

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

ACC's response to questions arising from the Hearing held 14-18 May 2007 from David Goddard, QC, Chairman

Remaining questions

- 6. What's ACC's view on whether if there were to be indexation of regulation payments the LCI would be the appropriate index factor, or whether some other index or some other mechanism would be appropriate? So it's a hypothetical – question that were there to be indexation of regulation payments, what would the most appropriate index be? (p50 of transcript)**

The IPRC (Indexation) Regulations 2002/186 provide for indexation of weekly compensation, abatement, lump sums, funeral grant, survivors' grant, child care payments for children of deceased claimants and independence allowance.

These use the Labour Cost Index (LCI) as the basis for indexation.

Indexation of other regulated payments would be work led by the Department of Labour and would involve wide consultation and input.

ACC considers that the LCI (salary and wage rates) could be the appropriate mechanism should there be a regular indexation of other Regulations. Please note that this is an indicative answer only - ACC would need to do more work on this should it become a 'non-hypothetical' matter. ACC's views would be only one perspective that would be considered in such a change to Regulations.

- 26. There's mention of deriving the price from the main co-payment plus one standard deviation and the price as a result of meeting or exceeding the current cost for providing the service for 84 per cent of physiotherapy practices. Was the reason for setting rates one standard deviation out rather than two, or you know, further out to capture a higher proportion of then prevailing rates a desire to derive efficiency improvements or some other goal? What was/is the rationale for selecting that cut-off point? (p84 of transcript)**

I would really like some help with why people say that the right answer is one standard deviation out or two standard deviations out, and what the factors are that influence that choice. We need to put that back to ACC and say well, why did you pick that particular benchmark? (p163)

The following response is a combined answer to the two questions posed above.

The EPN was never intended to be taken up 100 per cent nationwide. ACC considered it was up to the individual practice to assess their business and take up the EPN contract as they saw fit. The contract rate was set at 87 per cent as ACC considered this would attract sufficient uptake across the country. The argument was that it would provide 'access' to physiotherapy and allow claimants to complete their treatment, as anecdotally claimants were not doing so because of co-payments.

A level of 87 per cent was a sufficient incentive for practices that were collecting revenue under this mark to improve practice standards and procedures, and achieve accreditation. At that time, accreditation was seen as a way of improving the level of service provided to claimants. Also, as the HPCA Act had not yet been introduced, there was no associated compliance cost. Registration with the Physiotherapy Board only involved a fee for an annual practising certificate. Individual physiotherapists were responsible for their own continuing education, and there were no external checks in place unless brought to the attention of the Board. While some practitioners always actively maintained competency levels, many may not have done so. The introduction of the EPN went some way to facilitate professional development with the adoption of the accreditation scheme developed by the physiotherapy profession.

The rationale for deriving the price from the main co-payment plus one standard deviation was due to the results of the BRC Marketing and Social Research Physiotherapy Co-payment Survey: Mystery Shopping survey in 2003. The survey findings were:

- That ACC was paying above the mean plus one standard deviation for initial consultations;
- That ACC was paying below the mean plus one standard deviation for follow-up consultations.

The co-payment data collected from the survey was gathered from a number of geographic locations.

As the amount paid under Regulations was static for that period (e.g. \$19 or similar) ACC was able to add the Regulations payment to the co-payment to produce the range of prices charged by physiotherapists.

The range of prices was analysed to find the standard deviation from the range. When the EPN price was set at one standard deviation from the

mean, it was seen that 68% of physiotherapists currently charge prices up to that level. (Mathematically 1 sd=68%, 2sd =95% 3sd=99%)

27. There seems to have been an affordability issue or it might have been an explicit desire to bring the highest cost, highest charging practices more into line with others and drive efficiency improvements in those; what were the goals and what was the basis/rationale for those? Following on from that, whether any of the studies of co-payments, either that original one or the subsequent ones which have been provided with ACC's materials, looked at whether there were geographical differences in levels of co-payment charged by regulation providers? Is there any geographical analysis? (p84 of transcript)

ACC did not target practices with higher co-payment rates to try to bring them into line with other practices. ACC was more concerned about achieving nationwide coverage and 87 per cent was seen as sufficient to make this possible.

Geographical distribution of co-payment charges is detailed in the BRC Marketing and Social Research Physiotherapy Co-payment Survey: Mystery Shopping September 2003 (provided to the Reviewer on Wednesday 16 May 2007). For the purposes of the survey, ACC provided a database of physiotherapist practitioners likely to provide treatment for an ankle injury. EPN clinics, hospitals, District Health Boards, and individuals providing services only to members of a private organisation were not covered in the survey. The survey report lists co-payments for initial consultation and follow-up visits by region, territorial authority, territorial authority within each region, and community size.

46. Why is the EPN contract terminable on 3 month's notice and the answer I think was all your contracts are terminable on 3 month's notice, with service providers; is that right? Check to see whether any EPN contract has, in fact, been terminated on notice. That would be helpful. (p464/465)

Termination of a contract on three month's notice is a standard clause under the Master Agreement that ACC uses for all treatment and rehabilitation (Health) services, so the EPN termination clause is the same as that in other contracts.

ACC has not terminated any EPN providers under this clause, which reads as follows:

1 AGREEMENT TERMINATION OR SERVICE CANCELLATION BY NOTICE

1.1 By Notice as of Right

Either party may, without incurring any liability to the other for damages or other compensation, at any time give to the other no less than:

- 1.1.1 three calendar months notice of termination of this Agreement and all the Services;
or
1.1.2 three calendar months notice of the cancellation (or any lesser notice period for cancellation permitted under the applicable Service Schedule) from this Agreement of a particular Service Schedule and the Service(s) described in that Service Schedule.

47. ACC45 forms. An issue was raised about the signature of those forms in circumstances where the form is lodged electronically. Could you just explain briefly what the process is in terms of signature and the electronic lodgement context? (p466) Am I right to understand, though, that it's the responsibility of a provider, before submitting an electronic ACC45, to ensure that a hard-copy has been signed by the claimant at their practice? Is that right? MS SALTER: As a follow up on that, does that imply, though, that at the point where someone at your end may --at ACC's end --may be requesting clinical notes, they don't know for certain whether or not someone has signed it because if they had that signed copy is at the practitioner end it is no longer at the ACC end? (p467)

MR MORRIS: There is a problem there, and I think you have seen this reflected in some of the answers where in some situations, indeed my understanding is that in many situations, ACC when requesting clinical records gets a second consent in writing and provides that to the treatment provider. Reviewer: It would be sensible to deal with the electronic lodgement as part of the answer to the earlier process question.(p467)

A response to this question will be provided to the Reviewer by 8 June 2007.

Question from letter dated 11 May 2007

- 1. Does ACC accept the evidence of Strategic Pay on fair remuneration rates or does it stand by the benchmarking in the Deloitte Final Report, or does it have some other view?**

ACC has sought an independent opinion and a response to this question will be provided to the Reviewer by 8 June 2007.