Regulatory Impact Statement: Authorising paramedic prescribing

Decision sought	Analysis produced for the purpose of Cabinet decision making on granting prescribing authority to paramedics
Agency responsible	Ministry of Health
Proposing Ministers	Hon Simeon Brown
Date finalised	*6 May 2026*

The Minister's proposal is to create new regulations under the Medicines Act 1981 to authorise appropriately trained paramedics to prescribe specified medicines. Authorising paramedics to prescribe will support timely care outside hospitals and improve medicine access for rural and remote communities. It is also expected to reduce unnecessary patient transfers and alleviate pressure on emergency and primary services.

The proposed amendment will establish paramedics as designated prescribers under the Medicines Act 1981, in the same manner as pharmacist prescribers, nurse prescribers, podiatrist prescribers and dietitian prescribers. This will allow paramedics, who meet the necessary standards set by the Paramedic Council, to prescribe from a list of specified medicines. The standards set by the Paramedic Council will initially limit prescribing to Extended Care Paramedics, with staged expansion over time.

Summary: Problem definition and options

What is the policy problem?

Communities across New Zealand face increasing demand for urgent and primary healthcare, particularly in rural and remote areas. Paramedics already provide assessment, treatment, and medicine administration across emergency, urgent, primary, and community settings and have potential to help address increasing demand.

Paramedics are not authorised to prescribe medicines, instead relying on standing orders issued by authorised prescribers to supply and administer medicines. Standing orders support access to medicines but can limit efficiency, accountability and continuity of care. Paramedics are skilled healthcare professionals already established in the workforce. With additional training, they can expand their scope of practice and provide end-to-end care with reduced administrative burden, improving medicine access for patients.

The Paramedic Council has submitted an application for paramedics to be granted designated prescribing authority, allowing paramedics who undertake appropriate training and education to prescribe from a defined list of prescription medicines.

What is the policy objective?

The objectives are:

- Support the delivery of care in non-hospital settings, allowing patients to receive timely treatment closer to home and reducing unnecessary transfers.
- Improve access to timely treatment for people living in underserved, rural or remote areas, including Māori and Pacific peoples.
- Increase system efficiency by reducing delays, transport costs, repeat referrals, and easing pressure on emergency and primary services.
- Recognise paramedic expertise, support professional growth, and promote workforce sustainability through advanced practice pathways and increased retention.

What policy options have been considered, including any alternatives to regulation?

Regulatory options under the Medicines Act include granting paramedics authorised prescriber or designated prescriber prescribing authority. Authorised prescribing authority would allow paramedics to independently prescribe any medicine, while designated prescribing authority would limit them to a set list of approved medicines.

We also considered maintaining the status quo and continuing to rely on standing orders, potentially with efforts to improve governance, consistency, or scope.

What consultation has been undertaken?

Te Kaunihera Manapou | Paramedic Council (the Council) undertook a public consultation between November 2025 and January 2026. 197 respondents provided substantive feedback to the consultation. The majority of respondents were paramedics, with other respondents including employers, professional organisations, other health professionals, education providers and members of the public.

There was strong overall support for paramedic prescribing, with 88% of all respondents in favour of paramedics being able to prescribe. 148 paramedics supported paramedic prescribing, and 19 organisations. There was strong support for a phased introduction to ensure systems and safeguards are properly established.

86% of respondents supported paramedics becoming designated prescribers. This included 146 paramedics and 19 organisations. Key themes in support of this model included agreement with a balanced and pragmatic transitional model, and agreement with the level of risk management. Concerns included patient safety in relation to clinical knowledge and training, overuse of an already stretched paramedic service, and system readiness for paramedic prescribers. A few respondents preferred an authorised prescriber model, viewing a designated model as too limited. Authorised prescribing was seen as more appropriate and future-focused, enabling more flexibility for paramedics who work in a range of settings.

The Council also undertook a ‘temperature check’ survey in July-August 2025, to determine the level of support for paramedic prescribing among paramedics and stakeholders. A total of 610 (476 paramedics, 77 organisations, and 77 other individuals) respondents participated in this survey, and the feedback showed strong overall support (87%) for paramedic prescribing. 63% of respondents identified safety concerns associated with paramedic prescribing, but there was strong consensus that many of the risks could be managed through education, monitoring and system-level support for paramedics. The most common potential benefits identified by respondents were patients having timely access to

healthcare, reduced burden on other healthcare professionals, and improved access to medicines for patients.

Is the preferred option in the Cabinet paper the same as preferred option in the RIS?
Yes

Summary: Minister's preferred option in the Cabinet paper

Costs (Core information)

Outline the key monetised and non-monetised costs, where those costs fall (e.g. what people or organisations, or environments), and the nature of those impacts (e.g. direct or indirect)

The development and implementation of new training programmes for paramedic prescribers will require time and resources to ensure paramedics are adequately trained to prescribe. Administrative costs will be incurred through updating scopes of practice and undertaking audits to monitor outcomes. As paramedic prescribing becomes integrated into routine practice, there may be a temporary increase in workload for health providers employing paramedics.

The associated costs are likely to fall on employers of paramedics, regulatory agencies, and paramedics themselves, including expenses related to training, supervision, remuneration, and ongoing administrative requirements.

Benefits (Core information)

Outline the key monetised and non-monetised benefits, where those benefits fall (e.g. what people or organisations, or environments), and the nature of those impacts (e.g. direct or indirect)

Paramedic prescribing is expected to improve access to timely treatment for patients, particularly those in underserved, rural, and remote communities, including Māori and Pacific peoples. By enabling paramedics to provide appropriate care closer to home, the need for lengthy travel is reduced, ensuring that patients receive treatment sooner and in more convenient settings.

This change is expected to decrease unnecessary hospital transfers and the associated transport costs, as paramedics will be able to deliver end-to-end care in the community. As a result, patients will benefit from faster access to necessary medicines, improving both their overall healthcare experience and health outcomes.

Paramedic prescribing will also help to support busy primary and urgent care services. Enabling paramedics employed as part of a primary care team to prescribe will reduce the administrative burden associated with standing orders, enable specialist paramedics to work to top of scope, and reduce duplication of care associated with patient treatment often needing to be signed off by a doctor.

An additional benefit is that paramedic expertise will be more formally recognised within the healthcare system. This recognition supports professional growth and helps to sustain the workforce by offering advanced practice pathways and encouraging retention of paramedics.

Balance of benefits and costs (Core information)

Does the RIS indicate that the benefits of the Minister's preferred option are likely to outweigh the costs?

The RIS suggests the benefits, including system efficiency, patient safety, equity and workforce sustainability, are likely to outweigh the costs of implementation and ongoing monitoring. We are not able to make specific monetised estimates. Any costs will not occur as a direct result of the regulatory changes and will depend on the uptake of training and employment of paramedic prescribers.

Implementation

How will the proposal be implemented, who will implement it, and what are the risks?

This proposal will require new Regulations, under the Medicines Act 1981, which will provide the authority for paramedics, with the necessary training, to prescribe medicines.

Following the new Regulations taking effect, the Director-General of Health will be responsible for setting a specified prescription medicines list (pursuant to section 105(5A) of the Medicines Act 1981), following sector consultation. If any of these medicines are also controlled drugs under the Misuse of Drugs Act 1975, an amendment will need to be made under the Misuse of Drugs Regulations 1977.

Risks associated with implementing paramedic prescribing include concerns about patient safety, specifically relating to the adequacy of paramedics' clinical knowledge and training for prescribing medicines. There is also the risk that the health system may not be fully prepared to support this new responsibility, potentially leading to gaps in governance or insufficient resources. Additionally, allowing paramedics to prescribe could lead to the overextension of the paramedic workforce, increasing workloads and possibly impacting the quality of care delivered. Increased access to medicines may also result in minor costs to Pharmac for approving and enabling funding of medicines through prescriptions issued by paramedics, practitioner supply orders and special authority applications.

Comprehensive training and ongoing supervision are key to ensuring paramedic prescribing is implemented safely and effectively. Regular reviews and a phased rollout further support the process, allowing for continual improvement and adaptation.

The Paramedic Council will be responsible for the development of

- new paramedic prescriber scopes of practice
- specifying the education, training, and qualification requirements
- accreditation and monitoring of paramedic prescriber training provider(s)
- paramedic prescriber continuing professional development and recertification requirements
- accreditation and recognition requirements for paramedic prescribers from other jurisdictions.

Limitations and Constraints on Analysis

The exact costs associated with the training, supervision, and expansion of scopes of practice for paramedics are unclear. As paramedicine is a relatively newly regulated profession in New Zealand with evolving responsibilities and given the limited number of international examples of paramedic prescribing, it is difficult to definitively identify the full range of costs, benefits, and safeguarding measures required.

I have read the Regulatory Impact Statement and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the preferred option.

Responsible Manager(s) signature:

Allison Bennett
Group Manager, Health Services and Regulatory Systems Policy

6 May 2026

Quality Assurance Statement	
Reviewing Agency: Ministry of Health	**QA rating:** Meets

Panel Comment:

A Ministry of Health QA panel has reviewed the Impact Statement titled "Authorising Paramedic Prescribing", produced by the Ministry for Health and dated May 2026.

The panel considers that the Impact Statement **Meets** the quality assurance criteria.

The Impact Statement is clear and concise, consulted, complete and convincing. The analysis is balanced in its presentation of the information. Impacts are identified and appropriately assessed

Section 1: Diagnosing the policy problem

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

Paramedics work within a defined scope of practice

1. Paramedics are regulated healthcare professionals who apply their clinical expertise and judgement to deliver healthcare services, focusing on urgent and emergency assessment, diagnosis, and treatment. Their responsibilities also encompass providing clinical advice, making referrals, and arranging patient transport when necessary.

2. Paramedics work with other healthcare providers to ensure timely, coordinated care. They lead, supervise, and support clinical teams, and partner with individuals, families, whānau, and communities. They may also be involved in policy development, leadership, management, research, training, education, and public communication.

3. As of April 2025, there are 2,756 registered paramedics in New Zealand, with 2,242 holding practising certificates.

Specialist paramedic endorsements expand scopes of practice

4. There are currently three specialist paramedic endorsements in New Zealand, which demonstrate the potential for paramedics to work within expanded scopes of practice with advanced knowledge and skills.

Critical care paramedic (CCP)

5. A CCP is a registered paramedic specialising in the care of the critically ill or critically injured. They often work in emergency pre-hospital care services such as ambulance and aeromedical services. CCPs have advanced training and can perform complex procedures including airway management, cardiac care, and intravenous drug therapy. There are currently 245 CCPs in New Zealand.

6. Becoming a CCP requires undertaking postgraduate study, currently offered through Auckland University of Technology (AUT). Mandatory courses for a CCP endorsement cover resuscitation physiology, advanced resuscitation and contemporary intensive paramedicine, enabling graduates to provide advanced life support measures.

Extended care paramedic (ECP)

7. An ECP is a registered paramedic specialising in primary and preventative care for patients with non-urgent but often complex conditions. ECPs often work in primary care settings such as in general practice. Responsibilities of ECPs in primary care teams may include phone triaging, clinical assessment, out of hours consultations, home visits and providing extended care to avoid hospitalisation. There are currently 128 ECPs in New Zealand.

8. As with the CCP endorsement, becoming an ECP requires postgraduate study. Mandatory courses specific to the ECP pathway cover pharmacology science and therapeutics, advanced assessment and diagnostic reasoning, and community and remote paramedicine.

Intensive care paramedic (ICP)

9. This scope is similar to the CCP scope, and the Paramedic Council will stop accepting new applications in December 2026. There are currently 18 ICPs in New Zealand.

Health practitioners can prescribe medicines through three models

10. The Medicines Act 1981 (the Medicines Act) provides that prescription medicines can only be supplied on receipt of a prescription from someone authorised to prescribe. There are three models through which practitioners can prescribe medicines:

    - **Authorised prescribers** have full, independent prescribing rights. Medical practitioners, midwives, dentists, optometrists and nurse practitioners are all authorised prescribers in New Zealand. Authorised prescribing is limited to professions with a strong history of safe, independent prescribing, supported by robust regulatory, educational, and clinical governance systems.

    - **Designated prescribers** are limited to a list of prescription medicines, specified by the Director-General of Health by notice in the New Zealand Gazette following formal consultation. Designated prescribing uses strict regulatory frameworks, supervision, and competency requirements for safe prescribing. Current

professions with designated prescribing authority are nurse prescribers, dietitian prescribers, podiatrist prescribers, and pharmacist prescribers.

- **Delegated prescribers** have limited prescribing authority delegated to them by an authorised prescriber through a delegated prescribing order. The delegated prescriber can then prescribe certain prescription medicines as set out in the order. There are currently no delegated prescribers in New Zealand, as no regulations have been made.

Paramedics in New Zealand cannot prescribe medicines

11. Paramedics cannot prescribe medicines and must operate under standing orders to supply and administer medicines without a prescription. A standing order is a written instruction from a medical practitioner or nurse practitioner authorising specific people or groups, such as paramedics or nurses, to supply or administer certain medicines.

12. The decision on whether to supply or administer a medicine to a specific patient is made by the person acting under the standing order (e.g. the paramedic) according to the situation and their professional judgement. Standing orders are intended to improve timely access to medication, for example, by allowing paramedics to decide to provide necessary treatments in emergencies without direct oversight from a doctor or other prescriber.

13. While standing orders improve medicine access, they also have limitations:

    - Standing orders are burdensome to develop and require ongoing management, including countersigning or prescribed audit requirements, regular updates, and annual review.
    - Although paramedics make the clinical decision to supply or administer medicines, the legal accountability remains with the authorised issuer.
    - Primary care organisations can develop and apply standing orders differently, leading to inconsistent care across the country and, in many cases, paramedics not working to top of scope.
    - Due to the time required to update standing orders, it is common for standing orders to differ from the latest clinical guidelines and best practice recommendations.
    - For paramedics to supply medicines to a patient under standing orders, the medicines must be held in clinic stock (i.e. medicines supplied under standing orders cannot be dispensed to a patient by a pharmacy). This leads to unnecessary medicine wastage.
    - Standing orders cannot be used to supply or administer unapproved medicines under Section 29 of the Medicines Act. This would be problematic if all approved versions of an emergency medicine were to become unavailable.

Paramedics overseas can prescribe medicines

14. Paramedics are increasingly taking on expanded roles in primary care, both in New Zealand and internationally, as health systems respond to workforce pressures and rising demand for community-based care. A survey conducted by the Council in August

2025 showed that 16.7% of paramedics in New Zealand were working in general practice, 9% for a primary care provider, 8% in an urgent care clinic, 2% for a telehealth/virtual health provider and 1% for a Māori health service provider.

15. Paramedic practice is similarly expanding overseas, with paramedics employed in general practice, community health teams, and in-home care roles, helping to reduce pressure on emergency departments and general practices.

16. The United Kingdom implemented paramedic prescribing in 2018 to enable more medical issues to be treated at the scene rather than people being referred to hospital, to support the development of new care pathways and to improve patient safety through faster access to medicines. In the UK, paramedic prescribing has been associated with high patient satisfaction, faster treatment, reduced pressure on primary care, and improved career development. Reported implementation issues include role clarity, access to digital patient records/IT systems, and adequate clinical support.

17. In Australia, Victoria passed legislation in 2025 establishing paramedic practitioners as a registered class of paramedics with prescribing rights. The Paramedic Board of Australia also consulted in 2025 on regulating advanced practice paramedics, which would enable paramedics across Australia to undergo further training for independent prescribing. These developments reflect efforts to address rising healthcare demand, especially in rural areas, while utilising a surplus workforce and paramedics' interest in advanced clinical roles.

18. While long embedded within the health system, paramedicine only became a regulated profession in New Zealand in 2020 (compared with 2001 in the UK, and 2018 in Australia). As the profession matures it is appropriate to look at how scopes of practice can be expanded to allow paramedics to contribute more fully to the health system.

What is the policy problem or opportunity?

19. Communities across New Zealand face increasing demand for urgent and primary healthcare, particularly in rural and remote areas. Paramedics are accessible frontline professionals in these settings and increasingly provide care outside 'traditional' emergency response. Extending prescribing authority to paramedics would further enable the profession to be adaptable and responsive to the needs of diverse communities.

20. Standing orders were not designed to support the breadth and complexity of modern paramedic practice. Paramedics work autonomously but must refer patients to another healthcare professional when they need a prescription. A prescribing model for paramedics can help patients get medicines and treatment more quickly, reducing unnecessary referrals and transfers between services.

21. Paramedic prescribers can contribute across various settings:

    - **Home and community:** Paramedics can check, treat, and prescribe medicines to patients directly during home visits or telehealth consultations. For example, an asthma sufferer who has run out of inhalers could receive a prescription from a paramedic over the phone, speeding up the time it takes for the patient to receive an inhaler and reducing the need for an ambulance to attend.

- **Aged care facilities:** Paramedics with prescribing authority can quickly treat residents when their health changes, reducing the need for hospital transfers and keeping residents more comfortable. For example, an older patient who develops a urinary tract infection could be prescribed antibiotics from an attending paramedic prescriber, rather than waiting to see a doctor or being taken to hospital.
- **General practice and urgent care:** Paramedic prescribers can provide same-day care for urgent health issues and work alongside doctors, nurses, and pharmacists as part of a care team. For example, patient with a common urgent medical problem (such as a wound infection) could be seen by a paramedic prescriber in their general practice or urgent care clinic, rather than waiting to see a doctor.
- **Rural and remote areas:** In places where the number of medical staff is limited, paramedic prescribers can help fill gaps, making it easier for people to get the care and medicines they need. For example, a patient in a rural area with an ear infection could be seen by a paramedic prescriber in a rural medical centre or receive a home visit from a paramedic prescriber. The patient would receive a prescription for the full course of their treatment, rather than having to travel long distances to see multiple healthcare professionals. Paramedic prescribers could also support new integrated models of care, for example working in a rural medical centre while also responding to local 111 calls when needed, alongside rural ambulance staff/volunteers.

22. Designated prescribing offers a more flexible and efficient approach to patient care. It shifts responsibility and accountability for prescribing decisions to trained paramedic prescribers, who would operate within a regulated scope supported by education, governance, and clinical collaboration. It also acknowledges paramedics' advanced skills and clinical judgement.

What objectives are sought in relation to the policy problem?

23. The objectives sought in relation to the policy problem include:

- Supporting the delivery of care in non-hospital settings, allowing patients to receive timely treatment closer to home and reducing unnecessary transfers.
- Improving access to timely treatment for people living in underserved, rural, or remote areas, including Māori and Pacific peoples.
- Enabling paramedics to provide timely treatment when other services are limited, such as evenings and weekends, reducing delays and pressure on emergency departments.
- Allowing paramedics to provide end-to-end care rather than handing over care to another healthcare professional.
- Supporting primary care providers who employ paramedics by establishing a clear prescribing scope and reducing the administrative and oversight burden associated with developing, issuing, auditing and updating standing orders.
- Recognising paramedic expertise, supporting professional growth, and promoting paramedic workforce retention through advanced practice pathways.

What consultation has been undertaken?

24. Te Kaunihera Manapou | Paramedic Council undertook a public consultation between 21 November 2025 and 20 January 2026 to seek feedback on whether paramedics in New Zealand should be granted prescribing authority, and under what conditions. A total of 253 responses were received, with 197 providing substantive feedback.

25. There was strong overall support for paramedic prescribing, with 88% of respondents supporting paramedics being able to prescribe medicines. However, support was consistently expressed as conditional, with respondents emphasising the need for safeguards to ensure patient safety.

26. There was strong support for a designated prescriber model, phased implementation, and limiting initial prescribing authority to specialist practice paramedics, particularly Extended Care Paramedics. Respondents also supported establishing a separate scope of practice for paramedic prescribers to provide clarity and regulatory oversight.

27. Respondents raised concerns regarding patient safety, including diagnostic limitations, pharmacology knowledge, and prescribing in time-limited, episodic encounters. Concerns were also expressed about continuity of care, fragmented follow-up, and variable workforce capability if prescribing is not well integrated with primary care and supported by clear eligibility criteria.

28. Across submissions, respondents emphasised that any implementation would require approved postgraduate education, strong clinical governance, audit and quality assurance, access to patient records, and integration with the wider health system.

Section 2: Assessing options to address the policy problem

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

- Safety – patient safety is protected by prescribing safeguards and supported by timely access to medicines.
- Efficiency in healthcare system – practitioners across the system are working at top of scope, administrative burdens on health professionals are reduced.
- Implementation – changes are feasible and can be implemented easily.
- Equity – underserved communities receive timely access to medicines, barriers to healthcare access are reduced.
- Workforce development – paramedics have opportunities for professional development and advanced practice pathways, encouraging them to stay in the profession. A stronger paramedic workforce leads to better and more timely care for patients.

What scope will options be considered within?

29. We were directed by the Minister of Health to explore options for extending prescribing authority to paramedics to increase medicine access. In addition, Health New Zealand engaged the Council to explore, including through public consultation, the feasibility of

registered paramedics having legal authority to prescribe medicines. The Council then submitted an application for paramedics to be granted designated prescribing authority.

30. We considered international precedents set in Australia and the United Kingdom for paramedic prescribing, as well as recent changes made to extend designated prescribing authority to podiatrists in New Zealand. These informed our decision that the scope included options for granting prescribing authority under the Medicines Act.

31. The status-quo of retaining standing orders is included as a non-regulatory option. If the status quo were to persist, the way standing orders are used in paramedic practice could be improved (for example, improving consistency in how they are applied across organisations) or changes to standing orders under the Medicines Act could be considered.

32. We considered including delegated prescribing authority as an option, which would involve making regulations to enable authorised prescribers to grant delegated prescribing rights to other healthcare professionals. However, this was discounted as in practice it would work very similarly to the status quo of standing orders.

What options are being considered?

Option One – Status Quo

33. Under the status quo, paramedics would continue to supply and administer medicines under standing orders.

34. Standing orders require regular review and audit, which creates an administrative burden. While paramedics make clinical decisions under standing orders, legal accountability remains with the issuer, which does not reflect paramedics' training and autonomy.

35. In primary and urgent care, all medicines that may need to be supplied under a standing order need to be available in clinic stock. Paramedic prescribing offers the advantage of limiting clinic stock to only essential medications (such as those needed for after-hours care), as most prescriptions can be filled by a pharmacy.

36. Standing orders will continue to be an important tool for non-prescribing paramedics, but do not provide the necessary flexibility for advanced paramedic practice.

Option Two – Designated prescribing authority

37. Under option two, paramedics who undergo specific training approved by the Paramedic Council to become paramedic prescribers would be given designated prescribing authority. This would allow a group of paramedics to prescribe a limited range of medicines relevant to their practice.

38. The Medicines Act allows the making of regulations to enable health practitioners to become designated prescribers. Allowing paramedics to become designated prescribers, therefore, would only require regulatory change.

39. Designated prescribers can prescribe from a list of prescription medicines, specified by the Director-General of Health by notice in the New Zealand Gazette. A draft list of proposed specified medicines has been developed, and a formal consultation of the list will be undertaken by the Ministry following Cabinet approval of a prescribing model.

40. Designated paramedic prescribers will also be able to prescribe controlled drugs specified in a schedule to the Misuse of Drugs Regulations 1977. The list of the proposed controlled drugs has been drafted and will be consulted on at the same time as the specified prescription medicines list.

41. Standing orders do not allow paramedics to supply unapproved medicines to patients, which is problematic when funded versions of an emergency medicine become unavailable. Designated prescribing authority would allow paramedic prescribers to administer a funded alternative medicine (an unapproved medicine listed by Pharmac in the pharmaceutical schedule as an alternative to an approved medicine) if an approved medicine was in short supply. This would increase patient safety and efficiency in emergency care.

42. Designated prescribing would transfer responsibility and accountability for prescribing decisions from issuers of standing orders to trained paramedic prescribers working within clear regulatory frameworks, and subject to supervision, education, training, and competency requirements.

43. A designated prescribing model was strongly supported in the public consultation, with 86% of all respondents agreeing with the model, and 100% of organisations. Supportive respondents agreed with a balanced and pragmatic 'transitional' model, and with the level of risk management provided by a designated prescribing authority.

Option Three – authorised prescribing

44. Option three is to allow paramedics to become authorised prescribers. Authorised prescribers are allowed to prescribe a full range of prescription medicines unrestricted.

45. Extending authorised prescribing to paramedics would enable them to work with fewer restrictions, and to prescribe any medicine within their scope of practice and area of specialism with full discretion.

46. Authorised prescribing would increase paramedics' independence and efficiency, but the practical benefit is likely to be minimal compared with designated prescribing authority at this time. Designated prescribing would allow paramedics to prescribe a range of medicines relevant to their practice with the additional benefit of increased oversight.

47. The professions currently holding authorised prescribing authority have long records of safe, independent prescribing. In contrast, paramedics do not have an established prescribing history in New Zealand, and their broad scope of practice means that granting them full prescribing rights immediately may be too significant a change. Allowing paramedics to prescribe without restrictions may also present a risk to patient safety.

48. Most respondents to the public consultation agreed that a designated prescribing model is pragmatic and low risk. However, some respondents preferred an authorised prescribing model, stating that it would be better to avoid restrictive medicines lists and that authorised prescribing would better reflect the clinical autonomy of paramedics. Some respondents suggested that while designated prescribing is an appropriate starting point, there should be the potential to move towards authorised prescribing in future.

49. Authorised prescribers are listed in the Medicines Act. Extending authorised prescribing rights to paramedics would therefore require amendment to the Medicines Act, which would be time consuming compared to regulatory change.

How do the options compare to the status quo/counterfactual?

	Option One – Status Quo	Option Two – Designated prescribing	Option Three - Authorised prescribing
Safety	0 Patient safety is supported by strict oversight and guidance of medicine supply and administration. However, the barrier to timely access to medicines compromises patient safety.	++ Patient safety is increased by more timely access to medicines. Safeguards are in place to reduce the risk of inappropriate prescribing including oversight, education, training and competency requirements and a specified list of medicines and controlled drugs.	+ Patient safety is increased by more timely access to medicines, but unrestricted prescribing may present a safety risk.
Efficiency in healthcare system	0 Paramedics can supply and administer medicines but are restricted by what is specified in standing orders. There is an administrative burden to the system of administering, maintaining and reviewing standing orders.	+ Paramedics with designated prescribing authority can provide end-to-end care, reducing referrals and freeing other prescribing healthcare professionals' time for more complex patients. This also removes the burden associated with standing orders. However, efficiency is reduced by the need for ongoing supervision and maintaining an up-to-date medicines list.	++ Paramedics with authorised prescribing authority can provide end-to-end care, reducing referrals and freeing other prescribing healthcare professionals' time for more complex patients. This also removes the burden associated with standing orders.
Implementation	0 N/A	- Requires new regulations pursuant to the Medicines Act 1981 section 105 to make paramedics designated prescribers, the Director-General of Health to establish a	-- Requires amendment of the Medicines Act 1981 to add paramedics to the list of authorised prescribers. Does not require maintaining a medicines list. Paramedic

		list of specified medicines, and amendment regulations to make a new schedule of controlled drugs under the Misuse of Drugs Regulations 1977. Ongoing implementation work includes maintaining an up-to-date list of specified medicines.	prescriber training would take significantly more work to develop to ensure safe prescribing.
Equity	0 Patients in underserved, rural and remote communities face barriers in access to healthcare services, leading to longer delays in receiving medicines.	++ Access to medicines is increased, especially for people in underserved, rural and remote communities. Removing a barrier to care benefits people who typically face multiple barriers.	+ Access to medicines is increased, especially for people in underserved, rural and remote communities. Removing a barrier to care benefits people who typically face multiple barriers. Medicine access is not limited by paramedics only being able to prescribe from a specified list, but this may increase the risk of unsafe prescribing in underserved communities.
Workforce development	0 Standing orders do not align with the developing role of paramedics in the healthcare system. Professional autonomy, clinical judgement and specialised knowledge are not recognised.	+ Increased potential for individual role progression, career development, recognition and respect for the paramedic profession. Allows paramedics, and other healthcare professionals, to work at top of scope. Professional autonomy may be limited by the restrictions associated with designated prescribing.	++ Increased potential for individual role progression, career development, recognition and respect for the paramedic profession. Allows paramedics, and other healthcare professionals, to work at top of scope. Professional autonomy is supported.
Overall assessment	0	+5	+4

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

50. Option two (designated prescribing authority) is most likely to address the problem, meet the policy objectives and deliver the highest benefits by enhancing efficiency in the healthcare system and increasing medicine access for people in underserved communities. Designated prescribing also supports patient safety by setting out clear education, training and competency standards, supervision requirements, a list of specified prescription medicines, and schedule of controlled drugs that the designated paramedic prescribers may prescribe.

51. Possible unintended impacts include role overlap between paramedics and other healthcare providers, requiring clear communication and role definition. Additionally, changes in scope of practice may require updates to current processes and referral systems, which could temporarily affect how services are delivered. Updating IT (e.g., the shared clinical record) and electronic prescribing systems will be needed to enable paramedic prescribers do their jobs effectively.

Is the Minister's preferred option in the Cabinet paper the same as the agency's preferred option in the RIS?

52. Yes

What are the marginal costs and benefits of the preferred option in the Cabinet paper?

Affected groups	Comment	Impact	Evidence Certainty
Additional costs of the preferred option compared to taking no action			
Paramedics	Paramedics who want to prescribe will need to undertake further training and continuous professional development to meet prescribing standards. Role confusion may arise as paramedics' scope expands and overlaps with other health professionals. If training and support systems are inadequate, paramedics may experience isolation, lack of support, and increased anxiety and stress.	Low Monetary costs will be associated with training and supervision. Existing prescribing programmes for other non-medical health professionals cost approximately $12,000.	High
Paramedic Council	The Council will be responsible for designing the scope of practice, setting competency standards, education and training requirements, collaborating with education providers to develop and	Medium $180,000 was provided to the Council by HNZ to explore the feasibility of paramedic prescribing. The	Medium

	accredit prescribing courses. It will also be involved in annual recertification of paramedic prescribers, establishing and maintaining oversight mechanisms, and reviewing standards over time.	Council anticipates that more funding will be needed for the increased workload relating to implementation, but this is difficult to quantify at this stage.	
Employers of paramedics	Supervision requirements may lead to increased administrative workload for employers, including the need to develop new supervision processes and ensure senior clinicians have protected time to provide adequate supervision and support. Role confusion may necessitate internal training and system updates to address overlaps with other healthcare providers. Costs associated with updating practice management systems to enable paramedic prescribing.	Low Non-monetary costs: Increased operational complexity and possible transitional disruptions. Monetary costs: Cost associated with paying for paramedic prescriber annual practicing certificates (currently $600 for 12 months). Some monetary costs may be incurred for training and supervision.	Low
Health New Zealand	Costs to Health New Zealand may include updating IT systems and electronic prescribing platforms to enable paramedic prescribing. Costs are largely transitional, with the largest costs expected during initial implementation. Ongoing costs are expected to be lower. Risks include potential delays if integration is complex.	Low Paramedics will likely be able to use existing practice management systems and prescribe in the same way as nurse prescribers, so both monetary and non-monetary costs are expected to be low.	Low
Patients	Risk to patients if training is not adequate. Proper training and ongoing professional development are essential to ensure patient safety and effective prescribing. There may be transitional risks as paramedics adjust to expanded responsibilities. If standards are not maintained, there could be increased incidents of prescribing errors or adverse outcomes.	High Patient safety is paramount, therefore risks if paramedics prescribe inappropriately are high. However, there are safeguards in place to manage these risks.	Low
ACC	There may be costs to ACC for treatment injury related to inappropriate prescribing by paramedics.	Low Additional costs to ACC are likely to be negligible.	Low

Pharmac	The volume of medicines prescribed may increase due to easier access. Pharmac will be responsible for approving and enabling funding for paramedic prescriptions, practitioner supply orders and potentially special authority applications.	Low Prescriptions issued by paramedics would likely otherwise have been issued by another health professional had the paramedic not been able to prescribe. Therefore, it's unlikely that paramedic prescriptions will increase costs significantly.	Low
Non-monetised costs		Low	Medium
Additional benefits of the preferred option compared to taking no action			
Patients	Reduced costs of travelling to multiple appointments (ongoing benefit). Less pressure on urgent care, leading to improved access for the wider public.	Medium While monetised savings are likely, the main benefits are improved access and convenience.	Medium
Other prescribing health professionals	Reduced burden on other prescribing health professionals and issuers of standing orders. As paramedics gain prescribing authority, the workload associated with issuing and managing standing orders is likely to decrease. This may allow other health professionals to focus more on their core clinical responsibilities. There may also be improved collaboration between paramedics and other health professionals.	Low Enhanced collaboration, reduced administrative workload, and improved efficiency. Standing orders will still be used by non-prescribing paramedics, so the administrative burden will only be reduced in some cases.	Medium
Primary care providers	Paramedic prescribers will be able to fill gaps in primary care caused by workforce shortages. This will mean less pressure is placed on existing health professionals.	Medium	Medium
Non-monetised benefits		Medium	Medium

Section 3: Delivering an option

How will the proposal be implemented?

53. New regulations will need to be drafted under the Medicines Act to allow paramedics to prescribe. Once paramedics have designated prescribing authority the list of specified prescription medicines will be developed, including consultation, approved by the Director-General of Health, and published in the New Zealand Gazette.

54. A new schedule of controlled drugs that paramedics may prescribe will be developed under the Misuse of Drugs Regulations 1977.

55. The Paramedic Council will be responsible for designing a new scope of practice for paramedic prescribers, to sit alongside the existing scope of practice and specialist endorsements (ECP, CCP and ICP). The Council anticipates that prescribing authority will initially be implemented for ECPs.

56. The Council will also design education and training requirements, accredit training providers, and set continuing professional development and recertification requirements (including for prescribers from other jurisdictions). These will be subject to consultation before being finalised by the Council.

57. The Council's proposed approach for education requirements is that an existing postgraduate prescribing course will be used, with additional content tailored to paramedic practice. They will therefore need to approve and accredit a postgraduate prescribing course and assess its suitability for paramedic scopes and practice. This will reduce the lead-in time between regulations coming into force and the first paramedic prescribers entering practice.

How will the proposal be monitored, evaluated, and reviewed?

58. Paramedics are regulated under the HPCA Act and will continue to be monitored to meet the requirements as set out in the HPCA Act. The Ministry administers the HPCA Act and conducts periodic performance reviews of all responsible authorities, including the Council.

59. All paramedics who practice in New Zealand must be registered with the Paramedic Council and hold an annual practicing certificate. This assures the public that paramedics are fit to practice, hold the prescribed qualification and have met the required standards of competence to practice safely.

60. Paramedics with a prescribing scope will be required to meet the Paramedic Council's continuing education and recertification requirements, maintain their competence in the endorsement or scope of practice, and to declare this in their practicing certificate application each year.

61. Appropriate paramedic prescribing will also be monitored through notifications to the Paramedic Council, and complaints to the Health and Disability Commissioner.