

# **Second Hearing**

***Submissions of:  
Val Forster,  
Made by  
Warren Forster***

## **Submission to the Physiotherapy Inquiry**

**This is the submission of:**

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**Val Forster has previously stated that she wishes for her son, Warren Forster to appear before the inquiry to give evidence and speak to this submission**

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**Structure:** This Submission is structured in the following manner:

- Background
- Summary
- Relevant Facts
- Analysis and discussion of Systemic Issues

This submission is lodged by Warren Forster on the 9th of March 2007. We the undersigned, hereby provide express consent for the information contained in this submission and the information contained in its Annexes to be made available to the public. Furthermore, we believe that this information is in the public interest.

27 August 2007

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Warren Forster

Date

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## **PART I – INTRODUCTION**

### **BACKGROUND**

1. This submission adds to the Initial Submission of Val Forster dated 9 March 2007, the first Oral Submission and the Addendum provided to the Review.

### **PRELIMINARY ISSUES**

2. It is important to reflect upon the fact that the Diagnosis used for the Treatment Profile, ACC32 Analysis and other decisions is **extremely unreliable data**. ACC itself has acknowledged the limitations of their data and how it is being used.

3. According to ACC News, July 2004, Issue 69 only 34% of the 7600 patients in the study population had a diagnosis that supported the need for the surgery they received.

4. It is certainly clear from the above figures, and from the Patient Experiences related in the first hearing, that ACC is not very good at updating the diagnosis on their computer system

5. Making decisions that affect claimants’ lives, using this data in the manner in which ACC is doing so is extremely hazardous and dangerous to claimants. Thousands of claimants including my mother have suffered as a result of the fact that treatment has been cut short by ACC following an analysis and reliance on unreliable data.

6. The diagnosis and read code system used by ACC is inconsistent with evidence based nomenclature and is out of step with the remainder of the developed world.

7. ACC’s entire process surrounding the ACC32 Prior Approval of Treatment and Treatment Profiles are based on a diagnosis, which according to ACC’s own figures is at best unreliable. Is it reasonable to place the weight ACC is placing upon these diagnoses in making their decisions and denying treatment to thousands of claimants every year?

8. This does not mean that we should not put any measures in place to ensure that treatment is proper; it merely means that we must be cautious when making decisions using such unreliable data.

## **CAUSE AND EFFECT**

9. ACC developed a plan to develop Treatment Profiles and an Endorsed Provider Network to constrain costs and to ensure compliance with ACC’s objectives.
10. ACC has controlled the market by developing enforcement strategies. They created Financial incentives for providers to join the EPN and disincentives to remain on the Regulated Fee.
11. PART II of this Submission discusses the mechanisms developed and implemented by ACC to constrain the provision of Entitlement to Claimants, including the development and use of Treatment Profiles.
12. PART III examines the measures used by ACC to force providers to comply with treatment profiles including the legal framework for treatment profiles, the legal framework for the regulated fee and for the Endorsed Provider Network Contract and then discussing outside of the Act.
13. PART IV discusses Ethics and Rights, privacy and consent issues and finally, effective access to justice.

## **PART II**

### **CONSTRAINING THE PROVISION OF ENTITLEMENTS TO CLAIMANTS**

14. **Relevant Paragraphs of Draft Report.** Parts II and III of the second submission addresses para 5.15 of the Draft Report and the finding that “*the EPN Contract does not require compliance with the Treatment Profiles.*” Whilst strictly interpreting the contract, this statement may be considered correct, there is an expectation that EPN physiotherapists will abide by these profiles.

15. **Purpose.** The Purpose of this part of the Submission is to provide the Review with evidence regarding the expectation that Treatment Providers will abide by Treatment Profiles.

16. **Executive Summary.** Strong circumstantial evidence supports the fact that ACC intended for treatment to be limited to the Treatment Profiles, that detailed and deliberate action was taken towards achieving this and that the endstate was that this occurred.

### **EVIDENCE THAT ACC PLANNED COMPLIANCE WITH TREATMENT PROFILES**

17. **Summary.** There is significant evidence available that supports the view that ACC developed a plan to constrain the provision of entitlement to Physiotherapy Treatment and makes recommendations regarding the procurement of further evidence.

- i. **NZIER Report.** Already Provided to the Inquiry.
- ii. **ACC Healthwises’ KPI.** The Key Performance Indicators of ACC Healthwise as set out at **Annex xlvix** of Val Forster’s First Submission.
- iii. Furthermore, ACC have refused to release the full details surrounding ACC Healthwises’ KPI and remuneration of those involved. (Letter, ACC to Warren Forster, Early 2007)
- iv. **Clinical Governance in Healthcare.** Dr David Rankin’s Presentation, Evaluation of Clinical Practice. Healthcare Review Online. (4) 4; April 2000. Attached to this submission at **Annex A, Pages 50-67.**

- v. **Vote ACC.** The Evidence given to the Transport and Industrial Relations Select Committee. Attached to this submission at **Annexes G and H, Pages 85 – 138.**

18. **ACC’s Position.** Notwithstanding the above point. Evidence given to the Inquiry by ACC Staff led the Review to find in the Draft Report at Para 7.108, Page 94:

*ACC assured the Review that it was not using audit 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.*

19. It is clear that ACC planned to develop “enforcement strategies” and would appear that although ACC has assured the review that did not implement these, there can be no doubt that these measures were seriously contemplated by ACC. There is certainly a great deal of evidence that ACC did in fact implement these measures, and this will be discussed below.

20. The evidence given to the inquiry by ACC appears to be inconsistent with other available evidence.

21. **Recommendations regarding evidence.** It is recommended that further evidence be obtained from ACC regarding their plans to constrain provision of entitlements to claimants by the development and use of Treatment Profiles. This evidence would be best obtained from Dr David Rankin, Mr Garry Wilson, and Ms Cathy Scott, all of whom are no longer involved with ACC. It is expected that any doubt regarding what was planned could be clarified by seeking evidence from these persons.

22. Furthermore, the ACC Board Responsible for governance during this period discussed the EPN. Their evidence, along with any directions which they were given will also help clarify what appears to be a doubtful situation.

23. It is respectfully suggested that these people be invited to give evidence to the inquiry on the understanding that should any disclosures be made, that they be protected under the Protected Disclosures Act.

#### **ACC SET OUT TO IDENTIFY A “DISCRIMINATOR” SO AS TO ALLOW IT TO SELECT PRACTICES**

24. The New Zealand Physiotherapy Accreditation Scheme was developed under the auspices of the New Zealand Society of

Physiotherapists. To become accredited, the principal physiotherapist had to be a member of the New Zealand College of Physiotherapists. To be a member of the College, a physiotherapist had to be a member of the Society.

25. The New Zealand Society of Physiotherapists championed accreditation and wrote to ACC expressing their displeasure that ACC were not encouraging Physiotherapists to become accredited.

26. Accreditation against the NZPAS was “selected” by ACC as the entry criteria for their original trials of the Endorsed Provider Network and it was determined to be a robust discriminator.

- i. **ACC News, July 2001.** Accreditation was decided to be a robust discriminator. Attached to this Submission at Annex B, Page 68.
- ii. **Vote ACC.** The Evidence given to the Transport and Industrial Relations Select Committed by ACC is relevant here. Attached to this submission at **Annexes G and H, Pages 85 – 138.**

27. **Draft Report Finding.** The draft report has found that there are major issues surrounding the initial trials of the Endorsed Provider Network.

28. **Potential to Repeat the Development and Misuse of a Discriminator.** Extreme caution is required in developing a “discriminator.” Especially when measured are subsequently put in place to ensure that a group complies with the discriminator by changing their behaviour without careful considerations and management of the “outcomes” to ensure that the “outcomes” don’t drop.

29. Great care must be taken that another “discriminator” is not inadvertently developed and promulgated in a similar manner. It is not now a case of identifying those Physiotherapists with the lowest rate of ACC32 Lodging and calling them “best practice” and then providing them and other providers with additional incentives, because they are not the ones whom need to be able to approve additional treatment.

### **ACC REQUIRED A JUSTIFIABLE POINT AT WHICH TO LIMIT TREATMENT**

30. ACC required a level at which to limit treatment. It’s aim was to constrain the provision of entitlements to claimants however to maintain a veneer of legitimacy, it ..

31. **Development of Treatment profiles.** Evidence surrounding the development of the treatment profiles can be found in the following documents:

- i. **NZIER Report.** Already Provided to the Inquiry.
- ii. **ACC Healthwises’ KPI.** The Key Performance Indicators of ACC Healthwise as set out at **Annex xlvix** of Val Forster’s First Submission.
- iii. **Clinical Governance in Healthcare.** Dr David Rankin’s Presentation, Evaluation of Clinical Practice. Healthcare Review Online. (4) 4; April 2000. Attached to this submission at **Annex A, Pages 50-67.**
- iv. **World Confederation of Physical Therapists.** Keynotes, Evidence Based Practice – 2, the New Zealand Experience. as set out at **Annex liii** of Val Forster’s First Submission.
- v. **ACC News, July 2001.** Attached to this Submission at Annex B, Page 68
- vi. **Vote ACC.** The Evidence given to the Transport and Industrial Relations Select Committee. Attached to this submission at **Annexes G and H, Pages 85 – 138.**
- vii. **Submissions of other parties to the Review including NZSP, ACC, the Physiotherapy Trust and individual physiotherapists.**

32. **ACC 11.** The “ACC 11 – Physiotherapy Services” sets out the numerical treatment profiles – the number of treatment and the triggers. It states, in parts

**“Normal Treatment Numbers**

The treatment numbers relate to a specific diagnosis that has no complications and has been referred for, or has accessed, physiotherapy treatment at an early appropriate stage.”

“ACC will allow physiotherapists to treat these conditions within the treatment profile numbers without the requirement of a GP referral...”

“These Physiotherapy Treatment Numbers have been developed in a joint initiative between the NZSP and ACC. The project provides an initial framework for developing

evidence based practice or better practice guidelines. The numbers have not been developed as evidence-based practice or better practice guidelines, but rather provide a consensus on acceptable treatment ranges.”

33. The Draft Report has found that the Treatment profiles are not evidence based, and there is nothing to support the view that the treatment profiles have been subjected to consensus review.

34. **Provider Profiling Benchmarking Reports.** There is clear evidence that the ACC benchmarked against Treatment Profiles.

35. **Providers were measured against Treatment Profiles.** Initially providers were slow to take up Treatment Profiles, in fact ACC’s first attempt to implement them was abandoned. In their second attempt, ACC worked with the NZSP to develop them.

- i. “The Treatment Profiles constitute a consensus of opinion between NZSP members and ACC (D23, Page 127)”
- ii. Compliance with Treatment Profiles became an expectation of the EPN.
- iii. ACC measured providers against treatment profiles and used them to label providers from very good, to poor to neutral to bad to very bad. The majority were neutral, poor and very poor (*Rankin 2000, slide 14, Attached to this submission at Annex A, Page 56*).
- iv. It is still a “matter of concern” that 16% of ACC32 Applications are outside Treatment Profiles. (*ACC Primary Submission, page 25; Draft Report, Para 9.18, Page 100*).
- v. The Draft Report discusses the Treatment Profiles at page 100-105. It is clear that the Treatment Profiles, and their current use by ACC, is unacceptable and that change is required.

## **QUALITY AS A DISCRIMINATOR**

36. ACC set out to determine a level at which it could limit treatment. The aim being to constrain the provision of entitlements to claimants; in order to maintain a veneer of legitimacy, ACC developed a very elaborate system.

37. ACC sought to establish a position that was defensible. They developed treatment profiles in conjunction with the New Zealand Society of Physiotherapists and then developed measures to constrain provision of entitlements to these profiles.

38. The plan is clearly set out in Dr David Rankin’s Presentation from 2000. Attached to this submission at **Annex A, Pages 50-67.**

- i. **Slide 9** explains the prerequisites to “evaluation”.
- ii. **Slide 10** explains the **Treatment profiles.**
- iii. **Slide 11** sets out that the aim of Provider Monitoring is to **Change Provider Behaviour** into line with Treatment Profiles.
- iv. **Slide 11** shows that ACC **measures and rates performance against treatment profiles** (Slide 10 and 11).
- v. **Slide 12** identifies the profiling process and should be read in conjunction with slide 14, which shows that ACC is very quick to label providers poor or very poor (prior to investigating further).
- vi. **Slide 12** also sets out that ACC requests medical records in order to determine if treatment was appropriate. The Draft Report discusses the issues surrounding patient consent and the supply of notes. Evidence of what has happened to individual Physiotherapists suggests that by complying with the privacy requirements, they are assumed to be Fraudulent and subjected to ACC’s policy of “hounding fraudulent providers.
- vii. **Slide 14** shows that Treatment providers are labelled from Very Good to Very Poor. The majority of providers are with Neutral or Poor or very Poor. This is of great concern that most providers in New Zealand are not “good.”
- viii. **Slide 35** sets out the conclusions and includes “recognise and **reward superior performance**” and “**be ruthless with bad providers**”.

39. It is clear from this presentation that in the content of Physiotherapy, “quality” is measured by ACC as “Providing in accordance with Treatment Profiles.” “**Quality**” is clearly measured against this and ACC initially planned to “**change provider behaviour**” and if Providers didn’t change their behaviour and continued to be “**bad**” then ACC would be “**ruthless**” and “**hound**” them.

40. **ACC News, June 2001.** ACC’s newsletter, Issue 35 includes comment on the Endorsed Provider Network Trials Attached to this Submission at Annex B, Page 68.

- i. Improved focus on “**quality initiatives**”.

41. Dr Rankin made a presentation to the “**Contracting in the Health Sector**” about “**using quality as a discriminator**”. An ACC Case Study: Using Quality as a Discriminator in Contracting and Purchasing of Health Services. 23 Jul 2003. The abstract of this is available and is attached to this submission at Annex C, Page 69. This presentation included:

- i. Best Practice in effectively contracting
- ii. Defining and Measuring Quality Outcomes.
- iii. ACC shared its experience with Physiotherapy.

42. **Development of Guidelines**, i.e. Acute Low Back Pain Guidelines. These Low Back Pain Guidelines are not evidence based or subjected to consensus review. Attached to Val Forster’s first submission as **Annex li**.

43. **Using Guidelines to limit treatment**. See Rankin D, Evidence in Action, G-I-N Conference, 2 Nov 2004. Attached to this submission as Annex E. Pages 71 – 83

44. **Intervention Strategies for Reducing Variation in Practice**. This is an abstract from another presentation given by Dr David Rankin attached to this submission as Annex F, Page 84. It sets out that ACC has:

- i. “Demonstrated ability to significantly change provider behaviour by combing a range of intervention strategies”.

45. **Vote ACC 2004/2005**. Evidence given to the Transport and Industrial Relations Select Committee. 2004/2005 Estimates – VOTE ACC attached to this submission as Annex G, Page 85 – 110).

- i. **Page 16 (Annex G to Submission, Page 100)**. Evidence given by the minister sets out that by developing the EPN, ACC set out to “improve the quality of Physiotherapy Services” and “better accountability.” To achieve this, the EPN physiotherapists go through “improved training processes and accountability procedures”.
- ii. **Page 17 (Annex G to Submission, Page 101)**. Evidence given by Garry Wilson is that “ACC works on the principle that it’s acting on behalf of claimants who are often ill-informed and underprivileged, and really often can’t make their own judgements... So David [Rankin’s] job is to purchase health services on ACC’s behalf – on claimant’s behalf –

- from the best quality providers that we can find.”
- iii. **Page 18 (Annex G to Submission, Page 102).** Dr David Rankin’s evidence clearly shows that “there is **no doubt** that accredited providers through their continuous **quality improvement** programme, are focused on getting people back to work faster.” Dr Rankin goes on to state ACC is committed to **constraining behaviour against standards and guidelines** and this is done through **benchmarking and profiling.**
- iv. **Page 25 (Annex G to Submission, Page 109).** Mr Wilson gives evidence that Doctors don’t have a Quality Control Standard Process that they are prepared to abide by and that they do not have an accepted accreditation process. It is inferred that Physiotherapists do. The Quality Control Standard is not the accreditation. It is the treatment profiles.

46. **Vote ACC 2005/2006.** Evidence given to the Transport and Industrial Relations Select Committee. 2005/2006 Estimates – VOTE ACC, Annex H, Pages 111 - 139.

- i. **Page 41 (Annex H to Submission, Page 134),** Garry Wilson gives evidence that ACC has developed Guidelines that “New Zealand experts deem to be the **best treatment profile. We assess against that.** So it’s not just one we’re making up in ACC’s backroom, it’s actually endorsed by the physios...”

**Conclusion, Quality as a Discriminator.**

47. The available evidence strongly supports a conclusion that ACC used “quality” as a discriminator.

48. The evidence available strongly suggests that ACC measured quality treatment against compliance with Treatment Profiles.

49. The **Draft Report** sets out

- i. ACC’s objectives in introducing the EPN included “to encourage **Quality Treatment**” and “reduce weekly compensation durations”. Page 35, Para 5.13.
- ii. The certification / accreditation process is designed as a “best practice business management tool. Page 59, Para 6.5.

- iii. ACC was not able to point to any studies in relation to patient satisfaction or clinical outcomes were superior from EPN practices. Page 59, Para 6.8.
- iv. ACC acknowledged that it could not be demonstrated that EPN contracts are improving quality of services. Page 59, Para 6.9.
- v. ACC conceded that no useful conclusions about the relationship between Certification and outcomes can be drawn based on available data. Page 60, Para 6.11
- vi. There is no evidence available to support the conclusion that EPN treatment reduces Weekly Compensation Durations. Page 60, Para 6.11.
- vii. It is important to be clear internally and in the advice it gives to Ministers and the public about what Certification (EPN) delivers. Page 61, Para 6.16.
- viii. It needs to be recognised that the “expectations” about improvements in quality are “in principle expectations” that have not been verified through any robust studies or surveys. Page 61, Para 6.18.
- ix. ACC still measures quality against the “Treatment Profiles”. ACC has not provided any satisfactory explanation as to why this should be a matter of concern. Page 100, Para 9.19.

50. Considering the fact that considerable evidence exists that ACC used Quality as a Discriminator, and that findings of the Draft Report that there is no evidence that there is any quality difference, one is left to draw the conclusion that there is no basis for ACC discriminate against non-EPN providers. Therefore the actions and consequences of ACC in this regard must be examined.

### **CHANGING PROVIDER BEHAVIOUR**

51. Very clear and deliberate efforts were made by ACC to constrain provision of entitlements to claimants to “quality treatments” aka Treatment Profiles.

52. These strategies can be loosely grouped into three types of strategies.

- i. **Incentives** to join the Endorsed Provider Network. These were incentives given to

- Physiotherapists to switch to the Endorsed Provider Network.
- ii. **Disincentives** to remain on the Regulated Fee System. These included both deliberate measures and unexpected measures consequential on ACC’s interference with the market.
  - iii. **Direct “Enforcement Strategies” to change behaviour.** These strategies overlap with the disincentives to remain on Regulated fee and are generally designed to change provider behaviour into line with what ACC wants (but not necessarily force providers to switch to the Endorsed Provider Network).

### INCENTIVES

53. The major incentive to join the EPN was financial.
54. The Profession had been surviving on the Regulated fee rates for more than 10 years, during which the Co-payments were continuing to rise to a prohibitive level. The market was then, like it was prior to this review, unsustainable.
55. ACC realised this and exploited it through offering incentives to move to a system where the pay would be twice as much, and more attractive to patients by being free. This would clearly mean higher willingness for patients to undertake treatment and higher payment per treatment.
56. Nearly all Physiotherapists who responded to the Physiotherapy Trust’s survey said that they joined the EPN for financial reasons. It appears that Two providers who didn’t join for financial reasons may have been part of the initial EPN trials.
57. It is clear from the information outlined above (NZIER Report, Healthwise’s KPI’s, Dr Rankin’s presentations) that ACC wanted to contract treatment providers and intended that by paying them more and giving them better conditions and less compliance they could create a environment where Physiotherapists would see major incentives to join the EPN.

### DISINCENTIVES

58. The major disincentive to remain on the Regulated Fee was the inability to compete in the market where consumers could access what they perceived to be comparable services without cost.
59. The draft report has discussed many of these disincentives and they are also discussed below in effect on the Market. See Draft Report

- i. Page 34, para 5.10
- ii. Page 38, para 5.25
- iii. Page 44, para 5.50
- iv. Page 49, para 5.72 and 5.74.

### **ENFORCEMENT STRATEGIES**

60. The Corporation developed a number of interventions which were used to change provider behaviour. They Included:

- i. Contracts,
- ii. Provider “education”
- iii. Roadshows
- iv. Provider Profiling
- v. Treatment profiles
- vi. Fraud Investigations
- vii. Additional compliance
- viii. RAC Database Analysis
- ix. Threatening to remove bulkbilling
- x. Being “ruthless”
- xi. “Hounding”
- xii. Denial of Contract, whilst giving Competitors Contracts
- xiii. Denial of treatment for patients.
- xiv. Delaying processing of ACC32s
- xv. Telling patients to go to another provider

61. As is very clear from the draft report, the use of strategies on the EPN Contractors was very different from the use of strategies on Regulated Fee Providers, and it appears from the evidence available that particular providers within the Regulated fee framework were subjected to various combinations of these.

### **THE RESULTS OF ACC’s ACTIONS**

62. There have been a number of effects of the ACC’s Experiment. They will be discussed here under several headings.

63. **Executive Summary.** The Effects have essentially been as predicted by the NZIER Report and ACC’s plan, with the notable exception of spiralling physiotherapy costs to the scheme as the EPN has been taken up.

- i. Patients have gone for “free” treatment.
- ii. Physiotherapists have joined the EPN.

- iii. Physiotherapists feel bound by treatment Profiles.
- iv. It is becoming more and more difficult for Physiotherapists to survive on the Regulated Fee.
- v. ACC has successfully manipulated Physiotherapists Behaviour.

64. The market has been effectively manipulated, however this has also lead to a number of unexpected (or expected) side effects of the experiment.

- i. The cost to the ACC scheme of Physiotherapy has doubled since the development of the EPN, not reduced.
- ii. There is no clear evidence that the EPN has resulted in either “Quality Treatment,” reduced weekly compensation durations or achieved early, effective, sustainable rehabilitation outcomes – the objectives of EPN as set out on Page 35, para 5.13 of Draft Report.
- iii. Alarmingly, it appears that a significant number of EPN Contractors feel that they cannot treat patients to the Maximum Practicable Extent.
- iv. There is clear evidence that patients are not getting the treatment that they need.

#### **EFFECT ON THE MARKET**

65. The draft report has found that

- i. “The levels of co-payments that physiotherapists are able to charge are constrained by the availability of services from EPN providers who do not charge any co-payment. The widespread availability of EPN services, and the effect that 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.” (Page 34, Para 5.10)
- ii. No physiotherapists were compelled to take up EPN Contracts, however there are two points that must be taken into account:

1. regulation fees were so low that any increase was very attractive, even if it was inadequate.
2. once a significant number of practices went EPN and offered treatment with no co-payments, it became very difficult for remaining practices to charge a level of co-payment which would ensure costs were met fully. Inevitably, the strong incentive to reduce copayments in order to compete with EPN would hold down copayments for Regulation providers which would make EPN more attractive, even though EPN rates are below long term sustainable levels. *(Page 38, Para 5.25, Paraphrased).*
- iii. “...: significant fairness issues will still arise if, for financial or other reasons, the “co-payments permitted” regime is a not financially viable option for many providers because their ACC patients can obtain free treatment for an EPN Praticce.” *(Page 44, Para 5.50).*
- iv. “...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.” *(Page 49, para 5.72.)*
- v. “Other evidence before the review supported the view that current funding rates are not sustainable.” *(Page 49, Para 5.72).*
- vi. “... 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.”*(Page 49, para 5.74).*

**66. Effect on Regulation Fee Providers’ charging co-payments.** The evidence given to the 2005/2006 Vote ACC is relevant here. Appendix 2 sets out ACC’s response to further questions from the Transport and Industrial Relations Select Committee. It is clear from this that co-payments of Physiotherapists treating under the “Per Treatment Regulated Fee were being affected by the EPN. This evidence is included in *Annex H to this submission on pages 114 – 117.*

- i. Question 2 relates to the effect of the 2.5% adjustment to the Cost of Treatment Regulations (Page 4 *(Annex H, page 114 of this submission)*).

- ii. ACC’s answer to the first part of the question also sets a benchmark for the Co-payments over the two years prior to the increase.
- iii. Table 12 of that document on page 16 (*Annex H, page 117 of this submission*) of Vote ACC 2005/2006 examines the **Normal Co-payment charge: Per Treatment Rate [for Regulated Fee Physiotherapy]**. The results clearly show that between 2005 and 2006, **both the median and the mean “charge” of every measured service has either dropped or remained the same** (the real “charge” has dropped).
- iv. The second part of the question asks “to what extent are the co-payments made by ACC claimants expected to decrease after the upwards adjustment in regulated contributions” and ACC’s answer was “ACC has suggested that providers may wish to apply the increase to reduce or eliminate existing co-payments.” (*Page 4 of Vote ACC, 2005/2006 (Annex H, page 114 of this submission.)*)
- v. With due respect, after having no increase in more than a decade, a 2.5 % increase was never going to allow for the reduction of co-payments. Clearly any reduction would be created by other market forces, or in this case manipulation of the Market by ACC.
- vi. It is hard to believe that after a decade on the system, the Physiotherapists have finally worked out a way to do things significantly cheaper and so have passed this saving onto the patient...

67. With regard to ascertaining competitive market prices, the Draft report has identified difficulties in identifying competitive levels because the market has been screwed down by ACC for so long and that ACC’s pervasive effect on the physiotherapy market means that it is unlikely that the current situation can provide much information about competitive market prices. (*Draft Report, Page 41, paras 5.37 – 5.40.*)

68. **Shift from Owner/Operator to Employed.** The NZSP Second Submission shows at Table 14, Page 25 that although there has been a relatively consistent split between Private Practice and Public Practice, there appears to have been a significant shift recently from Private Practice Employer/Owner to Private Practice Employed.

- i. It would appear that there has been a change in number of practices – fewer practices, more physios employed.

- ii. If this is correct, then clearly the effect on this hasn’t been on EPN Practices as the Evidence given by ACC is that very few EPN Contracts have been terminated. **The full effect of this has been on Owner/Operators of Regulated Fee Practices.**

69. **Providers being placed under financial duress to join EPN.** There has clearly been a huge take up of the EPN contract.

- i. The Draft Report has identified the effect that the EPN could have on Regulated Fee Providers to join the EPN.
- ii. The evidence available suggests that this Is exactly what occurred, almost all EPN contractors who responded to the Physiotherapy Trust’s surveys indicated that they joined the EPN for financial reasons.

70. **Physiotherapy Trust’s Survey of EPN Contractors.** The Survey carried out by the Trust suggests that most EPN Contractors feel bound by Treatment Profiles, and nearly 40% of respondents felt that under their EPN Contract, they cannot treat claimants to the Maximum Practicable Extent. It also confirmed that nearly all Contractors joined the EPN for Financial Reasons.

### **EFFECT ON INDIVIDUAL PHYSIO PRACTICES**

71. The Effect on the Individual Physiotherapy Practices is and the lives of the people within those practices is enormous.

72. There is clear evidence available to the review that the Actions of ACC have had significant impacts upon Individual Physiotherapists.

73. If a Physiotherapist joins the EPN.

- i. They are agreeing to join a capped “closed” market where the price is fixed by the government owned monopoly setting an unfair price which undermines the sustainability of the profession, but their business got to survive, at least a bit longer.
- ii. The threats of Fraud Investigation and other enforcement strategies are reduced.
- iii. They, and their practice, have to abide by Treatment Profiles. They take the place of ACC in enforcing the treatment profiles amongst their staff.

74. Even if a Physiotherapist wants to join the EPN, ACC can decide not to give them a contract.

- i. The *ACC Delegation Manual*, which sets out the authority as delegated by the Minister to ACC staff pursuant to Schedule 5, Clause 25 of the IPRC Act, actually sets out the authority and process for ACC to decide **not** to give a contract to a particular treatment provider, even though that provider meets all of the Criteria.
- ii. Of course ACC routinely deny that this occurs but there is at least one example of this, which has been provided to this Review.
- iii. It is a total abuse of power for ACC to put measures in place to force treatment providers to join the EPN, actively encourage them to spend the money becoming accredited, but then decide not to give a contract to a particular provider because ACC want to punish him or her for speaking out against ACC or for providing treatment outside the Treatment Profiles.

75. If a Physiotherapist didn’t join the EPN, and doesn’t change their behaviour significantly then they are subjected to the enforcement strategies outlined above.

76. To understand the effects of such, it is recommended that the Review receives statements from Physiotherapists who have been subjected to these measures as they are in the position to fully explain the impacts of ACC’s actions.

#### **EFFECT ON ETHICS**

77. The Effect on the Physiotherapists’ Ethics has been significant however this will be discussed in Part IV of this submission.

#### **EFFECT ON INJURED NEW ZEALANDERS**

78. The Effect has been that thousands of injured New Zealanders have not received the treatment that they need.

79. The Injury Prevention, Rehabilitation and Compensation Act has not achieved its purpose.

80. Either the injured people have not received the Physiotherapy Treatment that they need in which case the system has failed, or alternatively, the cost has been successfully shifted to either the Physiotherapist or the Patient, which means that the

system has failed as the cost has been shifted to the individual or the Treatment Provider. These scenarios were expressly addressed in the Woodhouse Report as part of the fundamental Principles of the scheme and have been espoused into the purpose of the Act, but not the policy, procedures and systems implemented by the Accident Compensation Corporation.

81. The long-term cost of injury to society is compounded by the failure to rehabilitate to the maximum practicable extent. This causes conditions to become chronic and New Zealander’s lives to fall apart which ultimately becomes very expensive for society.

82. Simply put, the system that is in place does not meet the purpose of the Act. It does not minimise the impact of injury on the community.

### **CONCLUSION REGARDING TREATMENT PROFILES**

83. The entire Treatment Profiling process relies on data surrounding a initial provisional diagnosis. ACC’s own data shows that this information is unreliable.

84. The draft report has criticised the manner in which ACC uses data however special mention needs to be included of how they make decisions using the data from the diagnosis and how they refuse to update the diagnosis.

85. ACC has clearly set out to constrain provision of entitlements to claimants.

86. **ACC planned to use** Treatment Profiles to limit treatment to claimants and to control provider behaviour.

87. **ACC have used** Treatment Profiles to limit treatment to claimants.

- i. Every year, the treatment of more that 7000 claimants is interfered with by ACC because of delays in making a decision about their ACC 32.
- ii. Each year, 3000 claimants are denied treatment because ACC declines their ACC32.
- iii. The evidence available suggests that in addition, claimants are denied treatment because their Physiotherapists do not apply for ACC32, because of fear of consequences from ACC. For example being labelled a “Bad Provider.”
- iv. Thousands of peoples’ treatment has been interfered with through delay and denial of treatment.

- v. It would appear from the submissions of Jordan Salesa and Murray Hing that the patients of particular physiotherapists have been subjected to discrimination by ACC, as the data they have supplied does not even remotely resemble the figures provided by ACC. Clearly ACC have several processing mechanisms in place for processing ACC32s.

88. Physiotherapists are being forced to provide treatment in accordance with the specifications of ACC rather than to the Maximum Practicable Extent.

89. There is certainly evidence that EPN Contractors are expected to provide treatment in accordance with the Treatment Profiles, rather than to the Maximum Practicable extent.

90. Although it does appear that EPN Contractors are subject to the same scrutiny as Regulated Fee providers when it comes to Treatment Profiles, history has recorded the consequences for being an “outlier” are very different for Regulated Fee Providers than the consequences for an EPN Contractor.

91. The report stated at Para 1.5, Page 1

*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.*

92. It is certainly not in the long term interests of claimants that a system exists whereby most EPN Contractors feel bound by Treatment Profiles, a significant number of EPN Contractors feel that they cannot treat claimants to the maximum practicable extent, thousands of claimants are being denied treatment every year by ACC making poor decisions based on arbitrary

### **PART III**

## **CONTRACTING OUTSIDE THE ACT – THE TREATMENT PROFILES**

### **BACKGROUND**

93. Prior to examining the complex issues surrounding whether ACC and EPN Contractors are “Contracting out of the Act”, the Legal Framework for Treatment Profiles will be discussed, including the legal framework for Treatment Profiles within the Regulated fee system, as well as the Endorsed Provider Network Contract.

### **WHO IS THE PHYSIOTHERAPIST WORKING FOR?**

94. **Executive Summary. ACC=Patient contract evolves to ACC=Physiotherapist.** The advent of the EPN Contract, along with the strategies set out in this report make it very clear that the EPN Contract was designed in an attempt to save money by limiting treatment; something that it has miserably failed to do. ACC hypothesised that if they could put financial incentives in place for providers to do what they were told i.e. “*abide by Treatment Profiles*” then this would somehow limit the cost. A major part of this was that ACC contracts directly with the provider, as this allows them to legally place those conditions upon the provider. This saw a move from ACC=Patient contract to an ACC=Physio Contract.

95. **The Draft Report has stated at para 6.35**

*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. And 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)*

96. In light of these findings, I felt that it was necessary to provide additional evidence to the review for the review to consider.

97. **The Patients Fee.** Under the Regulations regime, the Corporation must contribute to a Patients’ costs of visiting a Physiotherapist. This Fee is actually payable to the Patient and it is, by law, payable for each treatment which the patient receives, which is aimed to restoring to the maximum practicable extent, a claimants health, independence and participation.

98. In the interests of administrative efficiency, in the 1980’s, the Corporation introduced “bulk billing” where hundreds of Physiotherapists would collect the fee on the patients’ behalf (rather than hundreds of thousands of patients interact with ACC each year).

99. Interestingly, one of the threats that ACC makes to Physiotherapists who do not “*do what they are told*” is that they will remove their Bulk Billing privilege, causing claimants to have to pay in full and seek reimbursement from ACC for treatment, so as to impede patients and therefore reduce the number of patients who are willing to attend that Practice and directly effect the financial viability of the Practice.

100. **The Physiotherapists Fee.** With the advent of the Endorsed Provider Network, it became known amongst both Providers and Claimants that the EPN Providers were bound by the Treatment Profiles, which ACC had developed. In return, they would get paid a rate which was much higher than their colleagues received and it would be paid directly by ACC for each patient that they treated, in accordance with the Terms and Conditions of their Contract.

101. **The Sports Team Physiotherapist situation.** In a Sports Team, although a physiotherapist may be contracted directly to the Team (and not the patient), there is no doubt that the purpose of the contract is to restore the Patient to the Maximum Practicable Extent as fast as possible. This is in the best interests of the Patient, the Team and the Physiotherapist and the purpose of the contract is not to save the Team Money by the team dictating to the Physiotherapist that he/she has to abide by treatment profiles and guidelines which are not evidence based, or subject to consensus review. Because all parties goals are aligned to getting the player back into the Team, there is buy in from all parties. It is absurd to think that a team would dictate to a Treatment Provider how an injury will be managed.

### **LEGAL FRAMEWORK FOR TREATMENT PROFILES**

102. The Draft Report has found that the EPN contract does not require compliance with the Treatment profiles, rather, *“the contract requires that service not be provided outside the Treatment Profiles without prior approval from ACC through the ACC32 Process.”*

103. Part II of this document discusses in detail how ACC use the Treatment Profiles.

104. It is submitted that the EPN contract does specifically require compliance with the Treatment Profiles and it is certainly expected that EPN Contractors abide by the Treatment Profiles. (See Part II of this submission, the Submission of the First Submission of the Physiotherapy Trust, and the submissions of Jordan Selesa.

### **LEGAL FRAMEWORK FOR THE REGULATED FEE**

105. There is no legal basis for ACC to restrict Regulated Fee Physiotherapists to provide treatment in accordance with the Treatment Profiles.

106. There is nothing in the Act or any regulation that can be used to arbitrarily limit the amount of treatment a claimant can receive.

107. There is no legal basis for ACC to restrict the treatment which can be provided to a claimant by a Regulated Fee Provider and paid for by ACC, except the requirements of the Act.

108. As is seen above, ACC has developed and implemented complex measures in an attempt to do restrict treatment to claimants.

109. It is submitted that Schedule 1 to the IPRC Act, is not given legislative force by an enabling section within the Act. The enabling section has “evolved” from the Act since 1992, in order to avoid ACC being seen as a “Treatment Provider”. A Schedule to an Act is only given legislative force through an enabling section. This is a matter, which must be remedied through legislative amendment.

110. The draft report discusses the legislative background to treatment including:

*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) para 5.2, page 32*

and

*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. Paragraph E7, Page 131*

111. Notwithstanding this point, in the absence of such an enabling section, it appears that the review has taken the approach that the intention of Parliament is the Corporation would be liable to pay for cost of treatment in accordance with the provisions of Schedule 1, Part 1, Clauses 1 to 7.

112. **The Regulations.** Regarding Regulated fee Physiotherapist providers, the Corporation is liable to pay or contribute to claimants' Cost of Treatment for personal injury for which the claimant has cover to the extent required or permitted under the IPRC (Liability to Contribute to the Cost of Treatment) Regulations, 2003.

113. These regulations define Specified Treatment Provider to include Physiotherapist (Reg 3, Interpretation). Reg 17 gives a Physiotherapist the choice of charging per treatment, in accordance with the rate set out in Schedule 1 of the Regulations under the heading "Specified Treatment Providers costs", or per hour in accordance with Reg 17.

114. The Regulations Schedule sets out that the Cost that ACC is liable to pay for all Treatment of a Physiotherapist is \$24.48. This means that for each treatment, ACC is liable to pay the cost of \$24.48 to a Physiotherapist or alternatively the Physiotherapist can elect for ACC to pay them an hourly rate at \$61.57 per hour.

115. Neither Schedule 1 to the IPRC Act, (Clauses 1 to 7), nor anything within the IPRC Cost of Treatment Regulations 2003, places any limits on the number of treatments that the Corporation is liable to provide to a claimant.

116. **Schedule 1 to the Act is not definitive regarding treatment.** It is acknowledged that Schedule 1 sets out a set of circumstances where the Corporation is liable to pay or contribute to the cost of treatment, however nothing in Clauses 1 or 2 limits the Corporations ability to pay for treatment in any other circumstances.

117. The Corporation is not limited to “only” paying for treatment as set out in Clauses 1 and 2, it is liable to pay for treatment in these circumstances.

118. **Prior Approval.** Notwithstanding those points, it is clear from Clause 4, that the Corporation is not required to pay the costs of a claimant’s treatment unless the Corporation has given its prior approval.

119. Unlike the EPN Contractor who is “exempt” through Clause 4 (2) (d) and can provide services to the extent set out in the Contract (treatment profiles) without having to apply for approval, a Regulated Fee Provider, by law has to seek ACC’s prior approval for every treatment.

120. The Draft Report has discussed prior approval at length including:

- i. Making recommendations that the Corporation reduce the numbers of prior approvals (Para 1.44)
- ii. Recommendations that balance has to be found between Prior Approval and Subsequent Audit
- iii. The high volumes of ACC 32 applications received by ACC... 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. (Para 9.24)
- iv. Further recommendations are made at para 9.33 about developing a new approach.

121. Clearly, either the Regulations of Clause 4 of Schedule 1 needs to be amended to remove the legal requirement of prior approval for all treatment that currently exists for those physiotherapists working under the Regulated fee.

122. The Draft Report has also discussed that the requirement to abide by the Treatment Profiles is the same for EPN as it is for Regulated fee:

- i. “...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.” (Para 5.15, page 42).

- ii. “In these respects, there is no relevant difference between EPN providers and regulation providers. Both groups of providers must complete an ACC 32 form in order for ACC to fund treatment beyond the trigger number in the profiles.” (*Para 6.38, Page 64.*)

123. Although ACC have been very careful to create the illusion that the situation is the same for EPN and Reg Fee, and in effect, it does appear that the EPN Contractors and the Regulated Fee funded providers both have to abide by the Treatment Profile process, the reasons for their compliance are very different.

124. **Approach prior to the EPN.** Prior to the EPN Trials, all Physiotherapists were on the Regulated Fee and none were subjected to Treatment Profiles. Prior to the late 1990’s Treatment by a Physiotherapist was “accessed” and “controlled” through the GP, but with the Gatekeeper being opened up, ACC sought to develop mechanisms to control the numbers of treatments.

125. ACC’s first attempt with the first Physiotherapy Treatment Profiles occurred in May 1999 when ACC introduced them (ACC News, Issue 12, May 1999) however they were rejected by the Physiotherapy profession. ACC tried again several years later and worked with the NZSP to develop the second attempt to bring the profession ‘into line’ using treatment profiles. Other submitters who were involved in this process are in a stronger position to elaborate on how the most recent Treatment Profiles were developed.

126. **EPN Trials.** When the first EPN Trials were carried out (*Draft Report, Appendix E*), the only treatment providers who were forced to abide by the “Treatment Profiles” were the EPN Contractors. It was a condition of the contract that Physiotherapists abided by Treatment Profiles and they would only provide additional treatment if prior approval was requested and approved by ACC.

127. Correspondence during the Trials, between ACC and the NZSP, provided to the review sets out that ACC was disappointed that the Treatment Profiles were not being supported and taken up by the rest of the profession.

128. The rest of the Regulated Fee providers went along with “business as usual.” They were not limited by Treatment Profiles.

129. **ACC introduces Treatment Profiles across the Board.** Ultimately, ACC did introduce Treatment Profiles across board to both Regulated Fee and EPN Physiotherapists, however there was one major difference. EPN Physiotherapists had a contractual obligation to abide by Treatment Profiles. Those who remained on the Regulated Fee were under no obligation to abide by the

Treatment profiles. As is discussed above in Part II, ACC determined treatment in accordance with Treatment Profiles to be “quality” Treatment and discriminated against those who for whatever reason would not abide by Treatment Profiles.

### **ENDORSED PROVIDER NETWORK CONTRACT**

130. Having examined the legal framework from which the EPN developed and operated, and the method of enforcement of treatment profiles on the Regulated Fee Physiotherapists it is important to clearly understand how EPN Contractors are affected by the Treatment Profiles, particularly within a legal framework.

131. The Service Schedule, Part B, Clause 16 sets out the definition of Physiotherapy Treatment Profiles:

***Physiotherapy Treatment Profiles*** means the description of physiotherapy treatment rehabilitation and expected incapacity duration for the specified injury of that name published by ACC from time to time.

132. The Contract sets out in the Service Schedule, Part B, Clause 7.1 for service providers.

#### **7.1 For Service Providers**

*The Vendor will ensure that clinically necessary Physiotherapy Services to Claimants for the purpose of rehabilitating and maintaining the Claimant’s maximum level of health and independence are only carried out by Service Providers...*

(d) *to the extent of, and not beyond the range of their skills, competencies and expertise provide treatment in accordance with ACC’s Physiotherapy Treatment Profiles and current Guidelines. When the number of treatments provided by a Service provider exceeds that detailed in the Physiotherapy Treatment profiles, then approval of an ACC32 Request for Further Treatment is required.*

133. Clause 7.2 Further states

#### **7.2 FOR PHYSIOTHERAPY SERVICES**

*The Vendor will ensure that all Physiotherapy Services provided under this agreement:*

(a) *Will comply with the policies and procedures as detailed in the quality standards documentation of the accrediting body (NZPAS, QHNZ) and*

(b) *Will include:...*

- *Provision of follow-up physiotherapy consultations in accordance with the Physiotherapy Treatment Profiles and any current guidelines that are clinically appropriate.*

134. Clause 7.3 and 7.4 further state

### **7.3 MODALITIES**

*The service provider will be monitored against the Physiotherapy Treatment Profiles and may be asked to explain practice outside these guidelines. ...*

### **7.4 ACC APPROVAL**

*Provision of treatment by service providers exceeding the Physiotherapy Treatment Profiles requires approval by ACC following submission of an ACC32 Request for Further treatment.*

135. There can be no doubt that ACC expects EPN treatment providers to provide treatment in accordance with ACC’s directives, and in particular their treatment profiles.

136. Furthermore, it is clear from the contract that the “quality” of a service providers treatment will be measured against their treatment profiles.

## **CONTRACTING OUTSIDE OF THE ACT**

137. **Executive Summary.** By contracting to abide by the treatment profiles that, in fact, have the effect of limiting the provision of entitlements to claimants, ACC and the Contractor may be contracting outside of the Act.

138. **ACC can contract.** It is accepted that the IPRC Act 2001 provided for the development of an alternative payment structure to the regulated fee by permitting ACC and providers to enter into contracts for treatment services that would apply in place or regulations. (Draft Report, page 131, para E6).

139. It is not suggested that ACC or a Physiotherapist contracted to ACC cannot or should not enter a contract or that merely by contracting, they are “contracting outside of the Act.”

140. However, these contracts like all other contracts are subject to s. 299 of the IPRC Act 2001, and would begin to approach the threshold of breaching the requirements of s. 299 if anything within them either means, or could be interpreted to mean that they are inconsistent with the requirements of the Act.

141. **EPN Contract and Treatment Profiles.** It is clear that EPN contractors are discouraged from providing treatment outside of ACC’s Treatment Profiles. It is clear that their actions are measured against these Treatment Profiles.

142. As set out above in Part II, the draft report of the Physio inquiry criticised the treatment profiles and in summary found that the treatment profiles should be replaced stating, *inter alia*,

*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 boarder interests of cost-effective operation of the scheme. Page 100, para 9.24.*

143. Furthermore, the manner in which ACC uses data, particularly as it relates to the quantitative analysis of EPN and Treatment Profiles has been criticised at paragraphs 9.34-9.39 (pages 103-105). Particularly, Para 9.36 and 9.37 state, in part

*The 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 the results from EPN studies. It is also apparent that the way ACC has come to use Treatment Profiles, with a strong focus on the numerical ranges specified, and without appropriate allowance for lack of knowledge about the frequency with which actual cases fall outside the circumstances addressed in the profiles.*

...

*To 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, it is positively misleading.*

144. There is further evidence that the Guidelines, especially the New Zealand low back pain guidelines are inconsistent with Evidence Based Medicine.

145. The evidence from EPN contractors is that the majority of them feel bound by the treatment profiles. (See Part II above)

146. **Conclusion.** It would therefore appear that there are issues surrounding a contractual obligation to abide by Treatment Profiles.

- i. This inquiry has found that there are significant issues regarding the manner in which Treatment Profiles are used.
- ii. The evidence is clear that, despite the possibility of requesting an ACC32, the EPN contract includes a requirement and an expectation that Contractors will, at least partially, limit treatment to that set out in the Treatment Profiles.
- iii. The effect is that the majority of contractors feel bound by the Treatment Profiles.
- iv. The effect is that claimants being treated by Contractors have experienced having their treatment terminated on reaching the Profile Levels.
- v. This has potential to significantly affect the Ethical responsibilities as well as the rights of the patient.

147. Clearly, this has potential to be an element of the contract, which is inconsistent with the purpose of the Act which is to provide treatment to the Maximum Practicable extent. This is actually acknowledged by a surprisingly high number of those EPN contractors who responded to the Physiotherapy Trust’s email survey.

148. Almost 40 of the EPN contractors who responded to the Survey felt that they could not provide treatment to the Maximum Practicable extent.

149. It is a matter of concern that any Physiotherapists feel that they are inhibited from providing treatment to the maximum practicable extent.

150. It is of great concern that each year, thousands of claimants are being denied treatment.

151. It is of much more concern that ACC have developed and implemented this system, as detailed in Parts II and III of this submission with the intent of, and effect of, manipulating physiotherapists and controlling their behaviour, and the Physiotherapy market.

## **THE WAY FORWARD**

152. It is respectfully submitted that more detailed research into this area is required including gathering evidence from those who were personally involved and have a detailed knowledge of the development of such.

153. The Question to be answered is:

“Is there any evidence that EPN Contactors have or are Providing Treatment to claimants in accordance with Treatment Profiles; if so, is there any evidence that claimants have not been treated to the Maximum Practicable Extent because of the requirements of complying with the Contract?”

154. If the answer to both parts of the question is “yes,” then it would appear that by creating such a situation where patients are being treated in accordance with Treatment Profiles, which are not evidence based or subject to consensus review, rather than being treated in accordance with the Act, the Parties to the Contract are “Contracting outside of the Act.”

155. Critically, these point exist independently of the mechanisms which ACC has used in an attempt to control Regulated Fee Providers, who may or may not have been subjected to various enforcement strategies.

156. This matter is directly relevant to points 3.1, 3.2, 3.3 and 4.3 of the Terms of Reference for this Review.

**PART IV**

**ETHICS & RIGHTS**

**BACKGROUND**

157. The Draft Report found on Page 7, Paragraph 1.32 and page 64, para 6.36 that:

*... there is nothing in the EPN Contract which requires a physiotherapists to act in a manner that is inconsistent with his or her ethical responsibilities.*

Para 6.36 continues on from this comment and further states

*It seems to me that these concerns, though genuine and deeply felt are misplaced.*

Para 6.38 also states:

*It was also suggested in submissions to the review the 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 ACC may have inadvertently contributed. There is in fact no requirement in the EPN contract that physiotherapists limit the number of treatments provider to target numbers specified in the Treatment Profiles.*

**EFFECT OF TREATMENT PROFILES AND ACC ENFORCEMENT STRATEGIES ON PROVIDERS’ ETHICS AND PATIENTS’ RIGHTS**

158. There can be little doubt that failing to treat an injured patient to the maximum practicable extent breaches numerous rights of the Patient as well as ethics of Physiotherapists.

159. A treatment provider does not just have an obligation to treat a patient. They also have an ethical obligation to advocate for that patient. To ensure that the patient receives the care that they need.

160. This point will be discussed further during the oral submissions.

**PRIVACY AND CONSENT ISSUES**

161. There are significant issues surrounding patient consent. Written Submissions on this topic will be provided to the review as an addendum to this Submission.

**EFFECTIVE ACCESS TO JUSTICE**

162. There are significant issues surrounding patients’ access to justice. Written Submissions on this topic will be provided to the review as an addendum to this Submission.

## **ANNEXES**

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A. **Presentation.** Rankin D, Evaluation of Clinical Practice.  
Healthcare Review Online. (4) 4; April 2000

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B. **Article.** ACC News June 2001, Issue 35. Endorsed Provider Network Results

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C. **Abstract.** Rankin D, *Contracting in the Health Sector.*  
ACC Case Study: Using Quality as a Discriminator in Contracting and Purchasing of  
Health Services. 23 Jul 2003

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D. **Slide.** From ACC Presentation. Quality as a Discriminator

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E. **Presentation.** Rankin D, Evidence in Action, G-I-N Conference, 2 Nov 2004.

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F. **Abstract.** Rankin D, Intervention Strategies for Reducing Variation in Practice,

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G. **Report.** 2004/2005 Vote ACC; Report to the Transport and Industrial Relations  
Select Committee.

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H. **Report.** 2005/2006 Vote ACC; Report to the Transport and Industrial Relations Select Committee.

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I. **Article.** ACC News, Issue 12, May 1999. Physiotherapy Profiles Imminent.

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J. **Schedule.** IPRC Act, Schedule 1, Clause 1-7

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K. **Regulations.** IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

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L. **Contract.** Service Schedule to Endorsed Provider Network (Physiotherapy) Service.

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