New Zealand’s 2005 ‘no-fault’ compensation reforms and medical professional accountability for harm

Katharine Wallis

Abstract


Methods Data for the 5 years before and after the 2005 reforms were compared including compensation claims to the Accident Compensation Corporation (ACC), ACC reporting to the authorities, patient complaints to the Health and Disability Commissioner and outcomes, referrals to the Medical Council and outcomes, and disciplinary proceedings and outcomes.

Results Following the 2005 compensation reforms, claims for compensation increased, ACC reporting overall increased but ACC reporting to the Medical Council decreased; patient complaints increased but the Health and Disability Commissioner investigated fewer complaints and referred fewer doctors for discipline while maintaining steady referrals to the Medical Council; referrals to the Medical Council decreased, and the Medical Council conducted fewer performance reviews and referred fewer doctors for discipline; disciplinary proceedings decreased but more hearings ended in guilty findings.

Conclusions Accountability via compensation decreased following the 2005 ‘no-fault’ compensation reforms, contributing to an overall decrease in medical professional accountability for harm.

In New Zealand, instead of the more usual tort-based malpractice system, we have a taxpayer funded accident compensation scheme to provide compensation for medical injury. The compensation scheme bars suing for compensatory damages for injuries covered under the scheme. As a consequence, there is no culture of suing in New Zealand and doctors pay comparatively low medical indemnity fees.

Despite the absence of suing and the near-absence of medical manslaughter in New Zealand, doctors do not practise in a void of accountability. There are separate processes to hold doctors to account. These include the Health and Disability Commissioner (HDC) patient complaints system, the Medical Council’s competence and fitness to practise processes, the Health Practitioners’ Disciplinary Tribunal disciplinary process. There are also in-house hospital and clinic accountability processes.

Under New Zealand’s regulatory system, in contrast to malpractice systems, compensation is determined according to outcome and may be awarded irrespective of fault or negligence, while doctors are judged (under the HDC patient complaints...
system) according to process of care and may be held to account irrespective of injury.

New Zealand’s compensation scheme was introduced in 1974 following recommendations from the Woodhouse report. The scheme is based on the founding principles of community responsibility, comprehensive entitlement, complete rehabilitation, real compensation, and administrative efficiency.\(^3\)

Medical injury has always been covered under the scheme although the eligibility criteria were not specifically defined until 1992. Then, in response to the perceived spiralling cost of medical injury compensation,\(^4\) compensable medical injury was defined as “medical misadventure”, which was either “medical mishap” (a rare and severe adverse event) or “medical error” (in effect negligence). The 1992 reforms (unfairly) restricted access to compensation for those suffering medical injury as opposed to general injury. The restrictive definition also increased the possibility of litigation from those not covered under the scheme.

The 1992 reforms also introduced fault (medical error) into the otherwise no-fault scheme and, as ACC was obliged to report all findings of medical error to the Medical Council, the compensation claims process could result in discipline for doctors. This made some doctors (and patients) unwilling to participate in the compensation claims process. It also led some doctors to contest findings of medical error, further restricting and/or delaying access to compensation for injured patients.\(^5\)

This situation was reversed in 2005 under the ‘no-fault’ compensation reforms.\(^6\) The 2005 reforms waived the prior anomaly of medical error and extended eligibility to all treatment injuries regardless of error or injury rarity and severity. The 2005 changes gave New Zealand’s scheme some of the most liberal eligibility criteria in the world, and brought the compensation of medical injury into line with the overall ‘no-fault’ scheme. The changes also shifted the focus of the scheme away from identifying error (or fault) to providing assistance with treatment and rehabilitation.

ACC’s prior duty to report to the Medical Council all findings of medical error was also waived under the 2005 reforms and replaced with a new duty to report “risk of harm to the public” to the “authorities responsible for patient safety”.\(^7\) This change was expected to reduce ACC reporting to the Medical Council, and thus to reduce accountability via compensation, but as ACC retained the power to report doctors to the Medical Council (as the Medical Council is an ‘authority responsible for patient safety’) the compensation claims process may yet result in discipline for doctors.

This study set out to discover the effect of New Zealand’s 2005 no-fault compensation reforms on medical professional accountability for harm in the context of overall trends in New Zealand’s medical professional accountability processes. Accountability, according to Webster’s dictionary, implies “imminence of retribution for unfulfilled trust or violated obligation”.\(^8\) Accountability may be individual or collective. The purpose of New Zealand’s compensation scheme was never to provide accountability, but rather to minimise both the incidence and impact of injury.\(^1\) There are separate processes in place to provide medical professional accountability. Decreased accountability via compensation may not matter, but given the extent of medical harm,\(^9\) the cost of medical injury compensation,\(^10\) and the importance of trust
in health care, it is prudent to be cognisant of the effect of the no-fault reforms on medical professional accountability.

Figure 1. Interactions between New Zealand's accident compensation scheme and professional accountability processes

Methods
Data for the 5 years before and after the 2005 compensation reforms (2001–2010) were compared including claims for medical injury compensation, ACC reporting of claims, patient complaints to the HDC, HDC investigations and referrals, competence and fitness to practise referrals to the Medical Council, Medical Council performance reviews and referrals for discipline, and disciplinary proceedings before the Health Practitioners Disciplinary Tribunal and their outcome.

Results
**Treatment injury claims**—Claims for medical misadventure compensation were increasing prior to the 2005 reforms, and claims for treatment injury compensation
increased further following the 2005 reforms before decreasing slightly in 2010 (Table 1).

Table 1. New claims registered with ACC and ACC reporting (ACC data)

<table>
<thead>
<tr>
<th>Year to 30 June</th>
<th>New claims</th>
<th>Claims reported by ACC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>To Medical Council (% claims)</td>
</tr>
<tr>
<td>2001</td>
<td>204</td>
<td>N/A</td>
</tr>
<tr>
<td>2002</td>
<td>192</td>
<td>42 (22)</td>
</tr>
<tr>
<td>2003</td>
<td>682</td>
<td>63 (9)</td>
</tr>
<tr>
<td>2004</td>
<td>1250</td>
<td>53 (4)</td>
</tr>
<tr>
<td>2005</td>
<td>1434</td>
<td>50 (4)</td>
</tr>
<tr>
<td>2006</td>
<td>2846</td>
<td>27 (&lt;1)</td>
</tr>
<tr>
<td>2007</td>
<td>3964</td>
<td>9 (&lt;1)</td>
</tr>
<tr>
<td>2008</td>
<td>5073</td>
<td>8 (&lt;1)</td>
</tr>
<tr>
<td>2009</td>
<td>5472</td>
<td>5 (&lt;1)</td>
</tr>
<tr>
<td>2010</td>
<td>5210</td>
<td>5 (&lt;1)</td>
</tr>
</tbody>
</table>

Note: Legislation came into effect 1 July 2005: 2001–2005 medical misadventure claims and reported medical error, 2006-2010 treatment injury claims and reported risk of harm to the public

N/A = Figure not available

Most new treatment injury claims (both accepted and declined) were assessed by ACC as having minor potential consequences (68%); 25% were assessed as major, 4% as serious, and 3% as sentinel. Medication was the leading cause of treatment injury. See Box 1 for ACC definition of claims’ potential consequences.

Box 1. ACC definition of claims potential consequences

<table>
<thead>
<tr>
<th>Potential consequences</th>
<th>ACC definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>results in minimal lessening of bodily function</td>
</tr>
<tr>
<td>Major</td>
<td>likely to result in short to medium term lessening of bodily function</td>
</tr>
<tr>
<td>Serious</td>
<td>has the potential to result in death or major permanent loss of function</td>
</tr>
<tr>
<td>Sentinel</td>
<td>resulted in death or major permanent loss of function</td>
</tr>
</tbody>
</table>

ACC reporting—ACC has responded to the new reporting duties by reporting to the Director General of Health all sentinel claims and those serious claims considered by ACC to have a high or moderate likelihood of recurrence. ACC also reports some of these claims to Medsafe and/or the registration authorities (such as the Medical Council).

ACC reporting overall increased following the reforms. ACC reporting increased from on average 53 doctors per year to the Medical Council prior to the reforms, to 365 events per year to the Director General of Health after the reforms – in addition to reporting some of these events to Medsafe (about one-third of reported events) and/or the Medical Council (about twelve doctors per year) (Table 1).20

ACC reporting to the Medical Council decreased following the 2005 reforms, as expected (Table 1 and Table 2). Comparing the 5 years before and after the reforms,
ACC data show ACC referrals decreasing from 53 to 12 doctors per year on average.\textsuperscript{10}

Table 2. ACC referrals to the Medical Council: comparing data from ACC and the Medical Council’s annual reports

<table>
<thead>
<tr>
<th>Year</th>
<th>ACC data (year to 30 June)</th>
<th>Medical Council data (year to 31 March)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002 (Medical error)</td>
<td>42</td>
<td>6</td>
</tr>
<tr>
<td>2003</td>
<td>63</td>
<td>7</td>
</tr>
<tr>
<td>2004</td>
<td>53</td>
<td>18</td>
</tr>
<tr>
<td>2005</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>2006 (Risk of harm)</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>2007</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>2008</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>2009</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Medical Council data show ACC referrals decreased from 10 to 1 doctor per year on average.\textsuperscript{10} The discrepancy between the ACC and Medical Council data is explained by the Medical Council’s filtering processes: the competence data reported in the Medical Council’s annual reports represent only the competence and fitness to practise referrals that Council forwards to its competence section.\textsuperscript{14}

The Director General has responded to ACC reported ‘risk of harm to the public’ by seeking feedback from providers about the ACC reported events. As no funding followed the 2005 legislative change, the Director General has had to resource action to remedy the ACC identified risk from within existing budgets. Medsafe has responded to the ACC reports by issuing warnings about medicines, and sometimes referring reported events to the Centre for Adverse Reactions to Medicines and/or the Medicines Adverse Reactions Committee.

The Medical Council may review a doctor’s performance or take disciplinary proceedings in response to an ACC referral. However, to date, ACC referrals have seldom prompted a performance review (about one per year) and no ACC referral has yet resulted in the Medical Council taking disciplinary action against a doctor.

According to Medical Council personnel, most ACC referrals result in the doctor being sent an ‘educational’ letter (effectively a warning letter) usually recommending that the doctor revise his or her practice and undertake further education.
Patient complaints to the Health and Disability Commissioner—Comparing the 5 years before and after the 2005 compensation reforms, patient complaints against all types of providers increased from 1206 to 1318 per year on average (Table 3). Despite the increase in complaints, HDC investigations decreased (Table 3).

In line with declining investigations, the Commissioner referred fewer providers (of any type) to the Director of Proceedings for possible discipline (from 21 to 16 per year on average) while maintaining steady referrals to the Medical Council (about 24 doctors each year) (Table 3).

<table>
<thead>
<tr>
<th>Year</th>
<th>New complaints</th>
<th>HDC investigations (% complaints)</th>
<th>HDC referral for possible performance review (% complaints)</th>
<th>HDC referral for possible discipline (% complaints)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1397</td>
<td>538 (39)</td>
<td>27 (2)</td>
<td>26 (2)</td>
</tr>
<tr>
<td>2002</td>
<td>1211</td>
<td>234 (19)</td>
<td>26 (2)</td>
<td>28 (2)</td>
</tr>
<tr>
<td>2003</td>
<td>1159</td>
<td>345 (30)</td>
<td>32 (3)</td>
<td>27 (2)</td>
</tr>
<tr>
<td>2004</td>
<td>1142</td>
<td>178 (16)</td>
<td>18 (2)</td>
<td>18 (2)</td>
</tr>
<tr>
<td>2005</td>
<td>1124</td>
<td>172 (15)</td>
<td>14 (1)</td>
<td>14 (1)</td>
</tr>
<tr>
<td>2006</td>
<td>1076</td>
<td>116 (11)</td>
<td>18 (2)</td>
<td>19 (2)</td>
</tr>
<tr>
<td>2007</td>
<td>1289</td>
<td>89 (7)</td>
<td>20 (2)</td>
<td>19 (1)</td>
</tr>
<tr>
<td>2008</td>
<td>1292</td>
<td>100 (8)</td>
<td>36 (3)</td>
<td>22 (2)</td>
</tr>
<tr>
<td>2009</td>
<td>1360</td>
<td>112 (8)</td>
<td>23 (2)</td>
<td>15 (1)</td>
</tr>
<tr>
<td>2010</td>
<td>1573</td>
<td>51 (3)</td>
<td>22 (1)</td>
<td>5 (&lt;1)</td>
</tr>
</tbody>
</table>

*Data from HDC annual reports, all types of providers.

Referrals to the Medical Council—Comparing the 5 years before and after the compensation reforms, Medical Council data reveal that referrals to the Medical Council decreased from 61 to 44 doctors per year on average (Table 4). The decrease was mainly due to declining referrals from ACC (Table 2).

Prior to the 2005 compensation reforms ACC accounted for 19% of all referrals but this decreased after the compensation reforms to only 4%. The Health and Disability Commissioner was the dominant source of competence referrals, accounting for about half of all referrals to Council. Referrals from peers and employers remained steady at...
less than 10 referrals each per year. College recertification programmes gave rise to few referrals.

In line with decreased referrals, the Medical Council conducted fewer performance reviews (from 35 to 26 per year on average) and referred fewer doctors to its professional conduct committee for possible discipline (Table 4). Disciplinary proceedings—Comparing the 5 years before and after the compensation reforms, both the HDC office (via the Director of Proceedings) and the Medical Council (via a Professional Conduct Committee (PCC)) brought fewer disciplinary charges against doctors before the Health Practitioners Disciplinary Tribunal (Table 4). Charges brought by the Director of Proceedings decreased from six to three per year on average, and charges by the PCC decreased from seven to five per year on average. More disciplinary hearings ended in guilty findings (from 65% to 83%) but overall fewer doctors were found guilty of professional misconduct (Table 4).

In comparison to the number of complaints and compensation claims lodged each year, very few doctors faced either a performance review or a disciplinary charge (Figure 4). Comparing the 5 years before and after the 2005 compensation reforms, fewer doctors were held to account by either the performance review process or the disciplinary process (Figure 3).

Table 4. Referrals to the Medical Council* and doctors’ disciplinary proceedings**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Council</th>
<th>Health Practitioners Disciplinary Tribunal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total referrals</td>
<td>Performance review (% referrals)</td>
</tr>
<tr>
<td>2001</td>
<td>82</td>
<td>37 (45)</td>
</tr>
<tr>
<td>2002</td>
<td>73</td>
<td>37 (51)</td>
</tr>
<tr>
<td>2003</td>
<td>50</td>
<td>58 (100)</td>
</tr>
<tr>
<td>2004</td>
<td>60</td>
<td>23 (38)</td>
</tr>
<tr>
<td>2005</td>
<td>41</td>
<td>20 (49)</td>
</tr>
<tr>
<td>2006</td>
<td>35</td>
<td>19 (54)</td>
</tr>
<tr>
<td>2007</td>
<td>38</td>
<td>18 (47)</td>
</tr>
<tr>
<td>2008</td>
<td>62</td>
<td>42 (68)</td>
</tr>
<tr>
<td>2009</td>
<td>42</td>
<td>29 (69)</td>
</tr>
<tr>
<td>2010</td>
<td>43</td>
<td>21 (49)</td>
</tr>
</tbody>
</table>

*Data from MCNZ annual reports **Data from Disciplinary Tribunal website
Discussion

In the years following the 2005 ‘no-fault’ compensation reforms, claiming for medical injury compensation increased, ACC reporting overall increased but ACC reporting to the Medical Council decreased. The reforms thus increased the barrier between the
compensation scheme and the Medical Council, and decreased accountability via 
compensation.

Doctors have responded to the no-fault compensation reforms by assisting more 
patients to lodge claims for compensation (reflected in increased claiming) and by 
contesting fewer claims decisions now that claims acceptance no longer implies 
wrong-doing or fault on the part of the doctor (reflected in the decreased claims 
decision time - from an average of 5 months to 13 days).  

The reforms have, therefore, improved both access to compensation for medical 
accident and the efficiency of the compensation scheme. The reforms have also 
increased the cost of medical injury compensation.  

While decreased ACC reporting to the Medical Council has freed doctors to engage in 
the compensation claims process with little fear of disciplinary repercussions, 
decreased ACC reporting risks leaving poorly performing doctors in practice 
unchecked. Patient safety is not likely to be greatly compromised by this, however, 
because ACC reporting seldom identified poorly performing doctors.

Furthermore, the greatest threat to patient safety comes not from the few poorly 
performing doctors but rather from all doctors, the majority of whom are competent, 
fit to practise, and well-intentioned.  

The decrease in ACC reporting to the Medical Council is offset by an increase in 
ACC reporting to the “authorities responsible for patient safety” overall. The 
increased reporting has provided the authorities with new opportunities to remedy 
“risk of harm to the public” and to improve patient safety.

Patient complaints to the Health and Disability Commissioner increased in the years 
following the compensation reforms, suggesting an increase in demand for 
accountability. This is not likely due to the reforms which, if anything, by improving 
access to compensation might have been expected to reduce patient dissatisfaction 
following an adverse event and thus to have reduced the demand for personal 
accountability via complaint.

Despite the increase in complaints, the Commissioner investigated fewer complaints 
and referred fewer providers for discipline while maintaining steady referrals to the 
Medical Council. The decrease in investigations is likely due, in part, to the HDC 
amendment Act 2003, which gave the Commissioner new (non-investigative) options 
in handling complaints, such as referring complaints to the Medical Council or back 
to provider without investigation. The decrease in investigations also likely reflects 
Commissioner Paterson’s efforts to catch up on a backlog of complaints from 
previous years when he took office in 2000, and his stated preference for early 
resolution: “early resolution is usually considered in the best interests of both 
complainant and provider, [and so] fewer cases are concluded by formal 
investigation.”

Decreased ACC reporting to the Medical Council contributed to an overall decrease in 
referrals to the Medical Council. The Medical Council responded by conducting fewer 
performance reviews and referring fewer doctors for discipline. The Medical
Council’s power to take a rehabilitative response to referrals as an alternative to discipline was introduced in the mid-1990s and continues today under the Health Practitioners Competence Assurance Act.\textsuperscript{30}

The reforms of the 1990s resulted in a decrease in disciplinary proceedings and a corresponding increase in performance reviews and educational programmes, reflecting a change in accountability as more doctors were held to account via the performance review process rather than the disciplinary process.\textsuperscript{31} In the years after the 2005 compensation reforms, however, both performance reviews and disciplinary proceedings decreased, reflecting an overall decrease in accountability (Figure 3).

Both the Medical Council and the HDC office brought fewer disciplinary charges against doctors before the Disciplinary Tribunal. It is not clear why this was so. The at times exorbitant cost of proceedings may be a factor. The scarcity of disciplinary proceedings means that Tribunal members have little opportunity to debate and determine professional standards and little opportunity to gain experience in the role.

In the years following the 2005 compensation reforms, then, there has been a decrease in ACC referrals to the Medical Council, referrals to the Medical Council overall, Medical Council performance reviews, HDC investigations, and medical disciplinary proceedings. These changes reflect decreased medical professional accountability.

Overall, very few poorly performing doctors are identified and dealt with in New Zealand each year, suggesting that either there are very few poorly performing doctors in New Zealand or that the current processes to identify and deal with them are ineffective. The previous Commissioner Paterson believes the latter and has called for change.\textsuperscript{32}

It is not possible to conclude from this study whether there is too much or too little individual accountability in New Zealand, or whether a different form of accountability is needed. Nevertheless, the trend for decreasing medical professional accountability in New Zealand’s raises the question of whether doctors are adequately held to account under New Zealand’s current regulatory system. However, since most harm stems from care that is well-intentioned and delivered by professionals who are competent and fit to practise, rather than (or in addition to) increasing individual accountability, we may do well to explore alternative models of collective or institutional responsibility.\textsuperscript{33}

In conclusion, accountability via compensation decreased following the 2005 ‘no-fault’ compensation reforms, contributing to an overall decrease in New Zealand’s medical professional accountability processes. There is no evidence that the trade-off in accountability has increased openness and learning about error and injury, or improved patient safety, but nor is there evidence to suggest that the change has led to worse patient care.

Further research is needed to understand the effect of the no-fault compensation system on health care ethics and practice, and to explore models of collective responsibility and incentives to reduce (unintentional) injury.

Further work is also needed and to learn from ACC reported “risk of harm to the public” and the provider feedback about ACC reported events to improve patient safety.
Competing interests: Nil.

Author information: Katharine Wallis, General Practice and Rural Health, Dunedin School of Medicine, University of Otago, Dunedin

Correspondence: Dr Katharine Wallis, General Practice and Rural Health, Dunedin School of Medicine, University of Otago, Hanover Street, Dunedin 9054, New Zealand. Email: katharine.wallis@otago.ac.nz

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