**SUBMISSION TO ACC**

**Proposed changes to ACC Cost of Treatment and Definitions Regulations**

**Date: April 2026**

Hauora Taiwhenua Rural Health Network is a national peak body representing rural health in Aotearoa New Zealand. We represent a broad coalition of rural health professionals, communities, and organisations committed to improving health outcomes for people living in rural and remote Aotearoa.

We welcome the opportunity to provide consultation advice on the proposed changes to ACC cost of treatment and definitions regulations.

Ngā mihi nui

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**QUESTION RESPONSES**

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

Option B.

This approach would more accurately reflect the true value and contribution of health professionals delivering these services. It would also help mitigate the risk of increasing numbers of patients being unable to access care due to rising costs, particularly as co-payments are likely to increase if there is a lower percentage increase in ACC contributions. This is especially critical in rural contexts, where there are higher proportions of people experiencing social and economic deprivation. As highlighted in Hauora Taiwhenua's *Rural Health NZ Snapshot 2026*, 39% of New Zealanders living in R3 areas reside within Q5 deprivation, compared with 19% of those living in U1 areas. Ensuring affordable access to care in these settings is essential to sustaining the rural workforce, particularly those employed in primary industries, who contribute significantly to Aotearoa New Zealand's GDP.

It would be beneficial to encourage providers to adopt innovative approaches to service delivery, alongside ACC developing clear, evidence-based guidelines outlining expected treatment pathways. This would help reduce the risk of over-treatment, particularly for low-complexity injuries, while supporting consistent, high-quality care.

We would encourage ACC to adopt a standardised inflation measure to be applied consistently for the annual uplift of all costs. This approach would remove the need for repeated consultation with each cost review cycle and provide greater certainty through regular, predictable adjustments to consultation and treatment fees for providers.

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

This w**o**uld likely result in increased co-payments for these services, reducing access to appropriate rehabilitation for some patients. As noted in the response to Question 2.1, this is particularly significant for people living in rural areas, who already face multiple barriers to accessing timely and appropriate healthcare.

**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?**

We would welcome the introduction of additional services that are accessible to both rural and urban communities.

**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?**

Yes, we support the provision of appropriate consultations via telehealth. This will be particularly beneficial for individuals living in rural or remote communities. However, telehealth is not a complete solution for these populations. As highlighted in Hauora Taiwhenua's *Rural Health NZ*

*Snapshot 2026*, only 64.6% of people living in R3 areas have access to a mobile phone, and while internet access is described as "nearly universal," the quality and reliability of that access vary significantly.

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

Yes, we support aligning the combined nurse practitioner and nurse rate with the methodology for combined medical practitioner and nurse rate.

**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?**

Yes, we support the inclusion of these two combined treatment options. Additionally, ACC should consider a combined paramedic–nurse consultation rate, as joint consultations may occur in certain circumstances depending on the respective scopes of practice of the clinicians involved.

**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?**

It is important to recognise that the consultation provided by a treatment provider is remunerated at the initial consultation rate, regardless of whether a specified treatment is ultimately delivered. Several of the service actions listed in the discussion section are not, in themselves, treatments e.g. referrals to another provider or the provision of a medical certificate (while acknowledging that prescribing medication does constitute treatment). We consider that all such activities should be encompassed within the fee paid by ACC to the provider, and that there should be a clear expectation that no additional fees are passed on to patients for these services.

**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?**

Yes, we support that there should be a 6 month time-limit to the cost of treatment regulations, which aligns to many other invoicing requirements.

**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?**

Yes, we agree that changes are required to the Cost of Treatment Regulations to reflect the fact that vocationally trained GPs are a type of specialist. Our preferred option is:

**Option B.** Replacing the term '*specialist'* with '*referred services'* because this would provide greater clarity by explicitly indicating that an individual is being referred for a different level of care. However, where a provider refers a client to a GP, this should not automatically be treated as a standard primary care consultation for payment purposes. While this will be appropriate in most cases, future models of care may include GPs who are micro-credentialled (or similarly recognised) in specific areas, such as minor surgery. In such instances, ACC would need to consider how these

referrals are costed when the service provided reflects a higher level of care than primary care, despite being delivered by a GP rather than a secondary care consultant.

**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?**

We consider the inclusion of oral health therapists and dental therapists as recognised treatment providers to be a positive development. This change would help expand the availability of appropriately qualified clinicians, particularly for populations with more limited access to services, including those living in rural or remote communities. In addition to improving access, a potential benefit is the ability for these practitioners to offer lower co-payments compared with dentists and may also increase the availability and timeliness of acute appointments for accident-related dental treatments.

**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?**

There may be an increase in service utilisation as more individuals are able to access care. However, earlier intervention may reduce the need for more costly downstream treatments, particularly for those who might otherwise delay seeking care.

**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?**

We are not aware of any specific issues at this time. More detailed feedback on this matter would be best sought from stakeholders working directly within the dental sector.

**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?**

Yes.

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

Yes, we support the inclusion of physician associates as a regulated health profession within the Definitions Regulations. However, we note that the Medical Council of New Zealand, which will have a role in the future regulation of this workforce, has recently consulted on the appropriate name for this profession. As the final nomenclature may differ from 'physician associates,' ACC should ensure its terminology aligns with the Medical Council's eventual decision.