He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Primary and secondary care joint market engagement – 29 May 2025

Questions and Answers

These questions were asked during our primary and secondary care joint market online engagement events on 29 May 2025. The event was held at 12 pm and 6 pm. If you don't find an answer to your question, or have further questions, email us at engage.primarycare@acc.co.nz or engage.secondarycare@acc.co.nz.

Find out more on ACC's website: www.acc.co.nz/health-sector-engagement

Topics

Issues impacting recovery rates

Could the increase in people remaining on weekly compensation be related to ACC changing their system processes, and high staff turnover?
We acknowledge that our case management model has had an impact on recovery rates and weekly compensation. To address this, we've recently changed our case management model. Now, kiritaki (clients) with injuries requiring weekly compensation will have a dedicated one-to-one case manager to build trust and consistency. Our case managers receive additional training to ensure cohesive messaging and expectations across all parties involved in recovery efforts.

We also know:

- More people are going onto weekly compensation, they are spending longer on weekly compensation, and they are taking longer to return to work than they were previously. This suggests that there are likely to be other factors at play

- Medical certificates are being written for longer periods and we're seeing an increase in fully unfit to work certificates compared to those for selected work (find out more about certification on our website: www.acc.co.nz/issuing-medical-certificates)
- Movements in macro-economic factors are key drivers of new claim volumes. There is strong correlation with four factors: population growth, gross domestic product (GDP), unemployment rate, and distance driven. Despite this, the increase in new weekly compensation claims has grown at a higher rate than new claims growth over the last few years.

Are you considering expanding who can sign off medical certificates? This would remove some burden from our already stretched GP colleagues.
We acknowledge that medical certification contributes to the challenges we're focusing on. Changes to who can sign off medical certificates would require legislative change and therefore take considerable time, resources and a different approach. At this stage, we're looking to work within our current legislative boundaries to solve challenges and help drive improvement in our rehabilitation rates for injured New Zealanders.

I find a key barrier is there is an early return to work plan, but GPs are not approving it due to the client not wanting to work. How do we improve this?
We understand there are many factors that can influence recovery at work for kiritaki. In response to this we updated our medical certificate definitions in 2023 to make it easier to select the right certification for your patient. As we developed these we consulted with the Medical Council of New Zealand (MCNZ), and they were supportive of these new definitions and have reflected similar messaging in their updated official position statement on medical certification, published in August 2023.

We've also been working over the last three years to engage with providers, employers and kiritaki around recovery at work, including promotional activity and providing improved information and resources to build understanding of what it means to recover at work and highlight the benefits. As part of this, we worked with a group of GPs and our internal clinical staff to develop a handout for clients to support GPs to have conversations with their patients.

Building awareness and understanding of recovery at work remains a priority for ACC and we would welcome any ideas you have to further support GPs with this challenge.

As clinicians we are seeing more chronic conditions requiring support for returning to work. What are you doing to prevent people's injuries from becoming more complex due to being off work?

We recently changed our case management model. Now, clients with injuries which are impacting on their ability to work will have a dedicated one-to-one case manager to build trust and consistency. The reason we're doing this work is we know how harmful it is to be off work for extended periods of time, and we want to prevent this from happening. That's why it's important we develop a model which ensures our clients can access the right support at the right time. We will also have a key focus on supporting recovery at work initiatives for our kiritaki.

Our kiritaki have experienced significant growth in time waiting to see a specialist and waits for high tech imaging. Do you think these long waiting times could be contributing to the increased time kiritaki are being signed off work?

There are multiple factors that are impacting on this growth and people staying on the scheme and away from work longer. There are significant workforce constraints between primary and secondary care and an increase in patient complexity.

We also know that there's some work that needs to be done to develop standards around triaging referrals, as we know not all clients need to be referred for surgical specialists. If we do this properly and we have pathways that are built on clinical evidence and best practice, this should help reduce the pressure and increase capacity for specialist referrals and imaging.

What is the reason case managers keep changing for kiritaki when someone has to start over and over with new case managers?

We acknowledge this is a genuine concern and are actively working to reduce this. While changes are sometimes necessary to align expertise with evolving kiritaki needs, in these situations we do our best to minimise disruption to rehabilitation. We're focusing on improving consistency through enhanced workload management, capability development, and more stable case assignment models.

External Reference Group and Clinical Advisory Group

How will you manage conflicts of interest if the reference group is reviewing the feasibility of proposals?
All advisory group members are required to declare any conflicts of interest and sign conflicts of interest forms. The External Reference Group and Clinical Advisory Group will not have decision making powers and won't be involved in the procurement process.

How did you select the members of the Primary Care External Reference Group?
We received an excellent response from the sector, including a range of clinicians and leaders in the primary care sector. Selection of members was completed by a panel who considered each application against strict criteria, including the roles outlined in the expression of interest form. It's important to us that this group is made up of a diverse range of professionals from across the primary care sector, which is reflected by the selected representatives.

What is the role of the Secondary Care Clinical Advisory Group?
The Clinical Advisory Group will provide guidance on potential solutions to improve recovery outcomes for people who have a musculoskeletal injury.

They will focus on topics like:

- referrals into secondary care
- care pathways
- measuring outcomes
- clinical governance

Are you expecting any specific crossover of members between the primary and secondary groups or is managing crossover done by ACC?
There are no members of the primary and secondary care advisory groups who sit on both groups. There are, however, topics that we expect to be discussed at both working groups, such as referrals and escalation between primary and secondary care. We intend to ask both groups for guidance on these areas.

Is the external reference group locked or can a new entrant who missed the commencement of this initiative still join?
Selection of the Primary Care External Reference Group members is now complete. However, there will be other opportunities to engage in this work. We will keep you updated through our Provider Update newsletter.

Integrated Care Pathways Musculoskeletal (ICPMSK)

The pathway you're talking about sounds like ICPMSK. What's going to happen with ICPMSK?
Integrated Care Pathways Musculoskeletal (ICPMSK) is for clients with an injury to the knee, back, or shoulder who need interdisciplinary rehabilitation and are likely to require surgery. Entry is limited to around 20 diagnoses. The scope we're considering for this work includes all musculoskeletal injuries. The ICPMSK contract expires in 2028. The future of the contract will depend on the outcomes achieved for our kiritaki against a broader picture of the benefits it delivers for ACC.

Can you share what MSK injuries are impacting you the most (eg duration, cost, impairment, slow return to work)?
Our challenge is broadly across all MSK injuries, with more kiritaki receiving weekly compensation and staying on weekly compensation for longer. In particular, soft tissue injuries make up an increasing share of weekly compensation volumes.

What are the key measures of success for ICPMSK?
We measure a variety of things to determine the value that ICPMSK delivers. The key measures of success at a service level include clinical outcomes, the patient reported experience and outcome measures, the weekly compensation savings achieved and service costs within defined benchmarks as well as the rates of re injury and subsequent surgery.

What are you doing to monitor changes in referral behaviours, especially MSK, within referrer-owned high-tech imaging practices, compared to radiology-owned practices?
We monitor High Tech Imaging Service volumes and who makes referrals. Where variation is

identified, our teams will work with suppliers to understand why. If appropriate, they will address any contractual issues.

Where there is a conflict of interest, suppliers have a management plan in place.

Our High Tech Imaging Services contract is an open contract (anyone can apply to hold it if they meet the application criteria) and it does not guarantee referral volumes.

About this work

How will the kiritaki voice be incorporated into the engage and design work?
We agree it's important to incorporate input and insights from kiritaki into the design of any new delivery or funding models. We're fortunate we have a considerable amount of kiritaki insights available to us, including from the primary acute care review, the ICPMSK design process and our regular client surveys, so that's a great starting point. We have work underway to determine how we'll incorporate the kiritaki experience and voice through this design process; we'll be able to share more about that in future updates.

If you're looking at designing new models of care, is there a risk that some of us service providers will lose income?
The purpose of designing new funding and delivery models is to reshape the strategic investment in both the primary and secondary care sectors over the coming years. We don't want our interactions with you to be in the same transactional manner they are today, ie. through contracts and unit pricing mechanisms. We want to collaborate with you on interventions that are going to improve recovery outcomes for kiritaki and then align our investments to those interventions. While that might mean that there are changes for suppliers, we'll share our thinking with you at every stage.

Do you have a budget for the delivery of solutions initiatives?
ACC is using the information gathered from the Request for Information to help inform and validate our thinking for future design work in primary and secondary care. We will continue to engage with the sector as this design work progresses, including through the External Reference Group and Clinical Advisory Group. Any future contract opportunities that result from the work will be advertised on the Government Electronic Tendering Service (GETS) and follow the government procurement rules and processes.

Can you please clarify whom you consider as 'primary care' as it seems as though a lot of focus in this space has been towards medical type professionals as opposed to allied health equivalents who hold a critical role within primary care?
When we refer to primary care, we're not only referring to general practice and nursing. We are referring to a broad spectrum of health providers who work in primary care. For example, allied health, dental, pharmacy, occupational health and others.

Can you provide an overview of the "two flagship" programmes and the 20-30 contracts impacted by these programmes?
The term 'flagship initiatives' is a name we're using internally within ACC to refer to the collective work we're doing with the health sector to innovate and find better ways of working together to improve client recovery outcomes – ie. getting people back to work and independence faster after an injury. More specifically, we're engaging with the sector to develop new delivery, data sharing and funding models for primary and secondary care services. This work is just beginning, and we don't know yet which contracts will be impacted. However, we'll be as transparent as possible as this work progresses.

What patient outcome data does ACC see as important and how can providers help provide that data?
The key areas we want to measure are:

- the experience of the client
- the functional outcomes that clients achieved
- return to work outcomes
- how quickly clients can access the services they need
- equity of access and outcomes, and
- return on investment (eg what outcomes were achieved and at what cost?).

We'd like to work with you to identify the most effective ways to measure whether the services are having the desired impact and what data is required to do that.

As part of Primary Care are you also considering the Community in Home Care providers who look after many kiritaki in their homes whilst recovering?

We recognise that Home and Community Support providers have an important role to play in the healthcare team and supporting our clients to recover from injury. We are interested in ideas that support better integration across primary and secondary care and the rehabilitation sector to improve client outcomes.

As many clients who access social rehabilitation services do not receive weekly compensation, we plan to engage directly with this sector in a similar way in early 2026 to explore improvements that could be made in this part of the rehabilitation system.

Has the referral from secondary care to GPs and allied health in primary care been considered?
Yes, a key focus of this work will be identifying solutions that support the safe and efficient sharing of client information between providers, along with better integration of our clients' end-to-end rehabilitation journey.

Will there be better integration with primary/secondary care and pain services? rather than the pain services just being the ambulance at the bottom of the cliff?
We want to strengthen the integration between primary and secondary care services and develop new models of care where pain services are an integral part of the broader rehabilitation pathway. This includes fostering shared accountability across primary and secondary care to enable earlier intervention, reduce fragmentation, and ultimately improve outcomes for individuals experiencing chronic pain.

Services such as pain management should not function solely as reactive, last-resort interventions. Instead, they should be embedded earlier and more proactively within the care journey.

As a certifying doctor why can't we get regular feedback on our certifying practices compared to the national average for example? That would really help us to understand our practice and would make a big impact on our perception of our practice and where we sit.
We are actively working on a solution that will allow us to share return to work data to all clinicians who are certifying people off work. This will allow you to see how you compare to your peers, and how you compare for different cohorts and demographics. This will help your

clinical practice to peer review and to understand your practice in more detail. We hope to have this available by the end of 2025.

Is it the priority of the ACC to accelerate early intervention for medical care/treatment to avoid secondary psychological injuries?
We are committed to ensuring our kiritaki receive the right interventions, at the right times, preventing and reducing the impacts of their injury.