Consultation paper

Options for regulation of paramedics

July 2012

Australian Health Ministers' Advisory Council
Health Workforce Principal Committee

This paper was prepared by the Department of Health, Western Australia, on behalf of the Health Workforce Principal Committee for the Australian Health Ministers' Advisory Council.

Contents

Acronyms

ACT	Australian Capital Territory
ACTAS	ACT Ambulance Service
ADF	Australian Defence Forces
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Council
AHPRA	Australian Health Practitioner Regulation Agency
AHWMC	Australian Health Workforce Ministerial Council
ANZSCO	Australian and New Zealand Standard Classification of Occupations
AQTF	Australian Quality Training Framework
AREMT	Australian Registry of Emergency Medical Technicians
ARTG	Australian Register of Therapeutic Goods
ASNSW	Ambulance Service of New South Wales
ASQA	Australian Skills Quality Authority
AV	Ambulance Victoria
CAA	Council of Ambulance Authorities
CC Act	*Competition and Consumer Act 2010* (Cth)
CAP	Certified Ambulance Professional
CART	Clinical Audit and Review Tool
COAG	Council of Australian Governments
ECU	Edith Cowan University
EMS	Emergency Medical Services
FTE	Full-Time Equivalent
HCCC	Health Care Complaints Commission
HCE	Health Complaints Entity
HPC	Health Professions Councils (United Kingdom)
HQCC	Health Quality and Complaints Commission
HSC	Health Services Commissioner
HSRC	Health Services Review Council
IGA	Intergovernmental Agreement
NP	National Partnership
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
PA	Paramedics Australasia
PEPAP	Paramedic Education Programs Accreditation Program
PHECC	Pre-Hospital Emergency Care Council
QAS	Queensland Ambulance Service
QLD	Queensland
RCA	Root Cause Analysis
RTO	Registered Training Organisation
SA	South Australia/South Australian
SAAS	SA Ambulance Service
SCRGSP	Steering Committee for the Review of Government Service Provision
SJA	St John Ambulance
SJANT	SJA Northern Territory
SJAWA	SJA Western Australia
TAS	Tasmania/Tasmanian
TASAS	Tasmanian Ambulance Service
TG Act	*Therapeutic Goods Act 1989* (Cth)
UK	United Kingdom
VIC	Victoria/Victorian
VET	Vocational Education and Training
WA	Western Australia/Western Australian

List of tables and appendices

Tables

Appendices

Executive summary

In February 2010, the Australian Health Workforce Ministerial Council[1] (AHWMC) requested advice on the proposal to include paramedics as a profession in the National Registration and Accreditation Scheme (the National Scheme). The proposal arose in Western Australia (WA) from a recommendation of the St John Ambulance Inquiry (2009).

By way of background, a national registration scheme for health practitioners, the National Scheme, commenced operation in 2010. Under the National Scheme, fourteen National Boards have been established under the *Health Practitioner Regulation National Law Act 2009* (the National Law), with extensive powers to protect the public. Health practitioners, who are regulated by a National Board, are registered to practice in all Australian States and Territories.

The powers to protect the public under the National Law do not extend to practitioners in health professions and occupations where registration is not a prerequisite for practice (referred to here as unregistered health practitioners). Registration is not a prerequisite to practice as a paramedic in any State or Territory. The current scope of practice of paramedics is governed by employers and encompasses a wide variety of roles and responsibilities.

Historically, paramedics have been employed within government related ambulance services and the Australian Defence Forces. In general, these employment sectors have strong employment and governance practices, which ensure that only those people suitable to be paramedics are employed as such. However, the employment picture for paramedics is changing, with paramedics increasingly being employed in the private sector in diverse areas such as private ambulance or aero-medical services, private industry (including mining) and the events sector. This is at a time when Health Workforce Australia is considering an extended scope of paramedic practice.

While there has been diversity in the level of education requirements for paramedics across Australia, this is now changing with most government related ambulance services requiring a tertiary (university) qualification as the minimum entry to practice requirement.

The combination of these factors raises questions about the extent to which the current regulatory framework protects the public and provides sufficient assurance of the quality of paramedic practice.

This consultation paper sets out what is known about the paramedic sector and includes definitions, employment requirements, education and training, regulatory arrangements and complaints management systems which apply to paramedics in each Australian jurisdiction. A risk assessment of paramedic practice is also included. The consultation is intended to gather information and views to assist in determining the adequacy of existing protections for consumers who use the services of paramedics and, if further public protection measures are required, what these should be and how they should be structured and administered. A number of options for strengthening the regulation of paramedics are proposed for consideration

[1] The Australian Health Workforce Ministerial Council (AHWMC), established under the *Health Practitioner Regulation National Law Act 2009,* comprises Health Ministers of the governments of the Commonwealth and all States and Territories.

Making a submission

Submissions are invited addressing the issues raised in the paper. Questions have been placed throughout the paper to assist with submissions and a response form is included at Appendix 11 to assist in framing responses. Respondents are asked to consider whether further regulatory protections are required, and the extent to which uniform arrangements are necessary or desirable.

Consultation arrangements

Information

This limited stakeholder consultation is being conducted under the auspices of the Australian Health Ministers' Advisory Council (AHMAC), on behalf of State, Territory and Commonwealth Health Ministers.

Further information on this consultation is available from:

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Submissions

Written submissions, making comment on the proposals in the consultation paper, may be emailed to: workforce.projects@health.wa.gov.au

or mailed to:

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Submissions should be received by **3 September 2012**.

Note: All submissions will be considered public documents unless marked 'private and confidential'.

1. Introduction

1.1 Background

On 1 July 2010 (18 October 2011 in Western Australia(WA)), a national registration scheme for health practitioners, the National Health Practitioner Registration and Accreditation Scheme (the National Scheme), commenced operation. Under the National Scheme, practitioners from ten health professions are registered to practise in any State or Territory. A further four professions are scheduled to enter the National Scheme on 1 July 2012. The list of health practitioners regulated under the National Law is included at Appendix 1.

Further information on the National Scheme is available at: www.ahpra.gov.au.

The National Scheme provides extensive powers for National Boards to protect the public by regulating practitioners from these 'statutorily regulated' health professions. However, these powers do not extend to practitioners from other 'unregulated' (i.e., unregistered) health professions and occupations, including paramedics.

In February 2010, the Australian Health Workforce Ministerial Council (AHWMC) agreed to refer consideration of the inclusion of paramedics in the National Scheme to the Health Workforce Principal Committee for advice. Previous government reports in Victoria (VIC), New South Wales (NSW) and WA raised the option of establishing a registration board for ambulance officers or the option of national registration of paramedics. The events relevant to this consultation on regulation of paramedics are identified in Appendix 2.

In November 2011, AHWMC agreed that limited stakeholder consultation be undertaken to assess the need for strengthened regulation of paramedic practice.

1.2 Scope of this consultation paper

This consultation paper has been prepared to assist stakeholders to consider options for regulation of paramedics. The paper explores the nature of current regulatory systems and includes discussion of the risks where there are health, performance or conduct issues on the part of a paramedic. A range of options are outlined, which examine the feasibility of regulation of paramedics and provide guidance for input to the consultation.

Eburn and Bendall (2010) offer a clear differentiation between 'ambulance services' and 'paramedics', describing ambulance services as involving the two related components of 'a) the provision of pre-hospital emergency care and; b) the transport of the sick or injured' (http://www.jephc.com/full_article.cfm?content_id=598). Patient Transport Service, is defined by Ambulance Service of NSW, as 'a non-emergency transport service that undertakes patient transport and care to and from pre-arranged hospital and medical appointments' (http://www.ambulance.nsw.gov.au/about-us/Patient-Transport-Service.html).

For the purposes of this consultation, personnel who engage in non-emergency patient transport (who are not qualified as a paramedic) are not considered to be within the scope of the proposals in this paper unless they hold qualifications that qualify them to work as a paramedic. Similarly, first aid volunteers (who are not qualified as a paramedic) are not considered to be part of the paramedic workforce.

It should be noted that there is no agreed definition of 'paramedic'. This issue is considered in Section 2.1.2 of this paper.

1.3 Policy context

Intergovernmental agreement

On 26 March 2008, the Council of Australian Governments (COAG) entered into an Intergovernmental Agreement (IGA) for the establishment of a National Scheme for the health professions. The National Scheme provides for a single national system of registration and accreditation of health practitioners in Australia designed to:

- allow health professionals to move around the country more easily
- reduce the regulatory burden on health professionals
- provide greater safety for the public
- promote a more flexible, responsive and sustainable workforce, and
- establish a public national register for each health profession to ensure that a professional who has been banned from practising in one jurisdiction would be unable to practise in the other Australian jurisdictions.

The IGA set out the framework for a single national system of registration and accreditation of health practitioners in Australia, commencing with nine professions that were registered in every State and Territory. The podiatry profession was added as the tenth profession to be regulated under the National Scheme from 2010, after the IGA was signed by COAG.

The IGA (2008, p. 22) contains six criteria which occupations must meet in order to be considered for registration under the National Scheme.

> Criterion 1:
> It is appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?
> Criterion 2:
> Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
> Criterion 3:
> Do existing regulatory or other mechanisms fail to address health and safety issues?
> Criterion 4:
> Is regulation possible to implement for the occupation in question?
> Criterion 5:
> Is regulation practical to implement for the occupation in question?
> Criterion 6:
> Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Appendix 3 provides the IGA Guiding Principles and further information on the criteria. The IGA can be accessed at: www.coag.gov.au/coag_meeting_outcomes/2008-03-26/docs/iga_health_workforce.rtf

To enable a national regulation scheme to be developed, the *Health Practitioner Regulation National Law Act* (the National Law) was first passed in Queensland (QLD), which was followed by

all other States and Territories enacting similar legislation. The QLD version of the National Law can be accessed at the following address:
www.legislation.QLD.gov.au/LEGISLTN/ACTS/2009/09AC045.pdf

Seamless national economy

In 2009, COAG entered into a National Partnership Agreement to Deliver a Seamless National Economy (the NP Agreement). The driving force behind the NP Agreement is to deliver more consistent regulation across jurisdictions, to address unnecessary or poorly designed regulation, and to reduce excessive compliance costs on business, restrictions on competition and distortions in the allocation of resources in the economy. The NP Agreement provides that the States and Territories have a responsibility to implement a coordinated national approach in a number of areas, including with respect to the health workforce. The NP Agreement included the implementation of the National Scheme for the health professions.

The NP Agreement can be accessed at the following address:

www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/seamless_national_economy_np.pdf

While the NP Agreement does not specifically include the regulation of paramedics or other unregistered health practitioners, the principles set out in the NP Agreement are applicable to the regulatory reforms addressed in this consultation paper.

Council of Australian Governments

In order to maximise the efficiency of new and amended regulation and avoid unnecessary compliance costs and restrictions on competition, COAG requires that a 'Regulatory Impact Statement' (RIS) be prepared and published whenever a Ministerial Council is considering the introduction of new regulation. To this end in October 2007, COAG published *Best Practice Regulation. A Guide for Ministerial Councils and National Standard Setting Bodies*, to guide this process.

The RIS requirements apply to any decisions of a Ministerial Council that are to be given effect through legislation which, when implemented, would encourage or force businesses or individuals to pursue their interests in ways they would not otherwise have done. This consultation paper has been prepared in accordance with the COAG guidelines.

Unregistered health practitioners

In November 2010, AHWMC agreed that national consultation be undertaken to consider whether there is a need for strengthened regulatory protections for consumers who use the services of unregistered health practitioners. In February 2011, Australian Health Ministers' Advisory Council (AHMAC) released a *Consultation paper: Options for regulation of unregistered health practitioners*. The occupations considered within this report are listed at Appendix 4. As an unregistered health profession, paramedics are within the scope of the unregistered health practitioners project and decisions taken by AHWMC in respect to the unregistered project may affect paramedics.

The findings of the national consultation are yet to be considered by all State, Territory and Commonwealth Health Ministers. Any relevant decisions taken by Health Ministers arising from the national consultation will be taken into account during this review.

Extended role of paramedics

Mulholland (2010), in his review of paramedic practice in urban and rural settings in Australia, describes the emergence of the 'paramedic Practitioner model' in the United Kingdom as a response to the 'need to reduce the burden on hospital emergency departments and provide greater community based care in both urban and rural areas' (p. 33). Similarly, in Australia, there are processes underway to extend the role of paramedics. In 2012, Health Workforce Australia[2] launched the Extended Care Paramedic model project, with the aim of paramedics providing more 'care to patients in their usual place of residence; thereby reducing emergency department presentations' (http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform/extending-role-of-paramedics).

[2] Health Workforce Australia is a Commonwealth statutory authority based in Adelaide.

2. Overview of the paramedic sector

This section describes the employment of paramedics, as well as the education and training of paramedics across Australia. In addition, the various regulations which paramedics are required to work within are identified and described.

At present the role and scope of practice of paramedics in Australia is determined by employers and, with the exception of NSW, there is no mechanism to prevent a paramedic, who has significant health, conduct or performance issues, from moving to another employer or another jurisdiction to seek continuing employment as a paramedic.

While there is an accreditation process available to tertiary institutions, through the Council of Ambulance Authorities, this accreditation is undertaken by universities on a voluntary and non-binding basis.

2.1 Employment

2.1.1 Workforce

The Australian Government Productivity Commission's Steering Committee for the Review of Government Service Provision (SCRGSP), *Report of Government Services 2012* (p. 9.47), identifies that 13,125 full time equivalent (FTE) salaried personnel were involved in the delivery of ambulance services nationally (excluding South Australia (SA)) in 2010-2011, with the majority being ambulance operatives (82.2%).

In 2010-2011, 4,544 volunteer personnel (comprising 4,234 operatives and 310 support personnel) participated in the delivery of ambulance services nationally (excluding SA). The proportion of volunteer personnel and the nature of their roles vary across jurisdictions. In 2010-2011, there were 40.8 FTE ambulance officers (including student and base level officers) per 100,000 people (excluding SA), with the FTE varying across jurisdictions (SCRGSP, 2012, p. 9.53).

The SCRGSP report also states:

> The role of paramedics is expanding to provide primary health care, improve emergency response capabilities and strengthen community healthcare collaborations in rural and remote communities (Stirling et al. 2007). Many rural and remote communities do not have access to adequate health care due, in part, to the difficulty recruiting and retaining health professionals. Paramedics provide some of these communities with extended access to health service delivery. Expanding roles are also developing in metropolitan areas as a response to overstretched emergency departments where paramedics can continue caring for patients on arrival at hospital (p. 9.52).

Government related ambulance services

Government related ambulance services, as listed in Table 1, either administered by government or operating under contract to government, employ the majority of the paramedic workforce in Australia.

Table 1 Government related ambulance services by State and Territory

Australian Capital Territory (ACT)	
ACT Ambulance Service (ACTAS)	ACTAS is one of four operational services of the ACT Emergency Services Agency, a portfolio of the ACT Directorate of Justice and Community Safety.
New South Wales (NSW)	
Ambulance Service of NSW (ASNSW)	ASNSW, a division of the Department of Health, operates under the *Health Services Act 1997* (NSW).
Northern Territory (NT)	
St John Ambulance Australia (NT) Inc (SJANT)	SJANT is a not-for-profit organisation that operates under contract to the NT Government.
Queensland (QLD)	
Queensland Ambulance Service (QAS)	QAS operates under the authority of the *Ambulance Service Act 1991* (QLD). QAS is a division of the Department of Community Safety which, in addition to ambulance services, is responsible for the provision of fire, search, rescue counter disaster and hazardous materials services.
South Australia (SA)	
SA Ambulance Service (SAAS)	SAAS became part of SA Health in 2008 and operates in accordance with the *Health Care Act 2008* (SA).
Tasmania (TAS)	
Tasmania Ambulance Service (TASAS)	TASAS was established under the *Ambulance Service Act 1982* (TAS). It is part of the Department of Health and Human Services, Acute Health Services Division.
Victoria (VIC)	
Ambulance Victoria (AV)	AV has been operational since 2008 when the Minister for Health merged the Metropolitan Ambulance Service, the Rural Ambulance Service and the Alexandra and District Ambulance Service to form a single statewide ambulance service.
Western Australia (WA)	
St John Ambulance Australia (WA) Inc (SJAWA)	SJAWA is a not-for-profit organisation that operates under contract to the WA Department of Health to provide ambulance services throughout WA.

Other settings

Outside of government related ambulance services, paramedics work in a variety of other settings, identified by Paramedics Australasia (PA) as including community, industrial, military and university settings as well as on humanitarian and relief operations. Paramedics also work with private operators providing ambulance services or aero-medical retrievals. Broadly, there are four categories of employment for paramedics outside of government related ambulance services:

- private providers of ambulance or aero-medical services
- event medical and first-aid providers
- the Australian Defence Forces (ADF), and
- industrial settings.

The actual number of paramedics employed outside the government related ambulance services sector is currently unknown. Anecdotally, it would appear that a substantial and growing number of paramedics are employed in the private sector, particularly within the minerals resource-rich States of WA and QLD.

Aero-medical arrangements in Australia

The SCRGSP (2012) identifies that arrangements for air ambulance or aero-medical services vary throughout Australia, advising that:

> Some of these arrangements involve services provided entirely by State and Territory ambulance services or by sub-contractors to these services, while others are provided completely externally to the State ambulance services. Some arrangements involve a mix of the two, where external organisations provide aircraft and/or air crew while ambulance service organisations provide paramedics to staff the air ambulances (p. 9.45).

2.1.2 Use of the term ‘paramedic’

There is no standard definition of ‘paramedic’ in Australia. The title ‘paramedic’ is often used to describe personnel involved in the provision of pre-hospital and out-of-hospital emergency medical services in a community or industrial setting, with the aim of stabilising the patient and transporting them to a hospital or health provider for further treatment. Use of the term has evolved as the skills of paramedics have developed beyond the scope of providing basic first aid and transporting the patient to a hospital or health care provider. The emergence of ‘community paramedics’, such as those in the East Coast Paramedic research trial in TAS (Blacker, Pearson & Walker 2009) and Newman (Department of Health, WA 2011, p. 13), is used to describe paramedics who now undertake primary health care roles.

The Australian and New Zealand (NZ) Standard Classification of Occupations (ANZSCO) is a skill-based classification of occupations, developed jointly by the Australian Bureau of Statistics, Statistics NZ and the Department of Education, Employment and Workplace Relations as the national standard for organising occupation-related information for purposes such as policy development and review, human resource management, and labour market and social research. ANZSCO defines an Intensive Care Ambulance Paramedic (Australia) and Ambulance Paramedic (NZ) as someone who ‘provides intensive pre-hospital health care to injured, sick, infirm and aged persons and emergency transport to medical facilities’ (p. 477).

PA, the professional association for paramedics and ambulance personnel, define a paramedic as:

> a health care professional providing medical assessment, treatment and care in the out-of-hospital environment. Paramedics respond to, assess and treat patients in emergency situations, transport them to a hospital for further treatment (if necessary) or arrange alternative treatment options http://www.paramedics.org.au/paramedics/what-is-a-paramedic/).

In Australia, the use of the term 'paramedic' is not restricted or licensed, it is a job title. Ambulance officer, paramedic 3, paramedic 4, ambulance paramedic, intensive care paramedic, advanced life support officer, advanced care practitioner and medic are some examples of job titles used by ambulance services. Job titles are often used by employers to delineate a clinical level or additional qualification above or below the base paramedic level. The titles used by government related ambulance services in each jurisdiction are listed in Appendix 5, along with the government related ambulance service employer requirements for each position.

2.1.3 Scope of practice

Out-of-hospital emergency services are a fundamental community service available to all Australian communities. According to the SCRGSP report (2012, p. 9.43), in 2010-2011 paramedics in ambulance services attended 3.1 million incidents nationally (excluding NT). The availability of paramedics is critical for rural and regional areas where there is more limited access to other health services than is available in the metropolitan area.

The tasks of ambulance officers and paramedics are described by ANZSCO (2006, p. 476) as including:

- attending accidents, emergencies and requests for medical assistance
- assessing health of patients, determining need for assistance, and assessing specialised needs and factors affecting patients' conditions
- performing therapies and administering drugs according to protocol
- resuscitating and defibrillating patients and operating life-support equipment
- transporting accident victims to medical facilities
- transporting sick and disabled persons to and from medical facilities for specialised treatment and rehabilitation
- instructing community groups and essential service workers in first aid
- attending public gatherings and sporting events where accidents and other health emergencies may occur
- ensuring that ambulances are adequately maintained and stocked with medical supplies, and that equipment is in good working order, and
- preparing written reports on the state of patients' injuries and treatment provided.

In all jurisdictions, paramedics deal with life and death and make routine clinical decisions on a daily basis, often without knowing a patient's medical or social history. Paramedics regularly triage, assess and clinically manage unconscious, incoherent or combative patients, sometimes in multi-casualty situations.

As there is currently no uniform regulation of paramedics at a national level, a paramedic's scope of practice is determined by employers and is not consistently defined. Employers are largely responsible for setting the levels of care to be provided, the skills required to be a paramedic and the protocols, guidelines and procedures that determine paramedic practice. This results in variations in the scope of paramedic practice, not only across jurisdictions but between government related ambulance services, the ADF and the private sector.

Paramedics provide direct patient care but, unlike many other health professionals, paramedics generally do not work under direct supervision. Much of their work is undertaken in a team of two and, in some circumstances, a paramedic may work alone.

In response to the AHMAC *Consultation Paper: Options for regulation of unregistered health practitioners* February 2011, PA made a submission outlining risks associated with varying tasks that paramedics undertake within various Australian jurisdictions. This information is included in Table 10 (p.40).

2.2 Education and Training

2.2.1 Paramedic educational requirements

Training for paramedics has transitioned from on the job training provided by State and Territory ambulance services to vocational and tertiary qualifications (Eburn and Bendall, 2010). Across Australia, paramedic training and education are provided in a variety of settings both at a tertiary level and through vocational training.

ANZSCO (2005) identifies that the basic educational requirements for paramedics vary, with the skill level for Ambulance Officer and Intensive Care Ambulance Paramedic identified as 'Skill Level 2':

> a level of skill commensurate with one of the following:
> - NZ Register Diploma or
> - AQF [Australian Qualifications Framework] Associate Degree, Advanced Diploma or Diploma.
>
> At least three years of relevant experience may substitute for the formal qualifications listed above. In some instances relevant experience and/or on-the-job-training may be required in addition to the formal qualification (p. 13).

To address increasing clinical practice expectations required of the industry by the community and government, since 2001 paramedic education and training, within government related ambulance services, have increasingly moved from the vocational education and training (VET) sector to the tertiary education (university) sector.

While there are differences in the qualifications required to practise as a paramedic in each State and Territory, there are some similarities between those qualifications. With the exception of NT, qualifications leading to a bachelor degree in paramedicine (and/or nursing and paramedicine) are offered by at least one university in each State and Territory.

2.2.2 Course accreditation

There is no single legislated national forum for standards of paramedic education, training and practice. This contrasts with health professionals who are registered within the National Scheme, whose educational programs are accredited by a national accreditation body established for the express purpose of assessing educational programs against national course accreditation standards established by each National Board.

The Australian Skills Quality Authority (ASQA) is the national regulator for Australia's VET sector, and is responsible for accrediting training courses and registering training providers as Registered Training Organisations (RTOs). Paramedic educational courses can be accredited with external agencies or professional bodies including the ASQA and the Council of Ambulance Authorities (CAA), the peak national body for ambulance authorities.[3]

CAA has provided a focus for the establishment of the Paramedic Education Programs Accreditation Program (PEPAP) which uses published training and education standards and practice/proficiency standards to evaluate and accredit paramedic programs being delivered by higher education providers in Australia and NZ. In their response to the AHMAC *Consultation paper: Options for regulation of unregistered health practitioners February 2011*, CAA advised that CAA member jurisdictions in Australia have indicated they will give preference of employment on merit to graduates from universities with accredited paramedic programs. Although it is voluntary for Universities to comply with the PEPAP Framework, CAA, whilst not having a legislative base, has nonetheless attempted to assure training/education and practice standards for paramedics.

CAA has a formal accreditation process for tertiary entry-level paramedic programs, to ensure that graduates from these programs have achieved the requisite competencies required for employment within an Australasian ambulance service, as an entry-level Ambulance Paramedic.

The governance arrangement for CAA accreditation includes representation from PA and specialist academics from the higher education sector. The aim of the CAA formal accreditation of higher education programs is, as far as practicable, to ensure that the required workforce skills and professional practice behaviours and competencies of paramedics are reflected in the education and training programs being provided by the higher education sector in Australia and NZ.

CAA strongly believes that accreditation of these programs is an essential part of a quality assurance process to assess that the required practice standards are being addressed and that there is a level of consistency in the core components of the education programs being offered that will meet the ambulance industry needs. According to CAA, this provides confidence to graduating paramedics that the programs in which they have participated will provide them with the requisite qualification to be eligible to seek employment within ambulance services in Australia and NZ.

Table 2 provides a list of all of the degree courses offered throughout Australia, and includes information provided by CAA on progress towards meeting their PEPAP requirements (current as of 7 March 2012). All Australian universities which offer an undergraduate degree in paramedicine (however called) have sought accreditation through the CAA PEPAP voluntary accreditation process.

Several of these courses are conducted in association with the local government related ambulance service. The Edith Cowan University (ECU) program in WA involves one year of full time university study, followed by three years of supervision and on going training through ECU and in the field with SJAWA. Entry is via an application to SJAWA for a position as a Student Ambulance Officer. The Flinders University program in SA, which currently meets the needs of the

[3] The Council of Ambulance Authorities, www.caa.net.au/

SA Ambulance Service (SAAS), is a feeder qualification to a twelve to eighteen-month supervised paramedic internship program.

Table 2 Australian University undergraduate paramedic programs and their current CAA PEPAP accreditation status

ACT	Program	Current CAA Accreditation status
Australian Catholic University	Bachelor of Nursing / Bachelor of Paramedicine	Provisional
NSW		
Charles Sturt University	Bachelor of Clinical Practice (Paramedic)	Full
	Bachelor of Nursing / Bachelor of Clinical Practice (Paramedic)	Full
University of Tasmania (NSW Campus)	Bachelor of Paramedic Practice	Preliminary
NT		
Nil	There is presently no NT-based provider of tertiary-level paramedic education.	N/A
QLD		
Australian Catholic University	Bachelor of Nursing / Bachelor of Paramedicine	Provisional
University of the Sunshine Coast	Bachelor of Paramedic Science	Provisional
Central Queensland University	Bachelor of Paramedic Science	Provisional
University of Queensland	Bachelor of Paramedic Science	Preliminary
Queensland University of Technology	Bachelor of Health Science (Paramedic)	Full
	Bachelor of Nursing / Emergency Health (Paramedic)	Provisional
SA		
Flinders University	Bachelor of Health Science (Paramedic)	Full
TAS		
University of Tasmania	Bachelor of Paramedic Practice	Preliminary
VIC		
University of Ballarat	Graduate Diploma of Paramedicine (for Bachelor of Nursing graduates only)	2012 Application
La Trobe University	Bachelor of Health Sciences and Master of Paramedic Practice	2012 Application
Monash University	Bachelor of Emergency Health (Paramedic)	Full
	Bachelor of Nursing / Emergency Health (Paramedic)	Provisional
Victoria University	Bachelor of Health Science (Paramedic)	Full
Australian Catholic University	Bachelor of Nursing / Bachelor Paramedicine	Provisional
	Bachelor of Paramedicine	Preliminary
WA		
ECU	Bachelor of Science (Paramedical Science)	Full

In NSW 'ambulance courses facilitated by the Ambulance Service of NSW are accredited by the VET Accreditation Board (VETAB)' (NSW Government *Response to the Legislative Council General Purpose Standing Committee No.2 inquiry into the Management and Operations of the Ambulance Service of NSW, 2009*, p. 9). In 2010, Pricewaterhouse Coopers began working with the ASNSW to transform it, with one of the aims being to ensure 'a defined, inspiring career path for paramedics, offering them more comprehensive, certified training and higher-level entry' (2010, p. 17). Similarly, SJA NT recently signed an agreement with ECU WA for the provision of their future paramedic education at an undergraduate level. ACTAS is completing its final VET programs and will move to recruitment from the higher education sector. Commencing in 2012, the Australian Catholic University is offering a double degree program from its ACT campus.

In addition to undergraduate degree programs offered at tertiary institutions, a variety of post-graduate programs are offered in 2012, including:

- Charles Sturt University (NSW)
    - Graduate Diploma of Clinical Practice (Paramedic); and
    - Postgraduate Certificate in Intensive Care Paramedic
- Curtin University of Technology (WA)
    - Graduate Certificate in Paramedicine (from second semester), a collaborative program offered in conjunction with SJAWA
- Flinders University (SA)
    - Graduate Diploma in Intensive Care Paramedic Studies (from second semester), a program sponsored by SAAS
- Monash University
    - Graduate Diploma in Emergency Health (Mobile Intensive Care Ambulance Paramedic)
- University of Ballarat
    - Graduate Diploma of Paramedicine
- University of Tasmania
    - Intensive Care Paramedic course accredited by AQTF

In their response to the AHMAC *Consultation Paper: Options for regulation of unregistered health practitioners February 2011,* CAA advised they recognise that a number of other VET providers also offer Certificate and Diploma level courses in paramedic studies. While these courses may have been developed to meet select third party employer needs, these courses are not recognised by CAA member jurisdictions for the purposes of employment as an entry level paramedic.

In addition to courses identified above, the following ambulance services also deliver post-employment diploma level paramedical studies programs to meet their current workforce needs:

- ACTAS
- ASNSW
- QAS
- SJANT, and
- SJAWA.

In the main, these programs will be replaced over time by provision of education through the higher education sector.

2.2.3 Ongoing professional development

In addition to any ongoing professional development requirements of their employers, PA offers a Certified Ambulance Professional (CAP) program to all members. The CAP program uses a points system for professional development. Participation in continuing professional development is not a requirement for ongoing membership with PA.

Membership of PA is voluntary and is not a requirement for employment as a paramedic.

Within their professional association capacity, applications can be made for PA to endorse events and activities for Continuing Paramedic Education points for paramedics.

2.3 Regulation

2.3.1 Overview

The Council of Australian Governments' (COAG) *Best Practice Regulation Guide for Ministerial Councils and National Standard Setting Bodies* (2007, p. 3) provides the definition for 'regulation' as referring to:

> the broad range of legally enforceable instruments which impose mandatory requirements upon business and the community, as well as to those government voluntary codes and advisory instruments for which there is a reasonable expectation of widespread compliance.

Presently, the regulation of paramedics varies significantly between jurisdictions. Some jurisdictions have legislation specific to paramedics or ambulance services, but there is little national consistency as to the range or extent of such regulation.

Paramedics, as health practitioners, are also generally subject to a range of laws which impact on and shape their practice. These include occupational licensing laws, health complaints laws, laws that regulate specific activities such as the use of medicines and therapeutic goods, public health regulation, consumer protection laws, employment laws, as well as criminal law, tort law (negligence) and the law of contracts.

As the role of the paramedic has evolved to include additional clinical procedures and the administration of new and potent medications, and more paramedics are practising outside of government related ambulance services, employers are also largely responsible for regulating paramedic practice.

Even though paramedics are subject to a wide-range of regulation, there is little national uniformity between jurisdictions. Jurisdictional regulatory arrangements are discussed in detail throughout this section.

2.3.2 Ambulance services regulation

State and Territory governments are responsible for the provision of ambulance services, as stated in the Australian Government Productivity Commission's SCRGP *Report of Government Services 2011* (p. 9.5):

> State and Territory governments are responsible for regulatory arrangements for protecting life, property and the environment, and they have primary responsibility for delivering emergency services (including fire and ambulance services) directly to the community.

Unlike other jurisdictions where the Minister for Health is responsible for Ambulance Services, in the ACT and QLD, the Minister for Health is not responsible. However, there are close links between the Health and Emergency Services departments in the ACT and QLD. Table 3 identifies the Minister responsible for ambulance services in each State and Territory.

Table 3 State and Territory Ministers responsible for ambulance services

State or Territory	Responsible Minister
ACT	Minister for Police and Emergency Services
NSW	Minister for Health
NT	Minister for Health
QLD	Minister for Police, Corrective Services and Emergency Services
SA	Minister for Health and Ageing
TAS	Minister for Health and Human Services
VIC	Minister for Health
WA	Minister for Health

There is presently no State, Territory or national registration of paramedics. Regulation of paramedics varies across jurisdictions, with many States and Territories having legislation specific to paramedics or ambulance services. Table 4 sets out relevant jurisdictional legislation.

Table 4 State and Territory regulation of ambulance services and paramedics

ACT - *Emergencies Act 2004*
Under the *Emergencies Act 2004* (ACT), the Chief Officer of ACTAS is responsible for matters relating to the technical and professional expertise of the ambulance service, for example, training and professional standards (s.28). The Chief Officer may also determine standards and protocols for medical treatment provided by the ambulance service (s.38). In doing so, he is supported by a clinical advisory committee who provide authoritative expert advice and recommendations on all clinical matters relevant to the functions outlined in the *Emergencies Act 2004*, and to maintain the quality of pre-hospital emergency and routine ambulance care to the community. Clinical Advisory Committee is chaired by the Medical Advisor to the ACTAS. Its membership includes: • specialist medical practitioners (ACT Ambulance Service) • specialist medical practitioners (Canberra Hospital & Health Services (CHHS) Emergency Department) • specialist medical practitioners Calvary Hospital Emergency Department, and • a General Practitioner from the ACT Medicare Local. Additional members are co-opted as required to provide specialist input. When employed, paramedics must undertake a clinical validation process prior to the issue of an Authority to Practice (ATP) from the Chief Officer to perform independently at a defined scope of practice. Maintenance of the ATP is contingent upon participation in the compulsory in-service training program along with mandatory minimum clinical hours. The compulsory in-service program may also include skills assessment, on an as-needs basis, for high risk activities or to address trends identified across the service. The Chief Officer also has the power to alter, withdraw or suspend the scope of practice of any individual within the service. In addition to the *Emergencies Act 2004*, the ACT Ambulance Service has established close links through cross-jurisdictional forums around patient safety including the Interagency Clinical Review Committee. The role of this multi-disciplinary Committee is to oversee interagency clinical review (across directorates/jurisdictions), and identify opportunities to improve patient safety and health care outcomes.
NSW - *Health Services Act 1997*
All paramedics are employed by the Director General under Chapter 5A of the *Health Services Act 1997* (NSW). There are regulatory provisions for paramedics under the Ambulance Services Regulation 2005, made under the *Health Services Act 1997* (NSW), which mean that ambulance employees in NSW are regulated under a complaints process and other clinical governance measures.
NT
There is no legislation specific to paramedics or ambulance services in the NT. Paramedics are regulated by the framework of their terms of employment or engagement, and the guidelines or governance developed by their employer.
QLD - *Ambulance Service Act 1991*
The *Ambulance Service Act 1991* (QLD) contains comprehensive arrangements for the governance of the QAS. Paramedics are employed under the *Ambulance Service Act 1991* (QLD) (s.13), and are required to disclose any previous history of serious disciplinary action prior to appointment (s.13A). Division 4 of the *Ambulance Service Act 1991* (QLD) sets out disciplinary action for current and former service officers. Part 4A outlines Root Cause Analysis requirements for reportable events.

Table 4 State and Territory regulation of ambulance services and paramedics (continued)

SA - *Health Care Act 2008*
The *Health Care Act 2008* (SA) defines the administrative arrangements for the provision of an emergency and elective ambulance service, but it does not cover credentialing or other professional requirements for the paramedic practitioner in emergency settings. It also contains the power by which SAAS clinical staff can force entry to property (s.61). Division 2 of Part 6 of the Act regulates the provision of ambulance services more generally.
TAS - *Ambulance Services Act 1982*
Tasmanian Ambulance Service (TASAS) is governed by the *Ambulance Services Act 1982* (TAS), under which a Tasmanian Ambulance Clinical Council is established (s.17).
VIC - *Ambulance Services Act 1986* *- Health Services Act 1988* *- Victoria State Emergency Service Act 2005* *- Non-Emergency Patient Transport Act 2003*
Under the *Ambulance Services Act 1986* (VIC), one function of the board of an ambulance service is to monitor the performance of the service. This includes, for example, ensuring the adequacy of risk management systems and systems to monitor and improve the safety, quality and effectiveness of the service (s.18). Paramedics are regulated by the framework of their terms of employment or engagement, and the guidelines or governance developed by Ambulance Victoria (AV). AV requires paramedics to have a Bachelor degree in paramedicine and tailored employment testing. Ongoing clinical assessment and participation in professional development through industry organisations and AV is mandatory. Paramedics working in the non-emergency patient transport field, whether employed by AV or a private organisation, are regulated by the *Non-Emergency Patient Transport Act 2003* (VIC) which establishes a licensing system for non-emergency patient transport services, and the Non-Emergency Patient Transport Regulations 2005.
WA
There is no legislation specific to paramedics or ambulance services in WA. Paramedics are regulated by the framework of their terms of employment or engagement, and the guidelines or governance developed by their employer.

2.3.3 Therapeutic goods and medicines regulation

Paramedic practice is subject to various therapeutic goods and medicines regulation.

Therapeutic goods regulation

The *Therapeutic Goods Act 1989* (Cth) (the TG Act 1989) provides for the establishment and maintenance of a national system of controls relating to the quality, safety, efficacy and timely availability of therapeutic goods that are used in Australia (whether produced in Australia or elsewhere) or exported from Australia. The TG Act 1989 also provides a framework for the States and Territories to adopt a uniform approach to control the availability and accessibility of medicines and poisons in Australia and ensure their safe handling. The TG Act 1989 establishes an Australian Register of Therapeutic Goods (ARTG), a computer database of information about therapeutic goods for human use approved for supply in, or export from, Australia. Unless

specifically exempt or excluded, all product must be entered on the ARTG before it can be supplied in Australia.

The TG Act 1989, Regulations and Orders set out the requirements for inclusion of therapeutic goods in the ARTG, including advertising, labeling, product appearance and appeal guidelines. The TG Act 1989 also includes provisions for reviews of decisions. Some provisions such as the scheduling of substances and the safe storage of therapeutic goods are covered by the relevant State or Territory legislation.

Medicines regulation

All States and Territories have Acts and Regulations that regulate the manufacture, sale, supply, storage, possession and use of medicines, variously labelled 'drugs', 'poisons', 'restricted substances' and 'controlled substances'. These laws provide offences and penalties for persons who breach the legislation, and powers to prosecute such persons before the relevant court. Table 5 identifies the relevant legislation in each State and Territory.

Table 5 Jurisdictional drugs and poisons legislation

ACT - *Medicines, Poisons and Therapeutic Goods Act 2008*
This legislation provides regulation for the availability and accessibility of medicines and poisons and their safe handling in the ACT. Under regulations, subordinate to the ACT legislation, there is a specific exemption for the Chief Officer of ACTAS under Schedule 1. As well as ACTAS, there is at least one other provider of non-emergency patient transport services in the ACT with an authority to carry prescribed or controlled medications or substances.
NSW - *Poisons and Therapeutic Drugs Act 1966*
This legislation provides for the 'approval of persons, employed in the Ambulance Service of NSW as an ambulance officer or as an air ambulance flight nurse, to have possession of and to supply drugs of addiction' (s.6.62s). The NSW Health Department provides authority to paramedics to administer Schedule 4 and 8 medications in the private sector, only if they are certified and trained by the ASNSW.
NT - *Poisons & Dangerous Drugs Act*
This legislation provides for the Chief Health Officer to 'authorise a person to possess a specified quantity of a specified poison where that poison is included in a medical kit and that person may possess that poison accordingly' (s.42).
QLD - *Health Act 1937* - *Ambulance Service Act 1991*
Under the *Health Act 1937* (QLD), the Queensland Health (Drugs and Poisons) Regulation 1996 does not require licensing for paramedics. The *Ambulance Service Act 1991* (QLD) outlines drug administering authorities for performing ambulance duties for QAS (s.66).
SA - *Controlled Substances Act 1984*
Amendments to this legislation, which are currently awaiting finalisation, make provision for the supply, possession and use of medications. A drug licence is provided to SAAS for the purchase, possession and use of specific scheduled medications by the drug licensing section within SA Health.
TAS - *Poisons Act 1971*
Ambulance officer practice is regulated by s.38 and s.47 of the *Poisons Act 1971* (TAS).

Table 5 Jurisdictional drugs and poisons legislation (continued)

VIC - *Drugs, Poisons and Controlled Substances Act 1981*
Individual operational members (i.e. paramedics) are authorised under the *Drugs, Poisons and Controlled Substances Act 1981* (VIC) regulations to be in legal possession of Schedule 4 poisons which are listed in the permit.
WA - *Poisons Act 1964*
The *Poisons Act 1964* (WA) and Poisons Regulations 1965 do not provide any direct 'group' type authority for 'paramedics' to access and administer scheduled medicines. A paramedic can only administer scheduled medicines under the authority of a person holding a Poisons Permit to purchase and store scheduled medicines for the purpose of providing 'health services' (Poisons Regulation 10AA).

2.3.4 Health complaints regulation

There are two main models of health complaints regulation of paramedics in operation in Australia.

Paramedic practice is subject to health complaints regulation. A 'health complaints entity' (HCE) is defined under the National Law as 'an entity that is established by or under an Act of a participating jurisdiction and whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system'.

In 2007, the NSW Parliament enacted legislation to address what was seen as a gap in regulation to strengthen public protection for health consumers who use the services of unregistered health practitioners. The NSW scheme established a statutory Code of Conduct that applies to any unregistered practitioners who provide health services, including paramedics, and also established powers for the NSW Health Care Complaints Commission to investigate breaches of the Code of Conduct and issue prohibition orders if necessary. A prohibition order may limit or attach conditions to the practitioner's practice, or prohibit them from providing health services altogether. Breaches of a prohibition order are subject to prosecution through the courts. Legislation is before the SA Parliament which, if enacted, will establish a similar regulatory scheme in that State.

In all other States and Territories the primary functions of HCEs are the investigation, resolution and conciliation of consumer complaints against health service providers, including paramedics, and investigation of health system failures. When a HCE investigates a complaint against a registered health practitioner and finds evidence of professional misconduct, the HCE may refer the matter to the relevant health practitioner registration board for further action, including referral to a tribunal for hearing if necessary. Where the practitioner is not registered, the HCE may seek to resolve the complaint between the complainant and the practitioner, investigate the complaint, or attempt formal conciliation. After an investigation, the HCE may refer the matter to another entity (for example, the police), but there is no avenue available, except in NSW, through which a prosecution and hearing may be conducted and sanctions imposed.

The details of State and Territory HCEs and their powers are provided in Appendix 6.

2.3.5 Consumer protection regulation

Paramedic practice is subject to consumer protection regulation, as consumers of paramedic services have rights under consumer law. Recent reforms have been enacted to Commonwealth, State and Territory consumer protection laws, with passage of *The Australian Consumer Law* in January 2011. These reforms draw on the final report of the Productivity Commission's Review of Australia's Consumer Policy Framework, published in April 2008. *The Australian Consumer Law* applies nationally, in all States and Territories, and to all Australian businesses. The package of reforms includes:

- the establishment of a single, national consumer law: The Australian Consumer Law
- a new national product safety system, and
- new penalties, enforcement powers and consumer redress options.

The Productivity Commission's report identified that Australia's consumer regulators have access to a range of tools for dealing with breaches of the law. These include criminal penalties (for higher level breaches), civil remedies (used for restorative purposes), administrative settlements (such as enforceable undertakings), and persuasion, liaison and education programs. This single, generic consumer law is based on the consumer provisions in the *Competition and Consumer Act 2010* (Cth) (CC Act) that have been modified to address gaps in the CC Act's coverage and scope. It provides powers to deal with:

- unconscionable conduct[4]
- misleading or deceptive conduct
- false or misleading representations and powers to:
    - grant an injunction to prevent contravention of the Law
    - issue a public warning notice
    - issue a substantiation notice requiring a person to provide information to substantiate or support any claim or representation they have made, and
    - issue an order disqualifying a person who has committed or attempted to commit a contravention of the Law from managing a corporation.

2.3.6 Public health regulation

All States and Territories have in place public health laws that are designed to promote, protect and improve public health in a range of ways such as:

- controlling risks to public health that lead to illness, injury, or premature death
- preventing and controlling the spread of infectious diseases
- responding to public health emergencies, and
- supporting local government authorities in their role in enforcement activities.

[4] The judicial meaning of unconscionable conduct has not been settled. However, in considering the issue, the courts have described unconscionable conduct as something being clearly unfair and unreasonable, conduct which shows no regard for conscience and conduct which is irreconcilable with what is right or reasonable.

Paramedic practice is subject to such legislation, which regulates areas such legionella and other disease control, and skin penetration. Authorised officers under these laws generally have powers to check compliance with the legislation, including powers of inspection, and the power to enter and search premises. These laws provide offences and penalties for persons who breach the legislation, and powers to prosecute such persons before the relevant court. Jurisdictional public health legislation is identified in Table 6.

Table 6 Jurisdictional public health legislation

State or Territory	Public health legislation
ACT	*Public Health Act 1997*
NSW	*Public Health Act 2010*
NT	*Public and Environmental Health Act 2011*
QLD	*Public Health Act 2005*
SA	*Public and Environmental Health Act 1987*
TAS	*Public Health Act 1997*
VIC	*Public Health and Wellbeing Act 2008*
WA	*Health Act 1911*

2.3.7 Voluntary self-regulation

In addition to legislated forms of regulation, paramedics, who choose to be members of their professional association, are guided in their practice through self-regulation in the form of a professional (voluntary) code of conduct.

PA[5] has rules surrounding the conduct of their members, and membership can be terminated if a paramedic:

> (a) is convicted of an indictable offence; or
> (b) does not comply with any of the provisions of these rules; or
> (c) provides inaccurate, misleading or false information regarding their eligibility for Paramedics Australasia membership on their application form or when asked for by the Chapter Chair, the Registrar or the Paramedics Australasia Secretary; or
> (d) has membership fees in arrears for at least three months; or
> (e) conducts himself/herself in a way considered to be injurious; or prejudicial to the or interests of Paramedics Australasia or the profession (n.d., p. 5).

PA has a code of conduct and has established a complaint management process involving a formal investigation process, to deal with paramedic members who breach this code. Penalties for confirmed breaches of the code can result in:

> (a) Termination of membership of Paramedics Australasia;
> (b) The member to provide written advice to the Board of their suitability to remain a member of Paramedics Australasia;
> (c) Reduction of recognition level;
> (d) The issue of a formal written apology by the member concerned to the victims of the offence (n.d., p. 10).

[5] Paramedics Australasia, www.paramedics.org.au/about-us/code-of-conduct/

The PA code has been established to deal with internal member complaint issues only, and is not intended to be a complaints mechanism for the public who would generally make a complaint to the employer.

In addition to professional self-regulation, all government related ambulance services have a code of conduct for their employees.

2.3.8 International perspective

Internationally the regulatory framework for paramedics varies from country to country.

United Kingdom

Paramedics in the United Kingdom (UK) have been subject to statutory registration since 2000, through the Health Professions Council (HPC). The HPC is an independent, UK-wide health regulator established under the Health Professions Order (2001). The HPC maintains a register for 15 different health professions, only registering persons who meet the required professional standards for training, professional skills, behaviour and health. The HPC will take action against health professionals who do not meet these standards or who use a protected title illegally. According to the HPC:

> Paramedics provide specialist care and treatment to patients who are either acutely ill or injured. They can administer a range of drugs and carry out certain surgical techniques.[6]

Training and qualifications are gained either through securing a student paramedic position with an ambulance service trust or attending an approved full-time course in paramedic science at a university.

Republic of Ireland

Paramedics have been subject to statutory registration in the Republic of Ireland since 2005, under the Pre-Hospital Emergency Care Council (PHECC). The PHECC Register is divided into three divisions:

- Emergency Medical Technician Division
- Paramedic Division, and
- Advanced Paramedic Division.

An Advanced Paramedic is a registered practitioner who has at least 3 years experience as a Paramedic.

Each division of the PHECC Register may contain subdivisions to facilitate:

- Trainees (limited for a specific purpose and duration as Council may determine)
- Internship (limited for a specific purpose and duration as Council may determine), and
- Tutors (limited for a specific purpose and duration as Council).[7]

[6] Health Professions Council, UK, www.hpc-uk.org/aboutregistration/professions/

[7] Pre-Hospital Emergency Care Council, www.phecit.ie/

South Africa

Similar to the UK system, all emergency medical services personnel in South Africa are required to meet the standards of the governing body, the HPC. A formal register is maintained for each type of emergency medical services certification:

- emergency care practitioner
- paramedics
- ambulance emergency assistants
- emergency care technicians
- basic ambulance assistants
- operational emergency care assistants, and
- emergency care assistants.[8]

New Zealand

Paramedics are not a registered health profession in NZ. NZ has a system of defining paramedics by the level of life support they are qualified or trained to deliver. The main provider of ambulance services in NZ is St John, a charitable organisation which operates independent of government.[9]

A report by Karo Consultants Ltd, commissioned by Ambulance NZ (2009), states that the term 'paramedic' is used to cover staff at the Intermediate Life Support and Advanced Life Support level as defined in the NZ Standard 8156:2008:

> Although the use of the term 'paramedic' has emerged as a general descriptor for ambulance personnel, the Standard, with a view to future registration of paramedics, restricts 'paramedic' to describing intermediate and advanced life support roles.

United States

Each State in the United States of America has a lead Emergency Medical Services (EMS) agency. The National Association of State EMS Officials is a national professional network which has members in all States.

The National EMS Scope of Practice Model defines and describes four levels of EMS licensure:

- Emergency Medical Responder
- Emergency Medical Technician (EMT)
- Advanced EMT, and
- Paramedic.[10]

[8] Health Professions Council, South Africa, www.hpcsa.co.za/board_emergency.php/

[9] St John NZ, http://www.stjohn.org.nz/

[10] National Association of State EMS Officials, www.nasemso.org/

3. The nature of the problem

The nature of any problems or deficiencies within the current system of regulating paramedics, as well as the risk they pose to the public, must be identified and addressed before further government intervention can be appropriately considered. These issues, which are complex and multifaceted, include:

1. wide diversity in the scope of practice of paramedics, with scope being determined by individual employers
2. the variability in paramedic education and training arrangements and standards and the absence of compulsory national accreditation standards for education and training.
3. there being no mechanism to prevent a paramedic who has significant health, conduct or performance issues, moving from one employer to another or one jurisdiction to another and continuing to work as a paramedic, and
4. complaints and clinical incidents data collection and reporting are not standardised or comparable across jurisdictions.

In relation to these matters, it is work noting in relation to scope of practice of paramedics, that none of the national regulation options will provide a defined scope of practice. As mentioned in section 2.2.2, CAA has a formal accreditation process for tertiary entry-level paramedic programs, however, there is currently no legislative basis underpinning this process.

3.1 Scope of practice, education and regulation

3.1.1 Paramedic scope of practice

Paramedics are health practitioners who perform an essential role within the health care system. The role of the paramedic is to provide pre-hospital care for emergency, trauma or unexpected exacerbation of health problems. There are elements of their practice that are closely aligned to the nursing and midwifery profession and the medical profession in terms of clinical assessment and practice, and they are accountable for their practice through the various regulatory provisions as previously described in section 2.3.

There is a significant level of risk inherent in routine paramedic practice. As previously stated throughout Australia paramedics practise within the terms of their employment or engagement. Their practice is determined by protocols, guidelines and procedures delegated by their employer or service provider. Paramedics provide direct patient care within this framework, which is predominantly and routinely undertaken without direct supervision. Inappropriate delivery of care at any stage of the assessment, delivery and transport continuum can have catastrophic consequences for the patient.

While high risk activities can be identified and defined within paramedic practice, gathering evidence on their frequency and likelihood of occurrence is problematic. While ambulance services in most Australian jurisdictions are subject to regulation, either through specific legislation or funding and services agreements, special consideration needs to be given to the following factors. To what extent:

- the practice of paramedics involves the use of equipment, materials or processes which could cause a serious threat to public health and safety
- the failure of a paramedic to practise in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), may result in a serious threat to public health and safety
- are intrusive techniques used in the practice of paramedicine, which can cause a serious or life threatening danger, and
- are certain substances used in the practice of paramedicine, with particular emphasis on pharmaceutical compounds.

Paramedics are often involved in care that is complex and highly invasive, such as the administration of intravenous fluids and drugs, and the management of severe trauma such as burns and spinal injuries. Whilst the scope of practice of paramedics would suggest inherent risks to the public, however, there is little Australian data available to indicate the extent to which these risks have been realised in practice. Thus, many are theoretical risks rather than actual risks since they appear to be well controlled in practice within an environment where traditionally the employer has been ambulance services administered by government or operating under contract to government.

Paramedics often provide life saving measures that can directly influence health outcomes. The situations faced by paramedics are often complex and require good judgement, to minimise the substantial risk of causing harm. This is carried out predominantly in the context of the provision of ambulance services, but paramedics also practise in industrial settings and in the community where referral may be to health providers other than hospitals.

Paramedics are increasingly moving from employment with government related ambulance services into the private employment sector in diverse areas such as private industry, mining and events. Within this expanding private employment sector, there is no assurance that these employers will use the same degree of rigor or standards in the development of clinical protocols and guidelines, or procedures delegated to their paramedic employees.

A comparative summary of the more invasive skills and practices of paramedics within all government related ambulance services across all jurisdictions is provided in Table 7. Table 8 contains a comparative summary of intravenous fluids and medications administered by paramedics, including medications which are regulated under schedule, through jurisdictional law.

Table 7 descriptor – identify procedures that carry risk.

Table 7 Paramedic skills by jurisdiction

	ACT			NSW						NT					QLD					SA						TAS					VIC							WA		
		Paramedic	Intensive Care Paramedic		Student Paramedic	Paramedic Intern	Qualified Paramedic	Intensive Care Paramedic	Extended Care Paramedic		Patient Transport	Student Paramedic	Paramedic	Intensive Care Paramedic		Paramedic P4 ICP	Paramedic P3 ACP	Paramedic P1 BLS	Paramedic P4 ICPFlight Specialist		Paramedic	Intensive Care Paramedic	Rescue Paramedic	Retrieval Paramedic	Extended Care Paramedic	Ambulance Officer		Paramedic	Intensive Care Paramedic	Ambulance Volunteer	Aeromedical		First Responder	BLS Paramedic	ALS Paramedic	MICA<12	MP	AAV/ARV		Paramedic	Critical Care Paramedic
AIRWAY MANAGEMENT																																						
Oral pharyngeal airway		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Nasal pharyngeal airway		✓	✓		×	✓	✓	✓	✓		×	×	×	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓			✓	✓	×	✓		×	✓	✓	✓	✓	✓		✓	✓
Laryngeal Mask		✓	✓		×	×	✓	✓	✓		×	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Intubation - endo tracheal		×	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Bougie		×	×		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		×	✓
Cricothyroidotomy		×	✓		×	×	×	×	×		×	×	×	✓		×	×	×	×		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	×	✓	✓		✓	✓
DEFIBRILLATION																																						
Manual External defibrillators		✓	✓		×	✓	✓	✓	✓		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		×	✓	×	✓		×	✓	✓	✓	✓	✓		✓	✓
Semi Auto External defibrillators		✓	✓		×	×	×	×	×		×	×	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓			×	×	×	×		✓	✓	✓	✓	✓	✓		✓	✓
Auto External External defibrillators		✓	✓		×	×	×	×	×		✓	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓		×	×	✓	×		✓	✓	✓	✓	✓	✓		×	×
Internal defibrillators		✓	✓		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×
INTERVENTIONS																																						
Insertion of Intraosseous device		×	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		✓	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Insertion of IV		✓	✓		×	×	✓	✓	✓		×	×	✓	✓		✓	✓	×	✓		✓!	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Decompress tension Pneumothorax		×	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Medical Anti-Shock Trousers		×	×		×	×	×	×	×		×	×	×	✓		✓	×	×	✓		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Pacing		×	✓		×	×	×	×	×		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	×	×	×		×	×	×	×	×	✓		×	✓
OBSTETRICS																																						
Birth		✓	✓		✓	✓	✓	✓	✓		×	×	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Shoulder dystocia		×	×		×	×	×	×	×		×	×	✓	✓		✓	✓	✓	✓		✓!	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Breech		×	×		×	×	×	×	×		×	×	✓	✓		✓	✓	✓	✓		✓!	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
EQUIPMENT																																						
C-Collars		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓•	✓
KED/RED		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		×	×	×	×		✓	✓	✓	✓	✓	✓		✓•	✓
Use of Spineboard/extrication board		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓•	✓
Pelvic splint		✓	✓		✓	✓	✓	✓	✓		×	×	✓	✓		✓	✓	✓	×		✓O	✓O	✓	✓	✓O	×		×	×	×	×		×	✓	✓	✓	✓	✓		✓	✓
Tourniquet		✓	✓		✓	✓	✓	✓	✓		×	×	✓	✓		✓••	✓••	×	✓••		✓	✓	×	×	✓	✓		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Pulse Oximetry		✓	✓		✓	✓	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓•	✓
End expiratory pressure device		×	✓		×	×	×	×	✓		×	×	×			×	×	×	×		✓	×	×	✓!	✓	×		×	×	×	×		×	×	×	✓	✓	✓		×	✓
PEEP Valves		×	✓		×	×	×	×			×	×	×	✓		✓	×	×	×		×	×	×	✓!	×	×		×	×	×	×		×	×	×	✓	✓	✓		×	×
Colormetric CO2 detection		×	✓		×	×	×	×	✓		×	×	×	✓		×	×	×	×		×	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Capnography		×	✓		×	×	×	×	✓		×	×	×	✓		✓	✓••	×	×		×	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	×	✓	✓	✓		✓	✓

Table 8 Paramedic intravenous fluids and medication administration by jurisdiction

	ACT	Paramedic	Intensive Care Paramedic	NSW	Student Paramedic	Paramedic Intern	Qualified Paramedic	Intensive Care Paramedic	Extended Care Paramedic	NT	Patient Transport	Student Paramedic	Paramedic	Intensive Care Paramedic	QLD	Paramedic P4 ICP	Paramedic P3 ACP	Paramedic P1 BLS	Paramedic P4 ICPFlight Specialist	SA	Paramedic	Intensive Care Paramedic	Rescue Paramedic	Retrieval Paramedic	Extended Care Paramedic	Ambulance Officer	TAS	Paramedic	Intensive Care Paramedic	Ambulance Volunteer	Aeromedical	VIC	First Responder	BLS Paramedic	ALS Paramedic	MICA<12	MP	AAV/ARV	WA	Paramedic	Critical Care Paramedic
THROMBOLYSIS																																								
TPA / RPA		×	×		×	×	×	×	×		×	×	×	×		✓	×	×	✓		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Aspirin (for MI)		✓	✓		✓	✓	✓	✓	✓		×	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
ANALGESICS																																								
Morphine		✓	✓		×	×	✓"	✓	✓		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓	✓	×	×		×	×	✓	✓	✓	✓		×	✓
Pethidine / Fentanyl		×	×		×	×	×	×	×		×	×	✓	✓		✓••	×	×	✓••		×	×	×	✓!	×	×		×	×	×	✓		×	×	✓	✓	✓	✓		✓	✓
Methoxyflurane		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	×		✓	✓	✓	✓	✓	✓		✓	✓
Entonox		×	×		×	×	×	×	×		✓	✓	✓	✓		×	×	×	×		×	×	×	×	×	×		✓	✓	✓	✓		✓	×	×	×	×	×		×	×
Aspirin		×	×		×	×	×	×	✓		✓	✓	✓	✓		×	×	×	×		×	×	×	×	×	×		×	×	×	✓		×	×	×	×	×	×		✓	✓
Panadol		✓	✓		×	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	×	×		×	×	×	×	×	×		×	×
Cophenylcaine		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		✓	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	×	×	×		✓	✓
Ketamine		×	✓		×	×	×	×	×		×	×	×	✓		✓	×	×	✓			✓	✓	✓	✓	×		×	×	×	×		×	×	×	×	×	✓		✓	✓
Intranasal Fentanyl		×	×		×	✓#	✓"	✓	✓		×	✓	✓	✓		×	×	×	×		✓	✓	✓	✓	✓	×		×	×	×	×		×	×	✓	✓	✓	✓		✓	✓
VASODILATION																																								
Oral nitrates		✓	✓		×	✓	✓	✓	✓		✓	✓	✓	✓		×	×	×	×		×	×	×	×	×	×		×	×	×	×		✓	✓	✓	✓	✓	✓		✓	✓
GTN patch		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	✓	✓	✓	✓	✓		×	×
GTN spray		✓	✓		×	×	×	×	×		×	×	×	×		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓!		✓	✓	×	✓		×	×	×	×	×	×		✓	✓
IV Nitroglycerine		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	×		×	×
CARDIAC AGENTS																																								
Adenosine		×	✓		×	×	×	×	×		×	×	×	×		×	×	×	×		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	×	×	×		×	×
Adrenaline		✓	✓		×	×	✓	✓	✓		×	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Atropine		✓	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	×	✓	✓	✓		×	✓
Calcium		×	✓		×	×	×	✓	✓•		×	×	×	×		✓	×	×	✓		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Frusemide		×	✓		×	×	×	✓	✓•		×	×	×	✓		×	×	×	✓		×	×	×	✓!	×	×		×	✓	×	✓		×	×	×	✓	✓	✓		×	×
Isoprenaline		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Lignocaine		×	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	×	✓	✓	✓	×		×	✓	×	✓		×	×	✓	✓	✓	✓		×	×
Amiodarone		×	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Aramine		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	✓!	×	×		×	×	×	×		×	×	×	✓	✓	✓		×	×
Dopamine		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓••		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Dobutamine		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓••		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Noradenaline		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓••		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	✓		×	×
Nifedipine		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×

Table 8 Paramedic intravenous fluids and medication administration by jurisdiction (continued)

	ACT			NSW						NT					QLD					SA						TAS					VIC							WA		
		Paramedic	Intensive Care Paramedic		Student Paramedic	Paramedic Intern	Qualified Paramedic	Intensive Care Paramedic	Extended Care Paramedic		Patient Transport	Student Paramedic	Paramedic	Intensive Care Paramedic		Paramedic P4 ICP	Paramedic P3 ACP	Paramedic P1 BLS	Paramedic P4 ICPFlight Specialist		Paramedic	Intensive Care Paramedic	Rescue Paramedic	Retrieval Paramedic	Extended Care Paramedic	Ambulance Officer		Paramedic	Intensive Care Paramedic	Ambulance Volunteer	Aeromedical		First Responder	BLS Paramedic	ALS Paramedic	MICA<12	MP	AAV/ARV		Paramedic	Critical Care Paramedic
ASTHMA																																							
Salbutamol (puffer/spacer)		✓	✓		×	×	×	×	✓		✓	✓	✓	✓		×	×	×	×		✓	✓	✓	✓	✓	✓		✓	✓	×	✓		×	✓	✓	✓	✓	✓		✓	✓
Salbutamol (nebulised)		✓	✓		×	✓	✓	✓	✓		×	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Salbutamol (IV)		×	×		×	×	×	×	×		×	×	×	×		✓	×	×	✓		×	×	×	✓!	×	✓!		×	✓	×	✓		×	×	×	✓	✓	✓		×	×
Adrenaline		✓	✓		×	✓#	✓	✓	✓		×	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Peak exp. Flow meters		×	×		×	×	✓	✓	✓		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		✓	✓
Dexamethasone		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	✓!	×	×		×	✓	×	✓		×	×	×	✓	✓	✓		×	×
Ipratropium		✓	✓		×	×	✓	✓	✓		×	×	×	×		✓••	✓••	×	✓••		✓	✓	✓	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓		×	×
Nebulized adrenaline (croup)		✓	✓		×	✓	✓	✓	✓		×	×	×	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓!	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Hydrocortisone		×	✓		×	×	×	×	×		×	×	×	×		✓	×	×	✓		×	✓	✓	✓	✓	×		×	×	×	×		×	×	×	×	×	×		×	×
DIABETIC																																							
Glucotol		×	×		×	×	×	×	×		×	×	×	✓		×	×	×	×		×	×	×	×	×	×		✓	✓	✓	✓		×	×	×	×	×	×		×	×
Glucagon		✓	✓		×	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓!		✓	✓	×	✓		✓	✓	✓	✓	✓	✓		✓	✓
Dextrose 10%		×	✓		×	×	✓	✓	✓		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		×	×	×	×		×	×	✓	✓	✓	✓		✓	✓
Dextrose 50%		×	×		×	×	×	×	×		×	×	✓	✓		×	×	×	×		×	×	×	×	×	×		✓	✓	×	✓		×	×	×	×	×	×		×	✓
Glucometer		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓		✓	✓
Glucose Gel		×	×		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		×	×	×	×		✓	✓	✓	✓	✓	✓		✓	✓
BM Stix		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		✓	✓	✓	✓	✓	✓		×	×
MISCELLANEOUS																																							
Benztropine		×	×		×	×	×	×	×		×	×	×	×		✓	×	×	✓		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×
Diazepam oral		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	✓	✓	✓	✓	×		×	×	×	×		×	×	×	×	×	×		×	×
Midazolam - seizures		✓	✓		×	×	✓	✓	✓		×	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓!		✓		×	✓		×	✓	✓	✓	✓	✓		✓	✓
Midazolam - sedation		✓	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		✓!	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Midazolam - sedation post intubation		×	✓		×	×	✓	✓	✓•		×	×	×	✓		✓	×	×			×	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	×	✓	✓	✓		×	✓
Haloperidol					×	×	×	×	×		×	×	×			✓	×	×	✓		×	×	×	×	×	×			✓	×			×	×	×	×	×	×		✓	✓
Naloxone		✓	✓		×	✓#	✓	✓	✓		×	✓	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓!		✓		×	✓		×	✓	✓	✓	✓	✓		✓	✓
Metoclopramide		✓	✓		×	×	✓	✓	✓		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		×	✓
Stemetil		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		×	×
Charcoal		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		✓	✓	×	✓		×	×	×	×	×	×		×	×
Bicarbonate		×	✓		×	×	×	×	×		×	×	×	✓		✓	×	×	✓		×	×	×	✓!	×	×		×	✓	×	✓		×	×	×	✓	✓	✓		×	×
Ondansetron		✓	✓		×	×	✓	✓	✓		×	×	×	×		✓••	✓••	×	✓		✓••	✓••	✓••	✓!	✓	×		×	✓	×	×		×	×	×	×	×	✓		✓	✓
Phenergan		×	×		×	×	×	×	×		×	×	×	×		✓	×	×	✓		×	×	✓!	×	✓	×		×	×	×	×		×	×	×	×	×	×		×	×
Mannitol		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	✓		×	×

Table 8 Paramedic intravenous fluids and medication administration by jurisdiction (continued)

	ACT			NSW						NT					QLD					SA							TAS					VIC							WA		
		Paramedic	Intensive Care Paramedic		Student Paramedic	Paramedic Intern	Qualified Paramedic	Intensive Care Paramedic	Extended Care Paramedic		Patient Transport	Student Paramedic	Paramedic	Intensive Care Paramedic		Paramedic P4 ICP	Paramedic P3 ACP	Paramedic P1 BLS	Paramedic P4 ICPFlight Specialist		Paramedic	Intensive Care Paramedic	Rescue Paramedic	Retrieval Paramedic	Extended Care Paramedic	Ambulance Officer		Paramedic	Intensive Care Paramedic	Ambulance Volunteer	Aeromedical		First Responder	BLS Paramedic	ALS Paramedic	MICA<12	MP	AAV/ARV		Paramedic	Critical Care Paramedic
FLUIDS																																								
IV Cannulation		✓	✓		×	×	✓	✓	✓		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Intraosseous Infusion		×	✓		×	×	×	✓	✓•		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Intraosseous device		×	✓		×	×	×	×	×		×	×	×	✓		✓	×	×	✓		×	✓	✓	✓	✓	×		×	✓	×	✓		×	×	×	✓	✓	✓		✓	✓
Hartmann's		×	×		×	×	✓	✓	✓		×	×	×	✓		×	×	×	×		×	×	×	×	×	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		×	×
5% Dextrose		×	×		×	×	×	×	×		×	×	✓	✓		×	×	×	✓		×	×	×	✓!	×	×		×	×	×	×		×	×	×	✓	✓	✓		×	×
0.9% Sodium Chloride		✓	✓		×	×	×	×	×		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	×		✓	✓	×	✓		×	×	✓	✓	✓	✓		✓	✓
Look after IV Line		✓	✓		×	×	✓	✓	✓		×	×	✓	✓		✓	✓	✓	×		✓	✓	✓	✓	✓	✓		✓	✓	×	✓		×	✓	✓	✓	✓	✓		✓	✓
IV Fluid Management		✓	✓		×	×	✓	✓	×		×	×	✓	✓		✓	✓	✓	×		✓	✓	✓	✓	✓	×		✓	✓	×	✓		×	✓	✓	✓	✓	✓		✓	✓
ANTIVENOM																																								
Box Jelly		×	×		×	×	×	×	×		×	×	×	×		✓	✓	✓	×		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×
BULL Ant (Medihaler BP)		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×
OTHER																																								
Verapamil		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	×	×	×		×	×	×	×		×	×	×	✓	✓	✓		×	×
Pancuronium		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓••		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	✓	✓		×	×
Rocuronium		×	×		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×		✓		×	✓
Suxamethonium		×	✓		×	×	×	×	×		×	×	×	×		×	×	×	×		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	✓	✓		×	✓
Antibiotic for meningoccocus		✓	✓		×	✓#	✓	✓	✓		×	×	×	✓		✓	✓	×	✓		✓!	✓!	✓!	✓!	✓	✓!		✓	✓	×	✓		×	×	✓	✓	✓	✓		×	×
Magnesium		×	✓		×	×	×	×	×		×	×	×	×		✓	✓••	×	✓		×	×	×	✓!	×	×		×	×	×	×		×	×	×	×	×	✓		×	×
Adrenaline - for anaphylaxis		✓	✓		×	×	✓	✓	×		×	×	✓	✓		✓	✓	×	✓		✓	✓	✓	✓	✓	✓!		✓	✓	✓	✓		×	✓	×	✓	✓	✓		✓	✓
Heparin		×	✓		×	×	×	×	×		×	×	×	×		✓	×	×	✓		×	×	×	×	×	×		×	×	×	×		×	×	✓	×	×	×		✓	✓
Tirofiban		×	×		×	×	×	×	×		×	×	×	×		×	×	×	✓		×	×	×	×	×	×		×	×	×	×		×	×	×	×	×	✓		×	×
Temperature		✓	✓		×	×	×	×	×		×	×	×	✓		✓	✓	×	✓		×	×		✓!	✓	×		×	×	×	×		×	✓	✓	✓	✓	✓		✓	✓
Clopidogrel		×	✓		×	×	×	✓"	✓		×	×	×	×		✓	×	×	✓		×	✓••	✓••	✓••	✓••	×		×	×	×	×		×	×	×	×	×	×		×	×

LEGEND

Performs this skill	✓	Does not perform this skill	×	Specific geopgraphic locations only	✓#	Paramedics who have completed P1 upgrade	✓"
ECP's who have completed ICP qualifications	✓•	Skill to be introduced	✓••	Currently being trialled	✓O	Following medical or specialist advice or authority	✓!

This is a broad snap shot of skills undertaken by paramedics in Australia. Please note that paramedics are required to undertake additional skills outside of the above scope.

3.1.2 Educational preparation

As previously mentioned, the use of the term ‘paramedic’ is not restricted or licensed in Australia. Because there are no legally enforceable barriers to entry to paramedics, and no offences for use of the title ‘paramedic’, anyone can hold themselves out as qualified to practise as a paramedic, regardless of their qualification. Because paramedics were primarily employed by state run or funded ambulance services, this has not been a particular problem in the past. However, as paramedics increasingly move into the private sector, there are less controls and more risks. At present, the fact that a paramedic is practicing is not a guarantee of his or her ability to do so at an acceptable standard.

3.1.3 Regulatory mechanisms

In response to the *Consultation paper: Options for regulation of unregistered health practitioners*, five submissions concerning paramedics were received. Of these, one was a confidential submission from an individual student. Two came from professional organisations, namely Paramedics Australasia (PA) and the Australian Registry of Emergency Medical Technicians (AREMT). Submissions were also received from the Council of Ambulance Authorities Inc (CAA), a peak body representing the principal statutory providers of ambulance services in Australia, NZ and Papua New Guinea, and from the ambulance section of United Voice QLD, an industrial organisation.

All expressed the view that existing regulatory mechanisms are not sufficient to adequately protect the public, and of particular concern was the current lack of a national regulatory framework. AREMT, PA and United Voice QLD all supported the introduction of a national, compulsory code of conduct and stronger complaints mechanisms. The CAA noted its continuing commitment to improving regulation of paramedics and voiced support for possible registration under the National Scheme. In summary, all submissions suggested a need for further regulation of paramedics, with the main question being what form it should take.

There are a number of issues which, together, call for consideration of whether the public is sufficiently protected by current regulatory arrangements. These issues are discussed in detail and the interplay between the many issues is considered.

Currently, a number of problems arise from the absence of national uniformity in the regulation of paramedics. For example:

- practitioners from other health professions who have been deregistered, due to serious concerns about their conduct, are able to seek employment as a paramedic (subject to holding qualifications as deemed appropriate by an employer)
- paramedics who have been subject to regulatory or employer action in one jurisdiction may freely move to and practice in another jurisdiction
- paramedics who have been subject to employer action in one jurisdiction may freely move to another place of employment in the same jurisdiction
- it is difficult to collect and collate information about harmful or potentially harmful behaviour by individual paramedics because:
    (1) there is no one point of complaint in each State and Territory, and
    (2) most complaints about paramedics are dealt with by individual employers

- consumer protection bodies may not have the power to protect the public in the event of 'repeat offenders' continuing to provide paramedic services.

There are also some extreme behaviours through which paramedics could cause serious harm to consumers. Examples would include practicing under the influence of alcohol or drugs, or sexual misconduct. Were misconduct to occur in this context, the risk and severity of potential harm to the consumer is high.

While the Chief Officer of ACT Ambulance Service (ACTAS) has the power to alter, withdraw or suspend the scope of practice of any individual within the service, with the exception of NSW, there is no mechanism to prevent a paramedic, who has significant health, conduct or performance issues, from moving to another jurisdiction or another employer in the same jurisdiction to seek continuing employment as a paramedic.

In light of the risks inherent in paramedic practice, and the nature of the harm that may be suffered by consumers, the issues arising from existing regulatory arrangements need to be seriously considered to determine if there are sufficient safeguards for the public under the current regulatory framework.

3.2 Defining and assessing risk

3.2.1 Defining risk

The 2007 Council of Australian Governments' Best Practice Regulation Guide for Ministerial Councils and National Standard Setting Bodies (p. 18) defines risk as 'the probability of an undesirable event occurring'. A risk assessment is a means of analysing the risk of an undesirable event occurring, and identifying the consequences that are liable to arise if it does occur. Such an assessment assists in determining what action may be necessary to reduce or eliminate the risk and/or its consequences.

The CAA undertakes an annual national Patient Satisfaction Survey. This report details the service quality and satisfaction rating of ambulance service patients across Australia and New Zealand. The purpose of this research is to measure the quality of the ambulance service, as perceived by its customers, and to compare these ratings across jurisdictions. The CAA Patient Satisfaction Survey of 2011 shows the overall satisfaction with the care provided by paramedics from Australian ambulance services was 98% (Kapulski and Bogomolova 2011).

The safety of the public is paramount, and ensuring good governance and accountability of any health practitioner is an essential goal. There are risks associated with any form of health care. However, identifying and quantifying the risk and assessing its significance is particularly complex in this context because the extent to which risks are realised or contained in practice depends on a range of factors and the interaction between them. In relation to paramedics, however, there is very little systematically collected information available about the extent of the problem.

The AHMAC 2009 *Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law* (p. 116) specifies 13 risk factors which were identified to evaluate whether a profession posed a risk to the public:

1. Putting an instrument, hand or finger into a body cavity.
2. Manipulation of the spine.
3. Application of a hazardous form of energy or radiation.
4. Procedures below the dermis, mucous membrane, in or below surface of cornea or teeth.
5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs.
6. Administering a scheduled drug or substance by injection.
7. Supplying substances for ingestion.
8. Managing labour or delivering a baby.
9. Undertaking psychological interventions to treat serious disorders with potential for harm.
10. Setting or casting a fracture of a bone or reducing dislocation of a joint.
11. Primary care practitioners who see patients with or without a referral from a registered practitioner.
12. Treatment commonly occurs without others present.
13. Patients commonly require to disrobe.

While high risk activities can be identified and defined, gathering evidence on their frequency and likelihood of occurrence is problematic, given that health practitioner and client interactions happen on so many occasions. Only a few high risk activities are subject to specific regulation, such as the use of scheduled medicines and application of hazardous forms of radiation.

Assessment of the paramedic scope of practice against these risk factors indicates that the typical scope of paramedic practice includes many 13 risk factors. However, in jurisdictions where paramedics have a broader scope of practice a greater number of activities posing a risk to the public are undertaken.

As part AHMAC ‘Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law (2009)’, the 13 risk factors were mapped for professions identified to join the National Scheme

By comparison, paramedics currently meet a greater number of risk factors than ten of the 14 health professions registered under the National Scheme.

However, these risks must be balanced against findings by government reports and coronial enquiries, as well as information obtained from jurisdictional complaints data.

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

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

X indicates that the practitioner's scope of practice typically includes the activity

	1. Putting an instrument, hand or finger into a body cavity[i]	2. Manipulation of the spine[ii]	3. Application of a hazardous form of energy[iii] radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administering a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psychological interventions to treat serious disorders or with potential for harm	10. Setting or casting a fracture of a bone or reducing dislocation of a joint	11. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others present[iv]	13. Patients commonly required to disrobe
Aboriginal & Torres Strait Islander health practitioners	X			X	X	X	X				X	X	X
Chinese Medical Practitioners	X	X		X	X	X	X	X			X	X	X
Chiropractors		X									X	X	X
Dental practitioners*	X		X	X	X	X					X		
Medical practitioners	X	X	X	X	X	X	X	X	X	X	X	X	X

i Beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body.

ii Moving the joints of the cervical spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust.

iii Electricity for aversive conditioning, cardiac pacemaker therapy, cardioverson, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electro magnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy.

iv Includes practitioners who practice solo or treat with no others present, such as medical specialists and practitioners who may be solely responsible for clinical care overnight or in a remote community.

* Dentists, dental hygienists, dental prosthetists, dental therapists.

	1. Putting an instrument, hand or finger into a body cavity	2. Manipulation of the spine	3. Application of a hazardous form of energy/radiation	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	5. Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs	6. Administering a scheduled drug or substance by injection	7. Supplying substances for ingestion	8. Managing labour or delivering a baby	9. Undertaking psychological interventions to treat serious disorders or with potential for harm	10. Setting or casting a fracture of a bone or reducing dislocation of a joint	11. Primary care practitioners who see patients with or without a referral from a registered practitioner	12. Treatment commonly occurs without others presen	13. Patients commonly required to disrobe
Medical radiation practitioners			X	X		X					X	X	X
Nurses and midwives	X		X	X	X	X	X	X	X		X	X	X
Optometrists					X						X	X	
Occupational Therapists			X								X	X	X
Osteopaths		X									X	X	X
Pharmacists					X		X				X		
Physiotherapists	X	X	X								X	X	X
Podiatrists				X	X	X					X	X	
Psychologists									X		X	X	
UNREGISTERED													
Paramedics**	X			X		X	X	X	X		X	X	X

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

3.2.2 Assessment of risk

The nature, frequency and severity of risk presented by a paramedic depends, in part, on the nature and scope of their practice, and the extent to which the paramedic undertakes potentially high risk procedures or activities. Risks may be divided into two main categories:

1. risks associated with the exercise of clinical judgement by a paramedic, such as:
    - incorrect application of treatment
    - misdiagnosis
    - failure to refer, and
    - failure to explain precautions or contraindications.
2. risks inherent in the procedures, activities or treatments applied, for example:
    - risks associated with the ingestion of substances:
        - predictable toxicity reactions due to overdose, drug interactions, drug/herb or drug/food interactions
        - unpredictable reactions such as allergy, anaphylaxis, idiosyncratic reactions
    - risks associated with the use of therapeutic goods
    - risks associated with poor infection control procedures; and
    - risks associated with trust and the nature of the practitioner/patient relationship.

The United Kingdom Department of Health Extending Professional and Occupational Regulation: The Report of the Working Group on Extending Professional Regulation (Department of Health, 2009) report provides a good overview of the challenges of risk assessment in this context. The report identifies many factors that contribute to the extent to which particular theoretical risks are realised in practice, for example:

> - whether the act is carried out by a practitioner on their own or as part of a supervised team who can support, guide and scrutinise practice;
> - whether the act is carried out by a practitioner who is part of a well managed organisation that has in place managerial assurance systems to protect patients and the public;
> - whether the act is carried out by a practitioner who has a stable employment pattern, where any problems might be identified over time, or whether it is carried out by a more mobile short term tenure practitioner working in a variety of locations, whose practice is less likely to receive consistent oversight;
> - the quality of education and training of the practitioner carrying out the act;
> - the experience of the practitioner carrying out the act; and
> - whether there are systems in place to ensure that the practitioner is regularly and effectively appraised and developed to ensure that they are up to date with current practice (Department of Health, 2009, p. 21).

The Working Group notes some factors that are likely to increase the incidence of poor, unethical or incompetent practice:

> - practising without the supervision or support of peers, managers and other regulated staff;
> - practising with vulnerable or isolated individuals;
> - highly mobile, locum or short tenure;

- practice that is not guided by a strong professional (or employer) code of conduct; and
- practice in roles where the training and educational requirements are short and there is no extended period through which the ethos and values that underpin safe practice can be imbued (Department of Health, 2009, p. 21).

The Working Group recognised the need for a robust evidence based approach to risk assessment (Department of Health, 2009, p. 8), but noted that there is currently no clear way to judge the risk associated with roles, due to uncertainty and complexity:

> The risk, benefits and costs of professional regulation are complex and multi-dimensional, involving difficult trade-offs and judgements. Where there is uncertainty and complexity, it is important that there is rigorous analysis of available evidence, clear criteria for decision making, and effective governance of the decision making process to avoid conflicts of interests and ensure that patients and the public are at the heart of the system.

Risks to the public may also be exacerbated when:

- the practitioner works in isolation from peer or supervisor support
- the practitioner suffers from a physical or mental impairment
- the practitioner is unqualified or incompetent
- the practitioner has a criminal history, falsified identity or false qualification, and
- the practitioner's behaviour places their own interests above those of their patients.

In their response to the AHMAC *Consultation paper: Options for regulation of unregistered health practitioners* February 2011, PA outlined specific risks which they believe to be paramedic-practice specific. These include such things as infection control, physical risks arising from the emergency response operating environment, personal risks to the practitioner and patient arising from assault and other forms of individual and group attack, patient handling and transport and psychological risks and post traumatic stress potentially affecting fitness to practice. In explaining the risks associated with paramedic-specific clinical practice, in their response to the *Consultation paper: Options for the regulation of unregistered health practitioners, February 2011*, PA provided a list of high risk interventions, and identified the potential clinical consequences of inappropriate treatment (Table 10).

Table 10 Examples of potential risks arising from paramedic interventions (as provided by PA)

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 from: o oesophogeal tube placement o prolonged attempts. • Trauma: Dental and soft-tissue trauma, perforation or laceration of upper oesophagus, vocal cords, larynx. • Laryngospasm and bronchospasm. • Dysrhythmias, hypertension/hypotension. • Oral or gastric contents.
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. • Arrhythmia as a result of administering induction agents. • All the above for intubation.
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. • Aspiration of blood into the lungs.

Table 10 Examples of potential risks arising from paramedic interventions (as provided by PA) (continued)

Intervention	Explanation	Potential clinical consequences
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. • Arrhythmia from pharmacological agents.
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 (Pneumothorax). • Can create a collapsed lung that fills with large amounts of blood (haemothorax). • May contribute to death of patient (unlikely).
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.
	Thrombolysis	• Clot dissolving medications that can have a dramatic impact on acute coronary syndromes (heart attacks), but can also result in significant side effects including stroke.
Referral / Advice	Paramedics are constantly making assessments and providing advice or informal referral to a range of health practitioners	• The decision to not transport someone to hospital and to empower them with alternative health choices places considerable onus on the paramedic without any protection from the employer.*

* Whilst PA identifies that there is no protection for referral / advice provided by the paramedic, protection would be provided by the employer, e.g. Public Liability Insurance.

3.3 Conduct of concern, government reports and coronial enquiries

3.3.1 Overview

Whilst the vast majority of paramedics do practise in a safe, competent and ethical manner, at the present time any paramedic with health, conduct or performance issues is free to move to jurisdictions or employers that have less regulatory scrutiny and continue to practise. Even though there may be only a small number of paramedics whose health, conduct or performance is so serious that they come to the attention of employers and regulatory authorities, serious issues of this nature can significantly impact the lives of affected patients and families and potentially impose a disproportionate burden on the health system.

Currently, it is the responsibility of an employer to comprehensively check potential employees before their appointment. While government related ambulance services may have well developed procedures to check an applicant's background, there are no nationally uniform or consistent legally enforceable qualifications or probity checks (including criminal history) required before a paramedic can commence practice.

3.3.2 Types of conduct of concern

There is a range of paramedic behaviour that may result in serious harm to consumers. Examples include paramedics who:

- fail to recognise the limitations of their practice
- fail to provide appropriate treatment, including incorrect medications, which may result in adverse patient outcomes
- provide inappropriate treatment which may result in adverse patient outcomes
- practise under the influence of alcohol or unlawful drugs
- have a physical or mental disorder which affects their capacity to practise, thereby, placing the public at risk
- have a criminal history which would make them unsuitable to provide health care; or
- engage in sexual impropriety.

At present, a paramedic may resign from their employment if they come under scrutiny for health, conduct or performance issues. These paramedics may then seek employment as a paramedic in the same or another jurisdiction. In general, the outcome of any investigation commenced by an employer cannot be acted upon once an employee has resigned. There is also no obligation on the part of an employer to disclose such information to any prospective employer. This means that a paramedic with serious health, conduct or performance issues may seek alternative employment and continue to practise without any serious issues being fully addressed.

However, the situation is different in NSW, where there is the option to report the paramedic to the Health Care Complaints Commission (HCCC). The HCCC can continue any investigation, irrespective of the employment status of the paramedic. The HCCC also has the ability to publish the findings, which adds a level of protection for the public against paramedics with serious health, conduct or performance issues.

While government related ambulance services may have a requirement that all paramedics, as new employees, undergo a criminal history, the same cannot be assured with private companies.

Within the expanding private employment market there is no assurance that all employers will use the same degree of rigour in their recruitment and management as those of government related ambulance services, or that they will require the same standards of practice.

Large public events are increasingly being supported by private companies, who provide first aid and/or paramedic services. In August 2011, at the annual Perth City to Surf fun run, medical assistance was provided by a private company. On this occasion, a 30 year-old runner collapsed and died, with the media reporting that there was no defibrillator available at the scene of the incident (Ninemsn Staff, 2011), a claim that was denied by event 'insiders'. While the findings of the Coroner are unknown at this time, information on social media sites (relating to this event) indicate that members of the public expect appropriate levels of emergency personnel and facilities to be available at such events.

3.3.3 Government reports

There have been a series of government inquiries and reports into ambulance services, with the primary focus of these inquiries and reports being upon the administrative arrangements through which ambulance services are delivered, and matters such as response times. A number of reviews and audits have endeavoured to inform State, Territory and Commonwealth government policy on a range of issues regarding the operational role of ambulance services.

Few inquiries and reports have addressed or made any specific findings with respect to issues arising from the conduct or performance of individual paramedics. Of the reports sighted, two make direct recommendations concerning the registration of paramedics, these being the 2008 NSW inquiry into the management and operations of the Ambulance Service of NSW and the 2009 Inquiry into the St John Ambulance Service WA. A 1999 review of the *Ambulances Services Act 1996* (VIC) recommended the establishment of a registration board for ambulance officers.

The following is a summary of issues relating to paramedics, as identified within the relevant reports.

Australian Capital Territory

ACT Auditor-General's Office Performance Audit Report - Delivery of Ambulance Services to the ACT Community ACT Ambulance Services (ACTAS) Emergency Services Agency June 2009.

Whilst the audit made no specific reference to the requirements for regulation or registration of paramedics, it did, however, identify 'deficiencies in planning, documentation of policies and procedures, risk management and performance management and review', and that ACTAS's clinical governance systems 'were not sufficiently robust to provide assurance of a quality service on patient care'.

New South Wales

Inquiry into the management and operations of the Ambulance Service of NSW (ASNSW) 2008.

This inquiry was commenced in May 2008 by the NSW Legislative Council General Purpose Standing Committee No. 2 (GPSC2). Whilst the report contained 45 recommendations, 33 of which were supported by the NSW Government, only one (Recommendation 17) specifically relates to paramedics:

> That the NSW Minister for Health initiate discussions with the Council of Australian Governments to explore the option of national registration of paramedics (p. 68).

The *NSW Government Response to the Legislative Council General Purpose Standing Committee No.2 inquiry into the Management and Operations of the Ambulance Service of NSW, May 2009*, in relation to this recommendation, states:

> In 1995, the Australian Health Ministers' Advisory Council (AHMAC) adopted a series of criteria for professions seeking registration. The test for registration of a particular group of service providers is warranted to protect the public. At the time the criteria was established it was determined that paramedics did not meet the criteria.
>
> Issues of qualifications, professional standards, competence and discipline can be readily addressed within that employment context. Further to this, paramedics are not registered in any State or Territory within Australia. Given this, the Government's view is that paramedics employed in the NSW Ambulance Service would not meet the prescribe AHMAC criteria. (p. 9)
>
> It is expected that the new national registration scheme (approved to commence in 2010) will retain the current AHMAC criteria to test the appropriateness of regulating new professional groups. The Intergovernmental Agreement has provisions for new groups of professions to be included in the National Registration and Accreditation scheme if they fulfil the criteria, which is then subject to a process of approval by the Australian Health Ministers' Council (AHMC) (p. 9).

Review of the Ambulance Service of NSW, Performance Review Unit 2008 NSW Government, Department of Premier & Cabinet 2008.

This Review provided an opportunity to look at a number of issues confronting the Ambulance Service of NSW, including the ever growing demand on ambulance services.

A key finding (10.6) relates to the registration and certification of ambulance paramedics, as follows:

> Registration may effectively shift some of the liability for professional errors from the employer to the employee, raising the prospect of the employer applying pressure and sanctions on the employee to accord with the employer's own requirements, in addition to those applied by the registering body. At the time of reporting, there has been some limited progress on the registration of paramedics.
>
> The operational benefits of registration do not appear to outweigh the costs in the short to medium term. It is likely that more momentum for registration of ambulance paramedics will ensue as the industry in Australia continues its transition from one that transports patients to hospitals to one where paramedics are recognised for the quality of healthcare provided to patients (pp. 91-92).

Queensland

The Queensland Ambulance Service (QAS) *Audit Report, December 2010*, Queensland Government 2007

In September 2010 the QLD Government commissioned a comprehensive audit of QAS. The audit arose out of concern about the pressures associated with increasing demands and the need to ensure that appropriate QAS resources were being directed to front line service delivery.

Recommendation 2.1 suggested 'QAS implement an integrated demand management strategy to reduce demand pressures on the organisation and its staff'. This required, amongst other things:

> To better match services with patient needs, the QAS is to adopt an expanded scope of practice for paramedics that will enable greater assistance to be provided to patients who may be able to be treated in their own homes thus avoiding an ambulance transport to an emergency department (p. 17).

Tasmania

Joint Standing Committee on Community Development, Inquiry into TAS [Tasmanian Ambulance Service], *Hobart, 13 May, 2003*. Parliament of Tasmania 2007.

While there were no specific findings in relation to paramedics, the Joint Standing Committee was informed that no Tasmanian Ambulance Service employee has been subjected to serious disciplinary procedure since 1994, when an ambulance officer was dismissed on the grounds of clinical deficiencies (p. 19).

It is noted, however, that evidence presented by a former Tasmanian Ambulance Service supervisor suggests that disciplinary issues reported to senior management were not always followed through.

Victoria

In their 1999 review of the *Ambulances Services Act 1996* (VIC), the Allen Consulting Group recommended the establishment of a registration board for ambulance officers for the purposes of offering protection of consumers, protection of certain titles, the public, and the provision of 'disciplinary and complaints handling provisions' (p. 79). In their response, the Victorian Government (1999, p. 9) indicate that there is no rationale for the creation of a registration board in the absence of competition in the provision of ambulance services.

Western Australia

St John Ambulance Inquiry (2009), Department of Health, Report to the Minister for Health, October 2009

This inquiry was instigated by the Minister for Health following a 2009 ABC Four Corners Program titled 'Out of Time' which detailed four deaths resulting from inadequate responses by the ambulance service. This was an independent inquiry conducted into the safety and quality of clinical practices at St John Ambulance (SJA) WA.

The SJA Inquiry report made one recommendation (recommendation 10) for paramedic registration:

> The Department of Health pursues, through the Australian Health Workforce Ministerial Council, the national registration of paramedics (p. 9).

Actions taken since these inquiries

It must be recognised that each of these inquiries contained a raft of recommendations relating to overall provision of ambulance services, which governments have sought to address. Ambulance services have also undertaken steps to address the recommendations, and many have strengthened their clinical governance guidelines.

Through an exploration of options for regulation of paramedics, the outcome of this consultation process may serve to address the recommendations in the NSW and WA inquiries specifically relating to consideration of national registration of paramedics.

3.3.4 Coronial enquiries

Where publicly available, coronial enquires have been reviewed to identify if any directly involved the care provided by ambulance officers and paramedics. Only three coronial enquiries were identified between 2005 and 2011 which contain issues which identify key risks associated with paramedic health, conduct or performance issues.

New South Wales

The Jerram (2010) NSW coronial case highlighted the risk associated with a paramedic, who was acknowledged by his employer (ASNSW) as being a difficult employee, with colleagues making complaints about him in relation to his irrational and threatening behaviours from 2000. The coronial investigation was into the deaths of the paramedic and his mother. Before committing suicide using a gun, the paramedic had shot and killed his mother.

Clause 11, Medical Examination, of the Ambulance Service Regulation 2005, under the *Ambulance Services Act 1990* (NSW), does contain provision that:

> (1) The Ambulance Service may direct that an employee undergo medical examination for the purpose of ascertaining the employee's fitness to perform his or her duties. An employee given such a direction must submit himself or herself to examination by a medical practitioner approved by the Ambulance Service.
> (2) The Ambulance Service may direct an employee to undergo such medical examination as the Ambulance Service considers necessary if there is reason to believe that the health of the employee:
> (a) may mean that the employee is a danger to other employees or to the public, or
> (b) is likely to be seriously affected by the employee remaining on duty (or, if the employee is absent from duty, by the employee's resumption of duty). (Ambulance Service Regulation 2005, NSW)

Whilst ASNSW did refer the paramedic for psychiatric assessment in 2007, the Coroner suggested that ASNSW did not have clear policies that supported action being taken against employees with whom there were concerns about their mental health status.

The *Ambulance Services Act 1990* (NSW) has been repealed, with regulatory provisions for paramedics now being within the Ambulance Services Regulation 2005 made under the *Health Services Act 1997* (NSW).

Northern Territory

In 2005, an inquest was undertaken into the death of a 37 year old male who had died in a suburb of Darwin, NT. An ambulance had been called to where the deceased had been, and after 8 minutes, the SJANT crew left the residence without transporting the man to hospital. SJANT was again called a few hours later, when the man, who had a previous history of heart surgery, was found to be deceased. Whilst the Coroner did not lay blame on the actions of the SJANT staff who attended, he reminded SJANT and their employees, 'that they are not and should not be the decision making gateway to access to emergency assessment' (Cavanagh, 2005).

Western Australia

In January 1992 SJAWA officers attended a 19 year old injured man who was on the roadside. The SJAWA officers took the man home, and put him into bed after assisting him to climb some stairs. Not long after, the man died of severe internal injuries which had been sustained from being beaten by two men and then run over by a car before he was attended to by the SJAWA officers.

Actions taken by employers

These cases illustrate that severe outcomes can arise from the actions of a paramedic who may have health, conduct or performance issues that make them unsafe to practice. Whilst the cases may be few, they do raise serious issues of impairment, conduct and performance of paramedics.

It is unknown what, if any, action(s) were taken by the respective employers of the paramedics involved in the NT and WA cases. However, given the findings of the Coroner, each of these cases may have formed the basis of a complaint being made to a regulatory authority, should one exist. In the NSW case, the HCCC would have provided a further avenue of reporting by concerned colleagues if it had been an available option at the time.

3.4 Risk assessment

In order to determine whether further regulatory measures are required with respect to the provision of health services by paramedics, an assessment is required of the activities of the profession, to determine whether they pose a significant risk of harm to the health and safety of the public. As indicated in Criterion 2 of the Intergovernmental Agreement Criteria - Guiding Principles (Appendix 3), consideration needs to be given to determine if the activities of paramedics pose a significant risk of harm to the health and safety of the public. Factors to consider when assessing the significance of risk include the nature and severity of the risk to the:

- client group
- wider public, and
- practitioner.

3.4.1 Risk and complaint management

Risk management

Regulated professions have strong institutional arrangements that operate to contain risk, for example, by increasing the barriers to entry to the profession, enforcing minimum qualifications requirements for training and practice, limiting the settings within which the profession may be practised, and ensuring peer review mechanisms are effective. Professions with established government-accredited training programs, a single peak professional association (rather than fragmented representative arrangements), and employment opportunities primarily in publicly-funded services may be less likely to have practitioners who engage in illegal or unethical practice. Public ambulance services do have established, government-accredited training programs which must comply with the Australian Quality Training Framework (AQTF). However, within the paramedic profession there is no single standard of education or training across Australia.

There are risks associated with any form of health care. However, identifying and quantifying the risk of paramedic practice and assessing its significance is complex, and the extent to which risks are realised or contained in practice depends on a wide range of factors and the interaction between them. There is very little systematically collected information available about the extent of any problems with paramedic practice, although there have been some high profile cases of unacceptable outcomes for consumers and for the health system.

In general, consumers have no choice of service provider and are unable to make a choice of paramedic practitioner. The clinical interventions and practitioner competence must be taken at

face value, with the average consumer not well placed to assess the type and quality of care or service provided. There is no open market and no independent and objective assessment of performance in the public interest outside of provider clinical governance and processes and/or complaints that have been referred to third party legislative authorities such as Health Complaints Commission, Coroner, Ombudsman, Police or responsible Minister.

Clinical Governance Guidelines of the WA Department of Health (2005) define clinical governance as 'A systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes' (p. 2). The NSW Ministry of Health further adds that clinical governance 'is about the ability to produce effective change so that high quality care is achieved. It requires clinicians and administrators to take joint responsibility for making sure this occurs' (n.d., www.health.nsw.gov.au/mhdao/clinical_governance.asp)[11].

Within a clinical governance framework, a range of complementary incident reporting systems usually occur. Clinical incidents and sentinel events are adverse events which result in death or serious harm to a patient.

The public ambulance service in each jurisdiction has systems of clinical governance including clinical incident and sentinel event reporting. Patient incidents and sentinel events are examined in all jurisdictions using a best practice approach to incident reporting and investigation. However, there is no formal mechanism for the sharing of lessons learned.

The establishment of privileged environments in sentinel event reporting and investigation within an ambulance service offers a mechanism for both enhancing the quality of care and addressing other issues. However, this is not a mechanism for publicly identifying individual paramedics who may have caused serious harm or could be incompetent.

Complaint management

The government of each Australian jurisdiction is committed to the implementation of effective complaints management systems, and all jurisdictions have processes for managing complaints for their publicly operated ambulance services. The complaints management systems can deal with complaints about paramedics from both members of the public and health professionals.

Paramedics are required to make clinical assessments, often quickly, and often in the critical period after an accident or acute medical event. They also perform invasive procedures and administer medications. Complaints about paramedics could relate to whether the paramedic had not acted appropriately or within the required standard of practice, competence and conduct. Complaints could also include issues such as whether the paramedic:

- can communicate effectively
- has a mental or physical impairment that could affect their ability to practice, or
- is of good character.

[11] NSW Ministry of Health, www.health.nsw.gov.au/mhdao/clinical_governance.asp

3.4.2 Jurisdictional complaints data

Where possible, each Australian jurisdiction has provided data on the numbers and types of complaints received (Appendix 7). It is difficult to make comparisons or draw conclusions from the data in relation to paramedics because there is no standardised method of collection or reporting across jurisdictions. The following is an extrapolation of the information provided, which may assist in understanding the level of risk which may be posed by paramedics to the public.

ACT

There were two sentinel events reported in the ACT in 2010 and 2011. Both cases related to a skills performance/clinical judgment at a standard below that accepted in relation to clinical judgment/poor skill.

ACT Ambulance Service (ACTAS) has a detailed complaints policy, reviewed in 2011. In addition, ACTAS has recently established a new business unit -Quality Safety and Risk Management. There were two sentinel events reported in the ACT in 2010 and 2011. Both cases related to a skills performance/clinical judgment at a standard below that accepted in relation to clinical judgment/poor skill.

From July 2010 to end June 2011 98 cases were logged in the external complaints database: These included 67 requests for review of an ambulance account.

Of the remaining 31 complaints:

- 6 were classified as Clinical
- 14 related to attitude
- 4 related to both clinical and attitude
- 4 related to response times
- 3 were classified as ‘other’

NSW

In 2010 there were two complaints managed and resolved by the HCCC with respect to NSW Ambulance Service paramedics. Previous years show similar low levels of complaints for this service. Data regarding complaints is made available to the public via the NSW HCCC web site: http://www.hccc.nsw.gov.au/Complaints/default.aspx. According to the HCCC’s 2010 - 2011 annual report (p. 107), one complaint was made against ambulance personnel in relation to professional conduct.

Complaints data for the NSW Ambulance Service (ASNSW) from 2009 - 2010 indicates that 78 complaint matters were considered, of which 50 matters involved serious allegations. In the first six months of the reporting year, 27 serious matters were finalised by ASNSW, with 23 of these matters being sustained or proved. Of these, 14 resulted in disciplinary action, including eight officers whose employment was terminated or ceased as a direct result of the disciplinary proceedings.

As a result of increased workplace awareness and clearer referral procedures, an increased number of serious allegations are being reported. The above data provided by NSW Health includes complaints and sentinel events and cannot be separated into specific complaint types.

NT

Complaints can be made through the employer, St John Ambulance NT, or through the Health and Community Services Complaints Commission and the Ombudsman NT. Information on complaints about St John Ambulance NT is not collected specifically. However, there are occasions where complaints are received through the Ministerial process, which, in general, relate to response times and access to ambulance services in remote areas.

In the NT Department of Health's (2011) Jurisdictional Consultation Response, in 2010 – 2011 there were seven complaints/incidents about the actions of SJANT paramedics. Of these, one relates to clinical care; three relate to treatment; and one relates to professional conduct when an impaired practitioner practiced as a paramedic while intoxicated by alcohol or drugs. There were a further two complaints/incidents identified in which the paramedic practiced at a standard which is below that accepted by the industry as evidenced by clinical error/poor skill.

There were three individual sentinel events, identified as relating (1) Clinical Care, (2) Treatment, and (3) Professional Conduct - Practiced as a paramedic at a standard which is below that accepted by the industry, i.e., involving clinical error/ poor skill.

It is unclear if the sentinel events are a cohort of the overall number of complaints/incidents or if they are in addition to the overall number.

QLD

In QLD complaints are lodged with the employer, QAS, such as via the website: http://www.ambulance.qld.gov.au/, or through other parties including the Minister for Emergency Services, the Ombudsman, Police and Coroner.

Between 22 June 2010 – 22 June 2011 87 complaints/incidents were reported, of which eight related to clinical care and/or treatment, nine relate to professional conduct, and 70 involved practice as a paramedic at a standard which is below that accepted by the industry in relation to clinical error/poor skill. The 70 sub-standard issues were assessed as being Level 3 Clinical Audit and Review Tool (CART). A Level 3 CART indicates a significant variation to documentation that could have lead to misunderstanding and patient harm and/or significant variation to clinical practice, skills performance or clinical judgement which could have resulted in harm but was a 'near miss'.

Between 22 June 2010 – 22 June 2011 12 sentinel events were identified, of which one was a professional conduct matter involving an impaired practitioner who practiced as a paramedic while intoxicated by alcohol or drugs. A further ten paramedics, involved in sentinel events, were found to have practised as a paramedic at a standard which is below that accepted by the industry in relation to clinical error / poor skill. These ten events were classified as CART Level 4. A Level 4 CART indicates a major variation to clinical practice, skills performance and / or clinical judgment or that resulted in harm to a patient, and/or practice outside scope of practice and/or authority. The remaining sentinel event involved a paramedic engaging in sexual misconduct in connection with their work. In QLD Root Cause Analysis (RCA) for sentinel events is required to be authorised by the Commissioner QAS who has the legislative authority for this action prescribed under the *Ambulance Service Act 1991* (QLD).

SA

Complaints about paramedics and other health professionals employed by SA Ambulance Service (SAAS) from members of the public may be made in accordance with the SA Health Policy directive "Consumer Feedback & Complaints Management and Policy Directive". SAAS is required to report all complaint and incident data to SA Health. This information is not made available to any other jurisdictions apart from the information that is in the public domain.

All complaints are categorised in accordance with the requirements of the National Health Complaints Information System. In 2010, there were 269 complaints received by SAAS. Of these, 110 relate to treatment, 33 involve professional conduct, 119 relate to communication and seven involve privacy/discrimination. The communication and privacy/discrimination complaints relate to the organisation as a whole, and are not all practitioner related.

In 2010, there were 401 clinical incidents reported, which includes internally reported incidents, (i.e. by practioners). Of the 401 clinical incidents reported, 201 relate to clinical management, 21 relate to medication error, 93 involved medical equipment; and 86 are classified as 'Other' which includes incidents relating to security, organisational management, blood products, oxygen/vapour/gas, stretcher collapse, behaviour/human, falls, documentation, accident/occupational health, building/fitting/fixture/surround and aggression/aggressor.

TAS

Complaints are made directly to the ambulance service, through the Minister for Health, or the Health Complaints Commissioner, Tasmania. The Health Department operates an electronic system for complaint and incident management, Data is generally not made available to the public unless the Health Department Secretary considers its release to be in the public interest.

In 2010 – 2011, 19 complaints/incidents were reported. Sixteen consumer complaints relate to 42 incidents, with a further three consumer complaints relating to professional conduct. There was one Sentinel Event reported, which was assessed as a Severity Assessment Code (SAC) 1.

The Department of Health and Human Services (2010) identify SAC 1 or 2 as including incidents that:

i. Affect health and wellbeing and result in:
   - Death or permanent injury that is unrelated to the ongoing health and wellbeing of the consumer and different from the immediate expected outcome of case management. Death or permanent injury may be:
     - Natural;
     - Accidental; or
     - Intentional.
   - Injury requiring admission to hospital, which may have resulted from:
     - Abuse;
     - Neglect;
     - Assault; or
     - Accident.
   - Permanent loss of function requiring an increased level of support; and
   - Theft or misappropriation of consumer funds.

ii. Affect the provision of services to consumers including:
   Complete or major loss of service, or significant service reduction due to;
   - An environmental event (fire, flood etc.) requiring:
     - evacuation and temporary or permanent closure; or
     - significant reduction in service.
   - A major external review that recommends closure or reduction in service provision or resources; and

- Financial loss, as a result of theft or misappropriation, that has a serious impact upon the community sector organisation's ability to provide services as described in the Funding Agreement (pp. 2-3).

VIC

In Victoria complaints are made directly to the individual service (employer), or to the Office of the Health Services Commissioner through the website, http://www.health.vic.gov.au/hsc/. An avenue is also available through Consumer Affairs Victoria but is likely to be less well used. The Department of Health receives and responds to a range of complaints regarding ambulance services, but statistics regarding numbers and categories are not collected. Sentinel events are reported to the Department's Quality, Safety and Patient Experience Branch.[12] The Victorian Office of the Health Services Commissioner collects and reports on complaints lodged about health service providers, including paramedics.

The Victorian Health Services Commissioner publishes an annual report that includes data on complaints handling. From July 2008 – June 2011, 258 complaints/incidents were made regarding the clinical care/treatment provided by paramedics. Of the 258 complaints/issues raised, 43 were substantiated. There were 12 professional conduct matters deemed as Level 1 incidents, five of which were classified as sentinel events requiring RCA. The 12 conduct matters involved practicing as a paramedic at a standard which is below that accepted by the industry in relation to clinical error/poor skill.

WA

St John Ambulance WA (SJAWA) measures complaints to commendations and analyses these as a proportion of total cases. The SJA website: http://www.ambulance.net.au/, is available for lodging complaints. Complaints made against paramedics are not made available to the public. A system for managing sentinel and adverse events has been developed in conjunction with the Department of Health and meets standards set by the Office of Safety and Quality in Healthcare. Commencing in 2011, sentinel and adverse events reported by SJAWA are incorporated into the annual WA Health Sentinel Event Report.[13] SJAWA also has a representative on the Peak Incident Review Committee which oversees sentinel events occurring in WA Health. SJAWA has an electronic tracking system to follow the progress of sentinel and adverse events, and holds regular Clinical Reference Forums.

From January 2010 – June 2011, 75 complaints/incidents were reported, 61 of which relate to clinical care; and 12 relate to treatment. A further two matters relate to professional conduct, whereby a paramedic practiced at a standard which is below that accepted by the industry in relation to clinical error / poor skill.

During the same period there were seven sentinel events, of which four relate to clinical care and three relate to treatment.

3.4.3 Analysis of jurisdictional complaints systems

Individual ambulance services have systems in place to deal with complaints or they can be made directly to the employer, the responsible government department or health complaints entity. Table 11 lists the health complaints entity for each State and Territory and the legislation under which the entity is established.

[12] www.health.vic.gov.au/divisions/hhsp/quality.htm

[13] www.safetyandquality.health.wa.gov.au/clinical_incid_man/sentinel_events.cfm

In their consultation response to the AHMAC *Consultation paper: Options for regulation of unregistered health practitioners* February 2011, PA expresses concern regarding the risks associated with the work of the paramedic sector and the difficulties in properly estimating the extent of this:

> There are cases in each jurisdiction where confidential settlements are reached and other cases settled by negotiation. Many practitioners moreover are bound by government or employer confidentiality constraints and there is no over-riding regulatory protection through a mechanism such as registration that would ensure effective external reporting. The result is that only the more egregious cases that enter the public spotlight normally attract attention and appropriate disclosure (p. 4).

Complaints concerning the ambulance service are about things such as delays in service and cost of the service. Complaints about paramedics are about professional conduct, poor communication, poor attitude or impairment through drugs, alcohol or illness.

At present, with the exception of NSW under the NSW Code of Conduct for unregistered health practitioners, there is no ability for this information to be shared across jurisdictions. However, this could change in the future once decisions have been made by AHMAC and AHWMC on the *Final report: Options for regulation of unregistered health practitioners*. The final report, considered by AHMAC in February 2012, has not been released.

As demonstrated above, there is no consistency in the collection, classification or handling of complaints made against paramedics. There is no doubt that information collected is incomplete, given the range of entities which collect, collate and analyse complaints. States and Territories also have different severity scales for classifying complaints, incidents and sentinel events. These issues present a problem when trying to review the current situation across Australia.

Table 11 Jurisdictional health complaints entity and establishing legislation

Jurisdiction	Health Complaints Entity
ACT *Human Rights Commission Act 2005*	Health Services Commissioner of Human Rights Commission
NSW *Health Care Complaints Act 1993*	Health Care Complaints Commission
NT *Health and Community Services Complaints Act*	Health and Community Services Complaints Commission
QLD *Health Quality and Complaints Commission Act 2006*	Health Quality and Complaints Commission
SA *Health and Community Services Complaints Act 2004*	Health and Community Services Complaints Commissioner
TAS *Health Complaints Act 1995*	Health Complaints Commissioner
VIC *Health Services (Conciliation and Review) Act 1987*	Health Services Commissioner
WA *Health Services (Conciliation and Review) Act 1995*	Office of Health Review

Whilst there is some information available about the health, conduct and performance of paramedics within government related ambulance services, there is no data available on complaints about paramedics employed in the private sector. The incidence of complaints may emerge as increasing numbers of paramedics move from employment within government related ambulance into a growing private sector employment base.

The lack of information available on complaints in Australia contrasts starkly with information that is available from the United Kingdom.

3.4.4 International experience – United Kingdom

Paramedics became regulated in the United Kingdom in 2000, under the Health Professional Council (HPC). On 29 February 2012, there were 219,918 health practitioners registered with the HPC, of which 17,829 are paramedics. Paramedics currently represent 8.1% of the total number of HPC registrants.

Since February 2005, the HPC has published the adverse findings of Conduct and Competence Committee inquiries.[14] In the last seven years, 162 Conduct and Competence Committee inquiry findings have been published in relation to the 15 health professions registered with HPC, 42 (25.9%) of these inquiries relate to the actions of paramedics. Of the 42 inquiries into the actions of paramedics, four cautions were issued (9.5%), on four occasions the paramedic was removed from the register (9.5%), on ten occasions the paramedic was suspended (24%), and on 24 occasions the paramedic was struck off the register (57%).

In 2010-2011, the HPC received 759 complaints about registered health practitioners, of which 188 (24.8%) related to paramedics. During this same time period, paramedics accounted for 7.8% of the total number of practitioners registered with HPC.

The HPC has established three committees to deal with health professional matters (HPC, n.d., p. 12):

- Conduct and Competence Committee which deals with misconduct, competence, criminal convictions or cautions, other regulator decisions and barring professionals
- Health Committee which deals with health matters which may be affecting the practitioner's ability to practice, and
- Investigating Committee for cases where Registration has been obtained fraudulently or incorrectly.

When looking at the inquiry information published by HPC, the number of adverse findings made against paramedics is at a disproportionate (higher) rate when compared to other health professions registered with HPC. There are 45 matters scheduled to be dealt with by HPC committees in March 2012, of which 12 (26.6%) relate to the health, conduct and/or competence of paramedics.

In examining each of the paramedic issues brought before the HPC's Conduct and Competence Committee, one of the most common themes to emerge is that the paramedic, whose practice comes under the scrutiny of their employer, resigns from their employment. Once a paramedic has resigned, the employer is unable to take any further action against that person, with the HPC being the only available course of action.

[14] www.hpc-uk.org/mediaandevents/pressreleases/

Whilst the information obtained from the HPC is useful in that actual cases and statistics are available in relation to actions actually taken against paramedics in the UK, because most complaints about paramedics in Australia are currently handled by employers, there is no data available to support or refute the same level or type of professional practice issues in Australia.

Table 12 UK HPC[15] Complaints by profession 2010 - 2011

Profession	Number of cases	% of total cases	Number of registrants	% of the register
Arts therapists	4	0.5	2,899	1.35
Biomedical scientists	37	4.9	22,627	10.52
Chiropodists / podiatrists	78	10.3	12,734	5.92
Clinical scientists	10	1.3	4,621	2.15
Dietitians	9	1.2	7,322	3.40
Hearing aid dispensers	44	5.8	1,587	0.74
Occupational therapists	62	8.2	32,126	14.94
Operating department practitioners	39	5.1	10,313	4.79
Orthoptists	0	0	1,303	0.61
Paramedics	188	24.8	16,782	7.80
Physiotherapists	104	13.7	45,002	20.92
Practitioner psychologists	118	15.5	17,165	7.98
Prosthetists / orthotists	1	0.1	901	0.42
Radiographers	40	5.3	26,615	12.37
Speech and language therapists	25	3.3	13,086	6.08
Total	**759**	**100**	**215,083**	**100**

[15] HPC 2011, p. 13, www.hpc-uk.org/aboutregistration/professions/.

Questions to assist with submissions

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

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

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

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

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

If so, please provide further details.

1.6. Do you know of instances where unqualified persons have been employed as a paramedic?

If so, please provide further details.

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

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

4. The objective of government action

The Council of Australian Governments' (COAG) Regulatory Impact Statement process must be undertaken in accordance with the COAG *Best Practice Regulation: A Guide for Ministerial Councils and National Standard Setting Bodies October 2007*. These guidelines are available at the following address: www.finance.gov.au/obpr/proposal/coag-guidance.html

Given the nature of the problems identified in this paper, the objective of government action is to:

- ensure an effective and efficient quality assurance system for the delivery of paramedic services, and
- adequately protect health service users within Australia from harm arising from paramedics who breach their legal and professional obligations and are not fit and proper persons to be providing health services. Such harm may be physical, psychological or financial.

Questions to assist with submissions

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

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

5. Options for regulation

5.1 Regulation

The Council of Australian Governments (COAG) 2007, *Best Practice Regulation: A Guide for Ministerial Councils and National Standard Setting Bodies* (p. 3) defines regulation as referring:

> to the broad range of legally enforceable instruments which impose mandatory requirements upon business and the community, as well as to those government voluntary codes and advisory instruments for which there is a reasonable expectation of widespread compliance.

As health practitioners, paramedics are generally subject to a range of laws which impact on and shape their practise. These include occupational licensing laws, health complaints laws, laws that regulate specific activities such as the use of medicines and therapeutic goods, public health regulation, consumer protection laws, employment laws, as well as criminal law, tort law (negligence) and the law of contracts. In addition, some jurisdictions have legislation specific to ambulance services, which incorporates paramedics.

However, there is little national consistency as to the range or extent of such regulation, with regulation of paramedics significantly varying between jurisdictions.

The evolving role of the paramedic raises questions as to the extent that current regulation can offer protection to the public.

Educational requirements and scope of practice also vary across jurisdictions, with these requirements resting largely with employers.

5.2 Overview of options

There are a number of options for regulatory reform. The following sections examine key options for consideration in the regulation of the paramedic profession:

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

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

Option 3: Strengthen State and Territory regulation of paramedics

Option 4: Registration of paramedics through the National Scheme

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

This option entails no change to existing health regulation. Under this option, existing statutory protections that have been enacted in NSW continue to apply, as will existing regulatory protections such as those available under the Australian Consumer Law, therapeutic goods, scheduled medicines, public health and health complaints laws, supported by the common law remedies for individuals to pursue action for negligence or breach of contract, and of course the criminal law.

Changes may be made over time to strengthen these existing regulatory regimes in individual States and Territories, or through nationally uniform schemes outside the health portfolio such as those introduced with the passage and adoption of the Australian Consumer Law.

Under the no change option, professional standards would be set out in a voluntary code of practice for paramedics, such as that developed by Paramedics Australasia. This option would allow paramedics and their representative bodies to continue to set their own professional and ethical standards.

Apart from existing Health Complaints Entity (HCE) powers to investigate complaints against paramedics and attempts to resolve or conciliate such complaints where appropriate, there would be no statutory body (except in NSW) with powers to investigate and prosecute and prohibit from practice paramedics who breach the voluntary code. Rather, professional associations would be encouraged to make observance of the code a condition of membership. Professional associations would also be responsible for monitoring observance of the code, and possibly report (via their annual reports) data on complaints received and how these have been resolved or managed.

Regulation covering ambulance services would continue in the States and Territories where it exists. NT and WA would continue without any defined legislation covering ambulance services.

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

This option was subject to a national consultation in 2011. For details of this option, see the AHMAC *Consultation paper: Options for regulation of unregistered practitioners, February 2011*.

Under this option, a nationally consistent and mandatory code of conduct would set out accepted professional standards of practice for paramedics. The code would apply in all States and Territories, and would specify standards along the lines of those of the *NSW Code of Conduct for unregistered health practitioners* (see Appendix 8).

Consumers would be able to make a complaint that a paramedic has failed to comply with the code of conduct. Following an investigation of the allegations, if the paramedic is found to have breached the code of conduct and the breach is serious enough, an order could be made prohibiting the paramedic from continuing to provide paramedic services, or attaching conditions to their practice. A register of prohibition orders would be publicly accessible on a website or websites, for consumers to access the details. Breach of a prohibition order would be a criminal offence, prosecutable through the courts.

Implementation issues such as the scope of the proposed scheme and its legislative and administrative arrangements are discussed in section 5.3 below.

Option 3: Strengthen State and Territory regulation of paramedics

Under this option, the regulation of paramedics would be strengthened by individual States or Territories, perhaps with a view to increasing the national uniformity of ambulance services legislation. Existing legislation could be amended as required, and those jurisdictions that do not have a statutory basis for the operation of their ambulance services (i.e. NT and WA) could enact legislation and regulations similar to those that apply in other jurisdictions.

Such an approach would allow for flexibility as to the scope of new or existing statutory schemes, which could be extended to regulate paramedics and paramedic practice more generally. Regulatory reform under this option could go beyond licensing schemes for ambulance services, for example, and address issues such as protection of the title 'paramedic', codes of conduct and minimum qualifications standards, and the collection and reporting of complaints and sentinel event data.

As legislation governing ambulance services already exists in some States and Territories to varying levels of effect, the schemes in those jurisdictions can be compared and considered to determine what level of regulation is desirable and appropriate, and successful schemes can be used as guidance for effective reform in other jurisdictions. The level of reform required may be different in each State or Territory.

Option 4: Registration of paramedics through the National Scheme

Under this option, *the Health Practitioner Regulation National Law Act 2009* (the National Law) would be amended to include the profession of paramedics as a regulated profession under the National Law. A National Board would be appointed by the Australian Health Workforce Ministerial Council, and a Register of Paramedics would be established, administered by the Australian Health Practitioner Regulation Agency. The National Board would have powers to set standards for registration as a paramedic which would include qualifications requirements and probity checking. The National Board would also have powers to receive and investigate complaints against registered paramedics, and to prosecute serious disciplinary matters before the relevant state or territory tribunal (or through the HCCC in NSW). If a paramedic was found to have engaged in professional misconduct as defined under the National Law, the tribunal would have the power to suspend or cancel their registration. The National Board would have a range of other powers to protect the public, including criminal history checking, monitoring of impaired registrants or those whose performance or conduct was unsatisfactory.

5.3 Discussion of options

Option 1: No change – rely on existing regulatory and non-regulatory mechanisms

Option 1 is the 'base case', with no regulatory changes to health legislation in response to the problems identified.

Under this option, existing regulatory protections would remain, such as those available under the Australian Consumer Law, therapeutic goods, scheduled medicines, public health and health complaints laws, supported by the common law remedies for individuals to pursue action for negligence or breach of contract, and of course the criminal law. Paramedics will continue to be required to comply with statutory codes, where they exist, and be subject to general consumer protection laws and employer regulation.

Existing HCE powers, to investigate complaints against unregistered health practitioners and attempt to resolve or conciliate such complaints where appropriate, would remain. Such powers would also continue to exist in NSW, under the NSW statutory 'Unregistered Health Practitioner' scheme. However, there would be no national statutory body with powers to investigate and prosecute and prohibit from practice any paramedic who breaches the voluntary code.

Under this option, professional standards for paramedics would continue to be under the existing voluntary code of practice, as developed by professional associations and other industry bodies that represent paramedics.

This allows paramedics and representative bodies, such as the Council of Ambulance Authorities and Paramedics Australasia, to continue to set minimum education, professional and ethical standards. Professional development activities would continue at the direction of the employer and agreed compliance with applicable Codes of Conduct would continue to be voluntary. Paramedical professional associations would continue to be responsible for monitoring observance of the code, and could report (via their annual reports) data on complaints received about paramedics and how these have been resolved or managed.

Paramedics with identified health, conduct or performance issues would be able to move between States and Territories. The responsibility for determining suitability for employment as a paramedic, including undertaking criminal history checks, would remain with the employer.

Under this option, jurisdictions will remain unable to share and compare non-public information about adverse outcomes arising from:

- internal and external enquiries concerning adverse and sentinel events
- litigation, or
- police and coronial investigations.

Within this option, there is no legislated protection for use of the title 'paramedic', which means that those without a basic or appropriate paramedic qualification will not be prohibited from using the title.

Whilst there would be no initial costs in terms of the development or amendment of any current legislation, such as health consumer and other laws, this may change as legislative amendments are required from time to time.

Benefits

The possible benefits of this option may include:

- there being no costs associated with additional regulatory or self-regulatory measures for paramedics, and
- flexibility to consider changing circumstances, such as where the scope of practice of a profession expands to include more high risk types of activities that may warrant greater public protection.

Costs

Potential costs associated with this option relate primarily to an employer's failure to deal in an effective and timely manner with paramedics who have serious (and on-going) health, conduct or performance issues that place the public at risk. These potential costs include:

- for employers – costs associated with:
    - dealing with paramedics who have serious health, conduct or performance issues that affect their ability to practice
    - recruiting paramedics who have left previous employers whilst under investigation for serious health, conduct or performance issues
- for individuals who suffer harm and their families – costs associated with pursuit of private actions for damages
- for the health system – costs associated with treating or caring for individuals (and their families) who have been harmed by paramedics, who continue to practice despite having serious health, conduct or performance issues
- for regulatory agencies responsible for enforcing the existing regulatory regime – costs associated with investigation and possibly prosecution of paramedics
- for the economy – costs associated with lost productivity of individuals unable to work due to harm suffered
- resourcing issues which may compromise the capacity of professional associations to apply and enforce a voluntary code in a fair, transparent and effective manner
- risks to the public associated with the actions of a paramedic who may have health, conduct or performance issues that make them unsafe to practice, and
- requirements to change associated legislations as required, from time to time, in some jurisdictions.

The no change option will not address the objectives of government to adequately protect the public by providing a cost effective mechanism for enforcing minimum professional standards and prohibiting persons who are not 'fit and proper' from practicing.

Is reliance on current regulation and professional code of practice sufficient?

At present, there is no restriction on use of the title 'paramedic'. Effectively, individuals who have completed short paramedic or first aid courses may, and do, call themselves a paramedic.

The NSW *Impact Assessment Statement on the Unregistered Health Practitioners Code of Conduct* found:

> While fair trading legislation and provisions in the Public Health Act dealing with false, misleading or deceptive advertising are able to address individual instances of this type of advertising, the processes involved in bringing these matters to conclusion can be lengthy and in many respects provide little if any ongoing protection for consumers (NSW Unregistered Health Practitioners Code of Conduct Impact Assessment Statement, 2008, p. 11).

There is a risk that relying on consumer protection legislation to deal with unethical conduct of paramedics may be insufficient to protect public health and safety.

Harm minimisation

The main difficulty with a voluntary code of practice is the lack of incentives for voluntary observance. With a non-binding code, practitioners can continue to practise if disciplined by or expelled from an association for misconduct. When self-regulatory arrangements fail and practitioners are not prepared to enter conciliation, the main option for aggrieved consumers is common law action.

If a practitioner is the subject of a complaint to their professional association and they choose not to cooperate with the investigation and disciplinary process, they may resign their membership (or let it lapse) and continue practising with no sanctions and few, if any, consequences. This has been a significant driver for many self-regulating professions to seek statutory registration.

Sylvan (2002) reported on the Australian Consumers' Association's assessment of four important self regulatory schemes and rated them on the basis of a number of criteria, including whether they had industry coverage, whether there was an open and participative consumer consultation process in the development of the industry code against which participants were regulated, whether the regulator had a balanced representative structure, whether there was public reporting of complaints, including statistics and public naming of poor industry performers, whether the disciplinary body had at its disposal a hierarchy of escalating complaints, and whether the scheme was subject to external audit (Sylvan p. 78).

Sylvan concluded that self-regulation should not be used where the market is characterised by information asymmetries, where consumers are dealing with non-experiential goods or services, where public health and safety is an issue, or in situations of limited competition – either natural monopolies or where a firm has achieved dominance (Sylvan p. 8). Self-regulation was considered to work best where it is underpinned in some way by the government, with an interested regulator in the background who has a 'big stick' to use, if necessary.

Implications of a statutory code of conduct applying only in some States and Territories

A statutory code of conduct for paramedics only applies in NSW at present. This results in a number of possible consequences.

First, health service users in jurisdictions without a statutory code will have fewer and arguably less effective avenues available for pursuing complaints against paramedics, and limited mechanisms for prohibiting from practice those paramedics found not to be fit and proper to provide health services.

Second, it is possible that paramedics in those jurisdictions where a statutory code applies may shift to another jurisdiction to avoid investigation and prosecution.

Third, where a prohibition order has been issued, it will have no effect outside the jurisdiction where it is issued, unless the laws provide for 'mutual recognition' of prohibition orders. Even where one jurisdiction recognises and applies, under mutual recognition, the prohibition orders of another jurisdiction, this is not a failsafe mechanism. The limitations of mutual recognition under (now repealed) State and Territory registration laws were evident when the National Scheme commenced. On transition to national registration, a number of registered health practitioners were found to have been registered in one jurisdiction while 'struck off' in another.

Questions to assist with submissions

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

Please explain the reason(s) for your answer.

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

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

Please explain the reason(s) for your answer.

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

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

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

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

Discussion regarding the adoption of a statutory code of conduct is set out in the AHMAC *Consultation paper: Options for regulation of unregistered health practitioners* February 2011 (pp. 26 & 31). This paper is available from the AHMAC website: http://www.ahmac.gov.au/cms_documents/Consultation%20Paper%20-%20Options%20for%20Regulation%20of%20Unregistered%20Health%20Practitioners.pdf

Under this option, a nationally consistent and enforceable code of conduct would set out accepted professional standards of practice for paramedics. The code would apply in all States and Territories, and would specify standards along the lines of those of the code of conduct for unregistered health practitioners in NSW and SA.

Consumers would be able to make a complaint that a paramedic has failed to comply with the code of conduct. Following an investigation of the allegations by a HCE, if the paramedic is found to have breached the code of conduct, and the breach is serious enough, an order could be made prohibiting the practitioner from continuing to provide health services, or conditions could be attached to their practice. A register of prohibition orders would be publicly accessible on a website or websites, for consumers to access the details.

This type of regulatory scheme, also known as a 'negative licensing scheme', would not set minimum standards for entry to the paramedic profession. Any concerns regarding a paramedic practitioner's health, conduct or performance would only come to light if a complaint was made to a HCE. This is likely to follow an incident of potential or real harm to a patient. Such a scheme could be based on the NSW Code of Conduct where ethical and legal obligations are currently in place for all unregistered health practitioners, including paramedics.

Within this option, there is no legislated protection for use of the title 'paramedic', which means that those without a basic or appropriate paramedic qualification will not be prohibited from using the title.

Benefits

The possible benefits of this option may include:

- minimum code of conduct acceptable to paramedics and the community
- standards developed for what is deemed a 'fit and proper person' to practise the profession of paramedicine
- paramedics being placed under some scrutiny with regards to health, conduct or performance issues, and
- provision for the scrutiny of the paramedics and, within the paramedicine health practice framework, allow prosecutions 'on the balance of probabilities'.

Costs

The possible costs associated with this option may include:

- those associated with the development and passage of new or amending legislation in each State and Territory
- establishment of a national regulator adopted as part of a national code of conduct, or an existing regulator taking on new functions, and
- investigation and prosecution of breaches of the code of conduct.

Policy and implementation issues

There are a number of policy and implementation issues that arise in relation to this option. These matters were considered in detail within the *Consultation Paper: Options for regulation of unregistered health practitioners February 2011*.

Under this option, the powers of existing State and Territory HCEs (other than in NSW) would be extended to issue prohibition orders for breach of a code of conduct. It would be up to each State or Territory to determine the body empowered to issue orders under legislation, such as the HCE itself (as in NSW), or an independent tribunal.

This option would build on existing State and Territory health complaints arrangements, including the power to investigate complaints against unregistered practitioners, providing a synergy of function and economies of scale with the existing HCE functions.

The enabling legislation would need to ensure that banning orders imposed by one State /Territory body would automatically apply in every other State and Territory, in order to deal with those practitioners who might be tempted to move states to avoid regulatory action. There are, however, concerns about the effectiveness of mutual recognition arrangements in dealing with practitioners who are mobile and are motivated to avoid regulatory scrutiny. As indicated in Option 1 above, limitations of mutual recognition under (now repealed) State and Territory registration laws were evident when the National Scheme commenced.

Questions to assist with submissions

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

4.2. Identify which organisation(s) could take on the role of regulator in your State or Territory

(Note – this does not apply in NSW where the HCCC has this function)

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

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

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

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

Option 3: Strengthen State and Territory regulation of paramedics

Under this option, the regulation of paramedics through ambulance services legislation would be strengthened by individual States or Territories. Those jurisdictions (i.e. NT and WA) that do not currently have a statutory basis for the operation of their ambulance services could enact legislation and regulations similar to those that apply in other jurisdictions. In addition, existing legislation could be amended as required.

Where employers are largely responsible for regulating paramedics and paramedic practice, as is currently the case throughout Australia, strengthening the regulation of ambulance services, as employers, may decrease the risk of harm to the public. At present, the regulation of ambulance services is different in each State or Territory, as discussed in Section 2. Government related ambulance services are usually administered by governments or operated under contract to governments, which may subject them to a reasonable amount of regulatory oversight. However, a number of privately-run ambulance services have been established around the country and may not be subject to the same level of regulation within a jurisdiction.

Strengthening and potentially homogenising the regulation of ambulance services would subject both private and public ambulance services to a higher level of regulatory oversight. This could be done through stringent conditional licensing schemes for ambulance services, as already exist in some jurisdictions. Mandatory requirements for the reporting of complaints and sentinel event data in annual reports, for example, could be established with a legislative basis within such schemes.

However, especially within the resources-rich states of WA and QLD, the paradigm of ambulance-based practice is outdated. While strengthened regulation of ambulance services would capture private operators of such services, an increasing number of paramedics are employed in industrial settings and on rural and remote mining sites, and within events management. To adequately address the risk of harm to the public by strengthening State and Territory regulation of ambulance services, that regulation would have to provide for coverage of paramedics working outside of government related ambulance services, either administered by government or operating under contract to government.

Through strengthening the regulation of ambulance services, it is possible to address a number of issues relevant to paramedics and paramedic practise more generally. Statutory schemes could include a number of components, the implementation of which could also provide for regulation of paramedics working outside of ambulance services:

- standardisation of complaints and sentinel event data collection and reporting
- protection of the title ‘paramedic’, and
- minimum qualification requirements for employment as a paramedic.

Such an approach would allow for flexibility as to the scope of new or existing statutory schemes, which could be extended to regulate paramedics and paramedic practice.

As described in section 2.2 of this document (Education and Training), CAA, the peak body for ambulance authorities, has a formal accreditation process for tertiary entry-level paramedic programs, to ensure that graduates from these programs have achieved the requisite competencies required for employment within an Australasian ambulance service, as an entry level Ambulance Paramedic. Although this is a voluntary process, it has been developed with rigor, using specialist academic and industry experts and linkages have been established with all the current and emerging higher education providers in Australia and New Zealand. Under this option, individual jurisdictions would be free to choose whether or not to adopt the CAA accredited

programs as the minimum education requirements for paramedics, which could then be included in ambulance service legislation.

Within this option, protection could be introduced for use of the title 'paramedic', which means that those without a basic or appropriate paramedic qualification, as determined by the appropriate mechanism in each jurisdiction, under ambulance legislation, would be prohibited from using the title.

Policy and implementation issues

The following is a summary of existing legislative provisions for ambulance services, which would need review to establish further regulatory mechanisms for paramedics.

Table 13 Issues of paramedic regulation under State and Territory ambulance and health service legislation

ACT- *Emergencies Act 2004*
Section 60 of the *Emergencies Act 2004* (ACT) defines ambulance services as 'the provision of medical treatment and pre-hospital patient care, and includes the transport of a patient by ambulance or medical rescue aircraft'. Persons must be approved to provide ambulance and emergency services (s.61), and the minister can impose conditions on the approval of such services (s.62(4)). An approval for the provision of services is a notifiable instrument (s.62(5)), and it is an offence to provide ambulance services without an approval (s.63). Therefore, under the *Emergencies Act 2004* (ACT), the ACT Government is potentially able to regulate the qualifications required by paramedics, as well as conditions about the quality of standards which could incorporate a code of conduct for non-ACTAS providers of emergency out-of hospital services.
NSW - *Health Services Act 1997*
Under the *Health Services Act 1997* (NSW), 'paramedical service' is included as part of the definition of 'health service'. Given that NSW has a comprehensive complaints management system for all unregistered health practitioners, including paramedics, the outstanding issues relate to the minimum qualifications required of a paramedic and protection of title.
QLD - *Ambulance Service Act 1991*
The *Ambulance Service Act 1991* (QLD) establishes the Queensland Ambulance Service (QAS) and provides for its administration. The *Ambulance Service Act 1991* (QLD) does not use the term 'paramedic' but refers to 'ambulance officers' as one type of 'service officer' within QAS, which means it does not provide for regulation of paramedics working outside of ambulance services. Division 4 confers a number of powers on the chief executive in relation to disciplinary action for service officers and former service officers, so that the chief executive can discipline a person in a number of ways for reasons such as incompetence, misconduct, substance abuse or contravention of a code of practice or code of conduct. Under Division 3, the chief executive can also require a person to disclose their previous history of serious disciplinary action. Part 4A of the *Ambulance Service Act 1991* (QLD) provides a comprehensive outline of the process for root cause analysis of reportable events that occur within QAS.

Table 13 Issues of paramedic regulation under State and Territory ambulance and health service legislation (continued)

SA- *Health Care Act 2008*
Under the *Health Care Act 2008* (SA), 'paramedical service' is included as part of the definition of 'health service'. Under Sections 57 and 58, a special license can be given to emergency and non-emergency ambulance services other than SAAS, with s.58(11) providing for the Minister to impose conditions on the approval of non-emergency ambulance services.
TAS - *Ambulance Services Act 1982* (TAS)
Under the *Ambulance Service Act 1982* (TAS), persons are not able to provide ambulance services without the written consent of the Director of Ambulance Services, with the Director having powers to impose conditions 'in relation to the provision of ambulance services by that person'. Under s.6(1) one of the functions of the Director is: (g) to determine the qualifications required to be held by, and the standards of experience, training, and efficiency required of officers of the Ambulance Service. Section 34 of the *State Service Act 2000* (TAS) provides for the functions and powers of heads of agencies, including the Ambulance Services of Tasmania. Under s.34(2): A Head of Agency may, with the approval of the Minister, make standing orders for the purposes of the administration and operation of the Agency.
VIC - *Ambulance Services Act 1986* (VIC) - *Health Services Act 1988* (VIC) - *Victoria State Emergency Service Act 2005* - *Non-Emergency Patient Transport Act 2003* (VIC)
Under Section 18 of the *Ambulance Services Act 1986* (VIC), one function of the board of an ambulance service is to monitor the performance of the service. This includes, for example, ensuring the adequacy of risk management systems and systems to monitor and improve the safety, quality and effectiveness of the service. Paramedics are primarily regulated by the framework of their terms of employment or engagement, and the guidelines or governance developed by Ambulance Victoria (AV). AV requires paramedics to have a Bachelor degree in paramedicine and tailored employment testing. Ongoing clinical assessment and participation in professional development through industry organisations and AV is mandatory. Paramedics working in the non-emergency patient transport field, whether employed by AV or a private organisation, are regulated by the *Non-Emergency Patient Transport Act 2003* (VIC), which establishes a licensing system for non-emergency patient transport service operators.
NT and WA
There is no current legislation specific to paramedics or ambulance services in the NT or WA. Therefore, consideration needs to be given to the establishment of legislation to control the operations of existing ambulance services. Issues that would need to be included are the minimum qualification required for a paramedic, code of conduct and protection of title.

Benefits

The possible benefits of this option may include:

- increased regulation of ambulance services, including those that are privately-operated
- legislative protection of the title 'paramedic'
- the public being assured that paramedics are appropriately educated and suitable to practice
- greater access to and transparency of standardised complaints and sentinel event data, increasing the accountability of paramedics and their employers

To maximise the benefits of this option, it may be desirable for State and Territory regulation of ambulance services to become more consistent across jurisdictions. Such reform would align with the COAG Intergovernmental Agreement and would promote standards of paramedic practise across the country. Further discussion on the desirability of national uniformity in this area is included below.

Costs

The possible costs associated with this option may include:

- those associated with the development and passage of new or amending legislation in each State and Territory
- those associated with the establishment and operation of standardised methods of complaints data collection and reporting, and
- those associated with the adoption and monitoring of a code of conduct for paramedics.

The costs involved in legislative reform are significant, especially when attempting to make legislation more consistent across jurisdictions.

National uniformity and diversity

Under Australia's federal system of government, diversity is to be expected and may even be desirable in some cases. With respect to regulatory schemes, there is a spectrum of uniformity, ranging from complete uniformity to no uniformity, with variations in between involving harmonisation, reciprocity (for example mutual recognition schemes), co-ordination of legislation and/or policy and mechanisms for exchange of information (The University of Melbourne 1999 p. 12).

When considering options for new or increased regulation of ambulance services within a federal system, it is necessary to consider what level of uniformity and coordination is necessary, appropriate and achievable to deal with the problems and achieve the desired outcomes. To what extent, for example, is it necessary or desirable for there to be:

- nationally uniform standards of conduct against which all paramedics are judged, regardless of the State or Territory in which they practise
- nationally uniform or nationally consistent policy and scope of a legislative scheme or schemes, and
- nationally uniform or nationally consistent arrangements through which breaches of standards of paramedic practise are investigated, prosecuted and determined.

The measures discussed under this option refer specifically to paramedics and each jurisdiction would be at liberty to consider taking such measures other than through the legislation that governs ambulance services in general.

Questions to assist with submissions

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

Please provide the reason(s) for your answer.

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

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

Please provide the reason(s) for your answer.

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

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

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

Option 4: Registration of paramedics through the National Scheme

The *Health Practitioner National Law Act 2009* (the National Law), includes objectives and guiding principles (Appendix 9). In addition, the National Law, Part 8, Health Performance and Conduct describes notifiable conduct and provides mechanisms by which matters of incident or complaint (known as notifications) may be reported to the National Board of the relevant health profession.

If the location of the incident was in NSW, the matter is referred to the HCCC. In adopting the national scheme, NSW elected not to adopt the national arrangements for managing complaints about practitioners, and notifications about poor performance and impairment issues. Accordingly NSW has retained the previous co-regulatory system which includes the HCCC as the independent investigator and prosecutor of serious complaints. The co-regulatory system requires that there be a professional regulation body, known as a Council akin to the former state boards, to receive and manage complaints in conjunction with the HCCC. Therefore the *Health Practitioner Regulation National Law* (NSW) establishes a regulatory council for each profession to undertake these functions. In all other jurisdictions, notification matters are reported to Australia Health Practitioner Regulation Agency (AHPRA), the organisation responsible for the implementation of the National Scheme.

Section 141 of the National Law requires all registered health practitioners who, in the course of practising their profession, form a reasonable belief that another practitioner has behaved in a way which constitutes notifiable conduct to report that conduct to AHPRA.

In Division 2, Mandatory Notification, (s.140) of the National Law provides the following definition of notifiable conduct:

> In this Division—
> notifiable conduct, in relation to a registered health practitioner, means the practitioner has—
> (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
> (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
> (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
> (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

The National Scheme provides a publicly available list of registered health professionals, a data base where members of the public, employers or other health practitioners can access current information concerning an individual's registration status and any conditions on his or her practice.

Registration aims to reduce the risk of unethical or fraudulent behaviour by applying fit and proper person requirements (to screen applicants for registration) and enforcing sanctions, for example, through deregistration. The purpose of regulatory oversight is to reduce health and safety risks and costs for consumers.

Consumers are likely to be more at risk when health practitioners use invasive techniques and equipment and carry out other types of high risk procedures (see Tables 7 and 8). If the incidence of harm associated with paramedics is small, the benefits of across-the-board registration will also be small. Therefore, the benefits to the community of extending the statutory registration regime to cover paramedics must outweigh the costs.

The National Scheme is self funded through the collection of practitioner registration fees. The National Law provides National Boards with extensive powers to regulate registered practitioners.

National Boards undertake probity checking of all applicants before deciding whether to grant registration, with all applicants being required to demonstrate that they are appropriately qualified and competent to practice.

The National Law, part 8, provides the full definitions of 'unprofessional conduct', 'professional misconduct', 'unsatisfactory professional performance' and 'impairment' (Appendix 10).

The National Scheme provides consistent and effective ways of dealing with practitioners who have professional conduct, practice or impairment issues. All professional misconduct matters are dealt with under the National Law by a tribunal, as constituted in each jurisdiction.

This option provides legislated protection for use of the title 'paramedic', with only those persons registered being able to use that title. Proof of registration, qualifications and any conditions or endorsements concerning areas of practice would be publically available on the AHPRA public website register. Any health, conduct or performance issues of a registered practitioner would continue to be managed irrespective of the jurisdiction in which they are working.

Depending upon the minimum educational standard required for registration, 'Grandfathering' will likely be required with regards to the existing workforce who may need to transition into any national registration scheme on the basis of 'equivalent' qualifications.

Should a decision be made to include paramedics in the National Scheme, amendments would be required to the National Law to incorporate paramedics. The National Law would then require the establishment of a national board for the profession of paramedicine. This could be achieved by the establishment of the Paramedic Board of Australia.

For paramedics to be included in the National Scheme:

- amendments will need to be made to State and Territory legislation. Amendments to the QLD Act flow on to State and Territory legislation, except in WA which will also need to amend its legislation
- additional infrastructure will be required within AHPRA to support the registration functions, and
- a national course accreditation process will need to be endorsed.

Implementation could follow the process undertaken for that is currently underway for the 2012 inclusion into AHPRA of Aboriginal and Torres Strait Islander health practitioners, Chinese Medicine practitioners, Medical Radiation practitioners and Occupational Therapists.

Under the National Scheme, ongoing administration costs for the National Board and AHPRA are required to be met by registration fees. However, the costs associated with the inclusion of paramedics in the National Scheme will need to be met by the State, Territory and Commonwealth Governments. Some of the costs to government will include:

- parliamentary sitting time, and
- establishment of a national board for paramedicine.

Benefits

The benefits associated with registration through the National Scheme may include:

- the public being assured that paramedics are appropriately educated and suitable to practice
- reduced risks to the public associated with the actions of a practitioner who may have health, conduct or performance issues that make them unsafe to practice
- establishment of a national board with the powers to deal with any registered practitioner who may have health, conduct or performance issues that make them unsafe to practice
- establishment of professional standards
- establishment of national minimal education standard for paramedics
- establishment of a national accreditation body for the assessment of educational qualifications leading to registration as a paramedic, and
- legislated protection for use of the title ‘paramedic’, with only those person registered being able to use that title.

Costs

The costs to paramedics associated with registration through the National Scheme may include:

- establishment costs that are generally met by governments, such as the cost of legislative drafting and parliamentary sitting time, the cost of establishing the infrastructure to support additional registration functions, the costs associated with establishing a registration board in advance of an available funding stream from registration fees
- ongoing costs of administering the regulatory regime, to be recovered from the registration fees paid by paramedics, and
- other compliance costs for individual paramedics, for example, the costs associated with achieving the qualifications necessary for initial registration, and the costs associated with meeting other regulatory requirements, such as maintaining professional competence, undertaking continuing professional development, and maintaining professional indemnity insurance.

The costs for registration under a National Scheme are determined by National Boards on an individual profession. The annual registration fees for the professions currently regulated under the National Scheme range from $115 for nurses and midwives, through to $650 for medical practitioners, with the unweighted average being around $385 a year.

Questions to assist with submissions

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

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

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

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

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

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

Questions to assist with submissions

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

Please provide the reason(s) for your answer.

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Appendix 1 - Health professions regulated under the National Law

Registered from 1 July 2010 (18 October 2010 in WA)
Chiropractors
Dental practitioners
Medical practitioners
Nursing and midwifery practitioners
Optometrists
Osteopaths
Pharmacists
Physiotherapists
Podiatrists
Psychologists
To be registered from 1 July 2012
Aboriginal and Torres Strait Islander Health practitioners
Chinese medicine practitioners
Medical radiation practitioners
Occupational therapists

Appendix 2 - Events relevant to this consultation on regulation of paramedics

Date	Event
1998	Release of NSW Parliament Joint Committee on Health Care Complaints Commission final report Unregistered Health Practitioners, The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints.
1999	Release of Victorian Department of Human Services report into the review of the *Ambulances Services Act 1996* (VIC).
2003	Release of Victorian Department of Human Services report, Regulation of the Health Professions in Victoria. A discussion paper, proposing a negative licensing scheme for unregistered health practitioners.
2005	Release of NSW Parliament Joint Committee on the Health Care Complaints Commission report Review of the 1998 Report into Unregistered Health Practitioners, The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints
December 2006	Passage of Health Legislation Amendment (Unregistered Health Practitioners) Act 2006 (NSW), amending various Acts to provide for the regulation of health practitioners who are not registered under a health registration Act.
March 2007	The Australian Health Ministers' Conference endorses a process and criteria for assessing the partially regulated and unregistered health occupations for future inclusion in the National Registration and Accreditation Scheme for the health professions.
May 2007	Release of South Australian Parliament's Social Development Committee report Bogus, unregistered and deregistered health practitioners which recommends expanding the Health and Community Services Commissioner's legislative powers to allow prohibition orders to be made against those practitioners who pose a substantial risk to public health.
January 2008	Release of NSW Health Unregistered Health Practitioners Code of Conduct Impact Assessment Statement
26 March 2008	The Council of Australian Governments (COAG) signs an Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions that includes arrangements for assessing unregistered health professions for inclusion in the National Scheme.
18 April 2008	Australian Health Ministers' Conference requests a paper addressing options for regulation of the unregistered health professions, in the context of the National Registration and Accreditation Scheme.
1 August 2008	NSW Code of Conduct for unregistered health practitioners made under the Public Health (General) Regulation 2002 (NSW), Schedule 3 comes into force.
October 2008	Release of the Inquiry into the management and operations of the Ambulance Service of NSW.
October 2009	Release of the WA St John Ambulance Inquiry Report to the Minister of Health.
December 2010	Release of the Queensland Ambulance Service Audit Report.
12 February 2010	Australian Health Workforce Ministerial Council (AHWMC) referred consideration of the inclusion of paramedics into the National Registration and Accreditation Scheme for the Health Professions to the Health Workforce Principal Committee for advice.

Appendix 3 - Intergovernmental Agreement Criteria - Guiding Principles

While it is acknowledged that occupational regulation may have a number of benefits, both for the occupation and for its individual practitioners, for the development of the criteria the following principles were adopted:

- the sole purpose of occupational regulation is to protect the public interest; and
- the purpose of regulation is not to protect the interests of health occupations.

Using these guiding principles six criteria were developed in the form of questions to address the issue of registration. Where appropriate, information to assist in addressing each criterion is also provided.

Note: It is considered that the occupation must meet all six criteria to be considered for registration.

THE CRITERIA

Criterion 1:

It is appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

Criterion 2:

Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

The following should be considered when assessing whether there is significant risk of harm to the health and safety of the public:

- the nature and severity of the risk to the client group
- the nature and severity of the risk to the wider public, and
- the nature and severity of the risk to the practitioner.

Areas which could be explored to identify a risk to public health and safety are:

- to what extent does the practice of the occupation involve the use of equipment, materials or processes which could cause a serious threat to public health and safety
- to what extent may the failure of a practitioner to practice in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), result in a serious threat to public health and safety
- are intrusive techniques used in the practice of the occupation, which can cause a serious, or life threatening danger
- to what extent are certain substances used in the practice of the occupation, with particular emphasis on pharmacological compounds, dangerous chemicals or radioactive substances, and
- is there significant potential for practitioners to cause damage to the environment or to cause substantial public health and safety risk. Epidemiological or other data, (for example, Coroners' cases, trend analysis, complaints), will be the basis for determining the demonstration of risk/harm.

Criterion 3:

Do existing regulatory or other mechanisms fail to address health and safety issues?

Once the particular health and safety issues have been identified, are they addressed through:

- other regulations, for example, risk due to skin penetration addressed via regulations governing skin penetration and/or the regulation of the use of certain equipment, or industrial awards
- supervision by registered practitioners of a related occupation, and
- self regulation by the occupation.

Criterion 4:

Is regulation possible to implement for the occupation in question?

When considering whether regulation of the occupation is possible, the following need to be considered:

- is the occupation well defined
- does the occupation have a body of knowledge that can form the basis of its standards of practice
- is this body of knowledge, with the skills and abilities necessary to apply the knowledge, teachable and testable
- where applicable, have functional competencies been defined, and
- do the members of the occupation require core and government accredited qualification.

Criterion 5:

Is regulation practical to implement for the occupation in question?

When considering whether regulation of the occupation is practical the following should be considered:

- are self regulation and/or other alternatives to registration practical to implement in relation to the occupation in question
- does the occupational leadership tend to favour the public interest over occupation self-interest
- is there a likelihood that members of the occupation will be organised and seek compliance with regulation from their members
- are there sufficient numbers in the occupation and are those people willing to contribute to their costs of statutory regulation
- is there an issue of cost recovery in regulation, and
- do all governments agree with the proposal for regulation.

Criterion 6:

Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Appendix 4 - Unregulated health professions considered in *Consultation paper: Options for regulation of unregistered health practitioners*, February 2011

The *Consultation paper: Options for regulation of unregistered health practitioners*, February 2011, considered some of the existing unregulated health professions, including:

- art therapists
- aromatherapists
- assistants in nursing
- audiologists and audiometrists
- ayuvedic medicine practitioners
- bioresonance practitioners
- cardiac scientists
- clinical perfusionists
- complementary and alternative medical practitioners
- counsellors and psychotherapists
- dental technicians (in States and Territories other than Queensland)
- dental assistants
- dietitians
- herbalists
- homeopaths
- hypnotherapists
- lactation consultants
- massage therapists
- medical scientists
- music, dance and drama therapists
- myotherapists
- naturopaths
- nutritionists
- optical dispensers
- orthoptists
- orthotists and prosthetists
- paramedics
- pharmacy assistants
- phlebotomists
- reflexologists
- reiki practitioners
- shiatsu therapists
- sleep technologists
- social workers
- sonographers
- speech pathologists (in States and Territories other than Queensland)

Appendix 5 – Paramedic levels and government related ambulance service employer requirements

ACT	
Level	**ACTAS Requirements**
Ambulance Paramedic	Diploma of Paramedical Science (Ambulance) or equivalent.
Intensive Care Paramedic	Advanced Diploma of Paramedical Science (Ambulance) or equivalent. ACT Ambulance Services (ACTAS) also accepts a Bachelor Degree plus an internal program of study leading to an ACTAS Authority to Practice.
NSW	
Level	**NSW AS Requirements**
Paramedic Trainee	Eight week induction course followed by nine months on road training with full supervision.
Paramedic Intern	12 months service (as Trainee) plus three weeks additional classroom training.
Paramedic	Three years (or equivalent) period of study, training and on-road practice and hold a Diploma of Paramedical Science (Vocational Education and Training (VET) qualification). Approximately 10% of the service staff has a tertiary qualification at baccalaureate level.
Casualty Access Team Paramedic	Qualified Paramedic with two years experience within ambulance and further training and qualification.
Intensive Care Paramedic	Hold an approved paramedic qualification plus Post Graduate Advanced Diploma in Paramedic Science (VET). Intensive Care Paramedics are accredited to perform clinical procedures and administer drug therapies above that of paramedics.
Extended Care Paramedic	Experienced paramedics who receive additional training in patient assessment and clinical decision making to enable them to identify low risk patients and offer them alternatives to emergency department care.
Rescue Paramedic	Qualified paramedic with two years experience within an ambulance service and further training and qualification.

NT	
Level	**SJANT Requirements**
Paramedic	Minimum of Diploma of Paramedical Science and successful completion of a range of case management exercises and panel assessment.
Intensive Care Paramedic	Diploma of Paramedical Science or an equivalent qualification with a minimum of two years post qualification whilst holding a current authority to practice at the paramedic level for at least two years. These candidates will then complete the Advanced Diploma of Paramedical Science (Ambulance) followed by a range of case management exercises.
QLD	
Level	**QAS Requirements**
Paramedic 1	Associate Diploma of Applied Science (Ambulance) with no additional skills or qualifications determined by the Commissioner, Queensland Ambulance Services (QAS) or: Certificate IV in Basic Emergency Care, or Basic Ambulance Care component of the Certificate IV in Basic Emergency Care and enrolled in the Diploma of Paramedical Science (Ambulance)
Paramedic 2	Associate Diploma of Applied Science (Ambulance): Additional skills as approved by the QAS (i.e. Manual Coronary Care) or qualifications determined by the Commissioner.
Paramedic 3 Advanced Life Support	Provides advanced care skills as per the QAS Clinical Practice Manual, acts as a clinical mentor for student paramedics and Paramedic 1 officers. Must hold a Diploma of Paramedical Science (Ambulance) or equivalent, with three years minimum experience in this field in a pre-hospital care emergency environment and currency of practice: Diploma of Health Science – post employment Diploma of Paramedical Science (Ambulance) – post employment Bachelor of Health Science (Paramedic Practice – pre employment
Paramedic 3 Extended Care	Associate Diploma of Applied Science (Ambulance) includes bridging program plus ISCEP, or: Diploma of Health Science (DHS), or Diploma of Paramedical Science (Ambulance), or Bachelor of Health Science (Paramedical) and QAS Extended Care program
Paramedic 4 Intensive Care	Must hold a Graduate Diploma in Intensive Care Paramedical Practice or equivalent and have a minimum of five years experience with two years full time as a qualified Paramedic 3, in a pre-hospital care environment and currency of practice.

SA	
Level	**SAAS Requirements**
Ambulance Responder	Certificate II trained volunteer emergency staff in regional areas – operate under defined practice protocols.
Ambulance Officer	Certificate IV trained volunteer emergency staff in regional areas. Career staff on patient transport and emergency support service – operate under defined practice protocols.
Paramedic	Degree (or equivalent) training – emergency ambulance workforce – operates via clinical practice guidelines.
TAS	
Level	**TASAS Requirements**
Paramedic Student	Undertaking Associate Degree or similar qualification.
Paramedic Intern	Holds a Bachelor of Paramedic Science or equivalent qualification approved by the service and works under the supervision of a paramedic.
Paramedic	Holds a Bachelor of Paramedic Science or equivalent qualification approved by the service.
Intensive Care Paramedic	Holds a Bachelor of Paramedic Science or equivalent qualification approved by the service plus additional qualification and relevant work experience as determined by the service.
Fixed Wing Flight Paramedic	Holds a Bachelor of Paramedic Science plus a Graduate Certificate in Emergency Health (Aero medical Retrieval) or equivalent.
VIC	
Level	**VIC AS Requirements**
Paramedic	Holds a recognised paramedic studies degree/equivalent and/or suitable experience.
Mobile Intensive Care Ambulance (MICA) paramedics	Advance level skills including complex management of patient conditions and injuries.
Air Ambulance Paramedics	Qualified and MICA paramedics.

WA	
Level	**SJAWA Requirements**
Ambulance Officer	Have completed one year full time of the Bachelor of Science (Paramedical Science) followed by 13 weeks of basic skills training with St John Ambulance (SJA). Spend nine months on the road training whilst completing further units of study.
Ambulance Officer Grade 1	Third year of the program, on the road training and undertake further competencies such as advanced life support and clinical placements (cannulation and intubation).
Ambulance Officer Grade 2	Fourth year of the program, complete their final degree units, including a four week training course with SJA.
Paramedic	Completed degree course.
Critical Care Paramedic	Further training required and selection for Critical Care Paramedic (Helicopter only).
Urban Search and Rescue (USAR)	Further training required and selection for USAR.

Appendix 6 - Health Complaints Entities - comparison of powers and functions across Australian jurisdictions

ACT - *Human Rights Commission Act 2005* *- Health Professionals Act 2004* *- Health Records (Privacy and Access) Act 1997*	
Commissioner	Health Services Commissioner of Human Rights Commission
Who can make a complaint	Human Rights Commission Act health service or older persons service complaint – anyone. Health Records complaint – a person.
Matters that may be the subject of a complaint	Health service complaint: • The service is not being provided appropriately or is not being provided • The person complaining believes that the provider of the service has acted inconsistently with specified standards, e.g. for health services: – the health code or health provision principles; – a generally accepted standard of health service delivery expected of providers of the same kind; – any standard of practice applying to the provider under the National Law or the or the *Health Professionals Act 2004*; etc. Health records complaint: • where there has been a contravention of the privacy principles in relation to a consumer; • a refusal to give access to a health record relating to a consumer; or • a refusal by a record keeper of a health record to give access to the health record
Complaints resolution functions	Complaints receipt and provision of complaints resolution process: • Conciliation including to binding agreement; • May compel parties to conciliation (offence to fail to appear); • Consideration of the complaint (separate from conciliation) to provide information that may be used to help conciliation of the complaint to work out whether the conduct complained about was engaged in the way complained about and whether there is adequate grounds for Commission to report; • Make recommendations in final report – note it is a strict liability offence (50 penalty units) not to advise the Commission of action taking following its recommendation. • Where the Commission considers a registered health professional's behaviour, it must give a copy of complaint and all related documents it gets to the relevant health profession board. (However it may continue to consider complaint); • May report to Minister on its own initiative.

ACT (continued)	
Other functions	In relation to health services and services for older people: • Encouraging and assisting users and providers of health services, and services for older people, to make improvements in the provision of services, particularly by encouraging and assisting service users and providers to contribute to the review and improvement of service quality; • Encouraging and assisting people providing services and people engaging in conduct that may be complained about under this Act, to develop and improve procedures for dealing with complaints; • Promoting community discussion, and providing community education and information about relevant matters; • Identifying, inquiring into and reviewing issues relating to the matters that may be complained about under the *Human Rights Commission Act 2005* and reporting to the Minister, and other appropriate entities, about each inquiry and review; • Advising the Minister about any matter in relation to the *Human Rights Commission Act 2005* (or a related Act; • Collecting information about operation of the *Human Rights Commission Act 2005* and related Acts, and publishing the information.
Ancillary bodies with complaints related functions	**Health profession boards** **Relationship with Human Rights Commission:** • Commission must consult with the board for a health profession in relation to a complaint made to the Commission under the *Human Rights Commission Act 2005* relating to a health professional in the profession. • In considering a report including a final review report relating to a registered health professional (i.e. a report that the practitioner has contravened a required standard of practice or does not satisfy the suitability to practice requirements) the board must consult with the commission. If the health profession board and the commission cannot agree about the action to be taken in relation to a report, the most serious action chosen by the board or commission prevails.
NSW - *Health Care Complaints Act 1993*	
Commissioner	Health Care Complaints Commission (HCCC)
Who can make a complaint	Any person.
Matters that may be the subject of a complaint	The professional conduct of a health practitioner or of a code of conduct prescribed under section 10AM of *Public Health Act 1991*), or A health service which affects the clinical management or care of an individual client and/or Against a health service provider.

NSW (continued)	
Complaints resolution functions	To receive and deal with the following complaints: • complaints relating to the professional conduct of health practitioners • complaints concerning the clinical management or care of individual clients by health service providers • complaints referred to it by a professional council under the National law. Assess to determine whether further action required and if so: • Investigate; • Conciliate; • Use voluntary resolution processes under Part 2 Div 9 • Refer to the Director-General (Department of Health) • Refer to professional council or other appropriate public health organisation or other body (s26) Where complaint concerns a health practitioner, after investigation the HCCC must consult with professional council and then: • refer the complaint to the Director of Proceedings; or • refer the complaint to the appropriate professional council (if any) for consideration of the taking of action under the National Law (such as the referral of the health practitioner for performance assessment or impairment assessment) or • make comments to the health practitioner on the matter the subject of the complaint, or • terminate the matter, • refer the matter the subject of the complaint to the Director of Public Prosecutions, • in relation to unregistered health practitioners, make a prohibition order under s 41A (where it finds the practitioner has breached code of conduct or been convicted of a serious offence and where it is of the opinion there is a risk to the health or safety of members of the public.
Other functions	*Prosecution functions:* Director of Proceedings, HCCC functions are: (a) to determine whether the complaint should be prosecuted before a disciplinary body and, if so, whether it should be prosecuted by the Commission or referred to another person or body for prosecution, (b) if the Director determines that the complaint should be prosecuted before a disciplinary body by the Commission, to prosecute the complaint before the disciplinary body, (c) to intervene in any proceedings that may be taken before a disciplinary body in relation to the complaint.

NSW (continued)	
Ancillary bodies with complaints related functions	**Health profession registration authorities** Registration authorities are responsible for the registration of health professionals. (s3A) **Professional councils** Professional councils are responsible for the management of complaints in conjunction with the Commission and protecting the public through promoting and maintaining professional standards.
NT - *Health and Community Services Complaints Act*	
Commissioner	Health and Community Services Complaints Commission
Who can make a complaint	A user of a health or community service or • in some cases, their representative, • an MP or the Minister or the Chief Executive of the Department or • in some cases, a person appointed by the Commissioner, • in some cases, a health or community service provider • any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint in the public interest
Matters that may be the subject of a complaint	That a provider acted unreasonably: • in providing a health service or community service or • by not providing a health service or community service, or • in the manner of providing a health service or community service; • by denying or restricting a user access to his or her records; • not making available to a user information about the user's condition that the provider was able to make available; • in disclosing information in relation to a user That the provision of a health service or community service or a part of a health service or community service was not necessary; That a provider or manager acted unreasonably in respect of a complaint made by a user about the provider's action not taking, or causing to be taken, proper action in relation to the complaint; or not properly investigating the complaint or causing it to be properly investigated. That a provider acted in disregard of, or in a manner inconsistent with the Code, Regulations etc. That an applicable organisation failed to comply with the Carers Charter.

NT (continued)	
Complaints resolution functions	Conciliate and investigate complaints Inquire into and report on any matter relating to health services or community services on receiving a complaint [or on a reference from the Minister or the Legislative Assembly]
Other functions	Inquire into and report on any matter relating to health services or community services on a reference from the Minister or the Legislative Assembly Encourage and assist users and providers to resolve complaints directly with each other; Record and keep a register of complaints; Suggest ways of improving health services and community services and promoting community and health rights and responsibilities; Review and identify the causes of complaints and to suggest ways: • to remove, resolve and minimise those causes or • of improving policies and procedures; and • to detect and review trends in the delivery of health services and community services; Consider, promote and recommend ways to improve the health and community services complaints system; Assist providers to develop procedures to effectively resolve complaints; Provide information, education, advice and reports.
Ancillary bodies with complaints related functions	**Health and Community Services Complaints Review Committee** **Health practitioner registration boards**

QLD - *Health Quality and Complaints Commission Act 2006*	
Commissioner	Health Quality and Complaints Commission (HQCC)
Who can make a complaint	For a health services complaint – a user, a person on behalf of a user (in some cases), the Minister or, if in the public interest, another person. (ss 40-41)
	For a health quality complaint – anyone (s38).
Matters that may be the subject of a complaint • **For a health services complaint:**	• That a provider of a health service (person or body or institution etc) has acted unreasonably by: – providing or not providing a health service for the user; or – in the way of providing a health service; or – in denying or restricting access to a user's health records to the user, or in disclosing information relating to a user; • That a registered provider acted in a way that would be a ground for disciplinary action under the National law. – That an entity providing a health service has acted unreasonably by not investigating or taking proper action in relation to a complaint.
• **For a health quality complaint:**	• The quality of a health service; • Any breach of duty of a provider (s20) to establish, maintain and implement reasonable processes to improve the quality of health services; and comply with any Commission standard.
Complaints resolution functions: • **For health services complaints:**	• receive, assess (to determine whether to accept) and manage; • encourage and help users to resolve complaints; • help providers to develop systems to effectively resolve complaints; • (for complaints it accepts): – conciliate or – investigate and produce a report with recommendations (e.g. may recommend a Board take action) or • if the complaint is about a registered health services provider, refer to the relevant registration board (if in the public interest).

QLD (continued)	
Complaints resolution functions: • **For health quality complaints:**	• respond to health quality complaints, including by conducting investigations and inquiries; • recommend ways of improving health services; • identify and review issues arising from health complaints. Conduct inquiries if in the public interest or as directed by the Minister.
Other functions	Develop Code of Health Rights and Responsibilities for consideration of the Minister Information, education and advise to users about health rights and responsibilities (s16) Suggesting ways of improving health services. Monitor and report on providers' compliance with section 20(1) (duty of a provider (s20) to establish, maintain and implement reasonable processes to improve the quality of health services; and comply with any Commission standard) Make **standards** relating to the quality of health services; Assess the quality o f health services and processes associated with health services; Promote continuous quality improvement in health services; Promote the effective coordination of reviews of health services carried out by public or other bodies; Receive, analyse and disseminate information about the quality of health services. Conduct inquiries if in the public interest or as directed by the Minister.
Ancillary bodies with complaints related functions	**Health profession boards** HQCC may refer complaints about a registered health services provider to the relevant registration board, if the Board is consulted and it is in the public interest (s66).

SA - *Health and Community Services Complaints Act 2004*	
Commissioner	Health and Community Services Complaints Commissioner
Who can make a complaint	A user of a health or community service or • in some cases, their representative, • an MP or the Minister or the Chief Executive of the Department or • in some cases, a person appointed by the Commissioner, • in some cases, a health or community service provider • any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint in the public interest.
Matters that may be the subject of a complaint	That a health *or community** service provider: • Has acted unreasonably: – by not providing or health or community service; – in the manner of providing a health or community service; – denying or restricting a user's access to records relating to the user; or – in not making available to a health or community service user information about the user's condition that the health service provider was able to make available; – in disclosing information in relation to a health or community service user to a third person; • Has provided all or part of a health or community service that was not necessary or was inappropriate. • Has failed to exercise due skill. • Has failed to treat a health or community service user in an appropriate professional manner. • Has failed to respect a health or community service user's privacy or dignity. • Has acted unreasonably by failing to provide a health or community service user with sufficient information or a reasonable opportunity to make an informed decision; or otherwise provided inadequate information about treatment, prognosis, further advice and education etc. • Has acted unreasonably by not taking proper action in relation to a complaint made to him or her by the user about a provider's action of a kind referred to in this section; • Has acted in any other manner that is inconsistent with the Charter of Health and Community Services Rights; • Has acted in any other manner that did not conform with the generally accepted standard of service delivery expected of a provider of the kind of service.

SA (continued)	
Complaints resolution functions	To receive, assess and resolve complaints, and where accept to: (a) Conciliate – including to enforceable agreement (Part 5); and/or; (b) Investigate and produce a report with opinions, comments and recommendations (Part 6); and/or (c) Consult with the registration body in relation to a complaint regarding a registered service provider and: – may refer with the agreement of registration body; – if they cannot agree – party that considers investigation is warranted may investigate or if both parties consider it warrants investigation, Commission may decide who investigates.
Other functions	To prepare and regularly review the Charter of Health and Community Services Rights; To identify and review issues arising out of complaints and to make recommendations for improving health and community services and preserving and increasing the rights of people who use those services; and To review and identify the causes of complaints and to— (i) recommend ways to remove, resolve or minimise those causes; and (ii) detect and review trends in the delivery of health or community services; and To provide information, education and advice To encourage and assist health and community service users to resolve complaints directly with health and community service providers; and to assist health and community service providers to develop or improve procedures to resolve complaints; and To inquire into and report on any matter relating to health or community services on the Commissioner's own motion or at the request of the Minister; and To advise, and report to, the Minister on any matter relating to health or community services or the administration or operation of this [*Health and Community Services Complaints Act 2004*] Act; and To provide information, advice and reports to registration authorities and to work with registration authorities to develop or improve procedures relating to the assessment and investigation of complaints and grievances.

SA (continued)	
Ancillary bodies with complaints related functions	**Health profession registration boards** – must deal with complains as referred **Health and Community Services Advisory Council** Functions include: Advising the Minister and Commissioner in relation to: • the redress of grievances relating to health or community services or their provision; and • means of educating and informing users, providers and the public on the availability of means for making health or community service complaints or expressing grievances • the operation of the Act; • any other matter on which the Minister requests the advice of the Council. • referring matters to the Commissioner.
TAS - *Health Complaints Act 1995*	
Commissioner	Health Complaints Commissioner
Who can make a complaint	A user of a health or community service or • in some cases, their representative, • an MP or the Minister or the Chief Executive of the Department or • in some cases, a person appointed by the Commissioner, • in some cases, a health or community service provider • any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint in the public interest

TAS (continued)	
Matters that may be the subject of a complaint	That a health service provider: • Has acted unreasonably: – by not providing or health service; – in the manner of providing a health service; – by denying or restricting access to records relating to the user or other information about the user's condition; or – in disclosing information in relation to a health service user; • provided a health service or of part of a health service was not necessary; • failed to exercise due skill; • failed to treat a user in an appropriate professional manner or user's privacy or dignity; • failed to provide user with sufficient information or a reasonable opportunity to make an informed decision; or otherwise provided inadequate information about treatment, prognosis, further advice and education etc. • acted unreasonably by not taking proper action in relation to a complaint made to him or her by the user; • acted in any other manner that was inconsistent with the Charter.
Complaints resolution functions	To receive, assess and resolve complaints: • May refer to the Ombudsman, a relevant registration board (after consulting the board) or other person more appropriate under a Tasmanian law; or • Conciliate (including to reach an enforceable agreement) unless there is a significant issue of public safety or public interest or a significant question as to the practice of a health service. • Investigate and produce a report

TAS (continued)	
Other functions	Prepare and regularly review a Charter of Health Rights Identify and review issues arising out of complaints and suggest ways of improving health services and preserving and increasing health rights; Provide information, education and advice in relation to – (i) the Charter; and (ii) health rights and responsibilities; and (iii) procedures for resolving complaints To encourage and assist health service users to resolve complaints directly with health service providers; To assist health service providers to develop procedures to resolve complaints; and To inquire into and report on any matter relating to health services at own discretion or on the direction of the Health Minister and to advise and report to the Minister and the Health Minister on any matter relating to health services or the administration of the [*Health Complaints Act 1995*] Act; and To provide information, advice and reports to registration boards.
Ancillary bodies with complaints related functions	**Health registration boards** (must investigate complaints referred)
VIC - *Health Services (Conciliation and Review) Act 1987* *- Health Records Act 2001*	
Commissioner	Health Services Commissioner (HSC)
Who can make a complaint	Health services complaint – A user, their representative or in some cases a provider. Health records complaint – an individual in relation to an interference of their privacy (including right of access to their health information)
Matters that may be the subject of a complaint	That a provider of a health service (person or body or institution etc) has acted unreasonably: • by providing or not providing a health service for the user; or • in the manner of providing a health service. That a health care institution has acted unreasonably by not properly investigating or not taking proper action in relation to a complaint made to it about a provider. Health records complaint - That there has been an act or practice that may be an interference with the privacy of an individual (i.e. breach of Part 5 of the Act relating to access to health information or a breach of the health privacy principles).

VIC (continued)	
Complaints resolution functions	Receive and Investigate complaints and: • review and identify causes of complaints, and suggest ways of removing causes; • conciliate between user and provider.
Other functions	Investigate any matter referred to the Commissioner by Parliament or a Committee, or the Minister or the Health Services Review Council (HSRC) (subject to the approval of the Minister) Provide advice to HSRC/refer issues to HSRC for advice Maintain register of complaints Publish info about complaints Determine what action has been taken by providers where complaints have been found to be justified Education, training and guidance about the prevention or resolution of complaints Conduct research into complaints relating to health services and mechanisms for resolving complaints relating to health services Issue guidelines under the Health Privacy Principles.
Ancillary bodies with complaints related functions	**Health Services Review Council (HRSC)** HSRC functions are to: • advise the Minister on the health complaints system and the operations of the Commissioner and • advise the Minister and the Commissioner on issues referred to it by the Commissioner. **Health profession registration boards** Related duties/functions of HSC: • have a duty to stop complaint where should be dealt with by Board or Victorian Civil and Administrative Tribunal. (Board must notify/copy to the HSC and, if agreed between Board and HSC that it is suitable for conciliation, may refer to HSC for conciliation).

WA - *Health Services (Conciliation and Review) Act 1995*	
Commissioner	Office of Health Review
Who can make a complaint	A user, a user's recognised representative or in some cases, a provider of a health service.
Matters that may be the subject of a complaint	• A public provider has acted unreasonably: – in providing not providing a health service for the user; • A provider has acted unreasonably in the manner of providing a health service for the user; – by denying or restricting the user's access to records kept by the provider and relating to the user; – in disclosing or using the users health records or confidential information about the user; • A manager has acted unreasonably in respect of a complaint made to an institution by a user about a provider's action which is of a kind mentioned in paragraphs (a) to (e) by not properly investigating the complaint or causing it to be properly investigated; or not taking proper action on the complaint; • A provider has acted unreasonably by charging the user an excessive fee; or otherwise acted unreasonably with respect to a fee; • A provider that is an applicable organisation as defined in section 4 of the *Carers Recognition Act 2004* has failed to comply with the Carers Charter as defined in that section. • A provider that is an applicable organisation as defined in section 4 of the *Carers Recognition Act 2004* has failed to comply with the Carers Charter as defined in that section
Complaints resolution functions	Undertake the receipt, conciliation and investigation of complaints; Provide advice on any matter relating to complaints under the Act, in particular— • advice to users on the making of complaints to registration boards; and • advice to users as to other avenues available for dealing with complaints. Refer a matter to a registration board if it relates to a registered provider and in the Director's opinion the complaint— (a) is not suitable for conciliation or investigation; or (b) should be dealt with by a registration board, (c) after consultation with that board; and (d) with the written consent of the person who made the complaint.

WA (continued)	
Other functions	Review and identify the causes of complaints, and to suggest ways of removing and minimizing those causes and bringing them to the notice of the public; Bring to the notice of users and providers details of complaints procedures; Assist providers in developing and improving complaints procedures and the training of staff in handling complaints; With the approval of the Minister, inquire into broader issues of health care arising out of complaints received; Publish information about the work of the Office. Investigate matters at the direction of the Minister. Maintain a register of complaints Take proceedings for an offence against the *Health Services (Conciliation and Review) Act 1995*.
Ancillary bodies with complaints related functions	**Health practitioner registration boards**

Appendix 7 - Jurisdictional complaints data

Each State and Territory has provided the following data on the numbers and types of complaints received in relation to paramedics. There is no national consistency on the type of data collected.

ACT	
ACT Ambulance Service (ACTAS) has a detailed complaints policy, and has recently established a new business unit -Quality Safety and Risk Management. There were two sentinel events reported in the ACT in 2010 and 2011. Both cases related to a skills performance/clinical judgment at a standard below that accepted in relation to clinical judgment/poor skill.	
Complaint / Incident Type - July 2010 - April 2011	**Number**
Review of Ambulance Account	67
Clinical	6
Attitude*	14
Attitude/ Clinical*	4
Response Times	4
Other	3
TOTAL	**98**

* indicates a new category introduced in 2011

NSW
In 2010 there were two complaints managed and resolved by the HCCC with respect to complaints made about paramedics in the NSW Ambulance Service. Previous years show similar low levels of complaints for this service. Data regarding complaints is made available to the public via the NSW HCCC web site, www.hccc.nsw.gov.au/Complaints/. **Data from 2009/2010** (Ambulance Service complaints) 78 matters were considered and of these, 50 matters involved serious allegations. In the first six months of the reporting year, 27 serious matters were finalised. Of these 23 matters were sustained or proved. Of these 14 resulted in disciplinary action, including eight officers whose employment was terminated or ceased as a direct result of the disciplinary proceedings. As a result of increased workplace awareness, and clearer referral procedures, an increased number of serious allegations are being reported. The above data provided by NSW Health includes complaints and sentinel events and cannot be separated into specific complaint types.

NT	
Complaint / Incident Type	**Number**
Clinical Care	1
Treatment	3
Professional Conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs)	1
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	2
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**7**
Sentinel Events	
Clinical Care	1
Treatment	1
Professional Conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs)	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	1
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**3**

QLD	
Complaints are lodged with the employer, Queensland Ambulance Service, such as via the website www.ambulance.qld.gov.au, or through other parties including the Minister for Emergency Services, the Ombudsman, Police and Coroner.	
Complaint / Incident Type – 22 June 2010 – 22 June 2011	**Number**
Clinical Care and/or Treatment	8
Professional Conduct	9
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error / poor skill leading to complaint or incident) **- Clinical Audit and Review Tool (CART) Level 3**	70
TOTAL	**87**
Sentinel Events – 22 June 2010 – 22 June 2011	
Professional Conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs)	1
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error / poor skill leading to complaint or incident) - **CART Level 4**	10
Engaged in sexual misconduct in connection with their work as a paramedic	1
TOTAL	**12**

CART – case auditing

Total audits: 81,838 (represents the auditing of 11.2% of all Ambulance Reports).

Variation Level 0: 74,484
Variation Level 1: 6,362
Variation Level 2: 912
Variation Level 3: 70
Variation Level 4: 10

CART - Audit variation levels definition

Variation Level 0

No deviation from clinical practice.

Variation Level 1

Minor variation from documentation standards.

Minor variation from clinical practice with justification, no harm to patients and within scope of practice and authority.

Variation Level 2

Significant variation from documentation standards.

Minor variation from clinical practice without justification, no harm to patient and within scope of practice and authority.

Variation Level 3

Significant variation to documentation that could have lead to misunderstanding and patient harm. Significant variation to clinical practice, skills performance or clinical judgement which could have resulted in harm but was a 'near miss'.

Variation Level 4

Major variation to clinical practice, skills performance and / or clinical judgment or that resulted in harm to a patient.

Practice outside scope of practice and/or authority.

Root Cause Analysis for sentinel events are required to be authorised by the Commissioner QAS who has the legislative authority for this action prescribed under the *Ambulance Service Act* (QLD).

SA
Complaints about paramedics and other health professionals employed by SA Ambulance Service (SAAS) from members of the public may be made in accordance with the SA Health Policy directive "Consumer Feedback & Complaints Management and Policy Directive". SAAS is required to report all complaint and incident data to SA Health. This information is not made available to any other jurisdictions apart from the information that is in the public domain.

Complaint / Incident Type*	**Number**	
	2009	**2010**
Clinical Care (Note - 2010 numbers are embedded in the treatment stats below)		
Treatment**	65	110
Professional Conduct**	37	33
Communication** (organisation as a whole, not all practitioner related)	100	119
Privacy/Discrimination** (organisation as a whole, not all practitioner related)	4	7
TOTAL	**206**	**269**

* This data only includes external complaints.

** Complaints are categorised in accordance with the requirements of the National Health Complaints Information System.

Clinical Incident* 2010	**Number**
Clinical Management	201
Medication Error	21
Medical Equipment	93
Other**	86
TOTAL	**401**

* This data includes internally reported incidents i.e. by practitioners

** Includes incidents related to security, organisational management, blood products, oxygen/vapour/gas, stretcher collapse, behaviour/human, falls, documentation, accident/occupational health, building/fitting/fixture/surround and aggression/aggressor)

TAS	
Complaints are made directly to the ambulance service or through the Minister for Health. The Health Department operates an electronic system for complaint and incident management which has been in operation for the past 12 months via the website, www.dhhs.tas.gov.au/contact. Data is generally not made available to the public unless the Health Department Secretary considers its release is in the public interest.	
Complaint / Incident Type	**Number**
Clinical Care	
Treatment	16 consumer complaints 42 incidents
Professional Conduct	3 consumer complaints
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs)	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	0
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**19**
Sentinel Events	**Number**
Clinical Care	0
Treatment	0
Professional Conduct	0
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs)	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	0
Engaged in sexual misconduct in connection with their work as a paramedic.	0
Other (please insert)	1 report as SAC 1
TOTAL	**1**

VIC	
Complaints are made directly to the individual service (employer), or to the Office of the Health Services Commissioner through the website, www.health.vic.gov.au/hsc/. An avenue is also available through Consumer Affairs Victoria but is likely to be less well used. The Department of Health receives and responds to a range of complaints regarding ambulance services, but statistics regarding numbers and categories are not collected. Sentinel events are reported to the Department's Quality, Safety and Patient Experience Branch.[16] The Victorian Office of the Health Services Commissioner collects and reports on complaints lodged about health service providers, including paramedics. The Victorian Health Services Commissioner publishes an annual report that includes data on complaints handling.	
Complaint / Incident Type – from July 2008	**Number**
Clinical Care/ Treatment Of the 258, 43 were substantiated, ie., 10.5 and 1.7 per 10,000 cases respectively	258
Professional Conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs)	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	0
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**258**
Sentinel Event (see below definitions)	**Number**
Clinical Care/ Treatment	0
Professional Conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs).	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident). Level 1 incidents, of these, five were deemed sentinel events and Root Cause Analysis was undertaken for each	12
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**12**
These Clinical Incidents have occurred at the rate of 0.05 and 0.02 per 10,000 cases respectively for the period June 2008 – YTD 2011. A Sentinel Event requires a Root Cause Analysis and findings are reported to the Board and Department of Health.	

[16] www.health.vic.gov.au/divisions/hhsp/quality.htm

WA	
St John Ambulance WA (SJAWA) measures complaints to commendations and analyses these as a proportion of total cases. The SJA website, www.ambulance.net.au, is available for lodging complaints. Complaints made against paramedics are not made available to the public. A system for managing sentinel and adverse events has been developed in conjunction with the Department of Health and meets standards set by the Office of Safety and Quality in Healthcare. Sentinel and adverse events reported by SJAWA are incorporated into the annual WA Health Sentinel Event Report (to commence in 2011).[17] SJAWA also has a representative on the Peak Incident Review Committee which oversees sentinel events occurring in WA Health. SJAWA has an electronic tracking system to follow the progress of sentinel and adverse events. SJAWA hold regular Clinical Reference Forums.	
Data from January 2010 – June 2011	
Complaint / Incident Type	**Number**
Clinical care	61
Treatment	12
Professional conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs).	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	2
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**75**
Sentinel Events	**Number**
Clinical care	4
Treatment	3
Professional conduct	
Impaired practitioner (practiced as a paramedic while intoxicated by alcohol or drugs).	0
Practiced as a paramedic at a standard which is below that accepted by the industry (clinical error/ poor skill leading to complaint or incident).	0
Engaged in sexual misconduct in connection with their work as a paramedic.	0
TOTAL	**7**

[17] www.safetyandquality.health.wa.gov.au/clinical_incid_man/sentinel_events.cfm

Appendix 8 – NSW Code of Conduct for unregistered health practitioners

Made under the Public Health (General) Regulation 2002, Schedule 3

1 Definitions

In this code of conduct:

health practitioner and ***health service*** have the same meaning as in the *Health Care Complaints Act 1993*.

Note. The *Health Care Complaints Act 1993* defines those terms as follows:

health practitioner means a natural person who provides a health service (whether or not the person is registered under the Health Practitioner Regulation National Law).

health service includes the following services, whether provided as public or private services:

(a) medical, hospital and nursing services,

(b) dental services,

(c) mental health services,

(d) pharmaceutical services,

(e) ambulance services,

(f) community health services,

(g) health education services,

(h) welfare services necessary to implement any services referred to in paragraphs (a)–(g),

(i) services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists, and psychologists,

(j) services provided by optical dispensers, dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers,

(k) services provided in other alternative health care fields,

(l) forensic pathology services,

(m) a service prescribed by the regulations as a health service for the purposes of the *Health Care Complaints Act 1993*.

2 Application of code of conduct

This code of conduct applies to the provision of health services by:

(a) health practitioners who are not required to be registered under the Health Practitioner Regulation National Law (including de-registered health practitioners), and

(b) health practitioners who are registered under the Health Practitioner Regulation National Law who provide health services that are unrelated to their registration.

Note. Health practitioners may be subject to other requirements relating to the provision of health services to which this Code applies, including, for example, requirements imposed by Part 2A of the Act and the regulations under the Act relating to skin penetration procedures.

3 Health practitioners to provide services in safe and ethical manner

(1) A health practitioner must provide health services in a safe and ethical manner.

(2) Without limiting subclause (1), health practitioners must comply with the following principles:

(a) a health practitioner must maintain the necessary competence in his or her field of practice,

(b) a health practitioner must not provide health care of a type that is outside his or her experience or training,

(b1) a health practitioner must not provide services that he or she is not qualified to provide,

(b2) a health practitioner must not use his or her possession of particular qualifications to mislead or deceive his or her clients as to his or her competence in his or her field of practice or ability to provide treatment,

(c) a health practitioner must prescribe only treatments or appliances that serve the needs of the client,

(d) a health practitioner must recognise the limitations of the treatment he or she can provide and refer clients to other competent health practitioners in appropriate circumstances,

(e) a health practitioner must recommend to his or her clients that additional opinions and services be sought, where appropriate,

(f) a health practitioner must assist his or her clients to find other appropriate health care professionals, if required and practicable,

(g) a health practitioner must encourage his or her clients to inform their treating medical practitioner (if any) of the treatments they are receiving,

(h) a health practitioner must have a sound understanding of any adverse interactions between the therapies and treatments he or she provides or prescribes and any other medications or treatments, whether prescribed or not, that the health practitioner is aware the client is taking or receiving,

(i) a health practitioner must ensure that appropriate first aid is available to deal with any misadventure during a client consultation,

(j) a health practitioner must obtain appropriate emergency assistance (for example, from the Ambulance Service) in the event of any serious misadventure during a client consultation.

4 Health practitioners diagnosed with infectious medical condition

(1) A health practitioner who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.

(2) Without limiting subclause (1), a health practitioner who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

5 Health practitioners not to make claims to cure certain serious illnesses

(1) A health practitioner must not hold himself or herself out as qualified, able or willing to cure cancer and other terminal illnesses.

(2) A health practitioner may make a claim as to his or her ability or willingness to treat or alleviate the symptoms of those illnesses if that claim can be substantiated.

6 Health practitioners to adopt standard precautions for infection control

(1) A health practitioner must adopt standard precautions for the control of infection in his or her practice.

(2) Without limiting subclause (1), a health practitioner who carries out a skin penetration procedure within the meaning of section 51 (3) of the Act must comply with the relevant regulations under the Act in relation to the carrying out of the procedure.

7 Appropriate conduct in relation to treatment advice

(1) A health practitioner must not attempt to dissuade clients from seeking or continuing with treatment by a registered medical practitioner.

(2) A health practitioner must accept the right of his or her clients to make informed choices in relation to their health care.

(3) A health practitioner should communicate and co-operate with colleagues and other health care practitioners and agencies in the best interests of their clients.

(4) A health practitioner who has serious concerns about the treatment provided to any of his or her clients by another health practitioner must refer the matter to the Health Care Complaints Commission.

8 Health practitioners not to practise under influence or alcohol or drugs

(1) A health practitioner must not practise under the influence of alcohol or unlawful drugs.

(2) A health practitioner who is taking prescribed medication must obtain advice from the prescribing health practitioner on the impact of the medication on his or her ability to practice and must refrain from treating clients in circumstances where his or her ability is or may be impaired.

9 Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not practise while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that detrimentally affects, or is likely to detrimentally affect, his or her ability to practise or that places clients at risk of harm.

10 Health practitioners not to financially exploit clients

(1) A health practitioner must not accept financial inducements or gifts for referring clients to other health practitioners or to the suppliers of medications or therapeutic goods or devices.

(2) A health practitioner must not offer financial inducements or gifts in return for client referrals from other health practitioners.

(3) A health practitioner must not provide services and treatments to clients unless they are designed to maintain or improve the clients' health or wellbeing.

11 Health practitioners required to have clinical basis for treatments

A health practitioner must not diagnose or treat an illness or condition without an adequate clinical basis.

12 Health practitioners not to misinform their clients

(1) A health practitioner must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or as to his or her qualifications, training or professional affiliations.

(2) A health practitioner must provide truthful information as to his or her qualifications, training or professional affiliations if asked by a client.

(3) A health practitioner must not make claims, either directly or in advertising or promotional material, about the efficacy of treatment or services provided if those claims cannot be substantiated.

13 Health practitioners not to engage in sexual or improper personal relationship with client

(1) A health practitioner must not engage in a sexual or other close personal relationship with a client.

(2) Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of their therapeutic relationship.

14 Health practitioners to comply with relevant privacy laws

A health practitioner must comply with the relevant legislation of the State or the Commonwealth relating to his or her clients' personal information.

15 Health practitioners to keep appropriate records

A health practitioner must maintain accurate, legible and contemporaneous clinical records for each client consultation.

16 Health practitioners to keep appropriate insurance

A health practitioner should ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.

17 Certain health practitioners to display code and other information

(1) A health practitioner must display a copy of each of the following documents at all premises where the health practitioner carries on his or her practice:

(a) this code of conduct,

(b) a document that gives information about the way in which clients may make a complaint to the Health Care Complaints Commission, being a document in a form approved by the Director-General of the Department of Health.

(2) Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.

(3) This clause does not apply to any of the following premises:

(a) the premises of any body within the public health system (as defined in section 6 of the *Health Services Act 1997*),

(b) private hospitals or day procedure centres (as defined in the *Private Hospitals and Day Procedure Centres Act 1988*),

(c) premises of the Ambulance Service of NSW (as defined in the *Health Services Act 1997*),

(d) premises of approved providers (within the meaning of the *Aged Care Act 1997* of the Commonwealth).

18 Sale and supply of optical appliances

(1) A health practitioner must not sell or supply an optical appliance (other than cosmetic contact lenses) to a person unless he or she does so in accordance with a prescription from a person authorised to prescribe the optical appliance under section 122 of the Health Practitioner Regulation National Law.

(2) A health practitioner must not sell or supply contact lenses to a person unless he or she:

(a) was licensed under the *Optical Dispensers Act 1963* immediately before its repeal, or

(b) has a Certificate IV in optical dispensing or an equivalent qualification.

(3) A health practitioner who sells or supplies contact lenses to a person must provide the person with written information about the care, handling and wearing of contact lenses, including advice about possible adverse reactions to wearing contact lenses.

(4) This clause does not apply to the sale or supply of the following:

(a) hand-held magnifiers,

(b) corrective lenses designed for use only in diving masks or swimming goggles,

(c) ready made spectacles that:

(i) are designed to alleviate the effects of presbyopia only, and

(ii) comprise 2 lenses of equal power, being a power of plus one dioptre or more but not exceeding plus 3.5 dioptres.

(5) In this clause:

cosmetic contact lenses means contact lenses that are not designed to correct, remedy or relieve any refractive abnormality or defect of sight.

optical appliance *has the same meaning as it has in section 122 of the Health Practitioner Regulation National Law.*

Appendix 9 - Health Practitioner Regulation National Law Act 2009 – Objectives and guiding principles

(1) The object of this Law is to establish a national registration and accreditation scheme for—

(a) the regulation of health practitioners; and

(b) the registration of students undertaking—

(i) programs of study that provide a qualification for registration in a health profession; or

(ii) clinical training in a health profession.

(2) The objectives of the national registration and accreditation scheme are—

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

(3) The guiding principles of the national registration and accreditation scheme are as follows—

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;

(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;

(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Appendix 10 - Health Practitioner Regulation National Law Act 2009 – Statutory definitions of 'unprofessional conduct', 'professional misconduct', 'unsatisfactory professional performance' and 'impairment'

As included in the National Law of each State and Territory

unprofessional conduct, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes—

(a) a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and

(b) a contravention by the practitioner of—

(i) a condition to which the practitioner's registration was subject; or

(ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and

(c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession; and

(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being; and

(e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and

(f) accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider; and

(g) offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner; and

(h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

unsatisfactory professional performance, of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.

professional misconduct, of a registered health practitioner, includes—

(a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession

impairment, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect—

(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or

(b) for a student, the student's capacity to undertake clinical training—

(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.

Appendix 11 - Response form

This form has been prepared to assist with the development of submissions relating to the Australian Health Ministers Advisory Council's Consultation paper: Options for regulation of paramedics.

Submissions can be provided by email or post and should be received by **3 September 2012**.

Email: workforce.projects@health.wa.gov.au

Post: Ms Carol Mirco
Project Manager
Policy and Planning Branch
Workforce Directorate - Department of Health, WA
PO Box 8172
PERTH BUSINESS CENTRE WA 6849

What organisation do you represent?

How many paramedics are employed/members of your organisation?

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

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

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

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

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

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

If so, please provide further details.

1.6. Do you know of instances where unqualified persons have been employed as a paramedic?

If so, please provide further details.

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

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

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

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

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

Options for regulation (Chapter 5 of consultation paper)

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

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

Please explain the reason(s) for your answer.

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

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

Please explain the reason(s) for your answer.

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

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

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

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

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

4.2. Identify which organisation(s) could take on the role of regulator in your State or Territory?

(Note – this does not apply in NSW where the HCCC has this function)

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

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

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

Option 3: Strengthen State and Territory regulation of paramedic

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

Please provide the reason(s) for your answer.

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

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

Please provide the reason(s) for your answer.

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

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

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

Option 4: Registration of paramedics through the National Scheme

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

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

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

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

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

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

Preferred option

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

Please provide the reason(s) for your answer.

Any other comments

Do you have any other comments to make?

Name:

Address:

Email:

Thank you for taking the time to make a submission.

Submissions will not be published. However, information provided will be used to inform any recommendations made in the Decision Making Regulatory Impact Statement.

1. Submissions may be made in confidence because they include personal or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth) or the *Freedom of Information Act 1982* (WA), which have provisions designed to protect personal information and information given in confidence.