



Widening prescriber scope for unapproved medicines – cost-benefit analysis of s29 and s29a changes

October 2025

Background

This CBA covers two proposed policy changes in the Medicines Amendment Bill (awaiting Second Reading as of September 2025): (1) extending section 29 use of unapproved¹ medicines to nurse practitioners (NPs) and pharmacist prescribers (PPs)², and (2) enabling all authorised prescribers to use a PHARMAC-funded unapproved alternative medicine during shortages (s29A).

The intent of these changes is to improve timeliness, remove the need for Nurse Practitioners and Pharmacist Prescribers to find a doctor to sign-off prescriptions, and allow other prescribers to keep treatment going during shortages, which have become more common in recent years due to global supply problems.³

These changes partly stem from The Ministry's Regulatory Response Team (RRT) issue RRT2024-025. The Ministry contributed to these ideas, which Ministry of Health has implemented.⁴ It is unclear whether the changes would have occurred without The Ministry's input, and/or to what extent The Ministry has sped up the changes. In the absence of this information, we have not attempted to determine what proportion of net benefits are attributable to The Ministry, and simply calculate the total net benefits of the changes.⁵

Factual and counterfactual

¹ Unapproved medicine are those unapproved by Medsafe

² The most recent amendment to the Bill has added Pharmacist Prescribers to s29: [Medicines Amendment Bill 134-2 \(2025\), Government Bill Part 2 Other amendments – New Zealand Legislation](#)

³ [cabinet-material-enabling-professions-prescribe-unapproved-medicines-during-supply-shortages.pdf](#). Note that The Ministry provided an exemption to requiring a Regulatory Impact Statement so there is no exiting cost-benefit analysis for this work.

⁴ Colm Williams (who wrote up this RRT issue) suggests it's difficult to say what proportion is attributable to The Ministry, and/or whether The Ministry's input sped up implementation. We present this CBA but note that changes may be more directly attributable to MoH than The Ministry.

⁵ Out-of-scope: the potential future changes to enable emergency ambulance personnel to prescribe unapproved medicines will be progressed via the Medical Products Bill. We exclude these changes from this CBA because the details are not yet determined.

The factual for this CBA is the changes brought about by:

1. the extension of s29 -- extending the use of unapproved medicines to Nurse Practitioners and Pharmacist Prescribers; and
2. the introduction of s29A -- enabling all authorised prescribers to prescribe a unapproved but PHARMAC-funded alternative medicine during shortages.

The counterfactual is where these changes do not occur, and only doctors can prescribe unapproved medicines with s29.

Benefits

We measure benefits across four areas:⁶

1. **Nurse Practitioners added to s29 – avoided GP sign-off costs.** These are the avoided costs of GP time, as Nurse Practitioners no longer need GP sign-off when prescribing unapproved medicines.
 - a. Formula = number of GP sign-offs of unapproved medicines for Nurse Practitioners multiplied by the cost of GP sign-off time.
 - b. Data and assumptions:
 - i. There are 910 Nurse Practitioners in New Zealand.⁷
 - ii. We estimate the average Nurse Practitioner does 13.6 prescriptions per year of unapproved medicine that would need GP sign-off in the counterfactual. We estimate this using a mix of NZ and overseas data: we estimate 2,726 prescriptions per nurse prescriber using data from 2019.⁸ We assume this same rate for nurse practitioners.⁹ We do not have data on the number of prescriptions of unapproved medicines, but use UK data that roughly 0.5% of all prescriptions are for

⁶ See the CBA excel sheet for details: [20250915 Nurse practitioners CBA.xlsx](#)

⁷ [Nurse practitioners in New Zealand | Ministry of Health NZ](#)

⁸ [Workforce statistics 2018–19.pdf](#) and [Examining non-medical prescribing trends in New Zealand: 2016–2020 | BMC Health Services Research | Full Text](#)

⁹ Nurse prescribers includes nurse practitioners plus other prescribing registered nurses who are authorised to prescribe: [Annual Report 2019.pdf](#)

unlicensed/unapproved medicines. We then multiply 2726 by 0.5% to get 13.6 prescriptions per year needing GP sign-off.

- iii. We assume 10 minutes of GP time saved from sign-off.¹⁰ A 20-minute GP consult costs the system \$93¹¹, so this gives \$46.5 for 10 minutes.

c. Annual benefits:

- i. We multiply $910 \times 13.6 \times 46.5$ to get \$580,000 per year in benefits.

2. **Pharmacist Prescribers added to s29 – avoided GP sign-off costs.** These are the avoided costs of GP time, as Pharmacist Prescribers no longer need GP sign-off when prescribing unapproved medicines.

- a. Formula = number of GP sign-offs of unapproved medicines for Pharmacist Prescribers multiplied by the cost of GP sign-off time.
- b. Data/assumptions: There are 74 Pharmacist Prescribers in New Zealand.¹² Using the same data and approach as for Nurse Practitioners, we estimate 17,000 prescriptions per pharmacist prescriber in 2019, and 85.3 pharmacist prescriber prescriptions needing GP sign-off in the counterfactual. We again assume that 10 minutes of GP time are saved in the factual, saving \$46.5 for each case.
- c. Annual benefits: we multiply $74 \times 85.3 \times 46.5$ to get \$290,000 per year in benefits.

3. **Non-doctors added to s29a – avoided GP sign-off costs.** There are additional avoided GP sign-off costs, as non-doctor prescribers no longer need GP sign-off in the event of a medicine shortage. We do not count benefits to doctors in this category, as doctors were already included in s29, and so do not gain from these changes.

- a. Formula = number of GP sign-offs to non-doctor prescribers during medicine shortage multiplied by the cost of GP sign-off time
- b. Data and assumptions:
 - i. First, we know the total number of prescriptions in New Zealand was 58.5 million in the 2023/24 financial year.¹³
 - ii. We estimate that 26,000 of these prescriptions are unapproved and given due to shortages, using the following approach. UK data shows around 0.5% of prescriptions are unlicensed medicines given to meet the specific needs of a patient, and that 17.8% of these unlicensed

¹⁰ A GP would previously need to look at the medicines the patient is on, their medical history, and different contraindications of the medicines, so 10 minutes is a reasonable estimate (source: New Zealand nurse).

¹¹ From Treasury's CBAX dataset.

¹² [2024-Demographic-Report.pdf](#)

¹³ [Top 20 Medicines in the community by number of prescriptions 2021/22 - Pharmac | Te Pātaka Whaioranga | NZ Government](#)

medicines are prescribed due to commercial unavailability. We conservatively assume 50% of commercial unavailability is due to a shortage, and translate these numbers to New Zealand to calculate 26,000 prescriptions ($58.5 \text{ million} \times 0.005 \times 0.178 \times 0.5 = 26,000$).

- iii. We then assume there are some repeats, as not every prescription represents a consultation with GP sign-off. We divide 26,000 by 1.2 to be relatively conservative and assume 1 out of 5 consultations lead to a repeat prescription. This gives 21,700 consultations.
- iv. Finally, we need to estimate the proportion of these consultations that are with non-doctor prescribers. The proportion of prescriptions in New Zealand given by non-doctors rose from 1.8% in 2016 to 3.6% in 2019.¹⁴ So we assume 5% of consultations above are with non-doctor prescribers, to allow for growth since 2019 in non-doctor prescribing. This saves GP sign-off for 1,085 consultations. We again assume 10 minutes of GP time is saved per consult, saving \$46.5 for each case.

c. Annual benefits: we multiply $1,085 \times 46.5$ to get \$50,000 per year in benefits.

4. **Non-doctors added to s29a – fewer health escalation costs.** These are the avoided escalation costs from treatment gaps. There is evidence that drug shortages lead to worse health outcomes for patients,¹⁵ but rather than estimating health costs we assume patients receive emergency care and look at health escalation costs. We use conservative estimates of the saved costs to the health system, in terms of fewer emergency department (ED) visits and ambulance call-outs for patients.

- a. Formula = number of non-doctor consultations leading to unapproved medicines during a shortage, multiplied by: (1) the probability of an ED visit due to the shortage times the cost of an ED visit, plus (2) the probability of needing an ambulance due to the shortage times the costs of an ambulance.
- b. Data and assumptions:
 - i. First, we take the number of non-doctor consultations leading to unapproved medicines from section 3 above, and get a value of 1,085.
 - ii. Then, we conservatively assume a 0.5% chance that a patient needing medicine in a shortage would end up in ED due to delays in receiving care. This is a low number, but we assume most patients will still

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/33941188/>

¹⁵ [Impact of Drug Shortages on Patients in the United States: A Case Study of Three Drugs - NCBI Bookshelf](#)

receive medicines (via their GP) after a short delay only without escalation to an ED visit. The cost of an ED visit is \$517.5.¹⁶

- iii. Finally, we conservatively assume a 0.2% chance that a patient needing medicine in a shortage would end up needing an ambulance due to delays in receiving care. This is a low number, but we assume most patients will still receive medicines (via their GP) after a short delay only without escalation to an ambulance call-out. The cost of an ambulance call-out is \$1,000.¹⁷

- c. Annual benefits: we multiply $1085 \times (.005 \times 517.5 + .002 \times 1000)$ to get \$5,000 per year in benefits.

Costs

We estimate one-off transition costs to implement the changes via new forms and IT systems. We assume these are relatively small changes, and estimate with plausible IT contractor hours and costs. Assuming 400 IT contractor hours, at an hourly rate of \$150, we get \$60,000 in one-off costs.

We assume no admin costs to prescribers who now use s29 and s29a. Although there are new admin costs, these are likely offset by the new admin benefit of not needing to get GP sign-off for the unapproved medicine, which we have not included in the benefits above which only estimated time savings for GPs.

We assume no health costs to patients from receiving unapproved medicines. Though unapproved medicines have higher risks as they have been less vetted in New Zealand, the main change of these policies is to speed up access to these medicines and reduce the burden to GPs – we assume patients would have received these medicines in the counterfactual. Similarly we assume there is no difference between GPs, Nurse Practitioners and Pharmacist Prescribers in their ability to appropriately prescribe medicines, such that increasing prescribing powers does not lead to worse health outcomes.

We do not calculate the policy costs of the changes.

Summary

Our summary of the CBA is shown below, using a 2% discount rate following Treasury's guidance for non-commercial projects.

Net benefits are \$866,000 in 2026, and \$926,000 per year from 2027.

The 10-year NPV with a 2% discount rate is \$8.3 million.

¹⁶ Treasury's CBAX model: [CBAX Spreadsheet Model | The Treasury New Zealand](#)

¹⁷ [Ambulance charges explained | Hato Hone St John](#)