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David Goddard QC
PO Box 12016
Wellington

By Email

Dear Sir

Responses to Questions Asked of NZSP at Independent Review Conference

1. Please find following the questions asked of NZSP at the First Independent Review Conference.
2. The Society notes that much of the Australian information was sourced from Phil Hart of the Australian Physiotherapy Association ("APA"). APA is the Australian equivalent of the NZSP. Phil is Manager, Professional Development and Specialisation, and was interviewed by telephone by the writer on 23 May 2007.
3. The Society regrets that little further hard data was able to be found, but considers that this source is reliable. All parts of this response based on Mr Hart's comments have been sent to him for confirmation, and he is satisfied that his views are represented correctly. The Society would be prepared to try and secure a sworn statement from Mr Hart if this was necessary. Alternatively, Mr Hart's contact details are available on request.

Question 1: Please provide a further brief submission on the interpretation of ILO 17 should NZSP wish.

Introduction

4. NZSP Acknowledges the advice provided by ACC that the New Zealand Government has ratified ILO convention 17, but not convention 121 or subsequent. However, the representative from the Department of Labour advised that non ratification of subsequent treaties is due to the lack of a complete medical scheme for workers in New Zealand, rather than related to the specific issue of work place injuries which is discussed herein.
5. NZSP's view of ILO 121 remains as per paragraph 186 of the first submission of NZSP. That is, although the State's obligation is to pay the whole or the vast majority of the medical and physiotherapy costs of an injured worker, this does not prevent charging of a small co-payment. It should be remembered that this convention is limited only to work place injuries, which is a far lesser scope of coverage than provided by the comprehensive ACC scheme.
6. If it is accepted that the ILO 121 allows co-payments, NZSP would have fundamental difficulty with an interpretation of ILO 17 requirements which effectively imposed upon New Zealand a higher standard than that imposed upon nations who have ratified the subsequent treaty. Whilst this is of course not an answer to the question of interpretation, the difficulties with that position do have some relevance to interpretation.

Relevant Provision of ILO 17

7. Article 9 of ILO 17 states:

Injured workmen 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 or invalidity insurance institutions.

8. The word defray is defined in the New Zealand Oxford Dictionary as:

provide money to pay (a cost or expense).

9. Defray is defined elsewhere as “to bear or pay all or part of”, but most definitions in common with the New Zealand Oxford do not specify whether “defray” refers to payment of the whole or part of a cost.
10. In NZSP’s view a strict interpretation of the word “defray” would probably interpret it as requiring the payment of all of the cost of whatever it referred to. However, NZSP also considers that “defray” does not necessarily refer to the payment of all of a cost, and a liberal interpretation may allow for the payment of less than the whole of a cost.

General Approach to Interpretation of Treaties

11. NZSP considers that a liberal interpretation is supported by the one brief sketch of treaty interpretation which they were able to source at short notice.¹ That commentary stresses the variation in how treaties will be interpreted. At page 36:

The long term treaty must benefit from a certain flexibility and room for development if it is to survive changes in circumstances relations between the parties. Changes and conditions like those that make rebus sic stantibus an attractive doctrine may lead a court or executive official to interpret a treaty liberally so as to give it a sensible application to new circumstances. ...

In addition, the difficulty in achieving agreement over amendments to long continuing multi lateral treaties may encourage their draftsman to express a “consensus” through norms of a general character, which have a better chance of surviving and carrying their broad purposes through changed conditions amongst the signatories.

12. NZSP considers that ILO 17 is self evidently a long continuing treaty. Particularly given the change in circumstances brought about by the introduction of ILO 121 amongst many of the original parties to ILO 17, a liberal interpretation of ILO 17 is the best manner in which to give ongoing sense to obligations under ILO 17.
13. This liberal interpretation does no violence to the language to the particular provision of ILO 17, which does not contain specific qualifying words requiring the defrayment of “the whole of” medical costs.

¹ **International Human Rights in Context – Law, Politics, Morals**, Steiner and Alston, Oxford University Press, Oxford, 1996 – Refer Appendix 1.

Vienna Convention

14. The Vienna Convention is not strictly applicable to the interpretation of ILO 17, as Article 4 states that the Vienna Convention is a non retroactive document. However, NZSP understands that the Vienna Convention is generally applied retroactively as the primary aid to interpretation, since large parts of the Convention are declaratory of the previously existing international customary law on treaty interpretation.
15. Article 30 of the Vienna Convention takes into account the position where an updating treaty may not be ratified by all parties to the original treaty, as is the case in relation to ILO 17 and ILO 121. Clause 4 of Article 30 effectively allows the continued application of the earlier treaty to states who are only parties to the earlier treaty.
16. That said, the real question is what interpretation should be given to the word defray, and a number of Vienna Convention articles are relevant. These articles are found in section 3 of the Vienna Convention, which specifically deals with interpretation of treaties.
17. The primary rule is that of article 31, which states:

A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in light of its object in purpose.
18. Article 31 clause 3 also states that:

There shall be taken into account, together with the context:.. (b) any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation; ...
19. Article 31.3 is particularly relevant to the question at hand. It is clear that New Zealand has for many years operated a system where co-payments for work injury have been a fact of life. To NZSP's knowledge there have never been any adverse comments by any international bodies as to the failure of this system to live up to New Zealand's requirements under ILO 17.
20. NZSP is unaware of this strictness or otherwise of other countries' interpretation of their duty to pay the medical expenses of any injured worker. NZSP has discussed the possibility of the Department of Labour representative using their more in depth knowledge to review the breadth of international practice under Article 9 of ILO 17, which will also be relevant to interpretation under article 31.3 (b). However, the fact of New Zealand's long practice in this matter, of allowing small co-payments, is considered a telling reason to support a liberal interpretation.
21. The other principal relevant clause of the Vienna Convention is article 32 which states that:

Recourse may be had to supplementary means of interpretation... when the interpretation according to article 31:... leads to a result which is manifestly absurd or unreasonable.
22. NZSP considers that an interpretation is available under article 31 which allows for small co-payments to be charged. However, if a strict interpretation were taken which imposed a stricter obligation on New Zealand than on signatories to

the later ILO 121, then NZSP would consider this to be manifestly absurd or unreasonable. Further interpretation assistance would therefore be available under article 32, for a more consistent interpretation of ILO 17 in accordance with later obligations.

Conclusion on Interpretation of ILO 17

23. NZSP considers that:

23.1. the wording of ILO 17;

23.2. the subsequent international practice (particularly of New Zealand) of allowing the charging of co-payments; and

23.3. the subsequent introduction of ILO 121, -

all allow a reading of ILO 17 which does not prohibit the charging of co-payments, so long as those co-payments are small relevant to the overall cost of treatment.

Question 2: Please work with ACC to attempt to resolve the difference between the average numbers of consults per day listed at NZSP Submission 2 para 93.

24. NZSP and ACC have worked together to clarify the differences between NZSP's reported consult per day figures, and those provided by ACC. The parties agree that these figures cannot be compared or strictly reconciled however, as they represent slightly different measures.

25. The NZSP figures are surveyed figures generated by NZPPA members when asked "On average, how many patients would a full-time physiotherapist treat in an 8 hour day?"

26. Those figures therefore represent an average outcome for a competent worker during a full day's service.

27. The key differences are that the survey conducted by NZSP included only full time workers working 8 hours per day. ACC analysis includes full time and part time workers regardless of the hours worked. Also ACC's data only relates to ACC claims whilst NZSP have considered all claims, not just ACC or non-ACC. This therefore explains lower average noted by ACC data.

28. The ACC data will be lower than that provided by NZSP for the following reasons:

28.1. There are a significant number of part time providers in the profession, and many of these may work less than 8 hours per day. They will naturally treat less patients over a shorter working day; and

28.2. There are also likely to be weekend days where providers may work part days or undertake only a couple of treatments, whether in clinic or with a sports team.

29. The above outcomes will be included in the ACC data and are inseparable from those who have worked FTE days. They will drive down the average as calculated by ACC, meaning that direct comparison is not possible.

30. The parties also agree that the ACC figures do not include private visits. This will also account for part of the difference between the NZSP and the ACC figure.

However, the extent of the difference attributable to this source is dependant on the size of the public / private split nationally, a subject on which the parties have different views.

31. Ultimately, ACC accepts that figures of the order of those provided by NZSP may represent the output of a competent FTE physiotherapist.

Question 3: Is NZSP able to provide further information on physiotherapist's remuneration in Australia to shed light on the accuracy and completeness of the information provided to date?

32. NZSP has not been able to source any hard data other than the FMRC benchmarking report for annual remuneration. NZSP had previously made inquiries regarding specific remuneration data, and was unable to find anything.

33. In spite of this, NZSP contacted their counterparts at APA to see if any further information was available. APA confirmed that they could not source any additional hard data, nor did they have any ideas as to where to get such data.

34. However, in the course of researching the issue of Australian workplace accident insurance, NZSP did come upon some very useful information in regard to hourly rates. The price schedules for the relevant schemes are contained at Appendix 2. See below for further details of those schemes.

35. NZSP considers that these rates are more reliable indicators and benchmarks than the FMRC data. They are a direct payment, and are not subject to the type of uncertainty which is inherent in the FMRC data, to which the Comments in KPMG's second brief are also relevant.

36. Either taking hourly rates specified or attempting to identify hourly rates from appointment prices, the Australian figures are as follows:

Name of Scheme ²	Hourly Rate excl GST
Workcover Queensland	\$134.03 ³
Workcover South Australia	\$137.00 ⁴
Workcover Victoria	\$118.85 - \$163.20 ⁵
Workcover NSW approved	\$135.10 ⁶
Workcover Western Australia	\$135.80 ⁷

37. NZSP has been unable to glean any information on the rates paid by insurers under compulsory third party insurance policies, save for Victoria, which has

² NZSP was unable to find fee information for Northern Territory, Tasmania or ACT.

³ Hourly rate quoted for a range of services 100287 – 100414.

⁴ This is the cost listed at PT300. Also, the figure of \$137.00 is reached by using the mid point (25 min) of PT215.

⁵ The lower rate is quoted for PY128. It is not know whether this is a discounted rate reflecting travel component. The standard consult PY102 is expressed as greater than or equal to 15 minutes. The figure of \$163.20 is the extrapolation of this visit price at 4 x 15 minute visits.

⁶ Hourly rate quoted for case conference.

⁷ See for example PE001.

similar rates to its Workcover rates, and South Australia which uses the Workcover rates for physiotherapy treatment of covered motor vehicle injuries.

38. As noted above, NZSP has also contacted APA regarding the above information. In regard to these hourly rates, Mr Hart advised that:

38.1. the work cover hourly rates were generally regarded as a little bit behind the market rate;

38.2. where private patients were treated, providers did tend to charge more per visit, in the range of \$5 – 10 per visit.

39. Returning to the question of Annual remuneration, Mr Hart considered that the FMRC benchmark figure of \$88,000 net profit per working owner did not represent the reality of private practice in Australia. His view is that this would need to be increased significantly to represent the net profit generated by a busy full time practitioner in Australia.

40. Mr Hart believed that the FMRC figures may have been distorted by part time businesses, though he did not seek to provide a definitive response on reasons why the FMRC figures may be wrong.

41. The Society considers that Mr Hart's observations in regard to the FMRC data are backed up by the hourly rates quoted above. Those rates are significantly in advance of New Zealand rates, and should allow for significantly greater profit. Following this further information, and particularly discussions with Mr Hart, NZSP considers that no reliance can be placed on the FMRC figures, and that the Reviewer should not regard those figures as setting any benchmark for New Zealand remuneration.

42. Mr Hart also noted in regard to employed physiotherapists that perhaps the most common means of remuneration was by payment of a percentage of fees earned by that practitioner, often in the range of 35 – 40%.

Question 4: Please provide any information on Australian accident insurance schemes which may contribute to distortion in the FMRC benchmarking figures for Australian physiotherapists and which may shed light on the difference in remuneration of other comparable professions, including, but not limited to, relativities with chiropractors).

43. The Australian rehabilitation market is also affected by a number of compulsory insurance schemes, but does have a significant sector of patients not covered by private insurance.

44. Each state has a separate Workcover insurance scheme, and a motor vehicle injury insurance scheme based around compulsory third party insurance (CTP). Where injured parties are over the age of 16, they are not covered by CTP insurance if they are the cause of the accident.

45. There is also a commonwealth scheme run for veterans through the Department of Veteran Affairs which covers physiotherapy. However, a significant part of the market, including sports injuries, is not covered by state insurance schemes.

46. Mr Hart of APA advised that by his estimate, 30 – 35% of the population would have private health insurance for physiotherapy services not covered by compulsory state schemes. He considered that neither privately insured patients

nor self-payers were reluctant to pay for physiotherapy services for non-covered injuries, as there was no expectation that anyone else would pay.

47. It is unclear however whether there is universal access for all Australians where an injury is not covered by one of the compulsory schemes. However, with individuals being liable for the cost of the treatment, it seems likely that there are significant issues regarding access for these types of injuries.
48. Mr Hart also advised that it is difficult to advise the average amount of work done by a practice under compulsory schemes as opposed to private paying / privately insured patients. For those providers in an industrial area targeting workcover patients, 90% of their work may be covered by compulsory schemes. Other practices exist in wealthy non-industrial areas, and 90% of their practice may be truly private. That said, it is clear that the absence of compulsory cover for sports injuries must mean that there is a bigger private market in Australia than in New Zealand.
49. NZSP consider that the existence of the wider private market is likely to mean that there is less distortion in Australia, and better ability to benchmark compulsory insurance rates off a purely private rate. However, NZSP still considers that the size of the compulsory insurance market in Australia means that there will be elements of distortion there. This can be seen in Mr Hart's views that the compulsory rates are not up to market level. NZSP considers that the compensable rate may in many cases also be an influence dragging down pure private rates, as many patients are likely to demand some reasonable parity between the compensable rate and the rate they are paying.

Question 5: Please provide comparative data for the gender of physiotherapists and chiropractors in New Zealand and Australia.

50. The following table comparing physiotherapist and chiropractor gender in New Zealand is taken from the National Health Information Service (NZHIS) data for Physiotherapy and Chiropractors 2004. 228 Chiropractors responded to the NZHIS survey (75% of those invoiced for an APC), compared to 1450 physiotherapists (53% of those invoiced for an APC).

	20 - 34 Male	20 - 34 Female	35 - 44 Male	35 - 44 Female	45 - 54 Male	45 - 54 Female	55 and over Male	55 and over Female	Total Male	Total Female
NZHIS Physiotherapy data 2004	6%	25%	5%	23%	4%	21%	1%	12%	17%	83%
NZHIS Chiropractic data 2004	16%	11%	20%	11%	16%	7%	17%	4%	70%	30%

51. Australian comparative gender data was able to be sourced from the Australian Allied Health Workforce (AHWAC) Report 2006. That report however took its data from the 2001 Census. The percentages are the percentage of each gender in that age bracket e.g. 53% of the male physiotherapy workforce is in the 20 - 34 age group.

AHWAC Australia 2001 data	20 - 34 Male	20 - 34 Female	35 - 44 Male	35 - 44 Female	45 - 54 Male	45 -54 Female	55 and over Male	55 and over Female	Total Male	Total Female
Physiotherapists	53%	39%	30%	30%	13%	21%	4%	9%	27%	73%
Chiropractors	31%	57%	30%	29%	21%	8%	18%	6%	73%%	27%
Occupational Therapist	60%	55%	22%	25%	15%	15%	2%	5%	7%	93%
Osteopath	36%	64%	26%	19%	25%	8%	12%	6%	57%	43%
Optometrist	33%	59%	36%	26%	20%	13%	11%	2%	59%	41%
Podiatrist	50%	51%	30%	26%	13%	12%	7%	10%	39%	61%

52. NZSP continues to consider that the female domination of the physiotherapy is likely to have contributed to historic salary issues in relation to the physiotherapy market, both in Australia and New Zealand. The Society considers that caution would be needed in any decision that international physiotherapy remuneration meant that reliance not be placed on the Strategic Pay figures. This is due not only to potential gender related issues, but also due to the lack of reliable remuneration data, save for the hourly Australian rates specified above.

Question 6: Please consider and advise of any areas in which you expect physiotherapists might make productivity gains in the future, and the extent of those expected gains.

53. NZSP considers that there are some areas where there is potential to make efficiency gains over time, but that it is questionable whether these will come to fruition. Countervailing factors may also come into play.

Information Technology

54. Information technology has been highlighted as an area for potential efficiency gains. However, significant investment would be required in most practices for adequate technology to be implemented, and most practices completely lack the required capital to make such investments.

Increasing Practice Size

55. The aggregation of practices and increasing practice sizes may also make some productivity gains over time. For example, Mr Monkton considered that the costs of accreditation are generally the same regardless of the size of the business.

56. However, there are also many practices in New Zealand which are small practices due to the small communities in which they operate. It is important that these practices remain viable in order to provide continued healthcare access. Equally, the relatively small size of practices means that there is a good geographical distribution of practices in New Zealand, including in cities. NZSP considers that this assists in achieving access goals, and is an important in itself.

57. Further, as an almost entirely service related business, aggregation does not significantly assist physiotherapists by increasing bulk buying power or similar. The efficiencies through increasing size are therefore likely to be limited.

ACC and Other Bureaucracy

58. NZSP has already indicated that ACC-related administration is a constraint on administrative efficiency. To this one may add the broad range of regulatory requirements which affect the health sector, and other more general administrative issues like Kiwisaver.

Changes of Policy / Government

59. NZSP also notes that major policy changes can have an adverse impact on efficiency. From previous experience, the Society strongly considers that the privatisation of parts of the insurance function under the last Government led to significant decreases in efficiency. These ranged from the fact that each insurance company ran different systems, to the fact that patients often did not even know who their insurer was.
60. NZSP is working with all parties to ensure that they are aware of physiotherapists' desire to minimise disruption to patients and to the sector caused by politically driven policy or structural changes.

Efficiency of Physiotherapy Consults

61. NZSP considers that efficiency, in terms of quality of service, is under continuing development and will continue to improve. However, increased quality does not necessarily mean increased efficiency in consults per day. In fact the Society considers that increases in quality may lead to less consults per day, and considers that this is exactly the scenario in terms of recent shifts in clinical best practice.
62. The Society further considers that any administrative efficiency increases would not allow practitioners to fit in an extra consult per day.

Conclusion on Efficiency

63. NZSP understands that Mr Newton of KPMG cautioned against the automatic application of efficiency gains to the sector as opposed to a fully private manufacturing or asset based operations. NZSP considers that the prospects of efficiency gains within the profession are not of sufficient strength, size, or continuing nature to warrant a discount on inflationary adjustment.

Question 7: Please keep a watching brief on the production of NZHIS 2006 workforce statistics and provide as soon as they are available.

64. NZSP will continue to check with NZHIS regarding the expected date for release of NZHIS 2007 demographic data, for both physiotherapists and wider allied health practitioners. NZHIS' latest estimate for production of the 2007 data is August – September 2007.

Question 8: Please provide data regarding demographics of overseas comparative professionals (Ms Salter's letter of 11 May).

65. Please find age group demographic data following for physiotherapists in New Zealand, the United Kingdom, Australia and Canada.

	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%

66. Age group demographic data also follows for allied health professionals in the UK and chiropractors in Australia. This is contrasted to the physiotherapy figures for each country for ease of reference. Broader comparative data has not been able to be found from public sources and is therefore unavailable.

	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%
Allied Health Professionals NHS (UK) 2005	9%	31%	29%	21%	9%
AHWAC Australia 2001 census data Physiotherapists	10%	33%	30%	19%	8%
AHWAC Australia 2001 census data Chiropractors	3%	35%	29%	18%	15%

67. A broader range of data for the Australian Allied Health Workforce (AHWAC) is available from their Report 2006. Data is again taken from the 2001 Census, but the age bands are different to the above analysis.

	% under 35	% 35 - 44	%45 - 54	% 55+	Total
Physiotherapists	43%	30%	19%	8%	10242
Chiropractors	38%	29%	18%	15%	2063
Occupational Therapists	55%	25%	15%	5%	5331
Osteopaths	48%	23%	18%	9%	412
Optometrists	44%	32%	17%	7%	2695
Podiatrist	51%	28%	13%	9%	1767

Question 9: Please provide further details on recent member concerns raised with NZSP regarding ACC investigations.

68. NZSP has only been able to make contact with one practitioner who has had concerns of ACC investigations post 2004. The outline of that practitioner's experience with ACC is attached as Appendix 3 to this response.

Conclusion

69. NZSP made detailed oral closing comments during the closing of the first Independent Review Conference. NZSP is happy to let those comments stand, and does not wish to expand on them at this time. Please contact NZSP if you have any queries.

Yours faithfully



Martin Taylor
Barrister

**CC: Diane Salter
Notification List**

APPENDIX 3

Re ACC Patient Visit

I have been requested by the New Zealand Private Physiotherapist Association and the New Zealand Society of Physiotherapy to provide details of the ACC visit to my practice in 2005.

Unfortunately as I am awaiting a re visit from the ACC I am unable to release my name or the name and location of my practice or specific dates to retain anonymity, for fear of jeopardizing the outcome of an intended revisit. I would appreciate this anonymity be honoured.

When Contacted

Part way through 2005 I received a letter from the Service Performance Manager Healthwise at ACC stating that along with another ACC employee I was to undergo a practice visit some weeks later. I had previously agreed to this visit having returned the appropriate paperwork.

I received a further letter 2 days prior to the impending visit stating a list of approx 30 patient's notes that would be required to be seen by the ACC personnel.

The visit took place as confirmed in 2005 at approximately 9.30am, after which the ACC personnel requested I meet with them in my office to discuss their findings. They also confirmed that I would also be receiving a written report of their findings.

The ACC personnel left my practice at 12.15pm.

Reason for Visit

The reason for the ACC visit to my practice initially was unclear, but on checking correspondence from ACC it appears the visit to my practice was a result of my applying and receiving approval to forward my ACC40 and /or ACC47 schedules electronically. This approval was given by the Provider and Vendor Registrations department who originally contacted me by telephone requesting that I apply for this service.

Comments of Visit

I didn't receive the report of the ACC visit to my practice until part way through 2006, some 2 or 3 months after the visit. The report stated some of the issues raised verbally by the ACC at the visit, and that:

“Our usual practice following a visit is to contact you for a follow up in months, I will contact you in 2006 to ensure the following changes as agreed are in place.”

Some of the comments mentioned in the report and told to me by ACC personnel and overheard by office staff and patients were:

- That I work too long hours

- That I am too personable (friendly) with my patients
- That I make my self too available, this was a reference to my treating a patient at my practice on Christmas Day, Boxing Day & following day (Stated in report)
- The general tenor of the visit was intimidatory to say the least.

The follow up visit didn't occur.

Current Situation

I received a telephone call from the ACC Service Performance Manager Healthwise later in 2006 stating that ACC would be ceasing bulk billing privileges after 5 working days as I had not complied with the issues raised in the ACC Visit Report. Having also receiving written confirmation of same, I immediately contacted my lawyer who contacted ACC.

Now after waiting since 2006 and having various threats of my bulk billing being removed again, I have been told that the ACC are revisiting my practice. This notification was received in 2007 and I am still waiting for a date.