Supplementary Submission to:
Northern Australia Workforce Development
Joint Select Committee on Northern Australia

The health workforce and paramedicine

Responses to the Issues Paper on Workforce Development in Northern Australia

December 2023

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About the author

The author of this submission is Adjunct Associate Professor Ray Bange OAM, and this supplementary submission is made in a personal capacity. Professor Bange is an independent researcher and policy advisor as well as an Executive Committee member of the Australian Health Care Reform Alliance.

Professor Bange holds adjunct appointments from the Central Queensland University and the University of the Sunshine Coast, and is the recipient of an Order of Australia Medal for contributions to paramedicine, education and the community.

Background to supplementary submission

On 12 October 2022, the Minister for Northern Australia, the Hon Madeleine King MP, made a referral to the Joint Select Committee on Northern Australia to inquire into and report on Northern Australia's workforce development. The Committee was charged with broad terms of reference including examination of the challenges to attracting and retaining a skilled workforce; and empowering and upskilling the local Indigenous population.

Constrained investment and lagging infrastructure have adversely affected population growth and retention across much of Northern Australia. Consequential outcomes are critical labour shortages across a range of industries and limited capacity to develop skilled and unskilled workforces.

Housing, education, healthcare services, childcare, and community safety underpin the region's community stability and economic welfare. Allied with these factors, growth of the Indigenous health workforce is perceived as being vital for the region's continued development.

The author lodged a submission in December 2022 addressing issues primarily related to the health workforce and the role of paramedicine.[1] The submission contained 11 recommendations intended to foster a stronger health workforce through the better mobilisation of paramedics *(Appendix A).*

The Committee has progressed the inquiry with 75 submissions listed as of 28 November 2023. It has conducted seven public hearings and assembled 25 additional documents and six tabled documents. The evidence received to date has highlighted limited access to healthcare as an impediment to workforce development *(Appendix B).* In June 2023, the Committee published an Issues Paper to guide further development and stakeholder input across several thematic areas.[2]

Examination of the Issues Paper shows no mention of paramedicine as a health workforce and no specific recognition of paramedic (aka ambulance) service providers, despite their significant roles both across the industrial sector and in community and emergency health care.

The author acknowledges that healthcare involves multiple practitioners – ranging from primary care to specialist, culturally diverse and chronic care, to mental and palliative care. However, there are availability and capability issues regarding paramedicine that warrant more consideration. This supplementary submission focuses on the health theme and these available resources.

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1 Bange R, *Hiding in full view: mobilising paramedicine to support the health and wellbeing of Northern Australians,* Submission 53, Northern Australia Workforce Development, Joint Senate Select Committee on Northern Australia, December 2022, https://tinyurl.com/238psecs Accessed 25/11/2023.

2 Joint Select Committee on Northern Australia, *Issues Paper - Workforce Development in Northern Australia*, Commonwealth of Australia, June 2023. https://tinyurl.com/2p99ys7y Accessed 22/11/2023

Using Australia's existing health workforce better

Recognising paramedicine and allied health practitioners

The Issues Paper notes (1.41) that the number one employing industry nationally and for all regions listed (except Mackay) is healthcare and social assistance. The Paper also notes (1.43) that according to the Department of Employment and Workplace Relations, in 2022, 69 per cent of recruiting employers in Northern Australia reported difficulty filling their most recent vacancies.

There is no doubt that an adequate health workforce is a critical component for development.

The Australian Government's Long-Term National Health Plan is committed to reforming the health system to be more person-centred, integrated, and equitable. In principle, the plan provides high-level policy goals including better funding models for a range of primary healthcare services, covering allied health, non-dispensing pharmacists, nursing, mental health services and support for rural and remote communities. However, more detailed implementation steps are needed.

While proposing the foundations for integrated care, the plan gives scant attention to the role of Allied Health Practitioners (AHPs), paramedics and other health service workers as independent stakeholders in primary care. When it comes to workforce data, paramedics are variously omitted (or included) as part of the allied health workforce in national and jurisdictional datasets.

This is despite paramedicine having more than 24,000 registered practitioners in Australia and their growing engagement within the public and private healthcare systems.

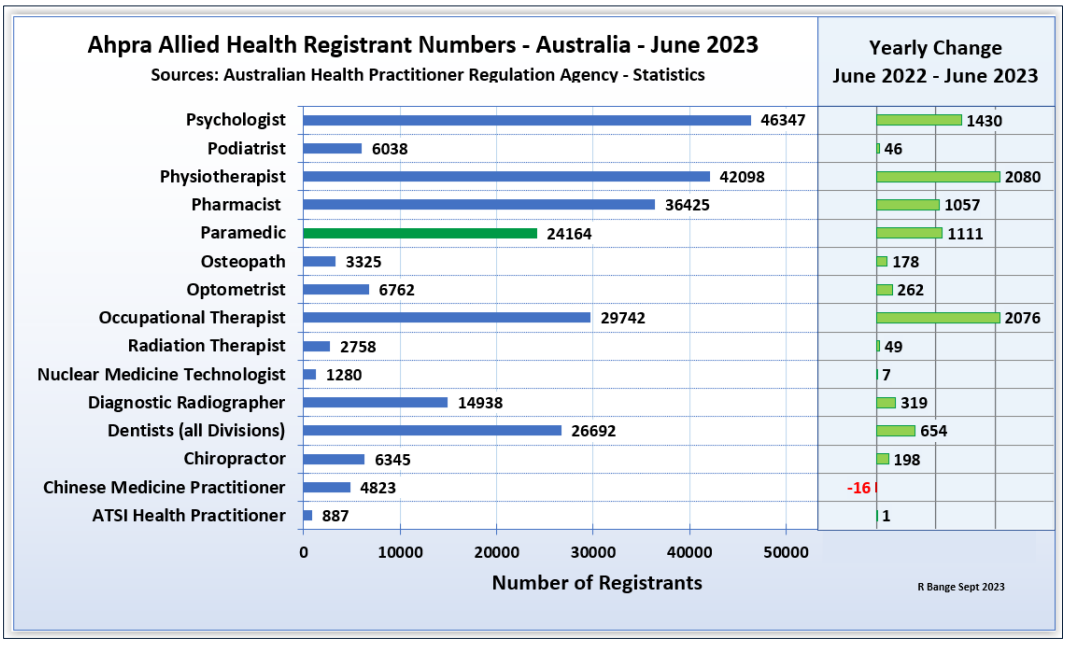

Figure 1. Ahpra Registered Allied Health Practitioners in Australia

The author's original submission (No 53) outlined how paramedicine is commonly not included within the lists of health professions eligible for Australian Government scholarships, or for practice and continuing education support and incentives for those working in higher category MMM regions. The submission also highlighted the absence of support for practitioners working in the public sector which is not conducive to professional recruitment and retention *(pp 19-21, Recommendation 2).*

The absence of professional support is a powerful disincentive for any health practitioner moving to less populous regions who must meet continuing education and competency requirements for registration. This omission may be unconscious – but it affects the mobilisation of available workforces in building effective health workforce teams.

There could be several reasons why that support might be left out, and for paramedicine, this could be due to not knowing what skills paramedics hold and their accountability for maintaining competence. Information on private providers is poorly captured - with the result that data on paramedicine are scattered, unreliable and inadequate.

In practice, few health workers are closer to the community than the paramedics working for private services, ambulance services or industrial organisations. Yet little reference is made in many policy discussion papers to the crucial work of ambulance (aka paramedic*) services operating daily at the immediate face of community contact and care.

First Nations and remote communities across much of Northern Australia face additional challenges due to limited health infrastructure, long distances and low population densities. Many service indicators reinforce the need for more Indigenous health workers which are reflected in the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (p 36).[3]

In addition to incentives and support for practitioners, Australia also needs to reform the regulatory and funding barriers to AHP practice and the mindsets that focus disproportionately on medical practitioners. GPs are crucial in delivering primary care but both GPs and AHPs need better support.

Teamwork is needed with more clinicians, such as Aboriginal and Torres Strait Islander Health practitioners, nurses, paramedics and other AHPs in serving the communities with the biggest gaps in care. These practitioners should be more widely deployed across Indigenous health agencies, outreach centres, GP clinics and other community healthcare centres.

The author thus welcomes recent developments to improve the distribution of the health workforce through the Working Better for Medicare Review. The Review is intended to identify ways to improve health access for all Australians, by building a stable and properly located workforce.[4]

The Review will look at the role of Medicare in locating the workforce, as well as the three main policy levers currently used to enhance the distribution of the health workforce, viz:

- Modified Monash Model,
- District of Workforce Shortage, and
- Distribution Priority Area.

This Review has significance for paramedics and other AHPs who have been largely overlooked for funding under Medicare. That omission has been advanced as a significant impediment to the mobilisation of paramedics more widely across the health domain.

*Throughout this submission the terms ambulance service and paramedic service may be used interchangeably.

3 *National Aboriginal and Torres Strait Islander Health Plan 2021–2031,* Department of Health, Australian Government, December 2021. https://bit.ly/3hmSReL Accessed 28/11/2023

4 The Hon Mark Butler MP*, Improving the uneven spread of doctors and health workers,* Department of Health and Aged Care, Media release, 21 November 2023. https://tinyurl.com/5xs3ppzx Accessed 28/11/2023

The Working Better Review will build on other current work to strengthen Medicare like the "Unleashing the Potential of Our Health Workforce" review, which will ensure that – wherever they work – every health professional can work to the extent of their skills, training, and experience.[5]

The aim is to have an appropriately located workforce, particularly in areas that find it difficult to attract and keep health practitioners, so that Australians can access the care they need when they need it. It is a positive objective that should foster Northern Australian development.

Paramedics as part of the solution

Paramedics in Australia became nationally registered as independent health practitioners under the Health Practitioner Regulation National Law Act (National Law) from 1 December 2018. This followed many years of rigorous assessment of the educational and practice foundations of the profession.

Becoming a registered profession in Australia required fulfilment of the (then) Australian Health Ministers' Advisory Council (AHMAC) regulatory assessment criteria for adding new professions to the National Registration and Accreditation Scheme for the health professions.[6]

The six criteria were:

1. Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
3. Do existing regulatory or other mechanisms fail to address health and safety issues?
4. Is regulation possible to implement for the occupation in question?
5. Is regulation practical to implement for the occupation in question?
6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

At the core of professional accountability and independent practice is Criterion 2 which deals with the risks of practice. AHMAC prepared a risk matrix that showed paramedicine is a demanding health profession with paramedics practising across at least ten of the 13 identified areas of risk.

A consequence of registration is that a person must not use the title or hold themselves out as a paramedic unless they are registered under the National Law. This ensures the standard of practice and protects the public.

Notwithstanding the advent of registration, the engagement of paramedics as independent health practitioners have been delayed in Australia by legislative and regulatory barriers, embedded documentation, outdated literature and publications, the conflation of paramedicine with ambulance services and the absence of an occupational classification aligned with the National Law.

5 Bange R, *Unleashing the potential of our health workforce – consultation*, The Paramedic Observer, Facebook 13 September 2023. https://tinyurl.com/3jufnpmr Accessed 28/11/2023.

6 Australian Health Ministers' Advisory Council, *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*, September 2018. https://tinyurl.com/3kewjjuw Accessed 21/10/2023

Practice settings may be highly variable and (like medical practitioners and nurses) a paramedic can work across many health and care settings apart from the highly regarded ambulance services.[7] While this diversity of employment is common in the UK it is less evident in Australia.[8, 9]

The current Australian and New Zealand Standard Classification of Occupations (ANZSCO) is based on data from a bygone era, yet is used by the Commonwealth for labour force statistics and by various recruitment agencies and employers for their occupational descriptors and labour force reporting.

These agencies have continued to use job descriptions calling for 'ambulance paramedics' for positions that are not ambulance service-based but may be in a clinic, hospital, or other facility such as industrial sites, or for aeromedical rescue, film production, cruise ships or casinos.[10]

Unlike the Commonwealth, which has been slow to recognise the profession, some jurisdictions have moved to formally recognise paramedicine with updated legislation that reflects the contemporary legal framework of registration. Two examples of this are Tasmania and Victoria.[11, 12, 13]

Despite such regulatory and legislative changes, outdated classification codes and definitions persist in Australian Bureau of Statistics (ABS) and Labour Force Survey data, which then permeate the documentation of workforce studies and limit the wider engagement of paramedics in health.

That situation needs to change if Australia is to mobilise an expert cohort of registered paramedics who are available to be deployed across Australia to enhance patient-centred care.

The capabilities of paramedics have been well-articulated by Dr Michael Eburn[14] who notes that in Australia, paramedics are registered health professionals under the National Law and that their authority to practice comes from their registration as accountable practitioners.

That legal status, including the protected title of paramedic, should be reflected in the ANZSCO classification and engagement of paramedics more widely across the health domain. Correct classification would see paramedicine identified as a health workforce and engaged as one of the key stakeholder groups in policy deliberations and healthcare delivery consistent with their capabilities.

The ABS is currently undertaking a review of ANZSCO and the author has proposed that paramedicine be located under Health Professionals with its own Minor Group 255 classification.[15]

7 *2023 CAA Patient Experience Survey*, The Council of Ambulance Services, October 2023. https://tinyurl.com/2ecf3ser Accessed 28/11/2023

8 Bange R, *A Roadmap to Practice*, The Paramedic Observer, Facebook, 22 March 2021. https://tinyurl.com/2jjer54b Accessed 02/10/2023

9 Bange R, *Paramedics in General Practice (England)*, The Paramedic Observer, Facebook, 11 September 2020. https://tinyurl.com/2s47wpan Accessed 12/10/2023

10 Natassia Chrysanthos, *Why this 'invisible' profession wants to step up in the healthcare system*, The Sydney Morning Herald, 1 October 2023. https://tinyurl.com/4dp5kdmd Accessed 06/10/2023

11 *Health Legislation (Miscellaneous Amendments) Bill 2022 (19 of 2022),* Parliament of Tasmania, 20 September 2022. https://www.parliament.tas.gov.au/bills/bills2022/19_of_2022 Accessed 06/10/2023.

12 Eburn M, *Health Legislation (Miscellaneous Amendments) Bill 2022 (Tas)*, Australian Emergency Law, 8 May 2022. https://bit.ly/3hE8LRZ Accessed 05/08/2023.

13 *Public Health and Wellbeing Amendment Bill 2022*, Parliament of Victoria. https://bit.ly/3MoDFYr Accessed 06/10/2023

14 Eburn M, *What it means to be a professional paramedic,* Australian Emergency Law, 15 May 2021. https://tinyurl.com/y52f5znj Accessed 06/10/2023

15 Bange R, *The classification of paramedics in Australia*, The Paramedic Observer, Facebook, 12 August 2023. https://tinyurl.com/2bxz772j Accessed 19/10/2023

Paramedicine as a significant and sustainable health profession

Data from the Paramedicine Board of Australia (PBA) and the annual Report on Government Services (ROGS)[16] provide useful insights. ROGS does not cover those paramedics working outside the jurisdictional (public) ambulance services.

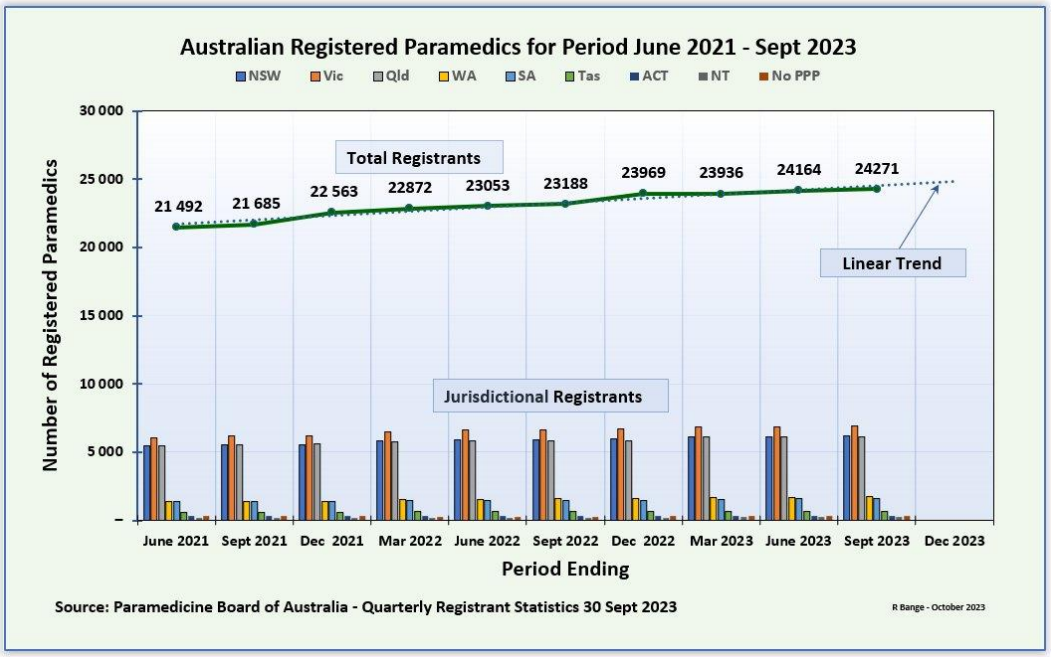

Figure 2. Australian Registered Paramedics – September 2023

Matching ROGS 2023 (Table 11A.2) and 2022 PBA statistics showing Australia had 24164 paramedics at 30 June 2023 indicates that up to one-third of registered paramedics do not work for jurisdictional ambulance services. Based on the PBA's latest registration data (30 September - 24271), more than 8000 paramedics potentially work outside the ambulance service sector.

Australian university enrolments are robust, and with future annual graduation rates exceeding 2,000 - 2,500 many graduates annually may not gain immediate employment within the public ambulance service sector based on past recruitment levels. These graduates will add to those practitioners already available to practice elsewhere across health - provided administrative, regulatory and other unwarranted practice impediments are removed.

Correct classification, formal recognition, effective data collection and reporting[17] are thus required so Australian communities can benefit from these hidden paramedics.

To facilitate the wider mobilisation of paramedics in primary care settings, the author has proposed the development of a nationally agreed practice framework and advisory materials dealing with the engagement of paramedics across a variety of practice and community settings which might inform employer groups like hospitals, outreach centres, paramedic health service providers and GP clinics.

16 Australian Government, *Report on Government Services 2023: Part E Section 11, Ambulance Services,* Productivity Commission, 2 February 2023. https://tinyurl.com/3r7m2y3j Accessed 27/09/2023.

17 Bange R, *The classification of paramedics in Australia,* The Paramedic Observer, Facebook, 12 August 2023. https://tinyurl.com/mr3cwntj Accessed 10/10/2023.

National consistency is desirable, with a task force approach suggested and consultation with all jurisdictions to ensure the articulation of a paramedicine framework at a national level. However, ahead of a formal framework, jurisdictions might begin with policy commitments and action to remove unnecessary barriers to paramedic practice that are (jurisdictionally) based.

This framework and supporting materials might form a suitable project for a consortium working in conjunction with relevant educational institutions, paramedicine professional bodies, the Department of Health and Aged Care, the RFDS, the Australian College of Rural and Remote Medicine,[18] Allied Health Professions Australia, The Council of Ambulance Authorities, Services for Rural and Remote Allied Health (SARRAH) and the Office of the National Rural Health Commissioner.

Separately, a rural generalist practitioner pathway for AHPs has been developed under the Allied Health Rural Generalist Pathway (AHRGP) for rural and remote private and non-government sector organisations with scholarship support administered by SARRAH.[19]

This program currently includes training options for medical imaging, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, podiatry and speech pathology. Additional profession-specific training options are expected to become available as the program develops.

The AHRGP scheme will see local service providers with (new or existing) early career AHPs implement and support an appropriate training position. Funded by the Commonwealth, training packages incorporate workplace grants paid to employers to support traineeships and scholarships paid directly to James Cook University to cover the coursework. A similar modified scheme might be developed for paramedics working independently in joint AHP practices or GP clinics.

Impediments to paramedic practice

While longer-established AHPs and professions like nursing are universally recognised as having a role in healthcare, embedded perceptions, historical barriers and outdated documentation remain from a bygone era that impede the wider engagement of paramedics.

The author's original submission (No 53) outlined several of these impediments such as:

- Embedded perceptions of role as being limited to ambulance services
- Inadequate formal recognition of paramedicine as an AHP/registered health profession
- Absence of relevant health lead policy roles – such as a Chief Paramedic Officer (CPO)[20]
- Omission from eligible professions recognised for scholarships, CPD and practice support
- Funding barriers and lack of payment mechanisms under MBS and NDIS
- Outdated or discriminatory routine practice restrictions – e.g. vaccination
- Obsolete ANZSCO classification and descriptors
- Absence of prescribing rights with (currently) no firm pathway/s to practice

18 Media release, *Rural Generalists and Paramedic Practitioners join forces to strengthen healthcare needs in rural and remote communities,* Australian College of Rural and Remote Medicine, 18 January 2022. https://bit.ly/33kEm4t Accessed 25/10/2023.

19 Services for Australian Rural and Remote Allied Health (SARRAH), *The Allied Health Rural Generalist Pathway*. https://sarrah.org.au/ahrgp Accessed 26/11/2023

20 Bange R, *Chief Paramedic Officer*, The Paramedic Observer, Facebook, 3 March 2017. http://bit.ly/2qqfcN5

- Restrictive provisions for the handling of medications and use of scheduled medications and the authority to carry, store, and administer a scheduled drug
- Limited workforce planning profiles and inadequate data collection and dissemination
- Restrictive job descriptions using profession-specific job descriptors unrelated to the functional work roles – and which are within the paramedic skillset.

Other impediments to wider practice are less definitive but equally significant such as employers and other health professionals being appreciably unaware of the skillsets of contemporary paramedics and the opportunities for engagement in multidisciplinary practice.

A long-standing public ambulance-centric focus also creates uncertainty regarding the status of unaccredited private paramedic service employers and inhibits the use of paramedics in other areas of health. Two of the jurisdictions involved (WA and NT) have contracted private ambulance services to deliver public services and no over-arching specific legislation.

These factors span both national and jurisdictional responsibilities. Those related to the Commonwealth arise presumably because the Australian government doesn't (generally) employ or fund paramedics or ambulance services, while the States and Territories previously were only accustomed to dealing with paramedicine through the lens of an ambulance service.

It's a situation that should have changed when paramedicine became a nationally registered health profession and as larger private service providers developed.

Ambulance services and community integrated healthcare

A strong theme in current health policy is the recognition of healthcare that is close to the community, and which ensures the right care, right patient, and right time. These principles align with national policies that envisage the growth of integrated out-of-hospital care to cater for an aging population and increasing incidence of chronic conditions that are largely preventable, with the burden particularly acute in rural and remote areas like across much of Northern Australia.[21, 22]

The author's original submission *(p 15, Figure 6).*outlined how most responses by ambulance services are not acute emergency cases demanding a 'lights and sirens' response. Rather, the services increasingly form part of community healthcare and should be included in related policy discussions as part of an integrated healthcare system.

Northern Australia embraces the operations of three jurisdictional ambulance services which operate under different legal frameworks, regulations and funding arrangements. All jurisdictions have their own legislation or regulations concerning the handling of medications.

The author has updated the aggregated figures of ambulance service funding from ROGS 2023 in adjusted 2021-22 dollars. The WA per capita contribution from the government for 2021-22 remains the lowest government funding of all services and substantially below Queensland (Qld) and the Northern Territory (NT). It is also well below the per capita national average (all services) at $148.1 *(Figure 3)*.

21 Australian Health Care Reform Alliance, *Health Workforce Policy Position Paper*, 28 June 2016. http://bit.ly/292oxB3 Accessed 10/10/2023

22 Gardiner F W, Bishop L, de Graaf B, Campbell J A, Gale L, Quinlan F. (2020). *Equitable patient access to primary healthcare in Australia*. Canberra, The Royal Flying Doctor Service of Australia, Barton ACT. https://bit.ly/3qtsNxk Accessed 10/10/2023

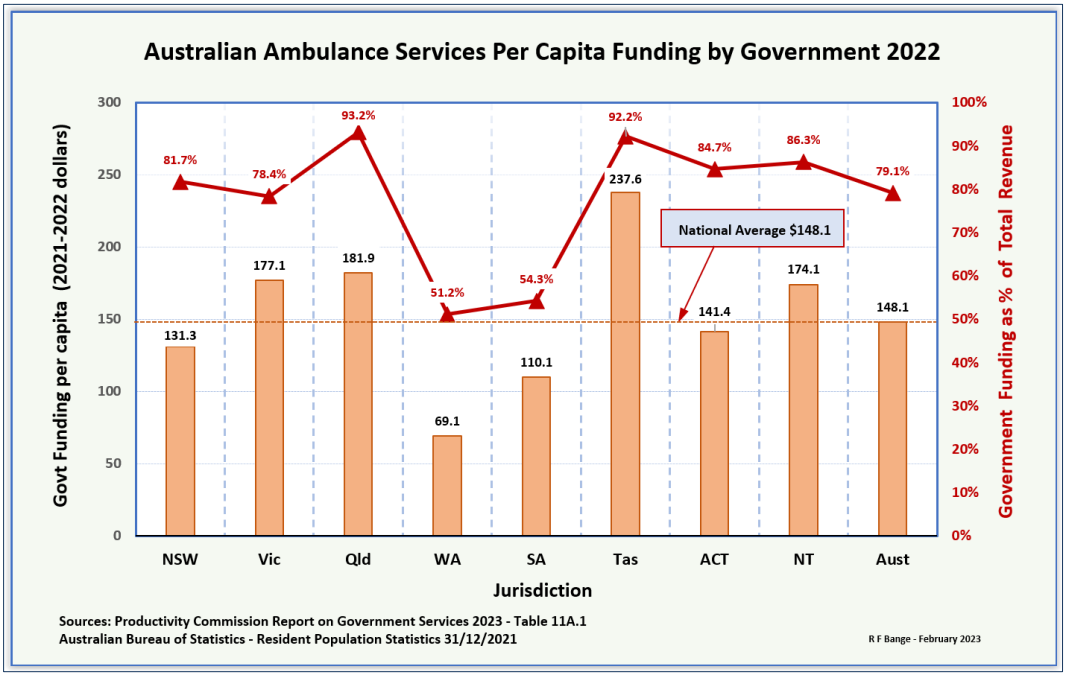

Figure 3. Australian ambulance service per capita funding by Government

The lower per capita funding by government in WA and SA is reflected in a much higher per capita contribution from transport fees *(Figure 4).* This means that a proportion of the population (those transported) is contributing to the maintenance (including overheads) of a service that the population generally considers should be universally available.

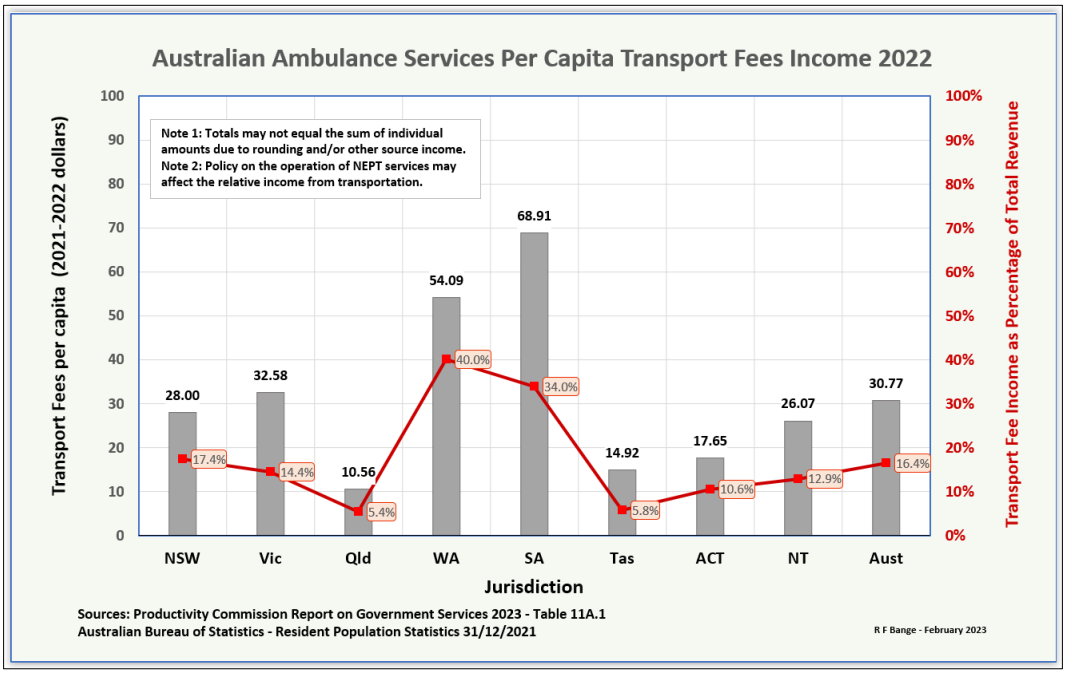

Figure 4. Australian ambulance services per capita transport fee income

Staffing of health services like St John Ambulance NT remains a problem, while the attrition rate for St John WA is also increasing *(Figure 5).* There may be multiple reasons for these increased rates but the outcomes show the importance of measures to improve recruitment and retention.

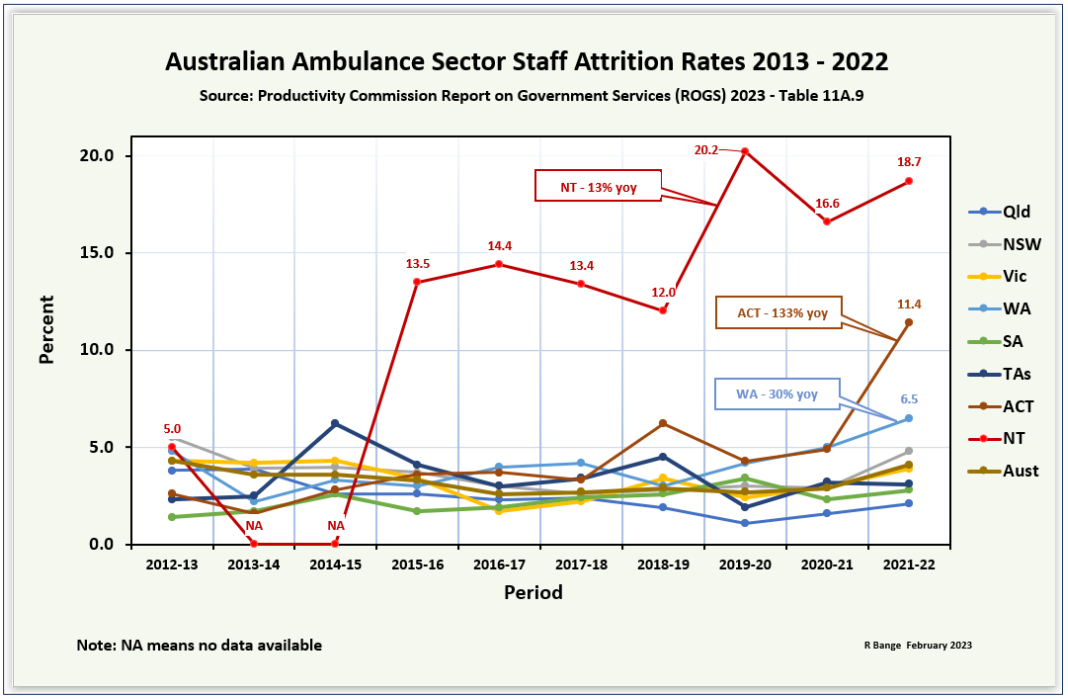

Figure 5. Australian Ambulance Sector Staff Attrition Rates 2013-2022

The author reiterates several observations from his original submission (No 53).

Additional government funding appears needed for the WA St John ambulance service while noting that there is a hybrid service role with government in the WA Country Health Service and the Royal Flying Doctor Service (RFDS). A commitment should be made to bring the per capita government grant to a long-term funding level commensurate with the national average per capita contribution adjusted for inflation and population.

A second observation is the significant burden of transportation fees placed on users to underpin the operations and overheads of a 'universal' jurisdictional service. A single stream of government funding is recommended, sourced from general revenue and partly or fully underwritten by a more general community levy or other source – preferably from a national level.

There is strong evidence that expectations of costs dissuade people from seeking help. On access and equity grounds, community-based funding from government-sourced revenue should be adopted, so the ambulance services are fully funded as essential community services like (say) Police and thus nominally 'free' for residents, like in Qld and Tasmania.

A third issue is that the ambulance sector is an orphan when it comes to national funding. The States and Territories have taken responsibility not only for the provision of the services but also for the government-based funding. There is a stark gap in the funding of these services and accountability between primary care and more definitive hospital and medical care.

The extensive Inquiry by the Tasmanian Legislative Council into Rural Health Services in Tasmania noted that integrated and multidisciplinary health care services are important in overcoming access barriers and their detailed nature requires an approach that is informed by local community needs.

The final Tasmanian report[23] highlighted that the Australian Government is responsible for funding of most primary health care and emphasised the need for ongoing collaboration between State, Territory and Australian Governments to address poorer health outcomes and access barriers and to meet the specific needs of individuals living in more isolated areas.

Finally, the attrition rates for public-funded or underwritten services like St John Ambulance NT show that appropriate conditions and remuneration are needed to attract and retain professional staff. For recruitment and retention of mobile practitioners in fields like healthcare there is no room for arbitrary public/private employment distinctions in support arrangements if we are to ensure best practice across the community.

What are some implications?

This supplementary submission provides fresh data confirming the availability of registered paramedics on a national basis. It continues the theme of the original submission No 53 and reinforces the message that Australia should mobilise the untapped potential of paramedicine as an expert health workforce that the community sees every day but doesn't put to wider use

Since lodging the original submission, a major national development is the examination of how healthcare workers can be empowered to use their full skills and training. Professor Mark Cormack has been appointed to this review, titled *"Unleashing the Potential of the Health Workforce"*.

With an interim report planned for December 2023 the outcomes of the review have relevance to the author's recommendations on the better mobilisation of paramedicine.[24] Good workforce policies that work for Australia will benefit Northern Australia.

Past funding arrangements in Australia have favoured acute care to the detriment of primary health care. The arrangements constrain flexibility in terms of employment, scope of practice and models of care; limit the capacity for team-based care; and present financial and professional barriers to health professionals who work in rural and regional Australia.

Funding models must provide the flexibility to make it easier for rural physicians, nurses and midwives, dentists, pharmacists and other AHPs to deliver primary health care across the gamut of health including aged care, disability services and palliative care.

Funding innovations might include modified fee-for-service; incentive programs; activity-based funding and bundled payments; capitation; blended funding; or pooled funding.

Some current scholarship and practice incentives have perceived limitations and need review. An important issue is that AHPs need to be considered in the context of services delivered as individual practitioners as well as in their adjunct roles to GPs.

The addition of more reimbursable practice roles that enable Primary Care Networks in the UK to add various AHPs to make up their multidisciplinary workforce has seen a rapid increase in the use of AHPs throughout the primary care landscape. Australia could do something similar.

23 Legislative Council Government Administration Committee "A", *Report on Rural Health Services in Tasmania*, Parliament of Tasmania, Hobart, 25 October 2022. https://bit.ly/3N0bVeq Accessed 25/10/2023

24 Bange R, *Unleashing the potential of our health workforce – consultation*, The Paramedic Observer, Facebook, 13 September 2023. https://tinyurl.com/3jufnpmr Accessed 28/11/2023.

At a provider level, Australia's ambulance services are among the best in the world and provide extensive coverage across jurisdictions for out-of-hospital and at-home and other community care. Significant benefits have been demonstrated by community paramedicine programs which have consistently shown positive outcomes and won awards.[25]

International experience and multiple pilot studies on the use of community paramedics have been overwhelmingly positive, leading the author to propose the wider use of community paramedics with long-term sustainable funding.

Community paramedics bring valuable services to the general population, working closely with GP's, Community Nurses, Aboriginal Health Services and other NGO's / Government Agencies to connect people to the most appropriate points in the health service.

The move to enhanced community care through ambulance services and community paramedics raises the important issues of funding complementary roles and primary care substitution that warrant Commonwealth funding for ambulance services.

The private nature of the WA and NT ambulance services and the need for more appropriate funding models also raise other issues of access and equity and reinforce the case for total funding by the government and potentially long-term operation of the services as essential government agencies.

Examining paramedicine as a standalone profession the case has been advanced for:

- establishment of a national task force to facilitate independent paramedic practice;
- identification and removal of unwarranted impediments to practice;
- access to MBS and NPS schedules for appropriately credentialled paramedics;
- eligibility of paramedics for rural and remote student and practitioner support;
- the preparation and distribution of paramedicine-related employment materials; and
- the appointment of a Chief Paramedic Officer at both jurisdictional and national levels.

The author acknowledges that legislative and other changes would be needed to implement changes that span jurisdictional and national responsibilities. For example, the introduction of advanced practice models of care and the use of paramedics in general practice, urgent care and hospital settings (among others) will be impacted by the various jurisdictional Drugs Poisons and Controlled Substances regulations for the handling of medications.

On the other hand, the registration of paramedics is a national issue spanning all practice settings, and the observations on practitioner support programs and innovative funding of multidisciplinary practice may embrace a national commitment as well as jurisdictional commitments.

25 SA Health, *Excellence in Strengthening Partnerships – SA Health Awards 2019*, https://bit.ly/2QEYpR1

Detailed responses to Issues Paper – Health

Targeted migration

Given the global and national shortfall of health workers, how could Australia ethically introduce targeted migration to help reduce severe health workforce shortages in Northern Australia?

The author does not see any particular ethical issues in bringing in more targeted migrants to fill healthcare gaps in Northern Australia.

What may be more important is whether there are relative advantages in sourcing personnel from overseas when there are opportunities to mobilise existing local workers. External recruitment also does not address the long-term retention of (all) healthcare professionals in regions of need.

Australia already has a large proportion of its rural and remote GP workforce sourced from international medical graduates. Despite severe and chronic AHP workforce shortages, no similar program of support has been available to enable AHP immigration, with supervision arrangements to enable registration to practice in Australia.

Current workforce shortages suggest Australia could develop and introduce such an AHP program to help address workforce and service shortfalls in the short to medium term. The timeframes involved in preparing students for practice mean even a targeted addition of rurally oriented AHP domestic students would not be available to significantly impact service demand in the short-medium term.

However, migration programs can have drawbacks. They may attract practitioners with basic qualifications for short-term work in disadvantaged areas, with the hope of later moving to more favourable urban locations or obtaining additional qualifications.

Such programs typically function within corporatised systems where clinicians may work under remote supervision. This can lead to higher risks for community health, and overall lower standards of care and cultural dissonance.

These stop-gap approaches fall short of providing comprehensive holistic care and can exacerbate inconsistent healthcare in different areas. While supplementing professional staff with international graduates can work well in a carefully managed team, this normally requires good support systems. Otherwise, it may result in cycles of clinician turnover. A well-founded and layered healthcare team can better manage changes in professional staff by maintaining consistency and community trust.

Research indicates that recruiting locally contributes to higher retention. In the long term, using domestically trained and locally experienced healthcare workers is likely to address the needs more efficiently and with better quality and safety compared to bringing in practitioners from different backgrounds who may not understand the local working environment and cultural nuances.

There are assertions that inadequate attention is paid to cultural differences. Like a skilled gardener who understands the importance of careful transplanting for a plant to thrive in new soil, it's crucial to be attentive to the motivations and support of incoming practitioners, especially initially.

It's important to first remove the systemic barriers faced by existing Australian professionals. Many registered paramedics may be available, even if they're not currently in Northern Australia.[26]

We should focus on reducing the barriers to workforce mobility. This could include making state medication laws more consistent and offering incentives like housing and financial support for Australians who move to areas with workforce shortages. Housing and family support are particularly important matters for a practitioner relocating.

Another approach could be to offer extended working visits including housing and travel expenses for appropriately qualified paramedics from the UK and North America where community paramedicine is more established. Their extensive experience in community care could be a valuable addition to many GP practices and clinics, and help develop familiarity and acceptance of the role.

Implementing the recommendations of the Kruk report[27] would be an important first step. This aims to make it easier for internationally trained and registered health professionals to have their qualifications recognised. For example, expedited visa assessment for overseas trained AHPs identified on the Skilled Occupations List – and prioritising sponsors who are AHPs providing services in an area of workforce need (MMM3-7).

New Zealand is well ahead of Australia in simplifying the professional registration, visa and residential status of immigrant health professionals and Australia should act now.

Figure 6. Issues associated with overseas recruitment (Kruk)

26 Bange R, *Integrating Paramedics into Primary Care,* The Paramedic Observer, Facebook, 20 April 2023. https://tinyurl.com/2bf9psbt Accessed 28/11/2023

27 Robyn Kruk AO, *Independent review of overseas health practitioner regulatory settings - Interim Report*, April 2023. https://tinyurl.com/yj6b53ay Accessed 28/11/2023

Effectiveness of policies

Despite decades of government initiatives, health workforce shortages remain in Northern Australia. What government policies have been most effective and what have not been effective?

Many government initiatives have been focused on the GP role in general practice and only more recently has attention turned to the importance of AHPs and nurses in the delivery of health services. Multidisciplinary teams are needed to maintain effective health service provision in these locations, particularly where some healthcare workers are transient and cannot maintain continuity of care.

All healthcare professionals should be connected through public hubs in more isolated locations and not disconnected and separate, so any gaps in care can be mitigated by the team. This would require healthcare worker funding to be available to all with a reduction in professional silos.

Limitations might be applied in allowing funding to be diverted to private practice in cases where it would be better to amalgamate state/federal funding sources for efficiency in delivering more comprehensive healthcare.

Some government policies have been too selective and thus only partly effective. Paramedics and other AHPs should be included under the Medicare Benefits Scheme (MBS), NDIS and any other fee-for-service systems for which they hold appropriate but unrecognised skills. Funding models must include the option to employ paramedics in private practice with direct payment for services.

These funding and regulatory reforms might support Rural and Remote Multidisciplinary Health Teams[28] with specific inclusion of community paramedics and paramedic practitioners. Paramedics are comfortable working autonomously and as members of multidisciplinary teams.

Community paramedic programs and paramedic practitioners are low-acuity specialists who can provide home visits for a variety of patient presentations. Their role is highly diverse and often tailored to the local context. They cover activities such as supporting the transition from hospital to home, assessing and referring patients to community-based programs, and providing direct preventive care and chronic disease management support.

Community paramedic roles have been expanding to include the authority to practice independently, prescribe medications, bill for services, and maintain other elements of autonomous practice. These practitioner roles are perceived as the logical next step in professional development but need support to become better established (see Cormack Review).

There is a vast body of evidence internationally that supports the effectiveness of community paramedicine programs in reducing the level of emergency calls, improving chronic disease management, and enhancing access to other pathways of community-based care. [29, 30]

28 Bange R, *Ngayubah Gadan Consensus Statement*, The Paramedic Observer, Facebook, 20 June 2023. https://tinyurl.com/33hctnje Accessed 29/11/2023.

29 Leyenaar MS, McLeod B, Penhearow S, Strum R, Brydges M, Mercier E, Brousseau AA, Besserer F, Agarwal G, Tavares W, Costa AP., *What do community paramedics assess? An environmental scan and content analysis of patient assessment in community paramedicine*, CJEM. 2019 Nov;21(6):766-775. doi: 10.1017/cem.2019.379. PMID: 31366416

30 Rural Health Information Hub, https://bit.ly/3cAakdk accessed 25/11/2023.

Community paramedicine models vary widely as can be seen in examples such as the Canadian Renfrew County Paramedics program;[31] the UK agreement to formally support the role of community paramedics;[32] plans for community paramedicine in Hawaii;[33] Mobile Integrated Health system in Alberta;[34] and the evaluation of community paramedicine in Ontario.[35] A related international group sharing ideas on rural healthcare is the International Roundtable on Community Paramedicine.[36]

In Australia, several pilot projects were sponsored by the former Health Workforce Australia along with an independent evaluation.[37] The evidence was that paramedics can provide a range of care that is highly beneficial and cost-effective at a community level – a finding in common with almost every study internationally. Despite the established effectiveness of these programs little action has been taken to implement them.

Reforms to ensure adequate health graduates

What reforms are needed to ensure there is a greater number of health graduates willing to work in Northern Australia?

Newer graduates generally seek a varied caseload to build experience within a field of specialisation or preferred practice. If new paramedic graduates were given the option, few would choose to work in rural or remote areas where there is a low monthly caseload due to concerns about developing expertise in the management of complex cases that they may rarely see in these areas.

Ambulance services staff these areas by requiring new staff to move under their contract of employment in a similar way to teacher graduates and police postings.

Similar views are held by practitioners from other health professions, and getting graduates to relocate to more remote areas will always be a challenge. Moving their family is even less attractive for more experienced practitioners regardless of the remuneration or housing assistance, so capturing recent graduates is likely to be more successful.

Innovative measures to expand rotational training and internship development would be attractive, including training positions that span both public and private sector roles. That requires changing mindsets that tend to pigeonhole graduates into fixed private/public roles.

Long-term position commitments offering funding and adequate leave with locum support for continuing professional development would be attractive incentives for healthcare professionals.

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31 Bange R, *A focus on Renfrew County paramedics,* The Paramedic Observer, Facebook 29 July 2019. https://bit.ly/38FLeIZ Accessed 25/11/2023.

32 Bange R., *NHS Agreement formally supports role for community paramedics*, The Paramedic Observer, Facebook 6 February 2019. https://bit.ly/3cx3DZJ Accessed 25/11/2023.

33 Eleni Avendano, *State Aims to Reduce Unnecessary ER Visits By Empowering Paramedics*, Hawaii News, Honolulu Civil Beat 26 July 2019. https://bit.ly/3eGx9yA Accessed 25/11/2023.

34 Alberta Health Services, *EMS Mobile Integrated Healthcare: Community Paramedicine* https://bit.ly/3lklU0o Accessed 25/11/2023.

35 Bange R., *Community paramedicine evaluated in Ontario*, The Paramedic Observer, Facebook, 14 May 2019, https://bit.ly/3rSYiCc Accessed 25/11/2023.

36 International Roundtable on Community Paramedicine, http://www.ircp.info/ Accessed 25/11/2023.

37 Thompson C, Williams K, Morris D, Lago L, Kobel C, Quinsey K, Eckermann S, Andersen P, Masso M, *HWA Expanded Scopes of Practice program evaluation: Extending the Role of Paramedics sub-project: final report*, Australian Health Services Research Institute, University of Wollongong, Australia, 2014. https://tinyurl.com/y2v8yawx Accessed 25/11/2023.

Having more regionally sourced and trained graduates generally results in better long-term retention and this suggests the provision of higher levels of funding for educational and research centres within the region and enhanced student support through scholarships or lower fees.

An example is the high turnover of paramedics in St John Ambulance (NT) and the recent addition of paramedicine programs at Charles Darwin University - which is too recent to assess the likely impact.

Another obvious solution is to expand the recruitment pool by including paramedicine among the nominated professions in advertisements for healthcare positions.

Paramedics and other AHPs should be included under the Medicare Benefits Scheme (MBS), NDIS and any other fee-for-service systems for which they hold appropriate skills. Funding models must include the option to employ paramedics in private practice with direct payment for services.

These funding and regulatory reforms might support the development of Rural and Remote Multidisciplinary Health Teams[38] with specific inclusion of community paramedics and paramedic practitioners. Paramedics are comfortable working autonomously and in multidisciplinary teams.

This will expand the employable workforce pools, including national and international paramedics from the UK and North America who have been practising in primary healthcare, community paramedic and paramedic practitioner roles for more than two decades.

In the interim, telehealth using reliable satellite communications and fly-in clinics may be a more feasible solution for AHPs as well as for medical and nursing /midwifery positions.

The impact of financial incentives

Have financial incentives at the tertiary level and clinical placements had a positive impact?

Despite some positive aspects, relying solely on financial incentives has limitations. While acknowledging some positive outcomes, financial incentives need to be considered in the context of more nuanced support factors to drive both recruitment and retention of healthcare professionals.[39]

Instead, fostering a connection to the community and a sense of belonging and integration into the community is essential for retaining staff. Factors such as housing, schools, and social events are commonly mentioned as key contributors to the longevity of health workers in rural or remote areas.

More positive moves would be reforming legislation and removing unwarranted barriers to practice. Suggested reforms include harmonising legislation such as state poisons legislation *(Recommendation 4 Submission 53)* and regulations that hinder practitioner mobility.

A transformation in funding and employment practices is needed to allow professionals from various healthcare fields to contribute in diverse capacities and not reserve policy, managerial and broader health and career development roles to a nominated profession unless inherent clinical requirements dictate otherwise.

This shift would enhance overall service quality and delivery by allowing professionals, such as paramedics and other AHPs to contribute across various leadership capacities.

38 Bange R, *Ngayubah Gadan Consensus Statement,* The Paramedic Observer, Facebook, 20 June 2023. https://tinyurl.com/33hctnje Accessed 29/11/2023.

39 Chauncey Crail and Rob Watts, *Effective Employee Retention Strategies In 2023,* Forbes Advisor, 13 July 2023. https://tinyurl.com/yv9w4adj Accessed 28/11/2023

In summary, while financial incentives play a role, they are not a comprehensive solution. A shift towards holistic programs, legislative reforms, and diversified roles is necessary to overcome existing barriers and promote sustained and integrated healthcare.

It's about creating an environment where healthcare practitioners feel deeply embedded in the community for long-term commitment, beyond just offering attractive salaries.

Reforms at a College level

What reforms are needed at the College level to recognise qualifications or increase the number of health practitioners?

This question appears to be a Freudian slip or parapraxis, based on unconscious perceptions that only physicians are health practitioners. Treating the question more generally in terms of (say) Ahpra registered practitioners, an increase in the available graduate education programs, and easier access to credentialled certification and continuing education courses would be helpful.

An example is a staff member who recently resigned from Darwin to complete a postgraduate program in Midwifery. She wanted to stay in Darwin but couldn't get the placements required.

The paramedic workforce is significantly underutilised in the North. It has been effectively pigeonholed into jurisdictional ambulance work. An increase in the flexibility of the mindset around the use of paramedics in a broader capacity would be a welcome reform and provide a significant increase in the number of available health practitioners.

Optimum incentives

What does evidence suggest most incentivises medical and health professionals to work in Northern Australia? For example, training pathways, accommodation subsidies, guaranteed employment for spouses, large salary packages.

Safe and secure accommodation and support with relocation and accommodation costs are pivotal to attracting staff. Above-award rate salaries that compensate people for living remotely and guaranteed employment for spouses, suitable childcare and school placements are all important.

The ability and available resources to travel for ongoing education and exposure to higher volumes of clinical experience have been major requests from the remotely located paramedic workforce.

In 2019 the NSW Ministry of Health commissioned a workforce rapid review by SARRAH on Strategies for Increasing Allied Health Recruitment and Retention in Rural Australia.[40] The strongest evidence concerning the recruitment of AHPs to rural and remote practice revolves around:

- Rural background
- Curriculum that reflects rural health issues
- Quality rural placements.

Factors found to influence retention are broadly categorised as professional and organisational, social (family and personal), and financial. These are modifiable to a varying degree.

40 Battye, K., Roufeil, L., Edwards, M., Hardaker, L., Janssen, T., Wilkins, R. (2019). *Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review.* Services for Australian Rural and Remote Allied Health (SARRAH).

Non-modifiable factors include location and community amenity, while modifiable factors include:

- Safe and supportive work environments
- Career development
- Nature of the work and outreach support
- Professional networks
- Public recognition of the role
- Appropriate financial incentives.

Summary of factors that influence recruitment and retention of Allied Health Professionals in rural areas across the professional lifespan

Elements	University	Early Career AHP	Establishing Career AHP	Mature Career AHP
Attraction and selection	• Describe the role and service environment • Market and promote the professional and personal benefits of rural practice and lifestyle			Re-entry programs and support mechanisms
Training pipeline	Quality student placements: • Supervision • Rural practice and community immersion • Multidisciplinary exposure • Service learning	Rural and remote ready: • Clinical and non-clinical skills and capability development	Continuing professional development Advanced skills to meet community need	
Mentoring, supervision and support	Co-design support strategies with allied health stakeholders: • Vocational planning • Case management transition to rural practice and/or new location • Preceptorship • Mentoring • Flexible supervision • Business development			
Accreditation and recognition	Nationally accredited postgraduate education programs for rural and remote practice and qualifications that are recognised and transferrable across jurisdictional boundaries			
Underpinning components				
Incentives	• Financial incentives individually tailored to career and life stages • Non-financial incentives - partner/spouse employment, family and social connection to community, good living conditions			
Supportive work environment	• Adequate staffing and leave relief • Infrastructure "to do the work" • Effective workplace - orientation and induction; communication; culturally sensitive; career advancement • Sustainable service delivery model - caseload, outreach • Management by senior allied health professional with rural and remote experience			
System capability	Enable allied health professionals to work to their full scope of practice by implementing: • Delegation (AHAs) • Telehealth • Skill sharing • Infrastructure - equipment			
Recognition of contribution of allied health	Building the evidence for: • Allied health intervention in 'real world' rural and remote models of care • Workforce strategies • Cost effective service models			

The author supports these findings as being applicable to Northern Australia.

Optimum models of health care

Which models of health care are working best in parts of remote Northern Australia, particularly in remote Aboriginal and Torres Strait Islander communities?

The most successful models of care appear to be those that are close to the patient and culturally sensitive. The complexity of many patient presentations points towards the development of team-based care systems that are comprehensive and multidisciplinary.

Priority changes in primary care

What needs changing in the delivery of primary health care in Northern Australia as a matter of urgency?

We need better ways to make decisions about healthcare and strategies that are multidisciplinary, multi-professional and genuinely inclusive. We particularly need to ensure that the right people, including representatives of key stakeholder populations and communities, are at the table. That extends to finding ways to engage with consumers, carers, and the broader community.

We need to be better at engaging with and empowering, people who are culturally and linguistically diverse. The pandemic response has shown that health systems can adapt in flexible ways and that some long-held practices could change for the better.

The implementation of community paramedicine (CP) is proposed as part of this process. CP is an evidence-informed, proven model of care that has been successfully implemented across the UK and North America for well over two decades.

Australia and to a lesser degree Aotearoa New Zealand have been slow to adopt CP programs although they have been in place on the Kapiti coast and elsewhere for several years. There are several rural and remote CP models of care currently in operation in Australia that could be adopted across Northern Australia along with models informed by lessons from many overseas examples.

Australian locations include Ceduna, South Australia (SA Ambulance Service), Mildura, Victoria (Sunraysia Community Health Services), Wiluna, Western Australia (Ngangganawili Aboriginal Health Service), Launceston, Hobart and Ulverstone (Tasmania),[41] In all of these models, community paramedics work as members of multidisciplinary teams to deliver person-centred care.

These and other recommendations formed part of the author's original submission *(Appendix A)*.

41 Jeremy Rockliff, *Community Paramedics to boost patient care for Tasmanians,* Tasmanian Government, 4 August 2023. https://tinyurl.com/4w7rnysj Accessed 28/11/2023.

Immediate action steps

Of the solutions proposed above, which do you consider have merit and should be adopted immediately?

The key premise of this submission is that the development of Northern Australia will depend upon the sustainability of a diverse workforce, which in turn will depend on the presence of an adequate and culturally sensitive health workforce and supporting infrastructure.

Health policy must be open to flexible models of care and more inclusive roles across the range of available workforces. Embedded perceptions and other impediments have meant that paramedic engagement in health is limited not by the capabilities of practitioners, but by issues such as public and professional awareness and other unwarranted impediments.

Overcoming such perceptions requires leadership at a senior level like that able to be provided by the appointment of a Chief Paramedic Officer (CPO) as a member of the peak health policy team in each of the relevant jurisdictions.

Change legislation to give billing rights to paramedics under the MBS and NDIS. This will then open up employment opportunities for the paramedicine profession and provide a wider range of health clinicians for employers to select from both nationally and internationally.

Other suggested moves depend on policy developments that are currently under review. The author nonetheless recommends implementation of the 11 recommendations of Submission 53 as soon as feasible within the context of those developments.

Abbreviations / Definitions

The following abbreviations and definitions are used in this submission.

AHP	Allied Health Profession/Professional/Practitioner
AHRGP	Allied Health Rural Generalist Pathway
ANZSCO	Australian and New Zealand Standard Classification of Occupations
Aphra	Australian Health Practitioner Regulation Agency
CP	Community Paramedic
CPO	Chief Paramedic Officer
GP	General Practitioner
MMM	Modified Monash Model 2019
NT	Northern Territory
PBA	Paramedicine Board of Australia
Qld	Queensland
RFDS	Royal Flying Doctor Service
ROGS	Report on Government Services (Productivity Commission)
UK	United Kingdom
SARRAH	Services for Australian Rural and Remote Allied Health
WA	Western Australia
WIP	Australian Government Workforce Incentive Program - Practice Stream

Registered Paramedic - A professional health care practitioner registered under the National Registration and Accreditation Scheme and whose education and competencies empower the individual to provide a wide range of patient-centred care and medical procedures in diverse settings including out-of-hospital scheduled and unscheduled care situations.

Community Paramedic – a broad term used to describe any paramedic, working outside the standard Ambulance sector framework, who has undergone additional training in low acuity patient assessment and treatment. Such paramedics may work in conjunction with primary care providers such as GP clinics or Urgent Care Clinics and other health settings.

Appendix A - Recommendations from Submission No 53

The key premise of this submission was that the development of Northern Australia will depend upon the sustainability of an adequate diverse workforce, which in turn will depend on the presence of an adequate and culturally sensitive health workforce and supporting infrastructure.

While there are many facets to healthcare and a wide range of professions and other stakeholders, the current national practitioner framework is built around the three major pillars of Medicine, Nursing/Midwifery and Allied Health.

Other stakeholders no doubt will address different practitioner issues, and the author's focus has been on the role that AHPs and paramedics can play in better health service delivery, thereby helping to create an environment that will attract and retain a stronger workforce and community spirit not only in Northern Australia but elsewhere across Australia.

1. Recognition of paramedicine as a discrete national health workforce

The Committee might recommend that the Commonwealth formally recognise paramedicine as part of the available health workforce for statistical, policy, planning, and development purposes.

This recognition would see paramedicine potentially aligned with Allied Health or as a separate professional cohort - with the paramedicine profession engaged as one of the stakeholder groups in deliberations on health policy and primary care strategy at state, territory, and national levels.

The Committee might also support the reclassification of paramedics under the ANZSCO scheme and make appropriate submissions to any relevant ABS consultations.

2. Mobilisation of paramedicine across the health domain

To ensure effective workforce mobilisation and long-term sustainability, the deployment policy for paramedicine should include eligibility for practice support, scholarships and incentive programs intended to foster rural and remote practice on a basis no less significant than that for other AHPs.

To facilitate AHP and paramedic engagement in primary care the Committee might support the enhancement of the Australian Government HWSP and Workforce Incentive Program - Practice Stream (WIP) with the specific inclusion of paramedicine as an eligible AHP.

The support schemes generally should be reviewed to simplify the conditions of use and enable long-term engagement and reimbursement of costs not only for the employment of AHPs as adjunct appointments to GP practices but also as independent practitioners in other provider roles. The experience of the UK Additional Roles Reimbursement Scheme should be considered in this review.

As a general principle, this policy might see support for practitioners working in the public sector as well as support for those in the private sector.

Particular attention should be made to engage the Rural Workforce Agency Network (or other relevant body) to ensure the inclusion of paramedicine as an eligible AHP for various support programs and in the Workforce Needs Assessment.

3. Identify and remove obsolete and unnecessary impediments to practice

The Committee might support the establishment of a multi-jurisdictional task force to explore the impediments to practice by registered paramedics at both jurisdictional and national levels; to enable access to MBS/PBS provider programs; referral pathways; prescribing rights; access to electronic and other health records; and other elements of independent practice.

In the short to medium term, jurisdictions might be encouraged to examine barriers to practice at the jurisdictional level, including the incorporation of paramedicine within workforce studies.

4. Harmonisation of drugs and poisons regulations

The Committee might draw attention to implementing a national approach to drugs and poisons regulations; through the development of model legislation or consistent legislation in all jurisdictions that aligns with the MBS and national regulation of the health workforce; to reduce impediments to practice, and avoid duplication or overlap of unnecessary legislative barriers to workforce flexibility.

5. A framework for paramedics in primary care

The Committee might support the development of a national information dissemination program regarding the use of paramedics in multidisciplinary practice settings in both the public and private sectors. The materials should embrace employer groups, professional associations, the Australian Institute of Health and Welfare; the Australian Bureau of Statistics; and the Productivity Commission.

Jurisdictions should be encouraged to engage with the Commonwealth in distributing these materials, including toolkits, that identify paramedicine as a health profession able to work across a wide variety of practice and community settings.

These practice guidelines on the role of paramedics and their integration into general practice, primary and other care settings (e.g., hospitals, clinics) might draw on the experience and materials developed in the UK for Clinical Commissioning Groups and the UK College of Paramedics.

6. Engagement of paramedics in practice environments

The Committee might liaise at Ministerial levels and with the Department of Health and Aged Care and related jurisdictional Departments of Health to explore the wider use of paramedics to meet workforce needs in public hospitals, clinics and other health and care settings including longer-term senior citizen and aged care, palliative care and mental health care.

As an interim step, the Committee might support and fund the development of practice information and incentives to assist primary healthcare providers generally in transitioning their workplaces to optimise the use of paramedics and AHPs.

7. Appointment of Chief Paramedic Officers

To ensure adequate consideration of paramedicine within the health domain, the Committee might support the appointment of a Chief Paramedic Officer as part of the peak leadership team within the Department of Health and Aged Care and encourage jurisdictions to make similar appointments.

If a Chief Paramedic Officer is not appointed, then the role of the Chief Allied Health Officer or equivalent should incorporate specific reference to paramedicine and the substantive position(s) made open to paramedics.

8. National public and private paramedic services accreditation

Noting the absence of specific legislation for ambulance services in WA and NT and the lack of national standards for service provision, the Committee might propose appropriate action at state and national levels to implement a regime of accreditation and licensing of all paramedic (aka ambulance) service providers that complement the registered status of paramedics.

Accreditation standards should include mandatory equipment, staffing, clinical governance, performance standards and transparency of public reporting including injury statistics related to physical and mental health.

Where relevant, this accreditation should extend to any subsidiary patient transport functions.

9. Funding of ambulance services

The Committee should note the inadequate government funding for essential ambulance services within the catchment of Northern Australia, and the implications of mixed revenue funding models.

As a consequence the Committee might engage in consultations with the relevant jurisdictions including the Commonwealth, and recommend that these services be fully funded by the government; with the Commonwealth providing a base level of funding under national health funding agreements in recognition of service provision of broader community care through community paramedics and other responses.

10. Data collection and outcomes reporting

The Committee might consider recommending better data collection and reporting of patient journey data and paramedic service provider activity. For public services that might involve enhanced national performance datasets such as the Report on Government Services.

ROGS and similar reports should report the number of employed registered paramedics as well as other registered practitioners and the gender, ethnic and cultural diversity of the paramedic service workforce.

In addition, measures should be taken to capture appropriate indicators that reflect longitudinal patient data and health outcomes and contemporary response models designed to enhance patient care while also reducing the need for conveyance.

For private providers reporting should be discussed with relevant organisations and be consistent with accountabilities under any national accreditation scheme.

11. Paramedic education programs

The Committee might consider providing special support for the development of tailored programs of paramedic education including their educational and practice foundations to engage and increase the number of Indigenous paramedics.

This support might include programs linked to education programs for Extended Care Paramedic and Advanced Paramedic Practitioner cohorts, with the greater use of these paramedics having a scope of practice enabling advanced assessment, interventions and prescribing of medications.

Appendix B – Issues Paper Questions – Health

The Issues Paper has raised to following questions for feedback:

a) Given the global and national shortfall of health workers, how could Australia ethically introduce targeted migration to help reduce severe health workforce shortages in Northern Australia?

b) Despite decades of government initiatives, health workforce shortages remain in Northern Australia. What government policies have been most effective and what have not been effective?

c) What reforms are needed to ensure there is a greater number of health graduates willing to work in Northern Australia?

d) Have financial incentives at the tertiary level and clinical placements had a positive impact?

e) What reforms are needed at the College level to recognise qualifications or increase the number of health practitioners?

f) What does evidence suggest most incentivises medical and health professionals to work in Northern Australia? For example, training pathways, accommodation subsidies, guaranteed employment for spouses, large salary packages.

g) Which models of health care are working best in parts of remote Northern Australia, particularly in remote Aboriginal and Torres Strait Islander communities?

h) What needs changing in the delivery of primary health care in Northern Australia as a matter of urgency?

i) Of the solutions proposed above, which do you consider have merit and should be adopted immediately?