Senate Standing Committee
on Legal and Constitutional Affairs

SUPPLEMENTARY SUBMISSION ON

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

February 2016

Ray Bange
Adjunct Associate Professor, Central Queensland University

Richard Brightwell
Associate Professor, Edith Cowan University

Brian Maguire
Professor, School of Medical and Applied Sciences, Central Queensland University

Paramedic - A professional health care practitioner whose education and competencies empower them to provide a wide range of medical procedures and care within their scope of practice in diverse out of hospital and unscheduled care situations

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1. Executive summary

The authors make this supplementary submission as foreshadowed on page 18 of our original submission. It takes account of on-going review activities in relation to the adequacy of existing and proposed regulatory systems for paramedics.

This additional advice follows the release of the 2016 Productivity Commission *Report on Government Services*[1] (RoGS*);* the identification (to a sufficient level) of a potential case of fraudulent misrepresentation; and the examination of Australian government tender proposals.

Those three areas of review have resulted in the following broad conclusions:

i. The data provided by the 2016 RoGS confirms the continued growth of government-funded paramedic services nationally; the absence of comprehensive data on private sector paramedic service provision; the potential under-reporting of aeromedical services; the continued substantial growth in undergraduate student enrolments; and the absence of any reported enrolments or in-house expenditure on diploma-level and non-accredited educational program(s).

ii. A case of potential fraudulent misrepresentation confirms the risks associated with a reactive negative licensing regime for paramedicine which could be mitigated by proactive registration and verification processes and thereby better protect the public.

iii. A tender call for the provision of aeromedical services by the Australian government illustrates the confusion associated with the current lack of a national regulatory regime defining the role, minimum qualifications and competencies of a paramedic.

These outcomes underline the concerns already held about the adequacy of the current regulatory arrangements and the necessary and sufficient provisions to protect the public. They also reinforce the perceived importance of mobilising the knowledge and skills of the paramedic profession in the interests of the community.

The authors again strongly recommend that all paramedics be regulated nationally through registration under the National Registration and Accreditation Scheme (NRAS), established under the Health Practitioner Regulation National Law Act (the National Law) and managed by an independent Paramedic Board under the umbrella of the Australian Health Practitioner Regulation Agency (AHPRA).

We would be pleased to respond as needed on any of the issues raised. Please address any enquiries in the first instance to:

Ray Bange
Adjunct Associate Professor
Central Queensland University
Mobile 0412 723 821
Land +61(0)7 5437 7817
Email: ray@bange.net.au

Facebook: https://www.facebook.com/ParamedProf
Twitter: @Arban70

[1] Productivity Commission, *2016 Report on Government Services (RoGS),* bit.ly/23kkJiK accessed 26/01/2016

2. Background

On 20 August 2015 Queensland Senator Glenn Lazarus secured the support of the Australian Senate for the Legal and Constitutional Affairs Committee to undertake an Inquiry into the national registration of paramedics and to report by the last sitting day in June 2016. The authors made a submission to the Inquiry on 29 January 2016.

The submission drew attention to statistical information to be released on the 29 January 2016 that might modify some of the submission observations. At that time an incomplete study also was underway concerning a potential fraudulent misrepresentation case related to paramedicine. Another matter relating to the provision of contracted health services for the Australian Defence Force (ADF) was also under examination. The authors therefore foreshadowed additional input through a supplementary submission (primary submission p 18).

This supplementary submission addresses three principal areas:

- updated data and conclusions on the role and contribution made by paramedics;
- the adequacy (or not) of current and proposed regulatory frameworks; and
- other related matters including the confusion in paramedic roles.

2.1 Best practice regulation

In their primary submission the authors highlighted that mobility is crucial for the health professions not only to ensure patient and practitioner safety but also to enhance workforce sustainability and to realise community benefits through better access to quality health care.

The registration of health professionals and the creation of a national register that records an individual practitioner's status are important elements in achieving reciprocity of recognition across jurisdictional boundaries and in fostering workforce mobility. It also protects practitioners from the arbitrary exercise of fitness-to-practice determinations by employers.

The authors noted the dangers of empowering industry associations, employer groups or sectional and jurisdictional interests with regulatory functions, given well-demonstrated examples of regulatory capture, moral risk and potential actions taken to progress their own interests, thus rendering suspect their competence to regulate[2] in the overall national interest.

Acknowledging that protection of the public is the primary and sufficient purpose to mandate a national (or multi-jurisdictional) scheme of regulation, the authors also outlined additional benefits that would accrue to the community through a national regulatory approach.

They noted international practice and the guiding principles set out in the Council of Australian Governments (COAG) *Intergovernmental Agreement* (IGA) and the implementation of the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory. They also outlined the *National Registration and Accreditation Scheme* (NRAS) whose objectives are set out in Section 3 of the National Law and the role of the *Australian Health Practitioner Regulation Agency* (AHPRA) as the organisation responsible for the administration of the NRAS.

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[2] Adams G, Hayes S, Weierter S, Boyd J, *Regulatory Capture: Managing the Risk,* Australian Public Sector Anti-Corruption Conference 24 October 2007 - Sydney bit.ly/1POjGO2 accessed 26/01/2016

The case for statutory regulation of health workers who perform functions above a given level of risk should not be controversial and a graded regulatory response may be appropriate based on the overall perceived risk. Two basic models have evolved in the Australian context. These are: statutory registration under the NRAS; and the adoption of a *National Code of Conduct*[3,4] (the Code) for unregistered health workers.

In the case of paramedics, the developing situation (based on declared intentions) is that there will be a third and unique hybrid regulatory model comprising a quasi-national scheme based on the NRAS and AHPRA administration; and a jurisdictional regulatory model catering for the NSW jurisdiction and the perceived interests of NSW Health[5] (the NSW model).

2.2 Holistic considerations in the primary submission recommendation

The authors' recommendation in their primary submission was that the NRAS and the operations of AHPRA through the various regulatory Boards and accreditation arrangements provided the most appropriate regulatory framework for paramedics. It would ensure regulation in the overall community interest as distinct from the interests of particular groups, individuals, or providers.

Their strong recommendation of NRAS registration took into account the adequacy of the NRAS/AHPRA model, the practical ramifications in executing certain functions such as accreditation, the additional costs and allocative inefficiencies of the NSW model, mutual recognition obligations and intergovernmental (including Trans-Tasman) factors.

It included consideration of the community benefits in maintaining public confidence and the gains in general health and welfare terms including workforce mobility and flexibility, consolidation of regulatory functions, sufficiency and timeliness of regulatory response, and the facilitation of extended paramedic roles and scope of practice to better serve Australian communities.

3. The contributions of paramedics - updated

There is no national register of practitioners. From various indicators the authors' primary submission suggested that paramedics may number between 15,000 and 16,000, but the actual number of people working as paramedics in Australia is unknown. The majority of paramedics work for public-funded paramedic (aka state, territory or other government owned or contracted ambulance) services and the data published annually relating to those services may be used as a proxy indicator of practitioner contributions.

The latest *Report on Government Services*[6] *(RoGS)* prepared by the Productivity Commission was released on 29 January 2016. Volume D Chapter 9 contains extensive data and physical performance reporting for Fire and Ambulance Services and may be accessed here: bit.ly/242sGtj Appendix A outlines the framework of reporting and shows the strong emphasis on non-health related performance measures and incomplete data in several performance categories.

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[3]COAG Health Council, *National Code of Conduct for health care* workers bit.ly/1oLeapB accessed 16/02/2016
[4]Australian Health Ministers Advisory Council, *Final Report: A National Code of Conduct for health care workers*, April 2015 bit.ly/1OIxKLa accessed 16/02/2016
[5] NSW Health, *Response to senate Inquiry into the establishment of a national registration system for Australian paramedics*, NSW government, Sydney, 2016 bit.ly/1PHnjrP accessed 16/02/2016
[6] Productivity Commission, *Report on Government Services,* Australian Government, Canberra, 29 January 2016 bit.ly/1Q7538O accessed 16/02/2016

As outlined in our primary submission, RoGS is not an accurate measure of total paramedic numbers and their contributions. It excludes military medics within the ADF and does not have comprehensive data on private sector paramedic services. While RoGS Table 9A.35 identifies different categories of ambulance service staff, it does not provide clarity in the number of persons who would meet the basic expectations of a registered paramedic – albeit grandparenting would provide for recognition of the majority of current practitioners.

Using the total number of *salaried ambulance operatives* (12686) as a base figure from the 2015 report and adding the estimated number of eligible practitioners from the ADF, universities and private sector providers (2500), the authors suggested the number of paramedics in 2015 might exceed 15500. The 2016 RoGS lists the number of salaried ambulance operatives as 12935 (an increase of 249) which would support that estimate. The number of *qualified ambulance officers* (a subset of the above) increased from 9631 to 10045 or an increase of 4.3%.

Nationally, RoGS (Table 9A.35) now records 15976 (cf 15503) full time equivalent paid personnel, 6211 (cf 5972) volunteers and 1122 (cf 2456) community first responders in 2014-15.

There was a very significant drop of community first responders from 1502 (2013-14) to 200 (2014-15) in Western Australia which bears review (community first responders are trained volunteers who provide an emergency response before the arrival of qualified paramedics).

The authors note that nationally, in 2014-15, there were 3.37 million incidents resulting in 4.2 million service responses to attend to 3.2 million patients (RoGS Table 9A.33). Total revenue across Australia was about $2.8 billion (Table 9A.32) of which some 68% was from government sources, confirming that public paramedic services remain a significant contributor to national expenditure on health-related services. The RoGS tabulations and comparative figures should be read in conjunction with voluminous qualifying notes.

The addition of private paramedic services would increase the significant contributions of paramedics to health care and the RoGS aeromedical services data provides a good example.

The Council of Ambulance Authorities (CAA) identified that 90 fixed and rotary wing aircraft were available nationally in 2014-15 (RoGS Table 9A.40) of which 26 units (28.9%) were operated by state ambulance services (principally in NSW). Queensland had the most private helicopters with 12 non-ambulance units making up 30% of the Australian total of 40 available rotary wing craft. Queensland also had the most aircraft (28) and along with Western Australia, South Australia and the ACT relied entirely on non-ambulance providers to service this sector. See notes for NT.

TABLE 9A.40

Table 9A.40 **Air ambulance medical resources and expenditure (2014-15 dollars) (a), (b), (c), (d)**

	Unit	NSW	Vic	Qld	WA (e)	SA (e)	Tas (e)	ACT	NT (e)	Aust
2014-15										
Total aircraft, operated by:										
State Ambulance Service										
Fixed wing	no.	6	4	–	–	–	1	–	–	11
Helicopter	no.	10	5	–	–	–	–	–	–	15
Other service providers										
Fixed wing	no.	2	–	16	16	5	–	–	–	39
Helicopter	no.	4	–	12	4	2	2	1	–	25
Total	**no.**	**22**	**9**	**28**	**20**	**7**	**3**	**1**	**–**	**90**
Expenditure	**$'000**	**117 405**	**57 745**	**–**	**1 335**	**–**	**4 995**	**417**	**–**	**181 897**

Total aeromedical expenditure in 2014-15 ($182M) was slightly less than 2013-14 ($187M) and again varied substantially, with some jurisdictions recording low (or no) expenditure, which materially distorts the overall funding picture. The zero expenditure in South Australia is a significant change ($13.2M in 2013-14) that bears review.

If the pattern of expenditure in NSW and Victoria were to be applied to Queensland and South Australia, the overall commitment by aeromedical services nationally for 2014-15 would likely be more than twice that reported.

Typical of the deficiencies in the collection of relevant data in this unregulated area of health care, the statistics do not show the human medical resources engaged. For example, the contribution of the Royal Flying Doctor Service (RFDS) is not shown explicitly. The RoGS funding figures thus continue to underestimate the actual provision of air ambulance and retrieval services - and without separation into human and physical asset classes.

The 2016 RoGS also shows continued growth in student enrolments in accredited paramedic courses in Australia (Table 9A.37). This is unlikely to represent all enrolments and does not include the non-accredited Diploma level students within the NSW jurisdiction. No figures are given for enrolments in two degree level programs in New Zealand which also feed graduates into the Australian and New Zealand paramedic workforce. In 2014 there were 6372 total enrolments (5871 in 2013) with 1253 students in their final year (984 in 2013).

Student numbers have been growing rapidly and applying a 9% growth factor to 2015 numbers, the indicative Australian undergraduate degree enrolments for 2016 would be 6945. This number aligns with the informal figures quoted in our primary submission that continuing university enrolments in 2016 potentially exceed 7000 in Australia alone (not including New Zealand enrolments or Diploma students trained by NSW ambulance).

With a CAA decision-in- principle several years ago to adopt degree level education as the base qualification for ambulance service paramedics, the only government agency known to be still actively recruiting from Diploma level programs is the NSW ambulance service where up to 40% of their annual intake remains qualified at Diploma level – an indicative 80 persons for 2016.

The significance of these figures is that with an operational workforce attrition rate of 3.6% (RoGS Table 9A.36) there are ample graduates from university degree level programs to meet the current projected needs of the major government-funded ambulance services[7] without the added expense of NSW providing a parallel and non-core basic educational activity.

Any recruitment of personnel from Diploma or other levels of education below a degree is thus a matter of employer choice rather than being driven by need or scarcity or by economic benefit. By inference it also appears that NSW is prepared to accept a lower level of base qualification for paramedics to care for its communities than do other jurisdictions.

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[7] Council of Ambulance Authorities, *CAA Position Statement: Higher Education Paramedic Student Enrolment Numbers*, Melbourne, June 2015 bit.ly/1RidZeB accessed 17/02/2016

4. Effective paramedic regulation

In his review of legal services[8] Sir David Clementi formed the view that for effective regulation it was desirable for some regulatory functions to be carried out by bodies that are wholly separate from the professional associations or service providers. The chief of these externalised functions are client complaints, professional disciplinary matters and the setting of practice rules. The NRAS makes provision for accreditation functions to be performed by an independent entity.

Fitness to practice mechanisms are needed that meet public expectations of community engagement and user-focus, rather than systems that are primarily profession or service-focused. This leads to the consistent view that the management of complaints should be handled independently[9] of a profession or employer and to properly command public support needs to have meaningful lay representation.

That is, to be acceptable, the engagement of consumers and the public interest must be at the heart of any regulatory system - as exemplified by the NRAS / AHPRA model – but absent from the current regulation of paramedics and the proposed NSW model regulatory framework.

Articulation of these principles shows the improbability of providing comparable provisions that ensure rigour and independence within any regulatory system composed primarily of either employers or practitioners. Regulation through CAA processes falls short on several counts – including conflict of Interest, sectional representation and lack of citizen (user) engagement.

Practitioners, professional bodies, employers, unions and community health advocacy groups have recognised these limitations and have remained adamant that only national registration under NRAS will meet the level of risk protection required. They also view piecemeal jurisdictional legislation as a stop-gap measure at best.

4.1 Negative licensing and prohibition orders

The Queensland Health Ombudsman can issue an interim prohibition order[10] if an unregistered health practitioner's health, conduct or performance means they pose a serious risk to people, and immediate action is necessary to protect public health and safety. This could be due to an unregistered health practitioner:

- practising unsafely, incompetently or while intoxicated by alcohol or drugs
- financially exploiting a person
- engaging in a sexual or improper personal relationship with a person
- discouraging someone from seeking clinically accepted care or treatment
- making false or misleading claims about the health benefits of a particular health service
- making false or misleading claims about their qualifications, training, competence or professional affiliations.

[8] Sir David Clementi, *Review of the Regulatory Framework for Legal Services in England and Wales Final Report*, December 2004 bit.ly/1QoUqka accessed 26/01/2016
[9] Department for Constitutional Affairs, *The Future of Legal Services: Putting Consumers First*, HMSO, Norwich, October 2005 bit.ly/1UnCOX3 accessed 12/02/2016
[10] Queensland Government, Office of the Health Ombudsman bit.ly/1Qxjm6F accessed 14/02/2016

An interim prohibition order can prohibit or restrict a health practitioner from providing any health service, or a specific health service. The Health Ombudsman can also enforce a prohibition order, or an interim prohibition order, issued in another state or territory where that interim prohibition order corresponds (or substantially corresponds) to the type of interim prohibition order that can be made in Queensland.

The Health Ombudsman must publish specific information in a register whenever an interim prohibition order is issued. Examination of the Queensland register (partial extract) shows the following entries which include a person providing health services as a paramedic without any qualifications:

Date order took effect	Name of practitioner	Type of practitioner	Details of the interim prohibition order	State/Territory original order issued in (interstate orders only
22 January 2016	Mr Robert Frank Mittiga	Counsellor	The Health Ombudsman has issued a corresponding interstate prohibition order in accordance with the prohibition order issued by the Health and Community Services Complaints Commissioner (South Australia) and published on their website on 24 November 2015. The practitioner is prohibited from providing any health service (paid or otherwise) in a clinical or non-clinical capacity, including providing counselling and rehabilitation services.	South Australia
29 December 2015	[redacted]	Person providing health services as a paramedic without any qualifications	Individual prohibited from any employment (paid or otherwise) in a clinical or non-clinical capacity, which relates to the provision of any health service.	
23 December 2015	Mr Guiseppe Trotta	Physiotherapist	The practitioner may only provide health services in a clinical or non-clinical capacity (paid or otherwise) to male clients over the age of 18.	
23 December 2015	Ms Sharon Ward	Message therapist	Practitioner prohibited from engaging in any employment or providing any services (paid or otherwise) in a clinical or non-clinical capacity, which relates to the provision of a health service.	

Figure 1 - Extract from Queensland Register of Prohibition Orders

Examination of the *List of Prohibition Orders in Force*[11] and of the *Public statement and warnings*[12] published by the NSW government Health Care Complaints Commission on 18 February 2016 shows no corresponding entry for the person listed by the Queensland Health Ombudsman on the 29 December 2015.

A search of information available within the public domain has disclosed that a person with the same name has occupied several positions of key responsibility in health care delivery over a lengthy period of time. This includes a role as Clinical Director of a significant corporate entity providing supply of fire and rescue, paramedical and security staff, safety and security risk management, project expertise, specialist consultancy and related education and training.

[11] NSW Health Care Complaints Commission, *List of Prohibition Orders in Force*
bit.ly/1PIjel8 accessed 13/02/2016
[12] NSW Health Care Complaints Commission , *Public statement and warnings*
bit.ly/1Vafooy accessed 13/02/2016

Among the claims of expertise listed in the public domain has been the statement that:

> *"... is a graduate of the University of Southern California Primary Care Medicine Physician Assistant program, holds a Post Graduate Certificate in Aviation Medicine, Advanced Diploma in Paramedical Science Intensive Care, Advanced Diploma of Trauma Medicine, and additional qualifications in Hyperbaric Medicine. [redacted] has worked within the medical industry for over 14 years in the United States and Australia including the US Military (Afghanistan), Westpac Rescue Helicopter, and Med Flight. .."* http://medicaltravelcompanions.com.au/team/

The execution of these indentified roles would normally include the provision of advice and training on medical and clinical practice matters as well as personal practice in a clinical capacity in treating patients, dealing with scheduled drugs and poisons, while holding himself out to be a paramedic or other registered health practitioner. The actions of the individual may include unlawfully administered immunisations as well as other high risk interventions.

Worldwide regulatory best practice espouses transparency - with regulators publishing information about the regulator, the regulated persons or entities, and the regulatory decisions made in each year. Under NRAS registration this reporting is available for the registered professions but not for other (unregistered) health care workers[13] e.g. paramedics.

If a relevant body such as the Queensland Health Ombudsman determines a case for a registered professional, immediate action is taken. The practitioner register is updated (usually within 24 hours or less of notification), the outcomes become enforceable nationally and the practitioner status is visible to the public and employers.

Quite apart from any police matters arising from breaches of health legislation or criminal law, this case highlights a number of regulatory issues including:

i. Timeliness and scope of application: It is unacceptable that an interim prohibition order issued in Queensland more than six weeks ago has no corresponding order or statement in other jurisdictions such as NSW, thereby not providing protection to the public through a transparent notification of status. The same situation applies in any jurisdiction in which a corresponding prohibition has not been actioned and in which the person may remain free to deliver health services (depending on the jurisdiction).
ii. Effectiveness: The absence of proactive registration that applies rigorous processes in validating the bona fides and compliance with registration standards prior to registration as a practitioner, has allowed potentially thousands of patients to be exposed to significant risk over several years before discovery. The reactive nature of negative licensing provides inadequate protection given the level of risk in paramedic practice.

The risk of misrepresentation by a person holding himself out to be a paramedic while not having the appropriate qualifications has previously been identified as one of the risks that would be minimised by NRAS / AHPRA registration.

This example may be a harbinger of other as yet undetected cases, and graphically illustrates why the authors remain adamant that the regulation of paramedics should be undertaken through the NRAS / AHPRA model of practitioner registration.

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[13] Australian Health Practitioner Regulation Agency https://www.ahpra.gov.au/ accessed 26/01/2016

4.2 Regulatory confusion

COAG requires that proposed additions of professions to the NRAS be assessed by the *Office of Best Practice Regulation* (OBPR). The assessment process includes production of a *Regulatory Impact Statement* (RIS) which was undertaken in relation to the registration of paramedics. The OBPR expressed a number of opinions regarding the RIS proposal for national paramedic registration. Among these was the view that:

- The confusion about who is a paramedic does not appear significant.

The authors draw attention to the confusion which clearly applies within the Australian government itself as exemplified by a recent call for tender by the ADF. The ADF operates across all Australian jurisdictions and conducts a number of activities in remote regions, including its areas of maritime jurisdiction (up to 50 nautical miles offshore).

The nature of many of these activities is such that Aero Medical Evacuation (AME) support[14] is necessary due to the distances from major health facilities, where delays in treatment could compromise patient safety and longer term outcomes.

AME support comprises advanced planning for each activity, provision of medical equipment including a Rotary Wing (Helicopter) and/or Fixed Wing aircraft and an AME team on stand-by for the duration of the activity. That support is actioned through a Standing Offer arrangement based on a tender process for which one recent example is the Defence Support and Reform Group ARMY 1516/029 tender.

The tender conditions include the following requirement (extract – authors' emphasis);

> *"3.1 The Contractor responsible for the medical component shall provide:*
> *a. an AME team consisting of a medically registered (Australian registration through Australian Health Practitioner Regulation Authority - AHPRA) physician and* ***state registered paramedic****, both suitably experienced and qualified for aeromedical duties:*
>
> > *(i) For the physician; Fellow of the Australasian College of Emergency Medicine (FACEM); the College of Intensive Care Medicine (FCICM) or other Australian recognised critical care specialty or a senior Registrar within the Fellowship program of one of these colleges under accredited training and supervision(essential);*
> > *(ii) For the paramedic; an Advanced Life Support Paramedical Certificate, or equivalent (essential); "*

In contrast with registered medical practitioners and registered nurses where there are clearly defined and transparent standards for registration, there currently is no national regulatory framework for paramedics. There is no set of prescribed standards for registration and no national minimum education standard whose completion qualifies a person to describe themselves as a paramedic. In addition, one jurisdiction (NSW) has proposed to adopt a minimum educational qualification that is at a lower level than a degree and is not accredited through the current CAA-administered process.

[14] Department of Defence, *Request for Tender, Army 1516/029* bit.ly/1mCgk9c accessed 14/02/2016

Despite Tasmania, South Australia and New South Wales enacting legislation for protection of title, these legislative instruments and definitions are not consistent, with only South Australia using the relevant NRAS legislative model for health practitioners as an interim measure.

The NSW model uses an amendment to provider-related legislation, thus creating a unique class of health worker defined essentially by their employment status with a single employer. Under normal circumstances, and other than provided under grandparenting arrangements, a NSW paramedic holding the minimum (NSW) educational qualifications should not be recognised for the purpose of registration in other jurisdictions. This is based on the likely adoption of an accredited university baccalaureate degree as the minimum educational standard recognised by a national Paramedic Board.

In short, there is no state or jurisdictional register of paramedics currently available or would be available under negative licensing, in order for bidders to meet this tender requirement. Compliance with the criterion is not feasible, thus demonstrating a significant level of confusion about paramedic regulation that is contrary to the view held by the OBPR.

The duration of the AME contract in question is 24 months with up to two further extensions of 24 months each, so a national or quasi-national AHPRA register of paramedics may become available during the extended life of the contract. In that case AHPRA registration in good standing would be a simple, clearly defined, sufficient and necessary prerequisite for the paramedic position from that time onwards.

This example again demonstrates the benefits of registration under the NRAS model and why it is the most appropriate vehicle for paramedic regulation.

4.3 Accreditation functions and registration standards

Since the lodgement of our primary submission the NSW legislation and regulations for protection of paramedic title has come into effect on 1 February 2016.

In its present form this legislation suggests that NSW intends to remain outside an otherwise national scheme of paramedic regulation (such as the NRAS model) and the paramedics recognised under the NSW model now need to be treated in the same way as for other practitioners educated and trained in any external jurisdiction(s).

If NSW continues to remain outside of a NRAS regulatory framework adopted by other jurisdictions, the question of its place in setting standards through any Paramedic Board and engagement with the formal accreditation activities conducted by that system must be reconsidered. If it is not part of the (quasi) NRAS system then it should not qualify as a full participating member of the regulatory process any more than other major employers. Its involvement should be treated on a similar basis to other external jurisdictions; as an observer; or at best, on an equivalent basis to New Zealand.

When it come to the resources involved in conducting accreditation functions, examination also needs to be made of the contribution that NSW should make in financial terms to the externalised costs associated with those functions, given that the current NSW legislation makes reference to what will then effectively be an external accreditation activity that also caters for university paramedic programs offered within NSW.

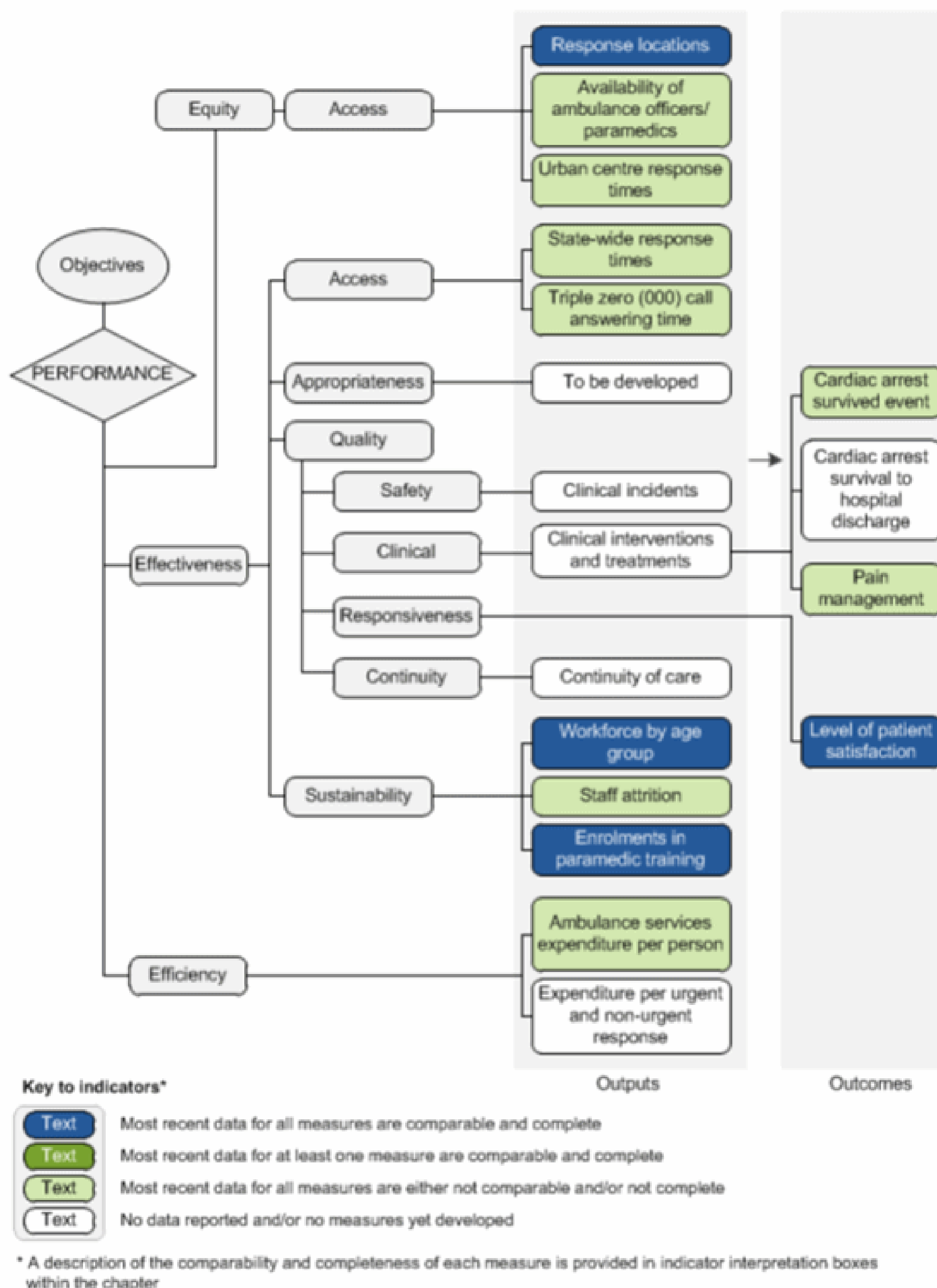
Glossary

The following abbreviations are used in this submission.

ADF	Australian Defence Force
AHPRA	Australian Health Practitioner Regulation Agency
AHMAC	Australian Health Ministers Advisory Council
AME	Aero Medical Evacuation
CAA	Council of Ambulance Authorities
COAG	Council of Australian Governments
IGA	Intergovernmental Agreement
National Code	National Code of Conduct for health care workers
National Law	Health Practitioner Regulation National Law Act
NRAS	National Registration and Accreditation Scheme (or National Scheme)
OBPR	Office of Best Practice Regulation
RFDS	Royal Flying Doctor Service
RIS	Regulatory Impact Statement
RoGS	Report on Government Services (Productivity Commission)

Appendix A - Ambulance events performance framework

Figure 9.20 **Ambulance events performance indicator framework**



Source : 2016 Report on Government Services – Volume D, Chapter 9 bit.ly/242sGtj