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Dear Ms Mirco

Thank you for inviting us to make a submission in response to the Australian Health Ministers Advisory Council's Consultation Paper: *Options for regulation of paramedics* ('The Consultation paper').

We recommend that the Health Minister's Advisory Council should advise the Ministers to adopt Option 4: registration of paramedics under the authority and provisions of the *Health Practitioner National Law Act 2009* ('The *National Law*').

Below we set out our reasons for making this recommendation. Our submission is based on the submission form set out in Appendix 11 of the Consultation Paper.

What organisation do you represent?

How many paramedics are employed/members of your organisation?

We do not represent any particular organisation. We are academics from the Australian National University (ANU) College of Law with an interest in the emergency services, paramedicine and specifically, the regulation and professional practice of paramedics. The views expressed here are our own and do not represent the views of the ANU or any other organisation.

It follows that the question of 'How many paramedics are employed/members of your organisation?' is not relevant. To the best of our knowledge the ANU employs no paramedics but even if it does, we are not representing their interest or the interest of the ANU nor, as noted, are we representing the views of any organisation that does employ paramedics.

The nature of the problem (Chapter 3 of consultation paper)

1.1. What are the risks or problems associated with the provision of health services by paramedics?

Paramedics are involved in providing health care to particularly vulnerable people who may have been the victim of accident, trauma or sudden illness. The work of paramedics mirrors the work of doctors and nurses but there are some significant differences. In particular paramedics may work alone or in teams of two. Unlike other health practitioners they do not have a team of allied professionals that they can easily call on at the scene of an emergency. Paramedics also work in a number of hazardous environments whether in a person's home or at the scene of an accident. Paramedics have to identify the nature of the patient's complaint, illness or injury and then apply treatment without extensive diagnostic assistance.

Whilst working in this information poor, complex environments paramedics provide a number of high risk interventions that may include some or all of the following:

- putting a hand, instrument, finger into body cavity;
- conducting procedures below the skin;
- the administration of a scheduled drug by injection;
- the supply of substances for ingestion;
- managing labour or delivery of baby;
- undertaking psychological intervention to treat serious disorders with potential for harm;
- acting as primary care providers without referral from registered practitioner;
- providing treatment commonly without other person present;
- providing care where the patient is commonly required to disrobe.¹

There is an acknowledgement that healthcare systems are inherently complex and as such inherently risky. Added to this is the sheer volume of work that paramedics undertake – in 2009-2010 Australian paramedics had 3.01 million patient contacts² - it is inevitable that this level of patient contact increases the exposure of patients to risk. Further it is known a large proportion of adverse events occur at the boundaries between providers.³ Measuring the incidence of adverse events in health care is difficult but if the rate of adverse event or near miss incidents experienced by paramedics is commensurate with that of other health care providers in other areas, then approximately 2.9-3.7% of cases would experience an adverse event.⁴ Based on 2009-2010 figures that would be between 87290 and 111370 patient contacts would have had some adverse event.

Examples of potential adverse incidents include incorrect endotracheal tubal placements, failure to apply a cervical collar, use of supplemental oxygen, checking of serum glucose levels and vital signs.⁵ It is likely that medication administration errors have also occurred. Previous court cases in Australia involving paramedics have identified risk areas around assessing the competence of patients to give or refuse consent for treatment which has the potential to limit the patient's chance at a better outcome.⁶

¹ Australian Health Ministers' Advisory Council Health Workforce Principal Committee, (July 2012) *Consultation Paper: Options for Regulation of Paramedics* (Canberra).

² Australian Productivity Commission (2011) *Report on Government Services* pg 9.51

³ Australian Health Ministers' Advisory Council, *Final Report of the Taskforce on Quality in Australian Health Care* (1996) cited by Martin Fletcher *The quality of Australian health care: current issues and future directions* (Commonwealth Department of Health and Aged Care, 2000), 8.

⁴ Adverse events are defined as injuries caused to the patient as a result of medical management as opposed to their underlying condition. A Meisel, Z; Hargarten, S, Vernick, J. 'Addressing prehospital patient safety using the science of injury prevention and control' (2008) 12 *Prehospital Emergency Care* 411-6. RM Wilson, WB Runciman, RW Gibberd, BT Harrison, L Newby and JD Hamilton, 'Quality in Australian Health Care study' (1995) 163 *Med J Aust* 458-47 found in one study of 14000 admissions to 28 hospitals in South Australia and NSW, 17% were associated with an adverse event and approximately half of those were preventable. See also WB Runciman, EE Roughead, SJ Semple and RJ Adams 'Adverse drug events and medication errors in Australia' (2003) 15 *Int J Qual Health Care Suppl* 1:i49-59; T Brennan et al 'Incidence of adverse events and negligence in hospitalized patients' (1991) 324(6) *New England Journal of Medicine*, <http://www.delcotrial.org/media/pdf/910207_adverse.pdf>.

⁵ A Meisel, Z; Hargarten, S, Vernick, J. 'Addressing prehospital patient safety using the science of injury prevention and control' (Oct-Dec 2008) 12 *Prehospital Emergency Care* 411-6.

⁶ *Neal v Ambulance Service of New South Wales* [2008] NSWCA 346; Michael Barnes, State Coroner, *Inquest into the death of Nola Jean Walker* (Queensland Courts, 2007), <http://www.courts.qld.gov.au/_data/assets/pdf_file/0003/106347/cif-walker-nj-20071123.pdf>.

The Consultation paper has noted coronial matters where issues of paramedic care have been considered along with Jurisdictional Complaints Data⁷ to identify that paramedic practice does pose real risks to those in need of optimal care. Complaints data is not the same as adverse event data. The difficulty in obtaining data, even by the Health Workforce Committee supports the need for more transparency and uniformity with the way in which adverse event data is obtained, measured and presented for consumers so that they may be better informed about the quality of the paramedic services they are receiving

1.2. What factors might increase the risk of harm to the public associated with paramedic practice?

A number of factors might increase the risk of harm to the public associated with paramedic practice. Some of these have been noted, including the fact that paramedics work largely alone or in small teams, without ready access to diagnostic tools, imaging or technology or associated health professionals.

Other risk factors are inconsistency in training. Paramedics may have a range of qualifications ranging from in-service training, diploma or other vocational education or university level degree training. Because the term 'paramedic' is not a protected title, anyone can 'turn out' and call themselves a paramedic. A patient seeking assistance from a paramedic cannot know what their level of qualification is or what skills they have.

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

1.3. What factors can reduce the risk of harm to the public associated with paramedic practice?

It is our submission that National Registration would reduce the risk of harm. National Registration would ensure:

- Nationally consistent training standards;
- A register to identify who is a qualified paramedic and by necessity, a definition of what that means;
- An independent complaints handling process that was independent of the paramedic's employer and would allow all aspects of paramedic practice to be monitored and action taken to protect the community interest.

1.4. What examples can you provide on the nature, frequency and severity of risks or problems associated with paramedic practice?

See the discussion under 1.1, above.

1.5. Do you know of instances of actual harm or injury to patients associated with the practice of a paramedic? This may relate to the conduct, performance or impairment of the paramedic.

If so, please provide further details.

We are aware of instances where paramedics have been called before the District, Supreme and Coroner's courts to provide evidence as to their treatment of patients in cases where the patient has been harmed.⁸

⁷ Australian Health Ministers' Advisory Council Health Workforce Principal Committee, (July 2012) *Consultation Paper: Options for Regulation of Paramedics* (Canberra), Appendix 7.

⁸ For example see *Neal v Ambulance Service of New South Wales* [2008] NSWCA 346; Michael Barnes, State Coroner, *Inquest into the death of Nola Jean Walker* (Queensland Courts, 2007) <http://www.courts.qld.gov.au/_data/assets/pdf_file/0003/106347/cif-walker-nj-20071123.pdf>; *Ambulance Service of NSW v Worley* [2006] NSWCA 102 although the paramedics were not found

Whilst these cases may not have necessarily established that paramedics (or indeed paramedic service providers) were liable for the harm done to the patient, they are illustrative of the nature of the work that paramedics do and the potential for harm to the patient that is associated with it. As discussed under 1.1 above, there is a great deal of difficulty in obtaining such data and again we note that the absence of data does not correlate with an absence of harm done to patients via the practice of paramedics. The basis of government healthcare policy and regulation is to take a 'preventative' approach to managing risks to health and this approach should apply equally to the practitioners who may create harm as it should to the patient managing their own health.

In the current regulatory environment, instances of actual harm to a patient will be dealt with by the paramedics employer. The employer has a conflict of interest as they need to protect their own reputation and standing and will be reluctant to 'out' their own employees. Paramedics own fear for their job security or fear of reprisals may make them reluctant to report incidents to their employer. The culture in some ambulance services has been the subject of criticism⁹ and this will not encourage frank disclosure of adverse events.

These problems may be overcome with national registration and an associated independent complaints system and the potential for mandatory reporting by other paramedics if they are aware of adverse practice or professional impairment.

1.6. Do you know of instances where unqualified persons have been employed as a paramedic? If so, please provide further details.

That is a question begging provision. There are no standard or formal qualifications for a paramedic. A person with a first aid certificate could be employed as a 'para-edic' but that does not make them an unqualified person employed as a paramedic. In the absence of registration or uniform training it is impossible to give meaning to the idea of an 'unqualified' person or what is a 'paramedic'. Some people may be employed as a 'paramedic' in one jurisdiction even if they only have skills that would mean some other service would not call them a paramedic.

Historically, in NSW only level V advanced life support officers were paramedics, but by mere administrative arrangements the Ambulance Service of NSW changed to refer to all ambulance officers as paramedics.¹⁰ On one view that means that everyone who was not a level V officer was now an unqualified person being employed as a paramedic, on another view, what was a paramedic simply changed.

In the absence of recognised minimum standards, this question cannot be answered. The fact that it cannot be answered is part of the argument for national registration.

negligent in this case, the protocol that the paramedics were working off may have been inconsistent with clinical best practice and that this had the potential to significantly harm the patient.

⁹ NSW Legislative Council *Inquiry into the management and operations of the NSW Ambulance Service* (Parliament of NSW, 2008), <http://www.parliament.nsw.gov.au/prod/parliament/committee.nsf/0/7E1C5F2F6AD04129CA25744A000801E5>.

¹⁰ Ambulance Service of NSW *New Uniform same excellence in care* (2008), <http://www.ambulance.nsw.gov.au/newsletters/summer0708/>,

1.7. If you are a non-government related employer of paramedics, please provide information on your medical control model or clinical governance model for paramedic practice.

Not applicable.

1.8. Can inconsistencies in current regulation be linked to risks to the public?

Yes, currently the paramedic sector is unregulated. Although most paramedics are employed by statutory ambulance services, or in the case of the Northern Territory and Western Australia, ambulance providers that contract with the government, there is a growing private sector in ambulance services and paramedic providers.¹¹

Today people are providing emergency health care services at workplaces and at public events in circumstances where members of the workforce or public cannot know what level of qualification or skill those 'paramedics' have nor what action they can take should they receive less than optimal care.

Given the term 'paramedic' is not a protected title, and given there is no national registration then the risk to the public is real, and growing with the growing private sector.

The objective of government action (Chapter 4 of consultation paper)

2.1. What should be the objectives of government action in this area?

The primary objective of government action in this area is to ensure, to the greatest extent possible, the protection of patients and the delivery of high quality pre-hospital health care.

2.2. Is there a case for further regulatory action by governments in this area?

Yes, the current paramedic profession is unregulated. Various mechanisms, identified in the consultation paper to regulate the practice of paramedics and to provide quality assurance largely depend on paramedics being employed by state based ambulance services rather than the increasing private sector.

Employers are faced with an inevitable conflict of interest when seeking to protect their own reputation, their financial position and their workforce. They cannot provide a truly independent review process that puts patient care as the primary consideration. Such a scheme is required.

Options for regulation (Chapter 5 of consultation paper)

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

3.1. Do current government regulations protect the public in relation to paramedic practice?

Please explain the reason(s) for your answer.

No, as noted above. In Western Australia there is no government regulation. In most states there is no regulation of the private profession. Even where there is regulation it is generally to the effect that private ambulance services are prohibited but these provisions are unclear (failing to identify what is an ambulance service) and are largely unenforced.¹²

The current regulatory scheme fails to:

- Identify who may call themselves a 'paramedic';
- What is the minimum level of training or skill set expected of a paramedic;

¹¹ Eburn, M and Bendall J, 'The provision of Ambulance Services in Australia: a legal argument for the national registration of paramedics' (2010) 8(4) *Journal of Emergency Primary Health Care*, Article 990414.

¹² Ibid.

- Provide an adequate disciplinary or quality assurance mechanism for paramedics in particular those outside the state ambulance services;
- Fails to clearly articulate that patient care is the primary consideration in regulating the profession; and
- Fails to provide a system to allow employers to confirm that potential paramedic employees are qualified, competent and are not seeking to move employers due poor performance or inadequate practice skills.

3.2. What are the compliance costs for you or your organisation resulting from the current regulatory mechanisms that apply to paramedics?

Not applicable.

3.3. Are professional organisations able to provide the necessary level of implementation and monitoring of any established voluntary code of practice?

Please explain the reason(s) for your answer.

Professional associations are not generally able to provide the necessary level of implementation and monitoring of any established voluntary code of practice. This has been demonstrated in a number of professions and has seen the move away from professional discipline to more ‘arms length’ disciplinary procedures as reflected in the *National Law* and the regulation of other health professionals.

The ability of professional organisations to monitor and implement a code of practice requires professionals to be a member of that professional organisation. In the context of paramedics, particularly in the absence of a protected title or minimum qualifications and skills, it is not clear who should be, or could be, a member of such a profession.

It is noted that in the discussion paper it was said ‘Similarly, first aid volunteers (who are not qualified as a paramedic) are not considered to be part of the paramedic workforce.’¹³ First aid volunteers may well provide extended care, using drugs, supplying substances for ingestion, managing labour or delivery of baby, acting as primary care providers without referral from registered practitioner; providing treatment commonly without other person present and providing care where the patient is commonly required to disrobe.¹⁴ Whether they could or should be members of a paramedic professional organisation depends on what is meant by paramedic. If they are not considered a paramedic, then the professional organisation cannot regulate their practice even if it should.

3.4. What support is there for paramedics participating in any established voluntary code of practice?

We make no submission on this question.

3.5. Can you identify and explain any problems with the current state/territory employer determined (1) paramedic standards, (2) qualifications for employment, and (3) management of conduct, performance or impairment issues?

Many of these issues have been noted above. As an employer the various ambulance services can and do determine paramedic standards, qualifications for employment and management of performance and impairment issues. The problems with that approach are:

¹³ Above n 1, 5.

¹⁴ Ibid, 34.

- They relate only to their employees and not to providers who are engaged outside the state/territory ambulance service.
- The standards are not consistent across Australia making it difficult for paramedics to have freedom to move from employer to employer and jurisdiction to jurisdiction. If an employer in one state wants to employ a paramedic from another they would have to go through a process to recognise prior learning rather than having a common educational standard and skill set.
- Whilst it is acknowledged that it is an employer's prerogative and indeed right to follow up and manage any complaint of unprofessional conduct, the lack of transparency to the public as a necessary element of protecting the confidential nature of information afforded to an employer about an employee means that public protection and safety may be afforded less importance than if a complaint was made to an external third party. Under employer managed complaints systems there is no mechanism for a practitioner to report themselves or another for an impairment or unprofessional conduct. In his review of the regulation of legal services, Sir David Clementi argued that effective regulation and public confidence was gained by having regulatory functions carried out by bodies that are wholly separate from the professional associations or service providers.¹⁵ This issue is addressed via an inclusion of paramedics to AHPRA placing them within the scope of the National Law (option 4, below).

3.6. Please provide the names of any courses for paramedic education and training that are not identified in the consultation paper.

We make no submission on this question.

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

4.1. Explain whether you think that a different code of conduct in each State and Territory will be acceptable to address paramedic practice issues?

No, it would not. The code of conduct would still need to identify who is a paramedic and what paramedics would do. A different code in each jurisdiction does not allow freedom of movement for paramedics nor a national system to ensure that impaired or incompetent paramedics are restricted in their ability to practice.

A state based statutory code of conduct does not allow for the development of a national curriculum, accreditation or educational standard. It does not address paramedic standards, qualifications for employment and management of conduct, performance or impairment. A statutory code of conduct will vary across jurisdictions and will, therefore, fail to ensure patient safety as it will not ensure that each state has the opportunity to inquire into the work history of a paramedic in another jurisdiction. If this option were to be adopted, it should be adopted on a national basis (which would make it not unlike option 4).

4.2. Identify which organisation(s) could take on the role of regulator in your State or Territory? (Note – this does not apply in NSW where the HCCC has this function)

In the ACT the relevant regulator should be the ACT Health Services Commissioner.

4.3. What benefits or issues do you see with each State and Territory investigating breaches of the code of conduct and issuing prohibition orders?

¹⁵ David Clementi, *Review of the Regulatory Framework for Legal Services in England and Wales Final Report* (2004) <<http://www.legal-services-review.org.uk/content/report/report-chap.pdf>>.

There are no benefits. The costs will be duplication across the jurisdiction, a failure to adequately regulate private providers and individual practitioners and a failure to apply standard health care regulation across all aspects of the health care system, from the moment the person first comes into contact with the health service, via the ambulance service, to ultimate discharge from care.

4.4. What do you see as being the compliance costs for yourself or your organisation associated with this option for a mandatory code of conduct?

We make no submission on this question.

4.5. What benefits do you see for protection of the public associated with this option?

Although this option would provide more protection for the public than currently exists, it would remain inadequate for the reasons we set in response to proposed option 4, below.

Option 3: Strengthen State and Territory regulation of paramedic

5.1. Could paramedics or paramedic practice be regulated through strengthening ambulance legislation?

Please provide the reason(s) for your answer.

No. First, neither the Northern Territory nor Western Australia has ambulance legislation. Second the ambulance legislation that does exist regulates the state ambulance services but is virtually silent on private ambulance providers.¹⁶ The legislation that does exist regulates the service provider but not individual paramedics.

Current legislation fails to take account of the growth of the private sector in ambulance/paramedic services and fails to provide for the fact that persons employed in various workplaces, or providing emergency health care at public events, are increasingly involved in delivering high risk, high intervention care and transport.

5.2. What do you see as being the compliance costs for your organisation associated with amendment or introduction of legislation for ambulance services?

We make no submission on this question.

5.3. Would strengthening of ambulance legislation be able to address current state/territory employer determined (1) paramedic standards, (2) qualifications for employment, and (3) management of conduct, performance or impairment issues?

Please provide the reason(s) for your answer.

Rewriting ambulance/paramedic legislation *could* address these matters but at a high cost, in particular the high cost of duplication. If every state and territory was required to enact legislation to regulate who could call themselves a paramedic, the level of qualification required, and how conduct, performance and impairment issues were dealt with there would, inevitably, be jurisdictional differences leading to many of the same problems that exist with workforce movement and patient care standards.

The cost to the economy of passing eight different ambulance/paramedic laws and setting up their required enforcement procedures is simply unnecessary when a national model, in the form of the *National Law*, already exists.

5.4. To what extent will this option provide national consistency for the regulation of paramedics and paramedic practice?

¹⁶ For an exception see *Non-Emergency Patient Transport Act 2003 (Vic)*.

That would depend on the cooperation between the jurisdictions, but there are many examples of cooperative legislative ideals, consider the model Criminal Code, the Evidence Act 1995 (Cth) and the recent attempts to bring in national Work Health and Safety laws. The model Criminal Code took over 10 years to develop, it was intended to be a Criminal Code for all Australian jurisdictions. The Commonwealth enacted its Criminal Code Act in 1995, but today only the Commonwealth, ACT and Northern Territory have moved to adopt the Code and even in those jurisdictions they have only enacted parts of the Code.¹⁷

With respect to evidence law:

... there were hopes when the *Evidence Act 1995* (Cth) was passed that this would lead to uniform legislation throughout Australia, this has not yet occurred. Federal courts and courts in the Australian Capital Territory apply the law found in the *Evidence Act 1995* (Cth) and some provisions have a wider reach. In addition, New South Wales, Tasmania and Norfolk Island have passed mirror legislation. These statutes are substantially the same as the Commonwealth legislation but not identical.¹⁸

In 2008 the Workplace Relations Ministers' Council agreed to harmonise Australia's workplace safety laws. A model work health and safety Act was developed by all Australian governments for implementation across Australia on 1 January 2012. Today, South Australia, Tasmania, Victoria and Western Australia have failed to enact the laws as agreed or have opted out of the harmonisation process all-together.¹⁹

The evidence does not suggest that leaving the regulation of anything, including paramedic practice, to each State and Territory would or does lead to national consistency.

5.5. What benefits do you see for protection of the public associated with this option?

Although there would be benefits, perhaps akin to national registration, this scheme would fail to provide consistency and would, due to duplication across the jurisdictions, come at a substantial cost.

5.6. Are there any alternatives through State or Territory legislation to regulate paramedics and paramedic practice?

No.

Option 4: Registration of paramedics through the National Scheme

6.1. How would the regulation of paramedics through the National Scheme provide further protection of the public?

Paramedics are important providers of health care. They are no longer mere 'ambulance drivers' any more than nurses are 'doctor's handmaidens'. Because paramedics are providing invasive, technically complex and potentially dangerous treatment, both the risk to and benefit for patients is increased. To recognise both their professional skills and to ensure patient protection, we submit that national registration is the only appropriate option.

¹⁷ Law Council of Australia *Model Criminal Code and Harmonisation of Criminal Law and Procedure*, <<http://www.lawcouncil.asn.au/programs/criminal-law-human-rights/criminal-law/model-criminal-code.cfm>>.

¹⁸ Australian Law Reform Commission 'The Uniform Evidence Acts The movement towards a uniform evidence law' in *Uniform Evidence Law (ALRC Report 102)*, (2006), Chapter 2 <<http://www.alrc.gov.au/publications/2.%20The%20Uniform%20Evidence%20Acts/movement-towards-uniform-evidence-law>>.

¹⁹ Safe Work Australia 'Model WHS Regulation' (2012) <<http://www.safeworkaustralia.gov.au/sites/SWA/Legislation/Pages/ModelWHSLegislation.aspx>>.

Registration of paramedics under the *National Law* would ensure that:-

- Consumers can be certain of the qualifications that are required to be held by a registered paramedic because they will be determined by the Paramedic Council (or its equivalent) under the National Act;
- The title 'paramedic' can be protected so that consumers can be confident that they are being treated by a suitably qualified and registered health practitioner in both the private and public sectors;
- There will be minimum competency standards that will be required to be obtained by practitioners to maintain their registration;
- There will be professional standards of practice that will be upheld consistently amongst paramedic service providers ensuring that consumers in all states and territories are offered equivalent standards of care;
- There will be an ability to sanction practitioners who fail to meet the requisite standard of knowledge, judgment, skill and conduct necessary to protect patient safety in a more transparent, fairer and more consistent system than is currently available;
- Meet health workforce needs by allowing paramedics to transfer their skills across state and international jurisdictions and between public and private providers of paramedic services.

6.2. Can you identify any barriers to a national accreditation scheme for the education and training of paramedics?

National accreditation will require all education providers, whether vocational trainers, university or ambulance services to ensure their training meets the national standard. This will involve a cost but in some ways the costs will be reduced as each provider will not have to determine for itself what training it thinks is necessary to meet its own, or the market's needs.

6.3. What is your view on whether the accreditation scheme currently in place and operated by CAA would provide a suitable model for establishment of an accreditation body?

We make no specific comment on the CAA scheme but note that given paramedics role in the health care system the obvious and suitable model for the regulation of paramedics is the *National Law*.

6.4. What do you see as being the compliance costs for yourself or your organisation associated with the option for paramedics entering the National Scheme?

We make no submission on this question.

6.5. What benefits do you see for protection of the public associated with this option?

Quality is a key driver in policy making in all areas including education and healthcare because it is seen as a tool of accountability.²⁰ A well accepted definition of quality in terms of health service provision is:

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.²¹

Quality and accountability are consistent with the purpose and objectives of the *National Law* and the regulation of healthcare professionals. Quality healthcare is delivered in part as a result of good education, the altruism, good intentions, solid work ethic of practitioners, and the threat of legal action for

²⁰ Fletcher, above n 2, 3.

²¹ Ibid, 5.

individuals who harm their patients.²² However, there appears to be an ‘absence of agreed standards and a lack of explicit, agreed national goals for quality improvement’ in paramedicine. This ‘makes it difficult to drive forward a meaningful and appropriately integrated national quality agenda’.²³ Because paramedics essentially undertake the bulk of pre-hospital care, it is essential to include them if there is to be a truly integrated approach to managing a national healthcare quality agenda. Bringing paramedics under the authority of the *National Law* will provide a mechanism for a national accreditation scheme and disciplinary process that will, in part, monitor and manage those that may be providing lower quality care. Paramedic registration already exists in the UK. There 16782 paramedics registered by the UK’s Health Professions Council (HPC). Practitioners are admitted to the register if they are ‘fit to practice’. ‘Fitness to practice’ is defined as a professional having the ‘skills, knowledge and character to practice their profession safely and effectively.’²⁴ In 2010-2011, 188 complaints alleging breach of a paramedic’s ‘fitness to practice’ were investigated by the HPC. As a result of those investigations:

- 33 paramedics were cautioned (for issues including refusal to attend emergency call out, failure to maintain adequate records, failure to secure ambulance leading to theft of controlled drugs, accessing inappropriate material on employers equipment);
- 14 were struck off the register (for matters such as making or possessing indecent photographs of children, theft, inadequate assessment and treatment of patient, failure to obtain driver’s license, incorrect administration of morphine and failure to maintain adequate records, fraud, administering drugs without proper training, failing to keep accurate records, perverting the course of justice, compromising patient safety, inappropriate sexual conduct towards patient, breach confidentiality, inadequate level of clinical care, failure to disclose police caution, overcharging group liability insurance, failure to pay for training course, failure to store and maintain records of controlled drugs);
- 5 were suspended (for theft, failure to pass courses and assessment of competence, failure to transport consumer directly to hospital, failure to meet standards of proficiency, knowingly practiced without registration);
- 1 was voluntarily removed from the register (failure to carry out clinical duties, complete service user records and communicate effectively); and
- 3 had conditions placed on their practice.

Although the data on complaints, above, comes from the UK it would be reasonable to assume that in Australia, too, there are examples of inappropriate practice. Notwithstanding the evidence that paramedics may engage in inappropriate conduct, in Australia at least, the satisfaction ratings given by patients with regards to paramedic services is consistently high at around 98% across all statutory public service paramedic providers.²⁵ One explanation for the low number of Australian complaints, and a high level of consumer satisfaction, may be that “... the vast majority of registrants are committed to their job and vocation to help others...and therefore maintain their competence, continue to develop professionally

²² Ibid, 3.

²³ Ibid, 4

²⁴ Health Professions Council, *Fitness to practise annual report 2011* (London), 7.

²⁵ Australian Productivity Commission, *Report on Government Services (2012)*, Fire, road rescue and ambulance Table 9A.38. The report said, “‘Level of patient satisfaction’ is defined as the total number of patients who were either ‘satisfied’ or ‘very satisfied’ with ambulance services they had received in the previous 12 months, divided by the total number of patients that responded to the *National Patient Satisfaction Survey* (CAA 2011).” The number surveyed nationally was 4503. See also *Council of Ambulance Authorities 2011, 2007 –2011 National Patient Mailout Satisfaction Research, Adelaide*.

and do not misbehave.”²⁶ Another explanation for the low number of complaints made but high satisfaction ratings is that the lack of publicly available, uniform and enforceable regulations around professional practice standards, curriculum requirements, competency standards and a code of conduct.

The public may have very little idea about what a ‘paramedic’ can and cannot do and how a ‘paramedic’ may be distinct from a ‘first-aider’ or ‘ambulance driver’. A low level of expectation as to the knowledge and skills that paramedics have may mean that satisfaction ratings are high if the patient’s expectation is simply that the paramedic will turn up in an ambulance and transport them to hospital and that expectation is met.

6.6. How would national registration be better than current regulatory arrangements?

Healthcare is a complex system providing care with ever increasing technical sophistication with a related, increased risk to patients. National registration, unlike current regulatory arrangements would lead to consistent national standards for accreditation of paramedic education programs, overseen by an *independent* national accreditation agency. Such a scheme will ensure quality standards of paramedic education and promote and protect the health of the Australian community.

The *National Law* states that the accreditation standard, for a health profession, that will provide a practitioner with an ‘approved qualification’.

... means a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.²⁷

This provision protects practitioners, providers and patients by ensuring that the standard of education programs accredited by the approved agency is sufficiently high to deliver safe and effective treatment.

Because paramedics provide vital and increasing health care services they should be regulated as other health professionals are, that is under the *National Law*. This would allow the appropriate National Paramedic Board to determine how standards for paramedic education will be set and monitored. The accreditation agency must be independent of industry so that it is protected from undue influence by stakeholders. In this regard we recommend *against* nominating any currently established industry representative group as the standards accrediting body but rather recommend the establishment of a new, independent council similar in makeup to that of the Australian Nurses and Midwifery Council or the Australian Medical Council.

National registration would allow the paramedic workforce to move across countries and across Australian jurisdictions. Registered paramedics could seek employment anywhere in Australia and employers could be sure that, as registered health professionals, they have satisfied the Board that they have met minimum educational and skill standards. This mechanism does not deny educational institutions an opportunity to ‘tailor’ their courses and market a unique element that differentiates them from other providers of the same qualification. This is best demonstrated by the providers of Medical and Nursing degrees at the various universities around Australia who have ‘personalised’ their courses to reflect their corporate brand or local need.

²⁶ Health Professions Council, *Regulating ethics and conduct at the Council for Professions Supplementary to Medicine – 1960-200* (nd, London), 49.

²⁷ *Health Practitioner National Law Act 2009*, s 5.

National registration of paramedics will build on the 'lessons learned' with respect to other health professionals. The establishment of the National registration scheme and AHPRA was a recognition that separate state registration schemes were inefficient and did not provide adequate consumer protection and workforce mobility. It would be inefficient to reproduce a scheme of state registration for paramedics when the limitations of that sort of scheme have already been recognised for doctors, nurses and all other registered health professionals. It is submitted that the current, virtually non-existent regulatory scheme for paramedics is insufficient; it follows that only reasonable alternative is option 4 and national registration under the *National Law*.

Preferred option

7.1. Which of the four options presented is the preferred option for you or your organisation?

Please provide the reason(s) for your answer.

Option 4, for the reasons stated above.

Any other comments

Do you have any other comments to make?

Paramedics perform essential medical tasks, just as nurses and doctors do. With increased skills and ability to provide advanced care, patients both benefit from, and are placed at risk by, paramedic practice. It is, therefore, anomalous to not have paramedics registered in the same way as other health professionals. Bringing paramedics under the gambit of AHPRA will meet all the objectives of the National registration and accreditation scheme. Those objectives are:-

- (a). to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
- (b). to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
- (c). to facilitate the provision of high quality education and training of health practitioners; and
- (d). to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
- (e). to facilitate access to services provided by health practitioners in accordance with the public interest; and
- (f). 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.

National registration of paramedics will be better than the current regulatory scheme because it will ensure that only those health practitioners who are suitably trained and qualified to practice are registered and this is a core component of improving the quality and safety of our healthcare system.

It will allow for the development of practice standards and accredited and approved educational programs that ensure that there is consistency and quality across all paramedic programs again providing improved protections for the public (individually and the healthcare system as a whole).

The adoption of the national system will provide for a reduction in bureaucracy which can lower costs (both economic and human) by centralising disciplinary processes for paramedics who have engaged in unsatisfactory professional conduct; and

A centralised disciplinary process and notification of impairment mechanism has the potential to prevent harms from arising rather than relying on a system that can only act once a harm has been caused.

National registration will assist with the mobility and flexibility of the workforce allowing paramedics to move between employers and across jurisdictions to help meet health workforce needs. National registration will therefore provide more accessible healthcare for the public which in turn can improve health outcomes and again lower both economic and human costs.

We recommend the adoption of option 4, Registration of paramedics through the National Scheme.

