

AUSTRALASIAN PARAMEDICINE WORKFORCE SURVEY

REPORT 2025-2026

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About the College

The Australasian College of Paramedicine (the College) is the peak professional body representing and supporting paramedics and student paramedics across Australia and Aotearoa New Zealand since 1973.

For further information about the College, please visit www.paramedics.org or contact info@paramedics.org

Thank you

The College sincerely thanks the Research Team (Appendix 1) led by Associate Professor Liz Thyer (Project Chief Investigator), Western Sydney University and the partnering universities for their work in survey design and administration, and analysing the data from which the Australasian Paramedicine Workforce Survey Report 2025-2026 has been prepared. The College also thanks the teams and individuals involved in preparing this report.

We extend our thanks to the many dedicated and passionate paramedics who provided responses to the Australasian Paramedicine Workforce Survey 2025-2026.

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Acknowledgement

The College acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land and sea in which we live and work. We recognise their continuing connection to land, sea and culture, and pay our respects to Elders past, present and future.

We recognise the unique role of Māori as Tangata Whenua and embrace Te Tiriti o Waitangi, recognising Māori as tino rangatiratanga of Aotearoa New Zealand while supporting the guiding principles of Te Tiriti – Tino rangatiratanga, Equality, Active protection, Options, and Partnership.

Message from the Chair



The Australasian College of Paramedicine (the College) is pleased to present the Australasian Paramedicine Workforce Survey Report 2025–2026, an initiative established by the College to support and strengthen the paramedicine profession across Aotearoa New Zealand and Australia.

This third and final report marks the conclusion of a three-year journey that the College regards as an invaluable body of work for the profession and the wider health system. Over this time, the survey has built an increasingly detailed and reliable picture of the paramedicine workforce, offering critical insights to guide workforce planning, professional support, and the profession's long-term sustainability.

In leading this landmark series, the College reaffirms its commitment to evidence-based advocacy and its role as a trusted voice for paramedics. The captured insights are vital to shaping policy, and ensuring paramedics are supported to deliver high-quality, person-centred care. They provide a clearer picture of the challenges and opportunities ahead, and a robust evidence base for decision-making at every level.

We stand alongside our workforce, and recognise the dedication, skill, and compassion paramedics bring to their communities every day. This report reflects their experiences and serves as a tool to drive meaningful change in how paramedicine is understood, valued, and supported.

Our sincere thanks go to the outstanding research team led by Associate Professor Liz Thyer, and to our academic partners at Western Sydney University, Auckland University of Technology, and Edith Cowan University, whose expertise and commitment have been instrumental in delivering this work.

Through this project, we have built a stronger foundation for paramedicine's future: one grounded in robust data, driven by interprofessional collaboration, and focused on meeting the changing health needs of communities across Australasia.

Ryan Lovett

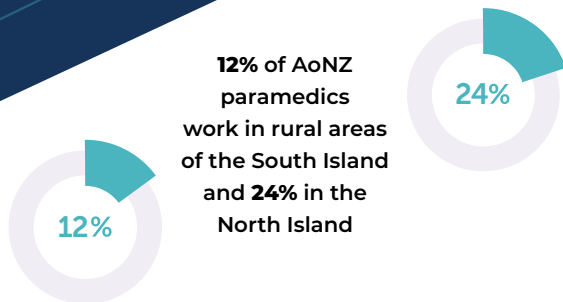
Chair

Australasian College of Paramedicine

KEY TAKEAWAYS



Over 50% of AoNZ and Aus paramedics have lived outside metro areas



12% of AoNZ paramedics work in rural areas of the South Island and 24% in the North Island



5% of Aus paramedics work in MMM6-7* locations



45% of Aus paramedics work in MMM1 locations

*Modified Monash Model



10%

of clinical Aus paramedics hold dual paramedic and nurse registration

2%

of clinical AoNZ paramedics hold dual paramedic and nurse registration



In Aus, 24% of paramedics are recent clinical entrants which is encouraging for workforce growth and sustainability

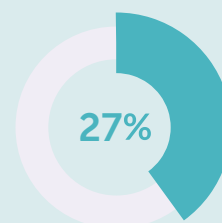
Abbreviations: AoNZ – Aotearoa New Zealand. Aus – Australia.

Gender and age

- Women make up the majority of paramedics under 40 (65% compared to 42%)
- Most management roles are held by men across both Aus and AoNZ (65% compared to 32%)



Care responsibilities



of paramedics requested a change of contract within the last 12 months



1 in 5 approx.

paramedics have care responsibilities for adult family members

2 in 5 approx.

paramedics care for children under 16



23

languages spoken
by respondents
across Australasia

33%

of AoNZ paramedics
were born overseas

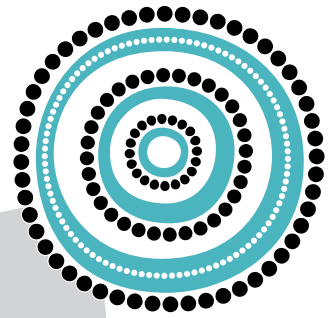


12%

of Aus paramedics
were born overseas



1 in 4 approx. paramedics
work for two or more employers

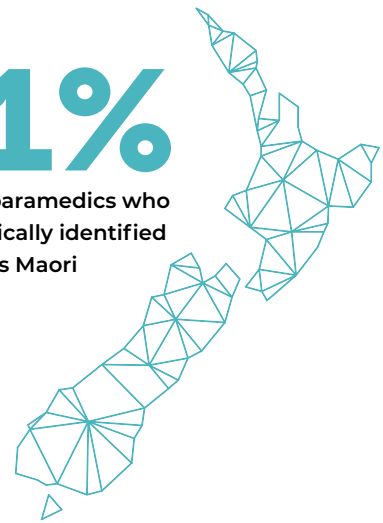


7%

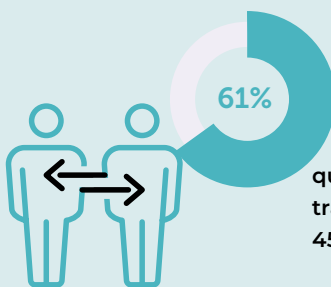
Aboriginal respondents represented
in the clinical paramedicine workforce

11%

of AoNZ paramedics who
work clinically identified
as Maori



Abbreviations: AoNZ – Aotearoa New Zealand. Aus – Australia.



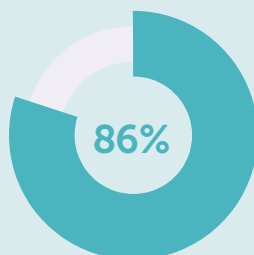
61%

of AoNZ paramedics
reported spending up to a
quarter of their shift on patient
transfers, compared to
45% in Aus

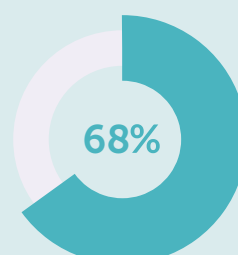
Majority of paramedics
across Australasia
reported having no time
for research activities
during their shift



77% AoNZ and 80% of Aus



of Aus paramedics view professional
memberships as valuable in enabling CPD



of AoNZ paramedics view professional
memberships as valuable in enabling CPD

Executive Summary

This is the third and final report of a three-year study exploring trends that affect the Aotearoa New Zealand and Australian paramedicine workforces. The research moves beyond the collection of demographic data to consider career tenure, trajectory and aspirations, work demands and conditions, and individual wellbeing. The workforce is considered in four broad areas: clinical, management, education, and research, reflecting the expanding scope of Aotearoa New Zealand and Australian paramedicine. The report presents two data snapshots: paramedicine student demographics and career aspirations, and paramedics who work for more than one employer.

Data were collected via an online survey during November 2025 to February 2026. During this time, 1098 valid responses were collected.

The key findings include:

- The demographic findings are largely reflective of the paramedicine population data that is available through the Paramedicine Board of Australia and Te Kaunihera Manapou | Paramedic Council although the sample had a high proportion of male respondents.
- Eleven percent of clinical paramedics in Aotearoa New Zealand identify as Māori, and 7% as Aboriginal in Australia. While workforce participation by Indigenous peoples is higher in Aotearoa New Zealand, it still lags population data. The Australian numbers exceed population data, but the lack of any respondents who are in management is concerning.
- Survey participants are well educated and well paid, exceeding population averages for both education and salary.
- Survey participants identify as having numerous ethnicities and speaking various languages other than English, however both lag population data indicating a less culturally diverse workforce.
- Students and paramedics under the age of 40 are predominately female, while those over 40, and particularly those in management positions, are predominantly male.

- More than two in every five paramedics had carer responsibilities for children under the age of 16 while working as a paramedic and at least one in every five has caring responsibilities for an adult family member.
- Currently, more than 20% of paramedics work for two or more employers. This may be to achieve an equivalent 1.0 FTE among multiple employers, or it may be an example of job crafting where employees actively alter the focus of their work to provide a more meaningful experience.
- Paramedics still typically work rotating rosters; however, nearly one third had requested changes to work patterns to develop skills or facilitate work-life balance. Additionally, nearly a third of paramedics from both Aotearoa New Zealand and Australia wanted to decrease the number of hours they currently worked.

Key considerations for the paramedicine workforce

- Career intentions of paramedics indicate a considerable number of respondents who intend to leave their current paramedicine employer within the next 10 years. This is reinforced by 17% of Aotearoa New Zealand and 15% of Australian paramedics planning to undertake formal education in a profession other than paramedicine.
- Many paramedics intend to apply for advanced clinical roles. These roles provide additional scope of practice to the individual, as well as playing an important role in increasing the visibility of paramedicine to the broader healthcare workforce.
- Education and research are at the forefront of developing the future paramedicine workforce, yet there seems little intention by paramedics to move into these roles. Insights into the barriers to these career pathways need to be prioritised.

Associate Professor Liz Thyer

Western Sydney University
Project Chief Investigator

Contents

Message from the Chair	3
Key takeaways	4
Executive summary	6
Contents	7
Figures	8
Tables	9
Introduction	10
Results	11
Demographics	12
Registration and tenure	19
Care responsibilities and leave	21
Career as a paramedic	26
Professional development, education, supervision and training	29
Employment and work demands	32
Wellbeing, resource adequacy and turnover intention	41
Snapshot: Paramedics with multiple employers	45
Snapshot: Student respondents	48
Appendix 1: Research Team	51
Appendix 2: Methods	51
Appendix 3: List of data points	54
References	58

Figures

Figure 1:	Gender by country	12
Figure 2:	Age and gender distribution	14
Figure 3:	Proportion of Māori peoples in Aotearoa New Zealand paramedic workforce by role	15
Figure 4:	Proportion of Aboriginal and Torres Strait Islander peoples in Australian paramedic workforce by role	15
Figure 5:	Paramedics born in country of operation	15
Figure 6:	Proportion of workforce that speaks a language other than English	17
Figure 7:	Previous experience living in non-metropolitan areas	17
Figure 8:	Aotearoa New Zealand workplace locations	18
Figure 9:	Australian workplace locations by Modified Monash Model (MMM) category	18
Figure 10:	Proportion of respondents with caring responsibilities	21
Figure 11:	Paramedic parental leave experiences	22
Figure 12:	Clinical paramedics' satisfaction with accommodation of family care	23
Figure 13:	Reasons for requesting a change to contracted work	24
Figure 14:	Likelihood of applying for an advanced role	27
Figure 15:	Likelihood of engaging in further education	27
Figure 16:	Future intention themes	28
Figure 17:	Reasons for not considering working rural or remote	28
Figure 18:	Qualitative content analysis of free text responses to barriers to CPD	30
Figure 19:	Annual gross income (NZD) from primary employer for Aotearoa New Zealand paramedics	32
Figure 20:	Annual gross income (AUD) from primary employer for Australian paramedics	33
Figure 21:	Percentage of income derived from respondents' primary paramedicine employer	33
Figure 22:	Contract type by country	35
Figure 23:	Hours worked per fortnight	35
Figure 24:	Hours of overtime and on call worked for per fortnight for any employer	36
Figure 25:	Desire to change or maintain hours with primary paramedicine role	37
Figure 26:	Reason for request for fewer hours from primary employer	37
Figure 27:	Role in clinical supervision by country	40
Figure 28:	Preparedness for clinical supervision by country	40
Figure 29:	Aotearoa New Zealand paramedics grouped by clinical and non-clinical roles – wellbeing, resourcing and turnover intention	41
Figure 30:	Australian paramedics grouped by role (education and research combined due to response rate) – wellbeing, resourcing and turnover intention	42
Figure 31:	Motivations of respondents to undertake a paramedic role	44
Figure 32:	Number of employers	45
Figure 33:	Motivations of respondents to undertake the paramedic role	50

NB: Numbers in figures, tables and charts have been rounded to the nearest whole number

Tables

Table 1:	Survey responses according to category	11
Table 2:	Gender by role type	12
Table 3:	Age category by role type	13
Table 4:	Sexual orientation and gender diversity by location	14
Table 5:	Respondent ethnicity – Aotearoa New Zealand	16
Table 6:	Respondent ethnicity – Australia	16
Table 7:	Registration type by role	19
Table 8:	Tenure – Aotearoa New Zealand and Australia	20
Table 9:	Types of leave taken in the last 12 months	25
Table 10:	Percentage of respondents who took extended sick leave (more than 10 consecutive days)	25
Table 11:	Career intentions	26
Table 12:	Highest degree awarded	29
Table 13:	CPD activities normally undertaken as part of mandatory annual commitment	29
Table 14:	Barriers to CPD activities – Aotearoa New Zealand and Australia	30
Table 15:	Enablers to CPD activities – Aotearoa New Zealand and Australia	31
Table 16:	Work settings for primary employer by country	34
Table 17:	Shift patterns	36
Table 18:	Job demands for clinical respondents working for their primary employer	39
Table 19:	Average agreement with wellbeing resource and turnover statements – Aotearoa New Zealand	42
Table 20:	Average agreement with wellbeing resource and turnover statements – Australia	43
Table 21:	Proportion of paramedics with multiple jobs - Aotearoa New Zealand	45
Table 22:	Proportion of paramedics with multiple jobs - Australia	45
Table 23:	Comparison of gender to multiple employers	46
Table 24:	Comparison of age to multiple employers	46
Table 25:	Comparison of income to multiple employers – Aotearoa New Zealand	47
Table 26:	Comparison of income to multiple employers – Australia	47
Table 27:	Comparison of hours worked per fortnight to multiple employers	47
Table 28:	Gender profile of paramedicine students	48
Table 29:	Age profile of paramedicine students	48
Table 30:	Desired workplace setting post-graduation	48
Table 31:	Likelihood of career-until-retirement in paramedicine	49
Table 32:	Expected years in clinical, patient-facing paramedicine role	49

NB: Numbers in figures, tables and charts have been rounded to the nearest whole number.

Introduction

This report offers a powerful picture of the evolving paramedicine workforce, revealing key trends that will shape future planning, professional wellbeing, and workforce sustainability across Australasia.

Comprehensive data exploring the Australasian paramedicine workforce is limited, especially when compared to other health professions. This is particularly true of paramedics who do not work in 'traditional' jurisdictional ambulance services but instead are employed by an increasingly varied number of private, public, and non-government organisations. Previous Australasian research into the paramedicine workforce can be largely categorised as high-level workforce statistics gathered by bodies such as the Paramedicine Board of Australia and the Australian Government Productivity Commission^{1,2} or detailed reports on specific groups. These specific groups include remote industrial and mining sectors,³ characteristics of the jurisdictional ambulance workforce participating in the Australian and New Zealand Cardiac Arrest Registry,⁴ Māori participation in the paramedic profession,⁵ paramedic academics in both Aotearoa New Zealand and Australia⁶ and jurisdictional ambulance services paramedic role types.⁷

Data collected via government agencies focuses largely on workforce demographics, providing broad coverage, but limited detail. The Paramedicine Board of Australia collects annual data covering number of registrants (both practising and non-practising), age and gender.² Some information has been collected by the Australian Bureau of Statistics and Stats NZ, but the lack of inclusive Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes that comprehensively applied to

paramedicine, constrains that data set.¹ The 2024 reclassification project, seeing the separation of Australian (Occupation Standard Classification for Australia) and Aotearoa New Zealand (National Occupation List) data, remains constrained. The Aotearoa New Zealand paramedic workforce information is also limited, as registration only commenced in 2020.⁸ The Council of Ambulance Authorities provides an annual workforce and gender report, but this is restricted to jurisdictional ambulance paramedics and provides limited in-depth data.

The primary aim of this survey was to record characteristics of the current and future Australasian paramedicine workforce to identify trends across demographics, fields of employment, intention to upskill, intention to leave the workforce and other key variables. It has achieved that aim in capturing a representative sample of the paramedicine workforce across Aotearoa New Zealand and Australia. The survey includes valuable information examining demographics, role types, work satisfaction and wellbeing, reasons for attrition and choices about place of work, along with other data that explores the Australasian paramedicine workforce in new and informative ways.

The workforce data contained in the report aims to assist the College and broader paramedicine and healthcare sectors in workforce planning to support all employers of paramedics better understand the needs of their workforce.

Results

Total survey responses

The total survey responses are summarised in Table 1. After agreeing to participate in the survey, respondents were asked which of the following categories best described their current position with their primary paramedicine employer. The response to this question determined the subsequent set of questions each participant received.

A total of 1098 respondents consented to participate in the survey; however, not all respondents completed the survey once they began. Those who completed between 1% and 59% of the survey (n=243) have been excluded so as not to skew results. A further 73 respondents completed between 60% and 99% of the survey. These were added to the 782 responses that completed 100% of the survey, for a total of 855 responses. There were 171 responses from Aotearoa New Zealand and 684 from Australia.

Of those working, and not working but still registered (n=623), there were:

- 541 registered paramedics
- 10 non-practising registered paramedics
- 50 dual-registered paramedic and nurse
- 7 dual-registered paramedic and another health discipline
- 15 other registrations.

The response rate was just short of the a priori sample size (647) for statistical power for paramedics (confidence level of 99% with 5% margin of error). Therefore, no inferential statistics are presented. The student paramedic data is presented as a snapshot toward the end of the report.

Table 1: Survey responses according to category

Group	Complete	Incomplete
Australian registered paramedic working in paramedicine (includes clinical, education, research and management roles)	443	150
Registered to practise with the Kaunihera Manapou Paramedic Council and working in paramedicine (includes clinical, education, research and management roles)	95	14
Student completing a pre-registration paramedicine degree	209	0
Working within paramedicine profession in Australia, but NOT a registered paramedic (e.g. emergency medical technician, military medic, mine site medic, tutor/lecturer)	12	6
Registered to practise in Australia but not currently working in a paramedicine role	74	0
Registered to practise with Kaunihera Manapou Paramedic Council but not currently working in a paramedicine role	11	0
Working within paramedicine profession in Aotearoa New Zealand, but NOT a registered paramedic (e.g. emergency medical technician, military medic, mine site medic, tutor/lecturer)	11	6
Total	855	176

*67 incomplete responses were unable to be allocated as they had not completed this question

Demographics

This section illustrates workforce diversity and representation across age, role and location to inform equitable workforce planning.

Gender representation

The gender breakdown for the paramedicine workforce (including students) across Aotearoa New Zealand and Australia is shown in Figure 1.

For both countries, the gender distribution is similarly balanced between males and females overall. However, within clinical roles (Table 2), those identifying as male make up the majority. The proportion of males to females in clinical roles is more pronounced in Australia, with a 61% to 37% split. The over-representation of males in management roles is common across both jurisdictions, consistent with other professions in the health sector.⁹ Female students outnumber males in both countries, identifying a possible pathway to boost gender equality into the future, in both clinical and managerial roles. Notwithstanding, the lower distribution of females in both role types, for both jurisdictions, likely points to structural career disadvantage which warrants systematic remedy. Priorities in such remedies must respond to gender imbalance in all role typologies, but particularly in the research and management spaces.

Figure 1: Gender by country

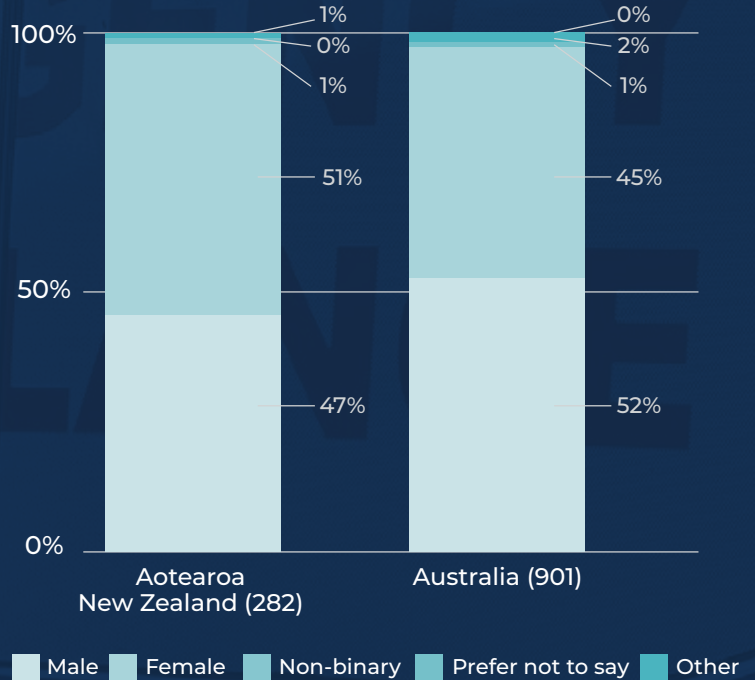


Table 2: Gender by role type

Aotearoa New Zealand	Clinical (92)	Research*	Education*	Management*	Student (89)	Not working*	Total (282)
Male	55%	-	17%	100%	31%	33%	47%
Female	42%	-	83%	0%	67%	67%	51%
Non-binary	1%	-	0%	0%	2%	0%	1%
Prefer not to say	1%	-	0%	0%	0%	0%	1%
Other	0%	-	0%	0%	0%	0%	0%
Australia	Clinical (362)	Research*	Education (24)	Management (37)	Student (138)	Not working (64)	Total (626)
Male	61%	100%	54%	65%	27%	44%	52%
Female	37%	0%	33%	32%	67%	55%	45%
Non-binary	0%	0%	4%	0%	4%	2%	1%
Prefer not to say	2%	0%	4%	3%	1%	0%	2%
Other	0%	0%	4%	0%	1%	0%	0%

* Categories with <20 respondents

Age distribution

Age distribution of the paramedicine workforce, for both Aotearoa New Zealand and Australia, is broadly consistent with national averages.^{10,11} (Table 3).

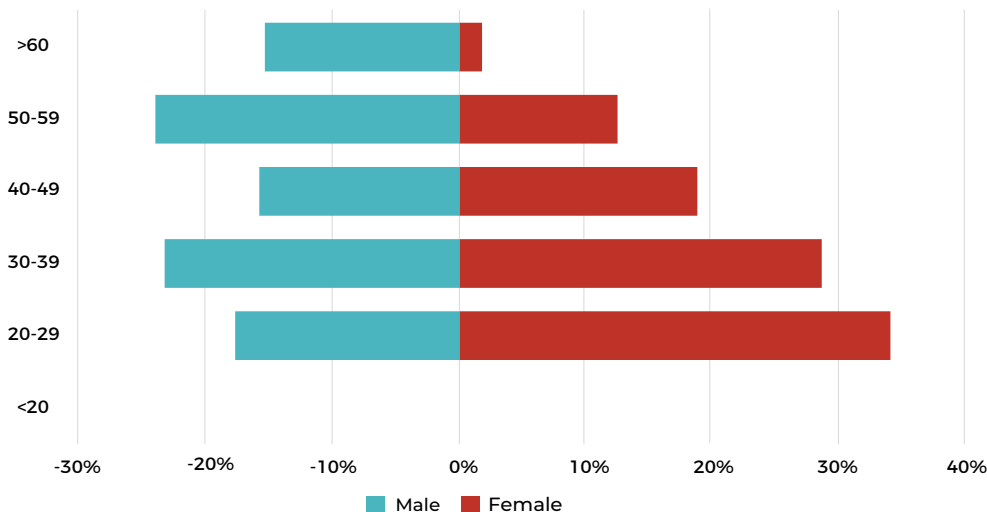
Table 3: Age category by role type

	Age (Years)	Clinical (91)	Research*	Education*	Management*	Student (88)	Not working*	Total (156)
Aotearoa New Zealand	<20	0%	-	0%	0%	0%	0%	0%
	20-29	20%	-	0%	0%	72%	17%	34%
	30-39	27%	-	50%	20%	11%	0%	22%
	40-49	25%	-	33%	20%	9%	33%	21%
	50-59	21%	-	0%	20%	6%	17%	15%
	60+	7%	-	17%	40%	2%	33%	8%
	Age (Years)	Clinical (359)	Research*	Education (24)	Management (37)	Student (138)	Not working (63)	Total (622)
Australia	<20	0%	0%	0%	0%	0%	0%	0%
	20-29	15%	0%	0%	3%	61%	25%	25%
	30-39	31%	0%	42%	30%	21%	24%	28%
	40-49	19%	0%	4%	16%	11%	22%	17%
	50-59	22%	100%	50%	41%	7%	17%	20%
	60+	13%	0%	4%	11%	1%	11%	9%

* Categories with <20 respondents

For Aotearoa New Zealand and Australia, 44% and 46% of the workforce is over 40, respectively. In both countries, nearly 10% of the workforce is aged 60 years or over. This implies careful consideration must be given to natural or premature attrition, reasonable workplace adjustments, and succession planning.

Figure 2: Age and gender distribution (combined sample)



Age and gender

Figure 2 illustrates structural trends in the gender composition of the Australasian paramedic workforce. Women dominate the under-30 age group, while men outnumber women from age 50 onward. This shift reflects a historically male-dominated field moving toward gender balance. However, the sharp decline in female representation after age 30-39 may suggest structural barriers which preclude sustained participation of women in the workforce. Alternatively, the graph may be capturing the progressive inclusion of women in the profession over time, notwithstanding the disproportionate role representations in Table 3 above.

Table 4: Sexual orientation and gender diversity by location

	Aotearoa New Zealand (163)	Australia (629)
Heterosexual	74%	76%
Gay or homosexual	3%	4%
Lesbian	6%	4%
Bi-sexual	9%	5%
Pansexual	1%	1%
Grey/Asexual	1%	1%
Queer	4%	2%
I use a different term	2%	1%
Prefer not to say	2%	7%

LGBTIQA+ representation

Table 4 presents the LGBTIQA+ and heterosexual orientation of the total paramedicine workforce across Aotearoa New Zealand and Australia. Workforce diversity is increasingly in the spotlight, with sexual orientation of the workforce being a key inclusion indicator.¹²

Those who selected 'I use a different term' had the option to provide a written response and ten answers were received. Of these, three participants reported identifying as 'straight', while one indicated being 'polyamorous'. Rather than revealing their sexuality, one respondent wrote that they were 'male', and another 'widowed'. The remaining entries documented participants' sentiment that this question was not relevant to the purpose of the survey.

The diverse response to this question is greater than previously reported in other Australasian paramedic workforce surveys, but consistent with previous data from earlier iterations of this survey. This may be representative of a changing workforce but could also indicate a greater willingness of respondents to answer this question in a survey which is not linked to either an employer or registering body.

Māori and Aboriginal and Torres Strait Islander representation

Paramedics who are representative of the communities they serve help break down barriers when delivering care.¹³ Māori representation in the Aotearoa New Zealand workforce, particularly in clinical roles (11%), is proportionally low relative to the population of 17.5%¹⁴ (Figure 3). Although neither country exceeds the national average, Aotearoa New Zealand had 16% of students identify as Māori, suggesting an increase for the future workforce. Meanwhile, 3% of Australian student respondents identified as Australian Aboriginal.

Although the sample size is small, it is encouraging to note that Aboriginal peoples in Australia are represented in both clinical (7%) and education (8%) roles at levels that exceed the national average of 3.8% (Figure 4).

Born in country of operation

Aotearoa New Zealand and Australia have experienced significant migration over the last three decades. Notwithstanding, the paramedicine workforce for both countries remains largely populated by those born in their country of operation (Figure 5). While the Aotearoa New Zealand workforce has a larger proportion of those born overseas, Australia's workforce appears below the national average for people born overseas (32%).¹⁵ This has implications for cultural safety orientation and provision of care in relation to culturally and linguistically diverse communities.

Figure 3: Proportion of Māori peoples in Aotearoa New Zealand paramedic workforce by role

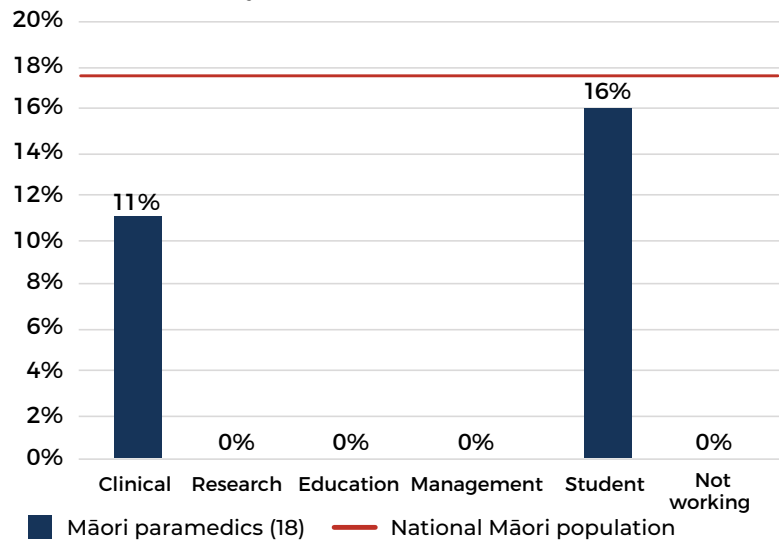


Figure 4: Proportion of Aboriginal and Torres Strait Islander peoples in Australian paramedic workforce by role

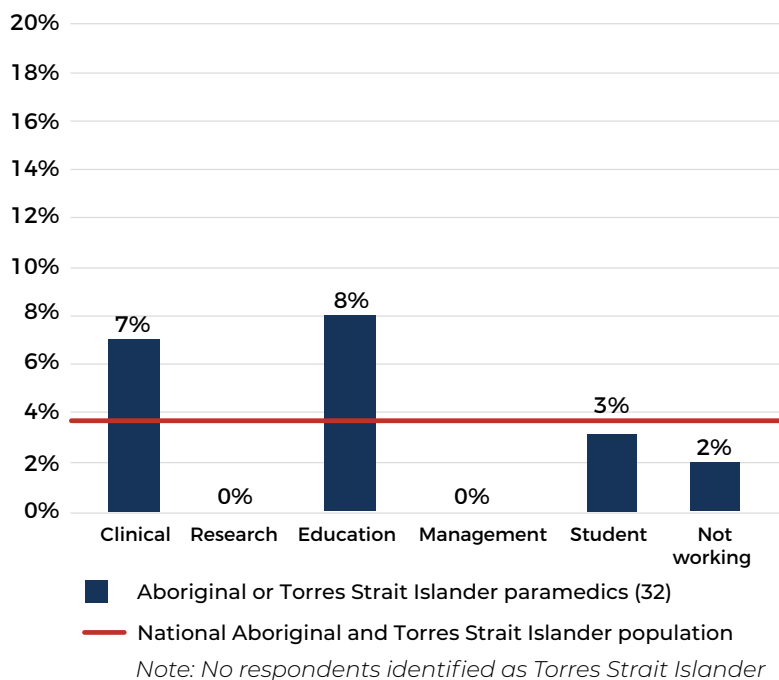
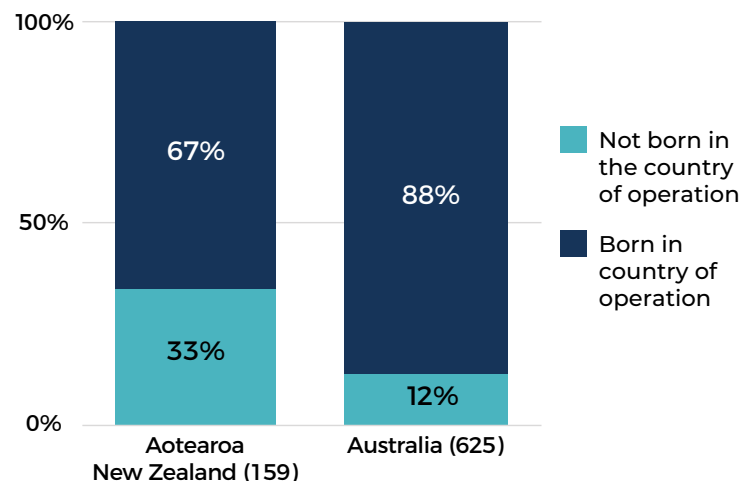


Figure 5: Paramedics born in country of operation



Ethnicity

Tables 5 and 6 outline the most common ethnicities identified by the paramedicine respondents for Aotearoa New Zealand and Australia. When compared to national population data, both Aotearoa New Zealand and Australia’s paramedic workforces appear to be less ethnically diverse.^{16,17}

Table 5: Respondent ethnicity – Aotearoa New Zealand

Aotearoa New Zealand (301)	
New Zealand European/Pākehā	76%
Māori	11%
Australian	6%
Samoan	2%
Chinese	0%
Indian	2%
Other	23%

Table 6: Respondent ethnicity – Australia

Australia (855)	
Australian	89%
English	10%
Irish	4%
Scottish	3%
Australian Aboriginal	5%
Torres Strait Islander	0%
Chinese	2%
Indian	1%
Italian	2%
Other	9%

Both countries have experienced a significant rise in migration from Asia, and particularly China and India, in recent years (alongside other countries including the Philippines, Nepal and Vietnam).¹⁸ Efforts to attract people from these and other ethnic backgrounds will assist the workforce in being more representative of the communities they serve and help further breakdown cultural barriers that may affect clinical care. In Aotearoa New Zealand this aligns with Te Tiriti obligations under Te Tiriti o Waitangi. Australia has no corresponding national obligations; however, some ambulance services have dedicated pathways for Aboriginal and Torres Strait Islander applicants.

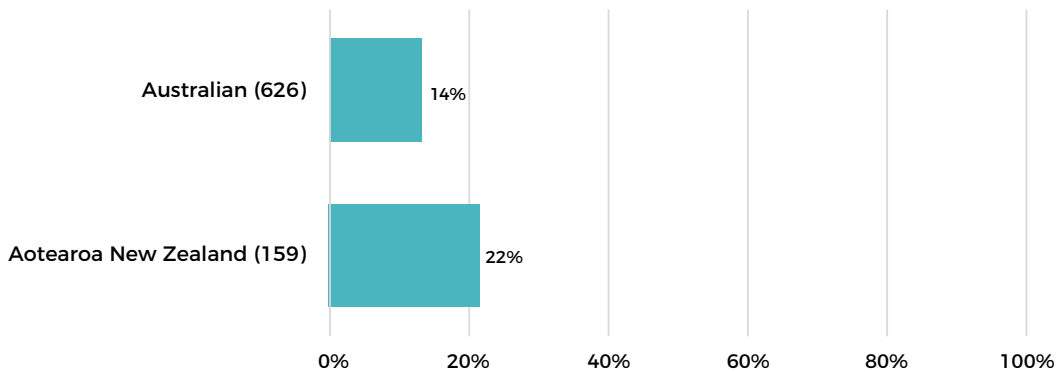
Ninety written responses were received across both countries. The most commonly reported ethnicities were English, European, and South African, with a range of other backgrounds including Maltese, Filipino, Scottish, and various Pacific and Asian identities.

Language(s) spoken

While Aotearoa New Zealand and Australia are both culturally and linguistically diverse nations, the proportion of respondents who speak a language other than English at 22% and 14% respectively (Figure 6), remains below the national average of both populations (~23%).^{19,20}

Research points to a need for clinicians to be able to communicate in languages understood by Indigenous peoples,²¹ and benefit could be realised by encouraging and developing a strategically deployed, multilingual workforce.

Figure 6: Proportion of workforce that speaks a language other than English



Survey respondents were able to manually enter any additional languages that they spoke, and 32 entries were received. A total of 23 languages other than English were spoken by paramedics across Aotearoa New Zealand and Australia.

Fourteen respondents based in Aotearoa New Zealand opted to add text entries for this question. The most common languages among this group were Spanish (4), and French (2). Less common were Urdu (1), Malagasy (1), Italian (1) and Hindi (1). Eighteen responses were collected from Australian respondents. These included Japanese (3), and Indonesian (2). All other entries were made just once and included Tok Pisin (Papua New Guinea), Tagalog (Philippines), AUSLAN, and Maltese.

Experience living in non-metropolitan areas

Aotearoa New Zealand and Australia cover some of the most remote and geographically dispersed communities in the world, yet both also have large metropolises where most of the population resides. Figure 7 shows that both countries possess a good proportion of paramedics with experience living in non-metropolitan areas. Over half of the respondents from Aotearoa New Zealand and Australia have lived in rural, regional, or remote areas at some stage up until the age they left school.

Figure 7: Previous experience living in non-metropolitan areas



Current workplace location

Employer operational demand across jurisdictional ambulance services has traditionally determined a paramedic's place of work. With increasing diversity of paramedicine employers, rurality and sustaining a rural health workforce is a known issue across Australasia.

Figures 8 and 9 show the current workplace location for respondents' primary employer for Aotearoa New Zealand and Australian respondents respectively. In the context of Australia, the Modified Monash Model (MMM) categories are recognised classifications of remoteness utilised by the Australian Bureau of Statistics, with categories ranging from MMM1 (major city) to MMM7 (very remote). Aotearoa New Zealand does not have a comparable system, rather, respondents self-classified locations as urban or rural.

In Aotearoa New Zealand (Figure 8), the graph highlights urban services in the North Island as holding most respondents. This is reflective of population spread in Aotearoa New Zealand, where approximately three out of four New Zealanders live on the North Island.²² Additionally, some jurisdictions staff remote areas, at least in part, with volunteers who were not included in the survey. Most Australian respondents (Figure 9) work in metropolitan and regional centres (MMM1 and 2), and just a small percentage work in remote and very remote communities (MMM6 and 7).

Figure 8: Aotearoa New Zealand workplace locations (n=106)

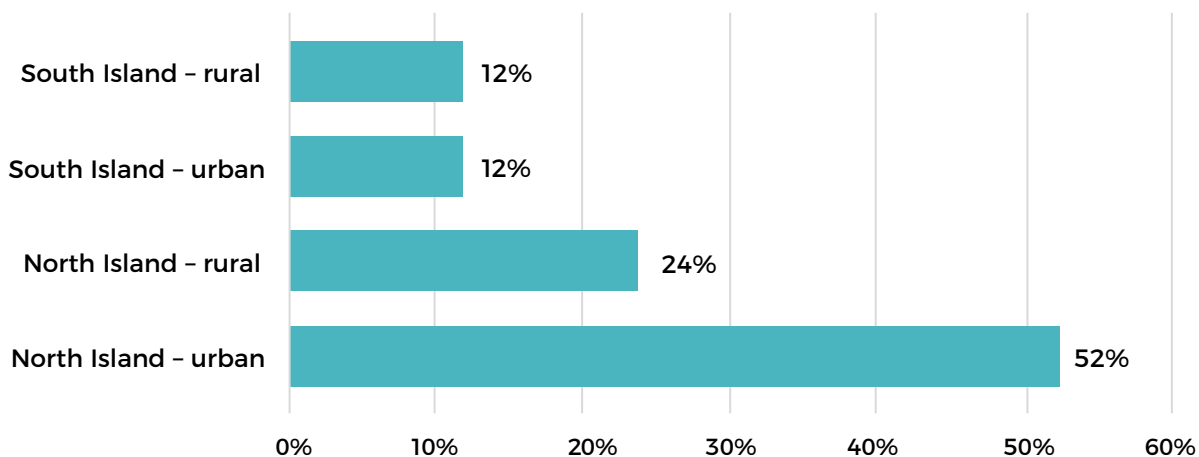
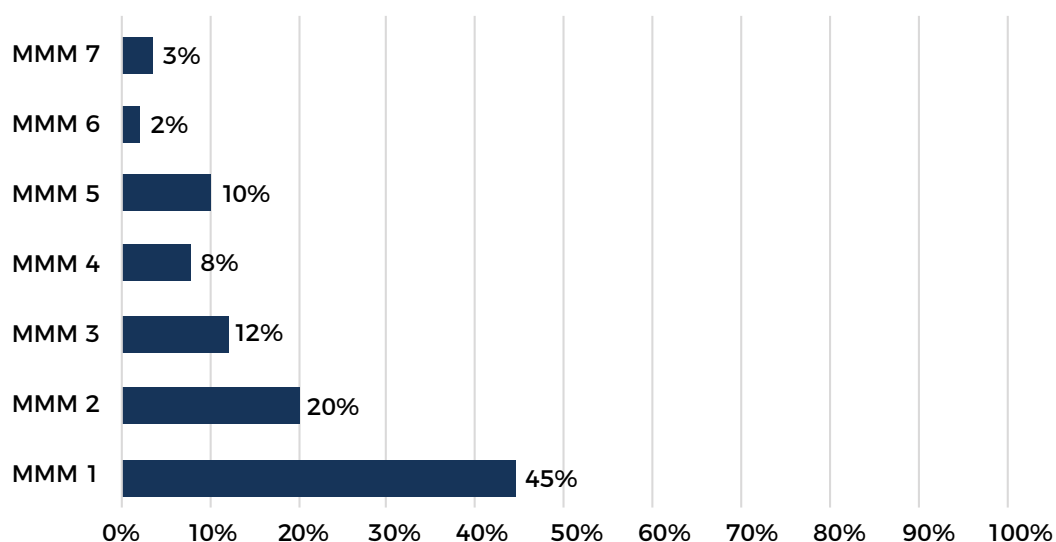


Figure 9: Australian workplace locations by Modified Monash Model (MMM) category (n=450)



Registration and tenure

An analysis of paramedic qualifications and experience, with insights into workforce stability and opportunities for growth.

Registered as a paramedic

The registration types of the paramedicine workforce are detailed in Table 7. Most respondents to this survey were registered paramedics. A proportion of Aotearoa New Zealand and Australian paramedics held dual registration, most commonly paramedic and nurse registration. Those who were maintaining their paramedic registration but not currently working in an Australasian paramedic role provided various reasons, including working as a paramedic or EMT overseas, and working in other health professions.

Table 7: Registration type by role

		Clinical (85)	Research*	Education*	Management*	Not working*
Aotearoa New Zealand	Registered paramedic	92%	-	100%	80%	50%
	Non-practising registration	0%	-	0%	20%	21%
	Dual registered paramedic and nurse	2%	-	0%	0%	0%
	Dual registered paramedic and other health discipline	0%	-	0%	0%	0%
	Other	6%	-	0%	0%	29%
		Clinical (378)	Research*	Education (25)	Management (38)	Not working (74)
Australia	Registered paramedic	89%	100%	80%	97%	69%
	Non-practising registration	0%	0%	0%	0%	12%
	Dual registered paramedic and nurse	10%	0%	16%	3%	9%
	Dual registered paramedic and other health discipline	1%	0%	0%	0%	4%
	Other	0%	0%	4%	0%	5%

* Categories with <20 respondents

Tenure in paramedicine

Tenure described the number of years a respondent had been working in paramedicine, as shown in Table 8. The data shows that there is a skew toward shorter tenure among clinical respondents. Results show 44% of Aotearoa New Zealand respondents and 47% of Australian respondents, had fewer than 10 years of experience.

Aotearoa New Zealand has seen fewer respondents in the early-career group, highlighting an opportunity to strengthen recruitment efforts. Targeted promotion campaigns could help attract new entrants to the profession and support the long-term viability of paramedicine services across the country.

Table 8: Tenure - Aotearoa New Zealand and Australia

Aotearoa New Zealand					Australia			
Tenure (Years)	Clinical (94)	Research*	Education*	Management*	Clinical (389)	Research *	Education (26)	Management (37)
0-4	16%	0%	0%	0%	24%	0%	0%	5%
5-9	28%	0%	50%	20%	23%	0%	8%	11%
10-19	33%	0%	33%	20%	22%	0%	50%	41%
20-29	18%	0%	0%	40%	17%	50%	8%	22%
30-39	1%	100%	17%	20%	11%	0%	31%	19%
40+	4%	0%	0%	0%	2%	50%	4%	3%

* Categories with <20 respondents

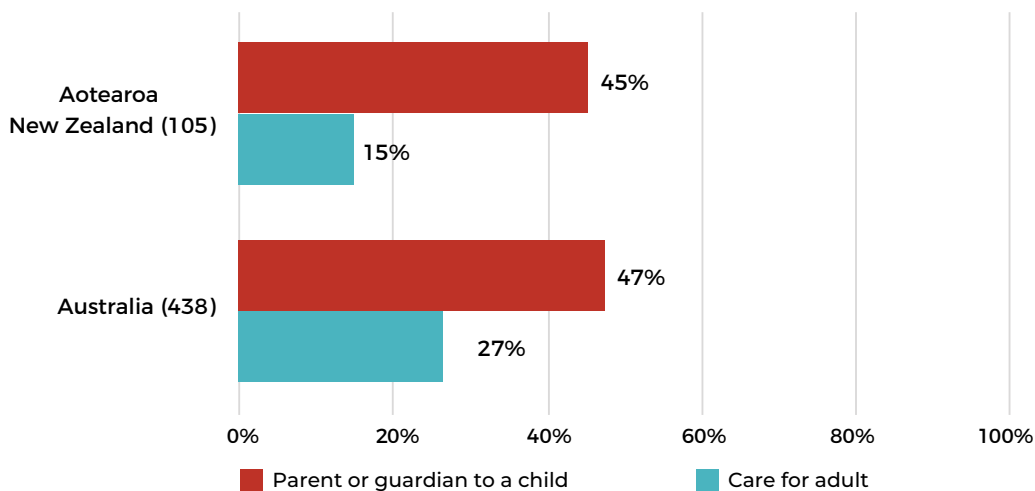
Care responsibilities and leave

This section highlights how caring roles and responsibilities intersect with professional demands. The data reveals that there are some work-life challenges that need immediate solutions to ensure a resilient and balanced workforce.

Caring responsibilities

Figure 10 shows the proportion of the paramedicine workforce who cared for a child under 16 or adult relative during their primary employment.

Figure 10: Proportion of respondents with caring responsibilities



The proportion of the paramedic workforce with caring responsibilities is in line with national statistics.^{23,24} Clinical roles pose challenges for those with caring responsibilities, owing to shift work and the potential for unscheduled overtime.²⁵ The tensions created by shift work have been cited as a factor that challenges broader workforce participation, particularly by female paramedics, who disproportionately carry the burden of care responsibilities.²⁵

Parental leave

The respondents were Aotearoa New Zealand and Australian paramedics undertaking clinical roles, who indicated that they have caring duties. (Figure 11).

Respondents from Aotearoa New Zealand indicate a more positive view across all three questions with median agreement ~75% for Q1 and Q2 and the 25-75th percentile responses being higher for all questions. Responses from Australian respondents generally indicated a 'neutral' level of agreement across the three questions with the median score (horizontal line) being 50%.

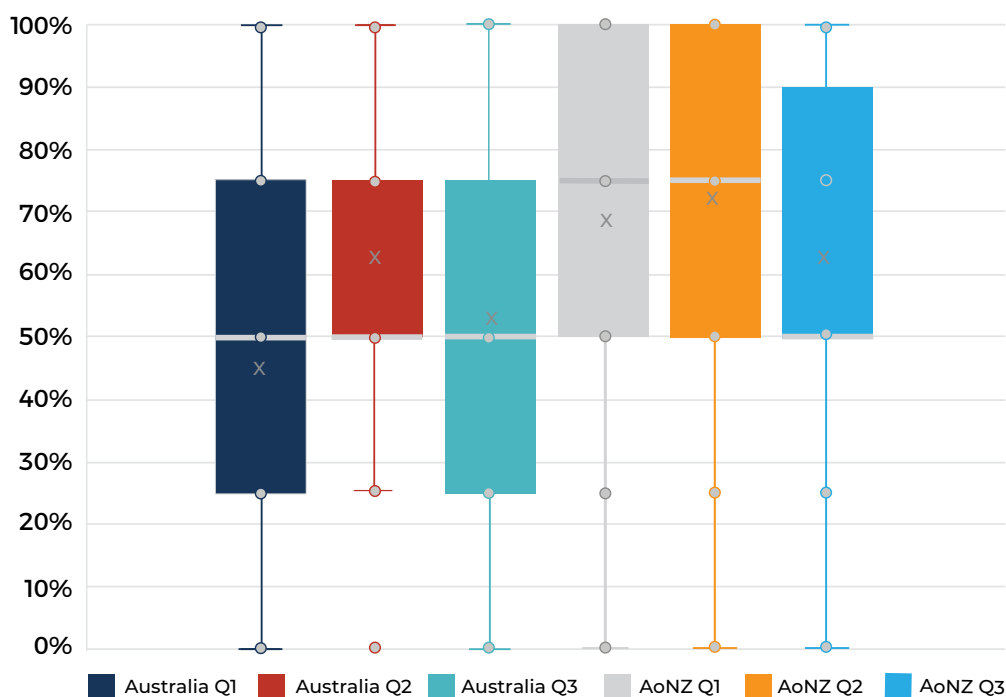
These findings suggest parental leave provisions were, in the main, available to Aotearoa New Zealand and Australian paramedics. Notwithstanding, people in both countries

had a spread of positive and negative responses, although responses from Aotearoa New Zealand were more positive. There have been significant legislative and company policy changes in parental leave provisions over the last two decades in both countries and, as such, the results presented here may not be reflective of current provisions and associated sentiment.

Responsibilities on return from extended leave

Most respondents confirmed they could return to the same role following parental leave. Only 7% of Aotearoa New Zealand respondents and 3% of Australian respondents were unable to do so.

Figure 11: Paramedic parental leave experiences Aotearoa New Zealand (n=43) and Australian (n=164)



Figures 11 and 12 use box-and-whisker plots, with the grey horizontal line showing the median score. A median score of 100% reflects strong agreement, 75% indicates agreement, 50% is neutral, 25% indicates disagreement, and 0% reflects strong disagreement. (See appendix 2)

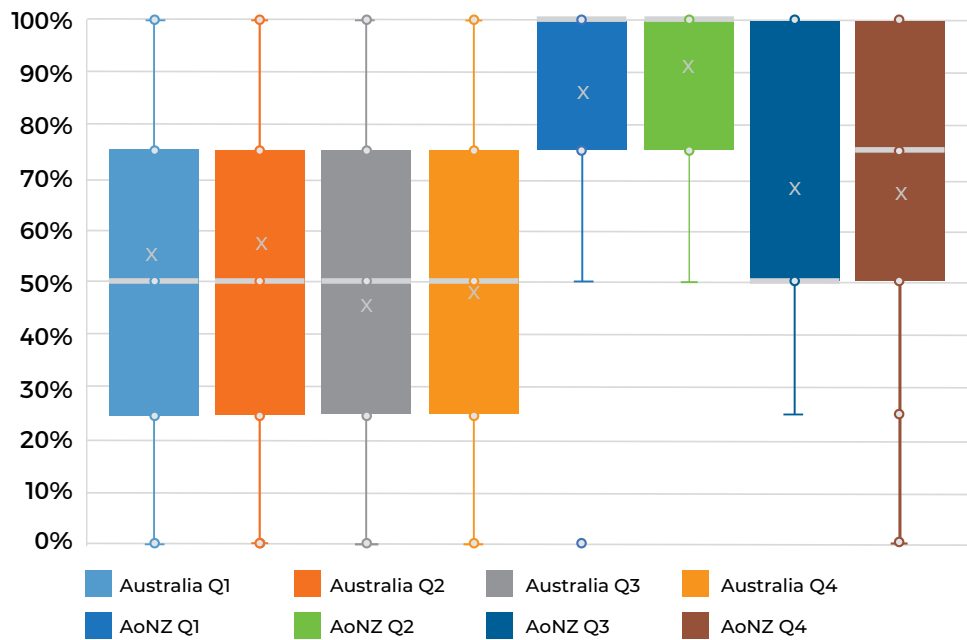
Aotearoa New Zealand and Australian paramedics undertaking clinical roles, who indicated that they have caring duties, were asked the following questions:

- Q1.** I was able to take time off for appointments I wanted to attend during my/my partner's pregnancy or child-related appointments in general
- Q2.** I was able to take short-term (2 weeks) parental leave around the time of the birth or adoption of a child
- Q3.** I was able to take extended leave to be the carer of a child if I wanted to.

Accommodating family care

Clinical paramedics in Aotearoa New Zealand reported more positive experiences with family care accommodations than their Australian counterparts, where responses were evenly distributed across positive and negative sentiments. (Figure 12). This disparity is noteworthy as research highlights that inflexible work arrangements compromise paramedic wellbeing and contribute to occupational trauma.²⁵ Australia may benefit from adopting leave accommodation practices used in Aotearoa New Zealand to reduce work-life conflict.

Figure 12: Clinical paramedics' satisfaction with accommodation of family care Aotearoa New Zealand (n=15) and Australia (n=96)



Clinical paramedics in Aotearoa New Zealand and Australia were asked four questions in relation to their availability to undertake caring duties:

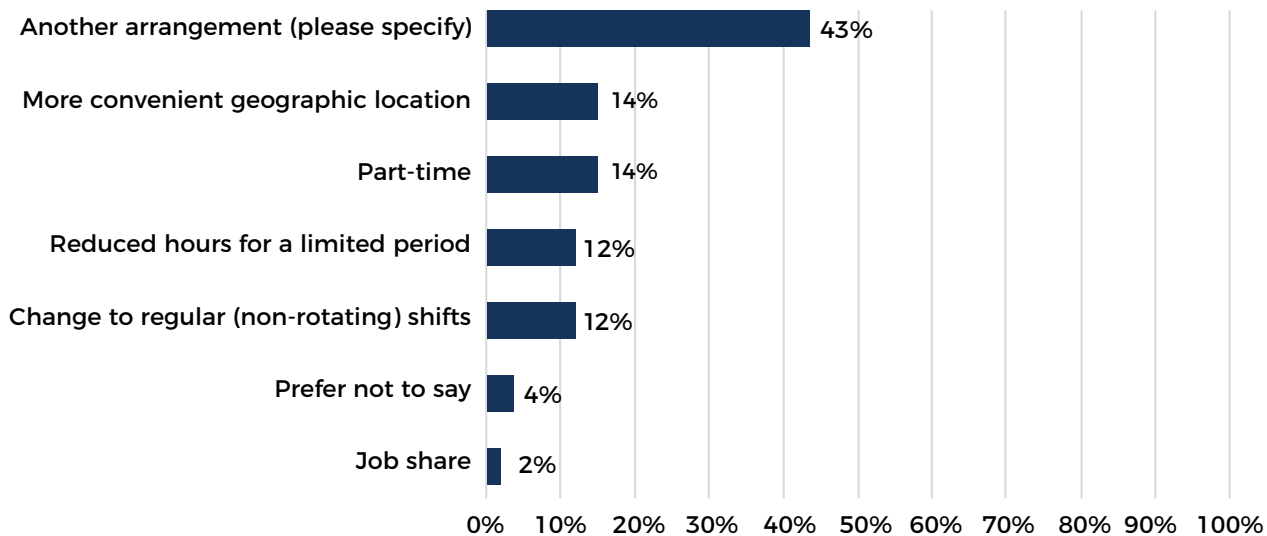
- Q1. I was able to take time off for relevant appointments*
- Q2. I was able to make leave arrangements to enable important caring duties*
- Q3. I was able to continue my career development while undertaking my caring duties*
- Q4. I found it easy to discuss my caring duties with my work colleagues*

Change of contract requests

The following section details whether respondents had requested a change of contracted work, the motivation for the request, and the outcomes.

Almost a third of respondents (27%) from both Aotearoa New Zealand and Australia reported requesting a change to their contracted work in the past 12 months. Reasons given for requested changes to contracted work arrangements are shown in Figure 13. The most frequently selected reason was 'another arrangement' other than those listed (43%), and respondents were provided a free-text option to elaborate.

Figure 13: Reasons for requesting a change to contracted work (combined sample n=543)



Fifty-nine written entries were received. Of these, 28 had moved between full-time, part-time and casual, or made other changes to their roster. For example, '*compressed working week*', '*move from full time to casual*' and '*changed start and finish times*'. Another 19 had made a request to change their contract for health, wellbeing and family, with examples including: '*reduced night shifts to reduce migraines and increase likelihood of fertility goals*', '*burnout – change of location*'; and '*needed the flexibility to get away from rural location to be able to see family & friends*'. Twelve respondents shared that they were changing hours to take on new opportunities including: '*split job role including control room work and patient facing*', '*overseas move for NGO work*' and '*split my time between ambulance and primary health care*'.

Non-standard leave provisions

Table 9 details the utilisation of non-standard leave by the Aotearoa New Zealand and Australian paramedicine workforce taken in the last 12 months. Non-standard leave is defined as leave other than annual leave or short-term sick leave (less than 10 consecutive days).

Carers leave was notably more common among Australian respondents (37%) than those in Aotearoa New Zealand (13%), while leave without pay was more prevalent in Aotearoa New Zealand (21%) than Australia (12%). Other leave categories were broadly comparable across both countries.

Table 9: Types of leave taken in the last 12 months

	Aotearoa New Zealand (61)	Australia (345)
Carers leave	13%	37%
Parental/adoption leave	8%	6%
Long service	15%	17%
Workers' compensation leave (Australia)	2%	17%
ACC leave (Aotearoa New Zealand)	28%	0%
Leave without pay	21%	12%
Prefer not to say	2%	2%
Other leave	11%	8%

If respondents did not feel that their type of leave was represented in the provided multiple choice options, they were able to enter written text. Overall, 33 entries were made with the most common being study leave (n=10) and annual leave (n=7). Three respondents took annual leave to study, suggesting availability of study leave differs among employers. Other leave types mentioned included bereavement leave (n=5), defence force leave, and special leave to care for a dying relative.

Leave beyond 10 days

In the previous 12 months, 14% of Australian and 12% of Aotearoa New Zealand clinical paramedics reported taking extended sick leave (more than 10 consecutive days).

It is perhaps unsurprising that those working in healthcare roles, and in close proximity to communicable diseases (despite protective equipment), could experience a need for extended sick leave. Notwithstanding, prolonged absences among 12–14% of the clinical workforce can create operational and capacity challenges, particularly in regional and/or remote areas. An ongoing focus on enhancing the mental and physical health and wellbeing of the workforce is strongly encouraged as a mechanism to reduce extended sick leave.

Table 10: Percentage of respondents who took extended sick leave (more than 10 consecutive days)

	Aotearoa New Zealand (n = 120)	Australia (n = 503)
Clinical paramedics	12%	14%

Career as a paramedic

By capturing paramedics’ career aspirations and intentions, we gain insights to help design strategies that build a sustainable workforce.

Career intentions

Table 11 details how long respondents wanted to remain with their current paramedicine employer.

Respondents’ career intentions reveal a concerning trend for workforce sustainability across both countries. In both Aotearoa New Zealand and Australia, 38% of clinical paramedics intend to remain with their employer for only 0–4 years. In Australia, nearly half of those in management positions report similar short-term intentions. While various factors may contribute to this limited tenure, the potential departure of a substantial portion of clinical and managerial staff poses a serious risk to operational continuity. A significant loss of personnel over a four-year period would place additional strain on those who remain, not only for day-to-day operations but also the responsibility of training new staff.

There is an urgent need to better understand the motivations driving these intentions, as high staff turnover can negatively impact quality and reliability of paramedic service delivery.

Specific retention-related research is recommended to provide a more comprehensive understanding of paramedics’ motivations. Gaining deeper insight into the factors influencing paramedics’ career intentions is critical to safeguarding the quality and reliability of service delivery.

Career planning

Paramedics currently working in clinical roles were asked the likelihood of them leaving clinical work. Most paramedics were planning on continuing with their clinical roles, but 9% of Aotearoa New Zealand and 16% of Australian respondents were very likely or somewhat likely to move out of their clinical role in the next 12 months.

Table 11: Career intentions

Aotearoa New Zealand	Clinical (90)	Non-Clinical*	Australia	Clinical (370)	Research*	Education (25)	Management (37)
0-4	38%	50%	0-4	38%	0%	44%	46%
5-9	33%	42%	5-9	24%	50%	20%	24%
10-14	17%	0%	10-14	16%	0%	20%	24%
15-19	2%	0%	15-19	8%	0%	0%	3%
20-24	7%	0%	20-24	8%	0%	16%	0%
25-29	1%	1%	25-29	4%	0%	0%	0%
30+	2%	0%	30+	3%	50%	0%	3%

Research, education and management responses for Aotearoa New Zealand have been combined into non-clinical due to small response rate

* Categories with <20 respondents

Career planning – an advanced role

To investigate career aspirations and planning, paramedics were asked the likelihood that they would apply for an advanced role during the next 12 months. These roles covered the four areas of clinical, management, education and research and could be with their current employer or another organisation.

Figure 14 shows that across both countries, the role most likely to be applied for was clinical; the least likely was management (Aotearoa New Zealand) and research (Australia). This may reflect perceptions of availability of these roles, or the qualifications required to undertake them.

Considering the responses to career intentions (Table 11), these findings present another opportunity for exploration to provide respondents with feasible career pathways. Notably, advanced clinical roles are playing an important role in increasing the visibility of paramedicine to the broader healthcare workforce. Education and research roles are at the forefront of developing the future paramedicine workforce, so lack of planning toward these roles is concerning.

Career planning – further education

A similar question was posed to respondents in relation to the likelihood of their engagement with further education, beyond the mandatory hours of continued professional development (CPD) (Figure 15).

Paramedics in both countries were most likely to engage in informal education that might include optional in-house training or external study. Respondents in Aotearoa New Zealand also had a higher likelihood of undertaking formal coursework education in paramedicine provided by a Recognised Training Organisation or university, compared to Australia.

Although undertaking formal education in a discipline other than paramedicine was much less likely than paramedic study, a notable proportion of respondents still indicated they were very likely to engage in this in the next 12 months. This study may be to complement the paramedic role, or for personal interest, but it may also signal a desire to retrain to move to another profession.

Figure 14: Likelihood of applying for an advanced role – Aotearoa New Zealand (n=105); Australia (n=431)

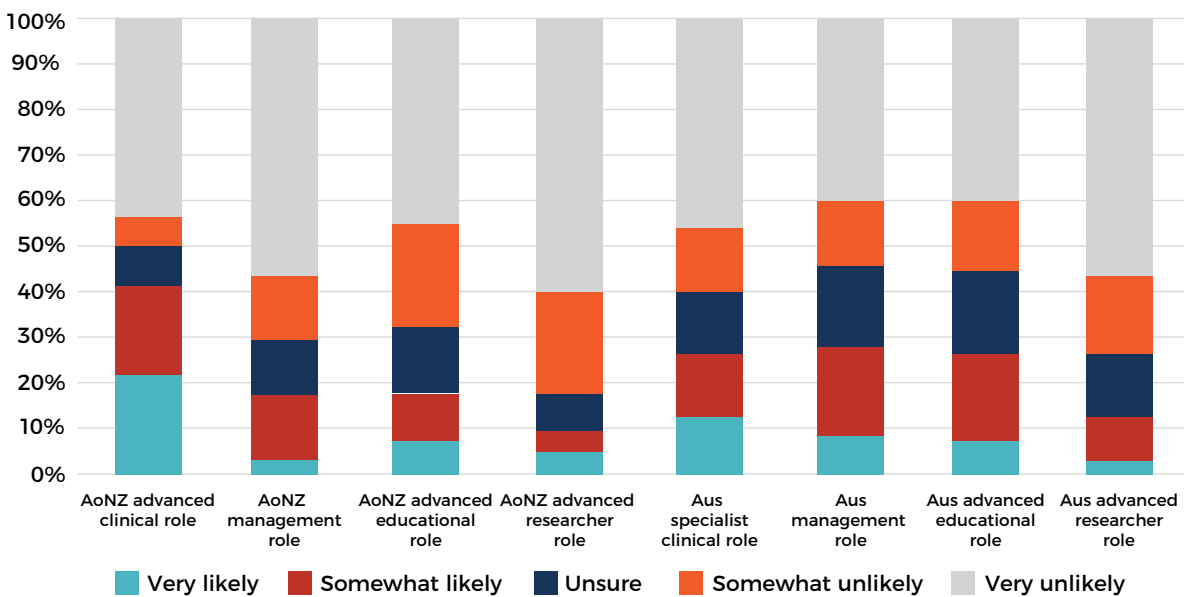


Figure 15: Likelihood of engaging in further education in Aotearoa New Zealand (n=184) and Australia (n=668)

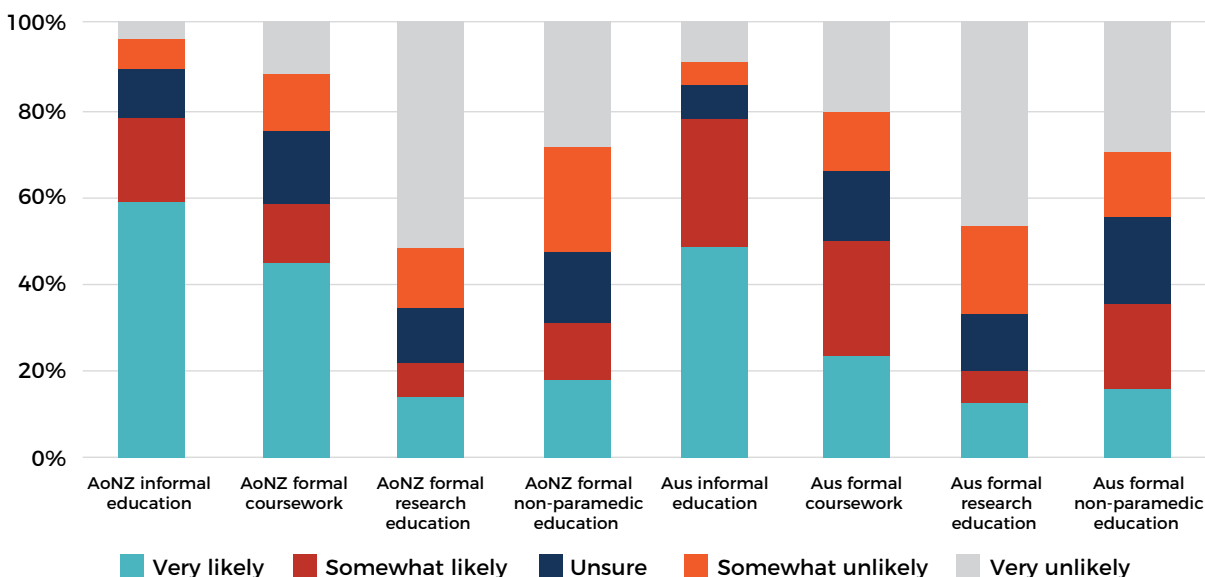
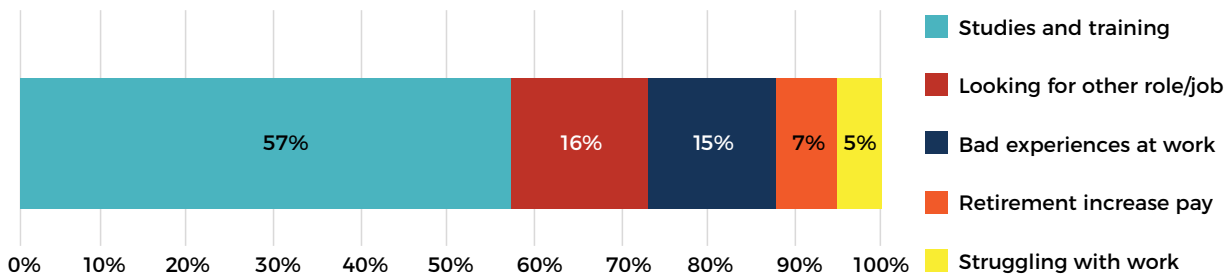


Figure 16: Future intention themes (analysis from 323 free text entries)



When asked to provide further information on their responses to the previous questions regarding their future intentions, 323 written answers were entered. These were subject to content analysis resulting in five overarching themes. These are presented in Figure 16:

Most responses related to individuals undertaking studies or additional training. Many respondents were enrolled in undergraduate or postgraduate studies, while others were considering commencing further studies. Sixteen percent indicated that they were interested in changing their role or job, including outside of paramedicine. For some, the demands of paramedicine informed these considerations.

“Passively seeking career progression options that include remaining in clinical paramedicine, or changing career pathways should I not find a way to increase my longevity in the paramedicine career.”

“Seeking study that would lead to alternative roles within paramedicine, so as not to have to continue working night shifts. 20 years of night shifts is enough and damaging to your health.”

Of the responses, 15% related to negative and challenging experiences at work, lack of trust in management, and trauma experiences in the line of duty.

Seven percent of the sample was working towards retirement, while 5% indicated that they were struggling with the demands of the job, and did not have any intentions beyond that.

“I'm burnt out and have had enough of paramedicine. It's a thankless job that causes a lot of damage both mentally and physically. Registration has not changed the options for paramedics to move into less frontline roles or ED, walk in centres. The options are the same as they always have been and I don't want to be on road anymore.”

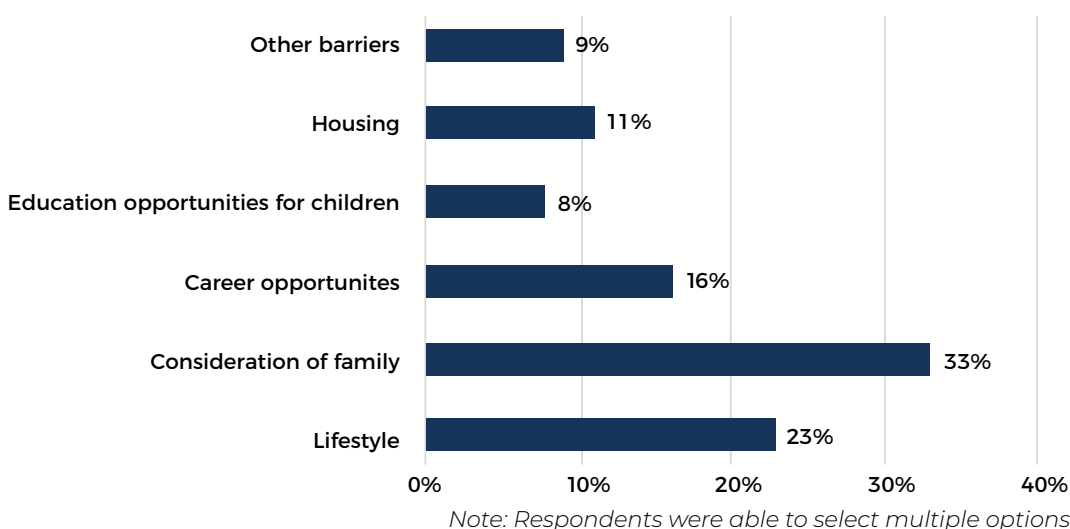
Career planning – location

Respondents were asked whether they would consider working in a rural or remote location. For rural work, 20% of Aotearoa New Zealand and 37% Australian paramedics indicated this was very or somewhat likely.

With regard to remote work, Aotearoa New Zealand and Australian paramedics indicated they were very or somewhat likely to make this decision at 26% and 28% respectively.

Ninety-nine respondents provided detail of why they would not consider working rural or remote, (Figure 17). This included 16 written text responses that detailed having previously worked remote and rural and not wanting to return; age; caregiver responsibilities; other employment; small towns; extended periods of driving; and demands of rural work.

Figure 17: Reasons for not considering working rural or remote (combined sample, n=99)



Professional development, education, supervision and training

A deep dive into the continued learning that empowers paramedics to evolve their capabilities and adapt to the changing demands of their profession.

Highest paramedicine qualification and country where degree was obtained

Respondents were asked their highest level of qualification achieved. The paramedicine workforce is highly trained with more than 80% possessing a bachelor's degree or higher, and more than 30% in Aotearoa New Zealand and Australia possessing a postgraduate degree (Table 12). This places the workforce well above the national population in terms of qualifications achieved.^{26, 27}

Most Australians obtained their degree in Australia (96%), with a small proportion from the UK (3%) and Aotearoa New Zealand (1%). In Aotearoa New Zealand, 88% received their degree locally with the remaining having studied in Australia (7%), the UK (4%) and the United States of America (1%).

Continuing professional development (CPD) activities

Participants were asked about their engagement with continuing professional development (CPD) activities to gain insights into ongoing learning across the workforce. The preferred types of CPD activities used to meet mandatory requirements are outlined in Table 13.

Paramedics prefer small/shorter and/or work-based education, likely due to accessibility and time availability. More formal learning, such as online courses or university degrees, was not as desirable.

Other CPD activities described in free text (n=14) included tertiary studies, self-directed learning, informal training with peers, peer review of scientific articles, mentoring, simulation training, and time spent in other clinical settings e.g. Emergency Department.

Table 12: Highest degree awarded

	Aotearoa New Zealand (106)	Australia (455)
No formal qualification	2%	0%
Certificate II/III/IV	8%	1%
Diploma	9%	18%
Bachelor's Degree	37%	48%
Graduate Certificate	9%	10%
Graduate Diploma	22%	12%
Master's (coursework/research)	13%	9%
PhD	0%	2%

Table 13: CPD activities normally undertaken as part of mandatory annual commitment (n=587 combined sample)

CPD activities normally undertaken	Rank preference
Participation in face-to-face or online conferences, seminars, workshops or employer-organised training	1st preference
Work-based learning or in-service education	2nd preference
Podcasts or other social media-based educational activities	3rd preference
Online course or short course	4th preference
Reading and reflecting on scientific journal articles or participation in a journal club	5th preference
Tertiary Degree	6th preference
Involvement in a research study as a participant	7th preference
Other	Least preferred

Barriers to CPD

Common barriers to accessing continuing professional development (CPD) reflect international trends²⁸ and are summarised in Table 14. Respondents from Aotearoa New Zealand were generally more positive about CPD access than their Australian counterparts.

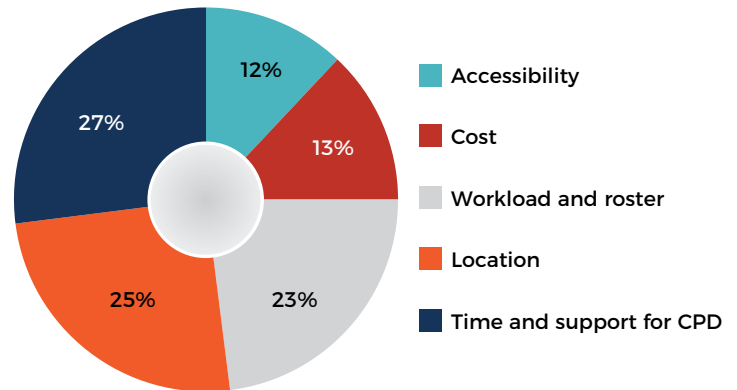
Cost was a more prominent concern in Australia, where 60% of respondents agreed that CPD opportunities were too expensive, compared with 46% in Aotearoa New Zealand.

Respondents could also provide a written answer (n=86) which underwent qualitative content analysis, resulting in five overarching themes as shown in Figure 18.

The primary barrier related to 'time and support' for CPD was a lack of support from employers.

“Poor culture of further education within ambulance sector compared to the clinic I work within. [Ambulance Service] poorly supports its staff to complete further education – no financial support for course fees, no study leave allocation – instead requiring AL [Annual Leave] to be used.”

Figure 18: Qualitative content analysis of free text responses to barriers to CPD (analysis from 86 free text responses)



Location of the professional development opportunities was a barrier for 25% of respondents, noting that they had to travel interstate or long distances to access development opportunities. One respondent specifically shared: 'face-to-face opportunities not available in regional areas'. Workload was a barrier for 23% indicating that their workload, in addition to any domestic responsibilities, did not leave time to undertake CPD.

Other barriers related to cost of the courses, the lack of financial support from employers, and the accessibility of development opportunities.

Table 14: Barriers to CPD activities – Aotearoa New Zealand (n=101) and Australia (n=479)

	Aotearoa New Zealand (101)				Australia (479)			
	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
There is a lack of time to complete CPD	35%	37%	19%	10%	19%	36%	24%	21%
I have few CPD opportunities available to me	37%	38%	21%	5%	22%	43%	25%	10%
The CPD opportunities are too expensive	20%	34%	35%	11%	9%	30%	41%	19%

Enablers of CPD

Paramedics were asked what, if any, enablers they experienced when completing their CPD, as detailed in Table 15. Collegial support, organisational support, and professional membership were all identified as key enablers.

Respondents in both countries reported strong levels of collegial support (Aotearoa New Zealand 88%, Australia 86%). Perceived employer support was lower in both countries (73% and 68% respectively), suggesting room for improvement in organisational support structures. Respondents in both countries valued professional membership for enabling CPD. Agreement was stronger in Australia (86%) than in Aotearoa New Zealand (68%).

Additional written responses (n=21) noted organisational enablers (n=10), such as paid study leave, rostered time for CPD activities, in-house free training, and management support. Six respondents indicated that there were no enablers to CPD for them, while five respondents identified their own motivation and interest as enablers of CPD activities.

Table 15: Enablers to CPD activities – Aotearoa New Zealand and Australia

	Aotearoa New Zealand (101)				Australia (479)			
	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
Colleagues are supportive of me completing CPD	2%	10%	53%	35%	3%	11%	61%	25%
My employer/manager is supportive of me completing CPD	7%	21%	42%	31%	10%	22%	49%	19%
I have professional memberships which support my completion of CPD	10%	23%	34%	34%	3%	12%	54%	32%

Employment and work demands

This section provides a detailed look at employment patterns and the intensity of paramedic work, offering valuable insights into the operational demands, workload pressures, and the broader implications for workforce sustainability and wellbeing.

Paramedics were able to provide information about up to three employers. Nearly 25% of paramedics in Aotearoa New Zealand and Australia advised that they had multiple employers and details of this group can be found in the Chapter “Snapshot: paramedics with multiple employers”. This section relates to the information that all respondents provided on their primary and, in some cases, only, employer (unless otherwise stated).

Annual income from primary employer

Paramedics were asked to report their annual gross (pre-tax) income from their primary employer. All responses were provided in local currency (NZD and AUD). Of the sampled Aotearoa New Zealand paramedics, 94% earned more than \$61,000, and 78% earned more than \$91,000, as shown in Figure 19. The average annual pre-tax salary in Aotearoa New Zealand is \$81,484²⁹ indicating that a large proportion of paramedics earn above the national average.

Figure 19: Annual gross income (NZD) from primary employer for Aotearoa New Zealand paramedics (n=104)

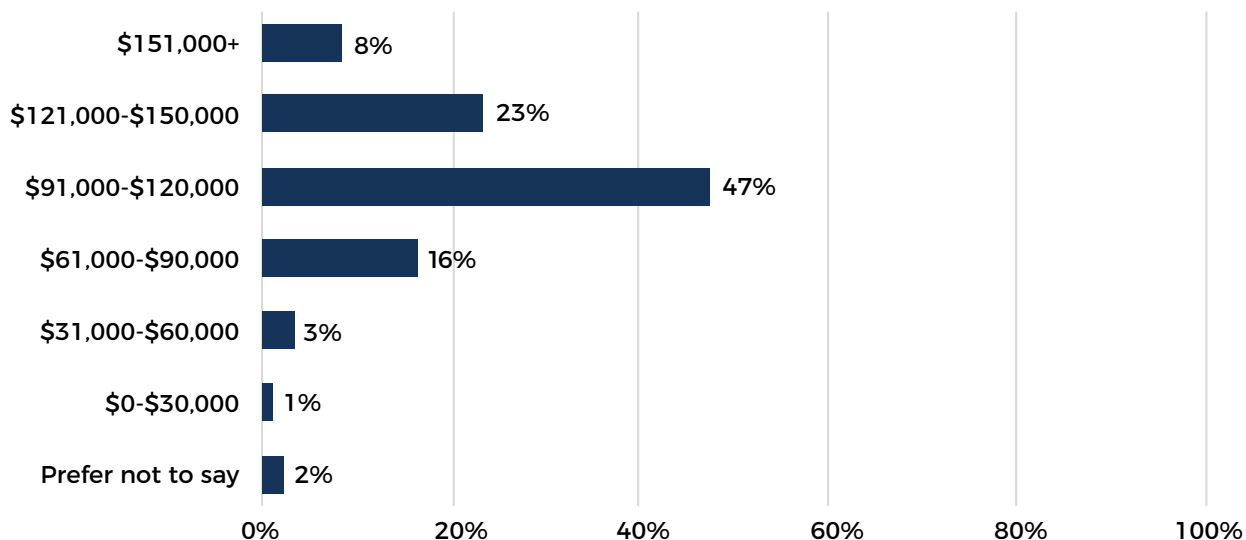
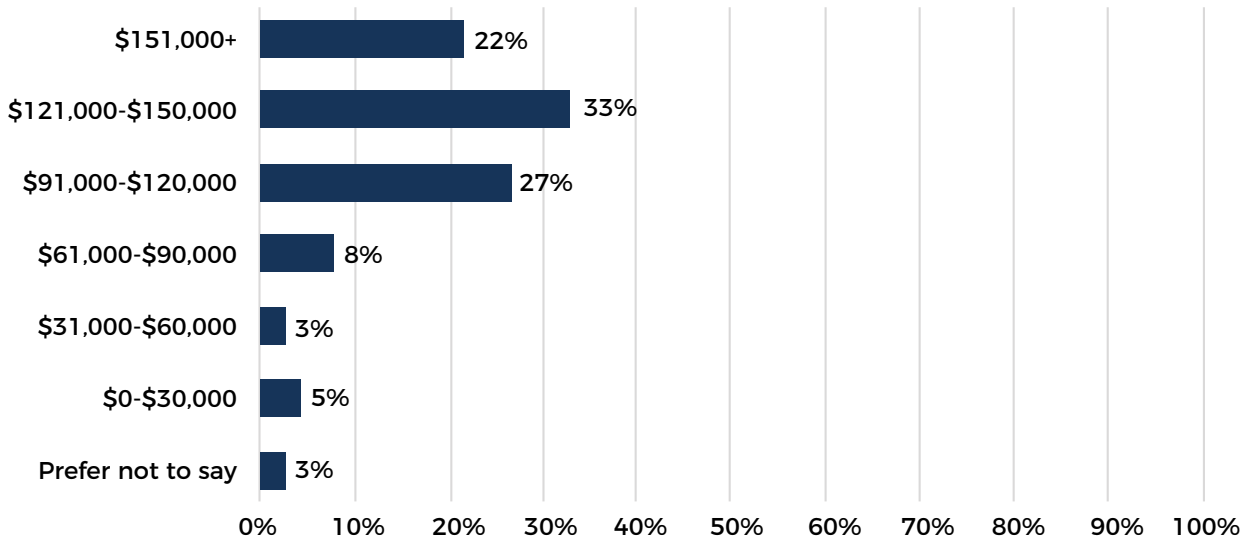


Figure 20: Annual gross income (AUD) from primary employer for Australian paramedics (n=454)

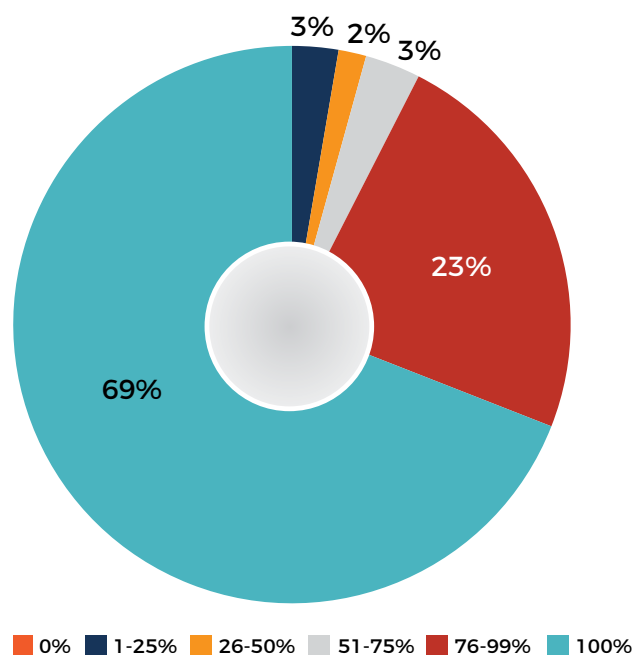


Of the Australian respondents, 82% earned over \$91,000 and 55% earned more than \$121,000, as shown in Figure 20. The average annual pre-tax salary in Australia is \$98,000³⁰ indicating that a large proportion of Australian paramedics also earn above the national average.

Percentage of income from primary paramedicine employer

As 32% of respondents worked for more than one employer, they were subsequently asked what proportion of their income came from their primary employer (Figure 21). Paramedics with only one employer selected 100%. Overall, 69% of paramedics surveyed indicated that their entire income was derived from their primary employer.

Figure 21: Percentage of income derived from respondents' primary paramedicine employer (n=559)



Primary work setting

A list of primary work settings was created, in line with information collected from the Australian Bureau of Statistics, paramedicine, and health surveys. Respondents selected their primary work setting from this list (Table 16) or chose 'Other' to provide a free-text response.

Jurisdictional ambulance services were the primary employers for the majority of paramedics in both Aotearoa New Zealand and Australia. Individuals who selected 'Other' were asked to specify the setting (n=11). These included school, community health, air ambulance, and public transport paramedic.

Table 16: Work settings for primary employer by country

	Aotearoa New Zealand (106)	Australia (455)
Jurisdictional (state/territory) ambulance service	71%	77%
Rescue service	12%	1%
Tertiary educational facility/research institute	2%	4%
Defence force	0%	0%
Events	0%	3%
Hospital	2%	1%
Mining/industrial/offshore	1%	10%
Non-emergency patient transport	0%	1%
Other government agency	0%	1%
Primary healthcare, not in an ambulance service	8%	1%
Other (Please specify)	4%	1%

Type of work

To explore the diversity of working arrangements, respondents were asked about their employment type and format. This included whether they worked full-time, part-time, casual or fly-in fly-out (FIFO), as well as their shift patterns and fortnightly hours.

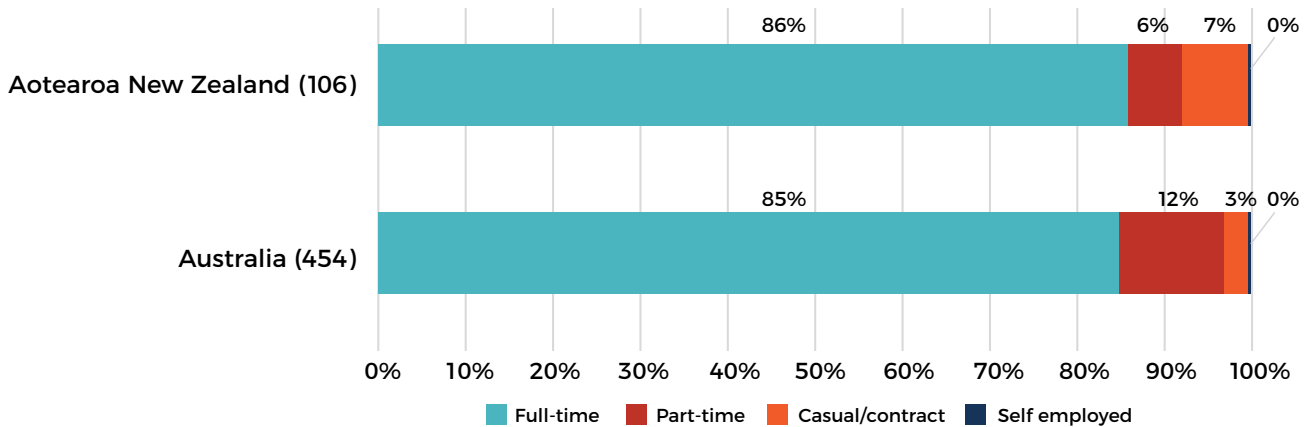
Of the Aotearoa New Zealand sample, 8% worked on a FIFO roster while, among the Australian sample, this was 15%. This is not a surprising finding as Australia has a large mining industry but may also have salary implications.

Contract type

The data presented in Figure 22 represents the contract types of all employers, not just the primary employer. No respondents selected self-employed.

In both countries, most respondents were employed full-time which may be the preferred option, or may indicate a lack of flexible contract opportunities.

Figure 22: Contract type by country (Aotearoa New Zealand n=106; Australia n=454)

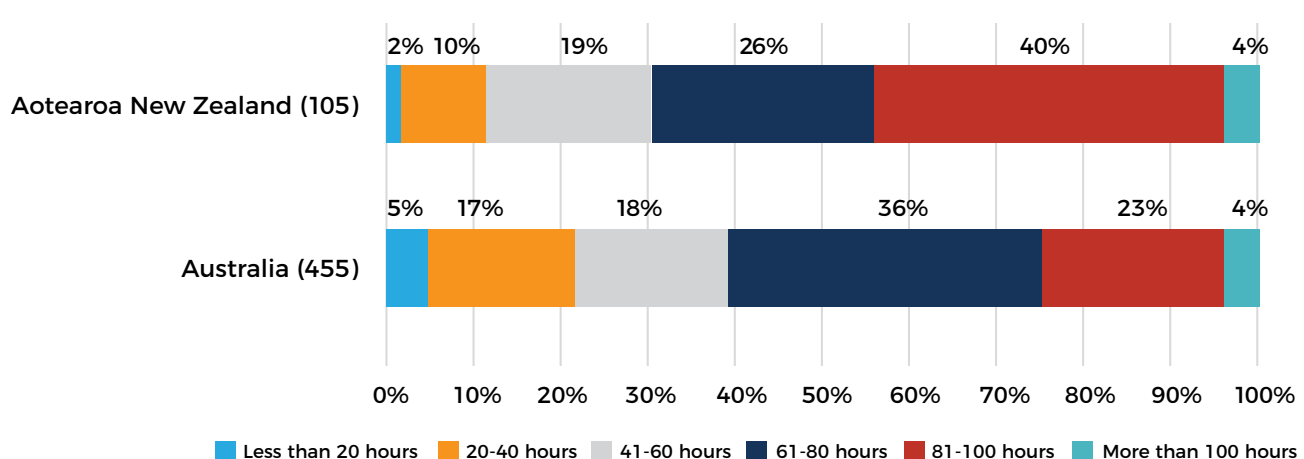


Hours worked per fortnight

Paramedics were asked to estimate the number of hours they worked per fortnight, excluding overtime and on-call hours. The presented data is an aggregate for all employers as the impact of working for one organisation will flow to others.

Figure 23 shows more than half of respondents reported working over 61 hours a fortnight. A difference was noted between countries for respondents working over 81 hours per fortnight, with 44% of the Aotearoa New Zealand sample reporting this higher workload, compared to 25% for the Australian sample.

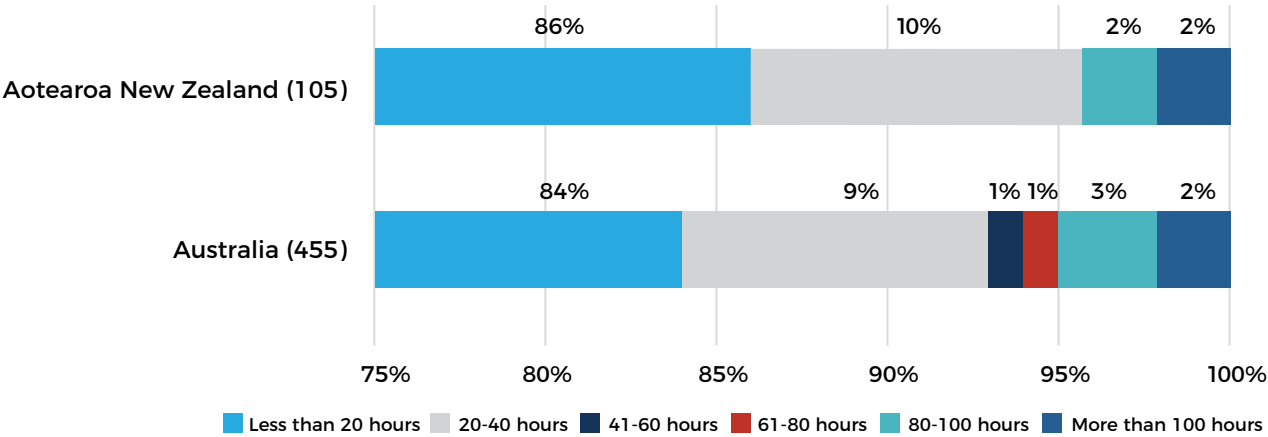
Figure 23: Hours worked per fortnight (Aotearoa New Zealand n=105; Australia n=455)



Hours per fortnight of overtime and on-call work

Most paramedics were working overtime or on call, with similar percentages in Aotearoa New Zealand and Australia (Figure 24). The proportion of incidental overtime, compared to additional shifts, is not available.

Figure 24: Hours of overtime and on-call worked per fortnight for any employer (Aotearoa New Zealand n=105; Australia n=455)



Work schedule/shift pattern

Most paramedics from Aotearoa New Zealand and Australia are working a rotating shift pattern of days and nights across the seven-day week (Table 17). A smaller proportion of respondents in both countries reported working days only, while avoiding night shift.

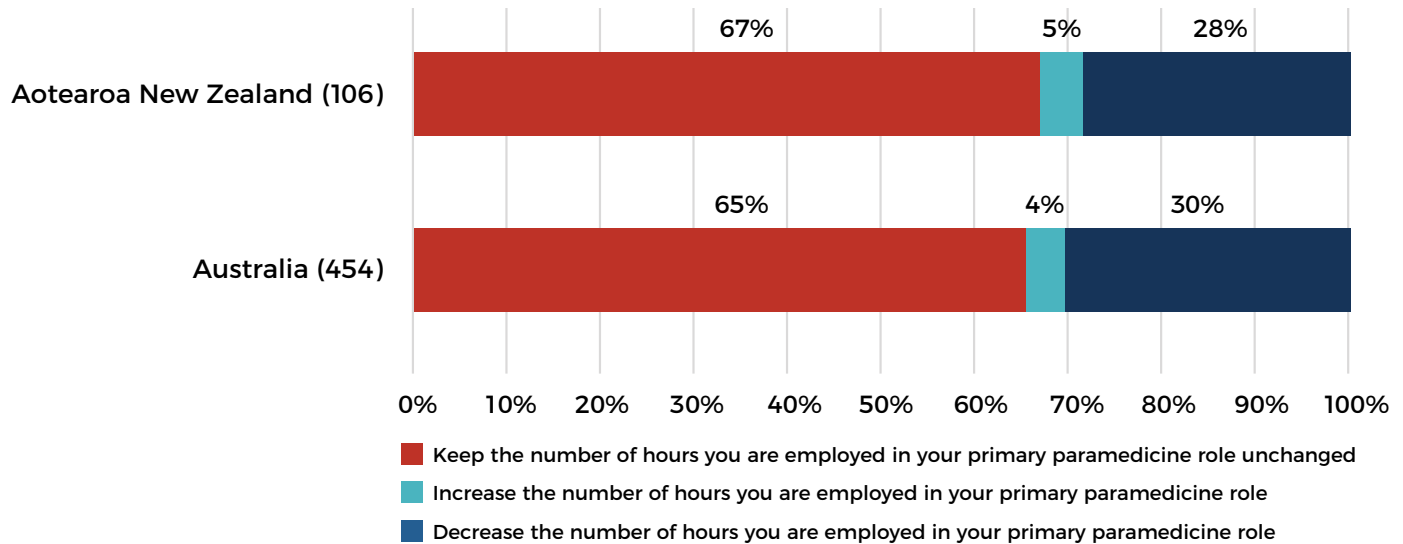
Table 17: Shift patterns

	Aotearoa New Zealand (106)	Australia (454)
Rotating shifts across the 7-day week	61%	62%
Rotating shifts across the 7-day week with on-call	4%	12%
Days and/or afternoons only (weekdays and weekends)	8%	6%
Days only (weekdays only)	19%	12%
Nights only	3%	1%
Split shifts	1%	0%
Ad hoc	4%	8%

Change to work hours

Paramedics were asked whether they were satisfied with the number of hours they worked for their primary employer, or if there was a desire to increase or decrease these hours (Figure 25).

Figure 25: Desire to change or maintain hours with primary paramedicine role



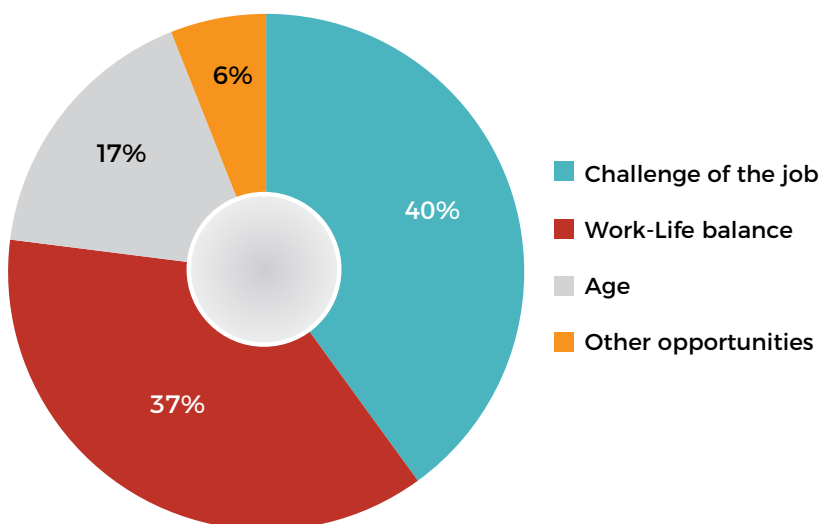
Increased hours

Only 5% of respondents in Aotearoa New Zealand and 4% in Australia wanted to increase their working hours. Among the 23 participants who provided details, three key themes emerged: gaining experience, financial incentives, and contributing to communities, particularly in remote areas.

Decreased hours

Nearly one-third of paramedics in Aotearoa New Zealand and Australia wanted to reduce their working hours. Twenty-three respondents provided their reasons for wanting to work less, which fell under four themes: job challenges, work-life balance, age and other opportunities (Figure 26).

Figure 26: Reason for request for fewer hours from primary employer (combined sample, n=167)



Challenges of contemporary paramedic work were described as:

“ Unjustified overtimes leaves us living at work and being lucky to visit home rather than the other way around. ”

“ Because I only get paid for 38 hours a week but have to work an average of 55 hours a week to get the work done because I am a manager. It is an unwritten rule; they bury their head in the sand and say we should only work our regular hours but acknowledge it is not possible to fulfil the role in 38 hours. ”

“ It is literally killing me. I love my job, and I do it to keep my teams getting what they need. But make no mistake it is taking a big toll on me, and I am already having major health episodes directly related to the stress. ”

The second theme was work-life balance. Respondents indicated:

“ I am at a stage in my life where I would like more of a lifestyle and spend time with my family than slog along at work. ”

“ Better work life balance. Constant shift extensions on rostered shifts - completing large amounts of overtime on every shift. Better balance with night shifts and days off if reducing rotation by a shift. ”

Those of older age and nearing retirement wanted to work fewer hours while a small group were working towards other opportunities. This included studying to work in another industry

“ as a plan to transition out of ambulance eventually ”

and diversification of their role

“ perhaps working 0.5 in frontline ambulance and 0.5 in aeromedical or community service. ”

Job demands

Participants were asked to estimate the proportion of their time spent undertaking different tasks during a typical fortnight for the primary employer.

Table 18 provides a comparison of Aotearoa New Zealand and Australian clinical paramedics and the break-down of their time.

Paramedics in both countries reported spending most of their shift on direct patient care and related activities. Direct patient care (not including transfer waiting time) occupied between a quarter and half of the shift for the largest proportion of paramedics in Aotearoa New Zealand (39%) and Australia (32%). Time spent waiting to transfer patient care to another health

professional accounted for up to a quarter of the shift for over half of Aotearoa New Zealand respondents (61%) and a substantial proportion of Australian respondents (45%). Engagement in research activities was uncommon, with 77% of Aotearoa New Zealand and 80% of Australian respondents indicating no shift time spent on research.

Meal breaks or downtime were more commonly reported in Aotearoa New Zealand, with 67% reporting up to a quarter of the shift spent on breaks, compared to 51% in Australia. Notably, 19% of Aotearoa New Zealand respondents and 43% of Australian respondents reported no time for meals or downtime at all.

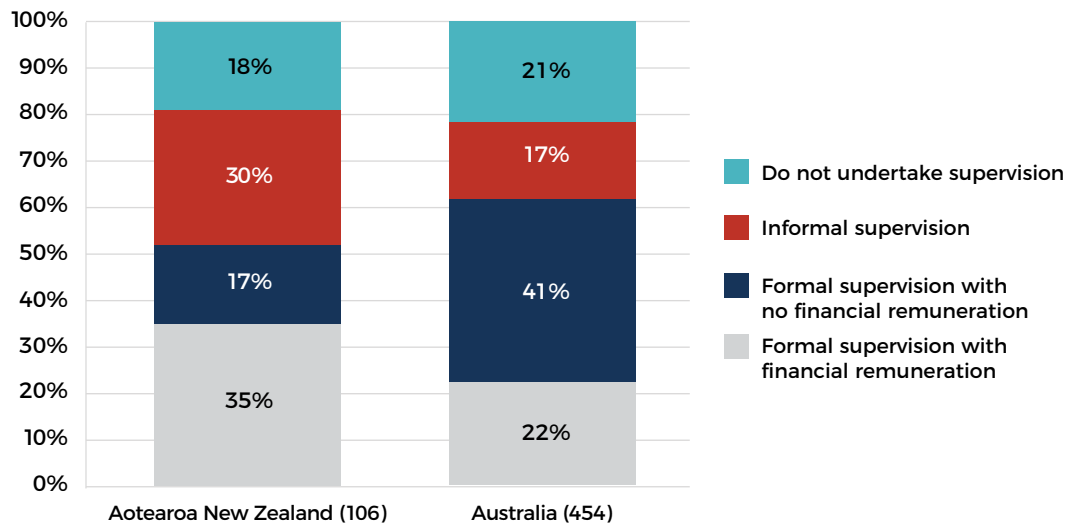
Table 18: Job demands for clinical respondents working for their primary employer (n=562 combined sample)

	Aotearoa New Zealand	Australia	Aotearoa New Zealand	Australia	Aotearoa New Zealand	Australia	Aotearoa New Zealand	Australia	Aotearoa New Zealand	Australia
	No time in shift	No time in shift	Up to a quarter of the shift	Up to a quarter of the shift	Between a quarter and half the shift	Between a quarter and half the shift	Half to three quarters of the shift	Half to three quarters of the shift	Three quarters to all the shift	Three quarters to all the shift
Direct patient care not including waiting to transfer patient care to another health professional	5%	9%	23%	22%	39%	32%	25%	23%	9%	13%
Direct patient care whilst waiting to transfer patient care to another health professional	31%	27%	61%	45%	5%	22%	2%	4%	1%	1%
Indirect patient care (travel to and from patient, paperwork, clinical audits or reviews)	17%	28%	59%	52%	20%	18%	3%	1%	1%	0%
Management and administration (including branch/station duties)	29%	43%	60%	40%	6%	10%	1%	2%	4%	4%
Educational activities (including mentoring/peer support/training)	31%	35%	59%	56%	5%	4%	0%	3%	5%	3%
Research activities	77%	80%	20%	18%	2%	1%	0%	0%	1%	0%
Meals/downtime	19%	43%	67%	51%	12%	4%	2%	1%	0%	0%

Role in clinical supervision

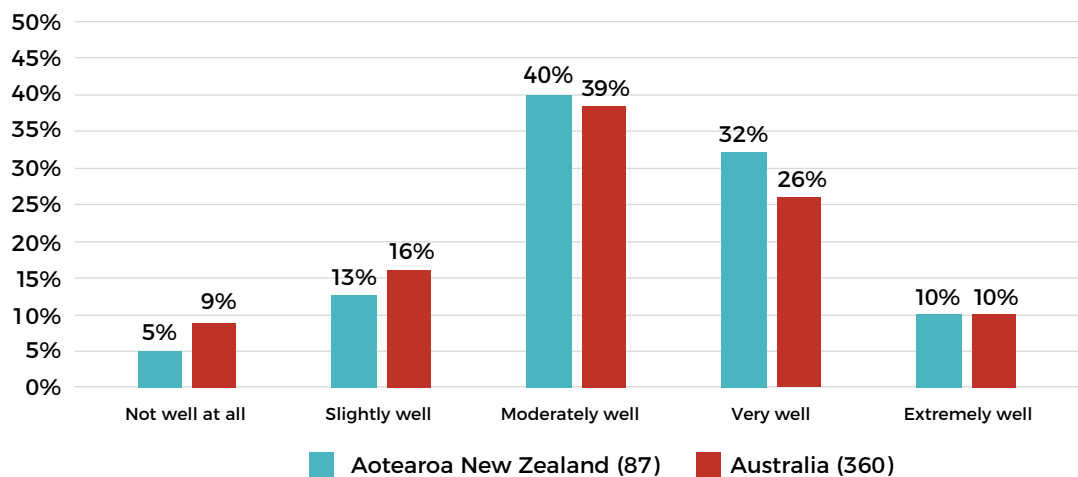
Most paramedics in Aotearoa New Zealand (82%) and Australia (79%) are providing clinical supervision of paramedic students and interns, and this role is formalised in most instances (Figure 27). Aotearoa New Zealand has a larger percentage of clinical supervisors who are undertaking this role in a paid capacity (35%) compared to Australia (22%).

Figure 27: Role in clinical supervision by country



More than 70% of clinical supervisors across both countries felt at least 'moderately well' prepared for their role. However, 18% of Aotearoa New Zealand paramedics and 25% of Australian paramedics felt 'not well at all' or only 'slightly well' prepared (Figure 28).

Figure 28: Preparedness for clinical supervision by country



Wellbeing, resource adequacy and turnover intention

An exploration of wellbeing and organisational support, revealing the factors that influence paramedics' commitment to their roles and organisations.

Wellbeing, resourcing and turnover

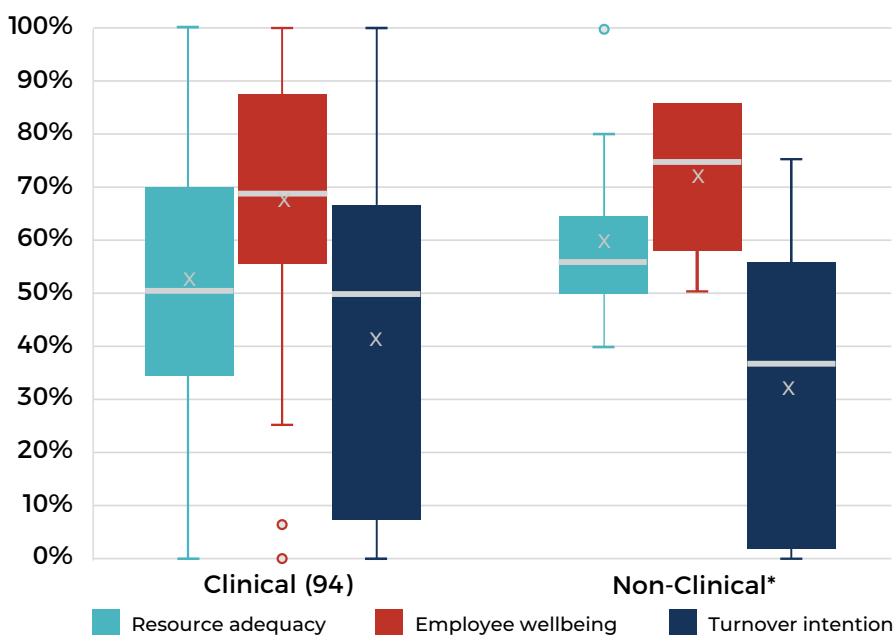
A range of pre-validated workforce psychometric question sets was used to investigate employee wellbeing, perceptions of resourcing, and intentions to leave, and are presented in box and whisker plots (Figures 29 and 30 and Tables 19 and 20). All responses relate to the respondent's primary paramedicine employer.

Perceptions of resource adequacy were broadly consistent across clinical and non-clinical roles in both Aotearoa New Zealand and Australia. Median scores for all groups fell between 40-55%, indicating a generally neutral view (Figures 29 and 30). However, average results indicate perceived under-resourcing around staffing levels across both jurisdictions, particularly among respondents in clinical roles (Tables 19 and 20). Although those in research positions appear more positive, this may be a factor of the low response rate for this cohort.

Employee wellbeing rankings were similar and generally positive across clinical and non-clinical roles for paramedics in

both Aotearoa New Zealand and Australia (Figures 29 and 30). However, high variability in the turnover intention median scores across all sectors in both countries presents a challenge for workforce management and renewal. Aggregate turnover intention scores were high among clinical paramedics. In response to the statement '*I frequently think about leaving this organisation*', clinical respondents from Aotearoa New Zealand and Australia gave mean agreement scores of 52% and 53% respectively, indicating marginal agreement on average (Tables 19 and 20). Respondents in research positions indicated strong average agreement across both countries, suggesting an inclination toward turnover. However, this may reflect the small size of this cohort rather than a broadly representative finding.

Figure 29: Aotearoa New Zealand paramedics grouped by clinical and non-clinical roles – wellbeing, resourcing and turnover intention



Figures 29 and 30 use box-and-whisker plots, with the grey horizontal line showing the median score. A median score of 100% reflects strong agreement, 75% indicates agreement, 50% is neutral, 25% indicates disagreement, and 0% reflects strong disagreement. (See appendix 2)

Figure 30: Australian paramedics grouped by role (education and research combined due to response rate) – wellbeing, resourcing and turnover intention

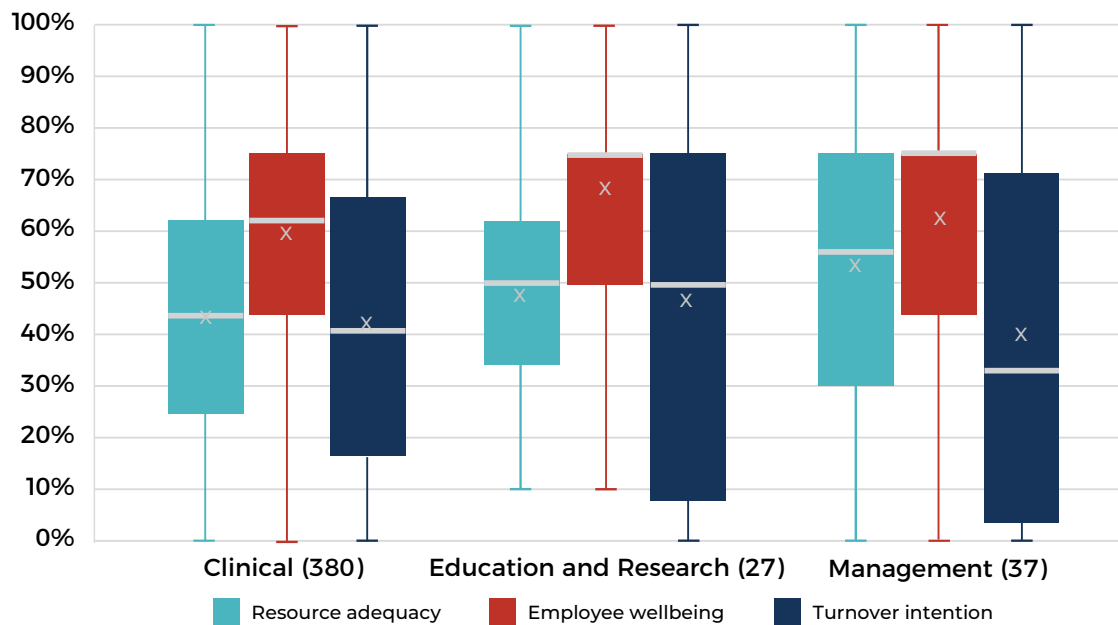


Table 19: Average agreement with wellbeing resource and turnover statements – Aotearoa New Zealand

Aotearoa New Zealand	Clinical (93)	Research*	Education*	Management*
Resource adequacy				
There are enough staff at my organisation to get the work done	40%	-	58%	30%
There are enough trained staff to ensure quality of care	43%	-	58%	55%
There is enough support to allow me to spend sufficient time with patients	67%	-	58%	50%
I have enough time and opportunity to discuss care problems with other medical/emergency staff	62%	-	75%	65%
Employee wellbeing				
Overall, I am reasonably happy with my work life	66%	75%	83%	65%
Most days I feel a sense of accomplishment in what I do at work	66%	75%	83%	65%
I feel content with my work	65%	25%	88%	55%
I get a sense of joy from my work	72%	75%	83%	60%
Turnover intention				
I frequently think about leaving this organisation	52%	50%	21%	50%
It is likely that I will search for a job in another organisation within the next year	47%	25%	21%	50%
It is likely that I will leave my current organisation within the next year	31%	75%	13%	40%

* Categories with <20 respondents

Table 20: Average agreement with wellbeing resource and turnover statements – Australia

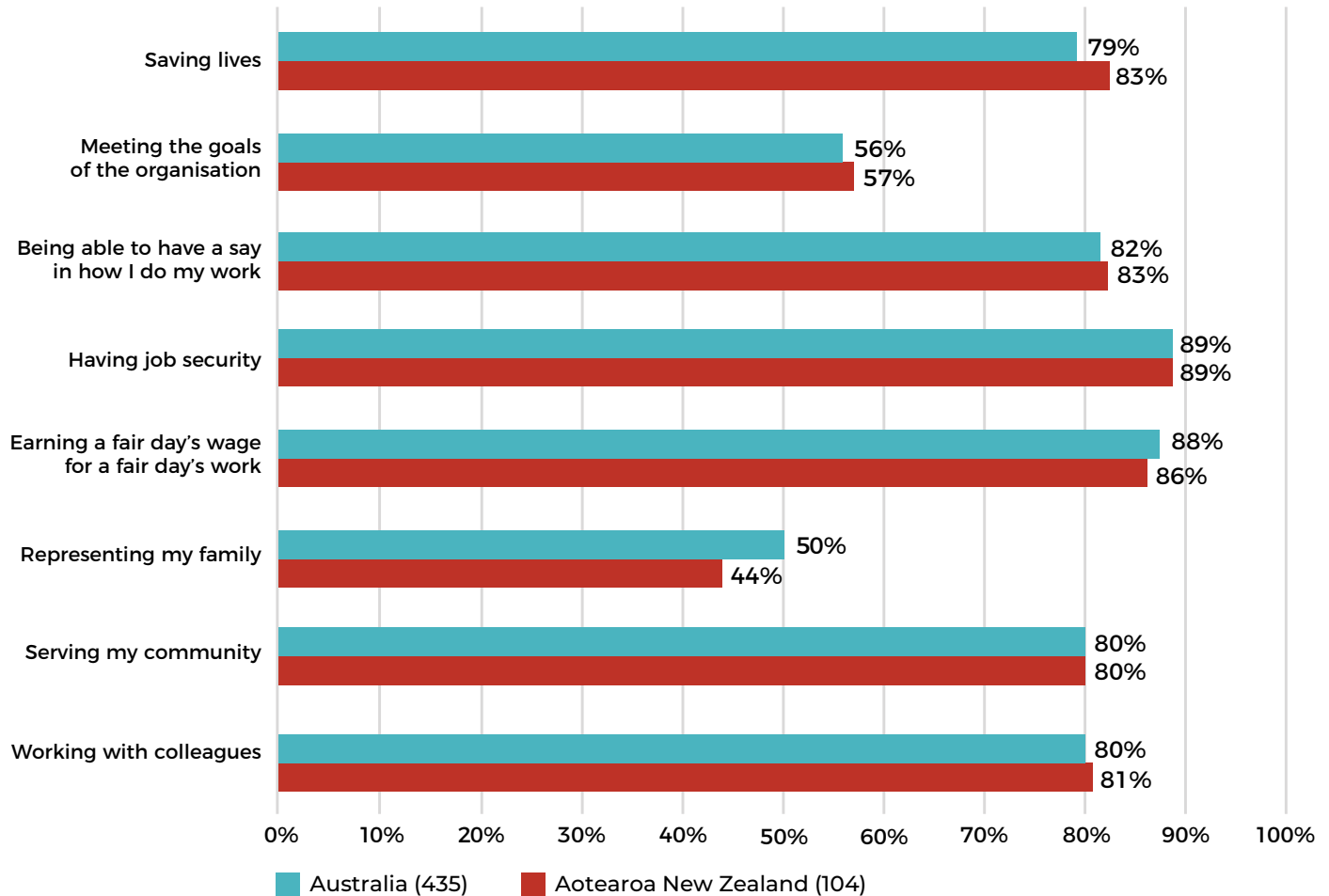
Australia	Clinical (378)	Research*	Education (25)	Management (37)
Resource adequacy				
There are enough staff at my organisation to get the work done	35%	50%	36%	43%
There are enough trained staff to ensure quality of care	36%	88%	43%	48%
There is enough support to allow me to spend sufficient time with patients	50%	75%	44%	56%
I have enough time and opportunity to discuss care problems with other medical/emergency staff	50%	88%	51%	61%
Employee wellbeing				
Overall, I am reasonably happy with my work life	60%	88%	63%	62%
Most days I feel a sense of accomplishment in what I do at work	58%	88%	70%	64%
I feel content with my work	59%	88%	61%	61%
I get a sense of joy from my work	62%	100%	67%	59%
Turnover intention				
I frequently think about leaving this organisation	53%	88%	48%	49%
It is likely that I will search for a job in another organisation within the next year	44%	100%	45%	36%
It is likely that I will leave my current organisation within the next year	33%	88%	36%	32%

* Categories with <20 respondents

Motivations to be a paramedic

Respondents were asked about their motivations to be a paramedic, with motivation levels determined using the average agreement for each item within a pre-validated question set (Figure 31). 'Having job security' was the strongest motivator across Aotearoa New Zealand and Australian respondents, followed by 'earning a fair wage for a fair day's work'. 'Representing my family' received the lowest score across both countries.

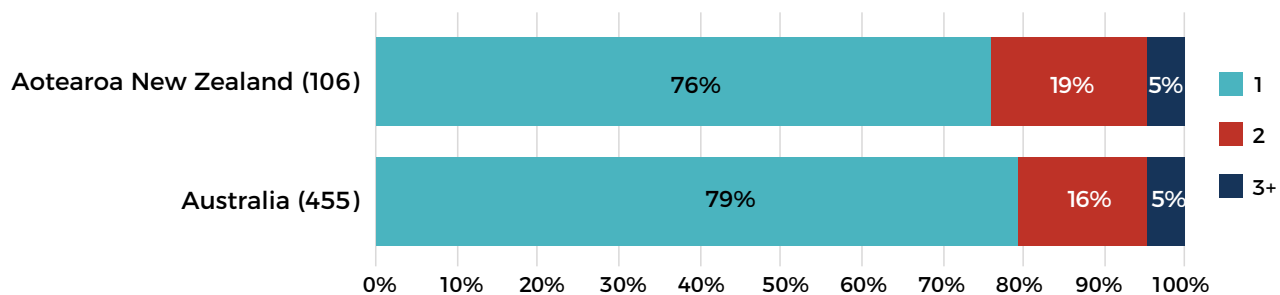
Figure 31: Motivations of respondents to undertake a paramedic role



Snapshot: Paramedics with multiple employers

This section examines the evolving nature of paramedics working across multiple roles and employment arrangements, offering insights into how varied job structures influence career progression and work-life balance.

Figure 32: Number of employers



Number of current employers

Multiple job-holding is not uncommon in both the Aotearoa New Zealand and Australian paramedic workforces, with nearly one quarter of respondents reporting more than one employer. In Aotearoa New Zealand, 19% of respondents reported having two employers, compared with 16% in Australia. Across both countries, 5% were employed by three or more employers (Figure 32).

Exploration of multiple employer respondents

Further exploration of multiple job-holding suggests secondary employment is a regular feature of both clinical and non-clinical roles for both countries (Tables 21 and 22).

Table 21: Proportion of paramedics with multiple jobs – Aotearoa New Zealand

Number of paramedicine employers	Clinical (94)	Non-Clinical*
One	80%	75%
Two	15%	25%
Three or more	5%	0%

Table 22: Proportion of paramedics with multiple jobs – Australia

Number of paramedicine employers	Clinical (389)	Research*	Education (26)	Management (38)
One	79%	50%	27%	76%
Two	16%	0%	62%	24%
Three or more	5%	50%	12%	0%

* Categories with <20 respondents

Exploration of multiple employer respondents

Gender

Similar percentages of male and female clinical paramedics undertook work with more than one employer, 23% for men compared to 22% for women (Table 23).

Age

Those aged over 30-39 years were most likely to have multiple jobs, with 31% reporting more than one employer (Table 24).

Table 23: Comparison of gender to multiple employers (combined sample)

Number of paramedicine employers	Male (316)	Female (197)	Non-binary*	Prefer not to say*	Other*
One	78%	78%	50%	73%	0%
Two	18%	18%	0%	18%	100%
Three or more	5%	4%	50%	9%	0%

Table 24: Comparison of age to multiple employers (combined sample)

Number of paramedicine employers	20-29 years (74)	30-39 years (161)	40-49 years (103)	50-59 years (126)	>60 years (60)
One	82%	69%	83%	76%	87%
Two	16%	25%	13%	17%	12%
Three or more	1%	6%	5%	6%	2%

While further analysis is needed to understand the motivations behind multiple job-holding, some possible data-based considerations include:

- A desire to job craft engagement with the profession, mixing clinical paramedicine work with education, research, management and/or other roles to maximise meaningfulness and income, while minimising work demands.
- Multiple employers were proportionally slightly more common for males, and those in the age ranges of 30-39, 40-49, and those over 60 years of age. This suggests that certain career stages may influence when people supplement their (in the main) clinical paramedic work, or other (education or management) paramedic work, with other functions, within and beyond paramedicine.

Income

To consider whether increasing income was a motivation for undertaking employment with multiple employers, those participants with two or more employers were reclassified into one category, and results compared against those with only one employer. As the currencies for Aotearoa New Zealand and Australia are different, the analysis is split by country.

A cross-tabulation of income brackets within the Aotearoa New Zealand and Australian samples are presented in Tables 25 and 26.

Table 25: Comparison of income to multiple employers – Aotearoa New Zealand (n=104)

Aotearoa New Zealand	Prefer not to say	\$0-\$30,000	\$31,000-\$60,000	\$61,000-\$90,000	\$91,000-\$120,000	\$121,000-\$150,000	\$151,000+
One	100%	100%	67%	76%	88%	67%	63%
Two+ employers	0%	0%	33%	24%	12%	33%	38%

Table 26: Comparison of income to multiple employers – Australia (n=454)

Australia	Prefer not to say	\$0-\$30,000	\$31,000-\$60,000	\$61,000-\$90,000	\$91,000-\$120,000	\$121,000-\$150,000	\$151,000+
One	81%	54%	79%	75%	82%	74%	72%
Two+ employers	19%	46%	21%	25%	18%	26%	28%

Hours of work per fortnight (not including overtime)

The data indicated that those with one employer and those with multiple employers worked a similar number of hours per fortnight when working more than 81 hours per fortnight, otherwise the results were variable (Table 27).

Table 27: Comparison of hours worked per fortnight to multiple employers (combined sample)

	40 hours or less per fortnight	41-80 hours per fortnight	81 hours or more per fortnight	Total
One employer (428)	18%	55%	27%	100%
Two+ employers (132)	27%	43%	30%	100%

Snapshot: Student respondents

A forward-looking view into the next generation of paramedics, capturing their expectations and motivations as they prepare to join the healthcare workforce.

The following section details key trends identified in those survey respondents who classified themselves as a student. Of the 209 respondents, 74% were studying their undergraduate degree in Australia, with 26% undertaking study in Aotearoa New Zealand. Data from this group are important to understand the future paramedicine workforce.

Gender and age profile of student respondents

Tables 28 and 29 highlight that the student cohort is, in the majority, female in both countries with a similar age profile in both cohorts. While retirement ages have trended up in both countries in recent decades, workforce longevity may be a consideration for future recruitment initiatives at the sector level.

Table 28: Gender profile of paramedicine students

	Aotearoa New Zealand (49)	Australia (138)
Male	31%	27%
Female	67%	67%
Non-binary	2%	4%
Prefer not to say	0%	1%
Other	0%	1%

Table 29: Age profile of paramedicine students

	Aotearoa New Zealand (47)	Australia (138)
<20 years	0%	0%
20-29 years	72%	61%
30-39 years	11%	21%
40-49 years	9%	11%
50-59 years	6%	7%
>60 years	2%	1%

Desired workplace setting post-graduation

Most graduates envisage working in jurisdictional ambulance services following graduation (Table 30), though the proportion is slightly lower for Aotearoa New Zealand students (78% to Australia's 81%). Additionally, there is a higher proportion in Aotearoa New Zealand who indicated a desire to work for 'rescue services' and 'overseas' work (combined 14% to Australia's 5%).

For those who indicated 'other' and provided a free-text response (n=5), their answers related to location, with three naming specific employers. The other two responses were 'mining' and 'community paramedicine'.

Table 30: Desired workplace setting post-graduation

	Aotearoa New Zealand (51)	Australia (147)
Defence force	2%	1%
Events	0%	1%
Hospital	0%	3%
Mining/industrial/offshore	2%	2%
Jurisdictional (state/territory) ambulance service	78%	81%
Rescue service	8%	3%
Primary healthcare, not in an ambulance service	2%	1%
Overseas	6%	2%
Non-emergency patient transport	0%	1%
Unknown	2%	3%
Other	0%	3%

Future career ambitions and aspirations in paramedicine

Although more than half of both the Aotearoa New Zealand and Australian students indicated that they were very or somewhat likely to remain in paramedicine until retirement (Table 31), 29% of Aotearoa New Zealand and 15% of Australian students plan to be in patient-facing roles for fewer than 10 years (Table 32).

“I see myself branching out into working within the broader health system, through health promotion or research for example. Additionally, I think clinical work is only sustainable for a relatively short period of my professional life (5-10 years).”

Table 31: Likelihood of career-until-retirement in paramedicine

	Aotearoa New Zealand (51)	Australia (146)
Very likely	41%	47%
Somewhat likely	35%	30%
Unsure	12%	13%
Somewhat unlikely	4%	7%
Very unlikely	8%	3%

Table 32: Expected years in clinical, patient-facing paramedicine role

	Aotearoa New Zealand (51)	Australia (146)
< 4	4%	1%
5 to 9	25%	14%
10 to 14	27%	27%
15 to 19	14%	15%
20 to 24	12%	12%
25 or more	18%	29%

When respondents were asked why they were unlikely to stay in paramedicine, 18 written responses were submitted. Of these, 14 were specific to the challenges associated with paramedic work, including the high workload, long hours, burnout risk, and fatigue. One comment particularly spoke to some of the challenges:

“It just doesn’t seem to be a workforce in which many survive, and I am aware that may be the case.”

The remaining entries pertained to other career plans.

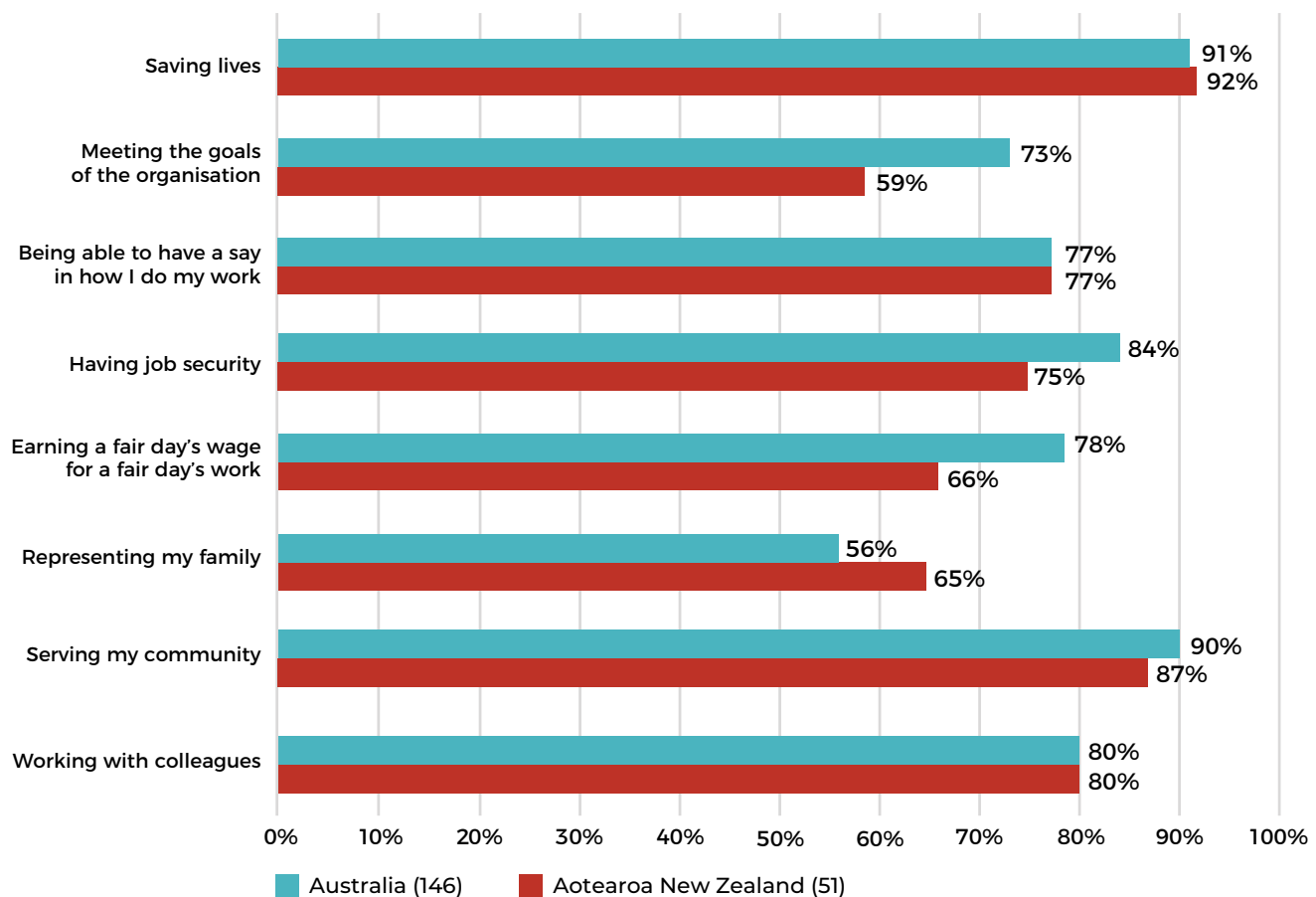
“Working in one field forever doesn’t interest me. A well round [sic] multi skill career where I expand my knowledge and career growth is a great interest. I do get bored of same environments and find change often is a good thing every few of years or so. A cycle of 5 to 10 years.”

Motivations for becoming a paramedic

Figure 33 highlights the average agreement level for each item in the pre-validated question set used to determine motivation toward undertaking the paramedic role. This can be compared to Figure 31 (pg 44) where the same question was asked to current working paramedics.

Student respondents held 'saving lives' as the top priority with 92% and 91% agreement compared to 83% Aotearoa New Zealand and 79% Australia for paramedics. This was followed for students by 'serving my community' which was not ranked as highly by paramedics (80% in both countries). Both paramedics and students rated 'representing my family' and 'meeting the goals of the organisation' as one of the lowest priorities although it was considerably lower rated by paramedics.

Figure 33: Motivations of respondents to undertake the paramedic role (Aotearoa New Zealand n=51; Australia n=146)



Appendix 1: Research Team

Associate Professor Liz Thyer	Chief Investigator – Western Sydney University
Dr Navin Naidoo	Associate Investigator – Western Sydney University
Ms Sascha Baldry	Research Assistant – Western Sydney University
Professor Kingsley Agho	Statistician – Western Sydney University
Dr Graham Howie	Associate Investigator and Site Co-lead – Auckland University of Technology
Mr Stephen Aiello	Associate Investigator – Auckland University of Technology
Mr Norm Wilkinson	Associate Investigator – Auckland University of Technology
Dr Verity Todd	Associate Investigator and Site Co-lead – Auckland University of Technology
Ms Alecka Miles	Associate Investigator and Site lead – Edith Cowan University
Dr Brennan Mills	Associate Investigator – Edith Cowan University
Professor Moira Sim	Associate Investigator – Edith Cowan University
Professor Ben Farr-Wharton	Workforce Strategy – Edith Cowan University
Dr Fleur Sharafizad	Workforce Strategy – Edith Cowan University
Dr Aglae Hernandez Grande	Workforce Strategy – Edith Cowan University

Appendix 2: Methods

Frequency or ‘proportion of the sample’ analysis

This research utilised a cross-sectional survey methodology, using an online purpose-built survey. The project will undertake repeated measures at approximately 12-month intervals for three data collections; these are the third set of data.

The methods were developed, and methodological decisions were made collaboratively by the research team drawing upon their research, professional and local expertise (Appendix 1).

Participants, setting and recruitment

Participants were drawn from both the Aotearoa New Zealand and Australian paramedic populations. Eligible participants were required to meet one of the following criteria: paramedics registered with Australian Health Practitioner Regulation Agency (Ahpra), paramedics registered with Te Kaunihera Manapou | Paramedic Council, individuals working in Australia or Aotearoa New Zealand with a jurisdictional ambulance service in a clinical role but not a registered paramedic (e.g., emergency medical technician), individuals working in Australia or Aotearoa New Zealand with a health service provider in a clinical role or with an education provider but not a registered paramedic (e.g. military medic or mine site medic), or students currently enrolled in a paramedicine degree at an Australasian University. Those who were retired, volunteers, or not currently working in a paramedic role, were excluded.

Recruitment was undertaken electronically via email or through social media between November 2025 and February 2026. Additionally, the Australasian College of Paramedicine, the Paramedicine Board of Australia, Te Kaunihera Manapou | Paramedic Council, and the Australasian Council of Paramedicine Deans all agreed to disseminate through their networks. Posts were made to relevant social media sites/groups that are frequented by paramedics and paramedicine students, and a targeted (paid) campaign was utilised on Facebook. All recruitment directed prospective participants to a link to the online survey.

Survey instrument

The survey was designed by the research team as there was no previous validated tool that suited the research aims. Small, validated questions sets were included in relation to workforce intentions and wellbeing, and guidance for sensitive questions was sought from government and university surveys and

Appendix 2: Methods continued

resources. Throughout the design process, consultation relating to important areas of focus occurred with paramedic industry (private and government) leaders, paramedic unions, and other health professions who had designed and run workforce surveys.

Minor adjustments were made to the tool between collection one and collection two. These primarily related to streamlining data, converting some free text options to a list generated from previous free text responses and allowing participants to choose multiple options for some questions. The changes were in response to participant comments, research team and stakeholder input and variations in responses in the initial data collection. No changes were made to mandatory questions.

The survey uses logic to direct respondents to appropriate questions dependent upon past responses but was designed to gather the greatest amount of data with the least impost. Broadly, question areas included demographics, current role(s) and future aspirations. Students received a slightly amended survey that focussed more on aspirations rather than current employment. A full copy of data points from the survey is provided in Appendix 3.

Data analysis

Data were collected via the online secure survey platform Qualtrics, downloaded, cleaned, analysed in SPSS and presented in Microsoft Excel.

The type of analysis adopted in the Australasian Paramedicine Workforce Report, consistent with quantitative analysis of survey data, utilises two primary kinds of analysis: 1) frequency or 'proportion of sample' analysis, and 2) box and whisker plots. These technical terms are explained below. In addition to these analyses, the survey utilised several open-ended questions where respondents could add extended text. For the most part, text was coded into categories and a count of the number of responses per category was included (quantitative content analysis).

Some categories have fewer than 20 respondents and, in those categories, responses were either combined or presented without the n value to protect respondents' anonymity.

Frequency or 'proportion of the sample' analysis

For the most part, the analysis tallied the number of responses to a particular question and tallied these against the total sample. This kind of analysis is used to show how one, or several factors or conditions, might distribute across a sample.

In the adjacent example, the proportion of clinical paramedics for Aotearoa New Zealand and Australia is displayed. While the percentage of respondents is indicated against each of the age groups, the total number of respondents is identified in the title for this column, for example 164 Aotearoa New Zealand respondents and 538 Australian respondents.

Importantly, for some of the questions in this report, not all respondents answered every question (people who didn't answer more than 40% of the questions asked of them, were not included in analysis – consistent with norms for survey analysis). As such, the number of respondents may vary from item to item.

Aotearoa New Zealand	Age	Clinical (164)
	<20	0%
	20-29	25%
	30-39	29%
	40-49	20%
	50-59	21%
	>60	5%
Australia	Age	Clinical (538)
	<20	0%
	20-29	16%
	30-39	25%
	40-49	22%
	50-59	24%
	>60	12%

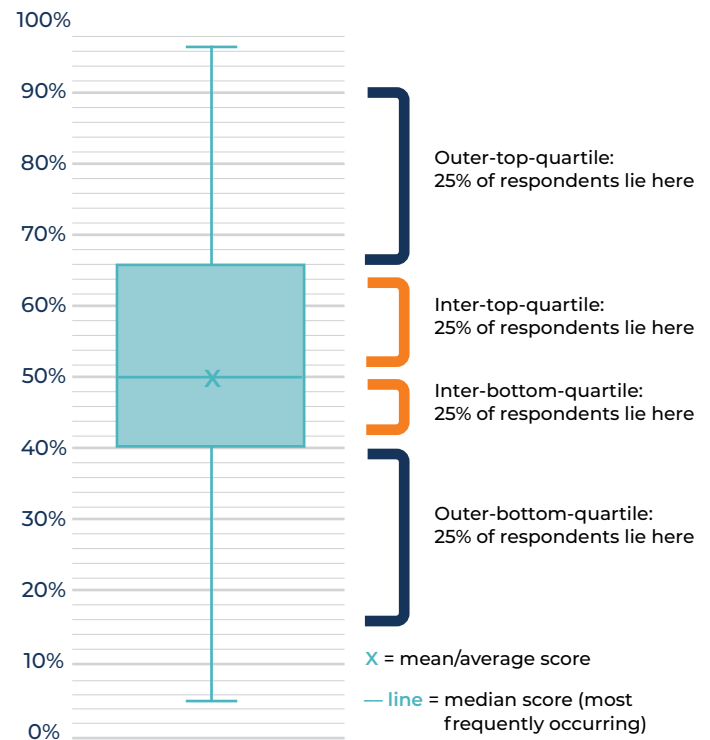
Appendix 2: Methods continued

Box and whisker plots/graphs

Analysis for responses to several questions from the survey utilise 'box and whisker' plots/graphs. Per the adjacent example, the box and whisker graphs are useful for understanding how the sampled respondents scored on each question relative to others. The percentage on the Y axis highlights average level of agreement.

If a person scored 100%, it would mean that they answered 'strongly agree' to all questions that comprise a set of questions, representing a construct (for example, 'intention to leave'). Equally, if a person scored 0%, it would mean that they answered 'strongly disagree' to all questions. 50% is indicative of the 'neither agree nor disagree'/'neutral' scaling point.

The box and whisker plot highlight the distribution of responses across the sample. The 'x' identifies the mean score (the average or sum of all scores divided by the number of respondents). This is a good indication of 'what happens most of the time.' The line represents the median value – this is the middle number in a sorted list of scores. The filled-in box encompassing the mean and median represents the inter-quartile range, where 50% of the sample have answered. The 'whiskers' (the stems protruding from the inter-quartile filled box) represent the outer values (roughly, where 25% of the lowest and 25% highest responses fell). Any dots appearing outside of the box and whiskers represent outliers, who had substantially different values to the rest of the sample.



Role classification

Some responses are presented with a breakdown of role type: clinical, research, education, or management. One of the early questions in the survey asked respondents which of the four roles best described their position with their primary employer. It is this response that is used to classify respondents in relation to later data where appropriate.

Terminology

Aotearoa New Zealand – both the Māori and English terms are used throughout the text.

LGBTQIA+ – Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, plus is an evolving acronym according to the Australian Institute of Family Studies and may change depending on the audience.

Appendix 3: List of data points

Demographic

- Gender (Man, Woman, Non-Binary, Prefer not to say, Other)
- Age
- Ethnicity
- Language(s) spoken
- Experience living in peri-urban, rural, or remote areas
- NZ or Australian-based
- Born in NZ, if NZ-based / Born in Australia, if Australia-based
- Parent or guardian to a child < 16 years
- Caring responsibilities for an adult
- Sexual orientation

Education and Training

- Highest paramedicine qualification
- Country of education
- Role in clinical supervision of students or trainees
- Level of preparedness
- Normal continuing professional development (CPD) activities in a year:
 - o Conferences, seminars or workshops
 - o Reading and reflecting on scientific journal articles or participation in a journal club
 - o Work-based learning or in-service education
 - o Degree, short course or online courses
 - o Involvement in a research study as a participant
 - o Other [Please specify]
- Barriers to CPD:
 - o There is a lack of time to complete CPD
 - o I have few CPD opportunities available to me
 - o The CPD opportunities are too expensive
 - o There are no barriers
 - o Other barriers [Please specify]
- Enablers of CPD:
 - o Colleagues or manager are supportive of me completing CPD
 - o My employer is supportive of me completing CPD
 - o I have professional memberships which support my completion of CPD
 - o There are no enablers

Professional membership:

- Yes - Australasian College of Paramedicine
- Yes - Australian College of Nursing
- Yes - New Zealand Nurses Organisation
- Other [Please specify]

Appendix 3: List of data points continued

Knowledge of the Australasian College of Paramedicine

- Are you aware of the role of the College and the services they provide
- How likely are you to join the College in the coming 12 months?
- Rank of the functions you would want a health professional association to undertake:
 - o Advocacy and leadership for the profession
 - o Education and professional development
 - o Access to the latest research
 - o Career and professional services
 - o Health and wellbeing services
 - o Publications, industry information and resources
 - o Clinical and professional standards
 - o Conferences, events and networking

Employment

- Annual gross (pre-tax) income from your primary employer
- Percentage of income from primary paramedicine role
- Current position in paramedicine [employment type & jurisdiction]
- Registration type
- Role [clinical, research, education, management]
- Title
- Principal work setting
- Principal work setting postcode
- Rural or remote work
- Fly-in-fly-out work
- Tenure in industry
- Tenure of current employer
- Contract type (full time, part time, casual/contract, self-employed)
- Hours worked per fortnight, excluding overtime and on-call
- Hours per fortnight of overtime and on-call work
- Work schedule/shift pattern
- Number of current employers
- Desire for more or less work
- Desire for single or multiple employment

Change of contract

- In the previous 12 months, have you asked for a change to your contracted work arrangements? Yes/No
- Reasons:
 - o Requested part time
 - o Requested job share
 - o Requested change to regular (non-rotating) shifts
 - o Requested reduced hours for a limited period
 - o Requested more convenient geographic location
 - o Prefer not to say
 - o Other

Appendix 3: List of data points continued

- Was this requested granted?
 - o Fully granted
 - o Partly granted
 - o Declined
 - o Not yet received a reply
 - o Prefer not to say

Job demands

- In a typical fortnight, in your work with your primary employer, what proportion (as a percentage %) of your work includes:
 - o Direct patient care not including waiting to transfer patient care to another health professional
 - o Direct patient care while waiting to transfer patient care to another health professional
 - o Indirect patient care (travel to and from patient, paperwork, etc.)
 - o Management and administration
 - o Educational activities
 - o Research activities
 - o Meals/downtime
 - o Other

Resource adequacy

- There are enough staff at my organisation to get the work done
- There are enough trained staff to ensure quality of care
- There is enough support to allow me to spend sufficient time with patients
- I have enough time and opportunity to discuss care problems with other medical/emergency staff
- [Not applicable]

Motivations

- What drives your motivation in your paramedicine work:
 - o Working with colleagues
 - o Serving my community
 - o Representing my family
 - o Earning a fair day's wage for a fair day's work
 - o Having job security
 - o Being able to have a say in how I do my work
 - o Meeting the goals of the organisation
 - o Saving lives

Wellbeing

- Overall, I am reasonably happy with my work life
- Most days I feel a sense of accomplishment in what I do at work
- I feel content with my work
- I get a sense of joy from my work

Intention to quit

- I frequently think about leaving this organisation
- It is likely that I will search for a job in another organisation within the next year
- It is likely that I will leave my current organisation within the next year

Career intentions

- How many years do you intend to remain in the paramedicine workforce in Australia?
- How many years do you intend to remain with your current, primary paramedicine employer?

Appendix 3: List of data points continued

Career planning (Aus and NZ)

- In the next 12 months, what is the likelihood that you will apply for the following roles?
 - o Specialist/advanced clinical paramedicine role
 - o Management role (with any employer)
 - o Advanced educational role (within an ambulance/health service or education provider)
 - o Advanced research role
 - o Engage in formal education provided by a Recognised Training Organisation or University and a discipline other than paramedicine
- Future study ambitions (Aus and NZ)
 - o Engage in informal education in addition to your mandatory continuing professional development. This might include optional in-house training or external study
 - o Engage in formal coursework education provided by a Recognised Training Organisation or University in paramedicine (not including research)
 - o Engage in formal research education in paramedicine. This would include Honours, Masters, PhD studies

Leave Provisions

Leave

In the past 12 month's what leave options have you taken (not including annual leave or short-term sick leave less than 10 consecutive days)

- Type of leave beyond 10 days:
 - o Parental/adoption leave
 - o Long service
 - o Workers' compensation leave
 - o Prefer not to say
 - o Other
 - o No
- Reason for leave beyond 10 days:
 - o Covid-19
 - o Physical illness
 - o Mental illness
 - o Prefer not to say
 - o Other

Parental Leave (those who indicated they had caring responsibilities of children under 16)

- I was able to take time off for appointments I wanted to attend during mine/my partners pregnancy or child-related appointments in general
 - I was able to take short term (2 weeks) parental leave around the time of the birth or adoption of a child
 - I was able to take extended leave to be the carer of a child if I wanted to
- Paid Parental Leave (Yes/No)
- Able to return to the same or similar role, responsibilities and pay following leave (Yes / No (why))
 - Family care duties Yes/No

Accommodation of family care duties

- I was able to take time off for relevant appointments
- I was able to make leave arrangements to enable important caring duties
- I was able to continue my career development while undertaking my caring duties
- I found it easy to discuss my caring duties with my work colleagues

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REPORT 2025-2026