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Tort Reform, Kiwi-Style

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INTRODUCTION

When ordinary Americans think of New Zealand (which is hardly at all), they probably envision the breathtaking mountains, glaciers, and lakes panoramically depicted in the film version of *Lord of the Rings*. For legal scholars, however, radical tort reform distinguishes New Zealand's approach to accident law from that of the United States (and indeed of all other jurisdictions). Not that tort reform has been lacking in the United States. In recent years, most states have enacted important changes, almost always to reduce tort liability: caps on pain-and-suffering, a revised collateral source rule, limits on punitive damages and joint liability, and protections for physicians facing malpractice claims, among many others. Federal tort reform has focused on class actions, firearms litigation, preemption, childhood vaccines, general aviation, FDA-regulated drug litigation, and other areas.

To American lawyers, such changes seem very far-reaching. But viewed from New Zealand, even Texas's robust version of tort reform, which has transformed the state into a much more defendant-friendly jurisdiction, looks like a mere rearrangement of the deck chairs on the Titanic. New Zealand, after all, abolished the most important areas of tort law more than three decades ago, and its people seem quite happy with the result.¹ In stark contrast, the American

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1. Indeed, according to Sir Geoffrey Palmer, who (prior to becoming Prime Minister) drafted a 1969 White Paper on accident compensation, favorable public opinion protected it from some proposed changes even as early as 1981-82. Geoffrey Palmer, *The New Zealand Experience*, 15 U. HAW. L. REV. 604, 608 (1993). See generally IAN CAMPBELL, *COMPENSATION FOR PERSONAL INJURY IN NEW ZEALAND* (1996) (tracing the history of the New Zealand system). More recently, the opposition National Party has advocated privatizing the insurance part of the scheme, but has not proposed returning to the tort system. E-mail from Geoff McLay,

tort system continues to expand and flourish, while representing (depending on whom one asks) either the essence of popular justice or a symbol of all that is wrong with our law. Even recognizing the many important differences between these two common law jurisdictions, the New Zealand experience with tort reform nevertheless highlights one striking feature of American tort law: the remarkable durability of our tort system in the face of persistent and growing criticism from many academic commentators,² business groups,³ and political leaders.⁴ But the United States is hardly distinctive in the durability of its tort law; the same is true of the other British Commonwealth countries, including, most notably, “neighboring” Australia, which specifically considered the New Zealand approach but did not adopt it.

I. TORT REFORM IN NEW ZEALAND

Early in the twentieth century, New Zealand adopted a national no-fault workers’ compensation scheme, replacing tort law for industrial accidents while leaving the rest of the system intact. It also mandated tort liability insurance against auto accidents.⁵ During the 1960s, New Zealand established a royal commission to explore possible reforms to its workers’ compensation system. As often occurs with such bodies—including our own constitutional convention in 1787—the commission decided not to be limited by its remit but proceeded, instead, to review the tort system more generally.

In 1967, the commission published the Woodhouse Report (as it is popularly known).⁶ It severely criticized the fault-based tort system’s “false morality,” unpredictable damage awards, and high transaction costs. Transaction

Reader in Law, Vict. Univ. at Wellington (June 16, 2008) (on file with the Yale Law & Policy Review).

2. See, e.g., JEFFREY O’CONNELL & CHRISTOPHER J. ROBINETTE, A RECIPE FOR *BALANCED* TORT REFORM 29-49 (2008).
3. See, e.g., COMM. FOR ECON. DEV., RESEARCH AND POL’Y COMM., WHO SHOULD BE LIABLE?: A GUIDE TO POLICY FOR DEALING WITH RISK (1989); Press Release, U.S. Chamber of Commerce, Chamber Marks House ‘Tort Reform Week’ by Urging Swift Passage of the Lawsuit Abuse Reduction Act (Sept. 13, 2004), available at <http://www.uschamber.com/press/releases/2004/september/04-122.htm>; Press Release, The Business Roundtable, White House Study Reveals Tort System’s Harm to America’s Workers and Consumers (Apr. 29, 2002) (on file with the Yale Law & Policy Review).
4. COUNCIL OF ECON. ADVISERS, WHO PAYS FOR TORT LIABILITY CLAIMS?: AN ECONOMIC ANALYSIS OF THE U.S. TORT LIABILITY SYSTEM (2002), available at http://www.whitehouse.gov/cea/tortliabilitysystem_apr02.pdf.
5. The American states enacted these changes (and the courts upheld them) a decade or two later.
6. Joan M. Matheson, *Compensation for Personal Injury in New Zealand: The Woodhouse Report*, 18 INT’L & COMP. L.Q. 191, 191-95 (1969).

costs were estimated to comprise over 40% of the system's total costs,⁷ a lower figure than the comparable costs of U.S. asbestos litigation first launched around the same time.⁸ In place of tort, the Woodhouse Report proposed extending the no-fault compensation scheme from workplace accidents to personal injuries generally. The document expressed hope that this system would provide wage-loss benefits roughly matching pre-injury earnings and additional benefits for permanent bodily impairment, while also promoting accident prevention, victim rehabilitation, and administrative efficiency.

In 1972, the National Party government, whose Justice and Labour ministries had actively promoted the commission's work and the Woodhouse Report, pushed through the Accident Compensation Act.⁹ It enjoyed bipartisan support and passed quite easily, a fact that will astonish any American lawyer observing the protracted, titanic struggles over even the mildest tort reforms in the United States. Amended in 1973 by the new Labour government to include accidents to non-wage earners, the Act went into effect in April 1974.¹⁰

Even more surprising, the public did not demand the new system. Instead, it was the handiwork of a small group of dedicated reformers led by influential and prestigious judges.¹¹ Success was assured when the major groups opposing the reform—the insurance industry, the bar, and labor unions—turned out to be politically weak and fragmented.¹² However, the new system was not the comprehensive abolition of tort that the Woodhouse Report had proposed. Rather, it limited no-fault coverage to motor vehicle-related injuries and to wage earners' injuries, regardless of whether the injuries were work-related. But the government subsequently expanded the system to cover virtually all accidental injuries and to confer very broad benefits on victims. New Zealanders today generally regard their system (some disputed details aside, some of which are listed at the end of Part II) as a mainstay of their social policy.¹³

7. GEOFFREY PALMER, *COMPENSATION FOR INCAPACITY: A STUDY OF LAW AND SOCIAL CHANGE IN NEW ZEALAND AND AUSTRALIA* 27 (1979).

8. RICHARD H. GASKINS, *ENVIRONMENTAL ACCIDENTS: PERSONAL INJURY AND PUBLIC RESPONSIBILITY* 305-06 (1989).

9. See Palmer, *supra* note 1, at 612-13.

10. The legislative history is detailed in GASKINS, *supra* note 8, at 325-50.

11. PALMER, *supra* note 7, at 69.

12. *Id.* at 115-30.

13. ACCIDENT COMP. CORP., *ANNUAL REPORT 2007*, at 5 (Sept. 2007) (on file with the Yale Law & Policy Review) (comments from the Interim Chair of the ACC Board, Brenda Tahiri).

II. THE FACE OF RADICAL TORT REFORM

The heart of the New Zealand system, in existence for more than thirty years, is a blanket prohibition on almost all personal injury damage actions.¹⁴ A government agency, the Accident Compensation Corporation (ACC), operates the scheme as a Crown entity. Although a National Party government briefly privatized the insurance function for workplace accidents in 1998, the Labour government soon returned to power and swiftly restored the ACC as New Zealand's sole insurer for such accidents.

The ACC provides generous no-fault benefits, including hospital and medical costs; wage replacement, starting only one week after injury, at a rate of 80% of average weekly earnings; rehabilitation and transportation costs; lump sum payments for permanent loss or impairment; and entitlements for surviving spouses and children. Most medical and dental services do not require pre-approval, and service providers, not consumers, complete paperwork for the ACC.

The ACC's benefit payments come from six different accounts; each corresponds to a category of victim and accident types, and each is funded separately by targeted levies or general revenues.¹⁵ To simplify somewhat, these accounts cover injuries from motor vehicle accidents on public roads, work-related injuries to employees and self-employed people, workers injured outside the workplace, work-related injuries suffered before 1999, medical treatment injuries, and injuries to those who are not in the active labor force (mostly children and the elderly).¹⁶

In fiscal year 2006-2007, the ACC had 1.6 million claims pending. The bulk of these was solely for medical treatment reimbursement covering a population of 4.3 million, approximately 1.75% of the U.S. population.¹⁷ In fiscal year 2005-2006, the ACC paid out NZ\$569 million on new claims and NZ\$964 million on preexisting claims. Claim denials, which can be appealed, are rare (1-3%) for most of these accounts, but occur in 15% of work-related accidents to employees, and 36.5% of medical treatment injuries.

14. Injury Prevention, Rehabilitation, and Compensation Act 2001, 2001 S.N.Z. No. 49 [hereinafter IPRCA].

15. About ACC, <http://www.acc.co.nz/about-acc/index.htm> (last visited Dec. 1, 2008).

16. *Id.*

17. PRICEWATERHOUSECOOPERS, ACCIDENT COMPENSATION CORPORATION NEW ZEALAND: SCHEME REVIEW iii (2008) [hereinafter SCHEME REVIEW]. Although comparisons are of little value here, the number of new tort filings in the United States that year can be estimated roughly at 615,000 for the state courts alone. See NAT'L CTR. FOR STATE COURTS, TORT CASELOADS IN STATE TRIAL COURTS OF GENERAL JURISDICTION, 1996-2005, http://www.ncsconline.org/D_Research/csp/2006_files/Table%204_05.xls (last visited Nov. 9, 2008). If tort filings in the federal courts are less than 10% of total civil filings, as has been estimated, this would produce a total of roughly 675,000 new tort cases in all courts.

Although the ACC scheme prohibits almost all personal injury actions for damages, it does permit some exceptions, including actions for intentionally or negligently causing property damage, for malicious prosecution or conspiracy “so long as plaintiff seeks recovery for damages other than those produced by ‘injury by accident,’” for some mental injuries not due to personal injury, and for exemplary damages.¹⁸

A comprehensive account of the New Zealand accident compensation scheme is beyond the scope of this Essay.¹⁹ Nevertheless, one can glimpse how the ACC system operates by considering several important categories of accident-related claims that are often handled through the tort system in the United States. I shall briefly discuss two of these categories: medical treatment injuries and emotional harm claims.

A. *Medical Treatment Injuries*

American tort reform has been driven partly by concerns about how medical malpractice law affects the remedies available to victims, the availability and cost of insurance for providers, the practice of defensive medicine, and rising health care costs.²⁰ With many of the same concerns in mind, New Zealand has struggled from the beginning to fit medical injuries into the ACC’s overall compensation scheme. This road has not been smooth, as it soon became clear that the no-fault system would treat medical injuries differently—and more restrictively—than other compensable injuries, largely because of the government’s desire to exclude illness from ACC coverage.²¹

A recently-published comparative study of medical malpractice compensation summarizes New Zealand’s experience. It is worth quoting at length:

Initially, all accidental personal injuries were covered, including medical malpractice, which was labeled “medical misadventure.” However, total expenditures from the program rose rapidly.

... The funding changed dramatically over the course of three decades and several reforms; a pay-as-you-go financing structure was established, a new levy for registered health professionals was created Also, the government retained the power to require risk-rated premiums for health professionals. Administrative cost, however, was only 10 percent of total expense. Even so, the overall costs of New Zea-

18. Richard S. Miller, *The Future of New Zealand’s Accident Compensation Scheme*, 11 U. HAW. L. REV. 1, 36 (1989). See also IPRCA, *supra* note 14, §§ 317, 319.

19. For such an account, see SCHEME REVIEW, *supra* note 17.

20. See, e.g., FRANK A. SLOAN & LINDSEY M. CHEPKE, *MEDICAL MALPRACTICE* 301 (2008).

21. This exclusion is apparently universal in current medical no-fault systems. According to the SCHEME REVIEW, the Netherlands covers all incapacity, including illness and sickness, but only for employees under its workers’ compensation scheme. SCHEME REVIEW, *supra* note 17, at xi.

land's no-fault program have proven to be burdensome. Cost per claim has risen considerably.

In response to rising costs, there was a major reform in 1992 which substantially restricted the scope of covered injuries, shortened the time within which claims could be brought, and eliminated lump sum payments for pain and suffering. As in Sweden, the New Zealand program now required a fourteen-day hospital stay or twenty-eight sick days as a requirement for eligibility. The newly restricted definition of medical misadventure introduced an element of fault, limiting claims to injuries resulting from medical error or mishap, and thus removing the problem of having to distinguish between injuries resulting from medical care and unavoidable or inevitable injuries. The introduction of fault in the 1990s was not a surprise; courts had used fault in their analyses of medical misadventures throughout the 1980s, and a substantial body of case law had developed.²²

Medical "error" closely resembled the American negligence standard, while "mishap" employed the no-fault criteria of rarity (defined as occurring in no more than 1% of cases) and severity (defined as certain periods of hospitalization, extended disability, or death) of the adverse consequence of treatment.²³ Another recent comparative study, discussed below, notes that New Zealand provided compensation under the "mishap" standard for *acts* that met the rarity and severity criteria, but not for *omissions* that satisfied the criteria (unless the omission qualified as medical "error").²⁴ Other boundary problems, the authors found, plagued this no-fault "mishap" standard:

Determining whether complications fell beneath the 1 percent threshold proved difficult in practice, often because of gaps in epidemiologic data. Moreover, decisionmakers soon realized that the threshold may be a moving target in medicine. A new type of prosthesis, for example, may initially be regarded as very safe, but with time and broader use, data may reveal a complication rate of greater than 1 percent. The peculiar result would be that an early cohort of claims would be compensable under the mishap rule, whereas later claims would miss out. Practical difficulties also emerged in applying the severity criteria. While death and hospitalization periods were relatively easy to meas-

22. SLOAN & CHEPKE, *supra* note 20, at 301-02 (footnotes omitted). This passage applies to the medical portion of the scheme, except for the administrative cost figure and some of the 1992 reforms, which are for the scheme as a whole. See E-mail from Lindsey Chepke, Research Assoc., Duke Univ. (Mar. 28, 2008) (on file with the Yale Law & Policy Review).

23. Allen B. Kachalia et al., *Beyond Negligence: Avoidability and Medical Injury Compensation*, 66 SOC. SCI. & MED. 387, 394 (2008).

24. *Id.* at 399.

ure, “severe disability,” which can be a highly subjective notion, left considerable room for interpretation.²⁵

When the New Zealand parliament narrowed the scope of “medical misadventures” in 1992 to introduce a fault element, it used these same criteria.²⁶ Such claims were themselves rare (0.14% of the total claims filed with the ACC), although the average size of each medical claim was far larger than that of other claims.²⁷

New Zealanders complained that the stringency of these “rare” and “severe” tests effectively rendered medical treatment-related injuries the only kind of accident not fully covered by the ACC. These complaints resonated politically because New Zealand, like the United States, lacks national health insurance. Relatively few employers in New Zealand offer private health insurance, in contrast to practices in the United States, where such insurance is very widespread (though perhaps less so than at times in the past).²⁸ Instead, New Zealand maintains a system of tax-funded public health clinics and hospitals that provide free care but that, like all such systems, also have long waiting lists, particularly for social services such as rehabilitation and long-term care. Under the ACC scheme, a child disabled by medical treatment at birth would receive extensive social services benefits, even full-time attendant care, while a baby born with Down syndrome would receive only the limited public benefits available through the public health system.²⁹

As a result of such anomalies, there is constant public pressure to expand ACC coverage to include not only “accidents” but also “illnesses” and other misfortunes. Not surprisingly, this line has proved hard to justify and to maintain, particularly in a country that has long viewed no-fault compensation for physical injuries as a basic social entitlement. Absent national health insurance, this pressure has focused on efforts to further enlarge ACC coverage and benefits. Since the ACC provides not only more benefits but also faster access to those benefits, especially medical treatment, these efforts have been intense.³⁰

25. *Id.*

26. Accident Rehabilitation and Compensation Insurance Act 1992, 1992 S.N.Z. No. 13, § 5.

27. Ken Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 *MED. L. REV.* 357, 365 (2007).

28. See Ian Urbina, *A Decline in Uninsured Is Reported for 2007*, *N.Y. TIMES*, Aug. 26, 2008, at A14.

29. Interview with John Miller, Barrister and Solicitor, in Wellington, N.Z. (Feb. 5, 2008).

30. On the other hand, recourse to the tort system remains an attractive option for certain victims who suffer medical accidents that are not covered by the ACC but in which plaintiffs can readily prove fault. This fact has caused at least one commentator to propose a split system in which a patient could choose between filing a no-fault claim to the ACC and pursuing a tort claim. See Petra Butler, *A Brief In-*

In response, the Labour Party government enacted important changes in 2005 that, among other amendments, substituted for “medical misadventure” a new and supposedly broader coverage category: “treatment injury.”³¹ This category was designed to liberalize the coverage standard for medical injuries by distinguishing treatment-related accidents from (1) the question of fault, which legislators wished to make irrelevant to compensation and (2) the natural progression of disease, for which compensation had never been intended. Although this change seems likely to open the door to greater coverage—indeed, that is the government’s intent—it still necessitates some very fine line-drawing. This combination of liberality and ambiguity probably explains why medical treatment claims nearly tripled in the first year, while the ACC’s denial rate for such claims declined by half (from 71% to 36%).³² Expenditures increased almost 28% in the first year after the change.³³ The government plans to evaluate the cost, implementation, and effects of these changes in 2010. Some officials believe that the increased number of claims will be fiscally manageable, although the costs of covered health care and allied services are rising rapidly.³⁴

Reportedly, medical patients who suffer adverse outcomes increasingly seek exemplary damages through tort actions in addition to their ACC benefits.³⁵ To do so, they must show that the defendant acted either with harmful intention or reckless intent, or, where the exemplary damages are based on the defendant’s negligence, that the negligence was truly exceptional or outrageous.³⁶ Exemplary damages, when awarded, are low by American standards, and they almost never are awarded in medical injury cases.³⁷

troduction to Medical Misadventure, 35 VICT. U. WELLINGTON L. REV. 811, 819 (2004).

31. Oliphant, *supra* note 27, at 357.

32. *Id.* at 385.

33. *Id.*

34. Interview with Graeme Buchanan, Deputy Sec’y of Labour, N.Z. Dep’t of Labour, and Staff, in Wellington, N.Z. (Feb. 5, 2008).

35. Butler, *supra* note 30, at 816-17.

36. Interview with John Miller, *supra* note 29.

37. According to John Miller, NZ\$30,000 may be awarded for sexual abuse, and NZ\$100,000 is the highest he can recall. *Id.* If the defendant already has been punished criminally, this fact may be considered in limiting the exemplary damages. See IPRCA § 319(3). In *Bottrill v. A*, a woman whose cancer was misdiagnosed by a pathologist received ACC benefits and sued for exemplary damages, but she was denied them by the Court of Appeal on the ground that such damages could only be awarded where a doctor “acts deliberately or recklessly” to put a patient at risk. [2001] 3 N.Z.L.R. 622, 636 (C.A.), *rev’d*, [2003] 2 N.Z.L.R. 721 (P.C.). The Privy Council reversed on the ground that his fault went far beyond simple negligence. *Bottrill v. A*, [2003] 2 N.Z.L.R. 721, 729 (P.C.) (“There may be the rare case where the defendant departed so far and so flagrantly from the dictates of ordinary or professional precepts of prudence, or standards of care, that his conduct satisfies

The New Zealand system's handling of medical accident claims reveals several other significant features. As the account excerpted above describes:

In addition to monetary compensation, claimants in New Zealand have the option of pursuing nonmonetary remedies. In 1994, the New Zealand Parliament created . . . the Health and Disability Commission (HDC). The HDC is also responsible for handling disciplinary complaints. However, the most common form of non-monetary relief sought from the HDC is not disciplinary action; rather, it is a request for corrective measures to address the cause of harm.

Error reporting in New Zealand is a regular part of the medical culture; acknowledgment of injuries in patient records is extremely high. Truthful, consistent error reporting provides opportunities to evaluate quality of care problems, a sharp contrast with the United States, where such reporting is rare.³⁸

Two other notable features are the speed with which the compensation is delivered (i.e., the ACC must notify claimants of its decision within nine months) and the emphasis on accountability to complaining patients through an explanation of what happened, an apology by the provider, or an assurance of a system change to improve patient safety in the future.³⁹ Nevertheless, many New Zealand physicians fault the system:

Nearly 40 percent did not think most complaints were warranted, and another 33 percent did not believe complainants were normal people. In addition, the complaint and disciplinary system is nicknamed "death by 1000 arrows" by some . . . due to its complexity. Some view this complexity as standing in the way of New Zealand's no-fault programs' accessibility, efficiency, and effectiveness. Also, New Zealand's no-fault system may lack incentives to improve patient safety, given its broad funding base and lack of experience rating.⁴⁰

A new study by American medical researchers (briefly discussed and excerpted earlier) compares the medical injury compensation schemes of New

this test even though he was not consciously reckless."). According to Professor Geoff McLay, an expert on ACC law, the *Bottrill* case is exceptional and may indeed be the only example of exemplary damages in a medical injury case. He also notes that, under New Zealand law, claims for exemplary damages die with the victim. E-mail from Geoff McLay, *supra* note 1.

38. SLOAN & CHEPKE, *supra* note 20, at 302 (footnotes omitted). Reporting is rare not only in the United States. According to a recent comparative study, Sweden and Denmark, unlike New Zealand, have erected "a Chinese wall between compensation and disciplinary activities." Kachalia et al., *supra* note 23, at 391. Recently, and controversially, the HDC has encouraged local health boards to publish provider ratings indicating their medical error rates. See Ruth Hill, *Push on DHB Reporting Will 'Lead to Less Safety'*, DOMINION POST (N.Z.), Mar. 19, 2008, at 16.

39. SLOAN & CHEPKE, *supra* note 20, at 302.

40. *Id.* (footnotes omitted).

Zealand, Sweden, and Denmark using interviews with administrators and stakeholders in the three systems.⁴¹ While New Zealand's system purports to be strictly no-fault (according to the authors, it covers any "injury that is not a 'necessary and ordinary' consequence of treatment"),⁴² the two Nordic countries use an "avoidability" standard, defined as an injury that would not have occurred in the hands of an experienced, or the best, specialist in the relevant field. According to the authors, "avoidability" denotes a higher standard of care (excellent) than the customary standard used in malpractice law (merely acceptable), although it does not go so far as to impose strict liability. They conclude that applying the "avoidability" standard has proved to be feasible.

B. Emotional Harm Claims

American tort law has experienced some difficulty in dealing coherently and predictably with claims of negligently-inflicted emotional harm. Skepticism about the authenticity and proof of such claims competes with a growing social and legal consensus that physical injury often leads to emotional injury and that the distinction between them is artificial, stigmatizing, and otherwise objectionable.⁴³ Courts, however, seem confident that juries can critically assess expert testimony about psychological phenomena. For decades, however, American courts have also continued to evince some skepticism and have devised legal doctrines that they think will more effectively separate meritorious claims from spurious ones. Such doctrines include a few notoriously arbitrary tests, including impact, zone of danger, and bystander reactions.⁴⁴

New Zealand's no-fault system likewise has struggled to deal with emotional harm claims in an effort to contain the potential costs of fully recognizing them. The ACC covered such claims until the late 1990s but then barred them; it now covers only mental injury of a serious nature caused by either a covered physical injury or a specified sex crime. Critics of this limitation argue that it, too, is arbitrary, justified only by the desire to draw a line that excludes most emotional harm claims.⁴⁵

41. Kachalia et al., *supra* note 23, at 391. This study was conducted in 2005, presumably before the "treatment injury" standard (newly established that year) was put into full operation. *Id.* at 392.

42. *Id.* at 394.

43. Forty-two states, both houses of Congress, and some other countries have passed some version of parity legislation. Sarah Kershaw, *The Murky Politics of Mind-Body*, N.Y. TIMES, Mar. 30, 2008, Week in Review, at 1.

44. See RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM (Proposed Final Draft No. 1, 2005). In New Zealand, the court applied similar limitations in *Van Soest v. Residual Health Mgmt. Unit*, [2000] 1 N.Z.L.R. 179 (C.A.).

45. Interview with John Miller, *supra* note 29.

Two pending court cases illustrate the difficulty of line-drawing in mental injury claims. In one, a claimant was prosecuted for failing to tell his sexual partner that he was HIV-positive.⁴⁶ If this failure constituted “indecent assault” (a sex crime), the ACC would pay for her psychiatric costs; if, instead, it was a criminal nuisance (arguably not a sex crime), then the ACC would not.⁴⁷ In another case, a woman was manhandled by robbers (wrenching her shoulder) and then suffered post-traumatic stress disorder (PTSD).⁴⁸ The ACC denied her claim, asserting that it was the fright, not the shoulder wrench, that caused her PTSD.⁴⁹ In such cases, the judgments that are required in order for the decisionmaker to apply the applicable legal standard (“of a serious nature caused by”) are inevitably subjective, if not arbitrary.

Not surprisingly, the ACC’s very limited coverage of mental injury claims has motivated victims to bring them as common law tort claims, which the courts so far have generally rejected.⁵⁰ Recent legislation extended coverage but only for diagnosed mental injury experienced by employees for sudden traumatic events in the workplace.⁵¹

C. Other Compensation Policy Issues

Many other modifications to the New Zealand system were enacted in 2008⁵² or remain under debate, but the scope of this Essay does not allow an adequate discussion of them. These would improve the ACC’s administrative efficiency; privatize the scheme’s insurance component; improve rehabilitation of the disabled; refine “experience rating” so that it more closely reflects actual risk and cost creation; enhance prevention incentives; cover more occupational diseases; clarify the status of so-called “wrongful birth” claims; deal with highly risky victim behaviors, including suicide; deal with mental illness; make “earnings” calculations fairer for non-standard work; clarify what constitutes “suitable work” that disabled persons must accept lest they lose benefits; determine when to allow lump sum benefits; clarify the standards for exemplary damages claims; and reform the “actual earnings” basis for work-related compensation

46. CLM v. Accident Comp. Corp., [2006] 3 N.Z.L.R. 127 (H.C.).

47. *Id.*

48. Woodd v. Accident Comp. Corp. (District Court, Wellington, AI 288/02854/03, Apr. 2, 2003, Cadenhead, J.).

49. *Id.*

50. See, e.g., JD v. Ross, [1998] N.Z.F.L.R. 951 (H.C.); Wiggins v. R, [1998] D.C.R. 204 (D.C.).

51. See Injury Prevention, Rehabilitation, and Compensation Amendment Act 2008 § 6, available at <http://www.legislation.govt.nz/act/public/2008/0046/latest/DLM1106388.html>.

52. See *id.*

for low-wage workers. There are also, of course, perennial calls for higher (or lower) benefit levels and levies.

III. BACK TO TORT LAW IN AMERICA: LESSONS FROM NEW ZEALAND?

New Zealand's experience without (much) tort law—particularly this very brief review of how its system handles treatment injuries and emotional harm claims—yields some general lessons beyond the obvious one that politics ultimately determines the shape of reform.

A. *Different Strokes for Different Folks*

New Zealand's experiment with minimal tort law reminds us that other modern liberal democracies pursue roughly similar social goals through programs that are quite different from our own, yet these countries can implement their programs in ways that manage to earn public legitimacy. Although costs are rising and many elements may need adjustment, New Zealand's compensation system remains quite popular after more than three decades.⁵³

B. *Tort Law Will Endure, Even Under a No-Fault Standard*

So long as any categorical boundaries between no-fault and tort exist—the examples of medical treatment injuries and emotional harm claims pose perhaps the most difficult boundary problems⁵⁴—claimants and their lawyers will always face strong incentives to prosecute claims in whatever remains of the tort system, litigating the precise contours of these legal boundaries, i.e., of no-fault coverage or its exceptions. Litigation will ensue at least where the underlying fault-based claim is strong enough that the expected tort award outweighs the delays, costs, and uncertainties entailed by the tort system. If this assertion is true even under a no-fault compensation scheme as comprehensive as New Zealand's, it should be even more so under the more limited, targeted no-fault schemes that the United States has adopted; after all, these schemes leave correspondingly greater scope for tort remedies.⁵⁵

53. See Palmer, *supra* note 1 and accompanying text. According to the SCHEME REVIEW, which was based on consultations with more than twenty “stakeholders,” including employer organizations, a “broad conceptual support . . . exists across New Zealand for the major proposition of the scheme: entitlement to 24 hour, comprehensive no-fault benefits in exchange for the loss of the right to sue for damages suffered from personal injury.” SCHEME REVIEW, *supra* note 17, at x.

54. See *supra* Sections II.A-B.

55. For a review of these targeted no-fault schemes, see Robert L. Rabin, *The Renaissance of Accident Law Plans Revisited*, 64 MD. L. REV. 699 (2005) and Robert L. Rabin, *The September 11th Victim Compensation Fund: A Circumscribed Response or an Auspicious Model?*, 53 DEPAUL L. REV. 769 (2003).

C. Causation: *Therein Lies the Rub*

By focusing on accident outcomes rather than on the process by which they occurred, a no-fault scheme can reduce some of the difficulties in establishing tort-relevant causation, but it cannot eliminate them. This truth is particularly relevant in the area of medical treatment, where adverse outcomes often are caused more by a patient's preexisting physical condition or bad luck than the treatment itself. So long as society is unwilling to compensate for the former, the causation issue will remain very difficult and costly to resolve.⁵⁶ Even with workers' compensation, which uses a very relaxed causation requirement (e.g., "arising in the course of employment"), causation issues abound.

D. Costs Matter—A Lot

New Zealand's experience with no-fault, especially in the medical injury area, is studded with cost and claims increases that inevitably have produced political reverberations and legislative reforms to the program. These consequences have not been severe enough to delegitimize the program, but much depends on the cost effects of the 2005 liberalization, which are not yet clear. It may be, as critics of tort law maintain, that the *magnitude* of the costs necessary to effectuate victim compensation is greater in the tort system than in a no-fault system. But this economic efficiency judgment tells us nothing about the *distribution* of costs in the two systems, which is often the more salient political issue. The U.S. tort system tends to over-compensate relatively slight injuries and to under-compensate more serious ones.⁵⁷ And in order to determine the distribution of costs (and benefits), one must specify the systems under comparison in far greater detail than has been done in most debates over the systems' comparative merits.⁵⁸

In 2008, the ACC released a consultant's study with that very objective in mind. The analysis compared costs between the New Zealand scheme and a hy-

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56. For examples from no-fault systems, see SLOAN & CHEPKE, *supra* note 20, at 304-05 (dealing with childhood vaccines); James K. Bradley & Daniel R. Schuckers, *Toward a Unified Theory of Unemployment Compensation Eligibility for Replaced Striking Employees*, 61 U. PITT. L. REV. 499, 514-16 (2000) (discussing a solution to the "causation problem"); Mark F. Grady, *Better Medicine Causes More Lawsuits, and New Administrative Courts Will Not Solve the Problem*, 86 Nw. U. L. REV. 1068, 1080 (1992) (book review) ("The no-fault auto insurance system saves administrative costs by dispensing with costly joint causation problems."). See also Kachalia et al., *supra* note 23, at 400-01 (citing examples from the area of medical injuries).
57. See, e.g., Theodore F. Haas, *On Reintegrating Workers' Compensation and Employers' Liability*, 21 GA. L. REV. 843 (1987).
58. For a valuable effort to provide this detail, see Stephen D. Sugarman, *Tort Reform Through Damages Law Reform: An American Perspective*, 27 SYDNEY L. REV. 507 (2005).

pothetical “no-ACC” scenario, which included premiums for workers’ compensation insurance, motor vehicle injury and other fault-based injury insurance, and additional health expenditures and increased social transfers. The study found that the ACC system cost NZ\$190 million per year more (relative to the no-ACC scenario), which was far less than the study’s estimate of the social value added by the ACC system, even limiting that value to those aspects that are measurable (e.g., increased workforce participation or increased participation in potentially injurious recreation).⁵⁹

E. *An Ounce of Prevention Is Worth a Pound of Compensation*

Prevention (or deterrence, as some prefer) is a most worthy but dismayingly elusive goal in all systems, whether tort or no-fault. Much depends on how compensation is financed and on the degree of congruence between risk creation and enhancement, on the one hand, and distribution of the costs (and benefits) of the risky conduct, on the other.⁶⁰ As noted earlier, the empirical evidence documenting the effect of liability rules and compensation practices on deterrence remains inconclusive, except perhaps at the extremes.⁶¹ All systems, therefore, have had to adopt auxiliary measures—information, education, administrative regulation, instinct for self-preservation, technology, market effects (including reputation), professional discipline,⁶² and other behavioral influences—to augment the call for accident prevention. We know that seat belts, Pap smears, prenatal care, and smoking cessation have large prevention payoffs,

59. SCHEME REVIEW, *supra* note 17, at v-x.

60. The classic exploration of this theme, of course, is GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* (1970).

61. E.g., STEPHEN D. SUGARMAN, *DOING AWAY WITH PERSONAL INJURY LAW: NEW COMPENSATION MECHANISMS FOR VICTIMS, CONSUMERS, AND BUSINESS* (1989); Don Dewees & Michael Trebilcock, *The Efficacy of the Tort System and Its Alternatives: A Review of Empirical Evidence*, 30 OSGOODE HALL L.J. 57 (1992); David Rosenberg, *The Causal Connection in Mass Exposure Cases: A “Public Law” Vision of the Tort System*, 97 HARV. L. REV. 851 (1984); Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313 (1990); W. Kip Viscusi et al., *Detering Inefficient Pharmaceutical Litigation: An Economic Rationale for the FDA Regulatory Compliance Defense*, 24 SETON HALL L. REV. 1437 (1994).

62. Several commentators have observed that the nature of the link—tenuous in the United States, close in New Zealand—between adverse medical outcomes and the process for engaging and perhaps disciplining the treating physicians or institutions may play a significant role in prevention. See SLOAN & CHEPKE, *supra* note 20, at 303; Kachalia et al., *supra* note 23, at 400 (noting recent moves to a higher threshold before the ACC is to report to the disciplinary bodies).

but also that the effects of many other preventive measures (annual checkups and child-proof drug packaging, for example) are more dubious.⁶³

With an eye toward reducing events that collectively account for at least 80% of deaths and serious injuries in New Zealand—motor vehicle accidents, suicides and deliberate self-harms, workplace injuries (including occupational diseases), assaults, falls, and drownings—the government adopted a New Zealand Injury Prevention Strategy (NZIPS) in 2003 which has initiated a number of efforts to reduce these preventable losses. In 2005, a new alcohol-focused initiative was added. The ACC reports significant declines in these harms during the 1990s but not during the years since its establishment, so it is difficult to separate the impact of government prevention efforts from other factors.⁶⁴ According to the 2008 consultant study, NZIPS has enjoyed some success but continues to exhibit significant shortcomings.⁶⁵

F. *Ignorance Is Bliss—and Arguably Remiss*

These facts, and the perceived success of the New Zealand scheme, make it all the more surprising that American lawyers are generally unaware of this international development. The exceptions include a few comparative law and torts scholars in the United States, such as Richard Gaskins and Stephen Sugarman,⁶⁶ who have studied and reported on it. Despite their efforts, how-

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63. Compare AUDREY T. HINGLEY, PREVENTING CHILDHOOD POISONING (1997), U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, RECOMMENDATIONS TO THE CONGRESS BY THE PEPPER COMMISSION (1990), Joni Hersch, *Smoking, Seat Belts, and Other Risky Consumer Decisions: Differences by Gender and Race*, 17 *MANAGERIAL & DECISION ECON.* 471 (1996), R. Pana-Cryan & M.L. Myers, *Prevention Effectiveness of Rollover Protective Structures—Part III: Economic Analysis*, 6 *J. AGRIC. SAFETY & HEALTH* 57 (2000), and Gregory B. Rodgers, *The Effectiveness of Child-Resistant Packaging for Aspirin*, 156 *ARCHIVES PEDIATRICS & ADOLESCENT MED.* 929 (2002), with Stephen Smith, *The Annual Physical Gets a Checkup*, *BOSTON GLOBE*, Oct. 22, 2007, at C1, and SAFEKIDS, *CHILD RESISTANT PACKAGING (CRP) FOR MEDICINES* (2001), available at <http://www.safekids.org.nz/downloads/child%20resistant%20packaging.pdf> (citing T.A. BLAKELY, *CHILD RESISTANT PACKAGING FOR MEDICINES AND TOXIC SUBSTANCES: A PROGRESS REPORT TO THE MINISTRY OF HEALTH* (1997)).
64. ACCIDENT COMP. CORP., *PROGRESS IN IMPLEMENTING THE NEW ZEALAND INJURY PREVENTION STRATEGY FOR THE PERIOD 1 JULY 2006 TO 30 JUNE 2007: REPORT OF THE MINISTER FOR ACC TO THE HOUSE OF REPRESENTATIVES* (Dec. 2007), available at http://www.nzips.govt.nz/documents/200804_Annual_report_2007.pdf.
65. SCHEME REVIEW, *supra* note 17, at xiii-xiv.
66. See SUGARMAN, *supra* note 61; Richard Gaskins, *New Dynamics of Risk and Responsibility: Expanding the Vision for Accident Compensation*, 35 *VICT. UNIV. WEL-LINGTON L. REV.* 951 (2004). For a new and entirely normative-theoretical argument raising doubts about doing away with tort law, see Jules L. Coleman, *Doing Away with Tort Law* (Mar. 2008) (unpublished manuscript, on file with the Yale Law & Policy Review). The leading casebooks on tort law do devote some atten-

ever, the New Zealand scheme has had essentially zero impact on our own personal injury law (or perhaps, even more surprisingly, on the laws of Commonwealth jurisdictions, as noted earlier). Why?

One answer could be that New Zealand is so small and remote that Americans simply do not pay any attention to its Lilliputian institutions and practices. There surely is some truth to the notion that what a country of just over four million does tends to fall beneath the already cloudy American radar screen. But there must be more to the story than that; after all, good feasible ideas are in short enough supply that one would expect them to be seriously considered wherever, as in the New Zealand system, they can be found. Yet the United States has not done so.

Another part of the answer may be found in various structural differences between the United States and New Zealand political, legal, and cultural systems. Before briefly identifying these differences, it bears emphasis that the two countries do *not* differ in their commitment to the rule of law and to claims of corrective justice. New Zealand simply has instituted what its people regard as a far better program for protecting and compensating accident victims.⁶⁷ Interestingly, Australia and the United Kingdom, aware of the New Zealand scheme, actively considered adopting some form of comprehensive no-fault for accidents. Neither did so.

CONCLUSION

In a 1993 article, Sir Geoffrey Palmer summarized the features of New Zealand and U.S. tort law that might account for the far more limited use of no-fault compensation in the United States.⁶⁸ First, New Zealand common law never developed a doctrine of strict liability for defective products; for judges to do so, he argued, “would not be regarded as appropriate.”⁶⁹ Second, New Zealand’s parliamentary system, coupled with its very strict party discipline, made it much easier for the government to adopt such far-reaching reforms. Third, Americans “want to sue each other. It is one way of redistributing the wealth,”

tion to the New Zealand scheme. See, e.g., RICHARD A. EPSTEIN, *CASES AND MATERIALS ON TORTS* 1012-18 (9th ed. 2008); MARC A. FRANKLIN, ROBERT L. RABIN, & MICHAEL D. GREEN, *TORT LAW AND ALTERNATIVES* 878-81 (8th ed. 2006).

67. My efforts to hear from the putative opponents of the scheme, particularly the Business Roundtable, concerning the nature of their objections have so far proved unavailing. *But see supra* notes 45-49 and accompanying text.
68. Palmer, *supra* note 1, at 610-12. On the point about New Zealand’s parliamentary system, see Matthew S.R. Palmer, *Towards an Economics of Comparative Political Organization: Examining Ministerial Responsibility*, 11 J.L. ECON. & ORG. 164 (1995). For an insightful review of Palmer’s earlier book, see James A. Henderson, Jr., *The New Zealand Accident Compensation Reform*, 48 U. CHI. L. REV. 781 (1981) (book review).
69. Palmer, *supra* note 1, at 610.

whereas New Zealand always exhibited far less litigiousness.⁷⁰ Finally, the United States does not embrace New Zealand's principle of community responsibility, evidenced by New Zealand's adoption of old-age pensions as early as 1898.⁷¹ To Palmer's list, one might add the fact that New Zealand has a far simpler, unified tax system, and (as noted earlier) relatively little first-party or employer-provided private health insurance.

Even so, I suspect a larger part of the explanation for why the New Zealand system has aroused little interest in the United States lies in the uniqueness of American tort law and its firm hold on the popular imagination. Proponents of the tort system in the United States persistently argue that no-fault would increase accident rates by encouraging risky behavior on the part of both injurers (because their contributions to the social insurance fund are not sufficiently experience-rated to reflect fully the costs of the risks that they create)⁷² and victims (because the fund will cover the injuries of even the careless). Sugarman and some other experts, however, raise serious doubts about whether tort law more effectively deters most negligent conduct. They argue that some combination of first-party insurance and safety regulation would better prevent accidents. Evidence for testing the validity of these positions on deterrence is notoriously hard to find.⁷³

In this domain, and in a wide array of others, the United States is exceptional,⁷⁴ and its politics and ideology reflect this pronounced singularity. Plainly put, New Zealand's comprehensive social insurance approach to accident law is simply inconceivable here.⁷⁵ This realization is not based solely on the outsized influence of the medical profession and the tort and insurance bar in the United States, on how our lawyers are compensated, or on our greater suspicion of government—although those are certainly factors. It is also because so many Americans venerate the image of the Solomonic judge and jury, insist on the common citizen's right to a day in court, and believe in tort law that levels the playing field.⁷⁶ The fact that the reality of tort law on the ground so often mocks these ideals seems to matter much less to Americans than does their ardent wish that the ideals were true.

70. *Id.* at 612.

71. *Id.*

72. According to the SCHEME REVIEW, the ACC should increase statistically-based experience rating. SCHEME REVIEW, *supra* note 17, at xxxii-xxxiii.

73. See *supra* note 61 and accompanying text.

74. See UNDERSTANDING AMERICA: THE ANATOMY OF AN EXCEPTIONAL NATION (Peter H. Schuck & James Q. Wilson eds., 2008).

75. This view is not just my own. See AM. LAW INST., 1 REPORTER'S STUDY ON ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 445 (1991).

76. See, e.g., Gillian K. Hadfield, *Framing the Choice Between Cash and the Courthouse: Experiences with the 9/11 Victim Compensation Fund*, 42 L. & SOC. REV. 645 (2008) (studying plaintiffs' attitudes and expectations from the tort system as compared to a non-tort compensation fund).

