COVERSHEET

Minister	Hon Matt Doocey	**Portfolio**	ACC
Title of Cabinet paper	Changes to ACC Regulations for Chinese Medicine, Paramedics and Audiometrists	**Date to be published**	19 September 2024

List of documents that have been proactively released		
Date	**Title**	**Author**
August 2024	Changes to ACC Regulations for Chinese Medicine, Paramedics and Audiometrists	Office of the Minister for ACC
6 August 2024	Changes to ACC Regulations for Chinese Medicine, Paramedics and Audiometrists EXP-24-MIN-0038 Minute	Cabinet Office
23 July 2024	Regulatory Impact Statement: Proposed changes to ACC regulations to deal with Chinese medicine, paramedics and audiometrists	MBIE

Information redacted **YES / NO** *[select one]*

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Regulatory Impact Statement: Proposed changes to ACC regulations to deal with Chinese medicine, paramedics and audiometrists

Coversheet

Purpose of Document	
Decision sought:	Approve additions to the *Accident Compensation (Definitions) Regulations 2019* (Definitions Regulations) for new treatment providers (who can receive ACC funding) and registered health professionals (who have their treatment covered by treatment injury provisions), and appropriate payment rates set in other ACC regulations. The analysis has been informed by submissions on the consultation document, which was open for consultation from 18 April to 16 May 2024.
Advising agencies:	Ministry of Business, Innovation and Employment (MBIE) with input from ACC (the operational agency).
Proposing Ministers:	Minister for ACC
Date finalised:	23 July 2024

Problem Definition
The Definitions Regulations define which treatment providers can be funded by ACC and which health professionals have their treatment covered by the ACC treatment injury provisions. The problem is that ACC claimants are currently not able to access treatment by as wide a range of treatment providers as are available to provide treatment under the health system. The wider the range of health professionals that can have treatment funded by ACC, the greater the choice patients have and the easier access to treatment is likely to be, and health outcomes may be improved. Having the treatment provided by a treatment provider covered by the ACC treatment injury provisions should also increase confidence in that treatment provider. In expanding which health professionals can funded and have treatment injury coverage it important to ensure that the treatment is safe and cost-effective, and that the differences between the health and ACC systems are minimised.

Executive Summary
A principal purpose of the Accident Compensation Scheme is to minimise the impact of injury on the community. This can be achieved by trying to ensure those injured receive

treatment that is safe and effective, that does not impose an excessive cost on the community (given the Scheme is largely funded by the community via levies).

To ensure safety, health professional competence requirements are imposed by the *Health Practitioners Competence Assurance Act 2003* (HPCA Act).

ACC draws on the HPCA to define in the *Accident Compensation (Definitions) Regulations 2019* (Definitions Regulations) who can provide treatment (treatment providers) and whose treatment is covered by treatment injury provisions (registered health professionals).

ACC cannot fund treatment provided by a health professional until they are defined as a treatment provider in the Definitions Regulations. This currently means certain treatment providers are being funded by the health system but not ACC.

One way ACC costs are constrained is by treatment payments being prescribed in Cost of Treatment Regulations and the use of contracts with treatment providers.

As described in the problem definition, there are benefits from having a wider the range of treatment providers and wider treatment injury coverage.

It is proposed to add:

- Chinese medicine practitioners as registered health professionals
- paramedics as treatment providers
- paramedic treatment rates to the Cost of Treatment Regulations
- audiometrists as treatment providers, and
- audiometrist treatment rates to the Cost of Treatment Regulations.

Public consultation was undertaken on all the proposals, and all were well supported apart from a significant number of submissions considering the proposed paramedic rates were too low or needed to recognise more highly qualified types of paramedics. New paramedic rates can be considered at the next two-yearly review of treatment rates, and most paramedics may have their treatment payments covered by the Rural General Practice contract which is provider agnostic.

Limitations and Constraints on Analysis

The analysis undertaken is limited to evaluating the options that were consulted on, which were proposals for change, compared to the status quo. Not all the proposals in the suite of proposed changes to the Definitions Regulations that were consulted on were significant enough to justify being included in the regulatory impact analysis. An exemption was obtained for amending the definition of acupuncturist, making paramedics registered health professionals, amending the definition of audiologist and amending the definition of nurse, as all of these proposals just ensure the continuation of existing practice.

There is insufficient data to provide any quantitative estimates of impacts but there is anecdotal evidence and the views of a significant number of people working in the affected areas. These views were given in response to a consultation paper that was published on MBIE’s website, open to submissions from 18 April to 16 May 2024.

The costs for the proposed changes were estimated by ACC, and determined to be immaterial.

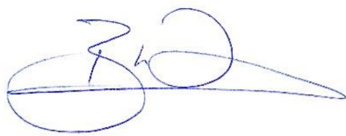
Around 200 submissions were received from a range of people associated with one of the health occupations affected by the proposed changes. The amount of content in the submissions varied according to main issue being submitted on. Submissions on Chinese medicine mostly just indicated if they supported the proposals while submissions on paramedics typically included supporting commentary and were often passionate. Audiology submissions also usually contained some commentary to support their reasoning.

Responsible Manager(s) (completed by relevant manager)

Bridget Duley

Manger, Accident Compensation Policy

Ministry of Business, Innovation and Employment



23 July 2024

Quality Assurance (completed by QA panel)

Reviewing Agency:	MBIE Regulatory Impact Analysis Review Panel
Panel Assessment & Comment:	The Ministry of Business, Innovation and Employment's Regulatory Impact Assessment Review Panel has reviewed the RIS and considers that it meets the quality assurance criteria.

Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop?

Background

1. The purpose of the Accident Compensation Scheme (the AC Scheme), administered by ACC, is to provide a fair and sustainable system for managing personal injury that aims to minimise both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs).

2. Minimising the impact of injury on the community can be achieved by trying to ensure those injured receive appropriate treatment, rehabilitation and compensation. Appropriate treatment is treatment that is effective and safe, and not impose an excessive cost on the community.

Ensuring health professionals are competent

3. 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.

4. 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.

5. 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.

6. 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.

7. The Definitions Regulations tend to take the competence requirements for health professions from the HPCA Act. However, 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.

8. 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.

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

Payment for some ACC treatment is regulated by the Cost of Treatment Regulations

10. 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.

11. 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.

12. 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.

13. 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.

14. 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 such as pay increases in health sector multi-employer collective agreements to determine how much the rates, or each group of rates, should be raised.

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

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

15. 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. 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.

16. 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, published by MBIE on behalf of the Minister for ACC.

17. ACC does also have contracts for the provision of less complex treatment by particular types of providers such as rural general practices. These contracts usually allow for a co-payment to be charged, and may prescribe the maximum co-payment allowed for particular patients such as Community Services Card holders.

What is the policy problem or opportunity?

18. Some types of treatment provider are currently not being funded by ACC so ACC claimants are potentially missing out on receiving the best or most prompt treatment. 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 they comfortable with.

19. Restrictions are required on which health professionals ACC funds. ACC needs to be assured of the competence of treatment providers and the effectiveness of their treatment, as was outlined in the previous section. However, the treatment providers in question already have their qualifications recognised by the health system and are being funded to provide health services.

20. There are also benefits from wider treatment injury coverage, but there are restrictions on which treatment providers are covered by the ACC treatment injury provisions to ensure these provisions apply only to genuine health professionals.

21. 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.

22. 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.

23. However, the level at which co-payments 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 objectives are sought in relation to the policy problem?

24. When considering proposals to widen the range of providers able to provide ACC treatment, we assessed how well the proposals promoted the following policy objectives:

    - keeping claimants safe
    - improving access to treatment
    - keeping costs sustainable, and
    - minimising differences between the health and ACC systems.

Objective 1: Keeping claimants safe

25. 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. This objective has the highest priority.

26. 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.

27. Although important, all the treatment providers in question already have their qualifications recognised by the health system so the safety objective has been met.

Objective 2: Improving access to treatment

28. 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.

29. 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?

30. 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.

31. 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.

Objective 3: Keeping costs sustainable

32. 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.

33. 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.

34. 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

35. 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.

36. 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.

37. 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.

38. However, the funding model for the health and ACC systems is quite different. At a general practice level, health funding is mostly provided via an annual per-enrolled-patient payment that depends on the type of patient. In contrast, ACC funding provided to general practice is per-service only, sometimes varied according to the type of patient.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

39. The criteria used to compare the options are:

    - keeping patients safe
    - improving access to treatment
    - keeping costs sustainable, and
    - minimising differences between the health and ACC systems.

What scope will options be considered within?

40. The options for change that are considered and evaluated in this RIS are limited to the options presented in the consultation paper.

41. The changes being proposed were driven by submissions from stakeholders in the case of the paramedic and audiology changes. These are the only cases we are aware of where treatment providers are recognised and funded by the health system but not ACC.

42. The proposed Chinese medicine change was driven by the move to have Chinese medicine regulated under the HPCA Act.

What options are being considered?

43. There are five significant proposals in the suite of proposed changes to the Definitions Regulations and the Cost of Treatment Regulations. Each proposal is compared to the status quo.

Adding Chinese medicine practitioners as registered health professionals so their treatment gets treatment injury coverage

44. Now that a range of Chinese medicine practitioners are regulated under the HPCA Act by the Chinese Medical Council (CMC) it is beneficial if the treatment performed by these practitioners is covered by the ACC treatment injury provisions. This aligns Chinese Medicine practitioners with other health professionals regulated under the HPCA Act.

45. 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.

46. 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 3.2A[3] – Don't extend treatment injury coverage

47. 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. For example, a Chinese medicine herbalist prescribing contaminated herbs that cause 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 apply.

48. 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 excluded because they 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.

49. It appears that the net number of covered claims is likely to be similar compared to extending coverage, so the cost savings from this option are likely to be minimal.

50. The main downside of not extending treatment injury coverage is that the 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 3.2B – Extend treatment injury coverage to all Chinese medicine practitioners regulated by CMC

51. Extending treatment injury coverage to all Chinese medicine practitioners may encourage more patients to access treatment because of the extra assurance that treatment 'mistakes' would be covered by ACC. However, the practical differences in coverage are subtle, with the boundaries shifting in both directions, as discussed above, and unlikely to be known by claimants. It is therefore considered that the willingness to access treatment is unlikely to change materially.

52. 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 not likely to increase sufficiently to impose a material cost.

53. 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 Act and already defined as RHPs. This would help minimise differences between the health and ACC systems.

54. This option was supported by 132 of the 133 submitters on Chinese medicine.

[3] The numbering given to the options follows the numbering of the questions dealing with these options in the discussion document.

Adding paramedics as treatment providers to enable ACC funding

55. 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.

56. 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.

<u>Option 4.1A – Not fund paramedics</u>

57. Adopting this option means paramedics wouldn't be funded to perform any treatment covered by ACC outside of the current ambulance arrangements.

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

59. This option would also maintain 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.

<u>Option 4.1B – Add paramedics as treatment providers so they can be funded by ACC</u>

60. 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.

61. Facilitating better access to treatment by funding paramedics to provide ACC treatment 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.

62. 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 like rural general practices not being able to use paramedics to meet their Primary Response in Medical Emergencies (PRIME) service responsibilities.

63. 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.

64. This option was unanimously supported by the 48 submitters submitting on proposed paramedic changes. Most submissions expect that it will result in outcomes that are beneficial to patients and practices. Paramedics were widely regarded as having skills that are complementary to other health professionals in general practice, so having them assist was expected to improve patient access while relieving pressure on the health system and GPs in particular.

65. A significant number of submissions considered that implementing the proposal would improve the attractiveness of the paramedic career path. It was also often asserted that the increase in attractiveness would bring more people into the profession and offset the likely move of some paramedics from ambulance services to general practice.

66. Some submissions considered allowing paramedics to be funded for ACC treatment would have to be carefully managed to ensure there are no adverse effects for ambulance services.

Adding paramedic treatment rates to the Cost of Treatment Regulations

67. 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.

68. As was discussed above, 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.

69. 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.

70. Also specified in the Cost of Treatment Regulations are rates for various types of treatment that may be undertaken during a consultation, for example, 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.

71. ACC looked at the current treatment rates for medical professionals and, considering the qualifications of paramedics, recommended the following set of base rates that are paid to the treatment provider:

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

72. 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 4.2A – Don't set paramedic rates

73. 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.

74. 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.

75. 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 4.2B – Add the set of paramedic rates recommended by ACC

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

77. 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.

78. 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.

79. Around half of the submitters supported the proposed new treatment rates. The rest of the submitters thought the rates were too low, needed more work or should include higher rates for the more highly qualified types of paramedic. No submitters favoured having no paramedic rates.

80. A significant number of submissions pointed out that there are three levels of paramedic qualification. There are ordinary paramedics, extended care paramedics (ECPs) and critical care paramedics (CCPs). It was often pointed out that ECPs can take on more tasks in general practice than an ordinary paramedic, making them more are like a nurse practitioner than a nurse and justifying similar treatment rates to a nurse practitioner.

81. There was also a request to consider adding combined treatment rates for where a paramedic and other health professional provide treatment together.

Mitigations for criticisms about this option

82. When paramedics are employed in rural practices covered by the Rural General Practice contract, any ACC treatment they undertake (if they become treatment

providers) will be covered by that contract rather than the Cost of Treatment Regulations. The payments under the Rural General Practice contract are provider agnostic so the payments to a practice for paramedic work will be the same as for the work of any other treatment provider in the practice undertaking that treatment.

83. The Rural General Practice contract appears likely to cover most of the paramedics employed in general practice. If so, this would largely mitigate the criticism about the proposed new regulated treatment rates being too low or otherwise inappropriate.

84. The set of paramedic treatment rates being proposed to be added to the Cost of Treatment regulations would apply to all levels of paramedic (when not covered by a contract), regardless of whether they have advanced qualifications like those held by extended care paramedics. However, this does not mean that the Cost of Treatment Regulations cannot later have higher rates added for extended care paramedics and other more highly qualified paramedics if this can be justified.

85. The Cost of Treatment Regulations must be reviewed every second year by ACC (as per section 324A of the AC Act). Although the review primarily looks at changes in the costs of providing treatment, it can also consider whether other amendments are needed such as adding new rates for particular classes of treatment provider. Higher rates might be justified for better qualified providers if qualification level is likely to make a difference to the treatment provided, e.g. a GP consultation (which has a higher payment rate) might be more thorough than that given by a nurse, but a hearing test is likely to be equally effective whether provided by an audiometrist or a more highly qualified audiologist.

Adding audiometrists as treatment providers to enable ACC funding

86. 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.

87. 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 5.1A: Continue not funding audiometrists to provide ACC treatment

88. This is the status quo option where audiometrists wouldn’t be funded to perform any treatment covered by ACC.

89. This option wouldn’t improve access to treatment and wouldn’t add any extra costs.

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

Option 5.1B: Commence funding audiometrists for ACC treatment

91. 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.

92. 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.

93. 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.

94. A clear majority of submissions, 39 out of 45, were in favour of the proposal with many pointing out that ACC work is within the scope of practice for audiometrists. It was also pointed that most of the ACC work is routine work that audiometrists are very familiar with and already undertaking for cases with health funding. Some submissions considered the proposal was likely to improve access to treatment for patients.

95. Some audiologists were against the proposal, asserting audiometrists aren't sufficiently qualified and would have to be supervised by audiologists anyway, or that there was a risk in letting them deal with cases that could turn out to be complex. Some of the same submitters also doubted the proposal would improve access given there was no data to prove that there are audiometrists in regional areas where access might currently be problematic. We don't consider there is a material risk in letting audiometrists undertake more of the same treatment they are already performing for the health system.

Adding audiometrist rates to the Cost of Treatment Regulations

96. 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.

97. As discussed above, 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.

98. ACC recommended that audiometrists be subject to identical payment rates to audiologists given they are performing the same treatment. 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. ACC has already budgeted for audiology treatment spending, so setting audiometrist treatment at the same payment rates as audiologists should not have any impact on the budget.

100. 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 5.2A: Don’t set audiometrist rates

101. 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.

102. 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.

103. 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 5.2B: Make all audiologist rates also apply to audiometrists

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

105. 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.

106. 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.

107. A clear majority of submissions were in favour of the proposal with many pointing out that it is fair to provide the same payment for undertaking the same work.

108. The same minority of audiologists, 6 out 45, who were against letting audiometrists undertake ACC work were also against setting identical treatment rates for audiometrists, who they considered less qualified.

How do the options compare to the status quo?

Adding Chinese medicine practitioners as registered health professionals to get treatment injury coverage

	Option 3.2A – Status Quo	Option 3.2B – Extend treatment injury coverage to all Chinese medicine practitioners regulated by CMC
Keeping patients safe	0	**0**
Improving access to treatment	0	0
Keeping costs sustainable	0	**0**
Minimising differences between the health and ACC systems	0	+
Overall assessment	0	+

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

109. Option 3.2B is likely to best meet the policy objectives of encouraging more patients to access treatment and minimising differences between the health and ACC systems, with most of the benefit coming from the latter objective. The treatment injuries of Chinese medicine professionals would be given the same coverage as other health professionals regulated under the HPCA Act. There may also be improved patient safety with ACC having visibility of treatment injuries. However, this was not considered significant enough to add a score to the evaluation.

110. Option 3.2B received overwhelming support from submitters, who were nearly all Chinese medicine practitioners.

Adding paramedics as treatment providers to enable ACC funding of treatment

	Option 4.1A – Status Quo	Option 4.1B – Add paramedics as treatment providers so they can be funded by ACC
Keeping patients safe	0	**0**
Improving access to treatment	0	+
Keeping costs sustainable	0	**0**
Minimising differences between the health and ACC systems	0	+
Overall assessment	0	++

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

111. Option 4.1B is likely to best meet the policy objectives of improving access to treatment and minimising differences between the health and ACC systems. Paramedics were regarded by submitters as having skills complementary to other health professionals in general practice so allowing them to be used in the same way will help relieve pressure on the health system while minimising differences.

112. Option 4.1B is likely to have an immaterial cost because paramedics should largely be providing treatment that would have occurred anyway, but they might provide it sooner and for a slightly lower cost.

Adding paramedic treatment rates to the Cost of Treatment Regulations

	Option 4.2A – Don't add paramedic treatment rates	Option 4.2B – Add paramedic treatment rates
Keeping patients safe	0	**0**
Improving access to treatment	0	**0**
Keeping costs sustainable	**0**	**+**
Minimising differences between the health and ACC systems	0	**+**
Overall assessment	0	**++0**

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

113. Option 4.2B is likely to best meet the policy objectives of keeping costs sustainable and minimising differences between the health and ACC systems.

114. Option 4.2B saves money compared to what might happen if paramedics are added as treatment providers without also adding payment rates.

115. The criticism of this option from submissions was not that it was adding payment rates, but that they are too low. We expect many paramedics in general practice will be covered by the Rural General Practice contract so the new rates will not apply. This will reduce both the positive and negative impacts of introducing the proposed new rates for paramedics.

Adding audiometrists as treatment providers to enable ACC funding of treatment

	Option 5.1A – Status Quo	Option 5.1B – Add audiometrists as treatment providers so they can be funded by ACC
Keeping patients safe	0	**0**
Improving access to treatment	0	+
Keeping costs sustainable	0	**0**
Minimising differences between the health and ACC systems	0	+
Overall assessment	0	++

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

116. Option 5.1B is likely to best meet the policy objectives of improving access to treatment and minimising differences between the health and ACC systems. Audiometrists have the appropriate scope of practice to provide ACC treatment to most patients.

117. Option 5.1B is likely to have an immaterial cost because audiometrists should largely be providing treatment that would have occurred anyway, but they might provide it slightly sooner.

Adding audiometrist treatment rates to the Cost of Treatment Regulations

	Option 5.2A – Don't add audiometrist treatment rates	Option 5.2B – Add audiometrist treatment rates
Keeping patients safe	0	**0**
Improving access to treatment	0	**0**
Keeping costs sustainable	**0**	**+**
Minimising differences between the health and ACC systems	0	**+**
Overall assessment	0	**++0**

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

118. Option 5.2B is likely to best meet the policy objectives of keeping costs sustainable and minimising differences between the health and ACC systems.

119. Option 5.2B saves money compared to what might happen if audiometrists are added as treatment providers without also adding payment rates.

120. All those submissions that supported adding audiometrists as treatment providers also supporting adding payment rates for them that are the same as the audiologist payment rates.

What are the marginal costs and benefits of the suite of proposed changes to the Definitions Regulations and Cost of Treatment Regulations?

Affected groups *(identify)*	**Comment** *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.*	**Evidence Certainty** *High, medium, or low, and explain reasoning in comment column.*
Additional costs of the preferred option compared to taking no action			
Chinese Medicine practitioners	The new costs imposed by being regulated by CMC will be incurred anyway. There may be reputational benefits.	Low	Low
Chinese Medicine patients	Some new 'treatment injuries' covered but some 'accident injuries' from treatment might stop being covered.	Low	Low
Total monetised costs	The monetary benefits are too uncertain to estimate	N/A	N/A
Non-monetised costs	The monetary benefits are too uncertain to estimate	Low	Low

Affected groups *(identify)*	**Comment** *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.*	**Evidence Certainty** *High, medium, or low, and explain reasoning in comment column.*
Additional benefits of the preferred option compared to taking no action			
Paramedic employers	Can make better use of paramedics which might improve business profitability and/or staff morale	Medium	Medium. All submissions were positive and many passionate.
Practice patients	Some patients may get treated more promptly and by someone more experienced in treating accident injuries. No data.	Low	Low
Total monetised benefits	The monetary benefits are too uncertain to estimate	N/A	N/A
Non-monetised benefits		Medium	Medium

Affected groups *(identify)*	**Comment** *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.*	**Evidence Certainty** *High, medium, or low, and explain reasoning in comment column.*
Additional benefits of the preferred option compared to taking no action			
Audiometrist employers	Can make better use of audiometrists which might slightly improve business profitability and/or staff morale	Low	Medium. Some convincing submissions.
Practice patients	Some patients may get treated more promptly. No data.	Low	Low
Total monetised benefits	The monetary benefits are too uncertain to estimate	N/A	N/A
Non-monetised benefits		Low	Low

Section 3: Delivering an option

How will the new arrangements be implemented?

121. If Cabinet gives its approval, it is planned that the proposed changes to regulations will take effect from 1 December 2024.

122. From the commencement date, new treatment providers can begin providing treatment to ACC clients.

123. ACC will be responsible for operationalising the necessary changes. Work includes making the necessary IT system changes and informing new treatment providers. This is routine work for ACC and the cost will be covered by ACC's operating budget.

124. For the new treatment providers to provide services under existing contracts, these will need to be amended via a contract variation or through the annual contract renewal process.

125. We don't consider there are any material risks posed by implementation.

How will the new arrangements be monitored, evaluated, and reviewed?

126. ACC undertakes monitoring of all treatment providers to check that appropriate treatment is being delivered (for example, they are not overtreating clients or engaging in deceitful billing practices). This is routine work covered by ACC's operating budget.

127. Issues relating to the conduct of treatment providers (such as malpractice, working out of scope or misconduct) will be escalated by ACC to the relevant regulatory authority.

128. As discussed above, ACC is required to undertake a regular two-yearly review of regulated payment rates and report to the Minister with its recommendations. Any issues identified through monitoring or stakeholder feedback can be addressed through this process.