537 million of ACC’s total liability of \$21.8 billion in the 2009 financial year, see G Cumming, “Truth the casualty of crisis management”, NZ Herald, 14 March 2009.

⁷¹ “Full funding” or “full pre-funding” means funding in an insurance sense i.e. the actuarial requirement that ACC has sufficient current assets to meet the full actuarial value of its liabilities.

⁷² See S St John, “The rationale for pre-funding ACC”, PensionCommentary 2009-2, Retirement Policy and Research Centre; M Littlewood, “Why does the Accident Compensation Corporation have a fund?” PensionCommentary 2009-1, Retirement Policy and Research Centre, available at www.accfutures.org.nz/resources.html

⁷³ See New Zealand 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), p 175.

⁷⁴ Minister for ACC, Proposals for the Injury Prevention, Rehabilitation, and Compensation Amendment Bill to Cabinet Social Policy Committee, dated 4 August 2009, para 19.

⁷⁵ With estimated savings across all accounts for 2010/11 of up to \$47-58 million, see Proposals for the Injury Prevention, Rehabilitation, and Compensation Amendment Bill to Cabinet Social Policy Committee, dated 4 August 2009, para 23.

funded elective surgery,⁷⁶ introducing guidelines in new sexual abuse claims under which ACC-funded counselling is available only for sexual abuse victims with a diagnosed mental condition caused by the abuse and counseling is restricted to 16 weeks subject to reviews,⁷⁷ and embarking on an internal value-for-money exercise. Amending legislation was passed in March 2010 to save costs by reducing cover in some areas and levels of compensation.⁷⁸ They include: repealing cover for work-related mental injury (enacted in 2008); restoring the disentitlement provision for wilfully-inflicted injury and suicide; repealing the more liberal test for causation enacted in 2008 for workplace gradual process, disease or infection; changing the capacity to work threshold from 35 hours per week to 39 hours; changes to the calculation of weekly compensation for seasonal and part-time workers which reduce its amount; returning Loss of Potential Earnings back to the pre-2008 level of 80% of the adult minimum weekly wage from 100%; requiring holiday pay to be abated against weekly compensation if employees lose their jobs; setting a 6% threshold for cover for injury-related hearing loss; substituting a more restrictive “repugnant to justice” disentitlement — at an estimated savings of \$55 million in 2010/11.⁷⁹ It also moved the full funding date from 2014 to 2019 in order to avoid very significant levy increases and reduce the volatility in levies.⁸⁰

The Minister for ACC has made it clear that these legislative changes are designed mainly to reverse extensions to cover and entitlements introduced by the previous government in 2008 and are thus only the first round of changes.⁸¹

Enhanced cover and entitlements in the IPRC Act have added to costs. While many potential changes to the legislation could be made to reduce ACC costs, only those that repeal legislative changes made in 2008 and those that require little additional policy and drafting work are included in this Amendment Bill.

⁷⁶ “ACC turning down surgery”, NZ Herald, 19 February 2010. Other initiatives include pruning claimants off its long-term client list with a hoped-for saving of \$1 billion by 2013, see “Long-term client list pruned”, The Press, 18 January 2010.

⁷⁷ See ACC, Sensitive Claims Clinical Pathway for New Claims (19 October 2009), available at www.acc.co.nz/news/index.htm. The Minister announced that an independent clinical review of the new approach to managing sensitive claims after six months of its implementation on 27 October 2009, see Minister for ACC, *Review of ACC’s approach to sensitive claims* (press release, 27 October 2009).

⁷⁸ The Accident Compensation Amendment Bill, originally named the Injury Prevention, Rehabilitation and Compensation Amendment Bill 2009, was reported back from the Transport and Industrial Relations Select Committee, received its second reading on 18 February 2010 and its third reading on 24 February 2010, and Royal Assent on 2 March 2010. The cost-containment measures identified in the text come into effect on 1 July 2010.

⁷⁹ Minister for ACC, Proposals for the Injury Prevention, Rehabilitation, and Compensation Amendment Bill to Cabinet Social Policy Committee, dated 4 August 2009.

⁸⁰ This provision came into effect on 3 March 2010.

⁸¹ Minister for ACC, Proposals for the Injury Prevention, Rehabilitation, and Compensation Amendment Bill to Cabinet Social Policy Committee, dated 4 August 2009, para 21; Associate Minister for ACC, Hansard 23 February 2010.

More wide-ranging changes will be considered by the government's top priority in the ACC portfolio, the ACC Stocktake, set up in mid-2009 and chaired by Mr David Caygill. Its purpose is to assess the performance of each of the ACC Accounts (an "account by account analysis"), analyse how the scheme could be improved to deliver value for money, and identify potential financial savings.⁸² Its terms of reference were extended in October 2009 to include an investigation of returning to competition in the Work Account.⁸³ An interim report was due by 1 February 2010, with the final report due at the end of June 2010.

The criteria of cover for Treatment Injury have so far escaped change, but it is vulnerable because it is an area of increased expenditure.⁸⁴ A year ago the Minister described it as "a problem area," stating that instead of costing an extra \$8.7 million a year as budgeted, costs for Treatment Injury had doubled from \$42 million a year to an expected \$82 million.⁸⁵ It will clearly come under the Stocktake's spotlight as a target for change. The Stocktake has been instructed that its analysis of each Account is to cover (inter alia): the underlying cost drivers and strategies to address them; how many people come into the account, how long they receive entitlements and what they get; how the interpretation of legislation impacts when providing those entitlements; key changes in legislation over time and their impact on claimant entitlements; and an analysis of the impacts of further legislative changes.⁸⁶

There has been a reduction in the extent of cover and broad entitlements under the scheme since its inception,⁸⁷ and despite restoration of some entitlements under the 2001 Act, "a clear erosion in the social contract over time, to the detriment of claimants."⁸⁸ The 1992 Act in particular made major cuts, and further attacks on cover and entitlements are currently underway. Given the underlying social contract that the first Accident Compensation Act 1972 constituted, any changes to the scheme need to be measured against the founding

⁸² Minister for ACC, *Stocktake of ACC Accounts: Proposed Terms of Reference*, paper for Cabinet Social Policy Committee, July 2009.

⁸³ See Minister for ACC, *Stocktake of ACC Accounts: Amendments to the Terms of Reference*, Cabinet paper 23 October 2009. The Government agreed with the ACT party to bring forward the investigation, which had been postponed to deal with immediate cost containment issues, in exchange for ACT's support for the IPRC Bill.

⁸⁴ ACC's claims liability in the Treatment Injury account has risen since the 2005 amendment, up from \$644 million (of total ACC claims liability of \$11,384 million) in 2004/5 to \$2,167 million (of total ACC claims liability of \$23,786 million) in 2008/9. Information sourced from ACC Annual Reports.

⁸⁵ "Free physio top of hit list in ACC shake-up", NZ Herald, 5 March 2009.

⁸⁶ Minister for ACC, *Stocktake of ACC Accounts: Proposed Terms of Reference*, paper for Cabinet Social Policy Committee, July 2009, paras 15-16.

⁸⁷ See Schedule to the ACC Futures Coalition, *Submission to the Stocktake of ACC Accounts*, which sets out the significant changes to ACC entitlements since 1974 as a result of legislative change under each piece of legislation, available at www.accfutures.org.nz/resources.html

⁸⁸ See ACC Futures Coalition, *Submission to the Stocktake of ACC Accounts*, para 10.2,

Woodhouse principles, relevantly community responsibility, comprehensive entitlement, complete rehabilitation, and real compensation. The proposed changes would appear to significantly undermine these further. Adverse medical events exact a significant toll in personal injury in the community.⁸⁹ Reductions in cover and compensation raise the spectre of injured patients and their families being left to bear the loss themselves or receiving only partial compensation.

Given that the ACC scheme is only part of our system for addressing the remedial interests of patients, we should consider the ramifications of changes to one part of that system for another. What might be the spill-over for the complaints regime of an even “leaner and meaner” compensation system? Some, including myself, have speculated that the more that injured patients perceive themselves as dealt with unjustly by the compensation scheme, the more this exacerbates their sense of grievance and fuels their quest for personal accountability from health professionals after an adverse event in healthcare. Conversely, if they feel society has honoured an obligation to compensate them for injury fairly, the less they are motivated to seek personal accountability from those they consider responsible for harming them.⁹⁰ Changes to the compensation scheme to shrink area of cover and entitlements could well increase peoples’ quest for accountability, and impact adversely on the complaints regime. So we could see:

- Greater levels of acrimony and increased demands for accountability in complaints to the Commissioner and the DP, accompanied by media attention;
- People may start to question whether the social contract has been breached and whether the trade-off remains worth the candle. We may see more concerted political pressure for a return to the ability to sue for personal injury and a return of patients’ attempts to bring civil actions for damages for personal injury, including exemplary damages claims, as happened in mid 1990s;
- dissatisfaction with the Treatment Injury head of cover if it is restricted by legislation.

Conclusion

I have discussed changes that might be made to New Zealand’s system to better address patients’ remedial interests after adverse events in health care. In my view any changes would be evolutionary, and not fundamentally alter existing processes. In particular, I have considered whether access to the HRRT by complainants and consumers needs to be less restrictive. I have concluded that s 51 of the HDCA needs amending to permit complainants in third party complaints to bring HRRT proceedings and to receive damages awards in appropriate cases, reversing *Marks v Director of Proceedings*. I have considered also the case

⁸⁹ The New Zealand Quality of Healthcare Study, which assessed the occurrence and impact of adverse events in a sample of New Zealand public hospitals in 1998, found that 12.9% of public hospital admissions were associated with an adverse event, and that their impact is significant. 33.7% of adverse events resulted in moderate and/or permanent disability or death. See P Davis et al, “Adverse Events in New Zealand Public Hospitals I: Occurrence and Impact,” (2002) 115 NZMJ 271 and P Davis et al, “Preventable In-hospital Medical Injury under the ‘No-Fault’ System in New Zealand” (2003) 12 Qual Saf Health Care 251.

⁹⁰ See J Manning, “New Zealand’s remedial response to adverse events in healthcare”, (2008) 16 Torts LJ 120, p 152, and the discussion of the extent to which patients’ motives are partially interchangeable in M Bismark & E Dauer, “Motivations for medico-legal action: lessons from New Zealand,” (2006) 27 J of Legal Med 55, p 69. See also, A Duffy, “The Common Law Response to the Accident Compensation Scheme” (2003) 34 VUWLR 367, p 372.

for opening up access to the HRRT for complainant-initiated proceedings further, such as where the HDC has declined to take action on a complaint, or the HDC has declined to conduct an investigation, or in the case of no-breach opinions, as under the HRA and (in some respects) the PA. There is an argument in favour of consistency in these three pieces of legislation and in their complaint processes. I have suggested that a better solution might instead be to strengthen the ability for complainants and consumers to access Commissioner investigations in appropriate cases, rather than to emphasise the more legalistic route via the HRRT, and that thought be given to developing a policy stating transparent criteria relating to the discretion to undertake investigations.

I have stated my concern that the latest round of cuts to cover and entitlements will compromise the ability of the compensation scheme to address the remedial interest of injured patients in compensation, and strain the underlying social contract still further. Reintroducing former restrictions to the terms of cover for Treatment Injury, apparently successfully reformed so recently, would seem a backward step.

In any event whatever changes are made to either pathway, the complaints regime or the ACC scheme, it needs to be remembered that there will be consequences felt in other parts of New Zealand's unique system for responding to adverse events. The system, though consisting of separate pathways, is best considered holistically.