# Prescribing Authority for Paramedics 2025

# Independent Consultation Analysis

## Contents

## Executive Summary: Prescribing Authority for Paramedics 2025–26: Full Consultation Analysis

### Consultation overview

Te Kaunihera Manapou | Paramedic Council (Te Kaunihera) undertook a public consultation in late 2025 to assess whether paramedics in Aotearoa New Zealand should be granted prescribing authority, and under what conditions. The consultation forms part of a broader programme of work aligned with Manatū Hauora | Ministry of Health's legislative and policy processes and is intended to inform a potential formal application in early 2026.

The consultation was open for eight weeks (21 Noema | November 2025 to 20 Hānuere | January 2026) and received 253 responses, with 197 providing substantive feedback to consultation questions. Respondents included registered paramedics, employers, professional organisations, other health professionals, education providers and members of the public. Analysis combined quantitative survey results with thematic qualitative analysis of free-text responses.

### Overall support

There is strong overall support for paramedic prescribing. 88% of respondents supported paramedics being able to prescribe medicines, rising to 92% among paramedics and 95% among organisations. Support was usually conditional, with respondents emphasising the need for robust education, governance, and patient safety measures.

### Scope of practice and prescribing model

There was no single preferred option for which paramedic group(s) should prescribe, but the strongest overall theme was support for a ***phased introduction***. Most respondents favoured starting with specialist paramedic practise endorsements (particularly Extended Care Paramedics) before considering wider rollout once systems and safeguards have been established and tested.

The designated prescriber model received high support (86% overall; 100% of organisations), with many viewing it as a pragmatic and low-risk starting point. Some respondents noted it should be considered transitional, with the potential for progression to authorised prescribing in the future.

There was strong support for establishing a new Scope of Practice for paramedic prescribers, seen as providing clarity, public confidence, and regulatory control.

### Controlled drugs

74% of respondents supported paramedic prescribers being able to prescribe certain controlled drugs, subject to strict limitations. Support was strongest for specific contexts such as palliative care and acute pain, with clear opposition to long-term or chronic prescribing.

### Potential impacts of granting prescribing authority to paramedics

Supporters identified improved access to medication and care as the primary benefit, particularly for rural, remote, Māori, Pacific, older, and disabled communities. Prescribing was

seen as enabling paramedics to 'complete' episodes of care, reduce delays, and decrease unnecessary referrals and transport to GPs and emergency departments. Many respondents described prescribing as a natural evolution of modern paramedic practice, aligning with international models and other Aotearoa New Zealand professions such as nursing and pharmacy. Benefits for paramedic workforce development and sustainability were also frequently cited, including expanded career pathways for specialist practice paramedics.

**Key concerns and conditions**

Concerns centred on patient safety, particularly diagnostic limitations, pharmacology knowledge, and the episodic nature of paramedic–patient encounters. Respondents highlighted risks of fragmented care, lack of follow-up, and the potential overuse of emergency ambulance services if prescribing is poorly implemented. Strong governance, postgraduate education, audit, access to patient records, and clear integration with primary care were consistently identified as prerequisites for safe implementation.

**Overall conclusion**

The consultation demonstrates clear, conditional support for paramedic prescribing in Aotearoa New Zealand. Respondents broadly agree that prescribing authority could improve access, equity, and system efficiency, provided it is introduced cautiously through a phased approach underpinned by strong education, governance, and integration with the wider health system.

# 1. Introduction and methodology

## 1.1 Consultation objectives and approach

In early 2025, Te Kaunihera Manapou | Paramedic Council (Te Kaunihera) started the hikoi | journey to explore paramedic prescribing authority for Aotearoa New Zealand. A 'temperature check' survey conducted in Ākuhata | August 2025 showed high levels of sector and public support, with 87% of online respondents supporting exploring prescribing authority for paramedics. This initial survey received 610 responses, 476 of whom identified themselves as paramedics.

In late 2025, Te Kaunihera launched a full consultation on the feasibility of prescribing authority for paramedics, seeking feedback on whether paramedics should be authorised to prescribe a specific range of prescription medicines, under a designated prescriber model, to enhance access to care while maintaining public safety. This report contributes to the mahi that is underway in parallel with Manatū Hauora | Ministry of Health's consultation and legislative processes.

The full prescribing authority consultation was shared online, sent to Te Kaunihera's register of paramedics, and a range of stakeholder organisations. The full consultation was open for eight weeks, from Rāmere, te 21 o Noema 2025 | Friday 21st November 2025 until Rātū, te 20 o Hānuere 2026 | Tuesday 20 January 2026.

Background information and the consultation documents can be found here.

## 1.2 Data analysis

All responses to the consultation were collated from the survey platform tool and individual submissions sent to Te Kaunihera. All submissions were combined into an Excel dataset to facilitate the individual and aggregated analysis of both quantitative (descriptive statistics) and qualitative (free text) information.

A combined deductive and inductive approach was used for qualitative analysis of the feedback. Themes were identified, coded and counted across each consultation item. Responses were grouped by sentiment (level of agreement with question), and by respondent type (all respondents, and subsets for those who identified as paramedics, and those submitting feedback on behalf of an organisation).

A focus for the analysis was to guide Te Kaunihera's decision to proceed with a formal application to Manatū Hauora | Ministry of Health in early 2026, and to highlight key themes and issues raised ahead of the next steps in the hikoi | journey. The specifics of eligibility criteria, education and supervision requirements, competencies, continuing professional development (CPD) requirements, prescribing scope of practice, prescribing standards and a safe, phased implementation plan will come in later stages of the hikoi | journey, and will include further consultation.

Strengths and limitations of the analysis:
The submission analysis was conducted by an independent contractor from the regulatory sector, with no association or conflict of interest within the paramedicine field. This maximised the objective assessment and analysis of feedback. Any quotes included in this report are anonymous.

## 2. Participation Analysis

This section summarises the respondents and quality of submissions received in response to the full consultation circulated by Te Kaunihera. This includes information about the respondents, and specific questions about prescribing authority for paramedics.

### 2.1 Descriptive analysis of respondents

The consultation feedback was collected through an online SurveyMonkey tool, and from written submissions received by Te Kaunihera. A total of 253 responses to the consultation were received. This included:

- 229 individual responses
  - 188 identified themselves as registered paramedics.
  - 17 identified themselves as a member of the public.
- 24 responses on behalf of an organisation, including:
  - 6 employers of paramedics
  - 3 education providers
  - 11 other organisation types, including professional organisations.

Organisations could identify with more than one 'role' type. Two organisation-level responses did not specify their name or type of organisation, with one stating it was a 'rural general practice'.

All of those who responded to the consultation were asked a range of optional demographic and employment questions. More information about the respondents can be found in Appendix 1.

### 2.2 Quality of submissions

While 253 respondents accessed the consultation feedback form and completed the initial page, only 197 of these respondents gave responses to the consultation questions themselves (78%). The analysis of descriptive statistics uses the number who answered each consultation question to calculate percentages.

A range of feedback was received through the survey feedback tool and written submissions, from both individuals and organisations, and all feedback was constructive and professional. Many submissions gave lengthy and detailed feedback about paramedic

prescribing and referenced content from the consultation documents. This showed encouraging engagement with the specific components of paramedic prescribing under consideration.

A small number of responses may have been generated using artificial intelligence (AI) or duplicated/shared across different respondents. All feedback was considered regardless of tone, to ensure the underlying concerns and feedback were recorded alongside all other responses. This ensures democratic participation while also maintaining the standard expected in professional reporting.

## 3. Consultation Analysis

### 3.1 Prescribing authority for paramedics – consultation areas of interest

The survey feedback tool asked a series of questions to gauge overall agreement with the concept of prescribing authority, and a range of factors that sit beneath the proposal. This section summarises the analysis for the consultation areas of interest, including:

- Overall support for paramedics being able to prescribe medicines in Aotearoa New Zealand
- Agreement with specific aspects of paramedic prescribing, including:
  - Which paramedic role(s) should receive prescribing authority
  - The choice of a 'designated prescriber' model
  - Prescribing of controlled drugs
  - Establishing a new Scope of Practice for paramedic prescribers
  - Impacts of paramedic prescribing on different communities (both positive and negative)
- General feedback about why paramedics should, or should not, be able to prescribe medicines.

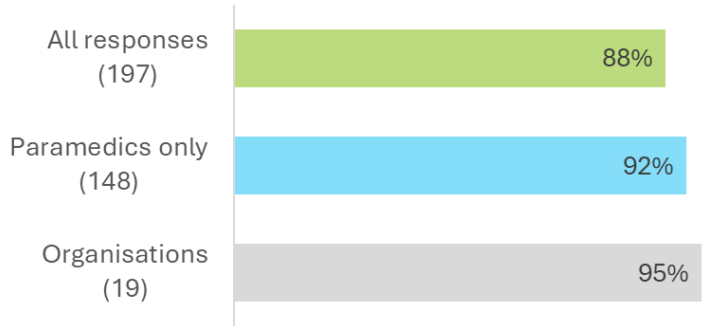
Each area of interest has a summary table with the original survey question, and charts showing the key results for all respondents, and for subgroups such as paramedics or organisations (where available). The numbers under each subset name in the charts indicate the number of respondents who answered that specific question.

Most of the survey items included an invitation for respondents to 'please feel free to tell us more'. Comments and feedback for these questions have been analysed for key themes, with the highest occurring feedback themes noted and described. Verbatim quotes have been included where they support and demonstrate key viewpoints and constructive suggestions (in italics). Where respondents used acronyms in their feedback, these have been written out in full for ease of understanding.

#### 3.1.1 Support for prescribing authority

| | |
|---|---|
| **Consultation item** | Do you support paramedics being able to prescribe medicines in Aotearoa New Zealand?<br>*Note - This would require changes to the Medicines Act 1981 regulations.* |

Most respondents to the consultation said that they support paramedics being able to prescribe medicines in Aotearoa New Zealand (88%), and for paramedics the support was slightly higher (92%). Almost all of the organisation-level responses supported paramedic prescribing (95%).




A total of 91 respondents gave additional feedback about paramedic prescribing in general, and feedback clearly showed strong support for paramedic prescribing, provided certain conditions are met. These conditions aligned with what was described in the consultation document, namely a gradual introduction, with strong education and clinical training, and safety and governance frameworks in place to support safe prescribing.

> *[Employer] is conceptually supportive of paramedics being able to prescribe medicines in Aotearoa New Zealand, provided this is introduced thoughtfully, at an appropriate pace, and supported by robust education, governance, and workforce frameworks. (Organisation)*

Key themes in support of paramedic prescribing included:

- ✓ Support for increased patient/public access to prescribers
- ✓ Conditional support, based on a phased/staged implementation approach, starting with specialist practice paramedic
- ✓ Support to enable modern, consistent paramedic practice and align with international experience
- ✓ Conditional support, based on governance and standards that support safe prescribing

Key concerns for those who do not support paramedic prescribing include:

- × Concerns relating to patient/public safety specific to clinical knowledge and training
- × Concerns about abuse/overuse of already stretched paramedic service to fill gaps in other areas of health system
- × Concerns about system readiness and rushing implementation

✓ **Support for increased patient/public access to prescribers**

The main reason that respondents supported paramedic prescribing was that it would improve patient care and service efficiency. Many participants note that prescribing rights would improve patient care, particularly in rural areas or situations where doctor access is limited.

> *I come from Kaitaia, raised in Houhora most of my life. The time to travel into Kaitaia, return, for some of our whānau is impossible. Often meaning our old people and our young go days without the right care. Having access to this resource on a local level would ease this strain on rural communities where paramedics do have greater access. (Member of the public)*

> *Yes, I support prescribing authority for paramedics when the right safeguards are wrapped around it. Working as an Extended Care Paramedic in a rural primary care setting, I see every week how a simple lack of prescribing ability can turn an otherwise straightforward case into a multi-step, frustrating journey for patients. Standing orders let me start good care, but they stop me from completing it. (Paramedic)*

✓ **Support to enable modern, consistent paramedic practice and align with international experience**

Those advocating for broader access argue that paramedics' roles are expanding, especially in community-based and rural settings, and prescribing aligns with modern paramedic practice. They view prescribing as a natural evolution of the paramedic role, supporting streamlined care, reduced delays, and better use of skills. It allows paramedics to be consistent with other health and allied health professionals, and brings Aotearoa New Zealand into alignment with other countries.

> *Prescribing enables paramedics to fully own and be accountable for their clinical practice. Under the current system, a paramedic's scope is partly determined by the organisation they work for. For example, a clinician may hold a CCP Authority to Practice with one provider but be restricted to a Paramedic Authority to Practice (ATP) with another, despite having the same qualifications and competencies. Introducing paramedic prescribing would allow clinicians to practise consistently across employers and reduce reliance on standing orders—an outdated model as paramedicine continues to professionalise. (Paramedic)*

> *Paramedic prescribing aligns with international practice, contemporary paramedic education, and the increasing role of paramedics in integrated primary and urgent care models. It also mirrors the implementation of prescribing scopes within other professionals including nursing, pharmacy, and podiatry. (Organisation)*

✓ **Conditional support: phased/staged implementation approach, starting with specialist practice paramedics**

Many respondents supported the concept of a staged approach, starting with specialist roles, and expanding based on evidence of safety and benefit. This is covered in the next consultation question (section 3.1.2); however, a number of respondents referenced the need for gradual introduction of prescribing rights in their initial feedback about paramedic prescribing more generally. Many respondents advocate for a staged rollout, beginning with specialist practice paramedics (namely ECPs) before expanding more broadly. This is viewed as a safe, evidence-based approach that allows for evaluation and refinement. ECPs were identified as the appropriate level due to their specialist training and experience, and recognition that ECPs work in roles where prescribing is most needed.

> *[Employer] supports the development of the paramedic profession, and supports the goals set out in the consultation document, particularly those that improve timely access to treatment, enhance care delivery, strengthen the wider health system, and promote health equity. We see clear value in Extended Care Paramedics (ECPs) being able to prescribe in the acute unplanned primary and palliative care settings. (Organisation)*

> *I am a Fellow of the Royal New Zealand College of General Practitioners (FRNZCGP) who oversees ECP at an urgent care centre with their standing orders and auditing. In my extensive auditing and experience so far, this is a highly trained set of individuals with training that is as close to medical school as one can get. Their algorithmic approach to health care is very safe, and they have demonstrated a very clear and safe set of knowledge of boundaries. I have zero safety concerns about their work so far. The evolution of health care teams means allowing ECP to prescribe is an obvious next step forward. (General practitioner)*

✓ **Conditional support: governance and standards that support safe prescribing**

Safety is a recurring concern: respondents stress the importance of clinical governance structures, protocols, and standardised competency checks to prevent inappropriate prescribing. Many highlight the need for paramedics to have postgraduate or advanced qualifications, comprehensive pharmacology knowledge, and clinical experience before being granted prescribing authority. A recurring and critical theme is the necessity of robust education pathways that are equivalent to other professions to ensure safe and effective prescribing. Respondents stress that training must be postgraduate-level, evidence-based, and regularly reviewed.

> *Our primary healthcare workforce is under immense pressure, and increasing the number of clinicians with an extended scope will help relieve some of that demand. Provided the training pathway for designated prescribers is robust, any safety concerns should be mitigated to the same standard we already see with nurse prescribers, whose introduction has had major benefits. (Paramedic)*

× **Concerns relating to patient/public safety specific to clinical knowledge and training**

Respondents specifically noted the removal of clinician oversight as being a risk to patient/public safety for paramedic prescribing, and whether paramedics have sufficient pharmacological knowledge and access to necessary diagnostic tools to prescribe safely.

> *Prescribing without [diagnostic test] 'safety nets' significantly increases the risk of adverse drug events. For instance, prescribing certain antibiotics or NSAIDs without knowing a patient's current kidney function—which cannot be accurately assessed in the field—poses a direct threat to patient safety. (Paramedic)*
>
> *We understand that the ability to prescribe a selection of medicines are dependent on the baseline competence of the practitioners (e.g. differential diagnosis, offering therapeutic options), appropriate training programme and the clarity of diagnosis. There will be instances where patients are not able to provide information (e.g. unresponsive patients) and information on allergies and medication history is not readily accessible. The risks and benefits of the prescribing should be considered alongside the existing mechanisms in place (e.g. medicines administered against standing orders). (Organisation)*

× **Concerns about abuse/overuse of already stretched paramedic service to fill gaps in other areas of health system**

Respondents worry that paramedic prescribing might lead to increased, inappropriate demand for ambulance or paramedic services — particularly if the public views them as a convenient, free alternative to GPs. This could result in overuse, resource strain, and slower emergency response times.

> *Reduced government urgency to address the falling Primary Health Care workforce (especially GPs). If given to paramedics working in frontline roles (ICP, CCP, Paramedic) - potential for ambulance services to divert funds away from real emergencies and abuse of 111 system by general public. (Paramedic)*
>
> [In response to Example 1 in the consultation document]: *If the patient does not require an ambulance for asthma, then they are likely using 111 as a free or easier option than GP/Pharmacy which… could have the unintended consequence of increasing demand on the Ambulance Service, particularly the Clinical Hub. Whilst you refer to reducing ambulance attendance, it does not reduce demand on the service altogether. (Organisation)*

- **Concerns about system readiness**

Some respondents were concerned about extending prescribing authority too quickly, given a perceived lack of governance and professional frameworks. Concerns about the reality of implementation and operationalising paramedic prescribing centred around funding, working with employers, and ensuring paramedics have access to the necessary technology (patient records, diagnostic tools) to support safe prescribing.

> *I support prescribing authority overall, but there are real risks that need to be acknowledged so the system does not move too fast or assume prescribing is a simple fix. One of my concerns is that prescribing could be introduced without strengthening the wider foundations needed for safe decision-making. (Paramedic)*

> *Due consideration should be given to aspects of clinical governance such as audit of prescribing, clinical collaboration as a quality improvement feedback loop for all health practitioners aspiring to becoming prescribers. (Organisation)*

> *Several consultation pātai require further detail before we can provide a more definitive position… Operationalising prescribing authority in the Emergency Ambulance Service context would introduce significant costs and complexities that would require further consultation, planning and support from our funders. (Organisation)*

Those giving feedback on the consultation highlighted the importance of looking to other professions such as nurse practitioners and pharmacy prescribers to ensure that appropriate safeguards are in place.

**Additional need for clarity: definition of 'prescribing'**

Several respondents noted that they were not clear about what is included in the definition of 'prescribing' in the paramedic context: Does it mean prescribe *and* administer? Prescribe *and* supply for immediate use? Give prescriptions for patients to fill later, for ongoing use? This lack of clarity also came through in later feedback about controlled drugs specifically (section 3.1.4). More clarity in this area would be useful, as there were concerns about issues such as the supply of medications (expectations on what paramedics would carry/have to supply), and also whether patients would have increased access to medications if they still need to visit a pharmacy to receive their medication.

> *As it relates to the Emergency Ambulance Service (EAS) setting, we acknowledge that paramedics being able to write a prescription and send it to a local pharmacy provides an alternative avenue for patients in the community (particularly those with reduced mobility or transport options) who require medicines but cannot obtain an appointment in primary care within an acceptable timeframe. However, it is worth noting again that this will not fully solve the equity of access to medicines problem, as it still relies on the patient (or family/whānau/caregiver/friend) to travel to the pharmacy and collect the medicines. In remote and rural areas, this trip to the pharmacy confers a significant barrier that cannot be solved by the emergency ambulance service. (Organisation)*

[In response to Example 4 given in the consultation document]: *The same challenge to access of medicines remains, whereby a paramedic may be able to prescribe, but that does not mean the medicine can be dispensed at the same time (therefore still requiring a medicine to be collected from the relevant pharmacy). (Organisation)*

### 3.1.2 Roles included under prescribing authority

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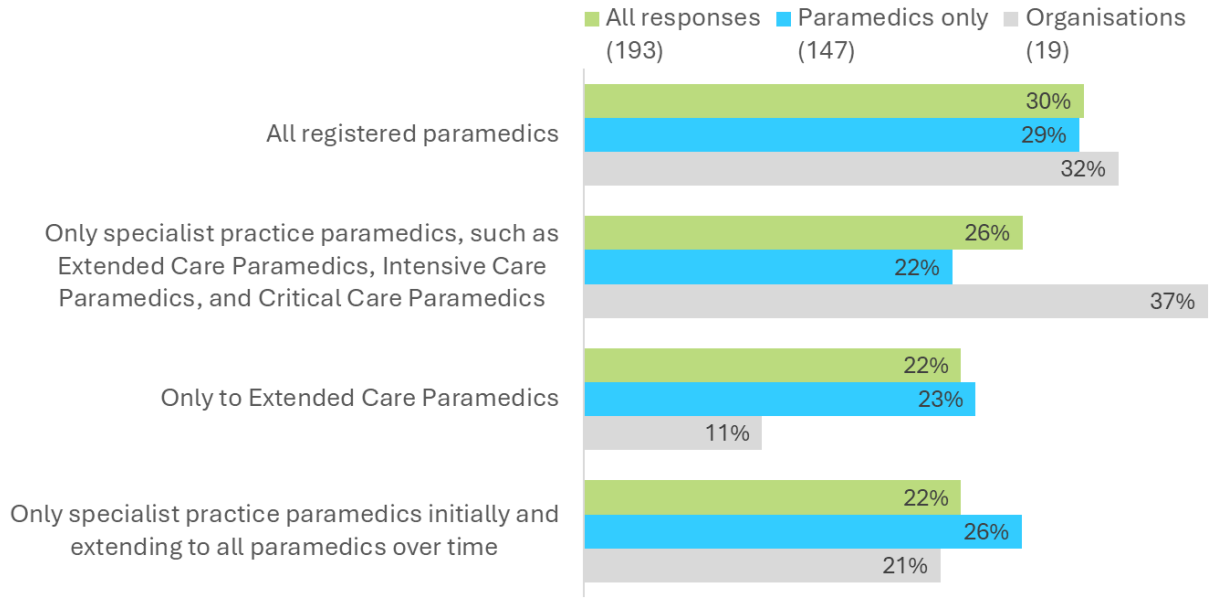
| **Consultation item** | If prescribing authority is introduced for paramedics (with appropriate education and support systems), should it be available to:<br>○ All registered paramedics<br>○ Only specialist practice paramedics, such as Extended Care Paramedics, Intensive Care Paramedics, and Critical Care Paramedics<br>○ Only to Extended Care Paramedics<br>○ Only specialist practice paramedics initially and extending to all paramedics over time |

Support for the different roles that should be included under paramedic prescribing authority was divided across the four categories, with close to a third supporting introduction for all registered paramedics (30%). The remaining 70% supported only specialist practice paramedics such as ECPs, ICPs and CCPs (26%), or limiting prescribing to ECPs only, or to specialist practice paramedics initially, and extending to all paramedics over time (22%). Respondents could select only one from a list of options for this consultation item.




A higher proportion of paramedics than other respondent types indicated a preference for a phased approach (only specialist practice paramedics being given prescribing authority initially, and extending to all paramedics over time, 26%, compared to 22% and 21% of the other subgroups). A higher proportion of respondents giving organisation-level feedback

preferred the option for specialist practice paramedics only (37%, compared to 26% and 22% of the other groups).

A total of 105 respondents gave additional feedback to this question, and those who gave feedback were evenly distributed across the four options for the specific role(s) to be included for paramedic prescribing. The feedback themes are grouped by the option that was chosen by respondents.

Overall, the strongest preference in both quantitative and qualitative responses is to start with one or all of the specialist paramedic endorsements initially, to enable a solid foundation for any future expansion of prescribing authority.

> *Starting with a smaller, well-prepared cohort would allow the Council, education providers and employers to refine training, audit processes, governance structures, collegial relationships and other requirements before expanding prescribing more broadly across the workforce. (Paramedic)*

**All registered paramedics (30% of all respondents)**
Those who support prescribing authority for all registered paramedics cited the need for broad workforce capability, and a clear call to action for greater access to prescribing (with appropriate education), especially in primary care, rural settings and emergency departments.

> *By opening this possibility across all registered paramedics, there is a larger cohort of available personnel providing this care option. (Paramedic)*

These respondents believed that appropriate training and protocols would be sufficient to allow and enable safe prescribing across what is a highly trained and skilled workforce, and where the right level of competency is demonstrated within a defined scope of practice. Those who gave feedback felt that the opportunity should be offered to all paramedics, to avoid creating divisions within the profession, and to ensure access to prescribers in areas where specialist paramedics may not be available.

> *Generally, in rural settings there are no ATPs at ECP, CCP, or ICP qualifications, so it would need to be authorised at a standard Paramedic ATP level to cover these regions. (Organisation)*

> *The need for prescribing of medications is more likely to apply in primary care and sub-acute settings than emergency settings. To that end, limiting this to just specialist or ECP paramedics would defeat its purpose to quite an extent. (Paramedic)*

Parallels were also drawn to the nursing profession, where all registered nurses can become prescribers, not just nurse practitioners.

*I feel it should be all paramedics - this would be in line with registered nurses where there are nurse prescribers who are not nurse practitioners. (Paramedic)*

**Only specialist practice paramedics, such as Extended Care Paramedics, Intensive Care Paramedics, and Critical Care Paramedics (26% of all respondents)**
Those respondents who support prescribing authority to be limited to specialist practice paramedics stress that specialist paramedics have the postgraduate education, advanced clinical judgment, and experience necessary for safe prescribing. Their feedback emphasised that limiting prescribing to specialists ensures an appropriate level of oversight, governance, and protection from risks associated with inadequate training. This option was most highly preferred among organisation-level respondents.

*Paramedics with specialist practice endorsements have completed postgraduate training and possess extensive clinical experience in paramedicine. This experience is essential for developing an understanding of health system strengths and limitations, as well as for enhancing clinical judgement and decision making in the prehospital setting. (Organisation)*

*I don't see a huge benefit in non-specialist endorsed paramedics having prescribing, in terms of scope, it would be very limited. I also think the educational requirements should be a baseline Postgraduate Diploma (PG Dip), which excludes paramedics by default. The Bachelor of Health Science (BHSc) degree alone does not provide nearly enough depth into pharmacology and advanced diagnostics that is required to safely supply medications that are continued beyond a single dose. (Paramedic)*

**Only to Extended Care Paramedics (22% of all respondents)**
Those respondents who supported prescribing authority for ECPs only felt that this workforce specifically have the right level of training and clinical decision-making to prescribe safely, and that their work in low-acuity, community-based settings was most relevant and beneficial for prescribing.

*We feel strongly that prescribing should be restricted exclusively to the ECP scope of practice. These clinicians are specifically trained at a postgraduate level to manage low acuity, single organ medical issues in the community within a pre-defined scope, supported by additional clinical guidelines. The nature of their clinical interactions allows for the time and focus necessary to act as a safe community prescriber. (Organisation)*

*I feel there is only a real need for ECPs to prescribe as they are treating low acuity conditions and have the training to consider differentials. I see no need for CCPs or ICPs to prescribe as they are specialised in emergency medicine where patients go to Emergency Department (ED). I think it's unsafe for paramedics to prescribe as they do not have advanced teaming in diagnosis and advanced assessment. (Paramedic)*

This option for prescribing authority differs from 'only specialist practice paramedics' in that it limits to the ECP specialist endorsement, and some respondents gave specific feedback about the 'limited benefit' for the other two specialist endorsements (CCPs and ICPs) having prescribing authority. Respondents felt that CCPs and ICPs work primarily in high-acuity clinical settings where standing orders are more appropriate, and prescribing authority is seen to offer little practical benefit.

> *I feel there is a very limited benefit to CCPs and ICPs having prescribing rights, as their current scope of practice and practice setting works well with standing orders. (Paramedic)*

> *The nature of frontline emergency work also does not provide the necessary oversight or on-scene time to perform complex safety checks (such as checking drug interactions) essential for safe practice. As such, there is no sound rationale for prescribing in this context [ICP or CCP] (Organisation)*

> *CCP/ICP prescribing also risks normalising the use of emergency ambulance services for low acuity work, which inappropriately lowers the threshold for ambulance attendance and degrades response times for life-threatening emergencies. (Organisation)*

**Only specialist practice paramedics initially and extending to all paramedics over time (22% of all respondents)**

This group of respondents advocate for a staged approach that starts with specialist paramedics to establish the required process and frameworks, then expand to all paramedics once these systems are proven safe and effective. They preferred a phased/staged approach to allow for evaluation, feedback, 'try/review/adjust' cycle.

> *A phased approach allows prescribing frameworks, education pathways, governance, and audit systems to be established and stress-tested safely, while avoiding unnecessary barriers to future expansion. (Organisation)*

It was seen as critical to start with those paramedics who have already undertaken additional training, as clinical knowledge and experience would be an important baseline for safety. They recommend starting with a '*slow approach… ensuring practice safeguards are robust*'.

> *Only specialist practice paramedics initially, with extension to all paramedics over time. Prescribing should be introduced in a staged manner that reflects education, clinical exposure, and system readiness. Specialist practice paramedics (ECP, ICP, CCP) already practise with a high degree of autonomy, advanced clinical reasoning, and complex pharmacological decision-making, making them the appropriate initial cohort. (Organisation)*

> *Safe prescribing is underpinned by a reasonable knowledge of pharmacology. Currently the only paramedics who are required to undertake advanced pharmacology study equivalent to nurse prescribers are extended care paramedics (ECPs). My proposal would*

*be to introduce paramedic prescribing to ECPs who are the closest paramedic equivalent to a nurse practitioner then expand designated prescribing to any paramedics who undertake an appropriate prescribing course, similar to the designated prescribing pathway for nurses. (Paramedic)*

Some respondents also noted that extending prescribing to all paramedics over time will provide the greatest equity benefits, particularly for rural communities where specialist paramedics are not present.

*Enabling all paramedics to prescribe over time will have the greatest equity benefit, given that specialist paramedics are not present in many rural areas, whereas 'generalist' paramedics are. (Organisation)*

### 3.1.3 Agreement with 'designated prescriber' prescribing model for paramedics

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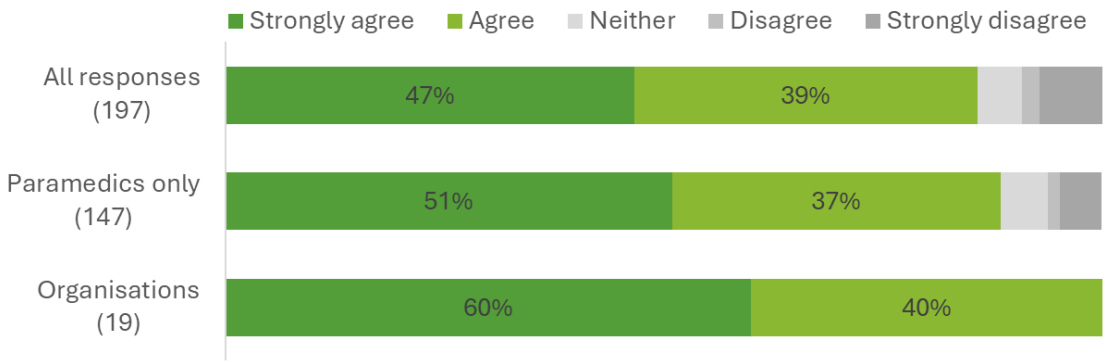
|---|---|
| **Consultation item** | The background document to the consultation outlines the three prescribing models currently recognised under Aotearoa New Zealand law. These are authorised prescribing, designated prescribing and delegated prescribing. Te Kaunihera has investigated the prescribing options and proposes an application is made for paramedics to become **designated prescribers**.<br><br>Do you agree with paramedics becoming **designated prescribers**?<br><br>*Note - You can read more about the three prescribing models in section 9 of the consultation document, available [via hyperlink].* |

There is high agreement with the choice of a 'designated prescribing' prescribing model for paramedics. Overall, 86% of all respondents said they strongly agree or agree with paramedics becoming designated prescribers. This is similar to the level of agreement for paramedics only, while 100% of those at the organisation-level agreed with the use of this prescribing model.



A total of 60 respondents gave additional feedback to this question, and (reflecting the results) most of those who gave feedback agreed or strongly agreed with the proposed model of paramedics becoming designated prescribers. Respondents largely support the designated prescriber model as a safe, structured, and progressive introduction to paramedic prescribing.

Key themes in support of the designated prescriber model included:

- ✓ Agreement with a balanced and pragmatic 'transitional model'
- ✓ Agreement with the level of risk management

Key concerns about the designated prescriber model included:

- × Concerns relating to patient/public safety specific to clinical knowledge and training
- × Concerns about abuse/overuse of already stretched paramedic service to fill gaps in other areas of health system
- × Concerns about system readiness and rushing implementation

✓ **Agreement with use of a balanced and pragmatic '*transitional model*'**

Respondents felt that the designated prescriber model was balanced, pragmatic, and gave the right level of structure as prescribing authority develops within the paramedic profession. It was seen as aligning with successful models already used by nurses, pharmacists and other health professionals in Aotearoa New Zealand, providing a tested regulatory pathway.

> *Designated prescribing offers the most pragmatic and sustainable way to begin paramedic prescribing. It allows paramedics to make independent prescribing decisions within a clearly defined governance framework, supported by collegial oversight from an authorised prescriber when required. This model protects patient safety while still enabling meaningful autonomy—similar to nurse prescribers, pharmacist prescribers, and others, which have shown to be safe and effective in NZ… at this stage, designated prescribing provides the right balance of autonomy, accountability, and feasibility. (Paramedic)*
>
> *Designated prescribing provides a proportionate and pragmatic "middle ground" that aligns with the development of the paramedic profession in Aotearoa New Zealand. This model allows prescribing within defined parameters while maintaining clinical governance through tertiary education, (continued professional development (CPD), and collaborative relationships with other prescribers. It also leverages off well established designated prescriber tertiary education programmes that already exist across multiple universities (Organisation)*

✓ **Agreement with level of risk management**

Respondents felt that the designated prescriber model manages risk well, provided it is underpinned by clinical supervision, governance and clear frameworks.

> *A designated prescriber position as indicated would be low risk. Authorised prescribing would introduce some risks, particularly in out-of-hospital care where consistency utilising Clinical Practice Guidelines (CPGs) may be challenged. The potential risks around pharmacology are likely to be addressed by following a model like nurse practitioners in NZ, whereby training includes pharmacology. (Organisation)*

**Concerns about a safety and scope 'mismatch' with the designated prescriber model**

Respondents question whether designated prescribing is appropriate for paramedics given their broad, generalist scope across all illness and injury presentations, lack of longitudinal patient relationships, and limited diagnostic infrastructure compared to specialty roles.

> *The consultation document defines designated prescribing as being for practitioners who have the training to prescribe within a 'specific area of practice.' However, in the paramedic context, the 'area of practice' is effectively the entire spectrum of human illness and injury encountered in the community... Unlike a specialist nurse prescriber (e.g., in diabetes or wound care) who operates within a narrow, well-defined clinical silo, a 'designated' paramedic prescriber would face vastly different pathologies every shift. (Paramedic)*

> *Designated prescribing under the Medicines Act 1981 is intended for roles where a practitioner has a longitudinal relationship with a patient or a very specific clinical focus. Paramedics usually have a single-encounter relationship with patients. Allowing designated prescribing in this 'one-off' encounter model increases the risk of adverse reactions and poor follow-up, as there is no legal requirement for the prescriber to be the one managing the long-term consequences of that prescription. (Paramedic)*

The consultation document noted the lack of a legal definition of prescribing authority in the Medicines Act, and that definitions rely on the legal framework for who may prescribe and under what conditions. In their consultation feedback, one professional organisation wanted to ensure Te Kaunihera is aware of upcoming legislative changes affecting prescribing models:

> *With upcoming legislative changes, it is possible the framing of authorised, designated and delegated prescribing may change. Moving to introduce prescribing by scope (which is also signalled by the legislation) is a wise approach that may mitigate the risks of any changes to the framing. (Organisation)*

- **Preference for authorised prescriber model over designated**

Those who disagreed with a designated prescriber model tended to prefer the 'authorised prescriber' model, with the reasoning that a designated model is too limited, and that paramedics, particularly advanced practitioners, should progress toward authorised prescriber status to avoid restrictive medicine lists and better reflect their clinical autonomy.

*While the designated prescriber model is a reasonable and cautious initial step, it should be regarded as a transitional pathway rather than the end state. For advanced paramedic roles with established postgraduate education, clinical autonomy, and high-acuity decision-making responsibilities, the authorised prescriber model is more appropriate and future-focused. (Paramedic)*

> *I think prescribers should be authorised not designated, the designated role limits them to a list of medicines that rapidly goes out of date and requires constant updating. There are sufficient checks and balances that can be enabled under the HPCA Act. (Pharmacist)*

A small number of respondents wanted better clarity about who can be a designated prescriber, and had concerns about the scope overlap between paramedics and other health professionals (nurses, doctors, emergency departments) and the existing paramedic hierarchy.

> *A delegated prescribing model for ECPs might actually be the best model moving forward. This would ensure more audit/follow up and also enable more flexibility for different ECPs to have different prescribing rights depending on the setting they are working in and the training they have done. (Paramedic)*

Feedback for this consultation question showed that respondents had considered all three model options (as were described in detail in the consultation documents) and weighed up the relative attributes of all three.

> *I did consider what delegated prescribing might have looked like for paramedicine, as it appears at first glance to be a logical mechanism for replacing the current Authority to Practice (ATP) and standing-order system. However, in practice, designated prescribing can achieve the same effect, and—as the Council notes—there are no existing examples of delegated prescribing in New Zealand to draw on. Designated prescribing is therefore the most appropriate and workable pathway for the profession at this stage… that supports the profession's continued evolution while maintaining public safety and aligning with international developments in advanced paramedic practice. (Paramedic)*

Some wondered if there might be a rationale for transitioning between different prescribing models over time.

> *I agree that paramedics need to start as designated prescribers initially to assess the patient safety aspect. (Paramedic)*

*I believe it is a reasonable approach to start off with designated prescribing with the long-term goal of having paramedic practitioners who can be authorised prescribers once we have a record of safe prescribing to support this. (Paramedic)*

**Additional feedback: Proposed medicine lists**

The consultation document did note that the list of medicines that paramedics may be able to prescribe would be finalised through a separate consultation conducted by Manatū Hauora | Ministry of Health (Appendix 1, p. 23). Some respondents gave specific feedback that related to the use of approved list of medications for paramedic prescribing. Some respondents expressed concern that an overly restrictive or limited gazetted medicines list could undermine the benefits of designated prescribing and perpetuate inefficiencies in practice.

*One risk of implementing a designated prescriber framework is that the medicines list does not allow a sufficient range of medicines to be prescribed, or 'lags' behind real world clinical practice. To mitigate this risk, it is crucial that the medicines list approved by the Ministry of Health is not unduly restrictive and where possible, includes 'classes' of medicines instead of individual medicines that may be affected by supply chain disruptions. While some stakeholders may advocate for a conservative medicines list, it is important to acknowledge that paramedics are increasingly practising in a range of clinical settings. There is little downside to having an extensive formulary, as all Paramedic Prescribers would be expected to prescribe within a defined area(s) of practice, supported by appropriate CPD and collaborative relationships with other providers. (Organisation)*

*The major barrier to designated prescribing is the requirement to prescribe by gazetted list. Registered nurse prescribers have identified their gazetted list as a significant barrier to best practice, limiting the utility of registered nurse prescribing and increasing barriers to access for the public. [Organisation]*

*[Organisation] supports a more enabling approach to health practitioner prescribing and has proposed that the Ministry of Health include more classes of medicines on gazetted lists. This approach would remove the barriers associated with rapid changes in best practice medicines use and the significant time taken to update lists when changes are required. To date, the approach has not been fully adopted by the Ministry of Health. The [Organisation] is happy to discuss this approach further with Te Kaunihera Manapou Paramedic Council. [Organisation] notes the Medicines Act 1981 states that there can be a requirement in the Regulations that designated prescribers must prescribe under supervision; supervision is not included as a requirement in the Medicines (Designated Prescriber—Registered Nurses) Regulations 2016. The [Organisation] suggests Te Kaunihera Manapou Paramedic Council supports a similar approach to avoid unnecessary restrictions such as ongoing supervision requirements in the secondary legislation developed for paramedics. (Organisation)*

### 3.1.4 Paramedic prescribing of controlled drugs

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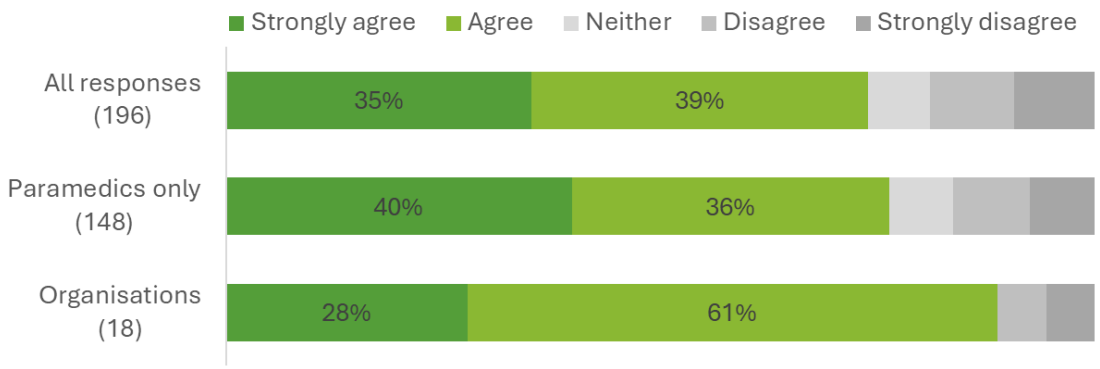
|---|---|
| **Consultation item** | Some medicines, such as morphine, fentanyl, and ketamine are classed as controlled drugs and have extra legal restrictions. Do you think paramedics who are trained and registered as a Paramedic Prescriber should be able to prescribe certain controlled drugs when needed for patient care? |

Three-quarters of respondents to the consultation agreed that paramedic prescribers should be able to prescribe certain controlled drugs when needed (74%).




A total of 104 respondents gave additional feedback to this question, and this was one area of the consultation where agreement was more often conditional – the question asking about 'certain' controlled drugs 'when needed' were seen as important qualifiers for support from paramedics and others. They emphasise that this should be restricted to specific contexts (e.g., palliative care, acute pain management) and to advanced practitioners with proven competence.

Key themes for those who agreed with paramedic prescribing of controlled drugs included:

- ✓ Existing and proven competence by paramedics in administering controlled drugs
- ✓ Conditional support if appropriate safeguards, education and oversight are in place
- ✓ Conditional support for use in certain contexts, namely end-of-life/palliative care, and for acute trauma pain.

Key concerns for those who disagreed with paramedic prescribing of controlled drugs included:

- × Risk of misuse with lack of comprehensive assessment, access to medical history and ongoing follow-up care

✓ **Existing and proven competence by paramedics in administering controlled drugs**
Respondents highlight that paramedics already handle and administer controlled drugs under standing orders, meaning they have existing expertise with these medications. They argue that prescribing is a natural progression of their current practice.

*Paramedics already administer controlled drugs such as morphine, fentanyl, and ketamine safely and routinely under standing orders, often in high-risk, time-critical environments. In the primary and urgent care setting, Extended Care Paramedics routinely supply controlled drugs such as oxycodone, codeine and tramadol. Allowing Paramedic Prescribers to prescribe specific controlled drugs is a logical extension of existing practice, not a radical departure. (Organisation)*

*First and foremost, prescribing controlled drugs is essential for paramedics to function as fully autonomous clinicians. Paramedics should not be reliant on standing orders or employer-issued authorities to provide medicines that are central to acute and emergency care. Analgesics and sedative agents such as morphine, fentanyl, and ketamine are core to paramedic practice, and the ability to prescribe them is consistent with safe, modern models of care. (Paramedic)*

✓ **Conditional support: limited to certain contexts**

There is strong support for paramedic prescribing of controlled drugs in certain contexts, namely for palliative care/end-of-life management, or acute trauma pain, and only for advanced practitioners with proven competence.

- End of life/palliative care ('*...essential to enable effective management in this area - particularly as the aging population and hospice demand grows*.' *(Paramedic)*

  *This is particularly important in end-of-life care, where timely access to morphine can significantly relieve pain and dyspnoea, support dignity, and prevent unnecessary hospital transfers when patients wish to remain at home. (Paramedic)*

- Acute trauma pain from injury such as fractures. Respondents were clear about limiting to acute applications, and that paramedics were less likely to have the necessary diagnostic or patient history information to prescribe in chronic pain situations.

*For paramedic prescribers, this would primarily involve short courses of oral morphine for acute pain where non-opioid options are insufficient, together with selected alternatives such as tramadol or neuropathic agents. Any prescribing should be limited in duration, clearly documented, and subject to mandatory GP review within two to three working days to maintain continuity of care and prevent inappropriate long-term use. (Paramedic)*

*Being able to provide stronger pain relief in the community or even overnight could prevent unnecessary ED presentations. (Paramedic)*

✓ **Conditional support: only once appropriate safeguards, education and oversight are in place**

Many respondents support paramedic prescribing of controlled drugs if appropriate training, governance, and scope limitations are in place.

> *The inclusion of controlled drugs must sit within a framework of strong clinical governance, clear audit requirements, and robust oversight to minimise the risk of misuse or harm. There are well-established governance models in medicine, nursing, midwifery, and dentistry that demonstrate how this can be achieved safely. Paramedic prescribing can be integrated into these existing systems with appropriate safeguards and monitoring. (Paramedic)*

> *The issue with controlled medication prescribing is primarily around safeguards. When the appropriate safeguards and accountability are in place, and if the prescription of controlled medications is considered aligned with how we see paramedic practice evolving, then it should be included. However, the medications listed here (morphine, fentanyl, and ketamine) tend to have more application in the acute environment, where prescribing is not relevant. Accordingly, we cautiously agree, subject to consideration of what drugs are proposed and for what indications, and if these remain aligned with good paramedic practice. (Organisation)*

× **Risk of misuse with lack of comprehensive assessment**

Respondents were very clear that prescribing controlled drugs requires thorough patient assessment, access to medical history, and ongoing follow-up care. These are not always feasible given paramedics' brief patient encounters and limited access to longitudinal patient history.

> *Paramedics often encounter patients in a 'snapshot' encounter without access to the long-term records needed to identify patterns of misuse. (Paramedic)*

> *They require a more global understanding of the patient, background history, things that are better suited to a regular practitioner of the patient. I feel it would also be easier for patients to mislead paramedics and obtain controlled drugs due to the short time spent on scene. (Paramedic)*

The concern about misuse extends to a perceived risk of controlled drugs being misused or obtained through manipulation, particularly with opioids like morphine or fentanyl. These respondents argue that controlled drug prescribing should remain tightly regulated/limited to protect public health and align with harm reduction strategies.

> *These patients should receive a more thorough assessment than is able to be provided in a paramedicine setting. The risk of opiate abuse and the complications this can have, including the potential for manipulation and abuse/assault from the public is not worth the risk of prescribing. If it is clear that paramedics cannot prescribe drugs of abuse this is likely to keep them safer in their role in the community. (Organisation)*

Other concerns from a small number of respondents noted safe handling and transport of controlled drugs and wanting clarity around how controlled drugs would be kept secure. They were concerned about expectations for the storage and transport of these medicines, and if that would put paramedics at greater risk.

Some respondents express caution that prescribing controlled drugs could blur the boundaries between paramedics and other clinicians, especially GPs and palliative specialists.
They recommend maintaining clear role differentiation and collaborative practice models.

> *Although this could be handy, I feel controlled meditation (sic) should be prescribed by the patient's own GP or specialist who sees/revisits on a regular basis. (Paramedic)*
>
> *I believe this needs to be fully assessed by a doctor as to underlying causes and diagnosis for long term use. Also, involvement of pain teams etc is often required at times. (Registered Nurse)*

The feedback revealed that some respondents wanted more clarity on what was meant by 'prescribing' controlled drugs – *Some consideration needs to be given to the difference between prescribing and administering or just prescribing. (Organisation).*

× **Need for clarity: scope of prescribing controlled drugs**

Many respondents to this consultation noted that paramedics already administer controlled drugs in a range of situations and sought clarity around whether the proposal means that paramedics would be prescribing controlled drugs for long-term situations beyond the immediate/acute situation they were responding to. As noted in the earlier section about conditional support for paramedic prescribing of controlled drugs, many respondents were very clear that they disagree with paramedics being responsible for long-term prescribing for chronic conditions, potential for misuse for larger quantities than 1-2 days.

> *This should be managed in primary care; there is little need for paramedics for any reason to be prescribing this sort of medication in an outpatient or isolated setting where appropriate follow up is not able to happen. (Paramedic)*
>
> *Paramedics in this situation should have these drugs available for short-term treatment pending higher level medical care and already approved under current CPG/Standing Orders.*
> *In settings of palliative care, a change to prescription or new prescription is mostly able to be provided by the palliative care team in due course. These are high-risk drugs that are subject to diversion in the community, and unless practicing in a Multidisciplinary Team (MDT) health care facility setting, community/ECP paramedics are unlikely to have full oversight of a patients risks/conditions. (Medical officer)*

### 3.1.5 Support for a new Scope of Practice for paramedic prescribers

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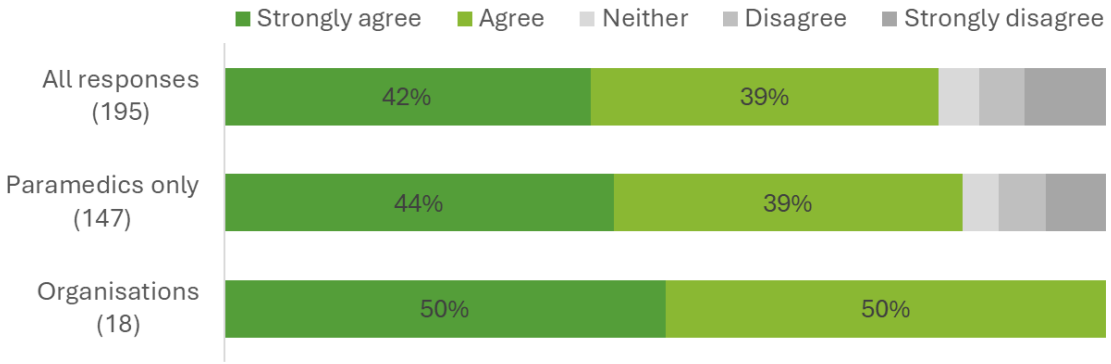
|---|---|
| **Consultation item** | Te Kaunihera proposes to establish a new Scope of Practice for paramedic prescribers. Do you agree with this approach?<br>*Note - You can read more about the proposed paramedic prescriber scope of practice in section 11 of the consultation document, available [via hyperlink].* |

The majority of respondents to the consultation agreed with the approach to establish a new Scope of Practice for paramedic prescribers (81%), and 10% of organisation-level responses agreed with this approach.




A total of 57 respondents gave additional feedback to this question, and most of those who gave feedback agreed or strongly agreed with a new Scope of Practice for paramedic prescribers.

✓ **Support for a new Scope of Practice as logical, safe and structured, giving clarity and public confidence**

Most respondents support creating a distinct Scope of Practice for paramedic prescribers, describing it as a logical, safe, and structured step that ensures clarity and accountability for the profession. Respondents emphasise the importance of clear boundaries and governance so both professionals and patients can easily identify competent prescribers. They view a distinct scope as helping ensure public trust, employer understanding, and professional credibility.

> *A paramedic prescriber scope of practice provides clarity for the public, employers, and the profession. It makes it clear who has completed the required training and who has not. It also allows Te Kaunihera to set the rules around supervised practice, competence, CPD requirements, and audit processes. (Paramedic)*

A specific Scope of Practice would also align with other professions (e.g., nursing) and a way to clearly define prescribing boundaries and standards. Aligning with other professions is seen as a tested, transparent framework for safe practice, and fits within Aotearoa New Zealand's existing regulatory frameworks under the HPCA Act.

*Establishing a new scope of practice for paramedic prescribers aligns with the view of further developing paramedicine and allowing for personal professional development. Having a separate scope ensures clarity on who is and is not permitted to prescribe, making it clearer to employers and the public when consulting the register. For example, 'Paramedic Practitioner' would align the scope with the Nursing Council and be aligned with international definitions. (Organisation)*

× **Concerns about a separate scope 'fragmenting' the profession, or causing confusion**

Respondents express concern that creating a separate prescribing scope would create unnecessary divisions within the profession, operational inefficiencies, and confusion about roles and capabilities. It was also seen as potentially duplicating processes that could be integrated into existing frameworks (e.g., ECP scope).

*Establishing a separate Paramedic Prescriber Scope of Practice risks fragmenting the profession and unnecessarily duplicating scopes based on a single function rather than overall clinical capability. Prescribing should be recognised as an advanced competency embedded within an existing or future advanced role, not as a standalone scope. (Paramedic)*

*I would prefer that all Extended Care Paramedics receive prescribing rights. Would be better that the education that they receive as part of their specialty training prepares them for prescribing, than having to do an additional course after completing ECP. It may cause confusion having ECP 'with' and 'without' prescriber status. (Clinical director / General practitioner)*

### 3.1.6 Additional feedback in support of paramedic prescribing

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|---|---|
| **Consultation item** | Is there anything else you would like to tell us about why you think paramedics should be able to prescribe medicines? |

A total of 90 respondents gave additional feedback in support of paramedic prescribing. Many of the key themes have already been covered in earlier sections of this report, and also mirror what was described in the consultation document (p. 18).

The most common themes in the additional feedback in support of paramedic prescribing include:

- ✓ Improved access to healthcare and reduced GP/ED pressure
- ✓ Workforce development and clinical career pathways
- ✓ Perceived need to update the current standing order model

- ✓ **Improved patient access, continuity of care, patient experience and outcomes (45+ comments)**

Respondents were most likely to reference improved patient access to care and better health outcomes when sharing additional feedback in support of paramedic prescribing. It was seen as improving timely access to medicines, particularly in rural, urgent care, or out-of-hours contexts. These respondents believe that paramedic prescribing will reduce delays, avoid unnecessary ED presentations and GP visits, and streamline the patient journey.

> *Prescribing authority would improve continuity of care, reduce avoidable emergency department presentations, and support patients to be treated safely in their own homes and communities—particularly in rural, remote, and underserved areas. (Paramedic)*

> *Paramedics should be able to prescribe because modern urgent and primary care relies on clinicians who can assess, diagnose and treat in a single encounter. The current model forces unnecessary handovers, delays and duplicate appointments, which is inefficient for the healthcare system and frustrating for patients. (Paramedic)*

Prescribing is also seen as a way for paramedics to 'complete' care episodes, reducing the need for handovers. However, as noted in section 3.1.7 below, this can also be seen as a concern or risk of paramedic prescribing – some respondents believe that paramedics are not the right provider to be 'closing the loop' as this should be done in follow-up with regular doctor or health provider.

> *Paramedics already carry significant responsibility for assessment, diagnosis, and clinical decision-making. In many cases we are identifying the problem, initiating treatment, safety-netting the patient, and planning follow-up, yet the one step we cannot legally complete is the prescription. That gap creates unnecessary delay and duplication for patients who often just want timely, practical care close to home. (Paramedic)*

> *It makes sense that prescribing should be part of the scope given the level of autonomy an advanced clinician like an ECP/CCP is. I currently work with nurse prescribers who have a narrower experience but more pharmaceutical therapies than I do as in current state I am limited to having to develop standing orders. I think it will broaden the role paramedics can play in a wide range of areas across the health sector and will reduce barriers to care for patients. (Paramedic)*

- ✓ **Workforce development and clinical career pathways (20+ comments)**

Respondents highlight that prescribing would recognise paramedic capability, support career progression, improve workforce retention, and reflect the professional maturation of paramedicine. It reflects the professional evolution and natural progression in paramedic practice, aligning with expanded clinical capabilities and advanced roles (such as ECPs).

> *Prescribing would also better integrate paramedics as full members of multidisciplinary teams, rather than treating them as perpetual extensions of other professions. Finally, prescribing is a critical step in the professional maturation of paramedicine. It will support workforce retention and career progression, helping to retain skilled paramedics within the profession. (Paramedic/Employer)*
>
> *Prescribing authority would also increase workforce sustainability. Many highly trained clinicians experience burnout in frontline ambulance roles, despite having valuable skills that could benefit other parts of the health system. Prescribing capability would allow paramedics to transition into roles such as urgent care, palliative care, assisted dying services, primary care, and rural hospital support. (Paramedic)*

- ✓ **Perceived need to address outdated and inadequate standing order model (15+ comments)**

Respondents argue that the current standing orders model is no longer fit for purpose, creates unnecessary complexity, and that prescribing would better align legal authority with actual clinical practice.

> *The current reliance on standing orders and indirect authorisation has become an increasingly strained workaround that adds complexity without adding safety. (Organisation)*
>
> *From an organisational viewpoint, paramedic prescribing would support the health system to function more efficiently at the point of care. Prescribing authority would reduce unnecessary referrals (e.g. to urgent care or emergency departments) for non-complex clinical presentations and reduce reliance on outdated and complex mechanisms such as standing orders that are no longer fit for purpose. (Organisation)*

### 3.1.7 Additional feedback in opposition of paramedic prescribing

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| **Consultation item** | Is there anything else you would like to tell us about why you think paramedics should not be able to prescribe medicines? |

A total of 45 respondents gave additional feedback when asked about reasons paramedics should not be able to prescribe medicines. It should be noted that 35 of those who gave feedback here had indicated support for paramedic prescribing earlier in their feedback, so this was a chance to note any conditions on that support, or other information that they wanted to be considered. As noted by one employer organisation, '*These concerns do not negate support for prescribing but highlight the importance of careful implementation and strong controls*.'

Key themes in those giving feedback about why paramedics should not be able to prescribe aligned with the potential risks in the consultation document (p. 20), and include:

- × Greater burden on the paramedic workforce, without addressing wider health system pressures
- × Concerns about clinical decision-making without the right tools and oversight
- × Risk of fragmented care and lack of follow up

× **Greater burden on paramedic workforce, without addressing wider health system pressures**

Respondents raise concerns about lack of resources, pay, and support for paramedics, suggesting that adding prescribing responsibilities could increase workload and burnout. Some respondents question whether prescribing addresses the real issues in healthcare delivery. Reliance on paramedics to fill gaps in wider health system, which could be detrimental to paramedics (burnout, workload) and to patients (not receiving full level of care required).

> *The aforementioned pressures might mean prescribing paramedics are used to plug gaps, and this could also mean pressure to treat more patients in the community, when a hospital visit is needed. This might impact those more rural and remote patients, and those with limited access to transport. (Organisation)*

> *Throughout the consultation document there are references to 'bridging gaps' where medical or nurse practitioner coverage is limited in general practice and community settings. We are concerned that encouraging paramedic prescribers to work in primary care settings in place of appropriately trained specialist general practitioners (or nurse practitioners), permits the wider health sector to absolve itself of its responsibility to adequately resource primary health with appropriate medical staff. (Organisation)*

*There would need to be robust systems in place to ensure that patients do not default to using an emergency ambulance service in place of seeing their regular Nurse or GP when available. There is a significant risk that we could see either increased demand (as we have previously mentioned) and increased cost (through wage pressures due to the additional skill / risk our staff will carry). (Organisation)*

× **Concerns about clinical decision-making without the right tools and oversight**

Several responses highlight the potential interaction between insufficient diagnostic tools and clinical decision-making causing patient safety risks, including concerns about governance, accountability, and whether paramedics have adequate support and oversight. Education standards for those paramedics who are able to prescribe need to be high, and governance and oversight are critical – there is a perception that these are currently inadequate.

*A major [risk] example is diagnostics. Paramedics still cannot order funded laboratory tests under our own name, which means that even with prescribing rights, there will be situations where we lack essential information such as renal function, infection markers, or pregnancy testing. Without solving this, prescribing risks becoming a half-step that still forces delays, handovers, or workarounds that are not ideal for patient safety. (Paramedic)*

*Paramedics now have 24-hour access to GP and Senior Medical Officer (SMO) expertise via high-definition video and phone links. This "collaborative" model allows the paramedic to perform the physical exam while the doctor - who has access to the patient's full history via the Shared Electronic Health Record - makes the final prescribing decision... (Paramedic)*

× **Risk of fragmented care and lack of follow-up**

Respondents worry that paramedic prescribing would fragment care, undermine the GP's role as the clinical anchor, and create gaps in follow-up and continuity of care. Frequent reference was made to a collaborative model of health and shared care plans, using examples of how paramedic prescribing could have adverse consequences with reducing engagement with primary care, or conflicting with recent changes to telehealth and the use of digital tools.

*There is also the broader concern of fragmentation. If prescribing is not properly integrated with general practice systems, especially in rural or high-need communities, some patients could lose contact with their usual care team. Those with complex conditions, frailty, low health literacy, or limited social support are particularly at risk. A prescribing model that is not aligned with primary care could unintentionally worsen inequity rather than improve it. (Paramedic)*

*The ECP role is designed to prevent unnecessary hospital admissions by providing acute community care. If an ECP identifies a need for ongoing medication, that patient should, by definition, be referred to a GP for a comprehensive review. Independent prescribing removes the "second set of eyes" (the GP) that acts as a vital clinical audit on the paramedic's initial assessment. (Paramedic)*

*New Zealand's health system relies on the General Practitioner as the "clinical anchor." Paramedic prescribing creates an "unanchored" clinical encounter where… there is no longitudinal follow-up for the medications prescribed, communication back to the GP is often delayed or lost, increasing the risk of polypharmacy and drug-drug interactions [and] it encourages "task-shifting" to lower-trained staff as a "Band-Aid" for GP shortages, rather than investing in the primary care infrastructure that patients actually need. (Paramedic)*

### 3.1.8 Additional feedback about the impact of paramedic prescribing on different communities

| | |
|---|---|
| **Consultation item** | Paramedics being able to prescribe medicines will impact different communities in different ways. This might include disability, ethnicity, gender, age, religion or belief, or human rights?<br>– Please describe any specific positive impacts<br>– Please describe any specific negative impacts |

A total of 107 respondents gave additional feedback about the impact of paramedic prescribing on different communities, and they were asked separately about whether these impacts were positive or negative. More respondents identified positive impacts than negative (95 and 57, respectively), and 47 respondents made comments about both positive and negative impacts on different communities. Many of the impacts shared by respondents were also referenced throughout different sections of the consultation (and this report), however this section focuses on those that were shared in this part of the survey.

Potential positive impacts for different communities that were most commonly cited include:

- ✓ Improved access and health outcomes for rural/remote communities, Māori and Pacific peoples, older people, people with disabilities, and other communities such as those with chronic illness and low health literacy, among others)
- ✓ Positive impact on emergency departments, GPs and hospitals through increased workforce capacity

✓ **Improved access and health outcomes for different communities**

Respondents overwhelmingly emphasise that paramedic prescribing would significantly improve geographic and financial barriers to healthcare access, especially in areas where GP access is limited. It was seen as a way to reduce travel barriers and enable timely treatment closer to home. Respondents identified a range of communities who would be positively impacted, including:

✓ Rural/remote communities
This 'community' was most commonly referenced by respondents who believe that paramedic prescribing would significantly enhance healthcare access in rural, remote, and underserved areas where GP and specialist services are limited. Respondents see paramedic prescribing as a way to reduce travel, wait times, and barriers to timely care.

> *Rural and remote communities: Faster access to necessary medicines where GP or ED care is distant, reducing avoidable travel and treatment delays. (Organisation)*

✓ Māori and Pacific peoples
Respondents highlight that paramedic prescribing would reduce health inequities for Māori and Pacific peoples by providing culturally safe, community-based care and removing barriers to timely access.

> *Māori and Pacific communities, who already experience inequity in timely access to care, may benefit from earlier treatment, more continuity, and more care delivered in the home or community. (Paramedic)*

✓ Older people
✓ People with disabilities
Respondents emphasise that paramedic prescribing would particularly benefit people with disabilities, mobility challenges, and housebound patients by enabling treatment at home and removing transport and access barriers.

> *Disabled people and older adults would be particularly supported, as unnecessary transfers or waiting-room visits can be uncomfortable, stressful, or even harmful. (Paramedic)*

✓ Other communities (those with chronic illness, low health literacy, low socioeconomic status, rangatahi | young people)

> *Paramedic prescribing has strong potential to improve access to timely care for communities who already experience barriers within the health system, particularly Māori, rural populations, older adults, people with disabilities, and those with limited access to primary care or transport. Paramedics are often the most readily available clinicians for these groups, and the ability to prescribe can reduce delays, repeated assessments, and fragmented care. (Organisation)*

> *Paramedic prescribing will assist in allowing patients to receive timely treatment reducing the requirement for a second review with a GP/nurse prescriber and potential travel. For those with low health literacy or lack of access to transportation to these appointments this will have an positive impact as they will receive the care they require from the paramedic prescriber without having to travel to get it or attempt to make a follow up appointment with another provider that they may not understand the significance of attending. (Paramedic)*

Many responses highlight that paramedic prescribing would lead to improved patient outcomes, including fewer hospital admissions, better chronic disease management, and reduced complications from delayed treatment. It's seen as enabling more complete, patient-centred care.

> *Less hospital admissions — better recovery if at home, especially in situations where whānau support is important. Also gives options that may better suit the situation. (Paramedic)*

✓ **Positive impact on emergency departments, GPs and hospitals through increased workforce capacity**

While this consultation question asked about the impact on different 'communities', a lot of respondents chose to also give feedback about the impact on the workforce and health system more generally. Respondents frequently note that paramedic prescribing would relieve strain on overcrowded EDs, GP clinics, and hospital systems by enabling more care to be delivered on-scene or in the community. Respondents believe paramedic prescribing would expand the effective healthcare workforce, particularly in areas facing GP and nurse shortages. This is viewed as improving system efficiency and patient flow.

> *Relieve the over-burdened health department and overcrowded waiting rooms with patients that could be treated and cared for at home. (Paramedic)*

> *Primary care is particularly stretched with a lack of GPs, NPs, and nurse prescribers. Increasing the pool of which patients can access needed medication will improve outcomes. (Paramedic)*

Potential negative impacts for different communities that were most commonly cited include:

- × Risk of worsening health inequities
- × Increased demand on, and misuse of, paramedic services
- × Greater risk of fragmented care and unsafe prescribing

**Risk of worsening health inequities**

Several respondents express concern that paramedic prescribing could unintentionally widen health inequities if not implemented carefully or equitably across regions. They worry that uneven rollout, variable training standards, or resource disparities could disadvantage some communities. In addition, the potential for unsafe prescribing could be increased for those communities who are already experiencing health challenges.

> *Some communities may feel uncertain or lack trust in expanded paramedic roles, especially if they have had previous negative healthcare experiences. There is also the possibility of unequal access if prescribing is introduced unevenly across regions, leaving rural or high-needs areas behind. (Paramedic)*

> *The aforementioned pressures might mean prescribing paramedics are used to plug gaps, and this could also mean pressure to treat more patients in the community, when a hospital visit is needed. This might impact those more rural and remote patients, and those with limited access to transport. (Organisation)*

> *Patients might have reduced contact with their usual GP if communication systems are weak, which can impact continuity of care, particularly for older adults, those with complex conditions, and groups who already struggle to navigate the health system. (Paramedic)*

Respondents also noted that paramedic prescribing may result in a lack of follow up care for those who need it most:

> *For those patients with risk factors for severe illness (low socioeconomic status, low health literacy, Māori and Pacific Peoples), follow-up care is important therefore it doesn't remove the need for those patients to be seen in primary care. (Organisation)*

**Increased demand on, and misuse of, paramedic services**

As noted above, while the consultation question asked about impacts on different communities, many respondents chose to give feedback about the potential negative impact on paramedic services and the health system in general. Respondents worry that paramedic prescribing might lead to increased, inappropriate demand for ambulance or paramedic services — particularly if the public views them as a convenient, free alternative to GPs. Several responses raise concerns that adding prescribing responsibilities could increase paramedic workload without corresponding support, funding, or workforce expansion. This could result in overuse, burnout, slower emergency response times and reduced quality of care.

> *Greater demand for service; we are a free service so once word is out paramedics can*

*prescribe why would patients bother to book a GP appointment when the ambulance service is free and nearly immediate? (Paramedic)*

*The community using the emergency service for non-emergency conditions creating delays in acute response times. (Paramedic)*

**Greater risk of fragmented care and unsafe prescribing (especially without access to patient medical records)**

*There is a risk of fragmented care if communication between paramedics, GPs, and other health providers is not well managed, which could lead to duplicated or conflicting treatments. (Paramedic)*

*Increase risks from fragmentation of care (e.g. excessive use of opioids) and not having ready access to patient's medical records can affect safe patient care. (Organisation)*

Many of those who raised potential negative impacts also acknowledged the solutions to identified risks in their feedback.

*Risk of medication and prescribing errors, and inappropriate prescribing - this risk is likely to be mitigated with robust process and access to IT and patient records. (Medical officer)*

*A potential negative impact is the risk of uneven prescribing standards if training pathways are not sufficiently rigorous. To ensure patient safety and public trust, prescribing should be limited initially to clinicians already working at an advanced level of practice (ECP, ICP, CCP), supported by a robust practicum, high assessment thresholds, and ongoing competency requirements. (Paramedic)*

## Summary of feedback for this consultation

The consultation shows clear, conditional support for paramedic prescribing. Success depends on phased implementation, strong education pathways, governance, access to patient records and diagnostics, and careful integration with the wider health system.

Respondents emphasised that prescribing is not a quick fix, but a significant professional and system change requiring careful design.

Across the responses, paramedic prescribing is overwhelmingly viewed as having significant positive equity impacts, particularly for rural, Māori and Pacific communities, and those experiencing complex and chronic illness. Key benefits include improved access, reduced health system pressure, better patient outcomes, and enhanced workforce capacity.

## Appendix 1

The following tables show key demographic and paramedicine-related information provided by those who responded to the consultation. The demographic questions were at the end of the feedback form and were noted as optional and intended for paramedic respondents. Overall, around 60% of those who responded to the consultation provided demographic and/or employment information. The total number of respondents who answered each question is noted in the tables.

| | All respondents | | Paramedics only | |
|---|---|---|---|---|
| **Gender** | Number | % | Number | % |
| **Wāhine \| Female** | 77 | 50% | 69 | 51% |
| **Tane \| Male** | 76 | 49% | 64 | 47% |
| **Another gender** | 1 | 1% | 1 | 1% |
| **Prefer not to say** | 1 | 1% | 1 | 1% |
| **Total who answered question** | **155** | | **135** | |

| | All respondents | | Paramedics only | |
|---|---|---|---|---|
| **Age group** | Number | % | Number | % |
| **18 to 24** | 9 | 6% | 8 | 6% |
| **25 to 34** | 31 | 20% | 28 | 21% |
| **35 to 44** | 60 | 39% | 55 | 41% |
| **45 to 54** | 25 | 16% | 20 | 15% |
| **55 to 64** | 25 | 16% | 21 | 16% |
| **65 to 74** | 5 | 3% | 3 | 2% |
| **75 or older** | 0 | 0% | 0 | 0% |
| **Total who answered question** | **155** | | **135** | |

| | All respondents | | Paramedics only | |
|---|---|---|---|---|
| **Primary practice level** | Number | %* | Number | %* |
| **Paramedic** | 6 | 4% | 4 | 3% |
| **Extended Care Paramedic (ECP)** | 68 | 46% | 67 | 50% |
| **Critical Care Paramedic (CCP)** | 4 | 3% | 4 | 3% |
| **Emergency Medical Technician (EMT)** | 23 | 15% | 23 | 17% |
| **Intensive Care Paramedic (ICP)** | 39 | 26% | 39 | 29% |
| **Other (please specify)** | 19 | 13% | 6 | 5% |
| **Total who answered question** | **149** | | **133** | |

* Respondents could select more than one category, so totals exceed 100%

Other primary practice levels included respondents who identified themselves as former/retired paramedics, GPs or doctors, registered nurses, pharmacist prescribers, and

other health professionals.

| Secondary practice level | All respondents Number | %* | Paramedics only Number | %* |
|---|---|---|---|---|
| **Not applicable** | 56 | 49% | 49 | 48% |
| **Paramedic** | 2 | 2% | 1 | 1% |
| **Extended Care Paramedic (ECP)** | 29 | 25% | 28 | 27% |
| **Critical Care Paramedic (CCP)** | 4 | 4% | 4 | 4% |
| **Emergency Medical Technician (EMT)** | 9 | 8% | 9 | 9% |
| **Intensive Care Paramedic (ICP)** | 12 | 11% | 12 | 12% |
| **Other (please specify)** | 12 | 11% | 9 | 9% |
| **Total who answered question** | 114 | | **102** | |

* Respondents could select more than one category, so totals exceed 100%

Other secondary practice levels included respondents who identified themselves as GPs or doctors, registered nurses or nurse practitioners, and as being former/retired paramedics or other health professionals.

| Type of employment | All respondents Number | %* | Paramedics only Number | %* |
|---|---|---|---|---|
| **Road ambulance service** | 95 | 63% | 93 | 70% |
| **Telehealth** | 16 | 11% | 16 | 12% |
| **Air ambulance service** | 15 | 10% | 15 | 11% |
| **Paramedic education** | 13 | 9% | 12 | 9% |
| **Ambulance management** | 9 | 6% | 9 | 7% |
| **Event services** | 8 | 5% | 8 | 6% |
| **Kaupapa Māori health provider** | 6 | 4% | 5 | 4% |
| **Hospital** | 6 | 4% | 5 | 4% |
| **Private ambulance service** | 5 | 3% | 5 | 4% |
| **Vaccination services** | 2 | 1% | 2 | 2% |
| **Oil and/or gas industry** | 1 | 1% | 1 | 1% |
| **Military services** | 1 | 1% | 0 | 0% |
| **Other (please specify)** | 43 | 29% | 31 | 23% |
| **Total who answered question** | **150** | | **133** | |

* Respondents could select more than one category, so totals exceed 100%

Most of those who selected 'other' to best describe their mahi / work specified that they worked in primary care (including rural primary care/general practice). A smaller number said they were retired or worked in policy/research or Government roles.

| Primary work environment | All respondents | Paramedics only |
|---|---|---|

| | Number | %* | Number | %* |
|---|---|---|---|---|
| **Urban** | 89 | 59% | 78 | 59% |
| **Rural** | 75 | 50% | 68 | 51% |
| **Metropolitan** | 32 | 21% | 31 | 23% |
| **Remote** | 11 | 7% | 10 | 8% |
| **Telehealth/Online** | 7 | 5% | 7 | 5% |
| **Offshore** | 2 | 1% | 2 | 2% |
| **Other (please specify)** | 5 | 3% | 4 | 3% |
| **Total who answered question** | **151** | | **133** | |

* Respondents could select more than one category, so totals exceed 100%

| | **All respondents** | | **Paramedics only** | |
|---|---|---|---|---|
| **Employment status** | Number | %* | Number | %* |
| **Full-time** | 120 | 79% | 107 | 80% |
| **Part-time** | 14 | 9% | 12 | 9% |
| **Casual** | 17 | 11% | 15 | 11% |
| **Volunteer** | 1 | 1% | 1 | 1% |
| **Not currently in employment** | 1 | 1% | 1 | 1% |
| **Other (please specify)** | 6 | 4% | 4 | 3% |
| **Total who answered question** | **151** | | **133** | |

* Respondents could select more than one category, so totals exceed 100%