

New Zealand's No-Fault Accident Compensation Scheme: Paradise or Panacea?

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Introduction

New Zealand's no-fault accident compensation scheme has long been a source of interest for policy-makers and academics in Canada and in other countries. It has also been of particular interest to physicians, eager to explore ways to eliminate what they perceive of as an expensive, arbitrary, and unfair tort-based system. Although much has been written on New Zealand's no-fault scheme, recent reforms, effective 1 July 1999, merit yet further writing. The 1999 reforms, by emphasizing competition and choice, signal a significantly different philosophy than that underlying the five principles advocated by the Woodhouse Commission in 1967 of community responsibility, comprehensive entitlement, complete rehabilitation, real compensation, and administrative efficiency.¹ In this paper, I will:

- briefly describe the development of New Zealand's no-fault accident compensation scheme;
- outline the recent changes to the scheme; and
- in light of New Zealand's experience, discuss some of the advantages and disadvantages of a no-fault system from the perspective of physicians.

Development of New Zealand's No-Fault Accident Compensation Scheme

The story of New Zealand's no-fault accident compensation scheme is one of decline: from the lofty aspiration of its creators to the 1999 reality of a lean system that has

managed to regain some of the negative features of a fault-based tort system.

The Accident Compensation Corporation (ACC) was formed on 1 April 1974 to administer a major public accident insurance fund designed to remove the risk of personal liability due to accident.² It was intended to be a no-fault scheme to the extent that a claimant did not have to establish negligence on the part of another in order to receive compensation. The compensation or benefits provided under the scheme are medical costs of accident victims, rehabilitation services and support in the home, 80% of lost earnings up to a cap of NZ\$1,246.27 per week in 1996/97 and, until 1992, lump sum compensation for permanent disability.³

The scheme is financed from four sources: employers, earners, motor vehicle owners/users, and general taxation revenues. The premiums that employers pay are risk-adjusted according to the risks associated with the industry they are in. On average, for every \$100 of wages or salary paid, an employer pays \$2.35 to the ACC. An employer in family medicine must pay 0.63 cents per \$100 of wages whereas an employer in hospital services must pay \$1.46 per \$100 of wages. All earners must pay \$1.07 for every \$100 of wages or salary earned to the ACC (this is not risk-adjusted on an industry basis). \$90 of the annual motor vehicle registration fee, along with 2 cents per litre of petrol, is paid to cover the costs of motor vehicle injuries. The balance of funds, needed to cover the costs of compensating non-earners for accidental injury, comes from general taxation revenues.⁴

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The 1974 legislation abolished the right to sue for personal injury caused by accidents. Section 394 of the *Accident Insurance Act 1998*, the most recent codification of the no-fault scheme, provides:

no person may bring proceedings independently of this Act, whether under any rule of law or any enactment, in any court in New Zealand, for damages arising directly or indirectly out of – (a) Personal injury covered by this Act; or (b) Personal injury covered by the former Acts.

Physicians in New Zealand are thus largely protected from civil claims for damages that arise directly or indirectly from their own negligence.⁵ However, patients suffering medical misadventure are still able to initiate common law claims for exemplary damages.⁶

“Exemplary damages are awarded to punish a defendant for high-handed disregard of the rights of a plaintiff for acting in bad faith or for abusing a public position or behaving in some other outrageous manner which infringes the rights of the defendant.”⁷ Thus, more than ordinary negligence is required in order to make a successful claim for exemplary damages and successful claims will be relatively rare. The 1998 legislation has, however, expanded the likelihood of an award for exemplary damages by specifically providing that a court may make an award for exemplary damages even although a defendant has been charged with a criminal offence involving the same conduct.⁸ As discussed further below, in addition to exemplary damages, since 1992, claims can also be made for damages associated with some mental injuries that are not consequent upon physical injury.

The ACC pays for medical services for accident victims and is a small but growing source of funding for the total health care system. Over the period 1980 to 1991 the ACC’s share of total health care expenditure increased from 0.7 to 6.6 %, declining somewhat to 5.3% of total health care expenditures in 1997/98.⁹ Between 1980 and 1998, ACC health expenditures grew from \$9.6 million to \$419.7 million, which is equivalent to an average real growth rate of 14.7% per annum.¹⁰

Despite its growing importance in financing health care, the no-fault accident compensation scheme has different goals and constraints than the balance of the public health care system and the dichotomy results in both unfairness and perverse incentives. For example, the growing waiting times

for public surgery, and the high cost of reimbursing lost earnings whilst accident victims were waiting for treatment resulted in the ACC increasingly buying services from private hospitals in order to treat accident victims more quickly so as to get them back to work. Thus, a patient receives more prompt treatment if he or she had suffered the misfortune of an accident rather than an illness. As another example, until 1992 the ACC covered the full cost of consultation between an accident patient and his/her general practitioner. Unlike Canada, there is no prohibition on user charges in New Zealand and patients pay a significant proportion, if not all, of the total fee for general

practitioner services. Thus, it was in a patient’s interest (and, as discussed below, still is to a lesser extent) to suffer an accident rather than an illness as the cost of general practitioner services was fully paid for by the no-fault scheme. Not surprisingly, the proportion of practitioner visits

classified as “accident related” rose from 15 % in 1981/82 to 22 % in 1989/90.¹¹ This indicates that either the number of accidents in New Zealand had increased, or (more likely) that doctors and patients were seeking to have injuries classified as “accidents” rather than as illness or sickness in order to jump queues in public hospitals and to avoid user charges.¹²

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1992 Reforms

In response to lobbying by business groups concerned about the rising costs of the no-fault scheme, the National (equivalent to the Conservatives) Government “reformed” the accident compensation system in 1992 by limiting the coverage and benefits available.¹³ Sir Geoffrey Palmer, former Prime Minister of New Zealand and an early and continued advocate of the no-fault scheme, notes that as a consequence of the 1992 reforms the scheme “is now more in the nature of a mean workers’ compensation scheme which covers injuries for twenty-four hours a day.”¹⁴

The 1992 reforms eliminated fully subsidized general practitioner care for accident victims. Accident victims are entitled to a subsidy of \$26; however the cost of a visit to a general practitioner is approximately N.Z. \$35.00-\$40.00. Thus, accident victims must now pay between N.Z. \$10.00 and N.Z. \$14.00 per visit. This still does not provide parity with visits to a general practitioner for illness in which case, unless the patient is poor enough to qualify for a government subsidy or holds private insurance, the patient must pay the full \$35-40. Consequently, many patients and



doctors still have had an incentive to expand the ordinary meaning of accident in order to obtain a subsidy.

Since 1 July 1992, lump sum payments for pain and suffering and loss of enjoyment of life are no longer made. A “disability allowance” is paid in lieu of lump sum payments of NZ \$40 a week for a 100% disability (the figure of \$40 is reduced proportionately depending on the degree of disability). This sum has since increased to \$61.68 a week for someone suffering a disability affecting 80-100% of his or her functions. The abolition of lump-sum payments has its strongest impact on non-earners such as women at home, children, compromised new-borns, and the unemployed (whether temporarily or persistently).¹⁵ Whilst the employed are able to collect 80% of their salary whilst recovering, non-earners are entitled to a maximum of \$61.68 per week for a 80-100% disability together with medical, rehabilitation, and some home care expenses. No lump-sum payment is made to a compromised infant to reflect his/her loss of earning potential over the course of their lifetime. Once an injured child reaches the age of 18 and is still incapacitated then he/she as a “potential income earner” is entitled to a fixed weekly payment of NZ\$179.20 which increases to \$224 upon turning 20.¹⁶ These payments only amount to basic subsistence support and do not vary depending upon any real assessment of a person’s potential income earning ability. Moreover, the payments are not made till a person turns 18, denying both the injured person and his/her family of some economic assistance during the childhood period.

The trade-off for covering more people in a no-fault system relative to a fault-based system may need to be smaller sums paid to each individual. However, the New Zealand scheme, at least since the 1992 reforms, is biased in its approach to compensation, putting much greater store on compensating the currently employed and providing only minimal compensation for loss of potential income-earning ability.

The 1992 reforms also restricted coverage for cases of mental injury unless attendant upon a physical injury or suffered as a result of being the victim of certain crimes, mainly sexual offenses. As mentioned above, claims for exemplary damages have always been allowed as these kinds of damages are not viewed as compensatory but to punish the wrongdoer for flagrant disregard of another’s interests. This 1992 exclusion of mental injury not consequent upon physical injury has opened up the possibility of civil claims against health professionals and

others alleging the negligent infliction of emotional distress. The Court of Appeal in the 1998 decision of *Queenstown Lakes District Council v. Palmer*,¹⁷ confirmed the right of those suffering a mental injury not due to a personal injury suffered by them to bring a civil action for that injury. Thus in the *Queenstown* case, a man was able to bring an action in the general courts for the mental injuries he suffered as a result of watching his wife drown in a white-water rafting accident.

In the last few years there seems to have been a significant rise in the number of claims being made against health care providers in New Zealand.¹⁸ The increased volume of claims made may reflect a hope that the courts would respond to the impoverished nature of the 1992 reforms by generously expanding the ability to make claims for exemplary damages or mental injuries. However, this hope will have to be tempered in light of the 1997 Court of Appeal case, *Ellison v. L*.¹⁹ This case involved a

claim against a dentist for negligently failing to remove packing after a dental operation. The Court of Appeal commented that Ellison’s claim for \$250,000 in exemplary damages was unrealistic “even if the conduct of the respondent had been outrageous and deserved to be marked by an award of exemplary damages....[t]he marking out and punishment of outrageous behaviour can be adequately achieved by a relatively modest penalty.”

The most significant change made in 1992 was to introduce the finding of fault back into the no-fault scheme. Prior to 1992, there had been no statutory definition of “medical misadventure.” Medical misadventure is, however, defined in the 1992 Act as a “personal injury resulting from medical error or medial mishap.” Medical mishap is defined as

[A]n adverse consequence of treatment by, or at the direction of, a registered health professional, properly given, if –
(a) the likelihood of the adverse consequence of the treatment occurring is rare; and
(b) the adverse consequence of the treatment is severe.²⁰

The Act goes on to define rare as those consequences that occur in 1% or less of the cases where the treatment is given. However, if the adverse consequence is rare in the ordinary course but not rare having regard to the circumstances of the patient, medical mishap is said not to occur when the patient (or their guardian) knew of the greater risk. A consequence

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of treatment is said to be “severe” if it causes death, hospitalization of a patient for more than 14 days, significant disability for more than 28 days, or causes disability of 10% or more.

Medical error is defined as:

the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances.²¹

The Act goes on to note that it is not a medical error solely because desired results are not achieved or because subsequent events show that different decisions might have produced better results.

Thus, apart from the small number of cases where the adverse consequences are sufficiently “rare” and “severe”, New Zealand’s no-fault scheme now requires, through the new definition of “medical error,” a process of fault-finding on the part of health providers before patients are entitled to compensation. Any benefits of improved physician/patient relationships are not necessarily realized in a system that requires patients to allege negligence in order to obtain compensation. A criticism of the fault-based tort system is that it only compensates a very small proportion of patients who have been the victims of medical negligence. To the extent that this is due to the fact that patients often do not have the information they need to detect or prove negligent treatment as opposed to the costs of litigation, then this will continue to be a barrier to those who have been a victim of medical negligence in the New Zealand scheme.

1993-1998 Reforms

As part of reform of New Zealand’s health care system in the early 1990s, responsibility for purchasing health care services for accident victims had been transferred from the ACC to Regional Health Authorities to create parity between accident and illness victims. A report by a government-appointed committee on the 1993/94 performance of the ACC found that it could not influence public hospital surgery schedules or transfer procedures and consequently rehabilitation of accident victims was impeded.²² The ACC found itself having to absorb rocketing income maintenance costs as accident victims waited with the ill in queues for treatment in the public sector. It estimated that there were between 13,000 and 20,000 accident claimants on waiting lists at this time with an average waiting-time of six months, at a cost of between \$70

and \$100 million in earning-related compensation.²³ As a consequence, in 1996, responsibility for purchasing non-emergency surgical services for accident victims was quietly transferred back from the Regional Health Authorities to the ACC.²⁴

In 1997, the *Crimes Act 1961* was amended after lobbying from the medical profession. The *Crimes Amendment Act 1997* changed the law so that the charge of negligent manslaughter can no longer arise from a breach of duties in sections 155 and 156 of the *Crimes Act 1961*. In order to establish a charge of manslaughter against a medical professional, the Crown must establish a “major departure” from the standard of care expected of a reasonable person.²⁵

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The 1999 Reforms

Despite cutbacks in 1992, further reforms of the accident compensation scheme were proposed in 1998 and came into force on 1 July 1999. These reforms were prompted in part by what were seen as continuing growth in expenditures. Reform proponents argue that the cost of the scheme has increased at an average annual real rate of 8% since 1985.²⁶ There was also some suggestion that New Zealand’s record of workplace safety was poor compared to other OECD countries.²⁷ It was contended that the existing no-fault scheme provided weak incentives for premium payers to invest in risk management or to facilitate rehabilitation.²⁸

The *Accident Insurance Act 1998* (“the Act”) provides that the ACC will no longer be the monopoly insurer of workplace injuries. Instead, employers must choose a new personal injury insurer for their employees’ work injuries. Employers can select any registered private insurer (meeting certain prudential requirements) or a new government-owned insurer (“@Work Insurance”). As at 1 July 1999, employers have a choice of six insurers (five private entities and one government-owned corporation.) The concept behind the 1999 reforms is to allow competition between private insurers within a framework of government regulation protecting the entitlements of the insured. It is similar in concept to that of President Clinton’s proposal for managed competition reform of the US health care system.

Each insurer must offer, upon request, an employer an insurance contract. However, there are no premium restrictions and insurers are free to charge as much or as

little as they choose as a premium price. The minimum benefits that employees are entitled to are stipulated in the legislation, for example, weekly compensation of at least 80 % of the employee's wage, rehabilitation services, and medical care.

Self-employed individuals, like general practitioners, may choose to take out an accident insurance contract with a private insurer or continue to be covered by the ACC. The ACC will, however, deduct an extra premium from the self-employed that choose to remain with the ACC to ensure competitive neutrality with other insurers. Presumably, those in low-risk industries will move to the private sector, leaving the high risks with the ACC.

The Act provides that insurers are not to purchase "public health acute services" (essentially emergency services) from hospital and health providers. HealthWise, a fully owned subsidiary of the ACC, is charged with the responsibility of purchasing public health acute services on behalf of private insurers²⁹ and insurers are required to contribute to the cost.³⁰ However, for non-emergency services, insurers are free to conclude arrangements with health care providers. There is the potential, with the advent of a number of private insurers who will be responsible for buying medical care for accident victims, for a significant increase in administrative and contracting costs. Section 57 of the Act provides that a treatment provider lodging a claim on behalf of a patient must assist the patient in deciding which insurer to lodge the claim with. Section 80 provides that a health provider cannot charge a patient a fee for any treatment that is covered under the Act and that the provider must instead seek payment from the appropriate insurer. New Zealand physicians have complained that the new administrative requirements will increase doctors' consultation times by 30 to 60 %.³¹ As a result, some doctors have increased their consultation fees, causing testy exchanges between the medical profession and the government anxious to consolidate the new reforms with a minimum of public concern.³²

Accidents that occur outside of the workplace, including medical mishap and medical error, will still be dealt with in the same way. The 1992 definitions of medical mishap and medical error are largely retained. Thus, unless an adverse consequence is sufficiently "rare" and "severe" to classify as medical mishap, a patient, in order to be compensated, must establish that the health professional in question acted negligently (i.e. failed to observe a standard of care and skill reasonably to be expected in the circumstances). Section 70 of the Act provides that an insurer must obtain independent advice from a "suitably qualified person" when assessing a claim for personal injury caused by medical misadventure. Review of an insurer's decision is allowed and section 135(4) allows a registered health professional to initiate a

review when a decision has been made that "medical error" (i.e. negligence) contributed to the patient's personal injury. Section 145 allows a registered health professional to be present at a review with a representative if he/she wishes. There is also the ability to appeal to the District Court from a review decision. Section 5(10) of the 1992 Act required the ACC, where it considered care may have been negligent or inappropriate, to report to the appropriate regulatory body after the registered health professional has had the opportunity to comment on the allegations. Interestingly, this requirement has been removed from the new Act.

Section 296 of the Act allows for the making of regulations to require health professionals to make premium payments to the "Medical Misadventure Account", which is the source of funding for all medical misadventure claims. Different classes of professionals may pay different premiums and classes may be defined according to "the profession concerned, the nature of the employment of the professional, any areas of specialisation, any areas in which the person does not practise, or on any other basis specified in the regulations."³³ Section 297(3) of the Act provides "the regulations may establish a system for the experience rating of persons liable to pay the premiums for medical misadventure, and the system may include no-claims bonuses, lower or higher premiums, or claim thresholds." Although previous legislation allowed for health professionals to be levied to fund the Medical Misadventure Account, this was not implemented. Nonetheless, it is instructive that the government maintained in the 1999 Act the power to require health care professionals to pay risk-rated premiums. Moreover, the scheme has a new orientation towards greater choice, more competition, and incentives for prevention. Thus it is certainly possible that in the future health care professionals themselves will be required to fund some proportion of medical misadventure claims on the basis of risk-adjusted premiums.³⁴

The 1999 Act challenges the dominance of general practitioners as gatekeepers to the consumption of other health care services. The Act creates a new class of providers, treatment providers, which include acupuncturists, audiologists, chiropractors, counsellors, dentists, laboratory technicians, nurses, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, registered medical practitioners, speech therapists and any other group provided for by subsequent regulation. An accident victim can visit any one of these treatment providers without a referral from a general practitioner. However, only a registered general practitioner can issue a medical certificate for time taken off work.³⁵ The prospect of patients being able to choose amongst 14 health care providers has caused some concern on the part of

physicians. They argue that it is vital for an injured person to continue to see their general practitioner first. They also warn patients that “injured people who choose to see another health professional, and then later go to their GP to certify time off work, should not be surprised if their GP is not able to provide retrospective certification. Professional ethics require doctors to certify only what they can personally verify.”³⁶

Advantages and Disadvantages of a No-Fault System: The Physician’s Perspective

In this concluding section it is appropriate, given the interest often expressed by Canadian physicians in moving to a no-fault scheme, to explore the advantages and disadvantages of a no-fault system from the perspective of physicians. Obviously, different considerations would apply if we explored the advantages and disadvantages of a no-fault system from the perspective of patients or from the perspective of society as a whole.

The biggest advantage for physicians in moving to a no-fault scheme like New Zealand’s is the removal of the risk of being sued for negligence. This means not only avoidance of the costs, inconvenience, and stress associated with litigation but the stigma of these suits. This is clearly a huge advantage for physicians and other health care professionals and one I would not wish to downplay; however, the bar against civil actions for personal injury does not necessarily mean that negligent actions will go unpunished or will not be publicized. There is still the possibility of disciplinary actions by the self-regulating body and there is also the possibility of criminal actions (although, in New Zealand, the expansive definition of manslaughter has now been narrowed in the case of health care professionals). Also, with government retrenchment there have been some small inroads made into the bar against negligence actions. Thus, in addition to the prospect of being sued for exemplary damages there is now the possibility of being sued for damages for mental injury that is not attendant upon physical injury, e.g. mental trauma to a mother upon giving birth to a severely compromised child.

Despite what may be viewed by many physicians as the overwhelming advantage of ridding themselves of the prospect of the costs, inconvenience, and stress associated

with tort litigation, there are a number of significant disadvantages for physicians in a no-fault scheme like New Zealand’s that should not be underestimated.

- In order for a patient to be entitled to compensation for “medical error” it must be established that a physician or other health provider has acted negligently. This opens up the prospect of an adversarial process to determine whether or not negligence has occurred. There will undoubtedly still be stigma attached to a finding of fault and it could have repercussions in professional disciplinary proceedings.
- There is the potential future requirement that physicians and other health providers will be required to pay risk-adjusted premiums to fund the cost of compensating the victims of medical error or misfortune.

Thus it is important for physicians to realize that a no-fault system would not only have an impact on their role as care providers but also would require them to assist in administering the scheme and would place duties on them as employers/self-employed.

- With the 1999 reforms to the system, there is extra paper work and administration needed in order to obtain compensation. As a result of this extra work, physicians have raised user charges for services, compounding access problems.

- As a cost-saving measure (presumably) accident victims are allowed to see other kinds of health care professionals without a referral from a general practitioner. Insurers in the post-1999 system are likely to engage in managed care initiatives with physicians and other health care providers.
- Physicians are required to be part of the administration of the scheme, e.g. called upon to assess whether or not a patient is fit to return to work, provide opinions on whether other physicians have been negligent, assist patients in ascertaining which insurer to file a claim with, etc.
- Physicians may be called upon to “bend” the scheme’s requirements to advance the interests of their patients. For example, a doctor may feel obliged to argue that a patient suffered an accident rather than illness in order to get the patient cheaper and/or faster treatment. After the 1999 reforms, a doctor may feel obliged to note that an accident was not work-related in order to avoid repercussions for the patient’s employer and workplace.



- As business people, whether employers or as self-employed individuals, physicians must make premium payments and comply with the administrative requirements of the scheme.

Thus it is important for physicians to realize that a no-fault system would not only have an impact on their role as care providers but also would require them to assist in administering the scheme and would place duties on them as employers/self-employed. New Zealand has had a very mixed experience with its no-fault scheme, and over the last 25 years it has declined from a visionary social program to a lean, (arguably) unfair, and complicated program that has reincorporated elements of the fault-based system. The New Zealand experience suggests that Canadian physicians and policymakers should look to sustainable and incremental reform of the tort-based system rather than pursuing the implementation of a full-fledged no-fault scheme.

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1. The 1972 Act originated from the recommendations of the 1967 Royal Commission on Compensation for Personal Injury in New Zealand, chaired by Sir Owen Woodhouse. See Royal Commission of Inquiry, *Compensation for Personal Injury in New Zealand* (Government Printing Office: Wellington, 1967). See also Rt. Hon. Sir G. Palmer, "New Zealand's Accident Compensation Scheme: Twenty Years On" (1994) 44:3 U.T.L.J. 223 at 227.
2. For a description of the history of the scheme and a critique of the 1992 amendments see Palmer, *ibid*. See also I. Campbell, *Compensation for Personal Injury in New Zealand: Its Rise and Fall* (Auckland University Press: Auckland, 1996).
3. Since 1 July 1992 a "disability allowance" is paid in lieu of lump sum payments. Payments for pain and suffering and loss of enjoyment of life are no longer made.
4. See generally B. Wilkinson, "New Zealand's Failed Experiment with State Monopoly Accident Insurance" (1998) 2 Green Bag (2d) 45 at 47.
5. The *Accident Compensation Amendment Act 1974* amended the term "personal injury by accident" to include "medical, surgical, dental or first aid

misadventure".

6. *Donselaar v. Donselaar*, (1982) N.Z.L.R. 97. This is now specifically provided for in s.396 of the *Accident Compensation Act* (N.Z.) (1998) No. 114.
7. *Ellison v. L.* [1998] 1 N.Z.L.R. 416, online: <http://www.brookers.co.nz/legal/judgments/default.htm>. (accessed 19 August 1999).
8. *Accident Compensation Act* (N.Z.) (1998) No. 114, s. 396.
9. C. Galapitige, *Health Expenditure Trends In New Zealand 1980-1998* (Wellington: Department of Health, 1999), Appendix 4, online: (under publications) <http://www.moh.govt.nz/moh.nsf>.
10. *Ibid.* at 19.
11. S. Upton, *Your Health and the Public Health – A Statement of Government Health Policy* (Wellington: Minister of Health, July 1991) 15.
12. In 1990, patients were required to sign a declaration affirming they had in fact suffered an accident. Consumer magazine reports that by 1993 accident claims had dropped by 570,000 compared with the 1990 figure – Consumer, "ACC: Adding Insult to Injury", May 1994, No. 326 at 6.
13. S. Todd & J. Black, "Accident Compensation and the Barring of Actions for Damages" (1993) 1:3 Tort L. Rev. 197. See the *Accident Rehabilitation and Compensation Insurance Amendment Act* (No. 2) (N.Z.) (1996) No. 106.
14. Palmer, *supra* note 1 at 237.
15. Some unemployed people are, in a very narrow range of circumstances, deemed to be employed and thus entitled to income-replacement compensation. Schedule 1, cl. 19, of the *Accident Compensation Act* (N.Z.) (1998) No. 114 requires that the unemployed person, in order to qualify for coverage, must have been an employee within 14 days of the accident and, prior to this have been employed continuously for 12 months and would have been an employed within 3 months but for the incapacity.
16. To be classified as a "potential income earner" the injured person must be presently incapacitated as a result of injuries suffered before the age of 18 or while a full-time student or trainee in a program that was commenced before the age of 18 and continued uninterrupted until after the age of 18. The injured person must also have been incapacitated for at least 6 months. See section 46 of the *Accident Rehabilitation and Compensation Insurance Amendment Act* (No. 2) (N.Z.) (1996) No. 106. See now sections 13 (definition of "potential income earner"), 87(2) (determination of incapacity) and Schedule 1, clause 22 of the *Accident Compensation Act* (N.Z.) (1998) No. 114.
17. *Queenstown Lakes District Council v. Palmer*, CA 83/98, online: <http://www.brookers.co.nz/legal/judgments/default.htm>. (accessed 19 August 1999).

18. A number of these claims are described by J.M. Miller, "No-Fault in New Zealand" (1998) 39 *Les Cahiers de Droit* 371 at 374, fn 11. In addition the following cases should be noted:
1. *Otter v. Residual Health Management Unit et ors.* (CA 137/98, 1999, online: <http://www.brookers.co.nz/legal/judgments/default.htm>. (accessed 19 August 1999) husband claiming unspecified damages for nervous shock as a result of the death of his wife.
 2. *A. v. B.*, (11 May 1999, HC Ak., Young J, noted 22 *TCL* 26/9). Plaintiff A was unsuccessful in claim or damages against B, a pathologist, for negligent reading of cervical smear tests. However, a newspaper publisher was successful in applying for discharge of a name suppression order so that the name of the Pathologist could be made public.
 3. *Brownlie v. Good Health Wanganui Ltd.* (CT 64-97, Dec 10, 1997). Eight former patients, wrongly diagnosed as free from breast cancer, were unsuccessful in their claim for damages for mental trauma as the court determined that the stress claimed was an inevitable consequence of the misdiagnosis. However, the plaintiffs were allowed to claim for damages for mental trauma for the window of time between finding out there was a possibility of misdiagnosis and the actual confirmation of the misdiagnosis. They were also allowed to proceed with their claim for exemplary damages.
19. *Ellison v. L.* [1998] 1 *NZLR* 416 also online: <http://www.brookers.co.nz/legal/judgments/default.htm>. (accessed 19 August 1999).
 20. *Accident Compensation Act* (N.Z.) (1998) No. 114., s. 37.
 21. *Ibid.* at s. 36.
 22. Noted in 18 (1996) *The Capital Letter* 17 :817 at 2.
 23. *Ibid.*
 24. See the *Accident Rehabilitation and Compensation Insurance Amendment Act (No. 2)* (N.Z.) (1996) No. 106, s. 6.
 25. For a discussion see K. Dawkins, "Medical Manslaughter" (December 1998) *N.Z.L.J.* 422.
 26. This is noted by M. Sloan & S. Plumley, "Raiders of the Lost ARCIC" (March 1999) *N.Z.L.J.* 49.
 27. See J. Wren, "A Matter of Priority", *Safeguard*, March/April 1998.
 28. See M. Mills, "The Case for ACC Reform", available from the Labour Market Policy Group, Dept. of Labour, New Zealand, at 4 [unpublished].
 29. See the HealthWise website, online: <http://www.healthwise.co.nz/> (accessed 26 July 1999).
 30. Section 362 of the *Accident Compensation Act* (N.Z.) (1998) No. 114.
 31. See New Zealand Medical Association Press Releases: "Should Doctors Subsidise Accident Insurance System?" [sic], 5 July 1999, online: <http://www.nzma.org.nz/news/subsidise.html> (accessed 26 July 1999).
 32. New Zealand Medical Association Press Release: "Doctors 'not to blame' for accident insurance increases", 15 July 1999, online: <http://www.nzma.org.nz/news/press.html> (accessed 26 July 1999).
 33. *Accident Compensation Act* (N.Z.) (1998) No. 114., s. 296(4)(b) and s.297.
 34. *Ibid.* s. 408 does require that the Minister consult with persons or organizations he/she considers appropriate before passing any such regulations.
 35. *Ibid.* at s. 84 requires that in determining incapacity for employment, an insurer consider an assessment undertaken by a registered medical practitioner.
 36. New Zealand Medical Association Press Releases, *supra* note 31.



