

RACP Position Statement on Physician Assistants/Associates (PAs)

RACP Position on PAs in Australia and Aotearoa New Zealand

The Royal Australasian College of Physicians (RACP) position on Physician Assistants/Associates (PAs) prioritises patient safety, patient outcomes, and the integrity of medical training.

The RACP does not support the introduction or widespread expansion of PAs in the Australian and Aotearoa New Zealand health systems.¹

PAs are not the appropriate solution to workforce shortages: adding a new, overlapping practitioner group risks fragmenting care rather than solving workforce challenges.

The RACP believes workforce pressures are better addressed by strengthening the domestic medical, nursing and allied health workforce than by creating a new profession.

Nonetheless, if PAs are introduced or used more widely by governments or health services in Australia and Aotearoa New Zealand, the RACP highlights several concerns:

- **The title of Physician Assistant/Associate should be amended to remove the term “physician” to avoid public and professional confusion, and the term “associate” should not be used. The RACP’s preferred term for this profession in Australia and Aotearoa New Zealand is Clinical Assistant.²**
- **PAs are not a substitute for physicians or physician trainees**, nor for nurse practitioners, a distinct profession with its own training and regulatory pathway that already provides an evolving advanced practice model in Australia and Aotearoa New

¹ Note: Previous RACP statements on PAs include:

- The Royal Australasian College of Physicians (RACP) (2026), Submission to Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ), Regulation of physician associates/assistants (PAs). Online, available: https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-to-mcnz-on-regulation-of-pas.pdf?sfvrsn=6187b31a_10 [last accessed 21/04/2026]
- The Royal Australasian College of Physicians (RACP) (2024), RACP statement: Governments should undertake thorough consultation before introducing ‘physician assistants’. Online, available: <https://www.racp.edu.au/news-and-events/all-news/news-details?id=8211c0af-bbb2-61c2-b08b-ff01001c3177> [last accessed 21/04/2026]

² Note: We use the terms Physician Assistants/Associates (PAs) throughout this Position Statement as it is the term currently in use internationally and in Australia and Aotearoa New Zealand. However, as outlined, we do not support the use of this term and our preferred title for this profession is Clinical Assistant.

DRAFT FOR CONSULTATION

Zealand. Introducing PAs risks duplicating functions nurse practitioners already perform, rather than resolving workforce shortages. More broadly, PAs should never replace any doctors on rotas or in clinical decision-making roles requiring specialist knowledge.

- **PAs should not assess or manage undifferentiated patients independently, perform complex procedures alone, or supervise physician trainees.**
- **PAs must remain primarily accountable for their own clinical decisions.** Supervision does not transfer accountability from the PA to the supervising physician, and supervision arrangements must be designed so that responsibility for a PA's decisions sits with the PA, not the consultant overseeing them.
- **Trainees must never be requested to supervise PAs.** Supervision requirements are resource intensive. Only consultant physicians and/or other qualified specialists should be considered as potential supervisors of PAs.
- **Consultants should be able to opt out of supervising PAs.** Supervision carries an active, ongoing liability burden. Supervision should be a negotiable, additional responsibility for consultants. and appropriately indemnified
- The use of PAs should be structured to complement, rather than compromise, opportunities for education, training, employment and supervision of medical trainees. **Investing in the next generation of physicians is key to meeting the long-term healthcare needs of communities across Australia and Aotearoa New Zealand.**
- **Clear governance and regulation are essential. Training and accreditation standards, scope of practice, credentialing, and responsibilities must be nationally standardised. Equity and cultural safety must be maintained. The deployment of PAs should not exacerbate disparities, particularly in Māori, Aboriginal and Torres Strait Islander and Pacific Peoples' communities and rural and remote areas.**

Any introduction or expansion of PA roles in either country requires thorough consultation with doctors, nurses and other existing health professionals as well as community groups, including Aboriginal and Torres Strait Islander, Māori and Pacific Peoples and other culturally and linguistically diverse communities.

Sustainable solutions to workforce pressures should focus on strengthening existing, locally trained workforces and ensuring approaches are culturally grounded and sustainable. Solutions to address workforce shortages and maldistribution should focus on:

- **Increasing the number of specialist training positions**, with growth targeted to correct the uneven geographic distribution of specialists rather than being spread evenly across all areas.
- **Strengthening domestic medical training**, particularly in Regional, Rural, Remote and Aboriginal, Torres Strait Islander, Māori and Pacific Peoples' contexts

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- **Supporting Māori, Aboriginal and Torres Strait Islander and Pacific Peoples' health workforce development**
- **Enhancing collaborative and multidisciplinary care between existing professions** including doctors, nurse practitioners, nurses more broadly, allied health professionals and other established healthcare professions, instead of introducing new professions.

In Aotearoa New Zealand, this requires strengthening domestic medical training and workforce pathways that are responsive to population need, with:

- **Sustained investment in Māori health workforce development**, grounded in Te Tiriti o Waitangi and led in partnership with Māori
- **Dedicated investment in Pacific health workforce development**, reflecting Pacific leadership, models of care, and community priorities

In Australia, strengthening medical training and workforce pathways requires **sustained investment in Aboriginal and Torres Strait Islander health workforce development**, supporting Indigenous leadership and community-controlled health services.

Across both Australia and Aotearoa New Zealand, governments need to **strengthen rural and remote training pathways, workforce development in culturally and linguistically diverse contexts and advanced practice roles for nurses, allied health professionals, and other established healthcare professions** to ensure timely access to quality care for all.

Purpose of the Position Statement

This statement outlines the RACP's position on Physician Assistants/Associates (PAs) in the Australian and Aotearoa New Zealand healthcare systems. It provides guidance on key considerations governments, health services, and other stakeholders should take into account before introducing or expanding PA roles to safeguard patient safety, workforce sustainability, and high-quality medical training.

The RACP has a core responsibility to ensure that physician training pathways remain robust, sustainable, and capable of producing a sufficiently skilled specialist workforce to meet current and future population health needs.

The statement reflects the RACP's commitment to constructive engagement. The RACP does **not** support the introduction or widespread expansion of PAs in the Australian and Aotearoa New Zealand health systems. However, we recognise that governments and health services may choose to introduce them or expand their use.

In line with its motto "hominum servire saluti / to serve the health of our people", the RACP seeks to identify risks, mitigation strategies, and areas where consultation and planning are essential for any introduction or expansion of PA roles in the Australian and Aotearoa New Zealand health care systems.

Background: Physician Assistants/Associates

Definition

The following section outlines how Physician Associates are commonly defined internationally and the range of activities that may fall within their scope of practice in different jurisdictions. This description is provided for informational purposes and does not represent RACP endorsement of these models of practice.

PAs are health professionals trained as generalists. They are not medical graduates and, in many jurisdictions, practice under medical supervision, although the level of supervision and autonomy varies across settings and regulatory frameworks.³ Final overall clinical responsibility typically remains with the supervising doctor where supervisory models apply.

PAs perform a range of tasks within their authorised scope of practice, including:

- Patient examination, history-taking, and assessment
- Ordering and interpreting tests, imaging and prescribing medications
- Assisting in surgical procedures and minor interventions
- Developing management plans under delegated authority

³ Note: In the United States for example, some PAs are no longer required to have a specific agreement with a doctor in order to practice. Source: American Academy of physician Associates (2026), What is a PA? webpage. Online, available: <https://www.aapa.org/about/what-is-a-pa/> [last accessed 24/04/2026]

International context

The PA role was established in the United States in the 1960s to address workforce shortages, particularly in rural and underserved areas, focused on the primary care context. The role also exists in other countries including the United Kingdom, Canada, Germany, the Netherlands, Australia and Aotearoa New Zealand.

It is critical that the problems experienced in some of the countries that have established the role of PA, and the lessons learned, be taken into consideration before this role is implemented or further rolled out in Australia and Aotearoa New Zealand.

The Leng Review report into the rollout of PAs in England⁴ is a profoundly challenging and valuable document, albeit having been declared “poorly conducted” and biased by some, including the American Academy of Physician Associates (AAPA).⁵ It has influenced the thinking of the Working group preparing this position statement.

As detailed in the Leng Review report, the rapid expansion of the PA workforce in England without clear scope definition, consistent regulation, or robust supervision has been associated with patient safety incidents, role confusion, and unintended impacts on medical training. This contrasts significantly with the United States’s experience where the PA profession has strongly established educational standards, national certification, recertification processes, and regulatory frameworks.^{6,7}

Of concern is the fact that, in many countries, the PA role has emerged primarily in response to workforce shortages and service delivery gaps, rather than through proactive workforce design. As a result, there has been limited opportunity to define the profession in a strategic or standardised way. Educational requirements and scope of practice have often been developed in an ad hoc manner and are frequently localised to areas of greatest need.⁸ This is not an optimal approach for the sustainable development and integration of a new health-care profession.

⁴ Leng, G. (2025). The Leng review: An independent review into physician associate and anaesthesia associate professions. BMJ, 390, r1482. Online, available: <https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report> [last accessed 21/04/2026]

⁵ The American Academy of Physician Associates (AAPA) (2025), Response to: “The Leng review: an independent review into the physician associate and anaesthesia associate professions”. Online, available: <https://www.aapa.org/download/153276/?tmstv=1761916932> [last accessed 21/04/2026]

⁶ National Commission on Certification of Physician Assistants (NCCPA) website (2026): <https://www.nccpa.net/about-nccpa/> [last accessed 04/05/2026]

⁷ Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) website (2026): <https://www.arc-pa.org/about-2/> [last accessed 04/05/2026]

⁸ Showstark, M., Smith, J., & Honda, T. (2023). Understanding the scope of practice of physician associate/physician associate comparable professions using the World Health Organization global competency and outcomes framework for universal health coverage. Human Resources for Health, 21(1), 50.

Current status in Australia and Aotearoa New Zealand

PAs remain rare in both Australia and Aotearoa New Zealand:

- As of April 2025 (the latest data available), there were around 50 PAs working across Aotearoa New Zealand with most of them working in rural general practice clinics and in acute/emergency care.⁹
- As of January 2025 (the latest data available), there were 6 PAs working in the public system in Australia, in Queensland.¹⁰ Similarly to Aotearoa New Zealand, their roles appear focused on primary and emergency care.¹¹
- At present there are no domestic training programs in either country. In Aotearoa New Zealand, recruitment relies on UK and US-trained PAs.
- At time of writing, regulation for PAs is being developed by the Medical Council of New Zealand.¹²
- In Australia, there are currently no plans to regulate PAs and they cannot access the Medicare Benefits Schedule (MBS) or the Pharmaceutical Benefits Scheme (PBS).

Workforce planning

Introduction or expansion of health professional roles requires clear and compelling evidence of an unmet clinical need which cannot be fulfilled appropriately by existing health professionals.

While workforce shortages, compounded by maldistribution, exist in Aotearoa New Zealand and Australia, there is no clear and compelling evidence that PAs are the appropriate solution to these shortages.

Existing workforce strategies and planning offer scant, if any, consideration of the potential use or expansion of PA roles. Consequently, expanding these roles risks duplicating functions already undertaken by established clinician groups, including nurse practitioners and other advanced practice clinicians, rather than addressing genuine workforce shortages or service gaps.

⁹ Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ) (2025), Regulating physician associates webpage. Online, available: <https://www.mcnz.org.nz/about-us/what-we-do/physician-associates/https://www.mcnz.org.nz/assets/Consultations/PA-Consultation/MCNZ-Consultation-document-regulation-of-PAs.pdf?vid=10> [last accessed 21/04/2026]

¹⁰ Australian Broadcasting Corporation (ABC) (Friday 3 January 2025), Queensland Health Director-General David Rosengren identifies workforce numbers as biggest challenge. Online, available: <https://www.abc.net.au/news/2025-01-03/queensland-health-director-general-david-rosengren-on-challenges/104764482> [last accessed 21/04/2026]

¹¹ Queensland Health (2024), Health Employment Directive No. 02/24, clause 8. Online, available: https://www.health.qld.gov.au/_data/assets/pdf_file/0018/1330542/hed-0224.pdf [last accessed 21/04/2026]

¹² The Royal Australasian College of Physicians (RACP) (2026), Submission to Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ), Regulation of physician associates/assistants (PAs). Online, available: https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-to-mcnz-on-regulation-of-pas.pdf?sfvrsn=6187b31a_10 [last accessed 21/04/2026]

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More broadly, the proliferation of narrowly scoped practitioner roles risks fragmenting healthcare delivery and blurring clinical accountability. This fragmentation sits in direct tension with a defining strength of the Australian and Aotearoa New Zealand medical training systems: the deliberate development of broadly trained generalist doctors, through undergraduate/prevocational training and, in Australia, rural generalist pathways, ahead of specialisation. Additionally, narrowly defined practitioner categories risk undermining this generalist foundation rather than complementing it.

Furthermore, introducing or expanding PAs may also incur substantial indirect costs that are often overlooked and should be considered alongside any proposed benefits. They include:

- Supervision time required for senior clinicians to provide supervision, oversight, and feedback
- Additional clinical and administrative effort required to identify, review, and rectify errors or inefficiencies arising from limited experience, unfamiliarity with local clinical practice, or limited knowledge of the Aotearoa New Zealand and Australian healthcare contexts and cultural frameworks.

This cost differential is compounded by a structural distinction: medical practitioners with general registration can practice independently, whereas PAs require ongoing medical supervision, governance, and credentialing. Once these ongoing costs are accounted for, investment in PAs is unlikely to be convincingly cost-effective compared with expanding the domestic medical workforce.

In Australia, a recent review identified a “lack of current, sectorally integrated, national, state and regional workforce data” as a “priority for Australian governments, employers and regulators to assist with planning for current and future needs”.¹³ It recommended that Australian health ministers “identify cross-cutting themes and mechanisms to deliver effective multidisciplinary workforce planning and develop integrated models of care”. All that work remains to be done and must be completed before any consideration can be given to the use of PA roles in Australia.

In Aotearoa New Zealand, the latest Health Workforce Plan¹⁴ also identifies a need for consistent use of high-quality data and models to support estimates of real current and future health system need. Although the plan identifies support for a wider range of roles to contribute to primary and community care, including PAs, it does not set out a case for their expanded use and it acknowledges a lack of estimates of current and future need that incorporate the plan’s proposals and improvements in care delivery.

Before considering introducing or expanding the use of PAs in Australia and Aotearoa New Zealand, governments need to:

¹³ Kruk, R. (2023), Independent review of Australia's regulatory settings relating to overseas health practitioners. [Independent review of Australia's regulatory settings relating to overseas health practitioners](https://apo.org.au/node/325439). Online, available: <https://apo.org.au/node/325439> [last accessed 21/04/2026]

¹⁴ Health New Zealand | Te Whatu Ora (2024), New Zealand Health Workforce Plan. Online, available: <https://www.tewhatauora.govt.nz/assets/Publications/Workforce/Health-Workforce-Plan-2024/New-Zealand-Health-Workforce-Plan-2024.pdf> [last accessed 21/04/2026]

DRAFT FOR CONSULTATION

- Build robust data models and undertake the necessary health workforce planning to assess whether there is a genuine unmet clinical need that would best be met by PAs.
- Consider the existing and evolving roles of medical practitioners, nurse practitioners and allied health practitioners, to ensure that the potential introduction or expansion of PAs is integrated thoughtfully into a complex healthcare workforce and does not inadvertently duplicate or fragment care.

Te Tiriti o Waitangi obligations (Aotearoa New Zealand)

In Aotearoa New Zealand, all considerations relating to workforce design and service delivery must be grounded in Te Tiriti o Waitangi partnership. This includes:

- recognising Māori as tangata whenua and Treaty partners, and
- ensuring that policy development, implementation, and evaluation are undertaken in partnership with Māori.

The Aotearoa New Zealand Ministry of Health's Te Tiriti framework¹⁵ establishes these obligations as foundational to achieving Māori health equity and system outcomes. Workforce planning should reflect Māori health priorities, including the development and sustainability of a culturally grounded Māori health workforce.

Treaty analysis guidance requires consideration of Te Tiriti obligations at every stage of policy development from problem definition through to implementation and evaluation and supports Māori leadership where appropriate.

Key considerations

Patient safety

Patient safety is paramount. It is the RACP's view that:

- PAs need to be trained to recognise complex or undifferentiated patients and escalate them appropriately, rather than managing them independently. Clear pathways for escalation to a consultant must be in place to support this.
- Direct in-person supervision by physicians or other relevant specialists is essential for patient safety in most cases although indirect/remote supervision could be considered as the PA gains experience.
- PAs must not perform advanced or other complex procedures alone, or act as supervisors for medical trainees.

¹⁵ Ministry of Health NZ | Manatū Hauora (2024), Te Tiriti o Waitangi framework. Online, available: [Te Tiriti o Waitangi framework | Ministry of Health NZ](#) [last accessed 05/06/2026]

Role titling

The RACP's preferred term for this profession in Australia and Aotearoa New Zealand is Clinical Assistant.

The terms “Physician Assistant” and “Physician Associate” are misleading in the Australian and Aotearoa New Zealand context:

- In both countries, “physician” denotes a medically qualified specialist.
- In Australia, “physician” is a protected title under the Health Practitioner Regulation National Law.¹⁶ This ensures that those using that title are appropriately trained, qualified and registered, meeting safe standards of practice.
- The term ‘physician assistant’ originated in the United States, where the term ‘physician’ is used much more broadly than in Aotearoa New Zealand or Australia, e.g. ‘family physicians’ in the United States performing a similar role to general practitioners in Aotearoa New Zealand and Australia.
- The work of PAs in Aotearoa New Zealand and Australia has been focused on primary and emergency care settings. In these settings, the term ‘physician’ is commonly understood to refer to a physician trained and credentialled through the RACP, rather than as a general descriptor for medical doctors. Patients in these settings are seeing a broad range of professionals, ranging from general practitioners, through to nurses and nurse practitioners, and a wide range of allied health professionals, rather than RACP physicians. Consequently, the PA term is inherently confusing and potentially misleading in those contexts; e.g. it may wrongly imply RACP physician involvement in a patient’s care.
- The practice of physicians and physician trainees generally involves a referral or request (usually by a GP or hospital doctor) for a specialist consultation, or those primary health or emergency care professionals working collaboratively with physicians or trainees. It is not the physician or trainee delivering primary or emergency care. This is very different to how PAs work in those settings, or elsewhere overseas.
- In some overseas jurisdictions, PAs also work in surgical settings, where the term ‘physician’ is rarely, if ever, used. If their role was to be expanded to surgical settings in Aotearoa New Zealand or Australia, further confusion would likely be created by incorporating the term ‘physician’ in their title.
- In the minds of governments, professions and communities, the practice of physicians and trainees is generally associated with the care provided in various physician specialties, not primary, emergency or surgical care. Clearly, a broader term than ‘physician’ would be needed to accurately represent the range of contexts in which PAs may work.

¹⁶ Australian Health Practitioner Regulation Agency (Ahpra) (2021), What’s the point of protected title webpage. Online, available: <https://www.ahpra.gov.au/News/2021-12-22-protected-title.aspx> [last accessed 21/04/2026]

DRAFT FOR CONSULTATION

Given this, there are significant risks to adopting the international title in Australia and Aotearoa New Zealand. These include:

- Public misunderstanding of qualifications, including the risk that patients may believe they are being assessed or treated by a fully qualified medical practitioner or receiving physician specialty care.
- Confusion among healthcare teams
- Potential compromise of informed consent and patient trust

Recommended alternative titles, particularly those which encompass the breadth of settings where these roles could practice include:

- Clinical Assistant (with specialty in parentheses, e.g., Clinical Assistant – Emergency Medicine)
- Medical Care Assistant
- Health Practitioner Associate / Assistant

Clear communication, public education, and nationally consistent terminology are essential. This includes clarifying ‘informed consent’ for patients when a PA is to be involved in their care, and the obligations PAs would have to provide information to patients.

Training and supervision implications

The introduction or further expansion of PAs in the Australian and Aotearoa New Zealand health systems is likely to have a significant impact on medical education.

It is the RACP’s view that:

- Introducing PAs without clearly defined supervision structures risks undermining the supervised learning environment medical students and junior doctors depend on for competency development. This could delay the progression of medical trainees and potentially reduce the future supply of specialist physicians.
- PAs must not replace doctors in training roles or reduce exposure to core procedures, initial patient assessments, or complex decision-making experiences.
- Supervision of PAs must not fall to trainees (registrars or residents).
- Consultant-level oversight is required, with protected time (minimum 0.25 FTE per PA supervised)¹⁷ and a strict limit on the number of PAs a doctor can supervise.
- Health services must actively support and mitigate supervision burden on supervising doctors which includes ongoing clinical oversight, escalation pathways, and

¹⁷ Note: This reflects the Royal College of Physicians (RCP)’s Interim guidance on supervision and employment in medical specialties published in December 2024. Online, available: https://www.rcp.ac.uk/media/m3djpfbj/pa_interim_guidance-on-supervision-and-employment-in-the-medical-specialties.pdf [last accessed 21/04/2026]

DRAFT FOR CONSULTATION

documentation. This is especially necessary for supervising doctors in rural, remote, or resource-constrained settings.

- Additional responsibilities associated with PA supervision (e.g. immediate clinical oversight, escalation pathways, documentation review, co-signing, and providing feedback), beyond routine supervisory duties, increase both the workload and cognitive demands on supervising doctors. Accordingly, doctors should be able to decline responsibility for PA supervision if they believe they cannot adequately meet the PA's training and supervision needs, or if taking on these additional responsibilities would compromise their existing clinical, teaching, or supervisory obligations.
- Supervising doctors should also be supported and able to withdraw from their supervisory arrangements subject to a valid reason and appropriate notice.¹⁸
- When PAs require assistance, they must seek it from their designated supervisor (which may include a primary or co-supervisor under an approved supervisor arrangement), rather than from another doctor who is not fulfilling a supervisory role.
- In rural and remote settings, it is imperative that any use of PAs does not impose additional burdens on supervisors or reduce physician training opportunities that are critical for developing and sustaining the necessary specialist workforce in those underserved areas.
- Rural and remote settings depend heavily on the breadth of clinical exposure that underpins rural generalist training; diverting procedural exposure or supervisory capacity toward supporting PAs risks eroding this breadth, undermining long-term rural workforce sustainability.

Scope of practice

Scope of practice comprises the range of activities a practitioner is qualified, competent, and authorised to undertake, and for which they bear professional accountability.

It is the RACP's view that:

- PAs should operate within a defined scope of practice clearly outlined by national regulatory bodies and not determined by employers.
- PAs should be required to pass a locally determined (Australia & Aotearoa New Zealand) competence examination before practicing in Aotearoa New Zealand or Australia.
- PAs should work within local protocols and guidelines and seek advice from a relevant specialist when operating outside these.

¹⁸ Note: This is in line with Queensland Health's Physician assistant Clinical governance guideline published in May 2024. Online, available: https://www.health.qld.gov.au/data/assets/pdf_file/0027/147627/qh-gdl-397.pdf [last accessed 21/04/2026]

DRAFT FOR CONSULTATION

- PAs should be required to be certified for specific procedures within their scope and require regular retraining similar to junior doctors.
- Clear frameworks should be in place to report and address breaches of scope.

Tasks which should be reserved for physicians include:

- Assessment and management of undifferentiated patients
- Performing complex procedural interventions¹⁹
- Supervising medical trainees

Supervising medical trainees: Medico-legal and regulatory considerations

The introduction or further expansion of PAs in Australia and Aotearoa New Zealand necessitates national regulation to standardise:

- Title
- Training and accreditation
- Scope of practice and credentialing
- Cultural competency and safety training
- Indemnity cover
- Supervision and escalation pathways
- Ongoing performance assessment
- Continuing professional development
- Incident investigation and complaint management frameworks
- Professional disciplinary mechanisms
- Data and monitoring/evaluation

Without governance, there is a risk of variable training, unsafe practice, and additional burden on medical supervisors.

From a legal perspective, further work would be required to clarify medico-legal and professional indemnity insurance impacts on physicians and trainees from working with PAs, particularly whether it could lead to increased legal risk and/or increased insurance premiums. For example, supervising physicians should have defined legal accountability and indemnity/insurance coverage.

¹⁹ Note: i.e. cardiac catheterisation, electrophysiological studies, endoscopic retrograde cholangiopancreatography (ERCP) and interventional endoscopy; subject to change upon completion of additional specialised training noting that these procedures must only be performed at accredited centres by accredited providers.

Equity and workforce considerations for Māori, Pacific Peoples, Aboriginal and Torres Strait Islander peoples and communities

Across both countries, deployment of PAs in rural, remote, and underserved settings must not reinforce existing inequities, particularly where access to care is already limited or inconsistent.

Cultural safety is a core expectation in both Aotearoa New Zealand and Australia. It requires healthcare practitioners and organisations to recognise and address bias, power imbalances, and systemic inequities, ensuring that care is defined as safe by patients, whānau, families, and communities.

PAs should not be viewed as a substitute for investment in locally trained healthcare professionals. This holds even if PAs are trained locally: preferential deployment of PAs in rural, remote and underserved areas still risks undermining long-term workforce capacity. Over-reliance on internationally trained PAs compounds this risk further, and may divert attention from building a locally trained and culturally responsive health workforce.

Equity safeguards

Implementation should be supported by:

- Cultural safety standards, education, accountability mechanisms, and regular auditing, reflected in the regulatory framework given the current absence of domestic PA training programmes in both Australia and Aotearoa New Zealand²¹ and the resulting reliance on an internationally trained workforce
- Clear supervision, scope of practice, and escalation frameworks
- Partnership and collaboration with Māori, Pacific Peoples, and Aboriginal and Torres Strait Islander providers, organisations, and communities
- Engagement with other priority populations, including culturally and linguistically diverse communities, people with disability, young people, and older adults
- Alignment with broader workforce development, recruitment, and retention strategies

Aotearoa New Zealand

Māori

In Aotearoa New Zealand, equity considerations must be explicitly grounded in Te Tiriti o Waitangi, recognising Māori as tangata whenua and Treaty partners.

Te Tiriti establishes obligations for partnership, active protection, and equitable outcomes. These obligations require meaningful Māori participation in the governance, design, implementation, and evaluation of health services and workforce initiatives.

Persistent inequities in Māori health outcomes demonstrate the consequences of failing to uphold Te Tiriti obligations across policy and practice, reinforcing the need for Treaty-grounded workforce decisions.

Considerations for Māori include:

DRAFT FOR CONSULTATION

- Partnership with Māori in the design, governance, implementation, and evaluation of any PA workforce model
- Clear articulation of how Māori workforce development will be supported, defined, delivered, and led by Māori in practice
- Sustained investment in Māori health workforce pathways that are culturally grounded, Māori-led, and aligned with hauora Māori models of care
- Alignment with national strategic directions, including Pae Tū: Hauora Māori Strategy,²⁰ which emphasises Māori leadership, Te Tiriti alignment, and growth of a sustainable Māori health workforce

Without clear and operational commitments to Māori workforce development, there is a risk that implementation may lack cultural grounding and inadvertently increase inequities in already underserved communities.

Pacific Peoples

Pacific Peoples should be recognised as a distinct population group with their own health priorities, cultural contexts, and workforce development needs.

Workforce design should ensure that Pacific leadership, Pacific models of care, and community-informed approaches are embedded throughout service planning and delivery.

Considerations for Pacific Peoples include:

- Dedicated Pacific workforce development strategies informed and led by Pacific communities
- Integration of Pacific health perspectives and culturally grounded approaches within service design and delivery
- Support for sustainable Pacific workforce pathways to strengthen access, cultural safety, and health outcomes
- Ongoing engagement with Pacific providers, leaders, and communities in implementation and evaluation processes

PAs should not be regarded as a substitute for investment in Pacific health workforce development. Without clear commitments to strengthening Pacific workforce capacity, service changes may fail to meet community needs or contribute to equitable outcomes.

Australia

Aboriginal and Torres Strait Islander peoples and communities

In Australia, equity and workforce considerations must recognise the continuing impacts of colonisation, racism, and structural disadvantage on health outcomes.

²⁰ Minister of Health. 2023. Pae Tū: Hauora Māori Strategy. Wellington: Ministry of Health. Online, available: [Pae Tū: Hauora Māori Strategy | Ministry of Health NZ](#) [last accessed 05/06/2026]

DRAFT FOR CONSULTATION

Implementation of any PA workforce model should support, rather than undermine, efforts to strengthen Aboriginal and Torres Strait Islander health workforce development and self-determination.

Considerations for Aboriginal and Torres Strait Islander peoples include:

- Meaningful engagement with Aboriginal and Torres Strait Islander communities, leaders, health professionals, and representative organisations in workforce planning, implementation, and evaluation
- Alignment with Aboriginal and Torres Strait Islander health priorities and Closing the Gap commitments
- Support for Aboriginal Community Controlled Health Organisations and community-led models of care
- Investment in Aboriginal and Torres Strait Islander workforce recruitment, training, retention, leadership, and career progression pathways
- Cultural safety requirements, accountability mechanisms, and ongoing professional development for all PAs working with Aboriginal and Torres Strait Islander communities
- Recognition of the value of Indigenous knowledges, strengths-based approaches, and culturally responsive models of healthcare delivery

PAs should not be viewed as a substitute for strengthening the Aboriginal and Torres Strait Islander health workforce. Sustainable improvements in health outcomes require long-term investment in Aboriginal and Torres Strait Islander leadership, workforce development, and community-controlled health services, particularly in rural, remote, and underserved settings where workforce shortages are often most pronounced.

Equity and workforce considerations for migrant and other ethnic minority communities in Australia and Aotearoa New Zealand

Migrant and other ethnic minority groups across both countries also experience health disparities, yet workforce planning frequently overlooks them.

Considerations for migrant and other ethnic minority communities include:

- Disaggregated data collection and reporting that reveals differences between specific migrant and ethnic minority communities where possible
- Genuine engagement with migrant and ethnic minority communities, providers, and organisations in workforce planning, implementation, and evaluation
- Attention to language access, interpreter services, and culturally responsive care models tailored to the needs of specific communities
- Recognition that migration history, settlement experience, and socioeconomic factors can compound health disparities within and across different groups
- Alignment with broader cultural safety standards and equity safeguards, ensuring migrant and ethnic minority communities are not treated as a residual "other" population

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As with Māori, Pacific Peoples, and Aboriginal and Torres Strait Islander communities, PAs should not be regarded as a substitute for investment in workforce development and service models that genuinely respond to the needs of migrant and ethnic minority populations.

Implementation challenges

Introducing or expanding the use of PAs in Australia and Aotearoa New Zealand requires:

- Further assessment of overseas qualifications to ensure these healthcare workers meet the requisite standards in Aotearoa New Zealand and Australia for health professionals
- Pilot models with rigorous evaluation before wider use is considered
- Development of domestic PA training programs and accreditation, based on nationally consistent curriculum²¹
- Consideration of how PAs would work within existing funding models (e.g. Medicare, private health insurance), particularly in community settings
- Legislative and regulatory frameworks across jurisdictions
- Defined governance, supervision, and scope policies
- Public and professional consultation to build trust and acceptance

All these steps require in-depth and sustained consultation with doctors and other existing health professional groups.

Without careful planning, expansion risks compromising safety, training, and service delivery, especially in rural and high-complexity settings.

Concluding remarks

The RACP sees no need for the introduction or expanded use of PAs in Australia and Aotearoa New Zealand. An introduction or further expansion presents significant risks to patient safety, workforce sustainability, and the integrity of medical training if implemented without appropriate safeguards.

If PAs were to ever have a supportive role in healthcare in Australia and Aotearoa New Zealand, the RACP emphasises that patient safety, medical training, and workforce sustainability must take precedence. Any introduction or expansion would require robust governance, supervision, and regulation to mitigate the potential for unsafe care, diluted medical training, and widening inequities in healthcare delivery.

²¹ Note: In Australia, James Cook University and the University of Queensland previously offered physician assistant courses; however, both programs were discontinued due to limited employment opportunities and uncertainty about the sustainability of a PA workforce in the Australian health system.

DRAFT FOR CONSULTATION

Sustainable solutions to workforce pressures should focus on strengthening existing, local trained workforces and ensuring approaches are culturally grounded and sustainable.

In Aotearoa New Zealand, this requires strengthening domestic medical training and workforce pathways that are responsive to population need, with sustained investment in Māori health workforce development, grounded in Te Tiriti o Waitangi and led in partnership with Māori and dedicated investment in Pacific health workforce development, reflecting Pacific leadership, models of care, and community priorities

In Australia, strengthening medical training and workforce pathways requires sustained investment in Aboriginal and Torres Strait Islander health workforce development, supporting Indigenous leadership and community-controlled health services.

Across both countries, governments need to strengthen rural and remote training pathways, workforce development in culturally and linguistically diverse contexts and advanced practice roles for nurses, allied health professionals, and other established healthcare professions.

The RACP is committed to working collaboratively with governments, health departments, and sector stakeholders to develop sustainable, culturally safe workforce solutions that strengthen access to high-quality care and address health system challenges without compromising patient safety or training standards.