By Simon Morrison

The New Zealand no-fault accident compensation scheme

The financial viability of the NZ model

Many proponents of no-fault compensation schemes hold out the New Zealand Accident Compensation Corporation (ACC) model as the benchmark for all insurance schemes to aspire to. One has to wonder how the benchmark scheme could, as recently as three years ago, have fallen into an unfunded liability of more than $10 billion, leaving taxpayers scrambling to fill the void of a scheme in enormous financial difficulty. This article examines the history of the ACC scheme and challenges some of the arguments advanced in support of the concept that no-fault insurance schemes are indeed the model upon which all schemes should be based.

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EARLY BEGINNINGS

The New Zealand no-fault scheme has its origins in the early 20th century, following the Bismarck model in Germany.[1] In 1900, the New Zealand government introduced a no-fault workers' compensation scheme through the *Workers' Compensation Act*. This scheme continued until 1974, when significant changes occurred.

In 1967, a Royal Commission was established to investigate complaints of inadequacies in workers' compensation benefits in the New Zealand scheme. The Commission's Chairman, Mr Justice Woodhouse, ordered an overhaul of accident compensation arrangements, moving to a new 'no-fault' model of compensation for personal injuries. The 'Woodhouse Report', as it became known, recommended a scheme to cover:

> 'all motor vehicle injuries, funded by a levy on owners of motor vehicles and drivers all injuries to earners whether occurring at work or not, funded by a flat rate levy on employers the cost of all injuries to their employees. A levy on the self-employed to pay for the injuries occurring at work or outside work was also proposed.'[2]

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The report emphasised five key principles:
1. Community responsibility
2. Comprehensive entitlement
3. Complete rehabilitation
4. Real compensation
5. Administrative efficiency

In 1972, the Parliament unanimously passed laws to commence the operation of the scheme. Three schemes were established under the legislation:
1. The Earners Scheme
2. The Motor Vehicle Accident Scheme
3. The Supplementary Scheme

The scheme became operational on 1 April 1974, being administered by the Accident Compensation Commission.

After five years of operation, concerns developed in relation to the cost of the scheme and employers became agitated at the requirement to pay the cost of non-work related claims. A committee was formed, chaired by the Honourable Derek Quigley, to review the scheme.[3]

The recommendations of the Quigley Committee included that:
'• The claimant should pay part of the cost for the first two visits to the doctor (they could recover this from the employer in the case of the work accident).
• The pause period for earnings-related compensation should be extended from one week to two weeks for non-work accidents (for work accidents, the employer would pay compensation for the first two weeks).
• Lump sum payments should be abolished except for serious cosmetic disfigurement.
• The levy collection method should be reviewed.'[4]

In 1982, a key change occurred, in that the funding model for the scheme was altered. Moving away from a traditional, fully funded model, the scheme was now to become a pay-as-you-go scheme. A series of payment reductions were also introduced, including reduction of weekly compensation from 100 per cent of wages to 80 per cent of wages for the first week following a work accident.

FURTHER REVIEWS

In 1986, a further review of the scheme was conducted. In particular, the body overseeing the review[5] focused on the difference between accident victims in the scheme and those with illness caused by disability.

Sweeping changes were suggested by a Law Commission Report. Key changes included:
1. Weekly compensation reduced to average weekly earnings as opposed to actual earnings.
2. The pause period for work-related compensation increased from one week to two weeks for non-accidents.
3. Lump sum payments for permanent impairment abolished.
4. Medical mishap not to be included in the scheme.
5. Special provisions for victims of sexual assault.[6]

A change of government in 1990 resulted in a further review of the scheme. A focus of the working party established to review the scheme was to consider reducing the cost to society by providing greater freedom between insurers and creating competition between public and private sector insurers. Legislation was passed by the Parliament in 1992, with the following key changes to the scheme:
'1. The scheme was separated into different accounts.
2. Earners account premium was introduced to cover non-work injuries.
3. For those in paid employment: employees paid for non-work injuries (instead of employers) through a premium collected by Inland Revenue.
4. Experience rating discounts [where claims are lower than forecast] and loadings were introduced for employers.
5. Entitlements, eligibility and rates were specified in regulations.
6. Calculation of weekly compensation was prescribed.
7. Lump sum entitlements were replaced by independence allowance.
8. The Accident Compensation Appeal Authority was scrapped. The District Court took over its role.'[7]

By 1998, private insurers were allowed access into the scheme, concentrated in the area of work-related injuries. Under the legislation, the Accident Compensation Corporation (ACC) was excluded from providing the workplace accident insurance market. Self-employed people were allowed to choose to stay with ACC. The office of the Accident Insurance Regulator was established to oversee the private market. Employers were advised to take out private accident insurance: if they did not, they could be forced to pay large penalties.

The scheme was also switched back to a fully funded model, as opposed to a pay-as-you-go model.

As a result of further changes in 2000, private insurers were removed from the scheme and were replaced by the ACC as the sole provider of accident insurance. Private insurers were prohibited from providing insurance after 30 June 2000, but were permitted to manage claims for injuries occurring between 1 July 1999 and 1 July 2000.[8]

Further amendments in 2001 included:
'1. Greater focus on injury prevention as a primary function of ACC.
2. Greater focus on rehabilitation.
3. New management of injury-related information across the different agencies within the injury prevention sector. The Act provides for an information manager to be appointed to oversee the collection of and access to data across the different government agencies.
4. Lump sum entitlements to be reintroduced for permanent impairment.'[9]

Further changes in 2005 included, *inter alia*, changes to the definition of medical misadventure, opening up better access for victims of sexual abuse, and covered injuries sustained by twisting,[10] and poisoning from eating mushrooms.[11]

Finally, key amendments were passed in 2008, removing barriers in relation to work-related gradual process disease and infection claims; increasing the length of time clients can access vocational rehabilitation beyond three years; and an occupational assessment that now takes into account a

client's pre-injury earning level when identifying potential employment opportunities, among others.

ACC SCHEME REVIEW BY PRICEWATERHOUSECOOPERS

In September 2007, PriceWaterhouseCoopers (PWC) was appointed by the ACC Board of Members to review the Scheme and to consider the following:

- '...to evaluate the economic and social returns on investment of the ACC Scheme, and in particular to understand the social, environmental and economic factors that will influence the sustainability of that return in the future.
- ... to provide an evaluation of the scheme's value to New Zealand and allow the decision-makers to direct the future implementation of the scheme.'[12]

In its discussion on no-fault versus fault, PWC concluded:

> 'Blended systems allowing access to tort law, which are the norm in Australian workers' compensation schemes, can be costly. Evidence indicates that access to common law benefits, even where significantly limited in nature, has been one of the primary drivers of cost blowouts in workers' compensation schemes in Australia.'[13]

Further, on the issue of costs inside no-fault schemes, PWC concluded:

> 'No-fault schemes can also impact system costs. In regards to treatment injury, no-fault systems tend to have lower costs of "defensive medicine", lowering system costs without any measurable impact on patient incomes.'[14]

On the question of how well the ACC Scheme performs compared with other schemes, PWC found:

> 'Overall, summarising our observations thus far, we conclude that the current ACC scheme is consistent with the Woodhouse principles; adds considerable value to New Zealand society and the economy and performed very well in comparison to alternate schemes in operation internationally.'[15]

FINANCIAL CONDITION REPORT 2010

In 2009/2010, the New Zealand government enacted legislation requiring the ACC to annually prepare a Financial Condition Report, following findings that the scheme was in significant financial difficulty.

The approved actuary overseeing the report found that:

'1. Historical financial condition

(a) Based on data and information through 30 June 2010 a **Hindsight Assessment** of the adequacy of ACC's historical accrued insurance liabilities and collected insurance premiums demonstrates that:

(i) Prior to 30 June 2009, ACC's outstanding claims liabilities reflected in its financial statements do not fully reflect the future cost of injury; **in hindsight**, they were underestimated. Therefore, **in hindsight** the financial condition of the scheme has proven to be worse than anticipated at the time.

(ii) **In hindsight**, the insurance premiums collected for the fully funded years have demonstrated to be inadequate to fully fund the costs of new injuries that have occurred. [All emphases are from the report itself.]

(b) The main reasons for the inadequate estimates include:

(i) Inflationary pressures on the cost of future services had been under-estimated. In particular, assumptions of the future cost and cost of uncertainty associated with future medical elective surgery, and social rehabilitation services, had been unrealistically accounted for.

(ii) Beginning in 2005, utilisation of the scheme began to increase. The rate of new injuries/claims rapidly increased, claims from prior years reactivated, and recovery rates began to deteriorate. These patterns of increased utilisation were not immediately responded to and funded for.

(iii) The cost of uncertainty associated with personal injury coverage was not adequately included in the estimates of the insurance liabilities until the adoption of the New Zealand equivalent of the International Reporting Standards (NZ IFRS) in 2008 and has never been accurately reflected in the insurance premiums collected.'

As a consequence, the financial position of the scheme as concluded by the actuaries was:

> 'ACC's current financial condition is best reflected through its net funding position which was a negative $10.3 billion as at 30 June 2010. ACC's current financial condition

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carries much opportunity for improvement.

ACC's current funding policy is not based on capital management best practice for an organisation in the business of insurance and therefore is inadequate in dealing with the uncertainties present in its business model.'[16]

FAULT v NO-FAULT

One could be forgiven for concluding, based on the views of PWC in its 2008 report to the New Zealand ACC, that no-fault insurance schemes are the most viable schemes when compared to fault-based schemes or hybrid schemes.

The Financial Condition Report of 2010 suggests that serious questions must be asked in relation to that proposition. Further, when schemes in Australia are considered in that light, the following observations can be made:

1. The scheme in Australia that appears to be in the worst financial condition is the South Australian Workers' Compensation Scheme. It currently has a funding ratio of 59 per cent; namely, its liabilities are nearly twice the size of its assets, and it has the highest premium level in the country at $2.75.[17]
2. By contrast, the Queensland Workers' Compensation Scheme – which is a hybrid scheme involving both no-fault coverage and fault coverage – has a funding ratio of 119 per cent, which means that not only is it meeting all of its liabilities, but it has a margin of 19 per cent, and its premium level of $1.42 is nearly half that of the South Australian scheme.[18]

If the financial condition of insurance schemes is examined closely, questions arise as to the right modelling if insurance schemes are to deliver the following key outcomes:

1. A financially sustainable and healthy scheme.
2. Delivery of benefits to claimants or beneficiaries of the scheme.
3. Suitable outcomes for all scheme stakeholders.

WHAT IS THE PERFECT MODEL?

As lawyers who act for clients claiming from insurance schemes, we gain an appreciation of what is important for those receiving benefits from such schemes.

Moreover, our access to most of the insurance schemes within Australia gives us an awareness of key patterns that emerge in relation to scheme health.

Our experience and familiarity with various schemes suggest that the following features characterise a successful scheme:

1. ***Adequacy of benefits***

   It is important that any insurance scheme offers adequate benefits to meet the needs of claimants.

2. ***Choice***

   Shortcomings of pure no-fault schemes include the fact that choice is limited for claimants. For example, not all claimants wish to remain tied to an insurance scheme for up to a decade. Claimants who are in receipt of payments on a pension basis are left with few choices in terms of the future. One of the key advantages of hybrid schemes is that such a choice is afforded to claimants. That is, those claimants who seek to actualise future entitlements, and move on, can do so whether it be through the vehicles of the tort system operating inside the scheme, or through other statutory mechanisms in the scheme.

When current schemes in Australia are analysed, compelling arguments begin to emerge with respect to some aspects of scheme design.

The South Australian model, generally known as a 'long-tail scheme', is in the poorest financial state of all workers' compensation schemes in Australia. The Queensland model, which is generally known as a 'short-tail scheme', is in one of the best positions financially of all the schemes in Australia.[19]

Key advantages of short-tail schemes are that insurers have greater certainty in relation to their liabilities in the scheme; claimants can be afforded the opportunity to bring claims to a conclusion and be adequately compensated for future requirements; and long-tail costs can be saved.

In our view, the hybrid model schemes in workers' compensation in Australia tend to produce the better results for all the scheme stakeholders – including claimants – when all criteria are considered.

CONCLUSION

One thing is certain, governments need to be very careful when considering scheme modelling of any insurance scheme in which they have an interest.

No government wants to be in a position where a poor choice of scheme model results in major unfunded liabilities which must be corrected, ultimately through taxpayer funds.

The key objective must be to produce sustainable and financially healthy schemes, that also meet the needs of all scheme stakeholders. ■

Notes: **1** The Chancellor of the German Empire, Otto von Bismarck, introduced a no-fault compensation scheme. **2** NZ Accident Compensation Commission, *History of ACC in New Zealand*: www.acc.co.nz. **3** *Ibid.* **4** *Ibid.* **5** The Officials Committee, comprising representatives from the ACC and various NZ government departments. **6** See note 2 above. **7** *Ibid.* **8** *Ibid.* **9** *Ibid.* **10** 'Twisting of the body' is a term used in the NZ scheme. **11** See note 2 above. **12** Accident Compensation Corporation New Zealand, *Scheme Review*, March 2008, PriceWaterhouseCoopers, pi. **13** *Ibid*, pvi. **14** *Ibid.* **15** *Ibid*, pxviii. **16** *Accident Compensation Corporation Financial Condition Report 2010*, pp1 & 2. **17** *South Australian WorkCover Annual Report 2011-12*, p4. **18** *WorkCover Queensland Annual Report 2011-12*, p7. The premiums cited are annual: that is, the employer pays $2.75 (in SA) and $1.42 (in QLD) in premium for every $100 of wages. **19** A short-tail scheme assumes that claims will be finalised in a shorter timeframe, typically two years. A long-tail scheme is a model that runs for a longer period, typically five to ten years.

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