

Final report

Options for regulation of paramedics

September 2015



Australian Health Ministers' Advisory Council

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Acronyms

ACT	Australian Capital Territory
ADF	Australian Defence Force
AHPRA	Australian Health Practitioner Regulation Agency
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZCP	Australian and New Zealand College of Paramedicine
ASNSW	Ambulance Service of New South Wales
CAA	Council of Ambulance Authorities
COAG	Council of Australian Governments
ECP	Extended care paramedic
HCE	Health complaints entity
HCPC	Health and Care Professions Council (United Kingdom)
HWA	Health Workforce Australia
NEPT	Non-emergency patient transport
NRAS	National Registration and Accreditation Scheme
NSW	New South Wales
NT	Northern Territory
PA	Paramedics Australasia
PEPAS	Paramedic Education Programs Accreditation Scheme
PPA	Private Paramedicine Australia
QLD	Queensland
RIS	Regulatory Impact Statement
SA	South Australia
SJA	St John Ambulance
Student PA	Student Paramedics Australasia
TAS	Tasmania
UK	United Kingdom
VIC	Victoria
VET	Vocational Education and Training
WA	Western Australia

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Executive summary

In 2010 the Australian Health Workforce Ministerial Council¹ requested advice on whether to include paramedics as a profession in the National Registration and Accreditation Scheme (NRAS) for health professions. Alongside a number of other options, this Decision Regulation Impact Statement (RIS) examines the option of including paramedics in the NRAS. It has been prepared to comply with the Council of Australian Governments' requirement for a regulatory impact assessment to be undertaken when the introduction of new regulation is being considered by a ministerial council.

As any form of regulation carries costs as well as benefits, it is important to identify regulatory measures that are targeted to, and commensurate with, the identified problem and which satisfactorily address the incidence of harm. This Decision RIS considers whether developments in the paramedic workforce and changes in the health system more broadly warrant strengthened regulation of paramedics and, if so, what form of regulation is appropriate.

Chapter 1 outlines the scope of this report and the policy context, including relevant national agreements and their intent, the principles of consistent regulation across jurisdictions and best practice regulation. The NRAS for registered health practitioners, and information relating to the evolving public ambulance sector and the emerging private sector, are also described.

Paramedicine is a growing profession that plays a key role in an expanding and evolving healthcare system. Regulation of paramedics in Australia has traditionally occurred primarily via employment arrangements within a small number of publicly-operated or funded ambulance services. The traditional focus of a 'treat and transport' model of care is changing. Modern paramedic work is wide ranging, increasingly complex and frequently high risk, as the scope of practice of paramedics expands, including extended care roles in a range of settings.

This chapter also outlines a field of healthcare which has evolved significantly in the last two decades. The transformation of the role of public ambulance services has required commensurately increasing sophistication of paramedic practice. Paramedics are carrying out many more invasive procedures that were previously carried out only in a hospital setting. Today, more than 13,000 people work as paramedics in Australia, of which approximately 15% are employed in the private sector.

Chapter 2 describes the regulatory context nationally and in each state and territory. It details the paramedic and broader ambulance workforce, its training, areas of employment and the various types of regulation that currently apply to paramedics. Jurisdictional variation impacting on paramedic practice is described – from public ambulance services legislation and other government regulation, including authorities – to use of scheduled medicines, reservation of professional titles and licensing of non-emergency patient transport.

The establishment of peak bodies that assist in self-regulation of the field are highlighted and the changing educational requirements for employment as a paramedic within major ambulance service are described. A bachelor's degree accredited through the CAA Paramedic Education Programs Accreditation Scheme (PEPAS) is currently the standard for public sector employment set by the Council of Ambulance Authorities (CAA 2014). Tertiary education institutions have responded through the provision of degree programs in

¹ The Australian Health Workforce Ministerial Council is established under the *Health Practitioner Regulation National Law Act*. Its membership is made up of the health ministers of all states and territories and the Commonwealth.

paramedicine. As discussed in this chapter student enrolments indicate that the demand for tertiary education has significantly increased.

Chapter 3 provides an overview of the three main areas of concern: first is the potential for harm (serious injury and/or death) to the community; second is confusion about who is a paramedic, arising from inconsistencies in training and qualifications required for employment as a paramedic; and third is the cost to employers of identifying and employing a suitable paramedic.

The risks associated with paramedic practice arise from the nature of the work, as well as from confusion about use of the term 'paramedic'. Apart from regularly triaging and assessing patients, paramedics frequently deal with life and death situations in emergency conditions, and often with limited or no access to the patient's medical or social history. In delivering out-of-hospital care, paramedics deal with patients who are particularly vulnerable, and manage patients who are unconscious, incoherent or combative, sometimes in multi-casualty situations.

In line with changing medical practice more generally, paramedic practice is becoming more complex and sophisticated. It carries a correspondingly higher risk of significant harm when things can and do go wrong. Expanding scopes of paramedic practice and practice settings, and the changing institutional context for practice all increase the risks associated with paramedic practice. Increased expectations of paramedic practice are reflected in both the findings of coronial inquiries discussed in this chapter. They are also reflected in the coronial inquiries detailed at Appendix 4, highlighting the importance of appropriate training in high-risk activities and procedures.

The extent of poor outcomes in Australia is difficult to establish, due to limited and inconsistent public reporting of such events. However, in addition to the findings of coronial inquiries when reported publicly, and media reports, through the national consultation process on the regulatory options held in mid-2012, both paramedics and employers reported that they were aware of instances of actual harm or injury to patients associated with paramedic practice.

In Australia, the two main avenues through which individuals can lodge a complaint about a paramedic are the health complaints entity (HCE) in the relevant jurisdiction and the employer or service provider.

Proportionate to the number of services provided by paramedics each year, a small number of complaints are made to HCEs. The low rate of complaints is understandable given that community members are generally in a very poor position to assess the treatment they receive, particularly at times when they are vulnerable and experiencing health crises. This makes the rigour, consistency and transparency of other mechanisms for notification and management of poor performance more important.

Public ambulance services regularly conduct investigations of adverse events. A survey of these services undertaken for this report is discussed in this chapter. The survey identified that they receive an average of 1,733 complaints about paramedics each year. These employers undertake disciplinary actions for misconduct. Remedial action, termination of employment and legal action relating to criminal behaviour are not uncommon. Details of sanctions applied by employers are generally not made public.

Compared with other health practitioners, paramedics are at higher risk of becoming impaired – through fatigue, work-related stress and mental illness – due to the nature of their work. These work-related stressors increase the risk of harm to patients, particularly when compounded by substance abuse or addiction. Media reports across Australia indicate that theft and/or misuse of scheduled medicines by paramedics is an issue of concern in all

jurisdictions. Theft of medication raises questions about a paramedic's ability to safely provide the treatment required by their patients. As discussed in this report an average of 17 paramedics has their employment with public ambulance services terminated each year, due to concerns about their conduct or performance. A further 12 paramedics are subject to legal action related to their conduct or performance each year.

Currently, confusion about who is a paramedic stems from inconsistencies in the training and qualifications required for employment. As noted, the CAA has determined that a CAA accredited tertiary degree is the entry level standard for the public ambulance sector. However, with the exceptions of the delivery of public sector ambulance services by St John Ambulance WA and NT, private sector employers are not members of the CAA.

These employers may or may not subscribe to the minimum education standards for paramedics agreed to by CAA members. Some private sector employers – such as those working at public events (music, sports and others), mining and construction sites and other industrial settings – are commonly reported as employing personnel who have much lower education and training standards than those required for employment as a paramedic in alternative settings.

The profile of employment opportunities for paramedics is changing rapidly, with evolution and growth occurring in the public sector as well as in the largely unregulated private sector. The lack of nationally uniform or consistent and legally enforceable qualifications standards leaves individual employers to bear the costs of determining suitability for employment. Pre-employment screening of paramedic employees involves assessing suitability to practise against requirements, including verification of identity and good character, assessment and verification of qualifications, undertaking a criminal history check (in Australia and overseas) and, for international applicants, confirmation of registration status with international regulatory bodies.

There is no effective mechanism for preventing paramedics who are impaired, poorly performing or who engage in misconduct with one employer from seeking employment as paramedics with another employer. Employers report cases in which reference checks have revealed nothing untoward about an applicant's work history and the person has been inducted and trained and commenced work before a problem with his or her performance is identified.

Employer submissions to the consultation process, and data provided in response to the 2014 survey for this review, reported cases where paramedics with conduct or performance issues have had their employment terminated more than once, but their disciplinary histories have not been available to new employers. The 2010–2013 survey identified 11 cases where paramedics had gained employment despite concerns by previous employers and/or termination of employment relating to performance, conduct or impairment. The employer has then borne the considerable cost of performance managing, closely supervising and, if required, terminating the employment of the paramedic in accordance with industrial agreements. **Chapter 4** discusses consultation findings and written submissions. Eight consultation forums, attended by 239 people, were held and 50 written submissions were received. These submissions provided examples of the problems identified in Chapter 3.

Respondents raised the lack of public accountability concerning the practice of individual paramedics, and questioned the adequacy of the existing employer-led disciplinary mechanisms. In particular, respondents noted that employers are constrained from sharing the performance records of individual paramedics, due to confidentiality agreements or fear of litigation. They raised concerns that, as a consequence, impaired and poorly performing paramedics can and do move between employers and jurisdictions. Other critical issues highlighted concerned the ability of employers beyond the health sector to recruit

appropriately trained and skilled paramedic personnel, to deliver adequate supervision and to provide the quality assurance mechanisms and support needed to ensure good practice.

Overall, the submissions were strongly in favour of increased regulation of paramedics, particularly national registration of the paramedic profession. Respondents argued that national registration would provide greater public accountability of individuals for their practice, particularly as paramedic practice becomes more sophisticated and the range of public and private sector employment opportunities continues to grow. There was also some support for stronger regulation of providers of paramedic services.

There were some notes of caution about the need to ensure that any regulatory response is commensurate with the problems identified. However, anticipated changes in the health workforce profile, and the expanding role of paramedic practice, indicate strong potential growth in the use of paramedics in non-traditional roles, both in the government and non-government sectors.

New South Wales Health submitted that registration was not an appropriate response in that jurisdiction at this time.

Chapter 5 considers the options for regulation. These are considered within the context of the objectives of government action. In summary the objectives are to protect the public by minimising the incidence of harm associated with the delivery of paramedic services, within the context of a seamless, cost-effective national economy.

Four options for regulation were canvassed in the Consultation Paper: Options for regulation of paramedics (AHMAC 2012). Responding to the feedback received in the consultation, five options were ultimately considered for their potential to achieve the stated objectives of government action. This chapter outlines the five options and considers the impact of Options 2–5, compared with Option 1 (the status quo) against the problems identified and the objective of government action.

Options under consideration

- Option 1: Maintain the status quo – rely on existing regulatory and non-regulatory mechanisms
- Option 2: Strengthen self-regulation of paramedics
- Option 3: License private providers of paramedic services
- Option 4: Extend registration to the paramedic profession under the National Registration and Accreditation Scheme
- Option 5: Establish statutory registration of the paramedic profession under separate state and territory regulatory schemes.

The impacts and costs of each option are considered, along with any impacts on competition for those groups most likely to be affected. The Decision RIS acknowledges that the status quo would be the default option.

As outlined in Chapter 2, jurisdictions have established a range of regulatory measures designed to provide additional public protection. However, these regulatory approaches have had limited application in addressing the identified problems and the objective of government action.

Option 2, strengthen self-regulation (voluntary registration) of paramedics, supports efficient and effective systems for recruitment, where the regulatory agency takes responsibility for

establishing minimum qualifications for entry to practice, assessing qualifications and has a mechanism for dealing with paramedics who are deemed unsuitable for registration in the event that they are impaired, incompetent or engage in professional misconduct.

Option 2 goes some way to supporting workforce mobility through the provision of a register of paramedics, assuming employers use the register as a basis for their employment decisions. However, it is unlikely to be effective in reducing preventable harm associated with paramedic practice. This is because it is difficult for a voluntary scheme to carry out effective disciplinary processes and share disciplinary information with employers and other regulators without a statutory basis (and the statutory immunities that protect those who administer the scheme).

Option 3, license private providers of paramedic services, would require individual governments to establish licensing standards, monitor licence holders and take action against those who do not comply with regulatory standards. Private providers of paramedic services would be required to pay licensing fees and meet any compliance and reporting requirements. Option 3 would impose significant costs on industry and has potential to restrict employment options in the private sector. Option 3 cannot deal effectively with incompetent, impaired or otherwise unfit paramedics or remove them from practice when necessary.

Option 3 may go some way to addressing aspects of the problems identified in Chapter 3. However, it does not establish national standards for employment as a paramedic. It would also afford limited protection from harm to the community, because it provides additional safeguards only within the private sector, which represents 15% of the paramedic industry.

As this scheme would be based on licensed standards established in each jurisdiction, Option 3 would not improve health workforce efficiency compared to the status quo, because it does not facilitate the mobility of paramedics across jurisdictional boundaries. In addition, Option 3 cannot deal effectively with incompetent, impaired or otherwise unfit paramedics, or effectively remove them from practice when necessary.

Option 4 involves extending registration to the paramedic profession under the National Registration and Accreditation Scheme (NRAS). The benefits of national regulation of health professions included in the NRAS include increased public protection (and reduced cost to the community as a whole), due to:

- *enforceable entry level qualifications, probity checking and other requirements before practitioners can commence practice*
- *more robust systems for identifying and dealing with complaints and to deal with poorly performing, impaired or unethical practitioners and, in serious misconduct cases, mechanisms to prevent such practitioners from continuing to practise*
- *the public availability of a national register of regulated practitioners and a separate listing of those deregistered*
- *better linkages with a variety of regulatory and funder/provider agencies that have a role in detecting poor or unethical practices, including international regulatory agencies.* (AHMAC, 2009, p16).

Mandatory reporting is a significant public protection measure under the National Law. It imposes a legal obligation on registered health practitioners and employers to notify the Australian Health Practitioner Regulation Agency (AHPRA) if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to their professional practice. Through the establishment of student registration, similar notification provisions exist for education providers to inform AHPRA in the event that

a student has an impairment that affects their ability to practice safely. In this way, mandatory reporting provides an effective early warning mechanism that is more likely to detect impaired, poorly performing or unprofessional paramedics, or poorly performing students, before they harm patients.

Option 4 would improve health workforce efficiency compared to the status quo, because it facilitates mobility of paramedics across jurisdictional boundaries such as during natural disasters. While Option 4 creates new costs for paramedics, employers would enjoy reduced recruitment costs associated with pre-employment screening, which would be undertaken by AHPRA.

Option 5, establish statutory registration for the paramedic profession under separate state and territory regulatory schemes, would reduce the risk of harm to the public more than the status quo. As with Option 4, public protection measures established through mandatory reporting would impose a legal obligation on registered health practitioners and employers to notify the regulatory authority in the jurisdiction where a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession.

Where student registration is established, similar provisions would exist for education providers to notify to the regulatory authority in the event that a student has an impairment that affects his or her ability to practice safely. As with Option 4, mandatory reporting provides an effective early warning mechanism that is more likely to detect impaired, poorly performing or unprofessional paramedics, or poorly performing students, before they harm patients.

Option 5 offers some of the benefits of Option 4, in terms of reducing employer recruitment costs and the risks of unknowingly employing impaired or incompetent practitioners. However, it is less efficient than Option 4 because it does not address:

- duplication of governance and standard setting by eight separate state and territory-based regulatory regimes
- employers needing to contact multiple regulators when undertaking probity checks on prospective paramedic employees
- individual employers needing to determine the qualifications requirements for employment of paramedics where jurisdictional registration does not exist
- facilitating movement of paramedics across jurisdictional boundaries such as during natural disasters.

Option 5 is more costly and less efficient than Option 4. The problems identified in Chapter 3 would only be addressed if all jurisdictions established statutory regulation for the paramedic profession and safeguards were put in place to ensure that conditions attached to registration in one jurisdiction apply where paramedics hold dual registration. Similarly, practitioners who have been deregistered in one jurisdiction should not be eligible for registration in another.

While Option 5 creates new costs for paramedics, some employers would benefit from reduced recruitment costs. These would be optimised if all jurisdictions enacted consistent legislation to regulate paramedics.

Chapter 6 concludes that industry and regulatory responses have mitigated the risks associated with paramedic practice to some extent at a jurisdictional level. However, a sizeable body of evidence suggests that existing state and territory regulatory frameworks are not sufficient to protect the public from the risks of harm or to reduce the costs including those incurred by employers trying to identify and employ a suitable paramedic.

Final report: Options for regulation of paramedics

The impact assessment shows that Options 2, 4 and 5 all have potential to reduce harm to the public compared with Option 1 (the status quo). However, the analysis concludes that Option 4, 'Extend regulation to the paramedic profession under the National Registration and Accreditation Scheme', is likely to deliver the greatest net public benefit to the community compared with all other options.

Option 4 is the recommended option put forward in the Decision RIS.

Chapter 7 briefly outlines amendments required to the *Health Practitioner Regulation National Law Act* (the National Law) to give effect to the preferred option, Option 4.

1. Introduction

This chapter provides the context for assessment of the proposal to strengthen regulation of paramedic practice. Background to the decision to undertake this assessment is presented: the policy context for this work is summarised (including relevant national agreements) and the scope of this Decision Regulation Impact Statement (RIS) is outlined.

1.1 Background

In 2010 the Australian Health Workforce Ministerial Council requested advice on a proposal to include paramedics in the National Registration and Accreditation Scheme (NRAS) for health professions. This Decision RIS provides that advice. The policy context for this project and relevant national agreements and their intent are set out below.

1.2 Policy context

A seamless national economy

In 2009 the Council of Australian Governments (COAG) agreed to the *National partnership agreement to deliver a seamless national economy* (the National Partnership Agreement) and committed to implement a suite of competition and regulatory reforms to enhance national productivity and prosperity (COAG, 2009). The driving force behind the National Partnership Agreement is three-fold: to deliver more consistent regulation across jurisdictions; to address unnecessary or poorly-designed regulation; and to reduce excessive compliance costs on business, restrictions on competition and distortions in the allocation of resources in the economy.

Under the National Partnership Agreement, states and territories have responsibility to implement a coordinated national approach in a number of areas, including with respect to the health workforce. The milestones set out in the National Partnership Agreement implementation plan include the implementation of the NRAS. The principles set out in the National Partnership Agreement are applicable to the regulatory reform considered in this Decision RIS.

The *National Partnership Agreement* can be accessed online at www.coag.gov.au/node/322.

The National Registration and Accreditation Scheme

In March 2008 COAG signed the Intergovernmental Agreement for a NRAS for the health professions (COAG, 2008). The Intergovernmental Agreement sets out the framework for implementation of a single national system of registration and accreditation of health practitioners in Australia. The NRAS was established following enactment of the *Health Practitioner Regulation National Law Act* (the National Law). The National Law was first passed in Queensland. All other states and territories subsequently adopted or enacted similar legislation. The NRAS, which commenced in 2010, regulates 14 health professions.

The Intergovernmental Agreement provides criteria that are applied by the Australian Health Workforce Ministerial Council when assessing new professions for inclusion in the NRAS. For details of the Intergovernmental Agreement, the professions regulated and the criteria for assessment of new professions see www.ahpra.gov.au.

In December 2013 the COAG Reform Council delivered its final report, titled *Seamless national economy: Final report on performance* (COAG, 2013). This report noted that a key achievement of the National Partnership Agreement was the establishment of the NRAS which provides:

... nationally consistent standards for a range of health professionals (p. 8).

COAG best practice regulation requirements

COAG requires that a RIS be prepared and published whenever a ministerial council is considering the introduction of new regulation. This aims to maximise the efficiency of new or amended regulation and to avoid unnecessary compliance costs and restrictions on competition.

The COAG RIS requirements apply to ministerial council decisions that are to be given effect through legislation which, when implemented, would encourage or force business or individuals to pursue their interests in ways they would not otherwise have done.

This Decision RIS has been prepared in accordance with the COAG *Best practice regulation guidelines* (COAG, 2007). These guidelines help ensure that regulatory processes in all Australian jurisdictions are consistent with the following principles:

1. *Establishing a case for action before addressing a problem.*
2. *A range of feasible policy options must be considered, including self-regulatory, co-regulatory and non-regulatory approaches, and their benefits and costs assessed.*
3. *Adopting the option that generates the greatest net benefit for the community.*
4. *In accordance with the Competition Principles Agreement, legislation should not restrict competition unless it can be demonstrated that:*
 - a. *the benefits of the restrictions to the community as a whole outweigh the costs; and*
 - b. *the objectives of the regulation can only be achieved by restricting competition.*
5. *Providing effective guidance to relevant regulators and regulated parties in order to ensure that the policy intent and expected compliance requirements of the regulation are clear.*
6. *Ensuring that regulation remains relevant and effective over time.*
7. *Consulting effectively with affected key stakeholders at all stages of the regulatory cycle.*
8. *Government action should be effective and proportional to the issue being addressed* (COAG, p. 6).

1.3 The changing face of paramedic practice

Changes in the health system are increasing the demands placed on the paramedic workforce. These changes are evident in both public sector ambulance services and in the emerging private employment sector.

1.3.1 The evolving public ambulance sector

According to Steering Committee for the Review of Government Service Provision (SCRGSP) reports, the number of incidents to which public ambulance services respond is increasing across Australia. In 2004–05, ambulance services organisations attended almost 2.4 million incidents nationally. Most were emergency incidents (43%), followed by non-emergency incidents (35.0%) and urgent incidents (21%). The corresponding figure for 2013–14 was over three million incidents. Most were emergency incidents (44%), followed by urgent incidents (31%) and non-emergency incidents (25%) (SCRGSP, 2006 & 2015). Not only has the number of incidents increased by 30% over this time, the proportion of incidents categorised as emergency and urgent has also significantly increased, from 65% in 2006 to 75% in 2013–14.

The growth in ambulance service demand is attributable, in part, to population growth and demographic changes, including population ageing. At the same time, technical advances in healthcare have increased expectations that the health system will respond effectively and efficiently to community needs. In addition to medical emergencies, greater demands on hospitals and constrained public sector resources mean that paramedics are increasingly attending and have the necessary skills to respond to more complex cases.

More broadly, there have been major drivers to increase health workforce efficiency and promote safer and more efficient healthcare delivery. Public ambulance services have been part of these changes, moving substantially beyond the ‘treat and transport’ model of care.

The roles and scope of paramedic practice continue to evolve and expand in parallel with these broader changes across the healthcare sector. In the public ambulance services sector, changes are being driven by demands for more highly-skilled paramedic responses, together with enormous growth in demand for ambulance services confronting all jurisdictions (Joint Standing Committee on Community Development, 2007). Vastly improved survival rates after paramedic resuscitation in both urban and rural Victoria, for example, are also attributed to the introduction of new paramedic models and systems since the creation of Ambulance Victoria. These include the ‘chain of survival’ model and use of early advanced care (paramedics) in response to cardiac arrests in that state (O’Meara, Tourle, Stirling, Walker, & Pedler 2012).

Increasing expectations are arising not only in the context of first response paramedic services. Paramedics who work within public ambulance services are increasingly expected to deliver a wide variety of clinical services beyond a ‘treat and transport’ role. According to the Council of Ambulance Authorities (2013):

Today’s ambulance services are mobile health care services not just an urgent means of transport with some first-aid available (p. 3).

This is particularly important for rural and regional areas, where there is limited access to other healthcare options compared with the metropolitan areas. Changing demands for paramedic services were evident in the Health Workforce Australia (HWA) Extended Care Paramedic (ECP) trials. Delivering care where patients live, including aged and community care facilities, this evolving paramedic role has now been trialled and or adopted in several jurisdictions. Requiring *expertise and clinical reasoning of a high order*, the ECP role is important for its proven ability to reduce pressure on hospitals. Financial and other benefits accrue to the wider health system (Thompson, Williams, Morris, and others 2014).

While the increasing the capacity of paramedics to respond doubtless improves access to complex care in emergencies, it also increase the inherent risks associated with paramedic practice (Chapter 3).

1.3.2 The emerging private sector

In addition to expanding public sector employment options for paramedics, employment opportunities are growing in the private employment sector – potentially faster than in public ambulance services, given the increasing demands on the public healthcare system. As previously indicated, on current estimates upwards of 1,100 paramedics are working in the private sector, with 900 more in the Australian Defence Force (ADF). The ADF medics are involved in public duty, with their primary roles being to provide paramedic services to members of the ADF within and outside Australia.

Paramedics Australasia (PA), a peak national professional association, suggests that most paramedics in the private sector are employed by private ‘ambulance’ or non-emergency patient transport (NEPT) services. The NEPT services enable public ambulance services to focus more efficiently on crisis response (PA, 2012a).

However, employment opportunities for paramedics are also growing outside the health sector. Increasingly, paramedics provide first response services at music, sports and other public events, in oil and gas exploration, stevedoring, mining and construction, as well as in public transportation systems and aeromedical services and in educational roles with universities and other training providers. While not always involving high acuity these are again roles that require a high level of expertise and clinical reasoning with little back up available particularly in remote areas (see further Chapter 4).

1.4 Scope of this report

The proposals in this Decision RIS cover paramedics, their representative bodies, public ambulance services, other public sector employers who provide emergency medical services and private sector employers who employ paramedics.

1.5 Further information

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2. Overview of the paramedic sector

This chapter provides an overview of the paramedic sector. The roles and size of the workforce are outlined, and the state and territory regulatory frameworks under which paramedics operate are described. This chapter also details self-regulatory mechanisms, qualifications and training of the workforce and outlines the emerging private sector.

2.1 Description of paramedic sector

While it is outside the scope of this report to provide a detailed analysis of the paramedic workforce, this section provides an overview of the main categories of providers, the types of work they perform and their typical scopes of practice.

Notwithstanding the range of qualifications held by experienced paramedics within public ambulance services, with the exception of NSW, all public ambulance services now require a recognised tertiary degree as the minimum entry level qualification for a paramedic consistent with the CAA standard. A wide range of position levels/classifications within each service has been established to meet individual organisational needs. This makes it difficult to make direct comparisons of public sector workforce and service provision across states and territories.

2.1.1 Definition of a paramedic

Paramedics Australasia (PA) defines a paramedic as:

a health professional who provides rapid response, emergency medical assessment, treatment and care in the out of hospital environment (PA Paramedicine Role Descriptions, n.d., p. 5).

The title 'paramedic' broadly describes healthcare workers who, as a key requirement of their roles, provide intensive emergency clinical care outside a hospital setting. As emergency health service providers, paramedics in Australia are predominantly employed by eight state and territory public ambulance services.²

In addition to the title 'paramedic', a number of other terms are commonly used to describe health service providers who operate at various levels within ambulance services. PA has developed a set of general role descriptions for clinical roles in paramedicine in Australia and New Zealand (PA, n.d.). These role descriptors have no legislative backing.

2.1.2 Role of paramedics

The 2013 Australian and New Zealand Standard Classification of Occupations (ANZSCO)³ identified the tasks of ambulance officers and paramedics as including:

² The term 'public ambulance service' is used to refer to ambulance services funded by state and territory governments, either directly or through service contracts.

³ *Australian and New Zealand standard classification of occupations (ANZSCO)* is a skill-based classification of occupations. It has been developed jointly by the Australian Bureau of Statistics, Statistics New Zealand and the Department of Education, Employment and Workplace Relations as the national standard for organising occupation-related information for purposes such as policy development and review, human resource management and labour market and social research (ANZSCO Version 1.2, 2013).

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- attending accidents, emergencies and requests for medical assistance
- assessing the health of patients, determining the need for assistance and assessing specialised needs and factors affecting patients' conditions
- performing therapies and administering drugs according to protocols
- resuscitating and defibrillating patients and operating life-support equipment
- transporting accident victims to medical facilities
- transporting sick and disabled persons to and from medical facilities for specialised treatment and rehabilitation
- instructing community groups and essential service workers in first aid
- attending public gatherings and sporting events where accidents and other health emergencies may occur
- emergency management, disaster emergency response and repatriation
- providing aero-medical services
- providing first aid and emergency medical care in industrial settings such as mines, rigs and construction sites.

An emerging private sector is also contributing to the changing practice environment. Health Workforce Australia (HWA) identified the main categories of service provided by private sector paramedics as:

- Occupational – emergency and non-emergency pre-hospital care, trauma response, general first aid, medical treatment for sick or injured staff, transportation of patients to local hospitals, arranging aerial evacuations, drug and alcohol testing and safety inductions. Locations include mining sites, construction sites and rigs.
- Events – attendance at events, response to injury and illness, trauma response. Venues include sporting events, music events, television and film production, festivals and rodeos.
- Education and training – teaching of undergraduate and postgraduate courses, involvement in lectures, workshops, assessment, research and academic administration and facilitation of first aid courses and certificates
- Aero-medical services – emergency evacuation and primary response, aero-medical transportation of patients from pre-hospital locations or airport to hospital, or transfers between hospitals (HWA Personal communication, November 14, 2013).

As public ambulance services evolve from a model of emergency treatment and transport, the role and scope of paramedic practice is expanding to better respond to the acute health needs of patients as well as to alleviate the demands on the healthcare system. Increasingly, paramedics are able to provide treatment that adequately resolves the patient's presenting issue, without the need to refer on or to transport the patient to a health facility.

Paramedics with advanced levels of skill and training may undertake interventions once exclusively performed by emergency physicians or critical care nurses in a hospital setting. Advanced skill paramedics include intensive care paramedics, critical care paramedics, mobile intensive care ambulance paramedics, retrieval paramedics and extended care paramedics (ECPs).

Extended care paramedic

Extended care paramedic (ECPs) have advanced-level training and skills and, in collaboration with other health professionals, are able to treat patients in their usual places of residence, including aged and community care facilities. This model of care reduces both disruption to patients and health system costs associated with emergency department presentations.

In 2012 HWA funded an ECP program as part of a broader extended scope of practice workforce project). The South Australia (SA) Ambulance Service and Edith Cowan University in Western Australia (WA) jointly developed the curricula for the HWA ECP program, which is ongoing at five sites (two in SA and one in each of Tasmania, NT and the Australian Capital Territory (ACT). In addition to training and clinical placements specific to the ECP role, ECPs generally require a minimum of two years' experience as intensive care paramedics or must hold a dual nursing and paramedicine degree (Thompson, Williams, Morris, and others 2014).

In NSW, ECPs are trained to perform medical examinations, undertake risk assessment and develop patient management plans 'based on a predominantly medical model' within the Ambulance Service of New South Wales (ASNSW), (ASNSW n.d). In contrast to the HWA model, NSW ECPs do not require a minimum of two years' training as intensive care paramedics; nor must they hold a dual nursing and paramedicine degree before commencing the ECP training program requiring 360 contact hours.

Queensland Ambulance Service established an Isolated Practice Area Paramedic (IPAP) role, extending the role of ECPs to undertake a broader range of clinical support for patients in rural and isolated communities where there is limited access to expert clinical services. This followed a major efficiency audit arising from concerns about the pressures associated with escalating demand for ambulance services (Queensland Government, 2007). The IPAP role also assists in dealing with health workforce shortages, and makes effective use of an increasingly highly trained resource. .

Activities or procedures undertaken by paramedics

The Australian Health Ministers' Advisory Council *RIS [Regulatory impact statement] for the decision to implement the Health Practitioner Regulation National Law (2009)* identified 13 high-risk activities or procedures undertaken by registered health professions. The typical paramedic scope of practice incorporates 10 out of 13 of these activities or procedures, as asterisked * in **Table 1** below. Some high-risk interventions are routinely undertaken by paramedics, while others are performed more infrequently by individual paramedics with advanced training.

Paramedics with a broader scope of practice, such as ECPs and intensive care paramedics and those working in isolated settings such as mines or remote industrial sites, may undertake up to 12 of the 13 activities or procedures.

Table 1: Activities or procedures undertaken by health practitioners that carry risk

Activity or procedure
* Putting an instrument, hand or finger into a body cavity, that is, beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body.
<u>Manipulation of the joints of the spine beyond the individual's usual physiological range of motion, using</u>

Activity or procedure
a high velocity, low amplitude thrust.
* Application of a hazardous form of energy or radiation, such as electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electromagnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy.
* Procedures below the dermis, mucous membrane, in or below the surface of the cornea or teeth.
Prescribing a scheduled drug, supplying a scheduled drug (including compounding), supervising that part of a pharmacy that dispenses scheduled medicines.
* Administering a scheduled drug or substance by injection.
* Supplying substances for ingestion.
* Managing labour or delivering a baby.
* Undertaking psychological interventions to treat serious disorders or conditions with potential for harm.
Setting or casting a fracture of a bone or reducing dislocation of a joint.
* Provision of a primary care service to patients with or without a referral from a registered practitioner.
* Treatment that commonly occurs without any other persons present.
* Treatment that commonly requires patients to disrobe.

Source: Adapted from the *Regulated Health Professions Act 1991* (Ontario).

Appendix 1 sets out the mapping of risk factors for the National Registration and Accreditation Scheme (NRAS) undertaken by the Australian Health Ministers' Advisory Council (2009) and compares this with the activities undertaken by the paramedic profession.

2.1.3 Size of the paramedic workforce

The 2011 Australian Bureau of Statistics Census uses two occupational codes for paramedics: ambulance officers (411111) and intensive care ambulance paramedics (411112). The total number of paramedics and ambulance officers included in the 2011 Census data was 11,940, an increase of 2,843 or 31% over the 2006 data. However, in its response to AHMAC's consultation paper, *Options for regulation of paramedics* (2012), PA noted that Australian Defence Force (ADF) paramedics appear to be under-reported in the 2011 Census. This raises questions about the accuracy of the Census data, which relies on self-declaration of employment by members of the public.

It is difficult to quantify the size of the private sector paramedic workforce, as there is considerable variation in the types of roles for which paramedics are engaged and in the qualifications required by employers within different settings. One organisation may employ 'first-aiders' with minimal qualifications and/or experience, while another may employ highly-qualified paramedics who have significant public ambulance sector work experience for the same role.

In 2013, as part of its *Ambulance officer and paramedic workforce study*, HWA conducted a survey of private paramedic employers, receiving responses from 44 organisations. It is not known what proportion of private sector employers responded (HWA personal communication, November 14, 2013). In July 2014, as part of the data collection for this report, public ambulance services and the ADF were surveyed on a number of matters, including current paramedic employment numbers.

Employment data from the 2013 HWA survey of private providers and the 2014 project survey of public ambulance services are presented in [Table 2](#). From these two sources, it is estimated that 13,031 persons are employed as paramedics in Australia, with 85% working in public ambulance services and 15% working with or on contract to, a diverse spectrum of private sector employers (including St John Ambulance (SJA) NT and WA).

Table 2: Number of paramedics employed in public ambulance services and the private sector by state and territory (2013; 2014)

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Public ambulance	189	3,334	–	3,098	842	326	3,284	–	11,073
Private sector									
SJA	–	–	130	–	–	–	–	652	782
Other	9	214	132	203	203	14	213	188	1,176
Total	198	3,548	262	3,301	1,045	340	3,497	840	13,031

The 2011 Census data indicates that the private sector workforce is growing rapidly, with contributing factors including:

- public ambulance services seeking to divest themselves of non-emergency service provision such as non-emergency patient transport (NEPT)
- growth in public events and in the mining and construction sectors
- new and emerging paramedic practice settings such as within the public rail transport system (Felgate, 2014).

2.2 Regulatory arrangements

2.2.1 Regulation of individual paramedics

Protection of title

In recent years the Tasmanian, SA and NSW governments have legislated to restrict who can use the title ‘paramedic’ within their jurisdictions.

This was given effect in Tasmania through the Ambulance Services (Paramedic) Regulations 2014, established under the *Ambulance Services Act 1982* (Tas), which prescribe the paramedic qualification as a Bachelor of Paramedic Science (or has equivalent understanding and knowledge contained within that degree). A ‘paramedic’ in Tasmania must be:

- an officer of Ambulance Tasmania who holds a prescribed qualification; or
- a qualified officer of a prescribed ambulance service in another jurisdiction; or

- a person prescribed by regulation.

The intent of amending the *Ambulance Services Act 1982* (Tas) was to help the public differentiate between emergency ambulance services, NEPT services and first aid. Words such as ‘ambulance’ and ‘paramedic’ are intended to be restricted to descriptions of emergency services and not, for example, a first aid post, with the Minister’s Second Reading Speech to Parliament noting that:

I don’t think any of us ever want a situation to occur where a person seeks the wrong provider through a misunderstanding of the difference between an emergency paramedic provider and a first aid provider as has happened in other states (O’Byrne, 2013, p.2).

The inclusion of qualified officers from other jurisdictions acknowledges the need to support workforce mobility across borders and facilitate assistance from interstate paramedics when required, whether at major incidents or events.

In SA, the *Health Practitioner Regulation National Law (South Australia) (Protection of Title–Paramedics) Amendment Act 2013* provides statutory protection of the title ‘paramedic’. . In SA, a person must not call themselves a paramedic, or create the impression that they are a paramedic, unless they hold a qualification prescribed by regulation or are exempted from this requirement by the Minister. This was in part a response to the demand for paramedics by commercial organisations seeking to provide emergency and non-emergency medical treatment in settings outside the health sector such as in defence, mining and events, including administering controlled substances (scheduled medicines).

The *Health Services Amendment (Paramedics) Bill 2015* (NSW) now also introduces protection of the title of paramedic in NSW .The object of this legislation is to join Tasmania and SA by making it an offence for any person to use the title if they do not hold the required qualifications, training or experience. The NSW Bill defines a paramedic as:

- (a) a person who holds qualifications, or who has received training, or who has experience, prescribed by the regulations, or
- (b) a person who is authorised under the legislation of another Australian jurisdiction to hold himself or herself out to be a paramedic, or
- (c) a member of staff of the Ambulance Service of NSW, or other person, who is authorised by the Health Secretary to hold himself or herself out to be a paramedic.

While these models restrict who can use the title ‘paramedic’, these models do not establish a register or provide any mechanism to establish fitness to practice. They rely on other mechanisms such as a complaint to a health complaints entity to investigate any concerns about a person’s right to practice as a paramedic, in the event of professional misconduct, poor performance or impairment.

National code of conduct

As at September 2015 NSW, Queensland and SA have all implemented code regulation regimes for unregistered health practitioners (Council of Australian Governments 2015a). These code regulation regimes provide regulatory tools to deal directly with unregistered health practitioners, including paramedics, who behave illegally or in an incompetent, exploitative or predatory manner towards their clients or patients.

There are two main elements of a code regulatory regime:

- a statutory code of conduct that sets standards that apply to all unregistered healthcare workers, as well as to any registered health practitioner who provides health services that are unrelated to his or her registration
- regulatory powers to deal with complaints from consumers (or other persons) about healthcare workers who breach the code of conduct.

Where an unregistered healthcare worker is investigated following a complaint and is found to have breached the code of conduct, and the person's continued practice is considered to present a serious risk to public health and safety, the responsible commissioner (or a tribunal) may issue a 'prohibition order'. Individual paramedics are subject to the code regulation regimes wherever they operate.

The Queensland Health Ombudsman powers to investigate an unregistered health practitioner and to impose an interim prohibition order do not rely on breach of a code of conduct. However the Health Ombudsman Act 2013 does provide for a code of conduct to be prescribed by regulation. Queensland Civil and Administrative Tribunal is the body responsible for issuing a prohibition order. The Queensland Health Ombudsman can also enforce a prohibition order, or interim prohibition order, issued in another state or territory, where it substantially corresponds to the type of prohibition order that can be made in Queensland.

These negative licensing regimes provide a mechanism for dealing with the worst cases of paramedics who breach minimum acceptable standards of practice and place the public at risk. The effect of a prohibition order in NSW, Queensland and SA may be to prohibit the person from continuing to provide health services, or impose conditions on his or her practice. It is a criminal offence for a person to breach such a prohibition order.

In April 2013 all health ministers agreed to strengthen state and territory health complaints mechanisms via a single national code of conduct. Each state and territory would enact powers to enforce the code, by investigating breaches and issuing prohibition orders where there is a serious risk to public health and safety. To support national enforcement of the code, ministers also agreed to a nationally accessible register of prohibition orders and mutual recognition arrangements between states and territories.

In April 2015 health ministers agreed to the terms of the first National Code of Conduct for health care workers, which will set standards of conduct and practice for all unregistered health care workers (Council of Australian Governments, 2015b).

Public ambulance service regulation

Ambulance services respond to over 2.25 million emergency and urgent incidents in Australia each year (Council of Ambulance Authorities, 2013).

In the ACT, NSW, Victoria, Queensland, Tasmania and SA, public ambulance services are provided by statutory agencies established under legislation within the respective jurisdiction. The enabling legislation establishes functions, governance and operational arrangements. Most jurisdictions with statutory ambulance services define an ambulance service as having two components:

1. provision of out-of-hospital emergency care
2. transport of patients.

There are two exceptions to this. The NSW definition does not mention patient transport and, under the SA definition, an ambulance service is specifically tied to patient transport.

The *Ambulance Service Amendment Act 2013* (Tas) defines ambulance services as ‘relating to the work of rendering out-of-hospital clinical care to, and the conveyance of, persons suffering illness or injury’. The Second Reading Speech highlighted that this definition aims to reflect the broad scope of contemporary ambulance practice and of paramedics, which now extends well beyond the provision of services from motor vehicles on public roads (Parliament of Tasmania, 2013).

There is no legislation underpinning the delivery of ambulance services in the NT or WA. The SJA is contracted under agreement with the respective health departments to provide ambulance services in metropolitan areas, within established operational and governance arrangements. The Remote Health Branch of the NT Department of Health provides public ambulance services in rural and remote areas of the NT. These services may be delivered by registered health practitioners and/or Aboriginal health workers. Rural and remote ambulance services in WA are contracted to SJA and staffed mainly by volunteers and a small number of employee paramedics.

Table 3 provides an overview of jurisdictional arrangements and the relevant state and territory legislation which governs the delivery of public ambulance services. The SJA WA and SJA NT have dedicated commercial business arms. The SJA WA describes its Event Health Services as the leader in the provision of healthcare at events in WA. A separate division provides paramedics to mines, offshore oil and gas rigs and other industrial settings.

Table 3: State and territory regulation of ambulance and patient transport services and paramedics (2015)

Jurisdiction	Responsible minister	Ambulance service provider	Ambulance service functions	Statutory protections
ACT <i>Emergencies Act 2004 (ACT)</i>	Minister for Police & Emergency Services	ACT Ambulance Service (Government administered)	The ambulance service may: <ul style="list-style-type: none"> provide medical treatment and pre-hospital or post-hospital patient care transport patients by ambulance, or transport patients by medical rescue aircraft. 	It is an offence to provide medical care and pre-hospital care and transportation of a patient without approval of the Minister. The offence section does not apply to doctors, an entity in relation to first aid, a person coming to the aid of a person without expectation of payment or other consideration and a Commonwealth or state agency.
NSW <i>Health Services Act 1997 (NSW)</i>	Minister for Health	Ambulance Service of NSW (Government administered)	To protect persons from injury or death, whether or not those persons are sick or injured.	It is an offence for a non-exempt organisation to provide, for fee or reward, transport for sick or injured persons or conduct 'any operations similar to the operations' of the state Ambulance Service without the approval of the Director-General. <i>The Health Services Amendment (Paramedics) Act 2015 (NSW)</i> amended the <i>Health Services Act 1997 (NSW)</i> , making it an offence for any person to use the title of paramedic if they do not hold the required qualifications, training or experience
NT No specific legislation	Minister for Health	St John Ambulance NT – metropolitan (Contracted private organisation) Remote Health – rural and remote areas (Government administered)	St John Ambulance NT provides: <ul style="list-style-type: none"> ambulance services volunteer first aid services training and education contract paramedics. 	
Qld <i>Ambulance Service Act</i>	Minister for Health	Queensland Ambulance Service (Government)	Functions include: <ul style="list-style-type: none"> to protect persons from injury or death, whether or not the persons are sick or 	It is illegal to provide unauthorised patient transport services.

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Jurisdiction	Responsible minister	Ambulance service provider	Ambulance service functions	Statutory protections
1991 (Qld)		administered)	<p>injured</p> <ul style="list-style-type: none"> to provide transport for persons requiring attention at medical or healthcare facilities to provide casualty room services. 	
SA <i>Health Care Act 1997 (SA)</i> <i>Ambulance Service Act 1992 (SA)</i>	Minister for Health & Ageing	The SA Ambulance Service Inc (Government administered)	Ambulance service means to provide medical treatment to patients being transported by ambulance to hospital, surgery or other place to receive medical treatment, or transporting a patient from a hospital, surgery or other place at which the patient has received medical treatment.	It is an offence to provide emergency ambulance services unless the person providing the service is prescribed by regulation or has an exemption granted by the Minister.
<i>Health Practitioner Regulation Law (SA) (Protection of Title – Paramedics) Amendment Act 2013</i>				A person must not call themselves a 'paramedic' unless they hold a qualification prescribed by regulation or are exempted from this requirement by the Minister for Health.
Tas <i>Ambulance Service Act 1982 (Tas)</i>	Minister for Health & Human Services	Ambulance Tasmania (Government administered)	Ambulance services means services relating to the work of rendering out-of-hospital clinical care to, and the conveyance of, persons suffering illness or injury.	It is an offence for a non-exempt organisation to provide, for fee or reward, transport for sick or injured persons or to conduct 'any operations similar to the operations' of the state Ambulance Service without the approval of the Director-General.
<i>Ambulance Service Amendment Act 2013 (Tas)</i>				<p>It is an offence for a person, other than a paramedic, to present him or herself in such a manner as to imply, or lead to the belief, that the person is a paramedic capable of providing ambulance services.</p> <p>The <i>Ambulance Service Amendment Act 2013</i> inserts a new s.35 into the <i>Ambulance Services Act 1982</i> which provides for the</p>

Jurisdiction	Responsible minister	Ambulance service provider	Ambulance service functions	Statutory protections
Vic <i>Ambulance Services Act 1986</i> (Vic)	Minister for Health	Ambulance Victoria (Statutory body corporate)	<p>The objectives of an ambulance service include:</p> <ul style="list-style-type: none"> to respond rapidly to requests for help in a medical emergency to provide specialised medical skills to maintain life and to reduce injuries in emergency situations and while moving people requiring those skills to provide specialised transport facilities to move people requiring emergency medical treatment to foster public education in first aid. 	<p>licensing of NEPT providers.</p> <p>Use of the word ‘ambulance’ or prescribed insignia that suggest that the provider is affiliated with Ambulance Service Victoria is prohibited.</p>
<i>Non-Emergency Patient Transport Act 2003</i> (Vic)				<p>A licensing scheme under the NEPT Act allows private providers to deliver non-urgent patient transport services including a system of accreditation for non-emergency patient transport licence holders who operate first aid and or medical stand-by services for public events.</p>
WA No specific legislation	Minister for Health	St John Ambulance WA (Contracted private organisation)	<p>St John Ambulance WA provides:</p> <ul style="list-style-type: none"> ambulance services including metro and country first responder services patient transfer service emergency rescue helicopter services events and industrial health services first aid training training and education. 	

2.2.2 Private ambulance and transportation services

Private ambulance services

All jurisdictions allow some private sector provision of ambulance services. However, the legal status of private providers is unclear in some jurisdictions. Where regulatory mechanisms exist which authorise private providers to provide ambulance services, this is generally achieved through licenses or exemptions to the offence provisions, issued by the relevant minister or director-general. Private ambulance services in WA and the NT are not required to be licensed as ambulance services.

In the absence of specific legislation, there is no regulation of the qualifications of paramedics employed by private ambulance services.

Non-emergency patient transport

In order to assure their capacity to meet their emergency responsibilities, public ambulance services across Australia have been divesting themselves of the delivery of NEPT services. Regulatory reforms have facilitated the growth in delivery of these services by the private sector.

In NSW, NEPT is provided by the ASNSW. However, the *Reform plan for NSW ambulance* (NSW Health, 2012) identifies the need to separate NEPT from urgent medical retrieval services and to engage:

... a range of providers including community, existing Ambulance green fleet, Local Health District transport services and private providers to provide existing and future NEPT services (p. 15).

In NSW, ASNSW and individual local health districts across the state currently provide non-emergency patient transport services.

Non-emergency patient transport is regulated in Victoria under the *Non-Emergency Patient Transport Act 2003* (Vic). The state Department of Health is responsible for the development and implementation of regulations and clinical practice protocols relating to NEPT, and for issuing licenses to private providers under the *Non-Emergency Patient Transport Act 2003* (Vic). There are currently 19 licensed NETP providers in Victoria. Under these licensing arrangements, organisations pay a differential licence fee based on the number of vehicles they operate. These providers can also apply for 'standby service accreditation'. This enables the NEPT licence holder to operate a service that provides staff and vehicles to attend public events and to provide stand-by services to participants who suffer unanticipated illness or injury. Regulations permit the carrying and use of certain scheduled medicines by certain NEPT personnel.

Provision for licensing existing and potential commercial providers of NEPT in Tasmania was included in PART IIIA – Non-emergency Patient Transport of the *Ambulance Service Act 1982* (Tas). A formal licensing scheme was considered important to ensure that these providers, and others seeking to enter the market, have a clear understanding of patient quality and safety requirements (Department of Health and Human Services, 2013). Currently, there are three private NEPT providers in Tasmania.

In SA, non-emergency ambulance service providers are regulated under the *Health Care Act 2008* (SA) through the issuing of a restricted ambulance service licence by the Health Minister. Currently, there are three private NEPT service providers in SA.

In Queensland, road ambulance transport services that require a paramedic, but are not provided by Queensland Hospital and Health Services, must generally be purchased from the

Queensland Ambulance Service. Non-urgent patient transport that does not require a paramedic may be purchased by Queensland Hospital and Health Services. Queensland Hospital and Health Services have discretion to purchase these services from a range of health transport providers, including Queensland Ambulance Service. In 2013 delivery of non-urgent patient transport services was trialled in the south of Brisbane utilising a private Victorian NEPT provider.

In WA, as in the NT (in metro areas), the majority of NEPT services are carried out under contractual agreement with a division of SJA. Other providers also offer these services.

In the ACT, NEPT services are delivered by the ACT Ambulance Service.

In the absence of specific legislation, no regulated minimum qualification is required by paramedics employed by NEPT service providers.

The licensing of private NEPT providers offers limited protection from harm, since it regulates only one small segment of the sector. It does not regulate public ambulance services or the SJA in NT and WA (i.e. emergency services), which employ more than 90% of the paramedic workforce (see [section 2.1.3](#), [Table 2](#)).

2.2.3 Regulation of scheduled medicines authorities

A scheduled medicine is defined under section 5 of the *National Law* as ‘a substance included in a Schedule to the current *Poisons Standard*, within the meaning of the *Therapeutic Goods Act 1989 of the Commonwealth*’.

In Australia, access to scheduled medicines is governed by a combination of Commonwealth and state and territory laws. The Commonwealth *Poisons Standard*, issued by the Therapeutic Goods Administration, classifies medications, poisons and controlled substances according to nine schedules, four of which are relevant to paramedic practice:

- **Schedule 2: Pharmacy medicine** – Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.
- **Schedule 3: Pharmacist only medicine** – Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.
- **Schedule 4: Prescription only medicine or prescription animal remedy** – Substances, the use or supply of which should be by, or on the order of, persons permitted by state or territory legislation to prescribe and should be available from a pharmacist on prescription.
- **Schedule 8: Controlled drugs** – Substances which should be available for use, but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

[Appendix 2](#) provides an overview of state and territory legislation relevant to the administration of scheduled medicines by paramedics employed in the public and private sectors.

While there are differences between jurisdictions, most state and territory ambulance services have a credentialing process and clinical practice guidelines which identify the respective practice levels for their ambulance personnel. Authority to administer scheduled medicines is dependent on practice level, which reflects qualifications and experience.

The extent to which paramedics employed in the private sector are able to obtain and administer scheduled medicines varies between jurisdictions. State and territory drugs and

poisons regulations contain mechanisms through which jurisdictions are able to provide a licence (or other authority) to private organisations to store, provide and administer scheduled medicines.

In all jurisdictions other than Victoria and Tasmania, private paramedic service providers have some access to Schedule 8 controlled drugs. In most cases, licenses are tailored to individual license holders. The range of medications available to paramedics employed in the private sector is generally much narrower than that available to statutorily employed ambulance officers. Lower standards of clinical governance, difficulty in assessing qualification levels, and lack of statutory oversight of employers have been identified as major barriers to extending the range of controlled substances available to private organisations.

2.2.4 Industry self-regulation

Four national bodies represent the interests of paramedics and/or paramedic employers. They are the Australian and New Zealand College of Paramedicine (ANZCP), Paramedics Australasia (PA), Council of Ambulance Authorities (CAA) and Private Paramedicine Australasia (PPA).

Australian and New Zealand College of Paramedicine

The ANZCP is a professional association that represents paramedics and those involved in pre- and out-of-hospital care. First established in NSW in 1973, membership includes paramedics from public ambulance services, the private sector and student paramedics. The ANZCP provides clinical professional development opportunities, scholarships and grants, work-related resources and makes representations to employers, policymakers, politicians and other professional bodies.

The ANZCP has a code of conduct with which members are expected to comply. Membership is voluntary.

Paramedics Australasia

Paramedics Australasia (PA) is a peak national professional association that represents paramedic practitioners and paramedic student members. Its primary role is to provide leadership in professional matters through the development and promulgation of policies and service standards. Activities include continuing professional development, workshops, scientific conferences and symposia and sponsoring and fostering evidence-based research.

The organisation has a code of conduct with which members are expected to comply. Membership is voluntary.

Council of Ambulance Authorities

The Council of Ambulance Authorities (CAA) is the peak body representing the principal public providers of ambulance services in Australia, New Zealand and Papua New Guinea. Its role includes:

- ensuring input to the development of public policies that impact on the provision of ambulance services
- developing a body of knowledge through research, exchange of information, monitoring and reporting
- maximising opportunity for the application of standards providing for improved quality.

In 2010 CAA published *Paramedic Professional Competency Standards* which form the foundation of education, training and practice for operational service delivery for its ambulance services members (CAA, 2010).

The CAA has an established accreditation program for assessing paramedic training programs ([section 2.3](#)). The CAA contributes to research to better understand, forecast, adapt and respond to the challenges of emergency ambulance service provision. It contributes collated ambulance services data to the Productivity Commission *Report of Government Services* (SCRGSP, 2015) and has conducted an annual *Patient Satisfaction Survey* since 2002.

Private Paramedicine Australia

Private Paramedicine Australia (PPA) was established in 2013 as a peak industry body to represent the interests of private sector employers of paramedics in Australia. The PPA consists of members from different service providers within the industry, including pre-hospital healthcare providers, private patient transport services, health training providers, the tertiary education sector and event first aid providers. It provides a voice for private employers and services for members.

Corporate membership is open to employers of paramedics. As a relatively new organisation, PPA does not yet have a strong role in the self-regulation of the sector and not all private providers of paramedic services are members.

2.2.5 Regulation of paramedics internationally

Regulation of the paramedic profession varies significantly in other countries. Some jurisdictions, notably United Kingdom, Ireland, some Canadian provinces and South Africa, have implemented registration regimes for paramedics and, in some cases, for other emergency medical services workers. In other jurisdictions, notably New Zealand, statutory regulation is under consideration.

2.3 Education and training

In Australia, paramedic education and training is provided in a variety of settings both at a tertiary level and by registered training organisations. As previously noted, considerable variation in the qualifications accepted by employers for employment as a paramedic in the private sector makes it difficult to generalise about the level of education and training required. This section primarily considers the education and training requirements for paramedics working for public ambulance services.

Before a bachelor degree program was established by the CAA as the public sector entry-level standard, all Australian CAA member organisations conducted in-house education programs for paramedics as Registered Training Organisations.

In general, CAA member organisations no longer recognise external Vocational Education and Training (VET) provider certificate and diploma courses for entry-level paramedic employment. The exception is NSW, which provides a vocational entry pathway upon employment with ASNSW. These entry pathway recruits complete a three-year Diploma of Paramedical Science program.

The focus of the Paramedic Education Program Accreditation Scheme (PEPAS) established by the CAA is to ensure tertiary entry level paramedic courses meet the needs of CAA members - public sector ambulance services. At the time of writing ten courses currently have full accreditation status; others have applied for accreditation, or received provisional accreditation, or preliminary accreditation approval.

Applications for preliminary approval are submitted to CAA when an educational institution intends to offer an entry-level paramedic education program for the first time, or when making a major change to an existing program. Full accreditation status is not granted by CAA until a university's first cohort of graduates has at least twelve months' practice experience following graduation. Accreditation ensures that graduates meet the requisite education, training and practice proficiency standards for employment as entry-level ambulance paramedics with Australian and New Zealand ambulance services. The CAA accreditation framework assesses whether the required practice standards are being addressed and there is a level of consistency in the core components of the education programs being offered that meets the needs of public sector ambulance services (CAA, 2014).

Accreditation is generally granted for five years. The CAA course accreditation costs are outlined in [section 5.5.1.2](#), [Tables 11, 12 & 13](#). Thus, while there is no mandatory set of standards for paramedic education, training and practice at the national level, Australian universities generally aim to comply with the PEPAS. This helps assure students that they will be suitably qualified for employment within the public ambulance sector on graduation.

Separate to the CAA course accreditation processes, other paramedic training courses are accredited through the Australian Quality Training Framework. A number of public ambulance services are Registered Training Organisations, which provide recognised VET courses. Some certificate and diploma courses offered through VET and Technical and Further Education providers have been developed to meet select third-party employer needs. The ADF conducts an in-house medic course, using the Diploma of Paramedical Science (Ambulance) and the Diploma of Nursing (which is required for registration as an Enrolled Nurse with the Nursing and Midwifery Board of Australia under the NRAS).

As at 2014, nine Australian programs have full CAA accreditation and five have provisional accreditation. A further six programs are at the preliminary accreditation approval or evaluation for provisional accreditation stages of the CAA accreditation approval process at the time of writing. As summarised in [Table 4](#), the largest number of degree programs is offered in Queensland (six) and Victoria (five), with two programs being offered by one university in three different states and territories.⁴

Of the 20 courses currently offered in Australia, 14 are offered as a bachelor of health science (or equivalent). One of these is also offered at a master's degree level; three as a dual degree (nursing and paramedicine); and three at graduate level as a postgraduate degree or for applicants who already hold an undergraduate health science qualification.

Table 4: University programs assessed under the CAA Paramedic Education Program Accreditation Scheme by state and territory (2014)

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Other	Total
Full accreditation	–	1	–	2	1	–	4	1	–	9
Provisional accreditation	–	1	–	1	–	1	1	–	1*	5
Preliminary accreditation approval	–	1	–	1	–	–	–	1	1**	4
Evaluation for provisional accreditation	–	–	–	2	–	–	–	–	–	2
Total		3		6	1	1	5	2	2	20

Note:

* Course offered in ACT, Queensland and Victoria.

⁴ See further CAA *Stages of accreditation* www.caa.net.au

** Course offered in Queensland, NSW and Victoria.

In line with employer expectations, there has been a significant increase in the number of paramedics obtaining bachelor's degrees in paramedicine. This is evidenced by Australian Bureau of Statistics Census data, which indicated that 40% of paramedics had a bachelor's degree or above in 2011; a significant increase from 29% in 2006 (as discussed in Paramedics Australasia, 2012).

Growth in the bachelor degree-qualified workforce has continued. Based on the available data, in 2013 the expected number of paramedic graduates was 984, which exceeded the predicted workforce demand of 933 paramedics (Table 5). The potential workforce is also growing dramatically. Table 6 shows that the estimated number of paramedic students enrolled in bachelor's degrees across Australia in 2013 was more than 5,800, of which 17% were in their final year. This compares with the estimated total current paramedic workforce described in Table 2 section 2.1.3.

Table 5: Enrolments in accredited paramedic training courses in Australia (2013)*

	ACT	NSW	NT**	Qld	SA	Tas	Vic	WA	Total
Total student enrolments	108	736	–	1796	417	100	2043	671	5871
Students enrolled in final year	–	210	–	362	149	44	144	75	984

(SCRGSP, 2015)

Note:

- * Figures represent the number of students enrolled as at 31 December 2013 for the completed course year (not Full Time Equivalent).
- ** No higher education providers based in the NT offer courses accredited by the Paramedic Education Programs Accreditation Scheme. Student paramedics employed by SJA NT study at Edith Cowan University, WA.

Continuing professional development

Many paramedic employers require their employees to participate in continuing professional development activities. Professional associations such as PA and ANZCP offer voluntary continuing professional development programs for their members.

3. The nature of the problem

This chapter outlines the three main areas of concern in relation to the regulation of paramedic practice: first, is the potential for harm to the community (serious injury and/or death); second, is confusion about who is a paramedic arising from inconsistencies in training and qualifications required for employment as a paramedic; and third, is the cost to employers of identifying and employing a suitable paramedic.

3.1 Potential for harm

The potential for harm associated with paramedic practice arises from the nature of the work, the complaints reporting and management environment and the potential for practitioner impairment and professional misconduct.

3.1.1 *The risk of harm*

Expanding scopes of practice and practice settings and the changing institutional context for paramedic practice all increase the risks associated with paramedic practice, which may result in patient harm. For the purposes of this report, harm is defined as:

- death or serious injury attributable to a practitioner's impairment, incompetence or unethical conduct
- loss of income associated with injury
- pain and suffering.

Inherent risks in paramedic practice relate to the nature of the work undertaken. The nature, frequency and severity of risk presented by individual paramedics depends, in part, on their levels of training, the extent to which they must exercise clinical judgement, and the nature and scope of their practice. Apart from regularly triaging and assessing patients, paramedics frequently deal with life and death situations in emergency conditions, often with limited or no access to the patient's medical or social history. In delivering out-of-hospital care, paramedics deal with patients who are particularly vulnerable and must often manage unconscious, incoherent or combative patients, sometimes in multi-casualty situations.

In line with changing medical practices more generally, paramedic practice is becoming more complex and sophisticated. It carries a correspondingly higher risk of significant harm when things can and do go wrong. Pre-hospital management by paramedics can be life-saving and directly influence the long-term quality of the patient outcome. [Appendix 3](#) outlines the potential clinical consequences of high-risk interventions undertaken by paramedics.

Increased expectations of paramedic practice are reflected in the findings of coronial inquiries. For example, in a recent Victorian inquest the Coroner noted that, in contrast to mobile intensive care ambulance paramedics, other paramedics are not trained in paediatric intravascular insertion. The Coroner recommended that this be remedied; a recommendation that Ambulance Victoria agreed to consider (G. Sassella, Chief Executive Officer, Ambulance Victoria, personal communication, in correspondence to J. Coate, State Coroner, February 11, 2011).

In a separate inquest, the Coroner recommended consideration of 'a more proactive role' by ambulance paramedics in the management of children with complex cardiac conditions (Jamieson, 2012).

Coronial inquests were held into the unrelated deaths of two children in rural Victoria in 2010 (Alsop, 2011a & 2011b). The respective coroners each explored, but were unable to formally determine that the availability of more highly-qualified staff might have affected the outcome. Each separately recommended that the Minister for Health conduct an inquiry to ensure that people who live in less-densely populated areas are not disadvantaged in terms of reasonable access to mobile intensive care ambulance services and specialist paramedic expertise.

Coronial findings highlight the importance of initial training in high-risk paramedic activities and procedures. They also underline the need for regular refresher training and continuing professional development for paramedics, so as to maintain competence and skills in-line with changing treatment methodologies. The absence of robust regulatory or administrative frameworks for assuring the competence of the paramedic workforce exacerbates the inherent risks of paramedic practice.

Improperly performed, these risky activities or procedures can have catastrophic consequences for an individual. By way of example, a United Kingdom (UK) Coroner's Report (Connor 2014) found that in 2013, an endotracheal tube that had been inserted into the oesophagus (tube to the stomach) rather than the trachea (tube to the lungs) contributed to the death of a 26 year old woman. The Coroner highlighted the importance of implementing national guidelines

The extent to which such adverse outcomes occur in Australia is difficult to establish, due to limited and inconsistent public reporting of such events. Within individual ambulance services, issues such as intubation may be dealt with through appropriate training and/or by limiting certain procedures to specific categories of paramedic. No such limitations exist for paramedics who work outside the ambulance services. . In addition, compliance with recommendations such as for national guidelines would be difficult to achieve without a mechanism for mandating it such as statutory registration (as in the UK).

Errors of clinical judgement can occur by commission and by omission. Risks of commission, which relate to direct and inappropriate acts undertaken by a paramedic while attending a patient, include:

- incorrect or inappropriate application of a therapy or procedure
- misdiagnosis
- variation from the accepted standard of care.

Errors of omission include:

- failure to transfer to hospital when indicated
- failure to undertake a handover to a hospital, or other members of the clinical team, at an appropriate standard.

During the consultation for this report, both paramedics and employers reported that they were aware of instances of actual harm or injury to patients associated with the practice of a paramedic, including where paramedics:

- failed to provide treatment that would have benefited the patient
- made inappropriate decisions to leave a patient at home
- administered inappropriate drug treatment
- provided an incorrect intervention and treatment
- physically assaulted a patient
- sexually assaulted a patient

- self-administered drugs of dependence taken from their employers.

In response to a survey of paramedics conducted by Paramedics Australasia in 2012, 55% of the 3,289 respondents indicated that they:

... personally knew of instances of actual harm to a patient associated with the practice of another paramedic, with 9 percent of these indicated to have resulted in a death (Paramedics Australasia, 2012a, p.9).

Details of matters involving paramedic care that are referred to a coroner – and the outcomes of such inquests – are not always made public or readily accessible in Australia. [Appendix 4](#) contains further examples from Australian coronial inquests, and incidents that have attracted media attention, in which each of these risks has been realised in practice. While these cases illustrate the types of harm associated with paramedic practice, they do not constitute a comprehensive review of Australian coronial inquiries in which the actions of paramedics have been considered. They do suggest that, while unusual, such events are neither rare nor confined to one state or territory. Risks to the public associated with paramedic practice are patently not theoretical, and catastrophic harm, including death, is a real and foreseeable risk.

However, in the absence of definitive data, it is difficult to quantify the likelihood of harm (serious injury and/or death) arising from the practice of paramedics. Australian case studies of harm associated with paramedic practice – drawn from surveys of ambulance service providers, consultation submissions and media reports – are included in [Appendix 5](#). In contrast to the UK, where the registration regime provides a level of transparency about how disciplinary matters are dealt with, it is unknown what, if any, actions were taken by employers in relation to the paramedics involved in the Australian cases.

While it is evident that paramedic practice has resulted in serious harm to patients in Australia ([Table 6](#)), the level of adverse outcomes is difficult to establish, due to limited and inconsistent public reporting of such events. For example data provided by public ambulance services' and St John Ambulance (SJA) for this report indicate that a rounded total of 49 sentinel events/root cause analyses are undertaken per year (averaged over the period 2010-11 – 2012-13) across Australia. These data indicate that a number of patients received treatment from paramedics that fell substantially below the level which should be reasonably expected of a competent practitioner.

Table 6: Sentinel event/root cause analyses conducted by public and SJA ambulance services (average per annum 2010-11 – 2012-13)

3-year average	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Sentinel event/root cause analyses	10	23	0	12	0	0	9	4	49

Sentinel events are defined differently in different jurisdictions. For example, Ambulance Victoria, defined a sentinel event as:

... an undetected oesophageal intubation, a hospital admission unrelated to the original presenting condition as a clear consequence of the actions or inactions by the Ambulance Service, death of a patient as a clear consequence of the actions or inactions by the Ambulance Service and a near miss of a sentinel event.

In NSW, 'sentinel event' has another meaning and the Ambulance Service conducts root cause analyses of events where a patient has died or suffered major loss of function unrelated to the natural course of illness or injury. Both measures are included in the above data.

3.1.2 Complaints reporting

In Australia there are two main avenues through which individuals can lodge a complaint about a paramedic:

- the health complaints entity (HCE)^{5,6} in the relevant jurisdiction
- the employer or service provider.

Given the number of interactions between paramedics and the public (3.1 million in 2013–14), a surprisingly small number of complaints are made to HCEs. The low rate of complaints is understandable given that community members are generally in a very poor position to assess the treatment they receive, particularly at times when they are vulnerable and experiencing a health crisis.

While complaints to HCEs are reported in annual reports, there is generally insufficient detail to establish the level and types of complaints about paramedics. In most cases, complaints to state and territory HCEs about ambulance services (such as billing or response times) cannot be separated from complaints about the conduct or clinical care provided by paramedics. In jurisdictions where types of complaints can be separated, most complaints are about issues unrelated to the performance of paramedics.

All public ambulance services in Australia have mechanisms in place to receive and deal with complaints from the public.

During the consultation, a common view expressed by both paramedics and employers was that there is substantial under-reporting of inappropriate actions by paramedics. Reasons for under-reporting may include:

- vulnerable/unconscious clients who may not be aware of misconduct or inappropriate care, or do not have the personal resources to complain
- colleagues may be reluctant to report workmates and reporting of paramedic misconduct by paramedics or other healthcare workers is not mandatory
- lack of confidence in how complaints are handled and resolved – a number of submissions from paramedics referred to complaints not being acted on
- conflict of interest for the employer, as both service provider and complaints manager
- patients feeling that they don't have the 'right' to make a complaint about a publicly provided service.

Feedback also indicated the commonly held view that action taken does not always resolve the issues of concern.

To gain a clearer picture of the scale of complaints and disciplinary action (and other relevant events), public ambulance services, the Australian Defence Force (ADF) and Private Paramedicine Australia (PPA) were surveyed for this report in 2014. Five public ambulance services were able to provide data.

⁵ A HCE is an entity established under state or territory legislation whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system.

⁶ In NSW, South Australia and Queensland, HCEs have the power to issue prohibition orders following an investigation into a complaint about an unregistered health practitioner who has been found to pose a serious risk to public health and safety.

Survey respondents reported receiving a total of 17,031 complaints about paramedics in the three years to 2012-13. There was significant variation across jurisdictions; ranging from an average of 764 complaints per year in SA to six in the NT.

While complaints lodged directly with ambulance service providers are not made public, they may be reported to the relevant minister as part of the ambulance service reporting obligations. These reports do not quantify the actual harm that arises from poor paramedic practice.

Appendix 6 contains a summary of complaints obtained from HCEs, as well as details of complaints, disciplinary action, employment termination and legal action for state/territory public ambulance services.

3.1.3 Practitioner impairment and professional misconduct

Ambulance officers and paramedics in Australia demonstrate a very high rate of occupational injury and fatality, representing the sixth highest rate of occupational injuries and new mental stress claims for men (Sofianopoulos, Williams, Archer, & Thompson, 2014)). Compared with other health practitioners, Maguire (2012) suggests there may be a higher risk of paramedics becoming impaired due to the nature of their work. In particular, the paramedic profession experiences significant issues relating to fatigue, work-related stress and mental illness. Research suggests that up to 10% of paramedics in Australia may be dangerously sleepy at any one time (Sofianopoulos, Williams, Archer, & Thompson, 2014). In its supplementary submission to the AHMAC *Consultation Paper: Options for regulation of paramedics*, based on 2011 Census data, Paramedic Australasia reported that 89% of paramedics worked full time and of these, 36% worked more than 49 hours per week.

The impacts of work-related stressors are of particular concern in that the risk of patient harm increases where practitioners have a physical or mental impairment, which may also be compounded by substance abuse or addiction.

Inquests such as that of Speering in NSW suggest that it is not uncommon for employees to face disciplinary issues in conjunction with a clinical impairment. Further, employer-based frameworks may be inadequate to assure public safety when an employee is under mental strain (Jerram, 2010).

In their survey responses, Australia's public ambulance service employers of paramedics indicated that paramedic misconduct cases frequently involve inadequate assessment and documentation of patient care records, falsification of patient care records and theft and substitution of Schedule 8 medicines. Media reports further highlight that these types of misconduct occur across all jurisdictions. This includes theft and abuse of scheduled medicines (see for example Boddy 2012, Butler 2012, Carlyon 2012, Cox 2012, Dawtrey 2012, Sandy 2012, Wahlquist 2012, ABC News on Line 2013, Channon 2013, Gordon 2013a, Gordon 2013b, O'Connell 2013, ABC News on Line 2014, Bucci 2014).

Theft of medication raises questions about a paramedic's ability to safely provide the treatment required by his or her patient. Substitution of medication means that the patient in need of pain relief may not receive the medication they require from the paramedic. In addition, pain relief medication subsequently given by other health practitioners may be at a lower dosage in the belief the patient has already been given pain relief.

Apart from the risks associated with practitioner impairment, the public is also at risk where paramedics:

- have a criminal history, which makes them unsuitable to provide healthcare
- engage in illegal activities or misconduct such as theft or sexual impropriety
- engage in other forms of unethical conduct.

Criminal history checks undertaken by most employers would not disclose spent convictions, which, if known, could influence suitability to be employed as a paramedic. This exposes employers to the risks of recruiting unsuitable persons.

While physical and sexual assaults of patients by paramedics may be uncommon in Australia, such incidents are reported. A Victorian newspaper described an incident in which a trainee paramedic observed a superior officer sexually assault a drug-affected patient in the back of the ambulance (Medew, 2007). A Queensland media report outlined the case of an advanced care paramedic who:

... dragged, dumped and kicked a female patient at Townsville Hospital (Dibben, 2013).

This case attracted media attention when the paramedic lost her appeal against termination of her employment. Dismissing the appeal, the Deputy President stated that the paramedic's:

... behaviour and conduct ... reflected total disrespect of, and callous disregard to, Patient A's personal welfare and her status as a patient of QAS [Queensland Ambulance Service]. Her actions were totally uncalled for and at complete odds with the expectations both QAS and the general public are entitled to have about a qualified paramedic paid from the public purse (Bloomfield, 2013, p11).

Work-related stressors can lead to physical and mental impairment among paramedics. Such impairments may result in adverse outcomes for patients, particularly when compounded by substance abuse or addiction. The survey for this review identified an average of 91 instances of disciplinary action against paramedics Australia-wide per annum (averaged over the three-year period to 2012-13), i.e. the conduct or performance of these paramedics fell below the standard their employers could reasonably expect.

The survey also identified that an average of 17 paramedics had their employment terminated by public ambulance services each year due to concerns about their conduct or performance. In addition, an average of 12 paramedics was subject to legal action related to their conduct or performance each year.

In the UK paramedics are regulated by the Health and Care Professions Council. For the sake of comparison, the annual rate of complaints for the UK paramedic profession is 1.4% of the registrant base. Thus between April 2009 and March 2014, 1,132 complaints were made against paramedics in the UK (HCPC, 2010–2014). Of the 346 cases that went to inquiry over this five-year period, action was taken on 249 occasions. This represents an average of 50 cases per year in which paramedics were either struck off the register or sanctioned in some other way.

In Australia, there is no effective mechanism to prevent a paramedic who has resigned, or been dismissed due to poor performance or professional misconduct, from moving to another employer or jurisdiction and continuing to work. This problem has been confirmed by submissions to the national consultation from paramedics and employers of paramedics (in both the private sector and in the ADF), as well as in survey responses from public ambulance service employers.

See further in relation to this issue and other case studies of paramedic misconduct at [Appendix 5](#).

3.2 Confusion about who is a paramedic

Confusion about who is a paramedic stems from inconsistencies in training and qualifications required for employment as a paramedic as well as from who can use the title. It also leads to inconsistencies in the ability of paramedics to deliver care that may be life-saving.

The CAA has determined that a health science or paramedic degree is the minimum qualification required to be employed in the public ambulance sector (CAA, 2014). The development of PEPAS, a scheme to accredit degree courses in paramedicine by CAA reflects the increased roles, scope and complexity of paramedic practice expected by the community. Beyond the university sector, Vocational Education and Training providers offer a variety of Certificate and Diploma level courses in paramedicine to meet particular employer needs..

With the exception of SJA in WA and the NT, private sector employers are not members of the CAA. As such they may not subscribe to the minimum education standards for paramedics agreed by CAA members. Given the widely varying levels of paramedic training available, some private sector employers are employing personnel who have much lower education and training attainment than would be required for employment as a paramedic in alternative settings. Public events (such as music festivals), mining and construction sites and other industrial settings are commonly reported as workplaces more likely to employ less qualified paramedics. For people attending public events, the presence of apparently qualified staff may delay decisions to seek or receive treatment for significant medical conditions from qualified healthcare workers.

Coronial inquiries in various Australian jurisdictions have also reported that problems created by a lack of agreement about who is a paramedic present significant risks to public safety. The Thoms inquest was into the death of a teenager at a music festival in WA. In his findings Coroner Mulligan warned of a high level of risk for the community when an individual identifying as a 'paramedic' delivers care in settings outside a traditional ambulance service. The Coroner was of the view that members of the public should not be at risk of confusing first aiders with paramedics. In addition employers of paramedics should be able to check that a practitioner meets the requisite standards and has not been subject to disciplinary sanctions or other restrictions on their capacity to practise (Mulligan, 2013).

While unable to conclusively determine whether the delayed decision to transfer Ms Thoms to hospital contributed to her death, the Coroner found that there is a high risk of adverse health events at large public events such as music concerts. As a matter of public safety, event organisers should be confident they have emergency care available at the standard the public expects. However, as the Coroner observed, this is not straightforward:

Whilst I have referred to these paramedics as paramedics, it is important to appreciate that there is no definition in Western Australia as to what a paramedic is or what qualifications or experience a paramedic needs to have before he or she can properly be referred to as a paramedic (Mulligan, 2013, p.34).

The problem this creates is that neither the organisers of large-scale public events nor the general public can be confident in the abilities of those who are protecting their 'medical interests' at such events. To redress this problem, the Coroner recommended:

... that the Director General of Health consider creating a definition of paramedic and that he considers a form of registration that will ensure that only appropriately qualified people are entitled to use the title of paramedic and to be able to practise in Western Australia as a paramedic. (Mulligan, 2013, p.43)

Following the death of Daniel Bucciante, a patron at the 2012 Rainbow Serpent music festival in Victoria, Coroner Heffey noted a series of shortcomings in the first aid arrangements, including:

The first aid attendants employed by the consultant firm, although billed as paramedics, were from interstate and were not authorised to work in Victoria as paramedics, and therefore, were not able to administer drugs in the same way as ... Victorian paramedics (Heffey, 2014, p.3).

The lack of a nationally consistent mechanism to identify who is a qualified paramedic limits the efficient deployment of the paramedic workforce to deliver emergency care across jurisdictions; both routinely in border areas and during major events or disasters. This includes restrictions on the ability of paramedics who work across jurisdictions to administer scheduled medicines to patients who require them. As identified in the death of Mr. Bucciante, this may delay timely access to lifesaving medicines and procedures, with potentially fatal consequences.

Similarly, the absence of a nationally consistent standard for entry to the profession of paramedic means that the public cannot necessarily have confidence that an individual practitioner who offers emergency care is appropriately qualified to deliver it safely.

3.3 Cost to employers in identifying and employing a suitable paramedic

The profile of employment opportunities for paramedics is changing rapidly, with growth occurring particularly in the largely unregulated private sector. Until recently, paramedic service expertise has largely been delivered and managed via government operated or contracted ambulance services. These large health sector employers have established benchmarks for training, supervision and scopes of practice for particular staff or categories of staff, including students and volunteers. The CAA has played an important role in determining appropriate qualification levels for paramedics. The CAA advises that:

The costs associated with reviewing paramedic qualifications of applicants from another State or Territory in Australia who are not graduates of a University which has a paramedic program accredited under the Council of Ambulance Authorities (CAA) Paramedic Education Programs Accreditation Scheme (PEPAS); or an overseas applicants qualifications (e.g. UK), is approximately \$450 to \$500 depending on the amount of follow-up enquiry that is required. It should also be noted that additional costs would be incurred where the applicant is required to complete a clinical skills competency validation assessment (CAA, personal communication, 2015).

Similarly a major private employer participating in the consultation indicated that the paramedic application assessment process involves collating required documentation and an average of 1.5 hours expert review and assessment by credentialing committee members, at an estimated cost of \$450 per applicant. This excludes the costs of developing credentialing standards and gathering information on overseas paramedic qualifications and standards. For employers who work across more than one jurisdiction, this is particularly problematic.

As the ADF noted in its submission, even for relatively large employers such as the ADF itself, the current system has:

... [a] requirement for relatively high levels of overhead to regulate a small workforce. Constant requirement for benchmarking and collaborative work with comparable state bodies is resource intensive and highly influenced by the ability to develop and maintain relationships (ADF, 2012, p.1).

Other employers, such as those in private industrial or events management settings, may not be well equipped to assess paramedic qualifications at all. However the lack of nationally consistent and legally enforceable qualifications and standards and of a national register leaves all employers to individually determine the suitability of applicants for employment as

paramedics and to bear the costs of this exercise. This includes verification of identify and good character, assessment of qualifications, undertaking criminal history checks (in Australia and overseas) and, for international applicants, confirmation of registration status with overseas regulatory bodies.

This creates further barriers to the effective management and employment of paramedics with inefficiencies and costs arising from the following:

- Employers who recruit personnel or deliver services across jurisdictions must be familiar with the different classifications and training requirements, practice protocols and guidelines, legislation and regulations that apply across jurisdictions.
- In the absence of a trusted source of information about who is qualified, competent and fit to practise as a paramedic, individual employers must:
 - carry out more extensive probity checking than would otherwise be required to satisfy themselves that an applicant is fit to practise and has no history of conduct, performance or impairment issues that might compromise their practice
 - carry out their own credentialing of those individuals who apply for employment as a paramedic, incurring costs in assessing the equivalence of qualifications of internationally trained paramedics
 - bear the costs of recruiting any unsuitable paramedics because fitness to practise information was not readily available; this may include performance managing and/or terminating paramedics whose conduct, performance or impairment means they are not fit to practise. (These matters are currently dealt with under the industrial relations framework and incur further costs associated with cases before Fair Work Australia or the relevant jurisdictional industrial relations commission, however called).
- Paramedics can find their expertise, qualifications and training post-entry to the field are not recognised by employers in other Australian jurisdictions.

These issues have significant cost implications, constrain workforce mobility and compromise the delivery of a seamless national health system.

The Productivity Commission report on government service provision (SCRGSP, 2015) provides a breakdown of operational workforce attrition rates for all ambulance services. **Table 7** shows that the attrition rate for 2012–13 varied between jurisdictions. The average was 4.3% of total workforce. Workforce attrition rates are highest in NSW (5.0%) and Victoria (4.3%) public ambulance services, which employ the largest number of paramedics, and in the private government-funded SJA services in NT (5%) and WA (4.8%).

Table 7: Operational workforce attrition rates in public ambulance services and SJA by state and territory (2012–13)

Year	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Average
2012–13	2.6	5.5	5.0	3.8	1.4	2.3	4.3	4.8	4.3

According to CAA, its members’ paramedic workforces are growing at 2.9% per year (CAA, 2013). Workforce data for 2013 ([section 2.1.3](#), **Table 2**) and jurisdictional attrition rates (**Table 7**), combined with this rate of workforce growth, have been used to estimate the number of new recruits to public ambulance services and SJA (**Table 8**).

Reliable workforce attrition and growth data are not available for the private sector (excluding SJA). In the absence of definitive data, an attrition rate of 4.3% and workforce growth of 2.9%

(totalling 7.2%) per annum has been used to estimate the number of new recruits required for the remainder of the private sector.

Table 8 shows the estimated number of paramedic recruits to the public and private sectors as 933 per year and presents a breakdown for each state and territory.

As the largest employers within the public ambulance sector, NSW, Victoria and Queensland ambulance services have the greatest demand for new recruits, while SJA WA has the greatest demand for new recruits within the private sector.

Table 8: Estimated annual number of recruits in public and private sectors by state and territory as at 2014

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Public ambulance sector									
Current	189	3,334	–	3,098	842	326	3,284	–	11,073
New recruits	10	280	–	208	36	17	236	–	787
Private sector									
SJA									
Current	–	–	130	–	–	–	–	652	782
New recruits	–	–	10	–	–	–	–	50	60
Other									
Current	9	214	132	203	203	14	213	188	1,176
New recruits	1	15	10	15	15	1	15	14	86
Total new recruits	11	295	20	223	51	18	251	64	933

There is no effective mechanism for preventing paramedics who are impaired, poorly performing or who engage in misconduct with one employer from seeking employment as a paramedic with another employer. The 2014 survey of public ambulance services, the ADF and PPA identified the lack of formal mechanisms for alerting other public ambulance services or private employers about such paramedics who had left an employer, either involuntarily or voluntarily, as a significant issue. Consultation submissions from employers, and responses to the 2014 survey, reported cases in which paramedics with conduct or performance issues have had their employment terminated more than once, but their disciplinary histories have not been available to a new employer.

The organisations surveyed indicated that prospective employers are usually provided with a statement of service. They are generally unable to obtain confidential information from previous employers about impairment, competence or misconduct issues, which may not have been addressed during previous employment. A number of respondents indicated that they were only able to advise of any disciplinary action if a government service requested a reference. One organisation indicated that its human resources department was unable to provide a negative reference. Public ambulance services and SJA NT and WA indicated that they did not have protocols to alert other employers about such issues. The exceptions were Queensland and NSW, which provide information only to other government departments within that state ([Appendix 6, Table 24](#)).

The organisations surveyed were asked whether they were aware of any paramedics who had gained employment elsewhere as a paramedic during the period surveyed (2010–2013), following concerns raised and/or termination of employment relating to performance, conduct or impairment. At least 11 such cases were identified:

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- ASNSW advised of **two** cases
- SA Ambulance Service advised of **three** cases
- Ambulance Victoria advised of **three** cases
- SJA WA advised of **two** cases
- Ambulance Tasmania advised of **one** case.

The actual number of such cases during this period may have been much higher. The SJA NT advised that it was aware of cases, but did not provide figures. The PPA advised of a number of cases in the private sector, including cases of re-employment after dismissal for misuse of Schedule 8 drugs, child sex offences and possession of fraudulent qualifications.

Responses to both the survey and the national consultation indicated that:

- paramedics can and do resign from their employment once concerns about their practice come under scrutiny by their employers
- the willingness of employers to inform prospective employers of known issues in relation to former employees is extremely limited due to fear of litigation
- confidentiality agreements – which are often a condition of settlement of cases involving serious misconduct, significant patient harm and/or death – prevent former employers from sharing disciplinary information with others.

For instance, in describing a series of incidents relating to the theft Schedule 8 controlled drugs, a submission from a major private employer of paramedics noted:

Aspen has direct experience of paramedics who have been dependent on Schedule 8 medications. Aspen identified these practices, but only after a great deal of concern, investigations and police involvement. It turned out that these paramedics has (sic) a long history of dependence on opioids. Unfortunately Aspen was only able to identify this after the fact. In the absence of an appropriate reporting mechanism, previous employers had simply dismissed these employees (Aspen Medical, August 30, 2012).

In addition to the costs of probity checking of prospective employees, as noted above significant costs are associated with managing the conduct and performance of paramedics who are unfit to practise, but who have 'slipped through the net'. The employer then has to bear the significant cost of performance managing, closely supervising and, if required, terminating the employment of the paramedic in accordance with industrial agreements.⁷

This lack of transparency places the public at risk by allowing paramedics who may not be 'fit and proper' persons to provide a health service to continue to do so in another jurisdiction, or with a different (private) employer.

⁷ The cost of replacing a professionally qualified employee is estimated as up to 150% of that person's annual salary (Australian Human Resource Institute, 2008).

4. Consultation

This chapter provides details of the national consultation process, the regulatory options provided for consultation and consultation participants. It highlights the key themes that emerged from the consultation forums and written submissions. It also discusses the responses to the options presented.

4.1. Consultation process

The national consultation was conducted from July to August 2012. A consultation paper was released on 2 July and published on the website of the Australian Health Ministers' Advisory Council Secretariat. The national consultation, and links to the consultation paper, was also advertised in The Australian newspaper inviting public submissions by 26 January 2013. Public comments were guided by a series of questions set out in a 'Response form' available to download from the website.

Four options were presented for comment in the consultation paper as follows:

- Option 1: No change – rely on existing regulatory and non-regulatory mechanisms and a voluntary code of practice
- Option 2: Strengthen statutory health complaint mechanisms – statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services
- Option 3: Strengthen state and territory regulation of paramedics
- Option 4: Registration of paramedics through the National Registration and Accreditation Scheme (NRAS)⁸

Consultation forums were held in each state and territory between July and August 2012. Invitations to key stakeholders were issued by state and territory health departments.

The 239 attendees included broad representation of key stakeholders, including public and private ambulance and patient transport services, industrial bodies, professional organisations, private sector employers, the Australian Defence Force (ADF), consumer organisations, health complaints entities (HCEs), education providers, the Australian Health Practitioner Regulation Agency (AHPRA), state and territory health departments and individual paramedics. [Appendix 7](#) contains a list of attendees.

A substantial majority of attendees indicated a preference for Option 4.

Fifty written submissions were received and are listed at [Appendix 8](#).

[Table 9](#) provides a summary of submissions received by type of respondent. The largest group of respondents was individual paramedics (26%), followed by employers of paramedics (14%), industrial bodies (12%) and government departments and regulators (12%). One submission was received from a consumer representative body. None were received from individual consumers.

⁸ For discussion of the five options developed in response to the feedback received during the consultation see Chapter 6.

Table 9: Number of submissions to the national consultation by type of respondent

Type of respondent	Submissions (No.)	Proportion of respondents (%)
Paramedics	13	26
Employers including event managers	7	14
Industrial bodies	6	12
Government departments and regulators	6	12
Education and training organisations	4	8
Peak bodies	3	6
Individual students / student representative bodies	3	6
Professional associations	3	6
Academics	3	6
Consumer representative bodies	1	2
Health complaints entities	1	2
Total	50	100

4.2. Key themes from submissions and forums

Key themes drawn from the submissions and consultation forums are summarised below.

It is difficult to estimate the size of the private sector workforce

Consultation forums held in NSW and the ACT raised some concerns regarding the lack of accurate workforce data.

Paramedics Australasia (PA) noted that based on 2011 Census data up to 18% of paramedics now work in the private sector (PA, 2012b, p.5). However this includes paramedics working for SJA in WA and the NT delivering public ambulance services. Not including these paramedics PA states that up to 7% of paramedics may be employed outside of state and territory ambulance services. PA further suggests most private sector employment growth is in allied health services and mining sectors (PA, 2012b, p. 5-6)

In contrast, the Council of Ambulance Authorities (CAA) estimates the number of paramedics employed in the private sector to be no more than 1–2% of the total workforce.

The private sector workforce is often part-time or casual and includes public ambulance service employees working in a private capacity. This compounds the difficulty of estimating the size of the workforce. For example while the CAA suggested that private sector employment numbers were likely to be very small it agreed with the Consultation Paper that there is a sector of other employment by organisations that provide health services at mass public events or to industrial or mining operations. It also agreed that it is difficult to obtain data on the size of this sector or of any changes in this over time (CAA, 2012 p.3).

The title 'paramedic' is not protected and does not guarantee a minimum level of qualification

The lack of a standard definition of the term 'paramedic' in Australia, and of a minimum qualification level was raised in many submissions and at all forums. As the skills of paramedics have developed beyond the scope of providing basic first aid and patient transport, respondents expressed concern that the title 'paramedic' is not protected.

Because the term 'paramedic' is not a protected title, anyone can 'turn out' and call themselves a paramedic (Academic).

A private First Aid Service provider has, for the past 3 years, provided event medical coverage to a large sporting event involving over 100,000 spectators over 3 days. Some of those employed by this provider have worn shirts with 'Paramedic' emblazoned across the back. These people are personally known to me, and have completed a Certificate IV in Basic Health Care through a private VET [Vocational Education and Training] provider. However, they completed limited, if any, supervised clinical practice as a paramedic student during the completion of their course. Are they paramedics? They and their employer both believe they are (Paramedic).

Many respondents noted that a growing number of paramedics are moving into the private sector, where there are fewer controls on qualifications and what constitutes a 'paramedic', thus increasing the risk of sub-standard care to the public.

Some private companies have incorporated the title 'Paramedic' into the name of their business even though they do not employ paramedics or paramedics with the qualifications and clinical practice required in an emergency ambulance service (Ambulance Employees Association – Victoria).

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

Members provided an example ... of a nurse who turned up at a mines site [in] one state where 'paramedics' were providing contracted services. The individual was employed on a contract as a 'paramedic' even though she clearly had never worked in such a role in the currently accepted sense of the term (National Council of Ambulance Unions).

There is no clearly defined paramedic scope of practice

Many respondents expressed concern there is no nationally agreed scope of practice for paramedics. It was noted that the scope of practice varies widely between government-related ambulance services, the ADF and the private sector.

Respondents expressed the view that where paramedics have a broader scope of practice, there is greater risk to the public, particularly where the paramedic has not undergone the appropriate level of training to perform higher-risk activities.

As the scope of services performed by paramedics increases and the fields in which they operate increase there is increased potential for harm to the public (Sitemed)

At present the extent of paramedic practice is inconsistent across the States and Territories, so that some paramedics may undertake clinical roles for which they are

not trained or are beyond their level of training and expertise (Australasian College for Emergency Medicine).

Respondents noted that the paramedic scope of practice is expanding within and beyond ambulance services, with paramedics providing more than the traditional pre-hospital patient care and transport services. Many noted that paramedics currently undertake complex clinical assessment and care independently (with minimal or no supervision, in dangerous and uncontrolled settings), including invasive procedures and administration of scheduled medications.

As skills, roles and scopes of practice have widened, in attempts to meet increasing demands on services, risk has increased exponentially (Paramedic).

Rapid advances in technology and the increasing complexity of the care provided by our members increase the likelihood of adverse events occurring from time to time (National Council of Ambulance Unions).

The community is not adequately protected from harm by existing safeguards

In their submissions and in feedback at the forums, respondents suggested that there is inadequate protection for the community from the harm that can result from paramedic practice. They noted that paramedics frequently work in environments where consent to treatment is not always possible, and with vulnerable people who have no choice of healthcare provider.

In most cases the people treated by paramedics have little choice of provider so the practitioner care is taken on trust. The patient can also be unconscious when treated – so that consent to treatment is not always possible (PA).

Respondents reported situations where paramedics' practise was below accepted professional standards (i.e. unethical or incompetent), or where they continued to practise with a health impairment (e.g. addiction), which affected their ability to practise competently. The community can be at risk because these issues are dealt with by employers, and there is no transparency in how complaints are handled and resolved. Such paramedics may remain in their employment, or obtain alternative employment with another ambulance service or in the private sector if they resign or are dismissed.

In its submission, the Australian and New Zealand College of Paramedicine (ANZCP)⁹ cited a case of a frontline paramedic manager, who was known to have:

... a drug dependence problem and at times would fraudulently write off restricted medications for his personal use ... when it was reported to his superior it was poorly investigated because of their relationship (ANZCP).

Following formal investigation by the ambulance service, the paramedic resigned and the matter was not dealt with by the NSW Health Care Complaints Commission.

The Consumers Health Forum' submission referred to feedback from a consumer focus group to the Health Workforce Australia's 'Extending the role of paramedic project':

Consumers wanted to know there were adequate safeguards in place for these extended roles, in particular consistent education and training and a consistent model of regulation for professions providing services outside their usual role (Consumers Health Forum).

⁹ Formerly the Australian College of Ambulance Professionals NSW.

Respondents noted that there are currently no consistent educational standards or ongoing clinical professional development requirements for paramedics. Some recommended a bachelor degree as the minimum educational qualification for paramedics. Others suggested that credentialing in advanced life support should be the minimum formal qualification.

Most respondents supported the establishment of national standards for paramedic education, training and skill development:

To ensure that we deliver the best care for our patients, a national standard for education, training and skill sets need[s] to be developed for the changing requirement of paramedic practice (Paramedic).

The CAA supports setting minimum qualifications for paramedics, including formal education at Bachelor Degree level plus appropriate Practica and internship (CAA).

From my experience it seems that the public expects a 'paramedic' to have a high level of interventional skill, which would closely equate to at least an Advanced Life Support level of training (Paramedic).

Because of the lack of a registered paramedic descriptor, industries have been legitimately able to employ individuals with minimal education as paramedics, when the public would associate a paramedic with a tertiary qualification or equivalent (Flinders University).

Paramedics are not mandated to maintain competence or undertake continuing professional development

Respondents highlighted the lack of mandated requirements for paramedics to engage in continuing professional development. It was noted the responsibility for monitoring suitability to practise lies with the employer and that voluntary uptake of such activities by paramedics is very low:

The current professional association for paramedics has a voluntary continuing professional development program that is modelled closely with the AHPRA requirements but the take up of this by the practitioners is very low (Paramedic).

CPD [Continuing professional development] is primarily designed to keep practitioners up-to-date with changes in knowledge, and does little to actually build upon the practical knowledge and experience of a professional once they graduate (Paramedic).

Mandated continuing professional development through national registration was supported by a number of respondents, for example:

Registration is the key to ensuring public safety through placing the responsibility for maintaining fitness to practice directly on the practitioner within a national regulatory framework (Student PA).

Other respondents expressed concern that some paramedics may not retain the clinical skills required to function effectively as a paramedic in emergency situations:

If a paramedic has been working in a rural situation for a prolonged period of time they may not have retained an appropriate amount of knowledge and skill to be able to provide emergency pre-hospital care to their patients (Anonymous).

Current systems for consumer complaints handling and reporting are inadequate

A number of submissions commented on under-reporting of complaints about the actions of paramedics, noting a lack of publicly available data to determine the actual rate of harm. For example:

Practitioners within the profession see a higher level of public risk than is evident in any current public reporting (Academic).

Another common theme raised during the consultation was inconsistent collection, classification and/or handling of complaints made against paramedics. In relation to this issue, confidentiality issues were cited as a barrier to public accountability:

Due to privacy considerations inherent in the settlement of these cases no further detail can be publicly supplied (National Council of Ambulance Unions).

Whilst it is acknowledged that it is an employer's prerogative and indeed right to follow up and manage any complaint of unprofessional conduct, the lack of transparency to the public as a necessary element of protecting the confidential nature of information afforded to an employer about an employee means that public protection and safety may be afforded less importance than if a complaint was made to an external third party (Academic).

Respondents noted that very limited data are currently available with which to quantify, with any degree of certainty, the actual likelihood of harm (serious injury and/or death) arising from the practice of paramedics.

In public ambulance services, a conflict of interest between their roles in consumer complaints-handling, and as employers of paramedics subject to complaints, was also highlighted by a number of respondents:

These events are largely under-reported and certainly not currently in the public domain. I have observed patients deteriorate with inappropriate paramedic care. I have reviewed cases of patients who have died during treatment where all potential risks have not been adequately considered. I have been associated with the performance management of paramedics who have been impaired for reasons of both substance use and mental health issues (Paramedic).

There is a lack of robust legislative frameworks for managing and acting on complaints outside of the internal organizational structure (Australian College of Ambulance Professionals NSW Ltd.).

There is no consistent model for complaints about paramedics across the States and Territories and thus no complaints and clinical incidents data collection and reporting comparable across the jurisdictions (Ambulance New Zealand).

Paramedics found to be unsuitable to practise by one employer may change employers within or across jurisdictions

Several respondents noted lack of information sharing between employers. This was seen as a particular concern given the growth in employment of paramedics in the private sector. At present, paramedics may resign from their employment if they come under scrutiny for health, conduct or performance issues. They may then seek employment as a paramedic in the same or another jurisdiction:

Another factor contributing to risk is the absence of any requirement for one employer to share information with another regarding an individual practitioner's fitness to practise ... The result is that a practitioner currently may resign from one provider while an investigation remains incomplete and seek employment elsewhere, without any caveats on their practice status and thus potentially placing the public at risk (PA).

A number of respondents reported instances of paramedics found to be unsuitable to practise by public ambulance services, who gained employment as paramedics with another service, in a public ambulance service or the private sector. One respondent gave the example of an individual gaining employment in Australia as a paramedic after being removed from the register of paramedics in the United Kingdom:

The NCAU has been provided with several examples of non-members who have been dismissed /offered [the] opportunity to resign by ambulance services for various reasons relating to their competence and fitness to practise who have subsequently gained employment with ambulance providers, both government and non-government in other jurisdictions. In one such example, an officer who was impaired due to addiction was permitted to resign from one service. The individual sought and successfully gained employment in another jurisdiction (National Council of Ambulance Unions).

In the absence of national registration, paramedics who have been found unfit to practice may move from employer to employer, and from jurisdiction to jurisdiction. This cannot be tracked and so further patients may be exposed to risk (Academic).

There is inconsistent legislation and regulation throughout Australia

Respondents reported that regulation of paramedics varies significantly between jurisdictions. Some jurisdictions have legislation specific to paramedics or ambulance services, while others have limited or no legislation.

The ADF identified this as a particular issue in relation to defence force paramedics who work across state borders. Some respondents suggested that strengthening state-based ambulance legislation would not address issues of paramedic regulation:

Strengthening the current state and territory legislation will not provide the national consistency required ... due to State and Territory regulatory frameworks not providing a national governance framework. This will continually create difficulties for Defence medics who practise across State and Territory boundaries (ADF).

Aspen requires a very mobile workforce, and any of our paramedics could be working in a number of jurisdictions over a relatively short time period. It is essential that the bureaucratic nightmare of state and territory based regulation be avoided (Aspen Medical).

The majority of respondents supported national regulation, expressing concern that strengthening state and territory legislation would not provide national consistency.

The NCAU believe paramedics and paramedic practice could be regulated through strengthening ambulance legislation. For this to be truly successful though, national consistent legislation is required. The NCAU rejects the notion that simply changing aspects of current State and Territory-based legislation, or introducing it into those jurisdictions without ambulance specific laws would fulfil ... national regulation of paramedics (National Council of Ambulance Unions).

The contrary view was expressed by the NSW Ministry of Health. It argued that regulation through the NRAS would not offer any significant benefit over that which is already achieved in NSW. It referred to the high level of government sector employment, regulation through the existing negative licensing scheme for unregistered health professionals, and, regulation through the *Poisons and Therapeutic Goods Act 1966* (NSW).

Other NSW submissions disagreed with this assessment, arguing for a stringent, enforceable and universal framework to ensure the health and safety of the Australian community:

A number of respondents reported incidents of concern that occurred despite the presence of NSW legislation aimed at enhancing the regulation of unregistered health professionals and allowing for prohibition orders to be made by the Health Care Complaints Commission ... [T]here were still a number of cases where such legislation appeared to have no perceivable benefit in managing breaches of the Code of Conduct enacted in the legislation (Australian College of Ambulance Professionals NSW).

Barriers impede the transfer of qualifications and skills across jurisdictions

Many submissions noted jurisdictional variations represent barriers that impede paramedics from working across jurisdictions or between the public and private sectors. A number of respondents noted difficulties when applying for new employment, as well as when cross-border responses to disasters such as bushfires and floods are required.

Similarly, the ADF noted that individuals employed as ADF medics find it difficult to gain employment after leaving the service. It indicated willingness to train its medics to any nationally agreed standard because:

National registration increases workforce mobility in enabling ADF and civilian paramedics to move around Australia for professional or personal reasons (ADF).

Others expressed similar views:

It is important that paramedics are able to have the flexibility to move between employers in the government run or funded ambulance services and the private sector. Presently, there is little incentive for paramedics to move away from an ambulance service given that in a state it is often only that ambulance service's accreditation that gives a paramedic some professional standing. Loss of that Ambulance Service certification will potentially limit the ability to demonstrate a professional standing and also to gain later employment with another ambulance service (Aspen Medical).

Paramedics need a qualification that is portable (of great benefit to those of us who live in state border areas) and consistent across the nation (Paramedic).

There is no nationally consistent qualification and probity checking process for all practitioners

Respondents noted that probity checking before employing a paramedic remains the responsibility of each individual employer. While public ambulance services may require all new paramedic employees to undergo a criminal history check, some respondents suggested that private employers may not.

The high costs to employers of assessing qualifications and probity checking for new employees was also raised:

The full compliance costs for Defence for the current regulatory mechanism is unknown but includes Human Resources, Health Competency Management and audit; and a wide range of regional and national regulator positions. Essentially, the current system has a high cost of internal human resources (ADF 2012, p.4).

Aspen has a number of paramedics who have qualifications from outside of Australia, including New Zealand, United Kingdom, Canada and United States of America. In every case, Aspen has to assess the qualifications to see if it aligns with our own minimum requirements. We are forced to 'reinvent the wheel', a very inefficient and frustrating process (Aspen Medical 2012, p.3).

Student registration should be considered to further protect consumers

It was reported during the consultation that student paramedics with ongoing health issues or unsuitable criminal histories, which may preclude them from registering as a health practitioner, are able to complete their education program and seek employment. Within the education system, explicit anti-discrimination requirements impact on the ability to act on these issues. Except where students are registered under the NRAS, the education sector is unable to effectively address situations where a person may not be fit to practise.

The following comments were noted during the consultation forums:

- *While students may be doing well academically, they may not necessarily be fit to practise.*
- *The lack of regulation of paramedic students means that 'unfit' students can move between universities, graduate and then obtain employment as a paramedic.*
- *Student registration will provide protection for student placement providers and customers/clients.*
- *Registration of students will have positive career path implications.*
- *There are no formal reporting processes in the university sector for students e.g. for students with mental health issues.*

A submission from a registered training organisation raised similar concerns:

Our diploma students are required to have a minimum of twelve months experience in an ambulance company as a patient transport officer together with a written recommendation from their employers. It is in this group that we found the highest percentage of unsuitable individuals presenting for training. Given they were already employed in the industry we cannot easily refuse them a place on physical or other grounds. As a result, we have graduated a number of individuals who were not suitable as paramedics. We are limited by the current system and are concerned that unsuitable individuals are being graduated and then passed from employer to employer without any oversight of why the individual has moved employers (Registered Training Organisation).

There is little or no regulation of the private employment sector

Several respondents noted that paramedics within the expanding private sector workforce are not regulated. This can result in persons deemed unsuitable to work in public ambulance services gaining employment in the private sector.

Many respondents expressed concern about the use of the title 'paramedic' at sporting and public events by people who hold basic first aid qualifications and have little practical

experience. Similar concerns were expressed about the employment of such people in the mining sector.

Respondents at the consultation forums also expressed concerns that:

- strengthening state and territory legislation may restrict private practice or fail to cover private service providers
- there is increased risk arising from growth in the private sector
- there is little protection for consumers at public events or in the private sector services.

4.3. Feedback on options

As earlier outlined, four options were presented for consultation.

Option 1: Maintain the status quo

Option 2: Strengthen statutory health complaint mechanisms

Option 3: Strengthen state and territory regulation of paramedics

Option 4: Registration of paramedics through the National Registration and Accreditation Scheme (NRAS).

There was significant support from forum participants for Option 4, registration of paramedics under NRAS. Of the 50 written submissions received, 44 respondents (88%) identified Option 4 as the preferred option. Many indicated that a national register, together with national regulation, were the only means to satisfactorily address risks associated with the paramedic profession.

Many also noted that national registration of the profession through AHPRA, with a national board supported by existing infrastructure, would be more cost-effective than state or territory-based regulation.

Of respondents who did not support Option 4, one (2%) supported Option 2, strengthen statutory health complaints mechanisms via a code regulation regime; two (4%) proposed alternative models of regulation, and three (6%) did not identify a preferred option.

Many respondents expressed the view that the cost to the community of doing nothing far outweighs the cost of extending regulation. Some considered that Option 4 alone – registration through the NRAS – would be insufficient to protect the public from private providers of ambulance or patient transport services. In addition to registration of paramedics, they argued that further regulation of the provider organisations themselves was required.

Option 2 – strengthening statutory health complaint mechanisms through the establishment of a statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services – was considered to provide a ‘safety net’ for consumers. However, respondents expressed concern that this regulatory model:

- does not offer protection of title
- does not enforce minimum qualifications for entry to practise
- does not provide for probity checking
- only triggers action when there is a complaint, after harm may already have occurred.

5. Objectives and options for action

In any reform process, it is important to consider alternative courses of action to address identified problems. This chapter of the Regulation Impact Statement (RIS) examines how these problems can be addressed in line with the stated objective of government action.

5.1 The objectives of government action

Given the problems identified in earlier sections, the objective of government action is to:

- ensure an effective and efficient quality assurance system for the delivery of paramedic services, within the context of a seamless, cost-effective national economy, and
- adequately protect the Australian public by minimising the incidence of harm associated with the delivery of paramedic services by personnel who are not fit and proper persons to be delivering such services or who breach their legal and professional obligations. Such harm may be physical, psychological or financial.

5.2 The options

As identified in Chapter 3, reinforced by the consultation feedback described in Chapter 4, there are three main areas of concern in relation to paramedic practice. The first area is the potential for harm (serious injury and/or death) to the community. The second is confusion about who is a paramedic arising from inconsistencies in training and qualifications required for employment as a paramedic. Third is the cost to employers of identifying and employing suitable paramedics and the ensuing constraints on the mobility of, and efficient deployment of the workforce across the nation.

Feedback from stakeholders was sought on four options during the national consultation. In response to that feedback the options were revised to include a fifth option. These five options were considered to reflect the spectrum of regulatory approaches for achieving the stated objective of government action. These options are:

- Option 1: Maintain the status quo – rely on existing regulatory and non-regulatory mechanisms
- Option 2: Strengthen self-regulation of paramedics
- Option 3: License private providers of paramedic services
- Option 4: Extend regulation to the paramedic profession under the National Registration and Accreditation Scheme (NRAS)
- Option 5: Establish statutory regulation for the paramedic profession under separate state and territory regulatory schemes.

This chapter assesses the relative merits of Options 2–5 against Option 1 (the status quo), through comparative analysis of their impacts and costs.

5.3 Affected parties

The parties likely to be affected by the proposals in this Decision RIS are:

- paramedic service providers (employers)
- consumers who use paramedical services

- paramedics and their representative bodies
- government, including regulators
- education institutions (universities and vocational training).

5.4 General assumptions and parameters

This analysis of the impact and costs of each option makes a number of assumptions:

- As shown in Table 2, approximately 13,031 paramedics are employed in Australia.
- The average annual salary of a paramedic is estimated at \$110,000.¹⁰
- According to the Australian Human Resources Institute (2008), the cost of recruiting an unsuitable employee is estimated at 1.5 times that person's average annual salary, i.e. \$165,000.
- Based on paramedic workforce data in Australia (13,031 paramedics), employers are expected to recruit 933 paramedics each year (section 3.3, Tables 7 & 8).
- Employer costs to complete pre-employment screening for each paramedic recruited are approximately \$500.¹¹
- Irrespective of any regulatory change, the minimum educational qualifications of paramedics would align with the entry level standard of a bachelor's degree set by the CAA (as discussed in section 2.3).

5.5 Options for regulation of paramedics

5.5.1 Option 1: Maintain the status quo – rely on existing regulatory and non-regulatory mechanisms

Chapter 3 outlines the nature of the problems with respect to current arrangements. The key issues identified relate to the potential for harm to the community, confusion about who is a paramedic and the cost to employers of identifying and employing suitable paramedics.

5.5.1.1 Impact of the current regulatory environment

At the date of writing this report, while legislation has been enacted to protect the title of paramedic in two jurisdictions, these are reactive models of regulation or 'negative licensing' that comes into play when things go wrong. There is no requirement or any mechanism for individuals to proactively register that they are practising as paramedics in any Australian state or territory.

As outlined in [section 2.2.1](#), statutory codes of conduct for unregistered health practitioners in NSW, SA and Qld provide a mechanism to prohibit practice by paramedics where a complaint has been made to a health complaints entity (HCE) and action is required to protect the public.

¹⁰ This figure is based on the average salary of paramedics employed by public ambulance services across Australia (including oncosts and allowance for overtime). This salary rate is similar to private service providers, including the resource sector.

¹¹ This figure is based on the costs to employers discussed in section 3.3.

In other jurisdictions there is currently no effective mechanism for preventing paramedics who are impaired, poorly performing or who engage in misconduct with one employer from seeking employment as a paramedic with another employer. Further where the code regulation schemes exist they rely on a complaint being lodged and the prohibition orders have no effect in jurisdictions lacking a parallel scheme with automatic recognition of orders issued in other code jurisdictions.

While rigorous pre-employment screening may reduce the risk of employing people who are unsuitable to practise as a paramedic, there are no regulatory safeguards to prevent this. Lack of transparency exacerbates the problem of paramedics, who may not be 'fit and proper' persons, continuing to provide health services in another jurisdiction or with a different employer. The 2014 survey for this review indicated that from 2010-11 - 2012-13, at least 11 paramedics had gained alternative employment as paramedics, despite termination of their employment and/or other concerns relating to performance, conduct or impairment.

Based on data provided by public ambulance services and SJA WA and NT ([Appendix 6, Table 24](#)), and allowing for a private sector paramedic workforce of 9% of total workforce (excluding SJA NT and WA), it is estimated that 20 paramedics have their employment terminated and 13 paramedics are subject to legal action each year.

Incidence of harm

The potential for harm associated with paramedic practice arises from the nature of the work, the complaints reporting and management environment and the potential for practitioner impairment and professional misconduct.

Nature of the work

Paramedic practice is becoming more complex and more sophisticated. As such, it carries a correspondingly higher risk of significant harm when things can and do go wrong. Expanding scopes of practice and practice settings, and the changing institutional context for practice are factors that increase these risks.

The extent of adverse outcomes in Australia is difficult to establish, due to limited and inconsistent public reporting of such events. During the national consultation, paramedics and employers reported that they were aware of instances of actual harm or injury to patients associated with paramedics' practice.

A sample of coronial inquest findings (Chapter 3) provides evidence that catastrophic harm, including death, is a real and foreseeable risk of paramedic practice. Data provided by public ambulance services ([section 3.1.1, Table 6](#)) indicated that 49 sentinel events/root cause analyses are investigated each year by employers of paramedics across Australia.

Complaints reporting and management environment

All public ambulance services in Australia have mechanisms in place to receive and deal with complaints from the public. However, complaints data from health complaints entities provides insufficient detail to distinguish the level and types of complaints about paramedics from general complaints about ambulance services (such as billing or ambulance response times).

Five public ambulance services provided data to this review, indicating an average of 1,733 complaints about paramedics each year. However, a common view expressed by paramedics and employers during the consultation was that there is substantial under-reporting of inappropriate actions by paramedics. As outlined in [section 3.1.2](#), the reasons for under-reporting included paramedics' reluctance to report colleagues and, often vulnerable patients who may not be aware of the conduct or that they have a 'right' to make a complaint about a publicly-provided service.

Practitioner impairment and professional misconduct

The impact of work-related stressors can result in physical or mental impairment for paramedics. Such impairments, particularly when compounded by substance abuse or addiction, may result in adverse outcomes for patients. Media reports across Australia indicate that theft and/or misuse of scheduled medicines by paramedics is of concern in many jurisdictions. Similarly, while physical and sexual assaults by paramedics in Australia may be uncommon, such incidents are also reported in the media.

Based on information provided by employers, it is estimated that 100 paramedics each year are subject to remedial/disciplinary action. An estimated 20 paramedics each year have their employment terminated and 13 are subject to legal action ([Appendix 6, Table 24](#)). While not all these events may be a consequence of patient harm, these data are a reasonable indicator of the incidence of serious harm to members of the public.

As noted, there is presently no effective mechanism to prevent paramedics who have resigned or been dismissed due to poor performance or professional misconduct from moving to another jurisdiction or employer and continuing to work as paramedics.

Confusion about who is a paramedic

Confusion about who is a paramedic stems from inconsistencies in training and qualifications required for employment as a paramedic as well as a lack of clarity about whether a person using the title has appropriate qualifications.

As noted earlier the Council of Ambulance Authorities (CAA) considers that a bachelor's degree is the minimum qualification required to be employed in the public ambulance sector. However, the CAA is unable to mandate these requirements and there are tertiary programs on offer that are not or not yet accredited. Vocational Education and Training (VET) providers also offer a variety of certificate and diploma-level courses in paramedic studies to meet private sector employer needs.

The absence of a nationally-consistent standard for entry to the profession means that the general public cannot necessarily have confidence that an individual practitioner who calls themselves a paramedic and or offers emergency care is appropriately qualified.

Paramedics

Paramedics are required to comply with existing state and territory legislation and employer regulation. Employers determine the requirements for employment as a paramedic and the scope of practice of the paramedic. Increasing enrolments in bachelor degree programs ([section 2.3, Table 5](#)) indicate that students are willing to bear the costs of obtaining a degree in paramedicine, in line with the public sector standard set by the CAA.

Under the status quo, practice rights are not portable between employers or across state and territory borders. Each time paramedics change employment, they must undergo probity checks and have their qualifications reassessed by their new employers.

It is not lawful for paramedics to use the title 'paramedic' in jurisdictions which have legislative protection of title, unless they meet regulatory requirements to use that title (SA and Tasmania). However as noted in [section 2.2.1](#) these schemes are minimalist and are not reinforced by a register or any systems to proactively prevent harm by unsuitable practitioners.

In coming years, more and more paramedics will be affected by the introduction of the National Code of Conduct for unregistered health practitioners. As noted earlier this will enable complaints to HCEs that may result in prohibition orders being issued against practitioners for serious incidents that result in harm to the public. As at the date of this report no prohibition

orders have been issued against paramedics working under the code regulation regimes in NSW, Queensland or SA.

5.5.1.2 Costs associated with the current regulatory environment

Employers

As discussed in section 3.3, the cost to employers of pre-employment screening of paramedics is significant and may be at least \$450 to \$500. Screening includes assessing suitability to practise against requirements, including verification of identity and good character, assessing and verifying qualifications, a criminal history check (in Australia and overseas) and, for international applicants, confirming registration status with international regulatory bodies.

Based on the average workforce attrition and growth rates for an estimated 933 new recruitments per year (section 3.3, Tables 7 & 8), the current (status quo) costs to employers of undertaking pre-employment screening are estimated to total \$466,500 per year (Table 10); an average of \$500 per new employee.

Table 10: Estimated pre-employment screening costs by service type and state and territory (as at 2014)

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Public ambulance	10	280	-	208	36	17	236	-	787
Recruitment costs	\$5,000	\$140,000	-	\$104,000	\$18,000	\$8,500	\$118,000	-	\$393,500
Private sector									
St John Ambulance	-	-	10	-	-	-	-	50	60
Recruitment costs	-	-	\$5,000	-	-	-	-	\$25,000	\$30,000
Other	1	15	10	15	15	1	15	14	86
Recruitment costs	\$500	\$7,500	\$5,000	\$7,500	\$7,500	\$500	\$7,500	\$7,000	\$43,000
Total									
New recruits	11	295	20	223	51	18	251	64	933
Cost	\$5,500	\$147,500	\$10,000	\$111,500	\$25,500	\$9,000	\$125,500	\$32,000	\$466,500

Education providers

Various educational institutions currently provide programs targeted at employee needs. Qualifications range from tertiary degree programs accredited by the CAA on behalf of its member organisations, to an Australian Defence Force diploma, to first aid and patient transport programs for some private sector employers. ASNSW employs degree qualified recruits but also offers its own vocational entry pathway.

As noted consistent with the CAA policy establishing a bachelor level degree as the standard for entry level employment, universities across Australia are producing increasing numbers of graduates. VET sector education programs for the sector may focus primarily on first aid and patient transport and on other programs, as they seek to meet industry needs.

Universities seeking CAA accreditation of their paramedicine programs are charged an application fee for preliminary approval and re-approval (if the course changes significantly), an annual accreditation maintenance fee, and a per capita fee based on the number of full time equivalent (FTE) enrolled students. CAA course accreditation fees as at 2014 are shown in Table 11.

Table 11: CAA paramedic education program accreditation scheme costs (2014).

Approval stage	Fee \$ (+GST)
Preliminary approval of a new program	4,545
Full accreditation/provisional accreditation	
Annual sustaining fee	2,250
Capitation fee per full time equivalent student enrolment	12
Accreditation site visit fees – direct costs of accreditation assessment team visit per site/campus	At cost

Fourteen of the 20 tertiary education programs for paramedics in Australia currently have full or provisional accreditation status ([section 2.3, Table 4](#)). The CAA course accreditation fees ([Table 11](#)) have been used to calculate annual accreditation costs for universities in each state and territory, as at 2014 shown in [Tables 12 & 13](#).

Table 12: Annual sustaining costs for courses granted full or provisional accreditation by state and territory (2014)

ACT*	NSW	NT*	Qld	SA	Tas	Vic	WA	Other**	Average
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
–**	4,500	–**	6,740	2,250	2,250	11,250	2,250	2,250	5,000

Notes:

* Data for ACT and NT were not available

** Course offered in ACT, Queensland and Victoria.

Student enrolment data from SCRGSP ([section 2.3, Table 5](#)) are based on the number of students enrolled in 2013, not actual full time equivalents (FTE). Full time equivalent student data obtained from CAA have been used to calculate total capitation costs for 2015, based on the location of the courses offered (CAA, personal communication, 2015). Some courses are provided by universities at more than one campus. For example, the Australian Catholic University has students enrolled in the ACT, Queensland and Victoria; the University of Tasmania has students located in NSW and Tasmania.

Table 13: Capitation costs per student (FTE) for courses granted full or provisional accreditation by state and territory (2015)

	ACT	NSW	NT*	Qld	SA	Tas	Vic	WA	Total
	\$	\$		\$	\$	\$	\$	\$	\$
FTE equivalent	160	170	–	1,448	845	90	1,794	685	5,192
Cost (\$ +GST)	1,920	2,040	–	17,376	10,140	1,080	21,528	8,220	62,304

Note:

* Data for NT were not available

Taking into consideration annual sustaining costs, capitation fees, additional costs for preliminary approval of new programs and accreditation site visit costs, course accreditation fees charged by CAA in 2015 are estimated at more than \$100,000. These costs will increase as more university courses are granted full or provisional accreditation.

As earlier discussed, industry has taken significant steps towards establishing a degree-qualified paramedic workforce over the past few years.

Conclusion

As outlined in Chapter 2, jurisdictions have adopted a range of regulatory measures, which provide varying degrees of public protection. However,

Under Option 1, the status quo, existing regulatory and non-regulatory mechanisms for paramedics would continue. Option 1 does not preclude additional legislation in states and territories to:

- protect the title 'paramedic', as in SA, Tasmania and NSW, or
- establish further regulation of non-emergency patient transport (NEPT) services, or
- proceed to enact a code regulation regime, similar to those operating in NSW and SA Australia-wide as agreed in principle by Australian Health Ministers, or
- establish jurisdictional statutory regulation of paramedics.

However the status quo is not effective in minimising the incidence of harm associated with the delivery of paramedic services, within the context of a seamless, cost-effective national economy. In summary, Option 1, the status quo, allows for continued confusion about who is a paramedic, risks unnecessary harms to the community in the course of paramedic practice and imposes significant recruitment costs on employers who must assess each applicant's suitability for employment as a paramedic.

5.5.2 Option 2: Strengthen self-regulation of paramedics

Under Option 2, strengthen self-regulation of paramedics, existing self-regulation arrangements initiated by the profession would be strengthened through the establishment of a voluntary register of paramedics.

Paramedics, possibly through their professional associations, would establish a national (non-statutory) agency, whose role would be to administer a voluntary register of paramedics. While the professional associations could provide support to establish a regulatory agency, the new agency would function independently and assume the role of promoting and advancing the discipline of paramedicine.

The agency could be self-funding through registration fees paid by individual paramedics and accreditation fees paid by education providers.

The functions of the agency might include:

- standard setting and guidance – setting the qualifications and other requirements for registration as a paramedic and issuing authoritative advice about practice standards for paramedics
- registration – assessing applications from individuals for registration and renewal of registration and maintaining a voluntary register of qualified paramedics
- complaints handling and discipline – managing the receipt and investigation of complaints of professional misconduct, conducting disciplinary hearings and applying sanctions, where necessary, including removal of a paramedic from the register, or asking a paramedic to complete specific education requirements or modify his or her practice
- accreditation – administering the processes of accreditation of programs of study that provide qualifications for entry to the voluntary register and setting standards against which training programs are assessed.

Incentives to encourage paramedics to seek and maintain voluntary registration could be offered through institutional recognition of the voluntary register, for example:

- ambulance and private paramedic provider organisations could set registration as a pre-requisite for employment
- government agencies could require, via funding agreements, that service providers employ a certain proportion of registered paramedics in particular roles
- other government departments and provider organisations could decide to rely on the voluntary register as the trusted source of information about qualified paramedics.

The agency and the register could be developed along similar lines to the Australian Orthoptic Board, which has established a self-regulatory mechanism for orthoptists in Australia. The function of the Orthoptic Board is to regulate the profession of orthoptics,¹² in order to protect the public. The Orthoptic Board maintains a register of suitably-qualified orthoptists and investigates the professional conduct and fitness to practise of registered orthoptists. The Australian Orthoptists Registration Body is a company limited by shares established under the *Corporations Act 2001* (Cwlth). While orthoptic registration is voluntary in Australia, employers are increasingly requiring orthoptists to hold registration as a condition of employment.

If established along similar lines to the Australian Orthoptic Board, the operation of a paramedicine regulatory agency would be underpinned by corporate law, and registration requirements would be established by a non-statutory paramedicine board.

The following discussion covers the impact and costs of Option 2, strengthened self-regulation.

5.5.2.1 Impact of strengthened self-regulation of paramedics

Incidence of harm

As earlier indicated, each year, an estimated 100 paramedics are subject to remedial or disciplinary action and 20 have their employment terminated.

Compared to the status quo, the incidence of harm to healthcare consumers could be reduced through establishment of a voluntary national register of paramedics. This would be further strengthened if all paramedic service providers employed only persons on the voluntary register (as currently occurs in the field of orthoptics).

The registration authority could be underpinned by a mechanism such as corporate law and agreements with employers and funding bodies, rather than legislation. The lack of statutory backing would mean that although a person's registration could be cancelled; there would be few directly enforceable disciplinary powers available to the registration body. For example, it would be unable to enforce a directive to prohibit a paramedic from practising. Further to avoid disciplinary action paramedics could also let their registrations lapse.

Paramedics

In agreeing to voluntary registration, paramedics would need to meet the registration requirements established by the profession's self-regulatory authority.

¹² See further Australian Orthoptic Board http://www.australianorthopticboard.org.au/Registration/Regn_faq.html Orthoptists are eye healthcare professionals trained in the assessment and treatment of eye disorders (Orthoptics Australia <https://www.orthoptics.org.au/>). Note that Orthoptics Australia is a professional association whose role is to promote and advance the discipline of orthoptics. It should not be confused with the Orthoptics Board, which is a regulatory body.

Paramedics would benefit from voluntary registration by having their qualifications recognised for entry to the register and by recognition of the register through co-regulatory arrangements with employers and or government agencies. The necessity for a voluntary register is likely to be less important in jurisdictions where the title 'paramedic' is protected by legislation (SA and Tasmania at the time of writing).

In other jurisdictions, Option 2 may promote portability of practice rights across state and territory boundaries subject to the registration body achieving agreement with employers to rely on the register for determining who is qualified as a paramedic.

In common with the status quo, under Option 2, as the National Code of Conduct for unregistered health practitioners is introduced it will impact on paramedics. A complaint made to an HCE could result in a prohibition order being issued against a practitioner for serious incidents which have resulted in harm to the public. It would not provide any proactive avoidance of harm.

Employers

A voluntary public register established under Option 2 would provide a limited source of information on who is qualified as a paramedic. Employers would benefit from voluntary registration in terms of:

- the establishment of national entry to practice qualifications for paramedics, with anticipated employer savings associated with assessing qualifications
- access to an alternative avenue to make a complaint about a registered paramedic, when they have concerns about the care provided or the behaviour of the practitioner
- a reduction in avoidable costs associated with recruiting unsuitable paramedics, if they employ paramedics who are on the voluntary register.

In essence, the success of Option 2 would depend on employers' and funders regard for the scheme.

Education providers

Under Option 2, a voluntary registration body for paramedics may opt to undertake its own course accreditation process or maintain the status quo, with CAA continuing to provide course accreditation through its Paramedic Education Program Accreditation Scheme. In this latter case, tertiary education program accreditation costs would continue as determined by CAA (Table 12).

Under Option 2, no change in the number of students interested in undertaking paramedicine degree programs would be anticipated.

The VET institutions are likely to be affected by Option 2, if private employers (or the contractors who supply paramedics) chose to employ only paramedics registered with the voluntary scheme, because the entry standard for registration would be a university degree. In this scenario, VET institutions would continue to provide first aid, patient transport and other programs designed to meet industry needs.

Anticipated effects on competition

The impacts of Option 2 on competition are likely to be minimal, dependent on the extent to which such a scheme was accepted by employers and funders. Unless the scheme was widely accepted across the industry it would not impose enforceable barriers to entry to the profession. Paramedics who chose not to register could still practise as paramedics, and public

and private providers (including contractors) could continue to offer paramedic services, without requiring their employee paramedics to be registered.

However, paramedics might decide to seek registration to gain a competitive edge in the employment marketplace. Similarly, to increase public confidence in their services, private providers might require their paramedics to be registered.

Option 2 is unlikely to reduce workforce availability or increase labour costs.

Impact on existing regulation within individual jurisdictions

The establishment of a voluntary registration scheme would have no impact on existing regulatory measures, including:

- scheduled medicines authorities
- public ambulance service regulation
- private ambulance and transportation services regulation, including licensing of private NEPT in Tasmania and Victoria
- protection of paramedic title and established accepted qualifications in SA and Tasmania
- the code regulation regime for unregistered health practitioners in NSW and SA
- the regulatory scheme for unregistered health practitioners in Queensland.

As with protection of title legislation, jurisdictional statutory regulation of paramedics would override any self-regulatory registration scheme in that jurisdiction.

Under Option 2, existing regulatory mechanisms for paramedics would continue. Option 2 does not preclude the possibility that additional states and territories may legislate to:

- protect the title 'paramedic', or
- establish further regulation of NEPT services, or
- establish additional jurisdictional statutory regulation affecting paramedics, or
- enact a code of conduct regulatory regime for unregistered health practitioners.

5.5.2.2 Costs associated with strengthened self-regulation of paramedics

General assumptions and parameters

In addition to the general assumptions and parameters on the impact and costs of regulatory options, discussed in [section 5.4](#), the following assumptions have been applied when quantifying costs associated with Option 2:

- Twenty per cent of eligible paramedics would register under the voluntary scheme (approximately 2,606 registrants).
- Registration numbers would remain low in the early years of a voluntary registration scheme, but may grow over time as paramedics and employers became more familiar with the scheme.
- Paramedics employed by public ambulance services would not seek registration, as registration would entail a personal cost without immediate benefit.

- Paramedics who are impaired, poorly performing or predisposed to engage in unethical or illegal conduct are unlikely to seek and or maintain voluntary registration.
- The cost of registration under a voluntary registration scheme would be lower than the costs of compulsory registration under a national statutory scheme.

Legislative changes

As a voluntary registration scheme, there would be no costs associated with the development of legislation.

Establishment costs

The establishment and ongoing costs of a voluntary registration scheme would vary according to a range of factors, including the type of register (such as a simple register which lists all registrants), the number of registrants and any administrative arrangements. The type of register and services offered under the scheme would influence data and infrastructure requirements and costs.

Establishment costs for an administrative agency are estimated at \$500,000.¹³ A significant proportion of these costs would be for legal advice to establish the scheme, office accommodation, staffing, equipment, information and communication technology, publicity and advertising, application materials, and costs associated with establishing a governance board and developing registration and accreditation standards.

Potential registrants would pay a one-off application fee to cover assessment of their suitability to practise. The fee would cover verification of identify and good character, assessment and verification of qualifications, a criminal history check (in Australia and overseas) and, for international applicants, confirmation of registration status with international regulatory bodies. The application fee for first-time registrants is estimated at \$300¹⁴ per registrant; a total of \$781,800 for the 20% of the workforce (2,606 registrants) it is assumed would seek voluntary registration from the outset. The application fee is likely to include the first year of membership.¹⁵

Cost offsets to employers

Based on estimated workforce turnover and growth rates, which equate to 933 new recruits per year ([section 3.3](#), [Table 8](#)), it is anticipated that cost offsets to employers would initially be low, but would increase over time as more paramedics entered the voluntary registration scheme and more employers used registration as a basis for employment of practitioners.

Based on the estimated employer costs of pre-employment screening of potential paramedic employees, ([Table 10](#)), a voluntary registration scheme would initially reduce the need for assessment of 20% (n=187) of new recruits. Based on pre-employment screening costs of \$500 per applicant for 187 applicants, this would amount to annual savings of \$93,500 although the specific savings per employer would obvious vary considerably.

¹³ This estimate is based on start-up costs provided by the Australian Orthoptic Board, the Australian Community Workers Association, and in line with the establishment costs of the licensing scheme for private providers of paramedic services.

¹⁴ This estimate is based on the eligibility assessment fee of \$300 for the voluntary registration scheme for community work practitioners in Australia, established by the Australian Community Workers Association (2012).

¹⁵ This is in line with the voluntary registration scheme established by the Australian Community Workers Association, which provides for members of the public to make formal complaints against members.

If all paramedics registered with the voluntary scheme, employer cost offsets of \$466,500 per year could be achieved, if all employers used registration as a basis for determining suitability for employment (933 applicants per year at \$500 pre-employment screening costs per person; total annual savings of \$466,500). However, 100% participation in voluntary registration is unlikely to be achieved in the foreseeable future.

Ongoing costs

On an ongoing basis, the estimated annual registration fee of \$300¹⁶ per registrant (based on 20% of all paramedics n=2,606 registrants), equates to \$781,800 per annum nationally.

In the first few years of the scheme, ongoing (new) costs associated with Option 2 are estimated to be \$688,300 per annum (i.e. registration fees of \$781,800 less savings to employers of \$93,500). Once well established, an increase in the number of registrants would increase total costs. The cost of registration could be reduced as uptake of voluntary registration increased.

Under Option 2, the establishment and ongoing costs of a national voluntary registration scheme could be fully funded from paramedic registration fees (Table 14).

Table 14: Estimated costs and savings associated with Option 2: strengthened self-regulation

Estimated costs	\$
Legislative changes	Nil
Establishment costs	
Administrative agency	500,000
Costs for first year of registration	
Application fee, including first year registration	781,800
Total new costs for first year	1,281,800
Ongoing annual costs	
Annual practitioner registration fee	781,800
Cost offsets for employers	-93,500
Total national ongoing (new) annual costs	688,300

Conclusion

Compared to Option 1, the status quo, Option 2 would support more efficient and effective paramedic recruitment systems, if the registration body assumed responsibility for establishing minimum qualifications for entry to the register and assessing applicants' qualifications and suitability for registration. These activities alone would generate cost savings for employers who utilised the voluntary register as the basis for employing paramedics.

Compared to the status quo, Option 2 would go some way towards reducing the incidence of harm to the community. However, as it is assumed that only 20% of paramedics would initially

¹⁶ This estimate is based on the annual membership fee for the voluntary registration scheme for community work practitioners, established by the Australian Community Workers Association (2012).

register under a voluntary registration scheme, the integrity of such a scheme would be limited. It is likely that membership coverage would increase over time if, as occurred in the orthoptists scheme discussed earlier, paramedics and employers recognised the benefits of voluntary registration.

While Option 2 would create new costs for paramedics, employers using registration as the basis for employment may see a reduction in avoidable recruitment costs.

To an extent, Option 2 would support workforce mobility through provision of a register of paramedics, if employers used the register as a basis for employment decisions. However, Option 2 would only marginally address the problems identified in Chapters 3 and 4, i.e. potential for serious harm to the community including the harm identified by coroners relating to confusion about who is a paramedic, and employer recruitment costs. While a paramedic's registration may be cancelled by the registration body, Option 2 cannot deal effectively with incompetent, impaired or otherwise unfit paramedics or remove them from practice, when necessary.

5.5.3 Option 3: License private providers of paramedic services

Option 3 involves establishment of a state and territory licencing scheme for private providers of paramedic services. Under Option 3, states and territories would legislate to establish new, or extend existing licensing regimes to cover private providers of paramedic services, including those who provide paramedics under contract. This would clarify the legal status of licensed private providers, for instance, to enable them to provide paramedic services as long as they do not imply that they are providing a public ambulance or emergency service where that is prohibited by legislation.

In order to provide paramedic services in a state or territory, a private provider would be required to hold a licence in that jurisdiction, and it would be an offence for an unlicensed person or body corporate to provide paramedic services.

Based on existing licensing schemes in Victoria (NEPT) and WA (Licensing standards for assessing suitability of a licence applicant or a licence holder), licence holders would have to demonstrate that they are 'fit and proper' to operate a paramedic service. This would include the requirements to be of good character and reputation, demonstrate sound financial reputation and stable financial background, and demonstrate competence to hold a licence. The licensing authority would require minimum standards to be met, as established by regulation or through licensing conditions in areas such as:

- the numbers, types and qualifications of staff
- staff management practices, including recruitment, clinical credentialing and continuing professional development requirements
- the delivery of clinical services including patient safety, medication management and infection control
- the provision, inspection and maintenance of vehicles, equipment and facilities
- the welfare of patients, including their comfort, privacy and respectful treatment
- record keeping, accountability and reporting requirements, including reporting of sentinel events
- insurance arrangements
- complaints handling processes, including collection and reporting of complaints data
- arrangements for monitoring, evaluation and quality improvement.

Strengthening regulation of private providers of paramedic services would make it possible to address a number of issues relevant to paramedic practice more generally. Statutory schemes could include a number of components, the implementation of which could also provide for:

- increased regulation/accountability of private providers of paramedic services, including non-regulated ambulance services
- licensing standards, which require employers to ensure that paramedics are appropriately qualified
- reporting mechanisms and requirements for complaints and sentinel events data.

The following discussion covers the impact and costs of strengthened regulation of private providers of paramedic services.

5.5.3.1 Impact of a licensing regime for private providers of paramedic services

Incidence of harm

Option 3 establishes licensing standards for private employers or contractors of paramedics, a small, diverse and potentially higher-risk section of the industry employing an estimated 15% of the total paramedic workforce. This may include public sector services provided on contract by SJA services in the NT and WA (as described in [section 2.1.3](#)). The spectrum of standards may include ensuring the qualifications of personnel employed as paramedics and ongoing requirements for their continuing professional development), operational accountabilities, reporting and complaints mechanisms for and requirements for employers to ensure that any paramedic services provided meet regulatory standards. A reduction in harm to the community would result from increased scrutiny of employers of paramedics.

It is expected that Option 3 would lead to improvements in the clinical governance and oversight of paramedics employed by some private providers. This would be the case where those providers have not already have established clinical governance or other standards such as those specified in the licensing requirements outlined above. Through minimum standards set by regulation or through licensing conditions, compared to the status quo, Option 3 could be expected to reduce the incidence of harm to healthcare consumers accessing private sector services.

Paramedics

Licensing regulations may specify staffing standards (including paramedic qualifications). Those employed or on contract as paramedics who do not meet the standards may be required to undertake further education and/or training. For example, if a licensing standard required paramedic employees to maintain their suitability to practise (such as through continuing professional development), paramedics may be required to undertake further education and training. Where such training was not provided or funded by the employer, these costs would be borne by individual paramedics.

Alternatively, to avoid new regulatory requirements, providers may choose to employ persons in lower level roles (however called, e.g., such as first aid), rather than as paramedics. Option 3 could have the effect of reducing the types of employment available to paramedics, compared to the status quo.

Compared to the status quo, Option 3 would not increase portability of practice between employers or across state and territory boundaries.

Employers

As identified in [section 2.1.3](#), [Table 2](#), private providers constitute a relatively small but growing segment of the industry).

Under Option 3, employers would continue to bear costs associated with assessing suitability to practise against requirements. These would include verification of identify and good character, assessment and verification of qualifications, criminal history checks (in Australia and overseas), and confirmation of registration status with international regulatory bodies for first-time international applicants. Employers would still risk employing practitioners who are impaired, incompetent or have engaged in misconduct, if they have not been effectively dealt with by previous employers.

Private providers of paramedic services who operate in more than one jurisdiction would be required to meet licensing requirements in each jurisdiction in which they work.

For paramedic service providers engaging small numbers of paramedics (such as in mining and construction), Option 3 may reduce the number of providers, if licensing costs and the increased regulatory burden were considered to be prohibitive. Rather than employ paramedics directly, some employers may elect to contract these services from a licensed provider of paramedic services. Such contractual arrangements currently exist in WA, where SJA WA contracts paramedics to the private sector (SJA WA, personal communication, 2015).

If a licensing standard required employers to employ only degree-qualified paramedics, it is anticipated that the current workforce would be sufficient to meet this requirement for the private sector. This would occur through employment of persons currently working with CAA member organisations and of an increasing number of new graduates.

Education providers

It is expected that CAA would continue to provide course accreditation through PEPAS to support public sector requirements. Tertiary education program accreditation costs would therefore remain as outlined in [section 5.5.1.2](#), [Tables 11, 12 & 13](#), as determined by CAA.

Under Option 3, no change in the number of students interested in undertaking paramedicine degree programs would be anticipated. It may be that an increasing array of degree courses would develop to more closely respond to the broader array of settings served by private, licensed providers of paramedic services.

The VET sector has already adapted to a changing environment in which industry has been moving towards a degree-qualified paramedic workforce. Therefore, Option 3 would not impact significantly on VET institutions, which would continue to provide programs focusing primarily on first aid, patient transport and other programs designed to meet industry needs.

Anticipated effects on competition

The competition impacts of Option 3 are considered to be significant. This is because over and above the direct costs of the licensing regime, licensing makes it illegal for anyone other than licensees to provide designated services. In the context of paramedicine it would mean that only licence holders could provide paramedic services outside a public sector ambulance service. Such arrangements are particularly onerous for providers who seek to operate at a national level and must comply with variances in jurisdictional schemes.

The impact would be less in those jurisdictions that have already moved to license certain types of services, such as private ambulance and transportation services regulation, including licensing of private NEPT in Tasmania and Victoria

However private sector delivery of paramedic services is diverse and licensing beyond specific services such as NEPT type services may be onerous. This impact could be ameliorated by limiting licensing to specific services such as NEPT. Alternatively, exemptions might be available under regulation, for example, for engagement of paramedics at events below a certain size and to allow for 'good Samaritan' acts.

Option 3 introduces new costs that would be borne by private providers of paramedic services. This may have the unintended consequence of limiting the number of private service providers, as a proportion of existing providers may decide to withdraw from the market, rather than meet the licensing costs.

It is difficult to estimate the cost impacts of such competition restrictions, but they are likely to be significant when compared to the status quo.

Impact of option on existing regulation within individual jurisdictions

Establishment of a licensing regime for private providers of paramedic services would have no impact on existing regulatory measures, including:

- scheduled medicines authorities
- public ambulance service regulation
- private ambulance and transportation services regulation, including licensing of private NEPT in Tasmania and Victoria
- protection of paramedic title and established accepted qualifications in SA and Tasmania
- the code regulation regime for unregistered health practitioners in NSW and SA
- the regulatory scheme for unregistered health practitioners in Queensland.

Option 3 does not preclude the possibility that additional states and territories legislate to:

- protect the title 'paramedic', or
- further regulate NEPT services, or
- establish jurisdictional statutory regulation of paramedics, or
- proceed with enacting a code of conduct regulation regime for unregistered health practitioners.

Under Option 3, jurisdictional statutory regulation of paramedics would need to complement a licensing regime for private providers of paramedic services in any jurisdiction where both forms of regulation were established.

5.5.3.2 Costs associated with a licensing regime for private providers of paramedic services

General assumptions and parameters

In addition to the general assumptions and parameters identified in [section 5.4](#), the following assumptions have been applied when quantifying costs associated with Option 3.

Paramedics Australasia (PA) indicates that there were 122 private sector employers of paramedics nationwide in 2012 and that of these, 57% operate across state and territory borders. Further slightly more than half deliver services outside the health and social services

sector, e.g., at public events and functions such as major sporting and entertainment events, at mining and construction sites, and so on (Paramedics Australasia, 2012a, 2012b).

Legislative changes

The introduction of a licensing scheme for private providers of paramedic services would require legislative changes in each jurisdiction. The costs associated with legislative changes required in all state and territories, including development of licensing standards, are estimated as \$100,000 for each jurisdiction (except for WA), equating to \$700,000 nationally.¹⁷ As the WA Department of Health already has a licensing regulation unit, changes would be required only to regulations in that jurisdiction, at an estimated \$30,000. Thus the Australia-wide costs are estimated at \$730,000 (based on \$700,000 for seven jurisdictions and \$30,000 in WA).

Establishment costs

Each jurisdiction would need to establish administration support for the licensing regime. Start-up costs would include office accommodation, staff, equipment, information and communication technology, publicity and advertising and application materials, which are estimated at \$340,000 (i.e. \$30,000 per three small jurisdictions and \$50,000 per five large jurisdictions).

In estimating the costs of licensing private providers of paramedic services, various Australian licensing regimes were examined, including private hospitals and the Victorian NEPT scheme. Data from private hospital licensing regimes across Australia indicate significant variation in the costs of applying for a license among facilities, ranging from \$133 in SA to \$6,362 in NSW. Annual license renewal fees also varied significantly across Australia. These disparities indicate that some jurisdictions subsidise their licensing schemes, while others base fees on a cost-recovery basis.

Under Option 3, the licence fee for providers of paramedic services could be based on the number of sites (such as mines or events) at which paramedic services are provided and/or the number of vehicles operated. Operating an inspection regime is likely to be significantly more expensive in jurisdictions with a more geographically dispersed provider base than in Victoria, particularly in Queensland and WA, which have large resource sectors. In common with licensing fees for private healthcare facilities, it would be expected that licensing fees for private providers would vary significantly between jurisdictions. The Victorian NEPT scheme is operated on a cost-recovery basis.

Drawing on data from the Victorian Department of Health NEPT licensing regime (Victoria State Government, 2016), the average annual licensing fee is estimated as \$3,400. This figure is based on the weighted average fee paid by the 19 licensed NEPT providers in Victoria, with a loading of 50% to reflect the fact that such a regime is likely to include inspection of premises as well as vehicles.

A total estimated cost of \$414,800 for licensing fees in one jurisdiction is calculated by multiplying the number of licensed agencies by the average licensing fee (i.e. \$3,400 licensing fee by 122 private providers). The PA indicates that 57% of private employers of paramedic services operate across state and territory borders. These providers would need to pay a licensing fee in each jurisdiction in which they operate, at an estimated cost of \$238,000 for an additional licence (based on 70 cross-border providers and the average licensing fee of \$3,400).

¹⁷ Based on information provided in the Australian Health Ministers' Advisory Council Decision Regulatory Impact Statement (AHMAC, 2013)

Based on these figures, the estimated total cost of licensing fees is \$652,800 for 122 providers, 70 of whom provide services in at least two jurisdictions (\$414,800 for first licence and \$238,000 for second).¹⁸

Cost offsets to employers

There are no cost offsets for employers under Option 3. Further the costs identified for these employers do not include the costs of ensuring and maintaining familiarity with any variances in compliance required between different jurisdictions where they operate in more than one.

Ongoing costs

Once established, new ongoing costs associated with Option 3 are estimated to be \$652,800 per annum (based on payment for one licensing fee by 122 service providers in a single jurisdiction, and additional licensing by 70 cross-border providers). This would include costs associated with:

- maintaining a database of licenses
- ongoing monitoring of licencing compliance
- inspection of provider facilities
- dealing with complaints
- removing or restricting licences, and any legal action that may follow.

Based on a cost recovery model, the first year costs to employers would be approximately \$1,305,600 (\$652,800 application fees and \$652,800 licensing fees). These costs would be lower if jurisdictions chose to subsidise their licensing regimes for private providers of paramedic services.

Establishment and ongoing costs (Table 15) would be borne by private providers of paramedic services (i.e. employers).

Table 15: Estimated costs to employers associated with Option 3: license private providers of paramedic services

Estimated costs	\$
Legislative changes	730,000
Establishment costs	
Administrative support	340,000
License application fees	652,000
License fees	652,000
Cost offsets for employers (first year)	Nil
Total cost, first year of operation	2,374,000
Cost offsets for employers per annum (ongoing)	Nil

¹⁸ This estimate does not take into account the licensing costs for private providers who provide services in more than two jurisdictions.

Total national ongoing (new) annual costs	652,000
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Conclusion

Under Option 3, jurisdictions would each establish licensing standards and monitor licence holders, taking action against licensed private providers who do not comply with regulatory standards. As establishing such a licensing scheme would require legislative changes, the industry would have adequate time to make necessary arrangements to ensure that paramedic employees are appropriately qualified to meet a licensing standard.

Private providers of paramedic services, including SJA in NT and WA, would incur new costs associated with licencing, and be required to meet any compliance and reporting requirements established under the licensing scheme. Employers who provide services across jurisdictions would need to meet licensing costs and compliance requirements in each jurisdiction.

Option 3 has potential to initially restrict the supply of paramedics in the private sector, in that providers of paramedic services would be required to ensure that persons employed as paramedics met appropriate standards, as established under jurisdictional licensing arrangements.

Option 3 would not limit community access to paramedic services within public ambulance services. With the exception of SJA NT and WA (which are non-government organisations), there would be no impact on other public ambulance service providers.

Option 3 may go some way to addressing some of the problems identified in Chapter 3 by setting standards for the safe delivery of paramedic services by private providers. It would have limited impact on protecting the community from harm, because it provides additional safeguards only within the private sector, which represents 15% of the paramedic industry. The standards would apply only at level of each individual jurisdiction, giving rise to the likelihood of inconsistent regimes being established. . This means that even in the private sector, it would not deliver nationally enforceable standards for the delivery of paramedic services. Relying on employers to ensure only persons with adequate qualifications and who are suitable to practice are employed would also have limitations in terms of ensuring safe paramedic practice.

As this scheme would be based on license standards established in each jurisdiction, compared to the status quo, Option 3 would not improve health workforce efficiency because it would not facilitate mobility of paramedics across jurisdictional boundaries. In addition, Option 3 would not deal effectively with incompetent, impaired or otherwise unfit paramedics, or effectively remove them from practice, when necessary.

5.5.4 Option 4: Extend registration to the paramedic profession under the National Registration and Accreditation Scheme (NRAS)

Under Option 4, the National Law would be amended to include paramedics as a health profession regulated under the NRAS. The regulator's role, as specified under the National Law, includes:

- Standard setting and guidance functions
 - setting qualifications and other requirements for entry to, and practice in the profession, and providing guidance about accepted standards of practice
 - mandated minimum standards for criminal history checking, English language competency, recency of practice, professional indemnity insurance and continuing professional development.
- Registration functions

- assessing applications for registration and renewal of registration and maintaining a register of qualified paramedics. Under the National Law, the powers of the national boards in relation to checking suitability for registration are included at [Appendix 5](#).
- Complaints handling, impairment management and disciplinary functions
 - managing receipt and investigation of complaints of unprofessional conduct, or professional misconduct, and disciplinary processes that may result in the suspension or cancellation of a practitioner’s right to practise.
 - Monitoring and managing concerns of health impairment affecting a student or practitioner’s ability to practice safely including the capacity to require a health or performance assessment
- Accreditation functions
 - setting standards against which programs of study for entry to the profession are assessed and managing, or overseeing assessment of these programs against the standards.

Under Option 4, a register of paramedics would be established and administered by the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of a national board under the NRAS.

It would be an offence for an unregistered person to use the title ‘paramedic’ or to hold him or herself out to as being qualified or registered as a paramedic. In the event that a student has an impairment that affects his or her ability to practice, student registration would be established to further protect consumers from harm.

The following discussion covers the impact and costs of extending regulation to the paramedic profession under the National Law.

5.5.4.1 Impact of registration of paramedics under the National Law

Incidence of harm

At a minimum, consumers want access to health practitioners and expect them to be competent to practise. As outlined in Chapter 3, there have been cases of actual harm in Australia related to confusion about who is a paramedic as well as those arising from paramedic practice, which of itself carries a relatively high predictive risk (potential for harm, whether or not a specific case of harm has been reported).

It is this high predictive risk that underpinned the coroner’s recommendation in the Thoms inquest for the introduction of a form of registration that will ensure that only appropriately qualified people are entitled to use the title and practise as a paramedic in Western Australia (as discussed in [section 3.2](#)). The data in Chapters 3 and 4 including coronial inquiries in other jurisdictions make it clear that the degree of predictive risk is not lower in other Australian jurisdictions.

Even statutory regulation cannot prevent all instances of harm to the public. However registration under the NRAS is a proactive model of regulation. Consideration of this model is appropriate where an occupation is assessed to carry a high degree of predictive risk. The NRAS model aims to minimise the risk of harm, through a number of means associated with the maintenance of a register. Some of these mechanisms were articulated in the case for establishment of the NRAS include increased public protection and reduced cost to the community as a whole. They include:

- *enforceable entry level qualifications, probity checking and other requirements before practitioners can commence practice;*
- *more robust systems for identifying and dealing with complaints and to deal with poorly performing, impaired or unethical practitioners, and in serious misconduct cases, mechanisms to prevent such practitioners from continuing to practise;*
- *the availability of a public national register of regulated practitioners and a separate listing of those deregistered; and*
- *better linkages with a variety of regulatory and funder/provider agencies that have a role in detecting poor or unethical practices, including international regulatory agencies (AHMAC, 2009, p. 16).*

Mandatory registration standards

The National Law requires all registered practitioners to comply with a range of mandatory registration standards, developed by each national board, the aim of which is to reduce the risk of harm to the community. Mandatory registration standards cover English language skills, criminal history, professional indemnity insurance, continuing professional development and recency of practice.

English language skills

All applicants must be able to demonstrate that they have the necessary English language skills for registration purposes. All national boards have established the International English Language Testing System (IELTS, 2016) academic level 7 (or equivalent), as the minimum standard required by applicants. The testing must be completed by internationally-qualified applicants and applicants who did not complete secondary-level education in English.

Criminal history

To comply with the criminal history standard, AHPRA undertakes a criminal history check for all new registrants when they first apply for registration. Thereafter, practitioners are required to declare any criminal history annually on renewal of registration. AHPRA audits compliance with this requirement annually.

Professional indemnity insurance

The National Law requires all registered health practitioners to maintain professional indemnity insurance. Professional indemnity insurance arrangements insure practitioners against civil liability incurred by, or loss arising from, claims made as a result of a negligent act, error or omission in their professional practice. This type of insurance, available to practitioners and organisations across a range of industries, covers the cost and expenses of defending legal claims, as well as any damages payable.

Most employers would currently hold this type of insurance to cover their employees. Some government organisations are covered by their own self-insurance policies.

Practitioners are required to declare their professional indemnity insurance status annually on renewal of registration. AHPRA audits compliance annually.

Continuing professional development and recency of practice

The National Law requires registered practitioners to maintain their skills in line with contemporary healthcare practice. This requirement can effectively reduce the potential for practitioners to harm the community. To demonstrate ongoing competence, practitioners must undertake continuing professional development activities and maintain recency of practice, in line with national board policies.

Continuing professional development is the means by which members of a profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their working lives. Each national board develops a registration standard covering continuing professional development activity requirements and the number of credits/points/hours that practitioners must spend each year on learning activities. Individual practitioners are required to maintain records relating to these activities.

Recency of practice means that a practitioner has maintained an adequate connection with, and recent practice in, the profession since qualifying or obtaining registration. National boards have sought to align their recency of practice standards, in line with the definition on the AHPRA website:

*... any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.*¹⁹

Each national board determines registration requirements for practitioners who have been absent from practice for a short period of time – such as two to three years, or longer absences of five to 10 years, or more than 10 years. For short-term absences, the standard may require a practitioner to complete continuing professional development activities. For longer absences, the practitioner may be required to undergo a period of supervised practice, or undertake additional education (for an absence of more than 10 years).

AHPRA also audits practitioners to ensure compliance with continuing professional development and recency of practice registration standards.

Mandatory reporting

Issues of paramedic impairment and misconduct are amongst the problems highlighted in Chapter 3.

The National Law establishes rigorous mechanisms enabling AHPRA to investigate and National Boards to take action on cases of impairment, incompetence or misconduct. These mechanisms are aimed at ensuring impairment or poor performance is addressed by the relevant paramedic. In cases of serious impairment, incompetence or misconduct a practitioner found to be unsuitable (either through competence or character) to work as a paramedic will be prevented from doing so.

In addition, mandatory reporting is a significant public protection measure delivered by the NRAS. The National Law imposes a legal obligation on registered health practitioners and employers to notify AHPRA if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of his or her profession.

Notifiable conduct is defined under the *National Law* as when a practitioner has:

- practised while intoxicated by alcohol or drugs, or
- engaged in sexual misconduct in the practice of the profession, or
- placed the public at risk of substantial harm because of an impairment (health issue), or

¹⁹ See further <https://www.ahpra.gov.au/Support/Glossary.aspx#P>

- placed the public at risk because of a significant departure from accepted professional standards (section 140).

Education providers are also obliged to make a notification if they have formed a reasonable belief that a student undertaking clinical training has an impairment that may place the public at substantial risk of harm. Mandatory reporting provides an early warning mechanism that may detect impaired, poorly performing or unprofessional paramedics, or poorly performing students, before they harm patients.

The AHPRA has reported that, since 2013, national boards have taken action when employers or practitioners have failed to make a mandatory notification. These actions have included cautioning a practitioner, writing to a state health minister about a hospital employer's failure to make a mandatory report and referring a practitioner to a tribunal for failing to make a mandatory report about allegations of serious unprofessional conduct by another practitioner (AHPRA, 2014a).

Paramedics

As earlier indicated, registration under the NRAS establishes national registration standards, including English language skills and minimum qualifications.

If a national board for paramedicine adopted the industry standard of a bachelor's degree as the minimum qualification required for registration, paramedic practitioners without this qualification could be eligible for registration under grand-parenting provisions (National Law s. 303(1)). Through establishment of a registration standard for grand-parenting and general eligibility, the national board would have power to register a person who did not meet the registration requirements set by the board, provided he or she:

- holds a qualification or has completed training in the profession that the board considers adequate for the purposes of practising the profession; or
- holds a qualification or has completed training in the profession, and has completed any further study, training or supervised practice in the profession required by the board; or
- can satisfy the Board that he or she has been practising the profession at any time during the previous 10 years for a consecutive period of five years, or for any periods which together amount to five years.

Under the National Law, persons who gain registration through grand-parenting arrangements are not required to upgrade their qualifications.

The use of grand-parenting arrangements effectively limits the impact of registration for those currently employed in public ambulance services and SJA NT and WA, who represent more than 90% of the paramedic workforce ([section 2.1.3](#), [Table 2](#)).

It is anticipated that at least 50% of the estimated 1,176 persons employed in the private sector, excluding SJA NT and WA ([section 2.1.3](#), [Table 2](#)), would be eligible for registration as paramedics, i.e. approximately 600 people. This is likely to include persons who have previously worked with a public ambulance service or SJA NT and WA as well as others who have completed a bachelor's degree but have not worked for a comparable service. The remaining 50% is likely to include persons who have other health practitioner qualifications or who hold basic first aid qualifications, but have little practical experience, who use the title 'paramedic' at sporting and public events or in the mining and construction sectors. While registration would not render these persons unemployed or unemployable, they (and their employers) would not be able to use the title 'paramedic' or imply that they are paramedics.

The ongoing costs for Option 4 would be met by registered paramedics through the fee structure established by the regulator. Persons eligible to register as paramedics would bear

the cost of a one-off application fee for initial registration and an annual fee to maintain registration. These costs are outlined later in this section. Registration fees are generally paid by registrants and can be claimed as employment expenses for taxation purposes.

Under Option 4, any person registered as a paramedic would be required to meet mandatory registration requirements relating to criminal history, professional indemnity insurance, continuing professional development and recency of practice, and to meet any costs associated with maintaining these registration standards. When applying for, or seeking renewal of, registration, paramedics would need to declare their criminal history and professional indemnity insurance status and show that they have met continuing professional development and recency of practice requirements.

As it is anticipated that most employers would hold professional indemnity insurance to cover their employees, only self-employed paramedics would need to pay for this type of insurance. In common with registration fees, paramedics could claim professional indemnity insurance costs as an employment expense for taxation purposes.

To maintain registration, paramedics would be required to undertake a minimum level of practice, as determined by the national board, and those who let their registrations lapse for a period of time (usually several years), may be need to undergo a refresher or re-entry program in order to re-register. Similarly, paramedics would be required to meet continuing professional development requirements, as specified in a national board registration standard. Some employers offer continuing professional development activities to all employees, which can be counted by the paramedic for registration purposes. Personal costs associated with other continuing professional development activities can be claimed as an employment expense for taxation purposes.

As indicated in [section 4.2](#), during the consultation some paramedics cited instances of paramedics who had practised below accepted professional standards, or continued to practise with a health impairment which affected their competence. They reported that these issues were not always dealt with effectively by employers and or that the practitioner was able to continue to practise by gaining employment with another employer. Under the NRAS, a national board has the ability to investigate such matters and take any action required to protect the public from harm. Mandatory reporting obligations for registered practitioners would go some way to addressing such concerns. Similarly, mandatory reporting obligations for employers would provide paramedics with assurance that serious concerns about their colleagues would be addressed.

A significant benefit of Option 4 for paramedics is that it provides portability of practice rights across state and territory boundaries.

Option 4 restricts use of the title 'paramedic' to those persons who are registered as paramedics. It does not prevent other classes of unregistered persons (such as first aid providers) from continuing to provide any of the services that fall within the scope of practice of a paramedic, including emergency or first aid services. However they must not identify themselves as a paramedic when providing such services.

Employers

As Option 4 involves regulation of individuals (rather than employers), the onus is on registrants to maintain their suitability to practise. However, public and private employers of paramedics would be able to identify whether their employees were registered under NRAS with the capacity for NRAS to prosecute persons who hold themselves out as registered paramedics when they are not.

Taking account of the employer costs in identifying and employing suitable paramedics (Chapter 3), under Option 4, the following measures would reduce the financial burden to employers:

- public access to a source of information on who is registered to use the title 'paramedic', including internationally qualified paramedics
- effective and efficient processes for determining the fitness to practise of student and registered paramedics seeking employment through publicly available information relating to any condition, undertaking, reprimand or caution relating to a person's registration.

As earlier outlined, efficiency gains for employers would also flow from mandatory reporting obligations. They would reduce risk of recruiting unsuitable paramedics who have impairment or competence issues affecting their ability to practise safely, or who have engaged in professional misconduct with a previous employer.

The NRAS incorporates functions such as drug testing and monitoring of impaired practitioners and compliance monitoring of conditions on registration. Based on data from the registered professions (such as nurses and medical practitioners), the NRAS, rather than employers, would bear up to 20% of such costs, which would be met through registration fees.

Option 4 would allow for portability of practice rights across state and territory boundaries, facilitating more efficient deployment of paramedics across jurisdictional boundaries, including during natural disasters.

Education providers

As earlier indicated, the CAA standard for the public sector requires entry-level paramedics to hold a bachelor's degree. Though NSW maintains a vocational entry pathway for Ambulance Service of New South Wales, tertiary institutions across Australia provide bachelor degree programs for which they seek accreditation through the CAA PEPAS. The costs of CAA course accreditation are outlined in [section 5.5.1.2](#), [Tables 11, 12 & 13](#).

One of the functions AHPRA under the National Law is:

... to establish procedures for the development of accreditation standards ... approved by National Boards for the purpose of ensuring that the national registration and accreditation scheme operates in accordance with good regulatory practice (Section 25 (c))

AHPRA has developed *Procedures for the development of accreditation standards* (AHPRA, 2014b) to guide accreditation bodies established under the National Law. In developing these procedures, it was recognised that educational institutions may decide not to offer courses if accreditation standards are unnecessarily onerous. This would impact on the supply of practitioners, which would ultimately have a negative effect on access to services.

Option 4 would see the establishment of nationally consistent and enforceable standards and processes for accreditation of paramedic education programs and providers. Accreditation of study programs against standards is a fundamental determinant of the quality of health practitioner education and training (AHPRA, 2013). Under the National Law, whether or not an applicant for registration has qualifications that meet the accreditation standards is a key means by which national boards assess whether or not that individual is equipped with the knowledge, skills and professional attributes to practise in the registered profession (Section (12(2))).

A national board can appoint an external body as the accreditation authority or establish its own accreditation committee. Of the 14 national boards within the NRAS, 11 have approved external bodies to exercise the accreditation function under the National Law on their behalf.

The three other national boards oversight professions that did not have national accreditation processes prior to the profession joining the NRAS. The national boards relevant to these professions have established accreditation committees. A Quality Framework for the Accreditation Function has been established, which supports quality assurance and continuous improvement of all the accreditation bodies under the National Law (AHPRA, 2013).

Under Option 4, a national board could take on accreditation responsibilities through establishing an accreditation committee, or may decide to retain CAA as an external accreditation agency. Given that CAA is widely accepted as the accreditation authority, it is likely that a national board would endorse CAA as its external accreditation authority. As such, CAA would provide accreditation services through its Paramedic Education Program Accreditation Scheme on behalf of the national board. Before making that decision, the national board would need to examine the CAA's *Guidelines for the assessment and accreditation of entry-level paramedic education programs* (CAA, 2010) to ensure that they are in line with AHPRA's procedures noted above.

If CAA was the accreditation authority for paramedics, tertiary education program course accreditation costs ([section 5.5.1.2](#), [Tables 11, 12 & 13](#)) would continue to be determined by it. Accredited course providers would be required to provide AHPRA with the names of students enrolled in undergraduate paramedicine programs, consistent with the student registration process established for health professions that are currently regulated under the National Law.

Under Option 4, no change in the number of students interested in undertaking paramedicine degree programs would be anticipated. Student enrolments may even increase, due to a perceived elevation in the status of paramedicine as a registered profession.

As earlier discussed, the VET sector has already adapted to a changing environment within which industry has been moving towards a degree-qualified paramedic workforce. Therefore, Option 4 would have no significant impact on VET institutions, which would continue to provide programs focussed primarily on first aid, patient transport and other programs designed to meet industry needs.

Anticipated effects on competition

Option 4 would impact on competition. Individuals would be prevented from using the title 'paramedic', or holding themselves out as qualified and registered to practise as paramedics, unless they held national registration. The requirement to obtain registration in order to use the title 'paramedic' would impose a regulatory burden.

Legislation to register paramedics would not define what constitutes a 'paramedic service', or prevent unregistered persons (such as other ambulance officers, patient transport officers and volunteers) from providing emergency or first aid services that typically fall within the scope of practice of registered paramedics. Except where otherwise prevented by law (for example, in jurisdictions where NEPT licensing legislation applies), private providers, including contractors, could continue to employ non-registered persons to provide paramedic type services, as long as the provider did not hold those practitioners out to the public as qualified, registered paramedics. From this perspective, Option 4 may slightly reduce the number of persons who could be employed as paramedics in the private sector.

Option 4 may increase labour costs, if industrial bodies sought to have payment of registration fees included in an industrial award. It should be noted, however, that other health professionals who pay registration fees are not reimbursed by their employers. Registration fees can be claimed as an employment expense for taxation purposes.

Impact of option on existing regulation within individual jurisdictions

Registration of paramedics under the NRAS would have no impact on existing regulatory measures at the level of individual jurisdictions. This includes scheduled medicines authorities and public ambulance service regulation in ACT, SA, Queensland, NSW or Victoria.

Consequential amendments may be required to any relevant legislation (as it relates to paramedics) in each jurisdiction.

Regulatory scheme for unregistered health practitioners

Under Option 4, the existing code regulation regime for unregistered health practitioners in NSW, SA, and QLD, would not be affected by registration of paramedics. While these regulatory regimes are generally not applicable to professions included in the NRAS, they do apply where registered health practitioners provide health services unrelated to their registrations.

Protection of title legislation

Under Option 4, the various protection of title legislation and or regulations introduced by some jurisdictions discussed under [section 2.2.1](#), would become unnecessary in light of the application of the more comprehensive NRAS scheme. These Acts could be repealed. This includes the *Health Practitioner Regulation National Law (South Australia) (Protection of Title – Paramedics) Amendment Act 2013*. In common with all other jurisdictions, the title ‘paramedic’ could be used in SA by any person registered under the national scheme as a paramedic.

The impact in Tasmania, would be that the title ‘paramedic’ would not be restricted only to Ambulance Tasmania officers, or officers of prescribed ambulance services in another jurisdiction, or persons prescribed by regulation. As in all other jurisdictions, the title ‘paramedic’ could be used in Tasmania by any person registered as a paramedic. would be that the Ambulance Services (Paramedic) Regulations 2014 (Tas), could be repealed if paramedics were included in the a more comprehensive NRAS scheme. This

Similarly the NSW legislation being introduced to protect the paramedic title could also be repealed if the more comprehensive NRAS scheme was adopted.

Non-emergency patient transport

As indicated in [section 2.2.3](#), non-emergency patient transport legislation and requirements differ between jurisdictions. The impact of Option 4 on NEPT by state and territory is summarised in [Table 16](#).

Table 16: Impact of Option 4: registration of the paramedic profession under the NRAS, on NEPT services by state and territory

Jurisdiction	Impact of Option 4
ACT	NEPT services delivered by the ACT Ambulance Service would not be impacted
NSW	NEPT services would not be impacted because they are provided by ASNSW and individual local health districts
NT	NEPT services carried out under contractual agreement with a division of SJA in metropolitan areas, and offered by other providers, would not be impacted
Qld	Road ambulance transport services in Queensland which require a paramedic would not be impacted
SA	Non-emergency ambulance service providers regulated under the <i>Health Care Act 2008</i> (SA), through the issuing of a restricted ambulance service licence by the Health Minister, would not be impacted
Tas	Licensing of commercial providers of NEPT in Tasmania under PART IIIA – Non-emergency Patient Transport of the <i>Ambulance Service Act 1982</i> (Tas) would not be impacted
Vic	Non-Emergency Patient Transport Regulations 2005 (Vic) stipulate the qualifications required for patient transport officers, ambulance transport attendants, ambulance officers and clinical instructors. As such, Option 4 would not impact on NEPT legislation in Victoria
WA	NEPT services carried out under contractual agreement with a division of SJA, and offered by other providers, would not be impacted.

5.5.4.2 Costs associated with registration of paramedics under the National Law

General assumptions and parameters

In addition to the general assumptions and parameters identified in [section 5.4](#), the following assumptions have been applied when quantifying the costs ([Tables 17 & 18](#)) associated with Option 4:

- All paramedics currently employed by all public ambulance services would be eligible for registration (11,073 paramedics).
- All paramedics currently employed by SJA NT and WA would be eligible for registration (782 paramedics).
- Fifty per cent of persons employed as paramedics in the private sector outside of SJA NT and WA (1,176 people) would be eligible for registration (588 paramedics).

For the purposes of estimating the costs of Option 4, the size of the paramedic workforce was compared to professions regulated under the NRAS and the United Kingdom (UK) Health and Care Professions Council (HCPC):

- The number of paramedics eligible for registration is comparable to the medical radiation profession (i.e. 14,387) regulated under the NRAS.
- The application fee for the Australian medical radiation profession is \$275 (AHPRA, 2014).

- It is assumed that the general economies of scale in administering a registration regime for paramedics under the NRAS would be comparable to those for the medical radiation profession.
- Based on these figures, the one-off application fee for registration as a paramedic is assumed to be slightly higher at \$300.
- Data for UK radiographers²⁰ and Australian medical radiation practitioners indicates that 0.2% of radiographers are subject to a notification raising concerns about fitness to practise in 2013/14 (HCPC, 2014; AHPRA, 2014).
- The UK HCPC data for 2010-11 – 2013-14 indicates that an average of 1.3% of paramedics registered in the UK are subject to notifications each year (HCPC, 2014).
- Data from the UK suggests that a greater number of notifications would be received about paramedics compared to the Australian medical radiation profession.
- Based on these data, and allowing for the increased costs of notification management, it is assumed that the cost of the annual registration fee for paramedics under the NRAS would be higher than for medical radiation practitioners, i.e. an estimated \$350.
- Based on data provided by public ambulance services and SJA NT and WA (Appendix 6, Table 24), it is estimated that employers would make 33 notifications per year to a regulatory board in relation to paramedics who have their employment terminated or are subject to legal action.

Legislative changes

Regulation of the paramedic profession under the NRAS requires change to the National Law.

An independent review of the NRAS in 2014 recommended changes to the National Law (Snowball, publication pending). Changes to the National Law required to register paramedics under the NRAS could be made at the same time as other changes. Therefore, under Option 4, there would be no additional costs to any state or territory to extend regulation to the paramedic profession.

Establishment costs

The AHPRA would provide administrative and operational support for the national board, funded through registrants' fees. However, in the 12 months leading to commencement of registration, the national board would not receive registrant fees to cover its running costs. As AHPRA is unable to use fees from other professions to cross subsidise a new board, governments would need to fund the work of the national board in the 12 months preceding commencement of a national registration scheme.

Based on the costs for the four health professions which joined the NRAS on 1 July 2012 (AHPRA, 2012 unpublished report on transition of four new professions into the National Registration and Accreditation Scheme), the establishment costs for entry of the paramedic profession to the NRAS are estimated at \$400,000. This would cover employment of a project officer, the establishment of a national board and its first year costs, changes to the information and communication technology system, and the establishment of registration standards and accreditation processes.

It is important that registration fees cover the costs of national regulation of the paramedic profession, which would initially include the processing of complex applications for registration

²⁰ In the UK, paramedics and medical radiation practitioners (radiographers) are regulated under the HCPC.

based on the grand-parenting (qualifications) provisions of the National Law and provision for student registration. (No fee would be charged for student registration.)

As paramedics are not currently registered in any jurisdiction, to continue to practise legally under NRAS, all paramedic practitioners would need to lodge a registration application. This would only be possible once the national board and AHPRA have determined processes, designed forms and undertaken a comprehensive communication strategy.

A one-off application fee covering assessment of suitability to practise would be charged for first-time registrants. This would include verification of identify and good character, assessment and verification of qualifications and criminal history (in Australia and overseas), establishing English language competence and, for international applicants, confirmation of registration status with international regulatory bodies.

The application fee is estimated at \$300 per registrant, which would amount to \$3,732,900 in total (\$300 application assessment fee by 12,443 registrants). An annual registration fee, estimated at \$350 per registrant, would also be charged, amounting to \$4,355,050 per annum in total (\$350 registration fee by 12,443 registrants). The estimated first-year application and registration costs for the public and private sectors and annual ongoing registration costs to paramedics by state and territory are summarised in [Table 17](#).

Table 17: Estimated application and registration costs of Option 4: registration of the paramedic profession under the NRAS, by state and territory*

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Australia Total
First year application costs (\$300 per applicant)									
Public ambulances	189	3,334	-	3,098	842	326	3,284	-	11,073
Cost per jurisdiction	\$56,700	\$1,000,200	-	\$929,400	\$252,600	\$97,800	\$985,200	-	\$3,321,900
Private sector									
St John Ambulance	-	-	130	-	-	-	-	652	782
Other (50%)**	5	107	66	102	102	7	107	94	588
Cost per jurisdiction	\$1,350	\$32,100	\$58,800	\$30,450	\$30,450	\$2,100	\$31,950	\$223,800	\$411,000
Total	\$58,050	\$1,032,300	\$58,800	\$959,850	\$283,050	\$99,900	\$1,017,150	\$223,800	\$3,732,900
First year and ongoing annual registration costs (\$350 per registrant)									
Public ambulances	189	3,334	-	3,098	842	326	3,284	-	11,073
Cost per jurisdiction	\$66,150	\$1,166,900	-	\$1,084,300	\$294,700	\$114,100	\$1,149,400	-	\$3,875,550
Private sector paramedics									
St John Ambulance	-	-	130	-	-	-	-	652	782
Other (50%)**	5	107	66	102	102	7	107	94	588
Cost per jurisdiction	\$1,575	\$37,450	\$68,600	\$35,525	\$35,525	\$2,450	\$37,275	\$261,100	\$479,500
Total	\$67,725	\$1,204,350	\$68,600	\$1,119,825	\$330,225	\$116,550	\$1,186,675	\$261,100	\$4,355,050

Note:

* Based on data provided in [section 2.1.3, Table 2](#).

** It is anticipated that 50% of paramedics employed in the private sector, excluding SJA, would be eligible for registration.

Based on these figures, the total estimated cost to paramedics of registration under NRAS in the establishment year would be \$8,087,950, of which \$7,705,750 (89%) would be borne by paramedics employed in the public ambulance sector and \$890,500 (11%) by paramedics employed in the private sector (including SJA NT and WA). The financial impact on public sector employees would be greatest in jurisdictions that employ larger number of paramedics, i.e. NSW, Victoria and Queensland. For private sector employees, the greatest impact would be in WA and NT.

Cost offsets to employers

Registration of paramedics under the NRAS would result in AHPRA assuming responsibility for assessing suitability to practise against requirements, including verification of identity and good character, assessment of qualifications, undertaking criminal history checks (in Australia, including spent convictions, and overseas) and establishing English language competence. To confirm registration status for international applicants, established links with international regulatory authorities would enable AHPRA to check whether any action had been taken against a registrant, or if there were any outstanding complaints matters. Through its links with national and international education providers, AHPRA would be able to ensure the authenticity of qualifications presented by an applicant (both Australian graduates and internationally qualified paramedics). Once a paramedic was determined to be suitable for registration, his or her name would be added to a national register available to the public online.

Through the national register, employers would be able to check whether applicants are registered to practice, resulting in savings associated with pre-employment screening.

Based on employer costs associated with pre-employment screening, it is estimated that a national registration scheme would reduce the costs of assessing identity, criminal history and qualifications for all applicants by 100% ([section 3.3](#), [Table 8](#)) (based on 933 recruits per annum by \$500 pre-employment screening costs; total annual savings \$466,500).

This estimate of savings to employers is based on the number of paramedics successfully recruited for employment. As such, it is conservative, as employers would consider more than one applicant for any job vacancy and bear the costs of assessing each applicant's suitability for employment. Given that public ambulance services are the major employer of paramedics in most jurisdictions (except in NT and WA), governments would benefit from a major proportion of savings for paramedic recruitment (approximately 90%).

Employers would continue to bear other recruitment costs, including checking for current registration, undertaking referee checks and assessing clinical skills, where required.

The National Law requires practitioners, employers and education providers to report 'notifiable conduct' to AHPRA, in order to prevent the public being placed at risk of harm. Section 140 of the National Law defines 'notifiable conduct' as when a practitioner has:

- (a) *practised the practitioner's profession while intoxicated by alcohol or drugs; or*
- (b) *engaged in sexual misconduct in connection with the practice of the practitioner's profession; or*
- (c) *placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or*
- (d) *placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.*

Option 4 assumes that employers would make a notification to a regulatory board in relation to paramedics who have had their employment terminated, or are subject to legal action (estimated in the [General assumptions and parameters](#) above at 33 notifications each year). Some of these notifications would be required under the National Law employer mandatory reporting obligations. The outcome of these notifications may involve issuing conditions, undertakings, reprimands, cautions or, for the most serious matters such as misconduct, suspension or cancellation of registration.

It may be anticipated that a regulatory board would take action in at least 33% of cases (11 paramedics). This estimate is supported by data provided by ambulance services for 2010–

2013, which indicated that 11 persons had gained employment elsewhere as paramedics, following either concerns raised and/or termination of employment relating to performance, conduct or impairment issues.

Under Option 4, information on the outcome of the most serious cases would be available on the public register, i.e. conditions on a paramedic's registration or suspension or cancellation of registration. A reduction in avoidable costs to employers associated with the recruitment, performance management, termination and duplication of the recruitment process associated with the employment of unsuitable paramedics is anticipated. Based on 11 fewer unsuitable paramedics recruited per annum (Appendix 6, Table 24), this would equate to annual savings of \$1,815,000 (11 persons by \$165,000 salary costs; total \$1,815,000). As action by a regulatory authority takes time, these savings would not be anticipated during the first year of a national regulatory regime.

National registration would not eliminate all risk of employing unsuitable employees. However, it would provide an avenue for consistent and transparent investigation of concerns. In those circumstances where mandatory reporting is required, it would create a legal obligation for employers to notify AHPRA of paramedic conduct that may result in the regulatory authority taking action. This information would then be available to other potential employers.

Combining costs savings relating to pre-employment screening (\$466,500) and 11 fewer unsuitable paramedics being recruited per annum (\$1,815,000), the introduction of national registration scheme could reduce in costs to employers by approximately \$466,500 in the first year and \$2,281,500 per annum in subsequent years.

Ongoing costs

Under Option 4, annual operating costs, funded through application and registration fees, are estimated at \$4,355,050 (Table 18). These costs are associated with management of the registration board and its committees, AHPRA administrative costs for assessing applications, undertaking investigation of notifications (complaints) and prosecution of serious misconduct matters before state or territory disciplinary tribunals.

Annual operating costs of \$4,355,050 per annum, borne by paramedics through fees, would be offset by employer savings of \$2,246,000 per annum. Therefore, ongoing (new) costs are estimated to be \$2,109,050 per annum, which would be borne by paramedics (Table 18).

Table 18: Estimated establishment and annual operating costs associated with Option 4: registration of the paramedic profession under the NRAS

Estimated costs	\$
Legislative changes	Nil
Establishment costs	
Administrative support	\$400,000
Costs to paramedics for first year of registration	
Application fee	\$3,732,900
Registration fee	\$4,355,050
First year national costs to paramedics	\$8,087,950
Cost offsets for employers	-\$466,500
Total new costs for first year	\$7,621,450
Ongoing annual costs	
Annual practitioner registration fee	\$4,355,050
Cost offsets for employers	-\$2,281,500
Total national ongoing (new) annual costs	\$2,073,550

While registration would be the responsibility of individual paramedics, employers would need to ensure that their paramedic employees were registered annually under the NRAS. The AHPRA has in place a streamlined registration checking process for employers who wish to undertake annual checks on large numbers of employees registered under the National Law.

Conclusion

Under Option 4, governments would enact legislative change to establish regulation of paramedics under the NRAS. National registration would establish mandatory registration requirements for any person wishing to practice as a paramedic.

In line with contemporary standards set by the CAA, a bachelor's degree is likely to be the minimum education requirement for registration. However, experienced practitioners not meeting this requirement would be eligible for registration through statutory grand-parenting arrangements. It is anticipated that 95% of the current paramedic workforce would be eligible for registration.

Option 4 would reduce the number of persons who currently identify themselves as 'paramedics' who would not meet registration requirements (such as first aiders). This of itself would serve to reduce the predictive risk of harm highlighted by various data including the findings of a range of coronial inquiries not least by clarifying who is a paramedic as recommended in the Thoms Inquest discussed in Chapter 3.

It would not prevent persons who do not hold paramedic qualifications from continuing to provide emergency or first aid services. Employers could choose whether to employ a qualified

paramedic or a lesser-trained first aid responder. They could not present lesser trained or less qualified personnel as paramedics.

Statutory registration of paramedics under NRAS would reduce the predictive risk of harm by paramedics. In part this arises from the protection provided by proactive assessment of eligibility to practice through the registration process. In addition, practitioners registered to use the protected title 'paramedic', would have an obligation to maintain their competence to practice in order to retain registration.

The mandatory reporting provisions relating to both practitioners and students under the National Law would further enhance public protection. As earlier noted they act as early warning systems to help identify impaired, poorly performing or unprofessional paramedics or students, before they harm patients.

Option 4 would also offer consumers a clear option to raise any complaints about whether or not a practitioner is a paramedic as well as any concerns regarding the care provided, or the behaviour of a paramedic.

While Option 4 creates new costs for paramedics, employers costs associated with pre-employment screening recruitment would be reduced, as this function would be undertaken by AHPRA. During the consultation, paramedics were aware that personal costs would be associated with registration under Option 4; however, these costs were not raised as a matter of concern.

Option 4 would impact on all public and private paramedic employers (including private contractors). Compared to the status quo, it would improve health workforce efficiency, because it would facilitate mobility of paramedics across jurisdictional boundaries – such as during natural disasters – and would not limit access to paramedic services within public ambulance services.

Establishment of this regulatory scheme would require legislative changes at a national level and paramedics would be given adequate notice of regulatory changes. Similarly, employers would have time to adjust their employment requirements in relation to paramedics.

5.5.5 Option 5: Establish statutory registration of the paramedic profession under separate state and territory regulatory schemes

Option 5 is similar to Option 4, except that paramedics would be registered and regulated under separately constituted and operated state and territory-based regulators. In line with jurisdictional health practitioner registration in place prior to establishment of NRAS, it is expected that regulators would have a similar range of powers and functions as a national board under the NRAS ([section 5.5.4](#)), which would be specified by statute to include:

- standard setting and guidance functions
- registration functions
- complaints handling and disciplinary functions
- accreditation functions.

Applying the NRAS model, a register of paramedics would be established and administered by individual boards in each state and territory. In any jurisdiction that established paramedic registration, it would be an offence for an unregistered person to use the title 'paramedic' or to hold him or herself out as being qualified or registered as a paramedic.

The powers of each board to check suitability for registration would be in line with those established by national boards under the National Law ([Appendix 15](#)).

These regulators would have powers to prevent impaired or poorly performing paramedics, or those who are not fit and proper persons, from continuing to practise, where necessary, to protect the public from serious risk. These powers would only apply in individual jurisdictions.

Student registration would be established to further protect consumers.

If a paramedic sought to work across state boundaries (for example, in aero-retrieval or in border towns), they would need to maintain registration in each jurisdiction in which they routinely practised. On 29 October 2014, the Victorian Government released an exposure draft of a Paramedics Registration Bill, for a proposed registration scheme for paramedics in that jurisdiction (Davis, 2014). Following a change of state government on March 2015, the Victorian Government released the interim report of the Ambulance Performance and Policy Consultative Committee on working with paramedics to end the ambulance crisis (State Government of Victoria, 2015). This interim report states that paramedics should be registered and regulated through the NRAS, and that:

A national system of registration would protect the title of paramedic, recognise the professionalism and level of skill and qualifications of paramedics, safeguard the public from impaired or poorly performing paramedics, allow more interstate movement and flexibility for paramedics and increase the commitment to continuing professional development. An independent and transparent approach to investigations into complaints about impairment, performance assessment and conduct through such a scheme is also regarded as a benefit (State Government of Victoria, 2015).

The following discussion covers the impact and costs of establishing statutory regulation for the paramedic profession under separate state and territory regulatory schemes.

5.5.5.1 Impact of statutory registration of the paramedic profession under separate state and territory regulatory schemes

Incidence of harm

Option 5 would include similar measures to reduce the incidence of preventable harm to the community to those outlined in Option 4. However, in this respect, Option 5 is unlikely to be as effective as Option 4 because the safeguards would apply only in individual jurisdictions. Prior to the establishment of the NRAS, where professions were regulated under individual state and territory boards, communication breakdowns between regulators resulted in some practitioners continuing to practise unconditionally in one jurisdiction after being deregistered, or having conditions attached to their registrations, in another jurisdiction.

Unless the contents of jurisdictional legislation were agreed nationally, each state and territory would set its own minimum qualifications and registration standards.

Paramedics

Under Option 5, jurisdictional regulation boards would establish a range of mandatory registration standards aimed at reducing the risk of harm to the community. Mandatory registration standards are likely to include English language skills, criminal history, professional indemnity insurance, continuing professional development and recency of practice.

In common with Option 4, under Option 5 paramedics would be required to meet regulatory requirements and the costs associated with obtaining and maintaining registration. Fee structures would be established by the individual regulators.

A paramedic would need to apply for registration in any jurisdiction in which they chose to work. While Option 5 would not provide automatic portability of practice rights for paramedics across

state and territory boundaries, registration in another jurisdiction would be facilitated under the *Mutual Recognition Act 1992* (Cwlth), provided the occupation is registered in both. That is, a paramedic could apply for recognition of their existing registration(s) and pay any applicable fee. While this would add to costs for any paramedic seeking to work in more than one jurisdiction it is also likely to impact on consumer access to services in border areas for example.

Option 5 would restrict use of the title 'paramedic' in any jurisdiction which established statutory regulation of paramedics. As in Option 4, this would mean that only those persons who are registered as paramedics may use the title.

Employers

Option 5 would regulate individuals (rather than employers), placing the onus on registrants to maintain their suitability to practice. Public and private employers of paramedics would need to ensure that their paramedic employees were registered in the jurisdiction where they were employed.

Taking account of employers' costs in identifying and employing suitable paramedics, as outlined in Chapter 3, the following measures would reduce the financial burden to employers:

- public access to a source of information (through individual registers) on who is qualified to use the title 'paramedic', including internationally qualified health professionals
- effective and efficient processes for determining fitness to practise of persons seeking employment through publicly available information relating to any condition, undertaking, reprimand or caution relating to a person's registration.

Option 5 would partially reduce employers' pre-employment screening costs with respect to those jurisdictions where regulation was established. Efficiency gains for employers would flow from mandatory reporting obligations, as these would reduce the risk of recruiting unsuitable paramedics who had impairment or competence issues affecting their ability to practice, or who had engaged in professional misconduct with a previous employer in that jurisdiction.

State/territory statutory regulation under Option 5 could include functions such as drug testing and monitoring impaired practitioners and monitoring compliance with conditions on registration. As indicated under Option 4, up to 20% of such costs would be borne by state/territory boards – through registration fees – rather than by employers. In the event that regulation was not consistent across jurisdictions, impaired, incompetent or unethical practitioners may continue to move to other jurisdictions to avoid sanctions and scrutiny of their practice.

Option 5 would not provide automatic portability of practice rights across state and territory boundaries, unless paramedics held registration in each jurisdiction. Therefore, Option 5 does not support efficient deployment of paramedic staff across jurisdictional boundaries, whether for the purposes of meeting regular work commitments, for intermittent events ranging from donor organ retrieval to music festivals or during natural disasters.

Education providers

Option 5 would not establish nationally consistent and enforceable standards and processes for accreditation of education programs and providers. Education providers would need to tailor educational programs and meet accreditation requirements, as required by a board in each jurisdiction.

Under Option 5, no change in the number of students interested in undertaking paramedicine degree programs would be anticipated. Student enrolments may even increase, due to a perceived elevation in the status of paramedicine as a registered profession.

Jurisdictional boards could take on accreditation responsibilities through the establishment of an accreditation committee or engage an external accreditation agency. If CAA remained the accreditation authority, tertiary education program course accreditation costs ([section 5.5.1.2, Tables 11, 12 & 13](#)), would continue, as determined by CAA. It is likely that additional costs would be incurred by the tertiary education sector to maintain accreditation within each individual jurisdiction in which paramedic education programs were provided.

Anticipated effects on competition

In common with Option 4, Option 5 is a protection of title model. It would not define what constitutes a 'paramedic service' or prevent unregistered persons (such as other ambulance officers, patient transport officers and volunteers) from providing services that typically fall within the scope of practice of registered paramedics.

In jurisdictions which established registration of paramedics, Option 5 may slightly reduce the number of persons who could be employed as paramedics in the private sector. Except where otherwise prevented by law (for example, under NEPT licensing legislation), private providers (including contractors) could continue to employ non-registered persons to provide paramedic type services, as long as the provider did not hold these persons out to the public as qualified, registered paramedics. From this perspective, Option 5 may reduce the number of persons who could be employed as paramedics in the private sector. In common with Option 4, Option 5 may increase labour costs, if industrial bodies sought to have payment of registration fees included in an industrial award.

The potential impacts on competition of Option 5 are slightly higher than for Option 4. Paramedics who routinely work across jurisdictional boundaries (estimated as at least 5% of the workforce) would need to hold dual, and possibly multiple, registrations.

Impact on existing regulation within individual jurisdictions

In any jurisdiction which introduced statutory registration, the impacts of Option 5 on existing regulation within individual jurisdictions would be in line with those described in relation to Option 4. This could include repeal of existing legislation to protect the title 'paramedic' in SA, Tasmania and NSW. Alternatively the existing legislation could be amended to incorporate a more comprehensive scheme reflecting the NRAS legislation (albeit with its impact limited to the relevant jurisdiction).

Option 5 does not preclude states and territories from legislating to protect the title 'paramedic' (as in SA and Tasmania), rather than adopting jurisdictional-based regulation of paramedics or enacting a code of conduct regulatory regime for unregistered health practitioners, similar to those established in NSW, SA and Queensland.

5.5.5.2 Costs associated with statutory registration of the paramedic profession under separate state and territory regulatory schemes

General assumptions and parameters

In addition to the general assumptions and parameters identified in [section 6.2](#), the following assumptions have been applied when quantifying the costs associated with Option 5, which are summarised in [Tables 19 & 20](#).

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- All paramedics currently employed by public ambulance services would be eligible for registration (11,073 paramedics).
- All paramedics currently employed by SJA NT and WA would be eligible for registration (782 paramedics).
- Fifty percent of all persons employed as paramedics in the private sector outside of SJA NT and WA (i.e. 1,176 persons) would be eligible for registration (equating to 588 paramedics).
- Each state and territory would enact jurisdictional legislation to regulate the paramedic profession.
- Registration of paramedics under separately constituted state and territory-based regimes would be more costly than a national scheme under Option 4, because economies of scale and coordinated resourcing are likely to be less.
- Approximately 623 paramedics (5% of all paramedics (2,443)) would hold registration in two more jurisdictions each year.
- Employers would notify (complain) to regulatory boards in relation to paramedics who had their employment terminated or were subject to legal action (an estimated 33 persons each year, based on data provided by public ambulance services and SJA NT and WA) ([Appendix 6, Table 24](#)).

Legislative changes

Under Option 5, each state and territory would need to enact legislation, at an estimated cost of \$700,000 (\$100,000 by 7 jurisdictions) (AHMAC, 2013). New costs have not been allocated for Victoria, given that draft legislation has already been developed for a proposed registration scheme for paramedics in that jurisdiction.

Establishment costs

Each jurisdiction would need to establish a paramedicine regulatory board. Establishment costs for separately constituted boards are estimated at \$6,500,000 (\$1 million for each of five large jurisdictions and \$500,000 for each of three small jurisdictions). These start-up costs would cover office accommodation, staffing, equipment, information and communication technology, publicity and advertising and application materials.

A one-off application fee covering assessment of suitability to practise would be charged for first-time registrants. This would include verification of identity and good character, assessment and verification of qualifications and criminal history (in Australia and overseas), establishing English language competence and, for international applicants, confirmation of registration status with international regulatory bodies.

The registration fee in a single jurisdiction would be higher than for national registration under Option 4 (estimated at \$350 per registrant). Under Option 5, an average fee of \$450 would equate to a total of \$5,599,350 per annum (based on \$450 registration fee by 12,443 registrants).

Based on these figures, under Option 5, separate jurisdictional registrations schemes, total costs for the establishment year are estimated at \$9,954,400. Of this, \$8,858,400 (89%) would be borne by the paramedics employed in the public sector through application and registration fees, and \$1,096,000 (11%) by those employed in the private sector. In common with Option 4, the financial impact on public sector employees would be greatest in jurisdictions which employ larger numbers of paramedics, i.e. NSW, Tasmania and Queensland. The greatest impact on private sector employees would be on WA and NT.

Paramedics who practise in more than one jurisdiction would be required to hold dual registration. Based on information provided by Australian Health Ministers' Advisory Council (2009) on dual registration of registered health practitioners prior to the establishment of NRAS, it is anticipated that 5% of the paramedic workforce would be registered in at least two jurisdictions under Option 5. If jurisdictional registration boards agreed to a reduced annual registration fee of \$225 per annum for a second registration, total additional costs are estimated at \$140,175 per annum (623 paramedics by \$225 registration fee).

Based on these figures, the total costs to paramedics of registration fees under separate state and territory regulatory schemes are estimated at \$5,739,525 (\$5,599,350 annual registration fees plus \$140,175 annual registration fees for dual registrations).

Estimated first year application and registration costs for the public and private sectors, and annual ongoing registration costs, by state and territory are summarised in [Table 19](#).

Table 19: Estimated application and registration costs to paramedics of Option 5: statutory registration under separate state and territory regulatory schemes, by jurisdiction*

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Australia Total
First year application costs (\$350 per applicant)									
Public ambulances	189	3334	-	3098	842	326	3284	-	11,073
Cost per jurisdiction	\$66,150	\$1,166,900	-	\$1,084,300	\$294,700	\$114,100	\$1,149,400	-	\$3,875,550
Private sector									
St John Ambulance	-	-	130	-	-	-	-	652	782
Other (50%)**	5	107	66	102	102	7	107	94	588
Cost per jurisdiction	\$1,575	\$37,450	\$68,600	\$35,525	\$35,525	\$2,450	\$37,275	\$261,100	\$479,500
Total	\$67,725	\$1,204,350	\$68,600	\$1,119,825	\$330,225	\$116,550	\$1,186,675	\$261,100	\$4,355,050
First year and ongoing annual registration costs (\$450 per registrant)									
Public ambulances	189	3334	-	3098	842	326	3284	-	11,073
Cost per jurisdiction	\$85,050	\$1,500,300	-	\$1,394,100	\$378,900	\$146,700	\$1,477,800	-	\$4,982,850
Private sector									
St John Ambulance	-	-	130	-	-	-	-	652	130
Other (50%)**	5	107	66	102	102	7	107	94	588
Cost per jurisdiction	\$2,025	\$48,150	\$88,200	\$45,675	\$45,675	\$3,150	\$47,925	\$335,700	\$616,500
Total	\$87,075	\$1,548,450	\$88,200	\$1,439,775	\$424,575	\$149,850	\$1,525,725	\$335,700	\$5,599,350
Dual registration annual registration costs (\$225 per registrant)									
Number of registrants	10	172	10	160	47	17	170	37	623
Cost per jurisdiction	\$2,250	\$38,700	\$2,250	\$36,000	\$10,575	\$3,825	\$38,250	\$8,325	\$140,175
Total	\$89,325	\$1,587,150	\$90,450	\$1,475,775	\$435,150	\$153,675	\$1,563,975	\$344,025	\$5,739,525

Notes:

* Based on data provided in [section 2.1.3](#), [Table 2](#).

** It is anticipated that 50% of paramedics employed in the private sector, excluding SJA, would be eligible for registration.

In common with Option 4, individual paramedics would be responsible for registration. However, employers would need to ensure that their paramedic employees were registered annually in the jurisdictions in which they were working. It is expected that jurisdictional authorities would establish a streamlined registration checking process for employers wishing to undertake annual checks of registration for large numbers of employees.

Cost offsets to employers

At present, each employer bears the costs of undertaking probity and qualification checks for all potential paramedic employees.

Based on the estimated costs to employers of assessing paramedics' applications for employment (including identity, criminal history and qualifications and probity checks), if all jurisdictions adopted registration schemes, as with Option 4, Option 5 would result in an estimated 100% reduction in these costs ([section 3.3](#), [Table 8](#)) (based on 933 recruits per annum by \$500 pre-employment screening costs; total annual savings \$466,500). These

savings could only be achieved if all states and territories enacted legislation to regulate paramedics.

In common with Option 4, this option assumes that employers would notify (complain to) a regulatory board about paramedics who had their employment terminated or were subject to legal action (an estimated 33 cases each year) (Appendix 6, Table 24). Some of these notifications would be mandatory under employer reporting requirements set out in jurisdictional legislation. The outcomes of these notifications may include issuing of conditions, undertakings, reprimands or cautions or, for the most serious matters (such as misconduct), suspension or cancellation of registration.

As outlined in Option 4, it may be anticipated that a regulatory board would take action in at least 33% of cases (11 paramedics), which would be expected to lead to reduction in avoidable costs to employers from recruiting unsuitable paramedics. However, unless a disciplinary process has been finalised and sanctions imposed, under Option 5 a paramedic may move jurisdictions to avoid disciplinary action by one board, and have a clean disciplinary record when seeking registration in another jurisdiction.

Option 5 is likely to reduce avoidable costs to employers arising from recruiting unsuitable paramedics although by 10% less than Option 4. That is, it would lead to recruitment of 10 fewer unfit paramedics per annum (Table 14) (10 by \$165,000 salary costs; total annual savings \$1,650,000). These savings could only be achieved if all states and territories enacted legislation to regulate paramedics. As action by a regulatory authority takes time, these savings would not be anticipated during the first year of jurisdictional regulatory regimes.

In common with Option 4, employers would continue to bear the costs of terminating unsuitable paramedic employees. However, jurisdictional registration would provide an avenue and, in some situations, a legal obligation for employers to notify the regulator of paramedic conduct that may result in the regulatory authority taking action. The legislation could be drafted so as to enable this information to be available to other jurisdictional regulators as well as to potential employers.

Under Option 5, combining costs savings relating to pre-employment screening (\$466,500) and 10 fewer unsuitable paramedics recruited per annum (\$1,650,000), the introduction of registration schemes in each jurisdiction would reduce employer costs by an estimated \$466,500 in the first year and \$2,116,500 per annum in subsequent years.

Ongoing costs

Under Option 5, annual operating costs – funded through application and registration fees – are estimated at \$5,739,525. These costs are associated with the management of registration boards and committees, administrative costs for assessing applications, undertaking investigation of notifications (complaints) and prosecution of serious misconduct matters before the relevant state or territory disciplinary tribunal.

Annual operating costs of \$5,739,525 per annum, borne by paramedics through fees, would be offset by employers' savings of \$2,116,500 per annum. Therefore ongoing (new) costs are estimated at \$3,623,025 per annum, which would be borne by paramedics (Table 20).

Table 20: Estimated costs associated with Option 5: statutory registration under separate state and territory regulatory schemes

Estimated costs	\$
Legislative changes	\$700,000
Establishment costs	
Administrative support	\$6,500,000
Costs to paramedics for first year of registration	
Application fee	\$4,355,050
Registration fee*	\$5,739,525
First year national costs to paramedics	\$10,094,575
Cost offsets for employers*	-\$466,500
Total new costs for first year	\$9,628,075
Ongoing annual costs	
Annual practitioner registration fee**	\$5,739,525
Cost offsets for employers**	-\$2,116,500
Total national ongoing (new) annual costs	\$3,623,025

Notes:

* Includes 623 dual registrants.

** These savings could only be achieved if all states and territories enacted legislation to regulate paramedics.

Conclusion

Under Option 5, state and territory governments would enact legislative changes to establish jurisdictional regulation of paramedics. In common with Option 4, jurisdictional registration would establish mandatory registration requirements for any person wishing to practice as a paramedic. In line with CAA standards, a bachelor's degree is likely to be established as the minimum education requirement for registration in most jurisdictions. During the establishment phase, practitioners who did not meet this requirement would be eligible for registration through legislative grand-parenting. It is anticipated that 95% of the current paramedic workforce would be eligible for registration.

Option 5 has some potential to reduce the number of persons who currently identify themselves as 'paramedics' who would not meet registration requirements (such as first aiders). It would not prevent persons who are not registered in the relevant jurisdiction from continuing to provide emergency or first aid services. Rather, employers could choose whether to employ a registered paramedic or a lesser-trained first responder.

Practitioners would have to demonstrate their eligibility for registration in order to, use the protected title 'paramedic', and would have an obligation to maintain their competence to practice in order to retain their registration.

In common with Option 4, public protection measures such as mandatory reporting requirements could be required, imposing a legal obligation on registered health practitioners and employers to notify the regulatory authority in the jurisdiction of any notifiable conduct by a

paramedic. Where student registration is established, similar provisions could oblige education providers to notify the regulatory authority in the event that a student had an impairment that affected their ability to practice safely. In common with Option 4, mandatory reporting would serve as an effective early warning mechanism of impaired, poorly performing or unprofessional paramedics, or poorly performing students, before they harm patients.

While Option 5 would create new costs for paramedics, employers would benefit from reduced recruitment costs. These benefits would be optimised if all jurisdictions enacted legislation to regulate paramedics. Under Option 5, registration and accreditation would be the responsibility of individual state and territory governments. In common with the jurisdictional based regulatory regimes for health practitioners in place prior to the establishment of the NRAS, this regulation model may result in variable standards and inconsistent approaches across the country. It may also impede practitioners' freedom of movement.

Where registration was established, Option 5 would rely on mutual recognition legislation as the primary mechanism for providing portability of practice rights across jurisdictional boundaries. While mutual recognition legislation allows for recognition of registration by other participating jurisdictions, as noted above it would not automatically facilitate mobility of paramedics across jurisdictional boundaries, including during natural disasters.

Prior to establishment of the NRAS, state/territory regulation of health practitioners had been associated with regulatory failures, for example, due to lack of systemic communication between regulators. For example, practitioners deregistered or with conditions attached to their registrations in one jurisdiction, continued to practise unconditionally in another. In common with jurisdictional based regulatory regimes for health practitioners in place prior to the establishment of the NRAS, this Option 5 may result in variable standards and inconsistent approaches across the country. It may also impede practitioners' freedom of movement.

Establishment of this type of regulation would require legislative change at a jurisdictional level, so paramedics would have adequate notice of regulatory changes. Similarly, employers would have time to adjust their requirements in relation to employees working as paramedics.

In common with Option 4, Option 5 would offer consumers an alternative avenue to complain about the care provided, or the behaviour of a paramedic. These concerns could be dealt with through regulation, in that safeguards could be applied to prevent persons who are not paramedics from representing that they are, and to prevent paramedics who are impaired, incompetent or engaged in professional misconduct from practising.

In common with Option 4, Option 5 features mandatory registration and mandatory reporting requirements, both of which would reduce the risk of harm to the community. It has potential to reduce employers' recruitment costs and the risks of unknowingly employing impaired or incompetent practitioners. The option is less efficient than Option 4 given:

- duplication of governance and standard setting by eight separate state and territory-based regulatory regimes
- employers needing to check with multiple regulators when undertaking probity checks of prospective paramedic employees
- individual employers needing to determine the qualifications requirements for employment of paramedics, where jurisdictional registration does not exist
- it does not efficiently facilitate movement of paramedics across jurisdictional boundaries, including during natural disasters.

While Option 5 would reduce the risk of harm to the public more than the status quo, it is more costly than any of the other options.

6 Conclusion and recommendation

Chapter 3 outlines the three main areas of concern in relation to the regulation of paramedics: first, is the potential for harm (serious injury and/or death) to the community; second, is confusion about who is a paramedic, arising from inconsistencies in training and qualifications required for employment as a paramedic; and third, is the cost to employers in identifying and employing a suitable paramedic. Given the nature of these problems, the main objective of government action is to protect the public by minimising the incidence of harm associated with the delivery of paramedic services, within the context of a seamless, cost-effective national economy.

Paramedicine is a growing profession that plays a key role in an expanding and evolving healthcare system. Traditionally, regulation of paramedics in Australia has occurred primarily via employment arrangements within a small number of publicly operated or funded ambulance services. The traditional focus of a 'treat and transport' model of care is changing. Modern paramedic work is wide ranging, often unsupervised, increasingly complex and frequently high risk, as the scope of practice of paramedics expands to include extended care roles in a range of primary care settings.

In line with changing health care more generally, paramedic practice is becoming more complex and sophisticated. It carries a correspondingly higher risk of significant harm (serious injury and/or death) when things can and do go wrong. While unusual, such incidents are not rare. Their impact can be catastrophic for consumers and increase the financial burden on the healthcare system.

The extent to which poor outcomes occur in Australia is difficult to establish, due to limited and inconsistent public reporting of such events. Given the number of services provided by paramedics each year, a relatively small number of complaints are made to health complaints entities by the public. However, through the consultation process, both paramedics and employers reported that they were aware of instances of actual harm or injury to patients arising from paramedics' practice and or confusion about their qualifications. Media reports, the survey of employers undertaken for this project, coronial and other inquiries also reveal serious disciplinary matters and occasions of harm including deaths.

Jurisdictions have responded in various ways to the challenge of protecting the public from the dangers inherent in healthcare. Regulatory measures for healthcare providers include the introduction of code regulation regimes and in respect of paramedics, jurisdiction specific protection of title legislation and establishment of minimum qualifications. While these measures go some way to addressing the identified risks, they are – singly and in combination – insufficient to adequately protect the public and ensure the competence of the paramedic workforce.

There are also costs for the health system arising from jurisdictional fragmentation. Employers bear the costs of identifying and employing suitable paramedics. Pre-employment screening of potential employees involves assessing suitability to practise against requirements, including verification of identity and good character, assessment and verification of qualifications, undertaking criminal history checks (in Australia and overseas) and, for international applicants, confirmation of registration status with international regulatory bodies.

Of particular concern, employers cannot share paramedics' disciplinary histories (relating to practitioner impairment, performance or professional misconduct) with other prospective employers, due to confidentiality agreements or fear of litigation. This lack of information can exacerbate both the risks and costs to employers of recruiting unsuitable paramedics and the risk of harm to consumers.

As outlined in Chapter 4, several key themes emerged through submissions to the consultation and the forums:

- It is difficult to estimate the size of the private sector paramedic workforce.
- The title 'paramedic' is not protected and does not guarantee a minimum level of qualification.
- Paramedic scope of practice is not clearly defined.
- Existing safeguards do not adequately protect the community from harm.
- Paramedics are not required to maintain competence or undertake continuing professional development.
- Current systems for consumer complaints handling and reporting are inadequate.
- Paramedics found to be unsuitable to practise by one employer may change employers within or across jurisdictions.
- Legislation and regulation are inconsistent throughout Australia.
- There are barriers to the transfer of qualifications and skills across jurisdictions.
- There is no nationally-consistent qualification and probity checking process for all practitioners.
- Consideration of student registration is needed to further protect consumers.
- There is little or no regulation of the private employment sector.

In addition to maintaining the status quo (Option 1), in Chapter 6, five alternative options for regulation of paramedics have been presented and assessment on their relative merits:

- Option 1: Maintain the status quo – rely on existing regulatory and non-regulatory mechanisms
- Option 2: Strengthen self-regulation of paramedics
- Option 3: License private providers of paramedic services
- Option 4: Extend regulation to the paramedic profession under the National Registration and Accreditation Scheme (NRAS)
- Option 5: Establish statutory regulation for the paramedic profession under separate state and territory regulatory schemes.

The impacts and costs of Options 2–5, and the extent to which they are likely to address both the problems identified and the objectives of government action in comparison to the status quo (Option 1), are summarised below:

Option 2: Strengthen self-regulation of paramedics

Compared to the status quo, Option 2 supports more efficient and effective systems for recruitment, assuming that a non-statutory registration agency establishes minimum qualifications for inclusion on a voluntary register and assesses qualifications and suitability for registration. These activities alone would produce cost savings for employers who sought evidence of registration as the basis for employing paramedics.

Compared to the status quo, Option 2 goes some way towards reducing the incidence of harm to the community and has potential to reduce employers' avoidable costs. It is assumed that only 20% of paramedics would initially register under a voluntary registration scheme.

Therefore, coverage and the integrity of such a scheme would be lower than that of other options. However, it is likely that coverage would increase over time, if paramedics and employers recognised the benefits of a voluntary registration scheme.

Option 2 creates new costs for the paramedic profession, i.e. application and registration fees. However, employers who used registration as the basis for employment would incur reduced recruitment costs.

Option 2 goes some way to supporting workforce mobility through the provision of a register of paramedics, if employers used the register as a basis for their employment decisions. However, Option 2 would not adequately address the problems identified in Chapter 3. While paramedics' registrations may be cancelled by the registration agency, Option 2 cannot deal effectively with incompetent, impaired or otherwise unfit paramedics, or effectively remove them from practice, when necessary.

Option 3

Under Option 3, governments would establish licensing standards, monitor license holders and take action against licensed private providers who did not comply with the regulatory standards. As establishment of this scheme would require legislative changes, the industry would have adequate time to arrange for paramedic employees to meet the qualification requirements set out in the licensing standard.

Private providers of paramedic services, including St John Ambulance (SJA) in NT and WA, would incur new costs associated with licencing and be required to meet any compliance and reporting requirements established under the scheme. Employers who provided services across jurisdictions would need to meet licensing costs and compliance requirements in each jurisdiction.

Option 3 has potential to initially restrict the supply of private sector paramedics, in that providers of paramedic services would be required to ensure that persons employed as paramedics met the standards established under jurisdictional licensing arrangements. Option 3 would not limit access to paramedic services within public ambulance services. With the exception of SJA NT and SJA WA (which are non-government organisations), there would be no impact on public ambulance service providers.

Option 3 may go some way to addressing the problems identified in Chapter 3. This would include reducing confusion about who is a paramedic and the potential for harm where a practitioner is not a qualified paramedic, as well as the potential for harm by incompetent or otherwise unsuitable paramedics. This is because the licensing schemes could require private employers to meet a range of standards including clinical governance requirements and specified qualification levels for practitioners employed as paramedics within the relevant jurisdiction.

However, it would not establish national standards for practice or employment as a paramedic. It would also have limited impact on protecting the community from harm, because it provides additional safeguards only in the private sector, which represents 15% of the paramedic industry.

As this scheme would be based on licensed standards established in each jurisdiction, compared to the status quo, Option 3 would not improve health workforce efficiency, because it would not facilitate mobility of paramedics across jurisdictional boundaries. In addition, Option 3 cannot deal effectively with incompetent, impaired or otherwise unfit paramedics, or effectively remove them from practice, when necessary.

Option 4

National registration under the NRAS establishes mandatory registration requirements for any person wishing to practice as a paramedic. Under Option 4, governments would adopt uniform legislative changes to establish statutory registration of paramedics enforceable both nationwide and across both the public and private sectors. This proactive approach to ensuring competence and clarifying who is entitled to use the title 'paramedic' would reduce the predictive risk of harm by paramedics outlined in Chapter 3. It would do this by establishing enforceable standards for initial and ongoing practice, restricting use of the title and reducing confusion about whether or not a practitioner is a paramedic, and rigorous processes for addressing substandard practice, misconduct and or impairment.

In line with the CAA standard, a bachelor's degree is likely to be the minimum education requirement for registration. Experienced practitioners who did not meet this requirement would be eligible for registration through grand-parenting arrangements in the legislation. It is anticipated that more than 95% of the current paramedic workforce would be eligible for registration.

Option 4 has potential to reduce the number of persons who currently identify themselves as 'paramedics' and who would not meet registration requirements (such as first aiders). This would help ensure that members of the public did not delay timely access to treatment due to confusion about the expertise of the practitioner providing their care, particularly in an emergency. It would not, however, prevent persons who did not hold paramedic qualifications from continuing to provide emergency or first aid services. Employers could still choose to employ a qualified paramedic or a lesser-trained first-aid responder so long as they did not represent them as being paramedics.

Practitioners registered to use the protected title 'paramedic' would be proactively assessed to ensure they have met the entry-level standards for safe practice. They would subsequently be obliged to maintain their competence to practice in order to retain their registration.

Consumers would have a clear avenue for raising any concerns about the care received, or the behaviour of a practitioner. These concerns could be dealt with under national regulation, in that safeguards could be applied to prevent a paramedic who is impaired, incompetent or engaged in professional misconduct, from practising.

Disciplinary provisions and other mechanisms in the National Law would apply to paramedics, ensuring impairment or poor performance is addressed in a consistent and transparent manner. Concerns about the mental health and or issues such as the need for monitoring of drug use can be addressed. Where appropriate whether for reasons related to competence or conduct a paramedic would be prevented from practising. .

Under the National Law, mandatory reporting obligations applicable to both registered health practitioners and employers strengthen the impact of the disciplinary and impairment provisions. This is perhaps particularly important where consumers may be unaware that there is cause for complaint about the care provided to them by a paramedic.

Student registration is coupled with similar mandatory reporting obligations. These are important public protection measures providing an effective early warning mechanism, intended to detect impaired, poorly performing or unprofessional practitioners and students, before they harm patients where possible.

While national statutory registration would create new costs for paramedics (application and registration fees), employers would enjoy reduced recruitment costs associated with pre-employment screening. These functions would be undertaken by AHPRA.

Option 4 would impact on all public and private employers of paramedics, including private contractors. Compared to the status quo, it would improve health workforce efficiency by facilitating mobility of paramedics across jurisdictional boundaries, including during natural disasters. Paramedics would not have to seek mutual recognition and would register once to practice anywhere in Australia. Further this model would not limit access to paramedic services to public ambulance services, enabling for example, innovation in the use of the private sector to reduce the pressure on public services.

Option 5

Under Option 5, state and territory governments would enact legislative change to establish jurisdictional registration of paramedics. As with Option 4, this approach would establish mandatory registration requirements for any person wishing to practice as a paramedic which would reduce the risk of harm to the community. Unlike Option 4 the impact would be jurisdiction specific and may vary between jurisdictions according to the specifics of the model adopted.

As with the jurisdiction specific regulatory regimes for health practitioners in place prior to the establishment of the NRAS, this regulatory model is likely to suffer fragmentation due to variable standards and inconsistent approaches across the country. While not necessarily eliminated by a national approach, state/territory regulation of health practitioners was associated with regulatory failures, including due to lack of adequate legislative attention to the mobility of practitioners between jurisdictions and the need for systematic communication between regulators to ensure attempts to evade regulatory action did not succeed.

If registration of paramedics was established on a jurisdiction by jurisdiction basis, the ability to practice across borders would not be automatic even in the case of national disasters. Option 5 would rely on mutual recognition legislation as the primary mechanism to facilitate portability of practice rights across jurisdictional boundaries. While this would add to costs for practitioners who would need to pay a fee in each jurisdiction they wished to practice in, it may also impede consumer access to services from practitioners lacking recognition outside the jurisdiction in which they were registered.

In common with Option 4, Option 5 would offer consumers an alternative avenue to complain about the care provided, or the behaviour of a paramedic. This option would also confer some further benefits of Option 4, in terms of the potential to enhance disciplinary and other arrangements for addressing impairment or conduct concerns. These could be enhanced if jurisdictions also adopted mandatory reporting requirements.

While Option 5 would create new costs for paramedics, employers would enjoy some reduction in recruitment costs associated with pre-employment screening, as more of these functions would be undertaken by the registration body. However jurisdiction specific approaches are, less efficient than the national approach supported by Option 4 in relation to:

- duplication of governance and standard setting by eight separate state and territory based regulatory regimes
- employers needing to check with multiple regulators when undertaking probity checks of prospective paramedic employees
- individual employers needing to determine the qualifications requirements for employment of paramedics, where jurisdictional registration does not exist
- failing to facilitate movement of paramedics across jurisdictional boundaries, such as during natural disasters.

While Option 5 would reduce the risk of harm to the public more than the status quo, it is more costly than any of the other options. The effectiveness of this option would be maximised, if all jurisdictions established consistent statutory registration schemes addressing paramedics.

Recommendation

When compared to all other options, Option 4 is considered best able to achieve the government objectives of:

- ensuring an effective and efficient quality assurance system for the delivery of paramedic services, within the context of a seamless, cost-effective national economy, and
- adequately protecting the Australian public by minimising the incidence of harm associated with the delivery of paramedic services by personnel who are not fit and proper persons to be delivering such services or who breach their legal and professional obligations.

As indicated in Chapter 4, there was significant support from forum participants for registration of paramedics under the National Registration and Accreditation Scheme (NRAS). Of the 50 written submissions received, 44 (88%) identified Option 4 as the preferred option. Among these, many respondents indicated that a national register, together with national regulation, were the only means to satisfactorily address the risks associated with the paramedic profession. Many respondents expressed the view that the cost to the community of doing nothing far outweighs the cost of extending regulation.

Analysis of the overall impact and costs associated with the five options indicates that Option 4, regulation of the paramedic profession under the NRAS, would deliver the greatest net benefit to the Australian community.

The benefits to public safety that would flow from nationally consistent registration of paramedics under the NRAS would outweigh both the costs of implementing and administering this model of regulation and any impact on competition that might arise from the introduction of registration of the profession.

Option 4 is the recommended option.

7 Implementation

To give effect to the recommended option, Option 4, amendments would be required to the *Health Practitioner Regulation National Law Act 2009* (the National Law), in Queensland. Health ministers, sitting as the Australian Health Workforce Ministerial Council (AHWMC), would need to reach agreement for the Queensland Health Minister to progress amendments to the Schedule of the National Law, via the Queensland Cabinet and the Queensland Parliament.

These amendments would include paramedics as the fifteenth profession regulated under the National Registration and Accreditation Scheme (NRAS). Western Australia would need to make similar amendments to the *Health Practitioner Regulation National Law (WA) Act 2010* to extend the operation of the arrangements to that state.

Health ministers would need to decide any departures from the standard regulatory model that applies to the other 14 nationally regulated professions. For instance, ministers may consider whether a separately constituted Paramedicine Board of Australia should be established to regulate the paramedic profession, or whether an existing national board be expanded to assume these additional responsibilities.

National board members would be appointed by the AHWMC. As with other national boards, the Australian Health Practitioner Regulation Agency would be responsible for overseeing the establishment of the national board and provide administrative functions to support the registration and regulation of paramedics.

The total establishment costs for Option 4 are estimated at approximately \$1,800,000 (\$300,000 for passage of legislation and \$1,500,000 for NRAS costs). Funding would need to be allocated for the establishment of the national board and for administrative arrangements in its first year of operation, prior to paramedics being required to register.

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*Appendix 1: Risk factor assessment for health professions under the National Registration and Accreditation Scheme**

Note: X indicates that the practitioner's scope of practice typically includes the activity

	1. Putting an instrument, hand or finger into a body cavity ⁱ	2. Manipulation of the spine ⁱⁱ	3. Application of a hazardous form of energy ⁱⁱⁱ radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administering a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psychological interventions to treat serious disorders or with potential for harm	10. Setting or casting a fracture of a bone or reducing dislocation of a joint	11. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present ^{iv}	13. Patients commonly required to disrobe	TOTAL risk factors per profession
Aboriginal and Torres Strait Islander health practitioners	X			X	X	X	X				X	X	X	8
Chinese medical practitioners	X	X		X	X	X	X	X			X	X	X	10
Chiropractors		X									X	X	X	4
Dental practitioners*	X		X	X	X	X					X			6
Medical practitioners	X	X	X	X	X	X	X	X	X	X	X	X	X	14
Medical radiation practitioners			X	X		X					X	X	X	6
Nurses and midwives	X		X	X	X	X	X	X	X		X	X	X	11
Optometrists					X						X	X		3
Occupational			X								X	X	X	4

	1. Putting an instrument, hand or finger into a body cavity ⁱ	2. Manipulation of the spine ⁱⁱ	3. Application of a hazardous form of energy ⁱⁱⁱ radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administering a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psychological interventions to treat serious disorders or with potential for harm	10. Setting or casting a fracture of a bone or reducing dislocation of a joint	11. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present ^{iv}	13. Patients commonly required to disrobe	TOTAL risk factors per profession
therapists														
Osteopaths		X									X	X	X	4
Pharmacists					X		X				X			3
Physiotherapists	X	X	X								X	X	X	5
Podiatrists				X	X	X					X	X		5
Psychologists									X		X	X		3
UNREGISTERED														
Paramedics**	X			X	X***	X	X	X	X		X	X	X	10

(AHMAC, 2009, p. 118)

- i Beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body.
 - ii Moving the joints of the cervical spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust.
 - iii Electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electromagnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy.
 - iv Includes practitioners who practice solo or treat with no others present, such as medical specialists and practitioners who may be solely responsible for clinical care overnight or in a remote community.
- * Dentists, dental hygienists, dental prosthetists, dental therapists.
- ** Paramedics included for comparison only. This risk assessment is not included in the original reference source.
- *** Qld Ambulance Service occurs where extended scope of practice has been approved in certain circumstances.

Appendix 2: State and territory regulation of drugs and poisons relevant to paramedic practice

	Legislation	Provisions	Mechanism of authorisation	Who is licensed to store and administer scheduled medicines?	Classes of medicines available to paramedics
ACT	<i>Emergencies Act 2004</i> <i>Medicines, Poisons and Therapeutic Goods Act 2008</i>	Schedule 1	Public sector		
			Specific exemption for the Chief Officer, ACT Ambulance Service under Schedule 1 of <i>Emergencies Act 2004</i>	ACT Ambulance Service Paramedics	S2, S3, S4 and S8
		Regulation 5	Private sector		
			First Aid Kit license	Paramedics and first aid providers employed by organisation with license	S2, S3, S4 and S8
NSW	<i>Poisons and Therapeutic Goods Act 1996</i>	S6.62a	Public sector		
			Delegation by Director General of NSW Health to the Chief Executive of ASNSW	ASNSW paramedics	S2, S3, S4 and S8
	Private sector				
	<i>Poisons and Therapeutic Goods Regulation 2008</i>		Authority by application under the regulations, specifically tailored to needs/conditions	Paramedics employed by private companies with an authority under the regulations	S2, S3, S4 and S8

	Legislation	Provisions	Mechanism of authorisation	Who is licensed to store and administer scheduled medicines?	Classes of medicines available to paramedics
NT	<i>Medicines, Poisons and Therapeutic Goods Act 2013</i>	S64, S130	<p>Public sector</p> <p>An approved ambulance officer may possess and administer a S3, S4 or S8 substance in the course of carrying out the officer's duties.</p> <p>A Medical Kit Authority authorises an individual to possess, supply and administer controlled substances.</p>	Paramedics who have been issued with a Medical Kit Authority. This includes St John Ambulance paramedics, paramedics employed on mines, rigs and at refugee detention centres.	S3, S4, S8. There are no restrictions on the use of S2 substances
Qld	<i>Queensland Ambulance Service Act 1991</i>	S66, 163AA, 168, 174A	<p>Public sector</p> <p>Queensland Ambulance Service is specifically mentioned in the Regulations as having an 'as of right of authority' to obtain, administer and supply scheduled medicines</p>	Paramedics First aid providers (limited) First responders (limited)	S2, S3, S4, S8
	Health (Drugs and Poisons) Regulation 1996	Section 18 of the Regulation	<p>Private sector</p> <p>An organisation not specifically mentioned in the Regulations must apply for approval under s. 18. Restricted to emergency use only.</p>	Paramedics employed by organisations with an approval under s. 18 of the Regulation	S2, S3, S4 S8 under the authorisation of a presiding medical practitioner

	Legislation	Provisions	Mechanism of authorisation	Who is licensed to store and administer scheduled medicines?	Classes of medicines available to paramedics
SA	<i>Controlled Substances Act 1984</i>	S55, S18, S31	Public sector		
			Licence issued by the Minister for Health	SA Ambulance Service paramedics	S4, S8
			Private sector		
			Licence issued by the Minister for Health	Organisations with a licence issued by Minister	S4 and S8 (limited) Licence is silent on S2 and S3 substances
Tas	<i>Poisons Act 1971</i>		Public sector		
			Clinical field protocols specified under regulation	Ambulance Tasmania paramedics	S2, S3, S4 and S8
			Private sector		
			By regulation	Relevant first aid organisations	Limited S4
Vic	<i>Drugs, Poisons and Controlled Substances Act 1981</i>		Public sector		
			Health services permit	Ambulance Victoria paramedics	S2, S3, S4, S8
			Private sector		
			NEPT license Health services permit	NEPT officers	S2, S3, S4 (limited)
			Health services permit	SJA	S2, S3, S4
			Secretary approval	Australian Ski Patrol Association patrol-qualified ski patrollers	S4 (limited)
WA	<i>Poisons Act</i>	Poisons	Private sector		

Legislation	Provisions	Mechanism of authorisation	Who is licensed to store and administer scheduled medicines?	Classes of medicines available to paramedics
1964	Regulation 10AA	Poisons permit	SJA WA First aid providers Occupational health services Private 'ambulance services'	

Appendix 3: Potential clinical consequences of high-risk interventions undertaken by paramedics

Intervention	Explanation	Potential clinical consequences
Endotracheal intubation	Insertion of airway management device	<ul style="list-style-type: none"> • Unable to adequately ventilate patient: prolonged hypoxia leading to brain damage or death from: <ul style="list-style-type: none"> – oesophageal tube placement – prolonged attempts • Trauma: dental and soft-tissue trauma, perforation or laceration of upper oesophagus, vocal cords, larynx • Laryngospasm and bronchospasm • Dysrhythmias, hypertension/hypotension • Oral or gastric contents
Sedation to enable intubation	Administration of powerful drugs to render a patient unconscious	<ul style="list-style-type: none"> • Problematic sedation • Unable to intubate patient: prolonged hypoxia leading to brain damage or death • Profound hypotension (low blood pressure) leading to multiple organ damage, particularly brain damage or death
Rapid sequence intubation	Administration of powerful drugs to render a patient unconscious and completely paralysed	<ul style="list-style-type: none"> • Problematic sedation • Unable to intubate patient: prolonged hypoxia leading to brain damage or death • Profound hypotension (low blood pressure) leading to multiple organ damage, particularly brain damage or death • Prolonged hyperthermia (high body temperature) leading to organ damage • Unable to execute failed intubation drill: prolonged hypoxia leading to brain damage or death • Arrhythmia as a result of administering induction agents
Cricothyroidotomy	Cutting an opening into the patient's windpipe so a small tube can be inserted to allow a patient to be ventilated (breathe artificially)	<ul style="list-style-type: none"> • Unable to execute procedure: prolonged hypoxia leading to brain damage or death • Surgical damage to surrounding organs leading to loss of blood and other complications including death • Aspiration of blood into the lungs
Sedation and paralysis post intubation	Administration of powerful drugs to maintain a patient unconscious and completely paralysed	<ul style="list-style-type: none"> • Profound hypotension (low blood pressure) leading to multiple organ damage, particularly brain damage or death • Prolonged hyperthermia (high body temperature) leading to organ damage • Undetected extubation: prolonged hypoxia leading to brain damage or death • Arrhythmia from pharmacological agents

Intervention	Explanation	Potential clinical consequences
Administration of range of parenteral medication & drugs	The clinical practice guidelines used by paramedics require clinical judgments to be made and treatments to be administered	<ul style="list-style-type: none"> • Possible wrong drug or treatment • Possible wrong dose • Possible patient harm
Decompression of tension pneumothorax	After cutting a hole in the patient's chest, insertion of a large needle deep into the patient's chest to allow a collapsed lung to reinflate and for the patient's heart to pump effectively	<ul style="list-style-type: none"> • Possible damage to heart or major blood vessels in the chest • Collapsed lung (pneumothorax) • Collapsed lung that fills with large amounts of blood (haemothorax) • Possible death of patient
Thrombolysis	Clot dissolving medications that can have a dramatic impact on acute coronary syndromes (heart attacks)	<ul style="list-style-type: none"> • Possible significant side effects, including stroke
Referral and advice	Assessment and referral to hospital and/or a range of health practitioners	<ul style="list-style-type: none"> • Possible significant harm to patient or patient death due to failure to refer or failure to transfer to hospital

Source: Adapted from Paramedics Australasia, 2011.

Appendix 4: Errors of clinical judgement in Australia – Cases of commission or omission

The following case studies are from Australian coronial inquiries or media reports from several jurisdictions.

Case 1

In 2012 preliminary autopsy findings showed the death of a Perth man apparently of a heart attack only hours after a St John Ambulance (SJA) WA crew failed to transport him to hospital. Two ambulances attended later the same day after the man lapsed into unconsciousness, but were unable to revive him. The matter has been referred to the State Coroner for investigation (Trenwith, 2012).

Case 2

In 2012 State Emergency Service volunteers, charged with removing a man's body from the wreckage after a car accident in metropolitan Melbourne, discovered a pulse some time after paramedics had declared the man dead and left the scene. According to Ambulance Victoria's Chief Executive Officer, the paramedics had "noted that the patient was breathing and yet equally pronounced the patient as deceased". The Ambulance Victoria review "found the paramedics failed to adhere to strict guidelines for determining if someone has died." (Dickens, 2012).

Case 3

A 2010 inquest investigated the death of a heart attack victim at his home west of Mackay in Queensland. Although the coronial findings suggested that a major cause of this death was the delayed arrival of an ambulance, the Coroner also noted a range of relevant changes introduced since by Queensland Ambulance Service. They included a clinical audit and review of all cases involving a death in care or a cardiac arrest to check for any significant variation in the standard of care provided (Risson, 2010).

Case 4

An inquest was held into the death of a woman in rural Victoria who died following significant haemorrhaging due to an ectopic pregnancy. Failure by ambulance officers (both at the scene and at the despatch centre) to consult her treating doctor, directly or at all, over decisions to delay the requested transfer to a larger hospital contributed to her death (Stuthridge, 2010).

Case 5

A 2007 inquest investigated the death of a 63 year-old man [M] in SA following an uncontrolled haemorrhage due to a ruptured aortic aneurysm. The Coroner found that the paramedic had failed to mention key symptoms at the handover to the Flinders Medical Centre:

I believe that [the paramedic] failed to mention the issue. She most certainly should have mentioned it, as it was crucial in assessing the triage category to which [M] should have been assigned. If it had been mentioned, [M] would have been assigned a higher triage category, and would have been less likely to have been "bumped" by other patients. I cannot say that it would have produced a different outcome; however it clearly would have given him a much better chance (Johns, 2007).

Case 6

A 2006 inquest in SA investigating the death of a 13 year-old [E] concluded, among other findings, that:

[E] experienced a catastrophic deterioration very soon after being loaded into the ambulance. Ambulance Officer [D1] failed to appreciate the significance of her condition, or even that there had be any change in it. He only realised that things had changed when he observed Ambulance Officer [D2's] reaction when [E] was unloaded at the Women's and Children's Hospital. Needless to say it is extremely concerning that [D1] did not appreciate the significance of [E's] symptoms (Johns, 2006).

Case 7

In 2005 an inquest was undertaken into the death of a 37 year-old man, [Mr Y] at home in a suburb of Darwin, NT. The initial ambulance crew left after a few minutes without establishing the cause of his chest pain and fever. By the time SJA NT arrived again, after a second call a couple of hours later, the man had died. The Coroner found that the initial crew had failed to appreciate the significance of obvious scarring due to previous major heart surgery, and:

... their 'judgement call' on the night not to take him to hospital (with the benefit of hindsight) was mistaken and wrong (Cavanagh, 2005).

Case 8

An egregious matter in 1992 in WA continues to elicit attention today. Walking home from a party in Perth, teenager Louis Johnson was randomly attacked and run over by strangers. Sometime later a passer-by called an ambulance. The ambulance officers did not take Mr Johnson to hospital. They took him home, telling his sister he would sleep it off. He died within hours from his serious multiple injuries, despite a second ambulance being called. His family initiated legal action against the SJA and the two officers who initially attended him, as well as the youths who attacked him. (Curtin University 2014; ABC 2003; National Museum Australia, n.d.).

Appendix 5: Australian case studies of harm associated with paramedic practice

The following Australian case studies draw on consultation submissions and media reports.

Case 1: medication theft and or abuse

Numerous media reports concerning theft of medications by paramedics indicate that it is a known risk as is the risk of paramedics with drug addiction problems (see for example Boddy 2012, Butler 2012, Carlyon 2012, Cox 2012, Dawtrey 2012, Sandy 2012, Wahlquist 2012, ABC News on Line 2013, Channon 2013, Gordon 2013a, Gordon 2013b, O'Connell 2013, ABC News on Line 2014, Bucci 2014).

They are risks that can involve harm of multiple patients without detection. In one case police investigated whether paramedics were implicated in the theft of fentanyl from at least five ambulance stations in less than three months (Bucci, 2014). Drug theft and substitution can have fatal consequences as indicated in the death of a woman who died after receiving what her family claims was a saline solution instead of fentanyl during treatment by ambulance officers (Gordon 2013).

In 2013 a state ambulance service discovered during routine auditing, the pain relief medications fentanyl and morphine had been replaced with sterile saline with seven patients believed to have been affected. In 2012, similar substitutions of tap water for fentanyl were discovered, likely to have affected hundreds of patients (Lauder 2012). Medication error by paramedics has also been blamed for administration by paramedics of saline instead of pain relief in at least one case where 19 patients were identified as potentially affected (ABC News on line, 2014). Media reports also suggested that in the four years from 2008 at least seven paramedics with one ambulance service had been implicated in drug thefts from their employer (Boddy 2012).

Case 2: assault

An experienced intensive care paramedic working in a state public sector ambulance service was reported and counselled over an incident involving excessive force with a patient. Some months later, a second incident involving the kicking of an unconscious overdose patient, was witnessed by a number of colleagues. Following investigation, the paramedic's employment was terminated. The paramedic sought reinstatement alleging 'unfair dismissal' through the Industrial Relations Commission. This claim was not successful. The paramedic has found work with other employers who may not be aware of this history (Paramedic employer). A similar case attracted media attention (eg Dibben 2013).

Case 3: inability to prevent practise by substandard paramedic

A registered nurse, working as a paramedic in a state public ambulance service, had been stealing fentanyl from ambulance stock, as well as misappropriating the residual drug volume following patient treatment. The possible substitution of normal saline for the actual drug and subsequent administration to patients was also suspected. Following an investigation, the facts of the theft were agreed by the paramedic and their employment was terminated. The ambulance service was later advised by AHPRA that the nurse had been struck off the national Nursing and Midwifery register. While this action restricts the ability to work as a nurse, it does not prevent employment as a paramedic (Paramedic employer).

Case 4: sexual assault and misconduct

A complainant was involved in a long and drawn out investigation of a paramedic colleague involving more than 20 serious matters, including death threats that he had made, as well as acts of physical and sexual violence against other staff, nurses at hospitals and even patients. One such allegation was that he repeatedly sent lewd photos of himself to the complainant.

Following the investigation, the paramedic's employment was terminated. Sometime later, the complainant discovered that the paramedic was working in an ambulance service in another state (Paramedic organisation). Media reports also confirm the risk of sexually related misconduct by paramedics ranging from sexual assault in an ambulance (Medew 2007) sending sexually explicit images and text messages to female colleagues and patients (O'Leary 2013).

Case 5: practise without qualifications

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

Case 6: lack of competence

One night, while on duty in the city we responded to a drug overdose at a dance party. When my partner and I got there, there was a private company providing paramedical services to event patrons. They had a young guy who they said was seen behaving erratically and they sedated him with Midazolam because they thought he was on drugs and was psychotic. I was shocked that they had used such a dangerous drug because these providers had no cardiac monitor or defibrillator present. When we got the patient into the ambulance we assessed him thoroughly, including taking a blood glucose level. His BGL was 1 and we later found out he was a type 1 diabetic. He wasn't drug affected at all. He was having a 'hypo' and they had managed him inappropriately (Paramedic organisation).

Case 7: inconsistent disciplinary responses

[W]e are aware of five cases of paramedics having self-administered drugs taken from the employer in the course of their employment. The addiction in these cases stemmed from stress related illness deriving from the trauma of their work which had often led to family breakdown and exacerbation of the addiction. Three were terminated even while not being convicted of an offence before the Courts. The other two were not terminated and were given an opportunity to rehabilitate themselves and remain in the job (Paramedic Union). Similarly media reports have highlighted that drug theft by a paramedic leading to a criminal conviction does not necessarily result in loss of employment (Sandy 2012).

Case 8: lack of information sharing

[O]ur organisation is aware of a problem several years ago that led to a blocked airway in a patient in one jurisdiction, caused by plastic from wrapping material occluding an endotracheal tube. This resulted in the near death of the patient and an extended ICU admission. The result of the subsequent investigation exonerated the individual paramedic involved in the incident. Defective training in the use of the equipment provided, amongst other causes, was identified as a root cause of this incident. The result was not passed on to other jurisdictions utilising similar equipment (Paramedic Union).

Case 9: misconduct and competence

The following cases were alleged by a private employer of paramedics:

- An ex-ambulance service employee, who is a convicted child sex offender, applied for and was successful in obtaining employment with a private healthcare provider.

- An ex-ambulance service employee, fired for alcoholism, applied for work in the private sector.
- A number of ex-ambulance service employees, fired for performance related issues, have sought employment in the private sector.
- A UK paramedic deregistered in the UK, sought work in Australia as a paramedic.
- An 'industrial medic' treated a patient for smoke inhalation lying supine and did not administer oxygen, although it was available.

Case 10: misconduct

A paramedic resigned and then moved to an interstate ambulance service following strong allegations that they had attempted to euthanase a patient with terminal cancer with Midazolam during a transfer. This occurred prior to the conclusion of an investigation. This paramedic was subsequently convicted of child sexual assault (Paramedic Organisation).

Appendix 6: Complaints, disciplinary action, employment termination and legal action by state and territory

Health complaints entities (HCE) complaints data

Table 21 shows complaints to HCEs about ambulance services and/or paramedics over the four years to 2013-14. Data were not available in many cases (indicated by '-').

Table 21: Complaints to health complaints entities about ambulance services and/or paramedics, 2010-11 – 2013-14

	2010-11		2011-12		2012-13		2013-14	
	A	P	A	P	A	P	A	P
ACT	7	-	4	-	2	-	4	-
NSW	36	1	21	0	28	1	28	1
NT	-	-	-	1	-	1	-	1
Qld	14	-	19	-	23	-	-	-
SA	37	-	36	-	29	-	23	-
Tas	5	-	4	-	0	-	1	-
Vic	26	-	23	-	18	-	19	-
WA	26	-	16	-	21	-	20	-

Legend: A indicates complaints about ambulance services. P indicates complaints about paramedics

Public ambulance services complaints data

In 2014, public ambulance service providers were surveyed regarding complaints about paramedics. Across the eight services respondents reported receiving a total of 17,031 complaints in the three years to 2012-13; an average of 1,732.6 complaints per service each year. Significant differences were noted across jurisdictions, ranging from an average of 764 complaints per annum in SA, to six per annum in the NT (Table 22). This may reflect different definitions of complaints and or receptiveness to complaints. For example, SA has established a safety learning system which encourages complaints reporting by a range of people, including clients, hospital staff and employees, as a means of improving services. Numbers of complaints may therefore appear higher than for other jurisdictions.

Table 22: Average number of complaints received by public ambulance services about paramedics each year (2010-11 – 2012-13)

ACT	NSW	NT	Qld	SA	Tas	Vic	WA	All
13	66	6	328	764	86	412	57	216.6

Table 23 provides a breakdown by type of complaint received each year for each jurisdiction.

Table 23: Events reported by public ambulance services by jurisdiction (2010-11 – 2012-13)

Type of Event	ACT			NSW			NT ¹			Qld			SA			Tas ²	Vic			WA ¹			
Year	10/11	11/12	12/13	10/11	11/12	12/13	11/12	12/13	13/14	10/11	11/12	12/13	10/11	11/12	12/13	10-13	10/11	11/12	12/13	11/12	12/13	13/14	
Performance	6	4	3	6	19	20	0	0	1	82	95	98	392 ⁶	628 ⁶	558 ⁶	244	109	190	203	33	41	79	
Impairment /intoxication	0	0	0	11	9	14	0	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
Attitude ³ / professional conduct	9	8	10	40	25	48	2	4	9	220	244	241	160 ⁶	265 ⁶	288 ⁶	15	213	254	265	n/a	5	9	
Sexual misconduct	0	0	0	1	2	2	0	0	0	3	1	0	0	1	1	0	0	1	0	n/a	3	1	
Remedial action ⁴ /disciplinary action	2	0	1	44	50	59	0	0	3	2	2	31	2	6	3	2	2	23	17	3	15	5	
Sentinel event ⁵	0	1	2	22	27	20	0	0	0	13	7	17	0	0	0	0	5	11	11	4	2	5	
Organisational action to address issues	0	1	2	n/a	n/a	n/a	0	1	7	n/a	4	8	80 ⁶	90 ⁶	85 ⁶	2	4	10	9	4	5	7	
Employment terminated	1	0	0	1	3	9	0	0	1	5	7	13	2	1	0	0	0	0	0	n/a	8	1	
Resignation as result of poor performance	0	0	0	n/a	n/a	n/a	0	0	0	0	0	0	Aware of such resignations but unable to quantify			0	0	1	0	0	0	n/a	
Legal action	0	0	0	9	6	2	0	0	0	0	0	0	Aware of such cases but unable to quantify. Most significant cohort, while small in number, would be drink-driving convictions & theft			1 criminal investigation of paramedic; multiple counts of stealing a controlled drug & 1 of using.		19 paramedics subject to legal action from 2010-13 (4 civil, 15 criminal). 7 paramedics subject to disciplinary action to date			n/a	n/a	n/a

Type of Event	ACT	NSW	NT ¹	Qld	SA	Tas ²	Vic	WA ¹
Protocols to alert other employers	No	Conduct and services checks are provided to NSW public sector employers when requested, and to other prospective employers with consent of employee ⁷	No	Disciplinary action advice provided to other State Government Department but not to other prospective employers.	No	No	No	No
Terminated staff gaining other employment	Not aware	2	Yes	No	3	1	3	2

1. Data provided for 2011–12 and 2013–14.

2. Amalgamated data for 2010–2013 provided.

3. Attitude defined as rudeness or incivility, lack of empathy, rough handling, threatening or harassing behaviour, improper conduct, demeanour or improper language.

4. Remedial actions may include counselling, managerial warning, verbal or written warnings, supervision, reallocation of duties, targeted education or temporary suspension.

5. Definitions of sentinel events vary across jurisdictions.

6. SA has established a safety learning system which encourages complaints reporting by a range of people, including clients, hospital staff and employees, as a means of improving services. Numbers of complaints may therefore appear higher than for other jurisdictions.

7. NSW Health has a Health Services Check Register and NSW Ambulance Service reports all serious matters where any workplace restrictions are imposed, including dismissal or resignation due to serious concerns, for listing on the register.

Disciplinary action, employment termination and legal action data by state and territory

For each jurisdiction, averaged over a three-year survey period, **Table 24** shows serious clinical events (sentinel events/root cause analyses), disciplinary actions, terminations of employment and legal action against paramedics.

Table 24: Disciplinary action, employment termination and legal action by state and territory – average per annum (2010-11 – 2012-13)

Event	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Remedial/disciplinary action	1.0	51.0	1.0	11.7	3.7	0.7	14.0	7.6	90.7
Employment terminated	0.3	4.3	0.3	8.3	1.0	0	0	3.0	17.2
Legal action	0	5.3	0	0	0	0	6.3	0	11.6

'Disciplinary action' indicates that a paramedic required counselling or re-education regarding clinical practice, supervised practice, or verbal or written warnings regarding practice. Such actions may have occurred following complaints concerning a paramedic's practice or due to an internal review of incidents. Data on the number of paramedics subject to disciplinary action and termination of employment are an indicator of potential for serious harm. Legal action against paramedics was included to capture serious misconduct that may or may not have led to a sentinel event/root cause analysis. Examples would include theft of medications.

*Appendix 7: Consultation forums attendance list***Perth, 20 July 2012 – 30 attendees**

Name	Position	Organisation
Ian Barrett	Senior Policy Officer	Workforce, Department of Health, WA
Luci Bertoli	Principal Policy Officer	Workforce, Department of Health, WA
Richard Brightwell	Coordinator Postgraduate Medicine and Paramedical Sciences School of Medical Sciences	Edith Cowan University
Des Callaghan, ASM	–	–
Charlton Campbell	Operations Manager Perth	International SOS (Australasia) Pty Ltd
Donelle Carver	Vice President	Ambulance Officers Union
Robin Collins	WA State Manager	Australia Health Practitioner Regulation Agency
Steve Cooper	Principal Advisor, Emergency Management	BHP Billiton
Samuel Dane	Industrial Officer	United Voice
Len Fiori	Director of Ambulance Services	St John Ambulance WA
Peter Franklin	Operations Manager and Critical Care Flight Paramedic	LinkHealth
Todd Hews	Advisor Emergency Management	BHP Billiton
Sarah Kippin	Graduate Officer	Department of Health, WA
Paul Little	Manager	Advanced Medical Support
Peter Masini	Emergency Management Specialist	Rio Tinto Iron Ore Regional Team
Stewart Masson	Director Medical Services	Safety Direct Solutions
Dr Paula McMullen	National Director	Australian College of Ambulance Professionals NSW
Matt O'Shea	Director and Principal Consultant	Patrick Rose Human Capital Investments
Liz Prime	Policy Officer, Regulation, Policy, Practice and Projects	Australia Health Practitioner Regulation Agency
Brendan Robb	Acting Director	Workforce, Department of Health, WA
Danny Rogers	Senior Portfolio Officer	Statewide Contracting, Department of Health, WA
Scott Sinclair	WA State Manager	National Patient Transport Group
Michael Smith	National Director and Treasurer	Australian College of Ambulance Professionals NSW
Andy Symons	Chair	Paramedics Australasia, WA Chapter
Gio Terni	Executive Director	Health Consumers' Council

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Name	Position	Organisation
John Thomas	President	Ambulance Officers Union
Wayne van Biljon	Committee member	Paramedics Australasia
Peter Watson	General Manager Perth	International SOS (Australasia) Pty Ltd
Christy Whitby	Director	Compass Health
Andrew White	Emergency Services Supervisor	BHP Billiton

Canberra, 24 July 2012 – 28 attendees

Name	Position	Organisation
Lyn Angel	Paramedic Course Coordinator	Charles Sturt University
Jim Arneman	Project Officer	National Council of Ambulance Unions
Ray Bange	Policy Advisor	Paramedics Australasia
Carol Brook	General Manager – Quality Safety and Risk	ACT Ambulance Service
Crystal Cooke	Student Paramedics Australasia	Charles Sturt University
David Dutton	Deputy Chief Officer	ACT Ambulance Service
Alan Eade	Director	Paramedics Australasia
Dr Michael Eburn	Senior Fellow	Fenner School of Environment and Society and College of Law, Australian National University
Bronwyn Ellis	National Workforce Officer	ACT Health Directorate
Jordan Emery	National Director – National Registration	Australian College of Ambulance Professionals NSW
Jennie Gordon	Director, Workforce Policy and Planning	ACT Health Directorate
Kinza Graham	Paramedic	–
Wayne Goodrem	–	–
Carpet Hughes	National Executive Director and Secretary	Australian College of Ambulance Professionals NSW
LCDR Andrew Jones	SO2 TRG and Health Systems Information	Joint Health Command, Department of Defence
Toby Keene	–	ACT Ambulance Service
Liam Langford	Ambulance Paramedic	ACT Ambulance Service
Matt Lee	Student Paramedics Australasia	Australian Catholic University
Shane Lenson	School of Nursing Midwifery and Paramedicine	Australian Catholic University
Cheryl Mason	Student Paramedics Australasia	Charles Sturt University
Steve Mitchell	Vice President	National Council of Ambulance Unions ACT Ambulance Service
Dr Louise Morauta	Consultant	Paramedics Australasia
Darren Penny	–	Paramedics Australasia

Name	Position	Organisation
Michael Rigo	Director	Ambulance Service Australia
Dr James Ross	Medical Director	Aspen Medical/Remote Area Health Corps
David Tassicker	Chair, ACT Chapter	Paramedics Australasia
Ruth Townsend	Lecturer Health Law, Ethics and Human Rights	College of Law and School of Medicine, Australian National University
Rod Wellington	Chief Executive Officer	Services for Australian Rural and Remote Allied Health

Sydney, 30 July 2012 – 26 attendees

Name	Position	Organisation
Joe Acker	Paramedic Discipline Leader	Charles Sturt University
Dawn Arneman	Senior Policy Officer, State and National Programs	NSW Ministry of Health
Jim Arneman	Project Officer	National Council of Ambulance Unions
Helen Banu-Lawrence	General Manager, Membership and Community Services	St John (NSW)
Warren Boon	–	Health Services Union East
Bill Britt	Manager Training and Clinical Operations	Emergency Medical Services Australia P/L
Greg Bruce	Vice President	National Council of Ambulance Unions
Timothy Burt	Manager, State and National Programs	NSW Ministry of Health
Adrian Cohen	Chief Executive Officer	Immediate Assistants Pty Ltd
Alan Eade	Director	Paramedics Australasia
Jordan Emery	National Director, National Registration	Australian College of Ambulance Professionals NSW
Steven Fraser	–	Health Services Union East
Deborah Frew	Deputy Director, Workforce Strategy and Culture	NSW Ministry of Health
Les Hotchin	National Secretary	Paramedics Australasia
Wei-Li Hum	Australasian College of Health Service Management Trainee, State and National Programs	NSW Ministry of Health
Donna Ingram	–	Metropolitan Local Aboriginal Land Council
Andrew Keshwan	President	Emergency Medical Service Protection Association
Pip Lyndon-James	Lecturer (Paramedic Practice)	University of Tasmania, Rozelle Campus
Graham McCarthy	Executive Director Clinical Governance	Ambulance Service of NSW

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Name	Position	Organisation
Paula McMullen	Coordinator, Sydney Paramedic Practice Program	University of Tasmania, Rozelle Campus
Alan Morrisson	Manager Education	Ambulance Service of NSW
Mark Newton	Chief Executive Officer	St John Ambulance (NSW)
Matthew Potter	Intensive Care Paramedic	Emergency Medical Service Protection Association
Steve Talbot	Intensive Care Rescue Paramedic	Immediate Assistants Pty Ltd
Mike Willis	Acting Chief Executive	Ambulance Service of NSW
James Wynd	Managing Director	Emergency Medical Services Australia P/L

Melbourne, 31 July 2012 – 28 attendees

Name	Position	Organisation
Bernard Agius	Manager, Strategic Planning and Program Management	Ambulance Victoria
Peter Bailey	Chief Operating Officer	Event Paramedics
Rachel Baxter	Senior Program Advisor, Ambulance Program	Department of Health
Stephen Burgess	Head, Postgraduate Coursework Programs Department of Community Emergency Health and Paramedic Practice, School of Primary Health Care	Faculty of Medicine, Nursing and Health Sciences Alfred Hospital Campus
Alan Close	Managing Director	LifeAid Pty Ltd
Peter Cormack	Operations Manager	National Patient Transport Pty Ltd
Grant Davies	Deputy Commissioner	Health Services Commission
Alan Eade	Director	Paramedics Australasia
Garry Fehring	Director of Clinical Services	Epworth Rehabilitation Richmond
Susan Furness	Senior Lecturer and Course Coordinator, Paramedicine	Faculty Health Sciences, La Trobe University
Narelle Greig	Assurance Manager	National Patient Transport Pty Ltd
Gavin Harrison	Corporate Services Manager	National Patient Transport Pty Ltd
Peter Hartley	Senior Lecturer/Course Coordinator, Paramedic Sciences	Victoria University
Danny Hill	Paramedic, seconded delegate to Ambulance Employees Australia	Ambulance Employees Australia, Victoria (United Voice Ambulance Section)
Les Hotchin	National Secretary	Paramedics Australasia

Name	Position	Organisation
Paul Jennings	Chair, Victorian Chapter	Paramedics Australasia
Steve McGhie	General Secretary	Ambulance Employees Australia, Victoria (United Voice Ambulance Section)
Richard Mullaly	Victorian State Manager	Australian Health Practitioner Regulation Agency
Sam Muscat	Human Resources Manager	LifeAid Pty Ltd
Peter O'Meara	Professor of Rural and Regional Paramedicine	La Trobe Rural Health School, La Trobe University
Paula McMullen	National Director	Australian College of Ambulance Professionals NSW
Laurie Park	Representative	Royal Flying Doctors Service, Victorian Section
Ian Patrick	President	Paramedics Australasia
Nicole Robertson	Committee Co-Chair	Student Paramedics Australasia
Mick Stevenson	–	Paramedics Australasia
Tony Walker	General Manager, Regional Services Division	Ambulance Victoria
Ken Whittle	Senior Lecturer, Paramedicine	School Health Sciences, Ballarat University
Beth Wilson	Health Services Commissioner	Health Services Commission

Hobart, 2 August 2012 – 38 attendees

Name	Position	Organisation
Trish Allen	Service Improvement Coordinator	Emergency Care Clinical Network Department of Health and Human Services Tasmania
Jim Arneman	Project Officer	National Council of Ambulance Unions
Leon Atkinson-McEwen	Ombudsman and Health Complaints Commissioner	Office of the Ombudsman, Energy Ombudsman and Health Complaints Commissioner
Kevin Bate	Director Emergency Medical Services	Ambulance Tasmania
Marnie Bower	Clinical Placement Project Manager	University of Tasmania
Francine Douce	Director of Nursing and Midwifery	Department of Health and Human Services, Tasmania
Jordan Emery	National Director, National Registration	Australian College of Ambulance Professionals NSW
Rod Franks	Staff Specialist	Emergency Department, Royal Hobart Hospital
Jim Galloway	Deputy Chief Pharmacist	Department of Health and Human Services, Tasmania
Kevin Gardner	Paramedic	Ambulance Tasmania

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Name	Position	Organisation
Brett Gibson	Regional Education Coordinator	Ambulance Tasmania
Matthew Hardy	Acting State Manager	Australian Health Practitioner Regulation Agency
Sally Gregor	Project Manager, Nursing and Midwifery	Department of Health and Human Services, Tasmania
Rian Holden	Manager	Emergency Medical Services Private Ambulance
Les Hotchin	National Secretary	Paramedics Australasia
Tina Ivanov	Director Clinical Services	Ambulance Tasmania
Tim Jacobson	Secretary	National Council of Ambulance Unions
Mike McCall	Associate Head of Paramedic Studies	University of Tasmania
Dominic Morgan	Chief Executive Officer	Ambulance Tasmania
Peter Morgan	Vice Chair	Paramedics Australasia Tasmania
Peter Mulholland	Manager, Education and Professional Development	Ambulance Tasmania
John Richardson	Paramedic	Ambulance Tasmania
Ken Richardson	Branch Senior Vice President	Health and Community Services Union, Tasmania
Amanda Roberts	Principal Officer Legislation	Legislative Review, Department of Health and Human Services, Tasmania
Mary Sharpe	Chief Pharmacist	Department of Health and Human Services, Tasmania
Clinton Smith	Paramedic	Emergency Medical Services Private Ambulance
Michael Smith	National Director and Treasurer	Australian College of Ambulance Professionals NSW
Steve Trewin	Chair	Paramedics Australasia Tasmania
Professor James Vickers	Head of School	University of Tasmania
Garry White	Duty Manager	Ambulance Tasmania

Darwin, 7 August 2012 – 18 attendees

Name	Position	Organisation
Linda Blair	Acting Director Workforce Strategy	NT Department of Health
Kevin Blake	Operations Manager- Southern Region	St Johns Ambulance NT
Zena Borg	Workforce Support Officer	NT Department of Health
Ross Coburn	Chief Executive Officer	St Johns Ambulance NT
Lisa Coffey	Commissioner	NT Health and Community

Name	Position	Organisation
		Services Complaints Commission
Erina Early	Senior Industrial Officer	United Voice – NT Branch
Malcom Johnston-Leek	Medical Director	St John Ambulance NT
Lorinda Knox	Paramedic, Katherine	St John Ambulance NT
Mick Lazell	National Director, Board	Paramedics Australasia – NT Chapter
Michael McKay	Director of Ambulance, Operations	St John Ambulance NT
Tim McKinlay	Fire Fighter Paramedic	GEMCO – BHP Billiton
Harry McSherry	Manager Performance and Contracts Acute Care Systems Performance	NT Department of Health – Health Reform
Jody Nobbs	NT Manager Executive Assistant	Australian Health Practitioner Regulation Agency
Arullan Naidoo	Senior Program Development Officer	NT Department of Health
Bradley Sanderson	Manager Paramedic Training College	St John Ambulance NT
Helgi Stone	Chief Poisons Inspector, Manager Medicines and Poisons Control	NT Department of Health
Tracy Watts	Contracts and Sales Manager	St John Ambulance NT
Julie Wickham	Paramedic	St John Ambulance NT

Brisbane, 9 August 2012 – 46 attendees

Name	Position	Organisation
Troy Aspinall	Intensive Care Paramedic	Queensland Ambulance Service
Russell Bowles	Commissioner	Queensland Ambulance Service
Alan Close	Managing Director	LifeAid Pty Ltd
Jane Carlisle	Director, Patient Transport Team	Health Services and Clinical Innovation Branch Queensland Health
Nick Coronas	Advanced Environmental Health Officer, Division of the Chief Health Officer	Health Services and Clinical Innovation Branch Queensland Health
Lucinda Clarke	Intensive Care Paramedic	Queensland Ambulance Service
Steve Dean	–	St John Ambulance Queensland
David Eeles	Assistant Commissioner Service Planning and Resourcing	Queensland Ambulance Service
Phoebe Everingham	Employee Relations Advisor	Queensland Ambulance Service
Helen Eyles	National Director, Board	Paramedics Australasia, Queensland Chapter
Ann Fitzgerald	Director, Office of the Principal	Health Services and Clinical

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Name	Position	Organisation
	Medical Officer	Innovation Branch, Queensland Health
Gerry Fitzgerald	Professor, Faculty of Health	School of Public Health and Social Work, Queensland University of Technology
Michael Freeman	State Council Member	United Voice
Ron Gui	Director	Australasian Registry of Emergency Medical Technicians
Toni Halligan	Clinical Education and Training Program Manager	Queensland Health
Amanda Hammer	Manager	Workforce Design and Liaison Unit Queensland Health
Andrew Hawkins	Principal Environmental Health Officer, Environmental Health Unit QH, Division of the Chief Health Officer	Health Services and Clinical Innovation Branch, Queensland Health
Brendan Horne	Committee Member	Health Consumers Queensland
Peter Lang	National Chairman	Australian College of Ambulance Professionals NSW
Richard Larson	National Director, Board, Vice President	Paramedics Australasia
Dr Bill Lord	Associate Professor	University of the Sunshine Coast
Dr Alex Markwell	State President	Australian Medical Association Queensland
Anne Morrison	Queensland State Manager	Australian Health Practitioner Regulation Agency
Sean Mutchmor	Manager Clinical Standards	Office of Medical Director Queensland Ambulance Service
Cathie Nesvadba	Nursing Director Professions and Practice	Office of the Chief Nursing Officer, Queensland Health
Neil Noble	–	Paramedics Australasia Queensland Chapter
Paul Oliveri	Lecturer Paramedic Science	Central University Queensland
Dr Paddy O’Luanaigh	Nursing Director, Education and Training The Nursing and Midwifery Office Queensland	Health Services and Clinical Innovation Branch Queensland Health
Dr Stephen Rashford	Medical Director Adjunct Professor	Queensland Ambulance Service Queensland University of Technology
Laura Regan	Director Safety and Health	Queensland Resources Council
Adam Rolley	Director of Paramedic Sciences Program The School of Medicine	The University of Queensland
Charles Russell	Manager Inservice Education Unit	Queensland Ambulance Service
Paula Schultz	Associate Professor and Deputy	Australian Catholic University

Name	Position	Organisation
	Head School, Nursing, Midwifery and Paramedicine (Queensland)	
David Sell	Acting Executive Manager Aeromedical and Referral Services	Queensland Ambulance Service
Paul Sheehy	Director, Special Legislative Projects	Legislative Policy Branch, Queensland Health
Michael Smith	National Director and Treasurer	Australian College of Ambulance Professionals NSW
Scott Stanton	Intensive Care Paramedic	Queensland Ambulance Service
Cath Stephens	Acting Team Leader Allied Health Professions Office Queensland	Health Services and Clinical Innovation Branch, Queensland Health
Jeanette Temperley	Ambulance Coordinator	United Voice
Vivienne Tippett	Professor, Faculty of Health School – Clinical Sciences	Queensland University of Technology
Daniel Townson	–	Paramedics Australasia
Gavin Trembath	Assistant Commissioner	Queensland Ambulance Service
Stephen Van Gerwen	Executive Officer, Corporate Client Services	St John Ambulance (Queensland)
Calvin Wahlburg	Clinical Director	Corporate Protection Australia Medical Pty Ltd
Tony Wain	Clinical Educator	Queensland Ambulance Service
Anita Westwood	Lecturer School of Nursing and Midwifery (Queensland)	Australian Catholic University

Adelaide, 10 August 2012 – 25 attendees

Name	Position	Organisation
Mark Ackland	President	Flinders University Student Paramedics Australasia
Jim Bartlett	–	SA Ambulance Service
Matt Calloway	Director	First Care Medical
Wayne Carty	State Industrial Officer	Ambulance Employees Association
Cliff Collett	–	Paramedics Australasia
Simon Coombe	–	Flinders University Student Paramedics Australasia
Ray Creen	Chief Executive	SA Ambulance Service
Ian Debono	–	SA Ambulance Service
Vic Dorsen	–	Paramedical Services
Keith Driscoll	Executive Director Metropolitan Patient Services	SA Ambulance Service
Anthea Evans	Flinders Clinical Effectiveness,	Faculty of Health Sciences,

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Name	Position	Organisation
	Paramedic, School of Medicine	Flinders University
Dr Hugh Grantham	Professor of Paramedics, Flinders Clinical Effectiveness, Paramedic School of Medicine	Faculty of Health Sciences, Flinders University
Amelia Gower	Senior Consultant, Health System Development	Department for Health and Ageing (SA)
Cindy Hein	–	Paramedics Australasia
Jo Hoiles	Director, Workforce Reform and Development	Department for Health and Ageing (SA)
Carpet Hughes	National Executive Director and Secretary	Australian College of Ambulance Professionals NSW
Roger Hunter	Principal Consultant	Workforce Operations and DHA Human Resources, Department for Health and Ageing (SA)
Richard Larson	–	SA Ambulance Service
Garry Mikhail	Managing Director	Paramedical Services
Greg Mundy	Chief Executive Officer	Council Ambulance Authorities
Nicole Nott	Director	Sitemed
James Pearce	–	First Care Medical
Glenn Peddey	Operations Manager	Sitemed
Paul Reardon	National Director Scholarships and Grants	Australian College of Ambulance Professionals NSW
Cathy Teager	Program Manager	Health Workforce Australia

Appendix 8: Written submissions to the national consultation (2012)

No.	Submitting entity	Profession
1	Anonymous	Paramedic
2	Professor Hugh Grantham	Academic
3	Jobfit	Employer
4	Consumers Health Forum of Australia	Consumer representative body
5	St John Ambulance Australia	Peak body
6	Australian College of Ambulance Professions NSW	Professional association
7	Associate Professor Richard Brightwell, Edith Cowan University and Paramedics Australasia	Academic
8	Charles Sturt University, Paramedic Students	Individual students/student representative bodies
9	Paramedical Services	Industrial bodies
10	Australian Defence Forces, Joint Health Command	Government department
11	Ruth Townsend and Michael Eburn, Australian National University	Academics
12	National Council of Ambulance Unions	Industrial bodies
13	Jim Arneman	Paramedic
14	Transport Workers Union	Industrial body
15	Student Paramedics Australasia	Individual students/student representative bodies
16	Drugs and Poisons Policy and Regulation, Environmental Health Unit, Queensland Health	Government department
17	Flinders University, SA	Education and training organisation
18	Ambulance New Zealand	Peak body
19	Ambulance Employees Australia Victoria	Industrial body
20	United Voice Queensland	Industrial body
21	Paramedics Australasia	Professional association
22	Health Services Union East	Industrial body
23	Greg Bruce	Paramedic
24	Cameron Edgar	Paramedic
25	Health and Community Services Union Tasmania	Industrial body
26	Jason Belcher	Paramedic
27	Mick Lazelle	Paramedic
28	John Bayley	Paramedic
29	James Falla	Paramedic
30	Cynergex Pty Ltd	Employer and education and training organisation
31	Kinza Graham	Paramedic

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No.	Submitting entity	Profession
32	Matthew Kemp	Paramedic
33	Council of Ambulance Authorities	Peak body
34	Ambulance Victoria	Employer
35	Aspen Medical	Employer
36	Paul Allan	Paramedic
37	Australian Health Practitioner Regulation Agency	Regulator
38	Alan Eade	Paramedic
39	Professor Brian Maguire	Academic
40	Steve Johnston	Paramedic
41	University of Tasmania	Education and training organisation
42	Australasian Registry of Emergency Medical Technicians	Employer
43	Sitemed	Employer
44	Victoria Health Services Commissioner	Health complaints entity
45	Health Workforce Australia	Peak body
46	Dr Jonathan Begley	Paramedic
47	Acute Health Pty Ltd	Employer
48	Emeritus Professor Frank Archer	Academic
49	Australian College for Emergency Medicine	Professional association
50	NSW Ministry of Health	Government department

Appendix 9: Health Practitioner Regulation National Law Act 2009 – Powers of National Boards to undertake probity checking of applicants for registration

53 Qualifications for general registration

An individual is qualified for general registration in a health profession if—

- (a) the individual holds an approved qualification for the health profession; or
- (b) the individual holds a qualification the National Board established for the health profession considers to be substantially equivalent, or based on similar competencies, to an approved qualification; or
- (c) the individual holds a qualification, not referred to in paragraph (a) or (b), relevant to the health profession and has successfully completed an examination or other assessment required by the National Board for the purpose of general registration in the health profession; or
- (d) the individual—
 - (i) holds a qualification, not referred to in paragraph (a) or (b), that under this Law or a corresponding prior Act qualified the individual for general registration (however described) in the health profession; and
 - (ii) was previously registered under this Law or the corresponding prior Act on the basis of holding that qualification.

55 Unsuitability to hold general registration

(1) A National Board may decide an individual is not a suitable person to hold general registration in a health profession if—

- (a) in the Board's opinion, the individual has an impairment that would detrimentally affect the individual's capacity to practise the profession to such an extent that it would or may place the safety of the public at risk; or
- (b) having regard to the individual's criminal history to the extent that is relevant to the individual's practice of the profession, the individual is not, in the Board's opinion, an appropriate person to practise the profession or it is not in the public interest for the individual to practise the profession; or
- (c) the individual has previously been registered under a relevant law and during the period of that registration proceedings under Part 8, or proceedings that substantially correspond to proceedings under Part 8, were started against the individual but not finalised; or
- (d) in the Board's opinion, the individual's competency in speaking or otherwise communicating in English is not sufficient for the individual to practise the profession; or
- (e) the individual's registration (however described) in the health profession in a jurisdiction that is not a participating jurisdiction, whether in Australia or elsewhere, is currently suspended or cancelled on a ground for which an adjudication body could suspend or cancel a health practitioner's registration in Australia; or
- (f) the nature, extent, period and recency of any previous practice of the profession is not sufficient to meet the requirements specified in an approved registration standard relevant to general registration in the profession; or
- (g) the individual fails to meet any other requirement in an approved registration standard for the profession about the suitability of individuals to be registered in the profession or to competently and safely practise the profession; or
- (h) in the Board's opinion, the individual is for any other reason—
 - (i) not a fit and proper person for general registration in the profession; or
 - (ii) unable to practise the profession competently and safely.

- (2) In this section— **relevant law** means—
- (a) this Law or a corresponding prior Act; or
 - (b) the law of another jurisdiction, whether in Australia or elsewhere.

78 Power to check applicant's proof of identity

- (1) If an applicant for registration gives a National Board a document as evidence of the applicant's identity under this section, the Board may, by written notice, ask the entity that issued the document—
- (a) to confirm the validity of the document; or
 - (b) to give the Board other information relevant to the applicant's identity.
- (2) An entity given a notice under subsection (1) is authorised to give the National Board the information requested in the notice.

79 Power to check applicant's criminal history

- (1) Before deciding an application for registration, a National Board must check the applicant's criminal history.
- (2) For the purposes of checking an applicant's criminal history, a National Board may obtain a written report about the criminal history of the applicant from any of the following—
- (a) CrimTrac;
 - (b) a police commissioner;
 - (c) an entity in a jurisdiction outside Australia that has access to records about the criminal history of persons in that jurisdiction.
- (3) A criminal history law does not apply to a report about an applicant's criminal history under subsection (2).

80 Boards' other powers before deciding application for registration

- (1) Before deciding an application for registration, a National Board may—
- (a) investigate the applicant, including, for example, by asking an entity—
 - (i) to give the Board information about the applicant; or
 - (ii) to verify information or a document that relates to the applicant;

Examples. If the applicant is or has been registered by another registration authority, the National Board may ask the registration authority for information about the applicant's registration status.

The National Board may ask an entity that issued qualifications that the applicant believes qualifies the applicant for registration for confirmation that the qualification was issued to the applicant.
 - (b) by written notice given to the applicant, require the applicant to give the Board, within a reasonable time stated in the notice, further information or a document the Board reasonably requires to decide the application; and
 - (c) by written notice given to the applicant, require the applicant to attend before the Board, within a reasonable time stated in the notice and at a reasonable place, to answer any questions of the Board relating to the application; and
 - (d) by written notice given to the applicant, require the applicant to undergo an examination or assessment, within a reasonable time stated in the notice and at a reasonable place, to assess the applicant's ability to practise the health profession in which registration is sought; and
 - (e) by written notice given to the applicant, require the applicant to undergo a health assessment, within a reasonable time stated in the notice and at a reasonable place.
- (2) The National Board may require the information or document referred to in subsection (1)(b) to be verified by a statutory declaration.

- (3) If the National Board requires an applicant to undertake an examination or assessment under subsection (1)(d) to assess the applicant's ability to practise the health profession—
 - (a) the examination or assessment must be conducted by an accreditation authority for the health profession, unless the Board decides otherwise; and
 - (b) the National Agency may require the applicant to pay the relevant fee.
- (4) A notice under subsection (1)(d) or (e) must state—
 - (a) the reason for the examination or assessment; and
 - (b) the name and qualifications of the person appointed by the National Board to conduct the examination or assessment; and
 - (c) the place where, and the day and time at which, the examination or assessment is to be conducted.
- (5) The applicant is taken to have withdrawn the application if, within the stated time, the applicant does not comply with a requirement under subsection (1).

109 Annual statement

- (1) An application for renewal of registration must include or be accompanied by a statement that includes the following—
 - (a) a declaration by the applicant that—
 - (i) the applicant does not have an impairment; and
 - (ii) the applicant has met any recency of practice requirements stated in an approved registration standard for the health profession; and
 - (iii) the applicant has completed the continuing professional development the applicant was required by an approved registration standard to undertake during the applicant's preceding period of registration; and
 - (iv) the applicant has not practised the health profession during the preceding period of registration without appropriate professional indemnity insurance arrangements being in place in relation to the applicant; and
 - (v) if the applicant's registration is renewed the applicant will not practise the health profession unless appropriate professional indemnity insurance arrangements are in place in relation to the applicant;
 - (b) details of any change in the applicant's criminal history that occurred during the applicant's preceding period of registration;
Note. See the definition of *criminal history* which applies to offences in participating jurisdictions and elsewhere, including outside Australia.
 - (c) if the applicant's right to practise at a hospital or another facility at which health services are provided was withdrawn or restricted during the applicant's preceding period of registration because of the applicant's conduct, professional performance or health, details of the withdrawal or restriction of the right to practise;
 - (d) if the applicant's billing privileges were withdrawn or restricted under the *Medicare Australia Act 1973* of the Commonwealth during the applicant's preceding period of registration because of the applicant's conduct, professional performance or health, details of the withdrawal or restriction of the privileges;
 - (e) details of any complaint made about the applicant to a registration authority or another entity having functions relating to professional services provided by health practitioners or the regulation of health practitioners;
 - (f) any other information required by an approved registration standard.
- (2) Subsection (1)(a)(ii), (iii) and (iv), (c) and (d) does not apply to an applicant who is applying for the renewal of non-practising registration.

130 Registered health practitioner or student to give National Board notice of certain events

- (1) A registered health practitioner or student must, within 7 days after becoming aware that a relevant event has occurred in relation to the practitioner or student, give the National Board that registered the practitioner or student written notice of the event.
- (2) A contravention of subsection (1) by a registered health practitioner or student does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

- (3) In this section—

relevant event means—

- (a) in relation to a registered health practitioner—

- (i) the practitioner is charged, whether in a participating jurisdiction or elsewhere, with an offence punishable by 12 months imprisonment or more; or
- (ii) the practitioner is convicted of or the subject of a finding of guilt for an offence, whether in a participating jurisdiction or elsewhere, punishable by imprisonment; or
- (iii) appropriate professional indemnity insurance arrangements are no longer in place in relation to the practitioner's practice of the profession; or
- (iv) the practitioner's right to practise at a hospital or another facility at which health services are provided is withdrawn or restricted because of the practitioner's conduct, professional performance or health; or
- (v) the practitioner's billing privileges are withdrawn or restricted under the *Medicare Australia Act 1973* of the Commonwealth because of the practitioner's conduct, professional performance or health; or
- (vi) the practitioner's authority under a law of a State or Territory to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of
- (vii) scheduled medicines is cancelled or restricted; or
- (viii) a complaint is made about the practitioner to an entity referred to in section 219(1)(a) to (e); or
- (viii) the practitioner's registration under the law of another country that provides for the registration of health practitioners is suspended or cancelled or made subject to a condition or another restriction; or

- (b) in relation to a student—

- (i) the student is charged with an offence punishable by 12 months imprisonment or more; or
- (ii) the student is convicted of or the subject of a finding of guilt for an offence punishable by imprisonment; or
- (iii) the student's registration under the law of another country that provides for the registration of students has been suspended or cancelled.

134 Evidence of identity

- (1) A National Board may, at any time, require a registered health practitioner to provide evidence of the practitioner's identity.
- (2) A requirement under subsection (1) must be made by written notice given to the registered health practitioner.
- (3) The registered health practitioner must not, without reasonable excuse, fail to comply with the notice.
- (4) A contravention of subsection (3) by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

- (5) If a registered health practitioner gives a National Board a document as evidence of the practitioner's identity under this section, the Board may, by written notice, ask the entity that issued the document—
 - (a) to confirm the validity of the document; or
 - (b) to give the Board other information relevant to the practitioner's identity.
- (6) An entity given a notice under subsection (5) is authorised to provide the information requested.

135 Criminal history check

- (1) A National Board may, at any time, obtain a written report about a registered health practitioner's criminal history from any of the following—
 - (a) CrimTrac;
 - (b) a police commissioner;
 - (c) an entity in a jurisdiction outside Australia that has access to records about the criminal history of persons in that jurisdiction.
- (2) Without limiting subsection (1), a report may be obtained under that subsection—
 - (a) to check a statement made by a registered health practitioner in the practitioner's application for renewal of registration; or
 - (b) as part of an audit carried out by a National Board, to check statements made by registered health practitioners.
- (3) A criminal history law does not apply to a report under subsection (1).