ACC and treatment injuries: is it time to rethink injury causation?

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ABSTRACT

In Aotearoa New Zealand, personal injuries resulting from medical treatment are covered under the *Accident Compensation Act 2001.* However, before victims of medical injury can receive cover and compensation, they must first satisfy several legal tests. Much criticism and legal action have surrounded the interpretation and application of these legal tests, primarily because of its focus lying on injury causation instead of supporting the incapacitated. This article examines the issues present within the current legislative framework for treatment injury coverage and proposes a potential solution to address the underlying problem.

In Aotearoa New Zealand, victims of personal injury caused by medical treatment are eligible to receive state-funded compensation under a no-fault accident compensation scheme (ACC scheme). However, before victims can obtain comprehensive cover and compensation, they must first satisfy several legal tests outlined in the *Accident Compensation Act 2001* (*AC Act*). The imposition of these statutory tests on the medically injured has not only drawn persistent criticism for the inequitable and preferential treatment of certain victims of injury but also led to a system that prioritises disputes over supporting victims adversely affected by medical treatment.[1–3] According to the Accident Compensation Corporation (ACC) website—the Crown entity responsible for administering the ACC scheme—approximately 37% of treatment injury claims are declined, while only 2% of non-treatment injury claims are rejected.[4,5] This disparity in injury coverage rates has ultimately led to many victims with treatment-related injuries receiving no state assistance despite suffering injuries that result in the same level of incapacity as those with non-treatment-related injuries.

The main aim of this viewpoint is to explore the drivers behind the disparities in injury coverage rates experienced by treatment injured claimants. An examination of the current treatment injury provisions under the *AC Act* illustrates that the criteria for treatment injury cover is ambiguous and arbitrary. Furthermore, an analysis of the treatment injury claim review process reveals its unjust and dysfunctional nature. The author concludes that addressing the aforementioned concerns requires a legislative revision of the treatment injury provision, coupled with the establishment of an independent, fair and transparent review process. This article also provides a potential example illustrating what such a reform might look like.

Overview of the treatment injury claim process

This section provides a brief summary of the treatment injury claim process.

When a patient sustains an injury while receiving treatment from a registered health/medical professional, they become eligible to lodge a treatment injury claim. All treatment injury claims must be lodged with ACC through a registered health provider.[6] After receiving a treatment injury claim, ACC will appoint a specialist cover assessor, who is a registered health professional (not necessarily a doctor), to assess the merits of the claim.[7] The primary objective of this assessment is to ensure that the patient's personal injuries satisfy the legal criteria for treatment injury cover as outlined in the *AC Act*.

Subject to legislative exceptions, a person in New Zealand injured as a result of medical treatment is entitled to cover and compensation, provided their injury was "caused" by the treatment given or sought.[8] This requirement is often referred to as the "causation test". Here, the assessor must be satisfied that, on the balance of probabilities, the injury was more likely than not caused by the medical treatment.

An exception to cover is made, however, for injuries that are *"a necessary part, or ordinary consequence"* of treatment, or "*wholly or substantially caused by a person's underlying health condition*", or "*solely attributable to a resource allocation*

decision", or "i*s a result of a person unreasonably withholding or delaying their consent to undergo treatment*".[9–12] The inclusion of several legislative exceptions in determining causation has led to much scholarly and legal action because the inherent effect of these exceptions is to preclude injured patients from receiving cover. While proving causation is straightforward in certain isolated situations, such as when a surgeon amputates the wrong leg, it becomes contentious in most other cases.

If ACC approves the patient's treatment injury claim, the patient can apply for entitlements/compensation. Conversely, if the patient's claim is denied, then the patient has the option to challenge the initial decision, leading to an independent review. This challenge must occur within 3 months of the initial decision. An independent reviewer will re-evaluate the case, allowing both parties to present additional evidence in support of their case. If the initial decision stands, the patient may appeal to the District Court for a rehearing. Generally, this serves as the final stage for dispute resolution, with the right to appeal to higher Courts reserved for exceptional cases.

The issue: an arbitrary claim boundary test and dysfunctional review process

Before delving into discussions regarding the key issues of the current treatment injury regime, including the arbitrary line drawing, unfairness and dysfunction plaguing the legislative "causation test" and its subsequent review process, it is essential to first explore the legislative history and rationale that underpin the statute's conception. Knowledge surrounding the scheme's historical context provides a strong illustration as to why legislative reform is needed.

New Zealand's accident compensation scheme was enacted following the recommendations of the 1967 *Royal Commission into Workers' Compensation in New Zealand*, more commonly referred to as the *Woodhouse Report*.[13] The *Report* identified numerous deficiencies in the common law system for compensating personal injury by accident, including the high administrative costs associated with litigation and the existing available redresses for injury being "a form of lottery".[14,15] The solution proposed by the Commission to address these deficiencies was to replace the common law action for injury compensation with a fully comprehensive, no-fault system that focussed on prevention, rehabilitation and compensation.[14]

At the core of this no-fault regime is the principle of community responsibility, built upon the idea that "a*s a modern society benefits from productive work of its citizens, so should society accept responsibility for those willing to work but prevented from doing so by physical incapacity*".[15] This principle imposes a societal obligation to reciprocate and compensate anyone injured, irrespective of the cause, in acknowledgment of their past contributions to society. However, it is evident that over the last 57 years there have been no successful efforts to fully embrace this vision.

The current no-fault compensation regime for treatment injuries faces two critical issues: firstly, the manner in which ACC opportunistically exploits the ambiguous legislative wording to use the "causation test" as a selective boundary to exclude treatment injury claims; secondly, challenging ACC's claim decisions is marked by a glaring lack of transparency and fairness. The absence of a robust framework for monitoring and accountability of injury claim decisions exacerbates the challenges faced by claimants, ultimately undermining the integrity of the system.

Difficulties in establishing causation often arise from ACC's interpretation and application of the exclusion tests outlined in section 32(1)(c) and section 32(2)(a) of the statue, namely the "ordinary consequence" and "wholly or substantially" tests.[9,10] This means that, under current law, ACC would not cover a personal injury caused by medical treatment if the injury is considered an "ordinary consequence" of the treatment or is "wholly or substantially" caused by an individual's underlying health condition.

However, the legislation does not define the terms "ordinary consequence" and "wholly or substantially", thereby giving ACC substantial discretion to arbitrarily determine instances in which claimants have satisfied one or more of the above exclusion tests and are, therefore, excluded from receiving treatment injury cover. The imprecise language used in the exclusion clauses permits ACC to engage in opportunistic and subjective assessments when establishing the proof of causation. Therefore, ACC can choose to selectively emphasise certain evidence while ignoring or lessening the weight of other evidence. Accordingly, this variation leads to different standards of causation under different circumstances, potentially resulting in inconsistent interpretations among different decision makers.

A 2017 report published by Acclaim Otago and

the Legal Issues Centre at the University of Otago, which looked into the complexities of obtaining injury cover, found that whenever ACC receives a claim that requires proof of causation, it often approaches it with scepticism, imposing a high evidentiary standard that must be satisfied before an injured person can access cover and entitlements.[16] While adopting such a pessimistic view may seem absurd, it is not too unreasonable to hold this position, especially when taking into account ACC's efforts to lower costs associated with medical treatment injury claims and past scandals involving ACC employees receiving financial bonuses for denying claims.[17,18] It is essential to clarify that the author does not allege that ACC staff and its associates are acting in bad faith; rather, it's systemic institutional practices and policies that have led ACC to adopt an unfair and restrictive interpretation of the treatment injury provisions.

A common theme observed in numerous legal cases pertaining to the denial of treatment injury cover is ACC's consistent reliance on an argument that revolves around the idea that a person's injury may result from a variety of factors, including the uncertain aetiology of the patient's condition, its multifactorial nature or the plurality of possible explanations for the condition.[19,20] The ambiguity in the treatment injury provision enables ACC to assert that the inherent complexities in determining causation makes it challenging to attribute the injury solely to the treatment in question. Consequently, this opens the door for a broad range of factors to be considered as contributing causes. The recent decision in *YZ v Accident Compensation Corp* (*YZ*) illustrates the difficulties in attributing an injury solely to a specific treatment.[21]

In *YZ*, a patient lodged a compensation claim with ACC for erectile dysfunction (ED), which he alleged was a treatment injury resulting from the use of a chemotherapy drug called Vincristine. However, ACC argued that several other significant factors, including his age and medical history, played a substantial role in the development of his ED, independently of the chemotherapy drug, and thus made him ineligible for coverage. The patient appealed to the District Court but was unsuccessful in overturning ACC's decision. Despite producing medical evidence in the form of journal articles and other similar research material indicating a probable link between the treatment and ED, the Court deemed that these sources of medical information were not "*evidence which can be relied upon to prove the existence of a particular medical condition*".[22]

Figures released under the *Official Information Act* revealed that out of all the treatment injury claims lodged between 1 July 2011 to 30 June 2021, 49,154 claims were declined.[1] Among these, 2,715 claims were later challenged through the independent review process.[1] The District Courts made an additional 209 decisions, affirming ACC's decision in 152 of those cases.[1] While only a small fraction of declined claims were challenged during that period, this does not necessarily imply that ACC made the correct decisions in the majority of cases, nor does it indicate the robustness of the review process. A 2015 independent review of the ACC dispute resolution process revealed that, due to the complexity of the legislation and ACC's procedures, many claimants found the appeal process and the legal aspects associated with their case difficult to understand.[23] The complexity of this process could be a reason why a significant number of initially declined claims were not later challenged through the review process.

A closer inspection of the claim review process further reveals the barriers faced by injured patients in accessing justice for their grievances with ACC. As a Crown entity, ACC has an abundance of resources at its disposal and thus maintains a significant tactical advantage in accessing and presenting additional evidence during the appeal process.[16] There is little to no incentive for ACC to facilitate patients' access to evidence because, if patients cannot produce new circumstantial evidence to contest the initial decision, the reviewer or Court will reject the appeal. Legal precedents, as set in *YZ*, highlight the necessity for patients to substantiate their claims by seeking the expertise of a medical professional, which can be financially challenging, particularly for patients from low socio-economic backgrounds. Furthermore, due to the limited availability of legal aid, many patients who choose to take their case to Court are forced to represent themselves in a complex legal case against a well-resourced Crown entity with substantial legal expertise.[16,19] Even if patients succeed in overturning ACC's initial decision, they are still burdened with the costs and stresses of litigation. Undoubtedly, such a process wastes valuable time and resources that could have been better utilised for the injured patient's rehabilitation and treatment.

Option for reform

This section suggests a revision of the treatment

injury provision to address the previously mentioned concerns.

In an ideal world, treatment injury cover should be unrestricted, reflecting the principle of community responsibility. However, adopting such a change would not be politically achievable without implementing legislative mechanisms to limit coverage due to concerns over fiscal irresponsibility.

Revising the existing treatment injury provision must achieve two primary objectives. First and foremost, the revised provision should establish a clear legal basis for the scope of claims, specifically avoiding the use of imprecise tests to determine the proof of causation. Secondly, the current system prompts a crucial question: why should ACC be the arbiter of deciding causation issues when its views may inherently favour its own interests? Therefore, any reform should institute a shift in decision-making authority to independent and impartial assessors who are not influenced by legislative pressures or financial incentives.

Such reform could look like the following:

32 Treatment injury

1. A person has cover for treatment injury if—
   a. the personal injury is suffered by a person—
   - (i) seeking treatment from 1 or more registered health professionals; or
   - (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
   - (iii) referred to in subsection (7).

2. Cover under subsection (1)(a) does not apply if—
   a. in the opinion of an ***independent panel*** of registered health professionals that is relevant to the person's care, the personal injury is solely attributable to a person's underlying health condition; or
   b. in the opinion of an ***independent panel*** of registered health professionals that is relevant to the person's care, the personal injury is a ***predictable risk*** of harm resulting from the treatment in question.

Note: Other subsections under section 32 are omitted because they do not require revisions.

6 Interpretation

1. In this Act, unless the context otherwise requires,—

independent panel means—

a. a panel consisting of registered health professionals appointed by the Health and Disability Commissioner.

predictable risk means—

a. Any adverse outcome arising from a medical intervention with diagnostic or therapeutic purpose that is intended or within the expected and likely range of treatment outcomes.

The suggested proposal, albeit with certain limitations, generally offers coverage for injuries resulting from treatment. Exceptions arise only in instances where there is compelling evidence indicating that the injury stems exclusively from the underlying health condition of the patient or is a foreseeable outcome of the treatment. This amendment uses plain language to prevent ambiguity. In cases where interpretation might be unclear, the legislation provides guidance for clarification. Thus, this reform requires assessors to apply an objective test in delineating the boundaries of coverage, eliminating arbitrary decision making.

Importantly, eligibility for cover is to be determined by an expert panel of health professionals relevant to the claimant's injury and appointed by the Human and Disability Commissioner (HDC), thereby transferring this authority away from ACC. This ensures an impartial evaluation free from any conflicts of interest, as these medical experts operate independently and remain uninfluenced by financial or legislative pressures that could compromise the decision-making process. Moreover, utilising a panel to make coverage determinations enhances the robustness of the decision-making process. It allows for a more comprehensive and multidisciplinary evaluation of the patient's condition, drawing on the collective expertise and perspectives of multiple health professionals. ACC would still handle the processing of claims, but it would no longer hold the authority to accept or reject treatment injury claims.

It's important to note that the proposed reform mentioned earlier does not provide fully comprehensive coverage. There will still be cases where patients might not meet the criteria for coverage. However, by establishing clear coverage boundaries and implementing a more objective claim determination process, the author believes that this approach would enable more medically injured claimants to qualify for cover. This would, in turn, ensure that their coverage is on par with that of accidental non-treatment related injuries, reflecting the principle of community responsibility while also maintaining a fiscally feasible compensation system.

In cases where disputes arise from a patient's disagreement with the panel's judgment, a transparent and fair review process is crucial. This becomes especially important for the patient, who may be at a disadvantage in terms of knowledge and bargaining power. Recognising the need for a robust review process to investigate and address complaints, the current investigative powers of the HDC would also need to be expanded. This allows the Commissioner to intervene, listen to patient complaints and work with patients to achieve a fair and satisfactory resolution. In this expanded role, the HDC can further investigate the patient's complaints, including the ability to commission an expert medical report to obtain another perspective on the merits of the patient's claim. Most significantly, all of this is achieved without placing an extra financial burden on the patient or subjecting them to the stress of litigation. The end result is a more equitable, transparent and fair mechanism for dispute resolution.

Conclusion

While the ACC scheme has been lauded as a radical and inspirational approach to dealing with personal injury, its failure to provide adequate cover and compensation for all injured New Zealanders has resulted in countless disputes, eroded public trust and confidence and exacerbated perceptions of injustice. The abuses within the current system, stemming from arbitrary line drawing and a dysfunctional review process, have resulted in a regime that is inconsistent with the foundational principles upon which the no-fault compensation scheme was built on—an abandonment that has become increasingly apparent over time.

COMPETING INTERESTS
There are no potential conflicts of interests.

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