What has ACC made possible for rehabilitation in NZ, and what are some of the possible unintended consequences?

Associate Professor Nicola Kayes
2004, Professor of Rehabilitation

2017, Multidisciplinary team

- Rehabilitation
- Health, Social and Clinical Psychology
- Physiotherapy
- Speech and Language
- Occupational Therapy
- Nursing
- Sociology
- Medical Anthropology
- Disability
Three core interrelated purposes

• Rethinking rehabilitation
• Embedding person-centredness
• Making a difference
Relationship with ACC?

- Research
- Consultancy
- Education
  - Rehabilitation providers
  - ACC Case managers
What has ACC made possible for rehabilitation in NZ?
ACC causing 'unacceptable harm' to many rejected, legitimate claimants each year, research finds

CECILE MEIER
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Scott Nichols, who had to fight ACC for back-injury cover, does his back exercises on the floor at home while his wife Monique watches television.

Hundreds of thousands of injured Kiwis are declined cover each year by ACC, causing "unacceptable harm" to many legitimate claimants, according to new research.

Injured people who have been denied cover "find themselves pitted against a huge, billion-dollar specialist Crown agency", the Law Foundation and University of Otago-backed report said.

The report, published on Tuesday, calls for the establishment of a personal injury commissioner to help people navigate the Accident Compensation Corporation's (ACC) "incredibly complex and difficult" complaints process.
A world class system

• Colleagues around the world are blown away by ACC and what that makes possible!

• Access to healthcare following injury, particularly in the acute phase is hard to beat when compared with other similar systems globally

• Claimants and stakeholders acknowledge the unique opportunities for rehabilitation made possible within our no fault compensation system (McPherson et al., 2007)

• ACC has the potential to be a global leader in the development and implementation of evidence-based rehabilitation

• Uniquely placed to work across the multidisciplinary team, including all key stakeholders
Building rehabilitation capability

• Vocational rehabilitation pathway
• Rehabilitation research review
• Case management education
I have worked harder FOR my clients. I am no longer doing rehab to the client, they are now involved.

Implications for case management practice

- Enhance case management practice and client outcomes
- Support the establishment of case management as a valued profession
- Allow for progression to research degrees, facilitating knowledge advance in the field
Advancing rehabilitation practice

• Putting rehabilitation on the map
• Service specifications
• TBI Pathways collaborative
What are some of the possible unintended consequences?
Some reflections....

1) The blurry edges: Establishing entitlements
2) ‘People before process’ or does process prevail?
3) What about the other half?
1) The blurry edges: Establishing entitlement
Working with complexity

• Acute services relatively straightforward
• However, most service provision is set up based on the assumption of a normative trajectory
Assumed trajectory

The reality

(Czuba et al., 2017)
Working with complexity

- Acute services relatively straightforward
- Most services are set up based on the assumption of a normative trajectory
- Barriers experienced when recovery does not follow assumed pathway
“People think oh well you look alright. My sister through there. . .
that’s what she said ‘but you look alright . . . what’s wrong with you?’
you know ‘why aren’t you feeling better? But I’m sure you must be a
lot better cos you look better’ and I’d say ‘but I’m not . . . I’m
absolutely exhausted’” (PwMildTBI)

(Czuba et al., 2017)
Working with complexity

• Acute services relatively straightforward
• Most services are set up based on the assumption of a normative trajectory
• Barriers experienced when recovery does not follow assumed pathway
• Successful outcome routinely relies on hidden privileges
“The biggest bonus would be the people, would be people, would be the nurses at the spinal unit. If you get good nurses and good doctors around you you’re, I would say it would double, triple your outlook on things, your, yeah they certainly affect your mood and your, and of course once again if you’ve got good staff around you then you’re getting that information and knowledge as well so it’s helping, it’s a twofold thing. But I think that’s what, that’s what helped pull me through. I’ve also got good family and also probably the friends I made in there as well and that I’m still friends with now. You know that includes the TASC group, so all of those people collectively just being I suppose friendly and helpful and informative helps pull you through dealing with all of the rubbish we’ve got to deal with.”

(PwSCI)

(Czuba et al., 2017)
Working with complexity

- Acute services relatively straightforward
- Most services are set up based on the assumption of a normative trajectory
- Barriers experienced when recovery does not follow assumed pathway
- Successful outcome routinely relies on hidden privileges
- Complexity not well addressed e.g.
  - Multimorbidity
  - Psychosocial factors
a) Multi-morbidity

• People with multimorbidity are 3.5 times more likely to have problems with activities of daily living and 6 times more likely to have physical function limitations than those without chronic diseases (Williams et al., 2016)

• The costs of health care are 2.5 times higher for those with multimorbidity compared to people with a single disease (Picco et al., 2016)

• People with multimorbidity have described the experience of health care as ‘overwhelming, draining and complicated’ and that care is fragmented, ‘like being split into pieces’ (Ploeg et al., 2017)
Closer to home?

• Prospective outcomes of injury study found co-morbidities to impact outcome from injury (Derrett et al.)

• Comorbidity at time of injury related to significantly worse outcomes at 12 months for people following major trauma (Czuba et al., 2017)
b) Psychosocial factors

“There was no education, nothing for the kids to say look, you know, this is what’s happened to your dad. He’s gonna get right. None of that. I got turfed out of hospital and ‘you’re an out-patient now, good luck’ that’s all we saw [....] A bit of psychology, bit of counselling would have gone a hell of a long way. I mean, I cos, again I had to develop all the strategies for me to function with my family, with my friends, with people.” (Following major trauma)

“I don’t think doctors and just everybody [usually] understand how you feel and what kind of things you’ve gone through with head injuries. It really messes with you and just changes everything [ . . . ]” (PwTBI)

(Czuba et al., 2017)
e.g. Depression and Vocational rehabilitation

- Dersh et al. 2007
  - n= 1323 chronic disabling occupational spinal disorders
  - Five times as many people developed Major depressive disorder for the first time after injury

- Franche et al. 2009
  - Lost time compensation for work-related musculoskeletal injury
  - n=599 (1 mth) and n=430 (6 mths) post-injury
  - High depressive symptoms 42.9% (1 mth) and 26.5% (6 mths)
  - 38.6% of workers who had not RTW at 6 mths or had recurrences had high depressive symptoms vs 17.7% who sustained RTW

- O’Hagan et al. 2012
  - n=494 injured workers
  - Post injury onset of mental health problems elevated compared to pre injury onset
So...

• Navigating the often fragmented and complex system can exacerbate suffering
• Need structures and processes in place that ensure access to optimal recovery does not rely on people alone
• Existing siloed funding structures fail to manage complexity well
• Whether pre-existing or not, psychosocial factors have the potential to impact outcome for people following injury
• A more active, explicit and integrated engagement with psychosocial factors is necessary and may yield greater cost-benefit in the long term
Some reflections....

1) The blurry edges: Establishing entitlements
2) ‘People before process’ or does process prevail?
3) What about the other half?
2: ‘People before process’ or does process prevail?

ACC's pendulum is swinging the right direction, advocates say

TOM PULLAR-STRECKER
Last updated 16:42, March 4 2016

ACC boss Scott Pickering says it will be a couple of years before work to better harness its "mountain of information" kicks off.

ACC is moving in the right direction by pushing ahead with a $456 million overhaul, people dealing with the state-owned insurer say.

Spinal Trust chief executive Ben Lucas, who chairs ACC's serious injury advisory group, said there was always going to be apprehension about changes.
Case managers

• A tension between delivering on person centred practice (PCP) in the legislative context

• Key performance indicators frequently act in conflict with PCP:
  • Timeframes
  • Compliance

• Leads to transactional versus interactional engagement with claimants

• Frequently constrained by the possibility of review in the future
Health providers

• Perceive ACC requirements to limit their ability to function in a truly person-centred way
  • Reporting requirements
  • ACC goals vs patient goals

• Feel constrained in their ability to draw on their own clinical reasoning

• Struggle to navigate the boundaries of ‘ACC as client’ or ‘patient as client’
In reality...

- ACC, necessarily, a process-heavy organisation
- Complex system often reliant on subjective decisions of individuals
- Legislative context potentially contributes to a transactional approach
- Potential for ACC to have undue influence over how rehabilitation is delivered
  - Pros and cons!!
Some reflections....

1) The blurry edges: Establishing entitlements
2) ‘People before process’ or does process prevail?
3) What about the other half?
3) What about the other half?

- Major gap between injury versus illness in NZ
- E.g. Traumatic Brain Injury versus stroke impacts access to:
  - Rehabilitation beyond acute phase
  - Housing modifications
  - Care needs
  - Social rehabilitation
  - Vocational rehabilitation
  - Weekly compensation
Beyond Woodhouse: Devising New Principles for Determining ACC Boundary Issues

Ken Oliphant

This paper argues that there is a need to identify new, mid-level principles that provide guidance as to how to draw the boundaries of ACC for as long as it remains a scheme of limited scope. The Woodhouse principles are not suited to this task as they point towards a universal scheme, embracing both injury and illness. The author believes that it is necessary to adopt a principled approach to what is included in ACC and what is left outside. The paper concludes by suggesting that these new principles should be based on a consideration of the nature of the dual public/private responsibility for incapacity and that where the question, "is it legitimate to leave this category of incapacity to the private sphere?" is answered negatively, there is a case for extending the scope of ACC coverage, even if this means transgressing the boundary between injury and illness.

1 Introduction

The boundary issues I am concerned with are summarised in the following question: Which injuries or incapacities are best covered by ACC, and which may reasonably be left outside the scheme? I believe that a principled approach to such questions is necessary, but that the relevant principles have not been subjected to sufficient critical examination in recent times. My starting point is that the Woodhouse principles, despite their critical role in the establishment of the scheme and their undeniable iconic status, cannot serve as the foundation for today's ACC. They point towards a universal scheme, embracing both injury and illness, not a scheme limited by and large to the former. Accordingly, they can provide little assistance in determining where the boundaries of a limited scheme are best drawn. As a consequence, the dividing line between (compensable) injury and (non-compensable) illness has assumed a significance that it does not warrant, and the consequent "accident focus" has effectively precluded the selective extension of ACC rights into the

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Oliphant argues...

- Woodhouse principles of *community responsibility* and *comprehensive entitlement* do not distinguish between injury and illness.
- Numerous attempts to expand the scheme have been largely thwarted due to cost or necessary changes to entitlement.
- The woodhouse principles don’t in themselves offer useful guidance on the boundary issue in the context of a limited scheme.
- Proposes a principle-based approach to determine the boundaries.
In summary

• ACC contributes to increased access, capability and knowledge advance in rehabilitation

• Looked on globally as a one-of-a-kind, world class system

• But, a range of complexities hamper the operationalisation of optimal rehabilitation practices
  • Particularly over time, in the context of enduring impact on individuals and whānau

• Important to note that these complexities are not isolated to ACC, but rather are reflective of system-wide issues that we need to tackle
References


