MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
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Consultation paper

Changes to ACC regulations for Chinese medicine, paramedics and audiometrists

April 2024

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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 on the changes proposed in this document by **16 May 2024.**

The document includes three packages of unrelated changes involving the *Accident Compensation (Definitions) Regulations 2019*, so it is possible that only one section of the document is relevant to any single submitter.

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

Please use the submission template provided at: ***https://www.mbie.govt.nz/have-your-say/changes-to-acc-regulations-for-chinese-medicine-paramedics-and-audiometrists***. This will help us to collate submissions and ensure that your views are fully considered. Please also include your name and (if applicable) the name of your organisation in your submission.

You can make your submission by:

- sending your submission in as Microsoft Word document or Adobe Acrobat, or a compatible format as an attachment to ***ACregs@mbie.govt.nz***
- mailing your submission to:

  The Manager, Accident Compensation Policy
  Ministry of Business, Innovation & Employment
  PO Box 1473
  Wellington 6140
  New Zealand

Please direct any questions that you have in relation to 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 proposed updates to the relevant regulations. We may contact submitters directly if we require clarification of any matters in submissions.

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Contents

Executive summary

On behalf of the Minister for ACC, the Ministry of Business, Innovation & Employment is consulting on the Minister's proposed changes to regulations made under the *Accident Compensation Act 2001* to deal primarily with the following three topics:

- Chinese medicine
- paramedics, and
- audiometrists.

The proposed changes amend the *Accident Compensation (Definitions) Regulations 2019* (Definitions Regulations) to update or add to who is a 'treatment provider' (so able to be funded by ACC) and who is a 'registered health professional' (so has their treatment covered by ACC's treatment injury provisions).

It is also proposed to add new payment rates 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* (together known as the Cost of Treatment Regulations) to ensure ACC can make appropriate treatment payments to the proposed new treatment providers.

Specifically, it is proposed to:

- Amend the definition of acupuncturist in the Definitions Regulations to recognise the Chinese Medicine Council as the new regulatory body to ensure ACC funding continues.
- Add Chinese medicine practitioners as registered health professionals in the Definitions Regulations so any injuries arising from their treatment are covered under the ACC treatment injury provisions.
- Add paramedics as treatment providers in the Definitions Regulations to ensure ACC can fund treatment provided by them beyond that covered under existing ambulance service contracts.
- Add appropriate new paramedic treatment rates to the Cost of Treatment Regulations.
- Add paramedics as registered health professionals in the Definitions Regulations to ensure that any injuries from their treatment continues to be covered under the ACC treatment injury provisions.
- Add audiometrists as treatment providers in the Definitions Regulations to enable ACC to fund treatment provided by them.
- Add appropriate new audiometrist treatment rates to the Cost of Treatment Regulations.
- Amend the definition of audiologist in the Definitions Regulations to align with the revised New Zealand Audiological Society definition.
- Amend the definition of nurse in the Definitions Regulations to recognise minor changes to the nursing scope of practice.

Where the proposals are expected to have a material impact, they have been assessed against the following policy objectives:

- Keeping claimants safe.
- Improving access to treatment.
- Keeping costs sustainable.
- Minimising differences between the health and ACC systems.

We invite feedback on the proposals from any stakeholders who may be affected, including treatment providers and population groups who have difficulty in accessing treatment. Specific questions for which we seek feedback are posed at the end of each of sections 3 to 6 of the document.

Process and timeline

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

1 Introduction

Ensuring health professionals are competent

1. It is important to protect the safety of the public by providing mechanisms to ensure health professionals are competent and fit to practise. This is achieved by imposing competence requirements like being a member of a relevant professional organisation and holding a practising certificate.

2. In New Zealand, health professional competence requirements are imposed by the *Health Practitioners Competence Assurance Act 2003* (HPCA Act). Health professionals meeting the competence requirements prescribed by the HPCA Act are defined as 'health practitioners'. New categories of health practitioners can be added to the HPCA Act by secondary legislation.

3. ACC similarly needs to define which health professionals can provide ACC-funded treatment so that:

    - ACC has assurance that treatment providers are properly qualified to provide safe, good quality treatment
    - ACC has assurance that 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, and
    - 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 defines each type of health professional it regulates and specifies their required professional memberships.

5. In addition, the Definitions Regulations defines health professionals covered by the treatment injury provisions of the AC Act as 'registered health professionals' (RHPs).[1] A treatment injury is an injury caused by the treatment received from an RHP, subject to criteria that includes excluding injuries that are an 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 circumstances which would not be covered under standard injury provisions. For example, if a Chinese medicine herbalist prescribed contaminated herbs that caused a serious adverse reaction, the treatment

[1] Treatment injury is defined by section 32 of the AC Act.

injury provisions would provide cover to the patient (if the provisions applied to herbalists) but the standard injury provisions would not.[2]

7. The Definitions Regulations copy the competence requirements for health professions from the HPCA Act when those professions are added. The professions regulated by the HPCA Act are largely included as RHPs in the Definitions Regulations. However, not all of those professions are also defined as treatment providers in the Definitions Regulations. There are also some additional treatment providers in the Definitions Regulations who are not regulated under the HPCA Act (e.g. audiologists), and the competence requirements for those treatment providers are set independently.

Payments for some ACC treatment are regulated by the Cost of Treatment Regulations

8. 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) set the payments that can be made to providers, by ACC on behalf of the claimant, for particular treatment. The Cost of Treatment Regulations are a cost containment mechanism that apply when there is no contract between ACC and the treatment provider. They tend to cover treatment for less complex injuries.

9. Historically, ACC aimed to contribute 60% of the market price of treatment when regulated treatment payments apply. This leaves claimants to make up the difference between the regulated rate and market price as a co-payment. Having some level of co-payment for claimants discourages unnecessary use of ACC funded services, particularly for treatment of non-acute injuries where there might be some ambiguity about how many treatments are required.

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

11. A disadvantage of co-payments is that they may discourage claimants from seeking needed treatment. Facilitating access to treatment is a policy objective for the ACC scheme which is discussed further in section 2 of this paper.

12. ACC has a statutory obligation under section 324A of the AC Act to review regulated payment rates (prescribed by regulations made under section 324) every second year to account for changes in costs. This review typically considers various measures of cost changes to determine how much the rates, or each group of rates, should be raised.

13. The review can also consider payment rates for new services, which might be required for a new type of service provider, and whether existing payment rates are working as intended.

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[2] Section 25 of the AC Act provides than an accident does not include the oral ingestion of a virus, bacterium or protozoan.

The factors to consider when adding a new payment rate include the underlying cost of the service and how it compares with existing rates for similar services.

14. In addition to the required two-yearly review, changes to the Cost of Treatment Regulations can be made at other times for other reasons (under section 324 of the AC Act) provided the Minister receives a recommendation from ACC and consults the persons or organisations the Minister considers appropriate. This consultation requirement can be met by including the proposed changes in a public consultation document like this one, published by MBIE on behalf of the Minister for ACC.

2 Assessing the proposed regulatory changes

What are the policy problems we are addressing?

15. The wider the range of treatment providers able to provide ACC funded treatment, the easier it should be for ACC claimants to access suitable treatment that they are comfortable with.

16. However, there are restrictions on which health professionals can provide ACC funded treatment so ACC can be assured of the competence of treatment providers and the effectiveness of the treatment, as was outlined in the previous section.

17. Similarly, there are restrictions on which treatment providers are covered by the ACC treatment injury provisions so ACC can be assured that these provisions apply only to genuine health professionals.

18. Ensuring that value is received for the money spent is also important. The Cost of Treatment Regulations helps to keep scheme costs, and therefore levies, sustainable by specifying the amount per treatment that ACC pays for. Limiting ACC's contribution means that claimants usually have to pay a co-payment to cover the difference between the market price and the amount the provider receives from ACC.

19. However, the level at which co-payment are set affects the ability of claimants to access the treatment required to assist rehabilitation, i.e. if co-payments are too high then a significant number of claimants may delay or not seek the treatment they require.

What are the policy objectives?

20. When considering proposals to widen the range of providers able to provide ACC treatment, we assess how well the proposals promote the following policy objectives:

    - Keeping claimants safe.
    - Improving access to treatment.
    - Keeping costs sustainable.
    - Minimising differences between the health and ACC systems.

Objective 1: Keeping claimants safe

21. As was discussed in the previous section, it is important to protect the safety of those seeking treatment by providing mechanisms to ensure health professionals are competent and fit to practise.

22. Each health profession usually has an organisation that sets the scope of practice for members, provides a code of conduct and monitors member behaviour. Usually these organisations issue an annual practising certificate to participating members with appropriate recognised qualifications. The aim is to provide a reasonable level of assurance that these members are competent and fit to practise.

Objective 2: Improving access to treatment

23. Access to treatment is important because an overriding goal of the accident compensation scheme is to minimise the impact of injury on the community. The impact will be minimised when those injured promptly access appropriate treatment.

24. The main factors that determine whether a person suffering an injury accesses appropriate treatment are:

    - Cost – is the treatment affordable for the claimant?
    - Convenience – is a treatment provider available in a convenient location for the claimant and can an appointment be arranged for a convenient time?
    - Cultural factors – is the treatment provider and the type of treatment being offered culturally acceptable, appropriate and safe for the claimant?

25. Any changes that improve these factors are likely to improve access. For example, a change that increases the number of locations offering treatment is likely to improve access.

26. It is also important to consider whether claimants have a choice when selecting a treatment provider and type of treatment. If there is choice, it means that not every treatment available has to be suitable for every claimant. Claimants will be best served when there is an option that is cost, convenience and culturally appropriate for them.

27. When considering these factors, especially cultural factors, the principles of te Tiriti o Waitangi/the Treaty of Waitangi should be considered and observed in line with the Crown's obligations under the Treaty.

Objective 3: Keeping costs sustainable

28. Future increases in the total amount of payments made to treatment providers should be kept to a level that means increases in ACC levies and appropriations (allocated through the ACC Non-Earners' Account) will be reasonable. Future increases in costs should also be predictable so they can be planned for by ACC, the government and levy payers.

29. To ensure that costs are sustainable, care needs to be taken to ensure that adding new types of treatment or treatment providers does not lead to unpredictable increases in future costs.

30. Having the amount of any new payments for treatment specified in regulation helps ensure the costs for ACC are predictable, and that there are incentives against excessive usage, as explained in section 1.

Objective 4: Minimising differences between the health and ACC systems

31. The health and ACC systems are similar in that they aim to keep or return people to good physical and mental health, often using the same treatment for very similar ailments. It is therefore desirable that the two systems are aligned where possible or differences minimised to stop tensions developing and possibly leading to undesirable behaviour. Tensions could develop from differences in how treatment is purchased, how it is provided or the standards imposed on providers.

32. This means that it is desirable, where appropriate, that the competency requirements of practitioners in the health system are copied by the ACC system. Similarly, it is desirable that findings by the health system about the effectiveness (or ineffectiveness) of a particular treatment are also recognised by the ACC system.

33. When setting the treatment payments made by ACC, we need to consider the payments set for the health sector, particularly in those areas where ACC and the health sector provide similar services, e.g. payments to GPs and nurses in general practice. If payments are too dissimilar, that could encourage undesirable behaviour, e.g. if the payment made for a type of treatment was markedly different between the health and ACC systems, treatment providers may be encouraged to mischaracterise borderline cases to fall under the system that gives the highest payment and allows the lowest co-payment to be charged to those being treated.

3 Proposed changes for Chinese Medicine

Recognising the Chinese Medicine Council as the new regulatory body

Background

34. Currently, ACC funds Chinese medicine in the form of 'acupuncture' when clients with a covered injury request it. This treatment is primarily the use of needles and other forms of stimulation to pressure points to treat pain from musculoskeletal injuries, but adjunct treatment can also include gua sha (scraping) and tui na (massage). Other forms of Chinese medicine (such as herbalism) are currently not funded by ACC.

35. There are certain requirements acupuncturists must meet before ACC will fund them. These are imposed by the Definitions Regulations which defines 'acupuncturists' as treatment providers. Acupuncturists have to be a full member of the New Zealand Register of Acupuncturists (Acupuncture NZ) Incorporated or a registered member of the New Zealand Acupuncture Standards Authority Incorporated (NZASA), and to hold a practising certificate.

36. There has been a programme of work for over ten years to better regulate the practice of Chinese medicine in New Zealand. This culminated in the establishment of the Chinese Medicine Council of New Zealand (CMC) in 2022 as a responsible authority under the HPCA Act, and CMC's subsequent work to establish scopes of practice for traditional Chinese medicine.

37. In April 2023, CMC set scopes of practice within which Chinese medicine practitioners may practise and the qualifications required. The scopes came into effect on 29 May 2023, and CMC commenced issuing annual practising certificates from 1 July 2023.

Amend definition of acupuncturist to ensure that funding continues

38. To ensure acupuncturists can continue to be funded as treatment providers by ACC, an amendment to the definition of acupuncturist in the Definitions Regulations is required to recognise CMC as the new regulatory body registering acupuncturists.

39. Until the Definitions Regulations are amended, the current registration requirements with Acupuncture NZ or NZASA continue to apply. This will mean, in the interim, acupuncturists who treat ACC clients will have to be 'double registered'. They will need to maintain registration with CMC **and** either Acupuncture NZ or NZASA. We understand that all three

organisations are working together to address this issue in the short term until the regulations can be amended.

40. The proposed amendment is supported by stakeholders and will ensure the continuation of the status quo of qualified acupuncturists being funded by ACC for providing covered treatment.

Question 3.1

Do you agree with amending the definition of acupuncturist in the Definitions Regulations to recognise the Chinese Medicine Council as the regulator, to ensure acupuncturists continue to be funded by ACC for providing covered treatment? Please provide reasons for your view.

Add Chinese medicine practitioners as registered health professionals to give them treatment injury coverage

41. Now that a range of Chinese medicine practitioners are regulated by CMC (under the HPCA Act) it is appropriate that the treatment performed by these practitioners is covered by the ACC treatment injury provisions, like the treatment of other health professionals regulated under the HPCA Act.

42. ACC treatment injury coverage can be extended to Chinese medicine practitioners regulated by CMC by defining them as 'registered health professionals' in the Definitions Regulations.

43. In assessing whether to extend treatment injury coverage to treatment by Chinese medicine practitioners, the following options were considered:

    A Don't extend treatment injury coverage

    B Extend treatment injury coverage to all Chinese medicine practitioners regulated by CMC.

Option A: Don't extend treatment injury coverage

44. As was discussed in para 6 of chapter 1, 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. There may be some treatment injuries that would **not** be covered under the standard injury provisions but would be covered under the treatment injury provisions. We gave the example of a Chinese medicine herbalist prescribing contaminated herbs causing a serious adverse reaction. In that case, the treatment injury provisions would provide cover to the patient (if the treatment injury provisions applied to herbalists) but the standard ACC injury provisions would not.

45. There may also be some treatment injuries that would not be covered under the treatment injury provisions but may be covered under standard injury provisions. This would include any treatment injuries that are a necessary part or ordinary consequence of the treatment. For example. it is not uncommon for cupping to have minor complications such as scarring, burns and bullae.

46. It appears that the net number of covered claims is likely to change very little compared to extending coverage, so the cost implications are likely to be minimal.

47. The main downside of not extending treatment injury coverage is that that approach would be inconsistent to that taken with other health professionals regulated under the HPCA and defined as RHPs, and would therefore increase differences between the health and ACC systems.

Option B: Extend treatment injury coverage to all Chinese medicine practitioners regulated by CMC

48. Extending treatment injury coverage to all Chinese medicine practitioners may encourage more claimants to access treatment because of the extra assurance the coverage would provide. However, the practical differences are subtle, with plusses and minuses as discussed above, and unlikely to be known by claimants. We therefore consider access to treatment is likely to be unaffected.

49. The cost implications of extending the treatment injury provisions to all Chinese medicine practitioners are likely to be minimal with the number of covered claims likely to increase only marginally.

50. The main benefit of this option is that it would make the treatment of Chinese medicine practitioners consistent with other health professionals regulated by the HPCA and already defined as RHPs. This would help minimise differences between the health and ACC systems.

Question 3.2

Do you agree that adopting option B, extending ACC treatment injury to all regulated Chinese medicine practitioners, best meets the objectives set? If not, why not? Please provide reasons for your view.

4 Proposed changes for paramedics

Fund paramedics to provide ACC treatment beyond ambulance service contracts

Background

51. Paramedics are trained health professionals whose qualifications are recognised under the HPCA Act. Their particular skills include providing emergency care and pain relief. Some paramedics have also undertaken extra training in community paramedicine.

52. Medical practices in rural New Zealand sometimes employ registered paramedics to assist nurses and doctors to treat patients as part of the general practice team. However, while the practice can be paid by the health system for the treatment of health patients by paramedics, current regulatory settings mean the practice cannot be paid by ACC for treatment of an injury-related condition if the treatment is carried out by a paramedic.

53. Paramedics cannot be funded directly by ACC for providing treatment to ACC claimants because they are not defined as treatment providers in the Definitions Regulations. However, the AC Act does provide for ACC to fund emergency transport services.

54. Accordingly, the only current funding of paramedics by ACC is indirect through its joint funding of ambulance services with Te Whatu Ora, via the Emergency Ambulance Services contract.

55. The general practice workforce is under pressure, particularly in rural areas. Many GPs are expected to retire in the next 10 years and there are reports of increased GP burnout. Often overseas-trained professionals are required to meet the demand for primary care services.

56. All the stakeholders are currently trying to understand how other health professionals can help mitigate this workforce pressure. Some stakeholders proposed that more use of paramedics in general practice might help ease this pressure.

Add paramedics as treatment providers to enable direct ACC funding

57. Adding paramedics as a treatment provider in the Definitions Regulations would allow them to receive funding by ACC for covered treatment work to help facilitate their employment in general practice.

58. In assessing whether to add paramedics as treatment providers, the following options were considered:

    A Continue the current arrangement of ACC not funding paramedics except indirectly for ambulance work.

B Add paramedics as treatment providers so they can be funded directly by ACC for covered treatment.

Option A: Continue not funding paramedics for ACC treatment

59. This is the status quo option so paramedics wouldn't be funded to perform any treatment covered by ACC outside of the current ambulance arrangements.

60. This option wouldn't assist with access to treatment but wouldn't add any extra costs.

61. This option would also continue the current differences between the health and ACC systems, with paramedics able to be funded for general practice work by the health sector but not by ACC for accident-related general practice work. This constrains the use of paramedics.

Option B: Commence funding paramedics for ACC treatment

62. Allowing paramedics to be funded for treatment covered by ACC (by defining them as treatment providers) should improve access to treatment by helping to alleviate the shortage of primary care health professionals, especially in rural areas. This might make it easier to get an appointment for treatment, etc.

63. Facilitating better access to treatment by funding primary care paramedics is estimated to have an immaterial cost to ACC. The paramedics providing ACC treatment should largely be undertaking treatment that would have occurred anyway. It would previously have been performed by another medical professional, but possibly not as soon and for a slighter higher cost.

64. This option significantly reduces the differences between the health and ACC systems by allowing paramedics to be funded for the same ACC work as other health professionals in general practice. It removes the current constraints on their use.

65. There is a risk that making it easier for paramedics to work in general practice may make it more difficult to recruit them for emergency ambulance work.

Question 4.1

Do you agree that adopting option B, commencing to fund paramedics for ACC treatment, best meets the objectives set? If not, why not? Please provide reasons for your view.

Add paramedic rates to the Cost of Treatment Regulations

66. If paramedics become treatment providers able to be directly funded by ACC, then it is also appropriate to add paramedic consultation rates to the Cost of Treatment Regulations. This would be consistent with the general approach taken with other primary care professionals such as nurses, nurse practitioners and medical practitioners (GPs) who have consultation rates specified in the Cost of Treatment Regulations.

67. As discussed in section 1, the purpose of the Cost of Treatment Regulations is to help keep ACC costs sustainable by setting the amount that ACC contributes towards the treatment for various types of mostly minor treatment.

68. For medical professionals, there is a consultation or base treatment rate that is specified in the Cost of Treatment Regulations. This can depend on the age of the claimant being examined and whether they have a Community Services Card.

69. Also specified in the Cost of Treatment Regulations are rates for various types of treatment that may be undertaken during a consultation, e.g. treating a dislocation of finger or toe with splint or strapping. These rates are listed as "Medical practitioners', nurses', and nurse practitioners' costs". The treatment rate is added to the base consultation rate to get the total payment made by ACC towards the claimant's treatment.

70. ACC looked at the current treatment rates for medical professionals and, considering the qualifications of paramedics, recommended the following set of base rates:

Paramedics' Costs - Item Description	**Rate (per visit)**
The claimant is 14 years old or over when the visit takes place and is not the holder of a community services card or the dependent child of a holder.	$16.99
The claimant is under 14 years old when the visit takes place	$36.17
The claimant is 14 years old or over when the visit takes place and is the holder of a community services card	$31.27
The claimant is 14 years old or over but under 18 years old when the visit takes place and is the dependent child of a holder of a community services card.	$37.18

71. In assessing whether to add the above set of a paramedic treatment rates to the Cost of Treatment Regulations, the following options were considered:

    A Don't set paramedic rates.

    B Add the set of paramedic base rates recommended by ACC.

Option A: Don't set paramedic rates

72. As discussed above, enabling paramedics to undertake ACC funded treatment should improve access to treatment by helping to alleviate the shortage of primary care health professionals.

73. However, if no specific rates are set for paramedic treatment then paramedics would still be able to undertake ACC funded treatment, but may be able to claim the full cost of the treatment. This would increase scheme costs.

74. Having no set of payment rates would be inconsistent with the treatment of other medical professionals and how they are treated by the health system. This would, therefore, increase differences between the health and ACC systems.

Option B: Add the set of paramedic rates recommended by ACC

75. Adding paramedic treatment rates would also improve access to treatment by enabling paramedics to undertake ACC funded treatment.

76. Funding paramedics to undertake ACC treatment is likely to have an immaterial impact on costs for ACC because the newly enabled paramedics should largely be undertaking treatment that would have occurred anyway. Having a set of treatment rates would help ensure costs are constrained.

77. Having a set of treatment rates for paramedics would be consistent with how other medical professionals are treated by ACC and the health system. This would, therefore, lessen differences between the health and ACC systems compared to not setting treatment rates.

Question 4.2

Do you agree that adopting option B, adding the above paramedic treatment rates to the Cost of Treatment Regulations, best meets the objectives set? If not, why not? Please provide reasons for your view.

Add paramedics as registered health professionals to confirm treatment injury coverage

78. Given paramedics were added to HCPA Act coverage in 2019, it is appropriate that they, like other health professionals regulated under the HCPA Act, be added as an RHP in the Definitions Regulations to ensure their treatment is covered by the ACC treatment injury provisions.

79. Injury caused by treatment from paramedics is already covered by the ACC treatment injury provisions, as paramedics working for St John and Wellington Free Ambulance work under the direction of an RHP (the medical director for their employer). This means there is no immediate practical effect of adding paramedics as RHPs.

80. However, now that paramedics have a separate regulatory body for their profession, adding them as an RHP will ensure that treatment carried out by paramedics will continue to be covered under the treatment injury provisions.

Question 4.3

Do you agree with adding paramedics as registered health professionals in the Definitions Regulations to ensure their treatment continues to be covered by the ACC treatment injury provisions? Please provide reasons for your view.

5 Proposed changes for audiometrists

Fund audiometrists to provide ACC treatment

Background

81. Currently ACC funds audiologists for tasks associated with diagnosing injury-related hearing loss and providing hearing aids to alleviate such hearing loss.

82. Audiologists are defined as treatment providers in the Definitions Regulations, and payment rates for the various services they provide to those with work or injury-related hearing loss are specified in the Cost of Treatment Regulations.

83. Audiometrists are qualified to undertake the same ACC work as audiologists for routine cases but currently cannot be funded by ACC for treatment because they are not defined as treatment providers in the Definitions Regulations.

84. Audiometrists are already funded by the health system on the same basis as audiologists for other hearing loss treatment.

85. There have been requests to amend the Definitions Regulations to include audiometrists to ensure they can receive ACC funding on the same basis as audiologists. This should improve access to treatment for some claimants. While audiological services are readily available in the main centres, we understand it can be difficult to get an appointment with an audiologist in some regions, and having audiometrists available for ACC funded treatment may make it easier to access treatment.

86. To ensure funding is limited to that already provided to audiologists, the Cost of Treatment Regulations would also need to be amended to make the audiology rates also applicable to audiometrists.

Add audiometrists as treatment providers to enable ACC funding

87. Adding audiometrists as a treatment provider in the Definitions Regulations would allow them to receive funding by ACC for covered treatment work and help facilitate their use in areas of higher need.

88. In assessing whether to add audiometrists as treatment providers, the following options were considered:

    A Continue current arrangement of ACC not funding audiometrists

    B Add audiometrists as treatment providers so they can be funded by ACC for covered treatment.

Option A: Continue not funding audiometrists to provide ACC treatment

89. This is the status quo option so audiometrists wouldn't be funded to perform any treatment covered by ACC.

90. This option wouldn't improve access to treatment and wouldn't add any extra costs.

91. This option would also continue the current differences between the health and ACC systems, with audiometrists able to be funded for health work but not ACC work.

Option B: Commence funding audiometrists for ACC treatment

92. Allowing audiometrists to be funded for treatment covered by ACC should improve access to treatment by increasing the pool of health professionals who can provide ACC funded hearing treatment. This should make it easier to get an appointment for ACC covered treatment in some areas.

93. Better access to treatment might lead to a slight rise in expenditure, although audiometrists should largely be undertaking ACC funded treatment that would have occurred anyway.

94. This option reduces the differences between the health and ACC systems by allowing audiometrists to be funded by ACC for the same sort of work they are already funded to perform by the health system.

Question 5.1

Do you agree that adopting option B, commencing to fund audiometrists for ACC treatment, best meets the objectives set? If not, why not? Please provide reasons for your view.

Add audiometrist rates to the Cost of Treatment Regulations

95. If audiometrists become treatment providers able to be funded by ACC then it is appropriate to add audiometrist treatment rates to the Cost of Treatment Regulations. This would be consistent with the approach taken with audiologists.

96. As discussed in chapter 2, the purpose of the Cost of Treatment Regulations is to help keep costs sustainable by setting the amount per treatment that ACC pays for various types of mostly minor treatment.

97. ACC has already budgeted for audiology treatment spending, so it is important that audiometrist treatment be subject to similar payment rates as audiologists.

98. ACC recommended that audiometrists be subject to identical payment rates to audiologists. The Cost of Treatment Regulations dealing with hearing loss entitlements, containing all the audiologist rates that would be replicated, can be viewed at:

https://www.legislation.govt.nz/regulation/public/2010/0424/latest/whole.html

99. In assessing whether to add audiometrists to the above set of treatment rates in the Cost of Treatment Regulations, the following options were considered:

    A Don't set audiometrist rates.

    B Make all audiologist rates also apply to audiometrists, as recommended by ACC.

Option A: Don't set audiometrist rates

100. As discussed above, enabling audiometrists to undertake ACC funded treatment should improve access to treatment by helping to improve the availability of treatment in areas where it can be difficult for claimants to arrange an appointment.

101. However, if no specific rates are set for audiometrist treatment then audiometrists may be able to claim the full cost of any ACC treatment they undertake, which would increase scheme costs.

102. Having no set of payment rates for audiometrists would also be inconsistent with the treatment of audiologists and how they are treated by the health system. This would, therefore, increase differences between the health and ACC systems.

Option B: Make all audiologist rates also apply to audiometrists

103. This option would also improve access to treatment by enabling audiometrists to undertake ACC funded treatment.

104. As discussed above, this option is likely to cause a minimal increase in costs, at most, because the newly enabled audiometrists should largely be undertaking treatment that would have occurred anyway.

105. Having a set of rates for audiometrists would be consistent with the treatment of audiologists and how they are treated by the health system. This option would, therefore, lessen differences between the health and ACC systems compared to not setting treatment rates.

Question 5.2

Do you agree that adopting option B, making all audiologist treatment rates also apply to audiometrists, best meets the objectives set? If not, why not? Please provide reasons for your view.

Make minor change to audiometrist definition to align with NZAS changes

106. The New Zealand Audiological Society (NZAS) recently changed their constitution to abolish the 'Full Member' category and replace it with Audiologist Membership and Audiometrist Membership.

107. The Definitions Regulations currently define audiologist as being a full member of NZAS so need to be updated to correctly refer to the Audiologist membership.

108. This effect of this update will be just to ensure the continuation of the status quo of audiologists continuing to be funded by ACC for providing covered treatment.

Question 5.3

Do you agree with updating the definition of audiologist in the Definitions Regulations to make it consistent with the NZAS constitution? If not, please provide reasons for your view.

6 Proposed minor change to nurse definition

Update definition of nurse to reflect new scope of practice

109. The scope of practice for enrolled nurses has been changed to remove the reference to performing general nursing functions, and the same change is being planned for registered nurses.

110. However, the wording used to define nurse in the Definitions Regulations has the phrase, "whose scope of practice permits the practice of general nursing". This inconsistency might, at some point, be used to try to prevent registered nurses from being funded for providing treatment to ACC claimants.

111. An update to the definition of nurse in the Definitions Regulations is proposed to make it consistent with the new scope of practice for nurses.

112. The effect of the update will be to ensure the continuation of the status quo of nurses being funded by ACC for providing covered treatment.

Question 6.1

Do you agree with updating the definition of nurse in the Cost of Treatment Regulations to make it consistent with the new scope of practice for nurses? Please provide reasons for your view.

7 What happens next?

113. Submissions on the proposed updates to the regulations close on 16 May 2023. The submissions will be reviewed for any insights they can provide for further analysis of the proposals. The submissions or a summary of submissions and responses will be published on MBIE's website.

114. After due consideration of the submissions has been given, MBIE will advise the Minister for ACC on how to proceed. The Minister will then seek Cabinet agreement to what is decided.

115. 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.

116. 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.