Senate Standing Committee
on Legal and Constitutional Affairs

SUBMISSION ON

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

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

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1. Introduction

We welcome the opportunity to comment on the establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety.

The authors hold an in-depth understanding of regulatory and accreditation principles gleaned from many years' experience in researching the health education, service delivery and regulatory landscape in Australia and internationally.

From 2007 to 2015 Adjunct Associate Professor Bange was the Principal Policy Advisor to Paramedics Australasia (PA)[1] in the development of proposals for registration of paramedics in Australia and New Zealand. That work encompassed all aspects of best practice health regulation and its implementation under the National Registration and Accreditation Scheme (NRAS).

Associate Professor Brightwell has been intimately involved in the education of paramedics for more than 20 years and was a National Director (2007-2015) and Vice President (2015) of PA prior to his recent retirement from Edith Cowan University. He has an outstanding knowledge of health educational pathways and the practice of paramedicine.

CQUniversity Professor Maguire is a former Senior Fulbright Scholar and internationally recognised paramedic educator and researcher whose work on the safety and quality of emergency medical services has provided ground-breaking insights into the occupational hazards associated with the profession.

Prof. Bange and Prof. Brightwell are both also Executive Committee members of the Australian Health Care Reform Alliance[2] while Professor Maguire has been the Chairperson of the Network of Australasian Paramedic Academics for the past five years.

The authors have an abiding interest in health care delivery, quality and equity standards. The views expressed in this submission have been shaped by their extensive experience and detailed research of relevant issues, broad regulatory background and the input gained from their close relationships with service providers, individual health practitioners and the two paramedic professional societies - Paramedics Australasia (PA)and the Australian and New Zealand College of Paramedicine (ANZCP).

Their close association with the profession has provided exceptional insights into the issues associated with paramedic regulation during their significant advocacy for enhanced professional standards.

Having considered the regulatory frameworks that will ensure the safety of the Australian public and realise optimum benefits in the public interest, the authors strongly recommend that all paramedics nationally be regulated under the National Registration & Accreditation Scheme (NRAS), established under the Health Practitioner Regulation National Law Act (the National Law) and managed by a Paramedic Board under the umbrella of the Australian Health Practitioner Regulation Agency (AHPRA).

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[1] http://www.paramedics.org.au/ accessed 26/01/2016

[2] http://www.healthreform.org.au/ accessed 26/01/2016

2. Background

On 20 August 2015 Queensland Senator Glenn Lazarus secured the support of the Australian Senate for the Legal and Constitutional Affairs Committee to undertake an Inquiry into the national registration of paramedics and report by the last sitting day in June 2016. The terms of reference of the Inquiry are outlined in Appendix A.

Australian paramedics respond to more than three million calls for assistance each year[3]. They are the mainstay professionals in the delivery of out of hospital urgent and unscheduled care and work from a position of unique responsibility and community trust unrelated to jurisdictional borders. However, to date, paramedics have fallen outside the scope of any formal national regulatory system.

Within the public sector, paramedic practice is controlled (or "regulated") by the respective ambulance service agencies as the primary employers of paramedics. Public sector agencies (or contracted private providers) are jurisdictionally bound for the purpose of that role.

Private sector paramedic services and defence force medics operate independently and across jurisdictions albeit subject to an increasing number of different legislative requirements.

To overcome the obvious difficulties for paramedics operating across jurisdictional borders such as the carriage of restricted medications, different scopes of practice and clinical practice guidelines, public sector services have adopted a number of arrangements for reciprocity and mutual acceptance. There are many examples of cross-jurisdictional practice and twin-city operations such as Coolangatta/Tweed Heads, NSW Queanbeyan-based paramedics working into the ACT and Canberra hospital, and ACT helicopter paramedics operating in surrounding areas of NSW.

Research and project work by the former Health Workforce Australia (HWA)[4] and other bodies[5,6] has identified the urgent need for a sustainable health and allied health workforce in Australia and the under-utilised potential for paramedics to contribute more towards meeting national goals of quality, access and equity in primary and out of hospital health care.[7]

The 2015 *OECD Review of Health Care Quality for Australia*[8] also has drawn attention to the opportunities for paramedics to play a bigger role in health care through changing scopes of practice and appropriate regulation.

These identified needs all raise the question of what regulatory provisions are present or are needed to best protect the public and mobilise the undoubted medical skills of the paramedic profession in the interests of the community.

While the Senate has no direct role in the health regulatory process, its powers of review can provide valuable input and oversight of public policy especially as the senate may hold a more holistic and reflective perspective of policy settings in the national public interest.

The authors commend this submission to the members of the Inquiry and would be pleased to respond as needed on any of the issues raised.

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[3] Australian Government Productivity Commission. *Report on Government Services, Chapter 9, Fire and ambulance services.* 2015. Available at: http://www.pc.gov.au/research/recurring/report-on-government-services/2015/emergency-management/fire-and-ambulance-services. Accessed 26/01/2016

[4] bit.ly/1JoLDzw accessed 26/01/2016

[5] bit.ly/1Qj9Fv2 accessed 26/01/2016

[6] bit.ly/1WAOYx7 accessed 26/01/2016

[7] bit.ly/1Rdhqiy accessed 26/01/2016

[8] bit.ly/1PcEXor accessed 26/01/2016 (page 31)

2.1 Why regulate at any level?

When faced with a choice of providers, many consumers may be unable or ill-prepared to make a rational choice. Professional services are thus generally taken at face value, with the consumer having to rely on the expertise of the practitioner and not well placed to assess the nature and quality of the service.

Regulation of a profession therefore may be justified if it can provide protection for the consumer by virtue of the regulatory body having more information and expertise at its disposal than the average consumer - and using that knowledge to license or register the practitioner. Regulatory controls also may mandate the standards of information disclosure with respect to maintaining professional standards and service quality and preventing misrepresentation or fraudulent behaviour.

If the service activity at a practitioner level (e.g. medical intervention) is provided in conjunction with an agency support function such as a hospital, clinic, diagnostic service or paramedic services provider (aka ambulance service), then the public interest becomes multi-dimensional. Regulation of both stakeholder groups may be warranted to ensure objective analysis and prevent blame-shifting or biased assessment.

An example of such dual regulation is provided by the Pre-Hospital Emergency Care Council of Ireland (https://www.phecit.ie/) which independently regulates both paramedic service providers and practitioners; or the combined regulatory functions of the UK Health and Care Professions Council (for practitioners) (http://www.hcpc-uk.org/aboutus/) and the Care Quality Commission (for providers) (http://www.cqc.org.uk/content/what-we-do).

Health care, with its multiple participants, specialised and expensive interventions and layers of interaction between different practitioners and providers, is subject to greater than normal public interest and consumer protection considerations. Not only are consumers commonly unable to judge the expertise of the individual professional but they are frequently faced with no choice of provider. In rural and remote areas, these constraints become even more marked.

Studies of professional regulation inside and outside of health care[9] have consistently raised the tendency of self-regulating professions to protect their scope of practice as a means of benefiting their members. The self-regulatory model thus suffers from perceptions of self-interest, conflict of interest, lack of accountability and lack of community (citizen) engagement.

In theory, selective professional regulation and licensing may restrict supply, increase the perceived value and incomes of the participants and promote exclusivity and status without contributing materially to public health or safety. In practical terms it can also mask poor governance, restrictive practices, internal divisions and professional rivalries and disputes.

Thus, while strongly supporting the case for substantial involvement of front-line practitioners and professional bodies in the regulatory process, the authors note that devolution of regulatory responsibility to professional bodies or employers does not guarantee best practice, nor does it remove the ultimate cost to the consumer if the same or equivalent outcomes are to be achieved. While potentially reducing the visible financial impact on government through cost-shifting, the words of the Rt Hon. John Hutton, former UK Secretary of State for Business, Enterprise and Regulatory Reform ring true when he says: "*there is no such thing as free regulation.* "

[9] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final report* (Ottawa: Commission on the Future of Health Care in Canada, 2002): 93

The impact of perceived as well as real risks is conspicuous in the health sector where the consequences of errors and maltreatment may go well beyond the immediate patient outcomes. Public expectations and perceptions play a significant role and any suspicions of inadequacy generate serious public concerns and loss of public confidence.

The case for statutory regulation of health workers who perform functions above a given level of risk should not be controversial. A graded regulatory response may be appropriate based on the overall perceived risk and public interest and two basic models have evolved in the Australian context which are: statutory registration under the National Registration and Accreditation Scheme (NRAS); and the adoption of a National Code of Conduct (the Code) for unregistered health workers.[10,11]

The additional community benefits from government intervention in directly protecting the public include the maintenance of confidence and the gains in economic and general health and welfare terms. These benefits come through consolidation, scale, the facilitation of practitioner mobility and extension of roles to better serve the community. These gains should not be under-estimated in any benefit cost analysis, especially when allied with perceptions of the public interest.

2.2 A coherent basis for regulation

In addition to the questions posed by the Inquiry, the authors have also considered other objective grounds in assessing the need for paramedic regulation, such as:

- What arrangements are already present to protect the public from potential harm?
- Would protection of title be sufficient to regulate the paramedic profession?
- Are there circumstances that require restricted entry to the role or restriction to particular tasks (e.g. prescribed scope of practice)?
- Will the benefits of having a particular regulatory regime outweigh the direct and collateral costs of formal regulatory intervention?
- Are there national or international regulatory requirements or protocols affecting the way the profession can be regulated?
- What circumstances make proactive intervention by government more appropriate than some form of (say) self regulation or a mandated code of conduct?

The authors are also cognizant of the requirement that proposals for regulation will be subject to the AHMAC registration criteria in any decision to regulate.[12, 13]

[10] http://www.coaghealthcouncil.gov.au/NationalCodeOfConductForHealthCareWorkers/ArtMID/529/ArticleID/40/A-National-Code-of-Conduct-for-health-care-workers accessed 26/01/2016

[11] bit.ly/1OIxKLa accessed 26/01/2016

[12] Australian Health Ministers' Advisory Council. Working Group Advising on Criteria and Processes for Assessment of Regulatory Requirements for Unregulated Health Professions.

[13] Australian Health Ministers' Advisory Council. *Working Group Advising on Criteria and processes for Assessment of Regulatory Requirements for Unregulated Health Professions Report,* 1995.

2.3 Regulation and labour mobility

Internationally, the impact of regulatory activities on the health professions has become part of the public policy and mutual recognition agenda. Furthermore, the realisation has grown that the underlying principles of best practice regulation are founded on common principles.

A constant theme in discussions about regulation is the portability of skills and mobility of practitioners. In that respect, the registration of health professionals and the creation of a national register that records an individual practitioner's status are important elements in achieving reciprocity of recognition across jurisdictional boundaries and in fostering workforce mobility.

Such mobility is crucial for the health professions to ensure safety and equity in health care. It also fosters workforce sustainability that benefits the community through better access to quality care and ultimately protects the public.

Minimum entry qualifications form only part of an effective regulatory regime. The ethical standards, complaint mechanisms, competencies framework and continuing professional competence are other key factors. While educational accreditation is a crucial element, it is only one piece of the jigsaw comprising the fabric of regulation. These aspects were covered in various sections of the consultation document and final report on the recent *Independent Review of the NRAS*[14] which found the NRAS to be an excellent model of good regulation.

2.4 Applying best practice regulatory principles

Any work undertaken by, or on behalf of, Ministerial Councils is subject to the requirements of the Council of Australian Governments (COAG) best practice regulation guide.[15] This is to ensure that where regulatory change is being contemplated there are effective arrangements to maximise the efficiency of new and amended regulation, and avoid unnecessary compliance costs and restrictions on competition. The dilemma lies in assessing adequacy, effectiveness and efficiency and the identification of costs and their location within the system.

For example, empowering industry associations or employer groups with regulatory functions, is fraught with the risk that they are subject to rent-seeking, limited vision, moral risk and tempted to seek progress in their own interests, thus rendering suspect their competence to regulate in the public interest.[16]

Considerable work has been done in the UK on the regulation of health care and health professionals as a result of highly public Inquiries which forced a reappraisal of the handling of complaints, the role of the General Medical Council and the revalidation of medical practitioners.[17] In addition, general principles of good regulation were developed by the UK Better Regulation Task Force (BRTF) [18] under the Better Regulation Executive (now superseded).

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[14] Review of the National Registration and Accreditation Scheme for health professions - final report bit.ly/1DWZRoq accessed 26/01/2016

[15] bit.ly/1NwnQIO accessed 26/01/2016

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

[17] The Shipman Inquiry, *Safeguarding patients: lessons from the past - proposals for the future* (Shipman Inquiry Fifth Report, 9 December 2004) bit.ly/1SfY4Pr accessed 26/01/2016

[18] bit.ly/1POtJTp accessed 26/01/2016

The guidelines say that regulation should be:

- **proportionate:** regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
- **accountable:** regulators must be able to justify decisions, and be subject to public scrutiny.
- **consistent:** Government rules and standards must be joined up and implemented fairly.
- **transparent:** regulators should be open, and keep regulations simple and user friendly.
- **targeted:** regulators should be focused on the problem, and minimise side effects.

European legislators have been at the forefront of regulatory reform given that their policies and legislation impact the lives of 500 million inhabitants across a welter of jurisdictions and legislative complexity that dwarf the jurisdictional issues found in Australia. To ensure competitiveness in the global economy while maintaining social and environmental sustainability, legislative action must lead to a simple, clear, stable and predictable regulatory framework that continues to add value as problems evolve, new solutions emerge and political priorities change.

To achieve these objectives The European Commission has prepared *Better Regulation Guidelines*[19] which embody a number of essential principles and in particular, include the concept of the *Fitness Check* (p 50).[20]

The reason for mentioning this approach is that the authors consider the regulation of paramedics to have multiple benefits, and while protection of the public is the primary and sufficient purpose for a national (or multi-jurisdictional) scheme, there are other outcomes that would also benefit the community from a national regulatory approach.

While the above principles provide guidance on the objectives and outcomes of regulation, they leave the detailed mechanisms unstated. However, they provide useful benchmarks for evaluating different systems including the current provisions (or lack thereof) for the regulation of paramedics.

In Australia, the regulation of 14 health professions through the NRAS is a well-established system under the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory. The objectives and guiding principles are set out in the COAG *Intergovernmental Agreement* (IGA) for the NRAS and Section 3 of the National Law.

The authors' evaluation is that the NRAS and the operations of AHPRA and the various regulatory Boards fulfil the primary functions of appropriate regulation (see Sections 2.5 and 3 - NRAS).

[19] COM(2015) 215 final - *Better Regulation Guidelines,* European Commission 2015 bit.ly/1ISuZEX accessed 26/01/2016

[20] The concept of a Fitness Check was introduced in COM (2010) 543 final – *Smart Regulation in the European Union* bit.ly/1QxaXoi accessed 26/01/2016

2.5 Identifying regulatory competence

It is in the interests of all stakeholders to have regulatory mechanisms that hold public confidence. The characteristics of good regulatory governance to achieve that goal are increasingly being recognised as: clarity, predictability, autonomy, accountability, participation, and open access to information.[21] Each of these factors aids in making a regulatory system transparent in the eyes of stakeholders, enhances the outcomes and instils confidence.

In his landmark review of legal services[22] Sir David Clementi formed the view that for effective regulation it was desirable for some regulatory functions to be carried out by bodies that are wholly separate from the professional associations or service providers. The chief of these externalised functions are client complaints, disciplinary matters and the setting of practice rules. The authors agree with those views.

When considering the management of complaints, there is a consistent opinion that they should be handled independently of a profession to properly command public support.[23] To serve the public interest, the complaints body also needs to have a substantial non-professional membership.

Furthermore, it was Clementi's view that clients (in this context – patients) should have access to a single point of contact (one-stop-shop approach) and not be expected to navigate a complex series of complaint processes, thus simplifying the process and making it easier for the user/patient. This principle has been one of the arguments behind the establishment of the office of the Queensland Health Ombudsman.[24]

Articulation of these principles shows the improbability of providing comparable provisions that ensure rigour and independence within any regulatory system that is primarily composed of either employers or practitioners.

Regulatory systems, fitness to practice and complaint mechanisms are needed that meet public expectations of community engagement and user-focus, rather than systems that are primarily profession or service-focused. The public interest in the fairness and transparency of the regulatory process thus demands that there be meaningful lay representation.

To be acceptable, the needs of consumers and the public interest must be at the heart of any regulatory system - as exemplified by the NRAS/AHPRA model – but currently absent from the regulation of paramedics.

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[21] Lorenzo Bertolini, How to improve regulatory transparency, Emerging lessons from an international assessment, GRIDLINES, Note No. 11 – JUNE 2006 bit.ly/1Sgf205 accessed 26/01/2016

[22] Review of the Regulatory Framework for Legal Services in England and Wales Final Report

Sir David Clementi, December 2004 bit.ly/1QoUqka accessed 26/01/2016

[23] The Future of Legal Services: Putting Consumers First, Response of the Legal Aid Practitioners Group, January 2006 (response to White Paper on reform of the legal services sector October 2005)

bit.ly/1UnCOX3 accessed 26/01/2016

[24] The Office of the Health Ombudsman http://www.oho.qld.gov.au/about-us/office-of-the-health-ombudsman/

3. National Registration and Accreditation Scheme (NRAS)

Governments at all levels have a shared interest on behalf of the community, especially if there are spill over effects from one level of government to another. While collaboration and partnership between different levels of governments can have positive effects, shared roles risk the creation of duplication and reduced allocative efficiency, creating strong arguments for national legislation to support safety, quality, and efficient national markets in the public interest.

Those considerations underpinned the recommendations of the Productivity Commission that resulted in the 26 March 2008 COAG decision to adopt the IGA and set up the NRAS for the health professions.
The essence of that decision was to have regard to the public interest in promoting access to health services; and to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery.
The IGA and its objectives can be accessed here: http://bit.ly/1NriyS8

The Commonwealth and the states and territories subsequently worked together to implement the NRAS health practitioner registration scheme. The outcome has been that most health professionals no longer require registration in multiple jurisdictions, but with the states and territories responsible for administering the scheme. Those NRAS arrangements also made specific allowance for the later entry of other professions to the scheme.

National registration of ten health professions began in 2010 (initially for existing registered health professions) and was augmented with a further four professions in 2012. The scheme operates under the provisions of *Health Practitioner Regulation National Law Act* (the National Law) and legislation in each state and territory. It currently regulates 14 health professions nationally including medical practitioners and registered nurses.

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

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

The *Australian Health Practitioner Regulation Agency* (AHPRA) is the organisation responsible for the implementation of the NRAS. Each health profession regulated under the NRAS currently has a National Board albeit this may change following acceptance of the recommendations arising from a recent review of the NRAS. The Boards and AHPRA work in partnership to implement the National Scheme, each with specific roles, powers and responsibilities set down in the National Law.

There has been some criticism of the NRAS and AHPRA performance since inception. The Victorian Legislative Council Legal and Social Issues Legislation Committee initiated an Inquiry in 2014 which cited a number of problems including financial transparency, efficiency, decision-making issues and problems with complaints handling mechanisms. None of these problems is unique or had not been raised in varying ways with the systems and procedures that the NRAS/AHPRA replaced.

The Victorian Inquiry recommended that *"...Victoria remain committed to the registration and accreditation components of the National Scheme and that the Victorian Government remain a signatory to the Intergovernmental Agreement..."*

The authors agree with that conclusion and suggest that the benefits to public safety of the national registration and accreditation components far outweigh any interim administrative and inter-jurisdiction matters. These are constructs in many instances of political opinion and not based on matters of community interest. Health care in a national Australian context should know no boundaries based on lines on a map.

Since the Victorian study, a further formal *Independent Review of the NRAS* has been conducted by Mr Kim Snowball, the former Director General of WA Health. The Review comprised an extensive consultation process which included more than 230 written submissions and involved more than 1000 individuals in consultation forums held in each capital city.

Health Ministers in considering Mr Snowball's report agreed that the National Scheme: *remains amongst the most significant and effective reforms of health profession regulation in Australia and internationally* [authors' emphasis]. Its achievements include:

a) Ensuring that the community can have confidence that health professionals providing treatment and care in Australia meet a national standard based on safe practice.
b) Consolidating 74 Acts of Parliament and 97 separate health profession boards into a single national legislation that covers the structure and functions for the regulation of 14 health professions comprising more than 619,500 health professionals. (Authors note - now more than 637,000).[25]
c) Increasing the mobility for health professionals working in Australia by removing the necessity for them to be separately registered in each jurisdiction.
d) Improving protection to the health system by ensuring that any health practitioner who has been found to have committed misconduct can no longer practice undetected in other states or territories.
e) Enabling significant improvements to health workforce information and planning due to the availability of accurate data on each of the 14 professions operating within it.

The communique issued from the Health Council meeting outlining the responses to the report's 33 recommendations can be seen here: (http://bit.ly/1IXrQ40) while the full Report can be viewed or downloaded here: (http://bit.ly/1DWZRoq).

Recommendation 8 deals with the entry of new professions into the Scheme and was only partly accepted, with the self-regulation quality assurance support option not accepted.

[25] bit.ly/1KwYD0N accessed 22/01/2016

4. The current status of paramedic regulation

Paramedics have long sought to adopt professional standards of best practice health care in the interests of the public. Among the principal objectives identified to achieve this outcome have been the accreditation of education programs and the national regulation (registration) of paramedics.

In 2007 Adjunct Associate Professor Bange was requested by the professional body Paramedics Australasia (PA)(then named the Australian College of Ambulance Professionals) to assist in this process by researching and preparing materials that would result in registration for the members of the profession. He and Associate Professor Brightwell have been intimately involved in the journey to paramedic professionalism since that time.

Many others at all levels from within and outside the paramedic profession have also contributed to the advocacy for paramedic registration. While too numerous to name and mindful that some might be inadvertently omitted, their valuable contributions nonetheless are gratefully acknowledged.

In 2009 the ABC TV 4 Corners program *Out of Time* detailed four deaths arising from inadequate ambulance responses in Western Australia (WA). The impact of this national program resulted in a public Inquiry[26] into St John Ambulance Service Inc (SJA) which (inter alia) recommended the registration of paramedics[27] (pp 48 et seq).

Recommendation 10

DoH pursues, through the Australian Health Workforce Ministerial Council, the national registration of paramedics.

The Inquiry report noted that paramedics were not registered and that changing to a registration model would bring the principles espoused by governments in the IGA into play. It also suggested that such independent registration offered an opportunity to alleviate some of the tension between SJA and their paramedic staff and bring innovation and greater access to care (p 49).

> *" ...Currently, ambulance providers are required to indemnify their workforce for their performance, and are totally accountable for the quality of the care provided, whilst the individual is protected from direct accountability in a non-registered health professional model. Not surprisingly, this leads to a more prescriptive approach to approving CPGs and scope of practice and causes division between parties.*
>
> *Registering paramedics would introduce greater balance into the equation as the paramedics would need to take responsibility for their performance, professional development and practice standards in partnership with the employer. Indeed, if paramedics are to work independently in community settings and extend their scope of practice alongside other registered health professionals, it is imperative that they are included in the NRAS within the next 3 –5 years..."*

[26] http://www.health.wa.gov.au/ambulance_inquiry/ accessed 26/01/2016

[27] http://www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf accessed 26/01/2016

Subsequently, in February 2010, the Australian Health Workforce Ministerial Council - a standing committee of the Council of Australian Governments (COAG) - requested advice on a proposal from the WA government to include paramedics as a regulated profession under the NRAS.

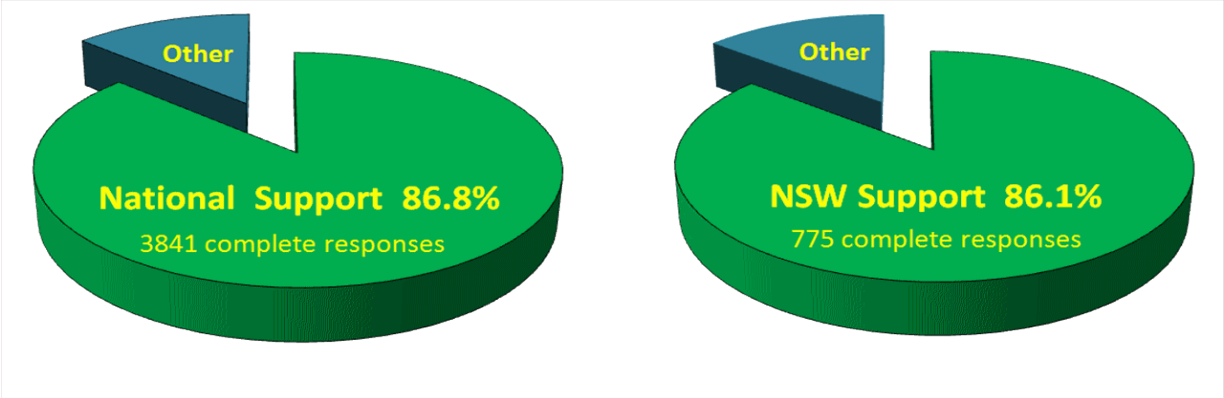
A West Australia Department of Health project team pursued the matter, with the scope of the feasibility study and advice being to:

- Identify and assess the benefits of including paramedics in the NRAS:
- describe the requirements for including paramedics in the NRAS: and
- make recommendations on the inclusion of paramedics in the NRAS prior to July 2014 for the consideration of AHMAC and the Australian Health Workforce Ministerial Council

A consultation paper, *Options for Regulation of Paramedics* (the Consultation Paper) was developed by the project team in consultation with the Australian Health Ministers Health Workforce Principal Committee (HWPC) and was released for limited consultation on July 2, 2012. The Consultation paper can be accessed here: http://bit.ly/1QxpXTQ

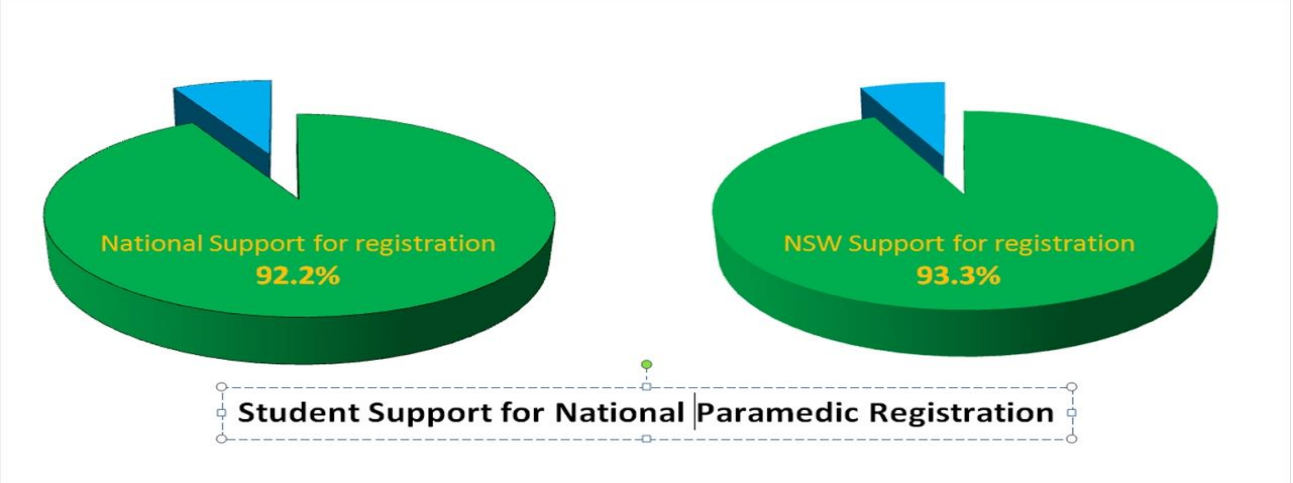
The need for proactive paramedic regulation was then explored through a lengthy process of national consultation that addressed the issues raised in the Consultation Paper and the six AHMAC registration criteria. This consultation engaged stakeholders from all walks of life but principally paramedic professionals, ambulance services, health departments, academics, lawyers, medical practitioners, nurses and others professional and community groups with an interest in health policy. That national process elicited overwhelming stakeholder support for national registration under the NRAS in every jurisdiction including NSW.

Among the notable features of the 2012 consultation process was the strong support for paramedic registration under NRAS and the disbelief expressed by many previously uninvolved stakeholders that paramedics were not already a registered profession. In nationwide forum sessions 34 out of 35 discussion groups recommended NRAS registration.



National and NSW Support for NRAS Registration - Source : National PA survey 2012

An on-line survey conducted by PA in 2012 found exceptionally strong support for registration from both practitioners and students, with overall support for NRAS registration being 86.8% from 3841 respondents. The support from students overall was 92.2% and peaked at 97% in one jurisdiction. That powerful support from the present and future professional practitioners is a stunning confirmation of the recognition of the risks to the public and acceptance of the need for change.



Source : National PA survey 2012

Extensive jurisdictional negotiations and further research and information gathering then took place with refinement of the risk impact study. That process further reinforced the substantial risks associated with paramedic practice, the absence of appropriate regulation and the parlous lack of relevant data to inform workforce planning.

It became patently obvious that robust and proactive regulation of paramedics was needed and that the risks having been identified and placed in the public domain, the issue had become one of not *'Why'* but *'When'* and *'How'* appropriate regulation to protect the public could be implemented. Governments progressively acknowledged this reality which saw the introduction of jurisdictional legislation to protect the title of 'paramedic' in Tasmania, South Australia and New South Wales.

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

At this time all state and territory governments except NSW have given commitments to support NRAS registration.

Concurrent developments which began in 2010 -11 involved consideration of the regulatory situation for unregistered health workers (other than paramedics) for which the Victorian government Health Department provided the lead agency. The outcome of that parallel consultation and policy development activity was the agreement by Health Ministers to adopt a *National Code of Conduct for health care workers* (National Code).[28] The National Code provides a 'negative licensing' regulatory regime that does not restrict entry to practice, but allows action to be taken against an unregistered health care worker who fails to comply with proper standards of conduct or practice.

The Code would also apply to paramedics if paramedicine is not a registered profession. While the authors support the introduction of a National Code of Conduct for lower risk and lower acuity functions that may be the realm of some other unregistered health workers, they do not support a code-based reactive model of regulation for paramedics.

[28] on.fb.me/1c1pHL9 accessed 26/01/2016

On 20 August 2015 Senator Glenn Lazarus secured the support of the Australian Senate for the matter of national paramedic registration to be referred to the Legal and Constitutional Affairs Committee for inquiry and report by the last sitting day in June 2016 (Appendix A). This paper has been prepared in response to the call for submissions by the Secretariat of the Inquiry.

After much consideration, Health Ministers made a firm decision on the way forward for paramedic regulation at the Health Council meeting of the 6th November 2016. Ministers decided that:

> *"…**Options for national registration of the paramedic profession***
>
> *Health Ministers discussed options for the registration of paramedics and, on a majority vote, the meeting agreed to move towards a national registration of paramedics to be included in the National Registration Accreditation Scheme with only those jurisdictions that wish to register paramedics adopting the necessary amendments. Ministers agreed that work would need to come back to AHMAC for consideration.*
>
> *This would include the consideration of implementation of the recommendations of the NRAS Review, resolution of the scope of the paramedic workforce and the development of vocational as well as tertiary pathways. It was noted that NSW will reserve its right to participate.*
>
> *The Commonwealth dissented from the decisions as it is not consistent with the principles of the NRAS as a national regulatory reform…."*

The Australian Health Ministers Advisory Council has since appointed the Victorian Health Department as the lead agency to progress the matter and it has commenced the necessary work.

Presentation of an additional full case for NRAS registration in this submission appears unnecessary given that the vast majority of papers for the original consultation strongly supported national registration under the NRAS and Ministers have agreed to proceed with that option, with the present exception of NSW. For completeness however, the authors direct the Inquiry to three submissions that are typical of the well documented cases for registration.

These are the submissions prepared by the two professional bodies representing paramedics in Australia – the Australian and New Zealand College of Paramedicine (ANZCP) and PA. The National Council of Ambulance Unions (NCAU) which collectively represents union members nation-wide also submitted a comprehensive submission supporting NRAS registration. All three organisations were well represented at the stakeholder consultation forum sessions along with many other stakeholder groups including ambulance service organisations, private sector employers and community health advocacy groups.

The authors commend the following three submissions to the Inquiry (alpha order):

ANZCP - Australian & New Zealand College of Para medicine bit.ly/1JuJtOR (26/01/2016)

NCAU - National Council of Ambulance Unions bit.ly/1JuNNNP (accessed 26/01/2016)

PA - Paramedics Australasia bit.ly/1uDRwuT (accessed 26/01/2016)

(see also the PA supplementary submission – *Paramedics in the 2011 Census* bit.ly/1PTGbBl)

5. Detailed responses to the Terms of Reference

The issues posed by the Committee under the terms of reference are addressed in greater or lesser detail in the following sections. Citations and cross-references are limited for brevity.

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

5.1 the role and contribution made by those in the paramedic profession, including the circumstances in which they are required to operate

Paramedics are best known for their role working with the major public-funded or contracted ambulance services, where they provide vital out-of-hospital and front line care in responding to urgent and unscheduled health needs. Paramedics also are arguably the most significant group of health professionals whose advanced medical interventions and contributions to health care are commonly forgotten when considering health care policy.[29]

Paramedics are renowned for the level of public trust they hold within the community. Patients readily trust paramedics with their personal information, medical history, current medications (as feasible) and rely on them to provide the best possible care at their time of need. The implied value attributed to paramedic interventions is shown by the nomination of paramedics as the most trusted profession in national Readers' Digest surveys[30] year after year.

Public emergency medical services are generally activated by a telephone call to a triple zero number (other mechanisms may be employed) where the incident is assessed and prioritised in regional call centres. In more densely populated areas the service providers respond with the despatch of one or more qualified paramedics in an ambulance or other mode of transportation (car, bike, helicopter) depending on the situation. These paramedics are tasked under various categories of urgency ranging from Code 1 (emergency –lights and sirens) to Code 4, intended to reflect the nature of the medical need.

Activation of crisis responses in less populated regions may involve the mobilisation of first-aid volunteers with basic first responder training. In other circumstance the Royal Flying Doctor Service also may respond. In more isolated settings such as on a ship, construction site, mine site or gas field, paramedics commonly work alone or provide the lead for an emergency response team.

Paramedics may be called at any time to respond to life-threatening situations or major trauma and disaster incidents which involves working in a stressful and time-critical environment. Paramedics thus may work at any hour of the day or night, under adverse weather conditions, and in situations of high risk exposure from their physical surroundings. Paramedics may need to provide advanced medical care to unconscious injured persons while surrounded by disorientated and/or inebriated, substance affected and combative people.

[29] bit.ly/1Pw343e accessed 26/01/2016

[30] bit.ly/1KvRjCF accessed 26/01/2016

On occasion, paramedics are subjected to inappropriate and abusive language or personal physical assaults. Studies have shown that paramedics suffer greater than normal occupational injuries, often associated with the movement or extrication of patients[31,32] as well as suffering disturbingly high levels[33] of Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD).

There is no national register of practitioners and the number of people working as paramedics in Australia is unknown. An analysis of the 2011 Australian census provides guidance that there were around 12000 people who identified as paramedics or ambulance officers at the time. This represented a gain of 31 percent over the previous 2006 census. With a putative growth rate of 6% annually the number of paramedics is estimated to be currently of the order of 15300.

The annual *Report on Government Services (RoGS)*[34] prepared by the Productivity Commission provides comprehensive information on the equity, effectiveness and efficiency of government funded ambulance services in Australia but excludes military medics and does not include consistent or comprehensive data on private sector services not funded by governments. Paramedic services are not covered by Medicare so that source of data also is not available for comparative study.

Advertised vacancies indicate that there are more than 120 private service providers in Australia. It is thus reasonable to conclude that the RoGS report underestimates the number of paramedics and the contributions they make in protecting the health of Australians.

For more extensive statistics, the authors draw attention to the latest available RoGS report (29 January 2015) Volume D Chapter 9 which contains comprehensive performance reporting for Fire and Ambulance Services. The full Chapter 9 may be accessed here: bit.ly/1Qq7LdX

Table 9A.31 outlines the administrative arrangements for ambulance service organisations and Table 9A.32 shows the major sources of revenue in 2013-14 dollars. The 2016 RoGS report on emergency management is planned for release on Friday 29 January and may form part of a supplementary submission to the Inquiry.

The use of terminology in RoGs referring to ambulance incidents and services is somewhat misleading as it conflates the roles of the paramedic and an ambulance (vehicle or service). It does not adequately recognise that the medical interventions provided by ambulance service organisations are performed by individual paramedics and other expert personnel (e.g. doctors, nurses, dispatchers) both in the field and through the provision of valuable support for communication, transport and other activities.

Just as hospitals and diagnostic services provide the infrastructure to support medical practitioners and nurses, the ambulance services support and supplement the functional health care role of the professional paramedic. The reporting of paramedic services within the emergency section of RoGS also presupposes a category of response (Code 1 - emergency) that represents only a proportion of the overall services (RoGS page 9.42).

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[31] bit.ly/1Nqtn3v accessed 26/01/2016

[32] bit.ly/1OdhJfa accessed 26/01/2016

[33] bit.ly/1ElWc8f accessed 26/01/2016

[34] bit.ly/23kkJiK accessed 26/01/2016

Terminology is important[35] and in many jurisdictions overseas and several private sector entities in Australia, the organisational service entities are renaming themselves to *Paramedic Services* (or similar) to better reflect the broader health care dimensions of their functional activities. [36, 37, 38]

Suffice to say that RoGS notes that ambulance services include preparing for, providing and enhancing: emergency and non-emergency pre-hospital and out-of-hospital patient care and transport; inter-hospital patient transport; specialised rescue services; ambulance services to multi-casualty events; and capacity building for emergencies.

Acknowledging that the performance reporting under RoGS includes only that information from public-funded ambulance service organisations, the authors note that nationally, in 2013-14, there were 3.1 million incidents resulting in 4.2 million service responses to attend to 3.2 million patients (RoGS pp 9.41 et seq). Recurrent expenditure across Australia was about $2.7 billion - making public paramedic services a significant contributor to national expenditure on health-related services.

There is a myriad of funding and payment arrangements. Services may be free for residents of a given jurisdiction or reimbursed under a user-pays principle (depending on the jurisdiction) or recouped in whole or part by insurance. Distinctions are also commonly made between emergency and non-emergency (transport) situations.

The diverse funding and service delivery arrangements for paramedic (aka ambulance) services result in the overall contribution of paramedics to health care not being well captured in public funded financial terms. Typical of their exceptional commitment to community welfare, paramedics are notably more inclined to volunteer[39] than the general populace, with the 2011 census recording 29 per cent of paramedics as volunteers. This compares with a rate of 19 per cent among all employed persons (excluding those who did not state whether they volunteered or not)

Paramedics also tend to work longer hours than the rest of the employed population (2011 Census analysis) with 36 per cent of paramedics working full time working longer than 49 hours per week compared to 26 per cent of the wider population.[40]

One must not forget the significant role played by the private sector in maintaining the health and wellbeing of the community and the addition of private paramedic services would increase the documented contributions of paramedics. These activities include paramedics working on entertainment and event activities, patient transport, on remote area gas fields or mine workforces, on ships, in humanitarian and peace-keeping activities across the world or working with a boatload of asylum seekers. On 2011 census figures there were about 2200 privately practicing paramedics working in these areas. There has been a significant increase in job advertisements in recent years but the authors are unable to quantify the actual number in the absence of relevant datasets.

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[35] on.fb.me/1PC0vXh accessed 26/01/2016

[36] bit.ly/1UhmiYD accessed 26/01/2016

[37] bit.ly/1SagNMe accessed 26/01/2016

[38] bit.ly/1SCJEu5 accessed 26/01/2016

[39] Paramedic Australasia, *Paramedics in the 2011 Census* November 2012 bit.ly/1PTGbBl accessed 26/01/2016

[40] Ibid

In their industrial and occupational health roles, paramedics may be required to undertake a substantial volume of other work apart from emergency response such as health assessments, testing, rehabilitation, staff exercise programs, work health and safety roles and many other areas of primary health care.

The Council of Ambulance Authorities (CAA) has identified that 88 fixed and rotary wing aircraft were available nationally in 2013-14 (RoGS table 9A.40). Air ambulance expenditure statistics vary substantially, with some jurisdictions recording low (or no) expenditure. Typical of the deficiencies in the collection of relevant data in this unregulated area of health care, the statistics do not include the overall human resources engaged. Neither do the expenditure figures represent the total cost of air ambulance services - only that component funded through the ambulance service organisations.

Nationally, RoGS records 15503 full time equivalent paid personnel, 5972 volunteers and 2456 community first responders in 2013-14. (Community first responders are trained volunteers who provide an emergency response and first aid care before the arrival of qualified paramedics.)

Neither RoGS nor the Census is a good indicator of total paramedic numbers in Australia. For example, in 2011 there were over 800 medics in the Australian Defence Force (ADF) who were not well captured by the Census because of coding and other descriptor anomalies but were known to the authors through direct advice from ADF sources.

While RoGS table 9A.35 identifies different categories of ambulance service staff, it does not provide clarity in the number of persons who would meet the normal expectations of a registered paramedic. An approximation would be the total number of *salaried ambulance operatives* who numbered 12686 in 2013-14 and may now be in excess of 13000 (rounded). When a further estimated 2500 paramedics and medics from the private sector, universities and the ADF are added to this total, the number of practitioners in 2015 may exceed 15500 (see earlier 15300 estimate).

Of particular significance is the number of students undertaking undergraduate and postgraduate paramedicine courses at university. The RoGS figures for 2013 (which might not represent all enrolments - see note) show 5871 enrolments with 984 in their final year. Recent CAA analysis indicates there were 6357 students enrolled in 2014 prompting an advisory position statement on student enrolments.[41]

There has been exponential growth in undergraduate student enrolments with paramedicine among the top first preference choices for courses at universities in every jurisdiction. Preliminary enquiries confirm that position still obtains for 2016 with total undergraduate course offers and continuing enrolments potentially exceeding 7000 in Australia alone (not including New Zealand).

This extraordinary growth in numbers presents both an opportunity to help meet Australia's demand for competent health professionals; and a danger that many graduates will find difficulty in employment within traditional public-funded ambulance services within Australia. As a corollary, there has been extensive recruitment of Australian paramedic graduates by the UK Ambulance Service Trusts (notably London Ambulance Service) which highlights the importance of educational programs that are accredited through processes conforming to internationally accepted standards.

[41] bit.ly/1K315RQ accessed 26/01/2016

Another feature of the paramedic workforce is the rapid change in gender balance, with the proportion of female paramedics having grown to 32% by 2011 and continuing to increase rapidly, with many university programs now containing well over 50% female students.

The majority of paramedics in Australia are employees, with state and territory paramedic services the dominant employers (82% of total paramedics in the 2011 census). The private sector has been growing rapidly and continues to recruit actively in all jurisdictions (based on advertised vacancies), but no definitive workforce statistics are available. The private sector is being increasingly viewed as a contracted provider or valuable backup for the emergency services in less acute roles such as non-emergency patient transport.

In countries like the UK where paramedic registration is in place, the private sector makes a substantial contribution through the provision of surge capacity and additional mainstream contracted services because of the recognised competencies and legal status of the registered paramedic practitioners. Australia is yet to realise the benefits from mobilising private paramedics other than for non-emergency patient transport and event support.

In summarising the diverse nature of paramedic contributions to out of hospital health care the authors note the following broad characteristics:

- Paramedic services are notable for having a higher proportional contribution from volunteers (generally qualified first-aiders) than other regular health care service sectors (excluding overtly volunteer support groups, humanitarian and not-for-profit organisations). In Western Australia, volunteers vastly outnumber salaried operative staff (RoGS table 9A.35).
- Private sector providers are contracted to Australian government departments to provide care for their employees whilst on missions overseas - an example being the Australian Federal Police deployment to the Solomon Islands and Border protection activities.
- Fixed wing and helicopter aeromedical services manned by paramedics and other health practitioners are provided by an array of public and private sector organisations - most notably by sponsored community helicopter providers and the Royal Flying Doctor Service.
- There is no nationally accepted regulatory framework for defining the scope of practice and regulation of paramedics. Private sector operators work independently under the constraints of various jurisdictional Acts while each public sector agency establishes the skills and knowledge required of the practitioner and the scope of practice within the relevant jurisdiction. Flow-on effects include the impacts on potential cross-border integration and operational issues.
- There is no nationally recognised and independent framework for community engagement and complaint mechanisms for service providers or for determining the fitness to practice of individual paramedic practitioners (complaints and fitness to practice cases are handled internally by employers leaving open the real possibility of a clinician found unfit to practice in one jurisdiction simply moving and working in another jurisdiction).
- ADF medic personnel have limited links to or comparable education and qualification standards shared with their civilian counterparts. One consequence is the potential loss of defence medics from the health care workforce on retirement from the ADF in the absence of a clear post-military career pathway.

- At an operational level, jurisdictional constraints are reinforced by the Drugs and Poisons Regulations. These vary between jurisdictions and restrict the carriage and administration of certain controlled substances.
- Legislative and operational constraints make it more difficult for paramedics to move and retain their professional standing than for other registered health professionals, thus limiting mobility and potential career development.

5.2 the comparative frameworks that exist to regulate the following professions, including training and qualification requirements and continuing professional development:

- ***paramedics;***
- ***doctors; and***
- ***registered nurses.***

Doctors and registered nurses

Doctors and Registered Nurses have been regulated under the NRAS since its implementation in 2010. In common with other professions the use of a specific title is restricted to registered practitioners. The general regulatory requirements under NRAS are essentially the same and differ only when it comes to the specific standards applicable to the profession which are determined by the individual regulatory Boards. The Medical Board and a Nursing and Midwifery Board separately manage their respective professions.

To become a Registered Nurse or medical practitioner, a candidate must have completed a course of study that has been accredited by the appropriate independent accreditation agency.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for the nursing and midwifery professions while the Australian Medical Council (AMC) is responsible for accrediting education providers and their programs of study for the medical profession. They each rigorously assess education programs submitted to them on behalf of their Boards to ensure the approved standards are met.

It's important to note that the accreditation agency/function is independent of the regulatory Boards. That is, the primary function of ANMAC as an accreditation authority is to ensure that programs leading to registration and endorsement of nurses and midwives in Australia meet the Nursing and Midwifery Board of Australia (NMBA) approved standards for accreditation. ANMAC operates under the legal structure of NRAS and was established as the accrediting authority by the NMBA under the provisions of the National Law. A similar situation obtains for the Medical Board and the AMC.

To gain registration, or to maintain it on an annual basis, several other standards[42]also must be met. These include a criminal history registration standard; English language skills registration standard; recency of practice; continuing professional development; and professional indemnity insurance registration standards, which are specific to the individual National Boards. These standards are openly and transparently available on the AHPRA website for each registered profession and may be accessed here: bit.ly/1P39Mg6.

[42] http://www.ahpra.gov.au/Registration/Registration-Standards.aspx accessed 26/01/2016

For example, among the requirements for continued registration is the maintenance of continuing professional development.[43] Under the relevant standard, a Registered Nurse is required to undertake 20 hours of professional development activity per annum to maintain registration. Records must be kept and these records can be audited as required. Details of the requirements for medical practitioners are available here: bit.ly/1nGQzWr

Under the National Law, all students enrolled in an approved program of study, or who are undertaking clinical training, must be registered as a student with their respective National Board prior to the commencement of their approved program of study or clinical training and will remain registered for the duration of study, or until they are no longer enrolled. The education provider is responsible for ensuring that this registration with AHPRA takes place.

Worldwide regulatory best practice already espouses the transparency principle. Almost all regulators now maintain open Web sites and publish annual reports with information about the regulator, the regulated persons or entities, and the regulatory decisions made in each year. Under NRAS registration this reporting is available for the registered professions of nursing and medicine.[44]

Paramedics

In contrast to doctors and registered nurses where there are clearly defined and transparent standards for registration, there is no national regulatory framework for paramedics. There is no set of prescribed standards for registration and there is currently no national minimum education standard whose completion qualifies a person to describe themselves as a paramedic.

As might be expected from a profession in transition, there is great variability in the qualifications held by paramedics, ranging from the more recent university paramedic education programs, to vocational education and training (VET) programs to short courses with little or no accreditation requirements. One jurisdiction (NSW) has proposed a minimum qualification that is different from (lower than) the minimum qualification level proposed by the other Australian jurisdictions.

There is no nationally consistent restriction on the use of the term paramedic although three states have recently implemented jurisdictional requirements for protection of title. In the case of Tasmania, South Australia and New South Wales these legislative instruments and definitions are not consistent, with only South Australia using the relevant NRAS legislative model for health practitioners. Tasmania and NSW have used an amendment to provider-related legislation, thus creating a unique class of health worker defined essentially by their employment status. These differing treatments create both anomalies and added complexity and costs for practitioners and service providers.

While medicine has clear guidelines for initial professional development through internships, paramedics have no nationally mandated requirements. Some jurisdictional public services such as the South Australian Ambulance Service have robust and structured internship programs to ensure that graduates have a period of supervised practice before being allowed to practice independently. The NSW legislation regulations are silent on practice or internship and competency requirements.

[43] bit.ly/23l9DtH accessed 26/01/2016

[44] https://www.ahpra.gov.au/ accessed 26/01/2016

At this time the authors are unable to comment with any certainty on what competency and skills training or internships are provided within the private sector providers. Anecdotally, in some private sector employment, a new graduate armed with only a few weeks of clinical placement experience may be placed into a remote location unsupervised and expected to manage whatever health emergency eventuates. If true, this would be an unacceptable, inadequate and highly risky introduction to practice as a clinician for a new graduate. The authors firmly believe the minimum requirements and pathways to professional practice need to be formalised on a national basis for all paramedics.

When it comes to continuing professional competence, in the absence of a national regulatory framework, people may hold themselves out to be paramedics with no ongoing competency requirements other than their own initiative and guided by the culture of the organisation(s) they belong to or the requirements of their employer.

Some employers have internal quasi-registration requirements for continuing professional development and other related internal policies to cater for criminal activity and notification of behavioural issues. Other employers including smaller operators in the private sector may not have the capacity to manage these aspects independently.

Major commercial organisations employing contracted providers or individuals also may have no particular insights into healthcare or greater expectations of their paramedics than of any other workers. The authors see mandating membership of a professional body as an ongoing requirement to be ineffective unless that membership includes rigorous, compulsory and auditable compliance requirements for continuing professional competency.

When comparing the functions of professions that may work together such as medicine, paramedicine and nursing, an important issue in evaluating regulatory relationships is the principle of equity. This principle embraces the concept of procedural fairness as well as equalisation of benefits or outcomes.

A fundamental intent of best practice regulation is to ensure individuals are treated with sensitivity and respect. The principles of natural justice and procedural fairness are manifested through the legal requirements for the right to notice and submissions before Committees as well as investigative rigour, procedural and evidential rights. While these rights are protected for nurses and medical practitioners through NRAS registration, no comparable rights apply nationally for paramedics.

Equality of regulatory obligations among health professions is another factor considered to be in the public interest. The legislative objective of equality is achieved through the application of a common regulatory framework for all comparable health professions, despite their differences in scope of practice or their overlapping scopes of practice. That goal is realised by treating all regulated health professions according to the same underlying regulatory principles.

Putting this in other words, it means that in dealing with paramedics, doctors and nurses, equivalent processes and procedure should apply in evaluating performance or complaints, albeit the particular standards applied to each may be different and involve different or overlapping scopes of practice. This commonality of procedural treatment presently only applies to nurses and medical practitioners and is a further powerful reason to bring paramedics under the umbrella of the NRAS.

5.3 the comparative duties of paramedics, doctors and registered nurses

Paramedics are the polymaths of unscheduled medical care, diagnosis, triage, initial patient treatment and transportation. Paramedics exercise a high level of clinical decision making and administer powerful restricted medications including narcotics, and introduce devices into the body that can have adverse outcomes for some patients.

Paramedics are most renowned for their emergency care performed with ambulance services and other emergency retrieval care providers. Paramedics also provide out of hospital care in relatively benign situations across the spectrum of needs within the community.

Australian paramedics most often work in unsupervised situations. They may work in isolation or within a well-structured and rigorous clinical governance environment (whether public or private). They also may be attached to a non clinical workplace with no clinical governance oversight or patient safety infrastructure.

Doctors and Registered Nurses also work in a range of settings and at different levels and scopes of practice and specialty within the public and private sectors. Those that work in acute emergency settings most akin to paramedic practice are only a proportion of the two professions, while the vast bulk of practitioners generally work in well-regulated environments where additional oversight, guidance, diagnostic tools and other complementary resources and medications are readily available.

Doctors and Nurses may be qualified in a wide variety of specialist fields through additional study with several Colleges (for example, the Australasian College of Emergency Medicine https://www.acem.org.au/About-ACEM.aspx). The nearest parallel to a paramedic would be the emergency physician or emergency nurse working in an acute setting in a hospital or for a retrieval service or the Royal Flying Doctor Service. Paramedic practice also incorporates elements of General Practice medical practitioners. Most doctors and nurses (apart from emergency practitioners) work in fixed locations and have scheduled workloads and foreknown patient presentations.

Doctors have the broadest scope of practice and are authorised to prescribe medications, refer patients, undertake the widest array of medical interventions (depending on their specialisation) and are recognised by the health care system and private health care insurers for access to funding arrangements such as Medicare and the Pharmaceutical Benefits Scheme. They also have direct access to a wide range of health care administrative, information and data sharing and collection processes (such as electronic patient records) subject to confidentiality and security requirements.

Nurses similarly have a nationally defined and broad scope of practice and work at a somewhat lower level of intervention than doctors. Their autonomy is restricted and they generally act in accordance with instructions or under advice from medical practitioners. Their powers to administer medications are limited and, in general, they do not have powers of referral and do not (generally) hold provider authority for Medicare access.

A distinguishing feature of paramedic practice is the unheralded nature of patient presentations in an out of facility environment. They must treat one or more patients holding a diverse combination of (often) unknown medical conditions and/or suffering minor or major trauma. Treatment of patients at a single or multiple-vehicle road accident on a country road at night surrounded by several inebriated or substance-affected patients of different ages and nationalities and uncertain medical histories is one example of their highly stressful, time critical and demanding role.

Paramedics must diagnose, triage and treat as needed with advanced procedures, under adverse physical conditions and while maintaining the necessary scene control. In emergency settings, paramedics rarely hold the medical history of their unprepared patients, unlike the well prepared patients and clinical conditions under which most medical practitioners and nurses work.

The Australian Health Minister's Advisory Council 2009 Regulatory Impact Statement highlighted thirteen practice risk factors to inform the extent to which the regulated professions may pose a risk to the public. This included nurses and medical practitioners and (indicatively) paramedics. These factors are shown in the tabulation of Appendix B which is taken from the consultation paper *Options for regulation of paramedics*.

The Australian Health Ministers' Advisory Council Health Workforce Principal Committee (July 2012) found that paramedic practice demonstrated risk exposure higher than ten out of the fourteen already registered health professions.

The authors suggest that extrication of patients from many scenes may involve a highly risky application of patient movement and knowledge of the spine that would engage risk category 2, albeit 'manipulation' as a procedure is not done on a planned basis. It is a consequential risk.

The tabulation of risks also does not acknowledge that paramedics apply hazardous forms of radiation and energy in defibrillation and synchronised cardioversion, and if the skillset of extended care paramedics is included, may involve setting or casting of a fracture or reducing dislocation of a joint. Inclusion of these risk factors would mean that paramedics enliven at least eleven of the thirteen risk factors, a nominal risk exposure level exceeded only by medical practitioners.

Discussions about health care are often bedevilled by a clinical and interventionist philosophy without due recognition of the holistic nature of health care. Many procedures and treatments may be diagnostic and preventive in their application but have significant impact on long term patient health without involving invasive procedures or direct clinical interventions.

Whilst acknowledging the matrix of risks within the consultation paper, one should reject the proposition that a health profession must satisfy a number of *invasive* procedures to define the risk of harm and to warrant registration. Paramedics regularly must deal with patients suffering mental issues and sedation is only one of the options to be considered. The risks associated with autonomous decisions or the exercise of professional judgement may be ample to meet a threshold level that justifies proactive registration rather than reactive regulation.

Risk is also relative and situational. For example, intubation of a trauma victim in the field by a paramedic operating under adverse physical conditions is demonstrably higher risk than a similar procedure (intubation) carried out by a registered medical practitioner under controlled clinical conditions in a hospital. Both procedures are clinically significant, but one carries substantially higher risk and requires a high order of judgement and skill in execution.

Given that regulation applies to the practitioner and not to the procedure, the authors suggest that the hierarchy of justification for regulation also should be related to the need to exercise judgement in a clinical context.

It is instructive to note that the policy position of the College of Emergency Nursing Australasia on mechanical ventilation of patients in emergency care[45] recognises the high level competencies of paramedics and recommends:

> *3.1 Care of the mechanically ventilated patient must take place in a safe environment, and as such, be equipped with appropriate resources and equipment to ensure patient safety. This includes the presence of appropriate staff competent in the skill of tracheal intubation (e.g. medical practitioner, **paramedic** or nurse with training and current accreditation in invasive/difficult airway management). [authors' emphasis]*

In addition to emergency responses, paramedics have the capacity to provide patient care in low acuity or highly complex co-morbidity patient cohorts. By addressing some conditions at home, and referring patients to other pathways of care such as social services, general practitioners and community care providers, paramedic care can reduce the load on hospital emergency departments and conserve both emergency and general health care resources.

While the benefits of extended paramedic care have been demonstrated to be clinically effective, most such *'community paramedic'* and *'extended care'* programs in Australia to date have been pilot studies and not part of national health care funding arrangements. More general use of these highly effective models of care also has been limited because of the absence of a strong regulatory framework facilitating independent practice.

Across the spectrum of care, paramedics also work in advanced programs involving early triage and treatment that only a few years ago were the province of hospital emergency departments (i.e. carry out thrombolysis then bypass to cardiac catheter lab or bypass hospitals to take patients directly to trauma centres).

These rapid advances in paramedic care have come from several sources of evidence-based research and technological advances, with the use of on-site diagnostic and monitoring tools such as 12-lead ECG and mobile ultrasound now becoming common.

In the words of Sir Bruce Keogh, NHS England Medical Director:

> *"Paramedics today … deliver treatments that would only have been done by doctors ten years ago …"*
>
> *Transforming urgent and emergency care services in England – November 2013*

[45] bit.ly/1ZPfnYd accessed 26/01/2016

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

In responding to this question the authors wish to draw a distinction between the process of registration of a health practitioner and the accreditation function that is normally associated with regulation and is (typically) an assessment of the capacity of an educational institution and course program to prepare graduates for practice. Successful completion of 'accredited' courses normally forms one element in the suite of standards or requirements adopted by a regulatory authority for practitioner 'registration'.

Accreditation may also apply to other aspects of service delivery and commonly forms part of an organisational quality management and assurance regime that confirms the capacity of the organisation to undertake functions for which they are 'accredited'. Accreditation thus might apply to the assessment of paramedic (aka ambulance) services as part of a licensing scheme or oversight program such as that performed by the UK Care Quality Commission (CQC). Australian paramedic services are not independently accredited and this lack of independent oversight is a matter of some concern to the authors(see later).

The registration of paramedics

Dealing first with overall regulation, the UK Ministry of Health[46] highlights the following key principles that should underpin statutory professional regulation, viz:

> *"First, its overriding interest should be the safety and quality of the care that patients receive from health professionals.*
>
> *Second, professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of Government, the professionals themselves, employers, educators and all the other interest groups involved in health care.*
>
> *Third, professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour.*
>
> *Fourth, professional regulation should not create unnecessary burdens, but be proportionate to the risk it addresses and the benefit it brings.*
>
> *Finally, we need a system that ensures the strength and integrity of health professionals within the United Kingdom, but is sufficiently flexible to work effectively for the different health needs and healthcare approaches within and out with the NHS in England, Scotland, Wales and Northern Ireland and to adapt to future changes..."*

[46] Secretary of State for Health, *Trust, Assurance and Safety –The Regulation of Health Professionals in the 21st Century*, HMSO, London, February 2007

The authors agree with these principles as being suitable for the regulation of paramedics. They further suggest that any regulatory scheme for paramedics should incorporate:

Effectiveness – the regulatory system should be effective in protecting the public from harm and fostering the provision of high quality health care;

Accountability – registration processes should provide accountability to the community for their decisions and operations;

Transparency – the decision making processes should be open, clear and understandable both to consumers and to practitioners;

Fairness – regulatory/registration boards should maintain an acceptable balance between protection of patients/consumers rights and interests, and those of the regulated health professions;

Efficiency – the resources expended and the administrative burden imposed by the regulatory system should be commensurate with the level of risk regardless of where in the system these costs are incurred;

Consistency - there should be consistency across different jurisdictions in the regulatory arrangements for the health professions (for example, between closely related sovereign states like New Zealand and Australia and their internal legal structures); and

Flexibility – the regulatory system should be able to respond to emerging issues in a timely manner as the health care system evolves and the roles and functions of health professionals change (for example, emerging health professions).

These principles align with the national approach taken by governments in adopting the IGA which sought to:

> *"provide protection of the public, facilitating workforce mobility, minimizing administrative burdens, facilitating high quality education and training, responsive assessment of overseas practitioners, access to services, developing a flexible, responsive and sustainable workforce, and enable innovation in the education of, and in the delivery of service".*

They also highlight the inappropriate nature of the present regulatory arrangements for paramedics which are fragmented and jurisdictionally based; employer focussed and parochial; lack transparency; vary in content, and do not facilitate mobility.

There can be no doubt that the NRAS has been a pivotal advance in health regulation despite some teething problems involved with the mammoth task of moving hundreds of thousands of practitioner into a new system in a short space of time (Section 3 - NRAS). As such, it provides an object lesson in how health regulation should be managed under best practice regulatory conditions and is considered to be the appropriate vehicle for paramedic regulation.

Nearly all occupations have the capacity to cause some harm but intervention may be reasonably limited to cases where the harm has the potential to be meaningful. Significant harm is defined as noteworthy harm to one person or moderate harm to a large number. Moderate harm to a large number might arise from one event, or from the aggregated actions of different providers of a service. Significant harm that is irreversible (such as permanent disability) is more likely to justify intervention than reversible harm.

The case for involvement in regulating an occupation is thus subject to a degree of interpretation by policy makers. Concepts such as *"significant harm"* cannot be defined with precision and may mean different things under different circumstances.

In assessing the overall level of risk in paramedic practice, the authors note that the clinical activities of currently unregistered paramedics nay vary across a wide spectrum (section 5.3). Like in many medical practices, the work varies from low to high risk where the interventions, based on clinical indications, clearly pose a serious risk of harm to the health and safety of the patient.

An example is a time critical decision about the immediate administration of restricted, powerful and potentially dangerous drugs. The responsibility for the administration of these drugs in an emergency situation may well rest solely with the paramedic in the field. Paramedic practice also comprises a range of physically invasive procedures that involve varying degrees of risk to the patient. The highest risk procedures such as sedation, paralysis, endotracheal intubation and artificial ventilation are known to have potentially fatal consequences if the paramedic's clinical judgment is in error or through poor execution of the procedure.

However, like medical practitioners, there is a great deal of patient care involving lower levels of risk. Paramedic practice thus has a combination of many lower or moderate risk activities and a irregular but substantial number of high risk activities.

The important outcome of this assessment is that these risks in normal practice situations cumulatively give rise to what the authors assess objectively as representing *'significant risk'* to the public that exceeds the threshold warranting formal statutory regulation.

Given that robust regulation is indicated for paramedic practice, the question then becomes one of how that should be implemented. One immediately looks at the NRAS which was established for the very purpose of providing appropriate national regulation of health professionals; its operations have been reviewed and found effective, and it conforms to best practice regulation principles.

The inescapable conclusion is that registration under the NRAS model is the most appropriate vehicle for paramedic regulation.

The accreditation of paramedic education

Despite wide-ranging educational developments, until recently there has not been any nationally recognised external course accreditation system for paramedic education. As noted previously, educational accreditation (as distinct from registration) is normally defined as a formal assessment process conducted by an independent and recognised authority to confirm that courses meet quality assurance requirements and are responsive to the needs of the community.

There is no doubt that with some 7000 or more students undertaking university courses in paramedicine across many campuses in Australia, a robust process of accreditation is needed to ensure consistent and acceptable course standards that will provide a level of confidence that graduates are competent to practice safely and effectively as beginning level professionals.

It would be unthinkable that the enormous investment in educational facilities, human resources, course development and the expenditure of hundreds of millions of dollars by students would not warrant appropriate accreditation of the course programs to ensure graduates were equipped with an appropriate education.

It is important that Australian accreditation processes meet international best practice standards. The accreditation process needs to be rigorous, transparent and fair, with assessment against tools developed for the purpose and made available to the educational body being assessed. The World Health Organisation/World Federation of Medical Education Guidelines for Accreditation of Basic Medical Education (2005)[47] suggest the following (p 4):

> *"The accreditation system must operate within a legal framework. The system must be pursuant to either a governmental law or decree; the statutory instrument will most probably be rules and regulations approved by government. The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession"*

In the absence of a national regulatory framework, the Council of Ambulance Authorities (CAA) administers a program[48] intended to deliver an accreditation system that will provide a set of standards and mechanisms for credentialing educational programs seen to be compatible with the CAA member ambulance services. The CAA is a peak body representing the major statutory employers, government-contracted service providers and other agencies within Oceania.[49]

The details of the accreditation arrangements are available on the CAA website.[50] Associate Professor Brightwell and Prof. Maguire have both served for some years as members of the CAA Paramedic Education Accreditation Committee which reviews and accredits entry-level university degree courses for paramedics.

Under the CAA-administered guidelines, paramedic education must meet benchmarks for appropriate curriculum content, satisfactory training facilities, funding and human resources, set by the *Ambulance Education Committee*[51] (a misnomer).

Educational accreditation is a critically important component of an effective regulatory regime and best practice would direct that accreditation be undertaken as an independent function from that of standards-setting or employment criteria.

The authors acknowledge the legitimate interests of the limited number of major employers who are presently members of CAA, but view the current structure of the CAA accreditation arrangements as carrying unacceptable conflicts of interest and moral risk. [52] The current arrangements do not adequately cater for public (external) engagement and involvement of practitioners at large, as well as the ADF and private employer groups who have a legitimate interest in the provision of appropriate paramedic educational programs. Nor do the current arrangements include a nationally recognised final assessment despite the internationally recognised importance of such assessments.

We also note the disconcerting and unacceptable situation that at least one member agency of CAA has declined to recognise graduates from a CAA-accredited university program(s).

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[47] bit.ly/1ntwZNz accessed 26/01/2016

[48] http://www.caa.net.au/paramedic-education/accreditation-resources-for-universities accessed 22/1/2016

[49] http://caa.net.au/about-us accessed 26/01/2016

[50] bit.ly/1PIngct accessed 26/01/2016

[51] The Ambulance Education Committee is a Standing Committee of the CAA

[52] Moral Hazard - The risk that a party to a transaction has not entered into the contract in good faith

If a service provider does not recognise the validity of accreditation from a system in which it has been instrumental in developing, it calls into question the credibility of both the accreditation process and the provider motivation (see above re moral risk or hazard).

Membership of accreditation panels should not over-represent the interests of the profession or employers. This is important in order to maintain independence of accreditation functions and to ensure that such bodies maintain their accountability to the public. At the same time, professional involvement in the accreditation function is important to ensure that the decisions are well informed.

In contrast with the internalised CAA-administered arrangements and contrary to common belief, AHPRA is not the accrediting entity but the umbrella organisation facilitating regulation. The NRAS has a well-defined legal model for accreditation by an independent entity that conforms to best practice and provides independent support for the registration process.

The authors support this arms' length and independent model as the most appropriate long term approach for accreditation, albeit it may require progressive steps in the transfer of current responsibilities for accreditation of paramedic programs to an independent entity that would build on the valuable work done on paramedic course accreditation to date. Any accreditation process would need to develop firm linkages and operating protocols with the existing accreditation process to ensure consistency and continuity in administration (which might include assessment and recognition of overseas qualifications and experience).

Registration of paramedics under NRAS would bring the benefits of a national approach to regulation that minimises the wasteful duplication of functions that would be present under other forms of regulation or independent and piecemeal jurisdictional regulation. From practical, economic and human resource viewpoints a single, uniform and independent accreditation process is required for paramedic education.

National registration of paramedics under the NRAS framework is therefore the system of choice for regulation of paramedics through its combined registration and independent accreditation functions and is highly recommended by the authors.

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

Inclusion of paramedic within the NRAS would be relatively simple and follow established legislative processes with the benefit of the administrative and other precedents set by the four recently added professions. The National Law would need amendment in each jurisdiction to include paramedics as a regulated profession, similar in many ways to the limited actions already taken in South Australia to protect the title of paramedic. Some variations may be needed to accommodate the changes in NRAS arising from the Independent Review of NRAS.

Consequential steps in implementation include the appointment of a Paramedic Board following a call for nominations, the selection and appointment of subsidiary working committees, the development and confirmation of appropriate Standards and grandparenting arrangements and establishment of the Register of Paramedics with an open call for registration by practitioners.

While there are many detailed steps in implementation they are all feasible, informed by precedent and would have the benefit of the support available from AHPRA.

Particular note is made of the scale of operations and size of the registered paramedic cohort (unknown but potentially more than 17000 within the next five years) and the likely workload associated with the management and administration of the register while also dealing with professional issues and complaints.

Although the current perceived level of complaints is low, the authors attribute this to several causes including the lack of transparency associated with many service providers. Past custom has seen the in-house treatment of fitness to practice issues and complaints with confidential settlements reached by service providers and limited reporting except for highly visible public and sentinel events. There is no mandated reporting from the private sector, so the scale and size of the additional regulatory workload from that source is unknown.

The size of the registered cohort from the private sector is also uncertain as the number wishing to practice as registered paramedics may be considerably fewer under a registered regime. Instead of registration, they may choose to work as emergency medical technicians, associates or other category of unregistered health worker. Those with dual qualifications such as nursing may prefer to keep their nursing registration rather than hold registration across two professions.

Registration is likely to shine a new light on these and other related performance matters as well as create a demand for specific expertise related to paramedic practice and the complex interaction between service providers and practitioners in the handling of complaints.

The blended practitioner/provider relationship in much paramedic service delivery creates unique and symbiotic care realities and perceptions that need to be preserved and nurtured through meaningful professional input to the regulatory process.

Because of these factors, the authors believe that paramedicine stands apart from other ‘low demand’ and much smaller professions and that a single stand alone Paramedic Board should be appointed, with administrative, publication, back-office and other activities shared as feasible within AHPRA to minimise operational costs

The Paramedic Board would have powers to set standards for registration according to the needs of the profession and within the policy guidelines and precedents of the AHPRA regulatory model. These powers should be equivalent in effect to those already held by other Boards like medicine that provide protection to the public, including criminal history checking, and monitoring of impaired registrants or those whose performance or conduct was unsatisfactory.

The number of registered paramedics should provide for sustainability both in terms of mobilising human resources to perform the accreditation and other regulatory functions and in financial terms through the generation of operating income. Excluding application and other fees, if one assumes a (hypothetical) yearly registration fee of $250 and a registered cohort of 15000 practitioners, then the annual income of $3.75M should be sufficient sustain a viable operation.

All professions would benefit from measures that ensured optimum regulatory performance, and while the authors propose a stand-alone Paramedic Board they also support the sharing of common regulatory functions across all boards to the extent feasible. Examples of this might be various forensic activities, legal advisory functions, financial and publication/communication operations.

Regardless of the 'front-end' operations of all Boards, AHPRA should explore common back-office operations and cost sharing across all Boards to the extent feasible.

Paramedics are becoming increasingly mobile with many organisations now recruiting nationally and internationally. In the 2011 Australian census 6 percent of paramedics indicated they had relocated interstate to their current location within the last five years. 29 percent of the Australian Capital Territory paramedic respondents had relocated to the ACT from another jurisdiction within the last 5 years. Likewise 27 percent of paramedics in the Northern Territory and 19 percent in Tasmania had moved from interstate to that jurisdiction in the last 5 years.

In addition to those permanent relocation statistics, ADF medics and private sector paramedics regularly work in different jurisdictions in any given year (or month as the need arises) and fly-in fly-out paramedics are known to be commonplace. Graduates in recent years have been increasingly moving interstate or overseas to find employment, which shows the need for nationally accredited course programs.

The attributes of paramedic practice make flexibility and mobility important factors in regulation and underpin some of the frustrations expressed by paramedics at the current restrictions that limit their contribution to health care. National registration is likely to see increased movements within the profession as the current significant barriers to relocation are reduced.

One of the primary objectives of the IGA and the NRAS was the facilitation of workforce mobility by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practice in more than one participating jurisdiction. This objective of the National Law is also consistent with The *Mutual Recognition Act 1992*, Australia's Mutual Recognition Agreement (MRA) and the Trans-Tasman Mutual Recognition Arrangement (TTMRA) which all aim to reduce the burden of jurisdictional navigation for workers, and to improve the overall safety of the public through a transparent register of approved providers.

Inclusion of all paramedics in the NRAS would provide a consolidated list of those authorised to practice within the participating jurisdictions. The register thus is an essential tool in the unrestricted movement of paramedics across jurisdictions that is accessible to the public and employers alike.

The present (partial) arrangements for protection of title legislation only address the use of the title, and do not address behavioural and education standards or other cross jurisdictional matters. This adds significant complexity as some paramedics would be recognised within a jurisdiction, and others not, and those who work across borders would have an increased administrative and compliance load. This creates barriers to seamless and unrestricted movement, and adds further regulatory burdens on both employers and practitioners.

In the event that one jurisdiction remains outside a quasi-national system formed by other jurisdictions within the NRAS and AHPRA framework, the result still will be to lessen the burden on paramedics and providers working in the participating jurisdictions. There will be no better protection of the public but the overall administrative, regulation and compliance loads will be increased for governments, providers and practitioners, together with other disadvantages.

The authors opine that the optimum solution to minimise the overall regulatory load is to have all paramedics registered under the NRAS which fulfils all the requirements for public safety, achieves economies of scale and conveys the additional benefits of seamless practitioner mobility.

5.6 any other related matters.

Some of the benefits of national paramedic registration under the NRAS have been outlined in the preceding sections including a number of issues that go beyond the basic patient safety imperatives. These benefits are real issues likely to affect the quality of health care and the overall development of the paramedic profession and the ultimate health and well being of the community. While not the primary purpose of registration these outcomes of registration form additional related benefits that are in the public interest.

5.6.1 Stakeholder support

The authors draw attention to the exceptional level of support for registration from knowledgeable professional and community stakeholders in every jurisdiction. They have rarely seen such unanimity in seeking the adoption of regulatory reform in a public policy sense. In any political context it would be seen as a mandate for action by every government of every political persuasion.

Governments should be mindful that few major regulatory changes ever reach such levels of support and that the time for paramedic registration has come, both in the eyes of stakeholders and public and objectively in the public interest.

5.6.2 Less obvious additional benefits

In his examination of service providers in several jurisdictions Prof. Bange has found that the absence of independent regulation of paramedics is a significant factor cited in the incidence of bullying and harassment and subsequent practitioner impairment through poor morale and other undesirable outcomes such as PTSD (and potentially paramedic suicide).

Repeatedly one sees inquiries that explore the poor culture within paramedic (aka ambulance) services that exhibit these common cultural threads. Such outcomes diminish the quality of patient care and place a dreadful toll on individuals, families and the community.

The authors note that currently there is widespread concern directed, particularly but not exclusively, at poor management practices within the NSW ambulance service that appear to be replicated in other jurisdictions. They also note that the NSW service was the subject of a Parliamentary Inquiry into its management and operations which disclosed widespread claims of discrimination, bullying and harassment. Several ambulance services have been subject to similar inquiries in recent years and currently in the ACT and WA.

Among the mechanisms claimed to have been employed have been threats to the right to practice and biased fitness to practice evaluations. These issues are directly related to an individual's self worth, capacity to practice as a paramedic and in the absence of national registration, are serious threats to their livelihood and wellbeing. Within the present system a paramedic can only claim the title as a job description during employment and there is significant psychological trauma when the title is lost on retirement or resignation.

Independent registration of paramedics with its clear procedures and objective processes has the potential to create a healthier, safer and more productive working environment (Section 4 - p 13). The climate of empowerment and added accountability through registration will be a bonus from improved morale and productivity on top of the benefits of registration in protecting the community.

Due to the absence of a formal national regulatory system, there is a paucity of information on the risks associated with the delivery of paramedic services.[53] For example, the authors know from other jurisdictions that:

- in one study of fatal ambulance crashes, 68% of the fatalities were patients, family members and community members; [54]
- Nine percent of paramedics in one U.S. study reported making a medication error within the previous 12 months[55] – if that rate is replicated in Australia there may be over 1,400 medication errors per year.

Australian studies have found that:

- There is no occupational group in Australia that has a higher injury or fatality rate than paramedics; the injury rate for Australian paramedics is twice as high as the rate for Australian police officers;[56]and,
- 10% of paramedics reported they were "dangerously sleepy".[57]

Registration of paramedics will be the first step in developing a far better knowledge of the paramedic workforce and its contributions to the community through improved data collection. It will open up new avenues of research into practitioner performance and determinants of wellbeing. When combined with compulsory and transparent provider accreditation and licensing the outcomes should inform new evidence-based approaches to best practice.

National registration of paramedics could facilitate a greater utilisation of the paramedic workforce in geographical areas which are under-resourced for traditional health care providers (doctors and nurses). Research and pilot studies in Australia and internationally have shown that planned paramedic care undertaken through *'community paramedic'* or *'mobile integrated healthcare'* programs can realise substantial health and economic benefits with improved outcomes, fewer unnecessary patient transports, lower hospital caseloads and higher patient satisfaction.

National registration of paramedics along with other innovations like access to relevant funding models such as the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, hold the promise of providing sustainable community paramedic care delivery models.

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[53] Maguire B.J. Australian Safety and Quality Goals. *Letter to the Australian Commission on Safety and Quality in Health Care.* 2012. Available at: http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/National-Goals-consultation-Submission-19-Brian-Maguire-Charles-Sturt-University-20-Jan-2012.pdf Accessed 26/01/2016

[54] Maguire BJ, Hunting KL, Smith GS, Levick NR. *Occupational Fatalities in EMS: A Hidden Crisis*. Annals of Emergency Medicine. 2002; 40(6): 625-632.

[55] Vilke GM, Tornabene SV, Stepanski B, Shipp HE, Ray LU, Metz MA, Vroman D, Anderson M, Murrin PA, Davis DP, Harley J. *Paramedic self-reported medication errors*. Prehosp Emerg Care. 2006; 10(4): 457-62.

[56] Maguire BJ, O'Meara P, Brightwell R, O'Neill BJ, FitzGerald G. *Occupational Injuries and Fatalities among Paramedics in Australia.* Medical Journal of Australia. 2014; 200(8): 477-80. [2.85]. Full text available at: https://www.mja.com.au/journal/2014/200/8/occupational-injury-risk-among-australian-paramedics-analysis-national-data

[57] Sofianopoulos S, Williams B, Archer F, Thompson B. *The exploration of physical fatigue, sleep and depression in paramedics: a pilot study*. Journal of Emergency Primary Health Care. 2011; 9(1).

5.6.3 Accreditation of educational programs

Accreditation of educational programs and training courses is usually done by panels constituted for that purpose. The Panels assess the application and all information forwarded by the education and training provider against specific assessment tools and carry out a visitation and consultation program with the institution, staff, students and graduates. They then draft a report for consideration of the decision-making body or committee. The constitution and expertise of assessment panels is important in ensuring that the process is objective and fair with institutions having the right to challenge the membership if necessary.

Like the appointment of members of the Paramedic Board, there is an expectation of an open and transparent appointment process for panellists and that each panel will include peer representation, education and training expertise and people who are not members of the profession.

If NSW remains outside of a NRAS regulatory framework the question of its place in setting standards through any Paramedic Board and engagement with the formal accreditation entity must be considered. If it is not part of the system then it hardly qualifies as a full participating member of the regulatory process and should be treated on a similar basis to other external jurisdictions, or at best, on an equivalent basis to New Zealand.

Given the significant resources involved in preparing for and in conducting accreditation it would be duplication and a waste of resources for the NSW government to conduct independent accreditation of university courses. There are also strong grounds for universities not to seek accreditation for separate NSW regulatory purposes especially when they already have to meet the costly and time consuming NRAS accreditation requirements.

5.6.4 Overseas trained paramedics

The effectiveness of any regulatory system needs to be evaluated in relation to its assessment and supervision of overseas trained practitioners or those transitioning to practice from other major systems such as medics from the ADF. There is no current national arrangement or common point of entry for these paramedics. A candidate must apply to their provider(s) of choice separately and each employer must assess and evaluate the qualifications and competency of applicants independently.

This is inefficient and costly duplication of functions as well as time consuming and likely to result in inconsistent evaluations. Not only is it a frustrating experience for any candidate, it also creates added risk through the potential application of inconsistent standards that may allow entry to practice in one jurisdiction that is then perpetuated as the individual moves to other jurisdictions.

The contrast with medical practitioners is stark. Doctors whose primary medical qualifications were obtained in a country other than Australia or New Zealand are known as international medical graduates. If they wish to practice in Australia they must have their overseas medical qualifications verified by the Australian Medical Council (AMC) prior to applying to register to practice medicine. All doctors practising medicine within Australia including those within the ADF must be registered with the Medical Board of Australia.[58]

[58] http://www.amc.org.au/ accessed 4/1/2016

Similarly, the Australian Nursing and Midwifery Accreditation Council (ANMAC)[59] assesses the skills of nurses and midwives seeking to migrate to Australia. ANMAC is the independent assessing authority authorised by law to conduct these assessments by the Department of Immigration and Border Protection. The consolidated ANMAC Revised Standards for Assessment of Nurses and Midwives for Migration Purposes (June 2013) support this role and describe the process of assessment of the educational qualifications and work experience of internationally educated nurses and midwives. Registration of nurses or midwives is then the responsibility of the Nursing and Midwifery Board of Australia.[60] Once again there is a clear pathway to assessment and recognition.

Unlike the present situation of separate and disparate employer assessment, the registration of paramedics under the NRAS model should enable a single pathway of assessment that will ensure timely and consistent evaluation of overseas trained paramedics.

If a jurisdiction remains outside an otherwise national scheme of paramedic regulation (such as the NRAS model) it is only appropriate that the health practitioners recognised under that regime be treated in the same way as for other practitioners educated and trained in any jurisdictions external to the Commonwealth of Australia.

In that respect NSW paramedics who wish to become registered across other Australian jurisdictions (under a NRAS model) will need to be considered as externally or overseas qualified candidates thereby breaching the objectives of the IGA to facilitate the mobility of health practitioners.

This is not a trivial matter and strikes at the heart of Australia's mutual recognition principles across all areas and not just the treatment of paramedic regulation.

One of the more important regulatory agreements is the Trans-Tasman Mutual Recognition Arrangement (TTMRA) which came into force on 1 May 1998. The TTMRA is a non-treaty agreement between the Australian Government, State and Territory Governments and the Government of New Zealand.

It says (inter alia):
"... a person registered to practice an occupation in Australia is entitled to practice an equivalent occupation in New Zealand, and vice versa, without the need for further testing or examination."

Only a mandatory national regulatory scheme would have the scope to realise the desired aims of mutual recognition and reciprocity within Australia and facilitate the recognition of international qualifications and experience. National registration of paramedics would bring Australia into line with many other countries, including the United Kingdom, Ireland, South Africa, most of the United States and Canada and in due course, one expects New Zealand.[61]

[59] bit.ly/1Jnzs62 accessed 4/1/2016

[60] http://www.nursingmidwiferyboard.gov.au/ accessed 12/1/2016

[61] http://www.ambulancenz.co.nz/104/latest-news-on-registration/ accessed

5.6.5 International practice

In today's world, reciprocity of professional practice goes well beyond local jurisdictions into the international arena, and parochialism will ultimately be to the disadvantage of Australia's health care system, providers and practitioners. That in turn will adversely impact the public and governments.

Paramedics who may wish to travel overseas and who seek recognition of their qualifications and experience to further their education or career or participate in disaster relief or humanitarian activities are disadvantaged by the current absence of a national registration system.

The authors are aware that one major public-funded service provider has on occasion refused to provide details of a former paramedic employee's credentials as a paramedic, arguing that having left the service, the individual was no longer a paramedic. This apparently unconscionable conduct highlights the absence of independent accreditation standards for service providers and is one manifestation of the adverse impact of not having a national system of paramedic regulation.

Australian service providers already have an enviable reputation for the deployment of paramedics overseas and have won export awards for their entrepreneurship and contribution to the export of services.[62] However, they also are disadvantaged in the international marketplace by the absence of national registration through the additional costs and difficulties in recruitment and an inability to reference a national regulatory system when bidding for contracts.

This situation is exemplified by a recent communication from a noted professional who opined:

> *" ... I just keep thinking back to when I was running a medical company in the Middle East and Afghanistan and had to recruit paramedics and other health workers from around the world. Without any international standard I had to pretty much only recruit Americans for paramedics and was left stranded when it came to other health workers. I couldn't even find a private group that had taken the lead in providing some kind of international certification scheme to take the guess work out of the hiring process...."*

The authors are deeply practical persons as well as being committed to public safety. They believe these situations (two examples of many) send strong messages that properly question why any jurisdiction would not support a national system of registration that achieves both the health and safety objectives of regulation as well as national economic benefits.

5.6.6 Grandparenting

A transitional process for registration is almost universally applied when introducing statutory (compulsory) registration or significant change to regulatory requirements. The process by which existing practitioners can apply for registration is called 'grandparenting'. The transition period and procedures for grandparenting ensure that current practitioners are not disadvantaged by the introduction of registration which may bring new or changed qualifications.

Grand-parenting is a well-accepted principle that has been applied to many professions including nursing. It allows individuals who have been practising at a relevant level during the preceding period (commonly 5 years) to apply for and be granted registration. It facilitates change in an emerging profession and would be appropriate to apply in the registration of paramedics.

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[62] http://www.aspenmedical.com.au/our-awards accessed 22/1/2016

The grandparenting period will normally be limited. After this period only those who hold an approved qualification(s) and other requirements approved by the regulatory authority (e.g. Paramedic Board) will be eligible to apply for registration.

Grandparenting provisions are embedded within the NRAS and can be found in s303 of the National Law - for example, in Queensland see http://bit.ly/1Fk7lMQ or in NSW http://bit.ly/1eBE8GU

There are procedures to follow along with required documentation, and in some cases there may be other provisions set by a Board. Normally at the end of the specified grandparenting period the transitional flexibility for registration no longer applies and the only route to registration is via the standard requirements then in force - such as completion of an approved course and compliance with other registration standards.

Several issues may arise if NSW remains outside of NRAS registration of paramedics. For example, under normal grandparenting arrangements requiring a period of prior practice, those newer personnel working within NSW and calling themselves paramedics under NSW law will not be eligible for recognition in the other jurisdictions unless they also meet the educational qualifications and other requirements for registration set by the NRAS Paramedic Board.

One outcome of that is to restrict practitioner mobility. Another potential consequence is that for long term registration eligibility, NSW personnel with a diploma level education need to follow that with an accredited degree, if a degree is set as the (otherwise) national standard for a paramedic.

Cross-border implications for practitioners and employers also loom large, with the result being greater complexity, increased costs and additional administrative overheads for everyone.

5.6.7 The anomalous situation of New South Wales

A regulatory scheme should provide as much consistency across jurisdictions as possible and this is embodied in the IGA and the NRAS. However under the federal system of government the different jurisdictions have the power to make different laws. This has often proved an impediment to change and carries economic costs unless there is uniformity.

In a sign of widespread support for national registration, the authors have received a communication from the Hon. Sussan Ley, the Federal Minister for Health that says, inter alia:

> *"... I can confirm that following consideration at the Health Ministers' meeting on 6 November 2015, agreement was reached to move towards registration of paramedics under the NRAS, with NSW reserving the right to participate..."*

Information recently received from the NSW government indicates that it believes it has adequate arrangements in place to protect the public. The NSW advice also notes that careful consideration is required as to whether any additional regulation through inclusion in the NRAS is necessary. How that view of public protection translates into the national policy scene is not stated.

That parochial response neglects to mention that paramedic registration under the NRAS need not involve additional regulation but rather, *more appropriate* regulation that is aligned with general legislative principles of relevancy. Paradoxically, it would replace bolt-on amendments to the Health Services Act in NSW with relatively minor changes to existing health practitioner legislation.

Adoption of the NRAS model would align with practitioner rather than service regulation and conform to the IGA principles that support a national regulatory regime, and which other governments already have committed to support as the regulatory model for paramedics. It would be consistent with the regulation of 14 other health professions, many of which carry less exposure to practice risk under recognised AHMAC risk criteria.

On 18 December 2015 the NSW Government gazetted the Commencement Proclamation Notice and the Regulation for the prescribed qualifications of a (NSW) paramedic under the recent Health Services Amendment (Paramedics) Act http://bit.ly/1Ocaecz. While the NSW government clearly recognises the risks involved in paramedic practice and the need for robust regulation to protect the public, it appears prepared to disregard the principles enshrined in the IGA through the exercise of its jurisdictional authority.

As outlined in Section 2.4 (p 9) the issue of *appropriate regulation that is also fit for purpose* does not end with patient safety. While protection of title is important, it is not the only policy issue in question when it comes to long term mechanism(s) for professional regulation affecting a nationally and internationally active profession whose members regularly work across borders. For example, treating practitioners in NSW differently through the provision of unique pathways of exemption not available elsewhere is contrary to best practice regulation and indefensible.

For example, the *Health Services Amendment (Paramedic Qualifications) Regulation 2015 [NSW]* defines a paramedic as a person who holds qualifications, or has received training, or who has experience, or who is authorised in another jurisdiction, or a member of staff of NSW Ambulance, or any other person who is authorised by the Health Secretary to hold themselves out to be a paramedic. The regulation prescribes the qualification to be a Bachelors Degree or Diploma in paramedicine as the base line qualification, but on the basis of how the legislation is framed this qualification requirement may or may not be exercised given the over-riding power of the Health Secretary.

It's thus not surprising that independent observers, community members, practitioners, providers, and policy experts in health, law and economics have found the current NSW reticence to embrace national registration to be inexplicable and acceptable only on the basis that it is an interim measure to provide public protection ahead of the implementation of registration under a national NRAS model.

The (hopefully temporary) NSW legislation and regulation overlooks the impact on the overall provision of care by practitioners and private providers – some of whom are bigger and have more extensive operations nationally (and in NSW) than the smaller public-funded ambulance services.

If NSW continues to remain apart and does not participate in the NRAS model, the regulations addressing issues such as minimum required qualifications, competency standards and exemptions will not be consistent and will create additional regulatory compliance and administrative costs by practitioners and service providers.

Patient safety is paramount but that is merely the beginning, and if further costs are imposed by unnecessary jurisdictional actions (since an NRAS regulatory model would achieve the primary goals of regulation) then the commitment of NSW to the principles of federation are placed into question.

Significantly, in the *Reform of the Federation: Health Issues Paper 3* (December 2014)[63] the case is made (p 30) that nationally consistent approaches are often warranted to realise broader national benefits including economies of scale and to avoid economic inefficiencies. The paper specifically quotes the variation of regulation and professional registration across the states and territories and the importance of assessing the efficiency and effectiveness of roles and responsibilities in the health sector.

The paper notes the national interest is served by addressing health regulation effectively and delivering the optimal balance between equity and efficiency. Each responsible government needs to be mindful of how decisions it makes in its areas of responsibility affect other levels of government and other jurisdictions.

Governments may have a shared interest on behalf of the community, especially if there are spill over effects from one level of government to another. These factors form strong arguments in the public interest for national legislation to support safety, quality, and efficient national markets. While collaboration and partnership between different levels of governments can have positive effects, shared roles risk the creation of duplication and reduced allocative efficiency.

Thus, while health practitioner regulation at a local or jurisdictional level may meet a number of immediate needs, that national approach was adopted for the IGA after extensive consultation - by all governments including NSW - to realise benefits in the national interest. It embodied the principles of good policy development which not only meets the basic and mandatory criterion of protecting the public, but also fulfils the objectives of fostering economic activity, operating efficiently, enhancing access and practitioner mobility, and facilitating innovation and best practice in the spirit of federation.

The current freestanding NSW moves for practitioner regulation based essentially around legislation to satisfy a single service provider do not appear to represent good long term public policy. It is an insular approach that fails to consider the spill over effects of their policy onto other governments, the community and practitioners, thereby reducing the allocative efficiency of the health sector and diminishing the competitiveness of NSW private sector health care providers.

Independent jurisdictional regulation is inconsistent with the principles embodied in Australia's Mutual Recognition Agreement (MRA) and the Trans-Tasman Mutual Recognition Arrangement (TTMRA) which apply to regulations affecting the sale of goods and registration of occupations, and is likely to create inefficiencies and competitive disadvantages within the economy.

The authors believe the current NSW arrangements for protection of paramedic title are sub-optimal and a stop-gap measure at best. The authors therefore recommend that the Senate Inquiry release this submission to the NSW government immediately and grant permission for that release. In that way the cogent reasons for national registration of paramedics outlined in this submission can form part of the additional considerations to be undertaken by the NSW government as soon as possible so that a single harmonised regulatory model for paramedics can apply across Australia.

[63] http://bit.ly/1IXrFeB accessed 26/01/2016

5.6.8 Accreditation of paramedic (aka ambulance) services

It should not be assumed that paramedic service providers such as public ambulance agencies are beyond reproach and can operate without suitable monitoring and review. In England all ambulance services are regulated by the Care Quality Commission (CQC)[64] under the provisions of the Health and Social Care Act 2008 and subsequent Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This requires all providers (including private and voluntary providers) to register, to meet certain standards of quality, and to submit to inspection of those standards. Organisations not meeting the standards can be sanctioned, or have their registration removed, preventing them from offering any medical services. This system of regulation began in 2010 with NHS ambulance services, and was extended in 2011 to cover all ambulance service providers.

Notably, one of the world's best-known services – the London Ambulance Service - recently was placed into special measures by the CQC http://on.fb.me/1loG3Sl. In a parallel move, the Larrey Society has examined how service provider regulation is working in the UK, and has made suggestions on where it could be improved in a recent report here: http://bit.ly/1XW5OuS

They found overwhelming support for a more rigorous inspection regime and that most people on the front line support more unannounced inspections and talking to randomly selected staff to forestall sanitised views of performance. Overall, there is wide support for the CQC's remit and goals to ensure the industry is as professional as possible.

While paramedic practitioners need appropriate regulation so too should service providers be subject to an appropriate regulatory regime as an integral element in delivering uniformly high quality care that will ensure the best possible outcomes for the community.

It is a travesty that despite the potential exposure of patients and practitioners to risk and harm, the absence of practitioner registration and independent accreditation and licensing of providers militates against transparent reporting that would provide more definitive data and bring a greater awareness of the risks and actual harm that occurs. That alone warrants regulatory change.need to

Further evidence of the need for service accreditation is the fact that paramedics have the highest rates of occupational fatalities and injury in Australia. It is clear that Australian ambulance services need to engage rigorous research by impartial experts on ways to limit the occupational risks that are facing paramedics and their patients every day.

Just as hospitals, pathology services, diagnostic services and university course programs may be accredited, the authors believe that all paramedic service providers in Australia should be subject to minimum standards of performance and review and operate under an independent accreditation and quality assurance regime. The authors recommend that these views be incorporated in the final Inquiry recommendations.

[64] bit.ly/1Ppdwd7 accessed 26/01/2016

Glossary

The following abbreviations are used in this submission.

ADF	Australian Defence Force
AHPRA	Australian Health Practitioner Regulation Agency
AHMAC	Australian Health Ministers Advisory Council
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council'
ANZCP	Australian and New Zealand College of Paramedicine
ASD	Acute Stress Disorder
CAA	Council of Ambulance Authorities
COAG	Council of Australian Governments
CPG	Clinical Practice Guideline(s)
CQC	Care Quality Commission (UK)
PCAA	Health Professions Competency Assurance Act 2003 (NZ)
HWA	Health Workforce Australia (closed)
IGA	Intergovernmental Agreement
National Code	National Code of Conduct for health care workers
National Law	Health Practitioner Regulation National Law Act
NCAU	National Council of Ambulance Unions
NRAS	National Registration and Accreditation Scheme (or National Scheme)
PA	Paramedics Australasia
PTSD	Post Traumatic Stress Disorder
RHPA	Regulated Health Professions Act (Ontario)
RoGS	Report on Government Services (Productivity Commission)
SJA	St John Ambulance Service Inc (WA)
UK	United Kingdom

Appendix A - Inquiry terms of reference

Senate Standing Committee on Legal and Constitutional Affairs

On the 20 August 2015 Senator Glenn Lazarus secured the support of the Australian Senate that the following matter be referred to the Legal and Constitutional Affairs Committee for inquiry and report by the last sitting day in June 2016.

------ ooOoo ------

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

a) the role and contribution made by those in the paramedic profession, including the circumstances in which they are required to operate;
b) the comparative frameworks that exist to regulate the following professions, including training and qualification requirements and continuing professional development:
    i. paramedics,
    ii. doctors, and
    iii. registered nurses;
c) the comparative duties of paramedics, doctors and registered nurses;
d) whether a system of accreditation should exist nationally and, if so, whether the Australian Health Practitioners Regulation Agency is an appropriate body to do so;
e) the viability and appropriateness of a national register to enable national registration for the paramedic profession to support and enable the seamless and unrestricted movement of paramedic officers across the country for employment purposes; and
f) any other related matters.

Appendix B – Risk factor assessment for health professions under the National Law

Consultation paper: Options for regulation of paramedics

Table 9 Risk factor assessment for health professions under the National Scheme

Original Source - Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law, September 2009 (p. 118)

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
Aboriginal & Torres Strait Islander health practitioners	X			X	X	X	X				X	X	X
Chinese Medical Practitioners	X	X		X	X	X	X	X			X	X	X
Chiropractors		X									X	X	X
Dental practitioners*	X		X	X	X	X					X		
Medical practitioners	X	X	X	X	X	X	X	X	X	X	X	X	X

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, cardioverson, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electro magnetic 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.

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Appendix B (continued)

	1. Putting an instrument, hand or finger into a body cavity	2. Manipulation of the spine	3. Application of a hazardous form of energy/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	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	13. Patients commonly required to disrobe
Medical radiation practitioners			X	X		X					X	X	X
Nurses and midwives	X		X	X	X	X	X	X	X		X	X	X
Optometrists					X						X	X	
Occupational Therapists			X								X	X	X
Osteopaths		X									X	X	X
Pharmacists					X		X				X		
Physiotherapists	X	X	X								X	X	X
Podiatrists				X	X	X					X	X	
Psychologists									X		X	X	
UNREGISTERED													
Paramedics**	X			X		X	X	X	X		X	X	X

** Paramedics included for comparison only. This risk assessment is not included in the original reference source.

Appendix C - Summary of some benefits under a national registration (NRAS) model

Identified benefits that would apply with paramedic registration through the NRAS:

- public assurance that paramedics are appropriately qualified and fit to practice;
- reduced risks to the public associated with the actions of a practitioner who may have health, conduct or performance issues that make them unsafe to practice;
- formal and consistent national registration standards (See the 5 AHPRA Standards);
- greater transparency in reporting and objective complaints management, with mandatory reporting to AHPRA (as required for other registered professions);
- establishment of a single national accreditation body for paramedic education with spin-off benefits to inform research, continuing professional competency and best practice;
- greatly simplified cross border and Trans-Tasman relationships associated with the recognition of paramedics and their utilisation in disaster and humanitarian relief operations;
- legislated and uniform protection for use of the title 'paramedic', with only registered practitioners being able to use that title or hold themselves out as being paramedics;
- enhanced practitioner mobility to better service Australia's health care demands;
- greater capacity to use paramedics in a wider range of health care settings, in remote health settings, in multidisciplinary health teams and community health care settings;
- greatly improved data collection for workforce planning;
- potential extension of scopes of practice, prescribing pathways and recognition for provider status in Medicare and Pharmaceutical Benefits Scheme thus bringing better care that forms part of the funding arrangements of health care policy;
- facilitation of international recognition for international education, research and engagement in humanitarian activities through WHO, Red Cross, MSF and other agencies;
- a single nationally recognised scheme and a potential one-stop-shop for incoming overseas trained practitioners; and
- wide-ranging benefits through vastly reduced administrative costs and other overheads for practitioners and service providers who operate across jurisdictional borders including the facilitation of export earnings by the private sector.