Australian & New Zealand
College of Paramedicine

Submission to

The
Parliament of Australia
Senate Legal and Constitutional Affairs Committee

reviewing

The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety

January 2016

The Australian & New Zealand College of Paramedicine strongly believes that it is of the utmost importance to the safety of the Australian public, that Paramedics nationally be included in the National Registration & Accreditation Scheme, established under the *Health Practitioner Regulation National Law Act* (the National Law) and managed by the Australian Health Practitioner Regulation Agency and a Paramedic Board.

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The Australian & New Zealand College of Paramedicine

The Australian & New Zealand College of Paramedicine (ANZCP) (formerly Australian Institute of Ambulance Officers NSW, 1973-2001, and Australian College of Ambulance Professionals NSW, 2001-2011) has been a professional representative body for Paramedics since 1973.

Today ANZCP represents a diverse body of Paramedic professionals across Australia and New Zealand drawn from both private and public sectors. Our members range from those working in busy statutory ambulance services providing a range of high level assessments and high risk clinical interventions, making in-depth assessments of a patients overall situation and making recommendations on the most appropriate treatment pathways; to those working in remote health settings working alone as the only available health professional, or in rural and regional areas as part of a multidisciplinary team providing a broad range of patient centred health care.

ANZCP is proud of being the lead body for Paramedics with a strong focus on professionalism and continuing professional development, the maintenance of high standards, the performance of regular member audits, and the delivery of education events through both direct and distance-learning (on-line) services.

ANZCP has maintained an active role in continuing discussions with Governments on the Paramedic regulation over an extended period. Regular communication has been maintained with States and Territory Ministers, and we have participated in consultation and focus groups as well as regular meetings with key officials. ANZCP was actively involved in meetings with NSW Ministry of Health officials on that state's implementation of independent protection of title legislation.

ANZCP was active in all consultation meetings prior to its subsequent submission to the 2012 limited consultation on 'The Options for the Regulation of Paramedics' undertaken by the Health Workforce Principal Committee. The work of this committee informed the most recent decision at the COAG Health Ministers meeting to work towards the registration of paramedics under the National Registration and Accreditation Scheme (NRAS). ANZCP put forth in that submission a number of examples submitted by our members highlighting the risks that members of the public are exposed to that were present and will continue to exist under the current regulatory environment. The 2012 submission is included as an Appendix to this document.

This submission addresses each part of the terms of reference in sequence.

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The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, with particular reference to:

a. **the role and contribution made by those in the paramedic profession, including the circumstances in which they are required to operate;**

Paramedics predominantly perform a specialised medical function within the Australian health system. Paramedics are best known for the provision of an out-of-hospital and front line health service. In an emergency, people call triple zero for urgent care from a public (or private) Ambulance Service and are in most cases attended by one or two qualified paramedics. In other settings such as on a ship, construction site, mine site or gas field, the residents may activate an emergency response team, which if it is a well-designed system will be staffed by a paramedic. The public trusts paramedics with their health care information, medical history, current medications, and expects them to provide the best possible care in times of need. Emergency response to life-threatening situations involves working in a high-pressure environment, is of a time critical nature, and has significant consequences if not done correctly.

In the 2011 Australian census 11940 people identified as paramedics or ambulance officers, a growth of 31 percent since the 2006 census. This has undoubtedly increased by a similar rate of growth over the last five years. 82 percent of paramedics work for public sector entities and 18 percent for private sector employers or in other roles. As an example, in 2012 there were nearly 1000 medics in the Australian Defence Forces (ADF) that were not well captured by the Census because of coding and other descriptor anomalies. 89 percent of paramedics worked full time, 32 percent were women (up by 6% from 2006) and 1.8 percent identified as Aboriginal and Torres Strait Islander peoples. Paramedics were identified in the census for a higher rate of working longer hours than the rest of the population, with 36 percent identifying as working longer than 49 hours, compared to 26 percent in the rest of the population.

The rate of paramedics indicating in the census that they had recently moved interstate (within the last five years) was at 6 percent nationally, with 29 percent of paramedics in the Australian Capital Territory, 27 percent in the Northern Territory and 19 percent in Tasmania having moved to that jurisdiction from another within the last 5 years. ADF medics and private sector paramedics regularly work in different jurisdictions.

State and Territory Ambulance Services comprising the bulk of Paramedics (82% of total paramedics 2011 census) make a significant contribution to the health of the public through their responses to calls for assistance. NSW Ambulance, comprising some 4,000 staff the majority of which are paramedics in 2013/14 provided 1,234,843 total responses to ambulance emergency calls. In 2014/15 Queensland Ambulance Service had 945, 850 responses (code 1 to 4) and Ambulance Victoria had 489,989 responses to emergencies (code 1 & 2). Calls for assistance to public-sponsored Ambulance Services are increasing on an annual basis.

In addition to mainstream emergency responses, there are a number of paramedic roles and programs that deal with low acuity or highly complex co-morbidity patient cohorts to better manage their care. Programs operate that try to manage low acuity patients at home, or to connect them to more appropriate providers of care outside of the emergency departments of local hospitals. Paramedic care in several advanced programs involves triage and treatment where paramedics by-pass emergency departments to access acute care facilities, such as trauma, cardiac care, stroke services. Paramedics also may deliver care normally reserved to specialised emergency department and then bypass to a specialised care facility (i.e. carry out thrombolysis then bypass to cardiac catheter lab or bypass hospitals to take patients directly to trauma centres).

Today's paramedics are clinicians primarily educated through tertiary level program and hold a bachelor's degree or higher (40%, 2011 census). There are currently more than 6500 students in undergraduate and postgraduate university courses in Australia alone. The profession is in transition and the remaining practitioners vocationally educated practitioner who have had several years on the job training in an Ambulance Service delivering high level emergency care to the community.

Today's paramedic usually undertakes substantial ongoing training, and self-directed professional development to maintain high acuity skills and develop knowledge and enhanced competence. Many of the major state or territory ambulance services require their paramedics to operate within a *certificate to practice* model where they undertake and demonstrate ongoing professional development to maintain their skills and knowledge.

Private sector paramedics play a significant role in maintaining the health and safety of the community. This may include their work with a remote area gas field or mine workforce, the crew and passengers of a ship, humanitarian activities across the world or a stranded boat of asylum seekers. In addition to responding to medical emergencies, paramedics may be required to undertake a substantial volume of other work including health assessments, testing, rehabilitation, staff exercise programs, work health and safety roles and many other areas of health care provision. Many of these paramedics are extensively trained and experienced having come from statutory services or from the military or a robust private sector training system.

However as demand has grown for better health care (especially in more remote settings) the absence of a strong national regulatory framework raises the prospect of some operators being employed with significantly less experience, lower qualifications and uncertain competence. Comprehensive and consistent regulation is required to protect the public by ensuring appropriate standards of education, training and continuing competency.

There is currently no minimal qualification for the role of paramedic, nor is there a nationally consistent restriction on the use of the term paramedic. Three states have legislation or have brought in amendments to existing legislation to restrict the use of paramedic title, but these definitions are not consistent and create both anomalies and added complexity to both practitioners and providers.

For example, the recent NSW legislative changes titled *Health Services Amendment (Paramedics) Act 2015 [NSW], and Health Services Amendment (Paramedic Qualifications) Regulation 2015 [NSW]* is indicative of how there is little appreciation of the issues and the impact on the overall provision of care by practitioners and private providers – some of whom have won national awards and are bigger than the smaller public-funded ambulance services.

The Act defines a paramedic as a person who holds qualifications, or has received training, or who has experience, or who is authorised in another jurisdiction, or a member of staff of NSW Ambulance, or any other person who is authorised by the Health Secretary to hold themselves out to be a paramedic. The regulation prescribes the qualification to be a Bachelors Degree or Diploma in paramedicine as the base line qualification, however the way in which the legislation is framed this qualification may or may not be required.

National registration of paramedics could facilitate a greater utilisation of the paramedic workforce in geographical areas that are under-resourced in regards to traditional health care providers (doctors and nurses). Paramedics are often already located at more remote communities and hold the necessary competencies so a greater engagement with the health care system would improve the access to health care and lower the level of risk that many communities face Research has shown that planned paramedic care can reduce unnecessary transport of patients to hospitals by "providing care at the place where a patient resides" (Tohira et al., 2013, p.7).

Paramedics have the capacity to impact greatly on patient care by addressing some conditions at home, and referring patients to other pathways of care such as social services, general practitioners and community care thus reducing the load on hospital emergency departments and conserving both emergency and general health care resources. Paramedics can do this "clinically effectively" (Mason et al., 2007), but most 'community paramedic' programs in Australia to date have been pilot studies and more general use of this highly effective model of care is limited because of the absence of a strong regulatory framework facilitating independent practice. Inclusion of paramedics into the NRAS will go some way to addressing this.

National registration of paramedics has other implication including potential access to relevant funding models such as the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme. Alternative funding models would assist with the sustainability of remote paramedic care delivery models. This might apply particularly in rural and remote locations where access to health care is limited and paramedics are already available but underutilised. In larger high workload areas, the better utilisation of the skills of the paramedic workforce could see a greater rate of safely redirecting patients to alternative health care settings and away from congested emergency departments.

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b. **the comparative frameworks that exist to regulate the following professions, including training and qualification requirements and continuing professional development:**
   i. **paramedics,**
   ii. **doctors, and**
   iii. **registered nurses;**

Doctors and Registered Nurses

Doctors and Registered Nurses have been regulated under The National Registration and Accreditation Scheme (NRAS) for the health professions (the National Scheme) since 2010. The scheme was established under the *Health Practitioner Regulation National Law Act* (the National Law) and legislation in each state and territory. It currently regulates 14 health professions nationally including Doctors and Registered Nurses. The National Law was the outcome of intensive study and was a conscious decision by all governments to bring together numerous inefficient and problematic State systems into the single NRAS model.

The objectives of the National Scheme are set out in section 3 of the National Law. These are:

- to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
- to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
- to facilitate the provision of high quality education and training of health practitioners; and
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
- to facilitate access to services provided by health practitioners in accordance with the public interest; and
- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the NRAS. Each health profession that is regulated under the NRAS currently has a National Board. The Boards and AHPRA work in partnership to implement the National Scheme, each with specific roles, powers and responsibilities set down in the National Law. There is a Medical Board and a Nursing and Midwifery Board that manages their respective professions.

To become registered as a Registered Nurse or Doctor, a student must have completed a course of study that has been accredited by the appropriate professional Board. An example is a Bachelor of Nursing qualification obtained from an accredited Australian University. The Australian Nursing

and Midwifery Accreditation Council is the independent accrediting authority for the nursing and midwifery professions in Australia. Likewise the Australian Medical Council is responsible for accrediting education providers and their programs of study for the medical profession. They each rigorously assess education programs submitted to them on behalf of their Boards to ensure the approved standards for accreditation are met. Students must have completed one of these accredited courses to meet the minimum educational standard for registration.

To gain registration as a Doctor or Registered Nurse, or to maintain it on an annual basis, several other standards have to also be met. A criminal history registration standard is common to all National Boards where practitioners must declare any criminal history (annually), and where there is something to declare it is reviewed on a case by case basis using ten factors in deciding whether a health practitioner's criminal history is relevant to the practice of their profession. The English language skills registration standard requires certain English language and literacy skills. Recency of practice, continuing professional development and professional indemnity insurance registration standards are specific to the individual National Boards and must be maintained, and declared annually. These standards are openly and transparently available on the AHPRA website for each specific profession. A Registered Nurse is required to undertake 20 hours of professional development activity per annum to maintain registration. Records must be kept and these records can be audited by the Agency as required.

Paramedics

There is currently no consistently prescribed education standard one must undertake to qualify as a paramedic. In fact a vast degree of variance exists in current paramedic education models from tertiary qualifications, to vocational education and training (VET) programs to short course with little or no accreditation process. Compounding this diversity is the implementation of jurisdictional requirements for protection of title that are themselves different both in content and in functional application with only South Australia using the relevant NRAS legislative model. The regulations addressing the issues of required qualification, competency standards and exemptions are not consistent and are almost certainly going to add additional regulatory and administrative costs in the provision of healthcare nationally. This is vastly different to professions registered under the NRAS.

Whilst most jurisdictional ambulance services have moved towards a university model of education for new recruits, and 40 percent of the total workforce of paramedics in Australia is degree qualified, of the 60 percent VET qualified practitioners most are diploma or graduate diploma qualified with the balance changing rapidly as new graduates enter the workforce. Jurisdictional ambulance services generally have robust and structured internship programs to ensure that graduates have a period of supervised practice to consolidate their learning into the context of practice in that jurisdiction before being allowed to practice independently. New graduates are not 'job ready' in terms of independent practice.

Conversely, in some private sector agencies, a new graduate armed with only a few weeks of clinical placement experience may be thrown into a remote location unsupervised and without a

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caseload expected to manage a major health emergency that may only occur only rarely. This is not an effective setting to prepare a new graduate for advanced life support practice as a clinician. Additionally, there are some who fulfil standby paramedic roles in remote high risk high consequence environments with only basic training (such as First Aid, Certificate II-IV or privately acquired Diploma without any internship experience and mentoring), limited experience and without any ongoing professional development, as the non clinical employer is unable to distinguish between this person and a much more qualified and experienced practitioner.

International practice is an increasing part of paramedicine, with hundreds moving to other countries and similar numbers coming to Australia on a regular basis. At present, each overseas trained paramedic is assessed differently by each jurisdiction, and as there is no standard method of doing this nationally, some employers do it better than others. In the digital age, the ability to create high quality false qualifications and the difficulty in checking these is increasing the risk that an untrained or poorly trained person is able to establish himself or herself as a clinician in Australia.

Unfortunately, in the absence of a national regulatory framework, people may hold themselves out to be paramedics with qualifications and ongoing competency standards dependant only on their own initiative, the culture of the organisation they belong to or the requirements of their employer. Some employers have internal quasi-registration requirements for continuing professional development and other related internal policies to cater for criminal activity and notification of behavioural issues, however other employers are essentially small operators without the capacity to manage these aspects. Other organisations employing contracted providers or individuals may have no particular insights into healthcare or greater expectations of their paramedics than of any other workers. Some providers are trying to mitigate their risks by prescribing professional college membership as an ongoing requirement, relying on or expecting the colleges to be an additional level of verification of qualifications and standards of behaviour.

There are two credible professional member organisations within the Paramedic environment that advocate for Bachelor level qualifications as a minimum for future Paramedic education, and who provide professional development activities and have expected standards of behaviour and ongoing professional development. The Australian & New Zealand College of Paramedicine, and Paramedics Australasia, both have a code of conduct, professional standard expectations, and ongoing education programs. The membership of these bodies is voluntary and is not a mandated requirement for employment, nor do they have any statutory powers or regulatory functions that can enforce or require certain behaviours or actions other than to meet their membership requirements. Greater formal regulation at a national level therefore is required.

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c. The comparative duties of paramedics, doctors and registered nurses;

Paramedics provide a specialised emergency medical function alongside or within the Australian health system depending on the context. Paramedics work in isolation and predominantly unsupervised in the community and are the front line emergency medical service providers in whatever setting they are working in. They can be working within a structured and well policy governed organisation (whether public or private) or be attached to a non clinical workplace with absolutely no clinical governance, oversight or patient safety structure in place. They can be doing this with extensive formal education, extensive experience, or with both or neither of these.

Doctors and Registered Nurses work in a range of environments including public and private environments, however those that work in acute settings are generally working in structured, highly regulated environments where clinical governance, oversight, consultation and supervision systems exists for patient safety. Registered Nurses generally only administer medications ordered by a Doctor for that patient, unless they are working in remote emergency departments and have authority to do so. This is generally only after specific training and includes a limited authority for a narrow scope of medications. Most Doctors and Registered Nurses work in a fixed facility, with the availability of colleagues, reference and other materials to support and guide their practice.

In an emergency, people call triple zero for assistance from a Paramedics, which is provided in the most part by paramedics in an ambulance or other mode of transportation (car, bike, helicopter). Alternatively, on a ship, construction site, mine site or gas field, the public may activate an emergency response team which if it is a well designed system will be staffed by a paramedic. Many of these paramedics work independently and outside of a medically supervised workplace. They work outside in an environment that is not structured or fixed and it is difficult at times to seek guidance in these difficult situations.

To demonstrate the comparative risk of the duties undertaken by paramedics, nurses and doctors, we refer to the Australian Health Minister's Advisory Council 2009 Regulatory Impact Statement that highlights thirteen specific risk factors that they rely on to inform the extent to which a profession may pose a risk to the public.

These are:

1. Putting an instrument, hand or finger into a body cavity.
2. Manipulation of the spine.
3. Application of a hazardous form of energy or radiation.
4. Procedures below the dermis, mucous membrane, in or below surface of cornea or teeth.
5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs.
6. Administering a scheduled drug or substance by injection.
7. Supplying substances for ingestion.

8. Managing labour or delivering a baby.
9. Undertaking psychological interventions to treat serious disorders with potential for harm.
10. Setting or casting a fracture of a bone or reducing dislocation of a joint.
11. Primary care practitioners who see patients with or without a referral from a registered practitioner.
12. Treatment commonly occurs without others present.
13. Patients commonly required to disrobe.

In the consultation paper “Options for regulation of paramedics” the Australian Health Ministers’ Advisory Council Health Workforce Principal Committee (July 2012) found that when their role was compared to these factors, paramedics demonstrated a greater risk than ten out of the fourteen already registered health professions.

ANZCP identified in its submission in 2012 to that Committee, the table provided in the consultation paper fails to recognize that paramedics do also apply hazardous forms of radiation and energy (Risk Factor 3) being defibrillation and synchronized cardioversion, and where the skill set of Extended Care Paramedics is included, also perform setting or casting of a fracture or reducing dislocation of a joint (Risk Factor 10). It has also been suggested since then that extrication from many accident scenes (smashed vehicles, industrial sites) involves a highly risky application of equipment and manipulation of the spine that would engage risk category 2, albeit ‘manipulation’ as a procedure is not done on a planned and regular basis – it is a consequential risk exposure. Inclusion of these two risk factors with the potential third risk, would mean that paramedics perform at least eleven (perhaps 12) of the thirteen risk factors identified and would only be superseded by medical practitioners in terms of comparison with other already registered professions.

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d. Whether a system of accreditation should exist nationally and, if so, whether the Australian Health Practitioners Regulation Agency is an appropriate body to do so;

In March 2008 the Council of Australian Governments entered into an Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (IGA). The National Law commenced operation from 1 July 2010 and brought together numerous inefficient and problematic State systems into one National Registration and Accreditation Scheme. That agreement sought to "provide protection of the public, facilitating workforce mobility, minimizing administrative burdens, facilitating high quality education and training, responsive assessment of overseas practitioners, access to services, developing a flexible, responsive ad sustainable workforce, and enable innovation in the education of, and in the delivery of service".

If paramedics were to be added, the Health Practitioner Regulation National Law Act (the National Law) would only need to be amended to include the profession of paramedics as a regulated profession under the National Law. A National Board would be appointed by the Australian Health Workforce Ministerial Council, and a Register of Paramedics would be established administered by the Australian Health Practitioner Regulation Agency. The National Board would have powers to set standards for registration as a paramedic which would include qualifications requirements and probity checking. Complaints would be handled in ways consistent with other related health professionals. If a paramedic were found to have engaged in professional misconduct as defined under the National Law, the tribunal would have the power to suspend or cancel their registration. The National Board would have a range of other powers to protect the public, including criminal history checking, monitoring of impaired registrants or those whose performance or conduct was unsatisfactory.

There has been some criticism of AHPRA and its performance since its inception in a number of areas, including by Victoria's Legislative Council Legal and Social Issues Legislation Committee in a 2014 Inquiry, which cited a number of problems including financial transparency, efficiency, decision making issues and problems with complaints handling mechanisms. Despite these issues the Inquiry recommended that "Victoria remain committed to the registration and accreditation components of the National Scheme and that the Victorian Government remain a signatory to the Intergovernmental Agreement". ANZCP believes the benefits to public safety of the national registration and accreditation components, far outweigh any ongoing administrative and inter-jurisdiction matters that some jurisdictions.

The benefits associated with paramedic registration through the existing National Scheme managed by AHPRA would include:

- the public being assured that paramedics are appropriately educated and suitable to practice
- reduced risks to the public associated with the actions of a practitioner who may have health, conduct or performance issues that make them unsafe to practice
- establishment of a national board with the powers to deal with any registered practitioner who

may have health, conduct or performance issues that make them unsafe to practice

- establishment of professional standards
- establishment of national minimal education standard for paramedics
- establishment of a national accreditation body for the assessment of educational qualifications leading to registration as a paramedic, and
- legislated consistent national protection for use of the title 'paramedic', with only those person registered being able to use that title.
- Consistency of professional standards across all of the significant health workforce groups
- Greater utilisation of paramedics in remote health settings, and in multidisciplinary health teams

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e. The viability and appropriateness of a national register to enable national registration for the paramedic profession to support and enable the seamless and unrestricted movement of paramedic officers across the country for employment purposes; and

Paramedics are becoming increasingly mobile with many organisations now recruiting nationally and internationally. In the 2011 Australian census 6 percent of paramedics indicated they had relocated interstate to their current location within the last five years. 29 percent of the Australian Capital Territory paramedic respondents had relocated to the ACT from another jurisdiction within the last 5 years. Likewise 27 percent of paramedics in the Northern Territory and 19 percent in Tasmania had moved from interstate to that jurisdiction in the last 5 years. In addition to those permanent relocation statistics, hundreds more paramedics regularly go to work over interstate borders with a variety of different companies on short term contracts in the private sector, and statutory based paramedics deploy interstate and internationally in times of extraordinary need, such as to bushfires, floods and other protracted events.

The National Registration and Accreditation Scheme for the health professions (the National Scheme) established under the *Health Practitioner Regulation National Law Act* (the National Law) and legislation in each state and territory, regulating the 14 health professions nationally (including Doctors and Registered Nurses) sought to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction. This objective of the National Law is consistent with The *Mutual Recognition Act 1992*, Australia's Mutual Recognition Agreement (MRA) and the Trans-Tasman Mutual Recognition Arrangement (TTMRA) which all aim to reduce the burdens of interstate jurisdictional navigation for workers, and to improve the overall safety of the public through a transparent and navigable registry of approved providers.

Inclusion of Paramedics in the National Register & Accreditation Scheme would enable National Registration for the Paramedic Profession and provide a list of those authorized to practice in the profession.

In recent years South Australia, Tasmania and most recently NSW have all introduced state legislation that protects the title of paramedic. Protection of title legislation restricts the class of person who can hold him or herself out to be a paramedic in that state with penalties for breaching this legislation. As these documents are unique to each State, there are inconsistencies between documents that fail to provide a national standard. There are also other Australian jurisdictions that do not have protection of title legislation. Protection of title legislation only addresses the use of the title, and does not address behavioural and education standards or address cross jurisdictional matters. This adds significant complexity as some interstate paramedics would be recognised, and others not, and those who work across borders on contracts have increased administrative burden. This provides a barrier to seamless and unrestricted movement, and adds further regulatory burdens on an already complex area.

The regulatory burden on reputable private sector employers by this mish mash of state regulation is significant. To employ a paramedic for a short term contract for example, there would need to a full assessment of their qualifications undertaken, assessment of their work history, probity, performance history and conduct. This is to ensure to the best of the ability of the employer the Paramedic is fit for employment as a Paramedic. Then the other regulatory processes need to be undertaken such as poisons licensing requirements (State legislation but may be conferred onto the employer to manage) and worksite requirements. A significant part of this burden could be alleviated by having a national Registration & Accreditation Scheme, that holds a register of approved persons able to work as a Paramedic with the necessary education, fitness, recency of practice and behavioural standards. A person under investigation for breaches, or a person suspended, or unqualified, would not be on the national register and therefore would not be considered.

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f. Any other related matters.

Much is made of the lack of complaints and coronial data regarding paramedics and their practice to validate the risk factors discussed previously. The absence of this data does not in itself justify complacency or a position that the risk of paramedics to the public is overstated. Paramedics certainly pose a greater risk by their interventions than do registered nurses and many other registered professionals currently under the NRAS. The reason there is not a corresponding bank of evidence supporting these risks is there is no reliable independent data collection or complaints handling mechanism to collect this data. Serious complaints are often dealt with in house to avoid public embarrassment of the particular organisation or government, and are dealt with as an employment issue in that employment setting, rather than as a professional in a profession. As paramedics predominantly work in an emergency setting in an external environment, it is also difficult to determine the actual cause of any adverse outcomes. Often the public perception of the events are also influenced by the care and compassion delivered by paramedics, and the difficult circumstances in which they work, rather than the clinical decisions made.

On 2011 census figures there were about 2200 privately practicing paramedics in the entertainment, events, mining and other industries with private paramedic providers in numbers we struggle to quantify. There has been a significant increase in job advertisement activity over recent years that indicate that this number is growing exponentially. The extent to which these providers ensure clinical competency, professional standards of behaviour and appropriate clinical care is largely unknown and perhaps largely unregulated. Public or government-contracted ambulance services are not immune to these same challenges with little reporting between jurisdictions, inadequate legislative frameworks in many states and territories, a lack of external oversight and limited or ineffective health care complaints mechanisms.

We identified many examples of problems associated with the current frameworks or lack thereof in our submission to the Australian Health Minister's Advisory Council Principal Committee in 2012. We included reports from paramedics about malpractice and other related matters identified as respondents A, B, C, D, E, F, and G. Many of these issues exist only because of a lack of a national regulatory framework, and these issues add weight to the argument for regulation. All of these unregulated aspects contribute to a system that is inherently unsafe for contemporary paramedic service delivery.

The main advantages of national paramedic registration revolve around enhancing patient safety and include:

- Cleary defined national standards of acceptable behaviour for paramedics and prescribed circumstances where mandatory reporting to AHPRA is required.
- A standardised approach to complaints and significant incident investigation.
- A publicly accessible and displayed national register of practitioners.
- The development of national education and accreditation standard to ensure that the same quality of clinicians are available throughout Australia.

- The title 'paramedic' would be protected nationally.
- It would be unlawful to identify and practice as a paramedic anywhere in Australia if not registered to do so under this scheme.
- National registration of paramedics would bring Australia into line with many other countries, including; the United Kingdom, Ireland, Scotland, South Africa, parts of the United States and Canada.
- A national system would allow for flexibility and a safe system of mobility within the paramedic workforce.

The Australian & New Zealand College of Paramedicine strongly believes that it is of the utmost importance to the safety of the Australian public, that Paramedics nationally be included in the National Registration & Accreditation Scheme, established under the *Health Practitioner Regulation National Law Act* (the National Law) and managed by the Australian Health Practitioner Regulation Agency and a Paramedic Board.

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Appendix

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Options for the Regulation of Paramedics

Health Workforce Principal Committee

3rd September 2012

Executive Summary

The Australian & New Zealand College of Paramedicine, abbreviated to ANZCP (formerly Australian College of Ambulance Professionals NSW), represents over two and half thousand individuals working or studying as paramedics throughout Australia. Whilst the vast majority of our members are employed within government or state-based ambulance services, we have a significantly growing membership base from private enterprise including the events industry, industrial and mining settings as well as paramedics from the Australian Defence Forces. Similarly we having a growing number of members who are completing full-time study in one of the many university-based paramedic programs offered Australia-wide. Excitingly, we are increasingly seeing membership being sought by paramedics from around the world completing both short and long term employment contracts within our borders.

The interest and passion that has been generated by the current consultation process has resonated throughout our members and their respective workforces, but also throughout the communities that have a good grasp of the work paramedics do and the climate in which we currently operate. The need for enhanced public safety and the potential to achieve these enhancements through some of the proposed initiatives is regarded as both a necessity and well overdue.

This document forms our formal submission to the limited consultation on ‘The Options for the Regulation of Paramedics’ being undertaken by the Health Workforce Principal Committee. It is a comprehensive document that has sought a great degree of input from our members and importantly from the key stakeholders of paramedical care, the community. This input has been received by various means including; completion of an online petition, completion of our member survey, submitting a written letter to ANZCP, submission of detailed emails to our generic ‘Registration’ email address and participation in community and workplace information and consultation forums held at various locations. Overwhelming the information has been highly constructive, well thought-out and has informed this final document. This feedback has not been received from the mouths or hands of a small few but from several thousand individuals. A large number of these have not been members of ANZCP but have participated given the great importance of such a consultation process. Concurrently, the input from our members has been at all levels and from all professional and academic backgrounds.

In producing this final submission ANZCP strongly believes that the introduction of paramedics, as registered health professionals, within the National Scheme is imperative. In fact, to not ensure that paramedic care is delivered within a stringent, enforceable, and universal framework is to expose the Australian community to an increasing degree of risk to their health and safety.

This submission will address the current state of affairs with regards to the delivery of paramedical services and highlight the fundamental shortfalls of the current regulatory mechanisms. In doing so, it will provide actual, de-identified submissions made to ANZCP from various individuals that highlight some of the many risks and challenges facing paramedics, employers, and the public. Furthermore, it will address the key elements of all four options currently proposed, giving credit to their strengths and identifying their weaknesses with regards to protecting the public. Whilst it is not appropriate to submit all the documents and evidence we have relied on to inform this report it is available within the confines of confidentiality and we would urge you to contact our General Manager should you require such detail.

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The Current Arrangements

In the vast majority of cases paramedics in all settings conduct themselves with integrity and professionalism. They are competent and consummate professionals who are committed to delivering high quality patient care in some of the most challenging of circumstances and environment. Within defined government settings reasonably robust models of clinical governance ensure patient safety and clinical quality are foremost concerns and deviations from this are dealt with promptly. However, a growing entertainment and events culture, as well as a boom in mining and other industries has seen an emergence of private paramedic providers in numbers we struggle to quantify. The extent to which these providers ensure, or are able to ensure clinical competency, professional standards of behavior and appropriate clinical care is largely unknown and perhaps largely unregulated. Public or government-contracted ambulance services are not immune to these same challenges with little reporting between jurisdictions, inadequate legislative frameworks in many states and territories, a lack of external oversight and limited or ineffective health care complaints mechanisms. All of these aspects contribute to a system that is inherently unsafe for contemporary paramedic service delivery.

Education

There is currently no prescribed education standard one must undertake to qualify them as a paramedic. In fact a vast degree of variance exists in current paramedic education models from tertiary qualifications, to vocational education and training (VET) programs to short course with little or no accreditation process. Whilst it is true that most jurisdictional ambulance services are moving towards a university model of education for new recruits, many privately practicing paramedics may have no more than a basic or incomplete qualification. The respondent below exemplifies this:

Respondent A –

“I was working as a full-time paramedic with the Ambulance Service after completing my university degree. A friend of mine from university had performed really poorly in her assessments. In fact she had failed most of the core subjects and ended up pulling out of the degree without finishing. When I asked her about what she was doing work-wise she explained to me that she had been able to get a job as a rescue paramedic with a private company. She said that most of the time she would work by herself and would provide care to patients without the assistance of any more suitably qualified employee.”

Similar reports of incidents have filtered through during this current consultation phase that represent the same degree of risk and potential for harm. This has been especially identified in cases where the employer is not a specific health care or paramedic company. In some industrial settings paramedics have been employed by, and report to a construction project manager or similar who has no specific knowledge of what a reasonable minimum qualification might or should be.

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Professional Suitability

Suitability to practice is a complex concept involving clinical competency, recency of practice, issues of impairment and paramedic conduct, or misconduct as may be the case. Procedural guidelines for dealing with misconduct vary amongst jurisdictions and providers and are largely dependent on organizational policies. The current arrangements do little to share information between different employers and allow for unsuitable individuals to move between states and even between employers within the same state. Respondent B provides a clear example of this.

Respondent B –

“I was a complainant in a serious investigation against a paramedic who worked in my area. It was a long and drawn out investigation around some really serious matters. The paramedic involved had to respond to over twenty serious complaints including death threats he had made as well as acts of physical and sexual violence against other staff, nurses at hospital and even patients. One such matter was where he repeatedly sent lewd photos of himself to me. I was told this was a criminal offence and would form a significant part of the investigation. Eventually he was terminated and did not appeal the ruling. Some time later I was in Melbourne and whilst walking along a busy street I noticed an ambulance pull up to attend to a patient. The paramedic who was in this ambulance was that same paramedic who had been terminated from my Service. I was so shocked given that we are two government ambulance services and one did not even know what had happened here”

This is an example of a serious failure between two government ambulance services with robust checks and balances for their staff. Where someone can move easily between two different state- based ambulance services despite being terminated from one for a matter of serious misconduct is of paramount importance when assessing the efficacy of current regulatory mechanisms. However as stated earlier, matters of misconduct are not the only contributors to one’s professional suitability. Another respondent raised concerns about an individual paramedic working for a private provider at a dance festival.

Respondent C –

“One night whilst on duty in the city we were responded to a drug overdose at a dance party. When my partner and I got there, there was a private company providing paramedical services to the event patrons. They had a young guy who they said was seen behaving erratically and they sedated him with Midazolam because they thought he was on drugs and was psychotic. I was shocked that they had used such a dangerous drug because these providers had no cardiac monitor or defibrillator present. But what was worse was that when we got the patient into the ambulance we began to assess him thoroughly. My partner took out our glucometer and took a blood glucose level. His BGL was 1 and we later found out he was a type 1 diabetic. He wasn’t drug affected at all. He was having a ‘hypo’ and they had managed him inappropriately.”

Similar concerns have been raised with regards to impairment and in many instances concerned centred on drug and alcohol use both as a medical problem amongst some paramedics but also as a causative element in professional unsuitability. Respondent D reported one such incident.

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Respondent D –

"I want to report an incident of a paramedic who my colleagues and I had worked with for some time. It was well known that he had a drug dependence problem and at times would fraudulently write off restricted medications for his personal use. One of the challenges was that he was our frontline manager and when it was reported to his superior it was poorly investigated because of their relationship. Eventually a more serious investigation was launched and upon determining the outcome he was given the option to resign or be sacked. He chose to resign and can now work for a private company."

This issue above not only fails to address the psychological wellbeing of the individual but also leaves an open opportunity for a paramedic who is significantly impaired to continue to practice. It also gives a brief insight into the challenges with regards to complaint management discussed later.

Aside from the theme of professional unsuitability shared by the above three incidents, one other common thread was identified. All three incidents, and in fact most of the incidents brought forward, have occurred despite the presence of New South Wales legislation aimed at enhancing the regulation of unregistered health professionals and allowing for prohibition orders to be made by the Health Care Complaints Commission. Whilst this legislation only applies in New South Wales and a number of respondents raised concerns that occurred in other jurisdictions, there were still a number of cases where such legislation appeared to have no perceivable benefit in managing breaches to the Code of Conduct enacted in the legislation.

Health Complaints Mechanisms

The current health complaints mechanisms for paramedics are also problematic. There is a lack of robust legislative frameworks for managing and acting on complaints outside of the internal organizational structure. The only jurisdiction that is an exception to this is New South Wales. The legislation aforementioned far exceeds the statutory powers of any health complaints entity in other jurisdictions. However even this has been demonstrated to not necessarily prevent unsuitable persons from operating as paramedics, as identified in the responses above.

Other issues raised throughout multiple submissions made to ANZCP were the political dimensions in which complaints were investigated. Particularly in some industrial settings, respondents reported that their day-to-day managers often had little clinical knowledge and were often not clinicians themselves. Subsequently those required to conduct investigations into matters of clinical competency or negligent clinical care were totally incapable of doing so.

Respondent E –

"Here I was working as a paramedic in a remote mine site with one other 'paramedic' who was virtually incapable of providing any quality pre-hospital care. The only person I could report it to was our boss who was like a site construction manager. He had no clinical knowledge whatsoever and so my complaints went no where and my colleague continued to treat patients"

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Other dimensions impacting on independent or impartial investigation of complaints included issues of retaining staff or minimum staffing levels, especially in rural or more remote paramedic settings, improper investigation where staff had personal relationships with those required to conduct the investigation (typically paramedic managers) and issues of inadequate investigative resources. The lack of an independent regulatory body in most jurisdictions, that could conduct robust investigations outside of individual organizational structures, has demonstrated a distinct shortfall in the current health complaints mechanisms.

Protection of Title

At present any individual may identify themselves as a paramedic irrespective of their educational qualifications, their actual paramedic experiences or their commitment to ongoing professional development and maintenance of clinical currency. This notion is of central importance and demonstrates a key failure of current regulatory arrangements. Whilst it is true to say that those who work for government ambulance services can confidently identify themselves as a paramedic, those working in the private industry may not be able to. This has two elements. Firstly, an individual may have worked many years as a paramedic, completed a tertiary qualification and maintained clinical competency throughout, and have no greater claim to the title 'paramedic' than someone who has completed one of the many unaccredited short courses who also identifies themselves as a paramedic. The second issue is directly related to this in that when seeking to employ or utilize privately practicing paramedics, there may be a vast difference in the quality of care or the capability of the two individuals, however on face value they are both the same, paramedics.

Respondent F –

"I had worked as a government-employed intensive care paramedic for over ten years and was now working in the private industry. I maintained my clinical competency and regularly took professional development courses to maintain my currency. Whilst I didn't have a university degree I did have a diploma and an advanced diploma as well as my years of experience. The other paramedic I was working with had completed a ten-day course on paramedics. He had never had any exposure to emergency care and yet would perform the same invasive clinical interventions as I would. Our employer thought we were at much the same level."

Respondent G –

"When looking for medical support for our events we thought paramedics would be better than first aid staff. We didn't realize that anyone could call themselves a paramedic and found that some people we used were highly capable and others had never done this work before".

The above examples, in all areas, are just a small number of the many deficits and irregularities in the current regulatory framework under which paramedics operate. Whilst systems of clinical governance, patient safety and clinical quality may be robust in some organizations, and to a reasonable degree in government services, there is a significant shortfall in across-the-board sharing of important information between jurisdictions and between private and public providers. Furthermore, the lack of independent oversight through external regulatory mechanisms means issues of impartiality and transparency remain prominent concerns for protection of the public health and safety.

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The Extent of Risk

The concept of risk was discussed extensively in the consultation paper released by the Health Workforce Principal Committee in July 2012. What was importantly acknowledged in that document is the lack of systematically collected information on the extent of undesirable events occurring that might highlight the degree of risk in the role of paramedics. This in part is due to the lack of external reporting and incident information sharing between providers. Additionally, there is a reliance on data obtained by the Council of Ambulance Authorities Patient Satisfaction Survey 2011 that shows overall satisfaction with Australian ambulance services is as high as 98%. As a point of interest, the Ambulance Service of NSW reports to respond to 1 million incidents annually and assuming that 2% are not satisfied with the care they received that is somewhere in the vicinity of 20,000 patients. It should be stressed that these figures do not rely on any actual data nor are they disparaging of any particular provider of ambulance services. In fact what cannot be interpreted from such data in the consultation paper is why such patients were dissatisfied with the care they were provided. This is important because there is a long-held anecdote amongst paramedics that it doesn't matter about the quality of care you provide but how nicely you deliver it. Importantly, this is not to encourage substandard care but rather to reinforce the message that many patients are not conversant with the specific clinical interventions they may require, or not require, they just want to be treated with courtesy and respect. Of course this is not an unreasonable expectation and the vast majority of paramedics conduct themselves in this manner always, however to what extent do we know if the clinical care they provide is to an acceptable standard?

The Australian Health Minister's Advisory Council also highlights thirteen specific risk factors relied upon to inform the extent to which a profession may pose a risk to the public. As identified in the consultation paper, paramedics demonstrated a greater risk based on these risk factors than ten of the fourteen registered health professions. The table provided in the consultation paper does however fail to recognize that paramedics do apply hazardous forms of radiation and energy (Risk Factor 3), being defibrillation and synchronized cardioversion, and where the skill set of Extended Care Paramedics is included, also perform setting or casting of a fracture or reducing dislocation of a joint (Risk Factor 10). Inclusion of these two risk factors would mean that paramedics perform at least eleven of the thirteen risk factors identified and would only be superseded by medical practitioners in terms of comparison with other already registered professions.

The risks of harm to the public are significant where paramedic practice is concerned. The vulnerability of our consumers, the unsupervised conditions in which we practice and the dynamic and largely unpredictable environments in which we deliver patient care all contribute to the great potential for harm to the health and safety of our patients. On page 72 of the Consultation Paper: Options for the Regulation of Paramedics, it reads, "If the incidence of harm associated with paramedics is small, the benefits of across-the-board registration will also be small". ANZCP does not support this sentiment and reinforces that incidence should be balanced against potential for harm and that low reported incidence is more likely due to a lack of quality reporting mechanisms, particularly with regards to external reporting, than an absence of such incidents occurring altogether.

The Objectives of Government Action

The objectives of government action listed in the Consultation Paper include;

- Ensure an effective and efficient quality assurance system for the delivery of paramedic services
- Adequately protect health service users from harm arising from the provision of paramedical services where paramedics breach their legal and professional obligations, or are not fit and proper persons to be providing such services.

ANZCP supports and espouses these objectives as central to the discussion of paramedic regulation. However, we reinforce the message that governments **must not** be informed by traditional models of paramedic service delivery that rely on the provision of care by government-based ambulance services only. The contemporary delivery of paramedic care is increasingly embedded in private industry and governments must give consideration to the relative lack of oversight and potential for harm in these settings. We must not only look to government ambulance services to ascertain if these objectives have been met, but explore the extent to which we can measure the performance of the private industry against such objectives.

Assessing the available Options

This component of the submission will address the four options currently put forward. It will attempt to address their merits and shortfalls giving prime consideration to the potential for increased safety to the public, or alternatively, the potential for harm to the public.

Option 1 – No change – rely on existing regulatory and non- regulatory mechanisms, and a voluntary code of conduct

This Option is not suitable as demonstrated by the first component of this submission. The currently regulatory mechanisms do not protect the public from harm for the following reasons:

- There is inadequate legislation covering ambulance services in the Northern Territory and Western Australia
- At the time of producing this submission New South Wales is the only jurisdiction to have a health complaints entity that has statutory powers to prosecute non-registered health professionals as well as a statutory code of conduct
- Voluntary codes of conduct established by professional associations including ANZCP have no binding authority and do not apply to a significant portion of the paramedic workforce
- Jurisdictions and providers are unable to publish or share important information about sentinel events or matters of serious conduct or performance in individuals
- There is no minimum national standard of education or accreditation to ensure those who identify

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as paramedics are suitably qualified.

- The title ‘paramedic’ will remain unrestricted and individuals may call themselves a paramedic irrespective of qualifications, experience, recency of practice, fitness to practice or matters of misconduct

- Individuals not fit to practice in one state or with one provider may move between providers are remain undetected

- Investigation of complaints will remain the responsibility of individual employers in most cases. As such a distinct conflict of interest will persist with regards to investigative processes and may contribute to inadequate outcomes

- There will remain a clear lack of transparent public reporting on matters of grave misconduct that may inform other employers or rightfully inform members of the public

The above issues clearly demonstrate the inadequacy of current arrangements and highlight the need for great reform in this area. The only perceivable benefit of the above option is that there is no immediate cost as no implementation activities are required. However ANZCP does not support this notion and believes that failure to act on the overwhelmingly inadequate system, despite having knowledge of its shortcomings, poses are far greater financial risk in terms of potential harm to the public and potential subsequent litigation. As such ANZCP is unequivocally opposed to Option 1.

Option 2 – Strengthen statutory health complaint mechanisms – statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services

ANZCP acknowledges some of the vast improvements that would be achieved under Option 2. Namely the implementation of more robust complaints mechanisms and the power to restrict individuals from practicing if they are not fit to do so is an important step forward. However complaints management is only one component of the current failings in regulation of paramedics. The following issues are important in assessing whether Option 2 is sufficient.

- This option is reactive and relies on poor conduct or care before action is taken

- In light of the above, it does not aim to prevent such incidents from occurring by setting minimum standards of education and processes of accreditation for persons entering the profession

- It relies heavily on the individual consumer being aware that the clinical care they have received was inadequate or detrimental and requires them to pursue such action. This may also apply within the National Scheme however it is balanced against other preventative measures listed above

- It would rely on mutual recognition arrangements between jurisdictions and providers where individuals are mobile and motivated to avoid regulatory scrutiny. The limitations of such mutual recognition arrangements were made clear with other health professions during the emergence of the National Scheme

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- The title 'paramedic' would remain unprotected and a person could continue to present themselves as a paramedics despite not being suitably qualified to do so

There would be significant costs to implement such a solution especially in the form of establishing health complaints entities. Similar legislative reform would be required if national registration were to take place however a significantly established framework already exists in the form of the National Law and the Australian Health Practitioners Regulation Agency (AHPRA).

ANZCP is not satisfied that Option 2 employs the adequate checks and balances to protect the public from harm. The reliance on a complaints management mechanism is reactive and doesn't employ essential preventative mechanisms required to reduce the risk of harm.

Option 3 – Strengthen State and Territory regulation of paramedics

Option 3 would see the implementation of many much needed improvements in the regulation of paramedics. For some jurisdictions, namely Western Australia and the Northern Territory, significant statutory reforms would be required and legislation would need to be enacted. Protection of title would likely be one of the importantly developments of such an option. The following issues are still of significant concern to ANZCP.

- Educational qualifications would not necessarily be to a national standard and individual jurisdictions would be free to adopt, or not adopt, the Council of Ambulance Authorities voluntary accreditation process. As such discrepancies in education standards may continue to exist between jurisdictions

- The establishment of 8 individual pieces of legislation and 8 state/territory-based boards has profound financial implications

- This model is still dependent on mutual recognition arrangements between jurisdictions and poses challenges for monitoring and preventing those individuals who are motivated to avoid regulatory mechanism

- This option is at odds with other health professions and best practice regulation, which has seen a move away from state-based boards into the National Scheme. To not employ the same approach for paramedics further reinforces the exclusion of them as key components of Australia's healthcare system and will result in a continued lack of inclusion of paramedics into constructive discussions about improving health service shortages throughout Australia

- A state-based system of registration is inconsistent with the Intergovernmental Agreement (IGA) and the National Partnership Agreement to Deliver a Seamless National Economy (The NP Agreement) by hindering mobility and flexibility with respect to moving betweenjurisdictions and further by implementing unnecessary and inconsistent regulation across jurisdictions

ANZCP does not support the implementation of jurisdictionally based registration. Such a system does not support a national standard of paramedic service delivery nor does it ensure the same quality of care is delivered to all Australians. Furthermore, it is unclear the extent to which such programs would affect private providers operating across multiple jurisdictions, and whether such a model would restrict

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competition and impose excessive regulatory burdens on paramedics employed by these providers.

Option 4 – Registration of paramedics through the National Scheme

ANZCP fervently supports national registration under the pre-existing National Scheme in order to ensure the necessary protection of the public from harm that may arise from paramedic service provision. A National Scheme would allow for a universal and robust quality assurance system that implements both preventative and reactive measures to minimize the likelihood of risk to the public and respond to matter of grave importance. The explicit benefits of national registration include;

- Significant enhancements to patient safety and protection of the community
- A system that is already in existence. Whilst there would be fairly significant costs in the initial implementation of such a scheme, the legislative and operational framework already exists in the form of the National Law and AHPRA.
- The National Law clearly defines acceptable standards of behavior irrespective of jurisdiction and prescribes circumstances for mandatory notification to AHPRA.
- AHPRA produces a publicly accessible and displayed register of practitioners. Private providers have informed ANZCP that this would significantly reduce some of the financial burdens placed on them during recruitment processes and allow for an efficient and dependable certification of an individual's suitability
- A national education and accreditation standard would be employed ensuring the same quality of clinicians are available throughout Australia
- The title 'paramedic' would be protected nationally and unauthorized use would attract legal penalties. Employers could therefore be confident those who identify themselves as a paramedic are in fact, qualified and authorized to do so
- A standardized approach to complaints and significant incidents investigation, even despite the continuation of the HCCC in New South Wales
- National Registration of paramedics would bring Australia into line with many other developed nations including the United Kingdom, Ireland, Scotland, South Africa, parts of the United State of America and Canada who have had paramedic registration in place for some time
- A national system that would be better aligned with the NP Agreement and IGA for reducing inconsistent regulatory burdens between jurisdictions and allowing for flexibility and mobility within the paramedic workforce

It is for these reasons that ANZCP wholly endorses Option 4 as the most appropriate and robust model for paramedic regulation.

Summary

The Australian & New Zealand College of Paramedicine firmly believes that in order to adequately protect the public from potential harm brought about by paramedic service provision we must become registered within the National Scheme. The current regulatory mechanisms do not allow for a national standard or comprehensive approach to public and patient safety. The lack of minimum education standards, rigorous accreditation mechanisms, independent health complaints processes and protection of the title ‘paramedic’ have all contributed to a system that has great potential to be unsafe. Clinical governance systems operating in government ambulance services have existed within silos and failed to ensure transparent information sharing between jurisdictions. At the same time, the every increasing emergence of private paramedic providers has gone virtually unregulated except where certain companies have been individually committed to doing so. Furthermore, the scope of practice for paramedics has also changed from one of simple transport to hospital, to one of advanced clinical care in a diversity of environments. We can no longer rely on government systems alone and the goodwill of individuals to drive quality and safety in patient care delivered by paramedics.

Similarly, there is great momentum for national registration of paramedics within the current workforce. Overwhelming our respondents have been committed to both the professional and financial obligations that national registration would entail. The need for enhanced accountability and better regulation is no more strongly felt than within the paramedic workforce themselves.

The Australian & New Zealand College of Paramedicine urges Australia’s Health Ministers to protect the public’s health and safety by introducing the national registration of paramedics within the existing National Scheme.