Review of the Way in Which Physiotherapy Services are Funded and Accredited by ACC

Final Report

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September 2007

REVIEW OF THE WAY IN WHICH PHYSIOTHERAPY SERVICES ARE FUNDED AND ACCREDITED BY ACC

1 EXECUTIVE SUMMARY

The focus of the Review

1.1 The purpose of New Zealand's ACC legislation is "to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community". The legislation provides that where injuries occur, ACC's primary focus "should be on rehabilitation with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence, and participation".[1]

1.2 This Review addresses a number of concerns that have been expressed in recent years about the funding and accreditation by ACC of physiotherapy services, and ACC's approach to audit and fraud investigations of physiotherapists.

1.3 Physiotherapy services are an integral element in the rehabilitation of accident victims. In the year to June 2006, physiotherapists provided some 2.6 million treatments to ACC claimants – more than any other group of treatment providers. Expenditure on physiotherapy treatment by ACC was some $120 million, out of total expenditure on medical treatment of approximately $402 million. By any measure, physiotherapy services represent a very significant part of the rehabilitation support provided to New Zealanders through the ACC scheme.

1.4 It was common ground among all participants in the Review, including claimant representatives, the physiotherapy profession and ACC, that the focus of this Review is not the interests of the physiotherapy profession, or ACC. Rather, the touchstone for any recommendations made by this Review should be the long term interests of those who suffer injuries, and more specifically their rehabilitation to the maximum practicable extent in accordance with the goals of the ACC legislation. It was also common ground that the long term interests of those who suffer injuries require that the ACC scheme be sustainable financially in the long term.

1.5 The Review's terms of reference emphasise the need to find practical solutions that work. I have endeavoured, wherever possible, to make specific practical proposals to address concerns identified. Where further information or study is needed to make high quality decisions, I have identified that need, and I have suggested interim steps that could be taken towards a sustainable and fair outcome while that work is under way.

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[1] Injury Prevention, Rehabilitation and Compensation Act, 2001, s3.

1.6 Some of the key decisions that need to be made in the light of this Review are policy choices for Government, which it is neither possible nor appropriate for me to make. Where this is the case, I have identified the relevant options and their advantages and disadvantages, in order to assist the Government in making these choices.

Summary of findings and recommendations

Sustainable funding of physiotherapy services

1.7 A major focus of the Review has been on the sustainability of arrangements for the purchase of physiotherapy services, in the long term interests of those who suffer injuries. Current purchase arrangements are, in summary:

1.7.1 Regulation funding: payments of either $21.76 per treatment or $54.73 per hour (excl GST). Providers are able to charge co-payments, and most if not all do so;

1.7.2 the Endorsed Provider Network contractual arrangements: four levels of payment that distinguish between simple and complex cases, and initial and follow-up consultations, reflecting an implicit hourly rate of approximately $103 per hour (excl GST). The contracts prohibit co-payments for treatments at a provider's practice in normal working hours.

1.8 The concerns raised about these arrangements focused on:

1.8.1 the level of fees paid, under the Regulations and under the EPN contracts;

1.8.2 the structure of current funding arrangements, and in particular the co-existence of two different funding mechanisms, which provide funding for the same services at very different levels;

1.8.3 specific aspects of the EPN contract, in particular the prohibition on co-payments being charged by EPN providers.

1.9 The current funding arrangements are not sustainable. EPN payment levels are significantly below the long term cost of providing physiotherapy services to accident victims, and co-payments to cover the balance of those costs are not permitted. Regulation rates are significantly lower still, and although co-payments are permitted the level of co-payment required to cover costs is not in practice recoverable from claimants, in an environment where treatment with no co-payment is available from EPN providers. EPN rates also function as a benchmark for many private purchasers, in particular accredited employers, who are not willing to pay more than ACC pays for comparable services.

1.10 The result is that neither EPN providers nor regulation providers can, in practice, recover the sustainable cost of providing treatment to accident victims. This creates medium to long term risks in terms of quality and availability of physiotherapy

services in New Zealand, and unfairly transfers the cost of injuries in New Zealand from the community to the physiotherapy profession.

1.11 ACC is conscious of the need for review of these funding arrangements, and has commissioned modelling work to shed light on sustainable levels of payment. The evidence before the Review in relation to this modelling work, together with other evidence on sustainable payment levels, suggests that a sustainable level of payment per hour if patient co-payments are not permitted is unlikely to be less than $137 per hour (excl GST), a roughly 33% increase from current rates. It could well be significantly higher. The available information is not adequate to form a firm view on what a sustainable rate of payment would be. If the available information is used to estimate a sustainable payment rate, reasonable assumptions about key inputs suggest a range of $144 to $165 per hour (excl GST). But as discussed below, data limitations mean these figures should be treated with considerable caution.

1.12 It is neither sustainable nor fair to maintain ACC payments below sustainable levels, while prohibiting co-payments.

1.13 The Government has a number of options for achieving sustainability of funding and fairness to physiotherapists, which are discussed in detail in section 5 below. The basic options are:

Option 1: retain the existing funding arrangements, including the prohibition on co-payments for EPN providers, and increase EPN payments to a sustainable level –likely to be above $137 per hour. These payments would need to be indexed to maintain their real value, and reviewed periodically against sustainability criteria – say every five years;

Option 2: remove the prohibition on co-payments for EPN providers, and increase payments so far as affordable, but to a lesser extent than under option 1.

1.14 Both options, especially option 1, raise significant affordability issues which the Government will need to consider. If affordability constraints preclude setting and maintaining fees at sustainable levels, the second option is more likely to ensure long term sustainability of physiotherapy services in the interests of claimants and all New Zealanders, and to avoid unfairly shifting the burden of providing rehabilitation away from the community, where the Woodhouse Report and the ACC "social contract" firmly placed it, to treatment providers.

Option 1: Current funding arrangements, with fees at sustainable levels and no co-payments

1.15 There is at present a practical difficulty in increasing EPN fees to a level that is sustainable: the information available does not enable a reliable estimate of sustainable fees to be made. Further research and analysis would be required in order

to obtain a sufficiently reliable estimate for use in a contractual environment where co-payments are not permitted, so there is no "safety valve" to accommodate errors in estimating the level of fees, or variations in the cost of providing treatments in different circumstances (eg in higher cost areas, or for higher cost cases).

1.16 If the prohibition on co-payments is retained, there is a strong case for:

1.16.1 an immediate interim increase in EPN payment rates, to not less than $137 per hour (excl GST); and

1.16.2 prompt work on designing and implementing a robust study of sustainable costs of treatment, to enable fees to be reset at sustainable levels.

Option 2: Remove prohibition on co-payments and increase fees towards sustainable levels

1.17 If payments are increased so far as affordable, and patient co-payments are permitted:

1.17.1 sustainability issues will be resolved;

1.17.2 providers will no longer be expected to bear a significant part of the cost of treatment for accidents.

1.18 The greater the increase in the ACC contribution towards a sustainable level, the greater the prospect that access goals will be achieved. As ACC's contribution nears a sustainable level, competition between providers will constrain co-payments, resulting in low co-payments in most cases. If co-payments become widespread and material, that would suggest ACC contributions are not set at or close to a sustainable level: funding could then be adjusted, so far as affordable, to meet access goals and international obligations with respect to work injuries.

1.19 Access goals could be further advanced under option 2 if ACC maintains a list of physiotherapists who undertake not to charge a co-payment for treatments provided at their premises during normal working hours. It would be optional for providers to give this undertaking. If they do, they will appear on the list of "no surcharge providers" kept by ACC, which would be available to the public on ACC's website and on request from ACC staff. This would make it easier for claimants to identify physiotherapists who do not charge a co-payment, reinforce competitive incentives for physiotherapists (by reducing information asymmetries), and give ACC high quality up to date information about the prevalence of co-payments.

1.20 Option 2 will achieve the Government's access goals and ILO17 compliance goals unless EPN payments are materially below sustainable cost, with the result that co-payments are widespread and non-negligible. But if EPN payments are set materially below sustainable cost, option 1 would fail to meet the goals of sustainability and fairness. In other words, for any given level of funding, if option 2 would not meet

1.21 Because it ensures sustainability of physiotherapy service provision, option 2 is the lower risk option, especially if there is inadequate information about long term sustainable costs; or if it cannot be guaranteed that fees will be maintained at sustainable levels.

Hybrid option: full funding and no co-payments for work injuries only

1.22 A further, hybrid option would be to:

1.22.1 increase payments to sustainable levels and prohibit co-payments for work injuries (ie option 1 for work injuries); and

1.22.2 for other injuries, increase payments so far as affordable (but not to full sustainable cost levels), and remove the prohibition on co-payments (ie option 2 for non-work injuries).

1.23 This approach would ensure sustainability, and fairness to providers. It would achieve compliance with New Zealand's ILO obligations, and, so far as work injuries are concerned, compliance with the goals of the ACC legislation. For other injuries this approach would be as consistent with the goals of the legislation as current arrangements. An increase in ACC payment rates for non-work injuries, to move towards a sustainable level, would advance those goals further still.

1.24 Distinguishing in this way between work injuries and other injuries would however be inconsistent with the "comprehensive entitlement" principle in the original Woodhouse Royal Commission report, and would result in some additional administration costs and boundary disputes.

Regulation rates

1.25 An increase in Regulation rates would also be consistent with the goals of the ACC legislation. They are well below sustainable treatment costs. Co-payments are paid by some 25% of claimants receiving physiotherapy services, and these can be substantial.

1.26 An adjustment in Regulation rates, though desirable, is not essential in order to meet the goals of the ACC legislation so far as physiotherapy services are concerned if all the recommendations relating to the EPN regime made in this report are implemented, and in particular if one of the options suggested above is adopted in respect of EPN fees, and all physiotherapists are able to access EPN contracts on reasonable terms. If however these recommendations are not implemented, an increase in Regulation rates to a level at (or very close to) the sustainable cost of providing the relevant services would be necessary in order to achieve the Government's access and ILO compliance objectives, and more generally to give effect to the goals of the ACC legislation.

Other specialised physiotherapy contracts

1.27 Some specialised contracts such as the Hand Therapy Contract appear to be working well. The NZSP submission recorded the existence of a good relationship between physiotherapists and ACC in the context of these specialised contracts. But there have been real difficulties in respect of both contract design and funding levels in the context of other specialised contracts, in particular the vocational rehabilitation contracts. Significant concerns were expressed about the time taken by ACC to address these issues.

1.28 It is important to ensure that all of these contracts are structured and funded on a sustainable basis. I recommend that as and when further studies are carried out in relation to the sustainable cost of providing general physiotherapy services, other significant ACC contract arrangements should be included in those studies, especially where (as with Activity-Based Programme contracts) the same providers may hold both general and specialised contracts. Including the full range of ACC physiotherapy contracts in the study will provide a better overall picture of sustainability issues, as well as assisting in setting payment rates for the specialised contracts.

EPN contract provisions

1.29 It is reasonable for ACC to expect certification of practices against NZS8171:2005 to improve (on average) the business practices and procedures of those practices, and to contribute to improved client satisfaction and quality of treatment for those practices. It is therefore reasonable for ACC to contract with practices for certification.

1.30 However ACC needs to be clear internally, and with external stakeholders, that this does not mean that certified practices deliver higher quality services than non-certified practices, either as a group, or comparing specific practices. Neither inference is justified, either qualitatively or based on any reliable quantitative studies. Suggestions that ACC has made in the past to the effect that certified practices produce better outcomes than non-certified practices (and in particular, that they achieve the same outcomes with fewer treatments or achieve an earlier return to work) are not based on any robust or reliable studies, and are not justified, even at an aggregate level.

1.31 Nor is certification the only reasonable basis for expecting improved quality of treatment from a practice. It is at least as plausible, at a qualitative level, that appropriate postgraduate training and experience can be expected to improve the quality of services delivered. I recommend that ACC consider adopting parallel entry criteria for the EPN programme, based on specified postgraduate qualifications and experience rather than certification.

1.32 The “Endorsed Provider” label has the potential to suggest to claimants that endorsed providers are seen by ACC as providing higher quality services than Regulation

1.33 I recommend that ACC give consideration to amending the EPN contracts to provide a longer period of notice for "no fault" termination, perhaps 12 months, with a shorter period retained for circumstances where there has been a breach of the provider's obligations under the contract. ACC has accepted this recommendation, and advised the Review that it will start work on this issue by the end of the year, including consulting with the physiotherapy profession to see if its suggested extension of the no-fault termination period from three months to six months addresses the profession's concerns.

1.34 I am satisfied that there is nothing in the EPN contract which requires a physiotherapist to act in a manner that is inconsistent with his or her ethical responsibilities. The concerns expressed by some physiotherapists about this issue, though genuine and deeply felt, are misplaced.

Monitoring, audit and investigation activities

1.35 There appears to be a broad consensus that the processes that ACC has put in place since 2005 for audits and investigations are clear, transparent and appropriate.

1.36 No specific concerns were identified in relation to ACC's current monitoring processes, but there is scope for those to be made more transparent and accessible. I recommend that further information be made readily available to providers that explains the objectives of the monitoring process, the process by which it is conducted, and the various outcomes that are contemplated. ACC has accepted this recommendation, and has advised the Review that initially it will make this information available to providers on its website.

1.37 The picture was more patchy in relation to implementation of ACC's audit and investigation processes. There are continuing concerns on the part of some physiotherapists and some claimants in relation to ACC's approach to audits and investigations. There are encouraging signs of positive steps being taken by ACC to address these concerns, and learn from the experiences of the past. One important step is the commissioning by ACC's chief executive of an independent review of ACC's Fraud Unit by Martin, Jenkins & Associates Ltd. That review identified a number of concerns with respect to ACC's fraud investigation processes, and made recommendations directed to addressing those concerns, and increasing the alignment between the Fraud Unit and ACC's broader culture and objectives. ACC has not yet

announced its response to that review: it is scheduled to do so in the near future. The findings of that review in relation to ACC's Fraud Unit, and the need for greater alignment of that unit to ACC's broader culture and objectives, are consistent with the evidence before this Review.

1.38 In order to improve the working relationship between ACC and physiotherapists in the context of audits and investigations, I recommend that ACC, in consultation with the physiotherapy profession and other relevant provider groups, carry out further work to:

1.38.1 align the approach of the Risk, Assurance and Fraud group with the broader culture and objectives of ACC, including shifting the group's focus away from detection of fraud to avoidance of fraud and other inappropriate practices, and support for ACC's partnership with providers to deliver high quality services to claimants;

1.38.2 ensure appropriate clinical input into investigations, in particular before reaching any views on the competence or honesty of providers, or making any communications suggesting concerns about competence or honesty, or proposing remedial action in connection with clinical or ethical matters;

1.38.3 provide clear guidance on the (very limited and preliminary) significance of outlier analysis and other data mining techniques for the purpose of identifying competence and fraud concerns;

1.38.4 provide clear guidance on what constitutes fraud, and training on the care needed before asserting or alleging fraud;

1.38.5 ensure ACC representatives have a balanced approach and an open mind in approaching fraud investigations, which gives full recognition to the likelihood of other explanations for discrepancies and errors;

1.38.6 ensure ACC representatives understand and accept that they have primary responsibility for clear and effective communication with affected providers and with claimants, and for approaching all inquiries with courtesy and patience, even if – perhaps, especially if – that clarity, courtesy and patience is not on some occasions reciprocated.

1.39 There is nothing in the evidence provided to the Review that supports the suggestion made by some submitters that the selection processes for audits and investigations may have been inappropriately targeted at particular individuals or professional groups.

1.40 However the disproportionate appearance in recent audits and investigations of senior physiotherapists providing services under the Regulations raises three issues which ACC should bear in mind for the future:

1.40.1 whatever the position may have been in the early days of the EPN regime, when data were limited, at present there can be no justification for focussing on Regulation providers rather than EPN providers in the context of audit and investigation processes;

1.40.2 senior experienced practitioners who treat a disproportionate number of complex cases are likely to be identified as outliers on some dimensions. So too will be senior practitioners who have not kept up to date with best practice. Outlier analysis cannot tell ACC whether one or other of these factors (or some other factor entirely) is driving the outlier status of a particular practice. Careful, open-minded, courteous and transparent inquiries are necessary to seek to ascertain what the causes of any unusual pattern in a practice's data may be;

1.40.3 there was some evidence of similar concerns being raised more than once with the same provider, after having been resolved in an earlier period. This is not an efficient use of the time and resources of the provider or ACC, and can appear at best disorganised, and at worst heavy-handed and oppressive. ACC should ensure that the information it obtains about the practices it audits or investigates, and any explanations for a practice's outlier status, are recorded and taken into account in future reviews.

The physiotherapy profession

1.41 Although there was considerable anecdotal evidence of senior members leaving the profession, and submissions from some former physiotherapists identifying ACC-related issues as the reason for their having left the profession, there was no evidence to suggest that New Zealand was materially out of step with comparable jurisdictions in retaining senior members in the profession.

1.42 This conclusion should not however obscure the importance of retaining and motivating senior, experienced members of the profession to continue to provide specialist input, guidance, training and mentoring in the long-term interests of ACC claimants and all physiotherapy patients. A number of the other recommendations made in this Review should contribute to that goal, by improving the viability of physiotherapy practices from a business perspective, and enhancing the quality of the relationship between ACC and physiotherapy service providers. This should ensure that both tangible and intangible rewards from practice are enhanced, especially for high-quality practitioners.

1.43 In other areas, such as teaching, the value and importance of postgraduate qualifications and experience is recognised in remuneration rates. As noted above, I recommend that ACC carry out further work on this issue, and in particular that ACC give serious consideration to alternative "entry criteria" for the EPN programme, recognising that a certain level of postgraduate qualifications and experience may justify an expectation of improved patient satisfaction and quality of treatment in the same manner as certification by reference to NZS 8171:2005.

1.44 There also appears to be scope for ACC to draw on the experience and expertise of senior practitioners to improve the quality and timeliness of delivery of services to claimants, by identifying a group of "advanced practitioners" who are authorised to approve, in the exercise of their own professional judgment, provision of further services over and above the level that would otherwise require ACC approval. I understand that an "advanced practitioner" designation is currently being developed by the profession, and that ACC intends to work with the profession to look at ways in which this concept may be relevant to the provision of ACC-funded services. This is a concept which has the potential to provide significant advantages to claimants, to reduce administrative costs for ACC, and to encourage the retention and motivation of senior highly qualified members of the profession. I recommend that ACC work closely with the profession to explore how best to achieve the potential benefits for ACC claimants from this initiative.

Process for approving number of treatments to be funded by ACC

1.45 The issue which attracted the most attention from claimants in the context of this Review, and was the subject of considerable concern on the part of claimant and provider groups, was the process for ACC approval of treatment once the trigger number in the ACC Physiotherapy Treatment Profiles is reached.

1.46 I recommend that ACC undertake further work in the near term towards developing a more sophisticated process for approval of an appropriate number of treatments to be funded for each claimant. Key elements of that work include:

1.46.1 striking an appropriate balance between the number of cases for which prior approval is required, and the number of cases in which subsequent audit is carried out;

1.46.2 reducing the number of cases in which prior approval by ACC is required for additional treatments. Trigger numbers should be reviewed, and consideration should be given to setting those trigger numbers on the basis of robust quantitative analysis that limits prior approvals to a pre-defined percentage of claims;

1.46.3 exploring the potential for ACC prior approval to be dispensed with for a specified number of additional treatments, where a physiotherapist certifies

that in his or her professional opinion those additional treatments are necessary;

1.46.4 exploring the potential for identification of a group of "advanced practitioners" who would be authorised to approve additional treatments, on the basis of a certificate that in their professional opinion those treatments are necessary;

1.46.5 putting in place a system of routine subsequent audits of certificates given by physiotherapists of the kind described above, to be carried out by appropriately qualified clinical advisers;

1.46.6 putting in place a system for granting longer-term approvals for continuing treatment in chronic cases, following an appropriate clinical review;

1.46.7 speeding up the communication of approvals using electronic communications.

1.47 ACC has advised the Review that it will review the Treatment Profiles, and the ACC32 process for approving additional treatments. I strongly recommend that this review address the more general issues identified above concerning the process for identifying the appropriate number of treatments to be funded for each claimant. These reviews should be a collaborative process, consistent with the partnership model discussed above. ACC needs to work with all relevant professional groups to ensure that changes to the treatment approval process are appropriate and workable, and will facilitate the provision of rehabilitation services to claimants.

Complaints process for providers

1.48 The mutual interdependence of ACC and physiotherapists means that it is important to have effective internal complaints resolution processes for providers, with a strong orientation towards restoring a high quality working relationship for the future.

1.49 ACC has a complaints process which is available to both claimants and providers. There is no reason why a single complaints process cannot in principle be flexible enough to accommodate both types of complaint. But ACC may wish to consider whether more focused guidance for provider complainants, and those who administer the process, would advance the partnership goals supported by all parties.

1.50 The information available to providers about the complaints process is less accessible than is desirable. I recommend that ACC provide clear, accessible information about its complaints process for providers (including relevant contact details, and a brief outline of the process) in the next edition of its Treatment Provider Handbook, in the next version of the audit protocol, and on its website. I also recommend that ACC's complaints information for providers include information about the matters that can be the subject of complaint to the Ombudsmen. ACC has advised the Review that it

accepts this recommendation, and will be providing this information on its website initially, and in the next edition of the Treatment Provider Handbook.

Provision of clinical notes to ACC in connection with audits and investigations

1.51 A number of concerns were identified in relation to the provision by physiotherapists to ACC of clinical notes, in connection with audits and investigations. In principle, the consent in the ACC45 injury claim form is sufficient to authorise provision of clinical notes to ACC for this purpose. However there are two respects in which the concerns expressed by some submitters appear to be well founded:

1.51.1 the ACC45 form should include on its face a more explicit authorisation for release of confidential patient information by the treatment provider to ACC. It is not as clear as desirable on the face of the form that the text on the back of the form includes a consent to disclosure of confidential medical information;

1.51.2 where claims are lodged electronically, appropriate consents may not always be obtained from claimants. Further work is needed on processes for ensuring that a hardcopy consent is obtained and retained by the relevant treatment provider in all cases where claims are lodged electronically.

1.52 It is entirely proper – indeed, essential – that physiotherapists who are asked to provide clinical notes ask ACC for a copy of the patient authorisation of disclosure, if the physiotherapists concerned do not hold that authorisation on their own files. A properly completed ACC45 form is adequate for this purpose. If a printed ACC45 form has been signed by a patient and a copy is held by the physiotherapist, it is not necessary to ask for a further consent from the patient.

1.53 I recommend that further work be carried out to ensure that the ACC45 form more clearly conveys to claimants that they are consenting to the release of confidential information, and to ensure that appropriate consents are sought and obtained in the context of electronic lodgement of claims. The Privacy Commissioner has indicated a willingness to work with ACC on these issues, and ACC has advised the Review that it is willing to undertake this work, and will do so in consultation with the Privacy Commissioner. Consultation with claimant representatives and provider groups will also be essential.

Referrals to Activity-Based Programmes

1.54 One specific context in which a failure of communication was identified by a number of submitters was referrals by ACC to an Activity-Based Programmes (ABP) of claimants already undergoing physiotherapy treatment. In order to ensure a good working relationship and a co-ordinated approach to the claimant's rehabilitation, a physiotherapist who is currently providing treatment to a claimant should be involved in the decision to refer the claimant to an ABP.

1.55 ACC recently released a consultation document in relation to the ABP which expressly refers to consultation with the existing treatment provider before an ABP referral occurs. ACC has advised the Review that it will implement this proposal by November 2007. I encourage it to do so, and to consult with the profession to ensure it is implemented in an effective and efficient manner.

Partnership and communication

1.56 An overarching theme in this Review has been the need for a partnership between ACC and the physiotherapy profession, if ACC is to succeed in achieving the statutory goal of rehabilitating injured people to the maximum practicable extent. Partnership requires mutual respect and trust; and open, clear, and effective communication. ACC is well aware of the need for good communication with treatment providers, and there are encouraging signs of improvements in communication. ACC has expressed its willingness to work in partnership with the physiotherapy profession.

1.57 But more needs to be done to enhance mutual respect and trust; and to maintain a genuine, timely and constructive two-way dialogue at all levels. The actions of both ACC and the profession need to be consistent with a genuine and consistent commitment to a partnership model.

1.58 The responsibility for good communication lies with both parties. In some cases, individual physiotherapists have failed to communicate as clearly or openly as desirable with ACC. But the evidence before the Review suggests that ACC could do a great deal to improve the quality of its communication with the physiotherapy profession, and with individual physiotherapists. ACC needs to regain the trust of the profession, which has been eroded over time by many factors, including a number of the issues canvassed in this Review. Some progress is already being made in this direction: it is important that it continue.

1.59 I recommend that ACC, in consultation with the physiotherapy profession:

1.59.1 expressly adopt a “partnership” approach to delivery of high quality rehabilitation services to claimants, in accordance with the Act;

1.59.2 expressly recognise the mutual interdependence that exists between ACC and the physiotherapy profession, and the importance of each other’s roles;

1.59.3 adopt a set of ACC Provider Principles that reflect, and spell out the central implications of, this partnership;

1.59.4 continue to work on the quality of communication with the profession as a whole, and with individual physiotherapists in relation to specific matters;

1.59.5 make better use of the Physiotherapy Liaison Group ("PLG") as a central clearing house for effective consultation and collaboration with the physiotherapy profession as a whole. There was support from the profession and from ACC for the suggestion made in the course of the Review that this would be assisted by the appointment of an independent chair of the PLG. I see real value in the appointment of an independent chair of the PLG. I recommend that the independent chair prepare a regular report for the participants in the PLG, at least annually and initially perhaps six-monthly, commenting on the effectiveness of the PLG as a forum for communication and for implementation of the partnership approach outlined above.

Quantitative analysis

1.60 I recommend that all quantitative analysis and all quantitative predictions prepared by ACC contain a statement of the purpose for which that quantitative material is provided, the basis on which it has been derived, and the level of confidence with which it can be used for that purpose, including sensitivity analysis in respect of key assumptions. This is an important discipline which should significantly improve the quality of policy advice provided by ACC. ACC has advised the Review that it is taking steps to improve the quality of its quantitative analysis, and the use of that analysis in decision-making.

2 TOPICS COVERED BY THE REVIEW

Establishment of Review

2.1 On 1 November 2006 the Minister for Accident Compensation, the Hon Ruth Dyson and the Deputy Leader of New Zealand First, Mr Peter Brown jointly announced the draft terms of reference for the Review.[2] The Review had been agreed as part of the Confidence and Supply Agreement between Labour and New Zealand First signed after the 2005 election. The terms of reference for the Review are set out in full in Appendix A. The terms of reference cover four broad topics:

- ACC Payments to Physiotherapists;
- the Endorsed Provider Network;
- the culture of ACC/Audits;
- the Physiotherapy Profession Generally.

ACC Payments to Physiotherapists

2.2 The terms of reference record that the Government wishes to ensure public access to high quality physiotherapy services by reducing co-payments, whilst ensuring the sustainability of physiotherapy service delivery. In the light of these objectives, I have been asked to address the following issues:

> 1.1. Are the levels of current payments for service delivery made by ACC to physiotherapists under:
>
> 1.1.1. Cost of Treatment Regulations;
>
> 1.1.2. the Endorsed Provider Network (EPN) contracts; and
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> 1.1.3. other contractual arrangements,
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> adequate to cover the cost of services whilst ensuring the retention of an appropriately sized, skilled and financially viable physiotherapy profession to meet the needs of ACC claimants?

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[2] Initially the Reviewer appointed by the Minister for ACC was Mr Bill Wilson QC. After his appointment to the Court of Appeal in December 2006, Mr David Goddard QC was appointed as Reviewer.

1.2. Bearing in mind the history of adjustments to physiotherapy charges under ACC "Cost of Treatment" Regulations, are the above payments likely to continue at an appropriate level in the foreseeable future?

1.3. In the long term interests of ACC claimants and the profession, are compulsory restrictions on co-payment (claimant part charges) appropriate?

1.4. What changes (if any) are necessary to pricing frameworks, annual adjustment indices, restrictions on ACC claimant co-payments and other relevant factors to ensure that the financial viability and integrity of the profession is maintained now and in the future?

The Endorsed Provider Network

2.3 The Endorsed Provider Network (EPN) has been piloted and implemented nationwide since 2004. I have been asked to consider the following issues in relation to the EPN:

2.1. Are initial and ongoing compliance costs for accreditation standards appropriately built into ACC payments when accreditation is a contractual requirement for EPN providers?

2.2. Are the differences between pricing frameworks and fee structures paid under cost of Treatment Regulations, as opposed to the EPN and other contract pricing frameworks, valid and justifiable in the interests of patients, and in maintaining a healthy and suitably qualified profession?

Culture of ACC/Audits

2.4 The terms of reference record that physiotherapists have raised concerns about the culture of ACC and its attitudes towards physiotherapists. I have been asked to consider the following issues:

3.1. Is there evidence of any inappropriate culture or attitude from within ACC towards physiotherapists which is detrimental to the funder / provider relationship between the parties?

3.2. Are audits and investigations being carried out only for proper purposes, in appropriate circumstances, and within appropriate guidelines for programmed and selected audits?

3.3. What changes, if any, are necessary to address any inappropriate culture, attitudes or activities found within ACC towards physiotherapists?

2.5 This Review is not intended to be an inquiry into specific cases, that results in recommendations concerning ACC's past dealings with particular physiotherapists.

Physiotherapy Profession Generally

2.6 The terms of reference record that there are challenges facing the physiotherapy profession as primary health care practitioners in ensuring that it continues to plays its vital public health role in rehabilitating and maintaining the quality of life of New Zealanders, including ACC claimants. In this context, I have been asked to consider the following issues:

4.1. In regard to the needs of New Zealanders, is the physiotherapy profession:

4.1.1. retaining adequate numbers of senior physiotherapists within the profession?

4.1.2. adequately remunerated for post-graduate qualifications and expertise?

4.2. What, if anything, can ACC or the Government do to assist with any deficiencies found regarding seniority and post-graduate training in the profession?

4.3. Are there any other matters arising out of this Review that impact upon the way in which physiotherapists are accredited and funded by ACC which ought to be addressed by the Government to encourage provision of sustainable and high-quality physiotherapy service to the public of New Zealand?

3 REVIEW PROCESS

Guiding principles for Review process

3.1 The terms of reference for the Review (set out in full in Appendix A) provide that the following principles should guide the way in which the Review is conducted:

- the Review is to be an investigative Review that is not overly legalistic or adversarial;
- the principles of natural justice must be complied with;
- the Review is to be consultative;
- officials will co-operate with the Reviewer;
- the process for the Review will be flexible in order to accommodate any changes in the Terms of Reference that may be required at the discretion of the Reviewer with the agreement of the Minister;
- the Review will focus on practical solutions that can work to any issues that are identified;
- given the investigative nature of the Review, it will be up to the Reviewer to determine what, if any, part of the Review should be held in public; and
- to the extent that the conduct of the Review requires ACC or any other agency to disclose to the Reviewer the content of legal advice, the Reviewer is to treat that legal advice as covered by legal professional privilege, and natural justice will not require disclosure to any other party.

Process agreed at preliminary meeting with parties

3.2 The Review commenced on a consultative basis, with a preliminary meeting in late November 2006 to discuss the draft terms of reference and the process for undertaking the Review. The meeting was attended by representatives of ACC, and representatives of the New Zealand Society of Physiotherapists (NZSP), the Physiotherapy Trust of New Zealand (Physiotherapy Trust) and the Auckland Private Physiotherapy Practitioners Association (APPPA) – the physiotherapy profession groups which were active in instigating the Review.

3.3 The parties present at the initial meeting agreed that the draft terms of reference covered all the relevant issues, and that Ministerial agreement should be sought to

confirming them. They also agreed to the iterative process proposed for undertaking the Review involving:

- public notices being placed in the main metropolitan daily newspapers to alert the public to the Review;
- the physiotherapy organisations using their internal communication systems to alert their members to the Review;
- initial written submissions from the parties and the public (to be circulated to all parties and available on the Department of Labour website, except where confidentiality was sought);
- the opportunity to make a second written submission, allowing the parties and the public to comment on others' views and re-iterate key points;
- public hearings on the submissions, with the parties having the right to be accompanied by any expert witnesses they wanted to participate;
- the hearings being intended to clarify the issues within the scope of the terms of reference and the degree of consensus and any divergences in view regarding how they should be handled;
- the Reviewer producing a draft report, to be circulated to the parties and available on the Department of Labour website;
- a conference on the draft report, again in open session, so that both areas of consensus and divergence could be explored and clearly understood;
- revision of the draft report and submission of the final report to the Minister of ACC by 30 September 2007.

Extension of parties to the Review

3.4 The parties present at the initial meeting also indicated that a number of other organisations might have an interest in becoming formal parties to the Review. These included the New Zealand College of Physiotherapy, the New Zealand Private Practitioners Association, the Auckland University of Technology School of Physiotherapy, the University of Otago School of Physiotherapy, the District Health Boards' Physiotherapy Advisers, Leaders and Managers Group (PALM), the New Zealand Physiotherapy Board and the Health and Disability Commissioner. These organisations were invited to become parties to the Review, and all but the last two accepted that invitation.

Implementing agreed process

3.5 Public notices were placed in the daily newspapers in Auckland, Hamilton, Wellington, Christchurch and Dunedin in mid-November 2007. These informed the public of the main features of the terms of reference, the closing date for public submissions of 28 February 2007, and the date and place of the two rounds of public hearings (the Westpac Stadium function rooms in Wellington, on 14-17 May and 29-31 August 2007).

3.6 In early December 2006 the first quarterly report to the Minister for ACC and Mr Peter Brown MP was produced. This outlined progress to date, and the proposed project plan for the Review, and recommended that the draft terms of reference be confirmed. Formal confirmation from the Minister was received in January 2007.

3.7 During January and February 2007 the project manager and principal analyst for the Review identified key documents and information sources, and drew on these to produce background reports for me on physiotherapy in New Zealand and its funding and accreditation by ACC.

3.8 Initial submissions to the Review closed on 9 March 2007 (the date having been extended from 28 February at the request of a number of the parties). By that date twenty-five written submissions had been received. Most submissions were from physiotherapy groups and individual physiotherapists, but a small number were from ACC claimants. ACC provided a substantial amount of background material attached to their submission, in response to requests from the New Zealand Society of Physiotherapists.

3.9 The second round of public submissions closed on 30 April 2007, with a further eighteen submissions received. In the main these were from the original submitters, but new submissions were received from the ACC subcommittee of the New Zealand Law Society, some individual physiotherapists and an ACC claimant group. Details of all those making written submissions to the Review are provided in Appendix B.

Public hearings and reports

3.10 The initial public hearings were held in Wellington from 14-17 May 2007, which enabled presenters from the various physiotherapy groups and consumers and ACC to make oral submissions in relation to the issues they had identified and proposed solutions. An Expert Panel session was also held on the Deloitte physiotherapy practice costing and pricing model, involving Deloitte (advisers to ACC) and KPMG (advisers to the NZ Society of Physiotherapists). The Expert Panel members agreed (at my request) to provide their input as independent experts, on essentially the same basis as expert witnesses before the High Court.

3.11 Appendix C lists the individuals and organisations who participated in the initial hearing.

3.12 At the initial hearing there was extensive questioning of submitters, to ensure the relevant issues were fully understood and explored. In many cases, further information was requested, to be provided after the hearings – in particular from ACC, but also from the physiotherapy organisations and some other presenters.

3.13 The further information sought from various parties at the initial hearing was received during June and early July 2007. After reviewing the information received, further follow-up requests for information were made to ACC.

3.14 To ensure that areas of agreement and disagreement between the experts on the question of practice costs and sustainable pricing of physiotherapy services were fully understood, further information was also requested from Deloitte and KPMG including some further sensitivity analysis of the Deloitte physiotherapy practice cost and pricing model. A follow-up meeting was held on 9 July 2007 with the Expert Group, with the discussion open to the parties to the Review by teleconference.

3.15 A draft report was prepared in July 2007, and provided to the Minister and to the parties for comment in late July 2007. It was also made available to members of the public on the Department of Labour website.

3.16 The second round of hearings on the draft report took place in Wellington on 29 – 31 August 2007. The purpose of these hearings was to provide an opportunity to test the preliminary findings, analysis and recommendations in the draft report, and to obtain further relevant information from the parties. Appendix C also lists the parties who participated in the second hearings. The parties made written submissions in advance of the second round of hearings, and a number of parties provided further written submissions after those hearings to respond to questions raised at the hearings. A further joint report on certain modelling issues was provided by Deloitte and KPMG, at my request.

3.17 All the submissions and information received by the Review throughout this process were made available on the Department of Labour website (with the exception of three confidential submissions, for which a summary of key issues was provided). Transcripts of the hearings and copies of PowerPoint presentations made by some presenters were also made available on the website.

3.18 This final report was prepared in September 2007 in the light of all the information received by the Review.

Support for Review from all parties

3.19 I would like to express my gratitude to all parties for their willingness to assist the Review by providing information and submissions, and appropriate expert assistance. Without the full support and cooperation of the parties, the Review would not have been possible. I have been impressed, and greatly assisted, by the quality, thoughtfulness and practicality of the submissions made by all parties.

3.20 Inevitably, the burden of responding to questions and further inquiries fell primarily on ACC. I should record that I have received full and willing cooperation from ACC, and that the ACC team's constructive approach to the Review has contributed significantly to its smooth operation to date.

3.21 I would also like to record my appreciation for the substantial assistance I have received in preparing this report from Diane Salter, the Review's Project Manager and Principal Analyst. Her efficient management of the process, and her familiarity with ACC policy and understanding of the issues raised by the Review, have been invaluable.

4 THE ACC SCHEME AND PROVISION OF PHYSIOTHERAPY SERVICES – AN OVERVIEW

The accident compensation scheme

4.1 New Zealand's accident compensation scheme is a unique response to the problem of injury by accident. It had its origins in the report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand, chaired by the Hon Mr Justice Woodhouse, which reported in 1967. The Woodhouse Royal Commission recommended that a new scheme be established to respond to the social problem of injury arising from accident, founded on five guiding principles:

4.1.1 community responsibility: the community has a duty, and a vested interest, in "urging forward the physical and economic rehabilitation of every adult citizen whose activities bear upon the general welfare"[3];

4.1.2 comprehensive entitlement: the scheme should not draw distinctions which depend upon the cause of injury, and in particular should not be restricted to work injuries alone. "Unless economic reasons demanded it the protection and remedy society might have to offer could not in justice be concentrated upon a single type of accident to the exclusion of others."[4] The Royal Commission recommended an integrated solution with comprehensive entitlement for all, and coverage in respect of every type of accident. This was described as the central recommendation of the report;[5]

4.1.3 complete rehabilitation: the Royal Commission emphasised that after prevention of injury, the next priority was rehabilitation, ahead of compensation. "The consideration of overriding importance must be to encourage every injured worker to recover the maximum degree of bodily health and vocational utility in a minimum of time. Any impediment to this should be regarded as a serious failure to safeguard the real interests of the man himself and the interest which the community has in his restored productive capacity."[6]

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[3] Woodhouse Royal Commission Report (December 1967), Compensation for Personal Injury in New Zealand, para 5.

[4] Woodhouse Royal Commission Report, para 6.

[5] Woodhouse Royal Commission Report, para 7.

[6] Woodhouse Royal Commission Report, para 58.

4.1.4 real compensation: there should be a realistic assessment of actual loss, both physical and economic, followed by a shifting of that loss on a suitably generous basis;[7]

4.1.5 administrative efficiency, which as the Royal Commission said, "needs no elaboration. It speaks for itself in terms which are clear enough."[8]

4.2 The Royal Commission recommended that the new scheme replace the piecemeal existing system, and in particular the ability to bring an action at common law for negligence causing personal injury, and the Workers Compensation scheme then in force. These recommendations were implemented by the Accident Compensation Act 1974.

4.3 Over the past 33 years, the legislation has evolved significantly. The scheme has at times faced significant challenges, including rapidly expanding costs. But the five guiding principles identified by the Royal Commission remain recognisable as the underpinnings of today's scheme. Indeed the current legislation, the Injury Prevention, Rehabilitation, and Compensation Act 2001, makes express reference to the social contract embodied in the original scheme, under which various entitlements including the ability to bring negligence proceedings were surrendered in exchange for the entitlements provided for by the accident compensation scheme. The title of the current legislation very deliberately reflects the priorities identified by the Royal Commission.

4.4 It is helpful to set out the purpose provision of the current legislation in full, as it is a fundamental guide in addressing the issues considered in this Review.

> **3 Purpose**
>
> The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs), through—
>
> (a) establishing as a primary function of the Corporation the promotion of measures to reduce the incidence and severity of personal injury:
>
> (b) providing for a framework for the collection, co-ordination, and analysis of injury-related information:

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7 Woodhouse Royal Commission Report, para 61.

8 Woodhouse Royal Commission Report, para 62.

(c) ensuring that, where injuries occur, the Corporation's primary focus should be on rehabilitation with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence, and participation:

(d) ensuring that, during their rehabilitation, claimants receive fair compensation for loss from injury, including fair determination of weekly compensation and, where appropriate, lump sums for permanent impairment:

(e) ensuring positive claimant interactions with the Corporation through the development and operation of a Code of ACC Claimants' Rights:

(f) ensuring that persons who suffered personal injuries before the commencement of this Act continue to receive entitlements where appropriate.

4.5 The scheme is administered by the Accident Compensation Corporation (ACC). ACC is a Crown Entity overseen by a board appointed by, and responsible to, the Minister for Accident Compensation.

4.6 The accident compensation scheme consists of six (until recently, seven) separate schemes:

4.6.1 the work account, established on 1 April 2007 by combining the employers account and the self-employed work account. The work account funds the cost of work related injuries suffered by employees and private domestic workers, and the self-employed. This account is funded from levies paid by all employers and private domestic workers and self-employed persons;

4.6.2 the earners account, which meets the cost of non-work injuries suffered by people in paid employment and the self-employed (except motor vehicle injuries). This account is funded by levies paid by people in paid employment and the self-employed;

4.6.3 the non-earners account, which funds the cost of injuries to people who are not in the paid workforce, such as students, beneficiaries, retired people and children (excluding injuries covered by the motor vehicle or medical misadventure accounts). This account is funded by the Vote ACC appropriation in the Government's budget, ie from public money;

4.6.4 the motor vehicle account, which funds the cost of injuries involving moving motor vehicles on public roads. This account is funded by a levy on the price of petrol, and from a component of the motor vehicle licensing fee;

4.6.5 the medical misadventure account, which funds the cost of injuries that result from treatment by a registered health professional. This account is funded 55% from the earners account and 45% from the non-earners account;

4.6.6 the residual claims account, which funds the cost of work injuries suffered before 1 July 1999 and non-work injuries suffered by earners prior to 1 July 1992. This account is funded by a separate levy paid by employers and the self-employed.

ILO Convention 17

New Zealand non-compliance with ILO Convention 17

4.7 An important factor in considering the issues raised by this Review is New Zealand's international obligations under International Labour Organisation Convention 17. New Zealand ratified ILO Convention 17 in 1938. Article 9 of ILO Convention 17 requires that the cost of work injuries be met by employers or insurers, and that employees should not bear these costs.

4.8 Under the Regulation funding regime introduced in 1989, discussed in more detail in section 5 below, the ACC scheme provides a contribution towards the cost of treatment for all injuries, including work injuries. It does not meet the full cost of most forms of treatment, including physiotherapy treatment. This is inconsistent with Article 9 of ILO Convention 17. In 1993 the New Zealand Council of Trade Unions made a formal complaint to the ILO about New Zealand's non-compliance with Convention 17, which was upheld by the ILO. The Government of the day responded by noting its agreement in principle to rectify the non-compliance. Since then, a number of options for achieving compliance have been considered, but full compliance has not been implemented.

4.9 ILO Convention 17 only applies to work injuries; it does not apply to other injuries. However the original Woodhouse Royal Commission principle of comprehensive entitlement does not support the drawing of a distinction between work injuries and other injuries. The cost of compliance with ILO Convention 17 in respect of work injuries would be magnified many times over if the principle of comprehensive entitlement is respected, and the same entitlements are provided in respect of all injuries, not just work injuries. And this cost would have to be met out of public money funded by taxation, so far as the non-earners account is concerned. It appears that the cost implications of meeting full treatment costs across the board have precluded achieving compliance with ILO Convention 17 to date.

4.10 One of the objectives of the Endorsed Provider Network (EPN) programme (discussed in sections 5 and 6 below) is to move towards compliance with ILO Convention 17. Claimants who suffer work injuries and receive treatment from an EPN clinic during working hours will not have to make a co-payment (though as explained below, they may be required to meet the cost of materials used eg strapping and orthoses). As EPN providers have become more numerous and more geographically widespread, the option of receiving fully funded treatment from an EPN clinic with no co-payment has become available to most employees who suffer work injuries. This represents significant progress towards compliance with ILO Convention 17 so far as physiotherapy treatment is concerned, though full compliance cannot yet be regarded as achieved.

4.11 It is also noteworthy that evidence before the Review suggested that there is no other OECD country in which workers are expected to contribute to the cost of treatment for work injuries. New Zealand is clearly out of step in this respect, in a manner which is difficult to reconcile with the pride New Zealanders take in our comprehensive, no fault accident compensation scheme.

NZSP submissions in relation to ILO Convention 17

4.12 The NZSP suggested in its submissions to the Review that Article 9 of ILO Convention 17 could be read as not requiring full payment of treatment costs. [9] Alternatively, the NZSP submitted that New Zealand's obligations under ILO Convention 17 should be read down in the light of subsequent ILO conventions (to which New Zealand is not a party) dealing with the same subject matter, which do not require treatment costs to be met in full in all circumstances.

4.13 The NZSP submissions on the extent of New Zealand's obligations under ILO Convention 17 are in my view inconsistent with the language of that Convention, core principles relating to the interpretation of international instruments, and State practice including the New Zealand Government's acknowledgement of non-compliance with Article 9.

Implications of ILO Convention 17 for this Review

4.14 I have been asked to identify practical solutions that can work to the concerns that have prompted this Review. In some cases, the ideal must give way to the possible. My terms of reference record the government's desire to *reduce* co-payments to enhance access to high-quality physiotherapy services; rather than an absolute requirement to *eliminate* co-payments. Accordingly, I have not treated compliance with ILO Convention 17 as an absolute goal. My recommendations identify some options for eliminating co-payments in respect of physiotherapy treatment; but also identify other options for achieving sustainability, fairness and access goals that could

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[9] NZSP First Submission, pp 37-38

be expected to reduce, but probably not eliminate, co-payments. As discussed in more detail below, the choice between these options involves significant policy and fiscal choices which can only be made by the Government, in the light of all relevant factors including New Zealand's international obligations, the underlying principles of the accident compensation scheme, and affordability constraints.

4.15 Some of the options that I identify would involve removing the prohibition on co-payments that is currently found in the EPN contracts, to provide greater flexibility in meeting the full range of costs of treatment and to ensure sustainability and fairness, coupled with an increase in payment rates to a level which should ensure that co-payments do not become widespread and material. Provided that all injured employees have realistic access to physiotherapy treatment at no cost, compliance with ILO Convention 17 does not require that every physiotherapist provides services without charging a co-payment.

4.16 Other options that I identify would involve differentiating between work injuries and other injuries, in order to achieve compliance with ILO Convention 17 in respect of work injuries without incurring the significant cost of extending entitlements to the full cost of physiotherapy treatment to all claimants, including non-earners. This is inconsistent with the principle of comprehensive entitlement. But it is worth recalling that even the original Woodhouse Royal Commission was not averse to staged responses to significant social issues. In its description of the principle of comprehensive entitlement, the Royal Commission recognised that economic reasons might demand a focus on particular types of accident. Although it did not consider that this was justified so far as accidents were concerned, in the circumstances of the late 1960s, the Royal Commission did look to economic considerations to draw what it recognised as being an equally illogical distinction between incapacity arising from accident, and incapacity arising from sickness and disease. As the Royal Commission said, "logic on this occasion must give way to other considerations."[10] And later, in the body of the report, the Royal Commission recorded its agreement with a dissenting opinion attached to the 1963 report of the Committee On Absolute Liability, in which Sir Richard Wild (Solicitor General in 1963; Chief Justice in 1967 at the time of the Woodhouse report) said: "If the basic aim is sound then the fact that all categories of misadventure cannot be provided for at once is not a ground for doing nothing."[11]

Physiotherapy services

4.17 Physiotherapists were seen, at the outset of the ACC scheme, as one of several key provider groups. The Royal Commission recognised that injured people required

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[10] Woodhouse Royal Commission Report, para 17.

[11] Woodhouse Royal Commission Report, para 167.

prompt assessment, treatment and rehabilitation by a team "wide enough to deal with all the features of many different cases: it should include, surgeon, physician, psychologist, psychiatrist, social worker, placement officer, *physiotherapist*, and occupational therapist."[12] [emphasis added]

4.18 In addressing the issues raised in the Review, it was necessary to gain a good understanding of:

4.18.1 the physiotherapy profession, and its role;

4.18.2 the range of conditions treated by physiotherapists, and the overlapping roles of physiotherapists and other treatment providers funded by ACC;

4.18.3 how physiotherapists are regulated in New Zealand.

Physiotherapy – an overview

4.19 The Physiotherapy Board of New Zealand – whose role is to register physiotherapists as competent to practice - defines physiotherapists and their general scope of practice as follows:

> "Physiotherapists are registered healthcare practitioners educated to apply scientific knowledge and clinical reasoning to assess, diagnose and manage human function. They promote mobility, health and independence; rehabilitate; and maximise potential for activity."[13]

4.20 NZSP provided a similar description of physiotherapists and their role:

> "Physiotherapists help people move and participate in their communities, especially when movement and function are threatened by aging, injury, disability or disease…After assessing a patient's potential for movement and function, the physiotherapist establishes (together with the patient, whänau/family and caregivers) treatment goals designed to restore or develop that function and maintain it." [14]

4.21 Finally, Basset has described physiotherapy as:

> "…an orthodox medicine profession, which assesses, treats and educates individuals who have problems with function and mobility utilising manual and movement therapies, and medical electricity. These methods are based on physical and physiological principles and are known to affect the individual

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12 Woodhouse Royal Commission Report, p 144

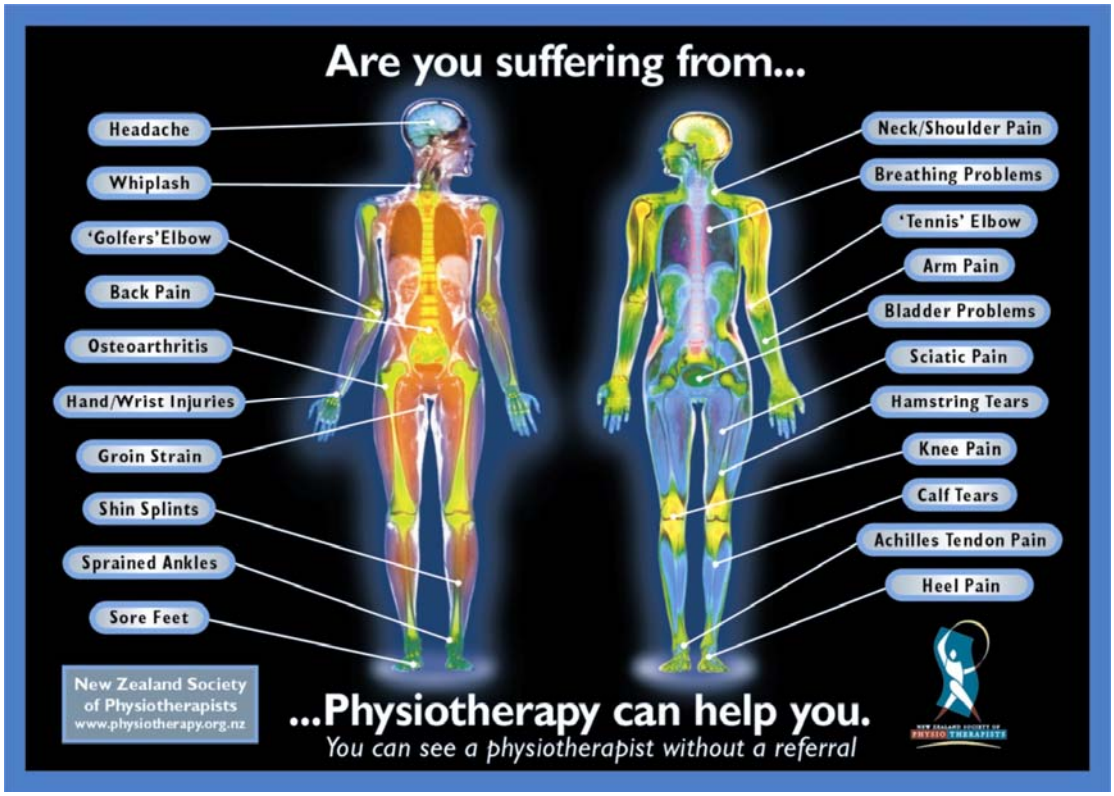
13 http://*www.physioboard.org.nz/pracdef.asp*

14 htpp://*www.nzsp.org.nz/index02/index_Welcome.htm*

physically, psychologically and spiritually. Using the clinical reasoning process, methods are selected so that they are suitable to the individual's needs and are applied in a manner which is both culturally sensitive and gender appropriate for the individual taking into account their social environment."[15]

Range of conditions treated by physiotherapists

4.22 Physiotherapists treat a wide range of conditions that can affect mobility and functioning, literally anywhere from the head to the foot of the body – as the following diagram demonstrates:[16]



4.23 The path by which an injured person comes to a physiotherapist varies. They may be referred by a general practitioner or other health provider, or go directly to the physiotherapist for diagnosis and treatment. The initial requirement that an injured person be referred by a GP in order for a physiotherapy treatment to be funded by ACC was removed in 1999, with the passage of the Accident Insurance Act 1999. This amendment also enabled physiotherapists to directly refer injured patients to other ACC-funded services such as radiology and orthopaedics.

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15 S Bassett, (August 1995), New Zealand Journal of Physiotherapy.

16 htpp://*www.nzsp.org.nz/index02/index_Welcome.htm*

4.24 A number of the conditions commonly treated by physiotherapists are also often treated by chiropractors and osteopaths and, to a lesser extent, acupuncturists. This includes not only back pain, but also neck and shoulder pain and problems with other joints.

Regulation of physiotherapists in New Zealand

4.25 The regulation of health practitioners in New Zealand is provided for in the Health Practitioners Competence Assurance Act 2003 ("HPCA Act"). The HPCA Act came into force in full on 1 September 2004. It repealed eleven occupational statutes governing 13 professions, including the Physiotherapy Act 1949 which formerly governed the physiotherapy profession.

4.26 The purpose of the HPCA Act is to provide a basic framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession. It includes mechanisms to assure the public that a health practitioner who is registered under the Act is competent to practise, with the emphasis on ongoing competence. It also includes the basic principles of the separation of registration and disciplinary powers, and provides consistent procedures across the professions for handling complaints against health practitioners, coordinated with the provisions of the Health and Disability Commissioner Act 1994.

4.27 The HPCA Act requires that before anyone can commence practice as a physiotherapist in New Zealand they must be registered with, and hold a current annual practising certificate issued by, the Physiotherapy Board of New Zealand. The primary function of the Physiotherapy Board is to protect the public by ensuring that physiotherapists are registered, safe and competent to practise.

4.28 The Physiotherapy Board has prescribed that to gain entry-level registration in New Zealand as a physiotherapist under the HPCA Act, individuals must be able to demonstrate competence in cardiopulmonary, musculoskeletal and neurological physiotherapy in all the following ten areas:[17]

- analyse the pure, behavioural and social science bases of physiotherapy and integrate this knowledge into practice;
- analyse consumer(s) health needs and wants;
- plan physiotherapy management;
- implement safe and effective physiotherapy management;

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[17] Physiotherapy Board of New Zealand (2000), *Registration Requirements: Competencies and Learning Objectives*, p iii.

- communicate effectively;
- provide education;
- apply management principles to physiotherapy practice;
- conduct research;
- develop individual professional growth;
- demonstrate accountability to the public and profession.

4.29 The process for achieving registration as a physiotherapist with the Physiotherapy Board of New Zealand, and becoming entitled to practise in New Zealand, varies depending on where the individual was educated, and where they are currently qualified to practise.[18]

4.30 New Zealand qualified physiotherapists must:

- have successfully completed a Bachelor of Health Science (Physiotherapy) at Auckland University of Technology or a Bachelor of Physiotherapy at Otago University;[19]
- provide all the documentation and information requested by the Board;
- pay a registration fee of $180; and
- meet the fitness to practise criteria specified in section 16 of the HPCA Act (regarding having adequate communication skills, no criminal convictions, being physically and mentally fit to practise, and not subject to disciplinary proceedings that reflect adversely on fitness to practise).

4.31 Australian physiotherapists who are registered to practise physiotherapy in an Australian jurisdiction are entitled to seek registration in New Zealand under the Trans-Tasman Mutual Recognition Act 1997. A registration fee of $180 is payable. Inquiries are made by the Physiotherapy Board of New Zealand to the Australian registration body to establish that the fitness to practise criteria are met.

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[18] http// www.physioboard.org.nz/registration.asp

[19] Prior to the introduction of degree courses in physiotherapy, the New Zealand tertiary qualification earned by physiotherapists was the Diploma in Physiotherapy. This qualification was grandparented for the purposes of entitlement to practise upon introduction of degree courses in New Zealand.

4.32 Physiotherapists from other overseas jurisdictions must, in order to gain New Zealand registration, meet the following criteria:

- hold a physiotherapy qualification that is sufficiently similar in theory and practice to the physiotherapy curricula undertaken by students in New Zealand;
- have completed one thousand hours of supervised clinical practice during their course of study;
- provide evidence of recency of practice, English proficiency, details of their legal and disciplinary proficiency, and a declaration of physical and mental fitness; and
- pay a fee of $600.

4.33 Under the Physiotherapy Act 1949, the issue of an annual practising certificate by the Physiotherapy Board was automatic on payment of the prescribed fee. The HPCA Act provides six grounds for the withholding of an annual practising certificate (section 27):

- failure to maintain standard of practice;
- failure to comply with conditions included in scopes of practice;
- failure to satisfactorily complete a competence program ordered by the authority;
- not holding an annual practicing certificate for three years preceding the application;
- inability to perform the functions required of the profession because of some mental or physical condition; or
- not having lawfully practised within the three years preceding the application.

5 ACC PAYMENTS TO PHYSIOTHERAPISTS

Background

5.1 The IPRC Act contemplates three types of arrangement for payment for services delivered by treatment and rehabilitation providers: payment of an amount specified in regulations; payment in accordance with a contract or agreement entered into between the provider and ACC; or (if no regulations or contract apply) payment of the appropriate cost of treatment as agreed with ACC. [20]

5.2 Clause 2 of Schedule 1 to the IPRC Act specifies the circumstances in which the Corporation is liable to pay the cost of treatment (whether under a contract or regulations):

> **2 When Corporation is liable to pay cost of treatment**
>
> (1) The Corporation is liable to pay the cost of the claimant's treatment where that treatment is for the purpose of restoring the claimant's health to the maximum extent practicable and the treatment –
>
> (a) is necessary and appropriate, and of the quality required for that purpose; and
>
> (b) has been, or will be performed only for the number of times necessary for that purpose; and
>
> (c) has been or will be given at a time or place appropriate for that purpose; and
>
> (d) is of a type normally provided by a treatment provider; and
>
> (e) is provided by a treatment provider who is qualified to provide that type of treatment and normally provides that treatment.
>
> (2) In deciding whether sub-clause 1 (a) to (e) applies to the claimant's treatment, the Corporation must take into account -
>
> (a) the nature and severity of the injury; and
>
> (b) the generally accepted treatment of an injury of that nature in New Zealand; and
>
> (c) the other options available in New Zealand for the treatment of such an injury, and

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[20] See IPRC Act ss 69, 70; Schedule 1 clause 1.

(d) the cost in New Zealand of the generally accepted means of treatment and of the other options, compared with the benefit the claimant is likely to receive from the treatment.

5.3 There are at present two parallel regimes for payment of physiotherapists providing services to ACC claimants: payment under the Injury Prevention, Rehabilitation and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 ("Cost of Treatment Regulations"), and payment under Endorsed Provider Network (EPN) Contracts.

5.4 The majority of providers now hold EPN contracts. As at 31 January 2007 293 physiotherapy businesses (incorporating 1205 physiotherapists) held EPN contracts, providing approximately 74% of all physiotherapy treatments funded by ACC.[21]

Regulation payment rates

5.5 If a physiotherapy practice has not entered into an EPN contract, services provided by that practice are paid for under the Cost of Treatment Regulations. The Regulations provide for payment on one or other of two bases (physiotherapists are required to elect to charge on one or other basis):

5.5.1 a per treatment rate which is currently $21.76 excl GST ($24.48 incl GST); or

5.5.2 an hourly rate which is currently $54.73 excl GST ($61.57 incl GST).

5.6 The history of payment under the regulations is described in Appendix D. Regulations limiting ACC's obligation to contribute to the cost of physiotherapy treatment were first introduced in 1989. The applicable rates since 1989 under the relevant regulations have been as follows:

Period	Regulation rates excl GST	Regulation rates incl GST
December 1989 - October 1990	$20.00 per treatment	$22.50 per treatment
October 1990 – January 1992	$20.00 per treatment OR $50.00 per hour	$22.50 per treatment OR $56.25 per hour
February 1992 – March 2006	$16.89 per treatment OR $42.49 per hour	$19.00 per treatment OR $47.80 per hour
April 2006 – March 2007	$17.32 per treatment OR	$19.48 per treatment OR

[21] ACC Primary Submission, p 19.

	$43.56 per hour	$49.00 per hour
1 April 2007 - present	$21.76 per treatment OR $54.73 per hour	$24.48 per treatment OR $61.57 per hour

5.7 The regulations do not provide for indexation of payment rates, or any other form of periodic adjustment. Payment rates can only be altered by amending the regulations, following a statutory consultation process. Any increases in Regulation rates are subject to Government funding constraints, as the Non-Earners Account is funded from general tax revenues, unlike the other accounts which are funded by levies on the relevant funding groups.[22] ACC advises that the regulatory change process can take up to 10 months before new regulations come into effect.

5.8 ACC has advised the Review that Cabinet has approved a proposal for amendments to the IPRC Act which would if implemented require ACC to conduct an annual review of the amounts prescribed by the regulations. The proposal also includes replacing the current consultation requirements in s 324(2) with a simpler and less prescriptive requirement that ACC consult with the persons and organisations that the Minister for ACC considers appropriate. ACC advised the Review that a Bill to give effect to these proposals is scheduled to be introduced in October 2007.

5.9 It was common ground between all parties that the current Regulation rates represent a contribution to the cost of providing treatment, and are not designed to cover the full cost of treatment. For most if not all providers, it is necessary to charge a co-payment in order to meet the cost of providing physiotherapy services.

5.10 The most recent survey of co-payments in July 2006 found that Regulation providers paid by ACC on a per treatment basis charge average co-payments of $14.26 for an initial consultation and $9.73 for a follow-up consultation, and Regulation providers paid by ACC on an hourly basis charge average co-payments of $19.18 for an initial consultation and $15.91 for a follow-up consultation (all figures include GST).[23]

5.11 The levels of co-payment that Regulation providers are able to charge are constrained by the availability of services from EPN providers who do not charge any co-

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[22] The IPRC Act permits different entitlements to be provided for work and non-work injuries. In principle, the regulations could be amended to prescribe different rates of payment for work injuries without needing to obtain further funding from public money for non-earner injuries. This possibility is discussed in more detail below.

[23] Research New Zealand, Physiotherapists Co-payment Survey, 2 August 2006. The survey reports standard errors, medians and measures of statistical significance for changes from the previous year. It does not however provide any measure of how representative the data gathered are of the full population of treatment providers or claims made.

payment. The widespread availability of EPN services, and the effect this has on the willingness of claimants to pay co-payments for services provided by Regulation providers, mean that Regulation providers are not able to recover the full sustainable cost of providing services even by charging a co-payment over and above the ACC contribution.

5.12 As noted above, ACC pays for rehabilitation treatment services only where those services are necessary and appropriate, and performed for the number of times necessary for rehabilitation purposes. ACC uses its Physiotherapy Treatment Profiles as a management tool in this context: ACC will pay for services up to the number of treatments specified in the Treatment Profiles, and after that will pay for services only if an ACC32 form is completed and further treatments are approved by ACC. The Treatment Profiles and the ACC32 process are discussed in more detail in Appendix D.

EPN payment rates

5.13 The EPN Service Agreement was rolled out nationally in April 2004, after pilots in 2000-2001 and 2001-2002. The results of the pilots, the origins of the EPN Service Agreement, the requirements for entry into it, and its terms, are discussed in more detail in Appendix E.

5.14 ACC's objectives in introducing the EPN were to:

5.14.1 encourage quality treatment;

5.14.2 eliminate claimant co-payments, with progress toward compliance with ILO Convention 17;

5.14.3 reduce weekly compensation durations; and

5.14.4 achieve early, effective, sustainable rehabilitation outcomes.

5.15 The central features of the EPN contract relevant to payment levels are:

5.15.1 a requirement that EPN providers be certified against NZS 8171:2005;

5.15.2 a requirement that a principal of the practice be a member of the New Zealand College of Physiotherapists;

5.15.3 a requirement that EPN providers interact electronically with ACC, in particular by lodging payment claims electronically;

5.15.4 provision for four different levels of payment for treatments provided, depending on whether the injury is simple or complex, and whether the consultation is an initial or follow-up consultation;

5.15.5 a prohibition on charging co-payments for services provided at the premises of the physiotherapist in normal working hours. Co-payments are permitted for services provided away from the provider's premises or outside working hours; for "no shows" where an appointment is not kept (as no ACC fee is then payable); and for materials used, eg strappings and orthoses;

5.15.6 indexation of payment rates by reference to the Labour Cost Index (LCI).

5.16 ACC also identifies in some of its explanatory materials, as a requirement of the EPN contract, that physiotherapists comply with the Treatment Profiles. Comments to this effect also appeared in ACC's written submissions to the Review.[24] In oral submissions ACC representatives pointed out, correctly, that the EPN contract does not require compliance with the Treatment Profiles. Rather, the contract requires that services not be provided outside the Treatment Profiles without prior approval from ACC through the ACC32 process. In this respect, service provision under the EPN contract is no different from service provision under the Regulations.

5.17 A concern that EPN providers are in some sense contractually bound to comply with the Treatment Profiles was reflected in a number of submissions: this is a misconception, but one to which ACC has in my view contributed. ACC has certainly encouraged a perception that EPN providers are expected to remain within the profile limits in most cases, and providers are very conscious of that expectation, although it is not a contractual obligation as such.

5.18 The current 2007/8 EPN payment rates are as follows:

EPN Fee category	**2007/08**	
	GST excl	**GST incl**
Level A (uncomplicated), initial consultation	43.56	49.01
Level A (uncomplicated), follow-up consultation	35.03	39.41
Level B (complex), initial consultation	76.69	86.28
Level B (complex), follow-up consultation	56.81	63.91

[24] See eg ACC Primary Submission section 3.3.3: "To apply for an EPN service agreement, physiotherapists must ... work according to the ACC Physiotherapy Treatment Profiles"; ACC response to questions arising from the second hearing Q21 "ACC considers that there is a certain level of expectation that non-complex injuries are treated within or up to the treatment profile limit.".

Hourly rate for travel (first hour)	46.66	52.49
(subsequent hours)	93.32	104.98
ACC32-A		
Request for additional treatment as assessment	34.09	38.35
ACC32-R		
Request for further treatment	34.09	38.35

5.19 Based on the mix of consultation types observed by Deloitte in their recent study of treatment costs, the per treatment rates equate to a 2007/8 hourly rate for EPN providers of approximately $103.24 (GST excl).

5.20 The EPN contract provides for payment for travel time at $93.32 per hour GST excl, with payment for the first hour of travel at half this rate. (There is also a distance-based allowance for travel costs, where travel exceeds 20 km.) This is somewhat less than the effective hourly rate for provision of physiotherapy services under the EPN contract estimated by the expert accountants giving evidence to the Review.

Initial setting of EPN rates

5.21 Current EPN rates were set in 2003, and as noted above have since been adjusted annually by the LCI, in accordance with the EPN contracts.

5.22 EPN payment levels for simple injuries were set in 2003 on the basis of a limited "Mystery Shopping" survey of co-payments charged by physiotherapists for treatment for a "hurt ankle". The payment levels for simple injuries were set equal to the ACC per treatment Regulation payment, plus the co-payment identified by the study as lying at the mean plus one standard deviation. The rationale appears to have been that this would fully cover the costs of 84% of practices ie all but the most expensive 16% of practices. However this approach was problematic for a number of reasons:

5.22.1 the geographical breakdown of the study results shows significantly higher co-payments in some areas, in particular Auckland and Wellington. It is not clear what proportion of metropolitan practices' costs would be met by these payments, but clearly it would be less than 84%;

5.22.2 as the study itself noted (footnote 2, page 3) there was no weighting of results to reflect the number of physiotherapists working at each practice, or the number of ACC treatments provided. It is likely that these numbers were greater in metropolitan areas, where reported co-payments were higher. As

the study authors noted, "The true average co-payment charged nationally is therefore likely to be greater than that implied by these tables."

5.23 The 2003 study also raises some methodological issues:

5.23.1 it is not clear whether the practices surveyed were selected randomly; and

5.23.2 a telephone inquiry about treatment cost, based on an imprecise description of an injury, is inherently less likely to provide reliable information than a study of co-payments actually charged.

5.24 The EPN fees for more complex injuries (Level B) were not set based on the 2003 study. ACC has provided a general explanation of how EPN fees to be paid for more complex injuries were set: it appears these were based on the EPN pilot rates, which in turn reflected a number of sources of information available to ACC. ACC has advised that internally it assumed that a Level A (specific injury, no complications) treatment would take 20 minutes, and a Level B (more complex) treatment 30 – 40 minutes. But the fees were not set based on assumed time allocations. There does not appear to have been any statistically reliable analysis in 2003 of the cost of providing treatment for more complex injuries, or indeed any methodologically robust analysis of this important issue.

5.25 In summary, in 2003 when the EPN service agreement was rolled out nationally there does not appear to have been a sound and reliable basis for forming a view on the average co-payment charged for the relevant types of ACC physiotherapy services in New Zealand. Considerable further information and analysis would have been needed to identify a sustainable level of payment for these services, especially in circumstances where it was clear that costs were materially higher in the areas where the highest volume of treatments were being provided.

5.26 The advice to Ministers from ACC that this was an appropriate level of payment, in the context of a prohibition on co-payments, appears to have been given on the basis of insufficient information, or possibly based on a misunderstanding of the significance and reliability of the information that was available. The risks in setting the fee level too low, in terms of long term sustainability, do not appear to have been fully appreciated.

5.27 It is of course true that no physiotherapists were compelled to take up EPN contracts, and that if the rates payable under those contracts were seen as inadequate, physiotherapists were (and remain) free to stay with the Regulation payment system. But for two reasons, this is not a complete response to the concerns identified above:

5.27.1 Regulation rates were so low that the attraction to providers of an increase, even an inadequate one, was very strong; and

5.27.2 once a significant number of practices entered into EPN contracts and were offering ACC treatments with no co-payments, it became very difficult for remaining practices to charge a level of co-payment over the Regulation rate that would ensure costs were fully met. Inevitably, the strong incentive to reduce or eliminate co-payments in order to remain competitive with EPN providers would hold down co-payments for Regulation providers, and this in turn would make EPN service provision more attractive than continued reliance on Regulation rates, even though EPN rates might be below long term sustainable levels.

Deloitte study of sustainable costs of treatment

5.28 Recognising the need to keep payment levels under review, ACC has commissioned Deloitte to carry out work on sustainable funding levels. Deloitte gathered data from a small group of practices selected by Deloitte and NZSP from a list of NZSP members who responded to a request for volunteers.[25] Based on that data, Deloitte modelled the cost of provision of physiotherapy services and the level of payment required to meet those costs. That work was the subject of thorough examination in the course of the Review, and provided the basis for independent expert evidence given to the Review by Deloitte and by KPMG.

5.29 Deloitte and KPMG carried out further work jointly, at my request, following the conclusion of the initial hearings. They prepared a joint report dated June 2007 which recorded the results of that work, and their areas of agreement and disagreement. That report was updated and extended, again at my request, following the second round of hearings, and a supplementary joint report was provided in September 2007.

5.30 The evidence given by the experts, and their joint reports, strongly suggest that:

5.30.1 Regulation funding is significantly below the full cost of treatment (a view confirmed by the Research NZ studies of co-payments referred to above);

5.30.2 the payments provided for under the current EPN contracts are below the full cost of treatment for most providers, and are not at a long term sustainable level;

5.30.3 in order to achieve sustainable funding levels, the hourly rate for services implicit in the EPN funding arrangements would need to increase significantly from the current implicit level of approximately $103 per hour excl GST.

5.31 A more detailed discussion of significant aspects of the modelling exercise is set out in Appendix F.

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[25] Ultimately 21 practices operating on 23 sites participated in the survey.

5.32 Considerable caution is required in drawing conclusions about the precise level of sustainable prices based on the modelling work undertaken by the experts to date, as there are significant data issues. There were also significant methodological differences between the experts, many of which reflected the limitations of the available data, and differing views on how best to allow for these deficiencies. These data issues and methodological differences are discussed in more detail in Appendix F. The relevance of the modelling work, and some suggestions for how to take it further, are discussed below.

Issues – ACC Payments

5.33 The principal concerns identified by submitters in relation to current ACC payment rates for physiotherapy services were:

5.33.1 the level of EPN payments, which the profession considers to be well below sustainable levels;

5.33.2 the prohibition of co-payments under the EPN contract, which is seen by the profession as unfair and inefficient;

5.33.3 the level of Regulation payments, which the profession considers to be even further below sustainable levels;

5.33.4 the impact of the EPN regime on the ability of Regulation providers to charge co-payments that cover their full sustainable costs;

5.33.5 the absence of indexation mechanisms for Regulation payments.

Findings and recommendations

Sustainability

5.34 My terms of reference require me to consider whether the levels of current payments for service delivery made by ACC to physiotherapists are adequate to cover the cost of services whilst ensuring the retention of an appropriately sized, skilled and financially viable physiotherapy provision to meet the needs of ACC claimants. The terms of reference identify, as one of the government's objectives, ensuring the sustainability of physiotherapy service delivery.

5.35 There appears to be a broad consensus on what is meant by sustainability, or adequacy of payments for service delivery, in this context. A sustainable/adequate level of payment for services is one that would enable a significant proportion of practices to continue to provide physiotherapy services in the quantity and at the quality reasonably required by users, in the long run. Despite some concerns expressed by members of the physiotherapy profession about the lack of investment in facilities in recent years, due to financial pressure, there also appeared to be a broad consensus that the current quality of services provided is appropriate. So the question of a sustainable level of payment is best understood as requiring an inquiry into the

level of payment necessary to ensure that services will continue to be provided at current levels of quality, in the quantity reasonably required by ACC claimants if they are to achieve rehabilitation to the maximum practicable extent.

5.36 In the course of the Review, ACC made the submission that it is not responsible for the sustainability of the physiotherapy profession. That is true, but only to a point. Because ACC is the purchaser of about 80% of all private physiotherapy services provided in New Zealand, and the fees it pays set a benchmark for other significant purchasers such as accredited employers, ACC funding arrangements play a critical role in the sustainability of physiotherapy services in New Zealand. If physiotherapy services supplied to ACC claimants are not remunerated at a sustainable level, then in the medium to longer term accident victims will suffer from a reduction in the availability and quality of physiotherapy services in New Zealand. That is not in the interests of accident victims, or consistent with the goals of the ACC scheme. The obligation of ACC under its governing legislation to focus on rehabilitation to the maximum practicable extent requires ACC to adopt a long-term view consistent with the sustainable provision of rehabilitation services, and to avoid the pursuit of short-term financial advantages that are likely to impair long-term sustainability.

5.37 Thus, although ACC may not strictly speaking be responsible for the sustainability of the physiotherapy profession, it cannot disregard the impact of its decisions on the sustainability of the provision of services by that profession.

5.38 In any event, the terms of reference for this Review expressly refer to the government's desire to ensure the sustainability of physiotherapy service delivery. So that is a central consideration in this Review.

5.39 There was also broad support for the proposition that a sustainable level of payment for physiotherapy services would be the level of payment that could be expected in a competitive market for the supply of physiotherapy services. The NZSP and some other submitters did however sound a note of caution about this approach, for two reasons.

5.40 The first is the difficulty, discussed in more detail below, of ascertaining what a competitive market price would be in an environment where prevailing prices and cost structures are so heavily influenced by the very funding levels that are being reviewed.

5.41 The second was a concern that market rates of remuneration for physiotherapists, a predominantly female profession, reflect historical gender-based pay differentials which are neither fair nor, in the long run, sustainable. [26] There is some evidence

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[26] The 2004/05 NZ Health Information Service survey of the physiotherapy workforce showed that 81.2% of New Zealand physiotherapists are female.

before the Review that supports this concern; but that is not an issue which it is possible, within the four corners of this Review, to explore in any detail.

5.42 There are a number of challenges in identifying a sustainable level of payment for physiotherapy services. Any attempt to do so by studying the cost structures and remuneration levels of the physiotherapy profession in New Zealand raises real problems of circularity: the pervasive effect of ACC funding on the financial position of the profession means that it is unlikely that current prices and cost structures can provide much information at all about competitive market prices for the provision of physiotherapy services. There are also real difficulties in using studies of pricing or cost structures in other professions, or studies of physiotherapy pricing in other countries, as it is far from simple to identify and implement appropriate adjustments to reflect relevant differences between the providers studied and the environment in which they provide services, and the New Zealand physiotherapy profession.

5.43 Because of the lack of readily observable and directly relevant data, it is inevitable that assumptions have to be made about key issues such as remuneration levels and the capital investment needed for a sustainable physiotherapy practice.

5.44 The evidence before the Review confirms the commonsense expectation that the cost of providing physiotherapy services varies significantly on a number of dimensions. In particular, the cost of providing services in some centres, such as Auckland and Wellington, is significantly above the national average. Any attempt to set a sustainable payment level based on national statistics involves a very real risk of setting payment levels below the sustainable level in the urban centres where a large proportion of New Zealanders live.

5.45 There was little support among the parties to the Review for setting different payment levels for different regions, and I accept that this raises concerns about arbitrary boundaries, and market distortions. Because no party was advocating different payment levels in different areas, that possibility is not explored in any detail in this Report. If the supply of physiotherapy services in the metropolitan centres is to be sustainable, payment levels must be set at a point that meets the cost of provision of services in those centres in the longer run. If a single level of payment is set nationally, it follows that it must be determined by reference to the higher cost, higher volume of metropolitan centre practices, despite the inevitable consequence of overpayment of some other providers, and increased cost for the scheme as a whole. Another important litmus test for overall sustainability will be smaller rural practices, where economies of scale in premises and other facilities cannot be achieved.

5.46 Similar difficulties arise in setting a sustainable payment level for the full range of severity of injuries and complexity of treatment required. It might in theory be possible to have a very sophisticated and nuanced schedule of payments for different circumstances: but this would involve increased administrative costs, and difficulty in

ascertaining the appropriate classification both for the treatment provider, and for ACC as steward of the funds it administers.

5.47 The difficulty of setting a single sustainable price for the provision of the full range of physiotherapy services throughout New Zealand, and the affordability implications of any attempt to do so, suggest that there may be advantages in a more flexible approach under which:

5.47.1 a single level of contribution towards the cost of physiotherapy services is provided by ACC, set at a level reflecting a reasonable but conservative estimate of the cost of providing services to most claimants in New Zealand;

5.47.2 service providers are permitted to charge co-payments to enable them to recover additional costs of service provision in certain areas, or in particular circumstances.

Fairness to providers

5.48 If prices are set below sustainable levels, the result in the medium to long term is, as noted above, likely to be a reduction in the availability and quality of physiotherapy services available to claimants and others and in New Zealand. In the short term, the commitment of physiotherapists to their patients and to their chosen profession means that they are for the most part likely to continue to provide services, and absorb the uncompensated costs of treatment. There was substantial evidence before the Review of remuneration levels for owners of physiotherapy practices that are consistent with that pattern.

5.49 It is unfair, inconsistent with the approach of the Woodhouse Royal Commission, and inconsistent with the social contract underpinning the ACC scheme, for treatment providers to be expected to bear a significant part of the costs of injuries in New Zealand. The report of the Woodhouse Royal Commission expressly addressed the question of the level of payment to treatment providers:

> "The question is one which needs to be considered in three ways. First it is a matter of national importance that every injured person should be restored to health and useful activity as soon as possible. Often this will mean specialised and expensive medical care or the attention of a general practitioner [or physiotherapist] over an extended period of time. Second there is the problem of persuading a man already facing some financial strain to seek specialised attention the reasonable cost of which might considerably exceed the assistance provided by the State or the Compensation Fund. Third it could not be reasonable to expect the medical profession to meet the difference between the reasonable fees and some arbitrary scale kept down for the reasons of economy. *If the problem of injury is accepted as a community responsibility particular sections of the community should not have to subsidise the cost.*

> Accordingly we recommend that reasonable medical fees for persons entitled to compensation under the new fund should be paid in full by the fund.
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> … If the recommendation is accepted, then we consider that the medical profession should recognise, for its part, that individual doctors could not reasonably expect to have their fees met by the fund regardless of all supervision and in the absence of a general scale of fees."[27] (emphasis added)

5.50 The concept of community responsibility that underpins the ACC scheme requires that the community as a whole, or the relevant section of it (eg motor vehicle users) meet the costs of accidents; not that the cost to be shifted to treatment providers.

5.51 This fairness concern is particularly acute for physiotherapists because of the very significant proportion of their work, and hence remuneration, represented by ACC claimants. It is not uncommon for the public sector to pay for some services at a level well below prevailing market rates. Many professionals are willing, in the public interest, to provide some services on that basis. For example, many lawyers carry out legal aid work at rates well below their normal market rates. But that is their own choice, and they are free to decline to do such work. For most such providers, moreover, the overall impact on their income is not material because the bulk of their work is carried out for other clients, at market rates. For physiotherapists, however, it is not generally realistic to decline to do ACC work if they wish to continue in private practice in New Zealand. ACC funded work represents a very large proportion of their overall practice income. Large numbers of physiotherapists withdrawing from provision of services to ACC claimants would also of course be an outcome inconsistent with the interests of accident victims, and the objective of facilitating rehabilitation to the maximum practicable extent.

5.52 The question of fairness to providers does not arise where ACC makes a contribution to the cost of treatment, and providers are free to set a level of co-payment which ensures their full costs are met, subject to competitive constraints. Fairness issues can however arise where co-payments are not permitted, as in those circumstances the inevitable consequence of setting payment levels below long-term sustainable cost is that part of the cost of treatment is shifted to treatment providers. Where two funding regimes operate in parallel, one of which permits co-payments (Regulation funding) and one of which prohibits co-payments (EPN contracts), the position is more complex: significant fairness issues will still arise if, for financial or other reasons, the "co-payments permitted" regime is not a financially viable option for many providers because their patients can obtain treatment from an EPN practice without any charge.

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[27] Woodhouse Royal Commission, paras 386-388.

5.53 The question of fair remuneration for physiotherapists featured prominently in submissions by the profession. The concept of a fair level of remuneration, as distinct from the question of market levels of remuneration, is a difficult and elusive one. For the purposes of this Review, I have focused on the question of market levels of remuneration, and have not sought to develop a distinct concept of fair remuneration. I do not consider that the material available to this Review provides either a satisfactory analytical framework for any attempt to do so, or sufficient relevant information.

5.54 Although some evidence was provided of Australian remuneration data for physiotherapists, no party to the Review suggested that this information was of real assistance in determining sustainable remuneration in New Zealand. The data were very limited, based on small samples of practices. No information was available as to whether these figures were also affected by public funding structures, so did not represent true market rates. And it was common ground that there are significant difficulties in translating Australian remuneration data into the New Zealand context. I have not derived any assistance from this material, or given it any weight, in the light of these concerns, which I consider are well-founded.

5.55 At this stage of the Review, on the information currently available to me, the most reliable benchmark for market rates of remuneration for physiotherapists in New Zealand appears to be public sector remuneration for physiotherapists in comparable roles. I consider that it is reasonable to proceed on the basis that physiotherapists employed in private practice can reasonably expect to earn about the same as physiotherapists employed in the public sector, and that owners of physiotherapy businesses that are reasonably efficient should on average expect to earn a similar return for time spent working in the business (ie excluding returns on capital invested in the business) as physiotherapy managers in the public sector receive for corresponding time spent at work, with lower earnings for those that run less efficient businesses, and the potential to achieve higher earnings through superior efficiency or working longer hours.

5.56 The appropriateness of using this benchmark is reinforced by two other considerations:

5.56.1 ACC payments are made out of public funds, so there is some logic in looking to the manner in which other providers of similar services are remunerated out of public funds. The NZSP says physiotherapists providing ACC services should achieve "marketplace parity with their peers"[28]: this is consistent with that approach, recognising that their peers are those providing similar services funded by the public sector;

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[28] NZSP First Submission para 81.

5.56.2 using these rates of remuneration as a benchmark for setting payment levels does not prevent the owners of physiotherapy practices from achieving superior remuneration levels, provided they operate practices at above the benchmark level of efficiency, or if they charge higher fees to private patients (if that is indeed what the market will bear), or if they choose to work longer hours. Practice owners that operate below the benchmark level of efficiency will earn less than they could in a public sector job: but it is not easy to see why payments out of public funds to a private sector service supplier should be set at a level that ensures better than public sector remuneration levels even for less efficient providers. The NZSP evidence refers to the risk assumed by the owner of a private-sector physiotherapy business, and the need for that risk to be compensated. Plainly that is correct, and points to setting prices in a manner which preserves a real opportunity for a significant number of physiotherapists to outperform the benchmark, and earn a reward for the risk they take in running their own business. It does not require setting payment levels at a point that guarantees higher remuneration to practice owners regardless of efficiency.

5.57 I also note that if patient co-payments are permitted, the need to accurately identify a market level of remuneration is much less acute. The process of competition between providers on levels of co-payment should, over time, result in a remuneration outcome that is consistent with competitive market levels. It is only if co-payments are prohibited that the need to identify a sustainable level of remuneration becomes acute, with significant fairness (and sustainability) implications if that level of remuneration is underestimated, or is incorporated in the price setting process in a manner that does not deliver an appropriate market level of remuneration to most physiotherapists.

5.58 One other dimension of fairness that was identified by the NZSP is fairness as between different groups of treatment providers, so far as the structure of remuneration systems is concerned, and in particular in respect of co-payments. The NZSP points out that there is no other significant treatment provider group that is funded by ACC on a basis that precludes co-payments. That gives rise to inevitable fairness concerns, which in my view have some substance. The only good answer to this fairness argument would be that the level of payment provided under the EPN regime is so clearly adequate that no reasonable physiotherapist could wish to charge a co-payment. However, for the reasons discussed below, that is not at present the case.

Impact of ACC funding on sustainability of physiotherapy services

5.59 There are three basic approaches that ACC could adopt in funding physiotherapy treatment services for claimants:

Approach A: pay a contribution that is likely to be significantly less than the actual cost of treatment for all or most claimants, in the expectation that

providers will recover the balance of the cost of providing treatment by requiring claimants to make a co-payment;

Approach B: pay a contribution that is expected to cover the actual cost of treatment for most claimants, in the expectation that providers will in most cases not charge a co-payment, but reserving the ability for providers to do so (for example, to meet higher costs of providing services in some areas, or higher costs of providing non-standard treatment);

Approach C: pay a contribution that is expected to cover the actual cost of treatment for all claimants, and prohibit co-payments.

5.60 Under approaches A and B, sustainability issues are unlikely to arise. The arrangement is in effect self-adjusting: if the ACC contribution is insufficient to meet costs for some practices, or falls behind general cost levels, the gap can be met through co-payments. Competition between practices can be expected to constrain co-payments, though information asymmetries and other factors that hinder price competition could enable some providers to charge above-market rates.

5.61 Approach A is the approach adopted by ACC from 1989 to 2004. It remains the approach reflected in the Cost of Treatment Regulations. Although approach A avoids sustainability concerns, it raises significant concerns in respect of:

5.61.1 the social contract underpinning ACC;

5.61.2 the goal of rehabilitation to the maximum practicable extent. For some claimants, significant co-payments could represent a real barrier to seeking necessary treatment;

5.61.3 New Zealand's international obligations under ILO Convention 17 in respect of treatment for work injuries.

5.62 Approach A on its own is less consistent than approaches B and C with the Government's objective, recorded in the terms of reference, of ensuring public access to high quality physiotherapy services by reducing co-payments.

5.63 Approach B avoids sustainability concerns, and provides flexibility in meeting different levels of cost of treatment in different areas, and for different forms of treatment. Provided contributions are maintained at realistic levels it is consistent with the social contract underpinning ACC, the goal of rehabilitation to the maximum practicable extent, access goals generally, and New Zealand's international obligations. If contributions fall below the cost of treatment:

5.63.1 more claimants will be required to make co-payments. If co-payments at a significant level become widespread, that has implications for the social contract and ILO Convention 17 compliance, and could prejudice

rehabilitation goals for those unable to meet co-payments. But this can be addressed by raising payment levels. Increasing prevalence and levels of co-payments would provide a readily observable measure of the adequacy of current ACC funding;

5.63.2 the quality, availability and long term sustainability of physiotherapy services will not be impaired in the meantime.

5.64 Approach C meets all the relevant objectives provided that funding is set and maintained at a level which covers the provision of physiotherapy services of appropriate quality for all claimants. If a single funding structure is set for all geographical areas and all claimants, those payments need to cover the cost of providing services on a sustainable basis in the highest cost areas, and in specialist practices with higher than average complexity of treatments. If payment levels fall below the cost of treatment generally, or in some geographical areas, or for some types of injury:

5.64.1 in the short run, this is unlikely to affect the availability and quality of service, and rehabilitation goals and ILO Convention 17 compliance will not be affected;

5.64.2 the cost of this short run gap in funding will be borne by the physiotherapy profession. This is neither fair, nor consistent with the original vision of the Woodhouse report;

5.64.3 sustainability issues will arise. In the medium to longer term, there are likely to be adverse implications for availability and quality of services, which is inconsistent with rehabilitation goals and ILO obligations in respect of availability of services.

5.65 Plainly it is not sustainable for ACC to pay an amount which is materially less than the sustainable level of fees, on a basis which prevents co-payments. That can be made to work in the short term, relying on the commitment of physiotherapists to their profession and to their patients. But it is a recipe for long term problems which would become increasingly difficult to resolve.

5.66 Paying for physiotherapy treatment at levels materially below cost is also unfair to physiotherapists, who end up bearing the cost of unsustainably low levels of funding.

5.67 It is important to bear in mind that approach B can deliver the access and other social goals that underpin the EPN scheme, with lower risk to sustainability. It will fail to do so only if payment levels fall below the sustainable cost of providing physiotherapy services to most claimants: but if this occurs, then approach C will also fail to achieve sustainability goals, and the long term consequences are likely to be more severe.

5.68 It is also possible to adopt combinations of these approaches. For example, the current arrangement is a hybrid of approach A (Regulation funding) and approach C (EPN contract funding, with no co-payments). However current payment levels are not in fact sustainable, as required to make approach C work in the medium to longer term, as discussed below.

5.69 Another possible hybrid is reflected in the provisions in the ACC legislation permitting different arrangements to be put in place for work injuries and other injuries. On this approach, one possibility would be to implement approaches B or C for work injuries, and retain approach A for non-work injuries.

Are the current arrangements sustainable and fair?

5.70 The current arrangement is, as noted above, a hybrid of approaches A and C. This combination could meet all relevant goals, provided that the EPN funding is set and maintained at sustainable levels, and provided that all physiotherapists have the option of providing services under either regime.

5.71 The current arrangements would also be fair to physiotherapists, despite the low Regulation rates, if EPN funding is set and maintained at sustainable levels, and all physiotherapists have a genuine choice of providing services under either regime.

5.72 However difficulties would arise with this hybrid approach if EPN payments fell below sustainable levels, and Regulation payments were lower still. In fact this hybrid could perform worse than approach A alone, in such circumstances. There would be a strong preference from claimants for EPN suppliers (to avoid co-payments), creating strong short term incentives for physiotherapists to sign up to EPN: but this in turn would create risks to quality and availability of services in the medium to long term. The self-adjusting nature of approach A would be compromised by competition from approach C suppliers charging no co-payment, making it difficult to recover the full co-payment required to meet sustainable costs. As co-payments by approach A suppliers are forced down, the relative attractiveness for providers of approach C would increase despite any inadequacy in payment levels, further reinforcing these trends, and increasing sustainability and fairness concerns over time.

5.73 The implicit hourly rate for treatment provided under the EPN contracts is currently approximately $103 (excl GST), as noted above. The hourly rate under the Regulations is $54.73 (excl GST).

5.74 The evidence given by the expert accountants described above suggests these rates are well below the sustainable cost of providing physiotherapy services.

5.75 Based on this expert evidence it is possible to be reasonably confident that current EPN rates are not set at sustainable levels. It is clear that Regulation rates are well below the sustainable cost of providing physiotherapy services.

5.76 Other evidence before the Review supported the view that current funding arrangements are not sustainable. The increasing numbers of vacancies and the time taken to fill them, increasing waiting times for treatment, loss of physiotherapists from the profession and anecdotal evidence of underinvestment in facilities all indicate a lack of sustainability that is having an increasing effect on service delivery – an effect that is still manageable, but diminishingly so.[29] [30] [31]

5.77 It follows that current EPN rates also are not fair to physiotherapists, who are being asked to bear a significant part of the long term cost of providing services to ACC claimants.

5.78 What is much less clear is what a sustainable and fair payment rate would in fact be. There was a significant difference between the "preferred" estimates given by each team of experts of the sustainable cost of physiotherapy services, resulting from the data issues and methodological differences discussed in more detail in Appendix F. Deloitte's final estimate in the joint report was $122.19, and KPMG's final estimate in the joint report was $318.26 (both excl GST). These are extreme points on a spectrum of estimates, based on assumptions discussed in more detail in Appendices F and G. If somewhat less extreme assumptions are made, the model suggests a range of $130.39 to $190.73 (both excl GST). The large range of these estimates emphasises the need for further work in this area, and the difficulty of reaching a view on what a sustainable level of fee actually is, based on this analysis.

5.79 In the draft report I expressed the provisional view that there was insufficient information available to this Review to enable a firm view to be expressed on what a sustainable and fair rate of remuneration would be, with any real confidence.

5.80 At the second round of hearings, NZSP urged me to make findings on this issue. NZSP argued that the information available was adequate for the purpose, and that it would be very difficult and onerous for physiotherapists to undertake a more extensive data gathering exercise in order to do better. I have given careful consideration to this request, but at the end of the day I simply do not consider that the information available in respect of a number of key factors is sufficiently robust and reliable to enable a price (or narrow range of prices) to be identified that would be

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[29] Waikato Management School (2006), New Zealand Business Benchmarking Survey, Financial Statistics 2005 – Physiotherapists, in NZSP (April 2007), Second Bundle of Documents Accompanying Second Submission of the New Zealand Society of Physiotherapists to Independent Review of the Relationship between Physiotherapists and ACC.

[30] New Zealand Society of Physiotherapists (April 2007), Second Submission to Independent Review of the Relationship between Physiotherapists and ACC, pp 13-14.

[31] Lynne Taylor, (March 2007), The New Zealand Physiotherapy Workforce - a Submission to the Review.

sustainable and fair both for physiotherapists, and for the ACC scheme (and levy payers and taxpayers).

5.81 However there has been considerable discussion about how a sustainable price could best be assessed, and it is in my view possible to identify some principles that should be applied when carrying out that exercise. Those principles are discussed in Appendix G.

Moving to sustainability and fairness

5.82 A number of options are available to address these sustainability and fairness issues. The choice between these options is ultimately a political one, with significant cost implications. This Review can identify the key options and their implications, but the ultimate decision must be for Government.

Option 1: retain current payment structure (with no co-payments for EPN providers) and increase EPN payments to a sustainable level

5.83 If the Government wishes to maintain the current mix of Regulation and EPN (with no co-payment) mechanisms, and move to sustainable funding of physiotherapy services in the long term interests of injury victims and in fairness to physiotherapists, it will be necessary for EPN rates to increase significantly. If rates are set at sustainable levels which reflect the cost of participation in the EPN, it is likely that most Regulation providers will switch to EPN. This would be a sustainable outcome, provided EPN rates are indexed to meet inflation costs, and reviewed regularly (say every 5 years) against current cost structures.

5.84 However there would in my view be real risks to sustainability in setting a new EPN rate based on the currently available information, while maintaining the prohibition on co-payments. There would also be a real risk of continuing unfairness to physiotherapists.

5.85 If the prohibition on co-payments is maintained, an interim increase to at least $137 per hour excl GST is in my view required to move towards sustainability, and reduce the unfair burden of providing treatment below cost that the physiotherapy profession is currently being asked to bear. This would need to be coupled with urgent further research and analysis on sustainable rates, to enable a rate to be fixed with some confidence that would be sustainable in all areas of New Zealand, and across all classes of injury. That figure is likely to be appreciably higher than $137 per hour.[32]

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[32] The manner in which this interim payment rate has been calculated is described in Appendix G: see in particular paras G13 to G14.

5.86 Key features of further research into sustainable payment rates would be:

5.86.1 prior consultation with expert advisers on quantitative analysis, to ensure that a sample of practices is selected which is likely to provide reliable information in relation not only to the national population of physiotherapy practices, but also specific groups that seem likely to face higher costs, eg metropolitan practices, and single practitioner practices in remote areas;

5.86.2 use of reasonable assumptions for remuneration rates, capital employed and return on investment. This avoids significant circularity problems if current market data are used. The assumptions identified in the joint expert report discussed in Appendices F and G provide a good starting point for these inputs;

5.86.3 collection of data on ACC/non-ACC consultation ratios and consultation times, perhaps involving a detailed study of a subset of the sample practices for a short period;

5.86.4 qualitative analysis of the drivers of cost differences across practices, to get a better understanding of the extent to which efficiency gains can reasonably be expected for a significant proportion of practices.

5.87 This research should be a collaborative exercise between ACC and the physiotherapy profession. This is likely to enhance the quality of the outcomes, as illustrated by the benefits achieved through the joint expert processes in this Review. It is also likely to enhance the credibility and acceptability to all stakeholders of the results. I suggest that a steering group under the auspices of the PLG, with an independent facilitator, be established to coordinate work on the design and implementation of this research.

5.88 Participating in this research is likely to impose significant demands on the time of physiotherapy practices involved. I recommend that ACC take steps to minimise this burden so far as possible for example by meeting the cost of accounting assistance to visit practices and gather data, and perhaps also by making some payment by way of compensation for the time and effort involved in participating in a study directed to the sustainable provision of services to ACC claimants, and to meeting the Government's access and ILO compliance objectives. It is not reasonable to expect a small subset of practices to bear significant costs to enable these objectives to be met.

Option 2: increase rates so far as affordable; remove prohibition on co-payments

5.89 The Government may consider that the cost of retaining the EPN with no co-payments and moving to sustainable and fair pricing is too great for levy payers and taxpayers.

5.90 The Government may also consider that this option involves real risks to sustainability in the medium to longer term, because of the risk of payments falling

below the sustainable level in the future, even if they are reset at that level today. There is a very acute trade off between cost and sustainability risk under option 1, because of the lack of a "safety-valve" in the form of co-payments. To ensure that physiotherapy services of an appropriate quality are widely available, it will be necessary to set rates at a level that accommodates high cost services (eg in central Auckland, or in remote rural areas), and services for high need claimants (assuming no regional or other variation in payment rates). This is likely to involve considerable further expenditure. If rates are not set at this level, sustainability concerns will arise at least in some areas, and for some higher need claimants.

5.91 If these affordability and long term sustainability concerns are seen as significant, the other basic option would be to remove the prohibition on co-payments for EPN providers, and increase EPN rates so far as affordable. This would be a significant step towards sustainability.

5.92 As ACC's contribution nears a sustainable level, competition between providers will constrain co-payments, resulting in low co-payments in most cases. [33] If co-payments become widespread and material, that would suggest ACC contributions are not set at or close to a sustainable level: funding could then be adjusted, so far as affordable, to meet access goals and international obligations with respect to work injuries.

5.93 A similar result could be reached by abandoning the EPN regime, and relying solely on Regulation provision, but with rates significantly increased (and modified to take account of different types of injury and consultation, as discussed in more detail below).

5.94 Under option 2 it would be appropriate to retain current indexation arrangements for EPN payments, to ensure that the real value of ACC contributions does not fall over time. A reduction in the real value of ACC contributions would be likely to lead to increases in co-payments, undermining access goals and ILO compliance goals.

5.95 Access goals and ILO compliance goals could be further advanced under option 2 if ACC maintains a list of physiotherapists who undertake not to charge a co-payment for treatments provided at their premises during normal working hours. It would be optional for providers to give this undertaking. If they do, they will appear on the list of "no surcharge providers" kept by ACC, which would be available to the public on

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[33] If EPN payments are increased to a level close to the estimated sustainable level, coupled with removal of the prohibition on co-payments, there are reasonable grounds for expecting outcomes consistent with access goals and ILO compliance goals. Estimates of sustainable prices, using reasonable assumptions for certain parameters, and the data gathered by Deloitte, are set out in Appendix G. Those estimates are subject to the reservations expressed above and in Appendices F and G in relation to the adequacy of the Deloitte study data, and other information on key inputs such as remuneration. But they provide some guidance on the level of payment likely to cover the costs of a significant number of practices, and thus likely to result in outcomes consistent with access goals and ILO compliance goals.

ACC's website and on request from ACC staff. This would make it easier for claimants to identify physiotherapists who do not charge a co-payment, reinforce competitive incentives for physiotherapists (by reducing information asymmetries), and give ACC high quality up to date information about the prevalence of co-payments.

5.96 NZSP suggested in their submissions on the draft report that a list of this kind could create unfair pressure on physiotherapists to refrain from charging co-payments, even if it was necessary to do so to earn sustainable returns. It seems to me that this risk is outweighed by the real difficulties that consumers of physiotherapy services (in common with consumers of many other professional services) face in obtaining information about the cost of services, and the risk that lack of transparency of pricing and search costs will dampen competition between providers in relation to co-payments.

5.97 NZSP also submitted that it should not be assumed that it is easy for physiotherapists to charge co-payments, and that the ability to charge co-payments did not reduce the need for ACC contributions to be set at or very close to the sustainable cost of physiotherapy services. This submission was based on an argument that consumers expect ACC to meet the full cost of services, so are reluctant to pay any co-payment, and this forces physiotherapists to reduce co-payments below efficient levels. This argument depends on some significant assumptions about consumer expectations that were not self-evidently correct, and were not the subject of any helpful evidence before the Review. But there is force in the point that ACC claimant expectations need to be aligned with reality, to avoid misperceptions and tensions in the provider-patient relationship. If ACC or the Government encourage claimants to expect that services will be provided at no direct cost to themselves, ACC funding needs to be provided to ensure that this is achievable on a sustainable basis; alternatively, if funding is provided at a level that will result in widespread co-payments, it should be made clear to claimants that ACC provides a contribution only, and that they will be expected to bear part of the cost of treatment themselves.

A hybrid option: different entitlements for work injuries and other injuries

5.98 ACC legislation makes express provision for the possibility of different entitlements for work injuries and other injuries. A variation on the above options that the Government may wish to consider, as it would achieve ILO compliance and access goals in respect of work injuries, but at lower overall cost, would be to:

5.98.1 increase payments for treatment for work injuries to a sustainable full cost level, funded through an increase in levies for the Work Account. This could be done either with or without a prohibition on co-payments. As explained above, if co-payments are prohibited for work injuries, the payments made by ACC for treatment for such injuries will however inevitably be higher, as they will need to cover the cost of treatment in higher cost areas and for higher cost

injuries. And if co-payments are prohibited, further work will be needed as a matter of urgency to develop a more reliable estimate of the sustainable cost of treatment; and

5.98.2 retain current EPN and Regulation rates for non-work injuries, or increase them so far as affordable but to a level below sustainable cost. The prohibition on co-payments for EPN providers would need to be removed so far as non-work injuries are concerned, to ensure sustainability and fairness goals are achieved. Access goals would be less effectively achieved in the short term in respect of non-work injuries, as co-payments would become more widespread. But this seems preferable to significant medium and long term sustainability issues for all physiotherapy services, and could be addressed through funding increases so far as affordable.

5.99 It would be unfortunate if affordability constraints in respect of the non-earners account were to prevent action consistent with the statutory goals, and with New Zealand's international obligations in respect of physiotherapy services provided in respect of work injuries.

5.100 On the other hand, this hybrid option does have some disadvantages that need to be weighed against its advantages:

5.100.1 it is inconsistent with the principle of comprehensive entitlement, identified in the original Royal Commission report as the central principle in the ACC scheme;

5.100.2 it will involve some additional administration costs, and boundary costs as claimants seek to have injuries classified as work injuries in order to obtain full funding for treatment costs;

5.100.3 the NZSP also suggested that there could be some problems with diagnosis of injuries, as claimants misreport causes of injury in an attempt to obtain full funding for treatment costs.

Regulation rate increases?

5.101 It would be consistent with the broader goals of the ACC legislation to increase the Regulation rate as well, if either option 1 or option 2 is adopted and the EPN regime is retained. But this would not be necessary in order to ensure sustainable physiotherapy services, or to meet the legislative goals, if the recommendations in this report in relation to the EPN regime, and in particular funding and access issues, are implemented in full.

5.102 Some physiotherapists may still choose not to switch to EPN, for a mix of reasons canvassed in the course of the Review. Concerns about the EPN regime that do not relate directly to rates of payment are discussed in section 6 below: many of these

concerns reflect misunderstandings about the EPN regime, and can be resolved through improved communication, without requiring modification of the EPN. Some physiotherapists have a principled objection to EPN: retaining a Regulation rate enables them to act on this objection, albeit at some personal cost.

5.103 If ACC were to abandon the EPN regime, and rely solely on Regulation funding of physiotherapy services, there would be a very strong case for significant increases in Regulation payment rates. Based on the expert modelling evidence, the current rates are less than half the sustainable cost of service provision: this is not a major issue if there is another funding mechanism which is widespread and adequate, but would be very problematic if the other mechanism were terminated. I have not addressed this scenario in detail, as ACC indicated its continuing support for a contract-based regime in parallel to the Regulation funding regime. But if this scenario were to receive serious consideration, very significant increases in Regulation rates would be needed to achieve access and ILO compliance goals, and significant increases would be needed even to maintain current levels of compliance with those goals.

5.104 A number of submissions in response to the draft report expressed strong concerns about the suggestion made above that an increase in Regulation payment rates is not essential. In the light of those concerns, it is important to clarify that this view is predicated on full implementation of the suggested changes to the EPN regime, and in particular the recommendations relating to funding options, and access to EPN contracts. If those were not to be implemented, there would be a very strong case for a significant increase in Regulation rates, in order to achieve the Government's access and ILO compliance objectives, and to reduce unfairness as between EPN and regulation providers.

Structure of Regulation payments

5.105 All parties to the Review supported retention of the Regulation payment regime, either as the primary mechanism for funding physiotherapy services, or as a fall-back coupled with a primary contract-based mechanism such as EPN.

5.106 If Regulation payments are retained, there is a strong case for introducing a more nuanced approach to "per treatment" payments, with a schedule of rates for initial and follow-up consultations, and for simple and complex cases. This schedule would replace the current single per treatment rate (and would require separate provision in the regulations for payment for physiotherapy services). The additional administrative complexity involved has been accommodated for the vast majority of claims in the EPN context, so should be manageable in the regulation context also; given the very significant difference in the cost of providing these different categories of service, it seems more appropriate to tailor payments accordingly.

Indexation of Regulation payments

5.107 The physiotherapy profession submitted that indexation of Regulation payments was desirable, as otherwise the real value of these payments diminishes each year, with implications for:

5.107.1 claimants, as costs that are not covered by ACC payments are recovered through co-payments, which can be expected to increase over time (subject to the constraint from EPN providers, discussed above);

5.107.2 sustainability, if it is not in fact practicable to recover the full amount of the diminution in real value of ACC payments in the form of co-payments;

5.107.3 fairness to providers, if it is not in fact practicable to recover the full amount of the diminution in real value of ACC payments in the form of co-payments.

5.108 The experience to date has been of a gradual erosion of the real value of ACC Regulation payments. Before the introduction of the EPN regime, this would have had adverse implications for claimants and for access and ILO compliance goals, but not for sustainability or fairness to providers as there were no surcharge-free services available to constrain increases in co-payments. Post-EPN, the impact on claimants is reduced (but not eliminated) by the availability of EPN-funded treatment with no co-payment. But significant sustainability and fairness issues have emerged as a result of the interaction between the two regimes.

5.109 If the primary form of ACC contribution to treatment costs were Regulation funding, the case for indexation would be very strong, in the interests of ACC claimants, and in order to avoid going backwards each year in terms of access and ILO compliance goals, absent annual adjustments. The IPRC Act recognises the need to maintain real levels of compensation paid under the Act, and requires indexation of these amounts.[34] The rationale for indexation of these sums applies equally to payments in respect of treatment costs. It would be appropriate to use either the Labour Cost Index provided for in the current EPN contract, or a composite index reflecting the approximate proportions of key input costs for physiotherapy, along the lines discussed in the joint expert report prepared by Deloitte and KPMG.[35]

5.110 ACC advised the Review that Cabinet has approved a proposal for amendments to the IPRC Act which would if implemented require ACC to conduct an annual review of the amounts prescribed by the Regulations. The proposal also includes replacing the current consultation requirements in s 324(2) with a simpler and less prescriptive requirement that ACC consult with the persons and organisations that the Minister for

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[34] IPRC Act, 2001, ss 115, 116, 327.

[35] Joint Expert Report, June 2007, p 30.

ACC considers appropriate. ACC advised the Review that a Bill to give effect to these proposals is scheduled to be introduced in October 2007.

5.111 The proposed amendments recognise the importance of ensuring that the real value of payments for services is not eroded through inaction. But the proposed process still requires consultation and an amendment to the regulations simply to maintain real payment values, unlike the automatic indexation applied to weekly compensation to claimants. It may well be simpler and more efficient to index Regulation rates in the first and second years after a reset, then schedule a mandatory review of payment levels after three years (say), with reference to relevant access and affordability goals.

5.112 There is some doubt as to whether the regulation making power in s 324 of the IPRC Act is broad enough to permit regulations to provide for indexation. On its face s 324 does appear sufficiently broad. But the specific provision that is made for regulations relating to indexation of compensation payments in s 327, and the absence of any comparable provision relating to indexation of payments in respect of treatment costs, raises questions about whether Parliament intended the very general language of s 324 to authorise indexation of treatment costs. It would in my view be prudent to amend the Act to expressly authorise indexation of sums prescribed in regulations made under section 324. This could be addressed in the Bill scheduled for introduction later this year.

Is the gap between EPN and Regulation rates a problem in and of itself?

5.113 Some submitters expressed significant concern about the large differential between EPN rates, and Regulation rates. It was suggested that this is unfair to regulation providers and their patients, and forces regulation providers to switch to EPN even though they do not receive adequate payment under the EPN contract and are required to give up co-payments.

5.114 The concerns expressed about the size of the gap between EPN rates and Regulation rates are in my view well-founded, in circumstances where EPN rates are well below sustainable costs and co-payments are prohibited under the EPN contract. This structure effectively prevents Regulation providers from recovering a co-payment sufficient to meet their sustainable costs, and creates pressure to move to the EPN programme even though the level of payments under that programme is also below long term sustainable cost.

5.115 However these concerns can be addressed, and the gap between EPN and Regulation rates will not in itself be an issue, provided that all physiotherapists have a genuine opportunity to become EPN providers, and either option 1 or option 2 above (or the hybrid option) is adopted.

5.116 One issue that was considered in the course of the Review was whether there was any justification for a differential between Regulation payments and EPN payments, and if

so, how large a differential would be justified. The current difference is the product of a number of historical factors, rather than being based on any qualitative or quantitative rationale. Unsurprisingly, therefore, it is not possible to draw any close connection between differences in the circumstances of Regulation providers and EPN providers, and differences in payment rates for those provider groups.

5.117 I accept the ACC submission that if Regulation providers are permitted to charge co-payments, and EPN providers are not, that would justify some differential. I also accept that because there are some requirements that apply to EPN providers and not to Regulation providers, in particular the certification requirement and the requirement to interact with ACC electronically, it is reasonable for EPN payment rates to be higher in order to cover the costs of meeting those requirements. However it is difficult to see how these factors alone could justify a differential of the size that currently exists. No other factors were identified that could justify a significant differential. In particular, as discussed in more detail in section 6 below, there is no reliable evidence of EPN providers achieving a reduction in number of treatments required for rehabilitation, or earlier rehabilitation, or other improved outcomes that would justify payment of a premium.

5.118 Ultimately, however, the question of how large a differential might be justified by these various factors does not need to be resolved, if the recommendations in this report in relation to the EPN regime are implemented. In those circumstances, the existence of a differential and its size would become very much secondary issues. The critical issue is that the primary payment mechanism for physiotherapy services be sustainable and fair, and achieve the access goals prescribed in the legislation and emphasised in the Review's terms of reference. If this is achieved, and provided all physiotherapists have genuine access to this primary payment mechanism, the central objectives identified in the legislation and the terms of reference will not be materially impaired by a large difference between the applicable payment rates under that primary mechanism, and lower Regulation rates.

Other contract payments

5.119 The parties to the Review did not provide the same level of detailed information relating to other contracts as was provided in respect of the EPN regime. Contracts relating to some specific services such as the Activity-Based Programmes and the Hand Therapy contracts appear to be operating well. No specific concerns were raised in respect of payments under these contracts, over and above the general issues discussed above.

5.120 However at the second round of hearings there was evidence of real concerns in respect of both contract design and funding levels in the context of other specialised contracts, in particular the vocational rehabilitation contracts, and significant concerns were expressed about the time taken to address these issues.

5.121 It is important in the long term interests of claimants to ensure that all of these contracts are structured and funded on a sustainable basis. This can be achieved either through ACC paying the full sustainable cost with no co-payments permitted, or through ACC making a contribution that is below sustainable cost with co-payments permitted. If co-payments are not permitted, care needs to be taken to ensure that ACC payments for these specialised services are set and remain at a sustainable level, or access to these services will be compromised over time, and providers will bear the short term costs of the shortfall in a manner that is unfair, and inconsistent with the underlying principles of the accident compensation scheme.

5.122 I recommend that as and when further studies are carried out in relation to the sustainable cost of providing general physiotherapy services, other significant ACC contract arrangements should be included in those studies, especially where (as with ABP contracts) the same providers may hold both general and specialised contracts. Including the full range of ACC contracts in the study will provide a better overall picture of sustainability issues, as well as assisting in setting payment rates for the specialised contracts.

6 THE ENDORSED PROVIDER NETWORK

Background

6.1 The origins of the Endorsed Provider Network are summarised in section 5 above, and described in detail in Appendix E. Payment levels under the EPN contracts are discussed in section 5 above. In this section of the report, the focus is on the broader issues of whether the EPN is achieving the objectives which it was intended to pursue, and on criticisms of the design of the EPN and the terms on which it operates which were put forward by some parties to the Review.

6.2 As noted above, ACC's objectives in introducing the EPN were to:

6.2.1 encourage quality treatment;

6.2.2 eliminate claimant co-payments, with progress toward compliance with ILO Convention 17;

6.2.3 reduce weekly compensation durations; and

6.2.4 achieve early, effective, sustainable rehabilitation outcomes.

Issues – EPN

6.3 Submissions to the Review by a number of physiotherapy groups and individual physiotherapists were critical of many aspects of the EPN regime; in some cases, highly critical. The submissions made by these parties were, in summary:

6.3.1 ACC claims that EPN providers are providing higher quality physiotherapy services, and achieving superior outcomes for their patients: however there is no proper basis for such claims;

6.3.2 it is inappropriate for ACC to compel providers to obtain certification against the relevant New Zealand standard;

6.3.3 ACC should not promote EPN providers as superior to other providers, either generally (for example, by using the term "endorsed") or by referring claimants to EPN providers in preference to Regulation providers;

6.3.4 entry into an EPN contract with ACC is inconsistent with a physiotherapist's ethical responsibilities to his or her patient;

6.3.5 in particular, EPN providers are obliged to comply with the physiotherapy Treatment Profiles, even where their patients require further treatment;

6.3.6 the three month termination provision in the EPN contracts is unfair and inappropriate, and prevents long term business planning by physiotherapists. It

also creates a threat of loss of income that can be used by ACC in its dealings with physiotherapists;

6.3.7 the NZSP or some NZSP and/or NZPPA executive members had conflicts of interest in connection with the introduction of the EPN.

6.4 These submissions are reviewed below.

Findings and recommendations

Expectations of superior quality in relation to certified practices?

6.5 The New Zealand standard against which EPN providers are required to be certified is described in detail in Appendix E. The standard is designed as a "best practice business management tool". It includes a large number of requirements in relation to the day-to-day management and organisation of the practice, and the manner in which the practice interacts with its clients. It does not prescribe how treatment should be provided, or contain any provisions relating directly to clinical matters or patient outcomes.

6.6 In its submissions, ACC described the purpose of the certification requirement as being "to lift the quality of treatment provided to claimants through improved systems and processes. Certification against the standard also recognises a quality management system within the business."

6.7 I explored with the parties and their witnesses whether it was reasonable to expect that certification against the standard would result in improved quality. The ACC representatives explained that ACC saw certification as ensuring that good business practices and processes would be in place, including continuing professional education, and explicitly addressing patient satisfaction with the services provided. ACC also noted that where patient satisfaction is part of a business model, it is inherent in that process that the business is pursuing continuous quality improvement. This approach was consistent with the views of an expert on certification matters, Mr Monkton, who gave evidence at the request of the Physiotherapy Trust and APPPA.

6.8 ACC was not able to point to any studies in relation to patient satisfaction that would confirm ACC's expectation that patient satisfaction would, in general, be greater in certified practices. Nor are there any data suggesting that clinical outcomes are superior following treatment by EPN practices, as compared with Regulation practices.

6.9 ACC acknowledged that it could not be demonstrated that the EPN contracts are improving quality of services, and suggested that ACC had not yet reached the point of being able to carry out a robust statistical analysis of the quality implications of certification, or the EPN regime.

6.10 A recent evaluation of the EPN programme suggested that patients of the EPN practices claim weekly compensation for fewer days on average than patients of Regulation practices. ACC did suggest in its oral submissions that this study provided some indication of improved quality of outcomes. This evaluation compared the average days on weekly compensation in the 12 month period to 30 June 2006, and found that during that period patients of EPN providers received, on average, 1.9 days less compensation than those that were treated by a physiotherapist working under the Regulations. However ACC representatives accepted that the data on the relationship between category of provider and time in receipt of weekly compensation are equivocal. Even in the period to 30 June 2006, the median time on compensation was the same for both categories of provider. In the preceding year, the mean period on compensation for patients of EPN practices was some four days longer than that for Regulation providers, with a similar differential in median periods also favouring Regulation providers. The ACC representatives were in my view right to concede that no useful conclusions on any relationship between certification and outcomes can be drawn based on this data.

6.11 ACC emphasised that an important goal for ACC and the health system generally is to try to improve outcomes, and that determining whether specific initiatives are delivering improved clinical outcomes is a very problematic area. ACC emphasised that in its view, putting in place expectations of improved quality of treatment is something which any responsible treatment provider, or funder of treatment, would do.

6.12 I agree that it is important for ACC to continuously strive to improve outcomes for ACC claimants. It seems to me that this should be a central element of the partnership between ACC and treatment providers which was proposed by NZSP, and endorsed by ACC.

6.13 I am also conscious that it is extremely difficult to measure the extent to which particular initiatives are delivering improved outcomes, and that it is often not possible to go beyond qualitative assessment of such issues.

6.14 On the basis of the evidence I heard, from physiotherapists and from those familiar with the certification process, it seems to me that it is reasonable for ACC to expect that for many physiotherapy practices, certification will result in improved business practices and processes. And it is reasonable to expect that improved business practices and processes will, over time, increase patient satisfaction, and may also (though this is less certain) improve treatment outcomes.

6.15 It should be emphasised that this will not be true of all physiotherapy practices: in some cases, practices that are not certified will have business systems and processes that are as good as, or better than, those of many certified practices. Certification of a practice against the New Zealand standard is not a guarantee that the practice is

6.16 It is important for ACC to be clear internally, and in the advice it gives Ministers, and in its public statements, about the limits of what certification can be expected to deliver, and the confidence with which it can be suggested that certification delivers benefits for claimants.

6.17 As noted above, a reasonable expectation that certification will in many cases improve quality within a practice does not translate into a reasonable expectation that at any given time certified practices will in general be superior to non-certified practices; and certainly does not translate into a reasonable expectation that any given certified practice will deliver superior quality services as compared with any given non-certified practice.

6.18 It also needs to be very clearly recognised that these are "in principle" expectations, that have not been validated through any robust studies or surveys. It is important that ACC have in place systems for evaluating the quality and effectiveness of its own initiatives. When programmes such as the EPN are introduced, careful steps should be taken to identify processes and timeframes for evaluating the extent to which the programme is achieving its objectives.

Appropriateness of requiring certification against NZS 8171:2005

6.19 It follows from the discussion above that it is reasonable for ACC to contract with physiotherapy providers on a basis that encourages them to obtain certification, especially if ACC meets the cost of that certification through increased payments. It is reasonable (indeed, necessary) for ACC to pursue improved outcomes for ACC claimants, and it is reasonable for ACC to consider that contracting for certification will contribute to this goal.

6.20 Some physiotherapists object strongly to being required to participate in the certification process. Some of those objections are related to the cost of achieving certification, against the backdrop of a payment regime that does not cover the full sustainable cost of providing services even before the cost of certification is taken into account. It seems to me that this objection is well founded, having regard to current EPN payment arrangements, but that it would cease to be justified if any of the options recommended above for achieving sustainable funding of provision of physiotherapy services is implemented.

6.21 Some of the objections come from physiotherapists who say, quite rightly, that they are senior and experienced practitioners with relevant postgraduate qualifications, who are already delivering a high quality of service to their patients. They see certification of their practices as unnecessary and wasteful, perhaps even intrusive and

demeaning. As noted above, there will be physiotherapy practices that will not benefit from certification, in particular those that are already achieving high quality processes and procedures and outcomes in other ways. Unfortunately, it is inherent in across-the-board compliance measures that they will in many cases be unnecessary. Most audits of financial statements, for example, do not identify any significant defects in those financial statements.

6.22 There is some force in the criticisms put forward by some submitters in relation to the initial EPN requirement of accreditation against the proprietary NZPPA standard, NZPAS, having regard to the nature of that standard, and the absence of competition to provide accreditation. However those concerns were recognised by ACC, and have been addressed through development of NZS 8171:2005, and the requirement for certification against this standard. Adopting a forward-looking, practical approach it seems to me that the concerns identified have been resolved, and that no specific recommendation is required in respect of this issue.

6.23 Provided that ACC is willing to meet the cost of certification for all practices which enter in to EPN contracts, in order to achieve expected quality improvements in some practices, it seems to me that that is a requirement which physiotherapists entering into contracts with ACC can reasonably be expected to meet, even if they consider that in their particular case it is unlikely to bring any benefits.

6.24 I have however recommended below that ACC consider adopting alternative entry criteria for the EPN, based on postgraduate qualifications and experience. Acquiring further qualifications and experience seems just as likely to deliver improved quality as certification, at a level of principle; and there is no quantitative study or other analysis which suggests one path is more or less effective than the other. See paragraphs 8.10 to 8.12 below.

Appropriateness of requiring membership of College of Physiotherapists

6.25 One of the requirements for a practice to hold an EPN contract is that at least one principal in the practice be a member of the New Zealand College of Physiotherapists. This requirement is seen by ACC as ensuring an appropriate level of professional experience and competence, and participation in continuing professional development. The College agrees that this is an appropriate quality control measure on the part of ACC.

6.26 Concern was expressed by some submitters that this requirement amounts to a requirement that EPN contract providers be members of the NZSP, as the rules of the College require its members to be members of the NZSP. This rule reflects the role of NZSP in establishment of the College in conjunction with the Physiotherapy Schools in Auckland and Otago, and its initial funding and support, as well as the continuing support provided by NZSP to the College in terms of co-location and use of office and other facilities.

6.27 If the College wishes to be recognised as the preferred pathway for demonstrating physiotherapy competence for the profession as a whole, it may over time be necessary for the NZSP membership pre-requisite in its rules to be revisited.

6.28 From an ACC contracting perspective, there is some force in the concerns expressed that although membership of the College may be an appropriate requirement for access to certain types of contract, it is less easy to justify an (indirect) requirement of membership of a particular professional association. This certainly does not mean that the requirement of College membership to hold an EPN contract is not appropriate: this is in my view a reasonable and appropriate requirement, consistent with ACC practice in other fields. But ACC could reasonably encourage the College to review the need to retain, in its rules, a requirement of NZSP membership.

6.29 This is not in my view an urgent issue, and especially in the early years of the College there have been obvious advantages for the profession as a whole and for ACC and other purchasers of physiotherapy services in the close relationship that exists between the College and the NZSP, without which the College might not have been viable. But as the College grows and becomes firmly established, it does seem sensible for the College to review whether requiring membership of NZSP continues to be appropriate, and consistent with its objectives. This needs to be balanced against the desirability of keeping the cost of College membership affordable for physiotherapists. And for so long as NZSP is providing direct or indirect financial support to the College, it is reasonable that NZSP members not be asked to pay twice for this facility – though this could for example be reflected in a discounted College membership fee for NZSP members, rather than a requirement of NZSP membership in order to join the College.

ACC promotion of EPN providers

6.30 Significant concerns were expressed by some parties to the Review in relation to promotion by ACC of the Endorsed Provider Network, and a perceived preference for referring claimants to EPN clinics generally, and in some cases to specific EPN providers.

6.31 As noted above, certification of a practice is not a guarantee that it will provide superior treatment as compared with non-certified practices. And there may be practices which are certified, but do not hold EPN contracts, for various reasons. In that context, it is important that ACC should not create or contribute to potentially misleading impressions to the contrary.

6.32 It is reasonable for ACC to draw to the attention of claimants the fact that some providers will offer them ACC-funded treatment without co-payments. That is a relevant factor for many claimants, and it is entirely proper that ACC should provide such information, and details of all such providers in the relevant area. Indeed clause 6(2) of Schedule 1 to the IPRC Act provides that "[t]o assist a claimant in choosing a

treatment provider, the Corporation may advise the claimant that treatment from a named treatment provider will result in the claimant contributing less or nothing to the cost of treatment." Clause 6(2) is subject to clause 6(1)(b), which prohibits ACC from declining to pay the cost of a claimant's treatment unless the claimant agrees to get treatment from a particular provider (unless the treatment is an assessment required by the Act, or a second opinion).

6.33 However there is no proper basis on which ACC could suggest to claimants that they are likely, other things being equal, to receive a superior quality of treatment from EPN providers. Care must be taken to avoid this.

6.34 The title "endorsed provider" is problematic in this context. The language of "endorsement" suggests a recognition of superiority, or some sort of approval, which is lacking in the case of providers that are not endorsed. I accept the submission made by some physiotherapists that a claimant comparing two practices, one of which is described as "endorsed" by ACC and one of which is not, might well take from this that ACC considered that the endorsed provider delivered higher quality services.

6.35 I therefore recommend that ACC cease using the "endorsed provider" title. Something much more factual, such as "contract provider" would be more appropriate, would avoid unnecessary unfairness to Regulation providers, and would reduce the potential for causing confusion to claimants. ACC has advised the Review that it accepts this recommendation, and will seek another name that better reflects the contract, to commence before the end of 2007.

6.36 There was evidence before the Review that, on occasion, case managers have steered claimants towards particular EPN providers. ACC confirmed that its employees are not authorised to steer claimants towards particular providers, and that internal guidance that this is not appropriate has been provided to case managers. Very strong justifications would be required for ACC to discourage claimants from using specific providers, or to encourage them to use specific providers in preference to others; no party to the Review identified circumstances in which it would be appropriate for a case manager to do so.

6.37 On the basis that conduct of this kind by case managers is recognised by ACC as being inappropriate and is discouraged, no specific recommendation on this issue seems necessary. However the evidence that such conduct has occurred on a number of occasions suggests that ACC needs to continue to provide clear information and training to case managers, to ensure they act appropriately in this respect.

Implications of EPN contracts for ethical responsibilities of physiotherapists

6.38 It was suggested by some physiotherapists that there is a tension between the ethical responsibilities of physiotherapists to their patients and the primacy of the

physiotherapist - patient relationship on the one hand; and entry into an EPN contract with ACC on the other hand.

6.39 There is no inherent inconsistency between the professional and ethical responsibilities of a physiotherapist to his or her patient, and the existence of a contractual relationship with ACC governing the process for interacting with ACC for the purpose of obtaining payment of the patient's ACC entitlement. There would only be an inconsistency if specific aspects of the contract were inconsistent with the physiotherapist's ethical responsibilities. For example, a contract that required the physiotherapist to disclose confidential information without the patient's consent plainly would be inappropriate, and would raise significant ethical issues.

6.40 Some submitters appear to have assumed that if an EPN provider has a contract with ACC, that provider does not have a contract with his or her patient, and is not directly accountable to the patient. This misunderstands the effect of the contract with ACC in relation to provision of services to claimants. That contract governs the provider's interaction with ACC, and payment mechanisms. It does not replace the contract between the physiotherapist and patient, which exists in the normal way in parallel with the EPN contract with ACC. There is no inconsistency between these contractual relationships. The EPN contract certainly does not displace the physiotherapist's professional and ethical accountability to the patient: it does not affect this in any way. (For completeness, I should note that even if there were no contract with the patient, as for example where a sporting organisation contracts with a physiotherapist to provide services to athletes, the physiotherapist has the same direct professional and ethical obligations to his or her patient.)

6.41 I have reviewed the EPN contract and the submissions made by parties concerning suggested inconsistencies between that contract and the ethical responsibilities of physiotherapists. I am satisfied that there is nothing in the EPN contract which requires a physiotherapist to act in a manner that is inconsistent with his or her ethical responsibilities. It seems to me that these concerns, though genuine and deeply felt, are misplaced.

6.42 Concerns raised by some physiotherapists about confidentiality of communications with patients, and clinical notes, are discussed in more detail in section 7 below. I am satisfied that there is nothing in the EPN contract which would require a physiotherapist to breach confidentiality obligations to a patient.

6.43 It was also suggested in submissions to the Review that ethical issues might be raised by a requirement under the EPN contract to comply with the physiotherapy Treatment Profiles. There appears to be some confusion on this point, to which as noted above ACC has (perhaps inadvertently) contributed. There is in fact no requirement in the EPN contract that physiotherapists limit the number of treatments provided to the target numbers specified in the Treatment Profiles. Rather, the EPN contract requires

that if the number of treatments provided exceeds that specified in the profiles, prior approval is required via an ACC32 Request for Further Treatment form. The contract also notes that the service provider will be monitored against the profiles and may be asked to explain practice outside these guidelines. In these respects, there is no relevant difference between EPN providers and Regulation providers. Both groups of providers must complete an ACC32 form in order for ACC to fund treatment beyond the trigger number in the profiles. Both groups of providers are monitored against the profiles, and may be asked to explain practice outside these guidelines.

6.44 The appropriateness of the manner in which ACC uses the profiles for treatment approval purposes, and monitoring purposes, is discussed in more detail in section 9 below. Some practical suggestions are made in relation to the use of the profiles and the ACC32 process. Those suggestions respond to practical operational concerns, and to the very significant concerns expressed by claimants and by physiotherapists in relation to timely access to appropriate services. They do not implicate in any way the ethical responsibilities of physiotherapists. The references to the Treatment Profiles in the EPN contract do not raise any ethical concerns.

6.45 One party to the Review submitted that the prohibition on contracting out of the Act in section 299 raised questions about the legality of ACC entering into contracts with providers. It is in my view very clear that such contracts, far from being prohibited by section 299 and related provisions, are expressly contemplated by the Act, and in particular by clause 1 of schedule 1 to the Act.[36]

Three month termination provision in EPN contracts

6.46 The EPN contract provides for termination on three months' notice by ACC or the provider. Some submitters expressed concern that this short termination period was unfair and inappropriate, and:

6.46.1 made it difficult for providers to engage in long-term business planning;

6.46.2 created a threat of immediate termination that could be held over the head of EPN providers, if they got offside with ACC.

6.47 ACC confirmed to the Review that all its treatment provider contracts contain a three month termination clause. ACC also confirmed that no EPN contract has been terminated by ACC to date; and that for its part it saw EPN contracts as long term, "evergreen" relationships.

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[36] Some confusion appears to have arisen because, in the IPRC Act, there is no express reference to the provisions of schedule 1 in the body of the Act. But the schedule is part of the Act, and it applies by virtue of the references to entitlements for which a claimant is eligible under the Act in section 67, and the references to provision of entitlements in accordance with the Act, and to the extent required by the Act, in section 68.

6.48 There was no evidence before the Review of any inappropriate use of the termination clause to terminate, or threaten to terminate, a physiotherapist's EPN contract. The concerns expressed about this risk are in my view theoretical, rather than real.

6.49 However the concern about business planning does have some substance. If ACC were to decide to end the EPN programme, long term investments in certification and equipment might never be recovered by a practice. I recommend that ACC give consideration to amending the EPN contracts to provide a longer period of notice for "no fault" termination, perhaps 12 months, with a shorter period retained for circumstances where there has been a breach of the provider's obligations under the contract.

6.50 ACC has accepted this recommendation, and advised the Review that it will start work on this issue by the end of the year, including consulting with the physiotherapy profession to see if its suggested extension of the no-fault termination period from three months to six months addresses the profession's concerns.

Conflict of interest for some physiotherapists in relation to EPN rollout?

6.51 Finally, in the course of submissions to the Review some allegations were made about the role of the NZSP and some of its former officeholders in connection with the development and national roll out of the EPN, suggesting possible conflicts of interest. Those allegations are not relevant to my terms of reference, and I do not propose to discuss them in this report. However I should record that there was no evidence before the Review that suggested anything other than that the NZSP and its officeholders dealt with ACC in connection with the EPN in good faith, and in what the NZSP and its officeholders perceived to be the best interests of the profession. Nor was there any evidence before the Review of any conflict of interest, or any unfair or inappropriate advantage obtained by any NZSP officeholder in connection with the EPN initiative.

7 CULTURE OF ACC/AUDITS

Background

7.1 ACC has provided extensive information and documentation in relation to the approaches ACC has taken to provider monitoring, audit and fraud investigations in general, and in relation to physiotherapists in particular. An overview of these approaches is set out below.

7.2 ACC spends over $120 million annually on physiotherapy services for ACC claimants.[37] In the year ended 30 June 2006 some 480,000 claimants made around 2.8 million physiotherapy visits for treatment to the 861 physiotherapy practices and 2721 physiotherapists registered with the Corporation.[38]

7.3 ACC has a statutory responsibility to provide entitlements only in the circumstances prescribed in the IPRC Act. Its responsibility for ensuring rehabilitation to the maximum practicable extent means that ACC has a keen interest in the quality and effectiveness of physiotherapy treatment provided to claimants. ACC also has a more general responsibility for prudent management of the funds which it administers, and for delivery of services to claimants and levy payers in a manner that is cost-effective and promotes administrative efficiency.

7.4 ACC advised the Review that its provider monitoring, audit and fraud strategies and processes are designed to assist ACC to meet these responsibilities, and to ensure that payments that are made are consistent with the relevant statutory requirements.

Structure of ACC Monitoring, Risk and Assurance and Fraud units

7.5 ACC has separate units that carry out its monitoring, audit and fraud work: the Rehabilitation Service Development teams, the Relationship Management team (formerly the Monitoring team), the Practice Audit Team, and the Fraud Unit.

7.6 Monitoring of contracts is undertaken by the Rehabilitation Service Development teams following the monitoring activities identified in the service monitoring plans. Any matters requiring further follow-up and investigation are forwarded to the Relationship Management team. The Relationship Management team is described by ACC as "[guiding] providers towards best practice behaviour and contract compliance."[39]

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37 ACC Presentation to Hearings 14-17 May, Slide 18.

38 ACC Primary Submission, pp 11-12.

39 ACC Submission on Draft Report, p 7.

7.7 The Practice Audit team's role is to audit providers' practices and services to determine whether or not the goods and services provided match ACC's requirements. They also ensure that payments and contributions initiated by the provider are appropriate.

7.8 ACC's Fraud Unit is responsible for detecting, investigating and prosecuting fraud. It has teams that investigate claimants and providers. It is this unit that performs investigation audits.

ACC provider monitoring

7.9 Since 2005 ACC Healthwise has had a dedicated Monitoring Team, now known as the Relationship Management team, whose role is to:

- work with providers in an educative and supportive role to ensure providers reflect best practice in their treatment and rehabilitation for claimants;
- implement monitoring activity using the Healthwise Provider Performance Monitoring Framework;
- assist with development, negotiation, and implementation of provider performance improvement plans; and
- manage provider issues and facilitate communication.[40]

7.10 The Relationship Management Team's two main streams of work are implementing the service monitoring plans, and dealing with provider issues that arise from day to day.

Service Monitoring Plans and Physiotherapist Outlier Analysis

7.11 The Relationship Management team undertakes periodic reviews of all services (including physiotherapy services) to identify and manage provider behaviour that is outside ACC's expectations and outside evidence-based practice. ACC has separate service monitoring plans for physiotherapy providers with whom they have an Endorsed Provider Network Service Agreement[41], and those who are paid under the Cost of Treatment Regulations 2003[42].

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[40] ACC Primary Submission, p 24.

[41] ACC (1 October 2005), Service Monitoring Plan – Endorsed Provider Network Services Agreement.

[42] ACC (23 March 2006), Service Monitoring and Evaluation Plan – Specified Treatment Providers (IPRC Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 – Physiotherapy, Chiropractor, Osteopathy, Podiatry, Acupuncture.

7.12 The rationale ACC identifies for having two separate processes is that the "needs and known issues were different".[43] Further explanation was sought from ACC on the rationale for these differences, and in particular why fraud is expressly identified as a risk in respect of Regulation providers, but not EPN providers, in its 2005/2006 service monitoring plans. ACC advised the Review that the purpose of the two reviews in 2005/2006 was different. The Regulation provider review was a formal analysis of Regulation providers to obtain information on potential outliers. The first EPN review, undertaken in 2005, was "primarily to get an impression of how the new services were being used by providers and to gauge the providers' interpretation of the contract and operational guidelines. It was intended as a service review."

Monitoring of Regulation-funded physiotherapists

7.13 For physiotherapists working under the Cost of Treatment Regulations, the service monitoring plan contemplates that each year the Monitoring Team (now the Relationship Management team) will carry out analysis of all the treatments provided relating to all ACC45 claim forms lodged and all ACC32 Request for Prior Approval of Treatment during the year.

7.14 Only one round of outlier analysis has been undertaken for Regulation providers in the last four years, in 2005. From 1999 to 2003, outlier analysis was undertaken on a regular basis. The outlier criteria used by ACC in 2005 were to identify those providers who are two standard deviations from the 25th and 75th percentile, measured across the following variables:

- total costs for the period measured;
- number of visits per day;
- number of visits per claim;
- total costs per claim;
- costs per visit; and
- number of claims per claimant.[44]

7.15 Providers identified as outliers on these variables were then the subject of further data collection and analysis by ACC to get a clearer picture of their mode of practice. The analysis involved collecting key claim information per provider and using pivot tables to identify or exclude evidence of outlier behaviour. The tables were used to identify

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43 ACC (January 2006), Provider Monitoring Process Memorandum, p 1.

44 ACC Secondary Submission, 3 May 2007, p 46.

claims and claimants the provider had treated to allow them to reconcile this data with their own records. Along with a letter detailing the specific areas of concern, these tables were sent to the providers to seek their assistance in clarifying the anomalies. This was intended to allow them to respond to the inquiries and identify any ACC process errors.[45]

7.16 The letter sent to identified providers included questions about whichever of the following was found to be relevant to the particular provider:

- For flat rate claimers, the reasons for high numbers of claimants treated per day and:
  - what the lengths of appointments are;
  - whether more than one person is treated at a time;
  - whether students are supervised;
  - whether ACC is invoiced for claimants who do not attend appointments;
- For hourly rate claimers, where more than ten hours per day were invoiced for:
  - whether the treatment invoiced for on those days was for direct one-to-one treatment for the whole period;
  - whether more than one person was being treated simultaneously;
  - whether students were being supervised;
  - whether ACC is invoiced for claimants who do not attend appointments;
- Where the provider had not applied for prior approval using the ACC32 process, why this was the case;
- Where multiple injuries were being treated simultaneously for multiple claims, why this was the case;
- Where family members had been treated, confirming this was the case and if so how this complied with the ACC guideline for treating family members;
- If the percentage of claims requiring an ACC32 requesting prior approval for treatment is higher than for peers, why this was the case;

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45 ACC Submission on Draft Report, p 11.

- If the incidence of new claims for the same or similar injury site arising within 28 days of the previous claim and this previous claim received a high number of treatments:

  - whether this was a new injury, a re-aggravation of a previous injury or a pre-existing condition;

  - if the latter two applied, why a new claim was lodged;

- Where an ACC32 had been lodged and then 3 or less treatments were delivered of those requested, why this was the case; and

- Where claims were lodged outside of the Claim Lodgement Framework for their clinical speciality, why this had occurred.[46]

7.17 The information provided by the physiotherapist was then assessed by the Monitoring Team to determine what the most appropriate form of action was. This could include further monitoring to see if behaviour has changed, and if not further follow up interactions with the provider. Where serious problems are identified, the result may be referral to the ACC Fraud Unit for a formal investigation (investigations are discussed below).

Monitoring of EPN physiotherapists

7.18 For physiotherapists with EPN contracts, the variables specified in the service monitoring plan are:

- total number of claims per provider;

- total number of visits;

- average visits per claim (if provider treated more than 20 claims in the period reviewed); and

- proportion of Level B services (if provider treated more than 20 claims in the period reviewed).[47]

7.19 No outlier analysis of EPN providers has been undertaken by ACC to date. While a report on the EPN was produced for ACC senior management nine months after the national rollout of the EPN, this was focused on understanding how the EPN contract

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[46] ACC Generic letter to providers 'Annual Service Assessment'.

[47] ACC Secondary Submission., 3 May 2007, p 48.

was being interpreted and applied overall rather than being a formal outlier analysis that led to individual provider follow-up.

Day to day provider issues

7.20 In addition to the annual service review, the Relationship Management Unit deals with day-to-day provider issues. Notifications that there is an issue generally come from internal sources – Case Managers in Branches, Case Co-ordinators in Contact Centres, the Payments Team, Programme Managers and ACC Complaints Service. Notifications are also received from claimants and other external parties.

7.21 The monitoring protocol requires that within five days of a notification being received, the relevant Service Performance Manager makes contact with the referrer to acknowledge the matter, obtain further information, discuss what the referrer would like to have happen and whether this is possible. The Service Performance Manager then collates the information gathered and determines the level of the issue as either:

- Level 1 – Knowledge Deficit;
- Level 2 – Overservicing:
  - A = Suspect accident claims;
  - B = More than 2 visits per day;
  - C = Inappropriate use of procedure;
  - D = Suspected overcharging of hourly rate;
  - E = Visits per claim;
  - F = Costs per claim;
  - G = Claimant visits per day;
- Level 3 – Clinical competency;
- Level 4 – Collusion;
- Level 5 – Scope of practice/contract; or
- Level 6 – Phantom claims – refer direct to Fraud.[48]

7.22 Most issues fall into the level requiring clarification of the service or contract, education on the service or contract, and ACC systems (including poor referral, Case Manager knowledge, payments systems etc).[49]

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[48] Provider Monitoring Process, ACC Memorandum, January 2006, Provider Performance Management Flowchart, p 1.

7.23 All issues must be logged into the Provider Performance Contact Register, which tracks all matters to completion and records interventions and outcomes. They are categorised in terms of the urgency of the response required: Urgent (responses in 24 hours); High (response within 1 week); Medium (response within one month); or Low (response within 3 months). The latter two categories relate predominantly to the programmed service reviews of providers, outlined under 'outlier analysis' above.

7.24 Once the issues are logged, a decision is made regarding who is the best person to take that action. This may be the Service Performance Manager, the Provider Relationship Manager, the Health Procurement Facilitator, a Team or Branch Manager, or Risk and Assurance.

7.25 The usual forms of action taken are a telephone call to clarify the issue, a visit to provide an education session, or the provision of guidelines, templates and fact sheets. Subsequent to those, feedback is provided to the Programme Manager on service issues and to the Health Procurement Facilitator on contract issues.

7.26 The process guidelines require that the provider is followed up after three months to ensure that the performance issue has been resolved. If the problematic behaviour has changed the matter is documented and the issue closed. If the problematic behaviour has not changed the matter is tabled with the Review Panel to explore possible strategies depending on the circumstances. This may take the form of, but is not limited to, referral to Risk, Assurance and Fraud, or referral to the applicable Registration Authority (in the case of physiotherapists, the Physiotherapy Board of New Zealand).

7.27 ACC advised the Review that it is in the process of implementing changes to the Relationship Management team, formerly known as the Monitoring team, and expects these to be complete by December 2007. These changes are intended to result in ACC better reflecting the interdependence and ongoing relationship with providers, including physiotherapists. A key focus of the team will be education.

7.28 The Relationship Management team will focus on providers identified by ACC as requiring additional contact for various reasons, including clarifying new contracts and service requirements, and data analysis that shows the business is markedly different from similar providers, and other triggers such as a referral from the payments processing team regarding documentation. This team is intended to have an emphasis on building the relationship between ACC and the provider.

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[49] ACC Presentation to Hearing, 14 May 2007, Slide 32.

Practice audits and fraud investigations

7.29 Another way that ACC monitors physiotherapy services is through auditing providers' practices and programmes.

7.30 There are two main types of audit. The first type is a practice audit, where there are concerns regarding compliance, clinical practices or over-servicing. The second type is an investigation audit, where there is an inquiry into irregular or questionable activities. In this context, the focus of ACC is on fraud.

Practice audits [50]

7.31 Practice audits are a formal investigation of an organisation's or an individual's:

- ACC accounts or financial situation;
- compliance with contracts/regulations (as applicable);
- confirmation of service provision meeting IPRC Act and regulation requirements;
- appropriateness of scheduled fees or contributions versus services provided; and
- adequacy of clinical notes.

7.32 These audits are conducted by the Practice Audit team according to the ACC audit protocol requirements introduced with effect from 1 March 2005.[51] Before this date, there was no formal audit protocol. An audit may be triggered by a specific concern raised with the Risk and Assurance and Fraud Unit, or may be the result of random selection of providers.

7.33 Practice audits are undertaken by a chartered accountant who is a trained auditor. The provider should be advised in writing at least ten working days prior to the audit of the general reasons why they have been selected for audit, and the expected audit process. A practice audit plan is developed which specifies the scope and issues to be examined during the audit, and specifies dates for the completion of a report and feedback to the treatment or rehabilitation provider.

7.34 A practice audit plan will normally include plans for:

- an initial interview with the provider or practice staff to confirm how the practice records match the claim records, and how other details such as the eligibility status and consultations are recorded;

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50 ACC Primary Submission, p 26.

51 ACC Audit Protocol (2005).

- an appropriate review of the provider's practice records;

- a discussion of an appropriate approach to specified claimants to confirm details of consultations. A sample of claimants might be contacted to confirm that a consultation took place; and

- other procedures as may be agreed upon between the auditors and the provider/s. For example, clinical records may be requested for review. In such cases the auditor would draw on the expertise of a clinical adviser who is a qualified physiotherapist.

7.35 Providers receive a written summary of the audit plan at least five days prior to the audit commencing, which provides an outline of the nature of the audit and the general areas to be covered.

7.36 At a pre-arranged time the auditors visit the practice to inspect relevant records. These may include ACC claim forms, clinical records and appointment registers. The auditors may speak to various staff at the provider's practice to discuss policies, systems, practices and procedures.

7.37 Where claimants are surveyed, they are asked to confirm:

- accident details (where the accident took place, what happened etc);

- injury details (what were the extent of injuries);

- services claimed to have been provided (eg how many visits took place, on what dates); and

- eligibility status (to ensure that only accident services are being claimed for).

7.38 The auditors provide a draft audit report as soon as possible, normally not less than four weeks after the audit. If this is not feasible, the auditors provide a progress update. The draft audit report will list the draft findings of the audit and will be provided to the provider for their response. Any comments from providers in writing will be included in the final audit report.

7.39 Where anomalies are identified as the result of an audit, ACC's Practice Audit team establishes whether these anomalies are a result of gaps within the provider's own processes and policies, or gaps within ACC's management of the relationship with the provider. Recommendations are made to both the provider and ACC regarding ways in which both parties might address those gaps and improve their professional

relationship. Any clinical issues identified in the audit are peer reviewed by an appropriate, independent, external health professional.[52]

7.40 Audit recommendations may include:

- a notification of no further action;
- notification that the matter has been recategorised as a fraud investigation as a result of suspicions of fraud or serious non-compliance;
- recovery of invalid payments;
- advice to the provider on correct compliance with the ACC contract or legislation;
- referral of the matter to an appropriate registration or complaints body; and/or
- application of billing restrictions.[53]

7.41 For physiotherapists, 11 practice audits have been conducted by ACC to date – all as part of the Activity Based Programme Review. Of these, 7 related to EPN practices and 4 to non-EPN practices.[54] None resulted in prosecution.[55]

Investigation audits

7.42 Specific fraud investigations are undertaken by the Fraud Unit when ACC has reason to suspect fraudulent claiming or serious breaches of the legislation, regulations or a contract or policy. The 2005 Audit Protocol also governs these audits.

7.43 Investigation audits follow substantially the same procedures as for a practice audit, and will include interviews with people whom auditors believe can assist the investigation. The provider will be advised of the general issues of concern prior to an investigation audit, unless auditors believe on reasonable grounds that such advice may prejudice the audit. Advance notice of visits may be reduced or not given at all if the auditors believe providing such notice may frustrate the investigation.

7.44 Where fraud or serious non-compliance is identified the matter may, at the discretion of the Manager, Risk and Assurance and Fraud, be:

- referred to court for prosecution;

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52 ACC Primary Submission, p 26.

53 ACC Audit Protocol, pp 9-15.

54 ACC Presentation to Hearing, 14 May 2007, Slide 51.

55 ACC Primary Submission, p 26.

- dealt with under the provisions of the contract;
- referred to a professional body;
- referred for ongoing monitoring;
- referred for recovery of payments; and/or
- referred for monitoring and billing restrictions.[56]

Operation Quest III

7.45 In 2002, ACC formed the view that it needed improved data on the levels of fraud occurring across the ACC scheme for internal strategic planning purposes, and instigated a formal study into fraud. The first two phases of Operation Quest focused on claimant fraud and general practitioner fraud. In April 2004 Operation Quest III commenced, focused on physiotherapists and chiropractors.

7.46 Operation Quest III involved a sample of providers being selected from invoiced billing schedules submitted by providers between 1 September 2003 and 31 January 2004. The sample population included only those physiotherapists and chiropractors who claimed by the 'per treatment visit' rate under the Cost of Treatment Regulations. ACC initially described this to the Review in oral submissions as an administrative decision, the rationale for which cannot now be ascertained. In its submissions on the draft report, ACC provided more information, and advised the Review that during Quest III ACC focused on Regulation providers because there were few EPN providers (in pilot areas only) for the period over which the analysis of fraud risk was undertaken. ACC advised that "[a]s the EPN contract was not nationwide during the analysis period, it was considered reasonable to focus on the largest proportion of physiotherapists, ie Regulation physiotherapists, which also captured those physiotherapists who went on to take up an EPN contract. There was no intention, either then or now, to treat EPN providers any differently from regulation providers." ACC also advised that there has been no working assumption by ACC that there was less or more scope for concern about inappropriate service provision or fraud on the part of EPN providers.[57]

7.47 ACC's primary submission to the Review said that the Quest III investigation "found that the level of fraud observed within the physiotherapist and chiropractor provider groups for individual transactions is 8.14%[58]. This very serious and surprising

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56 ACC Audit Protocol, pp 17 -20.

57 ACC Submission on Draft Report p 8.

58 ACC Primary submission para 4.6.

allegation was corrected in ACC's Second Submission.[59] Instead, ACC describes the 8.14% figure as relating to the level of risk of fraud rather than the level of fraud, on the basis that 8.14% of transactions "could not be validated as legitimate charges to ACC, but were not necessarily fraudulent".

7.48 Even this modified suggestion of a "risk of fraud" in such a large proportion of cases seems overstated and potentially misleading, in the absence of any indications of dishonesty as opposed to innocent administrative error by providers, or error as to dates on the part of a claimant. It is like saying that presence in a doctor's waiting room indicates a risk of life-threatening disease: it is certainly one possible explanation for why a person is there, but it is a relatively unlikely one that will apply only to a small number of cases.

Extent and outcomes of fraud investigations

7.49 Since September 2004 ACC has undertaken 6 fraud investigations of EPN physiotherapists and 55 of Regulation-funded providers.[60] Of the 49 recent and current fraud investigations as at December 2006, the sources of the referral for investigation have been:[61]

Referral source	No. of providers
Provider monitoring	10
Medical fees	1
Data analysis by Fraud Unit	17
Quest III	1
Clinical Advisers	4
Branch and other ACC staff	5
Information received	11

7.50 Between 1 September and 1 December 2006, outcomes were reported in relation to 37 physiotherapy practice investigations. Ten investigations were referred to another

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59 ACC Second Submission p 48.

60 ACC Presentation to Hearing, 14 May 2007, Slide 52.

61 ACC Presentation to Hearing, 14 May 2007, Slide 53.

ACC business unit (such as the ACC Monitoring Team or Debt Management Unit), three were warned, one was prosecuted, one had their billing restricted, and two signed administration agreements (formal cautions signed between ACC and the provider acknowledging that the provider's billing behaviour had been inappropriate and if it occurs again the provider may be prosecuted).[62]

7.51 As ACC noted in its submissions, the number of physiotherapists investigated is low compared with the total number of ACC registered physiotherapists. ACC's fraud investigation activity does not appear to be disproportionately targeted at physiotherapists, as compared with other provider groups. Physiotherapists account for 21% of the total current provider fraud investigations, and three of the 13 fraud investigations completed in 2006. Compared with the roughly 36% of all treatment visits funded by ACC which were provided by physiotherapists, these ratios do not seem out of the ordinary.

Evidence in relation to conduct of investigations and audits

7.52 The Review was provided with a great deal of evidence in relation to the manner in which particular audits and investigations had been conducted by ACC. The Review received submissions from physiotherapists about their personal experiences with the audit process, information from claimants about their experience of being contacted for the purpose of such inquiries, and submissions from professional bodies about the experiences of their members and resulting concerns In addition, I requested the files held by ACC in relation to investigations of two physiotherapists, and reviewed those files.

7.53 Some of the submissions in relation to the investigation and audit process raised issues about the transparency and appropriateness of the ACC processes for conducting investigations and audits. Some guidance on these issues is provided in the ACC Treatment Provider Handbook[63], but this is relatively limited. There were no formal internal protocols or guidelines governing these activities prior to the release of the ACC audit protocol in early 2005. The evidence before the Review suggests that before 2005, these processes were neither as structured nor as transparent as is desirable.

7.54 However no concerns in relation to the 2005 audit protocol (as distinct from the manner in which audits and investigations are conducted, an issue discussed below) were raised by any submitter. The NZSP noted in its initial written submissions to the Review that it no longer had concerns about audit and investigation since the launch of the new audit protocol in 2005, and that feedback to NZSP indicates that the majority of physiotherapists are now happy with the manner in which provider

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62 ACC Primary Submission, pp 27-28.

63 ACC Treatment Provider Handbook 2007, pp 25-26.

monitoring, audit and investigation is being undertaken.[64] However NZSP subsequently identified two recent complaints from members about the conduct of fraud investigations, and other submitters provided examples of recent concerns about audits and investigations.

7.55 Most of the submissions in relation to the audit and investigation process, including the recent matters mentioned above, concerned the manner in which ACC conducts audits and investigations. A significant number of physiotherapists found the approach of the ACC staff carrying out investigations confrontational and hostile, and felt that there was a working assumption that the physiotherapists concerned were incompetent, or dishonest. Certainly there was considerable evidence of poor communication between ACC staff and physiotherapists, and an atmosphere of mutual mistrust which was often contributed to by both parties, but which ACC as the initiator and manager of the process is best placed to address in the future. Some suggestions for how this might be done are made below.

Issues

7.56 The issues raised in submissions regarding ACC's provider monitoring, audit and fraud strategies and processes were, in summary:

- whether investigation or auditing of physiotherapists by ACC is always genuinely random or prompted by clear indications of inappropriate practice. Some submissions suggested that investigations and audits sometimes appear to be selectively targeted at critics of ACC policies and procedures, and that if it was random, there would not be such a high incidence of senior practitioners, claiming ACC payment under the Cost of Treatment Regulations in the Greater Auckland region, who are members of the APPPA, have publicly expressed their misgivings about the Endorsed Provider Network and consider it important that patients are rehabilitated to the maximum extent practicable rather than this being constrained by the ACC Physiotherapy Treatment Profiles;

- concern that ACC non-randomly targeting providers is consistent with the approach recommended to ACC by the NZIER in 'Framework for Analysis of the Endorsed Provider Network', May 2002, as follows:

> *"The emphasis of the EPN is on providing incentives to improve the treatment profile. Another way would be to put more constraints on non-accredited providers, particularly those that treat consistently outside the consensus number of treatments as documented in the Treatment Profiles…Options worth considering include…increasing service audits, claims reviews and other forms of monitoring for providers that treat*

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64 NZSP Primary Submission, paras 324, 357.

consistently outside the Treatment Profiles, while relaxing the controls for those who don't." p 14;

- concern that the wording adopted in initial standard letters to providers whose billing practices are under investigation is inappropriate. It implies wrongdoing at a stage where insufficient evidence of this is available;

- lack of clarity both in communications with providers and in internal ACC understandings regarding whether ACC is requesting information, undertaking a review, undertaking an audit or undertaking a fraud investigation – and a lack of clarity and consistency regarding the processes adopted in each case;

- ACC not advising physiotherapists that patients would be contacted in the course of an audit before the contacts are made;

- a private investigator interviewing patients making allegations of fraud against their physiotherapist;

- private investigators' manner of questioning leaving patients feeling bullied, intimidated or harassed;

- during interviews by investigators, patients being asked to recall treatments that were provided more than a year ago, with any inability to recall treatments being taken as evidence of fraud;

- concern that the performance targets specified by ACC in their contracts with private investigators – whereby "80% of referrals made result in either prosecution, cessation, suspension of entitlement, civil action, positive change in claimant capacity status, complaint to the appropriate medical board, referral to ACC for further action, civil action, overpayment identified or some other form of action has occurred"[65] – predispose private investigators to presume that those they are investigating are 'guilty until proven innocent';

- ACC refusing to provide providers they are investigating with copies of investigators' reports or patient interview notes;

- lack of opportunity in the review/audit process adopted for the reviewed/audited provider to contribute feedback on the accuracy of the information collected prior to determinations being reached about whether or not there is evidence of fraud;

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[65] Agreement for Private Investigation Services between ACC and Mainland Information Consultants, p 18.

- ACC escalating reviews of providers into fraud investigations for matters which are relatively minor administrative errors which do not meet the high standards for fraudulent acts specified in the ACC Treatment Provider Handbook, namely one that is 'intentionally dishonest and deliberate, for the purpose of obtaining payments that a person was not entitled to";

- ACC itself sometimes making errors in its extraction, analysis and interpretation of individual provider claim data, which it uses as the basis for initiating investigations. Where such errors are discovered, ACC does not provide a clear explanation as to how they came about, or apologise for the consequences of such errors;

- whether the sanctions threatened or applied by ACC (such as removal of bulk billing rights, being referred to the Physiotherapy Board of New Zealand for review under its Competence Committee process or seeking repayment of large amounts of payments for services provided) are appropriate, given the relatively minor or administrative nature of the problems identified with physiotherapy providers or the limited nature of the evidence of fault;

- lack of any robust, open or independent appeal process available for providers who consider investigations are not being fairly conducted;

- complaints procedures regarding review/audit/fraud investigation processes not being sufficiently independent or robust enough to provide confidence that ACC will be able to identify where improvements could be made or where it is performing well;

- whether patient rights to informed consent to the release of information are breached when ACC seeks access to clinical records for audit and fraud investigation purposes directly from providers without informing claimants that the information is being requested. Submitters considered good practice would be for ACC to always inform claimants that clinical records are being sought, and for what reason, and seek patient consent first rather than assume that having signed the ACC45 claim form is sufficient authorisation for the collection and disclosure of information; and

- where a patient expressly refuses to authorise a physiotherapist to provide clinical notes, the physiotherapist risks being in breach of the requirements of Privacy Act if they comply with an ACC request for such information, but risks being prosecuted by ACC for not providing information required under ACC legislation.

Findings and recommendations

ACC responsibilities require appropriate provider monitoring, investigation and audit

7.57 In order to ensure that ACC is meeting its statutory responsibilities in relation to provision of entitlements and cost-effective management of the scheme, it is appropriate and desirable for ACC to carry out monitoring of service providers by reference to available measures of the number and type of services provided, and quality/effectiveness of treatment. If some physiotherapists are providing treatment that is not necessary or is not appropriate, or are providing more treatments than necessary for that patient, or treatment that does not meet relevant quality standards, or are failing to keep proper records and meet other relevant administration expectations, it is desirable for ACC to identify this and ensure that appropriate remedial action is taken. Indeed, this is essential in the long-term interests of accident victims, and in the long-term interests of the sustainability of the accident compensation scheme. ACC provided evidence to the Review of the effectiveness of its monitoring activities in addressing concerns of this kind.

7.58 Recognising that there is a small but non-negligible risk of fraud on the part of providers, it is also appropriate for ACC to take steps to identify fraudulent conduct where it does take place, and take appropriate action against those responsible. Having appropriate measures in place to detect fraud can be expected to discourage such conduct in the first place, and should increase the likelihood that appropriate action can be taken in the very small number of cases where fraudulent conduct does occur. To this end, it is appropriate and desirable that ACC use a range of techniques for investigating the possibility of fraud, including data analysis, practice audits, and investigations.

7.59 The need for some form of "supervision" of providers of medical treatment was expressly recognised by the Woodhouse Royal Commission: this is not a new idea, or one which could be seen as in any way inconsistent with the original conception of the scheme.[66]

7.60 However it is essential that, in carrying out its monitoring and investigation and audit activities, ACC adopt a fair and balanced approach. ACC should approach all such inquiries with an open mind, astute to detect any failings or misconduct that might become apparent, but without any presumption that the physiotherapist concerned is not competent or, more importantly still, dishonest. Appropriate monitoring and investigation work should be able to be carried out in a manner consistent with mutual respect and a continuing partnership between ACC and the physiotherapist to deliver high quality services to claimants.

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[66] Woodhouse Royal Commission Report, p 149; see para 5.49 above.

7.61 ACC should make sure that there is good reason to suspect incompetence or dishonesty, and that other explanations do not exist that are equally or more likely to be correct, before dealing with physiotherapists or their patients or other third parties in a manner which suggests that ACC has such suspicions.

7.62 There are two critical ingredients required for ACC to perform its responsibilities in this manner:

7.62.1 ACC needs to have in place appropriate, transparent, *processes* for carrying out monitoring, investigation and audit activities;

7.62.2 ACC needs to ensure proper *implementation* of these processes, in a manner that is consistent with a partnership between ACC and the physiotherapy profession, and the balanced approach described above.

Processes for monitoring, investigation and audit activities

7.63 The introduction of the 2005 audit protocol appears to have addressed earlier concerns in relation to the structure and transparency of ACC's audit and investigation processes. As noted above, no concerns were identified by any party in relation to this protocol. The process concerns that were described to the Review all appeared to relate to the period before this protocol came into operation.

7.64 ACC has also made a substantial amount of information available to the Review in relation to its provider monitoring process. There is a brief but helpful summary in the ACC Treatment Provider Handbook. Further information about the monitoring process is set out in documents provided to this Review. No specific concerns were identified in relation to the content of these processes.

7.65 However the ACC monitoring processes are not as transparent for providers as the audit and investigation processes, and it would be constructive to address this. To ensure that there is the same level of clarity and transparency in relation to the monitoring process as has been achieved in respect of the audit and investigation process, I recommend that information be made available to providers which explains the objectives of the monitoring process, the process by which it is conducted, and the various outcomes that are contemplated. All of this information already exists; it is simply a matter of bringing it together in one place in a helpful and accessible form, with more detail than is found in the Treatment Provider Handbook[67]. ACC advised the Review that it accepts this recommendation, and will initially make this information available to providers on the ACC website.

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[67] ACC Treatment Provider Handbook 2007, pp 25-26.

Implementation of processes

7.66 The evidence in relation to implementation of ACC's monitoring, audit and investigation processes was more mixed. Most of the material before the Review related to events before the introduction of the 2005 audit protocol. But there was some evidence of continuing miscommunication, misunderstanding and tension in dealings between ACC staff responsible for audit, investigation and monitoring activities, and physiotherapists and their patients.

7.67 There is always going to be a level of tension associated with the process of undergoing an investigation. Investigations will always be inherently stressful for the physiotherapists concerned, exacerbated by the considerable influence ACC has over providers' livelihoods and professional reputations.

7.68 There are a number of steps which could be taken by ACC to improve the quality of their interactions with physiotherapists and their patients in this context. This is in the interests of all concerned, as it should improve the efficiency and effectiveness of these activities, and avoid some of the unnecessary stress and cost that has occurred in some cases in the past.

7.69 The first point is that ACC and its employees need to be conscious of the many possible explanations for the fact that a particular physiotherapist, or particular practice, is identified as an outlier in the course of data analysis. A physiotherapist who routinely provides a much higher number of treatments for knee injuries than other physiotherapists may need assistance with their diagnostic or treatment skills. But it may also be the case (as the Review heard from one physiotherapist) that they are receiving a large number of referrals for post-surgery physiotherapy treatment in complex cases, precisely because they are recognised as especially experienced and skilful in this area. ACC should not assume that an outlier is likely to be incompetent or in need of further training: those responsible for the monitoring or investigation process should keep an open mind, until further clarification has been sought.

7.70 It is even more important that those responsible for monitoring and investigation work should not assume that outlier analysis suggests dishonesty, in and of itself. Plainly it does not.

7.71 The second point is that ACC and its employees need to bear in mind at all times the significance and seriousness of an allegation of fraud. Fraud involves actual dishonesty, as the ACC Treatment Provider Handbook clearly explains.[68] This appears to have been lost sight of at times by relevant ACC employees and contractors.

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[68] ACC Treatment Provider Handbook 2004/05, p 108.

7.72 ACC representatives at the hearings referred to ACC's "zero tolerance for fraud" approach. Such an approach is entirely appropriate: fraud should not be tolerated on the part of providers or anyone else involved in the ACC scheme. But ACC needs to be satisfied that fraud has been identified, before adopting a "zero tolerance" approach to the person in question. There has in the past been an over-readiness to infer fraud from poor record-keeping, or inconsistencies in recollection between claimants and providers, or inconsistencies between information held by providers and information held by ACC. The small sample of cases discussed in the course of the Review illustrated the potential for issues of this kind to arise from limited administrative capacity in small businesses, pressure of work, poor recollection on the part of claimants, and errors in the data held by ACC. Until explanations of discrepancies have been sought and considered, ACC should keep an open mind as to whether there has been fraud; should not allege this to the provider; and should not allege or imply suspicion of fraud on the part of the provider in any dealings with third parties.

7.73 Perhaps the most striking example before the Review of an over-readiness to allege fraud was the claim in ACC's primary submission to the Review itself that Operation Quest III found the level of fraud on the part of physiotherapists and chiropractors was 8.14%. That extraordinary claim was corrected by ACC in its second submission. But the fact that this claim was made in a formal submission, and was not questioned by anyone within ACC at the time it was made, appears indicative of a tendency to blur what should be a very sharp distinction between on the one hand, inconsistencies in information that are capable of multiple explanations, and require further investigation; and on the other hand, findings of fraud.

7.74 A third, related, point is that those responsible for conducting investigations do not always appear to have the clinical knowledge or clinical input required in order to ask appropriate questions, evaluate the information provided, and make decisions on whether to take the investigation further, or on how best to do so. I recommend that there be appropriate clinical input into investigations before any action is taken that reflects on a provider's professional competence or honesty, including advising a provider of concerns about his or her competence or honesty. There should also be appropriate clinical input into any recommendation of remedial action in respect of issues identified (other than purely administrative or financial matters).

7.75 A fourth point is that there appears to be a tendency within the ACC Risk, Assurance and Fraud group to measure success in terms of the number of cases of fraud identified and prosecuted, or where some other form of enforcement action is taken. This tendency is reflected in the contract provisions referred to in paragraph 7.56 above. This orientation seems likely to have contributed to the over-readiness to suspect fraud mentioned above, and to an unnecessarily adversarial approach to some investigations. It is inappropriate for a number of reasons:

7.75.1 from a broader ACC perspective, the optimal outcome is that there is little or no fraud occurring, rather than that there is a substantial amount of fraud which is being detected. The overall focus should be on putting in place systems and relationships which reduce the likelihood of fraud, recognising that this will mean that most audits and investigations do not in fact detect fraud or other dishonesty, or result in enforcement action;

7.75.2 an approach to investigations which assumes that fraud is widespread among provider groups, and that providers cannot be trusted, is much more likely to be coloured by the hostile or adversarial overtones of which a number of physiotherapists complained. This is extremely destructive in terms of the broader relationship between ACC and the particular physiotherapist concerned, and in terms of ACC's relationship with the physiotherapy profession as a whole.

7.76 Fifth, ACC needs to emphasise to relevant staff the importance of courtesy and patience in their dealings with providers. In the light of the power imbalance perceived by physiotherapists in this context, and the inherently unfamiliar and stressful nature of even a routine or random audit, ACC representatives need to accept primary responsibility for clear and effective communication with affected providers, and with claimants who are contacted in this context. This is essential even if – perhaps, especially if – that clarity, courtesy and patience is not reciprocated.

Practical steps to address these concerns

7.77 There were some encouraging signs of positive steps being taken by ACC to address these concerns, and learn from the experiences of the past. One important step is the commissioning by ACC's chief executive of an internal review into ACC's Fraud Unit by Martin, Jenkins & Associates Ltd. That review identified a number of concerns with respect to ACC's fraud investigation processes, and made recommendations directed to addressing those concerns, and increasing the alignment between the Fraud Unit and ACC's broader culture and objectives. ACC has not yet announced its response to that review: it is scheduled to do so in the near future. The findings of that review in relation to ACC's Fraud Unit, and the need for greater alignment of that unit to ACC's broader culture and objectives, are consistent with the evidence before this Review.

7.78 In addition to the steps that have already been taken in this area, the evidence before this Review confirms that further work is needed to:

7.78.1 align the approach of the Risk, Assurance and Fraud group with the broader culture and objectives of ACC, including shifting the group's focus away from detection of fraud to avoidance of fraud and other inappropriate practices, and support for ACC's partnership with providers to deliver high quality services to claimants;

7.78.2 ensure appropriate clinical input into investigations, in particular before reaching any views on the competence or honesty of providers, or making any communications suggesting concerns about competence or honesty, or proposing remedial action in connection with clinical or ethical matters;

7.78.3 provide clear guidance on the (very limited and preliminary) significance of outlier analysis and other data mining techniques for the purpose of identifying competence and fraud concerns;

7.78.4 provide clear guidance on what constitutes fraud, and training on the care needed before asserting or alleging fraud;

7.78.5 ensure ACC representatives have a balanced approach and an open mind in approaching fraud investigations, which gives full recognition to the likelihood of other explanations for discrepancies and errors;

7.78.6 ensure ACC representatives understand and accept that they have primary responsibility for clear and effective communication with affected providers and with claimants, and for approaching the investigation with courtesy and patience, even if that clarity, courtesy and patience is not always reciprocated.

7.79 There is some overlap between the recommendations of the internal review of ACC's fraud unit, and these recommendations. The internal review also addresses a number of organisational structure and reporting issues on which those responsible for that review are best placed to comment: my silence on those issues should not be understood as disagreement. Rather, it reflects the differences in the two reviews' terms of reference, and in the respective reviewers' primary focus and expertise.

Complaint/appeal processes

7.80 Some physiotherapists expressed concern that ACC's complaints process for providers unhappy with the manner in which an audit or investigation was being conducted, or with other ACC decisions, was unclear. Some also suggested it is ineffective, and that an external independent complaints process is needed.

7.81 The mutual interdependence of ACC and physiotherapists means that it is important to have effective internal complaints resolution processes for providers, with a strong orientation towards restoring a high quality working relationship for the future.

7.82 ACC provides brief information about its complaint process for providers in the ACC Audit Protocol (2005). There is nothing on complaints by providers in the Treatment Provider Handbook 2007. If there is relevant information on the ACC website, it is not readily accessible by a simple search.

7.83 ACC advised the Review that ACC's Office of the Complaints Investigator (OCI) receives only a small number of complaints from providers. However, the OCI

follows the same complaints process as it would for a claimant. The only difference being that provider complaints fall outside the Code of ACC Claimants' Rights.

7.84 In the first instance, all complaints by providers are dealt with by ACC's Customer Support Service (CSS). The emphasis at this stage of the process is on quickly restoring a high quality working relationship. ACC advised the Review that this recently implemented approach, called Service Recovery, places responsibility for the recovery of the relationship on the business unit that primarily manages the most direct contact with that particular complainant. In this case, the CSS would work with the provider to identify the issue(s) quickly, refer it to the relevant business unit, and facilitate a resolution. The timeframe for this is four working days.

7.85 Alternatively, a provider may raise a complaint with their Relationship Manager (formerly known as a Provider Relationship Manager). Relationship managers work in the community with providers and may be able to resolve the complaint at an early stage, as well as enhance ACC's relationship with the provider.

7.86 However, where Service Recovery or a Relationship Manager does not produce an acceptable resolution, or the provider chooses not to pursue either of these routes, the complaint is escalated to the OCI for a formal investigation.

7.87 ACC advised the Review that:

> "[a]fter gathering all relevant information, a robust, impartial investigation is undertaken and a decision is issued. When the complaint is valid, recommendations are made to ACC as to how the situation may be remedied.
>
> As with Service Recovery, significant emphasis is placed on repairing the relationship with the provider. To this end, the recommendations consider the outcome the provider was seeking when they first submitted their complaint. For example, an apology may be issued where appropriate. In addition, follow-up contact is made with the provider to ensure they are satisfied with the outcome of the investigation and to verify that ACC has implemented any recommendations. If a systemic error is identified, action is taken to ensure that a similar issue does not occur again. The provider is advised of this and further follow-up contact may be initiated to inform the provider of any changes resulting from their complaint.
>
> Should a provider be unhappy with the decision issued by the OCI, they are able to raise their concerns with the Chief Complaints Investigator. The Chief Complaints Investigator can then review the investigation and issue a further finding as required.
>
> If the provider is still dissatisfied, they are able to approach the Office of the Ombudsman."

7.88 I recommend that ACC provide clear, accessible information about its current complaints process for providers (including relevant contact details, and a brief outline of the process) in the next edition of its Treatment Provider Handbook, in the next version of the audit protocol, and on its website. ACC has advised the Review that it accepts this recommendation, and will initially make this information available to providers on its website.

7.89 ACC's internal complaints process is used for both claimant and provider complaints. The guidance available on the process for use both internally and externally has a strong claimant focus. There is no reason why a single complaint process cannot in principle be flexible enough to accommodate both types of complaint. But ACC may wish to consider whether more focused guidance for provider complainants, and those who administer the process, would advance the partnership goals supported by all parties.

7.90 In particular, the information provided by ACC in relation to the internal complaints process does not clearly reflect the level of interdependence that exists between ACC and providers, or a focus on restoring a high quality working relationship for the future. This should be the touchstone for design of the internal provider complaints regime. The need to ensure that orientation is one reason for ACC to give serious consideration to a regime more specifically tailored to providers.

7.91 There was some evidence of a lack of distance between the ACC complaints team, and the ACC staff whose conduct is the subject of the complaint. Under current arrangements, internal ACC complaints reviewers will inevitably struggle to be, or be seen as, wholly independent and neutral. But that is not necessary for an internal complaints process, which is designed to facilitate the effective internal resolution of complaints, not to adjudicate on them impartially.

7.92 For complaints which cannot be resolved amicably through internal complaints processes, physiotherapists have access to the Ombudsmen under the Ombudsmen Act 1975. There was no evidence of this process being invoked to address complaints about ACC processes, perhaps because most physiotherapists are not aware of it. Improved awareness of the ability to access this wholly independent external process should in principle resolve concerns about adequate avenues for complaints. I recommend that ACC's complaints information for providers include information about the matters that can be the subject of complaint to the Ombudsmen.

Provision of clinical notes to ACC

7.93 Many of the difficulties encountered in dealings between ACC and physiotherapists in connection with audits and investigations relate to the question of disclosure by physiotherapists of clinical information in relation to their patients, and in particular the provision of copies of clinical notes.

7.94 It will often be necessary and appropriate for ACC to review clinical notes in relation to services provided by a treatment provider, and funded by ACC. Without access to clinical notes, ACC would not be able to perform its statutory responsibilities effectively.

7.95 The IPRC Act expressly contemplates the provision of clinical information to ACC for certain purposes. Section 55 provides:

> **55 Responsibilities of claimant to assist in establishment of cover and entitlements**
>
> (1) A person who lodges a claim under section 48 must, when reasonably required to do so by the Corporation,—
>
> (a) give the Corporation a certificate by a registered health professional that deals with the matters, and contains the information, that the Corporation requires:
>
> (b) give the Corporation any other relevant information that the Corporation requires:
>
> (c) authorise the Corporation to obtain medical and other records that are or may be relevant to the claim:
>
> (d) undergo a medical assessment by a registered health professional specified by the Corporation, at the Corporation's expense:
>
> (e) undergo any other assessment at the Corporation's expense.
>
> (2) Whenever reasonably requested to do so by the Corporation, a person who lodges a claim under section 48 must give the Corporation a statement in writing about any specified matters relating to the person's eligibility, or continuing eligibility, for cover or an entitlement.
>
> (3) If the Corporation requires the person to do so, the person must make the statement referred to in subsection (2) as a statutory declaration or in a form supplied by the Corporation.

7.96 Where a claimant receives an entitlement, section 72 applies:

> **72 Responsibilities of claimant who receives entitlement**
>
> (1) A claimant who receives any entitlement must, when reasonably required to do so by the Corporation,—
>
> (a) give the Corporation a certificate by a registered health professional or treatment provider that deals with the matters and contains the information that the Corporation requires:
>
> (b) give the Corporation any other relevant information that the Corporation requires:

(c) authorise the Corporation to obtain medical and other records that are or may be relevant to the claim:

(d) undergo assessment by a registered health professional specified by the Corporation, at the Corporation's expense:

(e) undergo assessment, at the Corporation's expense:

(f) co-operate with the Corporation in the development and implementation of an individual rehabilitation plan:

(g) undergo assessment of present and likely capabilities for the purposes of rehabilitation, at the Corporation's expense:

(h) participate in rehabilitation.

(2) Every such claimant must give the Corporation a statement in writing about any matters relating to the claimant's entitlement, or continuing entitlement, to an entitlement that the Corporation specifies, and must do so whenever the Corporation requires such a statement.

(3) If the Corporation requires the claimant to do so, the claimant must make the statement referred to in subsection (2) as a statutory declaration or in a form supplied by the Corporation.

7.97 In addition, clause 5 of schedule 1 of the IPRC Act provides for ACC to decline to pay the cost of a claimant's treatment unless the claimant supplies specified information to ACC in relation to the claimant's personal injury and treatment.

7.98 These provisions are broad enough to permit ACC to seek clinical notes and other clinical information in relation to a claimant after the relevant treatment has been provided, for the purpose of ascertaining whether entitlement to receive that treatment existed under the Act. That process necessarily extends to the question of whether the treatment was necessary and appropriate, was of the quality required, and was performed only on the number of occasions necessary for that purpose.

7.99 These provisions, and in particular section 72, are also broad enough to permit ACC to obtain medical and other records from a physiotherapist for the purpose of ascertaining whether an entitlement to receive treatment existed under the Act, provided that the obtaining of this information has been authorised by the claimant. The Act does not confer any authority direct on ACC to obtain such information from a treatment provider. It is very clear that the provision of information must be authorised by the claimant; however under the Act, a claimant who receives an entitlement has a statutory obligation to provide that authorisation.

7.100 Some submitters sought to draw a distinction, in this context, between clinical notes and clinical records. These are one and the same thing: there is no relevant difference. ACC can reasonably request a provider's original notes or records of a

consultation (subject to consent from the claimant, which as noted above the claimant has an obligation to provide). ACC is not required to limit its request to clinical reports which summarise the findings from consultations, and set out clinical opinions based on those consultations.

Consent to release of information in ACC45 forms

7.101 In order to receive an ACC entitlement, a claimant must lodge a claim with ACC for cover, and for the relevant entitlement. A treatment provider can lodge a claim on behalf of a claimant, and this is the standard practice. The first step in making a claim is completion of the ACC45 form. The printed version of the form includes parts to be completed by the patient and parts to be completed by the treatment provider. On the front of the form the patient is required to sign to confirm that they have "read and understood the important information; patient declaration and consent on the reverse of that the patient copy of this form." The text of the patient declaration and consent is set out in full in Appendix H.

7.102 The form also includes a treatment provider declaration which reads: "I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident. I also certify that the patient (or their representative) has signed the patient declaration and has authorised me to lodge the claim on their behalf."

7.103 Where the patient has signed the patient declaration and consent in the ACC45 form, the authorisation to collect and disclose information for the purpose of assessing entitlement under the IPRC Act is in principle sufficient to authorise ACC to collect, and the treatment provider to provide, information relevant to entitlement to treatment under the Act, including clinical notes in relation to that treatment. However it seems likely that in practice many patients do not read the information printed on the back of the form. There is nothing in the text on the front of the form which alerts patients to the fact that by signing this form, they are consenting to the disclosure of confidential medical information, including clinical notes. In the interests of claimants and the protection of their privacy rights, it is highly desirable that the ACC45 form make clear on its face that by signing the form, the patient consents to the disclosure of information by the treatment provider to ACC. For this purpose, it would be sufficient to add to the existing wording something along the lines of: " and I authorise my treatment provider to provide information to ACC in accordance with that patient declaration and consent."

7.104 Concerns were raised by some physiotherapists that fresh consent should be sought from patients where clinical notes are requested from a treatment provider some time after the event, rather than ACC relying on the consent in the ACC45 form. However if the original consent is effective, then it is not necessary for ACC to seek a further consent. I note, moreover, that the claimant would have a legal obligation to provide that consent under section 72 of the IPRC Act. In circumstances where a general

consent has already been provided, and the claimant would be obliged to provide a specific consent (unless, perhaps, the claimant could decline to do so on the grounds that a sufficient consent had already been provided in the ACC45 form) it does not seem necessary or sensible for ACC to adopt a practice of seeking specific consent in every case.

7.105 The position becomes more complicated, however, where the ACC45 form is lodged electronically. ACC advised the Review that it receives a significant proportion, currently in excess of 80%, of its 1.8 million per annum initial registrations through electronic media. The ACC Treatment Provider Handbook explains that in these circumstances, the treatment provider does not need to send a paper copy of the ACC45 form to ACC. "However, you should keep a signed copy in paper or image form that shows your patient authorised you to lodge the claim on their behalf."[69]

7.106 If the treatment provider has printed off a copy of the completed ACC45, and the patient declaration has been signed by the patient, there will be an effective consent to collection of information by ACC provided that the information which appears on the back of the hard copy pre-printed form has also been given to the patient. The consent to release of information would not however be effective if the patient did not receive a "patient copy of this form" which included the relevant authorisation.

7.107 There would also be an absence of effective consent to collection of information by ACC in circumstances where the ACC45 is filled out electronically, and the patient is never asked to sign a hardcopy version which includes the relevant consent.

7.108 ACC provided the Review with a copy of an ACC 46 form, described as an "ACC Electronic Input Injury Claim Form". The ACC 46 form includes the same declaration and consent as the ACC45 form. The consent in this form is also adequate to authorise ACC to collect, and the treatment provider to provide, information relevant to entitlement to treatment under the Act, subject to the same concern identified above in relation to the adequacy of the reference on the front of the form to the consent printed on its back. However my understanding is that the use of this form is not mandatory, and that it is not in fact used by all providers lodging claims electronically.

7.109 ACC pointed out in its submissions to the Review that the treatment provider has the responsibility under the Health Information Privacy Code 1994 to ensure that the sending of health information to ACC occurs with the patient's authorisation. However there is a significant distinction between authorisation to send ACC the information included in the ACC45 form, and a continuing authorisation to ACC to

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[69] ACC Treatment Provider Handbook (2007) p 138.

collect, and to the treatment provider to provide, information relating to treatment that is funded by ACC.

7.110 In response to follow-up questions, ACC advised that as a matter of course it seeks a further authorisation from a claimant at approximately 7 weeks after the date of the claim for cases that are being managed at a branch. This is stored on the ACC claim file. ACC also noted that there are a large number of other forms that may be submitted to ACC in hard copy following an electronic ACC45 lodgement. These forms also ask for the claimant's signature and have authorisation statements. These forms include the ACC32 (Prior Approval of Treatment), the ACC 18 (Medical Certificate), the ACC 250 (Transport to Treatment) and ACC 249 (Pharmacy Reimbursement). However no information was able to be provided on the proportion of claims in respect of which a subsequent written authorisation is obtained.

7.111 On the basis of the information currently available to the Review, it appears that there may be a significant number of cases where a claimant has not expressly authorised the provision of confidential information to ACC by treatment providers. It is reasonable for treatment providers to insist that there is clear evidence of such an authorisation, before providing information. This is recognised in ACC's Treatment Provider Handbook, which provides in the section dealing with privacy and consent issues (p 110) that a treatment provider can ask for a copy of the signed consent form before releasing any information. If the treatment provider in question holds a signed copy of an ACC45 form on the file, such a request would not be reasonable. But where they do not hold a signed consent, for example because they did not provide the initial treatment in respect of the injury, they can and should ask for a copy of the applicable consent, either in a signed ACC45 form or in some other form. It seems likely that in a significant number of cases ACC does not in fact hold such a consent, and does not know whether such a consent exists.

7.112 In summary, the processes adopted by ACC for electronic lodgement of ACC45 forms do not appear adequate to ensure that in every case the patient will have provided an effective consent to disclosure of information to ACC. This is unsatisfactory from the perspective of the claimant, whose consent has not been properly sought; the treatment provider, whose legal and ethical obligations in relation to provision of information requested by ACC are not as clear as they could reasonably expect; and ACC, whose ability to obtain information required to perform its functions is less clear than it should be.

7.113 This concern could be addressed by ensuring that in every case a patient receives, completes and signs a pre-printed ACC45 form that includes a clear and express authorisation to disclose information. That form would be retained by the treatment provider, and provided to ACC upon request. In submitting an electronic ACC45, the treatment provider would be required to certify that this pre-printed form has been completed.

7.114 ACC staff and contractors carrying out monitoring, audit and investigation activities do not in all cases appear sufficiently alive to the importance of ensuring that the treatment provider has express authority to release clinical notes. Concerns are on occasion brushed off by reference to the consent in the ACC45 form. But on the basis of the information received by the Review, it is not unreasonable for physiotherapists to be concerned that such consent may not in fact have been given in every case, and to ask to see it. Requests by physiotherapists for specific consents over and above a properly completed hard copy ACC45 are, for the reasons explained above, misconceived. ACC can properly respond with an explanation that the ACC45 form is sufficient. Confirmation that such a form (or an equivalent consent) does in fact exist, and has been signed by the patient, is however essential.

7.115 Finally, there is room for ACC to allay the concerns of some physiotherapists by providing clearer guidance about what is and is not required to be provided to ACC in response to requests for clinical notes. In particular, as ACC representatives at the Review confirmed, any requirement to provide clinical notes to ACC is limited to notes relating to the treatment in respect of which ACC funding was sought and obtained. There is no requirement to provide earlier clinical notes relating to other matters. There is no requirement to provide subsequent clinical notes relating to other matters. (Information about non-injury conditions and/or treatment may be required in some cases, if it affects the injury (eg an injury to a knee, where there is a degenerative condition of that knee.) The test is relevance to the ACC claim, and eligibility for cover or an entitlement.)

7.116 Where, in the course of an ACC-funded consultation a patient provides confidential information to a physiotherapist that is not relevant to the patient's ACC claim, for example in relation to personal problems, ACC has confirmed to the Review that it has no objection to such material being redacted. The deletion or covering up of irrelevant material is an appropriate procedure for providers to adopt, to avoid unauthorised and inappropriate disclosure of confidential information.

Suggested targeting of some physiotherapists for investigation

7.117 Finally, some submitters expressed concern that ACC used its audit and investigation processes to punish members of the profession seen by ACC as "difficult", or "dissenters". In particular, it was suggested by APPPA that many of its executive members had been selected for audit or investigation, and that it was implausible that this could be random.

7.118 These concerns were followed up with ACC, and information sought on the process by which these individuals had been selected for investigation. That information indicated that these providers had been affected by a number of different processes, including monitoring, audit and investigation. These processes had different triggers: random selection (from Regulation providers) for Quest III analysis; programmed audits of ABP contract holders; and the Regulation-funded providers outlier analysis.

7.119 There is nothing in the evidence provided to the Review that would suggest that the selection processes were inappropriately targeted at particular individuals or professional groups.

7.120 However the disproportionate appearance in these processes of senior physiotherapists providing services under the Regulations does raise three issues which ACC should bear in mind for the future:

7.120.1 whatever the position may have been in the early days of the EPN regime, when data were limited, at present there can be no justification for focussing on Regulation providers rather than EPN providers in the context of these processes;

7.120.2 senior experienced practitioners who treat a disproportionate number of complex cases are likely to be identified as outliers on some dimensions. So too will be senior practitioners who have not kept up to date with best practice. Outlier analysis cannot tell ACC whether one or other of these factors (or some other factor entirely) is driving the outlier status of a particular practice. Careful, open-minded, courteous and transparent inquiries are necessary to seek to ascertain what the causes of any unusual pattern in a practice's data may be;

7.120.3 there was some evidence of similar concerns being raised more than once with the same provider, after having been resolved in an earlier period. This is not an efficient use of the time and resources of the provider, or ACC, and can appear at best disorganised, and at worst heavy-handed and oppressive. ACC should ensure that the information it obtains about the practices it audits or investigates, and any explanations for a practice's outlier status, are recorded and taken into account in future reviews.

7.121 ACC assured the Review that it was not using audits and investigations to put pressure on Regulation providers to switch to the EPN programme, an option contemplated by the NZIER report. It would be entirely inappropriate for ACC to do so.

7.122 In response to the view expressed in the draft report that there appeared to have been a working assumption that there was less scope for concern about inappropriate service provision or fraud on the part of EPN providers, ACC advised the Review that this was not in fact the case. I accept that that is not now the case, and that it may not have been the case in 2005/6. However the approach adopted by ACC to Quest III, and to outlier analysis in 2005/6, provided a plausible basis for the concerns expressed by submitters, which could have been avoided by a more balanced and even-handed approach as between different groups of providers. It is important that ACC make decisions on which groups to audit or investigate that make sense in terms of the

concerns addressed by the audit and investigation process, and that these decisions be capable of explanation to those affected.

8 PHYSIOTHERAPY PROFESSION GENERALLY

Senior practitioners

8.1 Senior and experienced practitioners play a critical role in every profession, dealing with the most complex and difficult cases, and providing guidance, training and mentoring to less experienced members of the profession.

8.2 There is also increasing recognition in modern professions of the need for continuing education and training, and the importance of lifelong learning, in order to provide high-quality services to clients.

8.3 Concerns were expressed by a number of parties to the Review about the demographic profile of the physiotherapy profession in New Zealand, and what is seen as a small and shrinking pool of senior practitioners. The most recent demographic information available in relation to the physiotherapy profession in New Zealand, the UK, and some Australian and Canadian jurisdictions is set out in the table below.

Jurisdiction/Data source	Proportion of Physiotherapists by Age Group				
	Under 25	25 – 34	35 – 44	45 – 54	55 and over
New Zealand NZSP data 2007	9%	32%	25%	23%	10%
Chartered Society of Physiotherapists membership data - UK	7%	35%	27%	20%	11%
NSW Government physiotherapy workforce report 2003	6%	30%	30%	23%	11%
Queensland Physiotherapy Board of Queensland 2007	6%	36%	26%	22%	10%
Manitoba Canada 2007	5%	29%	26%	27%	14%
Canadian Alliance of Physiotherapy Regulators 2005	2%	31%	30%	23%	12%
College of Physiotherapists Ontario 2006	.4%	32%	31%	22%	15%

8.4 This table does not suggest that the proportion of senior practitioners in New Zealand has been significantly reduced by any factors peculiar to the New Zealand environment, and in particular does not suggest that current ACC funding of physiotherapy services has had any measurable impact on the demographic profile of the profession in New Zealand.

8.5 Although there was considerable anecdotal evidence of senior members leaving the profession, and submissions from some former physiotherapists identifying ACC-related issues as the reason for their having left the profession, there was no evidence to suggest that New Zealand was materially out of step with comparable jurisdictions in retaining senior members in the profession.

8.6 This conclusion should not however obscure the importance of retaining and motivating senior, experienced members of the profession to continue to provide specialist input, guidance, training and mentoring in the long-term interests of ACC claimants and all physiotherapy patients. A number of the other recommendations made in this Review should contribute to that goal, by improving the viability of physiotherapy practices from a business perspective, and enhancing the quality of the relationship between ACC and physiotherapy service providers. This should ensure that both tangible and intangible rewards from practice are enhanced, especially for high quality senior practitioners.

Recognition of postgraduate qualifications and expertise

8.7 There is no explicit recognition in current ACC payment mechanisms for postgraduate qualifications or training, or for experience as such.

8.8 Natural progression through the profession, and the importance of reputation in establishing and maintaining a successful private practice, can be expected to provide a significant degree of indirect reward for recognised expertise and experience.

8.9 A senior practitioner who heads a clinic employing a number of physiotherapists, receiving the same per treatment rate regardless of which physiotherapist provides the treatment, will in practice be remunerated for their professional and business leadership at least in part through the difference between the employee remuneration rate implicit in the ACC payment, and the salary cost of more junior employees. The same cannot however be said of senior practitioners in sole practice, or in practice with one or two other senior practitioners, whose focus is on treating particularly serious and complex cases.

8.10 ACC has indicated that there is no evidence available to it which suggests that practitioners with postgraduate qualifications or training provide higher quality services, or achieve better outcomes. As discussed above, however, the same can be said of certified practices. In the context of certification, ACC has been willing to proceed on the basis of qualitative analysis which suggests that improved business practices and procedures are likely to lead, other things being equal, to greater patient satisfaction and improved quality of treatment. It seems equally plausible that substantial postgraduate training and experience is likely, other things being equal, to result in greater patient satisfaction and improved quality of treatment.

8.11 One party to the Review drew to my attention a letter from the Minister of Health dated 26 September 2001 which read: "I understand that ACC have also recently undertaken a comparison study of physiotherapists with postgraduate qualifications and those without. No statistical difference was observed between the two groups. A copy of this report is available from ACC." However my inquiries did not lead to any such study being located by ACC. And of course there is an important difference between inability to confirm a hypothesis, and confirmation that it is incorrect. Even if such a study did exist, which seems unlikely based on my inquiries, it would do no more than leave the question open.

8.12 In other areas, such as teaching, the value and importance of postgraduate qualifications and experience is recognised in remuneration rates. I recommend that ACC carry out further work on this issue, and in particular that ACC give serious consideration to alternative "entry criteria" for the EPN programme, recognising that a certain level of postgraduate qualifications and experience may justify the same level of expectation of improved patient satisfaction and quality of treatment as certification by reference to NZS 8171:2005.

8.13 There also appears to me to be scope for ACC to draw on the experience and expertise of senior practitioners to improve the quality and timeliness of delivery of services to claimants, by identifying a group of "advanced practitioners" who are authorised to approve, in the exercise of their own professional judgment, provision of further services over and above the level that would otherwise require ACC approval. I understand that an "advanced practitioner" designation is currently being developed by the profession, and that ACC intends to work with the profession to look at ways in which this concept may be relevant to the provision of ACC-funded services. This is a concept which has the potential to provide significant advantages to claimants, to reduce administrative costs for ACC, and to encourage the retention and motivation of senior highly qualified members of the profession. I recommend that ACC work closely with the profession to explore how best to achieve the potential benefits for ACC claimants from this initiative.

Diversity in physiotherapy profession

8.14 Concerns were raised by one party to the Review about ethnic diversity on the profession, and in particular the small proportion of Maori and Pacific Island physiotherapists. It was submitted that this impairs the accessibility of rehabilitation services to all ethnic groups in New Zealand, and ACC's ability to achieve the policy goals of the IPRC Act.

8.15 This issue is not squarely within the terms of reference of this Review, and has not been addressed in detail in submissions. Another forum would be needed to examine the issue in more detail. The physiotherapy profession and ACC may wish to consider undertaking a joint study of the ethnic diversity of the profession, and any

9 OTHER ISSUES RAISED IN THE REVIEW

Partnership and communication

Need for enhanced partnership and communication

9.1 An overarching theme in this Review has been the need for a partnership between ACC and the physiotherapy profession, if ACC is to succeed in delivering the statutory goal of rehabilitating injured people to the maximum practicable extent. Partnership requires mutual respect and trust; and open, clear, and effective communication.

9.2 ACC expressed its willingness to work in partnership with the profession, and the language of partnership appears in places in the 2007 edition of the ACC Treatment Provider Handbook.

9.3 ACC is well aware of the need for good communication with treatment providers, and there are encouraging signs of improvements in communication. The NZSP submissions referred to a growing satisfaction with the culture of ACC, including the quality of communications between ACC and the profession, and recorded the existence of a good relationship between physiotherapists and ACC in the context of specialised contracts such as the hand therapy contract.[70]

9.4 But more needs to be done to enhance mutual respect and trust; and to maintain a genuine, timely and constructive two-way dialogue at all levels:

9.4.1 on matters of policy and contract arrangements, between ACC and representative professional bodies;

9.4.2 between ACC and individual treatment providers, in connection with the management of particular claimants;

9.4.3 between ACC and treatment providers identified for audit or review.

9.5 Many of the concerns identified by physiotherapists were the product of poor communication, either at a general level in relation to ACC processes (such as the process for provider complaints), or at a specific level in terms of decisions concerning particular claimants, or concerning treatment provider audits and reviews.

9.6 Some of the concerns identified reflected an erosion of trust over the last decade or so as a result of an attitude to the profession on the part of some ACC executives that was at times dismissive, or even confrontational. Examples were given to the Review

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[70] NZSP submission paras 318, 332.

of discourteous and offhand treatment of representatives of the profession in formal and informal meetings, which while arguably minor in themselves were plainly indicative of a very poor working relationship. Examples were also given of public presentations by ACC executives using language such as being "ruthless with bad providers", and "hounding" fraudulent providers. ACC confirmed to the Review that it considers that this type of language is inappropriate and should not be used by any ACC staff member, and that it does not fit with the current ACC vision and is not consistent with engendering a partnership with any provider group. I agree.

9.7 This history explains the emphasis that the profession places on ACC not only expressing a commitment to partnership, but also following through on that commitment with action consistent with a partnership model. ACC needs to regain the trust of the profession: this is a two-way street, but the primary responsibility lies with ACC.

9.8 The responsibility for good communication to support a partnership approach lies with both parties. In some cases, individual physiotherapists have failed to communicate as clearly or openly as desirable with ACC. But the evidence before the Review suggests that ACC could do a great deal to improve the quality of its communication with the physiotherapy profession, and with individual physiotherapists. Progress is already being made in this direction: it is important that it continue.

9.9 Progress towards an effective partnership would be assisted by an explicit framework for cooperation between ACC and the physiotherapy profession, which recognises the distinct roles each plays in rehabilitation, and their mutual interdependence in achieving the common goal of delivery of high-quality rehabilitation services to ACC claimants. The NZSP suggested that adoption of "ACC provider principles" which reflect this partnership, and spell out its key implications, could assist with this process. I agree.

9.10 I recommend that ACC, in consultation with the physiotherapy profession:

9.10.1 expressly adopt a "partnership" approach to delivery of high quality rehabilitation services to claimants, in accordance with the Act;

9.10.2 expressly recognise the importance of each other's roles, and the mutual interdependence that exists between ACC and the physiotherapy profession;

9.10.3 adopt a set of ACC Provider Principles that reflect this partnership, and spell out its central implications;

9.10.4 continue to work on the quality of communication with the profession as a whole, and with individual physiotherapists in relation to specific matters.

Physiotherapy Liaison Group

9.11 The Physiotherapy Liaison Group ("PLG") established by ACC has the potential to play a significant role in giving effect to a partnership approach between the profession and ACC, and enhancing communication. ACC's ability to work effectively with the PLG is likely to be seen by the profession as an important litmus test for its commitment to a genuine partnership approach.

9.12 At the second round of hearings, a number of concerns were expressed by submitters about recent failures to consult effectively with the profession through the PLG, for example in relation to ACC's "P-Gap" initiative. The misunderstandings that arose between ACC and the NZSP in relation to ACC's suggestion of further data gathering to assist the Review might also have been avoided if these issues had first been discussed at a PLG meeting.

9.13 The concerns expressed by submitters about the effectiveness of the PLG as it currently operates led me to raise, at the second round of hearings, the possibility of an independent chair for the PLG. This suggestion was supported by physiotherapy profession representatives and by ACC. The appointment of an independent chair is likely to assist in the rebuilding of trust and effective communication, and to enhance the effectiveness of the PLG. I recommend that the independent chair prepare a regular report for the participants in the PLG, at least annually and initially perhaps six-monthly, commenting on the effectiveness of the PLG as a forum for communication and for implementation of the partnership approach outlined above.

ABP referrals

9.14 One specific concern about communication between ACC and physiotherapists that was raised in the course of the Review, which it seems particularly desirable to address, related to the process by which case managers refer some claimants to specific forms of treatment in place of standard physiotherapy treatment. A number of physiotherapists gave examples of patients who had made appointments with them but did not keep those appointments, and on being contacted by the physiotherapist, advised that they had been referred to an Activity Based Programme ("ABP") with another physiotherapy clinic. The claimants were told by ACC that ACC would fund the ABP but would not continue to fund standard physiotherapy treatment at the original clinic, and in some cases that attendance at the ABP was required in order to ensure continued receipt of other entitlements such as weekly compensation.

9.15 At my request, ACC provided further information about the guidelines given to case managers in relation to referral of claimants to activity based programmes. The current guidelines on ACC's Intranet site spell out in some detail the circumstances in which an ABP may be appropriate, and the referral process. The guidance on the referral process provides: "Always involve the claimant's general practitioner (GP) in the decision to refer the claim for an activity-based programme. This ensures a good working relationship and a coordinated approach to the claimant's rehabilitation.

Once the claimant's GP has agreed to an activity based programme, prepare a purchase approval and referral for the provider …"

9.16 I strongly endorse the guidance given in relation to involvement of the claimant's GP in a decision to refer the claimant to an ABP. For precisely the same reasons — ensuring a good working relationship and a coordinated approach to the claimant's rehabilitation — a physiotherapist who is currently providing treatment to that claimant should be involved in the decision to refer the claimant to an ABP. In many cases, the current physiotherapist will be at least as well placed as the GP to assess the relative benefit from a rehabilitation perspective of continuing physiotherapy treatment, and an ABP. If ACC is committed to a partnership with physiotherapists to deliver high-quality rehabilitation services, ACC needs to engage with its partners to make high-quality decisions about rehabilitation services for claimants.

9.17 ACC recently released a consultation document in relation to the ABP which expressly refers to consultation with the existing treatment provider before an ABP referral occurs. ACC advised the Review that it intends to implement this proposal, and is drafting a referral framework that includes this step. ACC anticipates that this will be complete by November 2007, after consultation with the PLG. I strongly encourage ACC to implement this proposal, and to do so in a consultative manner which ensures that it is effective.

Ensuring treatment is provided on an appropriate number of occasions

9.18 Of all the issues canvassed in the course of the Review, the issue which received most attention from claimant representatives was the process by which ACC manages the number of treatments provided to a particular claimant. Considerable concern about this process was expressed by both claimant representatives and physiotherapist groups.

9.19 As explained in section 5 above, in the late 1990s ACC developed Physiotherapy Treatment Profiles in consultation with the NZSP. Those profiles specify a range of number of treatments considered by the physiotherapy profession to be the usual range for straightforward cases that present at an early stage. The figures represent a consensus of professional opinion, and are not evidence-based or founded on any quantitative analysis. The Treatment Profiles specify a trigger number of treatments for each diagnosis. Once the trigger number is reached, approval must be sought from ACC for provision of further treatment. If approval is not sought and obtained, ACC will not fund further treatment. In order to seek approval for further treatment, an ACC32 form must be completed by the physiotherapist.

9.20 Concerns raised by claimants and by physiotherapists in relation to this process included:

9.20.1 the appropriateness of using the Treatment Profiles in this way;

9.20.2 the time taken for ACC to decide applications for further treatment, and communicate a response to the physiotherapist and the claimant;

9.20.3 the qualifications of the ACC employees making decisions in respect of ACC32 applications, and in particular concern that these staff members do not have clinical qualifications;

9.20.4 the basis for the decisions made, and in particular the rationale for approving fewer treatments than sought, which it was suggested is a common outcome.

9.21 ACC advised the Review that it receives approximately 80,000 ACC32 forms each year from physiotherapists. Of these, approximately 96% are approved at least in part; only 4% are declined. Approval is for a specified number of treatments; it is not possible to receive indefinite approval. ACC provided the following data in respect of ACC32 decisions since April 2006 (when its current Medical Fees Payment system was fully implemented):

Outputs and Outcomes	Time Period		
	15 April 2006 1 July 2006	**1 July 2006 - 30 June 2007**	**1 July 2007- 25 August 2007**
Total ACC32 requests processed	20,378	101,091	17,723
YTD total treatment requested	170,334	787,936	140,938
YTD total treatment approved	164,168	757,100	136,495
YTD % of treatment approved	96%	96%	97%

9.22 No decision can be made to decline an application for further treatment without reference to a clinical adviser. ACC32 staff (who do not have clinical qualifications) do not have authority to decline applications. But they do make decisions on the number of treatments in respect of which approval should be given, based on guidance in ACC's internal materials on typical ranges of treatments for the relevant condition.

9.23 The target turnaround for approval decisions set by ACC since about 2001 is five working days. Data provided by ACC indicated that in 2005 and 2006, around 90% of ACC32 forms were dealt with within one week. Most of the remainder were dealt with within two weeks, with around 4% to 5% taking longer still. ACC advised that decisions can be delayed for a number of reasons, including insufficient information being provided to ACC by the provider, or requests being made for clinical notes or

other information to assist with the decision. The ACC data cannot distinguish between the causes of delays in deciding ACC32 applications.

9.24 In its primary submission, ACC observed that of the total yearly claims lodged by physiotherapists approximately 16% are outside the Treatment Profiles. ACC said: "it is a matter of concern that such a significant number of requests for prior approval received against a profession-developed treatment protocol."[71]

9.25 Further information was sought on why ACC considered this to be a matter of concern, given that the profiles are concerned with straightforward cases that present at an early stage, and are not based on any form of quantitative analysis. In particular, there did not appear to be any reliable basis for identifying the variability in reasonable treatment numbers for straightforward cases, or the proportion of cases that fell outside the "plain vanilla" category to which the Treatment Profiles are addressed. In response to this question, ACC was not able to provide any satisfactory explanation for why it should be a matter for concern that 16% of ACC32 applications fall outside the Treatment Profiles.

9.26 ACC advised the Review that "the Treatment Profiles will be updated and a close examination of these issues will be undertaken." At the second hearing, ACC also advised the Review that it will review the ACC32 process. These initiatives are strongly encouraged: they have the potential to deliver significant benefits for claimants, the physiotherapy profession and ACC.

Use of treatment profiles

9.27 As discussed above in the context of monitoring, ACC has a statutory responsibility to provide funding for rehabilitation treatment only where that treatment is necessary and appropriate, and performed on the number of occasions necessary for that purpose. ACC also has an obligation to administer the scheme in an efficient and cost-effective manner. ACC, like any funder of medical services, needs to have in place a mechanism for deciding how many treatments to fund that strikes a balance between on the one hand, ensuring that treatments provided are necessary, in the interests of the funders of the scheme and its long-term sustainability, and on the other hand, prompt provision of rehabilitation services to those in need without unnecessary delay, and more generally administrative efficiency and cost effectiveness.

9.28 It makes no sense for ACC to approve every individual treatment in advance: ACC would end up processing a vast number of applications, almost all of which would be approved, but in the process causing delay in the provision of rehabilitation services, and unnecessary and wasteful cost. Nor however is it appropriate for ACC to abdicate responsibility for ensuring compliance with the statutory requirement that

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[71] ACC Primary Submission, p 25.

treatments are performed only on the number of occasions necessary for rehabilitation purposes.

9.29 This inevitably means that ACC has to find some mechanism for considering whether treatment is necessary which will be applied in some but not all cases. This process can take place before treatment is provided (prior approval) or after treatment is provided (subsequent audit). Thresholds need to be identified for the cases in which prior approval will be required, bearing in mind the potential this has for delay and increased cost. Thresholds also need to be identified for audit after the event.

9.30 The high volumes of ACC32 applications received by ACC in respect of physiotherapy treatment, coupled with the very high rate of approval, raise real doubts about whether the threshold for prior approval has been set at an appropriate level. There appears to be a strong case for ACC to develop a more sophisticated approach to prior approval of treatment, in the interests of claimants, and in the broader interests of cost-effective operation of the scheme.

9.31 One option would be to replace the current trigger numbers in the Treatment Profiles with numbers derived from quantitative analysis, requiring prior approval only where the number of treatments exceeded (say) the 90th percentile figure for the diagnosis.

9.32 Whether or not a threshold is set for prior approval based on more rigorous quantitative analysis, another option is for additional responsibility for confirming that additional treatment is necessary to be assumed by the treating physiotherapist. The treating physiotherapist could be authorised to approve a further number of treatments, provided they give a certificate to ACC that in their professional opinion the further treatments are necessary.

9.33 The ACC32 form already requires the provider to sign a certificate that the treatment is for the personal injury for which the claimant has cover and is for the purpose of restoring the claimant's health to the maximum extent practicable, and is necessary and appropriate, and of the quality required, for that purpose. But it was apparent from the submissions to the Review that some treatment providers do not understand this certificate as an acceptance of responsibility on their part for certifying the need for further treatment. In some cases, at least, the ACC32 form is perceived more as a request to ACC than as a certificate that the treatment is necessary; and perhaps even as an advocacy document on behalf of the patient, rather than as an independent professional judgement for which the treatment provider is accountable. If physiotherapists are given greater authority to certify the need for additional treatment, clear communication will be needed in relation to ACC's expectations of providers in giving such a certificate.

9.34 ACC advised the Review that it is considering the potential for "advanced practitioners" (a designation currently being developed by the physiotherapy profession) to be authorised to approve additional treatments above the standard

threshold for prior approval by ACC. This is an eminently sensible suggestion which deserves immediate attention. It need not exclude the possibility of all physiotherapists being authorised to approve some level of additional treatment; there would still be scope for authorising approval by advanced practitioners of additional treatments, over and above the level that all physiotherapists can authorise.

9.35 Finally, ACC could consider reducing the number of cases in which it requires prior approval, but increasing the number of cases where it carries out an audit of the number of treatments provided after the event. This would be a logical consequence of placing more responsibility on physiotherapists, or advanced practitioners, to certify that additional treatments are necessary. ACC could select a random sample of cases in which such certificates are given, and subject those to a careful audit by an appropriately qualified clinical adviser. If treatments were found not to be necessary, a range of consequences could follow including requirements to undertake further training, withdrawal of the certification authority, and in cases where the opinion was not reasonable, repayment by the treatment provider of ACC contributions.[72]

Timeframe for processing ACC32 forms

9.36 There was no evidence before the Review to suggest that the timeframes for processing the vast majority of ACC32 forms were unjustifiably long, especially in light of the large number of such forms that ACC must handle each year. However there was a great deal of evidence, especially from claimants, concerning the adverse impact of delays in receiving ACC32 approvals. And even a small percentage of 80,000 forms per annum represents a significant number of individuals affected by delays: some 8,000 each year for whom approvals take over a week, and some 3,200 to 4,000 for whom approvals take more than two weeks. It is highly desirable, in the interests of claimants and the rehabilitation goals of the IPRC Act, that these timeframes be reduced.

9.37 A more sophisticated approach to approval of treatments on the part of ACC should reduce the number of claims which require prior approval, and reduce the number of applications requiring processing by ACC. This can in turn be expected to reduce the time required for processing the remaining claims that do require prior approval by ACC.

9.38 Decisions on ACC32 applications are currently communicated to treatment providers by post. This means that decisions are received at least one working day after being made by ACC, adding to the delays experienced by claimants. One very simple practical suggestion made by a party to the Review was that approvals should be

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[72] I put to one side cases where there was no good faith belief in the need for further treatment, as such cases are likely to be extremely rare, and should be considered in the context of fraud investigations discussed in section 7 above.

9.39 Reducing the number of cases in which prior approval by ACC is needed, and speeding up the decision-making and communication process, will also go a long way to addressing a practical dilemma that is encountered by physiotherapists under the current system. Where a request for further treatment has been made, but no response has been received, and it is clinically undesirable to interrupt treatment, the physiotherapist has to decide whether to continue to treat and risk not being paid if ACC declines to meet the cost of the treatment. The physiotherapist could explain to his or her patient that they need to pay for treatments until ACC makes a decision – but this will be a barrier to receiving treatment for some patients, and is not consistent with the basic philosophy of the ACC scheme. Although some submitters went too far in suggesting that this scenario gives rise to serious ethical issues for physiotherapists, it does create an unfair and unsatisfactory situation for physiotherapists and their patients: minimising the frequency with which it occurs is highly desirable.

9.40 Claimants and physiotherapists advised the Review that in their experience, the maximum number of treatments approved under any one ACC32 form was 12. ACC advised the Review that there was no upper limit in its system on the number of additional treatments that could be approved, and advised that ACC has approved requests for up to 36 treatments in the case of very complex injuries.

9.41 Because ACC needs to review the use of Treatment Profile triggers and the overall process for approving treatments, and has committed to doing so, I have not examined in any detail how the current approval process works in terms of number of treatments approved. This is an important issue, but it is best tackled as part of a broader review of the method for determining the appropriate number of treatments for each claimant.

Long term approvals for chronic cases

9.42 There was evidence before the Review that the need to seek regular approvals for additional treatments is particularly frustrating and burdensome in cases of chronic injury, where long-term physiotherapy is appropriate. One example given was continuing physiotherapy for pain management purposes, in circumstances where there is likely to be an indefinite need for such treatment.

9.43 In chronic cases that require long-term treatment, ACC will normally have in place a long-term rehabilitation plan for the claimant. It seems sensible to address, as part of this long-term plan, whether there is an established need for certain treatment on a continuing basis. That is an issue that would sensibly be addressed at a case management conference attended by the relevant treatment providers, an appropriately qualified ACC representative, and the claimant, following a full clinical

review. Where a case management conference confirms a long-term need for physiotherapy services, it seems sensible to put in place a longer term authorisation for treatment, subject to periodic review (perhaps annually). There is no advantage, and considerable disadvantage for claimants and everyone else concerned, in going through the process of seeking and granting separate approvals on a regular short-term basis, in such circumstances. And if there are delays in that process, that is at the least an inconvenience for all concerned, and at worst a concern from a clinical perspective resulting in unnecessary pain, or hindering rehabilitation.[73]

Recommendations

9.44 I recommend that ACC undertake further work in the near term towards developing a more sophisticated process for approval of an appropriate number of treatments for each claimant. Key elements of that work include:

9.44.1 striking an appropriate balance between the number of cases for which prior approval is required, and the number of cases in which subsequent audit is carried out;

9.44.2 reducing the number of cases in which prior approval by ACC is required for additional treatments. Trigger numbers should be reviewed, and consideration should be given to setting those trigger numbers on the basis of robust quantitative analysis that limits prior approvals to a pre-defined percentage of claims;

9.44.3 exploring the potential for ACC prior approval to be dispensed with for a specified additional number of treatments where a physiotherapist certifies that in his or her professional opinion, those additional treatments are necessary;

9.44.4 exploring the potential for identification of a group of "advanced practitioners" who would be authorised to approve additional treatments, on the basis of a certificate of that in their professional opinion those treatments are necessary;

9.44.5 putting in place a system of routine subsequent audits of certificates given by physiotherapists of the kind described above, to be carried out by appropriately qualified clinical advisers;

9.44.6 putting in place a system for granting longer-term approvals for continuing treatment in chronic cases, following an appropriate clinical review;

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[73] Transcript of Hearings, Day 3 (16 May), pp 326-7.

9.44.7 speeding up the communication of approvals using electronic communications.

9.45 The reviews of the Treatment Profiles and the ACC32 process should be a collaborative process, consistent with the partnership model discussed above. ACC needs to work with all relevant professional groups to ensure that changes to the treatment approval process are appropriate and workable, and will facilitate the provision of rehabilitation services to claimants.

ACC use of quantitative analysis

9.46 A recurring theme in this report is the manner in which quantitative analysis, and quantitative measures of performance, are used by ACC. In particular, the EPN pilots and the national roll-out of the EPN, and subsequent reviews of the EPN programme, were characterised by an unsophisticated use of quantitative analysis. Pilots and studies have generally not been designed in a way that is likely to produce statistically reliable results. Quantitative analysis of the resulting data has been presented without measures of reliability, or appropriate sensitivity analysis, and has been used as the basis for predictions about future clinical and fiscal outcomes without an adequate appreciation of the limited confidence that is appropriate in respect of that analysis.

9.47 It is extremely important that ACC staff providing policy analysis and advice draw on the best available information. This means that it is worth investing time and money in gathering and analysing quantitative data. It also means that the limits of that analysis must be clearly understood, and must be clearly explained to the senior executives, officials and Ministers who ultimately rely on that analysis and advice. Quantitative results and quantitative predictions tend to be seen as more precise and more reliable than qualitative conclusions and predictions. That is not necessarily the case. If the data are not sufficient for robust quantitative analysis, or if appropriate techniques are not used in that analysis, the spurious precision of quantitative results can be much less helpful, and has the potential to be much more misleading, than appropriately tentative qualitative conclusions.

9.48 This phenomenon of figures taking on a life of their own, and being understood as more definitive and authoritative than they really are, is apparent in some of the reporting of results from EPN studies. It is also apparent in the way ACC has come to use the Treatment Profiles, with a strong focus on the numerical ranges specified, and without appropriate allowance for a lack of knowledge about the frequency with which actual cases fall outside the circumstances addressed in the profiles.

9.49 If all that is being provided through quantitative analysis is a snapshot of the world as it currently is, then that is often a useful thing to have; but it should be clear that that is all that is being provided. If some greater significance is being attributed to the figures that are presented, for example if an inference is being drawn that similar results are likely in the future, it is critical that there be a clear statement of the basis

for attributing that significance to the figures, and of the confidence with which that can be done. Too often, policy advice in this area seems to slide from an observation of recent events (last time I tossed a coin, it came up heads) to a prediction that the same pattern can be expected in the future (when coins are tossed, they will always/usually come up heads). Not only is this not a legitimate inference, but it is positively misleading.

9.50 Often, careful consideration of the reliability of data and quantitative analysis based on that data leads to the conclusion that there is a significant degree of uncertainty in relation to the issues that are being studied. This in itself is useful information. High quality decision-making must always factor in what we do not know, and the risk of outcomes which differ from those we hope for or expect. Most policy decisions in the health sector are made in circumstances of uncertainty. The more that we understand about the extent of that uncertainty, the range of potential outcomes, and the risks associated with each of those outcomes, the better placed we are to make decisions that take account of those risks, and minimise adverse consequences.

9.51 I recommend that all quantitative analysis and all quantitative predictions prepared by ACC contain a statement of the purpose for which that quantitative material is provided, the basis on which it has been derived, and the level of confidence with which it can be used for that purpose, including sensitivity analysis in respect of key assumptions. This is an important discipline which should significantly improve the quality of policy advice provided by ACC.

9.52 ACC has advised the Review that it is taking steps to improve the quality of its quantitative analysis, and the use of that analysis in decision-making.

10 ANSWERS TO QUESTIONS IN TERMS OF REFERENCE

10.1 In this final section of the draft report, the findings and recommendations that have been reached on a provisional basis are set out as responses to the specific questions posed in the terms of reference.

ACC Payments to Physiotherapists

1. The Government wishes to ensure public access to high quality physiotherapy services by reducing co-payments, whilst ensuring the sustainability of physiotherapy service delivery:

1.1. Are the levels of current payments for service delivery made by ACC to physiotherapists under:

1.1.1. Cost of Treatment Regulations;

1.1.2. the Endorsed Provider Network (EPN) contracts; and

1.1.3. other contractual arrangements,

adequate to cover the cost of services whilst ensuring the retention of an appropriately sized, skilled and financially viable physiotherapy profession to meet the needs of ACC claimants?

10.2 The levels of current payments under the cost of treatment Regulations and the EPN contracts are not adequate to cover the long-term cost of providing sustainable physiotherapy services.

1.2. Bearing in mind the history of adjustments to physiotherapy charges under ACC "Cost of Treatment" Regulations, are the above payments likely to continue at an appropriate level in the foreseeable future?

10.3 Experience with affordability constraints suggests that there is a real risk that the level of current payments under the cost of treatment Regulations and the EPN contracts will not always remain at an appropriate level, even if the level of payments is set at an appropriate and sustainable level immediately following this Review.

1.3. In the long term interests of ACC claimants and the profession, are compulsory restrictions on co-payment (claimant part charges) appropriate?

10.4 A compulsory restriction on co-payments is appropriate only if a high level of confidence can be achieved that ACC payments for the relevant services will be set and maintained at a sustainable level. The level of payments needs to be sustainable

even in high cost areas such as metropolitan centres, and for practices treating a higher proportion of complex cases.

10.5 If it is not possible to set and maintain ACC payments at a level that can with confidence be identified as sustainable, it is contrary to the long-term interests of ACC claimants and the physiotherapy profession to prohibit co-payments. In circumstances where a sustainable level of payment cannot be identified with confidence, or may not be maintained in the future, it is in the long-term interests of claimants and the physiotherapy profession to permit co-payments as a "safety valve" to accommodate errors in identifying a sustainable price, variation in sustainable prices geographically and as between different classes of injury, and the risk of erosion of payment levels over time.

1.4. What changes (if any) are necessary to pricing frameworks, annual adjustment indices, restrictions on ACC claimant co-payments and other relevant factors to ensure that the financial viability and integrity of the profession is maintained now and in the future?

10.6 There are a number of options for modifying pricing frameworks and associated factors to ensure that, in the long-term interests of injury victims, the financial viability and integrity of the physiotherapy profession is maintained. These are described in detail in section 5 above. In summary, they are:

Option 1: retain the existing funding arrangements, including the prohibition on co-payments for EPN providers, and increase EPN payments to a sustainable level – likely to be above $137 per hour. These payments would need to be indexed to maintain their real value, and reviewed periodically against sustainability criteria – say every five years;

Option 2: remove the prohibition on co-payments for EPN providers, and increase payments so far as affordable, but to a lesser extent than under option 1.

10.7 There is at present a practical difficulty with option 1: the information available does not enable a reliable estimate of sustainable fees to be made. Further research and analysis would be required in order to obtain a sufficiently reliable estimate for use in a contractual environment where co-payments are not permitted, so there is no "safety valve" to accommodate errors in estimating the level of fees, or variations in the cost of providing treatments in different circumstances (eg in higher cost areas, or for higher cost cases).

10.8 If option 1 is preferred by the Government, there is a strong case for:

10.8.1 an immediate interim increase in EPN payment rates, to not less than $138 per hour (excl GST); and

10.8.2 prompt work on designing and implementing a robust study of sustainable costs of treatment, to enable fees to be reset at sustainable levels.

10.9 Because it ensures sustainability of physiotherapy service provision, option 2 is the lower risk option, especially if there is inadequate information about long term sustainable costs; or if it cannot be guaranteed that fees will be maintained at sustainable levels.

10.10 A further, hybrid option would be to:

10.10.1 increase payments to sustainable levels and prohibit co-payments for work injuries; and

10.10.2 for other injuries, keep payments at current levels (or increase them, but to a lesser extent), and remove the prohibition on co-payments.

10.11 Distinguishing in this way between work injuries and other injuries would however be inconsistent with the "comprehensive entitlement" principle in the original Woodhouse Royal Commission report, and would result in some additional administration costs and boundary disputes.

10.12 If any of the options identified above is adopted, and the recommendations made below in relation to the EPN contracts are implemented, it is not necessary to increase the levels of payment under the Cost of Treatment Regulations in order to ensure the sustainability of provision of physiotherapy services, and achieve the Government's objectives as identified in the terms of reference. It would however be consistent with those objectives to increase the level of payment under the Regulations, and to make the changes to payment structures under those Regulations set out in section 5 (more differentiated payment rates; indexation), so far as affordable.

10.13 Specific concerns were identified in relation to payment levels under some other specialised contracts, in particular vocational rehabilitation contracts. It is appropriate to keep payment levels under all contracts under review to ensure that they remain sustainable, in the long-term interests of ACC claimants. I recommend that as and when further studies are carried out in relation to the sustainable cost of providing general physiotherapy services, other significant ACC contract arrangements should be included in those studies, especially where (as with ABP contracts) the same providers may hold both general and specialised contracts. Including the full range of ACC physiotherapy contracts in the study will provide a better overall picture of sustainability issues, as well as assisting in setting payment rates for the specialised contracts.

The EPN

2. The Endorsed Provider Network has been piloted and implemented nationwide since 2004.

2.1. Are initial and ongoing compliance costs for accreditation standards appropriately built into ACC payments when accreditation is a contractual requirement for EPN providers?

10.14 Current EPN contract payments are not sufficient to cover the long-term sustainable cost of providing physiotherapy treatments to accident victims, including the initial and ongoing compliance costs for certification against NZS8171:2005.

2.2. Are the differences between pricing frameworks and fee structures paid under Cost of Treatment Regulations, as opposed to the EPN and other contract pricing frameworks, valid and justifiable in the interests of patients, and in maintaining a healthy and suitably qualified profession?

10.15 There is no principled justification for the differences between the pricing frameworks and fee structures under the cost of treatment Regulations and the EPN contracts. Some difference is justified, but not the current very large difference.

10.16 If the recommendations made in relation to payment levels under the EPN contracts, and certain other features of the EPN contracts, are adopted, and if all physiotherapists have a genuine opportunity to enter into such contracts, it is not necessary to make significant changes to the Cost of Treatment Regulations in the interests of patients, or in the interests of maintaining a healthy and suitably qualified profession. This can be achieved through an appropriately structured contractual regime. If however these recommendations are not implemented, an increase in Regulation rates to a level at (or very close to) the sustainable cost of providing the relevant services would be necessary in order to achieve the Government's access and ILO compliance objectives, and more generally to give effect to the goals of the ACC legislation.

10.17 I recommend that ACC cease using the "endorsed provider" title. Something much more factual, such as "contract provider" would be more appropriate, would avoid unnecessary unfairness to Regulation providers, and would reduce the potential for causing confusion to claimants. ACC has accepted this recommendation, and has advised the Review that it proposes to review the contract name before the year end.

10.18 I also recommend that ACC consider adopting alternative entry criteria for the EPN programme, based on postgraduate qualifications and experience in place of certification.

Culture of ACC/Audits

3. Physiotherapists have raised concerns about the culture of ACC and its attitudes towards physiotherapists.

3.1. Is there evidence of any inappropriate culture or attitude from within ACC towards physiotherapists which is detrimental to the funder / provider relationship between the parties

10.19 The evidence before the Review suggests that there are respects in which ACC's approach to dealing with the physiotherapy profession, and with individual physiotherapists, could be improved in a manner that would enhance the relationship between the parties, and enable ACC and the profession to deliver higher quality services to ACC claimants.

10.20 I recommend that ACC, in consultation with the physiotherapy profession:

10.20.1 expressly adopt a "partnership" approach to delivery of high quality rehabilitation services to claimants, in accordance with the Act;

10.20.2 expressly recognise the importance of each other's roles, and the mutual interdependence that exists between ACC and the physiotherapy profession;

10.20.3 adopt a set of ACC Provider Principles that reflect this partnership, and spell out its central implications;

10.20.4 continue to work on the quality of communication with the profession as a whole, and with individual physiotherapists in relation to specific matters;

10.20.5 make better use of the Physiotherapy Liaison Group ("PLG") as a central clearing house for effective consultation and collaboration with the physiotherapy profession as a whole. There was support from the physiotherapy profession and ACC for the suggestion made in the course of the Review that this would be assisted by the appointment of an independent chair of the PLG. I see real value in the appointment of an independent chair for this process. I recommend that the independent chair prepare a regular report for the participants in the PLG, at least annually and initially perhaps six-monthly, commenting on the effectiveness of the PLG as a forum for communication and for implementation of the partnership approach outlined above.

10.21 I recommend that ACC provide clear, accessible information about its complaints process for providers (including relevant contact details, and a brief outline of the process) in the next edition of its Treatment Provider Handbook, in the next version of the audit protocol, and on its website. I also recommend that ACC's complaints

information for providers include information about the matters that can be the subject of complaint to the Ombudsmen. ACC has advised the Review that it accepts this recommendation, and will be providing this information on its website initially, and in the next edition of the Treatment Provider Handbook.

10.22 A number of concerns were identified in relation to the provision by physiotherapists to ACC of clinical notes, in connection with audits and investigations. There are two respects in which those concerns appear to be well founded:

10.22.1 the ACC45 injury claim form should include on its face a more explicit authorisation for release of confidential patient information by the treatment provider to ACC;

10.22.2 where claims are lodged electronically, appropriate consents may not always be obtained.

10.23 I recommend that further work be carried out to ensure that the ACC45 form more clearly conveys to claimants that they are consenting to the release of confidential information, and to ensure that appropriate consents are sought and obtained in the context of electronic lodgement of claims. The Privacy Commissioner has indicated a willingness to work with ACC on these issues, and ACC has advised the Review that it is willing to undertake this work, and will do so in consultation with the Privacy Commissioner. Consultation with claimant representatives and provider groups will also be essential, in this context.

3.2. Are audits and investigations being carried out only for proper purposes, in appropriate circumstances, and within appropriate guidelines for programmed and selected audits?

10.24 No specific concerns were identified in relation to monitoring processes, but there is scope for those processes to be made more transparent. I recommend that further information be made readily available to providers which explains the objectives of the monitoring process, the process by which it is conducted, and the various outcomes that are contemplated. ACC has accepted this recommendation, and has advised the Review that initially it will make this information available to providers on its website.

10.25 There appears to be a broad consensus that the processes that ACC has put in place since 2005 for audits and investigations are appropriate.

10.26 The picture was more patchy in relation to implementation of those processes. There are continuing concerns on the part of some physiotherapists and some claimants in relation to ACC's approach to audits and investigations. There are encouraging signs of positive steps being taken by ACC to address these concerns, and learn from the

experiences of the past. Further work is however needed to address these concerns and ensure that an appropriate relationship is firmly established.

10.27 There is nothing in the evidence provided to the Review that would suggest that the selection processes for audits and investigations were inappropriately targeted at particular individuals or professional groups.

3.3. What changes, if any, are necessary to addresses any inappropriate culture, attitudes or activities found within ACC towards physiotherapists?

10.28 Some general recommendations in relation to ACC's working relationship with physiotherapists are set out in paragraph 10.20 above.

10.29 In order to improve the working relationship between ACC and physiotherapists in the context of audits and investigations, I recommend that ACC, in consultation with the physiotherapy profession, carry out further work to:

10.29.1 align the approach of the Risk, Assurance and Fraud group with the broader culture and objectives of ACC, including shifting the group's focus away from detection of fraud to avoidance of fraud and other inappropriate practices, and support for ACC's partnership with providers to deliver high quality services to claimants;

10.29.2 ensure appropriate clinical input into investigations, in particular before reaching any views on the competence or honesty of providers, or making any communications suggesting concerns about competence or honesty, or proposing remedial action in connection with clinical or ethical matters;

10.29.3 provide clear guidance on the (very limited and preliminary) significance of outlier analysis and other data mining techniques for the purpose of identifying competence and fraud concerns;

10.29.4 provide clear guidance on what constitutes fraud, and training on the care needed before asserting or alleging fraud;

10.29.5 ensure ACC representatives have a balanced approach and an open mind in approaching fraud investigations, which gives full recognition to the likelihood of other explanations for discrepancies and errors;

10.29.6 ensure ACC representatives understand and accept that they have primary responsibility for clear and effective communication with affected providers and with claimants, and for approaching the investigation with courtesy and patience, even if that clarity, courtesy and patience is not always reciprocated.

Physiotherapy Profession Generally

4. There are challenges facing the profession as primary health care practitioners in ensuring that it continues to plays its vital public health role in rehabilitating and maintaining the quality of life of New Zealanders, including ACC claimants.

4.1. In regard to the needs of New Zealanders, is the physiotherapy profession:

4.1.1. retaining adequate numbers of senior physiotherapists within the profession?

4.1.2. adequately remunerated for post-graduate qualifications and expertise

10.30 Although there was considerable anecdotal evidence of senior members leaving the profession, and submissions from some former physiotherapists identifying ACC-related issues as the reason for their having left the profession, there was no evidence to suggest that New Zealand was materially out of step with comparable jurisdictions in retaining senior members in the profession.

10.31 This conclusion should not however obscure the importance of retaining and motivating senior, experienced members of the profession to continue to provide specialist input, guidance, training and mentoring in the long-term interests of ACC claimants and all physiotherapy patients. A number of the other recommendations made in this Review should contribute to that goal, by improving the viability of physiotherapy practices from a business perspective, and enhancing the quality of the relationship between ACC and physiotherapy service providers. This should ensure that both tangible and intangible rewards from practice are enhanced, especially for high-quality practitioners.

10.32 In other areas, such as teaching, the value and importance of postgraduate qualifications and experience is recognised in remuneration rates. I recommend that ACC carry out further work on this issue, and in particular that ACC give serious consideration to alternative "entry criteria" for the EPN programme, recognising that a certain level of postgraduate qualifications and experience may justify the same level of expectation of improved patient satisfaction and quality of treatment as certification by reference to NZS 8171:2005.

10.33 There also appears to me to be scope for ACC to draw on the experience and expertise of senior practitioners to improve the quality and timeliness of delivery of services to claimants, by identifying a group of "advanced practitioners" who are authorised to approve, in the exercise of their own professional judgment, provision of further services over and above the level that would otherwise require ACC approval. I understand that an "advanced practitioner" designation is currently being developed

by the profession, and that ACC intends to work with the profession to look at ways in which this concept may be relevant to the provision of ACC-funded services. This is a concept which has the potential to provide significant advantages to claimants, to reduce administrative costs for ACC, and to encourage the retention and motivation of senior highly qualified members of the profession. I recommend that ACC work closely with the profession to explore how best to achieve the potential benefits for ACC claimants from this initiative.

4.2. What, if anything, can ACC or the Government do to assist with any deficiencies found regarding seniority and post-graduate training in the profession?

10.34 See the answer to question 4.1 above.

4.3. Are there any other matters arising out of this review that impact upon the way in which physiotherapists are accredited and funded by ACC which ought to be addressed by the Government to encourage provision of sustainable and high-quality physiotherapy service to the public of New Zealand?

10.35 I recommend that ACC undertake further work in the near term towards developing a more sophisticated process for approval of an appropriate number of treatments to be funded for each claimant. Key elements of that work include:

10.35.1 striking an appropriate balance between the number of cases for which prior approval is required, and the number of cases in which subsequent audit is carried out;

10.35.2 reducing the number of cases in which prior approval by ACC is required for additional treatments. Trigger numbers should be reviewed, and consideration should be given to setting those trigger numbers on the basis of robust quantitative analysis that limits prior approvals to a pre-defined percentage of claims;

10.35.3 exploring the potential for ACC prior approval to be dispensed with for a specified number of additional treatments, where a physiotherapist certifies that in his or her professional opinion those additional treatments are necessary;

10.35.4 exploring the potential for identification of a group of "advanced practitioners" who would be authorised to approve additional treatments, on the basis of a certificate of that in their professional opinion those treatments are necessary;

10.35.5 putting in place a system of routine subsequent audits of certificates given by physiotherapists of the kind described above, to be carried out by appropriately qualified clinical advisers;

10.35.6 putting in place a system for granting longer-term approvals for continuing treatment in chronic cases, following an appropriate clinical review;

10.35.7 speeding up the communication of approvals using electronic communications.

10.36 In order to ensure a good working relationship and a coordinated approach to the claimant's rehabilitation, a physiotherapist who is currently providing treatment to that claimant should be involved in the decision to refer the claimant to an ABP. ACC recently released a consultation document in relation to the ABP which expressly refers to consultation with the existing treatment provider before an ABP referral occurs. ACC has advised the Review that it will implement this proposal by November 2007. I encourage it to do so, and to consult with the profession to ensure it is implemented in an effective and efficient manner.

10.37 I recommend that all quantitative analysis and all quantitative predictions prepared by ACC contain a statement of the purpose for which that quantitative material is provided, the basis on which it has been derived, and the level of confidence with which it can be used for that purpose, including sensitivity analysis in respect of key assumptions. This is an important discipline which should significantly improve the quality of policy advice provided by ACC.

APPENDIX A – TERMS OF REFERENCE

REVIEW OF THE WAY IN WHICH PHYSIOTHERAPY SERVICES ARE FUNDED AND ACCREDITED BY ACC

December 2006

The Confidence and Supply Agreement between the Government and New Zealand First includes a review of the way in which physiotherapy services are funded and accredited. Accordingly, the Government has decided to undertake a Ministerial Review to assess the adequacy of the current regulatory and purchasing arrangement for physiotherapists within the ACC regime having regard to the context of the existing regulatory regime governing competency standards of health practitioners.

The Review will also have regard to the rehabilitation outcomes of ACC claimants including the provision of necessary and appropriate physiotherapy services to achieve improved claimant outcomes.

The Review will look at the ACC regime only. The regulatory arrangements for health practitioners' competency standards are outside the scope of the Review and will not be the subject of recommendations (though they may be looked at in order to provide context).

Content of the Review

The Commission of Inquiry or Independent Reviewer will inquire into and make recommendations to government on the following questions.

ACC Payments to Physiotherapists

1. The Government wishes to ensure public access to high quality physiotherapy services by reducing co-payments, whilst ensuring the sustainability of physiotherapy service delivery:

    1.1. Are the levels of current payments for service delivery made by ACC to physiotherapists under:

        1.1.1. Cost of Treatment Regulations;

        1.1.2. the Endorsed Provider Network (EPN) contracts; and

        1.1.3. other contractual arrangements,

adequate to cover the cost of services whilst ensuring the retention of an appropriately sized, skilled and financially viable physiotherapy profession to meet the needs of ACC claimants?

1.2. Bearing in mind the history of adjustments to physiotherapy charges under ACC "Cost of Treatment" Regulations, are the above payments likely to continue at an appropriate level in the foreseeable future?

1.3. In the long term interests of ACC claimants and the profession, are compulsory restrictions on co-payment (claimant part charges) appropriate?

1.4. What changes (if any) are necessary to pricing frameworks, annual adjustment indices, restrictions on ACC claimant co-payments and other relevant factors to ensure that the financial viability and integrity of the profession is maintained now and in the future?

The EPN

2. The Endorsed Provider Network has been piloted and implemented nationwide since 2004.

2.1. Are initial and ongoing compliance costs for accreditation standards appropriately built into ACC payments when accreditation is a contractual requirement for EPN providers?

2.2. Are the differences between pricing frameworks and fee structures paid under cost of Treatment Regulations, as opposed to the EPN and other contract pricing frameworks, valid and justifiable in the interests of patients, and in maintaining a healthy and suitably qualified profession?

Culture of ACC/Audits

3. Physiotherapists have raised concerns about the culture of ACC and its attitudes towards physiotherapists.

3.1. Is there evidence of any inappropriate culture or attitude from within ACC towards physiotherapists which is detrimental to the funder / provider relationship between the parties?

3.2. Are audits and investigations being carried out only for proper purposes, in appropriate circumstances, and within appropriate guidelines for programmed and selected audits?

3.3. What changes, if any, are necessary to addresses any inappropriate culture, attitudes or activities found within ACC towards physiotherapists?

Physiotherapy Profession Generally

4. There are challenges facing the profession as primary health care practitioners in ensuring that it continues to plays its vital public health role in rehabilitating and maintaining the quality of life of New Zealanders, including ACC claimants.

4.1. In regard to the needs of New Zealanders, is the physiotherapy profession:

4.1.1. retaining adequate numbers of senior physiotherapists within the profession?

4.1.2. adequately remunerated for post-graduate qualifications and expertise?

4.2. What, if anything, can ACC or the Government do to assist with any deficiencies found regarding seniority and post-graduate training in the profession?

4.3. Are there any other matters arising out of this review that impact upon the way in which physiotherapists are accredited and funded by ACC which ought to be addressed by the Government to encourage provision of sustainable and high-quality physiotherapy service to the public of New Zealand?

Process Issues

Governance

The progress of the Review will be monitored through regular reporting to the Minister for ACC, in consultation with Peter Brown, MP, NZ First.

Manner of conducting the Review

The conduct of the Review shall be carried out according to the following principles:

- the Review is to be an investigative review that is not overly legalistic or adversarial;

- the principles of natural justice are to be complied with;

- the Review is to be consultative;
- officials will cooperate with the Reviewer;
- the process for conducting the Review will be flexible in order to accommodate any changes in the Terms of Reference that may be required at the discretion of the Reviewer with the agreement of the Minister;
- the Review will focus on finding practical solutions that can work to any issues that are identified; and
- given the investigative nature of the Review, it will be up to the Reviewer to determine what, if any, part of the Review should be held in public; and
- to the extent that the conduct of the Review would require ACC or any other agency to disclose to the Reviewer the content of legal advice, the Reviewer is to treat that legal advice as covered by legal professional privilege and natural justice will not require disclosure to any other party.

Context for making recommendations

The Review will focus on whether current regulatory and contracting arrangements lead to adequate rehabilitation and compensation outcomes for claimants and what, if any, changes are required. The recommendations will be guided by the Government's objectives and goals, including:

- ACC scheme focus on rehabilitation with the goal of achieving appropriate quality of life;
- the proposed rehabilitation framework, which aims to provide a set of principles and/or definition on which to base all future rehabilitation policy, purchasing and service delivery;
- ACC scheme principle of fair compensation, including compliance with ILO 17;
- Woodhouse vision that health practitioners should not bear burden of costs of the ACC scheme;
- the Government goal of effective and efficient sector regulation, and principles underpinning health sector regulation; and
- the Government goal of building the capability of the health sector workforce.

Information provision

ACC and the Department of Labour will discuss issues surrounding the Review with the Reviewer and will make available relevant material and information as requested.

The Reviewer may use any other sources of information and advice considered to be useful in conducting the Review.

Consultation

The Reviewer will consult as required in order to contribute to the Review. It is expected that the following will be consulted: ACC, the Department of Labour, the Ministry of Health, the New Zealand Society of Physiotherapists Inc., the New Zealand Physiotherapy Trust, Auckland Physiotherapy Practice Association, individual members of the physiotherapy profession, physiotherapy accreditation providers, claimants or consumers of physiotherapy services, and other interested parties.

Timeframes and reporting

The Review will commence in October 2006 and is expected to report to the Minister for ACC by no later than September 2007. Interim reports will be supplied to the Minister for ACC quarterly. The final report will provide recommendations to the Minister for consideration.

APPENDIX B – WRITTEN SUBMISSIONS RECEIVED

B1 Written submissions were received at three different stages during the review: initial written submissions were received in February and early March 2007; further submissions were received in response to the initial submissions by 30 April 2007 and the final written submissions were received by 24 August 2004 in response to the draft report. All the written submissions except those provided on a confidential basis are available on the Department of Labour website (www.dol.govt.nz/physiotherapy.asp).

B2 The initial written submissions to the review were sought by direct invitation to the identified parties to the review, and through newspaper advertisements about the review in the main daily newspapers. The initial submissions received in response to these approaches were from the following individuals and organisations (in the order in which they were received, with those that were made as confidential submissions marked *):

- Ron Patterson, Health and Disability Commissioner;
- District Health Boards Physiotherapy Advisers, Leaders and Managers Group (PALM);
- New Zealand Private Physiotherapists Association Inc (NZPPA) (first submission);
- Murray Hing, Flexa Clinic Physiotherapy;
- Penny Martin, Cashmere Physiotherapy;
- Anya Worthington*;
- Cameron Green*;
- The Physiotherapy Trust of New Zealand (first submission);
- The New Zealand College of Physiotherapy;
- Philip Parker;
- Bruce Monkton;
- Physiotherapist X;

- Denise Powell;
- Malcolm Hood;
- Mrs X;
- Christopher La Pine*;
- Warren Forster (on behalf of Val Forster);
- ACC;
- University of Otago School of Physiotherapy & Auckland University of Technology School of Physiotherapy;
- Lynne Taylor, AUT;
- Kirsten Davie;
- New Zealand Society of Physiotherapists Inc (NZSP), including reports from Brent Wheeler Ltd, KPMG and Strategic Pay Ltd;
- Occupational Physiotherapists Special Interest Group, New Zealand Society of Physiotherapists;
- The Physiotherapy Board of New Zealand;
- Chris Kirkham, Workpro;
- Christopher Nelson;
- Kevin Blake;
- N T Anderson;
- Mark Plummer;
- Nyron Chick;
- Mrs PR Norton;
- Wendelien Bomer;

- New Zealand Law Society ACC Sub-Committee;
- Karen Sutton;
- Jordan Salesa;
- Jasper and Christina van der Heide;
- Max Bognuda;
- Dennis Shepherd.

B3 In the second round of submissions written responses to the issues raised in the initial submissions were received from the following organisations and individuals:

- ACC, with a supporting report from Deloitte;
- New Zealand Society of Physiotherapists Inc, with supporting reports from Strategic Pay Ltd and KPMG;
- Physiotherapy Trust of New Zealand;
- New Zealand Private Physiotherapists Association;
- Acclaim Otago;
- Warren Forster (for Val Forster).

B4 Finally, written responses to the draft report were received from the following parties:

- ACC (with supporting report by Deloitte);
- New Zealand Society of Physiotherapists (with supporting reports from the Occupational Health Physiotherapy Group, KPMG, Strategic Pay and Brent Wheeler Ltd);
- New Zealand College of Physiotherapists;
- Murray Hing;
- Jordan Salesa;

- Cameron Green;
- Physiotherapy Trust of New Zealand;
- Acclaim Otago;
- Warren Forster (for Val Forster);
- Bruce Monkton;
- Privacy Commissioner;
- Chris Nelson.

APPENDIX C – PARTICIPANTS AT HEARINGS/CONFERENCES

C1 Two public hearings/conferences were held in the course of the review. The purpose of the first hearing was to hear oral submissions from parties who had made written submissions, and allow the reviewer to question the parties and an Expert Panel on cost modelling and pricing. The purpose of the second hearing was to allow parties to make oral submissions on their responses to the draft report, and allow the reviewer to question the parties on their responses.

C2 The following organisations and individuals participated in the initial hearings of the review, held at in West Lounge 2 at the Westpac Stadium in Wellington on 14-17 May 2007:

- Accident Compensation Corporation (ACC), with the following expert witnesses:
  - Andrew Gibbs and Tim Richards, Deloitte;
  - Jean-Pierre de Raad, New Zealand Institute of Economic Research;
- New Zealand Society of Physiotherapists, with the following expert witnesses:
  - Brent Wheeler, Brent Wheeler Ltd;
  - Troy Newtown, KPMG;
  - Geoff Summers, Strategic Pay Limited;
- Physiotherapy Trust of New Zealand;
- New Zealand Private Physiotherapist's Association;
- Bruce Monkton;
- Auckland Private Physiotherapy Practitioners Association;
- Chris La Pine;
- Warren Forster (on behalf of Val Forster);
- Denise Powell (on behalf of Acclaim Otago);

- Murray Hing;
- Auckland and Otago Schools of Physiotherapy;
- DHB Physiotherapy Leaders, Advisers and Managers.

C3 The second hearings on the draft report were held from 29 – 31 August 2007 in the West Lounge 2 at The Westpac Stadium in Wellington. The following organisations and individuals made oral submissions:

- ACC;
- New Zealand Society of Physiotherapists (including Occupational Health Physiotherapy Group);
- College of Physiotherapy;
- Murray Hing;
- Jordan Salesa;
- Chris La Pine;
- Cameron Green;
- Physiotherapy Trust of New Zealand;
- Acclaim Otago;
- Warren Forster (on behalf of Val Forster).

APPENDIX D – REGULATION FUNDING OF PHYSIOTHERAPY SERVICES – HISTORICAL OVERVIEW

ACC impact on scope of physiotherapy market[74]

D1 The approach to accident compensation and rehabilitation introduced by the ACC scheme had significant implications for the physiotherapy profession in New Zealand. Prior to the introduction of the ACC scheme in 1974, physiotherapy services were either paid for by the injured person, or reimbursed by insurance companies. Treatment was funded by insurers in cases involving workers compensation, and motor vehicle accidents and other injuries where either the victim or the injurer had insurance cover. The cost of physiotherapy treatment was recoverable by the injured person as one component of tort damages, where fault could be proved.

D2 As the historian for the New Zealand Society of Physiotherapists, J Scrymgeour noted:

> "The 1974 Act had two main objectives – firstly to remove the aspect of fault in respect of payment for services, and secondly to promote rehabilitation. These factors generated a much larger physiotherapy market. Before the Act insurance companies were unwilling to negotiate physiotherapy fees which resulted in a very depressed private physiotherapy sector with little cohesion within its ranks. By increasing the range of compensable accidents to include non-earners and all sports injuries, the Act created a much greater demand for physiotherapy services."[75]

Evolving approach to fees paid by ACC

D3 The Accident Compensation Act 1974 provided for ACC to pay all treatment costs for personal injuries covered by the ACC scheme, provided that those costs were "reasonable by New Zealand standards", and subject to any regulations that might be made in relation to payment of treatment costs. At the inception of the ACC scheme, there were no regulations governing payment for treatment. ACC paid the full amount of reasonable physiotherapy fees, on the basis of bills submitted to it.

D4 Tensions between the physiotherapy profession and ACC regarding appropriate fee levels emerged early in the life of the scheme, and continue to this day. The NZSP historian records that "In the month before the Act was due to take effect, ACC

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[74]Scrymgeour, J (2000), Moving On, A History of the New Zealand Society of Physiotherapists Inc, 1973-1999, p 65

[75] Scrymgeor, J (2000), *op.cit*, pp 65-66.

argued for a capped fee of $4.00 per physiotherapy treatment, but the New Zealand Private Practitioners Association successfully negotiated a fee for service."[76]

D5 By 1979 concerns about the rising costs of the scheme and employers' concerns about subsidising the costs of non-work accidents led to a major review of the scheme.[77] The total cost of physiotherapy treatment had doubled by this time, and ACC considered that these costs needed to be contained[78]. There were also issues of administrative practicality in handling large numbers of bills for differing amounts. ACC decided to pay physiotherapists under a bulk-billing system at a fixed fee per treatment. Limited provision was made for supplementary payments, but otherwise any difference between the total fee charged by the provider and the ACC contribution had to be met by the claimant paying a co-payment or surcharge.

D6 This new approach raised issues in respect of New Zealand's compliance with International Labour Organisation ("ILO") Convention 17, to which New Zealand is a signatory. ILO 17 provides that workers should not have to meet the costs of treatment for work injuries.[79]

D7 In 1981, ACC set fees for physiotherapy treatment[80] at $6.75 per treatment, with physiotherapists able to charge co-payments in addition to the ACC contribution to meet the total cost of services provided.

D8 The following year a further ACC review occurred, again substantially because of concerns over rising costs. The concept of ACC payments for treatment being only part-payment continued to be endorsed by ACC.

D9 In 1985 the fee for physiotherapy treatment was increased from $6.75 to $11.50 (with co-payments permitted).

D10 In the late 1980s the New Zealand Society of Physiotherapists brought proceedings challenging the ability of ACC to pay less than the full cost of treatment, under the legislation as it then stood. Similar proceedings were brought by the New Zealand Private Hospitals Association. The proceedings were successful before the High

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[76] Scrymgeour, J (2000), *op.cit*, p 66.

[77] ACC, History of ACC, *www.acc.co.nz/about* acc/history of acc in new zealand

[78] Scrymgeour, J (2000), *op.cit*, p 66.

[79] Article 9 of ILO Convention 17, which New Zealand ratified in 1938, specifies that injured workers "shall be entitled to medical aid and to such surgical and pharmaceutical aid as is recognised to be necessary in consequence of accidents. The cost of such aid shall be defrayed either by the employer, by accident insurance institutions, or by sickness and invalidity insurance institutions."

[80] And treatment for other specified allied health providers including acupuncturists, chiropractors, occupational therapists, podiatrists and speech therapists.

Court and Court of Appeal, and ACC was held to be required to pay the full cost of treatment, provided that the fees charged were reasonable by New Zealand standards.[81]

D11 In 1989 regulations were made which expressly provided for ACC to pay a fixed amount towards the cost of treatment, in effect capping the obligation to meet full reasonable costs.[82] The 1989 regulations set a fee for physiotherapy services (and certain other services) of $20 per treatment (excluding GST). Physiotherapists were permitted to charge co-payments to cover the full cost of treatment.

D12 The approach of setting upper limits to ACC payments for physiotherapy and other services in regulations has continued through to the present day. ACC describes the regulations specifying the amounts payable for treatment by different types of health providers as "introduced to provide certainty and manage the costs associated with paying full market prices."[83]

D13 The 1989 regulations were replaced in 1990 by the Accident Compensation (Referred Treatment Costs) Regulations 1990, which set a maximum payment per treatment of $22.50 (incl GST), unchanged from the 1989 level, and introduced an option for physiotherapists and other specified treatment providers of charging at an hourly rate of $56.25 (incl GST).

D14 The 1990 regulations also introduced limits on the number of treatments that would be funded for any one patient in respect of the same claim, setting a maximum of 24 treatments within a defined period. A subsequent amendment in December 1990 modified the treatment limits to provide that additional treatments could be approved by ACC, up to 12 further treatments, subject to receiving evidence from the referring medical practitioners and the treatment provider in relation to the need for further treatment.

D15 By 1992 the costs of the ACC scheme had increased further still. A review in the early 1990s led to further legislative change, abolishing lump-sum compensation and levying a new premium on employees for non-work accidents.[84] The Accident Rehabilitation and Compensation Insurance (ARCI) Act 1992 attempted to define more precisely what an injured person should receive, with a greater emphasis on rehabilitation as opposed to compensation.

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81 *New Zealand Society of Physiotherapists v Accident Compensation Corporation* [1988] 1 NZLR 346 (HC); [1988] 2 NZLR 641 (CA).

82 Accident Compensation (Referred Treatment Costs) Regulations 1989.

83 ACC, (10 August 2005), Removing Patient Co-payments, Report to ACC Board, p 3.

84 ACC, History of ACC, *www.acc.co.nz/about* acc/history of acc in new zealand

D16 With effect from 1 February 1992, the regulated fee for physiotherapy treatment was reduced by 15%, to $19 per treatment or $47.80 per hour (incl GST).[85]

Cost of treatment regulations currently in force

D17 The regulations that currently apply to physiotherapy services are the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

D18 The rates payable under the regulations were increased in 2006 for the first time since the 1992 reductions. The increase of 2.5% took the per treatment rate to $19.48, and the hourly rate to $49 per hour (both incl GST).

D19 A further more substantial increase took effect on 1 April 2007, increasing the per treatment rate to $24.48 and the hourly rate to $61.57 (both incl GST).

Number of treatments that will be paid for by ACC

D20 As noted above, under the 1990 regulations there was a limit of 24 treatments that ACC would fund, with ACC approval required for funding of further treatments up to a maximum of another 12 treatments.

D21 Against a backdrop of continuing concern about increasing costs, in the late 1990s NZSP was involved in ACC pilot schemes to promote accountability among physiotherapists and a peer review mechanism to examine the appropriateness of physiotherapy interventions in individual cases.[86]

D22 In 1997 ACC and the NZSP worked in partnership on the development of the Physiotherapy Rehabilitation Assessment Scheme, which aimed to give the injured client a more specialised opinion if their rehabilitation did not meet the expected outcomes.

D23 A significant development in response to the growing volume of physiotherapy treatment visits was the introduction by ACC in 1998 of 'Physiotherapy Treatment Profiles'. These were developed collaboratively with NZSP. The Treatment Profiles constitute a consensus of opinion between NZSP members and ACC as to what are considered appropriate and common current practice for the most common musculoskeletal conditions, rather than being evidence based. They provide a range of expected treatment numbers for straightforward cases.

D24 Treatment numbers stated in the Profiles relate to a specific diagnosis without complications, which has been referred for treatment at an appropriate stage in the

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[85] Accident Compensation (Referral Treatment Costs) Regulations 1990, Amendment No. 3

[86] Scrymgeour, J (2000), *op.*cit, p 68.

healing process. The Profile document acknowledges that conditions that are more complicated may differ from the treatment description and differ from the average number or range of treatments suggested by the profiles.[87]

D25 Trigger numbers are specified in the Treatment Profiles, which indicate the number of treatments after which ACC will seek a review of the services that have been provided. The treatment provider is required to submit an ACC32 form explaining the need for further treatment, before ACC will agree to fund treatments in excess of the trigger number.

D26 The Treatment Profiles do not address the question of variability in the number of treatments required for such cases, or how complex cases are expected to differ from these estimates.

D27 Table 1 provides an example of the information provided in the Treatment Profiles, for the specific diagnosis 'Lumbar disc prolapse and radiculopathy'.[88] The range specified is 16 – 24 treatments, with a trigger of 24 treatments above which approval for further treatment must be obtained from ACC, using the ACC32 process, before ACC will meet the costs of such treatment.

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87 ACC (1998), *Physiotherapy Treatment Profiles*, p ii.

88 ACC (1998), *op.cit.*, p 1.3.

Table 1: Example of ACC Physiotherapy Treatment Profile

N12C2	Lumbar disc prolapse and radiculopathy				Number of treatments: 16-24	Triggers 24	
Key points	**Special Considerations**	**History**	**Examination**	**Differential Diagnosis**	**Complications**	**Treatment Rehabilitation**	**Onward Referral**
Back pain with referred leg symptoms, and possible neurological signs	Previous history Other pathologies Regional pain syndrome Yellow flag	Mechanism of injury – flexion/rotation disc injury commonly due to flexion/rotation forces as lifting Trauma most frequent cause of back pain Sudden or gradual onset, or an exacerbation after history of minor pain events Neurological symptoms – cauda equine General health/recent illness Nature and behaviour of pain Medications/steroids	Observation: standing posture/deformities/ pelvic obliquity/leg length disparity Presence of protective muscle spasm/ scoliosis/kyphosis, excessive lordosis Do functional activities match patient's description of pain? Objective physical measurements – physiological/ accessory Neurological examination Adverse neural tension Differentiating upper/lower motor neurone problems Palpation	Red flags (tumours, severe unremitting pain) Congenital disorders Cauda equine syndrome Spondylolisis Spondylolisthesis Stenosis Osteoporosis Inflammatory disease Circulatory disease Prostatic/uterine disease Pain of visceral origin	Red flags/ trauma/structural abnormalities Peripheralisation of symptoms Radicular sign/ stenosis signs and symptoms Cauda equine Yellow flags	*Acute:* Centralisations sign sought & pursued if found Palliative techniques Education/self management Manual therapy *Sub acute:* Centralisation sign sought and pursued if found Pain management strategies Education Stabilisation/strengthening Exercise and functional activities Task specific training Progression of graduated exercise programme Elimination of faulty movement patterns Emphasis on core/functional stability for workplace/recreation	GP Specialist Radiographic Case manager Multidisciplinary team – OT Clinical psychologist

Levels of claimant co-payments

D28 Any difference between the regulated amount per treatment paid by ACC and the price charged by the provider is met by patients, in what is known as a patient or claimant co-payment. As a consequence of the downward adjustment of the regulated fee in 1992 and the subsequent lack of any upward adjustment until 2006 to cover inflation in the cost of physiotherapy services, claimant co-payments have risen steadily over time. The overall level of inflation as measured by the Consumer Price Index was over 33% during this period.[89]

D29 There is a risk that some people will access services where there is little benefit to be gained, where there is no price to pay to access them. On the other hand it is, as the ACC paper on the subject put it, "well established in health research that co-payments represent a significant barrier to accessing health care generally. In particular, research suggests that direct charges put the heaviest burden on the poor. As the purchaser of health services for injury treatment, such a barrier compromises ACC's ability to facilitate a claimant's return to independence and manage scheme costs, as people delay treatment, possibly worsening their condition."[90]

D30 ACC commissioned BRC Ltd to monitor patient co-payments to physiotherapists since 2003/04, in order to provide information in regard to barriers to access (of particular relevance in relation to NZ being a signatory to ILO Convention 17.) The monitoring has focused on the normal adult charge by a physiotherapy practice for a specific set of consultation types: an initial consultation, a follow-up consultation, an initial consultation for an ankle sprain requiring strapping, a follow-up consultation for an ankle sprain requiring strapping, and an after-hours consultation. The data is collected and analysed for three types of practice, according to the way in which their services are funded by ACC – ie by hourly rate or per treatment payment (under regulations) or by EPN contract rates.[91] [92]

D31 For practices charging under the regulations, and charging an hourly rate, the BRC co-payment surveys found that the normal adult charges were as follows:

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[89] ACC (10 October 2005), *op.cit*, p 6.

[90] ACC (10 October 2005), *op.cit.*, p 7.

[91] BRC (October 2004) Physiotherapy Services Co-payment Charges Survey – 2003/04 and 2004/05 Co-payment Charges Survey.

[92] BRC (September 2005) Physiotherapy Services Co-payment Charges Survey – 2003/04 and 2004/05 Co-payment Charges Survey.

Consultation Type	2003/04	2004/05	2005/06
Initial consultation	$15.20	$16.65	$16.69
Follow-up consultation	$11.93	$14.06	$13.66
Ankle sprain requiring strapping: Initial consultation	$15.60	$17.29	$15.50
Ankle sprain requiring strapping: Follow-up with strapping	$12.92	$15.26	$13.71
After hours consultation	$18.64	$19.52	$19.06

D32 For practices charging under the regulations and charging a per treatment rate, the average normal adult charges were found to be as follows:

Consultation Type	2003/04	2004/05	2005/06
Initial consultation	$15.68	$15.69	$15.63
Follow-up consultation	$11.20	$10.50	$11.57
Ankle sprain requiring strapping: Initial consultation	$15.98	$14.90	$15.71
Ankle sprain requiring strapping: Follow-up with strapping	$12.37	$11.06	$12.54
After hours consultation	$21.29	$20.06	$15.84

D33 The detailed BRC analysis of practices charging under the regulations shows considerable within region and between region variability in rates charged in 2005, as follows – for an initial consultation for an adult over 18 years:[93]

[93] BRC (September 2005) Physiotherapy Services Co-payment Survey, Part 2 – Non-Endorsed Physiotherapists Summary Results, p 6.

Region	Mean co-payment $	Minimum co-payment $	Maximum co-payment $
Northland Region	$11.45	$0.00	$40.00
Auckland Region	$11.10	$0.00	$90.00
Waikato Region	$14.17	$0.00	$60.00
Bay of Plenty Region	$13.39	$0.00	$48.00
Gisborne Region	$8.00	$0.00	$20.00
Taranaki Region	$1.25	$0.00	$10.00
Manawatu-Wanganui Region	$10.12	$0.00	$20.00
Hawkes Bay Region	$7.89	$0.00	$20.00
Wellington Region	$19.20	$0.00	$45.00
Tasman Region	$7.50	$0.00	$15.00
Nelson Region	$15.83	$0.00	$30.00
Marlborough Region	$5.00	$0.00	$10.00
West Coast Region	$12.40	$5.00	$20.00
Canterbury Region	$11.06	$0.00	$47.80
Southland Region	$5.83	$0.00	$20.00
Otago Region	$7.84	$0.00	$27.00
National Total	$12.72	$0.00	$90.00

This research confirms that where claimants are treated by a physiotherapist funded by ACC under the Regulations, they will pay patient co-payments which can in some cases be significant.[94]

[94] Trends in co-payments paid by ACC claimants at EPN practices are outlined in paragraphs E92 – E94 of Appendix E.

APPENDIX E – DEVELOPMENT OF ENDORSED PROVIDER NETWORK ARRANGEMENTS

Origins of practice accreditation and EPN concept

E1 In the early 1990's the NZ Private Practitioners Association (a special interest group of the New Zealand Society of Physiotherapists Inc.) developed a voluntary quality accreditation system for physiotherapy practices known as the New Zealand Physiotherapy Accreditation Scheme (NZPAS). This evolved out of concern about escalating medical costs in the 1980's, which was seen as giving rise to a need for identifiable quality standards. The need for physiotherapists to undertake data collection prompted the NZPPA to implement its own accreditation scheme which would assure the public that reasonable services were being provided.[95] It was intended to persuade funders of the quality of the services provided by physiotherapists, which could justify funding and establish a base for increases in that funding, and establish a benchmark for best practice in physiotherapy services.[96]

E2 NZPPA committed itself to accreditation in September 1988, and worked with the New Zealand Council of Health Standards to develop the NZPAS programme. By 1990 procedures for practice accreditation had been developed and provisional accreditation was awarded on condition that essential criteria were met. By November 1991 the first group of five practices was ready for accreditation visits. By 1994 fifty-four practices had full accreditation.[97]

E3 Around 2000 ACC, while undertaking data analysis of trends in physiotherapy treatment rates, identified that NZPAS accredited physiotherapists appeared to have fewer visits per claim than non-accredited practices. While no systematic data were available on outcomes, the data available to ACC indicated outcomes in NZPAS-accredited practices were similar to those in non-accredited practices.

E4 It has subsequently been suggested[98] that NZPAS-accredited providers could treat the same injuries at lower cost to ACC and patients while achieving similar outcomes because they either:

- offered different, more effective treatments for a given injury: or

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95 Scrymgeour, J (2000), *op.cit.*, p 76-77.

96 NZPPA, 'The Future of NZPAS and How it Affects You", on *www.physiostandards.co.nz* (downloaded on 10 April 2006), p 1.

97 Scrymgeour, J (2000), *op.cit.*, p 77.

98 NZIER (April 2002), Framework for Analysis of the Endorsed Provider Network, p 3.

- were more effective than others in delivering the same treatment; or

- had the quality systems or knowledge to determine earlier when additional treatments no longer make a difference to rehabilitation outcomes.

E5 It was further considered that if this were correct, then patients and ACC would benefit if all providers would change to a similar treatment profile to that of NZPAS accredited providers (which came to be termed 'best practice').

Legislative context for ACC's new approach

E6 Prior to the passage of the Injury Prevention, Rehabilitation and Compensation (IPRC) Act 2001, ACC's liability for paying or contributing to physiotherapy treatment costs where a claimant had cover was, as noted above, governed by the Cost of Treatment Regulations. The IPRC Act 2001 also provided for an alternative payment structure, by permitting ACC and providers to enter into contracts for treatment services that would apply in place of the Regulations.

E7 Section 70 of the IPRC Act provides that a claimant who has suffered injury for which he or she has cover is "entitled to be provided by the Corporation with rehabilitation, to the extent provided by this Act, to assist in restoring the claimant's health, independence and participation to the maximum extent practicable. Section 69 provides that rehabilitation includes treatment. Entitlements to treatment are governed by Schedule 1. Clause 1 of Schedule 1 provides:

> "(1) ACC is liable to pay or contribute to the cost of a claimant's treatment for personal injury for which the claimant has cover if clause 2 applies –
>
> (a) to the extent permitted under contract or agreement with any person for the provision of treatment; or
>
> (b) if no such agreement or contract applies, to the extent required or permitted by regulations made under the IPRC Act 2001; or
>
> (c) if no agreement, contract or regulations apply, the cost of treatment.
>
> (2) In sub-clause (1)(c), cost means the cost –
>
> (a) that is appropriate in the circumstances; and
>
> (b) as agreed by the Corporation and the treatment provider."

E8 For physiotherapists, this opened the possibility that physiotherapy treatment costs could be met through what came to be called Endorsed Provider Network

contracts (details of which are provided below). Physiotherapists who did not enter into EPN contracts would continue to be paid under the regulations.

Rationale for the EPN

E9 In its initial submission to the Review, ACC identified the following objectives for the EPN programme:

- encourage quality treatment;
- eliminate claimant co-payments with progress towards compliance with ILO Convention 17;
- reduce weekly compensation durations; and
- achieve early, effective, sustainable rehabilitation outcomes.

E10 ACC has also described the rationale for the EPN as follows:

> "The EPN aims to reduce the number of treatments per claim through financial incentives on providers to put in place the quality processes associated with certification and a better treatment profile, and through incentives on consumers (no co-payments) to chose certified providers over non-certified providers."[99]

Achieving the accreditation requirement for participation in the EPN

E11 As practice accreditation was to be the key differentiator between EPN and non-EPN practices, it is important to understand what this involves and how it has evolved. As noted above, the initial standard for the EPN was developed by the New Zealand Physiotherapy Accreditation Scheme (NZPAS) – which has been operational for 15 years, and was owned by the New Zealand Private Practitioners Association. The NZPAS both prepared businesses for certification and audited the businesses against the standard.

E12 After ACC began piloting the EPN approach a number of organisations approached ACC requesting that their standard become part of the EPN contract. In order to have a consistent and fair quality framework, ACC contracted Standards New Zealand to develop NZS8171:2005 Allied Health Services Sector Standard (drawing on aspects of NZPAS, which ACC purchased from NZPPA).

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[99] ACC (6 March 2006), Service Evaluation Report: Endorsed Provider Network Physiotherapy Services, ACC Claims Management Committee Paper, p 3.

This has become the mandatory standard for certification for the EPN contract from January 2007.[100]

E13 The Standard specifies outcomes that each accredited practice is expected to achieve and criteria that it must meet in order to ensure that each of these outcomes is achieved. The twenty-nine outcomes which accredited practices are expected to achieve fall into the following six areas:

- consumer focused services;
- organisational management;
- pre-entry to services;
- service delivery;
- managing service delivery; and
- safe and appropriate environment.

E14 Standards New Zealand has produced a 179 page Audit Workbook to complement the Standard, designed to "set out the sector solutions, examples and additional information that will enable physiotherapy practices, in both public and private health and disability settings, to demonstrate compliance with the Allied Health Services Sector Standard while meeting the special and unique needs of New Zealanders seeking physiotherapy services."[101]

E15 ACC has standardised the process for auditing against the standard. Designated Audit Agencies (DAAs) or Conformity Assessment Bodies (CABs) are required to meet the ACC criteria,[102] which align with the Ministry of Health requirements for auditing against the Health and Disability Sector Standards. The four ACC-approved CABs are Bureau Veritas New Zealand, Quality Health New Zealand, Health and Disability Auditing New Zealand Ltd and Telarc Ltd. They all have JAS-ANZ third party accreditation against ISO/IEC Guide 62, JAS-ANZ procedure 32 Part 1.

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[100] ACC (8 March 2005), ACC Healthwise Auditing Requirements for Auditing Agencies to Audit against Standards for Healthwise Contracts.

[101] Standards New Zealand (2005) ANZ HB8171 Allied Health Sector Standard – Physiotherapy Work.

[102] Refer ACC (May 2006) ACC's Requirements for Conformity Assessment Bodies to Audit Against New Zealand Physiotherapy Accreditation Scheme Standards 2003; and/or NZS 8171:2005 Allied Health Services Standard. – Physiotherapy Services Audit Workbook, p 6.

E16 The main audit type undertaken by CABs is a full audit of a currently operating business to determine whether all the standards and criteria in the appropriate standard are attained. This will include a site visit to the main business site and a sample of multiple sites and/or off-site services. Policies and procedures must be viewed for off-site services with supporting evidence of their use and implementation. A clinical notes audit is required for each allied health professional within the service from a sample of at least 3 months in duration. If non-conformities are found to exist, they must be effectively corrected within a timeframe guided by the Risk Management Matrix (which determines action required by classifying likelihood and level of risk) and followed up by the CAB

E17 CABs also undertake provisional audits of new physiotherapy businesses prior to the commencement of service delivery, to ensure that the provider has the appropriate policies, procedures and systems documented in place to meet the requirements of the standard.

E18 Verification visits to a business are undertaken to enable the CAB to audit against the relevant criteria specific to the business that were not covered by the full or provisional audit. For a new business the verification visit will take place six months after the provisional audit and will include a clinical notes audit of allied health professionals employed. The purpose is to ensure that all appropriate systems policies and procedures developed have been effectively implemented and there is evidence that the business complies fully with all criteria.

E19 Finally, a surveillance audit of each business is required at eighteen months during the three year certification period to ensure the business is continuing to meet the standards based on the report of the original audit. The surveillance audit will assess those nonconformities identified at the full audit and ensure that the actions required, as identified in the Risk Management Matrix, have been taken and maintained. It will also include customer complaints, changes to the documented system, copies of clinical records, documented evidence of quality improvement and areas subject to change.

E20 The audit process requires the CAB to determine the level of attainment that the business achieves for each relevant criterion - in decreasing order of attainment as ‘continued improvement’, ‘fully attained’, ‘partial attainment’, ‘not attained’ or ‘not relevant’. Once audited, and providing the practice is ranked ‘continuous improvement’ or ‘fully attained’ for all outcomes and criteria, the auditor certifies that the practice meets the standard. Certification lasts three years. Change in ownership and the sale of a practice require that a verification audit is carried out within six months of the change of ownership.

E21 Costs of attaining the standard are both direct (payments to Conformity Assessment Bodies, and to any other organisations helping prepare a practice for assessment), and indirect (income forgone by the practice owner or other staff preparing policies and other relevant documentation, investment in necessary practice assets and premises improvements to achieve compliance. It is understood that NZPAS charged in the order of $7,000 for their role, but that the charges of some of the more recent entrants to the market can be as low as $2,500. The Deloitte pricing review initially made an allowance of $10,000 for initial accreditation costs (both direct and indirect) and a $2,000 allowance for ongoing accreditation costs.[103] Submissions to the Review and follow-up information provided by the parties placed the costs as much higher. Bruce Monkton, who is in the business of working with physiotherapy practices to help them achieve accreditation, estimated that the cost for initial three year certification was in the range of $22,300 - $79,940.[104]

The initial EPN pilot, 2001

E22 In 2001 ACC decided to pilot the EPN contracting process to test the feasibility of fostering the adoption of best practice amongst physiotherapists by altering the financial reimbursement provided. That is, reimbursing them with a predetermined 'reasonable fee' (which eliminated any patient co-payment) if they could demonstrate compliance with quality criteria. As noted previously, each physiotherapy practice needed to be accredited by NZPAS, and invoice ACC electronically.

E23 The initial EPN pilot[105] ran for the six months ended 3 March 2001 in Wanganui, Palmerston North and Rotorua. It involved three provider types (each with different quality criteria): general practitioners (Royal NZ College of General Practitioners Fellowship); physiotherapists (NZPAS accreditation) and radiographers (IANZ practice accreditation). Accredited physiotherapy practices in the pilot were paid $45 for a first visit and $30 for a follow-up visit, while all other physiotherapists continued to receive $19 or $47.80 per hour under the regulations (which at the time was estimated to equate to 61% of average physiotherapy charges).

E24 The numbers of participating providers and practices in the EPN pilot were as follows:

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[103] Deloitte (December 2006), ACC Physiotherapy Practice Costing and Pricing Review (Draft Report), p 17.

[104] Bruce Monkton, Supplementary Information on Standards and Accreditation Costs, p 4.

[105] ACC (May 2001), Endorsed Provider Network: Report on the trial.

Provider Type	Wanganui		Palmerston Nth		Rotorua	
	Total	**EPN**	**Total**	**EPN**	**Total**	**EPN**
General Practitioners (individuals)	32	32	60	9	55	49
Physiotherapists (practices)	6	1	17	2	11	1
Radiologists (practices)	2	1	2	1	2	1

E25 The trial gathered quantitative data for non-work claimants to measure changes in injury rates, claim duration and costs and service utilisation before and during the trial in the selected sites, as well as changes in reported injury complexity. For physiotherapists, the results for the four accredited practices were compared with those of the other thirty regulation-funded practices in the pilot areas. Qualitative information was also collected through claimant and general public surveys undertaken by Colmar Brunton.

E26 For physiotherapists ACC found that the main result was that by the end of the pilot in both Rotorua and Wanganui endorsed physiotherapy practices were averaging 3.17 visits per claim – a reduction of 18% on the overall average visits per claim before the trial started. However non-endorsed physiotherapy practices in those two centres also reduced the average number of visits from 3.76 to 3.6 visits per claim (or 4.2%). The context for this finding was a falling national average for visits per claim over the last four years, from 6 to 3.93 visits.

E27 The pilot also found significant provider switching by claimants towards endorsed physiotherapy practices in both Rotorua and Wanganui, as a proportion of claims treated by all physiotherapists. Finally, in Rotorua there was a shift in the type of patients the practice saw, with a significantly higher number being in the lower socio-economic group, more Maori, more elderly and more chronic cases (ie over eight weeks since the injury).

E28 There was no statistical analysis of the results from the pilot to assess whether any of the observations were statistically significant, and how confident one could be in drawing conclusions from the pilot. The small number of practices involved in the pilot and its short duration, coupled with the initial non-random method of selection of practices, almost certainly meant that no conclusions could reliably be drawn from this exercise.

The extended pilot, 2002[106]

E29 Following the initial pilot, the EPN was extended to further test the hypotheses concerning provider and claimant behaviour. The extended pilot ran from 13th August 2001 to 8th February 2002, in Christchurch, Invercargill, Rotorua and Wanganui and covered all types of ACC claims (work, non-work etc). Contracts were then extended in the four pilot sites at the end of the pilot period until 27th September 2002. Any newly accredited clinics in these sites were offered EPN contracts, if they met the inclusion criteria.

E30 The following table shows the number of endorsed providers, relative to total providers in each area:

	Accredited Providers		**Total Providers**
	December 2001	***June 2002***	
Site	**Number of clinics**	**Number of clinics**	**Number of clinics**
Christchurch	12	30	70
Invercargill	2	4	6
Rotorua	1	3	16
Wanganui	1	2	6
New Zealand	**64**	**98**	**603**

E31 ACC has described the findings of the pilot as equivocal. The main findings from ACC's analysis of the extended EPN pilot were reported by ACC as follows:[107]

- for work injuries, treatment by an endorsed provider was associated with a significantly shorter time (-13%) on weekly compensation, suggesting higher quality or more effective treatment;

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106 ACC (9 July 2002), The Endorsed Provider Network Extension Pilot: A Cost Benefit Assessment.

107 ACC (9 July 2002), *op.cit.* p 12.

- there was no observable difference between the total number of visits per claim between endorsed and non-endorsed physiotherapists, but endorsed physiotherapists had lower visits per claim per month than non-endorsed providers (6%) – arising from there being a longer interval between the first and last physiotherapy treatment;

- there was no observed increase in the number of claims treated in the pilot sites that could not be explained by previously existing trends;

- there was no evidence to indicate a change in the severity or complexity of claims.

E32 The July 2002 evaluation by ACC once again does not appear to have involved any statistical analysis of the reliability of the results obtained, or any sensitivity testing of those results. The analysis does not appear to provide a reliable basis for making any predictions about likely future outcomes.

E33 Some submissions made to the review were highly critical of the methodology and analysis ACC undertook in respect of the EPN pilots. In 2003 the APPPA and the Physiotherapy Trust commissioned Associate Professor Christopher Triggs of Auckland University to examine ACC's statistical analysis. He concluded that: "the EPN 'trial' did not meet the criteria that would be expected from a trial to justify the introduction of a new drug or new surgical or therapeutic procedure. These would include careful matching of the physiotherapy practices to be allocated either to the EPN or control conditions, the so-called endorsed and non-endorsed providers. Such matching in a formal trial would at least include comparisons of size, caseload, case severity and socio-economic status of patients between the two groups of provider practices…My conclusion on study design was that it was incomplete and that much more information would be required before unequivocal conclusions could be drawn."[108]

E34 Associate Professor Triggs was particularly critical of the validity of ACC's claim that the second pilot showed there had been a reduction of 13% in weekly compensation duration due to the introduction of the EPN. He questioned the validity of the way ACC had calculated the average weekly compensation durations for the two provider groups, being concerned that the average figures quoted were significantly inflated by the apparent inclusion of weekly

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[108] Letter from Associate Professor Christopher Triggs to Graham Hayhow, APPPA, 20 August 2003, in Physiotherapy Trust of New Zealand, Submission to the Review, Volume 2, Item 15, pp 1-2.

compensation durations for the very large number of persons who did not in fact need to claim it.[109]

E35 Associate Professor Triggs also questioned whether the appropriate summary measure was being applied by ACC. As a statistician, he considered a simple average is not an appropriate measure of the length of periods of compensation and cannot be used to formally test the statistical significance of any observed difference between endorsed and unendorsed providers. He observed that: "We expect to see most patients have very low weekly compensation duration with the numbers dropping rapidly as weekly compensation duration increases. The numbers will decrease to the very, very few patients with extremely severe injuries and very long weekly compensation durations. Simple averages do not summarise this type of data well as they are very vulnerable to the effect of the very small number of patients with very high weekly compensation durations. Medians, those values of weekly compensation duration for which 50% of the sample lie below and 50% lie above, provide much more robust summaries of data of this type."[110] He further noted the lack of provision of any other summary statistics – such as sample sizes and standard errors, and summary p-values.[111]

E36 The general thrust of these criticisms is in my view well founded. The design and analysis of the EPN Pilot does not appear from the material provided to me to have been adequate to enable conclusions to be drawn with any confidence at all about the likely future consequences or costs of implementing the EPN more broadly.

E37 ACC acknowledged in its submissions to the review that ACC and others are learning from experience in this area, and that what was done historically is not necessarily what is done today, or would be done in the future.[112] I understand from these comments that more rigorous standards would be applied to such a study today. In the light of that acknowledgement, it is neither necessary nor constructive to go into the criticisms of this work in detail. But two important lessons can, with the benefit of hindsight, be drawn from it:

- it is important that significant pilots and studies be the subject of careful design and analysis. Otherwise, the quality of policy advice based on these pilots and studies necessarily suffers, and there is a real risk of failing to

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109 Associate Professor Christopher Triggs, *op.cit*, Appendix 3, pp 8-9.

110 Associate Professor Christopher Triggs, *op,cit.*, Appendix 3, p 9.

111 Associate Professor Christopher Triggs, *op.cit.*, Appendix A, p 5.

112 Transcript of Review Hearings, Day 1 (14 May) p 96.

achieve desired outcomes, and producing unexpected and possibly undesired outcomes;

- ACC should engage openly and constructively with its critics, especially where they commission expert commentary on ACC's own work. ACC could have significantly improved the quality of its analysis, and of its advice to Ministers, if it had taken on board the concerns raised with it, and had reflected those concerns in its advice on extension of the EPN.

NZIER framework for analysis of national rollout of the EPN

E38 In 2002 ACC commissioned the NZ Institute of Economic Research (NZIER) to identify how a national rollout of the EPN contract was likely to influence physiotherapy treatment patterns and costs in the short and long term, using a basic economic framework.[113]

E39 NZIER recorded that the EPN aims to reduce the number of treatments per claim through financial incentives on providers (higher fees) to put in place the quality processes associated with a better treatment profile and accreditation, and through incentives on consumers (zero co-payments) to choose accredited providers over non-accredited providers.

E40 NZIER's analysis assumed that the certification process would lead to an increase in the quality of services provided by practices. It also appears to have assumed that treatment quality would on average be higher in certified practices, as compared with non-certified practices. These assumptions appear to have been based on claims data, but no detailed analysis of this data is included in the report, or referred to.

E41 Three further assumptions underpinned the NZIER analysis, which NZIER considered are supported by international research. The first is that the demand for physiotherapy is responsive to price differences (as well as the impact of an injury, and other aspects such as convenience). The second is that in deciding the level and mix of services to be offered, physiotherapists are motivated by income objectives, as well as ethical considerations and other non-monetary considerations. The third is that physiotherapy services are contestable – physiotherapists compete with each other and with close substitute services on price and quality and it is relatively easy to enter the physiotherapy and substitute markets.

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[113] NZIER (May 2002), Framework for Analysis of the Endorsed Provider Network.

E42 Using this model, NZIER predicted that the national roll-out of the EPN contracts would have the following effects:

- patients will switch from non-endorsed providers (and substitute health services) to endorsed providers;
- the average number of treatments per claim will reduce (but see the countervailing effects below);
- non-accredited providers will take steps to become accredited; and
- more claims will be made as the co-payment drops to zero.

E43 The NZIER analysis also indicated there would be countervailing effects:

- the marginal benefit per treatment may drop (because the additional demand will tend to be in relation to less serious injuries, for which individuals previously did not seek treatment);
- there may be an increase in treatments per claim if the zero co-payment induces more patients to complete the full course of treatment;
- there is a constraint on how fast non-accredited providers can become accredited (of up to 3-4 years) and subsequently endorsed. This creates a lag before the full potential reduction in the number of treatments per claim is realised; and
- this lag creates a queue of people waiting to see the 'free' endorsed provider, which may spill over into the non-endorsed provider market. To cope with this extra demand, non-endorsed providers may either drive up their co-payments in the short-run, or reduce the number of treatments per claim depending on the amount of competition among physiotherapists, and between physiotherapists and providers of substitute services.

E44 NZIER noted that these countervailing effects made it difficult to conclude *a priori* what the benefit of the EPN would be over a three to five year timeframe, if it were to be rolled out nationally. They concluded that what is clear is that the EPN will have significant redistribution effects, from tax and premium payers to claimants. Furthermore, the EPN may not necessarily reduce the cost of treatment, but may increase its quality.

E45 NZIER also noted that in order to achieve the objective of reducing the number of treatments per claim to achieve the same or better rehabilitation outcomes for less

cost, ACC could also increase the constraints on non-accredited providers.[114] They noted that options worth considering were:

- putting limits on the number of treatments per claim that non-accredited providers can provide before having to seek prior approval from ACC; and

- increasing service audits, claim reviews, and other forms of monitoring for providers that treat consistently outside the Treatment Profiles, while relaxing the controls for those that do not.

E46 NZIER warned, however, that "taking a more 'adversarial' or control approach can have negative impacts on the funder-provider relationship, which in the face of information asymmetry and poorly aligned incentives relies (according to the contracting literature) on mutual trust to be effective."[115]

E47 The NZIER analysis in this paper did not draw on the results of the EPN Pilot – it was a higher level, more theoretical treatment of the issues. It did not provide any basis for a conclusion that the cost of treatment would fall if the EPN Pilot was extended, or that time on weekly compensation would reduce, or that treatment outcomes would be better.

Approval for national roll-out of the EPN 2004

E48 In 2003 ACC recommended, and Cabinet agreed,[116] that the EPN contract be rolled out nationally. ACC based its recommendation on the results of the initial and extended pilots and the NZIER analysis. As noted above, the information available to ACC in those reports did not provide a sound basis for making any predictions as to likely outcome or likely cost of this initiative, but the unreliability of the information available does not appear to have been fully appreciated by ACC in giving this advice.

E49 The Minister for ACC agreed to this recommendation, and funding to cover the costs of this to the Non-Earners Account was included in budget bids, with funding allocated in the 2003/2004 budget. The estimated cost of the proposal in the non-earners account was $3.376 million in 2004/05, $4.059 million in 2005/06, $4.190 million in 2006/07 and $4.324 million in outyears.[117]

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114 NZIER (April 2002), *op cit*, pp 12-13.

115 NZIER (April 2002), *op.cit*, p 13.

116 Cabinet Minute (03) 13/09 (01).

117 Treasury Report (21 February 2003), Budget Bilateral Briefing for ACC and Vote: Women's Affairs, p 4.

Key parameters of national roll-out

E50 The operational guidelines for physiotherapy practices specify that the objective of the Endorsed Provider Network (Physiotherapy) Service is to provide claimants with timely access to a quality physiotherapy treatment service that facilitates a prompt, cost-effective and sustainable return to independence and/or work and education.[118]

E51 The philosophy of the EPN (Physiotherapy) Service is to provide quality treatment that is available at no cost to claimants for consultations during normal working hours. Under the operational guidelines, however, a claimant may be charged for out of hours consultations, treatment materials, 'no-show' appointments and travel to provide physiotherapy services for a claimant, where that travel is not covered by ACC's Provider Travel Policy for Contracted Providers.

E52 ACC developed a more differentiated pricing structure for the national roll-out than was used during the pilots. ACC based the EPN pricing framework for the nationwide roll-out of the EPN on a 'mystery shopper' pricing survey, and other available pricing information (see section 5.22 above).

E53 ACC consulted with the NZSP regarding the revised pricing structure, and made some changes to it in light of their response. [119] [120] ACC did not accept the NZSP proposal that there be regional rates, with higher payments in Wellington and Auckland. There was, however, agreement to incorporate a Labour Cost Index annual adjustment to the rates of payment for services provided.

E54 The resultant EPN contract has two service levels for treatments which are paid at different rates. Currently the rates are as follows:

- Level A – for a specific injury without complications
  - Initial appointment = $47.26;
  - Follow up appointment = $38.26;

- Level B – for injuries where the related clinical factors indicate extended physiotherapy consultation duration
  - Initial appointment = $83.22;
  - Follow up appointment = $61.64.

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[118] ACC (2004), Endorsed Provider Network: Operational Guidelines, p 1.

[119] ACC (10 October 2003), Endorsed Provider Network for Physiotherapists (WPN) – Pricing Approach, Briefing Paper to the Minister for ACC, pp 2-3.

[120] ACC (19 November 2003), ACC's response to the issues raised by the NZSP regarding the EPN roll-out, Briefing Paper to the Minister for ACC, pp 2-4.

E55 EPN providers must be certified against NZS 8171: 2005, and at least one principal in the practice must be a member of the New Zealand College of Physiotherapists.

2006 Evaluation of the national EPN roll-out – an overview

E56 In early 2006 ACC undertook a detailed analysis of the results of the EPN national roll-out.[121] The analysis showed that when the EPN contract was rolled out nationally on 1 April 2004 108 EPN contracts existed, and by the end of January 2006 215 clinics had taken up the contract – making up more than 60% of the total annual ACC physiotherapy claims overall.

E57 Analysis of the take-up data revealed there had been three distinct phases in the growth of EPN claims as a proportion of all claims:

- July 2001 – June 2002 – approx 5% of claims covered, in the initial EPN pilot;
- July 2002 – April 2004 – claims covered rise from approx 5 – 15% as the EPN pilot is expanded;
- April 2004 - December 2006, following the national rollout of the EPN contracts, claims covered rise from 15 to over 60% of all physiotherapy claims.

E58 Analysis of contracts indicated that the early joiners tended to be larger clinics (in terms of number of physiotherapists employed), with more of the smaller clinics joining later.

E59 There was considerable unevenness of EPN contract take-up across the country. ACC data analysis for the six months ended 30 June 2005 showed that 22 Territorial Local Authorities (31%) had no visits that had been paid under EPN contracts. These tended to be rural areas (like the Far North, Kaipara, Hauraki, Matamata-Piako, South Waikato, South Taranaki, Westland, Gray, Mackenzie; smaller towns (like Taupo, Kawarau, Whakatane, Opotiki and Wairoa); or poorer urban areas (like Porirua.) At the other end of the spectrum, in 15 (21% of Territorial Local Authorities all of the physiotherapy visits had been paid under the EPN contract. Some were small to medium towns (like Stratford, Wanganui,

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[121] ACC Analysis Report (3 February 2006): Data Analysis for the Service Evaluation of the EPN Physiotherapy contract.

Otorohanga, Gore), while others were substantially rural areas (like Banks Peninsula and Hurunui).

Expected impacts of the EPN contract

E60 The evaluation report begins by outlining what ACC expected to find, prior to doing the data analysis. ACC identified three factors as likely to have the most significant impact on the sector: higher ACC payments, no co-payments being charged except in limited circumstances, and certification against the standards.

E61 The impact of higher ACC payments was expected to depend on the extent to which they offset the cost of certification and the loss of co-payments – which they were expected to do for most physiotherapists. Where this was the case, ACC expected higher ACC payments would result in a higher rate of take-up of the EPN contract, increased profitability and increased supply of services (eg clinics open more hours, greater advertising and more visits per claim).

E62 ACC expected the impact of the restriction on co-payments to be:

- claimants switching from regulation-paid clinics to contract-paid clinics;
- an increase in the number of claims seen by physiotherapists overall;
- an increase in the number of visits per claim overall;
- a decline in volume and the level of profitability of non-EPN clinics, with a resulting decline in profitability and rise in business closure rates; and
- increased take-up of the EPN contract, driven by competitive pressures on clinics that would otherwise be reluctant to do so.

E63 ACC expected the impact of certification and the requirement to follow Treatment Profiles to result in treatment that was of a higher quality and more effective. ACC expected the results of this to be seen in:

- a reduction in the average duration that weekly compensation is paid;
- a reduction in the average duration of total treatment (including non-physiotherapy treatment); and
- a reduction in the number of treatment visits per claim (including non-physiotherapy visits).

E64 Some of the impacts were expected to counter-balance one another – eg more effective treatment due to certification might decrease the number of treatment visits and the overall duration of treatment, while reduced cost to claimants due to no co-payments might increase both treatment visits and treatment duration.

Actual impacts of EPN contract

E65 The analysis of the evaluation focused on the actual impact on a number of different variables, as outlined below.

E66 *Impact on the number of claims*: The national roll-out coincided with a reversal of what was previously a declining growth in physiotherapy claim volumes. At the same time, rates of growth in claims seen by other allied health providers (chiropractors, osteopaths and acupuncturists) all fell - despite having previously experienced high annual growth. This was particularly marked for chiropractors (growth in the number of claims falling from 24% to 2% per year between March 2004 and March 2005). It appears the national roll-out of the EPN contract increased the volume of claimants visiting physiotherapists, but this has probably been balanced to some extent by a reduction in the number of claimants visiting other allied health providers, given that the overall volume growth for all groups combined remained at around 10% per year.

E67 *Impact on the number of visits per claim*: Prior to the EPN national roll-out the number of physiotherapy visits per claim had been declining slightly (from an average of around 4.0 per claim in July 2001 to around 3.5 in April 2004) – and there was no marked change after the roll-out. Other allied health providers had also been experiencing falling visits per claim prior to April 2004, and there was no change in trend for them either after the roll-out.

E68 *Impact on access by Maori and Pacific Island people*: Studies typically show utilisation of health services by people in lower socio-economic groups responds positively to reductions in prices – and as a greater proportion of Maori and Pacific Islanders are in lower socio-economic groups, their utilisation of physiotherapy services should have increased relative to that of other groups as a result of the EPN roll-out.

E69 In fact, Maori visits as a percentage of all physiotherapy visits began to decline four months before the roll-out, and continued to decline after the roll-out (from around 7% to around 6.5% of all visits). A similar trend applied to the proportion of Maori visits for all other allied health providers (those proportions being lower than for physiotherapists). Analysis of endorsed physiotherapists relative to regulation physiotherapists visits showed it is the regulation physiotherapists who are providing more of the services for Maori - probably largely due to more Maori living in areas where no or few physiotherapists have taken up the contracts (like

E70 For Pacific Islanders: soon after the roll-out their share of visits to physiotherapists rose and their share to chiropractors fell – which may reflect a substitution between the two as a result of the zero co-payment. Their share of visits to physiotherapists, however, fell back again in late 2005. As with Maori, physiotherapists on EPN contracts saw a smaller proportion of Pacific Islanders than do physiotherapists remaining on regulation.

E71 *Impact on non-EPN physiotherapists*: Hypothesised impacts were a fall in the level of co-payments and of total income per visit, a fall in the volume of visits and providers going out of business or being forced to take up EPN contracts.

E72 Survey data showed average adult co-payments moved from $12.30 in March 2004 to $13.38 in October 2004 (an 8.8% increase) and to $13.39 in September 2005 (0.1% increase). Adding ACC payments to these amounts gives total income per ACC visit, which showed a 4.1% increase between March and October 2004 and a 0.4% increase between October 2004 and September 2005. The latter constitutes a real reduction in income, given the consumer price index rose 3.4% in the same period. However ACC concluded that the profitability of non-EPN physiotherapists per visit did not seem to have significantly reduced as a result of the roll-out of the EPN contract.

E73 As noted earlier, the trend in the volume of visits prior to the EPN roll-out was downward. This downward trend continued for non-EPN providers, while for EPN providers the number of visits per provider increased between June and December 2004 and fell slightly between December 2004 and June 2005. The falling volume will have resulted in falling profits for non-EPN practices. (This conclusion is not easy to reconcile with the preceding conclusions on profitability.)

E74 Analysis of trends in the proportion of providers in business the previous six months who are no longer making claims in the following six months showed that non-EPN providers had a higher business failure rate than EPN providers (10.9% versus 6.4% for the period Jan – June 2004), and that there was a jump in the failure rate of non-EPN physiotherapists in the subsequent period (rising to 14.8% for July 2004 to December 2004, while the rate for EPN practices fell to 5.2%). "Confounding factors" exist though: clinics not taking up EPN contracts are smaller on average, and smaller businesses have higher failure rates.

E75 *Impact on co-payments of other allied health providers*: analysis of co-payment data for physiotherapists, chiropractors, osteopaths and acupuncturists shows that

none of the groups had lower co-payments than they did before the EPN roll-out. Changes in the pattern of growth varied between the provider groups. Chiropractors had the lowest co-payment rise in the 18 months after the EPN roll-out. The main impact on their income and profitability will have been through the reduction in growth in the number of claimants visiting chiropractors.

E76 *Impact on effectiveness*: more effective treatment was expected to reduce the duration that Weekly Compensation was paid, the duration of treatment and the number of treatment visits per claim. Performance of 242 physiotherapists paid under EPN contracts for all of the six months ended 31 December 2004 (excluding those in the pilot as any change in their performance would already have occurred) was compared with that of 837 physiotherapists paid by regulation for all of the same period. Low volume providers (less than 50 claims and less than 5 weekly compensation claims) were excluded from both groups.

E77 Regulation-only providers saw 33% fewer claims than EPN providers (averaging 156 per month compared with 232 in 2004), and their average number of claims fell by 6% between 2003 and 2004, while it rose by 10% for EPN providers.

E78 *Impact on weekly compensation*: the average and median duration of weekly compensation of claimants treated by EPN providers did not fall relative to the Regulation-only group, rather they grew at the same rate (4.5% on average, 10.8% for the median claim). A somewhat higher proportion of EPN claims were on weekly compensation (8% compared to 6.8%), and the proportion increased for EPN practices (by 2.8%) and fell for Regulation-only practices (by 4.2%). Longer duration claims have a greater incentive to change to an EPN physiotherapist so as to reduce their cost of treatment – which means duration figures for Regulation practices may otherwise have been higher had the shift not occurred.

E79 *Impact on duration of all forms of treatment* subsequent to (and including) the first physiotherapy visit: this has increased for the EPN-only group (from 44 – 49 days) and hardly changed at all for the Regulations-only group (from 45 to 46 days on average.) The proportion still receiving all forms of treatment after 6 months has increased for all physiotherapy groups, with the EPN-only groups proportion increasing more (from 6.4% to 7.9% compared to 6.3% - 7.1% for regulation-only providers). Again this may reflect some claimants with more serious injuries switching to EPN providers. Just for physiotherapy treatments, average duration rose for EPN-only providers from 24 to 27 days, but was unchanged at 28 days for Regulation-only providers. A similar pattern was observed for the duration of non-physiotherapy treatment.

E80 The third indirect way of assessing treatment effectiveness was the change in the number of treatment visits (to all types of medical/hospital providers). These too increased for the EPN-only group (mean from 7 – 8 visits and median from 22 – 27 visits) while staying the same for Regulation-only (at an average of 7 and median of 23). Disaggregation of the data showed that increased number of treatments visits for EPN-only claims was true for both physiotherapy and non-physiotherapy treatments.

E81 *In summary*: By December 2005 the main impacts of the national EPN roll-out were that 60% of claimants were not paying co-payments, which was likely to have had an impact on the profitability and business survival rate of non-EPN providers relative to Regulation-funded providers, and that physiotherapy claim numbers were up while those of other allied health providers fell.

E82 In regard to effectiveness of treatment, the analysis of before and after outcomes found no evidence that this had increased. Relative to Regulation-only providers, EPN providers showed no improvement in the duration of weekly compensation, the total duration of treatment or the total number of treatment visits per claim. ACC identified, as a qualification to this conclusion, that further work is needed to establish if EPN clinics are seeing more serious injuries than they were before the roll-out, which could partly be contributing to the trends found in these indirect effectiveness indicators.

Fiscal impacts of the move to EPN contracts

E83 The implementation of the EPN programme has had significant fiscal impacts for ACC – both because EPN treatments are paid at considerably higher rates than under the Cost of Treatment (CoT) regulations, and because claim numbers have grown. The following table shows the transfer of claims and costs from Cost of Treatment regulations to EPN over the 2002 – 2006 period, and the growth in both claim numbers and total costs of physiotherapy treatment.[122]

[122] The information in the table is sourced from ACC (October 2006), Briefing for the Incoming Reviewer, p 4, but the totals columns have been calculated and included during this review.

Year	Claim Numbers			Claim Costs (excl. GST)		
	CoT Regs	EPN	Total	CoT Regs	EPN	Total
2002	360,192	19,806	379,998	$43,380,493	$3,183,250	$46,563,743
2003	358,031	48,523	406,554	$42,524,257	$8,656,616	$51,180,873
2004	348,506	84,352	432,858	$40,318,012	$14,858,170	$55,176,182
2005	245,997	212,099	458,096	$28,337,327	$44,070,949	$72,408,276
2006	189,214	305,510	494,724	$21,913,475	$66,643,023	$88,556,498

E84 In summary: over the 2002-2006 period, total physiotherapy claims have risen by 30.2% and the total costs to ACC of physiotherapy treatment have increased by 90.2%.

EPN impacts on the market environment for physiotherapy

E85 Beyond the impacts summarised above, the introduction of EPN has changed the market environment for physiotherapy. ACC noted that some EPN practices have purchased Regulation funded practices and brought them up to certification standard, resulting in some EPN owners owning multiple practices or sites under their service agreement. Small businesses have consolidated. In ACC's view "What we are witnessing is a maturing of the treatment market and perhaps the beginning of a decline in practice numbers as competition between practices increases." [123]

Patient Co-payments at EPN practices

E86 The BRC monitoring of patient co-payments outlined in Appendix D revealed that low levels of co-payments were being charged by some EPN practices, even during normal working hours, and that these rose between 2003/04 and 2004/05 and fell between 2004/05 and 2005/06– as follows (all figures reported are average normal adult rates):

[123] ACC (6 March 2006), Service Evaluation – Endorsed Provider Network Physiotherapy Service, Claims Management Committee Paper, p 8.

Consultation Type	2003/04	2004/05	2005/06
Ankle sprain requiring strapping: Initial consultation	$4.93	$6.67	$5.27
Ankle sprain requiring strapping: Follow-up with strapping	$3.77	$6.16	$5.26
After hours consultation	$3.77	$14.94	$11.51

E87 It should be noted that during this period the number of practices surveyed increased – eg for the second consultation type, from 43 to 104 to 137, reflective of the growing take-up of EPN contracts.

E88 An ACC paper providing a 'Data analysis of the service evaluation of the EPN physiotherapy contract' reports that: "Contract holders are not permitted to charge co-payments for normal consultation, however a survey of co-payments data suggests that 9% of clinics surveyed may be doing so."[124] In this case, the average figures shown may significantly understate the amount of co-payments charged by those 9% of EPN clinics who are charging patients for visits during normal working hours.

EPN evaluation March 2007[125]

E89 In March 2007 ACC undertook a further evaluation of the EPN services to report on progress of the service against the stated objectives, to summarise the results of the service review analysis, and to provide an update on the current work and market environment for physiotherapy.

E90 In regard to the first objective of encouraging quality treatment, the review notes that as a result of implementation of ACC's policy on auditing agencies outlined above, physiotherapy practices have a choice of audit agency and a consistent process and quality of audit is applied. It also means that physiotherapy practices now achieve an internationally recognised certification against a national standard. Since the implementation of the EPN 362 practices have achieved certification.

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[124] ACC (3 February 2006), Data Analysis for the Service Evaluation of the EPN Physiotherapy Contract, p 3.

[125] ACC (9 March 2007), Service Evaluation Report – Endorsed Provider Network Physiotherapy Services, ACC Claims Management Committee Paper.

E91 The second objective of the EPN was to eliminate claimant co-payments during normal business hours, enabling progress to be made towards compliance with ILO convention 17. Progress has been achieved, with the proportion of claims being treated by an EPN provider growing from 68% for the six months ending 30 June 2006 to 74% for the six months ending 31 December 2006.

E92 The third objective was a reduction in weekly compensation duration. Of the 3% of physiotherapy claimants who received weekly compensation, those weekly compensation claims that received treatment from an EPN provider received on average 1.9 less days in weekly compensation than those treated by a physiotherapist working under the Regulations. However this did not result in a reduced cost per claim for weekly compensation claims. Analysis based on the average wage to June 2006 of $610 per week, showed that the reduction of 1.9 days generated a saving of only $132.45 per claim for compensation, compared to the additional average treatment cost of $163.80.[126]

E93 In terms of the overall costs of the service, these have risen significantly. One factor is that for claims that did not receive weekly compensation (97%), EPN providers treated the claimants for an additional 0.9 visits per claim – which constitutes an average cost difference of $121.60 per claim. Applying this cost to all claims seen during the 2005/06 year, the additional cost to ACC was approximately $36 million per annum.

E94 In terms of access to services: the removal of co-payments has reduced financial barriers and improved access to physiotherapy. Only 11 out of 73 Territorial Local Authorities do not have at least one EPN contract in place (representing 3% of the population). This was up from 22 Territorial Local Authorities at the last annual review. The West Coast is the only region with no EPN providers.

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[126] The average cost to ACC per claim for physiotherapy treatment for a weekly compensation claim where treatment is provided by an EPN provider (with no co-payment) is $328.70; compared to a cost to ACC of treatment by a Regulation provider (who charges a co-payment) of $164.90; a difference of $163.80.

APPENDIX F – MODELLING OF PHYSIOTHERAPY PRACTICE COSTS AND PRICING

Objectives of modelling exercise[127]

F1 In 2005 ACC engaged Deloitte to develop a robust costing and pricing model to assist with determining the sustainable cost of operating a physiotherapy practice in New Zealand. The work was designed to assist ACC with determining an appropriate payment schedule for services provided by physiotherapy practices.

F2 The specific aim of the Deloitte project was to identify an average cost for a one hour consultation period based on the financial information provided by a selection of physiotherapy practices, and then model how this could inform pricing decisions over time.

Process for undertaking costing and modelling[128]

F3 Deloitte worked with the New Zealand Society of Physiotherapists (NZSP) to invite practices to participate in the project. Initially thirty-three practices were selected to cover a range of types of location (metropolitan, urban and rural) and operating circumstances (EPN accredited, regulation-funded accredited and regulation-funded non-accredited). Thirteen of these practices decided, for various reasons, not to participate, hence the analysis was based on twenty physiotherapy practices (representing twenty-three sites).

F4 The characteristics of the participating practices were as follows:

Location	**#'s**	**EPN v Regulation**	**#'s**	**Accreditation**	**#'s**
Metropolitan	15	EPN	10	Accredited	17
Urban	6	Regulation	13	Not-Accredited	6
Rural	2				

F5 While the practices were not selected on a statistically valid random basis, NZSP believe the participating practices are generally representative enough of the diversity of practices to provide an indicative basis for the pricing of physiotherapy services.

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127 Deloitte (March 2007), *Physiotherapy Practice Costing and Pricing Review: Final Report*, p 2.

128 Deloitte (March 2007), *op.cit.*, pp 2-4 and pp 15-18.

F6 The methodology Deloitte used to build the costing and pricing model involved:

- collating total actual costs (by component) for all of the twenty-three practice sites, based on the financial statements of the practices involved for the 2004/05 year;
- adjusting or 'normalising' the cost components so they are on a comparable cost basis across all practices[129];
- once all costs were normalised, each individual expense was allocated to one of the following cost pools: labour; equipment; consumables; facility; and administration – together making up total costs for all types of physiotherapy services provided (EPN/Regulation and other);
- using ACC consult numbers, survey data and other information to derive:
  - the revenue derived from EPN/Regulation consults as a percentage of total revenue ("ACC Split"); and
  - the number of hours spent in consult time for EPN/Regulation visits ("ACC consult hours");
- the total normalised costs (including a margin for a return on investment) are then multiplied by the ACC Split to derive "ACC Costs";
- ACC Costs are divided by ACC Consult Hours to get a 'cost per hour' for EPN/Regulation visits; and
- prices/cost per hour are then adjusted to take account of inflationary factors to provide an estimated price per hour based on an appropriate start date for new rates.

Results of modelling

F7 Based on the assumptions made the weighted average cost calculated by Deloitte for a one hour physiotherapy consultation in 2004/05 was $88.39 (excluding

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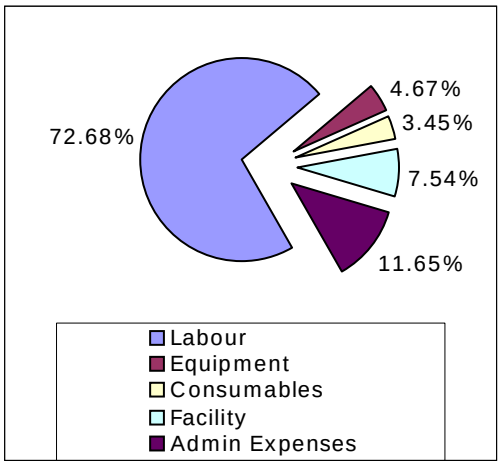
[129] This involved: identifying whether the cost related to other periods or only the period in which it was incurred; identifying other relevant costs that should be factored in to the model that would not show up in a practice's financial statements (like time spent on professional development, costs of Health Practitioner Act compliance, time spent on accreditation); identifying whether the cost is a normal part of the operation of the practice; recalculating depreciation and head office cost allocations and including appropriate market assessed salaries for physiotherapists.

GST). [130] There was considerable cross-practice variation amongst the twenty sampled practices – with the cost of providing a one hour consultation varying from a low of $67.49 to a high of $119.87.[131]

F8 For the average practice the composition of that weighted average cost of $88.39 was as follows:[132]

Weighted Average Cost Breakdown based on 2004/05 data

	Total
Labour	$64.25
Equipment	$4.13
Consumables	$3.05
Facility	$6.67
Admin Expenses	$10.30
	$88.39



F9 In order to arrive at an estimated sustainable price for a one hour consultation, the weighted average cost per hour of $88.39 (excluding GST) has a number of further assumptions applied to it. The price model calculates the price for future dates using appropriate inflationary factors for each of the various cost pool categories, and provides for a return to the business owner on the investment in capital assets and goodwill of the business. The rate of return is based on a

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130 Deloitte (March 2007), *op.cit.*, p 3.

131 Deloitte (March 2007), *op.cit.*, p 8.

132 Deloitte (March 2007), *op.cit.*, p 6.

subjective assessment of risk that owners bear when investing in a physiotherapy business.

F10 The following table shows the pricing results of the Deloitte model for a one hour EPN/Regulation consultation over a three year period (applying the inflationary factors), for three different rates of return on investment to the business owner:[133]

ROI	Pricing Year		
	2005/06	2006/07	2007/08
10%	$94.61	$98.57	$102.72
15%	$95.40	$99.36	$103.51
20%	$96.23	$100.19	$104.34

Issues raised in relation to Deloitte report[134] [135]

F11 NZSP actively participated in the selection of practices, and in providing information to assist in finalising some of the assumptions made regarding variables like the average consult times for different EPN consult categories, and time spent on professional development activities. However much of the NZSP feedback to Deloitte and to ACC on the draft Deloitte report was not taken into account in the final Deloitte report.

F12 In their first submission to the review, NZSP advised that consultation during the Deloitte process was not able to resolve disputes between Deloitte and ACC, and NZSP and their advisers KPMG, as to:

- the level of adjustments to be made to particular price items;
- technical issues relating to the treatment of costs and other data within that model;
- the overall reliability of the model outcomes, and the methods of implementation of the increases required to achieve sustainability and acceptable pricing.

F13 NZSP was prepared to accept that the majority of the survey data identified by Deloitte were historically representative of a range of physiotherapy practices in

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133 Deloitte (March 2007), *op.cit.*, p 3.

134 NZSP (March 2007), First Submission to Review, pp 45-56.

135 KPMG (March 2007) Annex to NZSP First Submission to Review, pp 11-29.

New Zealand, but had concerns with some eleven matters. The specific nature of those concerns is outlined below.

F14 *Time per consult*: for regulation-funded practices NZSP considered this had been over-estimated for both initial and follow-up consultations, because Deloitte took an average of the simple and complex consult times – which implies that an equal number of simple and complex consultations occurred. NZSP considered that because the vast majority of visits were simple (and therefore shorter), the total ACC consult hours estimated by the Deloitte model were over-stated and the cost per hour was proportionally understated.

F15 *Average revenue split between ACC and other sources*: the average EPN or regulation revenue for the 20 practices in the Deloitte sample is 67%, which NZSP considered is unrepresentatively low. NZSP considered that approximately 80% of revenue nationwide of private physiotherapy practices' income is derived from EPN and regulation treatments. They supported use of the approach suggested by Troy Newton of KPMG: namely using the median, rather than the average revenue split, which was 71.6% based on the sample data.

F16 *Salary levels:* the Deloitte report acknowledged that historic salary figures for business owners from the sample data are unsustainably low and that some adjustment is needed. Deloitte opted for using DHB physiotherapy salary rates as the benchmark, with a margin added for overtime as reported by the surveyed practice owners. NZSP considered the salary ranges in the Deloitte Final Report of $72,335 - $78,335 for business owners based on DHB salaries were also too low. They commissioned Strategic Pay Ltd to undertake a job evaluation for business owners and 3 categories of staff, using 10 factors to establish a job size, and then drawing on their database of pay rates for other positions with comparable job sizes in the New Zealand health sector.

F17 The outcomes of the Strategic Pay job evaluation analysis were as follows:

		Total remuneration	
Role	**Experience Level**	**Median**	**Upper quartile**
Business owner	Many 10+ years	$147,618	$160,960
Entry level practitioner	0-4 years	$52,488	$55,297
Mid-level practitioner	5-9 years	$67,082	$73,511
Expert Snr. practitioner	10+ years	$79,493	$91,378

F18 For the employed physiotherapist, NZSP argued that a weighted average should be taken. KPMG calculated this based on NZPPA survey data at $69,648 for the median and $77,907 for the upper quartile.

F19 *Allowance for practice fees and professional costs*: the Deloitte model builds in a 3% uplift for employed physiotherapist remuneration for costs such as study leave, professional development allowance, conference fees, annual practising certificate, payment of NZSP fees and provision of uniform. This is to account for the fact that this gives some parity with the public sector wages which Deloitte used as the base. NZSP believes that even if the Strategic Pay remuneration is used instead, these costs should still be separately assessed and incorporated in the model for employees (some of these are already likely to be incorporated in business costs for the business owner). They are estimated to amount to $3,000 – and once the weighted average employed physiotherapist wage is calculated, the proportion which $3,000 constitutes of the wage should be calculated and the resultant percentage increase to labour cost applied for each employee.

F20 Physiotherapists' professional development requirements are now for 120 hours over three years, or 40 hours per year. NZSP believes that 2% should be added to labour costs for each employed physiotherapist and the business owner to account for the loss of practice revenue and/or costs of locum cover.

F21 *Initial and ongoing costs of accreditation*: as certification under the Allied Health Services Sector Standard is a prerequisite of accessing the EPN contractual relationship with ACC, NZSP considered that both the initial and ongoing cost of certification should be incorporated into the model. They agreed with Deloitte that many of the costs are unlikely to be incorporated in the survey data, and

hence must be added in. The Deloitte model makes an allowance of $10,000 for initial accreditation costs and a $2,000 allowance for ongoing accreditation. For a 10 year period this equals $28,000 in costs, which they expensed over a 10 year amortization period, providing an annual cost of $2,800 per year. NZSP believes these amounts are insufficient.

F22 Based on information about the subcomponents of the costs, NZSP considered that $21,000 is a reasonable estimate of the likely initial costs (inclusive of all direct costs, and the indirect costs of business owner and staff time). In their view this should be incorporated as both an expense to be amortised, and a capital asset upon which a return on investment should be assessed.

F23 For ongoing costs of certification, NZSP recommended a figure of $3,000 per year be allowed – to take account of both direct costs (annual and three yearly for recertification) and business owner time invested.

F24 *Effect of Holiday Allowance (4 weeks)*: as the Deloitte survey data for 2004/05 only included three weeks paid holiday, NZSP recommended an allowance of 2% of labour costs be added to the model for all employees and business owners to account for the Holidays Act amendment providing for four weeks from 1 April 2007. Deloitte noted the issue and the likely cost, but did not incorporate an allowance for it in the model.

F25 *Fixed costs*: KPMG recommended that rather than allocating these between ACC business and other business on the basis of the revenue split (currently 67% in the Deloitte model), an Avoidable Cost Allocation should be applied. That is, ACC service delivery should be treated as the core business of the physiotherapy practice and the proportion of the expenses, revenues, assets and liabilities that could be avoided if the other 'incremental' business was not undertaken should be identified and backed out.

F26 KPMG argued that the 'unavoidable' costs that are required to operate the ACC core business for the five Deloitte cost pools are:

- labour: 90-100%;
- equipment: 100%;
- consumables: 90-100%;
- facility (premises): 100%;
- overheads: 100%.

F27 To apply these weightings in the model, KPMG argues that instead of taking 67% of each cost pool and allocating it to ACC costs, the process adopted should be to:

- convert the assumed 80% revenue split to the appropriate unavoidable cost split above (eg for equipment, multiplier to move from 80% to 100% = 100/80 = 1.25);
- substitute the median revenue split (72% after rounding) for the mean average currently used (67%); and
- apply the multipliers to the median, to derive the cost weightings to be applied to the respective cost pools within the model.

F28 The resultant multipliers and cost weightings to be used would then be:

Cost pool	Midpoint % cost allocation to ACC services	Multiplier	Cost weightings for model
Labour	95%	1.19 (ie 95%/80%)	86% (ie 72% x 1.19)
Equipment	100%	1.23	90%
Consumables	95%	1.19	86%
Facility/Premises	100%	1.25	90%
Overheads	100%	1.25%	90%

F29 *Basis for determining the value of fixed assets*: NZSP/KPMG rejected the Deloitte approach of using the book value of assets, without any allowance for inflationary factors, as inappropriate for assessing a sustainable asset base from which to operate a physiotherapy practice. Instead they advocated the use of 'Optimised Replacement Costs' (ORC) – where the asset value is 'optimised' such that the asset provides an efficient quantity and level of service commensurate with expected market demand. This reflects the cost of an efficient level of assets to a new entrant or competitor that may wish to enter the business and receive a normal rate of return on their investment, and is forward looking. The best approximation to this available is the facilities and set-up costs data provided by an NZSP member for a 4 bed facility, in Appendix III of the Deloitte Report. This was estimated to cost $175,000. NZSP argued that this data should then be incorporated into the final model as a basis for fixed assets, with additional

allowance for motor vehicles and other fixed assets not incorporated in the NZSP data.

F30 *Exclusion of required working capital***:** NZSP/KPMG argued that an adjustment for a return on working capital (in addition to a return on fixed asset investments and goodwill) should be included in the model. They estimated that there is a 14 day discrepancy between accounts receivable and accounts payable – hence working capital should be estimated and applied at 14/365, or 3.8% of total costs.

F31 *Understatement of good will and non-recognition of other intangibles*: NZSP/ KPMG disagreed with the historic accounting-based measure of goodwill used by Deloitte, as the residual of practice acquisition cost after deducting net tangible assets (approximately 48% of the value of the adjusted fixed assets, and added on to the fixed asset adjustment replacement costs). Instead NZSP/KPMG argued that the approach used by Deloitte in the IPAC report for the assessment of goodwill appropriate for GP practices should be applied. That is, use of an industry benchmark of 25-33% of gross practice revenue to estimate goodwill for the purpose of determining the total assets and subsequent estimation of return on investment.

F32 *Integration of sustainable salaries*: NZSP/KPMG argued that in the context of a prohibition on patient co-payments it is crucial that the ACC payment covers practice costs at a level that is sustainable, and that it was for this reason that when the EPN rates were originally set, ACC based those rates on the 87th percentile of actual practice charges identified in the survey. So rather than taking the average cost of all cost pools to establish the EPN price point, NZSP/KPMG argued that:

- all adjusted costs, other than labour, should be incorporated at average cost;
- salaries for all practices should be entered for all practices at the 75th percentile level (of the Strategic Pay estimates);
- practices should be ranked; and
- the practice at the 87th percentile should be taken as the appropriate EPN price point.

F33 All the above issues were the subject of detailed evidence and questioning in the course of the review, including being the subject of an Expert Panel (composed of Deloitte and KPMG accountants with relevant expertise at the initial public hearings in May 2007). The experts from Deloitte and KPMG agreed to provide their evidence as independent experts, on essentially the same basis as expert witnesses before the High Court.

Joint report by experts[136]

Issues considered

F34 At the request of the Reviewer, a joint report was prepared by Deloitte and KPMG for the review to address the issues identified above, and more generally with a view to shedding light on the sustainable price of providing physiotherapy services for injured ACC claimants throughout New Zealand. For the purposes of the joint experts' work, a sustainable price was taken as being a price per one hour consultation that would enable a significant proportion of practices to continue to provide those services in the quantity and at the quality reasonably required by ACC claimants in the long run. It was also assumed that practices are currently providing services of an appropriate quality.[137]

F35 The ten issues addressed by the expert group were:

1. *Cost allocation methodology*:

    a. the appropriateness of the activity-based costing ("ABC") methodology and assumptions currently applied in the Model to estimate costs relating to the provision of EPN/regulation consults;

    b. the appropriateness of the mean cost weighting for the proportion of physiotherapy services that were ACC-related (EPN/Regulation), which led to a 67% cost allocation to ACC services;

2. *Salary levels*: whether the salary assumptions adopted in the model for business owner-physiotherapists and other physiotherapists/clinical staff reflect sustainable salary levels in the long-term;

3. *Setting the percentile (modelling cost points)*: determining an appropriate percentile or range for pricing purposes to achieve a sustainable outcome for the majority of physiotherapy practices;

4. *Holidays Act 2003 and the future impact of Kiwi saver legislation*: determining whether the impact of the Holidays Act 2003 and proposed Kiwi saver legislation should be included in the pricing analysis;

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136 KPMG and Deloitte (June 2007), Physiotherapy practice costing and pricing review: KPMG and Deloitte independent response to queries raised during the review.

137 KPMG and Deloitte (June 2007), *op.cit*,, p 4.

5. *Goodwill*: determining an appropriate basis on which to estimate goodwill;

6. *Return on investment*: determining -

    a. whether the ROI methodology and the specific calculation provide a reasonable and sustainable return to business owners in the long-term;

    b. the appropriateness of the MS Excel financial function currently used in the Model to calculate ROI;

7. *Working capital*: determining whether a return on working capital is appropriate and the basis for calculating the return;

8. *Accreditation costs*: determining an appropriate quantum for initial accreditation costs and whether a return on accreditation costs is appropriate;

9. *Representativeness of sample*:

    a. determining whether the sample of practices included in the initial survey are representative of the overall population of physiotherapy practices in New Zealand;

    b. considering whether it is appropriate to exclude the outliers from the sample data for costing and pricing purposes;

10. *Geographic location*: determining whether the impact of different geographic locations should be included in the pricing analysis for metropolitan, urban and rural practices.

Results and sensitivity analysis

F36 KPMG and Deloitte reached a consensus view on a number of the matters raised during the Review including:

- salary adjustments in relation to overtime and additional benefits generally paid in the public sector and not in the private sector;

- the impact of the Holidays Act 2003 to salary costs;

- working capital;

- accreditation costs;

- treatment of outliers in the sample data;
- compliance costs;
- regulation consult times;
- inflation rates / price indexation;
- goodwill assessment;
- fixed asset values (on a replacement cost basis). Deloitte noted that they had not verified the figure for the cost of fixed assets for a newly established practice, and had relied on the figure provided by NZSP of approximately $175,000.

F37 The agreed adjustments took the sustainable hourly rate for ACC (EPN/Regulation) physiotherapy services from $103.52 in 2007/08$ (and assuming a 15% return on investment) to $138.52. The following table shows the specific assumptions made for each item, and the impact that applying each has on the sustainable hourly price.[138]

Modelling Changes	
Start Point	**103.52**
Agreed Adjustment	**Approximate Incremental ($) Impact**
Salary Adjustments: -Salary Rates for Business Owners and Clinical Staff adjusted to allow for overtime rates as applied in DHBs. Clinical staff base rate of $50,000 factored into model rather than using salary cost in financials. -Business owner base rates altered so that metropolitan, urban and rural practices all have a base rate of $62,930 (including allowance for professional development indirect costs).	$6.25
Salary costs increased for the impact of additional leave entitlements under the Holidays Act 2003.	$1.00
An increased allowance in respect of additional benefits generally paid in the public sector and not always paid in the private sector.	$1.40
Regulation consult times altered to maintain the same ratio of complex and simple consults as for EPN consults.	$9.75
Asset Base of Practices altered so that the fixed asset base of a physiotherapy practice are equal to the startup costs provided by NZSP for a four bed practice plus initial accreditation costs (note: this impacts depreciation expense, ROI and goodwill calculation)	$16.55
An ROI on working capital has been factored into the model.	$1.50
Initial accreditation costs increased to $20,000 with an allowance for $3,000 per year of ongoing accreditation costs.	$0.40
Outliers removed from the model in order to calculate the price per hour.	-$1.90
Total impact of changes on price for a one hour consult	**$138.52**

F38 There were four primary areas in which KPMG and Deloitte did not agree. These were:

- cost allocation methodology (use of 67% as the estimate of the proportion of consultations that were ACC-related);
- base salary levels (which have flow-on consequences for other elements of the model);
- setting the modelling cost point percentile (whether the weighted mean is appropriate);
- calculation of the return on investment at 15%.

F39 The further adjustments that KPMG considered were required would cumulatively result in an hourly rate for a physiotherapy consultation of $211.10. The following table describes the specific assumptions KPMG considered should be made for each item and the cumulative impact each has on the price for a one hourly consultation.[139]

Modelling Changes	($)
Start Point	**103.51**
KPMG Adjustments	**Approximate Incremental ($) Impact**
Base salary level for a Business Owner was adjusted to $90,000	10.40
Cost allocation increased to 80%	21.51
ROI approach was updated to reflect a 20% return on invested capital	10.37
KPMG Base Case	**145.80**
Agreed Adjustment	
Salary Adjustments: - Salary Rates for Business Owners and Clinical Staff adjusted to allow for overtime rates as applied in DHBs. - Clinical staff base rate of $65,000 factored into model rather than using salary cost in financials.	22.59
Salary costs increased for the impact of additional leave entitlements under the Holidays Act 2003.	1.25
An increased allowance in respect of additional benefits generally paid in the public sector and not always paid in the private sector.	2.01
Regulation consult times altered to maintain the same ratio of complex and simple consults as for EPN consults.	13.93
Asset Base of Practices altered so that the fixed asset base of a physiotherapy practice are equal to the start-up costs provided by NZSP for a four bed practice plus initial accreditation costs (note: this impacts depreciation expense, ROI and goodwill calculation)	12.35
An ROI on working capital has been factored into the model.	1.80
Initial accreditation costs increased to $20,000 with an allowance for $3,000 per year of ongoing accreditation costs.	0.49
Outliers removed from the model in order to calculate the price per hour.	10.89
Total impact of changes on price for a one hour consult	**211.10**

F40 Finally, KPMG and Deloitte undertook sensitivity analysis to identify the combined impact of the assumptions on which they had different views.[140] They concluded that the sensitivity analysis confirmed their preliminary view that cost allocation, salary levels and percentile are the most critical variables affecting cost and price per consult hour.

Further results and sensitivity analysis following second hearing

F41 Following the second round of hearings in August 2007, KPMG and Deloitte were asked to repeat their analysis to reflect the further submissions made by the parties, in particular in relation to fixed asset values and remuneration, and to provide further sensitivity analysis. They prepared a further joint report dated September 2007.

F42 In response to the analysis in the draft report, ACC submitted that the figure for fixed assets used in the previous round of modelling was too high, and that a more appropriate figure was $83,341. NZSP provided a revised estimate of fixed costs of $178,140. The main drivers of the difference were:

F42.1 whether the fixed costs should include a fully equipped gymnasium (NZSP revised estimate $54,985). ACC submitted at the second hearing that no gymnasium was required to supply EPN treatments. NZSP disagreed, and provided evidence that use of gymnasium-based exercise is considered best practice for relevant treatments, and that a large proportion of providers of these services have such facilities. ACC subsequently accepted that some exercise equipment may be appropriate, but that a fully equipped gymnasium is not needed to supply these services;

F42.2 IT costs, estimated by ACC at $12,563 and by NZSP at $34,142 for a four physiotherapist practice.

F43 In response to the draft report, NZSP submitted that the Strategic Pay analysis remained the best approach to identifying appropriate remuneration rates for physiotherapists, but that if one were to benchmark against public sector physiotherapist remuneration rates, the relevant benchmarks in 2007/8 dollars were $111,042 for business owners, and $79,011 for clinical staff (excluding overtime). ACC submitted that more appropriate remuneration benchmarks in 2007/8 dollars were $72,040 for business owners, and $59,315 for clinical staff (excluding overtime).

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[140] KPMG and Deloitte (June 2007), *op.cit.*, p 10.

F44 The results of the further modelling work undertaken in September 2007 to reflect these approaches, and provide further sensitivity analysis, were expressed by the experts in 2007/8 dollars to enable direct comparison with the implicit current EPN benchmark rate of $103 per hour. Where inputs were based on figures for earlier years the relevant figures were indexed, using the rates shown below:

Inflation Adjustors

		Year ending						
	Category	Original	Jun-05	Jun-06	Jun-07	2 years (05/06)	3 years (05/06/07)	Source
Labour	Business owner	**5.70%**	5.70%	4.60%	5.10%	**5.15%**	**5.13%**	*Statistics NZ - LCI (Salary and Wage rate) Table 5.2 Health Professionals*
	Physiotherapist & other clinical staff	**5.70%**	5.70%	4.60%	5.10%	**5.15%**	**5.13%**	*Statistics NZ - LCI (Salary and Wage rate) Table 5.2 Health Professionals*
	Admin staff	**2.40%**	2.40%	2.40%	2.90%	**2.40%**	**2.57%**	*Statistics NZ - LCI (Salary and Wage rate) Table 5.2 Office Clerks*
	Labour - others	**2.80%**	2.70%	3.20%	3.10%	**2.95%**	**3.00%**	*Statistics NZ - LCI (Salary and Wage rate) Table 5.2 All Occupations Combined*
Equipment	Excluding depn, and interest	**2.80%**	2.80%	4.00%	2.00%	**3.40%**	**2.93%**	*Statistics NZ - CPI Table 3.03 - all groups*
Consumables	Medical supplies	**2.90%**	1.40%	2.60%	2.80%	**2.00%**	**2.27%**	*Statistics NZ - CPI Table 8.02 - medical and health supplies*
Facility	Facility costs	**2.47%**	2.40%	4.16%	3.04%	**3.28%**	**3.20%**	*Statistics NZ - PPI Table 5 (1) electricity, commercial rent Ratio of electricity to rent is 1:15*
Admin	Head office administration cost	**2.56%**	2.53%	3.52%	2.65%	**3.03%**	**2.90%**	*Average of Salary admin and Facility Costs and Other Admin Costs*
	Other administration cost	**2.80%**	2.80%	4.00%	2.00%	**3.40%**	**2.93%**	*Statistics NZ - CPI Table 3.03 - all groups*

F45 Adopting ACC's preferred approach to fixed costs and remuneration levels, a cost allocation base of 67% and a mean percentile approach, the model produced the following results:

3.1 Lower Band Analysis (ACC's FA base)

	Deloitte ROI Approach	KPMG ROI Approach
Price Outcome (Price per hour)	$ 122.19	$ 127.73

F46 Adopting the NZSP preferred approach to fixed costs and remuneration levels (but based on NZSP's approach to benchmarking against public sector physiotherapy remuneration, rather than the Strategic Pay analysis), a cost allocation base of 95% and a 95th percentile approach, the model produced the following results:

3.2 Upper Band Analysis (NZSP's FA base & DHB salaries)				
	Deloitte ROI Approach		KPMG ROI	Approach
Price Outcome (Price per hour)	$	306.82	$	318.26

F47 The experts then provided, at my request, the following sensitivity analysis:

3.3 (a) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $83,341 as proposed by ACC in its submission dated 5 September 2007.
- Business owner base salary of $91,581 ($80,000 2004/05) (excl overtime)
- Clinical staff base salaries of $69,716 ($60,000 2004/05) (excl overtime).
- Cost allocation base of 80%

3.3 (a) Mid Band Analysis (ACC's FA base)				
Percentile	Deloitte ROI Approach		KPMG ROI	Approach
Mean	$	174.10	$	179.63
70th percentile	$	194.74	$	200.27
75th percentile	$	194.99	$	200.52
80th percentile	$	195.17	$	200.70
87th percentile	$	214.27	$	219.80

3.3 (b) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $178,140 as proposed by NZSP in appendix 6 of its submission dated 5 September 2007.
- Business owner base salary of $91,581 ($80,000 2004/05) (excl overtime)
- Clinical staff base salaries of $69,716 ($60,000 2004/05) (excl overtime).
- Cost allocation base of 80%

3.3 (b) Mid Band Analysis (NZSP's FA base)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI**	**Approach**
Mean	$	189.71	$	201.15
70th percentile	$	213.99	$	225.43
75th percentile	$	214.89	$	226.33
80th percentile	$	215.21	$	226.65
87th percentile	$	223.01	$	234.45

3.3 (c) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $131,241 reflecting the midpoint of those proposed by NZSP and ACC in their submissions dated 5 September 2007.
- Business owner base salary of $91,581 ($80,000 2004/05) (excl overtime)
- Clinical staff base salaries of $69,716 ($60,000 2004/05) (excl overtime).
- Cost allocation base of 80%

3.3 (c) Mid Band Analysis (Midpoint of NZSP/ACC FA base)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI**	**Approach**
Mean	$	181.90	$	189.32
70th percentile	$	203.15	$	210.57
75th percentile	$	204.22	$	211.64
80th percentile	$	205.04	$	212.46
87th percentile	$	222.14	$	229.56

3.3 (d) The following table reflects the following mid band assumptions, with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $83,341 as proposed by ACC in its submission dated 5 September 2007.
- Business owner base salary of $91,581 ($80,000 2004/05) (excl overtime)
- Clinical staff base salaries of $69,716 ($60,000 2004/05) (excl overtime).
- Cost allocation base of 67%

3.3 (d) Mid Band Analysis (ACC's FA base & 67% cost allocation)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI**	**Approach**
Mean	$	136.33	$	141.86
70th percentile	$	141.35	$	146.88
75th percentile	$	150.31	$	155.84
80th percentile	$	153.95	$	159.48
87th percentile	$	177.02	$	182.55

3.3 (e) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $178,140 as proposed by NZSP in appendix 6 of its submission dated 5 September 2007
- Business owner base salary of $91,581 ($80,000 2004/05) (excl overtime)
- Clinical staff base salaries of $69,716 ($60,000 2004/05) (excl overtime).
- Cost allocation base of 67%

3.3 (e) Mid Band Analysis(NZSP's FA base & 67% cost allocation)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI**	**Approach**
Mean	$	144.90	$	156.34
70th percentile	$	155.72	$	167.16
75th percentile	$	176.02	$	187.46
80th percentile	$	179.29	$	190.73
87th percentile	$	189.78	$	201.22

3.3 (f) The following table reflects the following mid band assumptions with the modelling percentile set at the mean 70%/75%/80%/87%:

- A fixed asset base of $131,241 reflecting the midpoint of those proposed by NZSP and ACC in their submissions dated 5 September 2007.
- Business owner base salary of $91,581 ($80,000 2004/05) (excl overtime)
- Clinical staff base salaries of $69,716 ($60,000 2004/05) (excl overtime).
- Cost allocation base of 67%

3.3 (f) Mid Band Analysis (Midpoint FA base & 67% cost allocation)				
Percentile	Deloitte ROI Approach			KPMG ROI Approach
Mean	$	139.56	$	146.98
70th percentile	$	148.84	$	156.26
75th percentile	$	165.20	$	172.62
80th percentile	$	165.39	$	172.81
87th percentile	$	184.49	$	191.91

3.3.1 *Rerun the above 6 tables with base salaries in 2006/7 of $58,000 for clinical staff and $76,000 for business owners, with appropriate adjustments to be made for overtime and additional benefits generally paid in the public sector and not in the private sector."*

3.3.1 (a) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $83,341 as proposed by ACC in its submission dated 5 September 2007.
- Business owner base salary of $78,688 ($68,738 2004/05, $76,000 in 2006/07) (excl overtime)
- Clinical staff base salaries of $60,952 ($52,458 2004/05, $58,000 in 2006/07) (excl overtime).
- Cost allocation base of 80%

3.3.1 (a) Mid Band Analysis (ACC FA base & suggested salaries)				
Percentile	Deloitte ROI Approach		KPMG ROI Approach	
Mean	$	160.07	$	165.60
70th percentile	$	178.44	$	183.97
75th percentile	$	178.96	$	184.49
80th percentile	$	180.13	$	185.66
87th percentile	$	198.40	$	203.93

3.3.1 (b) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $178,140 as proposed by NZSP in appendix 6 of its submission dated 5 September 2007.
- Business owner base salary of $78,688 ($68,738 2004/05, $76,000 in 2006/07) (excl overtime)

- Clinical staff base salaries of $60,952 ($52,458 2004/05, $58,000 in 2006/07) (excl overtime).
- Cost allocation base of 80%

3.3.1 (b) Mid Band Analysis (NZSP FA base & suggested salaries)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI Approach**	
Mean	$	175.68	$	187.12
70th percentile	$	197.10	$	208.54
75th percentile	$	198.06	$	209.50
80th percentile	$	200.00	$	211.44
87th percentile	$	214.15	$	225.59

3.3.1 (c) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $131,241 reflecting the midpoint of those proposed by NZSP and ACC in their submissions dated 5 September 2007.
- Business owner base salary of $78,688 ($68,738 2004/05, $76,000 in 2006/07) (excl overtime)
- Clinical staff base salaries of $60,952 ($52,458 2004/05, $58,000 in 2006/07) (excl overtime).
- Cost allocation base of 80%

3.3.1 (c) Mid Band Analysis (Midpoint FA base & suggested salaries)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI Approach**	
Mean	$	167.87	$	175.29
70th percentile	$	186.56	$	193.98
75th percentile	$	188.51	$	195.93
80th percentile	$	190.07	$	197.49
87th percentile	$	206.27	$	213.69

3.3.1 (d) The following table reflects the following mid band assumptions but with the modelling percentile set at the mean, 70%/75%/80%/87%:

- A fixed asset base of $83,341 as proposed by ACC in its submission dated 5 September 2007.

- Business owner base salary of $78,688 ($68,738 2004/05, $76,000 in 2006/07) (excl overtime)
- Clinical staff base salaries of $60,952 ($52,458 2004/05, $58,000 in 2006/07) (excl overtime).
- Cost allocation base of 67%

3.3.1 (d) Mid ACC FA base, suggested salaries & 67% cost allocation)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI Approach**	
Mean	$	125.57	$	131.10
70th percentile	$	130.39	$	135.92
75th percentile	$	143.03	$	148.56
80th percentile	$	143.44	$	148.97
87th percentile	$	162.77	$	168.30

3.3.1 (e) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%, and with the following revisions:

- A fixed asset base of $178,140 as proposed by NZSP in appendix 6 of its submission dated 5 September 2007.
- Business owner base salary of $78,688 ($68,738 2004/05, $76,000 in 2006/07) (excl overtime)
- Clinical staff base salaries of $60,952 ($52,458 2004/05, $58,000 in 2006/07) (excl overtime).
- Cost allocation base of 67%

3.3.1 (e) Mid (NZSP FA base, suggested salaries & 67% cost allocation)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI Approach**	
Mean	$	140.12	$	151.56
70th percentile	$	143.81	$	155.25
75th percentile	$	164.70	$	176.14
80th percentile	$	171.20	$	182.64
87th percentile	$	175.06	$	186.50

3.3.1 (f) The following table reflects the following mid band assumptions with the modelling percentile set at the mean, 70%/75%/80%/87%, with the following revision:

- A fixed asset base of $131,241 reflecting the midpoint of those proposed by NZSP and ACC in their submissions dated 5 September 2007.

- Business owner base salary of $78,688 ($68,738 2004/05, $76,000 in 2006/07) (excl overtime)
- Clinical staff base salaries of $60,952 ($52,458 2004/05, $58,000 in 2006/07) (excl overtime).
- Cost allocation base of 67%

3.3.1 (f) Mid (Mid FA base, suggested salaries & 67% cost allocation)				
Percentile	**Deloitte ROI Approach**		**KPMG ROI Approach**	
Mean	$	131.13	$	138.55
70th percentile	$	137.03	$	144.45
75th percentile	$	154.12	$	161.54
80th percentile	$	157.16	$	164.58
87th percentile	$	169.75	$	177.17

F48 I also asked the experts to specify the gross remuneration for clinical staff and business owners, incorporating relevant adjustments (but excluding returns on capital invested), that corresponds to each of the base salary levels used in the above sensitivity analyses. The experts advised as follows:

F49 The following table reflects the business owner remuneration outputs from each modelled scenario:

Gross Remuneration Analysis (Business Owner) ($)					
Scenario	**07/08 Base**	**Overtime**	**Total in the hand Pay**	**Other**	**Total**
3.1	72,040	28,686	**100,726**	1,081	**101,806**
3.2	111,042	40,744	**151,785**	1,666	**153,451**
3.3 (a)	91,581	34,180	**125,761**	1,374	**127,135**
3.3 (b)	91,581	34,180	**125,761**	1,374	**127,135**
3.3 (c)	91,581	34,180	**125,761**	1,374	**127,135**
3.3 (d)	91,581	35,640	**127,221**	1,374	**128,594**
3.3 (e)	91,581	33,424	**125,004**	1,374	**126,378**
3.3 (f)	91,581	33,424	**125,004**	1,374	**126,378**
3.3.1 (a)	78,688	29,833	**108,521**	1,180	**109,701**
3.3.1 (b)	78,688	29,833	**108,521**	1,180	**109,701**
3.3.1 (c)	78,688	29,833	**108,521**	1,180	**109,701**
3.3.1 (d)	78,688	31,052	**109,741**	1,180	**110,921**
3.3.1 (e)	78,688	28,118	**106,806**	1,180	**107,987**
3.3.1 (f)	78,688	31,052	**109,741**	1,180	**110,921**

Note: The gross remuneration analysis is based on the mean price point.

F50 The following table reflects the clinical staff remuneration outputs from each modelled scenario:

Gross Remuneration Analysis (Clinical Staff) ($)					
Scenario	07/08 Base	Overtime	Total in the hand Pay	Other	Total
3.1	59,315	4,818	64,133	3,944	**68,077**
3.2	79,011	2,473	81,485	5,254	**86,739**
3.3 (a)	69,716	2,182	71,898	4,636	**76,534**
3.3 (b)	69,716	2,182	71,898	4,636	**76,534**
3.3 (c)	69,716	2,182	71,898	4,636	**76,534**
3.3 (d)	69,716	5,662	75,378	4,636	**80,014**
3.3 (e)	69,716	5,672	75,388	4,636	**80,024**
3.3 (f)	69,716	5,672	75,388	4,636	**80,024**
3.3.1 (a)	60,952	5,962	66,914	4,053	**70,967**
3.3.1 (b)	60,952	5,962	66,914	4,053	**70,967**
3.3.1 (c)	60,952	5,962	66,914	4,053	**70,967**
3.3.1 (d)	60,952	4,950	65,903	4,053	**69,956**
3.3.1 (e)	60,952	5,565	66,517	4,053	**70,571**
3.3.1 (f)	60,952	4,950	65,903	4,053	**69,956**

Note: The gross remuneration analysis is based on the mean price point.

F51 The experts made the following notes in respect of these remuneration tables:

1 These remuneration outputs are driven by the alternative base salary inputs. Variations are also caused by the exclusion of different outlier practices under differing input assumptions.

2 Remuneration analysis has not been provided at differing percentile pricing points as this was difficult to calculate in the timeframe and was also potentially distorting given that reference would need to be made to salary data from one practice at a particular percentile point. Therefore the following salaries are shown based on a mean approach to setting the percentile.

3 The Other category above is made up of the 6.65% increase in clinical staff base salaries (professional development allowance, APC, NZSP and special interest groups; and an allowance for locum rates when staff members are on professional development courses).

4 Throughout the sensitivity analysis all salary information has been presented in reference to 2007/08 levels. Where salaries have been converted from another period to 2007/08 levels indexation rates as detailed above were used.

APPENDIX G – PRINCIPLES TO GUIDE MODELLING OF SUSTAINABLE PRICE FOR PHYSIOTHERAPY SERVICES

G1 Attempting to determine appropriate rates of remuneration, capital investment and return on investment based on studies of the market as it currently exists would be misconceived, as there would be insuperable problems of circularity: all of these are currently influenced strongly by prevailing ACC payment rates. For these inputs, reasonable assumptions need to be made based on external benchmarks.

G2 Other inputs should in my view be based on a carefully designed and robust study of physiotherapy practices providing the relevant services, which should cover matters such as:

G2.1 costs other than physiotherapist remuneration and cost of capital – in particular, premises costs in different areas in New Zealand, and for different sizes of practice;

G2.2 consultation times for different types of consultation;

G2.3 the proportions of different types of consultation; and

G2.4 ratios of ACC and non-ACC consultations.

G3 As mentioned above, the most helpful and appropriate approach to benchmarking remuneration rates is in my view to look to current DHB salary scales, (and to ensure that material changes in those scales flow through promptly into ACC payment rates). Those scales need to be adjusted to reflect relevant differences in the private sector environment: hours worked, benefits provided etc. (The joint expert report explains in more detail how such adjustments should be applied.) More work is needed on how best to benchmark private sector employees and business owners against this scale, and how to identify corresponding levels of seniority and responsibility for that purpose.

G4 In carrying out this benchmarking, no adjustment should be made to reflect the return to business owners on capital employed: that is a separate issue, and the fact that business owners invest capital in their businesses and earn an appropriate risk-adjusted return on that capital should not reduce the return they receive for time spent working in the business.

G5 Benchmarking against public sector remuneration in this manner is in my view preferable to the approach suggested by Strategic Pay based on its SP10 job sizing methodology. That approach depended on assessments of the role and responsibilities of physiotherapy business owners which were not self-evident,

and seemed somewhat on the generous side. It suggested an average remuneration level for business owners of $147,618 (in 2004/5) which was more than double the top step on the public sector scale for allied health professionals of $82,086 in 2006/7, which adjusted for inflation at the LCI equates to $73,488 in 2004/5; far above Australian business owner remuneration levels (based on the limited information available); and higher than average income for GPs in private practice in 2006 of $146,965, according to a recent study.[141] It may in the future be possible for the profession and ACC to agree on the use of a methodology of this kind, but there is sufficient uncertainty surrounding its application in this context that for the present it seems more prudent to use a less sophisticated and more intuitive approach.

G6 Capital requirements should be assessed based on fixed asset requirements for a new practice, goodwill (assessed in accordance with the joint expert report) and working capital (again, assessed in accordance with the joint expert report). The only material issue that was not agreed in relation to capital requirements was the appropriate level of fixed costs. ACC considered that a new four person practice would incur fixed costs of approximately $84,341. NZSP considered that a more realistic figure would be $178,140. The two main differences between these figures were:

G6.1 the cost of a gymnasium, excluded from ACC's costings (NZSP estimate $54,985); and

G6.2 IT equipment, estimated by ACC at $12,563 and by NZSP at $34,142.

G7 With further work it should be possible to significantly narrow the gap between the parties on these figures. It does not seem unreasonable for a new four person practice that is required to interact with ACC electronically to purchase new computers and a server, rather than ex-rental PCs with no server as assumed by ACC. It also seems clear, based on the evidence before the Review, that some gymnasium/exercise facilities are required to deliver best practice EPN physiotherapy services; and I understood ACC to accept that some exercise equipment would be appropriate. But the precise scope and cost of equipment required for this purpose merits further study.

G8 The parties disagreed on the appropriate return on investment (RoI) for physiotherapy practices, and on whether this should be applied to the initial capital requirement on an ongoing basis, or to a diminishing capital base as assets are depreciated. It seems to me that reference to studies of small business cost of

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[141] IPAC 2006 General Practice Business Study (June, 2007).

capital in New Zealand should assist with determining a reasonable range of RoI, and that a more sophisticated approach to modelling returns over time which expressly provides for reinvestment in the practice to maintain and replace fixed assets will reduce the scope for disagreement on methodology.

G9 The parties disagreed on how practice costs should be allocated as between ACC and non-ACC revenue streams. I recommend allocating costs in proportion to time spent on ACC and non-ACC consultations: this reflects the principle, which seems to me to be fair and consistent with the sustainability of the ACC scheme, that (where co-payments are not permitted) ACC should pay neither more nor less than a private patient would pay for any given service. I do not consider that it would be appropriate to apply the avoidable cost approach contended for by NZSP, which would result in ACC paying physiotherapy practices more per hour of services provided than the non-ACC patients of those practices.

G10 The remaining issue on which there was material disagreement was whether the sustainable price for services should be based on the average cost of providing services, the median cost, or some higher percentile. On this issue I have considerable sympathy for the approach adopted by NZSP. It seems to me that the price identified will be sustainable only if it enables a substantial majority of practices to cover their efficient costs, including the benchmark remuneration and cost of capital. I note that we are only concerned, here, with about 33% of practice costs because on the approach outlined above, some 67% of costs are based on external benchmarks rather than on existing practice data. It seems to me that a sustainable price would be one which enabled at least 67% of practices to cover their actual costs in respect of these items. This would require 33% of practices to achieve efficiency gains in order to achieve benchmark remuneration and return on capital. Some efficiency gains can reasonably be expected from higher cost practices – it seems to me that at the upper end of the range, a 90th percentile approach would be the highest point consistent with that expectation. The question of where to draw the line within this range is an issue on which reasonable people can and will disagree: this is a matter for discussion, and negotiation.

G11 I emphasise that this approach needs to be applied in a way which reflects different cost structures for practices in different areas, and with different patient mixes. In particular, a price will be sustainable for delivery of physiotherapy services in metropolitan areas (where premises costs and some other costs are higher) only if it is set at the relevant percentile of practices in those areas. National statistics are insufficiently disaggregated for this purpose.

G12 If I were asked to provide a very rough estimate of a sustainable price for physiotherapy services, based on the data available to the Review, I would adopt

an approach along the lines described above, and would make the following very rough estimates on the matters in dispute (which in my view require further research and analysis):

G12.1 reasonable base remuneration in 2006/7 dollars for clinical staff $58,000 (midpoint of steps 1 to 12 on the DHB scale) and for business owners $76,000 (midpoint of steps 10 to 15 on the DHB scale), with adjustments for extra time worked and other costs giving effective remuneration in 2007/8 dollars for clinical staff $66,000 approx and for business owners $109,000 approx;

G12.2 fixed assets of approximately $130,000, reflecting the need for some exercise equipment, but an absence of detailed information on what exactly is required to deliver EPN services;

G12.3 an RoI of 15%, using the KPMG "continuing business" approach;

G12.4 use of the 70th to 80th percentiles for costs other than remuneration and cost of capital.

G13 This very rough approach gives a sustainable range of prices of $144 to $165 (both GST excl), based on the sensitivity analysis above (see table 3.3.1(f) on page 196). The range is large, and it cannot be emphasised too strongly that I have real reservations about these figures for all the reasons canvassed above in relation to the adequacy and completeness of the available practice data, and the need for more work on benchmarking of remuneration and fixed capital requirements and cost of capital. I have proffered this range only as an aid to discussion between the parties and as a prompt for further analysis.

G14 For the purposes of interim arrangements under option 1, a still more conservative approach is justified. But in the interests of fairness to providers, and recognising the continuing strain on sustainability posed by current payment rates, there should be a real movement towards a sustainable price, even in the interim, if this option is adopted. For this purpose it would not be reasonable to use the ACC lower band estimate, as it is based on fixed asset costs which I am satisfied are too low (though how much they should be increased remains unclear), and would cover only the average of the studied practices' costs, which is in my view plainly unsustainable. There is also of course no allowance for the need to set a sustainable price that covers costs in higher cost areas. Taking all those factors into account, it seems to me that the most conservative approach that would be reasonable, on an interim basis, would be to use the above assumptions but with the Deloitte RoI approach (giving a price of $137.03 per hour). My view that a sustainable price is extremely unlikely to fall below that level is confirmed by a

comparison with the other sensitivity analyses. Most reasonable assumptions about fixed costs and remuneration lead to higher estimates, at the 70th percentile, even based on these national data.

APPENDIX H – ACC45 PATIENT DECLARATION AND CONSENT

I declare:

- that the information given in this form is true and correct and that I have not withheld any information likely to affect my application. I will inform ACC of any change in circumstances which may affect my entitlements.

I authorise:

- the collection and disclosure of any information about me to the extent necessary to determine cover and/or assess my entitlement to compensation, rehabilitation assistance, including medical treatment and/or the appropriate level of care and personal attention that I should receive, and/or the to assist the evaluation of services and the performance of the ACC Scheme and/or to support the administration of the Health and Safety in Employment Act 1992.

- the collection and disclosure of information for the purposes of research into injury prevention and effective assessment and rehabilitation.

- the treatment provider to lodge this claim for me.

I understand:

- that this authority relates to all aspects of my claim and authorises ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police, Occupational Safety and Health, treatment providers, IRD, Work and Income, assessment agencies, employers and witnesses to the accident).

- that the information collected on this form will only be used or disclosed in relation to the purposes of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use, disclosure and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.

- that I have the right to see, and ask for the correction of, any information that ACC holds about me.

- that this form may be used by accredited employers. In these cases where ACC is specified in the patient

declaration this should be read as applying to the accredited employer managing my claim.

The information collected by ACC on this Injury Claim Form (ACC45) and at other times will be used to process this claim in accordance with the authority and understanding set out above, and in accordance with the Privacy Act 1993 and the Health Information Privacy Code 1994. The Privacy Act gives you the right to see and correct personal information ACC holds about you.