MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HIKINA WHAKATUTUKI

Targeted consultation paper

Proposed changes to ACC Cost of Treatment and Definitions Regulations

April 2026

newzealand.govt.nz

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How to have your say

Submissions process

On behalf of the Minister for ACC, the Ministry of Business, Innovation & Employment (MBIE) seeks written submissions from selected stakeholders on the changes proposed in this document by **1 May 2026.**

The document discusses two packages of proposed amendments to the *Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003* and *Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010* (collectively referred to as the Cost of Treatment Regulations), and the *Accident Compensation (Definitions) Regulations 2019.*

Please respond only to the questions that are relevant to you. Where possible, please include evidence to support your views, for example, references to independent research, facts and figures, or relevant examples.

Please respond to the following email address and also direct any questions that you have on the submissions process to: ***ACregs@mbie.govt.nz***

Use of information

The information provided in submissions will be used to inform MBIE's policy development process and will inform advice to Ministers on the proposed changes to the relevant regulations. We may contact submitters directly if we require clarification of any matters in submissions.

Release of information

A high-level summary of submissions is likely to be included in the proactive release of the Cabinet paper that seeks decisions on the proposals discussed in the paper.

Your submission will also be subject to request under the Official Information Act 1982 (OIA) so please indicate what information, if any, in your submission that you do not want published because you consider it to be confidential or commercially sensitive. Please provide justification for your claims. The more justification you can provide about any information you want withheld, the easier it will be for MBIE to respond to any OIA requests. We will consult with submitters when responding to OIA requests if we are considering releasing more material than you have agreed to be published.

Private information

The Privacy Act 2020 establishes certain principles regarding the collection, use and disclosure of information about individuals by various agencies, including MBIE. Any personal information you supply to MBIE in your submission will only be used for the purpose of assisting in the development of policy advice in relation to this review.

As indicated above, please indicate if you do not wish your name, or any other personal information, to be published with your submission. This will also apply to any summary of submissions that MBIE may publish.

We may share your information with ACC, in accordance with the Privacy Act 2020 or as otherwise required or permitted by law.

We will keep your information safe by storing it in MBIE's electronic filing system which can only be accessed by authorised staff.

You have the right to ask for a copy of any personal information we hold about you, and to ask for it to be corrected if you think it is wrong. To do this, please contact us at ACregs@mbie.govt.nz.

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Executive summary

On behalf of the Minister for ACC, the Ministry of Business, Innovation & Employment (MBIE) is undertaking targeted consultation on proposed changes to regulations made under the *Accident Compensation Act 2001*. The proposed changes include:

- increasing regulated payment rates in the Cost of Treatment Regulations to respond to inflationary pressures (section 2)
- making the following seven minor amendments to the Cost of Treatment Regulations to improve their clarity, fairness, or effectiveness (section 3):
    - add rates for services already being provided by treatment providers on a non-contract basis that are within coverage of the Cost of Treatment Regulations
    - clarify that consultations provided under the Cost of Treatment Regulations can be provided via telehealth
    - revise the methodology for calculating the rate for a combined nurse and nurse practitioner consultation to make it fairer
    - add new combined rates for paramedics when they are working with other practitioners, similar to the existing combined rates for nurse/nurse practitioners and nurse/medical practitioners
    - clarify that even where no treatment specified in the Schedule is provided during a consultation, the consultation rate applies
    - add an invoicing time limit of six months for treatment provided under the Cost of Treatment Regulations
    - amend the relevant wording in the Cost of Treatment Regulations to recognise vocationally trained GPs as specialist GPs.
- amending the *Accident Compensation (Definitions) Regulations 2019* to add:
    - physician associates as registered health professionals (section 4)
    - oral health therapists and dental therapists as treatment providers (section 4)

We invite feedback on the proposals from you as a stakeholder who may be affected. Specific questions for which we seek feedback are posed at the end of each of sections 2 to 4 in the document. The feedback will be used to inform the final recommendations to the Minister.

Process and timeline

The anticipated timeline for the consultation process is set out below.

1 Introduction

Background

Regulations specify the ACC contribution to treatment cost

1. ACC pays, or contributes towards, the cost of treating and rehabilitating claimants who have been injured. These payments are set through contracts with treatment providers, prescribed under regulations, or set at an appropriate agreed amount if not covered by regulation or contract. In the 2024/25 year, ACC spent $1.532 billion on treatment where the cost was set by contract and $463 million on treatment where the cost was set by regulation.

2. The *Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003* and *Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010* (together known as the Cost of Treatment Regulations) are the regulations that set the payments that can be made to providers, by ACC on behalf of the claimant, for specified treatments. The Cost of Treatment Regulations help contain Accident Compensation Scheme (AC Scheme) costs by capping the amount paid per treatment and tend to cover treatment for less complex injuries.

Regulations specify which medical professionals can provide treatment and get treatment injury coverage

3. Regulations specify which health professionals can provide ACC-funded treatment so that:

    - treatment providers are properly qualified to provide safe, good quality treatment
    - the type of treatment provided is likely to be effective at rehabilitating injured claimants
    - treatment providers have certainty and consistency about what is required of them
    - there is alignment with the health sector where appropriate.

4. Since 2019, the health professionals who can provide ACC-funded treatment have been defined as ‘treatment providers’ by the *Accident Compensation (Definitions) Regulations 2019* (Definitions Regulations). The Definitions Regulations define each type of health professional it regulates and specifies their required professional accreditation.

5. In addition, the Definitions Regulations define the health professionals covered by the treatment injury provisions of the *Accident Compensation Act 2001* (AC Act) as ‘registered health professionals’ (RHPs). A treatment injury is an injury caused by the treatment received from an RHP, where that injury is not a necessary part or ordinary consequence of the treatment.

6. Generally, where a health professional is not an RHP, or under the supervision of an RHP, any injuries resulting from treatment would be considered under the standard personal-injury-caused-by-accident provisions. However, treatment injuries can include particular injuries which would not be covered under the standard injury provisions.

7. In New Zealand, health professional competence requirements are generally imposed by the *Health Practitioners Competence Assurance Act 2003* (HPCA Act). The Definitions Regulations generally reference these competence requirements.

Consultation must be undertaken before regulations can be changed

8. Before changes can be made to the Cost of Treatment Regulations or the Definitions Regulations, the Minister must consult the persons or organisations the Minister considers appropriate.

9. This document fulfils this purpose. MBIE, on behalf of the Minister for ACC, is setting out the proposed changes to regulations for consultation. The Minister considers the recipients of this document an appropriate person or organisation for consultation.

2 Proposed increases to regulated payment rates

Background

ACC must biennially review regulated payments

11. ACC has a statutory obligation under section 324A of the AC Act to review the payment rates specified in the Cost of Treatment Regulations every two years. The purpose of the review is to assess whether any adjustment to rates is required to take account of changes in the costs of rehabilitation. After completing the review, ACC must report to the Minister for ACC with its recommendations. The report may include alternative options ACC has considered.

12. ACC took the opportunity with its review due in December 2024 to also propose other changes to Cost of Treatment Regulations to clarify their intent, correct minor discrepancies and improve their effectiveness. These proposed changes are discussed in section 3.

13. The Minister for ACC may decide to amend ACC's recommendations to better fit the Government's policy objectives. However, the Minister must consult with appropriate parties before making any changes to the Cost of Treatment Regulations.

What is the policy problem addressed by having regulated payment rates?

14. The purpose of the Cost of Treatment Regulations is to help contain scheme costs by capping the amount per treatment that ACC contributes for various types of treatment needed by claimants.

15. The payment cap means that when claimants seek treatment from treatment providers receiving regulated payments, the claimant usually has to pay a co-payment to cover the difference between the provider's costs and the payment rate the provider receives. This co-payment is set by the treatment provider.

16. Having some level of co-payment for claimants discourages unnecessary use of ACC-funded services, particularly for treatment of non-acute soft-tissue injuries where there might be some ambiguity about how many treatments are required.

17. Co-payments also discourage cost escalation by encouraging competition between treatment providers on price. Treatment providers may also try to distinguish themselves by varying some aspect of how they deliver treatment.

18. A disadvantage of co-payments is that they may discourage claimants from seeking or completing needed treatment, potentially delaying recovery. Increased co-payments are likely to worsen this problem.

19. ACC funding via the Cost of Treatment regulations makes up a substantial portion of the revenue of some treatment providers in the allied health sector. That means that significant increases in payment rates could contribute to pushing up wages in the sector. There needs to be a balance between ensuring fair compensation for treatment providers and maintaining the long-term financial sustainability of the AC Scheme.

20. The significance of ACC funding in the allied health sector also means that constraining payment increases to this sector, rather than trying to mirror increased costs, incentivises organisations to seek efficiency gains through automation or better management practices to offset wage constraints.

What drives the cost of healthcare?

21. The main contributor to the cost of treating the injuries of claimants is the treatment provider labour costs.

22. There are various ways of estimating the changes in healthcare costs. These include examining changes in consumer prices shown by the Consumer Price Index (CPI) or the changes in labour cost shown by the Labour Cost Index (LCI).

23. The use of averages to estimate covered labour cost changes is not as accurate as tracking the pay increases of the various occupational groups in the health sector. For recent reviews of regulated pricing ACC referenced the Multi-Employer Collective Agreements (MECAs) that the former District Health Boards (DHBs) used to set the remuneration of their health professionals. In those reviews MECA based salary scale movements were referenced as contextual labour market signals to inform ACC's understanding of cost pressures, rather than being automatically or mechanically embedded in price adjustments.

24. For its 2024 review, ACC calculated provider-specific percentage increases in labour rates, based on MECA increases (some of which incorporated pay equity settlements) for the two-year period (July 2022 to June 2024). The increases observed using this approach ranged from 8.83% to 12.22%, with a weighted average of 9.45%.

What options for payment increases are being considered?

25. Officials considered various options for increasing regulated treatment payments to account for increases in the cost of rehabilitation and other relevant contextual changes. The following three options were chosen for this consultation:

    a. leave rates unchanged

    b. apply a blanket percentage increase of 9.45% to all regulated treatment rates to reflect the weighted average of employer collective agreement increases for the two-year period (July 2022 to June 2024)

    c. apply a blanket increase of 4.7% to all regulated treatment rates (which is approximately half of the increase proposed in option b) to support the AC Scheme's long-term sustainability **(*Minister's preferred option*)**.

What are the policy objectives?

26. To assess the options for adjusting regulated payments we applied the following policy objectives:

    - claimants are able to access appropriate treatment, meaning co-payments should be affordable
    - costs to ACC are sustainable
    - differences in payments between the health and ACC systems are minimised.

27. We have assessed each option against the policy objectives below.

Option A: Leave rates unchanged

28. Making no upwards adjustment to take account of the cost pressures faced by treatment providers increases the risk that providers will raise co-payment charges. Raised co-payment charges will likely reduce the ability of some claimants to access treatment.

29. Leaving payment rates unchanged would save ACC money in the short term. However, given the previously demonstrated cost pressures coming from sector wage increases leading up to the 2024 review, even larger increases in payment rates would likely be sought at the next review.

30. Treatment providers that provide both health sector and ACC funded services, like general practice clinics, would face increased cost pressures if they want to keep consultation fees for both sets of services similar, including the expected free consultations for under 14s.

Option B: A blanket percentage increase of 9.45% in all treatment rates, based on increases in labour rates

31. This option provides the most tailored estimate of how much regulated rates could be raised to compensate treatment providers for increased costs, based on the weighted average of health sector collective agreement increases for the two-year period (July 2022 to June 2024).

32. An increase of 9.45% is reasonably large and would place further pressure on ACC's long-term financial sustainability. It may also negatively impact ACC's work to improve its performance as part of its Turnaround Plan.

33. ACC notes that the costs of Allied Health services, for example, have consistently grown above population growth, driven by increased client volumes and higher prices. A significant increase in regulated rates at this time could encourage continued over-treatment of low complexity injuries, placing more pressure on AC Scheme sustainability.

34. A significant increase in funding to the allied health sector would also place upward pressure on wages across the whole sector, given the significance of ACC's funding of the sector. It would also reduce pressure on the allied health sector to innovate.

35. However, a more significant increase would help to ensure differences in payment rates between the health and ACC systems are minimised where similar services are being offered, like in general practice clinics.

36. A more significant increase would also mean it is also less likely that providers would raise co-payments, which would help maintain access for claimants and promote rehabilitation.

Option C: A blanket increase of 4.7%

37. A blanket increase of 4.7% increase is approximately half the relatively large increase proposed in Option B.

38. The AC Scheme is currently under significant financial strain with costs rising at a much faster rate than levies. This lower increase would respond to the AC Scheme's financial pressures and support its long-term sustainability.

39. Not fully adjusting payment rates for increased labour costs may encourage innovation and increased productivity in the sector.

40. The lower increase would lessen the significant financial injection into the allied health sector and so place less upwards pressure on wages in that sector.

41. Similarly to Option A, this lesser increase is more likely to result in providers raising the co-payments they charge, which could restrict access for some claimants and negatively impact their rehabilitation.

42. Treatment providers who provide both health sector and ACC funded services may also face increased cost pressures if they want to keep consultation fees similar between ACC funded and health sector funded treatment. Alternatively, they may be forced to increase or create a differential in co-payments between the two types of treatment.

Question 2.1

Which of the options for increasing payment rates do you prefer? What is your justification?

Question 2.2

How would the preferred 4.7% increase to payment rates under option C affect providers and claimants?

3 Minor amendments to improve the Cost of Treatment Regulations

Background

43. While not required as part of the biennial review, ACC has identified and developed proposals for additional minor changes to the Cost of Treatment Regulations to improve their effectiveness and administrative efficiency, and correct discrepancies. There are seven proposals to address issues raised by providers, health sector groups, ACC and MBIE.

44. The proposals are to:

    a. add rates for services already being provided by treatment providers on a non-contract basis that could be covered by the Cost of Treatment Regulations

    b. clarify that consultations provided under the Cost of Treatment Regulations can be provided via telehealth

    c. revise the methodology for calculating the rate for a combined nurse and nurse practitioner consultation to make it fairer

    d. add two new combined rates for paramedics when they are working with other practitioners

    e. clarify that if during a general practice consultation, no specific treatment specified in the Schedule is provided, the initial rate is the consultation rate that applies

    f. add an invoicing time limit of 6-months for treatment provided under the Cost of Treatment Regulations

    g. explore options to amend the wording in the Cost of Treatment Regulations to recognise vocationally trained GPs as specialists, whilst maintaining current rates.

3.1 Add rates for services already being provided by treatment providers on a non-contract basis

45. ACC pays for treatment through a mixture of contracts, regulated rates (specified in the Cost of Treatment Regulations) and non-contracted rates (which are not in the Cost of Treatment Regulations).

46. ACC has identified a range of non-contracted dental rates that it would be appropriate to include in the Cost of Treatment Regulations.

47. The use of non-contracted rates can be problematic due to their lack of visibility. This includes the risk that non-contracted rates are not considered when uplifts are made to the Cost of Treatment Regulations rates (like those resulting from the mandatory two-yearly review cycle), leading to rates being inconsistent.

Proposal

48. We propose to amend the Cost of Treatment Regulations to add the set of dental treatments and rates listed in the table below. These additions will ensure the rates are regularly reviewed and easier to monitor.

Table 2: Treatments and rates to be added to the Cost of Treatment Regulations based on current non-contracted rates

Portfolio	Code to be added	Description	Current rate (before any increase)
Dental	DG18	Removal of plates, wires and screws	$437.19
	DX6	Lateral or antero-posterior head films	$69.07

Question 3.1

Do you agree that the Cost of Treatment Regulations should be amended to include the treatments and rates listed in the table above? If not, why not?

3.2 Clarify that consultations provided under the Cost of Treatment Regulations can be provided via telehealth

49. ACC covers consultations conducted via telehealth by a range of medical practitioners and other health professionals. Telehealth rates are included in some GP contracts, but there are also a reasonable number of treatment providers being funded for telehealth via non-contracted rates. The payment rates for telehealth consultations mirror those for in-person consultations, but are not explicitly included in the Cost of Treatment Regulations.

Proposal

50. We propose to amend the Cost of Treatment Regulations to make it explicit that the payment rates for consultations apply whether the consultation is in person or via telehealth (if telehealth is clinically appropriate in the circumstances). This will clarify ACC's current position and expected practice.

Question 3.2

Do you agree that the Cost of Treatment Regulations should be amended to clarify that consultations provided under the Cost of Treatment Regulations can be provided via telehealth if clinically appropriate? If not, why not?

3.3 Revise the methodology for calculating the rate for a combined nurse and nurse practitioner consultation to make it fairer

51. A rate for a combined nurse practitioner and nurse consultation was added to the Cost of Treatment Regulations following the 2020 review. This rate is meant to be equivalent to the existing combined rate for a medical practitioner (generally a GP) and nurse consultation. However, the combined rate for a nurse practitioner and nurse consultation is lower than the solo nurse practitioner consultation rate, while by comparison, the combined medical practitioner and nurse rate is higher than the solo medical practitioner rate.

Proposal

52. We propose to revise the methodology for calculating the combined nurse practitioner and nurse rate to match that used for the medical practitioner and nurse combined rate, which sets the combined medical practitioner and nurse rate at 104.76% of the solo medical practitioner rate.

Question 3.3

Do you agree with the revised methodology? Why do you support or not support this methodology?

3.4 Add new combined rates for paramedics when they are working with other practitioners

53. As a result of recent changes to the Definitions Regulations, and consequential amendments to the Cost of Treatment Regulations, paramedics are now able to invoice for treatment under the Cost of Treatment Regulations.

54. However, the Cost of Treatment Regulations do not include any combined payment rates that apply when a claimant is treated concurrently by both a paramedic and another health professional. Such combined rates already apply for combined treatment by a medical practitioner and nurse, and by a nurse practitioner and nurse.

Proposal

55. We propose to add two new combined treatment rates to apply when a claimant is treated concurrently by:

    a. a medical practitioner and paramedic

    b. a nurse practitioner and a paramedic.

56. An equivalent methodology to that used for the medical practitioner and nurse combined rate will apply to calculate the rate (which sets the combined rate at 104.76% of the solo medical practitioner rate).

Question 3.4

Do you agree that two new combined rates should be added for concurrent treatment by a medical practitioner and a paramedic, and concurrent treatment by a nurse practitioner and a paramedic? If not, why not?

3.5 Clarify that even if, during a general practice consultation, no specific treatment specified in the Schedule is provided, the initial consultation rate applies

57. This proposal seeks to clarify how ACC applies the Cost of Treatment Regulations when a claimant has a general practice consultation even if the claimant doesn't receive any treatment specified in the Schedule to the Cost of Treatment Regulations.

58. The Cost of Treatment Regulations specify the amounts that ACC is liable to pay for treatment by various health professionals. Sometimes the amount is specified in the Schedule to the regulations and sometimes the amount is specified in a specific clause in the regulations. However, for medical professionals employed in general practice, the body of the regulations specifies an amount payable, that can depend on the age and circumstances of claimant, (the initial rate) "plus the amount specified for any treatment the claimant receives". Various treatments and payment amounts are specified in the Schedule. However, there are actions that could be considered treatment that are not specified in the Schedule, like referral to another treatment provider, prescribing medication or the provision of a medical certificate. It is not clear that the Cost of Treatment Regulations cover these actions and that no extra payment is payable for their provision.

Proposal

59. We propose to amend the Cost of Treatment Regulations to confirm that consultations given by treatment providers are covered under the Cost of Treatment Regulations at the initial rate specified in the regulations even when a specified treatment is not provided.

Question 3.5

Do you agree that the Cost of Treatment Regulations should be amended to confirm that consultations given by treatment providers are covered at the initial rate specified even when a specified treatment is not provided? If not, why not?

3.6 Add an invoicing time limit of 6-months for treatment provided under the Cost of Treatment Regulations

60. ACC's Standard Terms and Conditions for contracted suppliers specify that providers must provide an invoice within 12 months of treatment being provided, or cover being granted by

ACC (whichever is the later). ACC's website specifies that all invoicing must be submitted to ACC within 12 months of a service being provided. It also includes an expectation that ACC be invoiced within two months from the date of service, with the 12-month timeframe allowing late invoicing to occur where extenuating circumstances exist.

61. There is no similar or corresponding time limit in the Cost of Treatment Regulations, meaning providers can invoice for several years of past treatment.

62. By delaying invoicing, ACC is prevented from seeing the services provided to claimants. This potentially disadvantages a claimant when they seek further entitlements like surgery or weekly compensation as ACC may not have information which contributes to the decision-making process. The lack of an enforceable invoicing period also makes it difficult to assess whether treatment invoiced for is necessary and appropriate.

63. ACC needs to be able to detect fraud, waste and abuse in service provision and associated invoicing, and this becomes difficult when there is a significant lag between an invoice and the invoiced services. ACC's ability to detect fraud, waste or abuse would be enhanced by implementing a 6-month time-limit.

64. A 6-month time limit also aligns the Ministry of Social Development's (MSD) invoicing requirements for hearing aids.[1] As the majority of clients with cover for hearing loss have a combination of both injury and non-injury hearing loss, ACC has a Memorandum of Understanding with MSD which means ACC pays audiology suppliers for hearing aids, with MSD reimbursing ACC for its contribution. The current lack of a 6-month invoicing limit for ACC means that MSD is reimbursing costs for hearing aids outside of its 6-month time limit.

Proposal

65. We propose to add a time-limit of 6-months for providers to invoice ACC under Cost of Treatment Regulations. This time-limit will strengthen ACC's ability to detect fraud, waste and abuse.

Question 3.6

If an invoicing time-limit is added to the Cost of Treatment Regulations, should the time limit be six months? If not, what do you think it should be and why?

3.7 Explore options to recognise vocationally trained GPs as specialists, whilst maintaining current rates

66. Doctors practising in New Zealand will generally be registered as having a 'general' scope of practice by the Medical Council of New Zealand (Council). In addition to this they may have a vocational scope.

[1] CD5(2) of Hearing Aid Services Notice 2018 ***https://gazette.govt.nz/notice/id/2018-go959#CD4***

67. ‘General practice’ is a vocational scope of practice which requires the successful completion of a General Practice Education Programme. Doctors registered as having a ‘general practice’ scope of practice are recognised by the Council as specialists.

68. However, doctors registered as having a general practice scope of practice are not included in the definition of ‘specialist’ in the Cost of Treatment Regulations. This means doctors working in general practice have to bill ACC as a ‘medical practitioner’ and not a ‘specialist’ regardless of whether they are vocationally trained.

69. The ‘specialist’ category in the Cost of Treatment Regulations recognises the different type of service and greater amount of time on-referral specialist spends with a claimant (typically 30-45 minute consultations) compared to a medical practitioner in general practice (typically 15-minute consultations). The ‘specialist’ category is rarely used for billing given that most eligible specialists can opt to be paid under a relevant ACC contract (e.g. clinical services contract).

70. We have considered three options (in addition to the status quo), discussed below, to reflect the fact that vocationally trained GPs are a type of specialist. For all options, vocationally trained GPs would continue to receive the same payments under the Cost of Treatment Regulations (which reflect the service provided and duration of the consultation).

Option A: Status quo

71. Under the status quo there will be no improvement in recognition of vocationally trained GPs as specialists.

72. Cabinet would retain the ability to set payments that reflect the service provided and duration of a consultation with a GP.

73. The status quo is administratively efficient – the Cost of Treatment Regulations in its current form provides a familiar way of setting payment rates for services provided by different health professionals.

Option B: Replace the term ‘specialist’ with an alternative term

74. This option would remove the use of the term ‘specialist’ and replace it with another term such as “referred services” or “secondary care”. Apart from this change the regulations would remain unaltered.

75. This would reflect the current categories’ links to the nature and duration of the consultation while removing the confusion associated with the term ‘specialist’. This would prevent people from interpreting the Cost of Treatment Regulations as potentially indicating that these GPs are not a type of specialist.

76. There would be no additional cost to ACC, and Cabinet would have the continued ability to set payment rates that reflect the service provided and duration of the consultation – the changes would need to ensure that where another provider ‘referred’ a client to a GP, the GP would still be treated as a primary care medical practitioner.

Option C: Remove specialists and a payment rate for them from the Cost of Treatment Regulations

77. This option would simplify the Cost of Treatment Regulations while maintaining it as an important tool for managing the payment of treatment providers.

78. The option would not provide GPs with recognition as specialists, but it would provide a level playing field for all medical practitioners (specialist or not), and prevent people from interpreting the Cost of Treatment Regulations as potentially indicating a specialist GPs are not a type of specialist.

79. The small number of specialists currently billing as specialists under the Cost of Treatment Regulations (i.e. not under contract) could receive only the lower medical practitioner rates if they continued to use the regulations. This could result in co-payments being raised for these treatments which, in turn, could prevent some claimants from accessing treatment. However, the risk is low as most (non-GP) specialists operate under contract.

80. This option would encourage those specialists still using the Cost of Treatment Regulations for billing ACC to sign up to a contract.

Option D: Add vocationally trained GPs to the list of specialists in the Cost of Treatment Regulations but maintain current payment rate

81. Under this option the regulations would be amended to include vocationally trained GPs as specialists in the definition used in the regulations, but with accompanying provisions to ensure vocationally trained GPs continue to get paid the medical practitioner rate.

82. This option would recognise vocationally trained GPs are specialists but would maintain payment rates that reflect the service provided and duration of the consultation.

Question 3.7

Do you agree changes are required to the Cost of Treatment Regulations to reflect the fact that vocationally trained GPs are a type of specialist? If so, which of the options above do you prefer? Is there an alternative option that you think should be considered?

4 Changes to the Definitions Regulations

Background

83. The *Accident Compensation (Definitions) Regulations 2019* (the Definitions Regulations) control which health professionals can provide ACC funded treatment by defining them as 'treatment providers' and setting professional membership requirements. The Definitions Regulations also specify which health professionals are covered by ACC's treatment injury provisions by defining them as 'registered health professionals' (RHPs). The Definitions Regulations are generally guided by the regulation of health professionals under the *Health Practitioners Competence Assurance Act 2003* (HPCA Act).

84. The purpose of the HPCA Act is to protect the safety of the public by providing mechanisms to ensure health professionals are competent and fit to practise. It imposes competence requirements like being a member of the relevant professional organisation and holding a practising certificate. Health professionals meeting these requirements are defined as 'health practitioners'. New categories of health practitioners can be added by secondary legislation.

85. Any health professionals added as health practitioners under the HPCA are generally added as RHPs under the Definitions Regulations given their recognition as medical professionals by the Ministry of Health. However, health practitioners are added as treatment providers only if ACC has established there is a need they can fulfil by providing treatment likely to be effective at rehabilitating injured claimants.

Add oral health therapists and dental therapists as treatment providers

86. Oral health therapist is a relatively new profession, established in 2017, combining the roles of dental therapists (formerly school dental nurses) and dental hygienists. A little over half of oral health therapists work in the private sector and mostly provide treatment to adults.

87. Dental therapist remains a recognised profession, concentrating on the treatment of children and adolescents up to age 18. While most dental therapists work in the public sector, some do work in the private sector providing treatment to young people.

88. Both oral health therapists and dental therapists are already designated as RHPs under the Definitions Regulations but are not defined as treatment providers.

89. Both oral health therapists and dental therapists practising under the full scope of practice are qualified to provide the treatment required for a tooth that has suffered minor to moderate damage in an accident. However, because oral health therapists and dental therapists are not

currently defined as treatment providers they cannot be funded by ACC to provide such accident treatment. Currently only dentists are defined as treatment providers and can receive funding to provide restorative dental treatment via the Cost of Treatment Regulations.

Proposal

90. The proposal presented for consultation is to amend the Definitions Regulations to add oral health therapists and dental therapists as treatment providers so both professions working in the private sector can receive ACC funding to provide treatment to accident damaged teeth, where it is in their scope of practice. This change should provide claimants with more choice in treatment provider. It may also give some claimants the option of choosing treatment with a lower co-payment, if dental practice charges reflect the lower pay rates of oral health therapists and dental therapists compared to dentists.

91. ACC-related dental treatment makes up a very small portion of dental work, so we expect that allowing oral health therapists and dental therapists to undertake ACC work would have minimal workforce impacts.

92. Following consultation, further analysis of this proposal will be undertaken to better assess benefits and potential negative impacts.

Question 4.1.1

What benefits for claimants do you think there are from oral health therapists and dental therapists being made treatment providers? Please explain how these benefits would arise and what needs would be better served than currently? Are there any other potential treatment providers who could meet these needs?

Question 4.1.2

Do you expect any increase in costs to ACC from making oral health therapists and dental therapists treatment providers? If so, what do you expect to cause the increased costs and why? Would the increased costs be outweighed by extra benefits?

Question 4.1.3

Do you anticipate any detrimental consequences from making oral health therapists and dental therapists treatment providers? If so, please describe these and why you consider they are likely to arise.

Add treatment rates for oral health therapists and dental therapists to the Cost of Treatment Regulations

93. If oral health therapists and dental therapists become treatment providers able to be funded by ACC then treatment rates for oral health therapist and dental therapist treatment need to be added to the Cost of Treatment Regulations. There are already appropriate treatment rates specified for dentists that cover the range the treatments that could be provided by an oral health therapist or dental therapist.

Proposal

94. We propose that treatment rates for oral health therapist and dental therapist be added to the Cost of Treatment Regulations by specifying the same treatment rates that apply to dentists. The Schedule that specifies the treatment rates for dentists can be viewed at:

https://www.legislation.govt.nz/regulation/public/2003/0388/latest/DLM236570.html

Question 4.2

Do you agree that treatment rates for oral health therapists and dental therapists be added to the Cost of Treatment Regulations by specifying the same treatment rates applying for dentists? If not, why not?

Add physician associates as RHPs

95. Physician associate services were designated as a health profession (making physician associates health practitioners) by Order in Council under the HPCA on 28 April 2025, taking effect on 30 May 2025.

Proposal

96. To ensure that the ACC treatment injury provisions apply to any treatment provided by physician associates, we propose that they be added as RHPs in the Definitions Regulations. For affected health professionals who are already practising, it is likely they have treatment injury coverage on the basis that they are supervised by an RHP.

97. A 'treatment injury' is an injury caused by treatment received from an RHP (sometimes called 'medical misadventure'). Treatment injuries are subject to specific criteria, such as whether an injury is a necessary part or an ordinary consequence of treatment (which would not be covered).

98. Generally, where a health professional is not an RHP, any injuries resulting from treatment would receive standard accident cover. However, treatment injuries can include incidents which would not be covered under standard injury provisions and vice versa.

Question 4.3

Do you agree with adding physician associate as a registered health professional in the Definitions Regulations? If not, why not?

5 What happens next?

99. Submissions on the proposed updates to the regulations close on 1 May 2026. The submissions will be reviewed for any insights they can provide for further analysis of the proposals.

100. After due consideration of the submissions has been given, MBIE will provide recommendations to the Minister for ACC on how to proceed. The Minister will then seek Cabinet agreement to final policy decisions. We expect this to occur in June 2026.

101. Should Cabinet agree to the changes, amending regulations will be drafted and approved, with the updates coming into force at least 28 days after the approved regulations are gazetted. Therefore, we expect the new regulations to come into force in September 2026.

102. The changes enabled by amending the regulations will be implemented and monitored by ACC. There is an opportunity for any concerns related to payment rates to be addressed each time the required two-yearly review occurs.