PHARMACY GUILD OF NEW ZEALAND

14 August 2026

Ministry of Business, Innovation & Employment
PO Box 1473
Wellington 6140

Sent via email to: ACregs@mbie.govt.nz

Dear Sir/Madam,

Re: Submission on proposed changes to streamline and update ACC Regulations

1. Introduction

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation and the largest representative of community pharmacy owners in New Zealand. We provide leadership on all issues affecting the sector and advocate for the business and professional interests of community pharmacy.

We welcome the opportunity to comment on the proposed amendments to the Accident Compensation (Definitions) Regulations 2019 and the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Our submission relates solely to Package 1 – Designating pharmacist prescribers as specified treatment providers, as this is directly relevant to community pharmacy practice, service delivery and business sustainability.

We support the overall direction of the proposal. Recognition of pharmacist prescribers as ACC treatment providers is a positive and logical step that reflects the continuing evolution of pharmacist prescribing and supports better use of New Zealand's health workforce.

Our comments focus primarily on clarifying whether, and under what arrangements, pharmacist prescriber services may be delivered from community pharmacies premises and ensuring that the proposed funding and implementation arrangements make this viable in practice.

This submission is not confidential.

2. Overall position

We strongly support pharmacist prescribers being recognised as ACC treatment providers.

Pharmacist prescribers are registered health practitioners practising within an additional scope of practice. They have specialised clinical, pharmacological and pharmaceutical knowledge relevant to their defined area of prescribing practice and are professionally accountable for the care they provide.

Within that area of practice, pharmacist prescribers can initiate, modify, discontinue or maintain medicine therapy, order and interpret investigations, assess and monitor a patient's response to treatment, and provide education and advice about medicine therapy. They must practise within a collaborative health team environment and are not the primary diagnostician.

Recognition as ACC treatment providers is therefore appropriate and consistent with the objective of better aligning ACC-funded treatment with the wider health system.

However, we are concerned that the proposal is currently described as applying only to pharmacist prescribers providing treatment in "general practice and like settings." The consultation document does not define a "like setting" or explain whether pharmacist prescribers may deliver ACC-funded pharmacist prescriber services from community pharmacy premises.

Prescribing from community pharmacy premises does not appear to be expressly prohibited. However, pharmacist prescribers cannot provide an unrestricted walk-in prescribing service. Under current Pharmacy Council requirements:

- prescribing must occur within the pharmacist prescriber's defined area of practice;
- the claimant must be under the care of the pharmacist prescriber's collaborative health team;
- the pharmacist prescriber must have timely access to relevant clinical information and be able to update the claimant's clinical record;
- appropriate clinical governance, communication, referral and monitoring arrangements must be in place; and
- the pharmacist prescriber should not be involved in any part of dispensing a prescription they have written.

Community pharmacy is one of New Zealand's most accessible healthcare settings and should not be excluded solely because of the physical practice setting. It may provide an appropriate environment for ACC-funded treatment pharmacist prescriber services where all relevant professional, clinical governance, and ACC requirements are met.

3. Community pharmacy-based delivery requires clarification

The consultation document states that the proposal would apply to pharmacist prescribers working in "general practice and like settings." It does not define a "like setting" or explain whether, and under what arrangements, community pharmacy may be included. We consider this ambiguity unnecessary and potentially restrictive.

We acknowledge that the physical location of a pharmacist prescriber consultation is only one consideration in determining whether a pharmacist prescriber service can operate safely. A pharmacist prescriber cannot provide an ACC-funded prescribing service solely because a claimant presents at a community pharmacy.

The final regulatory wording and implementation guidance should clarify whether community pharmacy is intended to be included within "like settings", and, if so, what professional, clinical and operational requirements must be met. Eligibility should be based primarily on the pharmacist prescriber's registration, competence, defined area of practice, collaborative health team arrangements, access to clinical information, clinical governance and ability to meet ACC requirements. It should not be unnecessarily restricted according to whether the practitioner is physically located in a general practice or another appropriate healthcare setting.

An appropriately designed community pharmacy-based model could support the policy objectives identified in the consultation by:

- improving claimant access to timely medicine-related treatment
- increasing available primary care workforce capacity

- supporting effective medicines management following injury
- reducing avoidable demand on general practice and other primary care services
- improving equity of access, particularly in rural and underserved communities
- allowing care to be delivered from an accessible setting where the necessary clinical safeguards are in place.

Community pharmacy already delivers a growing range of publicly funded clinical services, including vaccination, medicines optimisation and adherence services, emergency contraception, anticoagulation management and the Extended Pharmacy Service. These services demonstrate the sector's established infrastructure and capability to deliver funded patient care within appropriate professional and clinical governance arrangements.

Community pharmacy also provides an access model that differs from, and complements, traditional general practice through extended opening hours, walk-in accessibility, broad geographic coverage, established and often longstanding relationships with patients, and the ability to integrate prescribing decisions with medicines management, supply, monitoring and follow-up.

Although the pharmacist prescriber workforce is currently small and predominantly based in general practice and secondary care, it is growing. In July 2026, the Pharmacy Council also noted that further work is required to understand and define how pharmacist prescribing will operate across the full continuum, including community, hospital and general practice settings.

We recommend that MBIE and ACC confirm that community pharmacy premises may be an eligible "like setting" where all relevant professional, collaborative, clinical governance and operational requirements are met, and clearly specify those requirements in the implementation guidance.

4. Funding must reflect community pharmacy practice

We support pharmacist prescribers being appropriately remunerated for ACC-funded consultations. However, the consultation provides insufficient information to determine whether the proposed consultation rates adequately reflect the costs of delivering pharmacist prescriber services from community pharmacy.

ACC advises that the proposed rates have been developed using assumptions including salary ranges, employment obligations, indirect clinical time, business operating expenses and margins. We support the inclusion of these factors.

Our concern is whether the assumptions and values applied to those factors accurately reflect the community pharmacy delivery model. The consultation does not disclose the assumptions used, including the consultation duration, salary cost, allowance for indirect clinical and administrative time, operating costs or expected patient contribution. Without this information, it is difficult to assess whether the rates are reasonable or sustainable for a community pharmacy-based model. Without this information, it is difficult to assess whether the proposed rates are reasonable or sustainable for a community pharmacy-based model.

The proposed standalone contribution ranges from $25.61 excluding GST for a claimant aged 14 or over without a Community Services Card to $54.52 for a claimant under 14. However, the time and professional resources required may not differ significantly according to the claimant's age or Community Services Card status.

This structure mirrors existing general practice contribution categories, where higher contributions support free visits for certain patient groups. A community pharmacy providing this service would not ordinarily receive general practice capitation or an equivalent funding stream to cross-subsidise the lower adult contribution. Unless a significant patient contribution is charged, $25.61 may not adequately cover the consultation, documentation, liaison, follow-up, claiming and associated business costs. A significant patient charge could also undermine the objective of improving access.

The consultation also proposes combined rates based on an assumption that a consultation comprises 80% medical practitioner or nurse practitioner input and 20% pharmacist prescriber input. That combined model may be appropriate in some general practice environments, but it should not shape or constrain a model in which a pharmacist prescriber independently assesses and manages an ACC claimant within their scope of practice.

Within community pharmacy, a pharmacist prescriber may be the principal treating practitioner for the consultation, supported by pharmacy premises, clinical and dispensing systems, administrative infrastructure and other pharmacy staff. They may deliver a complete medicines-management consultation within their defined area of practice and collaborative health team arrangements. The funding model should recognise the full pharmacist prescriber contribution in these circumstances, including clinical review, assessment and treatment, documentation, communication with other providers, referral where required, ACC claiming and other indirect clinical activity.

Accordingly, we recommend that MBIE and ACC:

- provide further information about the methodology and assumptions used to calculate the rates
- validate the proposed standalone pharmacist prescriber rates against the actual cost of any community pharmacy-based delivery model, including indirect clinical and administrative activity
- ensure the funding model does not assume pharmacist prescribers will predominantly provide only a supplementary component of another practitioner's consultation
- ensure the standalone rate appropriately recognises a complete pharmacist prescriber medicines-management consultation and clarify whether relevant treatment and procedure codes may also be claimed
- engage directly with community pharmacy stakeholders before finalising the pricing and implementation model.

Appropriate remuneration is essential if the proposal is to translate from regulatory recognition into genuine improvements in claimant access.

5. Implementation, accountability and clinical integration

We recommend that clear implementation guidance accompany the regulatory changes.

The existing regulatory framework is intended not only to determine which practitioners can receive ACC funding, but also to provide certainty about the professional standards and requirements expected of treatment providers.

Implementation guidance for pharmacist prescribers should clearly address:

- ACC provider registration and eligibility responsibilities

- whether the individual pharmacist prescriber, their employing organisation or the pharmacy business will hold the relevant ACC provider registration
- clinical and professional accountability
- the respective responsibilities of pharmacist prescribers, pharmacy owners and other members of the collaborative health team
- how a claimant will come under the care of the pharmacist prescriber's collaborative health team
- documentation and record-keeping requirements
- access to relevant clinical and ACC claim information
- the ability to enter information into, or update, the appropriate shared clinical record
- claiming processes and applicable service codes
- communication and information sharing with other healthcare providers
- referral, escalation, monitoring and follow-up expectations
- professional indemnity requirements
- operational separation between prescribing and dispensing
- management of actual or perceived conflicts of interest where prescribing and medicine supply occur within the same pharmacy business
- protection of the claimant's choice of dispensing pharmacy
- any restrictions on the frequency, duration or type of treatment that may be claimed.

The Pharmacy Council states that pharmacist prescribers should not be involved in any part of the dispensing process for prescriptions they have written. The implementation model must therefore explain what separation is required where prescribing occurs from community pharmacy premises.

The proposal must also clarify whether pharmacist prescribers will be able to lodge an initial ACC claim or whether their treatment role will commence only after an injury has been diagnosed and an ACC claim established by another treatment provider.

This is particularly important because pharmacist prescribers are not the primary diagnostician under their current Pharmacy Council scope of practice. The operational model must clearly distinguish between diagnosing an injury and assessing and managing the claimant's medicine-related treatment needs.

Providing this clarity before implementation will encourage participation by pharmacist prescribers and pharmacy owners and support nationally consistent, safe delivery.

6. Supporting better access to care

We support the underlying policy intent of making better use of pharmacist prescribers within ACC-funded care.

MBIE anticipates that recognising pharmacist prescribers could improve access for claimants requiring complex medicines management, including complex medicines management, and potentially generate longer-term savings where better treatment results in improved outcomes, such as faster return to work or independence.

Community pharmacy premises could provide an accessible location for appropriately designed pharmacist prescriber services. However, accessibility of the physical setting must be

accompanied by the clinical information, collaborative arrangements and governance required for safe prescribing.

Community pharmacists are highly accessible health professionals and are frequently approached by people seeking advice about pain, minor injuries and medicines used to manage them. Pharmacist prescribers practising within this environment could, where clinically appropriate and within their scope, assess ACC claimants, prescribe or adjust medicines, optimise existing treatment, monitor outcomes and coordinate referral or escalation.

A service could potentially operate through agreed referrals, booked consultations, shared-care pathways or other arrangements that bring the claimant appropriately under the care of the collaborative health team.

This could provide claimants with another appropriate point of access to treatment while complementing, rather than duplicating, general practice and other primary care services.

The proposal should therefore be viewed not simply as a technical funding amendment, but as an opportunity to develop appropriately governed models to make better use of an increasingly capable primary care workforce.

7. Responses to consultation questions

Question 1.1.1

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

Yes. The Guild strongly supports pharmacist prescribers being designated as ACC treatment providers.

Pharmacist prescribers are registered health practitioners practising within an additional scope of practice. They have specialised expertise in medicines management and are professionally responsible and accountable for the care they provide within their defined area of practice and collaborative health team arrangements.

Their designation as ACC treatment providers appropriately recognises their existing clinical capability and supports the stated objectives of improving claimant access and better aligning ACC with the wider health system.

As outlined in sections 2 and 3, community pharmacy premises should not be excluded solely because of physical practice setting. They may provide an appropriate setting where all relevant professional, collaborative, clinical governance and ACC requirements are met. We recommend that community pharmacy be explicitly confirmed as an eligible “like setting” from which pharmacist prescribers may provide ACC-funded treatment.

Question 1.1.2

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

The benefits and risks are discussed in sections 3, 5 and 6.

The principal benefits include improved access to medicines-related treatment, better use of pharmacist prescribers' expertise, improved medicines management and monitoring, reduced avoidable demand on other primary care services and potentially improved claimant outcomes.

The principal risks relate to implementation rather than designation. These include unclear eligibility, inadequate access to clinical information, fragmentation of care, prescribing outside collaborative arrangements, uncertainty about diagnosis and initial claim lodgement, insufficient separation between prescribing and dispensing, conflicts of interest and unsustainable funding.

These risks can be managed through clear eligibility and service requirements, appropriate clinical governance, access to relevant information, sustainable funding and comprehensive implementation guidance.

Question 1.1.3

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

Not in their current form.

The Guild supports the establishment of dedicated ACC consultation rates for pharmacist prescribers and acknowledges that ACC's methodology includes salary costs, employment obligations, indirect clinical time, business operating expenses and margins.

However, we are not satisfied that the proposed rates have been demonstrated to reflect the actual cost of independently delivered pharmacist prescriber services within community pharmacy.

As outlined in section 4, the consultation does not provide sufficient information to determine whether the rates are reasonable or sustainable for a community pharmacy-based model.

We recommend that ACC publish its underlying assumptions, validate the standalone rates against actual delivery costs, ensure the rates recognise a complete pharmacist prescriber medicines-management consultation and engage with community pharmacy stakeholders before finalising them.

Question 1.1.4

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

Yes. As discussed in sections 3-5, MBIE and ACC should clarify:

- Whether and under what arrangements community pharmacy premises may be an eligible "like setting".
- How a claimant comes under the care of the pharmacist prescriber's collaborative health team.
- Whether pharmacist prescribers may lodge an initial claim or only treat an established injury and claim.
- Provider registration, clinical information access, documentation, claiming and accountability requirements.

- The required separation between prescribing and dispensing, management of conflicts and protection of claimant choice.
- Whether relevant treatment or procedure codes may also be claimed.
- How the Pharmacy Guild, Pharmacy Council and wider community pharmacy sector will be involved in implementation.

Thank you for the opportunity to provide feedback on this consultation. If you have any questions about our feedback, please contact our Senior Advisory Pharmacists, Martin Lowis (martin@pgnz.org.nz, 04 802 8218) or Cathy Martin (cathy@pgnz.org.nz, 04 802 8214).

Yours sincerely,

Nicole Rickman
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