PUBLIC RISK AND PARAMEDIC REGULATION

RESPONSE TO THE AUSTRALIAN HEALTH MINISTERS'
ADVISORY COUNCIL CONSULTATION PAPER:
OPTIONS FOR REGULATION OF PARAMEDICS

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Paper prepared by Paramedics Australasia

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TABLE OF CONTENTS

Contents **page**

EXECUTIVE SUMMARY

Today there is a rapidly changing environment for paramedic practice. Many paramedics work outside government-related ambulance services. Paramedics are mobile nationally and internationally. Increasing numbers are employed in the private sector. There is a large market for casual and intermittent roles. The range of clinical interventions is growing rapidly as is the use of alternate referral pathways instead of the transportation of all patients to hospital. Paramedic education has shifted largely from in-service and VET training to the university sector.

This changing environment is increasing the risk of harm to the public from paramedic practice. This increasing risk comes on top of the ongoing risks associated with paramedic practice related to the type of interventions paramedics undertake, the emergency setting for practice and the fact that paramedics operate away from direct supervision.

Paramedics Australia (PA) believes that governments must act urgently to address these risks of harm to the public. PA has long advocated that the only acceptable regulatory approach is the registration of paramedics through the National Registration and Accreditation Scheme (NRAS).

Governments have responded, and in July 2012 a consultation paper was issued by the Australian Health Ministers' Advisory Council Health Workforce Principal Committee on *Options for regulation of paramedics*. The consultation paper set out four options for the future regulation of paramedics.

In examining these four options, PA assessed their efficacy in reducing the risk of harm in terms of how effectively they addressed the following seven risk reduction factors:

1. public access to an independent complaints mechanism;
2. ensuring only those who meet approved educational and practitioner standards can use the title of paramedic;
3. preventing paramedics with fitness-to-practice issues from moving from job to job without oversight or restriction;
4. making checks on qualifications, probity and criminal history a condition of practice;
5. compulsory and independent accreditation of training and education programs;
6. regulation which covers all paramedics wherever they choose to work; and
7. regulation which covers all employers of paramedics.

The outcome of those assessments was that PA strongly supports Option 4 which is the registration of paramedics through the National Scheme.

This strong support extends throughout the paramedic profession and other professional and community stakeholders. In a survey conducted by PA 87 per cent or 3298 of the paramedic and student respondents preferred Option 4. The regulatory options were separately examined by a wide range of stakeholders and discussed at consultation sessions nationally with similar overwhelming support for Option 4.

In reviewing the various options, the following observations apply**:**

Option 1. No change - does not address any of the seven PA risk reduction factors.

Option 2. Strengthen statutory complaints mechanisms - provides an independent complaints mechanism, can prevent paramedics with problems moving from job to job and covers all paramedics and all employers of paramedics to the same extent. By taking a reactive rather than a proactive approach, however, this option does not adequately address the other PA risk reduction factors.

Option 3. Strengthen State and Territory regulation of paramedics through ambulance legislation - places regulatory powers in the hands of a group of major employers, the government ambulance services. Although there may be some difficulties relating to legislative interpretation and the COAG agreement on health practitioner regulation, Option 3 could be framed to ensure approved educational and practitioner standards are met; make practitioner checks a condition of practice; and ensure all paramedics and all employers of paramedics are covered by these arrangements. However it is not efficient; it does not address all the PA risk reduction factors and it is unlikely to produce a uniform national system.

Option 4. Registration of paramedics through the National Scheme - provides a uniformly high level of oversight and regulation of paramedic practice based on national standards and should result in the greatest reduction in risk of harm to the public in terms of clinical and patient safety. Option 4 addresses all seven of the PA risk reduction factors.

The net benefits to the economy from the outcome of appropriate regulation are likely to be highest for Option 4, while the costs to governments are likely to be lowest for Option 1 and lower for Option 4 than either Option 2 or 3.

PA's assessment of the four options can be summarised as follows:

Risk reduction factor	Option 1	Option 2	Option 3	Option 4
1. Independent complaints mechanism	✗	✓	✗	✓
2. Approved educational and practitioner standards to use the title	✗	✗	✓	✓
3. Preventing paramedics with issues moving from job to job	✗	✓	✗	✓
4. Checks a condition of practice	✗	✗	✓	✓
5. Compulsory and independent accreditation of training and education	✗	✗	✗	✓
6. Cover all paramedics	✗	✓	✓	✓
7. Cover all employers of paramedics	✗	✓	✓	✓

PA strongly supports Option 4 as being the most effective in reducing the risk of harm to the public, and providing a sound basis on which the contribution of paramedics to the wellbeing of the Australian community can continue to grow and develop. It will also create an appropriate regulatory base for the rapidly growing private sector demand for paramedics in a way that assists practitioner mobility within Australia in line with the objective of a seamless national economy.

1. PARAMEDICS AUSTRALASIA

Paramedics Australasia (PA) is a national professional association representing paramedics engaged in the delivery of out of hospital emergency clinical care services to the community. PA's primary role is to provide leadership in professional matters. PA provides a national platform for the development and promulgation of policies and service standards that will enhance the quality of patient care.

PA's activities include programs of continuing professional development; publication of a quarterly general interest journal *Response* and a peer-reviewed electronic *Journal of Emergency Primary Health Care;* provision of information through a website and other media; holding scientific conferences and symposia, and sponsoring and fostering evidence-based research. PA also represents the profession by preparing submissions to government and engaging in discussions with government and other stakeholders on matters that affect the future of the profession.

Work undertaken by PA has included consideration of competence and fitness to practice, education, accreditation of training jointly with the Council of Ambulance Authorities (CAA), setting of professional practice standards, promoting ethical practice, and processes for dealing with poor performance and misconduct.

PA also sponsors two Special Interest Groups; the national student network Student Paramedics Australasia (SPA) for those in training to be paramedics; and the Rural and Remote Special Interest Group which places a particular focus on paramedic practice to support Australia's rural and remote communities.

In addition to membership based activities, PA supports the development of the profession in the public interest and advocates the profession's policies and views on health care issues to governments and other external stakeholders.

PA is a company limited by guarantee and registered under the *Corporations Act 2001*.

PA welcomes the opportunity afforded by this consultation to provide its views on the options for regulation of paramedics. PA stands ready to assist governments in any way it can to improve the quality and safety of the services provided by paramedics to the Australian community.

To help PA fairly represent the views of practitioners and students in responding as a professional association to the consultation process, PA conducted a national online survey to gather views on the consultation proposals and regulatory options. The survey was open to all paramedics and students and ran for the period 20 July to 27 August 2012.

There was a strong response to the survey with 3841 complete responses. This level of response shows the profession's interest in the consultation process and the importance to the profession of the issues surrounding the quality of care and risk of harm to the public. The views of respondents are included throughout this document.

PA gratefully acknowledges the input from all who took the time to complete the survey and contribute to this submission.

2. THE NATURE OF THE PROBLEM

An overview of paramedics in Australia

Consideration of the regulatory issues raised in this consultation requires as clear a picture as possible of the paramedic practice environment.

PA has identified a number of different data sources on paramedics in Australia. These are described in detail in Attachment A. Important among these sources are the 2006 census and the 2011 household Labour Force Survey as well as the administrative data published annually on the eight government-related ambulance services. Information on the labour market also can be derived from job advertisements.

As already mentioned, PA has conducted a comprehensive online survey (referred to here as the PA Survey) to inform its views. A description of this survey is provided at Attachment B.

The picture of the profession that has emerged from these sources updates the estimates from our previous submission on unregistered health practitioners (PA 2011: 4), and can be summarised as follows:

- Our current estimate of the total number of paramedics in Australia in 2011 is 12,800 although the figures from which this estimate comes are subject to sampling error;
- In 2006 adjusted numbers from the census suggest there were around 8700 paramedics;
- The number of paramedics in employment is growing rapidly, with estimated growth over the last five years of 47 per cent;
- Growth in paramedic employment has been faster outside the eight government -related ambulance services where growth in the number of paramedics has been 26 per cent over the last four years;
- In 2006 about 2500 paramedics (28 per cent of all paramedics) were working outside State and Territory government employment;
- In 2011 there were an estimated 4500 paramedics working outside State and Territory government employment representing 36 per cent of the total estimated number of paramedics;
- There are an estimated 5000 students studying to be paramedics, with 96 per cent of these being in degree programs;
- Paramedics are in high demand with an estimated unemployment rate of 0.7 per cent;
- The Internet Vacancy Index for paramedics is rated as “very high” and rose by 20 per cent over the 12 months to June 2012 during a period when vacancies for all occupations fell;
- 90 per cent of paramedics work in the health care and social assistance industry;
- 78 per cent of respondents to the PA survey thought that paramedics could not move easily between Australian jurisdictions;

- Despite perceived barriers to movement paramedics are mobile across State and Territory boundaries with 23 per cent of paramedics in the PA survey (709 respondents) having worked as a paramedic in more than one jurisdiction;
- 2400 paramedics have paid to register with the voluntary non-government Australasian Registry of Emergency Medical Technicians (AREMT);
- The ADF is the fourth largest employer of paramedics in Australia after the three State ambulance services of New South Wales, Victoria and Queensland;
- PA has identified 122 permanent private sector employers of paramedics in Australia (not including those who only employ paramedics on a casual or intermittent basis);
- Of these 122 private sector employers 57 per cent operate across State and Territory boundaries and slightly more than half of these (52 per cent) operate outside the health care and social assistance industry;
- There is an active secondary labour market for casual and intermittent employment of paramedics with a large range of employers including private first aid providers, statutory ambulance services, and private industrial / resource service providers;
- Secondary employment is high with 33 per cent of paramedics in the PA survey holding a second job, mainly as paramedics;
- Four major private sector employers alone (not including St John Ambulance services) employ 178 paramedics on an ongoing basis but have more than triple that number (619) employed on a casual or intermittent basis;
- Australia is part of an active international labour market for paramedics. 267 permanent migrant paramedics have moved to Australia over the last five years and 229 temporary migrants under sub-class 457 visas arrived over the last seven years, most of them from the United Kingdom; and,
- Of 402 job advertisements placed on the PA website over the last two years, 59 or 15 per cent were for positions outside Australia.

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

PA agrees with the consultation paper (page 35) that the risks to the public from paramedic practice appear greater than for many of the 14 other health professions already registered under the National Registration and Accreditation Scheme (NRAS).

PA considers that there are a number of risks associated with the nature of paramedic practice that are essential to the nature of the occupation and the clinical interventions performed. PA described these risk factors in some detail in an earlier submission (PA 2011: 4-6; Appendix 1). They include:

- invasive procedures;
- administering scheduled drugs;
- working away from supervision;
- providing complex and critical clinical assessments and care; and
- working in dangerous and uncontrolled settings.

These risks interact with one another. For example, the risks posed by invasive procedures and medication errors are greater in badly lit, wet, noisy and emergency circumstances than in a more conventional clinic or hospital environment.

Paramedic practice is increasingly changing from a focus of *'treat and transport'* to a more contemporary healthcare model of *'assess, treat and appropriately refer'.* This practice development places a greater responsibility on the practitioner and poses an increased risk of harm to the public.

The volume of activity forms part of the risk profile. In 2010-11 in the eight government ambulance services alone, there were 3.1 million incidents recorded in which ambulance services were involved (SCRGSP 2012: Table 9A.30). This figure does not include any incidents attended by those paramedics working outside the eight ambulance services. There is no national record of these other incidents or services.

In most cases the people treated by paramedics have little choice of provider so the practitioner care is taken on trust. The patient can also be unconscious when treated - so that consent to treatment is not always possible. There is usually a large gap in knowledge and understanding of the interventions between the person being treated and the paramedic.

These factors underscore the pivotal role played by trust in paramedic care – trust in the practitioner's competence and fitness to practice, trust in the interventions and referrals and trust in the provider support systems.

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

Beyond the inherent risks of the occupation, there are a number of factors in the changing environment for paramedic practice which are tending to increase the risk of harm to the public and which require appropriate government responses.

These factors include:

1. increasing numbers of paramedics working outside the government-related ambulance services (and hence outside the current most-established quality assurance systems);
2. high demand for paramedics and competition in an increasingly diverse national and international labour market putting pressure on employers to hire those without appropriate qualifications or to make inflated claims about qualification levels;
3. increasing mobility of paramedics;
4. a rapidly growing group of private sector employers, many of whom operate across jurisdictional boundaries;
5. many employers engaging paramedics on a casual or intermittent basis;
6. increasing variability in training and education standards (including arrangements for clinical placements) as new educational providers in the university sector move into the field. Only 7 of 20 current undergraduate programs across Australia have full accreditation under the voluntary scheme run by the CAA (consultation paper, page 15);

7. changing roles for paramedics including in rural areas where other health services are in short supply;
8. paramedics from overseas including New Zealand coming to work in Australia;
9. Australian companies providing paramedic services offshore who are competing with providers from countries such as the United Kingdom, South Africa and Ireland where paramedics are a registered profession; and,
10. the risk of variable standards within the profession when individual employers are the primary credentialling bodies.

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

The regulatory regime for paramedics should be aligned with accepted best practice arrangements in health practitioner regulation. This alignment of regulatory principles will cater for both the risk arising from current deficits in the regulatory environment and the increasing risk arising from recent practice developments.

PA considers that addressing the following seven factors would result in a reduction in the risk of harm associated with paramedic practice:

1. public access to an independent complaints mechanism involving an investigation and sanctions regime;
2. ensuring only those who meet approved educational and practitioner standards can use the title of paramedic;
3. preventing paramedics with significant health, conduct or performance issues moving from job to job or from practising in any jurisdiction without oversight or restriction;
4. making qualifications, probity or other checks a condition of both initial and continuing practice (for example, checks of criminal history, and continuing professional development);
5. compulsory and independent accreditation of training and education programs;
6. regulation which covers all paramedics wherever they choose to work; and,
7. regulation which covers all employers of paramedics, whether they work within or across State and Territory boundaries,

All of these factors are amenable to regulatory intervention. Moreover, with the risks having been identified so clearly in the consultation paper, they *must* be addressed urgently by governments.

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

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.

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

It is instructive to see the assessment of risk of harm to the public outlined in the consultation paper borne out by the experiences and views of paramedics in the PA survey.

Respondents gave sobering responses to the question: "Do you personally know of any instances of actual harm or injury to a patient associated with the practice of a paramedic?". These responses are provided in Table 1. The numbers are of considerable concern, indicating that practitioners within the profession see a higher level of public risk than is evident in any current public reporting.

Table 1. Knowledge of actual harm or injury among paramedic respondents

Response	Number of respondents	Per cent of respondents
No	1360	44
Yes - minor harm/injury	857	28
Yes - moderate harm/injury	337	11
Yes - significant harm/injury	250	8
Yes - death	277	9
Total	3081	100

Source: PA Survey, Question 15. Excludes university students

Tellingly, following on from the figures in Table 1, a large majority of paramedics in the survey (74 per cent) either agreed or agreed strongly that paramedics have the potential to pose a risk while carrying out their necessary health care functions.

One third of paramedics (1066 respondents or 35 per cent) also said that they personally knew of cases where unqualified persons had been employed or had operated as a paramedic.

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.

PA is not a non-government-related employer and has not undertaken a review of individual employer governance systems. However there is strong anecdotal evidence that the governance systems within the private sector vary widely in the absence of any national regulatory framework either for paramedic practitioners or service providers.

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

Yes. For many of the PA risk reduction factors listed above, inconsistencies in the arrangements between jurisdictions can increase the risk to the public. For example, where different jurisdictions recognise different educational standards for nominally similar roles, there is no nationally consistent assessment of what constitutes a safe level of training.

If regulatory inconsistencies can be reduced or eliminated, the public is more likely to receive the same level of benefit from paramedic practice regardless of where they live. Uniformity of regulatory arrangements also admits of better data collection and the development of key performance indicators that will better inform practice and thereby reduce risk.

Paramedics commonly respond across jurisdictional borders both in terms of daily operations and in times of disaster response. The current regulatory arrangements pose a number of challenges to these operations - such as legal arrangements for the use of controlled substances that potentially restrict the provision of health care by these practitioners.

Another factor contributing to risk is the absence of any requirement for one employer to share information with another regarding an individual practitioner's fitness to practise, or current or completed investigations on a fitness to practise issue. There may even be statutory impediments to information sharing such as privacy laws. The result is that a practitioner currently may resign from one provider while an investigation remains incomplete and seek employment elsewhere, without any caveats on their practice status and thus potentially placing the public at risk.

3. THE OBJECTIVES OF GOVERNMENT ACTION

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

The objective of government regulatory action should be directed towards improving public safety. PA supports the propositions in the consultation paper (page 57) that ensuring an effective and efficient quality assurance system and adequately protecting health services users from harm are key outcomes to be sought.

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

Yes. A compelling case for further regulatory action by governments lies in:

- the risk of public harm inherent in the healthcare functions performed by paramedics;
- the current and increasing risk of harm posed by the changing environment of paramedic practice and employment in Australia;
- the desire of governments to explore new roles for paramedics to meet the healthcare needs of the community (consultation paper, page 8); and,
- the need for a sound regulatory framework consistent with the creation of a seamless national economy to underpin the rapidly growing private sector demand for paramedics.

4. OPTIONS FOR REGULATION

In evaluating the four options for regulation, PA has assessed each option against the seven PA risk reduction factors (see question 1.3 above) and followed the structure of the questions posed in the 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.

PA does not support a 'do nothing' option. The consultation paper analysis of risk also comprehensively demonstrates the need for regulatory change.

Given that the identified risk of harm to the public requires an urgent response, adopting this option could be seen as irresponsible and carries grave implications for public safety together with political risk.

In summary, the no-change option does not address any of the seven PA risk reduction factors. It does not:

- provide an independent complaints mechanism;
- ensure only those who meet approved educational and practitioner standards can use the title of paramedic;
- prevent paramedics with issues moving from job to job;
- create enforceable checks as a condition of practice;
- set up an independent accreditation system for education and training;
- cover all paramedics; or,
- cover all employers.

It is likely that the risks to the public would continue to increase under this option, as a consequence of an increasing number of paramedics and providers operating in the diversifying labour market outside the longstanding government-related ambulance services.

Risk and trust need to be considered separately, because trust can be misplaced.

The Reader's Digest poll that has found consistently that paramedics are the most trusted profession in Australia is not a valid assessment of the level of risk associated with unregulated paramedic practice. *"For eight years, paramedics have held the title of Australia's Most Trusted Profession, while members of the poll's top five professions continue to hold our lives in their safe and careful hands"* (Reader's Digest 2012).

This level of trust could partly reflect the levels of distress felt at the time people need a paramedic and their relief when one arrives, rather than a well-based understanding of what constitutes sound paramedic practice and the measures in place to minimise risk.

Uncritical trust in paramedics could also pose a risk for governments. The public may be assuming that everything paramedics do is covered by the normal health regulatory structures. When something goes wrong (and we argue that risks are increasing) the public will come looking for answers and may be dismayed to find the regulatory arrangements are so far behind those for other health practitioners who pose equivalent or lesser risks to the public.

The consultative process itself is thus a source of political risk for governments in relation to Option 1 because the discussion paper has set out clearly the risks of public harm. In the face of this explication it will be more difficult in future for governments to claim they did not know there was a risk when an adverse event occurs.

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

There are no compliance costs for PA itself. However individual paramedics bear a number of costs from the absence of practitioner regulation. If they wish to change jobs they have to assemble documentation and seek employer endorsement for a statement of standing.

Many paramedics are concerned that their mobility within Australia is currently restricted and associate that situation with limited career progression and opportunities for professional development.

To have some kind of cross-jurisdictional and international certification, 2400 paramedics have paid for voluntary registration with the private registry body AREMT. This certification currently is not accepted by Australian public sector service providers (ambulance services). The level of independent review, rigour and accountability of the accreditation and certification process lies in the hands of the private registration agency.

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

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

Option 1, with the exception of complaints mechanisms already in place in NSW and the existing regulatory framework described in the consultation paper, relies on self-regulation by employers and by the profession.

There are strong general arguments against relying on self-regulation by either employers or the profession when the risks of harm to the public are high and where there is inequality of knowledge and understanding between service providers and end-users (very common in health care). These arguments are well described in the consultation paper on *Options for regulation of unregistered health practitioners (*AHMAC 2011: 29-30*)* and in previous PA and ACAP submissions (ACAP 2010a: 13-14; 24-25; PA 2011: 8-9).

There is a useful role for voluntary and largely unsanctioned professional codes of conduct in creating an environment of increased responsibility and public accountability within a profession. However, in terms of enforcement in the public interest, such codes are unlikely to be fully effective in reducing the risk of harm to the public.

The problems relating to enforcement mechanisms can be illustrated by the case of PA's own Code of Practice for members. Under the PA constitution (PA 2010a) all members are obliged to observe the code of conduct. Under the constitution and the rules of the company (PA 2010b), members can be disciplined for breaching the code of conduct or other provisions of the constitution and rules.

The inherent deficiency with this approach is the lack of real sanctions. Membership of PA is voluntary. If people do not want to become members of PA they suffer no penalty in their career or workplace. If a member was found to have breached the code, constitution or rules, and a penalty was imposed in some way, the most likely outcome would be that the person would cease to be a member either of their own accord or by decision of the PA Board. In either event this would not impose any penalty on the ex-member in terms of their employment unless the matter was so serious as to be referred to the police, an integrity agency or a health complaints process.

The difficulty in gaining support for voluntary regulation is also shown by the relatively low number of practitioners who have chosen to participate formally in the voluntary Certification process under the PA Continuing Professional Development Program. While the scheme has good intentions, the limited take-up is attributed to the fact that it is not a mandatory requirement for employment.

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?

There are limitations with the current State/Territory employer-determined arrangements.

There is an important role for all employers including the State and Territory ambulance services in determining the standards and qualifications for employment and in the management of conduct, performance or impairment issues as they relate to employment within those services.

What individual employers cannot do is provide an overarching regulatory framework that provides protections to the public beyond their service provider boundaries and across the whole profession nationally wherever practitioners may work, albeit some ambulance and health care Acts do empower government to apply controls across private employers within a single jurisdiction.

None of these arguments deals with the expectation that employers will provide a sound and well ordered environment for the paramedics who work for them and thus provide considerable protection from harm for the public.

PA notes the submission made by CAA to the consultation on the regulation of unregistered health practitioners (CAA 2011b). In that submission the CAA sets out the ways in which member ambulance service employers determine clinical competence at every level of practice, monitor and review clinical practice and determine clinical protocols. They also determine which employees will cease clinical practice or "drop" to a lower level of practice or undergo refresher training and skills assessments. They have procedures in place between members of CAA to review standards of education and clinical practice when paramedics move between member employers and in credentialling paramedics from overseas, (CAA 2011b:6).

These measures are consistent with the level of clinical governance that PA would expect of any employer when operating within an acceptable framework of provider and practitioner regulation.

An analogy can be made here with hospitals. The public and governments expect hospitals to have strong internal clinical governance arrangements which encompass the performance and competence of health practitioners. The implementation of jurisdictionally-based and then later national registration of health practitioners did not remove the expectation that hospitals (as employers) have good clinical governance arrangements and undertake similar oversight activities to those currently undertaken by ambulance service providers.

Rather, the independent regulatory arrangements for health practitioners complemented the arrangements within hospitals and provided for a greater level of public safety beyond the walls of the hospitals. The advent of NRAS augmented the existing internal hospital provisions particularly with regard to mandatory reporting for practitioners and employers.

Similar situations would be expected to apply in the case of paramedic employers in their management of registered practitioners and clinical governance requirements. The public would expect that whichever regulatory option governments adopt for paramedics, existing ambulance service organisations would continue to provide the high standards of internal clinical governance which they currently provide and which make such an important contribution to public safety.

While recognised as providing a high order of quality service, there have been concerns in the past about governance standards within ambulance services. Problems have been highlighted in New South Wales, Queensland and Western Australia (see summary in ACAP 2010b: 7-10). As outlined in that submission, good governance protects the public from risk of harm through:

- open and transparent reporting including provisions for whistleblower protection,
- external reporting of sentinel events and appropriate feedback mechanisms,
- independent and community-engaged complaint and dispute resolution mechanisms,
- effective organisational and administrative systems that foster participative decision making, mutual respect and matching responsibilities and accountabilities,
- appropriate accreditation and other quality assurance mechanisms for both individual practitioners and service providers, and
- over-riding acceptance of public accountability for health care outcomes (ACAP 2010b: 14).

PA has consistently drawn attention to the limitations of the current regulatory arrangements and the need for change.

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

PA has no names of courses to add at this time. However, the range of courses at undergraduate and postgraduate levels in Australian universities is in a constant state of flux both in regard to content and location. One new course program commenced at the University of Queensland in 2012 and a new satellite location for course delivery is expected to be established in the near future for Charles Sturt University. Similar developments are expected to occur elsewhere as the paramedic single and double degree course programs develop into a more mature state.

A number of VET-based courses still remain within the system but the transition to university-based education of paramedics is largely complete.

Other considerations

In terms of costs to the economy Option 1 contains the elements that would make it a relatively high cost option because of the increasing risks of harm to the public, the costs flowing from adverse clinical events, subsequent medical and litigation costs and the costs imposed on employers by the absence of national arrangements.

This option is likely to present the lowest nominal cost to governments because it does not involve any new activities. At the same time it must be recognised that currently there are many hidden regulatory costs in the operations of employers including the government ambulance agencies.

This option does not impose any extra costs on the profession.

This option does not require legislative changes.

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?

PA does not support differential codes of conduct for a practitioner regime where patients, employers and practitioners may be involved across multiple jurisdictions. As we read the consultation paper at page 65, Option 2 proposes"… a nationally consistent and enforceable …" code of conduct.

A different code of conduct in each State and Territory clearly would not be acceptable, and only a national uniform code would provide a simpler system for paramedics and employers working across or moving between jurisdictions and for students training in educational institutions across Australia.

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)

PA does not support individual jurisdictional regulation of paramedic services that are delivered across a national landscape and therefore does not consider that any local (jurisdictionally-based) authority or organisation is appropriate to regulate the profession.

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?

An arrangement where each State and Territory provided isolated investigatory and regulatory functions would be inefficient and ineffective. A national framework would be needed for Option 2 providing national consistency in investigating and issuing prohibition orders and in providing data to the public in a consistent manner. Were this not to occur there would be risks to the integrity of the system particularly since its benefits flow entirely from the improved handling of a small group of problematic practitioners and not the broad body of paramedics.

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?

There are no compliance costs for PA itself. The costs for individual paramedics remain as for Option 1.

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

This option would appear to provide some benefits for protection of the public but does not address all seven PA risk reduction factors. Potential outcomes are:

- It directly addresses the lack of public access to an independent complaints mechanism in relation to paramedics;
- In providing the ability to order a practitioner not to continue to provide health services and providing a publicly available register of such orders (whether on a national or a jurisdictional basis), the option goes some way to addressing the problems of the public and employers who are trying to validate the fitness to practise status of particular paramedics;
- the prohibition orders system would prohibit some practitioners from continuing to practise or practise without restriction, and the associated public registers would also make it more difficult for paramedics to leave one jurisdiction and practise in another or to change employer with impunity; and,
- on condition that the same mechanisms are set in place in every jurisdiction, Option 2 would cover all paramedics and all employers equally.

The main difficulty with this option is that it is a reactive option which provides an after-the-event response. The option does nothing to increase up-front protections for the public. Option 2 only draws into its scope those events arising from complaints made by the public to the complaints mechanism and is thus seen as inadequate for the higher risk levels associated with paramedic practice.

For example in NSW, where Option 2 is in place in some respects, the Health Care Complaints Commission (HCCC) did not resolve any complaints in 2010-11 relating to ambulance personnel (HCCC 2011: 124) and only one complaint was received about ambulance personnel (HCCC 2011: 105). In the five years up to and including 2010-11, only three complaints were received about ambulance personnel.

In contrast, in the first six months of the 2009-10 reporting year 27 "serious matters" were resolved within the NSW Ambulance Service resulting in disciplinary action for 14 officers including eight officers "*whose employment was terminated or ceased: as a direct result of the disciplinary hearings"* (page 105 of the consultation paper). Under Option 2 none of this internal material on specific practitioners from the ambulance service would be publicly reported.

Option 2 does not address three of the seven PA risk reduction factors, namely ensuring only those who meet approved educational and practitioner standards can say they are paramedics, making qualifications, probity and other checks a condition of practice, and compulsory and independent accreditation of training and education.

4.6 How would national registration be better than current regulatory arrangements?

National registration provides the only option that adequately addresses all seven of PA's risk reduction factors. Our response to this question is further outlined in the concluding section of this submission which provides a summary comparison of all options.

Other considerations

It is difficult to assess the costs to the economy of Option 2 but any reduction in harm and therefore costs would flow only from the complaints brought forward to the new mechanisms. The costs to the economy are more likely to be reduced if this were a fully national arrangement.

There are likely to be considerable additional costs to State and Territory governments, apart from NSW, in setting up the necessary institutional arrangements and in funding the ongoing arrangements as a public good (the NSW model for Option 2).

This option does not impose any extra costs on the profession nor does it relieve paramedics of the costs they bear under the current system.

Detailed legislative work and change would be required in most States and Territories.

Option 3: Strengthen State and Territory regulation of paramedics

5.1 Could paramedics or paramedic practice be regulated through strengthening ambulance legislation? Please provide the reason(s) for your answer.

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.

Ambulance service provider legislation is not an appropriate route for regulation of paramedic practitioners. There are three in-principle reasons for this answer, added to which there are specific reasons related to the seven PA risk reduction factors.

First, there may be difficulties related to the interpretation of legislation by the courts with combining two sets of not necessarily fully consistent objectives in one piece of legislation. This applies in those jurisdictions where ambulance legislation is separate from general health services legislation. Ambulance legislation is not health practitioner legislation but legislation built around governments' legitimate objectives relating to ambulance service provision.

This approach would potentially subordinate the needs of the community in relation to general paramedic practice (healthcare) to the needs of the community in relation to ambulance services. It is akin to using hospital legislation to regulate nurses and medical practitioners.

In that respect, ambulance legislation sits *alongside* health practitioner legislation for other registered health practitioners employed by ambulance services such as doctors and nurses. There is no justification for ambulance legislation to move into the practitioner regulation role for one category of employees and not for others.

Second, Option 3 may not be consistent with the *Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the Health Professions* (COAG 2008) signed by COAG on 26 March 2008 and underpinning the National Law governing NRAS. Option 3 may not sit well with the general objectives and principles in that agreement (Sections 5.3 and 5.4) which underwrite NRAS as the COAG-agreed way to regulate health practitioners in Australia across jurisdictions. Consistent with this approach, the IGA envisages the addition of new professions to the scheme under specified circumstances (Section 7.5 and Attachment B).

As noted in the submission on *Statutory regulation of the health professions* (quoted in ACAP 2010a: 18-20) equality of regulatory obligations among health care professions is also considered to be in the public interest. The legislative objective of equality is achieved through the application of a common regulatory framework to all professions, despite their differences in scope of practice or their overlapping scopes of practice.

For example, in Ontario, Canada, the *Regulated Health Professions Act (Regulated Health Professions Statute Law Amendment Act, 2009)* treats all regulated health professions the same and obliges all governing Colleges to adhere to the same corporate structure, purposes and procedures. This approach is similar in many respects to the general tenor of the IGA and supports the concept of paramedic regulation under the NRAS and not another mechanism.

Third, Option 3 shares a number of the drawbacks of the employer self-regulation model including the fundamental issue of conflict of interest created by a major employer (and competitor) also being the regulator in each State and Territory.

Best practice professional regulation requires a regulator independent of both employers and practitioners with public/community involvement - see United Kingdom Ministry of Health approach (quoted in PA 2011: 6-7).

In terms of the seven identified criteria for risk reduction, Option 3:

- does not provide an independent complaints mechanism;
- ensures only those who meet approved educational and practitioner standards can say they are paramedics;
- does not prevent paramedics with problems moving from job to job;
- would establish minimum qualifications on a jurisdiction-by-jurisdiction basis but not other checks as a condition of employment;
- does not establish compulsory and independent accreditation of training and education;
- covers all paramedics; and,
- covers all employers.

PA argues below that Option 3 is unlikely to provide consistent national arrangements.

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

There are no compliance costs for PA itself. The costs for individual paramedics remain as for Option 1.

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

If national consistency were the primary objective, one would start with a national legislative framework and not with separate State and Territory legislation. Health practitioner regulation has been specifically developed on the premise of a seamless national economy and facilitating practitioner mobility that optimises the use of the available workforce. Option 3 on the other hand is constructed on the premise of jurisdiction-specific State and Territory ambulance legislation.

One of the lessons learned from the process of developing NRAS was how hard it is to develop a single set of national arrangements from diverse beginnings. Under the NRAS intergovernmental agreement there could not be a scheme unless and until agreement was reached on a single national law.

The CAA for example, has not been able to create a harmonised regulatory regime for all employers and there are no requirements to link information, standards, titles or clinical protocols across jurisdictions. Practice limitations that may apply in one jurisdiction are not automatically translated across other jurisdictions, and resignations may remove a practitioner from the ambit of one employer during the course of an unresolved investigation to then work in another jurisdiction or for another employer.

PA's view is that starting from the premise of separate jurisdictional legislation and the disparate needs and history of ambulance services across the country, national consistency across eight different sets of ambulance legislation is unlikely to be achieved. There would simply be no incentives to create national consistency.

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

PA does see benefit to the public in improvements in ambulance services legislation and the independent accreditation of service providers. If ambulance legislation were to provide greater consistency in its coverage across jurisdictions, provided for more public reporting of complaints and incidents, and increased accountability to the public, this would be of benefit in terms of transparency and consistency.

This option would improve the protection of the public using ambulance services but it is not best practice to build a practitioner regulatory system around major employers rather than around an independent and publicly accountable structure.

Consistent with the COAG National Partnership Agreement to Deliver a Seamless National Economy, jurisdiction by jurisdiction arrangements for practitioner regulation have now been superseded by a single national regulatory arrangement, NRAS.

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

Purpose built State and Territory health practitioner regulation would be preferable to modifying ambulance legislation whose primary purpose is ambulance service provision.

Specific practitioner legislation could be enacted providing appropriate complaints mechanisms, protecting title, making enforceable checks a condition of practice, providing an independent regulator, covering the whole paramedic profession and covering employers outside the ambulance services.

However since there is no health practitioner regulation for paramedics anywhere in Australia and only Queensland (Qld) maintains regulation for two health professions not covered by NRAS, the time has passed for this option. If paramedics are to be regulated and the regulatory arrangements are to meet best practice requirements paramedics need to be regulated nationally under NRAS.

Other considerations

The costs to the economy remain largely unaltered because Option 3 does not relieve the public, paramedics or employers of any of the current problems and costs they are facing where these costs arise from risk of harm to the public.

The costs to governments are likely to be moderate to the extent that the option makes use of existing ambulance service structures to deliver the regulatory functions. Some additional costs are envisaged in terms of expanded activities to cater for wider employer and practitioner coverage as well as additional coordination and liaison costs for any inter-jurisdictional activities.

This option does not impose any extra costs on the profession nor does it relieve paramedics of the costs they bear as a result of the current system.

Significant and detailed legislative change would be required in each State and Territory for this option to be implemented, with new legislation required in Western Australia (WA) and the Northern Territory (NT). To the extent that it was considered desirable to achieve a degree of national uniformity this legislative work would need to be underpinned by extensive discussion and negotiation between governments likely to be well in excess of that required for Option 4 under an existing framework.

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?

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

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

Option 4 would address all seven PA risk reduction factors. It would provide:

- public access to an independent complaints mechanism (albeit differently configured in NSW from other States and Territories);
- protection of title to ensure that only those who have met approved education and practitioner standards are able to identify themselves as a paramedic;
- measures to prevent practitioners with problems moving from job to job through a national registration system, public national registers and transparent outcomes of health, performance and conduct processes, with these processes supported by mandatory reporting requirements on practitioners and employers;
- checks on criminal history, qualifications, language and continuing professional development as ongoing conditions of practice;
- compulsory and independent accreditation of training and education (see discussion below at questions 7.2 and 7.3);
- a single national system which would cover all paramedics wherever they worked and however they moved across jurisdictional boundaries; and,
- a single national system which would cover all employers.

PA acknowledges that no regulatory system can completely protect the public from the risk of harm. National registration of practitioners is not the sole arbiter of quality and safety. However regulation of this kind can help to create an environment of increased responsibility and public accountability and thereby reduce public risk.

Registered practitioners also must meet employers' requirements, standards, rules and policies. If things are working properly the health practitioner profession, the regulatory structure and the quality assurance mechanisms put in place by employers work in unison and do not replace or compete with one other. In that regard, there may be a case for further work on quality standards for providers of paramedic services (employers of paramedics).

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

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?

There are no insurmountable barriers to establishing a national accreditation scheme for the education and training of paramedics. Work undertaken so far by the CAA and others should underpin any new arrangements.

There has been substantial development in accreditation of paramedic education programs under the auspices of the CAA since 2004, working with PA and its predecessor the Australian College of Ambulance Professionals Limited. In conjunction with PA, CAA issued Paramedic Professional Competency Standards in 2010 and is currently performing the role of accrediting training programs against these standards with such accreditation being on a voluntary basis.

This work is more fully described in the consultation paper (pages 14-15). CAA is to be commended on supporting these initiatives so important to the development of the profession.

The national boards, the Australian Health Practitioner Regulation Agency (AHPRA) and the Forum of Australian Health Professions Councils (FAHPC) have been working on accreditation arrangements under the National Law (The Forum now has 12 members all being external accrediting authorities operating under the National Law.)

Of particular interest for the purpose of this consultation is a paper prepared between the national boards, AHPRA and FAHPC on accreditation under the National Law. This paper draws on national and international best practice and includes an agreed quality framework for the accreditation function (FAHPC 2011: 6-7, 22-28). The quality framework is the principal reference document for the boards and AHPRA to assess the work of accreditation authorities under the National Law.

Two of the eight domains in the quality framework are governance and independence (FAHPC 2011: 25). Under governance the main statement for the domain is

> *The accreditation authority effectively governs itself and demonstrates competence and professionalism in the performance of its accreditation role.*

Two of several attributes under this domain read as follows:

> *The accreditation authority is a legally constituted body and registered as a business entity.*
>
> *The accreditation authority's governance and management structures give priority to its accreditation function relative to other activities (or relative to its importance).*

Under independence, the main statement for the domain is:

> *The accreditation authority carries out its accreditation operations independently.*

One of two attributes under this domain reads as follows:

> *Decision making processes are independent and there is no evidence that any area of the community, including government, higher education institutions, business, industry and professional associations - has undue influence.*

In light of the provisions of this quality framework for health practitioner accreditation, the paramedic profession should have an independent accrediting authority.

PA has long advocated the principle of independent accreditation and believes it is imperative that a new entity be established that builds on the work done by PA and the CAA and draws on the existing expertise to the maximum extent possible.

This realignment of existing accreditation arrangements would not be difficult and PA notes that institutional rearrangement of accreditation functions occurred in some other professions in the lead up to the commencement of NRAS on 1 July 2010.

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?

As a professional body there will be no direct compliance costs, although there will be a commitment on the part of the profession to maintain its continuing professional development and other representative activities in supporting the NRAS.

Option 4 relieves paramedics of much of the documentation and other costs that they currently bear when changing jobs. There will however be additional costs to all practitioners in the form of registration fees, with recurrent costs covered by paramedic registrants as they are for the other 14 professions in NRAS. Respondents in the PA survey had mixed views on the question of registration fees with 44 per cent being concerned or very concerned compared to 31 per cent who were unconcerned or not at all concerned.

PA accepts that in the interests of the public, the profession will need to shoulder these costs but that the costs need to be kept to the minimum. There will be economies of scale for every profession joining the new scheme since a number of overhead costs are shared across all professions.

Professional indemnity insurance

Some questions have been raised about the impact under Option 4 of the NRAS requirement for professional indemnity insurance cover, if paramedics were to be nationally registered.

There would be no real change in the existing conditions relating to vicarious liability, and in most cases for paramedics it would be employers who would provide the indemnity cover since few paramedics currently are in private practice on their own account. Many employers already hold cover for other registered health practitioners.

The indemnity requirement would provide an additional level of discipline on health service providers. This discipline is particularly important where there are such a large number of casual and intermittent employment arrangements. It would ensure protection for the public wherever and however paramedics worked.

The national and international labour market

National registration under Option 4 addresses the problems identified by employers and paramedics about barriers to mobility and costs to employers of not having national registration. As already noted, 57 per cent of private sector employers operate across State and Territory boundaries, as does the fourth largest employer, the ADF. Among paramedic survey respondents 78 per cent thought that paramedics could not easily move between Australian jurisdictions.

National registration would underpin a well-functioning national labour market with a single standard for registration wherever paramedics lived and worked. National registration reduces the costs of mobility for paramedics and employers through the national registers and registration documents.

There are also benefits from Option 4 in relation to the international labour market for paramedics. Option 4 would provide Australian companies and paramedics with clearer statements of standing in the international market and facilitate inward and outward migration.

For incoming paramedics either from New Zealand or under the employer-sponsored migration scheme, eligibility for registration as a paramedic would be established once for the whole of Australia through a process agreed by the national board. Subject to migration requirements for those from beyond New Zealand, national registration would provide for potential mobility between employers and within Australia.

Recognition of overseas qualifications for migrants under the employer sponsored migration scheme currently lies with the generalist Vocational Education and Training (VET) assessment provider VETASSESS, rather than with a professional organisation such as the Australian Nursing and Midwifery Accreditation Council which is the assessing authority for enrolled nurses from overseas seeking registration under NRAS.

Under Option 4, national recognition of overseas qualifications could pass over time to a process specific to paramedics and likely associated with the accreditation function.

Other considerations

In terms of costs to the economy, Option 4 provides the best result. It not only maximises protections against the risk of harm, but it also removes the costs associated with having to document and check fitness for employment on a recurring basis for paramedics who operate or move across jurisdictional boundaries. These costs commonly fall on paramedics, as well as the business sector and employers.

In terms of costs to governments, this option takes advantage of the existing investment in establishing NRAS. All the information technology, staffing and accommodation systems are in place. There are ready-made structures and regulatory processes and procedures. Governments would bear only the marginal set-up costs of adding a new profession to an existing scheme on a one-off basis on the same basis as for the four professions added to NRAS on 1 July 2012.

Since both options 2 and 3 will involve some ongoing costs for governments, and option 2 requires the setting up of new institutional structures in most jurisdictions, the costs of Option 4 to governments is likely to be considerably lower than for any other option except Option 1, the do-nothing option.

In terms of the legislative burden on governments, Option 4 is likely to require less legislative work than options 2 and 3. There would need to be internal and external consultative work done by the new board and AHPRA.

However it appears that the only legislative amendments required to the National Law (Qld 2009) would be: to add paramedics to the list of health professions (ambulance services are already included in the definition of health services) (Section 5); to establish a board for the profession (Section 31); to establish title protections (Section 113), to determine the name of the public national register and any divisions within that register (Section 222) and to establish the day on which registration for paramedics is to commence (Section 250).

5. THE 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.

PA prefers Option 4.

PA considers that Option 4 will provide for the greatest reduction in the risk of harm of all the options and will address in one way or another all the PA risk reduction factors identified in this submission . Table 2 portrays our assessment of the four options.

While producing the best outcomes, Option 4 is also the cheapest for governments (with the exception of the do-nothing option) and is likely to produce the most beneficial economic outcomes.

Table 2. Assessment of regulatory options against factors that can reduce risk

Risk reduction factor	Option 1	Option 2	Option 3	Option 4
1. Independent complaints mechanism	✗	✓	✗	✓
2. Approved educational and practitioner standards to use the title	✗	✗	✓	✓
3. Preventing paramedics with issues moving from job to job	✗	✓	✗	✓
4. Checks a condition of practice	✗	✗	✓	✓
5. Compulsory and independent accreditation of training and education	✗	✗	✗	✓
6. Cover all paramedics	✗	✓	✓	✓
7. Cover all employers of paramedics	✗	✓	✓	✓

PA's preferred option is also reflected in the views of respondents to the PA survey. 87 per cent or 3298 of paramedic and student respondents supported Option 4, with the remaining 13 per cent split roughly equally between the other three options.

Survey returns showed a good understanding of what Option 4 meant for paramedics. Even where there were areas of concern for a minority of respondents, these appear not to have translated into opposition to Option 4 as the preferred option. Further details are provided in Attachment A.

PA's preferred option also accords with the views of the overwhelming majority of those stakeholders who attended the forums to discuss the consultation paper in each State and Territory.

PA believes that if governments adopt Option 4 and establish national registration for paramedics, this will

- reduce the risk of harm to the public arising from current circumstances
- provide a sound basis on which the contribution of paramedics to the wellbeing of the Australian community can continue to grow and develop, and
- create an appropriate regulatory base for the rapidly growing private sector market for paramedics in a way that assists mobility within Australia in line with the objective of a seamless national economy.

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ACRONYMS USED

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACAP	Australian College of Ambulance Professionals Limited
ADF	Australian Defence Force
AHMAC	Australian Health Ministers' Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AREMT	Australasian Registry of Emergency Medical Technicians
CAA	The Council of Ambulance Authorities
COAG	Council of Australian Governments
CPD	Continuing professional development
DEEWR	Department of Education, Employment and Workplace Relations
FAHPC	Forum of Australian Health Professions Councils
FTE	Full-time equivalent
GNGP	Government/Non-Government employer indicator
HCCC	Health Care Complaints Commission
IGA	Intergovernmental Agreement
LFS	Labour Force Survey
NCVER	National Centre for Vocational Education Research
NRAS	National Registration and Accreditation Scheme
NSW	New South Wales
NT	Northern Territory
PA	Paramedics Australasia
Qld	Queensland
SA	South Australia
SCRGSP	Steering Committee for the Review of Government Service Provision
SPA	Student Paramedics Australasia
Tas	Tasmania
Vic	Victoria
VET	Vocational Education and Training
WA	Western Australia

ATTACHMENT A - DATA ON PARAMEDICS IN AUSTRALIA

Sources

The main sources for data used in this attachment are:

- the Australian Bureau of Statistics (ABS) Labour Force Survey (ABS 2012) reproduced for individual occupations in the Department of Education, Employment and Workplace relations Job Outlook series (DEEWR 2012a and 2012b)
- the 2006 census (ABS 2006a; AIHW 2009; customised tables using TableBuilder on www.abs.gov.au (hereafter described as customised tables)
- the CAA administrative data reported annually (CAA 2011a)
- the Report on Government Services 2012 (SCRGSP 2012) which draws on CAA collated data, and
- an online survey of paramedics and paramedic students conducted by PA in 2012, referred to as the PA survey (see Attachment B for details).

Unfortunately 2011 census data on occupational classifications which is needed to identify paramedics will not be available until October 2012.

Numbers of paramedics

The key numbers relevant to questions of regulation of paramedics are the numbers of paramedics practising in Australia. These are the people who, through engaging in clinical assessment, and treatment of the public, may place the public at risk of harm. PA has found it useful to use the following definition of a paramedic:

> *A paramedic is a health practitioner whose education, training and skills enable them to provide a range of out of hospital emergency procedures and clinical care interventions*.

While there are good annual data on numbers of people employed in the eight government-related ambulance services (CAA 2011a and SCRGSP 2012), these data cannot give us a picture of the profession as a whole across Australia.

PA therefore has turned to nation-wide data collections which include occupational classifications. These are the 2006 census and the Labour Force Survey (LFS). Unfortunately, the new 2011 census data on occupational classifications will not be available until after this response has been submitted. PA intends to analyse this information when it is issued and will make the analysis results available to those interested in this consultation.

The estimates from the 2006 census are more robust than those from the LFS because the LFS is a sample survey designed to produce reliable estimates only for major national employment aggregates. The LFS is based on a sample of private dwellings (approximately 29,000 houses, flats etc) and non-private dwellings, such as hotels and motels. The sample does not cover the ADF. The sample covers about 0.33% of the Australian civilian population aged 15 years or over (ABS 2012). The sample size means that estimates relating to paramedics will be subject to some error.

Both the 2006 census and the LFS use two occupational codes in the standard classification for occupations for

- ambulance officers (code 411111), and
- intensive care ambulance paramedics (code 411112) (ABS 2006b: 476-477).

For a combined number the four-digit code used is 4111, Ambulance officers and paramedics). The overall definition for this code is

> *Ambulance officers and paramedics provide emergency health care and transport for injured, sick, infirm and aged persons to medical facilities.*

Within the ambulance officer code group is included the specialisation "patient transport officer". A patient transport officer is not regarded as a paramedic in other sector statistics such as those of the CAA where patient transport officers are listed separately from qualified ambulance officers.

As a result of the definitions currently used, there is no exact correspondence between code 4111 and practising paramedics. The inclusion of patient transport officers means the numbers in 4111 will be higher than the real numbers of paramedics. There may well be others included in 4111 who work with ambulance services who are not paramedics.

A clue to the size of the group who are not paramedics in 4111 in both the 2006 census and the 2011 LFS is the number of people (1092) in 4111 without any formal post-school qualifications.

Of these 1092 people 243 were students aged up to 49 years studying for their first qualification and therefore not working as qualified paramedics. Of the remaining 849, some will have been working as paramedics with on-the-job training leading to recognition of experience equivalent to qualifications and working as qualified paramedics, but the majority were probably not working as qualified paramedics. For example many would have been working as patient transport officers (all of whom would have been classified under 4111), reported to number 506 in the government-related ambulance services alone (SCRGSP 2012: Table 9A.32). Thus a minimum of around 750 of the 1092 were not working as qualified paramedics in 2006.

We can judge the reasonableness of using 1092 as a proxy adjustment by looking further at the 2006-07 CAA data (SCRGSP 2012: Table 9A.32). In addition to the 506 patient transport officers there were 1592 students and base grade officers in the government-related ambulance services in 2006-07. Few if any of the latter would have been working as qualified paramedics who are classified separately by the CAA, but may well have been reported in 4111. This is a total of 2098 persons in government-related ambulance services alone who may have been captured by 4111 but are unlikely to be qualified paramedics.

We therefore consider it reasonable to use the numbers of people without formal qualifications in the 2006 census, a total of 1092, as a modest proxy for the number of non-paramedics in 4111 to improve the estimates.

A second difficulty in using the national surveys for our purposes relates to the ADF. In the 2006 census only 131 paramedics in the ADF were included in 4111, with the rest (estimated at around 700) presumably being shown under defence occupations. The LFS specifically excludes ADF employees.

There may well be other weaknesses in using the 2006 census and the LFS to derive paramedic numbers but these are the two for which we can make adjustments to arrive at improved estimates of the total number of paramedics in 2006 and 2011 as shown in Table A1.

Table A1 Estimates of paramedic numbers in 2006 and 2011

Item	2006 census numbers	2011 LFS numbers
Numbers in code 4111	9097	16,000
Less those without post-school qualifications	-1092	-4,000
Plus ADF numbers not counted in data	+710	+841
Final estimate	8715	12,841

Sources: 2006 census data: customised tables
LFS: DEEWR 2012b
Note: ADF numbers assumed to be the same in 2006 as in 2011

Using the method shown in Table A1 and noting that the 2011 LFS estimate is inherently less reliable than the 2006 census because of sampling error, we might estimate that there were in the order of 8700 paramedics practising in 2006 and around 12,800 in 2011.

Proportion of paramedics working for State and Territory governments

The 2006 census provides information on what is called the Government/Non-Government employer indicator (GNGP). This shows that 1995 (78 per cent) of those captured by code 4111 were employed by State and Territory governments, with 21 per cent in the private sector and 1 per cent employed by the Commonwealth. The private sector will include employees of the St John Ambulance services in WA and NT which have contracts with their respective governments to provide public ambulance services. Comparable figures on GNGP are not available from the LFS.

Using the methodology in Table A1, it is estimated that in 2006 there were around 2500 paramedics (28 per cent of the total) working outside State and Territory employment with ADF personnel and St John Ambulance employees in WA and NT being included in the 28 per cent. Our analysis of the 2006 census means there were an estimated 6249 paramedics working for the six State and Territory governments with their own ambulance services, a figure very close to the CAA data which shows 6085 qualified ambulance officers in 2006-07 in those services (SCRGSP 2012: Table 9A.32).

Growth in paramedic numbers

The number of people working as paramedics is growing rapidly and growth is accelerating. The LFS internal data shows an estimated growth rate of 51 per cent over the five years to November 2011.DEEWR 2012b). The figures in Table A1 suggest a growth rate of 47 per cent over five years.

The LFS two-year and ten-year growth rates to November 2011 place paramedics in the top 10 per cent of occupations in Australia in terms of job growth. DEEWR also expects that employment for ambulance officers and paramedics will "grow very strongly" to 2016-17 (DEEWR 2012a).

These growth rates in overall paramedic numbers can be compared with the growth rates in the administrative data for the eight government-related ambulance services (SCRGSP 2012: Table 9A.32, with the addition of SA number from 2009-10 adjusted by growth rate in other jurisdictions for 2010-11 since SA data was not available in time for inclusion in the published report). From these data the numbers of qualified ambulance officers in the eight government-related ambulance services grew from 6548 to 8245 or 26 per cent over the last four years.

This is a much lower growth rate than for the paramedic workforce as a whole. As a result the proportion of paramedics employed outside the government-related ambulance services and in the private sector is likely to be significantly higher in 2011 than it was in 2006.

As an indicator of the trend, an estimate can be made of the numbers working outside State and Territory employment in 2011 using the estimates in Table A1 and the growth rates in the government-related ambulance services. If we use the Table A1 figure of 6249 in State and Territory employment in 2006 and increase it by 26 per cent over the four years to 2010-11 plus add an assumed 5 per cent in 2010-11 to 2011-12 (the growth rate in the previous year), we can estimate that the number of paramedics employed by State and Territory governments in 2011 was 8267. Comparing this to the 2011 total estimate of 12,841, this would suggest there were around 4500 paramedics outside State and Territory government employment in 2011, or 36 per cent of all paramedics.

Student numbers

From university responses to PA enquiries, PA estimates that in May 2012 there were 4813 students in entry level (bachelor degree) programs in 16 institutions. In July 2012 there were another 112 students at the ADF School of Health, bringing the estimate of the total number of students to 4925.

In the VET sector in 2011, there were only 113 Diploma in Paramedical Science (Ambulance) students remaining, no advanced diploma students, 89 students in Certificate IV level courses and 2907 in Certificate III level courses (NCVER 2012). VET sector enrolment figures for 2012 are not available.

Taking the diploma as the minimum paramedic qualification, then around 5000 (5038 on the figures above) are currently training to be paramedics, with 96 per cent of these being in degree programs.

Demand for paramedics

Unemployment rates for paramedics are low compared to other occupations. In 2011 the unemployment rate was estimated at 0.7 per cent (DEEWR 2012b). Paramedics rated in the second lowest decile of unemployment among all occupations in Australia at the end of 2011 (DEEWR 2012a).

The Internet Vacancy Index for paramedics is rated as "very high". The index rose by 20 per cent over the 12 months to June 2012 during a period when vacancies for all occupations fell by 13 per cent (DEEWR 2012b). Paramedics were in the second highest decile on the index for all occupations (DEEWR 2012a).

Labour market and geographic mobility

With high demand for paramedics, movement between jobs and around Australia is an increasing feature of the paramedic workforce.

The PA survey provides some insight into the geographical mobility of paramedics across State and Territory boundaries. The survey found that 709 or 23 per cent of respondents had worked as a paramedic in more than one jurisdiction. Of these 5 per cent (140) had worked in three jurisdictions and 6 per cent (191) had worked in more than three.

From the PA survey it appears that respondents would like to be able to move more easily across State and Territory borders. In response to the proposition that paramedics can, in relation to professional practice, easily move around/between Australian jurisdictions, 2391 paramedic respondents (78 per cent) said they disagreed or disagreed strongly.

There is a clear demand among paramedics for some kind of certification/registration. This appears to arise from the views of private sector employers (including those wishing to employ paramedics overseas) who would prefer to have employees certified in some way. In the absence of a formal government system, paramedics have registered voluntarily at various levels of qualification with the private AREMT organization.

The international labour market for paramedics

Australia is part of an active international labour market for paramedics. We have undertaken an analysis of the 402 paramedic jobs advertised on the PA website in the period between 18 April 2010 and 15 August 2012. Of the jobs advertised, 59 or 15 per cent were for overseas deployment (12 of these were in New Zealand). The majority of these advertisements were placed by overseas companies and recruitment agencies. Australian-based companies do not find it necessary to advertise so widely although several companies are very active offshore and employ paramedics to work overseas. Much of this overseas recruitment effort is related to resource sector projects.

The countries/regions where work was being offered were:

- Afghanistan
- Africa
- EU
- Indonesia
- Iraq
- Israel

- Kuwait
- Malaysia
- Middle East
- New Zealand
- Papua New Guinea
- Qatar
- Saudi Arabia
- SE Asia
- Sierra Leone
- Solomon Islands
- Somalia
- South Pacific
- Timor Leste
- UAE, and
- USA.

The two occupational classifications in which paramedics are to be found, ambulance officer and intensive care ambulance paramedic, are also listed on Schedule 2 of the Consolidated Sponsored Occupations List for potential migrants to Australia (Department of Immigration and Citizenship 2012). This means that paramedics from overseas may apply for sponsored general migration scheme visas in 2012 but not for unsponsored general migration scheme visas. New Zealand paramedics do not need visas to work in Australia.

Australia has received several hundred paramedics from overseas under these immigration arrangements. Figures supplied by the Department of Immigration and Citizenship show that in the five years from 2007-08 to 2011-12 there were 267 permanent migrant paramedic arrivals to Australia. By far the majority of these came from the United Kingdom (73 per cent) and a much smaller number from South Africa (15 per cent). Subclass 457 visas for temporary work in Australia were granted to 229 paramedics in the seven years from 2005-06 to 2011-12, again with the majority coming from the United Kingdom (63 per cent).

Industry of employment

The LFS provides estimates of paramedic employment by industry. Table A2 shows that in November 2011 90 per cent of paramedics were employed in the health care and social assistance industry and a further 7 per cent in public administration and safety.

Table A2. Estimates of paramedic employment by industry in 2011

Industry	Per cent of persons employed (raw LFS)	Per cent of persons employed (adj LFS)
Health care and social assistance	96	90
Construction	1	1
Mining	1	1
Public administration and safety	0	7
Transport, postal and warehousing	1	0
Other	1	0
Total	100	99*

Source: DEEWR 2012a with adjustments as per Table A1
*Note: * in some tables rounding causes a total other than 100 per cent*

The 2006 census provides more detailed information on the industry in which people worked in that year with the overall picture broadly reflecting the adjusted LFS data.

Industry of employment was mainly coded using written responses on the business name and address of a person's employer (questions 40 and 41 on the household form) where the business may already be coded from known data and on the type of industry and main goods or services produced by the business of the employer (questions 42 and 43) (ABS 2006a).

Table A3 shows that adjusting for the same factors as in Table A1 an estimated 83 per cent of paramedics worked in either public or private ambulance services in 2006. Of the remaining paramedics, 11 per cent were in public administration and safety (including defence), 5 per cent in other health services and the remainder in other industries.

Table A3. Industry of employment of paramedics, 2006

	Sub-industry (Number of paramedics - raw data)	Number of paramedics (raw data)	Per cent in industry (raw data)	Per cent in industry (adjusted data - see Table A1)
Health care and social assistance	hospitals (295)			
	other health services (212)			
	ambulance services (8168)			
	social assistance & residential care (26)			
	other health and social assistance (41)			
	Total in industry	8742	96	88
Mining		29	0	0

	Sub-industry (Number of paramedics - raw data)	Number of paramedics (raw data)	Per cent in industry (raw data)	Per cent in industry (adjusted data - see Table A1)
Manufacturing		12	0	0
Public admin and "safety*		227	3	11
Transport, postal and warehousing		24	0	0
All other industries		44	1	1
Total		9078	100	100

*Source: Customised tables on 2006 census. Excludes persons where industry of employment was not known. * 48 in public administration, 131 in defence, and 48 in public order, safety and regulatory services in raw data*

PA survey data on industry and employment

The PA survey provides further information on these broadly defined industries of employment for paramedics. While the majority of paramedic respondents (77 per cent) worked in public statutory ambulance services, Table A4 describes in some detail where others worked. Of particular interest are the paramedics working in the ADF and the private sector and the numbers with private industrial or resource sector employers.

Table A4. Primary engagement of paramedics, 2012

Primary engagement	Number of respondents	Per cent of respondents
Public Statutory Ambulance Service	2368	77
Private Statutory Ambulance Service	116	4
Private Prehospital Ambulance Service Provider	110	4
Private First Aid Service Provider	35	1
Private Industrial/Resource Service Provider	142	5
Australian Army	77	3
Australian Airforce	26	1
Australian Navy	97	3
University Sector Education	42	1
Other	71	2
Total respondents	3084	101

Source: PA survey 2012 Question 2. Which of the below are you primarily engaged/operating in?
Note: Excludes university students

A large secondary labour market for casual and intermittent employment

An interesting finding in the PA survey was the number of respondents who had a secondary engagement in the paramedic work force as well as a primary one. We asked people about other roles in paramedicine with the results being shown in Table A5. In the next question we asked them about whether they were engaged as students, employees or volunteers. Scaling back the answers because multiple answers were permitted, we found that 33 per cent of paramedics had a second role as an employee, with another 13 per cent working as volunteers and 6 per cent studying part-time.

Further details are illustrated by Table A5 although it should be noted that this table also includes volunteers as well as employees across many of the categories and the two educational categories will be a mix of students and academic staff.

. **Table A5. Paramedics and secondary engagement**

Response	Number of responses	Per cent of respondents who gave this answer*
No other engagement	1876	61
Public Statutory Ambulance Service	259	8
Private Statutory Ambulance Service	38	1
Private Prehospital Ambulance Service Provider	94	3
Private Aeromedical Retrieval Service Provider	71	2
Private First Aid Service Provider	333	11
Private Industrial/Resource Service Provider	189	6
ADF	168	5
VET sector	84	3
University sector	316	10
Other (mainly non-paramedic)	103	3
All respondents	3084	not applicable

*Source: PA survey 2012 Question 6.Which of the below are you otherwise engaged or operating in? * Respondents who did have a secondary engagement could provide more than one answer. Excludes those whose primary role was university students.*

The table indicates that secondary jobs for paramedics were largely in the paramedic labour market and were particularly common with private first aid providers, public statutory ambulance services, private industrial/resource service providers and the ADF (reserves). The largest single group of those included in the “other employment” category are paramedics who are dual qualified as nurses (and this will be a growing group with the current structure of double-degree university courses).

Comparing tables A4 and A5, we see that ambulance service providers rely mainly on full-time employment while many of the providers in the private sector rely more on casual or intermittent employment of paramedics.

To give an indication of the scale of this secondary labour market, PA invited some of the major employers of paramedics to provide figures on how many paramedics they employed and whether their staff were employed on an ongoing basis or on a casual or intermittent basis.

We have received responses from Aspen Medical, Hostile Environment Services, International SOS (Australasia) Pty Ltd and Immediate Assistants Pty Ltd. These companies have advised that they have 178 paramedics in ongoing employment and three times that number (619) employed on a casual or intermittent basis.

While there will be overlap between the casual employee lists of companies these figures give some indication of the scale of the demand for casual or intermittent work... At the other end of the scale in a small company which responded to our enquiries, there was one permanent paramedic employee with 25 casual paramedics, an even more extreme ratio of ongoing to casual and intermittent employees.

It would seem that this secondary labour market has arisen from a number of factors: the general high demand for paramedics, some demand that is intermittent or short-term in nature (around projects, construction, public events or training), and the preferences of some paramedics to retain an ongoing employment base and not to relocate long term to remote or overseas locations.

Employers of paramedics

An important element of the changing labour market for paramedics is the increase in the number and variety of employers.

In the government sector, there is some employment of paramedics outside the ambulance services. The largest single employer outside the ambulance services is the Australian Government through the ADF with 841 employed. Other government sector employment outside the ambulance services is minor.

In terms of employer ranking, the ADF is the fourth largest employer of paramedics in Australia after the statutory ambulance services in NSW, Vic and Qld (figures from SCRGSP 2012: Table 9A.32).

In the private sector there are some large employers, including St John Ambulance in WA and NT with these two employers being in the top ten nationally.

PA has assembled a list of named employers who at the time of advertising or our recent web-based research were either looking to employ or were employing paramedics. No employer was included unless there was evidence from their website that they employed paramedics on a permanent basis, the business was owned and operated by paramedics or the employer had advertised for paramedics. The list does not include employers who only engaged paramedics on a casual or intermittent basis.

Table A6 lists 122 private sector employers who could be regarded as employers of paramedics on an ongoing basis. Many but not the majority of these employers (48 per cent) are in the health care and social assistance industry, with 17 per cent in education and training and 15 per cent in mining.

Of these employers the majority (57 per cent) operate across more than one jurisdiction. A further 19 per cent operate only in WA and 8 per cent operate only in Qld. These figures and the focus on WA and Qld show the influence of the growth of the resources sector on the paramedic labour market.

Many of the health industry employers also provide specialised services to the resources sector, including the provision of industrial and mine site paramedics, as well as to the ADF and a few other Commonwealth government agencies.

Table A6 Private sector employers of paramedics in Australia

Industry	Employer	State/ Territory	Source
Administrative and support services	Civil Pacific Services Pty Ltd	Qld	3
Arts and recreation services	Burswood Entertainment Complex	WA	3
Construction	Bechtel Corporation	Multiple	3
	McConnell Dowell Constructors (Aust) Pty Ltd	Multiple	2
	NRW Holdings Limited	Multiple	3
	Southern SeaWater Alliance	WA	3
	Thiess Group	Multiple	3
	Transfield Services	Multiple	3
Education and training	4Life Pty Ltd	Multiple	1
	AMA Services (WA) Pty Ltd	WA	3
	Australian Catholic University	Multiple	1
	Central Queensland University	Qld	3
	Charles Sturt University	NSW	2
	CPR First Aid Training	Multiple	3
	Eagle Training Services NT	NT	1
	Edith Cowan University	WA	2
	Flinders University	SA	3
	KidsFIRSTaid	Multiple	3
	La Trobe University	Vic	3
	Monash University	Vic	3
	Parasol EMT	Multiple	1
	Premium Health	Multiple	2
	Queensland University of Technology	Qld	1
	SETS Enterprises Pty Ltd	WA	3
	University of Ballarat	Vic	1
	University of Queensland	Qld	3
			cont/…..

Industry	Employer	State/ Territory	Source
	University of Tasmania	Multiple	3
	University of the Sunshine Coast	Qld	1
	Victoria University	Vic	3
Health care and social assistance	31C Pty Ltd	Vic	3
	4C Risk Pty Ltd	Multiple	3
	Acute Health	Multiple	3
	Advanced Medical Support Pty Ltd	WA	2
	Ambulance Service Australia	Multiple	1
	Ambulance Private Pty Ltd	Tas	1
	Anodyne Services Australia	Multiple	3
	Aspen Medical	Multiple	3
	Australian Red Cross	Multiple	2
	Careflight	Multiple	3
	Compass Health	WA	3
	Country First response emergency medical service	Multiple	1
	Customer Care Pty Ltd	Multiple	3
	Elite Medical Solutions	Multiple	1
	Emergency Medical Services Australia Pty Ltd	Multiple	1
	EMT Medical Services	Multiple	1
	Emergency Response 24 Pty Ltd	Multiple	3
	Event Medical Services	Multiple	3
	Event Medical Solutions	Multiple	1
	First Aid Services	Multiple	1
	First Care Medical	SA	1
	First Line Emergency Care Pty. Ltd.	SA	1
	Hard Hat Health Pty Ltd	Multiple	3
	Health Care Options Pty Ltd (incl Event First Aid)	Multiple	3
	Hostile Environment Services	Multiple	2
	Immediate Assistants Pty Ltd	Multiple	3
	Industrial Medical Services	Multiple	3
	Intercept Medical Pty Ltd	NSW	1
	International Health and Medical Services Pty Ltd	Multiple	3
	International SOS (Australasia) Pty Ltd	Multiple	2
	Kinetic Health	Multiple	2
	LifeAid Pty Ltd	Multiple	1
	Link Health Pty Ltd	WA	2
			cont/…..

Industry	Employer	State/ Territory	Source
	Mater Misericordiae Health Services Brisbane Ltd	Qld	3
	Medic Aid WA	WA	3
	Medic One Pty Ltd	WA	2
	Medical Edge Australia	Multiple	1
	Medical Emergency Solutions	Multiple	1
	Medical Field Care Response Unit	Qld	1
	Medical Rescue Australia Pty Ltd	Multiple	1
	National Patient Transport Pty Ltd	Multiple	2
	Occupational Medical and Training Services	Qld	1
	Paramedic Services Queensland Pty Ltd	Qld	1
	Paramedical Services Pty Ltd	Multiple	1
	Providence Paramedical.	NSW	1
	Remote Medical Care	WA	3
	Royal Flying Doctor Service of Australia	Multiple	1
	Sitemed	Multiple	3
	Skymed Aeromedical	Multiple	1
	Snowyhydro Southcare	Multiple	1
	Southcare Medical & First Aid Services	NSW	1
	St John Ambulance (NT) Inc	NT	3
	St John Ambulance Australia	Multiple	3
	St John Ambulance Australia WA	WA	3
	St John Ambulance Queensland	Qld	3
	Staying Alive Paramedical Services Pty Ltd	Vic	1
	Unified Healthcare Group	Multiple	2
	WorkAir Group Pty Ltd	SA	3
Manufacturing	Megapro	Multiple	3
Mining	Apache Energy Limited	WA	3
	Atwood Oceanics	WA	1
	Barrick Australia Pacific Ltd	WA	3
	BGC (Australia) Pty Ltd	Multiple	1
	BHP Billiton	Multiple	2
	Consolidated Minerals	WA	3
	Crocodile Gold Corp	Multiple	1
	Diamond Offshore General Company	WA	3
	Doray Minerals Ltd	Multiple	2
			cont/…..

Industry	Employer	State/ Territory	Source
	Evolution mining	Multiple	2
	Global Mining Services Pty Ltd	WA	3
	Gold Fields Australia Pty Limited	WA	2
	HWE Mining Pty Ltd	Multiple	3
	Kalgoorlie Consolidated Gold Mines Pty Ltd	WA	3
	Kimberley Metals Group Pty Ltd	WA	3
	Mount Gibson Iron Limited	WA	3
	Newcrest Mining Limited	Multiple	3
	Rio Tinto	Multiple	2
	Territory Iron Limited	Multiple	3
Professional, scientific and technical services	Monadelphous	Multiple	3
	Wood Group PSN	Multiple	3
Public administration and safety	Australasian Emergency Response Specialists Pty Ltd	Tas	1
	Corporate Protection Group Australia Pty Ltd	Multiple	3
	Cynergex Group	Multiple	3
	EMC Rescue Services	Multiple	3
	Gold Security Group (International) Pty Ltd	Multiple	3
	MSS Security	Multiple	2
	NDS Security	Multiple	3
	Paull and Warner RECEO (PWR)	Multiple	2
	Safety Direct Solution Pty Ltd	WA	1
	Surf Lifesaving (WA)	WA	1
Retail trade	Weatherford Australia Pty Ltd	Multiple	3
	WesTrac Pty Ltd	Multiple	2
Transport, postal and warehousing	Maersk	Multiple	3

Sources:
1. PA internet research
2. Job advertisements on SEEK website 21/7 to 11/8/12
3. Job advertisements on PA website in period 18/4/10 to 15/8/12
Notes: State/Territory from PA internet research; industry by PA using standard classifications (ABS 2008)

Views of paramedics and paramedic students on national regulation

The PA survey sought the views of respondents on a number of aspects of national regulation including the four proposed options and some of the implications of national registration.

Starting with the four options, 3298 respondents or 87 per cent of paramedic and student respondents supported Option 4, national registration, with the remaining 13 per cent split roughly equally between the other three options - Option 1 (157), Option 2 (137) and Option 3 (208).

In assessing what might be the impacts of national registration, respondents agreed most strongly with the following propositions:

- 95 per cent agreed or strongly agreed that national registration would make it easier to transfer skills and employment across organisations, Australian jurisdictions and/or overseas;
- 89 per cent agreed or strongly agreed that paramedics who don't maintain their practice to the required standard may have to practice at a lower level or even face being de-registered;
- 88 per cent agreed or strongly agreed that national registration would mean that paramedics would have to do more continuing professional development (CPD) each year;
- 88 per cent agreed or strongly agreed that national registration would help to maintain and improve the clinical standards of paramedics; and,
- 86 per cent agreed or strongly agreed that national registration would result in certain activities becoming restricted and only available to be practised by registered paramedics with the appropriate qualifications.

In looking at what might concern them about national registration**,** respondents had more mixed views. Respondents were most concerned that:

- the current CPD provided by employers may no longer be available with 51 per cent being concerned or very concerned; and,
- paramedics would be individually responsible for the costs associated with national paramedic registration with 44 per cent being concerned or very concerned compared to 31 per cent who were unconcerned or not at all concerned (a mixed picture).

It is notable that a number of features of national registration did not raise concerns with respondents. These features are some of the essential reduction of risk of harm elements embodied in national registration:

- individual paramedics will need to do more CPD each year where 72 per cent were unconcerned or not at all concerned;
- paramedics who don't maintain their practice to required standard may have to practice at a lower level or even face being de-registered where 72 per cent were unconcerned or not at all concerned;
- national registration makes each individual responsible for maintaining their skills and competence where 71 per cent were unconcerned or not at all concerned; and,

- national registration may discourage people from volunteering in the sector where 42 per cent were unconcerned or not at all concerned and 32 per cent thought this may or may not be of concern.

Overall respondents showed a good understanding of what Option 4 meant for paramedics and very strong support for its implementation. Even where there were areas of concern or concerns for a minority of respondents, these did not translate into opposition to Option 4 as the preferred option.

ATTACHMENT B - THE PARAMEDIC REGULATION SURVEY

(The PA survey)

To gain a fuller picture of the paramedic workforce and obtain the views of paramedics and students on the regulation options outlined in the consultation paper, PA conducted an online survey of paramedics through its website in July and August 2012. The survey was called the Paramedic Regulation Survey. 3841 complete responses were received. (We received a total of 4424 responses but discarded those where the respondent had not completed all sections of the survey in case the same respondent had subsequently provided a complete response.)

The survey was open to all people who considered themselves to be an Australian paramedic or a paramedic student. There was no requirement to be a member of PA to take part and the survey was available on the public part of the PA website. The survey was powered by SurveyMonkey, an online survey tool which provided the capacity to collect and analyse data simply. Survey responses were provided voluntarily and anonymously. The presentation of data in this and any future reports by PA will protect the confidentiality of those who responded by ensuring that individuals cannot be identified in the report.

The survey consisted of 49 questions in the following sections:

1. Respondent information
2. The case for regulation of paramedics
3. Meeting the criteria for national registration
4. Effects of national paramedic registration
5. Potential impact of national paramedic registration
6. Concerns regarding the impact of national paramedic registration, and
7. Options for paramedic regulation.

The respondents

The 3841 final respondents to the survey fell into two groups: 757 university students and 3084 paramedics, or approximately 20 per cent university students and 80 per cent practitioners. In several tables in this submission we have excluded university students so that the analysis can focus on paramedics, for example in discussions of the paramedic workforce.

Table B1 describes the different roles currently played by paramedic respondents. Given the diversity of job titles around Australia some paramedics responded in the category of ‘other’ when their roles could have been accommodated explicitly in the roles set out as options in the question and described in Table B1. We have therefore included these responses under the relevant roles in the table. The students remaining in this table are not university students in terms of their primary engagement.

Table B1. Current level of clinical practice among paramedic respondents

Category	Number of respondents	Per cent of respondents
Not currently practising	59	2
Student BLS Medic (Ambulance Officer)	14	0
BLS Medic (Ambulance Officer)	82	3
Student Paramedic	167	5
Paramedic intern	116	4
Paramedic	1753	57
Intensive care paramedic	678	22
Retrieval (flight) paramedic	93	3
Extended care paramedic	73	2
Other	49	2
Total	3084	100

Source: PA Survey Question 1. Which of the below best describes your current level of clinical practice in paramedicine? Figures exclude university students.

How representative were the respondents?

The main issue with a website survey where people participate on a voluntary basis is that it is not possible to know how representative the respondents are of everyone in their group. In this case that means of all paramedics and of all paramedic students.

When sample numbers are large the level of convergence increases and the patterns of response change little as the numbers grow. With 3841 respondents the survey is considered highly representative. This view is confirmed by very little observed movement between the outcomes at 2000 responses and at the completion of the survey.

It is also possible to gain some feel from independent data of how representative the survey respondents are of the paramedic population. To do this we can compare survey answers on some basic questions about demographics and employment with similar information we have about the wider population. A number of questions in the PA survey lend themselves to this approach.

Comparison of survey respondents and the wider paramedic population

Information is available from the 2006 census and the 2011 LFS on four variables covered by the PA survey. These are:

- State and Territory of residence (Table B2);
- region of employment (Table B3);
- industry of employment (Table B4); and,
- qualification (Table B5).

In tables B2, B3 and B4 below we use the raw rather than the adjusted census and LFS data to produce percentages. No LFS data are available on region of employment.

Table B2. State and Territory of residence of paramedics

Source	2006 census	2011 Labour Force Survey	2012 PA survey
State or Territory	**Per cent of paramedics**	**Per cent of paramedics**	**Per cent of paramedics**
NSW	33	31	20
Vic	26	29	23
Qld	23	23	22
SA	7	5	18
WA	6	8	9
Tas	2	2	4
NT	1	1	2
ACT	1	1	2
Other	0	0	1
Australia	99	100	101

Sources: 2006 census: AIHW 2009, Appendix 5, Table 2.7
2011 LFS: DEEWR 2012a
2012 PA survey Question 9. In which State or Territory do you live? Excludes university students

Table B3. Region of employment in Australia of paramedics

Source	2006 census	2012 PA survey
Region	**Per cent of code 4111**	**Per cent of paramedics**
Capital city	58	46
Regional	38	40
Remote	3	7
Defence Force	0	6
Total	99	99

Sources: 2006 census: AIHW 2009, Appendix 5, Table 3.3. Excludes persons where location of employment not known. Includes those with no post-school qualifications
2012 PA survey Question 5: In which one of the following areas do you primarily work/study? Figures exclude university students.

Table B4. Industry of employment of paramedics

Source	2006 census	2011 Labour Force Survey	2012 PA survey
Industry	**Per cent of paramedics**	**Per cent of paramedics**	**Per cent of paramedics**
All ambulance services (public and private)	(83)		(84)
Other health	(5)		(6)
All health care and social assistance	88	90	90
Construction	-	1	0
Mining	0	1	0
Manufacturing	0	-	0
Public administration and safety	11	7	6
Transport, postal and warehousing	0	0	0
All other industries	1	0	4
Total	100	99	100

Sources: 2006 census: AIHW 2009, Appendix 5, Table 2.7 Includes some ADF in Public Administration and Safety industry adjusted as per Table A3
2011 LFS: DEEWR 2012a adjusted as in Table A2
2012 PA survey Question 2, excluding university students

Table B5. Qualifications of paramedics

Source	2006 census	2011 Labour Force Survey	2012 PA survey
	Per cent of paramedics	Per cent of paramedics	Per cent of paramedics
No post-school qualification	0	0	10
Certificate level	15	0	2
Diploma/Advanced diploma	55	41	47
Bachelor degree	25	59	28
Post graduate degree/graduate diploma/graduate certificate	5	0	13
Total	100	100	100

Sources: 2006 census: Customised tables adjusted as per Table A1
2011 LFS: DEEWR 2012a adjusted as per Table A1
2012 PA survey Question 12, Which of the following qualification levels do you hold in paramedicine? (please indicate all that apply.) Figures exclude university students. Because respondents could give multiple answers answers are scaled back to 100%.

Reviewing these data, it would appear that the PA survey paramedic respondents are:

- broadly typical of the distribution of paramedics across States and Territories with slightly fewer respondents from NSW and more from South Australia than would have been expected from the census and LFS distributions
- distributed between geographical regions (capital cities, regional etc) in much the same way as in the 2006 census
- working in similar industries to paramedics in the 2006 census and the 2011 LFS, and
- similar to paramedics in the other data sets in educational terms, noting that the LFS and 2006 census had all those without paramedic qualifications removed.

From these comparisons PA believes that the paramedics who responded to the survey are representative of the wider population of paramedics as found in the 2006 census and the 2011 LFS and the survey outcomes thus may be used with confidence.