03 March 2022

[redacted]

Tēnā koe [redacted]

Your Official Information Act request, reference: GOV-015829
Thank you for your email of 10 December 2021, asking for the following information under the Official Information Act 1982 (the Act):

> *…the Corporations' most recent views/ awareness as documented about claim costs etc that will arise for ACC if the current practice & subsequent case law is relaxed for these cases?*

On 10 December 2021 you clarified that you were seeking information about age-related conditions. On 18 January 2022, we advised you we were extending the timeframe to make a decision on your request because of the consultation required. We are now able to respond.

Estimated impact to ACC
Please find attached as an appendix a May 2019 ACC Board paper titled *Degenerative conditions within the Accident Compensation scheme* and the associated excerpt from the May 2019 Board minutes. This is the most recent paper providing estimates of the increase in ACC's outstanding claims liability (the OCL) that could occur with changes to the Accident Compensation Act. The estimates of the increase to the OCL are provided on the basis that there are changes to the existing legislation to broaden the scope of the Scheme.

We have withheld the names of former ACC staff members from these documents, as we could not consult with them regarding the release of their names. This decision is made under section 9(2)(a) of the Act. In doing so, we have considered the public interest in making the information available and have determined that it does not outweigh the need to protect the privacy of these persons.

We have also withheld information that is legally privileged, this decision is made under section 9(2)(h) of the Act. In making this decision we considered the public interest in disclosure have and determined that it does not outweigh the need to maintain legal professional privilege.

How to get in contact
If you have any questions, you can email me at GovernmentServices@acc.co.nz.

As this information may be of interest to other members of the public, ACC has decided to proactively release a copy of this response on ACC's website. All requester data, including your name and contact details, will be removed prior to release. The released response will be made available here.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

Nāku iti noa, nā

Sasha Wood
Manager Official Information Act Services
Government Engagement & Support

Title	Degenerative conditions within the Accident Compensation scheme
Status	Decision ☒ Information ☐
Meeting Date	30 May 2019
Agenda Item	[Reflects Board agenda – Corporate Secretariat to complete]

1 Purpose

1.1 The Board has commissioned ACC to carry out an analysis of issues facing clients with an underlying degenerative condition. This paper explores a range of options to improve the experience and management of clients and providers, as well as setting out work already underway.

1.2 This paper summarises the key themes of ACC's targeted discussions with external stakeholders, including General Practitioners, the New Zealand Orthopaedic Association, Grey Power, and ACC's Older Person's Advisory Panel.

2 Key Take-Outs

2.1 While ACC is not responsible for covering illness or symptoms caused solely by degenerative conditions, ACC acknowledges that some decisions affecting people with pre-existing degenerative conditions aggravated by an accident can seem unfair. Both clients and providers have raised a range of concerns, including about the differences between Elective Surgery services provided by the Ministry of Health and ACC, as well as ACC's decision-making.

2.2 Degeneration is not a term used in the Accident Compensation Act (the Act) to define personal injury exclusions to cover. However, pre-existing degenerative conditions are captured by the exclusion to personal injuries caused by ageing-related conditions and the exclusion of gradual process conditions.

2.3 Having a pre-existing health condition or degeneration does not exclude a person from cover and entitlements, however they only apply to the consequences of the covered injury and not the consequences of underlying degeneration.

2.4 Our analysis confirms that ACC is operating within the bounds of the legislation and consistent with case law by excluding injuries caused "wholly or substantially" by ageing-related conditions.

2.5 There is a spectrum of options that would help address the identified issues, ranging from incremental business improvements, to joint funding arrangements with the Ministry of Health, through to significant legislative change to cover and entitlements.

2.6 In terms of business improvements to better support clients and providers, many are already underway as part of ACC's transformation programme. We have summarised some of these in this paper and can continue to update the Board on progress implementing improvements as part of regular updates on the Miriam Dean Review.

2.7 It would be possible to extend cover and entitlements to people whose condition has been aggravated or made symptomatic by an accident through legislative change. This change is estimated to increase the OCL by between $220m (to cover requests currently declined by ACC due to degeneration) and $830m (also covering some of the unmet demand). These estimates are based on an assumed increase of 5,500 to 21,000 elective surgery requests. The actual demand could exceed this, resulting in an even bigger OCL impact.

3 Recommendations

3.1 It is recommended that the ACC Board:

Note Our clients and providers have reported challenges with ACC's approach to the provision of entitlements for the consequences of degenerative conditions;

Note ACC has conducted inquiries and analysis to better understand the problems faced by clients and providers, and explored opportunities to address the feedback we have received;

Note Existing legislative settings do not enable cover to be provided for injuries caused by pre-existing degenerative conditions, however we have explored a range of possible legislative changes;

Note we have also identified changes that would improve the experience of clients and providers. A number of initiatives are planned or already underway, including those within the Integrated Change Investment Portfolio.

4 Current State

Degeneration affects all adult New Zealanders

4.1 Degeneration refers broadly to a multi-factorial process that occurs gradually over time. Osteoarthritis, an example of a common degenerative condition, has multiple causes and risk factors including genetic factors, bone mineral density, diet, as well as a single trauma or multiple micro-traumatic events over a prolonged period.

4.2 People begin to exhibit signs of degeneration from about 18 years—however, people are increasingly likely to have a co-morbidity as they get older. For example, it is estimated that over 30 percent of people aged 65 years and over have osteoarthritis. As New Zealand's

population ages, the prevalence of arthritis is estimated to grow by approximately 30 percent by 2040 (across all age cohorts).[1]

4.3 Data is limited on the number of ACC claims where a pre-existing degenerative condition results in declined cover or entitlements. Most claims for joint-related injuries are accepted for cover (including over 99 percent of sprains and strains),[2] however, up to approximately 15 percent of all surgery requests are declined because of no causal link to the covered injury (approximately 8,000 requests per annum, 5,500 for those aged over 45 years). [3]

4.4 Decisions to decline entitlements can be distressing for clients because they may feel ACC does not believe them, or is making inconsistent decisions. One of the principal reasons these decisions matter is that the care provided by ACC is, or is perceived to be, more timely than that provided in the public health system. If the experience were similar, regardless of where clients were treated (in terms of access, timeliness, affordability, and quality), then this would be less concerning.

We are currently operating within our legislative framework, and consistently with case law

4.5 Degeneration is not a term found in the Act, however the Act excludes personal injuries caused, wholly or substantially, by the ageing process or gradual process. For the purposes of this paper, we have focussed on a commonly-occurring issue for clients: when the presence of a pre-existing degenerative condition, whether symptomatic or asymptomatic, such as osteoarthritis, affects cover and entitlements.

4.6 Having a pre-existing health condition or degeneration does not exclude a person from cover and entitlements, however they only apply to the consequences of the covered injury and not any underlying degeneration. District and High Court decisions have found that entitlements are not available for the effects of a pre-existing health condition, aggravated or accelerated by an accident. Appendix 1 provides an overview of the relevant case law.

Operational settings

4.7 Eighty-eight percent of all ACC claims are managed by providers and require minimal input from ACC; for example, a straightforward injury that requires seven visits to a physiotherapist. To facilitate the process for clients and providers, operational settings allow cover to be accepted automatically and clients to access allied health providers, such as physiotherapists, without prior approval. This rate has remained steady over the last five years and is unaffected by age. Similarly, over 75 percent of surgery requests are approved based on the surgeon's assessment, without a clinical review by ACC.

4.8 This means that, in many cases, the existence of degeneration, and a determination of causation, will not surface during the initial interaction with ACC. For many clients and providers, the first time causation is considered closely by ACC is when an entitlement such as extended weekly compensation or an elective surgery request is declined.

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[1] *The economic cost of arthritis in New Zealand in 2018*. Deloitte Access Economics for Arthritis New Zealand
[2] It is only in rare cases (less than 1 percent) that a cover request for a joint sprain or strain injury is declined, and this rate is consistent across all age groups.
[3] Exact numbers of requests that are declined due to degeneration are unavailable, as the reason for declined surgery is not recorded in EOS. That said, a useful proxy is "no causal link" which ACC's Clinical Advisory Panel has explained predominantly refers to degeneration.

4.9 As most claims are managed by providers and approved automatically, clients may assume that receiving cover and initial entitlements means all future entitlements will be approved.

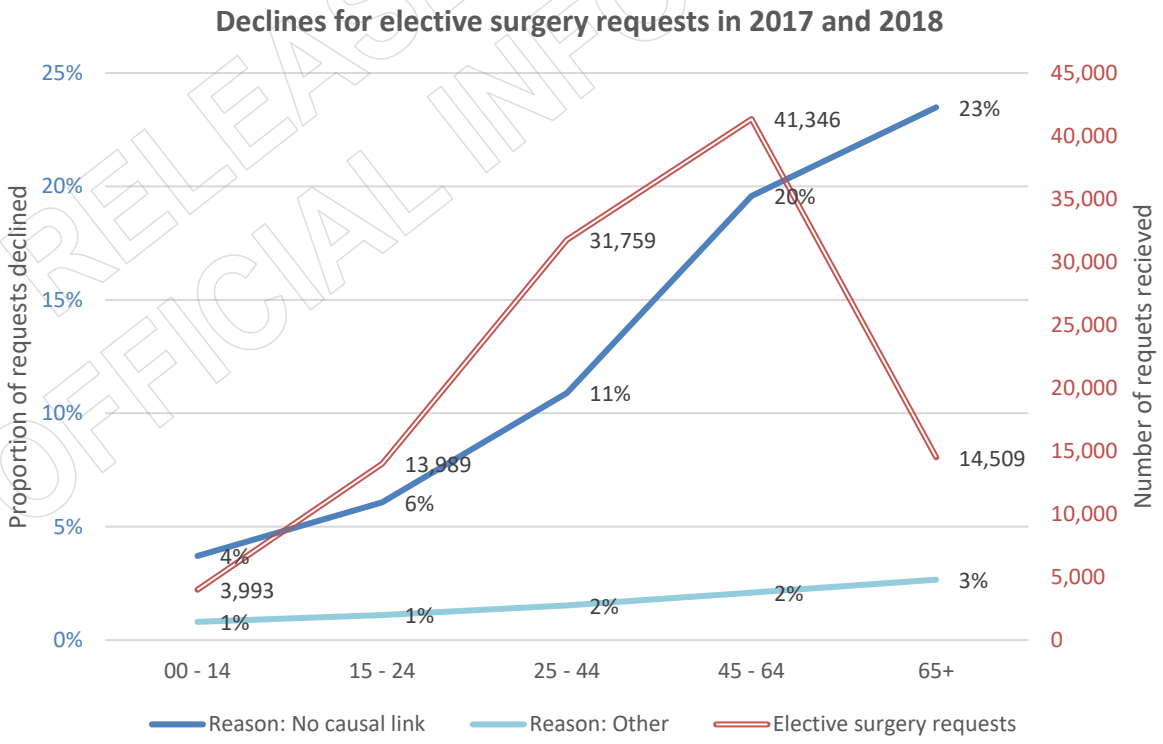
4.10 Given the high volume of low-cost, provider-led claims, this pragmatic approach to approvals for cover and straightforward entitlements works well. However, some improvements could be made to communication and expectation-setting with clients, as well as information sharing and education for providers.

5 Problem definition

Elective surgery requests provide a useful way of understanding the problem

5.1 We have looked at elective surgery requests because this is a decision point where clinical evidence of causation is considered, and we have a relatively well-documented decision-making process.[4]

5.2 Over 50,000 requests for elective surgery are assessed each year, with budget of $361.2m in 2019/20. Data for the 18 months from mid-2017 through to December 2018 indicates that 15 percent of these are declined for "no causal link". Rates vary across age groups; for people aged over 65 years the decline rate is 23 percent, and 20 percent for those aged between 45 and 64 years. Surgery request numbers and decline rates have been relatively stable over the last 5 years. (Appendix 2 outlines the decision process and outcomes for elective surgery requests.)



5.3 While the greatest proportion of declines due to "no causal link" is amongst the 65+ age group, the number of surgery requests is substantially lower than for younger cohorts. One reason for

[4] We would expect that some of the trends apparent in elective surgery will also be found in other entitlement requests, such as, for example, weekly compensation.

this may be that clinicians filter out cases of degeneration before submitting a request for ACC to contribute to elective surgery costs, as offered by the New Zealand Orthopaedic Association when we met with them.

Issues raised by stakeholders

5.4 In undertaking this work ACC has reviewed feedback from surveys, and consulted with a range of individuals and representative groups. Consultation has been undertaken with:

a) the Older Person's Advisory Panel;
b) Grey Power;
c) the New Zealand Orthopaedic Association;
d) General Practice, including the Chair and Chief Executive of the New Zealand Medical Association, Medical Director of the Royal New Zealand College of General Practitioners and Island Bay Medical Centre;
e) Participants from the Board's strategy day, including representatives of ProCare and Mercy Ascot;
f) Auckland DHB; and
g) internal subject matter experts, including those with clinical, resolutions, provider, analytics and legal expertise.

5.5 In undertaking consultation, there were three consistent issues raised by clients and providers:

Not covering the acceleration of existing conditions, or conditions that had previously been asymptomatic, means that not all the consequences of an accident are being addressed.

Q. If there is one action that ACC can take to increase your trust and confidence, what would it be?

A. Do not always tell older people that their injuries are age-related. We have paid ACC levies for many years. *General Public survey- Q3 2019*

A. ACC needs to understand that normal 'wear and tear' is, or can be, progressed by an injurious event i.e., because of the injury there is an increased amount of degeneration - that should be covered and not declined by ACC. *Provider Survey November 2018*

5.6 It may seem unfair to clients and clinicians that ACC will cover some initial treatment (for example, of a sprain), and then decline subsequent entitlements, even though a client still experiences pain and/or incapacity, because it is linked to the aggravation of a pre-existing condition.

5.7 The initial acceptance of sprain and strain injuries can result in an expectation that all treatment and entitlement requests will be accepted. This has been reported in complaints, and was also echoed by some clinicians, who commented that it can be hard to explain the legislated exclusion of ageing and illness-related conditions to clients when expectations are not well-managed by ACC at the time a cover decision is made.

5.8 A survey of ElderNet users conducted by a member of the Older Person's Advisory Panel reported that the majority of respondents were not aware they had a degenerative condition prior to their accident, and had experienced no symptoms that might have been related to that condition. Panel members also made the point that, for many people, learning that their surgery request was declined because of an underlying pre-existing health condition, such as arthritis, was the first time they realised they had a degenerative condition. This could exacerbate the potential distress experienced from declined surgery.

The treating clinician knows their patient and the circumstances around their treatment best—ACC should trust their judgement.

> Q. If there is one action that ACC can take to increase your trust and confidence, what would it be?
>
> A. More participation in declined decisions that are made by ACC, so support can be provided to the patient. *Provider Survey, August 2018*
>
> A. Don't write everybody off from the word go. I had a genuine accident and they said that it was old age related (degenerative), yet from my doctor and myself and my history, there was no issue particularly to my injury to my shoulder. *Managed Clients Survey, February 2019*

5.9 Clinicians and clients raised two main issues about the relationship between ACC and providers.

5.10 First, clinicians (particularly GPs) were not kept informed by ACC about decisions that impacted their patient's treatment. For instance, if GPs are not informed of declined surgery request, there can be delays supporting patients into alternative services.

5.11 A lack of feedback loops to providers is an identified issue within ACC. In the most recent National Provider Survey (Q3), 31 percent of providers identified that they were not informed when a cover request was declined. Both GPs and the Older Person's Advisory Panel identified the importance of the navigation and support role played by General Practice, and the opportunity provided by GPs to help claimants understand decline decisions, and access alternative community or health services instead.

5.12 GPs also raised the concern that they are not permitted to provide some diagnoses to ACC, or lodge provisional diagnoses. An example raised in more than one forum was ACC policies that prevent the diagnosis of suspected tears being lodged, limiting diagnosis to a sprain or a strain, until imaging is carried out to confirm the tear diagnosis. This can have implications when requests for additional treatment are made. Forty percent of Providers want ACC to work on making it easier to change an initial diagnosis.

5.13 Second, clinicians (particularly orthopaedic surgeons) commented that they are best placed to make treatment decisions for their patients, and that ACC's clinical advisors make decisions without full patient histories.

5.14 We heard from professional bodies that they believe decision-making by the Clinical Advisory Panel is weighted towards declining requests for surgery. ACC accepts around 83 percent of surgery requests[5] when they are first considered, and only a small number of the most complex continue to the resolutions team and/or to review. Of these, the proportion of overturned decisions or settlements is approximately 25-50 percent. This is an area of continuing focus for ACC, although it is worth noting that decisions overturned at review account for 1 percent of all surgery requests. A breakdown of decisions is summarised in a flowchart at Appendix 2.

[5] Around 77 percent at initial triage by the Treatment Assessment Centre, and a further 6 percent after the Clinical Advisory Panel has provided advice.

ACC does not work closely enough with the public health system (and private providers) to support people who have both accident-related and pre-existing degenerative conditions.

> Q. If there is one action that ACC can take to increase your trust and confidence, what would it be?
>
> A. More support offered for a client who sometimes gets declined as their injury is classified as degenerative condition, as this cohort of people are still needing some sort of care/management. *Provider Survey, January 2019*

5.15 When an elective surgery request is declined by ACC, clients will likely seek the same surgery through either their DHB, or through a private insurer (if available). This 'handover' from ACC to another system provides a point at which ACC could better support clients and clinicians.

5.16 The linear process of assessment by ACC, and then the public health or private insurance systems, was raised as leading to delays. For private insurance-funded treatment for accident-related injuries, often a decline decision from ACC will be required before the insurer will approve the request. This is the case even if it is a complex injury that takes some time to work through. An alternative model is that used for treatment injury claims, where, for example, ACC and Southern Cross will consider a request concurrently, and then determine which entity is responsible for payment after the surgery.

6 Initiatives to resolve the identified issues

Integrated Change Investment Portfolio (ICIP) projects will deliver significant improvements

6.1 Issues experienced by clients with pre-existing conditions often reflect broader issues of poor customer experience and complaints. ACC's Transformation programme is substantially changing the ways we interact with and deliver services to clients. This will a number of the issues raised by providers and clients about degeneration. Some initiatives are well advanced, whereas others are more recently underway. Further changes are possible once key infrastructure projects are complete, for instance EOS scheduled changes or the implementation of Analytics 2.0.

6.2 We have identified further changes that could be considered once existing projects come on-line. For example, taking into account the feedback from clients and providers, there are opportunities to do more around communication and education. Appendix 3 sets out potential short and medium-term changes, noting that many of these have dependencies related to ICIP.

Changes to our systems and infrastructure will allow us to better support and understand clients with degenerative conditions

6.3 The implementation of Analytics 2.0 will create a platform from which we can get a fuller understanding of degeneration-related issues. This will enable ACC to develop resources and targeted information, relevant to clients likely to be impacted.

6.4 The first phase of the Lodgement project has delivered efficiencies in how claims are assessed, with simple and straightforward claims approved instantly and consistently, while more complex claims can be explored. Further opportunities to consider in Lodgement include the adoption of SNOMED clinical terminology, which will allow for more granular diagnostic information to be captured, and differential or provisional diagnoses may also be possible with future system capabilities, addressing one of the issues raised by GPs.

We are focused on improving outcomes for our clients

6.5 Through the Health Services Strategy, we are considering how we can work differently with health providers to achieve better outcomes. Through the development of a Health Outcomes Framework for ACC, we will have a robust and comprehensive approach to measuring and purchasing for health outcomes.

6.6 Clients are accessing diagnostic imaging more quickly through the High-Tech Imaging Proof of Concept, and will be supported to navigate their care pathway through the Escalated Care Pathways programme. This programme also provides for enhanced decision-making by clinicians, including in terms of causation. This will go some way to address one of the key concerns by clinicians about a lack of trust on the part of ACC in their clinical judgement.

6.7 The GP Connect Project will support better links with Primary Care to improve access and outcomes for clients. The relationship we develop with primary care clinicians will allow us to better support conservative clinical pathways for clients who would benefit from non-surgical interventions, or to connect clients to other supports or access to DHB-funded care.

6.8 Injury Prevention programmes, such as the 'Live Stronger for Longer' programme, which aims to reduce the risks of falls and fractures in those over 65 years, provide an opportunity to collaborate with DHBs.

Building a shared understanding with clients and providers would contribute to a better experience

6.9 Many people we spoke to indicated that the management of expectations by ACC could be improved. One way to address this is by giving clients more information about their covered injury. Proactive sharing of cover information, as is now occurring through MyACC, will go some way to address this issue.

6.10 In September 2018, a re-designed cover letter developed by a behavioural scientist was released, and as systems changes including the EOS 8.8 upgrades are completed, further changes can be made to the cover letter to better manage expectations with clients.

6.11 Work is underway to strengthen mutual understanding of causation between ACC and providers. In March 2019, a module on causation for contracted physiotherapists and hand therapists was released, and there is scope to extend this module further and develop a specific module focusing on ageing.

6.12 In collaboration with the New Zealand Orthopaedic Association, agreed Consideration Factors used to assess surgery requests for orthopaedic surgery have been developed, for instance for knee injuries and rotator-cuff injuries.

We are improving our review process and learning from our decision-making about entitlements

6.13 Since the Miriam Dean Review continuous improvement processes are underway through Resolutions@ACC. Procurement is currently underway for the Navigation Service, which will better support clients to understand what ACC offers, and to help clients navigate to the right place if their treatment is declined by ACC.

6.14 Work is also underway to analyse all decisions to identify potential trends or any unintentional biases amongst reviewers or clinicians. The insights from this analysis are intended to support better decision-making at the initial stage and improve both client and provider trust and experience.

What more can we do?

6.15 In addition to business improvements, there are other options, which can only be achieved through legislative amendment.

Legislative amendments to the definition of "personal injury"

6.16 Providing cover and entitlements for the effects of, or trauma associated with, an accident, including the aggravation and acceleration of previously a asymptomatic condition, would require legislative change to the current definition of personal injury. We have considered two ways of doing this:

a) Repeal the current exclusion of injuries caused wholly or substantially by the ageing process (s26(4)(a)).

6.17 Initial legal and policy work suggests that even under this option, every degenerative condition caused by the ageing process would, *prima facie,* continue to be excluded by s26(2) exclusion of gradual process injuries.

b) Amend the definition of personal injury (s26) to include any aggravation or acceleration of a gradual process, disease, or infection, to the extent that it was aggravated or accelerated by an accident.

6.18 One of the issues with this option is the likely impact on cover and entitlements as it would extend to all the effects of aggravation or acceleration. We have considered adding that the effects of the aggravation or acceleration would be limited to where there is a "significant reduction in function". This could be problematic, resulting in disagreement around the definition of "significant". This was the case when the term was included in the statutory definition of "medical mishap" which applied up to 2005.

6.19 We also considered whether to include a time limit to establish a relationship between the covered injury and the aggravation, in order to avoid evidential difficulties. For instance, specifying that the effects of the aggravation should present within a year of the accident. On reflection, initial legal and policy work suggests that there would likely be fairness concerns using timeframes to supplant the causation rules that would otherwise apply. This would also be the case if we considered including a time limit on the provision of entitlements.

6.20 While this option is feasible, we consider that the potential for this to expand the scope of the Scheme is significant. ACC would potentially be liable for chronic conditions that could be exacerbated by accident. For instance, a person with pre-diabetes has an accident, and they subsequently develop diabetes as a consequence of being sedentary during rehabilitation, resulting in long-term health problems.

Develop a joint funding model

6.21 Shared funding arrangements between the ACC and the Ministry of Health for clients with both degenerative conditions and injury from an accident could provide a way to improve the client experience.

6.22 There are already examples of joint funding arrangements in the legislation: for acute services (through Pubic Health Acute Services), ambulance services, and hearing loss. There are also operational arrangements to share costs in cases where someone has an accident whilst in residential care.

6.23 There are a number of complexities and questions that would need to be addressed in order to develop new joint funding models. These would need to be worked through with the Ministry of Health.

6.24 There are structural options that would need to be considered, including the most appropriate budget holder, or whether a separate entity would be best placed to manage purchasing, along the lines of the National Ambulance Sector Office. Given the restrictions in the Commerce Act, it may be that joint purchasing arrangements would require a specific legislative exemption, similar to emergency transport funding provisions.

6.25 The other structural issue to agree would be the apportionment model or formula applied to agree costs with the Ministry of Health. For example, the hearing loss model applies an age-related sliding scale that could be used. That said, for the breadth of possible conditions to be covered by a new model, this may be too reductionist. While the apportionment model works well for purchasing hearing aids, and could be applied to health treatment such as elective surgery, there are likely to be challenges applying it to other entitlements, particularly weekly compensation.

6.26 In addition to the mechanisms for joint funding, ACC and the Ministry of Health would need to agree eligibility and triage, namely: how broadly this would apply and should there be severity threshold, along the same lines as the hearing loss framework? The scale of services and clinical pathways would also need to be agreed, including prevention, primary and secondary services.

6.27 In spite of the complexities of joint funding arrangements, there would be benefits including a seamless experience for clients and reduced treatment delays for those with mixed cause conditions. To trial a new approach, options could include piloting at either a local level (such as through an existing relationship with a DHB). If the Board considers there is merit in further work on this option, the next steps would include engagement with the Ministry of Health.

7 Alignment to Strategic Direction

7.1 At the Board Strategy Day on 29 November, the Board expressed concern that clients may experience confusion, distress, and delays if their injury involves underlying degeneration. This paper progresses work requested from ACC by the Board.

7.2 A new approach for clients with injuries caused by both an accident and a pre-existing degenerative condition supports ACC's strategic priorities to improve our customer service, and further enhance our partnership with the health sector.

7.3 We are also cognisant of the need to maintain Scheme sustainability so it continues to provide support for levy and tax payers. Some of the options that we have considered could have a significant impact on ACC's OCL and require increases to levies and government appropriations. While large structural changes to the Act to cover degenerative conditions would improve client experience, it may be possible to achieve positive outcomes with a lesser impact on OCL.

8 Financial Impact

8.1 To calculate the impact on the OCL, we have make certain assumptions about the possible range of additional claims that could be eligible were ACC to cover aggravated pre-existing conditions:

a) At the low end, there are approximately 5,500 cases per year, for people over the age of 45 years, whose elective surgery is currently declined because there is 'no causal link'.[6]

b) At the high end, potential demand is difficult to estimate. We think that joint replacements not currently funded by ACC represent the largest area of potential increase.

To estimate this potential demand, we have considered the rate of joint replacements required for people over the age of 45 years[7]. Approximately 21,000 joint replacements are undertaken per year, however total demand could be as high as 340,000 (estimated for all joints).[8]

Any increase would need to be met by an increase in capacity. The number of surgeons, theatres, anaesthetists and other resources required is relatively fixed but there is scope for more surgery if more funding is available.

For the high end estimate, we have assumed that capacity doubles and a total increase of 21,000 surgeries occur each year.

8.2 The estimated impact of the additional 5,500 to 21,000 claims on OCL is $220m-$830m. This allows for weekly compensation, surgery and other health treatment costs. If the actual number of claims is higher, then the impact on the OCL will also increase.

8.3 . Of this potential increase, it is estimated that about 65 percent is for elective surgery. This would represent an increase in the elective surgery OCL of 4-16 percent. A further 21 percent is for weekly compensation, with the remaining 14 percent related to medical costs and non-serious social rehabilitation

The table below shows the estimated impact on levy/appropriation:

Accounts	**Estimated levy / appropriation impact**	
Earners (per $100 liable earnings)	$0.02	$0.08
Work (per $100 liable earnings)	$0.01	$0.04
Motor vehicle (per vehicle)	$0.15	$0.57

[6] For this ages 45+ and for category 'Decline: No Causal Link': 2017 declines number 5,752; 2018 declines number 5,606 (as at data 25 Feb 2019).

[7] Population estimate (based on 2013 census) for 2018 as at 18 Feb is 1,969,330 people over 45.

[8] A UK Survey found 7 percent of population are in need of knee joint replacements, including those with co-morbidities (such as obesity).*Inequalities in access to knee joint replacements for people in need | Annals of the Rheumatic Diseases*. https://ard.bmj.com/content/63/11/1483.
According to the NZOA Joint Registry in 2017 there were 8,298 knee replacements undertaken in New Zealand, or a total of 20,699 registered joints for the year. This gives a knee to all joints ratio of 1:2.5, therefore assumed unmet need for all joints of 17.5 percent

Accounts	Estimated levy / appropriation impact	
Non-Earners	$11.5m	$44.0m
Treatment Injury – Earners' portion (per $100 liable earnings)	$0.00	$0.00
Treatment Injury – Non-Earners' portion	$0.5m	$2.0m

9 Risks

9.1 If the Board wishes to further investigate legislative change and/or joint funding, a full risk assessment will be conducted.

10 Whāia Te Tika

10.1 ACC research has highlighted that Māori are more likely to experience a serious injury, but less likely to access ACC services. The impact of any potential changes to better address operational or scheme issues for people with degeneration should also positively impact access for Māori.

10.2 Looking at requests for elective surgery, surgery requests for Māori customers are less likely to be declined due to a lack of a causal link between the surgery and the covered injury than other groups (no causal link serving as a proxy for pre-existing or degenerative conditions). The decline rate due to no causal link was 11 percent for Māori clients in 2018, compared to 16 percent for European patients and 15 percent for Asian patients.

10.3 Previous research has indicated that Māori clients are less likely to be referred for elective surgery than non-Māori clients.[9] This indicates that the rates of approvals and declines once a request is received by ACC cannot give a complete picture of whether or not there are systemic issues with Māori access to services due to degeneration.

11 Communications Approach

11.1 We intend to provide a high-level summary of outcomes and next steps to those who have been consulted in developing this Board paper, including the Older Person's Advisory Panel and the New Zealand Orthopaedic Association.

11.2 No further communications are proposed at this point.

[9] Wren, Dr J (2015) *Evidence for Māori under-utilisation of ACC funded treatment and rehabilitation support services, ACC.* The High-Tech Imaging Proof of Concept has delivered improvements in referrals of Māori clients to high-tech imaging, particularly in the 15-34 year age group

12 Recommendations

12.1 It is recommended that the ACC Board:

Note Our clients and providers have reported challenges with ACC's approach to the provision of entitlements for the consequences of degenerative conditions;

Note ACC has conducted inquiries and analysis to better understand the problems faced by clients and providers, and explored opportunities to address the feedback we have received;

Note Existing legislative settings do not enable cover to be provided for injuries caused by pre-existing degenerative conditions, however we have explored a range of possible legislative changes;

Note we have also identified changes that would improve the experience of clients and providers. A number of initiatives are planned or already underway, including those within the Integrated Change Investment Portfolio.

Written by:

9(2)(a)
Strategic Advisor - Governance

9(2)(a)
Senior Policy Advisor

Endorsed by:

[redacted]
Chief Governance Officer

[redacted]
Chief Customer Officer

Appendix 1

section 9(2)(h)

section 9(2)(h) [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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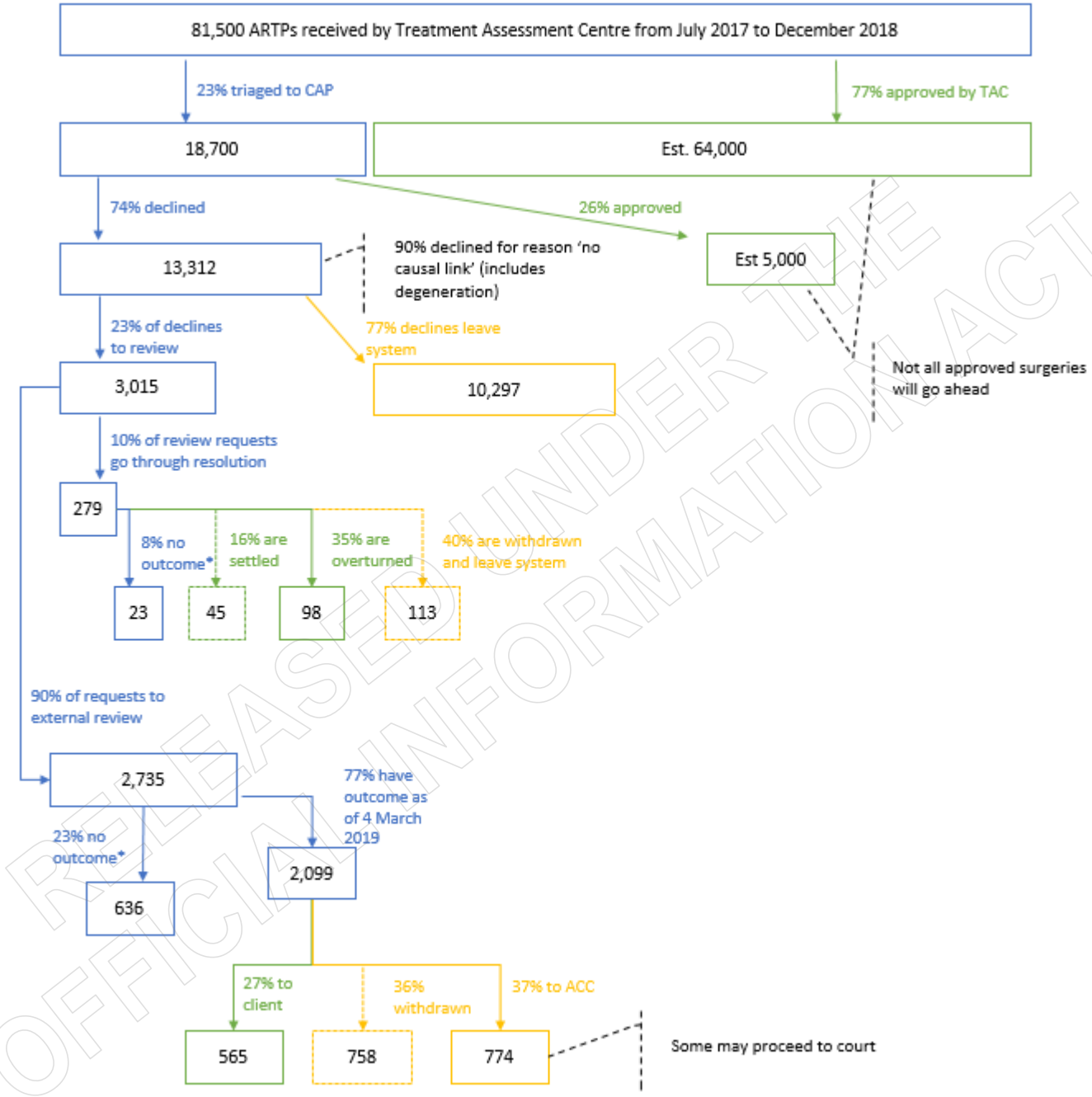
section 9(2)(h)

Appendix 2: Decision process and outcomes for elective surgery requests



*'No outcome' will change as cases are resolved. Data as at 4 March 2019

Appendix 3: Potential changes to current business practices

Option	Connection to other projects and priorities	Estimated timeframe to start
Make existing module on Causation available to a broader range of providers (currently only for contracted physiotherapists and hand therapists).	Health Services Strategy	Shorter
Revise cover letter to include the covered injury and better manage expectations about entitlements.	Customer Feedback Strategy	Shorter
Develop a client-focused information sheet on how age-related diseases fit within Accident Compensation scheme.	Health Services Strategy	Shorter
Explore other initiatives within Primary Health Care such as 'Active Rehabilitation' to support more conservative Injury pathways.	Health Services Strategy	Shorter
Develop purchasing guidance on appropriateness of interventions where a client already has degeneration.	Health Services Strategy	Shorter
Work with MoH to support a better 'handover' to the public health system.	Health Services Strategy	Shorter
Continue analysis of elective surgery decisions that proceed to formal review.	BAU post-Miriam Dean Review	Shorter
Make it easier for providers and clients to update diagnoses of covered injuries, and for diagnoses to be accessible to relevant physicians.	Dependant on Transformation changes.	Medium Already available for clients through My ACC
Capture more accurate information on initial diagnosis through the use of SNOMED codes.	Dependant on Transformation changes.	Medium
Develop and use improved analytics to identify cohorts likely to be impacted by degeneration, and provide relevant information.	Analytics 2.0	Medium
Develop a module for providers on ACC processes and rules around age-related conditions, including case law and the expectations ACC has of providers.	Health Services Strategy	Medium
Use PROMs/PREMs as part of the clinical decision-making process, in addition to imaging and surgeon report	Health Outcomes Framework Health Services Strategy	Medium
Build relationship with General Practice to support clients with degenerative conditions, bringing them 'into the loop' on decisions.	Health Services Strategy: GP Connect	Medium
Better record keeping of 'degeneration' as a reason for a request to be declined.	EOS 8.8 Upgrade	Medium: currently under discussion to bring forward.

Shorter	Medium	Longer
Less than 6 months	6-24 months	Longer than 2 years

Option	Connection to other projects and priorities	Estimated timeframe to start
Improved customer analytics could be used to identify cohorts likely to be impacted, and to provide relevant information (e.g. targeted provision on degeneration).	Customer Feedback Strategy Analytics 2.0	Medium
Establish ability for providers to include a working diagnosis in initial lodgement.	Dependant on Transformation changes.	Longer
Allow Clinical Advisory Panel to deliver findings of 'ambiguous' or 'not certain' on elective surgery requests and allow case managers to consider other factors for final decision.	Not yet scoped.	Longer

Shorter	Medium	Longer
Less than 6 months	6-24 months	Longer than 2 years

Excerpt from Board meeting minutes dated 30 May 2019

6.4 Degenerative conditions within the Accident Compensation scheme

[redacted] summarised the paper, and highlighted the following three matters:

- Operational changes and the extent to which communication with providers could resolve unhappiness in the system (managing expectations). The Board suggested that ACC's approach was inconsistent. If providers had clarity on what ACC could and could not cover, they would be more supportive. Providing feedback to the referrer when ACC rejected a claim would help significantly. In response to a Board query as to why ACC did not provide statistics to providers to show how their referrals related to their peers', 9(2)(a) [redacted] agreed to check how quickly this could be implemented. The Board also asked whether the 6-24 month timeframe referred to in the Appendix for resolving operational changes could be narrowed down further.
- Legislation Change – the Board left this discussion for a later date.
- Working together with DHBs to manage workflow. The Board discussed that, while it seemed attractive, in practice there were quite different levels of care between the entitlement system of ACC and the rationed care in the general health system.

The Board asked Management to consider how much angst would be removed from the system if all the operational changes proposed in the Appendix to the paper were resolved: if 90%, then there was the solution; if 10%, then it left a lot more to be done. [redacted] responded that interviews with providers indicated that if access to elective surgery in the health system was better, a lot of the issue would go away.

ACTIONS: Management to—

- Provide an update on the progress of the operational improvements at a future Board meeting.
- Provide an update on progress with Degeneration to a future Board meeting.

RESOLVED: The ACC Board resolved to:

(a) **Note** Our clients and providers have reported challenges with ACC's approach to the provision of entitlements for the consequences of degenerative conditions.

(b) **Note** ACC has conducted inquiries and analysis to better understand the problems faced by clients and providers, and explored opportunities to address the feedback we have received.

(c) **Note** Existing legislative settings do not enable cover to be provided for injuries caused by pre-existing degenerative conditions, however we have explored a range of possible legislative changes.

(d) **Note** we have also identified changes that would improve the experience of clients and providers. A number of initiatives are planned or already underway, including those within the Integrated Change Investment Portfolio.