Submission
No 190

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Organisation: Australian College of Ambulance Professionals

Name: Mr Ian Patrick

Position: President

Date received: 30/07/2008

Australian College of Ambulance Professionals Ltd.

280708

Hon Robyn Parker MLC, Committee Chair
General Purpose Standing Committee No.2

Re: Management and Operations of the NSW Ambulance Service

I write to you as the National President of the Australian College of Ambulance Professionals (ACAP) which is the national body representing the professional interests of paramedics in Australia. Information concerning ACAP and its key role in paramedic practice may be found by accessing our website at http://www.acap.org.au/index.php.

I have enclosed a copy of a recent submission entitled *Meeting the Challenge: Submission on National Health Care Reform,* which has recently been lodged with the National Health and Hospitals Reform Commission (NHHRC), for the Committee's reference and consideration.

ACAP has an abiding professional interest in policy matters that affect the delivery of Emergency Medical Services (EMS) regardless of the jurisdiction or location and is uniquely positioned to provide objective insights into the role of EMS in the continuum of health care.

Our primary concern in making this approach to the Committee, and in providing the above submission, is to ensure that the best possible outcomes are realised from the current Inquiry that will result in a high standard of out of hospital emergency health care for the community.

In addressing the potential issues and challenges to be met in the delivery of EMS in New South Wales, we have been guided by:

- the background to the Inquiry and its broad terms of reference;
- the extraordinary level of public and practitioner concern;
- the observations and evidence provided in the available published submissions;
- the submission prepared for the Committee by NSW Health
- the content of the public hearings and transcripts to date;
- input from members comprising professional paramedic practitioners; and
- comparative operational studies locally and internationally.

Our evaluation of the available information leaves us in no doubt that many of the issues relating to professional paramedic practice are not unique to New South Wales, although

the particular management outcomes (and resulting symptoms) may differ from jurisdiction to jurisdiction. Our studies indicate that ad-hoc approaches to the provision of EMS should be avoided in favour of a much more fundamental analysis of the role of EMS and paramedics as primary providers of emergency health care.

For this reason, we believe a holistic view must be taken of EMS and a nationally consistent, credible and equitable system needs to be adopted for emergency out of hospital health care that is subject to appropriate funding, and national performance standards and regulatory controls. From a professional perspective we believe that the recommendations of the enclosed submission are directly relevant to all States and Territories and fall within the ambit of your Inquiry and its Terms of Reference.

The unique, and at times anomalous, role of EMS in the Australian context has had a number of impacts in relation to management practices and service delivery. The resulting fragmentation and diversity of operations is outlined in our NHHRC submission (see pp13-14). It is instructive to note that figure 4 of the submission by the NSW Department of Health has multiple footnotes attesting to the different treatment of fundamental operational statistics from jurisdiction to jurisdiction.

For example, the resource issues outlined in various submissions may well stem from the historical development and highly variable funding arrangements for EMS in Australia and the absence of EMS as a discretely funded component of the Australian Healthcare Agreements. Figure 14 of the NSW Health submission and Appendix 1 of our NHHRC submission highlight the different funding approaches adopted across Australia for a fundamental health care service that should be provided to all Australians on an equitable and nationally funded basis.

In reviewing the delivery of EMS in NSW we urge the Inquiry to examine not only the immediately obvious symptoms of a system that appears to be under considerable stress but also to take into account the 15 underlying principles proposed by the NHHRC to shape the health care system. These principles outline a philosophical basis on which to operate and are divided broadly into two main groups comprising general system design principles and underlying governance principles as outlined below.

Design principles (what we as citizens and potential patients want from the system).

1. People and family centred
2. Equity
3. Shared responsibility
4. Strengthening prevention and wellness
5. Comprehensive
6. Value for money
7. Providing for future generations
8. Recognise broader environmental influences which shape our health

Governance principles (generally how the health system should work)

9. Taking the long term view

10. Safety and quality
11. Transparency and accountability
12. Public voice
13. A respectful and ethical system
14. Responsible spending on health, and
15. A culture of reflective improvement and innovation

Our support for these principles is outlined in the NHHRC submission and is based on professional grounds and the public interest. In particular, we draw attention to the significance of these principles in relation to shared responsibilities, safety, quality, transparency and accountability and the role of the public/patient consumer in health care matters.

As outlined in our submission (Part 5) the characteristics of good *regulatory governance* are increasingly being recognised as clarity, predictability, autonomy, accountability, participation, and open access to information. Each of these elements helps in creating an ethical and responsive workplace and a regulatory system that is transparent in the eyes of stakeholders. These factors are generally replicated in the statement of NHRRC healthcare principles that are endorsed by ACAP.

It is vital that NSW adopt regulatory mechanisms that hold public confidence. For example, there is a consistent international view that to properly command public support the management of practitioner complaints should be handled independently of a profession or service provider. Widespread dissatisfaction with the treatment of external and internal complaints within the Service appears to be one of the key areas of concern.

From a professional perspective it is disappointing that the available submissions to date appear to deal with the basic regulatory issues including training, course accreditation, practitioner regulation, complaints management and service provider accreditation in a cursory manner. These are fundamental aspects in achieving good governance and system integrity and the College draws attention to the significance of such matters in Part 5 of our submission.

In making this submission to the Committee we place no constraints on its publication and availability within the public record, believing all the observations and recommendations of the submission are in the public interest and the adoption of the recommendations would provide increased public safety and enhanced standards of health care. We also assure the Committee of our willingness to contribute to its deliberations and would be happy to respond to any further enquiries.

Yours sincerely

Ian Patrick

President

Australian College of Ambulance Professionals

Australian College of Ambulance Professionals Ltd.

Meeting the Challenge

Submission on

National Health Care Reform

to the

National Health and Hospitals Reform Commission

PO Box 345W
Ballarat West
Victoria 3350

May 2008

Meeting the Challenge - Executive Summary

1. The *Australian College of Ambulance Professionals (ACAP)* is the national body representing more than 4000 practitioners engaged in the delivery of out of hospital emergency health care. ACAP has an abiding professional interest in policy matters that affect the delivery of Emergency Medical Services (EMS) and is uniquely positioned to provide insights into the role of EMS in the continuum of health care.
2. In preparing this submission ACAP has placed a focus on identifying issues of broad policy significance as befits the initial stages of enquiry by the National Health and Hospitals Reform Committee (NHHRC). These should be the topic of further in-depth research culminating in a number of *'white papers'* for informed debate and community input for an appropriate period of time before determination of major policies.
3. The submission gives a brief overview of the health care system and the nature of present-day EMS in Australia. It acknowledges the several excellent outcomes of Australian health care policy, and recognises that formidable challenges remain. These include issues of equality and access, demographic change, affordability, safety and quality, workforce issues and the need to redress grave imbalances that apply across particular groups in society.
4. ACAP endorses the decision to establish the NHHRC; the NHHRC Terms of Reference; the philosophical approach to reform as outlined in the 15 NHHRC Principles for Australia's Health System; the general reform agenda and time frame; and the immediate short-term measures to ensure continuity of funding through the Australian Health Care Agreements.
5. The submission notes the long term nature of reform and the importance of appropriate implementation and evaluation processes in achieving the stated goals. To fulfil these objectives it recommends the establishment of a permanent National Health Care Commission.
6. The submission draws attention to several omissions in the Terms of Reference and immediate funding proposals including the shape of the Australian Health Care Agreements, viz:
    - the absence of any specific reference to the role and funding of out of hospital emergency care and the omission of EMS as a key component of the health care system;
    - the need for a nationally driven policy approach to the provision of EMS under consistent funding and administrative arrangements including universal access and equity principles with base funding provided by the Commonwealth; and
    - the need to better identify and use existing EMS capabilities by a national assessment of available resources – to include the private sector and the physical assets and human resources of medical personnel, nurses and paramedics of the Australian Defence Force (ADF).
7. The submission outlines the importance of appropriate health care regulatory regimes and confirms ACAP support for the Council of Australian Governments (COAG) decision to introduce a national registration scheme for health practitioners and to implement a national course accreditation scheme.

8. ACAP draws attention to the underlying purposes of regulation and notes that the regulatory proposals for health professions initially will be limited to nine occupational groups. It urges the inclusion of other health occupations within the COAG framework and proposes that paramedic practitioners be subject to national regulation as an urgent priority on the grounds that the practice of the profession poses exceptional risks to public health and safety.

9. The submission proposes that matters of long term health policy be integrated with workforce planning which in turn is related to issues such as accreditation and regulation. It recommends that the NHHRC recognise EMS as a distinct field of professional health care and that the education, accreditation and regulation of paramedics be considered in conjunction with other workplace policies intended to provide seamless and cost effective health care.

10. The submission summarises a number of characteristics of EMS in Australia, viz:

    - jurisdiction-bound public sector EMS providers having various administrative arrangements leading to different funding bases, different equipment, different practice standards and different operational metrics resulting in fragmentation when viewed at a national level;
    - lack of coverage by Medicare and a myriad of payment and cost recovery arrangements with potentially inequitable distribution of access and costs to the community;
    - a growing number of private EMS providers that employ paramedics outside the ambit of the traditional ambulance sector without the protection of a nationally accepted regulatory framework for defining the scope of practice and the licensing of paramedics;
    - the relative absence of common equipment and systems, communication resources and other physical assets that would permit greater operational efficiencies and more cost-effective procurement, facilitate interoperability and enable the rapid and smooth aggregation of resources for catastrophic events regardless of location;
    - the absence of any nationally accepted and independent framework for the objective accreditation of EMS service providers (public, private, military and not-for-profit);
    - the absence of a nationally recognised and independent framework for community engagement and complaint mechanisms for service providers and paramedic practitioners;
    - the absence of a nationally recognised external accreditation system for paramedic education within the COAG framework (notwithstanding the Council of Ambulance Authorities (CAA)/ACAP model);
    - the independence of ADF paramedic personnel from their civilian counterparts and other barriers to workforce mobility occasioned by legislative and operational constraints; and
    - the diversity of educational routes to paramedic qualification and the growth of university-based paramedic education programs.

11. The submission makes a number of recommendations for the NHHRC to examine in overcoming these perceived deficiencies such as:

    - facilitating arrangements to bring funding and administration of EMS under the umbrella of national health care policy with appropriate statistical and performance metrics that enable better assessment of the EMS contribution to the health of the community;
    - establishing funding arrangements for corresponding State and Territory service providers on the basis of administration as a primary emergency *health* service;
    - establishing a national accreditation regime for all EMS providers and an independent complaint process with community and practitioner representation for service complaints;
    - facilitating the national regulation of paramedics under the COAG regulatory regime or facilitating an alternative national scheme of regulation (including independent complaint processes with community and professional representation) to protect the public;
    - establishing guidelines and protocols to foster interoperability of EMS providers; and
    - undertaking a national assessment of EMS resources and their distribution to determine whether and how these resources may be better deployed in the national interest for access, equity and homeland protection.

12. The submission should be read in conjunction with Attachment A – NHHRC Terms of Reference and Attachment B – NHHRC Principles for Australia's Health System. A consolidated list of recommendations is also provided in Attachment C – Summary of recommendations.

On behalf of its members, ACAP commends the submission to the NHHRC in the interests of achieving enhanced outcomes for the community from the delivery of excellent out of hospital emergency medical services as an integral part of the continuum of health care.

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Part 1 – Overview

Australian College of Ambulance Professionals

The *Australian College of Ambulance Professionals (ACAP)* is an independent professional association first established in 1973 as the Institute of Ambulance Officers (Australia). It is the national body representing 4204 paramedic professionals engaged in the delivery of out of hospital emergency care. ACAP operates through a national council and State branches and has a national headquarters whose activities are overseen by a representative Board of Directors.

The objectives of ACAP are those of a professional association with an abiding interest in policy matters that affect the access, equity, efficiency and effectiveness of Emergency Medical Services (EMS). It has a wide-ranging constitution [1] under which it conducts various programs of professional development, voluntary regulation, publication and professional activities designed to enhance the standards of out of hospital emergency care and thereby better protect the health and safety of the community.

Health care is a deeply personal issue that affects everyone. It is notable for the involvement of a myriad of stakeholders as recipients or providers of care, or as funders through a multitude of arrangements including taxation, levies, insurance, direct charges and other fund-raising activities as well as charitable donations and volunteer work.

Health care is also an industry with powerful commercial interests and influential groups having overlapping interests that at times appear to conflict with broader welfare and community objectives. ACAP acknowledges these interests and their viewpoints. At the same time ACAP cautions against accepting proposals that are not well-founded in policy and funding principles or not demonstrably in the public interest.

Another significant representative body with a role in EMS is *The Council of Ambulance Authorities (CAA)*. The CAA is a representative body (incorporated in 2002) comprising the major EMS providers in Australia, New Zealand, and Papua New Guinea. The CAA meets regularly to share information and conducts a range of research and development projects.

Although ACAP and CAA both have a primary interest in and commitment to EMS practice neither body has any legislated powers or responsibilities. Both therefore lack the capacity to mandate change and bring about reforms that might better integrate EMS with other health care programs under the basic principles espoused by the National Health and Hospitals Reform Commission (NHHRC).

For example, ACAP and the CAA in the past have had no explicit role or input into shaping the Australian Health Care Agreements (AHCA) that might ensure more equitable funding arrangements for EMS.

Given the direct interest of paramedic practitioners in the delivery of EMS, the input of ACAP across a range of health care policy issues would appear unquestionable under the principle of community consultation articulated by the NHHRC *(NHHRC Principle 3)*.

ACAP commends the recommendations of this submission as a first step in contributing more extensively to the development and implementation of a new era in Australian health care policy. The submission should be read in conjunction with Attachment A – NHHRC Terms of Reference and Attachment B – NHHRC Principles for Australia's Health System.

1 Constitution of the Australian College of Ambulance Professionals
http://www.acap.org.au/national/constitution/constitution.htm

ACAP philosophy of emergency health care

The primary goal of ACAP is to help develop the full potential of EMS as part of a system that will deliver quality health care to all Australians. To achieve this objective, ACAP believes that health care policy should:

- recognise the benefits of holistic care delivered by health professionals operating in a multidisciplinary environment;
- ensure an equitable health system by providing EMS for all Australians according to need and regardless of race, creed, gender, location or economic circumstances;
- establish funding arrangements at Federal, State and Territory levels that facilitate the delivery of better integrated health care services and minimise duplication of effort by optimising the use of available physical and human resources of the private, public, not-for-profit and defence sectors;
- ensure responsiveness, quality and high service standards through community engagement that recognises the legitimate role of consumers and by the establishment of performance metrics for practitioners and service providers based on objective measures and operational protocols;
- provide adequate educational opportunities for the recruitment, training and professional development of EMS practitioners to ensure a sustainable workforce; and
- provide a national regulatory regime for health professionals and the accreditation of health care providers to ensure consistent service standards, public safety and facilitate the mobility of the health workforce.

The Australian health care system[2]

Australia's national health care system is intended to give universal access to health care while allowing individual choice through a substantial private sector involvement. Health care is financed largely from general taxation revenue, which includes a Medicare levy based on a person's taxable income. Medicare covers all Australians, permanent residents, and visitors from countries that have reciprocal arrangements.

Responsibility for funding and delivery of public health services is shared between the Commonwealth and the State and Territory governments.

The Commonwealth Government has a limited role in service delivery and primarily acts as the source of funding for medical, pharmaceutical and aged-care services. It also plays an important role in regulating and subsidising private health insurance; as well as contributing funds to support State and Territory health services.

A mix of public and private sector providers deliver health services. State and Territory governments own and operate public hospitals as well as delivering a variety of mental health, dental, health promotion, school health and community health programs. States are also responsible for public EMS under a variety of administrative arrangements. Private and not-for-profit organisations operate private hospitals as independent or group enterprises.

2Adapted from http://www.commonwealthfund.org/fellowships/fellowships_show.htm?doc_id=372961

The majority of medical practitioners are self-employed, and a small proportion is employed by State or Territory governments. A two tier structure generally applies with a patient's first (and continuing) contact taking place with a general practitioner who provides referrals to various specialist practitioners or diagnostic service providers as needed.

Overall diagnostic standards in radiology and pathology in Australia are very good with the service delivery, accreditation and quality assurance processes appearing to work well and more transparently in these areas than in clinical activities. EMS providers are not subject to the same level of independent accreditation scrutiny.

Because of their establishment costs and technological implications, pathology and diagnostic services are available from a limited number of centres or service providers. In the main these are hospitals or substantial commercial ventures. Patients are referred to these providers by in-house physicians or general practitioners, allied health professionals or medical specialists.

Some diagnostic tools are subsidised by government or have been the subject of special grants and financial incentives. The funding, availability and referral of diagnostic services has raised some concerns in terms of equity of access and the potential for corruption.

Expensive equipment and rapid changes in technology with stringent quality assurance and regular accreditation require substantial fees and a high turnover to cover costs. The high fixed costs and lower marginal costs per service mean that many diagnostic services can be highly profitable once the breakeven point is passed. Pathology and diagnostic services consequently have become key areas for consolidation and rationalisation largely through the process of corporatisation[3] until today only a relatively few privately owned and operated services remain outside of hospitals and significant commercial providers.

The Commonwealth Government's Medicare Benefits Schedule lists a wide range of consultations, procedures, diagnostic examinations and tests, and the standard or schedule fee for each of these items. Entry to the schedule is determined by the Medical Services Advisory Committee based on evidence of safety, cost-effectiveness and benefit to patients.

Patients receive a reimbursement benefit from Medicare for medical services ranging from 75 percent to 100 percent of the Schedule fee depending on factors such as where and by whom the service was delivered. The difference between the benefit received and the fee charged is met by the patient as an out-of-pocket (or "gap") payment.

Where a patient or family receives many services in a calendar year, there is a safety net provision to limit their out of pocket cost. When the "gap" payments exceed a certain threshold amount, all further benefits in that year are paid at 80 per cent of the actual fee charged.

Some services are not covered by Medicare benefits, such as cosmetic services, services for which State or Territory governments have received commonwealth funding, services covered by workers' compensation and EMS rendered by the various State-based agencies.

Medical practitioners can charge whatever they wish unless they "bulk-bill". In that case the practitioner charges a fee equal to the benefit entitlement under Medicare and claims the value of the benefit directly from Medicare. Some 70 percent of all eligible services are thought to be currently bulk-billed, although the actual proportion varies significantly over time and between individual practitioners, specialties and localities. Over-servicing and the adroit use of bulk billing have resulted in a number of cases of Medicare fraud.

3 http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/health/path_rad_aus.html#Medicare

The practice of charging differential fees for what is essentially the same service at the option of the service provider rather than on the grounds of medical need raises equity and access issues and has been blamed for placing greater demands on public sector facilities which may be inadequate to cope with the workload.

Until recently Medicare benefits were only payable for services delivered by medical practitioners but they are now also available in particular circumstances to patients who use practice-based nursing, psychology, dental and other defined allied health services. Why life-saving EMS interventions are not covered when they may be more invasive than procedures carried out in other environments is not clear.

Since 1948 the supply of medicines has been directly subsidised under the Commonwealth Pharmaceutical Benefits Scheme (PBS). The PBS is managed by the Department of Health and Ageing and administered by Medicare Australia.[4]

The PBS subsidises the supply of a comprehensive range of approved drugs. The subsidy normally covers only part of the final patient cost with most people making a co-payment. The co-payment amount may vary for the same medication depending on several factors including age, economic status and various concessionary schemes.[5] Medicare also provides a safety net to limit the cost of medications once an individual or family reaches the nominated threshold expenditure in any year.[6]

Private health insurance can cover private and public hospital charges (public hospitals charge only patients who elect to be classified as private patients in order to be treated by the practitioner of their choice), and a portion of medical fees for private patients' inpatient services. Private insurance can also cover allied health services (such as physiotherapists' chiropractors' and podiatrists' services) and some aids and appliances (such as eye glasses).

Private insurance coverage of the population has ranged from 50% in 1984 to 32% in 1997 and is now estimated at about 43% - but is strongly dependent on perceived benefits of membership driven by changing government policies.[7] In keeping with the principle of universal access to health care, private health insurance in Australia is community-rated and all comparable persons or family units pay the same premium regardless of health status.

The Federal Government has recently announced a package of changes to private health insurance regulations, including expansion of hospital cover to outpatient and out-of-hospital services, as well as chronic care management for conditions such as diabetes and asthma, and disease prevention measures. There will also be some important consumer information initiatives designed to improve transparency, e.g. insurers will be required to provide standard product information to help people compare policies and to understand their entitlements.

Australians enjoy generally good health. Life expectancy for females and males are among the highest in the world and the infant mortality rate in 2004 was 4.7 per 1,000 live births, placing it in the middle range among developed countries. In the National Health Survey carried out in 2004–05,[8] 84 per cent of respondents aged 15 years or over assessed their health as good, very good or excellent.

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4 http://www.pbs.gov.au/html/consumer/pbs/about#d52347e32

5 http://www.centrelink.gov.au/internet/internet.nsf/payments/conc_cards.htm

6 http://www.medicareaustralia.gov.au/public/services/msn/pbs.shtml#what_to_do

7 Buchmueller, Thomas, *Community Rating and the Cost of Adverse Selection: Evidence from Australia* University of Technology Sydney, February, 2007 (preliminary outcomes)

http://www.melbourneinstitute.com/forums/seminars/phiac_risk6_Buchmueller.pdf

8 http://www.abs.gov.au/ausstats/abs@.nsf/mf/4363.0.55.002?OpenDocument

These averages conceal significant variations in health status especially as they affect indigenous Australians. Life expectancy for indigenous Australians is substantially lower for both males and females; and the indigenous infant mortality rate is estimated to be about three times that of the non-indigenous population.

To some degree these differences can be attributed to the fact that indigenous Australians are disadvantaged when measured against a range of socioeconomic factors: they typically have lower incomes, poorer education achievements, higher rates of unemployment and lower rates of home ownership than other Australians. They also have higher levels of smoking and alcohol misuse, and there is a strong body of evidence that many are exposed to other risk factors such as sexual abuse and physical violence.

Despite the several excellent outcomes of health policy in Australia, there remain formidable health care challenges.[9] These include issues of equality and access, demographic change, affordability, safety and quality, workforce issues and the need to redress the grave imbalances in health care especially for indigenous Australians.

Emergency medical services in Australia

While emergency medical care in one form or another has been around for many years, EMS as we know it today is a relatively recent development. As the benefits of appropriate emergency care in greatly improving patient outcomes have come to be better recognised,[10] EMS practices have been evolving at a rapid pace along with technological advances.

Initially, emergency care was provided by nearly anyone who would take on the task regardless of their training. Sometimes the local police officers provided emergency support and even funeral parlours and military personnel were used to supply patient transport. Often the fire brigade would "rescue" a patient and take them to hospital. Medical practitioners made house calls for many cases that EMS commonly respond to today.

Indeed, the word *ambulance* is derived from the Latin word *ambulare* meaning to walk or move about - which is a reference to early medical care where patients were moved by lifting or wheeling. Non-emergency patient transport cases still make up a substantial proportion of the total workload of the traditional EMS providers in Australia.[11]

In earlier days EMS providers did the best that they could with limited training and resources. Ambulances were inappropriately designed and ill-equipped and typically operated from one, two or three person centres. The service providers relied on substantial volunteer support and community–based funding arrangements.

Public EMS providers have grown from those small local and regional ambulance enterprises into today's large and more coherent State-based organisations. In 2006/07 there were 11,733 full time equivalent salaried personnel employed by public ambulance services Australia-wide with the majority (80.9%) employed primarily for operational purposes.[12]

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9 *Beyond the blame game: Accountability and performance benchmarks for the next Australian Health Care Agreements*, A Report from the National Health and Hospitals Reform Commission, April 2008

http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/504AD1E61C23F15ECA2574430000E2B4/$File/BeyondTheBlameGame.pd

10 http://www.ambulance.net.au/conten

10 *2006-07 Annual Report*, The Council of Ambulance Authorities, Flinders Park, South Australia 5025t.asp?id=90

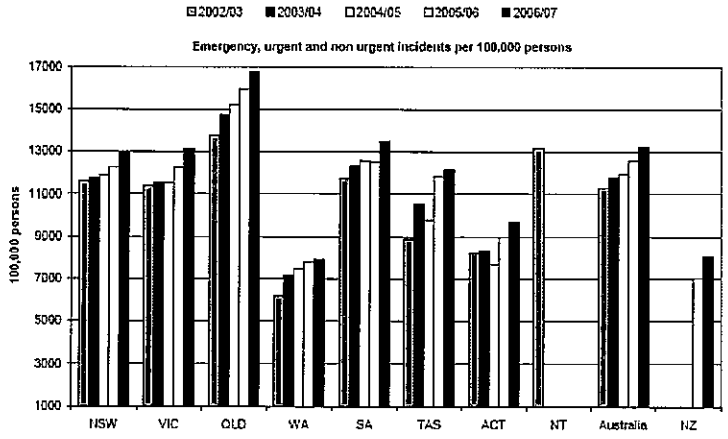
11 http://www.saambulance.com.au/

12 *2006-07 Annual Report*, The Council of Ambulance Authorities, Flinders Park, South Australia 5025

Ambulance response locations numbered 1091 of which 61.7% were salaried staff units, 30.1% were wholly volunteer and 7.4% mixed stations (the Queensland Ambulance Service did not provide a count of stations where there is a mixed workforce). In 2001, ambulance personnel / paramedics made up about 1.5% of the total number of health professionals in Australia.[13]

Volunteers remain powerful contributors to the overall EMS effort with substantial contributions in all States[14] except New South Wales (minor) and the Australian Capital Territory (none). In 2006/07 there were 6409 volunteers in ambulance services of whom 82.2% were involved at an operational level.[15] The distribution varies widely, with services in Western Australia, South Australia and Tasmania primarily relying on the services of volunteers in country and rural areas. It is estimated that ambulance volunteers are on-call approximately 6.6 million hours per year.

Figure 1 Emergency, urgent and non urgent incidents per 100,000 persons



Jurisdiction	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia	NZ
2002/03	11639	11393	13789	6211	11744	8885	8230	13186	11282	na
2003/04	11745	11493	14714	7182	12299	10520	8312	na	11750	na
2004/05	11857	11510	15196	7483	12592	9777	7718	na	11925	na
2005/06	12271	12270	15962	7781	12523	11846	8997	na	12579	7060
2006/07	12944	13133	16779	7901	13509	12155	9696	na	13219	8085
% change										
1 year	5.5%	7.0%	5.1%	1.5%	7.9%	2.6%	7.8%	na	5.1%	14.5%
5 year	11.2%	15.3%	21.7%	27.2%	15.0%	36.8%	17.8%	na	17.2%	na

Australian totals exclude NT

The contribution of EMS to the wellbeing of Australians should not be understated, and is graphically illustrated by *Figure 1* showing the emergency, urgent and non-urgent incidents per 100,000 persons and *Figure 2* showing the patients transported per 100,000 persons.[16]

13 Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra
http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf

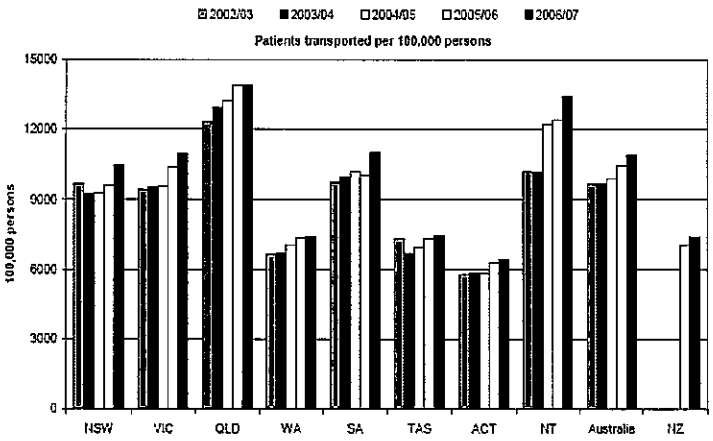
14 Emergency Services in Australia and New Zealand:, Problems and Prospects for Volunteer Ambulance Officers. Report of the Stand Up and Be Counted Project, May 2002 University Department of Rural Health, Tasmania
http://www.ruralhealth.utas.edu.au/band-aid/Emergency-service-publication.pdf

15 Ibid

16 *2006-07 Annual Report*, The Council of Ambulance Authorities

These statistics do not record the contribution made by the private sector or by EMS personnel who attend major sporting and other events in a preventive, risk minimisation and unfortunately too often, active role.

Figure 2 Patients transported per 100,000 persons



Jurisdiction	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia	NZ
2002/03	9683	9413	12322	6616	9707	7290	5781	10193	9752	na
2003/04	9190	9533	12909	6712	9932	6685	5842	10105	9785	na
2004/05	9284	9584	13222	7047	10196	6955	5854	12215	9988	na
2005/06	9626	10377	13892	7353	10037	7306	6297	12424	10532	7036
2006/07	10430	10960	13876	7386	10981	7445	6433	13443	10982	7383
% change										
1 year	8.3%	5.6%	-0.1%	0.4%	9.4%	1.9%	2.2%	8.2%	4.3%	4.9%
5 year	-0.6%	10.2%	12.7%	11.1%	3.4%	0.2%	8.9%	21.9%	8.0%	na

Physical and medical emergencies may occur in conjunction or separately, with the catalyst for an EMS intervention most often an independent medical event or service request. This intermingling of response modes has contributed to a situation of widely variable funding and administrative arrangements. Governments have had to cope with rapid changes in technology and clinical practices while at the same time grappling with the hybrid nature of the EMS role and its transition from a largely volunteer-based activity to a more salaried workforce.

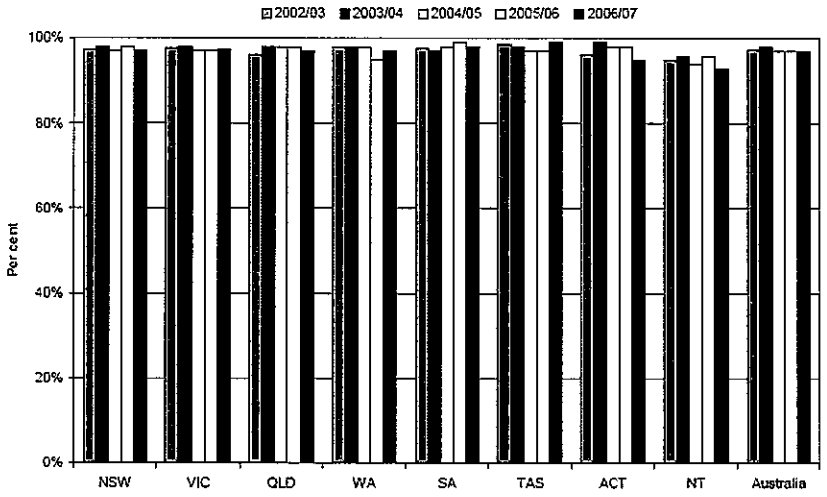
For example, the charitable order of St John Ambulance was an important early provider of first-aid services and is still the principal EMS provider in Western Australia and Northern Territory. In other States, EMS is the responsibility of State agencies which operate under different Ministers. In South Australia responsibility for the ambulance service was transferred to the Minister for Health in April 2004 whereas in Queensland, EMS comes under the Minister for Emergency Services.

The result is that EMS today is carried out under disparate organisational arrangements with a variety of funding sources instead of forming part of a seamless and equitably-funded health care system *(Appendix 1)*[17].

17 SCRGSP (Steering Committee for the Review of Government Service Provision) 2008, *Report on Government Services 2008*, Productivity Commission, Canberra.

Nonetheless it is gratifying that paramedics as a profession and EMS service providers as a whole enjoy an exceptional level of community respect as shown by *Figure 3.*[18]

Figure 3 Proportion of ambulance users who were satisfied or very satisfied with the ambulance service



Source: 2006-07 Annual Report, The Council of Ambulance Authorities

It is difficult to reconcile the community perceptions of EMS as a vital and caring component of the health care system with the poor recognition previously afforded by the Commonwealth in its funding arrangements and health policies. EMS should be funded appropriately as an on-going business enterprise with well qualified staff having clear career options and held to account in the same way as other health care practitioners and service providers.

If the voice of the community is to be heard, it is time for this oversight to be corrected and for EMS to take its rightful place as one of the key delivery mechanisms of health care by being incorporated in deliberations on national health policy.

Education and training of paramedics

The evolving role of the paramedic, increasing community expectations and the threat of litigation, have all contributed to increased EMS training requirements.[19] Other drivers for change have been advances in triage and available out of hospital procedures for medical emergencies such as cardiac arrest and asthma attacks.

Paramedics now carry and administer a range of powerful restricted drugs within the jurisdiction of their agency, although they are not enabled to prescribe drugs for patients outside the authority of their agency unless they are also qualified and registered independently as medical practitioners within that jurisdiction.

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18 *CAA National Patient Satisfaction 5 Survey 2007* The Council of Ambulance Authorities, Flinders Park, South Australia 5025

19 Emergency Services in Australia and New Zealand:, Problems and Prospects for Volunteer Ambulance Officers. Report of the Stand Up and Be Counted Project, University of Tasmania, Department of Rural Health May 2002 http://www.ruralhealth.utas.edu.au/band-aid/Emergency-service-publication.pdf

The introduction of mobile defibrillators, improved clinical procedures and new medications have provided clinical technology that allows paramedics to administer resuscitation and advanced life support - and also bring demands for greater knowledge, continual professional development and regular re-accreditation.

These developments mean that the educational demands to meet the competency requirements of paramedic practice now go well beyond the application of technical skills. They include not only traditional first aid and transport principles, but also appropriate studies in anatomy, physiology, pathophysiology and pharmacology to increase the capacity of paramedics to make immediate and independent life-saving decisions in the field.

Like their counterparts in other allied health professions, paramedics must hold formal qualifications, ranging from a basic qualification through to advanced degree status.[20]

In the past, the employing agencies were tasked with the provision of training and education as well as quality control of services and professional discipline of practitioners. EMS providers in each jurisdiction set their own unique standards (although many features of training and service standards were similar).

Attempts to standardise education nationally in the 1980s and early 1990s by the informal group of ambulance services that predated the CAA were only partially successful. Rapid changes in educational programs to reflect technological advances and practice developments together with the general move towards university-based education have reached beyond those earlier efforts.

There is a standard education curriculum set out in the "Health Services Training Package" (Vocational level qualifications). This package allows sufficient leeway for considerable variances in agreed practice between agencies to provide for geographic and demographic demands. While this framework provides a suitable structure for the Vocational Education and Training (VET) level qualifications, it has not addressed the university level programs.

EMS providers in the main have supported the introduction of tertiary qualifications. Some jurisdictions have formally adopted university programs as the basic entry qualification for a professional paramedic, although others have continued to also accept internal diploma and VET programs in the face of critical staff shortages.[21]

The result is a complex web of training arrangements and routes to professionalism, with paramedic education currently provided internally and through outsourced agencies, the VET sector and university degree programs. The university-based programs are growing rapidly and it is likely that they soon will form the only entry route to professional practice.

The profession is very conscious of the increasing demands on today's paramedic to meet community expectations for consistently high quality out of hospital health care and ACAP strongly supports the efforts of the CAA[22] and others to foster appropriate programs of paramedic education and training.

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20 http://www.mas.vic.gov.au/Main-home/Careers/Paramedic/What-it-takes.html

21 http://www.stjohnnt.com.au/

22 Submission to the Australian Government: Department of Education, Science, and Training, Review of the impact of the Higher Education Support Act 2003: Funding Cluster Mechanism Funding of Clinical Disciplines), The Council of Ambulance Authorities Inc. Discussion Paper, December 2006

http://www.dest.gov.au/NR/rdonlyres/2F515244-5225-4DFF-BE37-1898BF1F9C7D/15848/048TheCouncilofAmbulanceAuthoritiesRevised.pdf

Accreditation of paramedic education

Despite wide-ranging educational developments, until recently there has not been any nationally recognised external course accreditation system for paramedic education.

Accreditation (as distinct from regulation) is a formal assessment process conducted by an independent and recognised authority to confirm that courses meet quality assurance requirements and are responsive to the needs of the community.

With several designated EMS course programs being conducted by universities and other training organisations across a range of locations and jurisdictions, a robust process of accreditation is needed to ensure consistent and acceptable course standards that will provide a level of confidence that graduates are competent to practice safely and effectively as beginning level paramedics.

In the absence of commonwealth government initiatives, the CAA in collaboration with ACAP, has sponsored the *Paramedic Education Programs Accreditation Program* (PEPAP) which is intended to deliver an accreditation system that will provide national standards for education and a mechanism for credentialing those programs. The first round of assessment and accreditation of a sample of paramedic courses began in 2006 and the process is ongoing.[23]

All accredited paramedic education would need to meet national benchmarks through appropriate curriculum content, satisfactory training facilities and adequate funding.

ACAP sees educational accreditation as an important component of a much more extensive regulatory regime needed to protect the public and ensure the delivery of the health care outcomes envisaged by the guiding principles of the NHHRC *(Attachment B).*

In addition to *course accreditation* that will provide beginning practitioner assurance, there is a further need for independent *service accreditation* to validate the standards and integrity of EMS service providers and their quality systems in the delivery of health care (see later).

ACAP holds a number of concerns about how the interests of the community will be incorporated within the present course accreditation scheme and the desirable inputs and links with the paramedic profession that should be present under the new health reform agenda (quite apart from the legitimate interests of public and private employers).

For example, it is not clear how the current accreditation proposals will be integrated with the newly stated goals of community consultation and other access, equity and quality principles outlined by the NHHRC; or what impact the COAG health care regulatory proposals may have on the existing voluntary certification program for paramedics currently administered by ACAP.

ACAP also holds concerns about the COAG agreement to ask Skills Australia to advise on the possible allocation of up to 50,000 additional vocational education and training places for areas of national skills shortage (including vocationally-trained nursing, emergency care and allied health occupations).

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23 Submission to the Australian Government: Department of Education, Science, and Training, Review of the impact of the Higher Education Support Act 2003: Funding Cluster Mechanism Funding of Clinical Disciplines), The Council of Ambulance Authorities Inc. Discussion Paper, December 2006
http://www.dest.gov.au/NR/rdonlyres/2F515244-5225-4DFF-BE37-1898BF1F9C7D/15848/048TheCouncilofAmbulanceAuthoritiesRevised.pdf

Any advice on workforce training must take cognisance of practical workforce developments, the suitability of courses to meet actual workplace needs and the continuing recognition of qualifications. Workforce matters should not be examined in isolation and the long term employability of graduands must be considered in the face of fundamental changes already underway in educational and career pathways and evolving needs for the regulation of paramedic practice.

The advent of the current health care reform agenda and the COAG regulatory proposals for health care professionals therefore provide a timely opportunity to revisit the whole question of paramedic roles, education, accreditation and regulation.

In this respect, the ACAP Board is overwhelmingly supported by its membership[24] in the view that to protect the public interest, the introduction of a national regulatory regime for paramedics is long overdue.

For quality assurance and public safety reasons, ACAP believes there should be corresponding accreditation of EMS providers. This accreditation should be based on providers meeting national benchmarks across a range of performance and management indicators under the same basic quality assurance principles that are applied to the assessment and monitoring of other health care providers such as hospitals, nursing homes and diagnostic services (e.g. pathology laboratories).

Implementing an effective regulatory regime for paramedics would necessarily involve several functions including assessment and approval of course content, setting and enforcement of standards and accreditation. Regardless of the ultimate administrative and funding arrangements for the management of EMS, any regulatory framework would need to develop firm linkages and operating protocols with the accreditation process to ensure consistency in administration (which would include assessment and recognition of overseas qualifications and experience).

Depending on the final regulatory arrangements, this might require modifications to the existing accreditation proposals to incorporate suitable government or independent professional and community inputs. One outcome may well be the transfer of ultimate responsibility for accreditation to an independent regulatory agency that would build on the valuable work to date by CAA and ACAP.

Professional recognition and regulation of paramedics

Paramedics are the mainstay in the delivery of out of hospital EMS and work from a position of unique responsibility and community trust unrelated to jurisdictional borders. However, to date, paramedic practitioners have fallen outside the scope of any formal national regulatory system.

Within the public sector, paramedic practice is essentially controlled (or "regulated") by the respective agency while the private sector and defence forces operate independently. To overcome some practice difficulties for paramedics operating across jurisdictional borders, public sector agencies have adopted a number of reciprocity arrangements and mutual acceptance of clinical guidelines (which begs the question of the need for any difference).

24 http://www.acap.org.au/index.php

The absence of formal regulatory arrangements has been partially addressed by ACAP which currently offers a voluntary self-regulation program that was designed in consultation with the CAA. This program[25] is known as the "Certified Ambulance Professional" (CAP) program which is available to all ACAP members based on their demonstrated competence.

The primary aims of CAP are to:

- contribute towards high standards of patient care by encouraging EMS personnel to manage, and take responsibility for their own knowledge and competency in relevant areas of paramedic practice; and
- provide a process that facilitates the registration of qualified ambulance professionals and thereby enhance the recognition of qualifications and mobility of practitioners across all EMS providers in Australia.

Underpinning the CAP program is the desire to enhance public safety by embracing a quality-based regime through the ongoing (bi-annual) certification of practitioner competence. Among the functions of the CAP program are the maintenance of a public register of practitioners, the fostering and endorsement of continuing development activities, and the referral and investigation of practitioner complaints.

ACAP views the CAP program as an important contribution towards meeting the goals of quality, access and equity in out of hospital health care. Providing increased workplace mobility should help offset some of the critical shortages in professional skills and a national register of practitioners should assist both public sector and private sector employers in the recruitment of qualified persons.

ACAP acknowledges the limitations of any voluntary regulatory program and the absence of enforceable complaint and disciplinary processes which would be needed for a truly effective regulatory regime. For example, CAP currently conveys few discernable benefits for qualified paramedics who may wish to travel overseas and who seek recognition of their qualifications and experience to further their education or career.

In today's world, reciprocity of professional status goes well beyond local jurisdictions into the international arena, and parochialism will ultimately be to the disadvantage of Australia's health care system. To ensure an informed community and assist employers, there should be universal regulatory coverage of practitioners and better integration with private EMS providers. This coverage should cater for private practitioners and qualified members of the defence forces as well as Australian paramedics operating independently overseas on relief and humanitarian endeavours.

Only a mandatory national regulatory scheme would have the scope to realise the desired aims of mutual recognition and reciprocity within Australia and facilitate the recognition of international qualifications and experience. National regulation of paramedics therefore should form part of the reform agenda for health care in Australia and a recommendation to this effect is provided later.

25 www.acap.org.au

Summarised characteristics of EMS in Australia

The chequered and diverse history of emergency out of hospital health care development has given rise to the following broad characteristics of EMS in Australia:

- Funding arrangements vary between jurisdictions, but all government-sponsored providers rely in part or in whole on government funding obtained through a variety of mechanisms including levies[26] and subsidies.
- Ambulance costs are not covered by Medicare and there is a myriad of payment arrangements, Services may be free for residents of a given jurisdiction[27] or reimbursed under a user-pays principle[28] (depending on the jurisdiction) or recouped in whole or part by insurance.[29] Distinctions are also commonly made between emergency and non-emergency (transport) situations.
- EMS is notable for having a higher proportional contribution from volunteers than other regular health care service sectors (excluding overtly volunteer support groups, humanitarian and not-for-profit organisations). In South Australia, Western Australia and Tasmania, volunteers in all categories outnumber salaried staff almost 2 to 1.
- A growing number of private operators service particular industry sectors and independent emergency services are maintained by major corporate entities e.g. mines, resorts, oil rigs etc. These ventures employ paramedics (and other health care professionals) outside the ambit of the traditional public sector providers.
- Private sector providers are contracting to Australian Departments to provide EMS care for their employees whilst on missions overseas - an example being the Australian Federal Police deployment to the Solomon Islands.
- Aeromedical services, both fixed wing and rotary, are provided by an array of public and private sector organisations - most notably by various community helicopter providers and the Royal Flying Doctor Service.
- The administration of EMS varies from jurisdiction to jurisdiction - in some cases being a subset of an Emergency Services Department[30] and in other cases a subset of a Health Department or a contracted incorporated association.
- The public sector EMS environment is fragmented with autonomous jurisdictions operating independently and having different funding bases, different equipment, different practice standards and different operational metrics.
- There is no nationally accepted and independent framework for the accreditation of service providers.
- There is no nationally accepted regulatory framework for defining the scope of practice and the licensing of paramedics. Private sector operators work independently under the constraints of various Public Health Acts while each public sector agency establishes the skills and knowledge required of the practitioner and the scope of practice within the relevant jurisdiction.

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26 http://www.ambulancecover.qld.gov.au/general.shtml

27 http://www.dhhs.tas.gov.au/services/view.php?id=412

28 http://www.ambulance.vic.gov.au/Main-home/Membership/Membership-Cover/Billing-Policy.html

29 http://www.saambulance.com.au/

30 http://www.emergency.qld.gov.au/publications/annreport/2004_05/pdf/DES_Annual_Report_2004_05_p005.pdf

- There is no nationally recognised and independent framework for community engagement and complaint mechanisms for either service providers or individual paramedic practitioners.
- There is sharing of some data but little planned commonality of equipment and systems, communication resources and other physical assets that would enable greater operational efficiencies and more cost-effective procurement, or facilitate cross-border operations or the aggregation of resources in the event of catastrophic events.
- ADF paramedic personnel have no direct links to or comparable education and qualification standards with their civilian counterparts. One consequence is the potential loss of defence medics from the health care workforce on retirement from the ADF because they have no clear post-military career pathway. To help retain their services, ACAP and the ADF have adopted a qualification map to assist ADF medics in joining ACAP at an appropriate level.
- EMS practice is currently regulated in each State and Territory by Acts of Parliament, with practitioners licensed by their respective employers and operating under different clinical guidelines. Paramedics are not enabled to practice independently outside the bounds of their State-authorised agency.
- At an operational level, jurisdictional constraints are reinforced by the Drugs and Poisons Regulations. These vary between jurisdictions and restrict the carriage and administration of certain controlled substances.
- Paramedic practice is affected by other legislative instruments including the State Health Practitioner Registration Acts. The application of these restrictions and their role in serving the public interest are at times questionable. In the past they have been used to restrict the scope of paramedic practice even to the carriage of stethoscopes - which is unlikely to be in the best interests of patients.
- Legislative and operational constraints make it difficult for paramedics to move and retain their professional standing. Flow-on effects include the impacts on potential cross-border integration and operational issues, more difficult recruitment of personnel and restrictions on mobility and career development.
- Chronic paramedic staffing shortages are reported in several jurisdictions which have resulted in continuing problems of absenteeism, stress-related illnesses, staff attrition and industrial unrest. This creates the moral risk that employers may adopt lower than desirable qualification and practice standards to maintain staff levels.
- EMS education is in a state of flux. Some States have formally adopted tertiary education programs as the basic entry qualification for the professional paramedic level, while others are continuing (pro tem) with a mixture of degrees and internal diploma programs. Nonetheless, university-based paramedic education programs will soon be the only entry route to paramedic practice and employment in Australia.
- To date there has been no nationally recognised external accreditation system for paramedic education, although the accreditation development effected by CAA in partnership with ACAP has gone some way towards addressing this issue for those graduates employed by CAA member organisations.

Notwithstanding the professional endeavours of ACAP and the laudable objectives of the CAA, the need for a less fragmented approach to emergency care demands a more strategic and national vision that properly integrates EMS with the health care system.

Part 2 - Current reform initiatives

The health care reform agenda

On the 26 March 2008, COAG adopted a comprehensive reform agenda with a particular focus on health and regulatory reform.[31]

The Commonwealth agreed to provide an immediate $1 billion for health and hospitals by indexing the previous Commonwealth allocation for 2007-08 together with a further $500 million in new funding giving an overall increase in Commonwealth funding for public hospitals for 2008-09 of 10.2 per cent.

Commonwealth-State financial relations form a crucial component of health care policy and COAG also agreed on the key elements of a new Intergovernmental Agreement on Commonwealth-State financial arrangements.

COAG agreed that in developing the new Australian Health Care Agreement (AHCA), the Commonwealth should fund an appropriate share of services provided under the public hospital system. Other initiatives were that jurisdictions move, as appropriate, to a more nationally-consistent approach to activity-based funding for services, reflecting the Community Service Obligations required for the maintenance of small and regional hospital services.

Consistency and equity of funding together with accessibility of services hold particular significance for EMS but apparently have not featured in these funding discussions.

In conjunction with sweeping proposals embracing 27 areas of regulatory reform, COAG agreed to the introduction of a national registration and accreditation system for health professionals and steps to address health workforce skills shortages.

COAG adopted an Intergovernmental Agreement on the health workforce[32] which will create a single national registration and accreditation system for nine currently regulated health professions. These new regulatory arrangements are intended to facilitate the mobility of health professionals, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce.

Timetable for reform[33]

COAG agreed to the implementation of health reform in three stages.

- The first stage involves immediate action on health workforce registration and transitional arrangements for the current health care agreement. These will lay the foundation for longer term reform of the health system.
- The second stage involves COAG consideration of the new National Health Care Agreement as part of the Specific Purpose Payment (SPP) Financial Framework.
- The third stage will involve COAG consideration of additional longer term health reforms to be implemented following the report of the newly established NHHRC in June 2009.

31 Communique of Council of Australian Governments' Meeting, Adelaide 26 March 2008

32 Ibid

33 Ibid

National Health and Hospitals Reform Commission (NHHRC)

On the 25 February 2008, Federal Cabinet approved the establishment of the NHHRC.[34] The ten-member Commission has been tasked to provide a long-term health reform plan with an interim report to the Commonwealth Government by the end of 2008, and a final plan in mid 2009.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through the Minister to the Prime Minister, COAG and the Australian Health Ministers' Conference (AHMC). The Commission will also advise the Government on the key aspects of the framework for the next AHCAs between the Commonwealth and the States and Territories.

The full terms of reference for the NHHRC are outlined in *Attachment A*.[35]

Among the first actions taken by the NHHRC has been a call for submissions from interested parties as part of its commitment to community engagement in seeking input from the public, frontline health workers, professional and consumer groups, and other interested people and organisations.

ACAP's response

This ACAP submission represents the well-formed views of a significant professional group with first-hand knowledge and experience of the health care issues involved with out of hospital EMS. From this perspective ACAP can provide unique insights into the role of EMS in the continuum of health care.

The submission covers:

1. ACAP's views on the current COAG initiatives and NHHRC Terms of Reference;
2. An overview of additional issues in EMS health care with a number of proposed remedies and recommendations.

ACAP's priority has been to identify issues of policy significance that should be researched and considered by NHHRC in meeting its national reform objectives. The observations and recommendations in the following pages therefore are given in broad outline as befits the initial stages of enquiry by the Commission.

ACAP remains ready to work with the Commission and to provide further input in writing or orally as various policy issues are explored in greater depth over the coming months.

34 http://www.nhhrc.org.au/

35 http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/terms-of-reference

Part 3 – Meeting the challenge

Formation of NHHRC and timetable for reform

ACAP welcomes the establishment of a new reform agenda for health care and the formation of the NHHRC. It is especially pleased to see the Commission's commitment to engagement with the community. The ACAP Board of Directors looks forward to working with the Commission and trusts that the willingness to seek informed comment will extend to further involvement in future NHHRC studies and initiatives.

ACAP supports the general tenor of urgency and the proposed development timetable. It recognise s the need to take immediate steps (as feasible) to overcome the more egregious deficiencies in health care standards, accessibility and equity, such as those associated with Australians who are disadvantaged through economic and regional circumstances and members of our indigenous communities.

At the same time it acknowledges the importance of maintaining continuity of existing health care services during the various stages of reform to ensure that particular groups are not inadvertently cast adrift from appropriate health care.

Given the complexity of the issues confronting health care in Australia, ACAP believes that a much longer timescale will be required to overcome the existing fragmentation, structural deficiencies and entrenched attitudes of many of the participants in the health care system.

If a longer time frame is required to deal with the issues, the initial timetable should be extended for a reasonable period in the interests of achieving better outcomes.

In the context of introducing reforms and managing change, the most important thing is to get the overall policy right rather than to seek a series of 'quick fixes'. Understandably, this process may take the form of a number of incremental steps with concurrent research, monitoring, evaluation and reflection to gauge the impact of initiatives. Realistically the change agenda is likely to take several years to reach fruition.

ACAP therefore sees merit in the role of a national body with the capacity to develop, integrate and implement health care policy over a longer timeframe. It considers that the work of the present Reform Commission should continue after the initial reform process under the guidance of an ongoing and permanent body.

The reasons for such an institution are several and include the need to establish national standards and performance measures; provide effective workforce planning and national regulatory regimes; develop consistent information and reporting metrics; implement seamless communication and information systems; and invest in appropriate facilities and technological resources to meet the long term needs of all Australians.

Appointments to the new (on-going) Commission should be broadly based and include representation from consumers, policy experts, health professionals and those with practical business and economic expertise. More extensive research and advice may be provided by contracted research, internal experts and teams, and various special purpose advisory committees or subcommittees.

Among the goals of any new National Health Care Commission would be the assessment of existing health care facilities (auditing of human and physical capital) and evaluation of new developments with the aim of reducing overlap and fragmentation by optimising the use of available resources.

Recommendation 1

ACAP recommends that the Commonwealth establish a permanent national body or National Health Care Commission to coordinate and continue the development and implementation of health care policy following the initial work of the NHHRC.

The terms of reference for such a body should broadly mirror those of the NHHRC as amended to suit the implementation and monitoring role of an on-going oversight and coordination body. There should be a seamless transition from the present Reform Commission to this new entity whose success and continuing justification should be regularly and objectively evaluated at four or five yearly intervals.

A degree of continuity and longevity should apply to the membership of the permanent body. The Chair might be appointed for a period of (say) three to five years (renewable) with members serving a three-year appointment with a possible renewal for a further three years. Appointment should be phased with a proportion of the membership (say 1/3) retiring each year to ensure both continuity and turnover.

Appointments to the Commission should be broadly based and include representation from the community at large as well as policy experts, health professionals and those with practical business and economic expertise.

NHHRC objectives and terms of reference

The NHHRC has been tasked with developing immediate responses to ensure continuity of existing health care arrangements and implementing urgent programs to overcome previously identified and critical deficiencies. At the same time it is to develop a "long term health reform plan for the nation".

These activities are embodied within the terms of reference for the NHHRC shown in *Attachment A* and complemented by the 15 underlying principles of health care prepared by the NHHRC and reproduced in *Attachment B*.

ACAP strongly supports the role envisaged for the NHHRC in providing a national focus for the development and implementation of health care policy based on the principles of equity and universal access and with essential funding support through federal taxation.

ACAP also endorses the objectives to develop long-term affirmative strategies to raise the health-status of economically and/or socially disadvantaged groups within the Australian community and provide an integrated and seamless system that is outcome-based and includes prevention activities and other interventions across the full spectrum of health care.

Recommendation 2

ACAP endorses the role envisaged for the NHHRC as outlined in the published Terms of Reference as well as the complementary health care principles envisaged by the Commission to help it shape the national policies for health care.

While supporting in principle all of the outlined objectives of the terms of reference, ACAP has identified certain omissions, especially in relation to the use of the existing resources in the most effective way possible and arrangements for equity in providing EMS.

ACAP believes that any national assessment of available resources should include consideration of the substantial investment in physical assets and intellectual capital within the ADF. Medical practitioners, nurses and paramedics of the various service arms of defence possess valuable professional skills and expertise in providing both general health services and particularly EMS.

A national strategy to meet the challenges in a field of such fundamental importance as health care should take account of these sometimes underutilised resources in times of peace as well as war. Similarly, the resources of all EMS providers should be able to be mobilised to best effect in times of national danger or as required for homeland security.

Recommendation 3

ACAP recommends that the terms of reference for the NHHRC be expanded to include consideration of the defence forces as potential reservoirs of professional skills and to examine the ways in which mobility of professional staff both to and from the military services may be facilitated.

ACAP is gravely concerned by the absence of any specific reference by NHHRC to the role and funding of out of hospital emergency care. The omission of EMS as a key component of the health care system raises the strong likelihood that the impact of national health policies and associated funding and organisational arrangements on the capacity of EMS to deliver equitable emergency care will not be given adequate attention.

Currently there is no uniform approach to funding, access, and administration of out of hospital emergency medical care in Australia.[36] Funding arrangements vary between jurisdictions with a combination of direct State or Territory revenues, subscription schemes, insurance and user charges.[37] The Commonwealth does not provide direct funding and the EMS services are not included as a component of the AHCAs.

It is difficult to see any reason why EMS should remain outside the shared funding arrangements between the Commonwealth and the States and Territories given that any policy covering the delivery of health care at a community level is likely to have significant impacts on both EMS providers and paramedic practitioners.

Noting that EMS are not covered by Medicare, it is clear that the myriad of funding arrangements for health care under various guises should be harmonised under consistent funding principles including universal access and equity. Emergency events hold no respect for jurisdictional boundaries and ACAP proposes that EMS should have a national focus with base funding provided by the Commonwealth.

Recommendation 4

ACAP recommends that the terms of reference for the NHHRC be expanded to make specific reference to the role and funding of EMS as an integral component of the long term national health care strategy. ACAP further recommends that in the context of the immediate AHCAs, discussions be initiated between the various levels of government with a view to extending the reach of the Agreements to include services beyond those of public hospitals (with the particular inclusion of EMS).

Recommendation 5

ACAP recommends that in examining the net benefits, cost effectiveness and equity of funding, the NHHRC undertake a comprehensive structural review of all existing health care funding mechanisms including not only the AHCAs but also Medical Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Public Health Outcomes Funding Agreements, aged care etc..

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36 *Submission to The Department of Health and Ageing relating to the Inquiry into Health Funding*, The Australian Council of Ambulance Authorities, Flinders Park, South Australia, August 2006, (Table 1 p7)
http://www.aph.gov.au/house/committee/haa/healthfunding/subs/sub148.pdf

37 http://www.ambulance.qld.gov.au/pdfs/Payment_of_QAS_invoices_to_non_QLD_residents.pdf

Recommendation 6

ACAP recommends that the contribution of EMS to national health care objectives be recognised by the collation of specific data relating to EMS funding and performance with public reporting by the proposed National Health Care Commission (Recommendation 1) and the Australian Bureau of Statistics(ABS). ACAP also recommends that the NHHRC examine the appropriateness of existing reporting parameters for EMS including the adequacy of occupational classifications within the ABS statistical database.

ACAP believes the commitment to a patient-oriented approach to health care with greatly enhanced community engagement is overdue. ACAP supports the view that the users (the public) should play a significant role in the development, planning and implementation of health policy and health services at both provider and practitioner levels.

Among the fundamental issues to be resolved in the provision of a sustainable healthcare system will be:

- mechanisms to establish, monitor and maintain quality and delivery standards under consistent and independent protocols for accreditation and operational performance;
- mechanisms to improve integration between all parts of the health sector including the interface between EMS and hospital-based care;
- mechanisms to ensure transparency and accountability through objective assessment and resolution of provider and practitioner complaints; and
- the need to address workforce issues, including education and planning and the desirable form of scope of practice constraints to ensure the various elements of health care are delivered by the most appropriate health professionals.

The examination of these and other issues will not be an easy task and there will be an extensive range of policy options to be considered.

The present call for submissions is valuable in identifying issues and formulating initial directions and proposals. However, in the absence of comprehensive background information and policy options, it does not fulfil the objectives of meaningful community engagement in evaluating the merits of various options and making informed choices about the preferred strategies for health care in the future.

Informed debate will be essential in determining long term policy directions and achieving real health reform. The starting point should be a better understanding of health care needs on an objective and non-political basis, from which may be derived some idea of the services that will best meet those needs, culminating in the design of sustainable mechanisms for funding, delivery and evaluation of those services.

Recommendation 7

ACAP recommends that in pursuing the long term health reform agenda, the examination of issues and the available policy options should be outlined in the form of a number of 'white papers' prepared by NHHRC and made available for discussion and further community input for an appropriate period of time before final determination.

NHHRC health care principles

ACAP has examined the underlying principles proposed by NHHRC to shape the health care system. The principles outline a philosophical basis on which to plan and are divided broadly into two main groups comprising general system design principles and underlying governance principles. For completeness and easy reference purposes these are reproduced in full in *Attachment B* and in outline form below.

Design principles (what we as citizens and potential patients want from the system).

1. People and family centred
2. Equity
3. Shared responsibility
4. Strengthening prevention and wellness
5. Comprehensive
6. Value for money
7. Providing for future generations
8. Recognise broader environmental influences which shape our health

Governance principles (generally how the health system should work)

9. Taking the long term view
10. Safety and quality
11. Transparency and accountability
12. Public voice
13. A respectful and ethical system
14. Responsible spending on health, and
15. A culture of reflective improvement and innovation

Our assessment of these principles has been undertaken in the context of the ethical framework embodied in the ACAP Constitution and Rules, practical application of the ACAP Code of Professional Conduct and the objectives of the CAP program - tempered by the experience of seasoned professionals in the field. In some cases only a brief observation is made.

Principle 1. People and family centred:

Endorsed - ACAP believes that health care should be 'de-mystified' to the extent feasible and efforts should be made to embrace a holistic lifestyle approach to health care with education and prevention activities an important component of general funded care.

Individual responsibility needs to be enhanced within a system that is responsive to individual needs. The concept of care being provided in the most favourable environment close to home is consistent with our view of emergency medical centres staffed by competent paramedics and allied health professionals able to provide advice, first aid, first responder and emergency care and transport (if needed) to more intensive medical treatment in a hospital setting.. ACAP submits that holistic care involving prevention and wellness aspects is best carried out in a community setting where people feel at home and are more receptive to advice and treatment.

Principle 2. Equity:

Endorsed – ACAP views access to appropriate EMS on the basis of need as being an inviolable right of individuals in a caring society and one for which there is a national responsibility to fund on the basis of equity.

ACAP also recognises the practical dimensions of the problems to be overcome in bringing EMS to many diverse settings ranging from geographic isolation, socio-economic status, language, culture and indigenous status. ACAP supports the equity of community rating and universality already embodied in the design of Medicare, the Pharmaceutical Benefits Scheme and public hospital care. ACAP moreover believes that affirmative action should be taken where needed to redress current imbalances and identified inequities in the delivery of health care.

Principle 3. Shared responsibility:

Endorsed - ACAP holds the view that all Australians owe a duty of care to develop, fund and use the health system responsibly and to work cooperatively with health professionals.

Health professionals similarly have a responsibility to act ethically and competently, communicate clearly, and empower patients to take an active role in managing their health in a relationship of mutual respect.

As part of the continuum of care, EMS practitioners must participate effectively in multidisciplinary teams to realise these shared objectives, ranging on the one hand from working under demanding conditions with law enforcement and emergency response units to seamless transfer of patients to expert medical staff in the clinical environment of a hospital emergency room.

At all times the paramedic must recognise and value the important roles of both consumers/patients and other health care staff. To realise the goals of self reliance and better health care outcomes there should be appropriate sharing of information and a level of transparency and support that will help people to make informed decisions in dealing with complex health needs.

Principle 4. Strengthening prevention and wellness:

Endorsed and extended – ACAP supports the concept of a comprehensive and holistic approach to the organisation and funding of health services and the need to work towards improving the health status of all Australians *(Recommendations 4 and 5)*.

ACAP agrees with the objective of helping people stay healthy through appropriate investment in wellness, prevention and early detection and appropriate intervention activities including actions to prevent disease and injury. ACAP also takes the view that some of these objectives may be met by better use of existing facilities and allied medical resources which include EMS response centres and the skills of paramedics.

Principle 5. Comprehensive:

Endorsed and extended – ACAP recognises the variety of individual health needs and the extent to which these change during life. Meeting those needs requires a system built on a foundation of strong primary health care services, with timely access to acute and emergency services.

ACAP believes that the role of EMS providers and paramedics should be expanded to cater for the holistic components of primary health care that may involve preventive care with the patient's first point of entry to the health system based on their interaction with a professional paramedic.

Principle 6. Value for money

Endorsed – ACAP agrees that a primary objective of an effective health system must be to deliver value for money. To meet this goal the most effective technology and practices must be used based on demonstrated performance and supported by appropriate data. This information should be easily available to both professionals and patients.

The introduction of new technology should be driven by evidence and cost-effectiveness but not to the exclusion of reasonable innovation and experimentation based on acceptable risk management criteria. Information technology should be harnessed appropriately to enable a smooth transition of patients through the various stages of care from beginning EMS to ultimate resolution while maintaining continuity of care at all times.

Appropriate protocols for scope of practice should be in place to ensure a smooth interface between different health professionals with the timely and accurate transfer of information critical to effective patient outcomes.

Principle 7. Providing for future generations

Endorsed - ACAP's vision of health care is firmly fixed on a dynamic and changing world. As the first persons to minister to people in distress, paramedics are acutely aware of the impact of demographic changes, community expectations and changing health needs.

The evidence is that paramedic practice has not been fettered by the profession, which has been at the forefront in seeking better avenues to care and clinical practice. The barriers to innovation are perceived to lie more in administrative and funding systems that are unresponsive or inappropriate for the circumstances together with the entrenched attitudes and resistance to change by some professional groups.

ACAP accepts and encourages the view that health professionals must be able to adapt to service future health needs, commencing with a firm grounding in basic principles through accredited education and training in partnership with the education sector. To cope with change, continuing education should be mandatory (see CAP program) and there must be a commitment to support research and development activities that will create new knowledge for the benefit of patients.

Principle 8. Recognise broader environmental influences shape our health

Endorsed – Although this principle is couched in very general terms, ACAP agrees with the underlying philosophy and the potential effects and consequences of interrelated events. ACAP recognises the likely adverse impact of decisions outside the immediate health environment and in particular those relating to air and water pollution, energy use, urban design principles and occupational health and safety.

ACAP therefore supports the thrust of the NHHRC proposal to examine ways in which the physical and socio-economic environments affect health and to work across multiple levels and agencies outside the immediate health system to promote practices beneficial to the long term health of Australians.

Principle 9. Taking the long term view

Endorsed – ACAP believes that effective governance and leadership comes from policies that are based on long-term strategic developments divorced from short term (often politically driven) considerations. Planning must be based on long term projections of supply and demand, respond to changing demographics and health care practices and retain the flexibility to take advantage of likely technological advances and economic fluctuations.

ACAP agrees that to fulfil the aims of this principle will require integrated research, monitoring and consultation processes well beyond current levels.

Principle 10. Safety and quality

Endorsed and expanded – ACAP supports the principles of responsible and accountable management at all levels of the health system and an ethical culture of continual improvement that eschews self interest and embraces the service objectives of patient safety and quality outcomes. Among the components of these governance and quality systems must be:

- Open and transparent reporting including provisions for whistleblower protection;
- Independent and community oriented complaint resolution mechanisms;
- effective organisational and administrative systems;
- 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.

Principle 11. Transparency and accountability

Endorsed and expanded – In concert with Principle 10 (safety and quality), ACAP believes there should be mechanisms that enable correlation between inputs and outputs or cause and effect in the funding and provision of health care.

Funding should be transparent and not contain hidden cross subsidies, with the sources and application of funds clearly delineated. The performance benchmarks established for health care should apply generally and embrace not only public sector providers but also private and non-government service providers and the defence forces.

ACAP agrees with the NHHRC view that Australians are entitled to regular reports on the status, quality and performance of the whole health care system, ranging across the spectrum from primary to tertiary care and at local, State and national levels.

Principle 12. Public voice

Endorsed – ACAP agrees that particular efforts should be made to ensure that the views of knowledgeable groups such as ACAP itself should be sought and considered in the determination of health care policy.

Principle 13. A respectful, ethical system

Endorsed – ACAP supports the view that the health care system must apply the highest ethical standards in a manner that is consistent with the ACAP Code of Professional Conduct. To ensure those working within the health sector are aware of ethical considerations in their daily practice, ACAP believes that special training and firm guidelines are needed to promote ethical behaviour, minimise conflicts of interest and prevent medical and financial fraud.

Principle 14. Responsible spending on health

Endorsed without further comment.

Principle 15. A culture of reflective improvement and innovation

Endorsed without further comment.

Part 4 - Identifying EMS and paramedic practice

The identification of appropriate professional roles in the health care environment has long been a topic of debate between different professional groups. Nurses, radiologists and other allied health professions have had to work assiduously to establish the legitimacy of their roles in the face of sometimes fierce (and even misinformed) opposition. The inflexibility of the health system to change has been highlighted by the Productivity Commission.[38]

The reality is that no one professional group has a monopoly on knowledge and some of the greatest advances in public health and diagnostic techniques have been wrought by biologists, geneticists, engineers, microbiologists and computer scientists to name just a few of the many groups that have contributed to improved community health.

Water supply and sewerage systems attest to the skills of engineering and advanced imaging techniques such as computed tomography have only been made possible by advances in mathematics, image processing and computing.

What is notable is that the best health outcomes most often come from the cooperative endeavours of a dedicated team of professionals working within a multidisciplinary environment of mutual respect *(NHHRC Principle 3)*.

The educational and practice requirements for EMS practitioners have grown by leaps and bounds to keep pace with new procedures, advanced technology[39] and better understanding of emergency patient care. The role of the EMS practitioner has evolved until today the paramedic is a key professional in the delivery of out of hospital care.

Unfortunately, despite attempts to gain agreement between the major EMS providers, the role of EMS and even the term 'paramedic' remain confused and may mean different things in different States.

The management of EMS is further complicated by complex administration and funding arrangements and the dichotomy of role, which is partly a legacy of the historic beginnings of ambulance services and may be compounded by the continuing (and much appreciated) contributions from volunteers.

One may question whether EMS is the *emergency arm* of health services, or the *health arm* of emergency services?[40] Under which framework will EMS be able to deliver the best health care outcomes for the community, given that situations requiring the expertise of a professional paramedic most often occur in isolation and unrelated to any physical event?

For example, the South Australian Ambulance Service reports that only 5.8% of their emergency work is in response to vehicle accidents and the largest proportion of work is in patients' homes in response to a medical event or condition, such as a heart attack or asthma.[41]

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38 Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra
http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf

39 http://www.ohsonline.com/articles/44867/

40 *A Description and Evaluation of Improved Organisational Performance Through the Use of a Continuous Improvement Process by Queensland Ambulance Service*, Russell Linwood, Qualcon 2005, Annual Conference of the AOQ, Brisbane, October 2005
http://www.aoq.org.au/PDF/Linwood.pdf

41 http://www.saambulance.com.au/

The absence of relevant informed debate in Australian research literature is reflected in some key Australian publications. For example, the premier source of general data on national output, the ABS, makes no mention at all of *ambulance*, and uses the word *paramedic* only once in 41 pages on health (ABS, 2002).[42]

It is even more disconcerting to find that in the first report prepared by the NHHRC[43] dealing with AHCA and performance benchmarks, the term emergency is applied almost exclusively in the context of hospital-based services, the word ambulance appears twice in reference to a transport vehicle and the term paramedic does not appear at all.

These observations suggest a significant gap in the understanding of health care delivery mechanisms and coverage of a key component in patient care - at least in the recognition by government of the health care role of EMS and official Australian data gathering and reporting regimes.

To place this situation in perspective, one may imagine what might be the outcome and public dismay if the whole of the EMS workforce and related infrastructure suddenly did not exist – as it would appear from health care statistics and the NHHRC papers to date.

This parlous state of affairs may stem from a misunderstanding of the role of EMS arising from historical development and the vagaries of collocation of ambulance services within State bureaucracies. The outcomes in health care terms may not always be in the public interest and may even compromise the standards of paramedic practice and patient care.

For example, consideration of EMS as a health care service may have the potential to facilitate cooperation with the National E-Health Transition Authority[44] in the implementation of national electronic health records and their integration with EMS activities, resulting in earlier improvements to service quality and patient outcomes.

Ambulance Services in Victoria, Queensland and Tasmania have implemented an e-Patient Care Record linked to a comprehensive clinical information system known as the Victorian Ambulance Clinical Information System (VACIS). Ambulance services in the ACT, NT, NSW and South Australia are also in the process of exploring the introduction of this system in their respective jurisdictions.

This information system has been built on an agreed National data set. This data set and the systems future developments and enhancements are being managed through a CAA collaboration to ensure its National relevance and sustainability. An opportunity exists to link VACIS data with other health data to provide a comprehensive picture of the entire patient journey from pre-hospital to hospital to post hospital care.

Freed of organisational arrangements that might restrict perceptions of EMS responses to that of an outdated reactive transport role, health care policies could be considered that take better advantage of paramedic resources and supporting physical facilities in assessing optional pathways of care. More holistic policies would result with the use of appropriate measures of effectiveness.

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42 Ibid

43 *Beyond the blame game: Accountability and performance benchmarks for the next Australian Health Care Agreements*, A Report from the National Health and Hospitals Reform Commission, April 2008
http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/504AD1E61C23F15ECA2574430000E2B4/$File/BeyondTheBlameGame.pd

44 http://www.nehta.gov.au/

These nationally reported measures should include:

- accreditation and audit outcomes;
- access to services (time, location, socioeconomic and other categories);
- compliance with clinical guidelines;
- cost effectiveness of services;
- specific performance indicators for particular 'at-risk' groups;
- specific performance indicators for particular practices or services;
- patient satisfaction/consumer experiences of care;
- practitioner complaint outcomes;
- safety and quality indicators;
- service provider complaint outcomes;
- consistent data collection and performance reporting (to assist comparison);
- implementation of electronic patient records consistent with nationally adopted health records; and
- workforce factors (staffing, workloads, service ratios, engagement, retention etc.).

Close operational links will always be necessary between EMS personnel and other reactive responders to emergencies such as the fire brigade, police and special emergency response units. Suitable records will also need to be maintained to place the services in context.

Considering the on-going contribution of the EMS clinical role to patient care outside physical emergency situations (which may range from preventive through to highly interventionist activities), ACAP is firmly of the view that paramedic practice and the administration and management of EMS should fall within the overall ambit of healthcare services and national health care policy.

In this way, appropriate attention will be given to issues of equity, funding and cost/effectiveness for overall health outcomes under a regime of relevant data collection that will enable better assessment of the EMS contribution to the health of the nation.

Development of the performance benchmarks as reported by NHHRC[45] therefore should be extended to cater for EMS in the monitoring of health care performance and patient outcomes.

Recommendation 8

ACAP recommends that the NHHRC recognise EMS as a significant and discrete component of out of hospital health care. Funding and policy matters dealing with EMS matters therefore should be considered in the context of the delivery of health care services. While maintaining close links to other emergency response services the administration of public sector EMS providers preferably should be undertaken within the health care environment rather than within other administrative portfolios.

Recommendation 9

ACAP recommends that performance benchmarks be developed to cater for the specific services and patient outcomes arising from the provision of EMS out of hospital care and consistent with the performance principles adopted by the NHHRC for the monitoring of other health care services.

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45 *Beyond the blame game: Accountability and performance benchmarks for the next Australian Health Care Agreements*, A Report from the National Health and Hospitals Reform Commission, April 2008
http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/504AD1E61C23F15ECA2574430000E2B4/$File/BeyondTheBlameGame.pd

Part 5 - Health care and regulation

The scope and form of regulation varies widely between professions and between countries.[46] Some professions are particularly highly regulated such as law and medicine, while other fields of endeavour may have few regulatory controls e.g. economists.

The European Union has made great efforts to improve and simplify the regulatory environment in promoting cross border trade and competition for professional services, thus opening discussion concerning the nature of regulatory frameworks.[47] The United Kingdom has taken a lead in regulatory reform and in 2004, undertook a landmark review of legal services[48] in order to foster competition and innovation, as well as provide consumer protection and to ensure an accountable regulatory system.

Internationally, the impact of regulatory activities on the professions has become part of the public policy agenda. It is therefore disturbing to find the jurisdictional silos within Australian health care that restrict mobility and innovation and ultimately militate against the interests of the community.

Realising regulatory objectives

The reasons advanced to justify regulation are typically founded on three main premises:

- Market interest (to create an informed market place)
- Public interest (to protect the public through quality standards)
- Self interest (to protect exclusivity, status and economic welfare of practitioners)

Some professions stress the need for self-regulation, on the basis that only a rigorous system of peer review is sufficient to limit the risk of poor quality service. These calls have been particularly strident in the health sector. The self-regulatory model however, suffers from perceptions of self-interest, conflict of interest and lack of accountability.

Other calls for regulation may stem from private interest. That is, the regulation of professional services might be a self-seeking objective because it is in the interests of the members of a profession. Regulation in this context may tend to operate like a cartel. In theory, selective professional licensing may restrict supply, increase the perceived value and incomes of practitioners and promote exclusivity and status.

ACAP eschews such approaches as being contrary to its professional objectives. Paramedics hold dearly to their obligations to provide an essential health care service based on the application of expert knowledge and skills obtained through education and training, a high degree of personal integrity and a fiduciary relationship with patients. Regulation is needed for more fundamental reasons.

The market-based rationale for regulation suggests that when faced with a choice of service providers, many consumers may be unable to make a rational choice. Because of their specialist nature, professional services are taken at face value, with the consumer generally having to rely on the expertise of the practitioner and not well placed to assess the type and quality of the service.

46Extending the Disciplines on Domestic Regulation for Accounting to other Professional Services, Patricio Contreras, PECC Trade and Investment Issues in WTO and APEC Study Group on Services, Focus Workshop on Trade September, 2003

http://www.pecc.org/PECC2003Brunei/papers/trade-workshop/session-3/Services-contreras.pdf

47 Stocktaking Exercise on Regulation of Professional Services, Overview of Regulation in the EU Member States, 2003.

48 Review of the Regulatory Framework for Legal Services in England and Wales, Consultation Paper, Sir David Clementi, 2004.

Regulation in that case may be justified if it can provide protection for the consumer through guaranteeing quality of service based on the regulatory body having more information and expertise at its disposal than the average consumer.

If the practitioner level service is provided in conjunction with the agency function - as occurs with employed professionals in (say) hospital and EMS activities, the public interest becomes multi-dimensional and regulatory obligations encompass both the individual and the agency.

Regulation may also be justified by a failure to have an open market. In the Australian context *(NHHRC Principles 2 and 3),* EMS generally should fall into the category of a public good and there is normally only a single service provider. In rural and remote areas in particular, the local EMS/ambulance service is often the only available source of immediate out of hospital emergency care.

When consumers (patients) have no choice between competing services, regulation can provides a framework in which to set quality standards and performance benchmarks.

Given the significant risk and danger to the health and welfare of the community, EMS providers and paramedics are subject to greater than normal public interest and consumer protection considerations on the grounds of quality, choice and availability of services. ACAP draws particular attention to the risks of paramedic interventions *(Appendix 2)* and the underlying responsibility of the NHHRC to minimise those risks in the public interest.

ACAP submits that rigorous licensing (or an equivalent regulatory mechanism) is therefore needed for EMS providers and paramedic practice.

While the case for regulation should not be controversial and has been accepted by COAG, there is no single model for regulatory best practice and it is a question of government policy as to what form regulation should take.

The functions of regulation

The characteristics of good *regulatory governance* are increasingly being recognised as: clarity, predictability, autonomy, accountability, participation, and open access to information.[49] Each of these elements helps in making a regulatory system transparent in the eyes of stakeholders and enhancing the outcomes. These factors are generally replicated in the statement of NHRRC principles that are endorsed by ACAP.

It is axiomatic that it is in the interests of health care professionals to have regulatory mechanisms that hold public confidence. For example, there is a consistent view that to properly command public support[50] the management of complaints should be handled independently of a profession or service provider.

Having established the need for a suitable regulatory framework within the health care sector, one may examine the measures available.

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49 How to improve regulatory transparency, Emerging lessons from an international assessment, Lorenzo Bertolini GRIDLINES, Note No. 11 – JUNE 2006

http://www.ppiaf.org/Gridlines/11regulatorytransparency.pdf

50 The Future of Legal Services: Putting Consumers First , Response of the Legal Aid Practitioners Group, January 2006

http://www.lapg.co.uk/docs/LAPG%20response.pdf

In this respect, ACAP supports the views of Sir David Clementi who outlined the functions of regulation in his 2004 review of legal services[51] as:

- setting minimum entry standards and training;
- formulating professional roles to which individuals are expected to adhere;
- monitoring the individuals providing services;
- enforcing professional roles where necessary;
- implementing a complaints procedure; and
- implementing a disciplinary procedure for individuals who are negligent or breach the professional roles of practice.

Almost all regulators maintain Web sites and publish annual reports with information about the regulator, the regulated persons or entities, and the regulatory decisions made in that year. The content of annual reports varies substantially, reflecting the wide range of requirements for information disclosure.

Regulators also face the challenge of building the demand, awareness, and capacity of consumers and other stakeholders to participate effectively in the regulatory process. Strategies to involve patients and heighten public awareness of the regulatory role need to be developed and implemented *(NHHRC Principles 2, 3 and 12).*

ACAP is not alone in seeking a consistent regulatory regime within the health care industry.

The Australian Government Productivity Commission undertook a research study in 2005 to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals. In its research report[52] the Productivity Commission was explicit in recommending that the AHMC should establish a single national registration board for health professionals and give the new board the authority to determine which professions to register and which specialties to recognise.

The NHHRC role in regulatory reform

ACAP welcomes the COAG decision to introduce a national professional registration scheme for health practitioners and implement a national course accreditation scheme to be jointly funded by the Commonwealth and the States and Territories. [53]

The scheme will consist of a Ministerial Council, an independent Australian Health Workforce Advisory Council (the 'Advisory Council'), a national agency with an agency management committee, national profession-specific boards ('boards'), committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each State and Territory.

There will be boards for each of the professions which will be responsible for both the registration and accreditation functions. Initially there will be nine separate professional registers, with divisions of registers as listed in *Figure 4.*

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51 Review of the Regulatory Framework for Legal Services in England and Wales Final Report, Sir David Clementi,, December 2004 http://www.legal-services-review.org.uk/content/report/report-chap.pdf

52 Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf

53 http://www.coag.gov.au/meetings/140706/docs/attachment_b_health_workforce_registration.pdf

Figure 4 – Proposed registers and divisions of registers

Profession	Proposed Register	Proposed Divisions of the Register
Chiropractic	Register of chiropractors	Nil
Dental	Register of dental care providers	Dentists Dental therapists Dental hygienists Dental prosthetists
Medical	Register of medical practitioners	Nil
Nursing and Midwifery	Register of nurses and midwives	Registered nurses Enrolled nurses Midwives
Optometry	Register of Optometrists	Nil
Osteopathy	Register of Osteopaths	Nil
Pharmacy	Register of Pharmacists	Nil
Physiotherapy	Register of Physiotherapists	Nil
Psychology	Register of Psychologists	Nil

Jurisdictions will continue to have discretion to regulate additional core practices through local public health, drugs and poisons, and radiation safety legislation or through other funding or administrative mechanisms.

While accepting that the regulated professions at first may be limited to the nine occupational groups that are currently subject to statutory registration in all jurisdictions, ACAP draws attention to the underlying purposes of regulation outlined in the preceding paragraphs and urges the inclusion of other health occupations within this framework, based on their meeting the criteria outlined in the relevant Intergovernmental Agreement.[54]

ACAP acknowledges the independence of these bodies and the important role they will play in the future of health care in Australia. However, ACAP is concerned that matters of long term health policy should be integrated with workforce planning. Consideration of matters relating to regulation of the health professions must not be considered in isolation from other workplace policies intended to provide seamless and cost effective patient care *(NHHRC Principles 3, 6 and 7)*.

For example, recognising the role of EMS as a distinct field of professional practice immediately draws attention to scope of practice issues and the separation of functions between the paramedic (primary diagnosis and out of hospital health care) and hospital emergency room functions. Restrictions on the scope of practice can greatly affect the vertical integration between different stages in care, creating cost and service inefficiencies that can have an adverse impact on a patient.

54 http://www.coag.gov.au/meetings/260308/index.htm#related

The interaction of the paramedic with other health care professionals must be facilitated in the same way that other professional groups such as nurses and medical practitioners have come to accept appropriate and complementary roles in their multidisciplinary delivery of high quality health care *(NHHRC Principle 3).*

Issues relating to role, responsibilities and system interoperability must be resolved if regulation and health care reform is to be successful. These matters and the ramifications of regulation for each major participant or component of health care delivery should be considered in an holistic manner and in the context of both the NHHRC reform plan and the COAG regulatory scheme.

Given the importance that ACAP attaches to public safety and service quality it is the intention of ACAP to begin discussions with the Australian Health Workforce Advisory Council and its component units with a view to implementing national regulation of paramedic practitioners as an urgent priority.

Recommendation 10

ACAP recommends that the NHHRC acknowledge the provision of services by paramedic personnel as a unique professional field of allied medical practice.

In concert with that recognition, NHHRC should review its use of terminology generally, with the use of Emergency Medical Services (EMS) in preference to ambulance services to better describe the out of hospital and pre hospital provision of health care. Similarly, the term paramedic should be used to describe a professional person whose education, training and skills enable them to deliver a range of out of hospital emergency procedures and medical care and who complies with strict practice guidelines and a code of ethics.

Recommendation 11

ACAP recommends that in shaping the health care system for the future, the role of EMS and paramedic practice be incorporated into the consideration of appropriate pathways of care and that discussions be initiated with the Australian Health Workforce Advisory Council to ensure appropriate national regulatory arrangements are put in place that facilitate multidisciplinary care.

Recommendation 12

ACAP recommends that the establishment of any regulatory regime for paramedics be based on a national perspective and that professional regulation be applied universally across the profession and encompass public, private and defence personnel (in a manner similar to the regulation of military paramedics in the United Kingdom - see also recommendation 3).

Complaint mechanisms and accreditation of EMS providers

In his extensive study of regulation of the legal profession, Clementi formed the view that for effective regulation and public confidence it was desirable for some regulatory functions to be carried out by bodies which are wholly separate from the professional associations or service providers. [55] The chief of these externalised regulatory functions are client complaints, disciplinary matters and the setting of practice rules.

[55] ibid

Furthermore, it was Clementi's view that clients should have access to a single body in order to make complaints and not be expected to navigate a complex series of complaint processes. *(NHHRC Principle 10).* To serve the public interest, the complaints body also needed to have a very substantial non-professional membership *(NHHRC Principle 12).*

ACAP agrees with these principles and notes that there are no comparable provisions that would satisfy these requirements in the present fragmented and jurisdiction-bound administration of EMS in Australia.

While the national COAG regulatory scheme would appear to contain the necessary elements of complaint management and handling of professional disciplinary matters at an individual practitioner level it does not apply (at least at this time) to paramedics.

Professional disciplinary matters may or may not involve a direct patient complaint. Conversely, a service complaint may be unrelated to the performance of a paramedic practitioner. In some cases service quality is impacted through an intermingling of causes with both practitioner and provider contributing to adverse outcomes. However, both types of event may affect the ability of the practitioner to continue to practice.

A system of quasi-regulation where the employing agency sets the rules, processes complaints and determines the outcomes across both professional issues and employment is fundamentally conflicted and contrary to natural justice. The public interest in the fairness and transparency of the professional disciplinary process also demands that there be meaningful lay representation *(NHHRC Principle 3).*

The absence of independent and objective examination of professional practice matters (as distinct from supervisory accountability) is perceived to severely disadvantage the individual practitioner and is a further powerful argument for a national regulatory regime such as that provided by the COAG model. An independent complaint mechanism is urgently needed to meet community expectations of engagement and user-focus, rather than profession or agency-focussed.

Recommendation 13

ACAP recommends that in the event that paramedic practice is not captured under the COAG national regulatory scheme, all EMS providers in Australia be required as a condition of accreditation (and funding for public EMS providers) to establish an independent national complaint scheme with community and practitioner membership, to deal with matters of professional competence and practice. This scheme must comply with the normally accepted principles of fair and open enquiry, natural justice and transparency, with the outcomes of any enquiries subject to mandated reporting and sharing of data in a manner sufficient to adequately inform all EMS providers and the public.

Just as practitioners must perform competently and be held accountable, so also must EMS providers. ACAP believes that the principles of independent quality assurance and complaint management should apply to all EMS providers (public, private and not-for-profit) and service delivery must be conducted under a periodic, quality based, certification or accreditation scheme no less demanding than that applying to the delivery of hospital and diagnostic services.

The end result should be two separate quality assurance and complaint modes to cater for professional matters on the one hand, and service issues on the other. Under a properly constituted set of complaint mechanisms these two modes could be combined in the form of a "one-stop-shop" either nationally or more likely within each jurisdiction, to simplify the complaint process and make the process easier for the user/client/patient.

Service and practitioner complaints often overlap and persistent service complaints may indicate there is a professional conduct or disciplinary issue. Information gathered from dealing with service complaints therefore could inform and improve professional practice (and vice versa) and strong formal links should be developed to make sure that related issues are not ignored through process barriers and that each activity is suitably informed by the outcomes of the other.

In general, a complainant should not be required to bear the cost of any complaint that is not frivolous or vexatious, and funding of complaints might be considered apart from other aspects of regulation. Service-based complaints might attract a service fee from the relevant agency and professional misconduct cases might operate on a similar basis with the individual practitioner being responsible for the costs where a complaint is upheld (legislative protection, employer indemnity and other forms of protection such as insurance may become part of the practice landscape).

There will need to be enforcement remedies should a fee, charge or levy not be paid e.g. removal of an individual's right to professional membership or to practice. In the case of service deficiencies, restitution, transparent reporting and even loss of operating licence may form some of the remedies to be considered.

All operators should be required to complete the prescribed accreditation process at least once in each three-year period and meet all of the quality requirements set out in nationally benchmarked standards, thus providing public assurance of their quality regimes and enabling comparable performance measures to support funding and other initiatives.

As part of this accreditation, service providers should be required to implement internal complaint management processes that include representation from the public and appropriate peer groups.

Recommendation 14

ACAP recommends that all EMS providers in Australia operate under a national licensing system that incorporates regular accreditation and nationally benchmarked service standards together with independent and transparent complaint management and resolution mechanisms.

In addition to quality and service accreditation there should be an independent complaints process and mandated reporting and sharing of complaint and outcomes data to prevent blame shifting and to identify systemic problems as distinct from professional practitioner competence issues.

Part 6 –Other issues

New roles for paramedics are emerging which may challenge the traditional models of service delivery and the dominant role of State-based EMS providers as the sole employers of paramedics and guardians of professional standards.

New employment avenues include the engagement of paramedics in industrial areas such as mine sites, oil rigs, ships and resorts as well as professional support roles in university education. These roles demand greater clinical independence and reinforce demands for portability of qualifications and professional recognition. Improved paramedic mobility will help to overcome severe health care deficiencies - especially in more remote areas.

New challenges and risks have been identified that go beyond the everyday single vehicle accident or industrial accident. Catastrophic events may occur on a previously unimagined scale as witnessed by the Asian Tsunami, the World Trade Centre building collapse and China's Sichuan earthquake. Climate change is likely to result in more severe cyclones and floods while larger industrial fires and multiple-vehicle incidents are increasingly common. The community is now faced with the spectre of massive terrorist attacks using explosives, chemical and radiological weapons and biological vectors.

ACAP's view is that the health care system and particularly the first level response services by out of hospital EMS now must be designed to cope with the shocks of unprecedented disasters. Planning to mobilise resources in times of need will likely have additional benefits by highlighting the available options and promoting developments in multidisciplinary care that will improve general access, equity and health care standards.

Among the key issues to be considered by NHHRC that will enable more coherent and appropriate EMS responses than the present fragmented system are:

- Regionally adequacy and situational appropriateness – examination should be made of the ways in which existing resources can be best mobilised from multiple providers and centres including an assessment of land transport facilities, fixed and rotary wing services, private sites and providers and military installations and resources.
- Uniform practice obligations and standards – out of hospital EMS by its very nature is not confined to borders and jurisdictional boundaries. Barriers to practice should be minimised. NHHRC should explore the ways in which EMS providers and practitioners can operate under harmonised scope(s) of practice, consistent drugs and medication guidelines, and appropriately uniform legal and liability provisions.
- Education and training - system-wide planning and policy development to deliver high quality EMS must take into account the interrelationship of workforce planning and regulatory issues which include curriculum and course accreditation matters, continuing professional development and the assessment of overseas qualifications and experience. A holistic approach is needed to include all EMS practitioners including those working in the private sector and ADF personnel.
- Mobilisation and interoperability – a focus should be placed on achieving greater rationalisation and standardisation of equipment, technological standards, information technology and communication facilities (equipment, frequencies, operating protocols, mobile uplinks etc.). The compatibility of civilian and military systems should be explored as well as enhanced links with other emergency response units (Fire, Emergency Services, and Police).

ACAP believes that consideration of EMS health care delivery at a system-wide level will identify a number of initiatives that will result in improved access, better service and cost effective development.

Recommendation 15

ACAP recommends that the NHHRC approach to system planning and policy development take account (to the degree feasible) of the opportunity to use all discrete EMS resources within Australia including public, private and not-for profit facilities.

Among the objectives of policy development should be an exploration of ways in which enhanced interoperability can be achieved, as well as harmonisation of scopes of practice, clinical guidelines and other potential barriers that may inhibit out of hospital emergency care. A beginning point in this process may be the conduct of a comprehensive audit of EMS resources in Australia to establish the true scope of available human and physical resources.

Glossary

The following terms are used in this submission.

ABS	Australian Bureau of Statistics
ACAP	Australian College of Ambulance Professionals
ADF	Australian Defence Force
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHCA	Australian Health Care Agreement(s)
CAA	The Council (Convention) of Ambulance Authorities
CAP	Certified Ambulance Professional
COAG	Council of Australian Governments
EMS	Emergency Medical Services
NHHRC	National Health and Hospitals Reform Commission
Paramedic	A professional person whose education, training and skills enable them to provide a range of out of hospital emergency procedures and medical care
PBS	Commonwealth Pharmaceutical Benefits Scheme
PCA	Productivity Commission Australia
PEPAP	Paramedic Education Programs Accreditation Project
SPP	Specific Purpose Payment
VACIS	The Victorian Ambulance Clinical Information System
VET	Vocational Education and Training

Appendix 1 - Major sources of ambulance service organisations revenue (2006-07 dollars)(a)

Table 9A. 18

	Unit	NSW (b)	Vic (c)	Qld	WA	SA	Tas	ACT	NT	Aust
Australian	%	–	1.5	–	–	0.2	0.9	–	–	0.5
State/Territory	%	72.5	55.8	78.5	32.4	45.4	87.2	78.2	65.5	64.8
Local	%	–	–	–	–	–	na	–	–	–
Subscription fees	%	–	18.8	–	1.7	14.1	–	–	2.1	6.4
Transport fees										
Interhospital	%	12.5	4.3	7.9	4.1	9.0	–	–	–	7.8
Other fees from citizens	%	6.7	9.1	1.4	31.5	19.5	1.0	–	6.0	8.6
Workers' compensation	%	na	1.1	0.7	–	0.4	0.5	–	0.3	0.5
Motor accident insurance	%	3.3	4.1	2.5	3.5	4.4	5.1	–	2.2	3.4
Veterans' Affairs	%	2.8	–	3.9	3.9	2.9	3.7	0.6	0.5	2.3
Other	%	–	0.8	0.5	–	0.1	0.6	20.2	0.6	0.6
Donations	%	–	0.2	0.3	0.8	0.1	–	–	1.1	0.2
Miscellaneous	%	2.2	3.6	4.3	22.1	3.9	1.0	1.0	21.8	4.8
Indirect government revenue	%	–	0.5	–	–	–	–	–	–	0.1
Total share	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Government grants	%	72.5	57.3	78.5	32.4	45.7	88.1	78.2	65.5	65.2
Indirect government revenue	%	–	0.5	–	–	–	–	–	–	0.1
Other revenue (d)	%	2.3	22.6	4.5	24.5	18.1	1.0	1.0	25.0	11.4
Transport fees	%	25.3	19.8	17.0	43.1	36.2	10.9	20.8	9.5	23.3
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Government grants	$m	337.6	245.2	289.9	34.7	54.7	26.6	14.7	11.6	1 015.0
Indirect government revenue	$m	–	2.2	–	–	–	–	–	–	2.2
Other revenue (d)	$m	10.6	96.5	16.8	26.3	21.7	0.3	0.2	4.4	176.9
Transport fees	$m	117.7	83.7	62.7	46.2	43.4	3.3	3.9	1.7	382.7
Total	**$m**	**466.0**	**427.6**	**369.5**	**107.3**	**119.8**	**30.2**	**18.9**	**17.7**	**1 556.7**

REPORT ON GOVERNMENT
a) SERVICES 2008 :s, data reported may differ from data in agency annual reports and other sources.
b) NSW has a subscription scheme but funds are deposited to the consolidated revenue of the NSW Treasury.
c) Victorias 2002-03 other revenue includes profit on sale of non-current assets of $489 million.
d) Other revenue is equal to the sum of subscriptions, donations and miscellaneous revenue.
e) na Not available. – Nil or rounded to zero.

Source : ABS Cat. no. 3303.0 (unpublished), State and Territory governments (unpublished).

Appendix 2 – Examples of potential risks arising from paramedic interventions

INTERVENTION	EXPLANATION	POTENTIAL CLINICAL CONSEQUENCES
Endotracheal intubation	Insertion of airway management device	• Unable to adequately ventilate patient: prolonged hypoxia leading to brain damage or death
Sedation to enable intubation	Administration of powerful drugs to render a patient unconscious	• Problematic sedation: • Unable to intubate patient: prolonged hypoxia leading to brain damage or death • Profound hypotension (low blood pressure) leading to multiple organ damage, particularly brain damage or death.
Rapid sequence intubation	Administration of powerful drugs to render a patient unconscious and completely paralysed	• Problematic sedation: • Unable to intubate patient: prolonged hypoxia leading to brain damage or death • Profound hypotension (low blood pressure) leading to multiple organ damage, particularly brain damage or death. • Prolonged hyperthermia (high body temperature) leading to organ damage. • Unable to execute failed intubation drill: prolonged hypoxia leading to brain damage or death

Appendix 2 – Cont.

INTERVENTION	EXPLANATION	POTENTIAL CLINICAL CONSEQUENCES
Cricothyroidotomy	Cutting an opening into the patient's windpipe so a small tube can be inserted to allow a patient to be ventilated (breathe artificially)	• Unable to execute procedure: prolonged hypoxia leading to brain damage or death. • Surgical damage to surrounding organs leading to loss of blood and other complications including death.
Sedation and paralysis post intubation	Administration of powerful drugs to maintain a patient unconscious and completely paralysed	• Profound hypotension (low blood pressure) leading to multiple organ damage, particularly brain damage or death. • Prolonged hyperthermia (high body temperature) leading to organ damage. • Undetected extubation: prolonged hypoxia leading to brain damage or death.
Decompression of tension pneumothorax	After cutting a hole in the patient's chest, insertion of a large needle deep into the patient's chest to allow a collapsed lung to reinflate and for the patient's heart to pump effectively.	• Possible damage to heart or major blood vessels in the chest. • Can create a collapsed lung. • Can create a collapsed lung that fills with large amounts of blood. • May contribute to death of patient.
Administration of a range of parenteral medication and drugs	The clinical practice guidelines used by Paramedics require clinical judgments to be made and treatments to be administered.	• Potential to give wrong drug or treatment. • Potential to give wrong dose. • These actions may result in patient harm

Australian College of Ambulance Professionals Ltd.

Submission on National Health Care Reform to the National Health and Hospitals Reform Commission

Meeting the Challenge - Executive Summary

1. The *Australian College of Ambulance Professionals (ACAP)* is the national body representing more than 4000 practitioners engaged in the delivery of out of hospital emergency health care. ACAP has an abiding professional interest in policy matters that affect the delivery of Emergency Medical Services (EMS) and is uniquely positioned to provide insights into the role of EMS in the continuum of health care.
2. In preparing this submission ACAP has placed a focus on identifying issues of broad policy significance as befits the initial stages of enquiry by the National Health and Hospitals Reform Committee (NHHRC). These should be the topic of further in-depth research culminating in a number of *'white papers'* for informed debate and community input for an appropriate period of time before determination of major policies.
3. The submission gives a brief overview of the health care system and the nature of present-day EMS in Australia. It acknowledges the several excellent outcomes of Australian health care policy, and recognises that formidable challenges remain. These include issues of equality and access, demographic change, affordability, safety and quality, workforce issues and the need to redress grave imbalances that apply across particular groups in society.
4. ACAP endorses the decision to establish the NHHRC; the NHHRC Terms of Reference; the philosophical approach to reform as outlined in the 15 NHHRC Principles for Australia's Health System; the general reform agenda and time frame; and the immediate short-term measures to ensure continuity of funding through the Australian Health Care Agreements.
5. The submission notes the long term nature of reform and the importance of appropriate implementation and evaluation processes in achieving the stated goals. To fulfil these objectives it recommends the establishment of a permanent National Health Care Commission.
6. The submission draws attention to several omissions in the terms of reference and immediate funding proposals including the shape of the Australian Health Care Agreements, viz:
   - the absence of any specific reference to the role and funding of out of hospital emergency care and the omission of EMS as a key component of the health care system;
   - the need for a nationally driven policy approach to the provision of EMS under consistent funding and administrative arrangements including universal access and equity principles with base funding provided by the Commonwealth; and
   - the need to better identify and use existing EMS capabilities by a national assessment of available resources – to include the private sector and the physical assets and human resources of medical personnel, nurses and paramedics of the Australian Defence Force.
7. The submission outlines the importance of appropriate health care regulatory regimes and confirms ACAP support for the COAG decision to introduce a national registration scheme for health practitioners and to implement a national course accreditation scheme.
8. ACAP draws attention to the underlying purposes of regulation and notes that the regulatory proposals for health professions initially will be limited to nine occupational groups. It urges the inclusion of other health occupations within the COAG framework and proposes that paramedic practitioners be subject to national regulation as an urgent priority on the grounds that the practice of the profession poses exceptional risks to public health and safety.

9. The submission proposes that matters of long term health policy be integrated with workforce planning which in turn is related to issues such as accreditation and regulation. It recommends that the NHHRC recognise EMS as a distinct field of professional health care and that the education, accreditation and regulation of paramedics be considered in conjunction with other workplace policies intended to provide seamless and cost effective health care.

10. The submission summarises a number of characteristics of EMS in Australia, viz:

    - jurisdiction-bound public sector EMS providers having various administrative arrangements leading to different funding bases, different equipment, different practice standards and different operational metrics resulting in fragmentation when viewed at a national level;
    - lack of coverage by Medicare and a myriad of payment and cost recovery arrangements with potentially inequitable distribution of access and costs to the community;
    - a growing number of private EMS providers that employ paramedics outside the ambit of the traditional ambulance sector without the protection of a nationally accepted regulatory framework for defining the scope of practice and the licensing of paramedics;
    - the relative absence of common equipment and systems, communication resources and other physical assets that would permit greater operational efficiencies and more cost-effective procurement, facilitate interoperability and enable the rapid and smooth aggregation of resources for catastrophic events regardless of location;
    - the absence of any nationally accepted and independent framework for the objective accreditation of EMS service providers (public, private, military and not-for-profit);
    - the absence of a nationally recognised and independent framework for community engagement and complaint mechanisms for service providers and paramedic practitioners;
    - the absence of a nationally recognised external accreditation system for paramedic education within the COAG framework (notwithstanding the CAA/ACAP model);
    - the independence of ADF paramedic personnel from their civilian counterparts and other barriers to workforce mobility occasioned by legislative and operational constraints; and
    - the diversity of educational routes to paramedic qualification and the growth of university-based paramedic education programs.

11. The submission makes a number of recommendations for the NHHRC to examine in overcoming these perceived deficiencies such as:

    - facilitating arrangements to bring funding and administration of EMS under the umbrella of national health care policy with appropriate statistical and performance metrics that enable better assessment of the EMS contribution to the health of the community;
    - establishing funding arrangements for corresponding state and territory service providers on the basis of administration as a primary emergency *health* service;
    - establishing a national accreditation regime for all EMS providers and an independent complaint process with community and practitioner representation for service complaints;
    - facilitating the national regulation of paramedics under the COAG regulatory regime or facilitating an alternative national scheme of regulation (including independent complaint processes with community and professional representation) to protect the public;
    - establishing guidelines and protocols to foster interoperability of EMS providers; and
    - undertaking a national assessment of EMS resources and their distribution to determine whether and how these resources may be better deployed in the national interest for access, equity and homeland protection.

Australian College of Ambulance Professionals Ltd.

Submission on National Health Care Reform to the National Health and Hospitals Reform Commission – May 2008

NHHRC Terms of Reference

Terms of Reference

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies..

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.

2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:

a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;

b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;

c. bring a greater focus on prevention to the health system;

d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;

e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;

f. improve the provision of health services in rural areas;

g. improve Indigenous health outcomes; and

h. provide a well qualified and sustainable health workforce into the future

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and between four to six part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.

Attachment B

Australian College of Ambulance Professionals Ltd.

Submission on National Health Care Reform to the National Health and Hospitals Reform Commission – May 2008

NHHRC Principles for Australia's Health System

The Commission has developed a set of principles which to a large extent should shape the whole health and aged care system - public and private, hospital and community based services.

Proposed design principles (generally what we as citizens and potential patients want from the system)

1. People and family centred: The direction of our health system and the provision of health services must be shaped around the health needs of individuals, their families and communities. The health system should be responsive to individual differences, cultural diversity and preferences through choice in health care. Pathways of care, currently often complex and confusing, should be easy to navigate and, where necessary, people should be given help to navigate the system including through reliable and evidence based information and advice to make appropriate choices. Care should be provided in the most favourable environment: closer to home if possible and with a preference for less 'institutional' settings and with an emphasis on supporting people to achieve their maximum health potential.

2. Equity: Health care in Australia should be accessible to all based on health needs not ability to pay. The multiple dimensions of inequality should be addressed, whether related to geographic location, socio-economic status, language, culture or indigenous status. A key underpinning for equity is the principle of universality as expressed in the design of Medicare, the Pharmaceutical Benefits Scheme and public hospital care. Addressing inequality in health access and outcomes requires action beyond these three programs, including through engagement with other policy sectors (such as the education system, and employment). The health system must recognise and respond to those with special needs (the marginalised or underprovided for groups in society). Special attention needs to be given to working with Aboriginal and Torres Strait Islander people to close the gap between indigenous health status and that of other Australians.

3. Shared responsibility: All Australians share responsibility for our health and the success of the health system. We each make choices about our life-style and personal risk behaviours, shaped by our physical and social circumstances, life opportunities and environment, which impact our health risks and outcomes. As a community we fund the health system. As consumers or patients we make decisions about how we will use the health system and work with the professionals who care for us. Health professionals have a responsibility to communicate clearly, to help us understand the choices available to us, and to empower us to take an active role in our treatment in a relationship of mutual respect. The health system can only work effectively if everyone participates according to these shared responsibilities,

recognising and valuing the important roles of both consumers/patients and health staff.. The health system has a particularly important role in helping people of all ages become more self reliant and better able to manage their own health care needs. This includes helping people to make informed decisions through access to health information and by providing support and opportunities to make healthy choices; and by providing assistance for managing complex health needs.

4. Strengthening prevention and wellness: We need a comprehensive and holistic approach to how we organise and fund our health services and work towards improving the health status of all Australians. The balance of our health system needs to be reoriented. Our health system must continue to provide access to appropriate acute and emergency services to meet the needs of people when they are sick. Balancing this fundamental purpose, our health system also needs greater emphasis on helping people stay healthy through stronger investment in wellness, prevention and early detection and appropriate intervention to maintain people in as optimal health as possible. Recognising the diverse influences on health status, our health system should create broad partnerships and opportunities for action by the government, non-government and private sectors; balance the vital role of diagnosis and treatment with action and incentives to maintain wellness; create supportive environments and policies, protect our health and prevent disease and injury in order to maximise each individual's health potential.

5. Comprehensive: People have a multiplicity of different health needs which change over their life course. Meeting those needs requires a system built on a foundation of strong primary health care services, with timely access to acute and emergency services.

6. Value for money: The resources available to support our health care system are finite, and the system must be run as efficiently as possible and be positioned to respond to future challenges. Delivering value for money will require appropriate local flexibility in financing, staffing and infrastructure. The health system should deliver appropriate, timely and effective care in line with the best available evidence, aiming at the highest possible quality. Information relating to the best available health evidence should be easily available to professionals and patients. Introduction of new technology should be driven by evidence and cost-effectiveness. Pathways to care should be seamless with continuity of care maximised, with systems in place to ensure a smooth transfer of information at each step of the care pathway, making effective use of information technology.

7. Providing for future generations: We live in a dynamic environment and changing populations. Health needs are changing with improved life expectancy, community expectations rising, advances in health technologies, an exploding information revolution and developments in clinical practice. There are new avenues and opportunities for how we organize and provide necessary health care to individuals, using the health workforce and technologies in innovative and flexible ways. Health professionals need to be able to adapt to future health needs. The education and training of health professionals across the education continuum are a responsibility of the whole health community in partnership with the education sector. Continuing education ensures that health professionals are prepared to meet

these changing needs. The important responsibility of the health care system in teaching, training future generations of health professionals for a changing health care sector and roles, participating in research and in creating new knowledge for use in Australia and throughout the world should be actively acknowledged and resourced appropriately as an integral activity. The health sector's commitment to education and research, and its relationship with the education and training sector, should be planned and implemented in a logical and seamless way involving all relevant sectors: public and private, institutional and community.

8. Recognise broader environmental influences shape our health: Our environment plays an important role in affecting our health and in helping us to make sensible decisions about our health. The environment here is taken to mean the global climate, the physical and built environment (air quality, the workplace, planning decisions which affect our health) and the socio-economic environment (people in the workforce generally have better health than the unemployed, better educated people have better health and have responded better to health campaigns and tend to smoke less). Peers and family shape both our health (and development of our children) and our adoption of healthy lifestyles. The health system of the future needs to work at these multiple levels to promote health with many and varying agencies and partnerships. These partnerships must be effective and with players outside the health system, whether they be transport departments, local councils, employers, business and worker organisations, and schools and universities.

Governance principles (generally how the health system should work)

9. Taking the long term view: A critical function for effective governance of the health system is that it acts strategically: that short-termism and the pressure of the acute does not crowd out attention and planning for the long term. A responsible forward-looking approach demands that we actively monitor and plan the health system of the future to respond to changing demographics and health needs, clinical practices and societal influences. This requires capacity to seek input from the community and those within the health sector (providers and managers), to assess evidence and develop and implement plans to improve health and health care.

10. Safety and quality: There should be effective systems of clinical governance at all levels of the health system, to ensure we learn from mistakes and to improve the safety and quality of services. The first step in ensuring effective clinical governance is that there is a culture that embraces improvement in patient safety and quality. This includes an emphasis on open, transparent reporting. There must be a just and positive culture in dealing with adverse events, mistakes and near misses. All of this requires the development of effective organisational systems that promote safety and quality, including appropriate systems of open disclosure and public accountability for the whole system.

11. Transparency and accountability: The decisions governments, other funders and providers make in managing our health care system should become clearer and more transparent. Funding should be transparent. The responsibilities of the Commonwealth and state governments and the private and non-government sectors

should all be clearly delineated so when expectations are not met, it is clear where accountability falls. Accountability extends to individual health services and health professionals. Australians are entitled to regular reports on the status, quality and performance of our whole health care system, both public and private, ranging across the spectrum from primary to tertiary care and at local, state and national levels.

12. Public voice: Public participation is important to ensuring a viable, responsive and effective health care system. Participation can and should occur at multiple levels, reflecting the different roles that individuals play at different times in their lives. This includes participation as a 'patient' or family member in using health care services, participation as a citizen and community member in shaping decisions about the organisation of health services, and participation as a taxpayer, voter, and in some cases shareholder, in holding governments and corporations accountable for improving the health system.

13. A respectful, ethical system: Our health care system must apply the highest ethical standards, and must recognize the worth and dignity of the whole person including their biological, emotional, physical, psychological, cultural, social and spiritual needs. A significant focus must include respect and valuing of the health workforce. Those working within the health sector must be aware of ethical considerations throughout their training and in their daily clinical practice.

14. Responsible spending on health: Good management should ensure that resources flow effectively to the front line of care, with accountability requirements efficiently implemented and red tape and wastage minimised. Funding mechanisms should reward best practice models of care, rather than models of care being inappropriately driven by funding mechanisms. Funding systems should be designed to promote continuity of care with common eligibility and access requirements to avoid program silos or 'cracks' in the health system. There should be a balanced and effective use of both public and private resources. New technologies should be evaluated in a timely manner, and where shown to be cost effective, should be implemented promptly and equitably. Information and communication technologies, in particular, should be harnessed to improve access in rural and remote areas on a cost effective basis, to support and extend the capacity of all health professionals to provide high quality care.

15. A culture of reflective improvement and innovation: Reform, improvement and innovation are continuous processes and not fixed term activities. The Australian health system should foster innovation, research and sharing of practices shown to be effective and to improve not only the specific services it provides, but also the health of all Australians. Audit, quality feedback loops and 'Plan, Do, Study, Act' cycles, supported by information and communication technologies, can enable and drive this. The continuum of basic science, to clinical and health services research will underpin this and needs to be embedded.

Attachment C

Australian College of Ambulance Professionals Ltd.

Submission on National Health Care Reform to the National Health and Hospitals Reform Commission (NHHRC) – May 2008

Meeting the Challenge - Summary of Recommendations

Recommendation 1

ACAP recommends that the Commonwealth establish a permanent national body or National Health Care Commission to coordinate and continue the development and implementation of health care policy following the initial work of the NHHRC.

The terms of reference for such a body should broadly mirror those of the NHHRC as amended to suit the implementation and monitoring role of an on-going oversight and coordination body. There should be a seamless transition from the present Reform Commission to this new entity whose success and continuing justification should be regularly and objectively evaluated at four or five yearly intervals.

A degree of continuity and longevity should apply to the membership of the permanent body. The Chair might be appointed for a period of (say) three to five years (renewable) with members serving a three-year appointment with a possible renewal for a further three years. Appointment should be phased with a proportion of the membership (say 1/3) retiring each year to ensure both continuity and turnover.

Appointments to the Commission should be broadly based and include representation from the community at large as well as policy experts, health professionals and those with practical business and economic expertise.

Recommendation 2

ACAP endorses the role envisaged for the NHHRC as outlined in the published Terms of Reference as well as the complementary health care principles envisaged by the Commission to help it shape the national policies for health care.

Recommendation 3

ACAP recommends that the terms of reference for the NHHRC be expanded to include consideration of the defence forces as potential reservoirs of professional skills and to examine the ways in which mobility of professional staff both to and from the military services may be facilitated.

Recommendation 4

ACAP recommends that the terms of reference for the NHHRC be expanded to make specific reference to the role and funding of EMS as an integral component of the long term national health care strategy. ACAP further recommends that in the context of the immediate AHCAs, discussions be initiated between the various levels of government with a view to extending the reach of the Agreements to include services beyond those of public hospitals (with the particular inclusion of EMS).

Recommendation 5

ACAP recommends that in examining the net benefits, cost effectiveness and equity of funding, the NHHRC undertake a comprehensive structural review of all existing health care funding mechanisms including not only the AHCAs but also Medical Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Public Health Outcomes Funding Agreements, aged care etc..

Recommendation 6

ACAP recommends that the contribution of EMS to national health care objectives be recognised by the collation of specific data relating to EMS funding and performance with public reporting by the proposed National Health Care Commission (Recommendation 1) and the Australian Bureau of Statistics (ABS). ACAP also recommends that the NHHRC examine the appropriateness of existing reporting parameters for EMS including the adequacy of occupational classifications within the ABS statistical database.

Recommendation 7

ACAP recommends that in pursuing the long term health reform agenda, the examination of issues and the available policy options should be outlined in the form of a number of 'white papers' prepared by NHHRC and made available for discussion and further community input for an appropriate period of time before final determination.

Recommendation 8

ACAP recommends that the NHHRC recognise EMS as a significant and discrete component of out of hospital health care. Funding and policy matters dealing with EMS matters therefore should be considered in the context of the delivery of health care services. While maintaining close links to other emergency response services the administration of public sector EMS providers preferably should be undertaken within the health care environment rather than within other administrative portfolios.

Recommendation 9

ACAP recommends that performance benchmarks be developed to cater for the specific services and patient outcomes arising from the provision of EMS out of hospital care and consistent with the performance principles adopted by the NHHRC for the monitoring of other health care services.

Recommendation 10

ACAP recommends that the NHHRC acknowledge the provision of services by paramedic practitioners as a unique professional field of allied medical practice.

In concert with that recognition, NHHRC should review its use of terminology generally, with the use of Emergency Medical Services (EMS) in preference to ambulance services to better describe the out of hospital and pre hospital provision of health care. Similarly, the term paramedic should be used to describe a professional person whose education, training and skills enable them to deliver a range of out of hospital emergency procedures and medical care and who complies with strict practice guidelines and a code of ethics.

Recommendation 11

ACAP recommends that in shaping the health care system for the future, the role of EMS and paramedic practice be incorporated into the consideration of appropriate pathways of care and that discussions be initiated with the Australian Health Workforce Advisory Council to ensure appropriate national regulatory arrangements are put in place that facilitate multidisciplinary care.

Recommendation 12

ACAP recommends that the establishment of any regulatory regime for paramedics be based on a national perspective and that professional regulation be applied universally across the profession and encompass public, private and defence personnel (in a manner similar to the regulation of military paramedics in the United Kingdom - see also recommendation 3).

Recommendation 13

ACAP recommends that in the event that paramedic practice is not captured under the COAG national regulatory scheme, all EMS providers in Australia be required as a condition of accreditation (and funding for public EMS providers) to establish an independent national complaint scheme with community and practitioner membership, to deal with matters of professional competence and practice. This scheme must comply with the normally accepted principles of fair and open enquiry, natural justice and transparency, with the outcomes of any enquiries subject to mandated reporting and sharing of data in a manner sufficient to adequately inform all EMS providers and the public.

Recommendation 14

ACAP recommends that all EMS providers in Australia operate under a national licensing system that incorporates regular accreditation and nationally benchmarked service standards together with independent and transparent complaint management and resolution mechanisms.

In addition to quality and service accreditation there should be an independent complaints process and mandated reporting and sharing of complaint and outcomes data to prevent blame shifting and to identify systemic problems as distinct from professional practitioner competence issues.

Recommendation 15

ACAP recommends that the NHHRC approach to system planning and policy development take account (to the degree feasible) of the opportunity to use all discrete EMS resources within Australia including public, private and not-for-profit facilities.

Among the objectives of policy development should be an exploration of ways in which enhanced interoperability can be achieved, as well as harmonisation of scopes of practice, clinical guidelines and other potential barriers that may inhibit out of hospital emergency care. A beginning point in this process may be the conduct of a comprehensive audit of EMS resources in Australia to establish the true scope of available human and physical resources.