The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Tēnā koutou

MBIE targeted consultation — Proposed changes to streamline and update ACC regulations

Our position

The College supports the overall intent of these proposals to streamline and modernise the ACC regulations, and welcomes measures that improve timely, equitable access to treatment. Our substantive interest is in Package 1 — designating pharmacist prescribers as ACC treatment providers — which we support in principle, conditional on the role being fully integrated with, and complementary to, GP-led general practice, and on funding settings that provide additional, not redistributed, funding into multidisciplinary care, and which do not shift unfunded workload onto general practice. We also seek a published equity and distributional analysis of the proposed move from the AMA4 to the AMA6 in Package 3, given its potential to reduce compensation for mental-injury claimants. We offer brief, supportive comments on Package 2 and no substantive comment on Package 4. Across all four, equity for Māori, Pacific peoples and rural communities should be an explicit design consideration.

Introduction

Thank you for the opportunity to comment, on behalf of the Minister for ACC, on MBIE's targeted consultation on proposed changes to streamline and update a suite of Accident Compensation regulations. The Royal New Zealand College of General Practitioners (the College) is Aotearoa New Zealand's largest medical college, with 6,018 specialist General Practitioners (GPs) forming around 40 percent of the medical workforce. The College sets standards for, and trains, the specialist GP and Rural Hospital Doctor workforce through its General Practice Education Programme (GPEP) and Rural Hospital Medicine Training Programme (RHMTP). Specialist GPs are the first point of contact for around 90 percent of patient healthcare concerns in the community and provide holistic care across some 24 million patient contacts each year.

This submission continues the College's engagement with MBIE and ACC, most recently our May 2026 submission on the Cost of Treatment and Definitions Regulations. The consultation groups the proposed changes into four packages. Consistent with our advocacy approach, we have focused our response on the proposals most material to general practice and to equity, and where the College is a distinctive voice. We comment substantively on Package 1, offer an equity comment on Package 3 and a brief supportive note on Package 2, and do not comment on Package 4. Our comments are preceded by a cross-cutting point on te Tiriti o Waitangi, equity and access.

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1. Te Tiriti o Waitangi, equity and access (cross-cutting)

The College is committed to honouring te Tiriti o Waitangi, upholding Māori health rights, and eliminating health inequities — and we regard equity as a design feature of any reform, not an add-on. The Accident Compensation scheme is a vital support for injured New Zealanders, but access to, and outcomes from, ACC-funded support are not experienced equitably. The College is concerned that Māori, Pacific peoples, disabled people and rural communities can face barriers to accessing ACC support relative to their need. We ask that each proposed change be tested for its equity impact, and that ACC and MBIE collect and report data — by ethnicity, geography and deprivation — to monitor whether these changes narrow or widen inequities over time.

We recommend that MBIE and ACC:

- Assess each proposed change for its impact on equity of access and outcomes, particularly for Māori, Pacific peoples and rural communities.
- Embed cultural safety in the standards and settings that govern who provides ACC-funded treatment and how impairment is assessed.
- Collect and report ACC access and outcome data disaggregated by ethnicity, geography and deprivation, and use these data to identify, monitor, and address inequities.

2. Package 1 — Designating pharmacist prescribers as ACC treatment providers

The College supports, in principle, designating pharmacist prescribers working in general practice and like settings as ACC treatment providers. Pharmacist prescribers are registered health practitioners with a distinct scope who provide specialist input into complex medicines management within collaborative teams. Enabling them to be funded by ACC for treatment provided in general practice is a sensible, modest expansion that can improve timely access for claimants whose injuries require complex medicine management, and make better use of the general practice team.

Our support is conditional. The benefits will be realised, and the risks managed, only if the role is fully integrated with, and complementary to, GP-led general practice. The College's consistent position is that new and expanded team roles should complement — not substitute for — the GP–patient relationship, and that care must remain coordinated and continuous. In practice this requires shared records, timely notification to the patient's usual GP or team, and agreed handover and follow-up pathways, so that pharmacist-prescriber care is integrated rather than fragmenting.

Reform of this kind must not shift unfunded workload onto general practice. Follow-up, medicines reconciliation and management of any complications should not become an unfunded burden on general practice, and clinical responsibility should be clear where care initiated by a pharmacist prescriber is continued by the GP.

On the proposed consultation rates in the Cost of Treatment Regulations, the College refers to the time-based consultation pricing principle set out in our May 2026 submission: consultation rates should reflect a consistent unit-of-time cost applied across providers for equivalent services, rather than embedding specialty-based differentials. Rates should be set so they sustain well-integrated, team-based care and do not create incentives to substitute pharmacist-prescriber consultations for comprehensive GP care where the latter is clinically indicated.

The College seeks clarification on the proposed consultation funding model, including the rationale for the proposed allocation of consultation payments where pharmacist prescribers are involved. It is unclear whether the proposal represents additional investment in multidisciplinary care or a redistribution of existing consultation funding. MBIE should demonstrate that the model does not reduce funding available to general practice, create unfunded clinical responsibilities, or disproportionately affect practices serving high-needs populations. Clinical accountability should also be clearly defined where multiple providers contribute to an episode of ACC care.

We recommend that MBIE and ACC:

- Support designating pharmacist prescribers (in general practice and like settings) as ACC treatment providers, on the conditions below.
- Require integration with general practice, including shared clinical records, timely notification to the patient's usual GP or practice team, and agreed handover and follow-up pathways, to ensure the pharmacist prescriber role complements, rather than substitutes for, the GP-patient relationship and ongoing continuity of care. Funding settings should also avoid creating incentives for substitution.
- Avoid cost-shifting: MBIE should demonstrate that the funding model represents additional investment rather than redistribution of existing funding, and that follow-up, reconciliation and complication management do not transfer unfunded workload to general practice. Clinical responsibility should be clearly defined where care is shared across providers.
- Set consultation rates on a consistent, time-based basis (per the College's May 2026 submission), so they sustain team-based care and avoid unwarranted specialty differentials.
- Define the "general practice and like settings" limitation clearly to prevent unintended scope-creep.

3. Package 3 — Updating the Lump Sum Regulations (assessment tools)

The College supports the principle that the tools used to assess whole-person impairment should reflect current clinical best practice. The American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition (AMA4) are dated, and we understand the guidance is limited or absent for some impairments — including certain cancers and mental injury. Updating the assessment framework is reasonable in principle.

We raise one significant concern. MBIE's own analysis of its preferred option (adopting the AMA6) notes that it could result in lower compensation payments, on average, for mental-injury claimants compared with the current approach. The College is concerned that any assessment framework which systematically results in lower compensation for permanent mental injury than the current approach should be supported by evidence that it provides a more accurate assessment of permanent impairment, rather than simply reducing entitlements. Around 5,000 claimants undergo a permanent-impairment assessment each year. Given that Māori and Pacific peoples carry a disproportionate burden of injury and mental distress, a change that reduces mental-injury compensation carries real equity risk.

Permanent psychological injury can have profound and lifelong impacts on function, wellbeing, participation and whānau, and assessment frameworks should appropriately recognise these impacts. Before this change proceeds, the College asks MBIE and ACC to publish an explicit equity and distributional impact analysis, and to ensure the transition does not disadvantage mental-injury claimants or widen inequities.

The College also encourages ACC to seek clinical input on the updated guidance — including the ACC Mental and Behavioural Assessment Tool and guidance on rating cancer-related impairment — so the tools are both current and equitable in application.

We recommend that MBIE and ACC:

- Support updating the impairment assessment tools to reflect current clinical best practice.
- Before adopting the AMA6, require and publish an explicit equity and distributional impact analysis, with particular attention to mental-injury claimants and to Māori and Pacific peoples, and demonstrate that any reduction in compensation for permanent mental injury reflects a more accurate assessment of permanent impairment rather than simply reducing claimant entitlements.
- Ensure implementation does not unfairly disadvantage mental-injury claimants or widen inequities, and monitor outcomes across population groups.
- Seek clinical input on the updated guidance, including the Mental and Behavioural Assessment Tool and cancer-impairment rating.

4. Package 2 — Modernising the Counsellor Regulations (brief comment)

The College supports modernising the Counsellor Regulations, which have not been substantially updated since 1999, and welcomes measures that safely expand access to counselling and mental-health support — an area of high and rising unmet need for our patients, including in rural communities. We support, in principle, streamlining registration for providers assured by an appropriate body, and expanding the range of providers (including suitably qualified mental-health nurses and occupational therapists) able to deliver ACC counselling, provided quality, safety and cultural-safety safeguards are maintained. From a general practice perspective, we ask that these changes support timely referral and clear information-sharing back to the patient's GP, so that mental-health care remains coordinated. The College is not the lead voice on the technical detail of these regulations and defers to counselling and mental-health bodies on the specifics.

We recommend that MBIE and ACC:

- Support streamlining registration and expanding provider types, provided quality, safety and cultural-safety safeguards are maintained.
- Ensure changes support timely referral pathways and information-sharing back to the patient's GP, so mental-health care stays coordinated.

5. Package 4 — Audiology (no substantive comment)

The College has no substantive comment on the proposed technical amendment adding audiometrists to the Hearing Assessment Regulations. As audiometrists are already approved treatment providers and are already recognised in the Hearing Loss Regulations, the change appears to be a sensible correction that aligns the regulations with current practice.

Summary of recommendations

- Test every proposed change for its equity impact, embed cultural safety, and monitor ACC access and outcomes by ethnicity, geography and deprivation.
- Support designating pharmacist prescribers in general practice as ACC treatment providers, conditional on full integration with GP-led care and evidence of additional, not redistributed, funding.
- Require shared records, GP notification, and agreed handover and follow-up so pharmacist-prescriber care complements rather than fragments continuity — with no unfunded cost-shifting to general practice.
- Set pharmacist-prescriber consultation rates on a consistent, time-based basis that sustains team-based care and avoids substitution incentives.
- Support updating impairment assessment tools, but require a published equity and distributional analysis before adopting the AMA6, safeguarding mental-injury claimants.
- Support the safe expansion of, and streamlined registration for, ACC counselling, with coordinated referral back to the GP.
- No substantive comment on the audiology amendment.

Closing

The College supports the intent of these proposals to streamline and modernise the ACC regulations, and we thank MBIE and the ACC team for the opportunity to contribute. Our comments are offered to ensure the changes improve timely, equitable and well-coordinated access to care — in particular by keeping expanded team roles integrated with and complementary to GP-led general practice, and by safeguarding equity in how permanent impairment is assessed. We would welcome the opportunity to continue working with MBIE and ACC as these changes are finalised and implemented.

Answers to specific questions asked in the targeted consultation document are attached as Appendix A.

Nāku noa, nā

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APPENDIX A: Answers to Questions on Packages 1-3 in the Consultation Document

Package 1 — Adding pharmacist prescribers as specified treatment providers

Question 1.1.1 Do you agree that pharmacist prescribers should be designated as approved treatment providers?

Yes, in principle. The College supports designating pharmacist prescribers working in general practice and like settings as ACC treatment providers. Pharmacist prescribers are registered health practitioners with a distinct scope who provide specialist input into complex medicines management within collaborative teams, and enabling ACC funding for treatment they provide in general practice is a sensible, modest expansion that can improve timely access for claimants whose injuries require complex medicine management and make better use of the general practice team. Our support is conditional on the role being fully integrated with, and complementary to, GP-led general practice (see 1.1.2 and 1.1.4).

Question 1.1.2 What are the risks and benefits of designating pharmacist prescribers as approved treatment providers?

Benefits. More timely access to treatment for claimants requiring complex medicines management (reducing avoidable visits); better use of the multidisciplinary general practice team; and potential relief of GP workload, allowing GPs to focus on complex, longitudinal and preventive care.

Risks (and how to manage them). The principal risks arise if the role is not integrated:

- **Fragmentation of care —** the patient's GP is unaware of what was prescribed or why, risking duplication or conflicting treatment. Managed through shared records, timely notification to the usual GP or team, and agreed handover and follow-up pathways.
- **Substitution —** funding settings that create incentives to substitute pharmacist-prescriber consultations for comprehensive GP care where the latter is clinically indicated. The role must complement, not substitute for, the GP–patient relationship.
- **Cost-shifting —** follow-up, medicines reconciliation and management of complications becoming an unfunded burden on general practice; clinical responsibility must be clear where care is continued by the GP.
- **Equity —** the change should be designed and monitored so it improves access for Māori, Pacific and rural communities, rather than benefiting better-resourced settings first.

Question 1.1.3 Do you agree with the proposed treatment rates for pharmacist prescribers? Why or why not?

The College's position is on the principle by which rates are set, rather than the specific dollar figures. Consistent with our May 2026 submission on the Cost of Treatment Regulations, consultation rates should reflect a consistent unit-of-time cost applied across providers for equivalent services, rather than embedding specialty-based differentials. On that basis, rates for pharmacist prescribers should be set so they sustain well-integrated, team-based care and do not create incentives to substitute pharmacist-prescriber consultations for comprehensive GP care where the latter is clinically indicated. We do not object to the proposed rates in principle, but ask that they be tested against this time-based consultation-pricing principle and against the sustainability of team-based delivery in general practice. We also seek clarification on whether the proposed allocation of consultation payments within the proposed funding model represents additional investment in multidisciplinary care, or is a redistribution of existing consultation funding. MBIE should demonstrate that the model represents additional investment and that unfunded workload will not be transferred onto general practice.

Question 1.1.4 Is there anything else that needs to be considered in terms of this proposal?

Three points. First, integration is decisive: the proposal should be accompanied by requirements for shared records, timely notification to the patient's usual GP or team, and agreed handover and follow-up pathways, so the role complements GP-led continuity. Second, the "general practice and like settings" limitation should be defined clearly to prevent unintended scope-creep beyond the intended setting. Third, implementation should include monitoring of access and outcomes (including by ethnicity, geography and deprivation) to confirm the change improves equity of access, together with clear billing and operational guidance to avoid claiming errors and administrative burden on practices.

Package 2 — Modernising and streamlining the Counsellor Regulations

The College supports modernising the Counsellor Regulations and welcomes measures that safely expand access to counselling and mental-health support, given high and rising unmet need among our patients. The College is not the lead voice on the technical detail of these regulations and defers to counselling and mental-health professional bodies on the specifics; our answers focus on principles, patient and cultural safety, and the interface with general practice.

Clarify and update the Counsellor Regulations

Question 2.1.1 Do you agree with the proposed technical updates? Why or why not?

Yes, in principle. The Counsellor Regulations have not been substantially updated since 1999, and clarifying and modernising them to reflect current practice is sensible and supports clarity for providers and claimants. We support updates that improve clarity, quality and safety, and defer to counselling professional bodies on the technical wording.

Question 2.1.2 For proposal 2.1(a), does the proposed definition of "counselling" adequately capture the activity and provision of counselling? Why or why not? If not, how could it be improved?

The proposed definition — a structured, collaborative therapeutic process addressing psychological, emotional and psychosocial needs — appears reasonable and broad enough to reflect contemporary practice. The College is not the lead voice on this definition and defers to counselling and mental-health bodies; we would encourage the definition and its application to reflect culturally safe practice responsive to Māori, Pacific and other communities.

Question 2.1.3 For proposal 2.1(b), do the six listed courses of education represent the core skills and capabilities required of a provider to deliver quality counselling services?

The College defers to counselling professional bodies on the specific competency set. In principle, requiring a recognised NZQA Level 6 qualification and demonstrated knowledge across the core domains is a reasonable baseline for safe, quality practice.

Question 2.1.4 For proposal 2.1(c), do you think the proposed definitions are accurate? Is there anything you think has been missed?

The College does not hold a specific position on these definitional matters and defers to the counselling and mental-health bodies best placed to comment. We support definitions that provide clarity and set clear, safety-focused expectations for the sector.

Question 2.1.5 For proposal 2.1(d), do you foresee any issues arising if reference to suppliers of counselling services are removed from the Counsellor Regulations?

From a general practice perspective we do not foresee issues with removing references to suppliers that are obsolete or now managed via contract, provided referral pathways for patients remain clear and access to services is not disrupted.

Question 2.1.6 For proposal 2.1(e), do you think the updated list appropriately captures the range of providers in the current list?

The College defers to counselling and mental-health bodies on whether the updated list is complete. We support recognising the relevant responsible authorities and professional bodies, provided each has robust quality-assurance, complaints and disciplinary mechanisms.

Question 2.1.7 For proposal 2.1(f), what are the benefits and/or risks of aligning with the Clean Slate Act?

Aligning the conviction look-back period (from five to seven years) with the Clean Slate Act supports consistency and clear, fair expectations for providers, while maintaining patient-safety protections. We see no significant risk in this alignment.

Question 2.1.8 For proposal 2.1(g), do you agree with the proposed range of convictions that would disqualify a provider from registering with ACC? Are there any to add or remove?

The College supports broadening the range of disqualifying offences to protect vulnerable ACC clients, consistent with a patient-safety-first approach and alongside other checks (such as police vetting and children's-worker safety checks). We defer to counselling and safeguarding bodies on the precise offence list, and would support erring toward the protection of clients.

Question 2.1.9 Is there anything else that needs to be considered in terms of these proposals?

Two points from a general practice perspective: changes should support timely referral pathways and clear information-sharing back to the patient's GP, so that mental-health care remains coordinated; and cultural safety and equity of access (for Māori, Pacific and rural communities) should be explicit design considerations.

Streamlining the requirements for registering as an ACC counsellor

Question 2.2.1 Do you agree with the proposed streamlined approach? Why or why not?

Yes, in principle. Reducing unnecessary administrative burden on providers and ACC — while maintaining assurance of qualifications, supervision and safety through membership of an appropriate body — is a sensible way to support timely access to counselling. Our support is conditional on quality and safety safeguards being maintained.

Question 2.2.2 Are the proposed requirements for the streamlined approach correct? Are any requirements missing, or any that could be removed?

Relying on an Annual Practising Certificate (as evidence of membership and compliance with qualification and supervision requirements), together with a CV and evidence of meeting standard requirements, appears reasonable. We would want to ensure cultural-safety competence and appropriate safety checks are retained, within either the body's assurance or ACC's requirements. We defer to counselling bodies on the detailed requirements.

Question 2.2.3 Do you agree with the proposed list of bodies for the streamlined approach? Why or why not?

The College defers to counselling and mental-health bodies on the specific fast-track list. We support limiting the streamlined pathway to bodies with robust, demonstrable quality-assurance, complaints and disciplinary mechanisms.

Question 2.2.4 Is there anything else that needs to be considered in terms of this proposal?

Ensure the streamlined pathway does not inadvertently reduce cultural-safety or safety-check requirements, and that it supports, rather than complicates, coordinated referral and information-sharing with the patient's general practice team.

Expand the types of providers that can provide ACC counselling services

Question 2.3.1 What is your preferred option and why?

The College's overriding interest is improving safe, equitable and timely access to counselling for our patients, given high and rising unmet mental-health need. We support expanding the range of providers where this can be done safely. If a single preference is required, we favour a controlled, targeted expansion — such as adding suitably qualified mental-health nurses and occupational therapists (Option 3) — because it improves access while retaining clear oversight. We remain open to a broader approach (Option 2) provided ACC is properly resourced to assess providers against clear, safety-focused criteria. We defer to counselling and mental-health provider bodies on the final choice, provided quality, safety and cultural safety are not diluted.

Question 2.3.2 What do you think the benefits and/or risks of the proposed options are?

- **Benefits.** A larger approved workforce, improved and more timely access to counselling (including in rural and underserved communities), and reduced delays.
- **Risks.** Any weakening of quality-assurance oversight could compromise safety; broad discretion for ACC to approve new bodies could create undue pressure and inconsistency unless supported by a qualified, resourced assessment process; and expansion must maintain cultural safety. Equity of access should be monitored so that expansion reaches high-need communities.

Question 2.3.3 Is there anything else that needs to be considered in terms of this proposal?

Coordination with general practice (referral and information-sharing), maintenance of cultural safety as a core competency, and monitoring of access and outcomes across population groups.

Package 3 — Updating the Lump Sum Regulations (options for updating the assessment tools)

The College supports the principle that impairment assessment tools should reflect current clinical best practice. Permanent-impairment assessment is undertaken by ACC-appointed specialist assessors rather than GPs, so we defer to medico-legal and specialist assessors on the clinical detail of the tools. The College's distinctive contribution is on equity.

Question 3.1.1 What is your preferred option and why?

The College supports moving away from the status quo (Option 1), as the AMA4 and current User Handbook are clinically outdated — particularly for cancer-related and mental-injury impairments. We do not object in principle to adopting a current framework such as the AMA6, provided the equity concern below is addressed. Because assessment is undertaken by specialist assessors, we defer to them on the clinical choice between updating the User Handbook (Option 2), the hybrid approach (Option 3) and adopting the AMA6 as the standalone tool (Option 4). Our support for any option that could reduce mental-injury compensation is conditional on a published equity

and distributional analysis and safeguards for affected claimants; if that analysis shows the AMA6 materially reduces mental-injury compensation without providing a more accurate assessment of permanent impairment, an approach that retains the current mental-injury methodology (such as Option 3) may better protect those claimants in the interim.

Question 3.1.2 What do you think the benefits and/or risks (clinical or otherwise) are with adopting the AMA6?

- **Benefits.** The AMA6 reflects current clinical understanding and offers a more structured, consistent and less subjective methodology, improving the validity and consistency of physical-impairment ratings (including cancer-related impairments) and reducing variability between assessors.
- **Risks.** MBIE's own analysis notes that adopting the AMA6 could result in lower compensation payments, on average, for mental-injury claimants compared with the current approach. Around 5,000 claimants undergo a permanent-impairment assessment each year. Because Māori and Pacific peoples carry a disproportionate burden of injury and mental distress, a change that reduces mental-injury compensation carries a real equity risk. There are also transition risks — assessor training and change management — and a need for clinical input on the ACC Mental and Behavioural Assessment Tool and cancer-impairment guidance to ensure the tools are applied equitably. MBIE and ACC should publish an explicit equity and distributional impact analysis with particular attention to mental-injury claimants, and to Māori and Pacific peoples to demonstrate that any reduction in compensation for permanent mental injury reflects a more accurate assessment of permanent impairment rather than simply reducing claimant entitlements.

Question 3.1.3 Is there anything else that needs to be considered in terms of this proposal?

Before adopting the AMA6, MBIE and ACC should publish an explicit equity and distributional impact analysis, with particular attention to mental-injury claimants and to Māori and Pacific peoples, and ensure that the implementation does not unfairly disadvantage mental-injury claimants or widen inequities, particularly if the AMA6 does not provide a more accurate assessment of permanent impairment. Outcomes should be monitored across population groups, and clinical input sought on the updated guidance.