What has the government done to ACC since the election? What has happened to services on the ground? 2011 and beyond.

Glenn Barclay, Convenor, ACC Futures Coalition

Introduction

This paper will provide an overview of changes in ACC since the last election. It will briefly consider ACC as it was in 2008 before proceeding to outline the new direction established by the government and the main changes that have occurred since then. The paper is my reflections on the changes in ACC and what they might mean. It is based on both the headlines concerning ACC over the last 3 years, and the experience of groups affiliated to the ACC Futures Coalition.

The ACC Futures Coalition consists of community groups, academics, organisations representing those who use ACC services, health treatment providers and unions who have come together around the following aim:

To build cross-party support for retaining the status of ACC as a publicly-owned single provider committed to the 'Woodhouse Principles', with a view to maintaining and improving the provision of injury prevention, treatment, rehabilitation and 'no fault' compensation social insurance system for all New Zealanders.

We came together following a seminar on the future of ACC in September 2008 and were formally launched in April 2009.

ACC in 2008

In 2008 ACC had been in existence for 34 years and been through many changes. However, it remained a public owned and funded monopoly provider of injury prevention, treatment rehabilitation and compensation services, offering 24 hour no-fault cover. Following the experiments with limiting entitlements and privatizing the work account in the 1990s it had been largely restored to its original focus as a social insurer. The Labour-led Government re-nationalised the ACC work account in 2000 and passed the Injury Prevention, Rehabilitation and Compensation Act 2002. This Act repealed the Accident Insurance Act 1998, reintroduced lump sum compensation in place of the independence allowance of the previous Act and also made some other ameliorating amendments to the range of injuries covered by the 1992/1998 Act.

In 2004 the Government introduced the Endorsed Provider Network, in which physiotherapy providers who met certain audit standards were endorsed to receive extra funding in order to eliminate co-payments for those ACC clients who used the services of those providers. This scheme was divisive within the profession but enabled New Zealand to meet its obligations under ILO conventions regarding cost of treatment. However, its costs far exceeded its original estimates.

In 2007 the board of ACC, chaired by Ross Wilson, commissioned PriceWaterhouseCooper, Sydney Australia, to undertake a comprehensive review of ACC to "evaluate the economic and social return on investment of the ACC scheme, and in particular to understand social, environmental and economic factors that will influence the sustainability of that return in the future.[1]" The scope of the review was "designed to provide an evaluation of the scheme's value to New Zealand and allow decision makers to direct the future implementation of the scheme".

The review concluded that the "…ACC scheme is consistent with the Woodhouse principles, adds considerable value to New Zealand society and economy and performs well in comparison to alternative schemes in operation internationally."

So in 2008 ACC was performing reasonably well. The Achilles heel was that the Labour-led government had not repealed the previous government's full-funding of the scheme and it was this that left the scheme exposed to attack after the election.

Financial 'Crisis'

National went into the election promising to investigate opening up the work account to competition. They also promised that "an incoming National Government would conduct a full stock-take of the state of the various components of the ACC scheme, evaluate progress to full funding, and identify areas of cross-subsidy or cost-shifting, and underfunding of newly legislated entitlements"[2].

On coming into office they found that ACC had fallen behind on its target of achieving full funding by 2014. The Minister, Nick Smith, promptly declared that ACC was 'technically

[1] PWC Australia, *Accident Compensation Corporation New Zealand: Scheme Review*, March 2008
[2] *National Party ACC Policy Background*, http://www.national.org.nz/files/.__0_0_ACC_paper.pdf

insolvent' and attacked both the previous government's stewardship and the competence of the board. The attack on Ross Wilson was gratuitous and personal and ultimately the Minister replaced all the union representatives on the board being replaced with business leaders, and John Judge as chair.

So what was the truth behind the claims? For the purposes of this presentation there is no need to go into detail but I will just quote from two respected commentators. Actuary Jonathan Eriksen had this to say:

"All this talk of liabilities being blown out is complete nonsense. It's ill-founded and smacks of scare-mongering, which, given the current economic picture is the last thing people need to be told. ...on paper the losses have ballooned when in reality there's nothing wrong with it[3]"

Rod Oram in his Sunday-Star Times article concluded:
"The government can only be taking its extreme line on ACC because it's panicking or politicking. If it is the latter, it must have its sights set on sharply cutting ACC's services."[4]

And it was the politicking path that the government took.

Physiotherapy

First under the spotlight was the endorsed provider network for physiotherapy. The EPN contract was cancelled and an 'interim' contract was imposed on the profession, which reintroduced a co-payment for patients. There is room for debate about the merits of the programme in light of the increased costs but the manner of its termination and the move to the new regime was poorly handled with only minimal consultation with the profession and little concern on the impact on patients.

Treatment and rehabilitation from the physiotherapist will involve a series of visits, for some it will only be a few, for others it is a long-term commitment to returning to full mobility and therefore another outgoing which may not be affordable, especially if the patient is not working or the family has no certainty of income.

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[3] Dominion Post Mar 12, 2009
[4] Sunday Star-Times, March 15, 2009

The initial drop in numbers was significant and that period became quite protracted (18 months-2 years) before the trend started to reverse. Patients who are on lower incomes, or for whom distance to the provider is a problem, or who have other more important "events" going on in their lives, will develop a higher tolerance for their pain and physical under-performance. The effects for patients of delaying or deferring treatment is to compound the problem/injury, so that when treatment is sought, the injury has become more complex, the sprain or strain has been exacerbated by other factors and thus return to full mobility or wellness takes much longer.

Physiotherapists were not supported by ACC in dealing with the public perceptions around the introduction of co-payments and were largely left to try to manage the communication alone.

Sensitive claims

ACC itself responded to the new climate by introducing administrative changes that resulted in reduced access to entitlements. One that received a considerable amount of publicity, thanks to the campaigning efforts of consumer groups and the counseling and psychotherapy professions, was 'sensitive claims' – the treatment of victims of sexual abuse.

The New Clinical "Pathway" for sensitive claims was introduced on 10 August and implemented on 14 September 2009 without proper consultation with ACC's own Sensitive Claims Advisory Group.

The main problem was ACC's insistence on a mental illness diagnosis rather than mental injury as stipulated in the Act. Individuals had to see a New Zealand Registered Clinical Psychologist or Psychiatrist for an assessment prior to commencing counseling and therapy. The diagnosis had to be from the Diagnostic and Statistical Manual of Mental Disorders which means, once diagnosed and claim accepted, that a person who had experienced sexual abuse trauma was pathologised via a diagnosis such as depression, generalised anxiety, post-traumatic stress disorder etc. While this approach *seems* clinically reasonable – it was an approach that put many off seeking treatment. A fundamental therapeutic principle was being ignored – that effective therapy is relationship based and the client has

to be treated as a 'subject' (s/he who speaks for self) rather than the 'object' of a medical approach.

For sexual abuse survivors, this was a re-traumatising process, a barrier to accessing treatment and to recovery. There were significant delays in accessing therapy and the number claims fell by nearly 50% in the year following the introduction of the pathway. Many therapists withdrew from providing the service because they felt it was unethical.

The clinical pathway was reviewed in 2010 by a working group chaired by Dr. Barbara Disley. Their report was highly critical of the pathway and as a consequence ACC provided for up 16 "support" sessions. While these were not called treatment or therapy sessions it is impossible to 'support' and not to treat. Indeed ACC expected these to be about good therapy, so that if a person is able to recover in that time the claim is closed. The sessions could be accessed relatively quickly and would allow time while an ACC approved person could be found to assess and diagnose mental disorder (although the injuries may have been well assessed and described by the therapist/counsellor in the support sessions). This insistence on manual based diagnosis seems expensive and often unnecessary and remains potentially stressful for claimant.

Response by professionals to the new pathway is mixed. There are relatively few psychotherapists still engaged with the work, while counselors feel that ACC's communications have improved and there is a slow process towards reconsidering the continued reliance on a mental illness diagnosis.

Accident Compensation Amendment Act 2010

The main legislative change has come via the Accident Compensation Amendment Act 2010, which (among other things) amended the title of the legislation from the Injury Prevention Rehabilitation and Compensation Act to the Accident Compensation Act.

However, important as the narrowing of focus in the title of the legislation is, I want to look mainly at the some of the specific provisions of that Act, most of which were designed to reduce or limit coverage and entitlements.

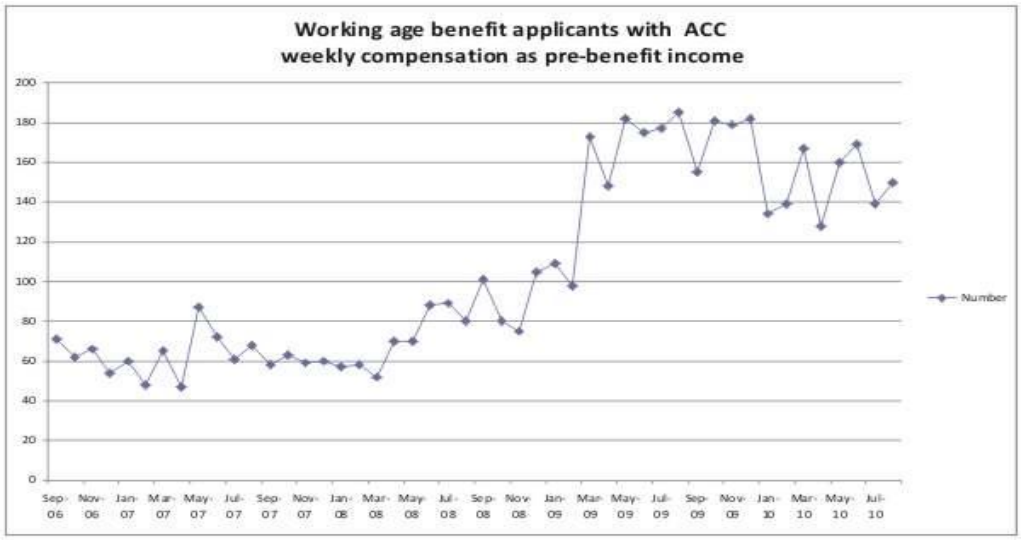
Vocational independence changes

The Amendment Act has made two changes to the requirements for vocational independence.

It changed the definition of 'vocational independence' to refer to the injured person's capacity to engage in work to which they are suited from 35 hours to 30 hours, and made it optional for occupational assessors to take a claimant's level of pre-injury earnings into account. This gives ACC much more flexibility to declare injured workers fit for work and then to force them off weekly compensation and onto benefits, such as the sickness and invalid's benefit, which is likely to be the outcome for many in these times of high unemployment.

Yet, significant as this law change was it was just another tool for the new regime committed to reducing the numbers on ACC. Figures elicited by the Greens last year demonstrated that from March 2009 there had already been a significant jump in the number of working age applicants for benefits who had ACC weekly compensation as their previous income, suggesting that there was some other policy in place prior to the law change.

Figure 1[5]



[5] http://www.greens.org.nz/node/24591

6% threshold for noise-induced hearing loss

The legislation also amended the definition of 'personal injury', by stating that personal injury did not include any degree of hearing loss that is less than 6% of binaural hearing loss. Put shortly, this ruled out cover for claimants whose (otherwise coverable) level of hearing loss is less than 6%.

This change was of great detriment to claimants with a coverable hearing loss of less than 6%. More broadly, it was the first time that a rigid, numeric threshold for cover has been enacted in the life of the scheme. Whilst the scheme currently includes specific thresholds in relation to certain *entitlements* (e.g. lump sum compensation for whole person impairment), no such thresholds exist for the granting of *cover.*

This is discriminatory. No other injury has to meet a threshold before ACC will consider a claim. Currently, even personal injuries that are very minor are granted cover. It is important to point out that cover does not guarantee entitlements. Cover is merely the first step – once this is granted, the provision of various entitlements is decided by reference to the appropriate tests within the legislation. Therefore, very minor injuries (e.g. grazes, bruising) might not attract any entitlements at all, even though they are covered. However, this is as a result of an assessment of the individual claimant's need for a particular entitlement – rather than a blanket rejection on the basis that the injury has been pre-classified as 'minor'. It denies affected people access to rehabilitation that could make a difference.

It is evident that the government believes a hearing loss of less than 6% to be insignificant. However, this is untrue. The New Zealand Audiological Society has prepared case studies, which show that a hearing loss of less than 6% is neither trivial, nor minor and can significantly affect the injured person's quality of life and their productivity. The National Foundation for the Deaf has been campaigning on this issue and earlier this year presented a petition to parliament.

Cover for work-related gradual process injuries

The amendment act reinstated the 3-part test for causation of gradual process claims, first introduced in 1992 and subsequently ameliorated by the 2008 amendment to the Act. Occupational health is covered in more detail by others at this symposium, but suffice to say

that: the burden of proof for gradual process injuries is placed squarely on the injured worker to demonstrate that the cause of the injury is not found to any material extent in his/her non-work activities or environment; and that the risk of suffering this injury is significantly greater for people who perform the employment task, or work in that type of environment, when compared with people who are not.

Cuts in weekly compensation

The amendment also cut compensation for two groups: those under 18 who had their potential earnings reduced from 125% of the minimum amount weekly earnings allowed for in the Act to 100%; and low income claimants who are now not entitled to receive minimum weekly compensation until the 6th week of incapacity. Low income employees who are incapacitated for 5 weeks or less will not be entitled to the minimum amount of compensation.

Abatement of holiday pay

There is one provision that particularly sums up the mean-spiritedness of these changes. The requirement that an injured worker must use up any outstanding holiday entitlement due on termination of employment before they become eligible for weekly compensation shifted means that the employee must meet some of the costs of the injury out of monies that were earned prior to the incapacity. Holiday pay is a payment made to a claimant in respect of a time when that claimant was not injured. Therefore, even though the actual payment may take place at a point in time when the claimant is incapacitated, it was 'earned' at an earlier point in time. It was difficult to see the logic of this measure but its aggravation factor was high.

Elective surgery

Over the last year the NZ Herald[6] has highlighted a number of cases where it appeared that ACC was declining claims for elective surgery because the claimants had pre-existing degenerative conditions in the areas of the body where the injuries had occurred. There was a clear impression left in the public's mind that someone in this situation was likely to be turned down for cover by ACC, and the independence and competence of the Corporation's advising clinicians was called into question.

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6 See for example, http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10700804

ACC commissioned an internal review which noted that ACC had changed its policy in this area (there was no change of legislation) on the back of increasing costs which were rising at the rate of 14% a year between 2002 and 2009. This was considered unsustainable and out of line with what would be expected based on broader changes in injury rates, claim numbers or medical inflation.[7] The report noted that the change process was commenced in mid 2008, and involved a move away from the 'green light' approach for straightforward claims to a more thorough review of the circumstances in each case. This required ACC to increase its clinical advisory capacity.

Although the change pre-dated the change of government, nonetheless the approach and the impact coincided with the other cost saving measures covered in this paper and fed concerns about ACC's general approach.

Regardless of the rationale, there were real problems with the implementation of this policy. As a proportion of the total number of elective surgery applications that ACC manages each year, the number of ACC's Elective Surgery Unit's (ESU) surgery decisions overturned via the independent review process was small (less than 2% of all surgery applications and around 6% of all declined surgery applications). However, since early 2010 the proportion of reviews of ESU surgery decisions found in favour of the client had increased. In the 2010/11 financial year to March 2011, reviews of ESU elective surgery decisions were found in favour of the client at an average rate of 44% compared to 25% for other types of reviews.

The review found there were problems and proposed a range of measures, many of which were focused on improving communication. However, it also proposed that ACC review the clinical advisor resource, role and capacity across ACC to ensure sufficient robust medical comment on cases, particularly before a decision to decline is confirmed and before cases go through the independent review process. ACC should also consider securing additional technical/legal expertise to support clinical advice[8].

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[7] *ACC Review of Elective Surgery Decision Making*, May 2011 p. 40 http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_communications/documents/reports_results/wpc093171.pdf

[8] ibid. p. 28

Other measures

Since the legislation passed there have been a number of other changes introduced, all with a detrimental impact on ACC clients.

Travel payments for home support workers

In November 2009 ACC changed its travel reimbursement policy for home support worker caring for ACC clients. Previously home support workers were reimbursed for their travel costs if they had to drive more than 20km to assist an ACC claimant recovering from an accident. ACC cut the funding and now expects them to pay for the first 20km they drive to get to the homes of people on accident compensation. This had a significant impact on workers providing those services in rural areas.

Injury prevention

Injury prevention is also a concern. Given New Zealand's poor work injury record, the Corporation's spending on injury prevention is small and is steadily reducing. In 2005/06 it was $41.4 million, and had fallen to $39.5 million by 2008/09. It was $30.6 million in 2009/10, forecast to be only $29.2 million in 2010/11 (despite an original forecast of $38.2 million at the time of last year's levy consultation), and $26.7 million in 2011/12 (p.5 of the Introduction to the Levy Consultation). That is a fall of over a third in the expenditure over 6 years - and of approximately 45 percent in real terms (after inflation)[9]. Earlier this year ACC closed its successful Safer Industry Forums and made most of the workers redundant who supported them.

Part charges for hearing loss rehabilitation

On 1 January this year ACC introduced part charges for rehabilitation costs for those experiencing noise-induced hearing loss, including the cost of hearing aids. ACC's share of the costs will equal the percentage of hearing loss that is considered to have been caused by injury, while the Ministry of Health is expected to contribute something and the claimant pays the rest. This affects new claims as well as existing claims.

While ACC pays what it considers its "share" of the rehabilitation bill, the Ministry of Health contribution does <u>not</u> cover the rest, leaving claimants having to find potentially thousands

[9] Figures cit. NZCTU Submission ACC Levy Consultation 2012/13

of dollars to contribute towards their rehabilitation. Many people on limited incomes cannot afford this.

As the National Foundation for the deaf has made clear, the real cost of this change for individuals who cannot afford to pay towards their rehabilitation is in social isolation (people avoid social gatherings because it is too hard to hear); stress, frustration and sometimes anger at not being able to hear well; loss of independence; and the associated impact on family.

Growth in appeals

Not surprisingly, given list of changes outlined here, in 2009/10 there has been a 35% increase in new review applications coming to Disputes Resolution Services Ltd (DRSL) compared to the 2008/09 year, with an average of almost 800 new reviews applications per month. This is consistent with last year, when there was also an increase in review application numbers of over 30% from the previous year. For DRSL, this means there are over 60% more review applications being processed now compared with two years ago[10]. Whatever finer points of interpretation can be applied to these figures, one thing is clear – more ACC claimants are unhappy with their treatment since March 2009 than previously.

Impact on health professionals

The measures outlined in this paper have all impacted primarily on clients, but they also impact on the health professionals who provide treatment and rehabilitation and damaging the relationship between them and the Corporation. The evidence from the last few years is not encouraging.

There are themes around professional judgement being questioned and processes that either marginalize health professionals or bog them down in paperwork. The sensitive claims issue was a challenge to the professional judgement of the therapists involved as the increase in claim refusal has been for orthopaedic surgeons. The increase in claim refusals has also just impacted on others such as physiotherapists, acupuncturists and osteopaths. All report increases in paperwork.

[10] DRSL Annual Report 2010 p. 8
http://www.drsl.co.nz/files/DRSL%20Annual%20Report%202010.pdf

Acupuncturists report problems with a bias against the profession in some parts of the ACC hierarchy, notwithstanding that ACC has recognised acupuncture since 1990. The recently received consultation document on amendments to the treatment payment regulations completely excluded reference to the profession.

Health professionals have had to bear the brunt of criticism of ACC's and the government's policy changes. Physiotherapists were scapegoated by the Minister over the EPN, and both they and audiologists have had to deal with frustrated and occasionally angry clients who have not been informed by ACC of the changes to the funding of the services they provide.

Many health professionals are withdrawing from ACC work or reducing their commitment to avoid the frustrations for both clients and themselves. This must have an impact on the availability of treatment over time.

Conclusion

The government created a climate of panic and fear over the state of ACC's finances and this has not been conducive to considered policy making through proper engagement with stakeholders. There may well have been justification for some of these changes but the overall manner of their introduction and implementation has been to alienate many ACC clients and contracted health professionals. Unions have been shut out from the governance of the scheme, which is vitally important to the wellbeing of their members.

However driven by panic these policy changes may have been, they are consistent with one theme – a narrowing of the focus ACC away from being "social welfare in nature and purpose[11]" to an insurance model, concerned primarily with compensation and structured to support a shift to privatization. This is assisted by the difficulty the public sometimes have in distinguishing between government policy and ACC's administrative policies. If ACC can be blamed then perhaps the public will be less concerned when the work account is privatised.

[11] Sir Owen Woodhouse, Speech to the ACC Futures Seminar, September 2008 p. 4 http://issues.co.nz/library_images/accfutures/sir-owen-woodhouse_speech.pdf