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

3 July 2026

Ministry of Health | Manatū Hauora
PO Box 5013
WELLINGTON 6140

By email: info@health.govt.nz
By online submission

Tēnā koe

RNZCGP Submission to the Ministry of Health – Manatū Hauora: Consultation on Developing a Specified Prescription Medicines List for Designated Paramedic Prescribers

Thank you for the opportunity to provide feedback on the proposed specified prescription medicines list (SPML) for designated paramedic prescribers. This submission is made by the Royal New Zealand College of General Practitioners (RNZCGP, the College) and focuses on patient safety, workforce sustainability, continuity of care, and equitable access to high-quality primary care — particularly for Māori, Pacific Peoples, rural and underserved communities. It draws on feedback from across our membership and from our clinical leadership.

We have also responded separately to the medicine questions in the "Share your views" online consultation.

Our position

The College supports, in principle, measures that improve timely and equitable access to medicines and reduce avoidable demand on general practice and emergency departments. This reform responds to recognised access challenges across the health system and could support more integrated, patient-centred models of care, particularly where paramedics are embedded in local primary care pathways and whānau can receive safe, timely support closer to home. The greatest benefit is likely in rural, remote and after-hours settings where access to primary care is limited. In urban centres, where ambulance services exist primarily for rapid emergency response, implementation will require particular caution so extended primary-care encounters do not reduce crew availability or slow response times.

Our support for the proposed SPML is therefore conditional on implementation that treats equity and te Tiriti o Waitangi as core design features, alongside the clinical, governance and continuity safeguards set out below. Those safeguards should enable safe implementation — not become the whole narrative — and must ensure the model does not transfer unfunded workload onto general practice, Māori health providers or other providers serving underserved communities, nor compromise emergency ambulance capacity. These conditions reflect the concerns raised across our membership.

Summary of key points

- **Equity and te Tiriti o Waitangi built in, not added on.** Equity must shape the model from the outset — including prioritisation, design, governance, clinical pathways, workforce development and monitoring — rather than being treated as a later implementation consideration.
- **Continuity of care is the central risk.** Without shared records, timely GP notification, and clear handover and follow-up pathways, prescribing risks duplication, conflicting treatment and weakened continuity, which is associated with poorer patient outcomes.
- **Rural and urban settings require different approaches.** The strongest case is rural and remote communities where paramedics are integrated with local general practice. In urban areas, extended

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encounters risk reducing ambulance availability and emergency response capacity, against an existing backdrop of workforce shortages.

- **Tight, clearly bounded limits.** Begin with a short list within clear clinical algorithms; favour short courses or stat doses, cap long-term-condition medicines (around one month's supply), and embed antimicrobial stewardship.
- **No cost-shifting; clear responsibility.** Follow-up, reconciliation and complication management must not fall unfunded on general practice or Māori and community providers, and clinical responsibility must be clear.
- **Patient safety and a tightly defined scope.** Prescribing in prehospital and community settings carries real risk — particularly where paramedics lack access to a patient's renal function, allergies or history — increasing the risk that serious disease may be masked or missed. The list must stay limited and clearly defined, with decision support and the training and competence requirements set by Te Kaunihera Manapou.

Recommendations

1. **Embed equity and te Tiriti o Waitangi throughout** — equity should shape prioritisation, design, clinical pathways, governance, workforce development and evaluation, with cultural safety as a core prescribing competency and co-design with Māori and Pacific providers.
2. **Require robust training, competence and governance as a condition of prescribing authority** — the approved postgraduate prescribing qualification, ongoing competency assessment, and documentation and accountability standards set by Te Kaunihera Manapou, aligned where practicable with those for designated nurse prescribers.
3. **Mandate integration with general practice** — shared electronic health records, timely notification to the patient's GP or primary care team, agreed handover, referral and follow-up pathways, and robust audit, so GPs are informed, not bypassed. Prioritise rural and integrated settings, and evaluate impacts on ambulance response capacity before wider urban rollout.
4. **Protect continuity and safety by prescribing tightly** — short courses or stat doses where clinically appropriate, limited quantities of long-term-condition medicines, explicit antimicrobial-stewardship safeguards, and confirmation that prescribers can access essential clinical information (allergies, renal function, relevant history) before prescribing. Clinical algorithms should include explicit red flags and mandatory escalation or referral criteria where symptoms may indicate serious or deteriorating illness.
5. **Clarify clinical responsibility and avoid cost-shifting** — clear guidance on where responsibility sits when paramedic-initiated care is continued in general practice, with resourcing so follow-up is not transferred unfunded to primary care or Māori and community providers.
6. **Keep the medicines list limited and clearly defined** — explicit indications and situational limits, a short initial list, and a transparent, clinically-led process for reviewing it over time.
7. **Monitor equity and safety outcomes and act on them** — report access, prescribing patterns, outcomes and adverse events by ethnicity, geography and deprivation, targeting rollout to high-need communities and informing audit, with Māori data collected, governed and used consistent with Māori data sovereignty principles (Te Mana Raraunga).

Detailed feedback

Access, equity and patient safety

Allowing a designated paramedic to assess, treat and prescribe in one encounter can reduce separate GP or ED visits, travel and waiting times. This is expected to have greatest impact in rural and after-hours settings and for communities with higher unmet need, where the current standing-orders framework adds administrative burden and delay. Because expanded roles may appear first in better-resourced urban areas, rollout should be deliberately designed to reach high-need communities first and to support integrated, patient-centred models of care. Equity and te Tiriti o Waitangi obligations should therefore shape prioritisation, governance, clinical pathways, workforce development and monitoring from the outset. Safety remains essential: paramedics often work in low-information environments and may lack access to renal function, allergies or wider history, with a risk of masking serious disease. Prescribing should therefore be restricted to designated paramedics who have completed an approved postgraduate prescribing qualification and meet the competence, supervision and

recertification requirements set by Te Kaunihera Manapou — within a clearly defined scope, supported by decision-support tools, access to essential clinical information, and robust clinical governance.

Rural and urban settings

The greatest benefit is likely in rural and remote communities where paramedics are integrated with local practices and primary-care access is limited — reducing delays and unnecessary travel and extending the local team. This will be most effective where paramedics have established relationships, access to clinical information, and clear follow-up pathways.

In urban areas the benefits are less certain: ambulance services are configured for rapid emergency response, and extended primary-care encounters may reduce crew availability and slow response times — against a backdrop of paramedic and crew shortages and the risk that easier access to prescriptions increases demand. Paramedic prescribing should not substitute for adequately resourced urban primary care, and any urban implementation should be evaluated to ensure it does not compromise emergency response.

Integration with general practice, continuity and funding

The impact on general practice depends on integration. Done well, paramedic prescribing removes low-value, transactional workload — such as prescription-only visits after ambulance attendance — and lets GPs focus on complex, longitudinal and preventive care. Done poorly, it fragments care, with GPs unaware of what was prescribed or why, risking duplication, interactions and conflicting treatment; continuity is a well-documented determinant of patient outcomes and was a concern strongly emphasised by our members. The critical enablers are shared electronic health records, timely GP notification, clearly defined scope, agreed referral and follow-up pathways, and robust audit. Paramedics should manage the immediate need; general practice provides continuity over time. There must be clear guidance on clinical responsibility when care is later continued in general practice, and the reform must not shift unfunded follow-up, reconciliation or complication-management workload onto general practice or Māori and community providers.

The proposed medicines list

We support a limited formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review. It should start short, sit within clear clinical algorithms, and apply tight quantity limits (short courses or stat doses for many medicines and around one month's supply for long-term-condition medicines) to prompt re-engagement with the usual provider. Antimicrobial prescribing should be anchored to national guidance and subject to stewardship audit. We also see value in recognising the established and growing role of extended-care paramedics and not limiting the paramedic care model unnecessarily to ambulance work, provided training and guardrails are robust.

Equity, te Tiriti o Waitangi and monitoring

The College is committed to achieving Māori health equity, honouring te Tiriti o Waitangi and upholding Māori health rights, and we consider equity an essential design feature, not an add-on. Implementation should be consistent with te Tiriti o Waitangi principles — tino rangatiratanga, equity, active protection and partnership — which in practice means:

- cultural safety as a core prescribing competency; co-designing scope, pathways and communication with iwi, Māori and Pacific providers;
- investing in Māori and Pacific paramedic recruitment and leadership;
- ensuring whānau understand what has been prescribed and why; and
- accountability: data on access, prescribing patterns, outcomes and adverse events should be reported by ethnicity, geography (rural versus urban) and socio-economic deprivation, and used to direct the model toward the communities that stand to benefit most.

About the RNZCGP

The College is Aotearoa New Zealand's largest medical college. Our 6,018 specialist General Practitioners (GPs) make up about 40 percent of the medical workforce. The College sets standards and trains the specialist GP and

Rural Hospital Doctor workforce through its General Practice Education Programme and Rural Hospital Medicine Training Programme. The College is accredited by the Medical Council of New Zealand to deliver Continuing Professional Development, and assures the quality and safety of general practice through its Foundation Standard.

Te Akoranga a Māui — the first Indigenous medical practitioner rōpū established within any New Zealand or Australian medical college, with more than 200 members — provides governance and leadership that embeds indigenous perspectives across our work. The College is committed to reducing health inequities experienced by Māori, honouring te Tiriti o Waitangi, and upholding the rights and aspirations of Māori.

Conclusion

The College supports the intent of this reform and a limited, clearly defined SPML for designated paramedic prescribers. The greatest benefits will come where the model improves timely and equitable access through integrated, patient-centred care, particularly in rural and remote communities where paramedics work as part of a local primary-care team. Realising those benefits depends on implementing the safeguards recommended above, with equity and te Tiriti o Waitangi built into design, delivery, monitoring and accountability from the outset. We welcome the opportunity to work in partnership on the detailed design and implementation of this change.

Nāku noa, nā

Dr Luke Bradford
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President | Te Tumu Whakarae

Submitted to Consultation on developing a specified prescription medicines list for designated paramedic prescribers

Medicine questions

8 Do you agree with the proposed medicines for Anaesthesia?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of anaesthesia-related medicines where they reflect existing standing-order practice and are used for time-critical emergency care, procedural analgesia, local or regional anaesthesia, or opioid reversal in out-of-hospital settings. Higher-risk medicines such as rocuronium and suxamethonium should only be available within tightly governed advanced practice pathways, with clear credentialling, decision-support, monitoring requirements, and escalation thresholds. Access to timely analgesia and urgent treatment in the community is also likely to benefit people facing barriers to emergency or primary care, including Māori, Pacific peoples, and rural and remote communities, provided implementation is equitable and not overly dependent on urban training or hospital-based supports.

9 Do you agree with the proposed medicines for Cardiovascular system?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of cardiovascular medicines used for acute, time-critical presentations that paramedics already assess and manage in urgent and emergency settings. Because cardiovascular presentations can deteriorate rapidly and some medicines carry significant haemodynamic risk, inclusion should be accompanied by tight indication limits, clear exclusions, escalation rules, documentation standards and audit. From an equity perspective, the potential benefit is strongest where prescribing helps avoid delay for populations who already face barriers to urgent care, including rural communities and Māori.

10 Do you agree with the proposed medicines for Central nervous system?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of central nervous system medicines where they are used for clearly defined acute indications within paramedic scope and where timely treatment prevents deterioration or unnecessary transfer delays. Medicines in this category may carry risks relating to sedation, respiratory depression, altered mental status or diversion, so their use should be stratified by prescriber level and supported by monitoring, reassessment, and clear handover processes. Implementation should also ensure culturally safe communication with patients and whānau.

11 Do you agree with the proposed medicines for Ear, nose, and oropharynx?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.
We support inclusion of medicines for ear, nose and oropharyngeal indications where these are used for procedural care, symptom relief, or acute urgent presentations that paramedics can assess and manage safely. These medicines should remain linked to narrow indications and clear referral thresholds, particularly where symptoms may indicate a more serious underlying condition or require follow-up dental, ENT or primary care review. This category may also improve access for people who would otherwise struggle to obtain prompt urgent care, including those in rural or remote communities.

12 Do you agree with the proposed medicines for Endocrine system?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of endocrine medicines where they address acute and readily identifiable presentations and where timely prescribing can avert deterioration or unnecessary transport. Because some endocrine conditions can be clinically complex, medicines in this category should be supported by protocols, red-flag criteria, documentation requirements and follow-up arrangements, especially where the patient may need further review rather than one-off treatment. Equity monitoring will be important to ensure the model benefits people who face barriers to accessing prompt assessment and treatment, including Māori and rural communities.

13 Do you agree with the proposed medicines for Eye?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of eye medicines for clearly defined acute indications, particularly where they support assessment and short-term treatment of presentations such as suspected corneal abrasions or foreign bodies. Use should remain tightly limited to short-term assessment or urgent treatment pathways, with clear referral thresholds where there is visual loss, penetrating injury, chemical exposure, infection concern or lack of improvement. This category has potential to improve access to timely care in the community, but safe implementation depends on strong protocols and follow-up communication.

14 Do you agree with the proposed medicines for Gastro-intestinal system?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of gastrointestinal medicines where they are used for acute symptom management or urgent community care, and where

prescribing can reduce distress, dehydration, or avoidable escalation while patients are awaiting or accessing further care. Medicines in this category should remain focused on short-term, clearly protocolised use, not ongoing management of chronic gastrointestinal conditions. Clear red flags and referral or escalation expectations are important, particularly where symptoms may represent serious abdominal pathology or sepsis.

15 Do you agree with the proposed medicines for Infections?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of anti-infective medicines only where indications are narrow, clearly protocolised, and linked to strong antimicrobial stewardship. If antibiotics are included for paramedic prescribers, their use should be limited to a small number of clearly defined acute indications where early treatment is likely to produce clear patient benefit and where delay in seeing another prescriber is a real problem. Prescribing should include documentation of indication, allergy status, intended duration, safety-netting, and communication to the patient's usual general practice or follow-up provider. We would be concerned about any broad or discretionary model that enables antibiotic prescribing for non-specific symptoms, recurrent presentations, or conditions requiring longitudinal review or microbiology.

16 Do you agree with the proposed medicines for Musculoskeletal and joint diseases?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of medicines for musculoskeletal and joint conditions where they improve timely pain relief and function in acute injury or inflammatory presentations. These medicines should be accompanied by clear checks for contraindications and cautions, including renal impairment, gastrointestinal risk, dehydration, anticoagulant use, pregnancy where relevant, frailty and comorbidity, along with reassessment and handover where further care is required. Improved access to rapid pain relief may be particularly valuable in rural settings, where transfer times are longer and access to in-person urgent care can be limited.

17 Do you agree with the proposed medicines for Nutrition and blood?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of medicines in the nutrition and blood category where they are relevant to acute, identifiable presentations and can be used safely within a paramedic prescribing encounter. This category should not drift into longitudinal management of chronic conditions that are better managed through primary care, specialist care or structured follow-up. Monitoring by ethnicity and rurality will help ensure this category improves access without increasing fragmentation.

18 Do you agree with the proposed medicines for Obstetrics, gynaecology, and urinary tract disorders?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of medicines in this category where they address acute presentations in community or urgent settings and where timely prescribing can reduce harm or unnecessary delay. Because this category may involve pregnancy, breastfeeding, pelvic pain, infection risk, and the possibility of serious underlying pathology, prescribing should remain tightly protocolised, with conservative thresholds for escalation and referral. The potential access gains may be significant for rural communities, where distance and service availability can make urgent review more difficult, but culturally safe communication and reliable follow-up are essential.

19 Do you agree with the proposed medicines for Respiratory system?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of respiratory medicines for acute respiratory presentations where paramedics are already assessing and treating patients and where timely prescribing can avoid deterioration or delayed treatment. Respiratory medicines should be linked to clear clinical pathways, reassessment requirements, escalation thresholds and handover expectations, particularly where patients may have severe exacerbations, competing diagnoses, or need ongoing review after the immediate event. This category likely has particular importance for equity because delayed access to urgent assessment and treatment can disproportionately affect Māori and rural communities.

20 Do you agree with the proposed medicines for Skin?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of skin medicines where they are used for acute, clearly defined presentations in urgent or community care. The most appropriate medicines are those that can be used safely as part of a single urgent encounter rather than ongoing dermatology management. If this category includes anti-infective skin treatments, they should be subject to the same antimicrobial stewardship principles outlined above: narrow indications, documentation, and avoidance of broad empirical use where follow-up review is needed. The category could improve access for people with barriers to timely treatment, but safe implementation depends on clear red flags, referral pathways and continuity with usual care.

21 Do you agree with the proposed medicines for Vaccines?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of vaccines where they are clearly relevant to paramedic practice, operationally feasible, and supported by strong governance, including competency, documentation and appropriate follow-up arrangements. Any vaccine use should remain tight in scope and indication, rather than becoming a broad general immunisation function unless there is a clear clinical rationale and supporting implementation framework. From an equity perspective, vaccine-related prescribing could improve access in some underserved settings, but benefits will depend on how well the operational model reaches rural communities and priority populations.

22 Do you agree with the proposed medicines for Controlled drugs?

Yes, I agree with the proposed medicines

Please provide comment if appropriate. If you disagree, name the medicine(s) and state your reason(s) why you disagree with its inclusion on the list.:

Overall, the College supports a limited, clearly defined formulary matched to paramedic scope and to conditions that are common, predictable and amenable to safe community management, with clear indications, situational limits and transparent review processes.

We support inclusion of controlled drugs where they are used for acute pain, urgent sedation or other time-critical indications that are already closely associated with paramedic emergency or urgent care practice. Because controlled drugs carry higher risks relating to safety, diversion, documentation and monitoring, this category requires the strongest governance settings: clear prescriber-level limits, secure storage and reconciliation arrangements, mandatory documentation, audit, and robust clinical oversight. If implemented well, access to controlled drugs for truly acute indications may reduce unnecessary suffering and improve care equity, particularly in rural or remote settings where transfer times are longer, but the safeguards need to be explicit.

Other comments

23 Are there any other comments you would like to make?

Comments:

Yes. We have emailed a cover RNZCGP submission to info@health.govt.nz and also make some general comments on gaps.

Overall, we support the development of a specified prescription medicines list for designated paramedic prescribers where it improves timely access to treatment, reduces delays associated with the current standing-order framework, and supports care in emergency, urgent, community and rural settings.

However, several important gaps remain. First, the list should not operate as a broad, undifferentiated prescribing authority. One gazetted list should continue to be supported by sub-lists and corresponding indications by prescriber level. Higher-risk medicines, or medicines requiring greater diagnostic certainty, follow-up or monitoring, should be restricted to practitioners with advanced credentials and tightly defined indications.

Second, antimicrobial stewardship needs stronger emphasis. If antibiotics are included, prescribing should be tightly limited to a small number of clearly defined indications, with documentation of indication and duration, safety-netting, and communication to the patient's usual general practice or follow-up provider.

Third, the equity rationale for paramedic prescribing is strong, but it should be operationalised rather than assumed. Implementation should include culturally safe prescribing training, whānau-centred communication, strong handover and referral pathways, and routine monitoring of access and outcomes by ethnicity and rurality.

Fourth, there should be clearer expectations around clinical governance and system integration. Because paramedic prescribing will often occur in mobile, urgent, and out-of-hospital settings, governance should include credentialling, decision-support, escalation requirements, documentation standards, audit, peer review and incident review. It should also include reliable communication with the patient's usual general practice, rural provider or other follow-up service so that prescribing improves continuity rather than creating fragmentation.

Finally, a clear evaluation framework should be published before implementation. This should assess whether the policy is improving access to timely treatment, reducing unnecessary delays or transfers, supporting rural care closer to home, and reducing or worsening inequities for Māori and other priority groups. Without routine monitoring by medicine type, indication, ethnicity, rurality and service setting, it will be difficult to know whether the intended benefits are being realised in practice.

Privacy and publishing submissions

24 Publishing submissions

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