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David Goddard QC / Diane Salter
Public Submissions,
Review of Physiotherapy Services

Re: Personal Submissions in response to Draft Report 23rd July 2007

Dear Sir:

My name is Jordan Salesa. I qualified as a Physiotherapist in 1998 and have post graduate qualifications in Sports Medicine and Manipulative Physiotherapy. I currently co-own and run eight physiotherapy clinics in Auckland. These clinics are located in broad geographical, cultural and socioeconomic suburbs, including central Auckland, Kohimarama, Glen Innes and Otara.

I have had varied involvement in a number of professional and community bodies in the Health sector including:

- President, Auckland Physiotherapists Private Practitioners Association
- Chairman, Auckland Branch of the New Zealand Society Physiotherapists (NZSP)
- Trustee, Total Healthcare Otara a Primary Healthcare Organisation (PHO)
- Committee, Physical Activity Advisory Committee Lotu Moui Project - Counties Manukau District Health Board (CMDHB)
- Working Group member and Author, National Pacific Diabetes Initiative (NPDI) - CMDHB
- Committee, Allied Health Services Sector Standard NZS 8171: Physiotherapy Audit Workbook

I have also been privileged to be appointed to several International Teams as; Lead Physiotherapist with NZ Swimming Team, Manu Samoa Rugby Team, New Zealand Commonwealth Games Team – Melbourne, Samoan Olympic Games Team – Sydney, Samoan Commonwealth Games Team, Manchester and as a Team Physiotherapist with New Zealand Olympic Team - Athens.

These are my personal submissions in response to the draft report of 23rd July 2007.

Kind Regards



Jordan Salesa
Physiotherapist

Introduction:

1. I congratulate Mr. Goddard and Ms Salter (and support teams) for the depth and breadth of knowledge displayed in the draft report. There exceedingly clear insight into a very complex multi-factorial issue. This independent review has been long overdue. ACC has readily monitored, reviewed, audited and investigated claimants and providers alike but seemed somewhat reluctant to apply the same ideals to them. It has been very clear to those who have involved themselves in this review that the skills and knowledge of the reviewer is indeed considered, insightful, intelligent, independent and socially responsible.
2. My submissions are aimed at addressing a few issues pertinent to my practices. My eight practices are located around Auckland in markedly contrasting socioeconomic areas. From Otara in South Auckland to the Tepid Baths in central Auckland. This has afforded us a unique view of the physiotherapy profession and its interactions with ACC. We employ 29 Physiotherapists in varying full / part time roles.
3. We hold an ABP contract and were one of the first five contractors in Auckland in 2002.
4. We joined the EPN for 6 of our clinics in early 2006. As mentioned in my first submission our practices were the first ones nationally to undergo the new certification process under the Conformity Assessment Bodies (CAB) regime. Our interaction with ACC is significant and like many physiotherapy practices ACC business forms a large part of our business depending on the clinic and its local population.
5. I hold the ACC scheme in high regard; it is a valuable legacy and is socially just. I personally (as I'm certain many if not most New Zealanders do) would not like a dramatic policy change or the demise of the scheme. I do however wish the scheme to achieve its general objectives and that the ideals that it is based on be upheld. This in my opinion has been eroded over the last 10-15 years. In specific reference to physiotherapy the burden of the scheme has increasingly placed onto the providers and as a direct consequence patients have suffered from this erosion. I give examples of this below.
6. I support the submissions of APPPA and the Physiotherapy NZ Trust and agree with much of the draft report.
7. Specifically I will provide some information around the ACC32 request for further treatment and some practical risks these pose.
8. I will also address some specific points from the draft report.

Access and Quality:

9. I received a letter from the Minister for ACC in late 2005 (in response to me questioning the Minister on access issues for Maori and Pacific peoples) outlining key reasons for the rollout of the EPN, with the main ones being increased access due to the removal of co-payments and increased quality of treatment.
10. Any evidence to bare out such claims have been shown to be incorrect (E68, E69). Indeed many pacific people remained with regulation providers, presumably still paying co-payments (E69).
11. In regards to quality the EPN has not delivered on this front as well (6.8-6.18).
12. **This leads one to conclude that the EPN has failed to deliver on its main objectives. Careful, collaborative re-construction of service delivery methods must be pursued. Importantly this must not be with one provider organisation as was the case with the EPN. All key stakeholders groups must be consulted and certainly not just economic modelers.**

ACC32's:

13. The table below displays the number of ACC32's awaiting approval. This information is taken from one day in July 2007 from our clinics.

Clinic:	Number of ACC32's awaiting processing	Range (days) of time-frames since lodging
GI	9	10 – 20 days
WW	5	3 – 14 days
WAI	3	1 – 23 days
KH	11	10 – 114 days
PRG	1	9 days
PP	26	4 – 37 days
TP	7	2 – 61 days
BRD	5	7 – 19 days

14. Direct contact with ACC gives explanations including;

- 14.1. ACC32's have not been received (despite other ACC32's being sent with them already having been approved)
 - 14.2. Some of these are waiting for claim decisions.
 - 14.3. Incorrectly or incomplete forms.
 - 14.4. However most are simply waiting for decisions.
 - 14.5. These patients are offered a simple choice once reaching their profile limit – pay privately whilst awaiting decision or just wait for a decision.
 - 14.6. All claims are followed up with ACC by administration staff on a 1-2 times per week basis.
15. While this process is a dynamic one this is a typical scenario in our clinics. I cannot speak to whether or not this is the case nationwide, although the sheer number (80,000 per annum) might suggest delays are commonplace.
16. Why this amount of ACC32's? Plainly many reasons will exist; my view is clear profile limits are not realistic. Other reasons may include incorrect diagnoses from other providers, in-experienced staff, and non-compliant patients and so on.
17. I agree with the draft report (9.29) these delays are of real concern. In our example of the 67 ACC32's 40% are longer than 10 days. Irrespective of reasons first and foremost these delays affect patients, patient entitlements, patient outcomes and their lives.
18. ACC statistics from 2005 and 2006 show that 10% of ACC32's take longer than 2 weeks. This translates to approximately 3000 people on the given figure of 80,000 ACC32's last year. This while a little different to our scenario is still unacceptable.
19. The Health and Disability Commissioner expressed (in his submission to this review) the need for patients to receive timely treatment.
- 20. The recommendation in 9.20 is in my view appropriate but I would suggest that it is a matter of urgency and as mentioned above (10) a wider consultation process takes place as apposed to just ACC and one provider group.**

Misconception of EPN Treatment Profiles Requirements:

21. We made a clear business decision to join the EPN for financial reasons. 60% of our ACC related patients were not paying co-payments predominantly because the bulk of our patients were serviced in 3 practices in lower socioeconomic areas which could not afford co-payments. It made good financial sense to join the EPN for these clinics especially when other practices in close proximity have joined the EPN. This was not the case for our other clinics as they were able to maintain co-payments to afford a more realistic fee for service level. We at the time of signing the EPN contract were left in no doubt (from road shows & discussion) adherence to the profiles was a key component for the EPN.
22. The reviewer is satisfied that there is no contractual requirement in the EPN contract to limit the number of treatments to the profile levels (6.38), also asserting that both regulation and EPN providers are monitored to the treatment profiles (6.38).
23. On the surface (absent from the contract) this would seem to be the case, however considering that ACC expected that certification and the requirement to follow treatment profiles to be key determinants in reducing average weekly compensation, average duration of total treatment and a reduction in number of treatments per claim and given this was implicit in many descriptions during the EPN rollout it is reasonable to argue (in my view) that many providers joined the EPN for financial reasons whilst also understanding the implied conditions of sticking to the profile figures.
24. This has created a culture (at least in our clinics and in my experience) a culture of EPN contractors delivering services to the profile figure only and almost going out of their way not to fill in ACC32's as there is a perception of not rocking the ACC monitoring boat by filling in too many ACC32's. Again patients bear the brunt of this.
25. In my view whilst there is no explicit reference in the EPN contracts to adhering to treatment profiles there was implicit reference to profile adherence and this has heavily influenced provider behavior in and around profile triggers. Perceived or real the effect on providers is and was real. EPN providers are bound to the treatment profiles; this is

not misconception and as a consequence has a real payoff between professional ethics and implicit obligations under the EPN.

Certification:

26. As mentioned above we were “crash test dummies” for the new CAB audit / certification process. Our estimate on costs to get certified was \$65,000 (personal primary submission). Whilst I acknowledge and agree with the reviewer's opinion that it is reasonable to assume that certification may produce improved practices and processes and subsequently patient satisfaction. It is also clear that the current certification does not deliver this at present (6.9).
27. \$65,000 to certify ourselves for where there is clear evidence that it does not help deliver better clinical services in a climate that the reviewer suggests EPN providers are underfunded by %34 could be viewed as negligent if it were public money. Who will wear and who has worn these losses? ACC? Physiotherapists? Or will it be our patients as we work harder and longer just to survive.
28. A couple of quick phone calls to other health professions who go through similar certification processes reveal interesting facts. An Institute for the criminally insane who one would expect has very clear, transparent and transferable processes does not have a surveillance audit at 18 months their certification is for 3 years not for 3 years plus a quick check up at 18 months.
29. The implications for both providers and ACC are profound. Cost reduction in terms of auditing costs for our clinics alone would have been \$1600 for the audit and a probable loss in 8 -12 hours of clinical labour.
- 30. The Physiotherapy Board stated (primary submission) stated “Physiotherapy in New Zealand is generally regarded as a safe profession” (page 4). Given this and the lack of evidence to show quality outcomes of the present certification why the need for this exhaustive compliance and surveillance and audits costs can and must be reduced. It is inappropriate and inefficient.**

Equity in the Profession:

31. While the draft document addresses some issues around retention of senior practitioners and maintaining a motivated, experienced workforce. There is no mention in the draft document on the issue of a culturally appropriate physiotherapy workforce. This may well not fall directly under the terms of reference for this review although there are clear obligations for government agencies to work towards assisting Maori. ACC are doing this via a specific consultative strategic plan and have recently signed off on a Pacific plan.
32. These strategies are not looking at culturally appropriate workforce. Whose responsibility is this? Is it even a need? **Given the poor uptake of Maori, Pacific and Asian populations of ACC services it seems eminently important that ACC play some role in working with the physiotherapy profession to shed light on this issue.**

Final Comment:

33. Much ACC policy and behavior has had detrimental effects on the physiotherapy profession. The review has gone a long way in the right direction to right the indiscretions of the recent past and whilst ACC has a seemingly new found vigour for collaboration and are returning towards original Woodhouse principles. Much of the past transgressions have forced or guided physiotherapists to interact with patients in a manner not necessarily of the professions choosing. This has impacted on providers such as me treating patients in a less than ideal manner. My hope from this review is that recommendations are heard acted upon by both the profession and ACC for the betterment of those in their time of need.

Jordan Salesa