

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

ACC's response to questions arising from the second Hearing held 29-31 August 2007 from David Goddard, QC, Chairman

5 September 2007

Questions arising from the Physiotherapy Review Hearing 29-31 August 2007

- 1. Annual review of regulations.**
Why is that seen as more appropriate than indexation on a year-on-year basis with periodic substantive reviews, say, 5 yearly? Would you anticipate it flows into a regulation change process, or is there some simplified process it will feed into? Will the review have to happen, and then an amendment to the regulations, or will there be some more informal, swifter process for implementing the outcome of the review? Would it give limited scope for updating in some less formal way, e.g. a Gazette notice by the Minister? Pg 9

Ministers have not been in favour of annual indexation of the amounts prescribed by regulations made under section 324. However, Cabinet have agreed to a proposal that, if implemented, will require ACC to annually conduct a review of the amounts prescribed by regulations under section 324 of the Injury Prevention, Rehabilitation, and Compensation Act 2001.

The purpose of the annual review is to assess whether amounts should be adjusted to take into account changes in the costs of rehabilitation. If implemented, this proposal will require ACC, by 1 December each year, to:

- provide a report on the results of the review to the Minister, and
- include in that report any recommendations for change.

The proposal also includes repealing section 324 subsection (2) (which requires among other things that ACC notify the public through the New Zealand Gazette and publication in major daily newspapers and specifies a 28-day period) and substituting this with a requirement for ACC to consult with the persons or the organisations that the “Minister for ACC sees as appropriate”. This change is designed to simplify the process that ACC is required to follow and bring about a swifter process for implementing changes to the amounts payable.

This proposal is included in an upcoming Injury Prevention, Rehabilitation, and Compensation Act Amendment Bill scheduled to be introduced in October 2007.

- 2. EPN contract change of termination period.**
How was the 6-month period selected? What process was followed to determine it? Was there consultation with the physio profession to ascertain whether that was a sufficient period for business planning purposes? Pg 10

ACC offers over 80 health-related services. There are more than 1,500 vendors and over 3,500 contracts. ACC manages these contracts on a sound

commercial basis and the standard termination period for anyone who contracts with ACC is three months.

Following the recommendation in the Draft Report to extend the termination period for the EPN contracts, ACC, as an act of good faith, decided to revise the termination period for the EPN contracts from three months to six months. This was to demonstrate a willingness to address concerns raised by the New Zealand Society of Physiotherapists (NZSP) through the review.

ACC will start work on this by the end of 2007 and will consult with the physiotherapy profession to understand more about the background to this request, and to see if the revised termination period addresses their concerns.

3. ACC32 data for 2005/06
Would like to see some data over two years, 2005 and 2006, which sets out the number of ACC32s submitted and then breaks that down by the number of treatments requested and the number of treatments approved. What is the range of numbers of treatment approved? From zero up to what? Pg 11

ACC does not hold sufficient historical information to be able to provide the full information requested.

ACC gradually transitioned from Pathway on to the Medical Fees Payment system (MFP) during 2005, with final implementation in April 2006. While Pathway captured ACC32s, it only held the amount of treatments approved, not the amount of treatments requested. We would need to refer back to the physical forms to be able to fulfil this request fully.

The following information relates only to data collected in MFP from April 2006 onwards.

	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%

ACC has approved requests for further treatment within a range from 0 to 36 treatments. Approval for 36 treatments would only be given for the most complex of injuries.

4. Provide a copy of the ACC45 e-lodgement form Pg 12

The electronic form of the ACC45 paper version is called an ACC46. A copy of the ACC46 is included with this document.

5. Clarifying inaccuracy. Are we at cross-purposes? There were two \$103 amounts...the original output from the Deloitte model, but I had also asked the experts to work out what the implicit hourly rate was in current EPN payments. See discussion Pg 13

ACC agrees with the concept of the work done by Deloitte and KPMG. This was not available to ACC when initially checking the stated amount in the Draft Report. ACC used the raw data as supplied in ACC's Second Submission. These data did not break down the work into standard and complex cases, which resulted in the lower price of \$95 per hour.

However, there is an adjustment that ACC would like to make to the joint Deloitte and KPMG work. The consultation times of 20 and 30 minutes have been rounded, but they were not rounded in the model. The model uses 20.76 minutes and 31.6 minutes. Substituting the accurate figures for the rounded figures generates the data below.

Consult	Price	Time	Weight	Hourly rate	Number of consults	%	Rate \$
1	43.56	31.6	1.90	82.71	7,113	14.4%	11.94
2	35.03	20.76	2.89	101.24	38,064	77.2%	78.20
3	76.69	40	1.50	115.04	473	1.0%	1.10
4	56.81	30	2.00	113.62	3,633	7.4%	8.37
					49,283		
					Weighted hourly rate		\$99.61

The value of \$103, as an implicit hourly rate, is open for discussion and relies solely on the timings used for the standard follow-up consultation, as this has the greatest impact on the price. The longer the time taken to perform this follow-up consultation, the lower the effective hourly rate becomes.

**6. Further information requested from NZSP. Are you able to explain to me what the purpose was of requesting that information in relation to some regulation practices? Pg 14
Need clarity about the question you are trying to answer, and then the relationship of the data to that question. How might one go about tackling some of these joint information gathering and analytical issues? Pg 15**

ACC asked for more information from NZSP to gain further insight into the assumptions listed in paragraph 5.80.2 of the Draft Report. In approaching NZSP for access to regulation providers to ask for further data, ACC considered it was beginning to implement the Reviewer's recommendation.

The additional data would have enabled ACC to compare the new data with the model and with other forms of information for salaries, capital, and return on investment. The information was not to be substituted into the model, but to inform us of the situation in a more thorough way. As the costing model

has data from only 23 physiotherapist practices, we were looking for more information in that area. The data would have allowed ACC to determine if more research was needed from outside the physiotherapy sector.

ACC was acting in good faith in an attempt to validate and/or to determine the level of external benchmarking that was required.

7. ACC's Appendix 1 Fixed assets pricing. Why is there a \$3,192 difference... between the NZSP pricing and the ACC pricing for the four times treatment room? Pg 16

The ACC pricing is \$3,192 higher than the NZSP pricing because of the quote received for the specialist physiotherapy equipment from Auckbritt, a company supplying physiotherapy equipment.

Auckbritt quoted the standard price for one piece of equipment. With equipment need for four treatment rooms, this amounted to \$31,680 from this supplier. However, there would usually be a discount offered and/or a prompt payment discount applied. This would lower the cost of the purchase price of the equipment.

In addition, on reviewing the inventory list, the sheets and towels should not be included as fixed assets, which would reduce the price again by a further \$600. A breakdown for this was provided to the Reviewer on Monday 27 August 2007 and was submitted again on Thursday 30 August 2007.

8. The NZSP suggest that 2.6 million physiotherapist provided treatments to ACC claimants in the year to June 2006, not 2.8 million pg 17

Physiotherapists provided 2.6 million treatments to ACC claimants in the year to June 2006, not 2.8 million as stated in the primary submission.

9. NZSP: Return on investment: the concern we have at the moment is that both are very low – well, at least not a high percentage is taken, and a project approach is taken, and that seems to have a compounding effect. Chairman: I was interested in that observation, and if Deloitte had been here I was going to ask them if they agreed with the effective rate identified in here. That is still a question I may follow up in writing later. Pg 50

Deloitte have chosen to wait for the Reviewer to contact them directly before responding to this question.

10. We need to hear more from ACC about the...need to have a gym facility, even if one is not entering into those other specialist contacts. Does ACC consider that high quality services can and should be provided without such a facility? Pg 54

If ACC has more information about significant numbers of practices that don't have those facilities in NZ today, or elsewhere, that would be helpful pg 272

Dr Morris provided ACC's response to this question on Day 3 of the second Hearing. The NZSP is to provide the research evidence conveyed to the Reviewer during the Hearing.

ACC is aware that NZSP has initiated a survey of its members in order to gather information about the numbers of practices that don't have a gymnasium. ACC considers that some equipment for muscle strengthening and rehabilitation may be necessary for a physiotherapy practice, but does not consider it a requirement for all physiotherapy practices to need a fully-equipped gymnasium.

- 11. Is there a principled approach/method to choosing a percentile? Any help on...how to think about the choice between 70, 75, 80, if the objective is to ensure that the fees paid cover sustainability, the cost of providing the service, it seems that must be the cost of providing it for a significant proportion of providers, but what proportion, how would one go about choosing between those different levels? Pgs 61, 62**

Deloitte suggest that use of a percentile approach may be appropriate if the actual costs of a practice and the distribution of those practices were being considered. The Deloitte model replaced many of the actual costs for individual practices with higher amounts and, in some cases, near to maximum amounts (approximately two-thirds of the costs are now not based on the actual practice data gathered). Replacing actual costs with higher amounts results in prices per hour that are at artificially inflated rates from the data gathered.

If input assumptions are at the higher end of plausible alternatives, this would mean that any setting of a percentile should be at the lower end of plausible alternatives.

Using the 50th percentile does not mean that 50 per cent of physiotherapy practices will not achieve a sustainable outcome and that 50 per cent conversely will. The financial performance of the business will have a significant bearing on the sustainability of that business over time. Deloitte say that it is a known fact that the economic performance of a business will vary because of a range of factors; some include management capability, and the level of revenue and cost management. This issue means that it is particularly difficult to determine a percentile (or even a range).

Setting an appropriate percentile will provide pricing signals for practices to invest or disinvest in services. Using an average price still drives change. Striking the percentile at a lower price will drive different rates of change, for example, some providers exiting. Likewise, striking a percentile at a higher than average price will enable more providers to take super-normal profits and

potentially reduce their drive for continuous improvements in operational performance.

There are challenges in terms of setting an appropriate percentile. There was no comparable industry data that Deloitte have been able to source to assist in this discussion.

Deloitte state that percentiles cannot be looked at in isolation from the other factors in the model. It is best to consider the total price that the model is producing and determine if this reasonable.

It is worth considering the number of physiotherapy providers operating in New Zealand over the past seven years. If the amount paid by ACC to physiotherapists for consultations had not been sustainable over this period one would have expected the number of physiotherapy practices in New Zealand to decline. However, data gathered by ACC shows the opposite trend.

**12. Response to Occ Health submission
Comment briefly on...whether there are:**

- **Gaps in the contract structure**
- **Timeframes for responding to those Pg 94**

Dr Morris provided ACC's response to this question on Day 3 of the second Hearing.

13. Provide comment on Mr Goddard's idea of setting up a steering group, with participants from ACC, different groups in the profession, and perhaps even an independent facilitator who would help, jointly, to design a study that would be worthwhile and robust and would then supervise its conduct. Pg 85

ACC will work with the physiotherapy sector to establish a steering group to facilitate future information-gathering processes. ACC supports the suggestion that the steering group has an independent chairperson.

14. Mr Hing: The (ACC) request is that they don't want additional reporting. If you have computer notes like I do, then you need to do additional reporting, you need to cut and paste, you need to be able to delete those areas which are not applicable. Chairman: I don't think I would understand that as additional reporting, Mr Hing. I think that to blank out whether physically or through computer techniques, material that is irrelevant isn't reporting, that's simply removing material outside the request which seems to me both appropriate and consistent with that form of request...We can certainly clarify that with ACC.

ACC does not consider the removal of material that is not relevant to a claimant's injury from clinical notes to be additional reporting.

- 15. Advanced practitioners: Spell out for me very clearly what ACC is currently doing in relation to that concept and what ACC envisages is the path forward... Pg 121**

Dr Morris provided ACC's response to this question on Day 3 of the second Hearing.

- 16. ACC32 approvals: Is it true that they are all posted at the moment, and if so...whether there is any reason why email isn't an option? Pg 121**

ACC's current approval system does not provide for an email option in a secure and confidential environment. However, ACC is looking at a secure email option, which should be available mid-2008. We have also started investigating options to capture provider email addresses and to identify providers that would like to communicate with ACC electronically.

Please note that securely transmitting information electronically to ACC is already in place for some of our high volume transactions (i.e. ACC45 Injury claim form and ACC40 Invoice for treatment services). ACC is currently developing systems and processes for other high volume transactions (e.g. ACC18 Medical Certificate) as well as generic email messages.

- 17. Is it correct that ACC won't pay for treatment above the trigger number that's given before the ACC32 approval is reached? What I am particularly interested in is where that trigger is reached, but the patient and the physiotherapist are so confident that it's an appropriate case for further treatment that they are willing to continue and themselves take the risk of a decline. In those circumstances, if the ACC32 comes through, can it then be applied retrospectively to those treatments, or are the treatments given in the interim not fundable by ACC? Pg 122**

ACC will not pay for extended treatment until the ACC32 request has been considered and approved. If the trigger is less than 16, then ACC will pay for extended treatment up to a limit of 16, without requiring prior approval. If the trigger is over 16, then ACC is unable to fund treatment until approval has been given.

If the service provided has not been previously invoiced, is in the coverage period and is within the quantity approved on the ACC32 extension, then ACC will pay. The approval is given from the date the ACC32 is signed. Once approved, payment can be made for services dating back to the date on the ACC32. ACC will also consider extenuating circumstances when validating treatment. Please refer to pages 71-73 of 2007 ACC Treatment Provider Handbook for more details.

- 18. Mr Hing described in his submissions to the process of making inquiries about access to the internal inquiry on fraud issues, and the time at which that was available. That was also raised with me**

in advance, and it did seem, in principle, reasonable that the board of ACC should see that before it was disclosed to me or to the parties to the inquiry, but I would just like to know whether it's correct that it was given to media in advance of going to the board and to me and to the parties, and if so, why? Pg 122

ACC released the Fraud Unit Report to ACC staff, the media, the Consumer Outlook Group, the New Zealand Society of Physiotherapists, and to the Reviewer via Ms Salter on Wednesday 22 August 2007. It was also posted on ACC's website on this date. The report was not released by ACC to the media before it was made public.

- 19. ACC's views on the fixed cost schedule, what inappropriate fixed costs were. I'd be interested to know what the basis was for those, what inquiries were made, what information was obtained, whether it was from physiotherapists or internal views, just what the foundation is for it, because if I end up having to form a view on that sort of issue, knowing whether it is simply ACC's view or whether it's based on some sort of external inquiry or information, possibly seeing that information would obviously be helpful. Trace things back to their original source. Pgs 122, 123**

The prices on the fixed asset schedule were established by checking prices published on the internet, or by calling a supplier such as Auckbritt. The pricing schedule supplied to the Reviewer with this document has the source of the price of each inventory item listed beside it.

As noted in question 7, no discount was applied in this costing exercise. However, it is assumed that some discount would be offered, particularly in the purchase of physiotherapy beds and machines. In the pricing schedule supplied, where the source is listed as Estimate, then that cost has been estimated, based on the experience of ACC's Pricing Analyst. For example, an estimate was used for installation on cabling which relies heavily on the actual office size and configuration.

- 20. Physiotherapy treatment profiles. We've seen some slides, heard some submissions, suggesting that although there is no legally binding obligation to comply with the profiles, and indeed that they might be exceeded as expressly contemplated by the contract, nonetheless, there's strong pressure, strong expectation, to stay within them. I wonder if you could comment on whether that's the case today, if not whether that represents a change in emphasis, if so, why? Pg 211**

The treatment profiles were developed jointly with the NZSP and have been considered a consensus of opinion from NZSP members on what is appropriate and common current practice.

ACC considers that there is a certain level of expectation that non-complex injuries are treated within or up to the treatment profile limit. However, the provider may submit an ACC32 to request prior approval of further treatment beyond the profile limit. Treatment providers who provide treatment outside the treatment profiles before the requisite prior approval has been granted are likely to have payment declined.

- 21. Membership of the Society is effectively a requirement for certification (clarified as a requirement to have an EPN contract) because there is a requirement for College membership. What is the rationale for that requirement? Is membership of the College, or membership of the Society, a requirement to hold an EPN contract, if so why? Pgs 211, 212**

Dr Morris provided ACC's response to this question on Day 3 of the second Hearing.

- 22. Copy of printed ACC32, and copy of electronic version.**

The current version of the ACC32 – Request for Additional Treatment form is included with this document. There is currently no electronic version available from ACC for the ACC32, although some Practice Management Systems have developed their own versions for providers to complete and print. These are also included with this document.

- 23. EPN contract applications declined or deferred.**
At the last conference when I asked whether any EPN contract applications had been declined, you said no, not to date, but here are some reasons why they might be or why they might be deferred. One of those, was we have been reminded today, was that outliers...where outliers hadn't provided explanations of why they were outliers, and the comment was made that in those circumstances they wouldn't be awarded a contract because they may breach the contract, and it was suggested that it was implicit in that the contract requires compliance with the profiles. If you could shed some light on what was intended to be conveyed by that, why there was a concern that those outliers who hadn't provided the information might breach the contract, that would be helpful. Pg 212

ACC has not declined any applications to date, but has deferred a small number of applicants. An application may be deferred for the following reasons:

- Should a provider be currently undergoing prosecution by ACC's Fraud Unit, acceptance of the application is deferred pending the prosecution outcome.
- Providers identified as an outlier, but who have not responded to an ACC request to assist with understanding the profile of that practice that may

explain the 'outlier' behaviour. This information is required to ensure that contractual compliance is likely to occur.

There are currently two providers whose applications have been deferred, as they have declined to provide the information that ACC has requested following the 2005 analysis of the physiotherapy provider group, i.e. the Annual Service Review which identifies potential outliers.

ACC has communicated the reasons for deferment and the issues are currently being negotiated.

The legislation sets out ACC's liability to fund services in the Injury Prevention, Rehabilitation, and Compensation Act 2001 Schedule 1 Clauses 1–6. In acknowledgement of that liability, there are ten key areas for which ACC seeks information from providers following an Annual Service Review:

1. The number of visits per day – if this is unusually high there may be some concern regarding the quality of treatment provided;
2. Treating without prior approval (exceeding treatment profile limits);
3. Treating without prior approval (required if 52 weeks since date of injury or date of last treatment);
4. Treating family members;
5. Potential over-servicing (examined where there is 20% or greater proportion of claims serviced that have an ACC32 submitted);
6. Visits per claim are consistently high, frequently reaching the treatment profile;
7. New claim in close proximity to proceeding claim's last treatment for same claimant;
8. Treating multiple injuries across multiple claims on the same or consecutive day. (This criterion was used until 2005 and is no longer used in reviews);
9. Potential over-servicing (checked where a number of ACC32s are submitted with the delivery of 0 – 3 follow up treatments);
10. Lodgement of claims outside of the Claims Lodgement Framework (e.g. Gradual Process caused by work – this may only be lodged by a Registered Medical Practitioner).¹

On receipt of an Expression of Interest from a provider who would like to apply for an EPN contract, ACC undertakes a pre-application screening process. If the screening produces no areas of concern, a pack is sent to the applicant within 15 working days.

During the pre-screening process, ACC checks invoicing and claims data to measure provider compliance while treating under the regulations (i.e. the above criteria). The invoicing data for the immediate six months prior to application are examined.

¹ Criteria can be found in letter to providers regarding Annual Service Assessment of <<Service Type>>. Submitted as supporting documents to ACC's Primary Submission, Tab 16 Folder 2.

The turnaround time from the date of receipt of the provider's signed contract by ACC and returning a signed contract to a provider is generally 10 working days. There may be exceptions to this due to unforeseen circumstances.

- 24. We've seen some slides and speeches in which language like "hounding fraudulent providers" and "being ruthless with bad providers" has been used by senior ACC staff members. I am not requiring you to comment on this, but I am inviting you to consider whether you want to comment on ACC's use of language of that kind and its consistency with the sort of partnership approach that certainly is now aspired to. Pg 212**

ACC considers that this type of language is inappropriate and should not be used by any ACC staff member when communicating either with internal or external people. This type of language does not fit with the current ACC vision and is not consistent with engendering a partnership with any provider group, regardless of their profession.

- 25. Fixed assets
I'd welcome both of you (ACC and NZSP) providing me with revised schedules of assets, to the extent that you consider revisions are necessary, identifying the differences between the two of you, and with some annotations explaining why those differences are appropriate or inappropriate as the case may be. Pg 272**

A revised fixed assets spreadsheet is included with this document. The spreadsheet now includes VIP Software Licence costs.

- 26. Benchmarking and Strategic Pay submission
Interested to hear from ACC about its views on the submission from Strategic Pay, and in particular the views expressed on whether, if one adopts the benchmarking against public sector health remuneration that I indicated a preliminary preference for in my draft report, one should look at a different step from the one that was used by Deloitte. Mr Summers... goes on to say that even if that approach is retained, and though he thinks it is suboptimal, it should be done differently and that the experts have looked at the wrong steps.
Pg 17 For further context see pg 43 "I am looking for some help on .." I need some help now on how to think about the relevance of the various points in that scale to coming up with an indicative average figure, or weighted average figure for employees, and weighted average figure for business owners, and whether that's based on years in practice and where people actually sit in that DHB scale, whether it's based on some sort of comparability... pg 272, 273**

I do want your help and the help of other parties in relation to how I might go about proposing a structure for benchmarking against the existing arrangements and against whatever comes through, and whether that's by reference to levels of seniority, and in that case how are levels of seniority of physiotherapy business owners mapped to positions on existing and any future pay scales, or whether you say it should be done by reference to some sort of evaluation of comparable levels of responsibility, and if so how that tracks across. Pg 224

Mr Taylor: ...reinforces the approach of Mr Summers minimum being provided (revised approach to benchmarking with public sector salaries)...we look forward to hearing whether ACC has any comments to make on that. Chairman: I have asked ACC to help me with this benchmarking issue as well. Pg 225

Deloitte have provided the following response to the Strategic Pay submission on the draft report:

Deloitte asked NZSP if it had any relevant benchmarking data for input into the original model. NZSP supplied a December 2004 NZSP survey of public sector physiotherapists, which formed the basis of the benchmarking in the original Deloitte report in March 2007. If better benchmarking data is now available than this 2004 survey, then it would be appropriate to reference this data as inputs into the model.

The DHB/PSA Salary Scale has been identified as another benchmark that could be used to assess appropriate salary rates.

The current Deloitte model uses a base salary of \$50,000 for clinical staff and this has then been increased by 6.65% to account for expenses paid for in the private sector that are not paid to the same extent in the public sector. The base salary used in the Deloitte model (before overtime) for clinical staff is therefore \$53,325.

The relevant DHB step on the DHB/PSA Salary scale that reflects the experience level of clinical staff in private practice would be appropriate to use as a benchmark.

Business Owners

The relevant DHB step on the DHB/PSA salary scale that reflects the experience level of typical business owners in private practice would be appropriate to use as a benchmark.

Business owner physiotherapist salaries in the revised model (including overtime rates) are approximately \$110,500 per full-time equivalent (FTE) physiotherapist business owner. This total average salary rate is high, due to the high levels of overtime that were captured from the sample practices. For some practices this was 25-30 hours per week.

On top of this, the business owner is receiving a return on investment (ROI) on the capital assets and goodwill of the physiotherapy practice. The ROI is designed to compensate the business owner for their investment in the business and the risks that they take as a business owner. Mr Summers appears to have neglected in his benchmarking analysis any discussion of ROI and the fact that total remuneration to a business owner in the Deloitte model is comprised of both a base salary and also a ROI.

The following is ACC's view on benchmarking:

ACC has looked at some benchmarking studies and considers the use of the DHB/PSA salary scale appropriate. ACC recommends the appropriate step to use is step 6 of the DHB/PSA scale.

There are a number of reasons that have validated this recommendation for ACC.

Source	Sample Size	Criteria	Salary AUD	Salary NZD
2006 National Employers Wage & Salary Survey by EMA New Zealand ²	2 employers 9 employees	HE14 Physiotherapists (New Graduate)		\$54,120
	6 employers 14 employees	HE16 Physiotherapists (Experienced)		\$56,103
August 2007 Australia Pay Scale Salary Survey Report for Physiotherapists ³	110 employees	Physiotherapists	\$50,740	\$56,921
		1-4 years experience	\$44,553	\$49,981
		5-9 years experience	\$49,750	\$55,811
		10-19 years experience	\$59,403	\$66,640
		20 years of more experience	\$62,454	\$70,063
University of Melbourne Graduate Destination Survey 2006 ⁴	Reported median annual salary of all graduates in 2006	Physiotherapy graduates	\$44,500	\$49,921

The exchange rate is based on 0.8914 exchange rate on 3 September 2007.

These salaries are comparable to the DHB/PSA salary scale.

Possible scenarios (subjective estimates)

ACC has attempted to estimate the number of physiotherapists working at each year of experience with input from a number of reference materials:

² http://www.nzsalarysurvey.org.nz/purchase_reports.htm

³ http://www.payscale.com/research/AU/Job=Physiotherapist/Salary/show_all

⁴ www.upo.unimelb.edu.au/Public/WV_GDS_2006_MDHS_Final.pdf

- Using the DHB scale;
- Otago University Physiotherapy School estimate of approximately 200 Physiotherapy graduates each year;⁵ and
- Otago University Research in 2001 showing 24% of physiotherapy graduates moved to Australia to work and 76% gained work in New Zealand.⁶

The following table is based on approximately 180 graduates staying in New Zealand for the first six working years following graduation. The percentage of staff in following years is assumed to decrease to 2.5% at 20 years' experience.

	DHB Salary	% at Years of Experience	Weighted \$
Year 1	40,000	7.2%	2,880
Year 2	43,300	7.2%	3,118
Year 3	46,000	7.2%	3,312
Year 4	48,600	7.2%	3,499
Year 5	54,000	7.2%	3,888
Year 6	54,000	5.0%	2,700
Year 7	56,304	5.0%	2,815
Year 8	56,304	5.0%	2,815
Year 9	59,636	5.0%	2,982
Year 10	59,636	5.0%	2,982
Year 11	61,472	5.0%	3,074
Year 12	61,472	5.0%	3,074
Year 13	64,177	5.0%	3,209
Year 14	64,177	5.0%	3,209
Year 15	64,177	5.0%	3,209
Year 16	67,911	3.5%	2,377
Year 17	67,911	3.0%	2,037
Year 18	67,911	2.5%	1,698
Year 19	71,308	2.5%	1,783
Year 20	71,308	2.5%	1,783
		100.0%	56,442

Using this theory and these estimates, the weighted average salary is \$56,442. This is aligned to the Sydney median salary for 2007.⁷ Please note that this information is subjective, as any change in the percentage of physiotherapists working at any of the years' experience levels will change the weighted average at the end.

Additional information on a point discussed at the second hearing

Labour cost index usage:

⁵ www.dol.govt.nz/consultation/physiotherapy/aut-and-otago-university-physio-schools-submission.pdf

⁶ Disability Workforce Analysis Report February 2003 Page 20
<http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/dc8bb8005495b1ffcc256d64007704b2?OpenDocument>

⁷ http://www.payscale.com/research/AU/Job=Physiotherapist/Salary/show_all

CHAIRMAN: Can I just stop you there with two questions? The first is the 5.7 percent, is that the labour cost index figure for the relevant years?

MR TAYLOR: It is labour cost index for health professionals, and it is used by Deloitte. This is the model to adjust both clinical and business owners. Pg 39 Line 5

ACC response to the above question from Mr Goddard

Yes, 5.7% is the Labour Cost (Salary and Wage) Index. However, Deloitte have taken a single year figure and used this to inflate multiple years' salaries. The correct figure used should have been 8.9% for the two years (as outlined below - Labour Cost Index – Salary and Wage).

ACC uses the Labour Cost Index (All Labour Costs) (as outlined below – Labour Cost Index – All Labour), as its index and this would have been 7.9% for the two years.

The background data to this follows:

Labour Cost Index – Salary and Wage - 8.9% as a Salary Inflator

The June 2005 Labour Cost (Salary and Wage) Index states:
The settlement of collective employment agreements for registered nurses, public health and district nurses, and resident medical officers was the main reason given for the rise in the June 2005 quarter. Annually, health professionals' salary and wage rates (including overtime) increased 5.7%, the largest increase since the series began in the December 1993 quarter.

This index looks solely at salary and wages paid.

Year ending June 04	3.1%
Year ending June 05	3.2%
Year ending June 06	5.7%
Year ending June 07	5.2%

Therefore, the use of 5.7% per annum as an inflationary figure for 2004/05 and 2005/06 is incorrect, as the index increase over this time was 8.9%.

Labour Cost Index – All Labour Costs – 7.9% as a Salary Inflator

The Labour Cost (All Labour Costs) Index looks at the total cost of employing a staff member, of which salary and wages is 83.7%. It also includes annual leave, superannuation, and ACC levies. Using the same health and community services segment of the index, for the same period, the increases were:

Year ending June 04	2.3%
Year ending June 05	3.9%

Year ending June 06	4.0%
Year ending June 07	To be released 19 October 2007

ACC considers these inflationary increases reflect the total cost to the business of employing staff. Using this index, an inflationary figure for 2004/05 and 2005/06 would be 7.9%.

It is ACC's policy to use the Labour Cost Index (All Labour Costs) for all industries, not just health and community services. For services that incur significant non-labour related costs, a combination of 60% LCI / 40% PPI (Producers Price Index - inputs) is applied.