



Australian College of Ambulance Professionals Ltd.

Registration Bulletin

The Regulation of Paramedics in Australia:

A response to the Council of Ambulance Authorities Position Statement

The CAA statement

On Monday 18 August the Council of Ambulance Authorities (CAA) released a position paper on the regulation of pre-hospital care providers. This may be viewed on the CAA website at <http://convention.ambulance.net.au/>

The general substance of the CAA statement is that:

- Members of the CAA see no demonstrated need to change the status quo for the funding or management of out of hospital Emergency Medical Services (EMS) or for any form of independent national regulation or registration of paramedics engaged in providing out of hospital health care services.
- In lieu of an independent national regulatory regime, CAA members propound the use of individually applied and jurisdictionally-bound controls through various educational, internal clinical monitoring and quality assurance processes.
- CAA cites the near absolute employment control internally exercised by its members through clinically credentialing each employee and applying disciplinary processes to practitioners.

The Australian College of Ambulance Professionals (ACAP) notes that in adopting their position statement the CAA has recognised that:

- Pre-hospital health care or EMS forms part of the continuum of community health care and properly falls within the scope of an allied field of medical practice.
- Pre-hospital health care or EMS should be appropriately regulated in the public interest.

The CAA policy position and accompanying comments raise a number of concerns about the directions of EMS provision in Australia. The ACAP Executive has therefore authorised the release of the following observations to ensure a better-informed public and profession.

The environment of change

ACAP is intrigued by the CAA release of a policy position supporting the status quo in the face of the Federal Cabinet establishing the National Health and Hospitals Reform Commission (NHHRC)¹ to develop a long-term health reform plan for a modern Australia.

Among the tasks of the NHHRC will be the development of a blueprint for tackling future challenges in the Australian health system including:

- The rapidly increasing burden of chronic disease;
- The ageing of the population;
- Rising health costs; and,
- Inefficiencies exacerbated by cost shifting and the blame game.

¹ <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/home-1>

The NHHRC will examine many issues and place a focus on health financing, maximising a productive relationship between public and private sectors, and improving rural health. In fulfilling this mandate, the NHHRC has already released a set of 15 comprehensive Principles for Australia's Health System.²

ACAP views with concern the CAA suggestion that because the Australian government has had no role in funding or regulation of ambulance service provision in the past, that the same situation would obtain in the future.

ACAP accepts that the Federal Government has acted in good faith in establishing the NHHRC and in nominating its charter for change, and would look towards the various States and Territories and their constituent agencies also contributing positively to achieving improved health care outcomes for the community. ACAP fully supports the NHHRC charter for change and would call on all federal, state and territory bodies involved in EMS to proactively participate in this process.

Looking at sister jurisdictions, the CAA policy position stands in considerable contrast with the release of the New Zealand Ambulance and Paramedical Services standard NZS8156:2008 in May 2008, the Report of the Air Ambulance Reference Group to the Accident Compensation Corporation and Health Ministers³ (NZ) of 28 February 2008 and the recently released Parliamentary Select Committee Report on Ambulance Services in New Zealand⁴ in July 2008.

Among the findings of the Select Committee were the recommendations that:

We consider that it is essential that ambulance services in New Zealand be underpinned by nationally recognised clinical standards, to ensure appropriate care and training.

We consider that it is essential that paramedics be registered under the Health Practitioners Competence Assurance Act 2003; and that a governing body be established to allow registration.

It is significant that these recommendations were made following an extensive review of ambulance services in New Zealand which has a low population density, relies heavily on volunteers working for a limited number of service providers, and whose principal statutory EMS provider (St John New Zealand) is a member of the CAA.⁵

Reminiscent of Australia's complex EMS funding and cost recovery practices, the Select Committee found that costs to patients using ambulance services are not consistent across New Zealand. The Committee formed the view that public funding for the provision of ambulance services needs to be reviewed, with the desirable outcome being a single stream of public funding.

Looking to the future, the Committee also observed that:

'...restructuring of the ambulance sector would significantly improve the effectiveness and the performance of ambulance services. Any restructuring should aim to improve collaboration and co-operation between ambulance providers and other health professionals, and increase transparency.'

² <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/principles-lp>

³ <http://www.moh.govt.nz/moh.nsf/indexmh/report-air-ambulance-reference-group>

⁴ Inquiry into the provision of ambulance services in New Zealand, Report of the Health Committee Forty-eighth Parliament, July 2008

http://www.parliament.nz/NR/rdonlyres/EA7A27CE-1581-4C0B-A815-75180664BB5B/86847/DBSCH_SCR_4100_6073.pdf

⁵ Council of Ambulance Authorities Inc 2006-07 Report

At a local level, the recent comprehensive audit⁶ of the Queensland Ambulance Service (QAS) suggested the need for a number of organisational and funding changes including consideration of the QAS as part of the health system rather than as part of an emergency management system. The Audit also concluded that it was not viable to continue with the current funding arrangements should demand for services not decline. The option of funding ambulance services through the Medicare levy was also seen to have merit.

Standards and regulation

ACAP notes with concern that the CAA has referred in deprecatory terms to the UK system of registration of health professionals under the Health Professions Council⁷ (HPC) which administers the Health Professions Order 2001 (as amended).

As a national regulator, the HPC maintains a register of more than 180,000 professionals from 13 professions who meet the relevant standards for training, professional skills, behaviour and health. These professionals include paramedics who carry a protected title and whose professional interests are represented by the British Paramedic Association.

The HPC requires that to be registered, registrants must meet the standards set for the relevant profession. These standards determine the registrants' 'fitness to practise' and encompass:⁸

- Character;
- Health;
- Standards of proficiency;
- Standards of conduct, performance and ethics;
- Standards for continuing professional development; and
- Standards of education and training.

Contrary to the Australian situation where there is no national set of standards, the HPC registration standards are defined, nationally uniform and transparent. What these standards are for any given profession is a matter for the UK regulator.

ACAP is not able to reconcile the CAA observations concerning relative standards of paramedic practice especially when there is no nominated Australian benchmark, no indication in which areas the UK standards are perceived to be deficient and without any evidence of a formal assessment process.

ACAP finds little relevance between the principles and processes of registration and the CAA comment that there are significant variations in the standards of education and training and clinical practice between different UK employers. Different employers can choose to adopt different operational standards and employment criteria which may equal or exceed the required minimum requirements for individual registration. UK employers have this choice in the same way that Australian EMS providers currently claim the freedom to adopt different educational standards, clinical practices and other protocols.

ACAP also sees scant relevance to registration in the CAA statement that:

'These findings dispel the myth that registration is some sort of panacea to standards of clinical practice'.

The most obvious conclusion to be drawn is that this statement denigrates the concept of independent and objective practitioner regulation through registration, and by association, casts aspersions on the UK regulatory regime.

⁶ Queensland Parliament, *Queensland Ambulance Service Audit Report December 2007*, Brisbane <http://www.emergency.qld.gov.au/publications/pdf/FinalReport.pdf>

⁷ <http://www.hpc-uk.org/index.asp>

⁸ <http://www.hpc-uk.org/aboutregistration/standards/>

The so-called ‘findings’ outlined by the CAA seem to be undocumented assertions and may stem from some misperceptions of the overall role of registration. ACAP does not subscribe to any such ‘myth’ and its views on the regulation of practitioners and service providers are based on more fundamental premises.

Other significant differences between UK and Australian practices that were not highlighted by the CAA position statement include the UK regulator’s provision of:

- A national register of all practitioners readily available for public scrutiny;
- Independent assessment processes with external representation in many cases;
- Publication of disciplinary actions and outcomes regarding practitioners;
- Statutory reporting obligations providing operational transparency; and,
- Independent public complaint processes (through the HPC) concerning fitness to practice thereby minimising potential employer conflicts of interest and providing greater public confidence.

Based on these provisions alone, the UK regulatory regime engages the community substantially more than the major Australian EMS providers and complies far better with the 15 key Principles for Australia’s Health System⁹ proposed by the NHHRC than do the present operational practices of CAA members.

At a time when the largest EMS employer in Australia is beset by allegations of inadequate servicing, poor workplace safety and health practices, bullying, intimidation and harassment sufficient to warrant a Parliamentary Inquiry¹⁰ that has recommended registration of paramedics,¹¹ ACAP finds it anomalous for the CAA to make claims about inferior employer standards or the role of regulation in the UK in the absence of documented supporting evidence.

ACAP therefore notes its disagreement with the CAA observations and the implied criticisms of the UK health care regulatory regime as outlined in the CAA position statement on: the regulation of pre-hospital care providers dated July 2008.

Health care reform

ACAP does not agree with the CAA’s view that there is currently no demonstrable need to advance the cause of registration in Australia and the apparent desire to maintain the status quo for the funding and administration of out of hospital EMS.

The CAA position is perceived by ACAP to be contrary to the community’s desire to achieve improved health care outcomes in the broad public interest as articulated by the Australian government and the general thrust of the underlying principles for health care outlined by the NHHRC.

An overview of ACAP’s vision for health care reform including funding arrangements, practitioner registration, provider accreditation, quality assurance, complaint procedures and community engagement is provided by ACAP’s recent extensive submission to the NHHRC. This submission may be viewed on the ACAP website at <http://www.acap.org.au/index.php>.

ACAP is firmly of the view that leadership is needed to bring about important changes in the administration of out of hospital EMS in Australia and this process should form part of the current health care reform agenda. Among the desirable changes are:

⁹ <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/principles-lp>

¹⁰ *Management and Operations of the NSW Ambulance Service*, Inquiry of the General Purpose Standing Committee No. 2, Legislative Council, NSW Parliament, Sydney NSW
<http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/7E1C5F2F6AD04129CA25744A000801E5>

¹¹ New South Wales Parliament. Legislative Council. General Purpose Standing Committee No. 2. *The management and operations of the NSW Ambulance Service*, Report No 27 October 2008. NSW Parliament, Sydney NSW, ISBN 978192128285

- National recognition of out of hospital EMS as an essential part of health care;
- National funding of EMS on an equitable basis;
- Regulation of paramedic practitioners under the COAG¹² regulatory provisions;
- Accreditation of EMS providers to minimum national standards; and,
- Appropriate independent and objective complaint processes with effective community and practitioner engagement.

Conflicts of interest

ACAP agrees that without the benefit of an independent regulatory regime for paramedic practitioners and EMS providers, in certain circumstances there is the potential for a public perception of a potential conflict of interest by directly affected stakeholders.

In this regard, it appears that the CAA is unaware of the clear ACAP policy position designed to avoid regulatory capture and minimise any perceptions of conflict of interest by calling for an independent regulatory regime within the same COAG framework that has been adopted for other health professions.

Paradoxically, while advancing the argument that there is the potential for a conflict of interest between professional bodies and registration boards, the CAA ignores the exceptionally strong perceptions of self-interest and conflict inherent in its support for internal employer-based controls as an alternative to independent regulation.

For a contemporary understanding of the dimensions of conflict of interest with particular relevance to the public sector, reference is made to the joint publication of the Queensland Crime and Misconduct Commission (CMC) and the NSW Independent Commission Against Corruption entitled *Managing Conflicts of Interest in the Public Sector*.¹³ Another valuable reference that outlines the risks of misconduct and regulatory capture is the CMC publication *Regulatory Risks; Minimising misconduct risks in agencies with regulatory functions*.¹⁴

Universal coverage

ACAP does not understand the rationale behind the CAA statement that:

“Another issue where there is scope for potential conflict between ambulance employers is in recognition afforded to ambulance volunteers...”

An independent and uniform national approach to paramedic registration should not give rise to employer conflict unless perhaps the intention is to suggest that there is a moral risk that some employers would be prepared to adopt lower credentialing standards than the minimum regulatory requirement when considering service provision by volunteers.

While accepting there may be different levels of qualification and specialist certification just as for other health practitioners, ACAP does not subscribe to the concept of differential primary level registration. This approach could be confusing and detract from one of the key reasons for having registration which is to provide an assurance of a practitioner having an acceptable level of competency.

ACAP believes that all Australians are entitled to similar levels of service and standards of EMS delivery and is not prepared to compromise agreed minimum regulatory standards on the grounds of expediency.

¹² Council of Australian Governments

¹³ ICAC and CMC 2004, *Managing Conflicts of Interest in the Public Sector; Guidelines and Toolkit*, CMC Brisbane and ICAC Sydney, ISBN: 1 920726 08X
<http://www.cmc.qld.gov.au/data/portal/00000005/content/25370001124425549294.pdf>

¹⁴ CMC 2003, *Regulatory Risks: Minimising misconduct risks in agencies with regulatory functions*, Building Capacity Paper No. 2, CMC, Brisbane.
<http://www.cmc.qld.gov.au/data/portal/00000005/content/30071001129616228768.pdf>

As outlined in its NHHRC submission, ACAP supports the adoption of a uniform regulatory regime that will encompass all relevant practitioners whether based within the private sector, public sector or ADF,¹⁵ and regardless of their employment status as full-time, fractional time or volunteer staff.

Minimising the risks

ACAP agrees that CAA-affiliated bodies currently employ the majority of personnel involved in out of hospital EMS care in Australia. At the same time, there is no consistent administrative, funding, staffing or practice model. A diversity of provider arrangements and standards are employed, including the use of a contracted non-government charitable organisation. Given the fragmentation of the current Australian scene, there is little evidence to suggest that equally good EMS could not be provided by the private sector under a suitable regulatory framework as is done in many overseas' jurisdictions.

ACAP does not accept the CAA's view that national registration is unnecessary because the risk exposure of the community to out of hospital EMS currently delivered by other than CAA providers is 'miniscule' - especially when viewed in the context of affected persons.

An example of the involvement of allied medical care practitioners operating outside the scope of CAA members is the intervention of ADF personnel in the Northern Territory. The Royal Flying Doctor Service of Australia (RFDS) is another organisation whose valuable contributions to regional communities should not be ignored.

When it comes to the relative involvement of potential non-CAA registrants, ACAP draws attention to the CAA's potentially misleading use of the total raw number of CAA operative personnel rather than the actual contribution they make to front line services.

According to the Productivity Commission's Report¹⁶ the number of full time equivalent (FTE) salaried personnel in the categories of qualified ambulance officers and clinical staff was 6582 in 2006-07 while the number of volunteer ambulance operatives was 5265 with no indication of their actual contribution on a FTE basis.

The Productivity Commission Report carries many caveats and urges caution in making comparisons between various ambulance services because of differences in data collection, geography, population dispersal and service delivery models.

The Report observes that for South Australia, the number of volunteers was an estimate only, while for Western Australia the number of volunteers includes staff involved in the provision of first aid services which accounts for 47.5% of corporate personnel. The proportion of the first aid related personnel who might be operating at the level of a qualified paramedic and thus eligible for potential registration is unknown.

In the absence of an appropriate regulatory regime and a suitable statistical framework that would offer more appropriate and accurate data, the case-load capacity of persons engaged in delivering out of hospital paramedic (or equivalent) level services and not within the ambit of CAA members is estimated at 10-12% of the total workforce caseload capacity. In ACAP's view, this potential exposure of the community to practitioners operating outside even the controls of a CAA member provider represents an unacceptable level of risk.

That being the case, ACAP is disappointed to see an apparent lack of concern by CAA members towards the health and wellbeing of those Australians who may potentially be adversely impacted by the fact of their not falling within the scope of a CAA member provider.

¹⁵ Australian Defence Force

¹⁶ SCRGSP (Steering Committee for the Review of Government Service Provision) *Report on Government Services 2008*. Table 9A.20 Ambulance service organisations' human resources, Productivity Commission, Canberra.
<http://203.0.25.146:7988/gsp/reports/rogs/2008/emergencymanagement/chapter09.pdf>

ACAP's position on regulatory coverage is unequivocal and embraces the health care principles espoused by the NHHRC. In essence, this envisages the protection of the public through a national uniform and universally applied regulatory framework for the registration of paramedics under the COAG arrangements.

Safety and quality

As a professional association, one of the primary goals 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 has placed an initial focus on identifying issues of broad policy significance at a national level rather than become embroiled in detailed operational matters.

ACAP has to date maintained an apposite separation between this professional role and what might be considered as industrial and health and workplace issues that come more properly within the scope of union bodies such as the HSU and ACTU, except where there are clear overlaps or potential negative impacts in the delivery of care.

ACAP is thus disappointed by the CAA's endeavour to link 14 hour night shifts to the underlying purposes and processes of registration. ACAP sees little relationship between the principle of practitioner registration and an employer's management of working hours, and it would be disconcerting if CAA members were willing to adopt workplace practices that they knew were inherently unsafe.

Workplace issues having been raised, ACAP records its support for the principles of participative management and the adoption of workplace practices that ensure a competent, ethical and empowered workforce. Moreover, ACAP is opposed to situations that create an environment of fear or intimidation that may have a negative impact on the performance of paramedics and the best delivery of EMS.

In this respect, ACAP does not support conditions that lead to:

- Intimidation, harassment or bullying within the workplace;
- Internalised, conflicted and non-transparent complaint and disciplinary procedures;
- Excessive working hours, extended shifts and excessive overtime likely to pose a clear danger to paramedics, their patient(s) and other members of the community;
- Inadequate human and physical resourcing practices and poor management of working shifts and rosters; and,
- Waste or maladministration likely to bring the provision of EMS into disrepute, and by association, damage the fragile but crucial bond of trust that should exist between a patient and an attending paramedic.

ACAP and corporate governance

ACAP recognises the importance of good governance in the administration and delivery of EMS. It supports the concepts 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 provider processes and internal and external reporting including provisions for whistleblower protection;
- Independent complaint resolution mechanisms that engage the community;
- 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.

ACAP philosophy of EMS

In outlining its general philosophy towards EMS delivery, ACAP endorses the health care principles proposed by the NHHRC. It 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;
- provide funding arrangements at Federal, State and Territory levels that facilitate the delivery of integrated health care services and optimise the use of the physical and human resources of the private, public, not-for-profit and defence sectors;
- ensure responsiveness and high service standards through appropriate community engagement that recognises the legitimate role of consumers and by the establishment of nationally recognised metrics for practitioners and service providers that are based on objective performance measures;
- 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 paramedics and the accreditation of EMS providers that will assist in delivering consistent service standards, facilitate the mobility of the health workforce and thereby contribute towards public safety and welfare.

ACAP calls on all stakeholders at Federal, State and Territory levels to embrace a philosophy of change and reflective review in seeking outcomes that will benefit the community through improved arrangements for the funding, regulation and delivery of emergency health care services.

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