Submission to:

Department of Health

Tasmanian Government

The Future of Health in Tasmania:

mobilising the forgotten health profession

A submission highlighting how paramedicine can be mobilised to support the delivery of health and care in Tasmania

Ray Bange OAM

July 2022

"In the short to medium term, increasing the healthcare workforce, bed capacity, resourcing primary care and general practice and the provision of alternative care pathways with additional diagnostic facilities in the community could ease the burden on our emergency departments.

But we also need to cast the net wider and earlier in the form of public health interventions at population level. Addressing the social determinants of health and initiating policies which will improve health outcomes will have an impact on hospital crowding in the long term."

Dr Niamh Cummins,
Lecturer in Public Health, School of Medicine,
University of Limerick

"The people I have with me are not funded through Medicare. I have a paramedic practitioner who works as my physician assistant. She can't bill through Medicare, so all of my earnings are important. If I allow her to see a patient, and I don't see them, they get seen for free.

I either have to see all of my patients and all of her patients, or we find another model where we can fund her, and we make legislative change where we can do that."

Dr Meg McKeown, Vice President, Rural Doctors Association of Tasmania,
Hansard Public Hearing Transcript, Rural Health Services Inquiry,
Tasmania, 26 November 2021.

Executive Summary

The overarching objective in healthcare should be the provision of the right care – at the right place – and at the right time, focusing on the needs of the patient.

Minimising the barriers to access will help to achieve those goals by encouraging early and appropriate patient engagement with the healthcare system.

Investment in primary healthcare is seen as a crucial factor in prevention and early management of care – particularly in the case of the chronic conditions that are already the major healthcare burden on an ageing society, and which are projected to increase.

To encourage early assessment and provide patient-centred care, the author advocates the philosophy of 'taking healthcare to the patient'.

Appropriate mobilisation of the paramedicine workforce is proposed to leverage the capacity of the GP cohort, enhance the opportunities for multidisciplinary care and increase overall health practitioner resources.

The submission recommendations include:

a) Recognising paramedicine as a key professional group within the health workforce.

b) Providing support for a review of the current ANZSCO classification of paramedic.

c) Incorporating paramedicine more extensively in workforce data collection and planning.

d) Removing unnecessary impediments to practice for paramedics to facilitate their engagement in primary care and elsewhere throughout the health system.

e) Appointing a Chief Paramedic Officer in the Department of Health at a senior policy level.

f) Ensuring access to financial incentives and support for paramedics in rural practice.

g) Supporting significant review and enhancement of the existing Australian Government Workforce Incentive Program – Practice Stream.

h) Providing information toolkits and other resources to Workforce Agencies, GP clinics and other healthcare agencies and service providers to guide them on how best to use the paramedicine workforce.

i) Supporting the creation of Community Paramedic roles, allowing patients to be comprehensively assessed, treated, or referred from their own homes.

j) Facilitating the creation of Paramedic Practitioner roles, with access to MBS/PBS provider programs, referral pathways, prescribing rights, electronic and other health records, and other elements of independent practice, to allow appropriately trained paramedics to directly serve local communities.

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The author

The author of this submission is Adjunct Associate Professor Ray Bange OAM, and the submission is made in a personal capacity. An independent policy advisor and Executive Committee member of the Australian Health Care Reform Alliance, Professor Bange is the recipient of an Order of Australia Medal awarded for contributions to paramedicine, education, and the community.

About this submission

On 6 June 2022, the Tasmanian Premier and Minister for Health released a key document for public consultation, outlining a vision for future healthcare within the state. The Exposure Draft of *"Our Healthcare Future: Advancing Tasmania's Health"* sets out a shared vision and policy direction for the future of health services in Tasmania over the next 20 years.[1]

This document is described as the first step in a comprehensive health system planning framework and sets an aspirational vision and policy direction for how healthcare will be delivered in Tasmania, now and over the next 20 years.

The Healthcare Future Exposure Draft sits alongside the *Healthy Tasmania Five-Year Strategic Plan: 2022-2026*[2] which was released in March 2022 to guide preventive health initiatives across all levels of government and in partnership with communities. A governance structure incorporating strong clinical and consumer participation is part of this vision.

The author agrees that robust clinical and consumer input will be essential to achieve better access to health services that deliver more cost-effective services with better quality and safety outcomes.

As part of the process of engagement, the Department of Health held a public consultation on the development of the Tasmanian Health Senate for which the author provided a submission.[3]

One of the dangers inherent in strategic reviews is the consideration of the status quo and entrenched perceptions of established models of care, workforce groups and professions - rather than examining the barriers to change and the options available to foster innovation and fill gaps in care. A common misperception held by the public and many health professionals is that paramedics work only for ambulance (aka paramedic) services.

A key aspect in realising the proposed strategic objectives are matters associated with the flexibility and development of the health workforce.[4] Workforce issues loom large as Australia enters a post-COVID-19 era where the health system must perform its essential functions subject to multi-level federated governance, funding, and regulation.

Successfully implementing the objectives of Health Workforce 2040 will require the Tasmanian Government, the private sector, and educational institutions to work in partnership to develop shared research, educational, recruitment and employment strategies and to mobilise scarce professional resources including the contributions from Allied Health Professionals (AHPs).

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[1] Department of Health, *Advancing Tasmania's Health: Exposure Draft*, State of Tasmania, June 2022. https://bit.ly/3aR6tv7

[2] Department of Health, *Healthy Tasmania Five-Year Strategic Plan: 2022-2026*, Tasmanian Government, March 2022. https://bit.ly/3QlLaCi

[3] Bange R, *Informing Health Policy and Practice,* The Paramedic Observer, Facebook, June 2022. https://bit.ly/3OEBTUB

[4] Bange R, *Health Workforce Strategy 2040 – Tasmania,* The Paramedic Observer, Facebook, 14 December 2021. https://bit.ly/3xNbyhn

Doing things differently and better

Australia's health system is facing significant challenges with rising demand for health services, driven by an ageing population, changing patterns of disease, and increasing multi-morbidity along with increasing patient expectations when faced with more complex and long-term care.

In November 2020, the Tasmanian Government announced a long-term reform agenda to consult, design and build a highly integrated and sustainable health service for Tasmania. The "*Our Healthcare Future: Immediate Actions and Consultation Paper"* released at that time highlighted the importance of having clinical planning that considers the community's needs for health services.

A companion document, "*Drivers of Tasmania's Future Population Health Needs*" provides further information on key trends which will influence health planning in the future.[5] Complementing this document is a health needs assessment paper published by Primary Health Tasmania.[6]

The Australian Government has announced a Primary Health Care 10-Year Plan which is intended to set a vision and path to guide future primary health care, as part of the Government's Long Term National Health Plan.[7] Under this long-term Plan, the Australian Government is committed to reforming the health system to be more person-centred, integrated, efficient, and equitable. The author notes that these commitments align with the Tasmanian Future Health proposals.

The Australian government's health agenda envisages increased investment in prevention and primary care; enhanced mental health and aged care provisions; a greater contribution from AHPs to community healthcare; and the implementation of new models of care.

The national primary health care plan outlines high-level policy goals and roles for a variety of professional groups working in primary health, including the development of innovative funding models for a range of primary health care services, covering allied health, non-dispensing pharmacists, nursing, mental health services and support for rural and remote communities.

Disconcertingly, there is little consideration by the Commonwealth of the role that could be played by the significant registered paramedic cohort and only recently has the Tasmanian Government included reference to paramedicine as an allied health workforce.[8]

The author supports the general thrust of the Exposure Draft strategy, with the caveat that the strategy must be a dynamic framework informed by the input of consumers, clinical, and operational staff, with regular reviews to inform progressive outcomes and the evolving directions of the strategy.

No one group holds all the answers, and this submission places a focus on the engagement of paramedicine across the health domain in achieving a shared vision of better health for all Tasmanians. It explores the mobilisation of paramedics in education, research, and service delivery through the medium of public services, private healthcare providers and individually.

It highlights the flexibility and capacity of registered paramedics to work independently in private practice and in multidisciplinary health service settings alongside other health professionals.

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[5] Department of Health, *Drivers of Tasmania's Future Population Health Needs*, Tasmanian Government, June 2022. https://bit.ly/3nCtipy

[6] Primary Health Tasmania, *Health in Tasmania: Primary Health Tasmania health Needs Assessment 2022-23 to 2024-25*, Primary Health Tasmania, November 2021. https://bit.ly/3QsDnTu

[7] *Draft recommendations from the Primary Health Reform Steering Group*, Department of Health, Australian Government, June 2021. https://bit.ly/3cVmjTR

[8] Bange R, *Health Workforce Strategy 2040*, The Paramedic Observer, Facebook, 14 December 2021. https://bit.ly/3uqCdhK

Primary Care and Allied Health

If the health system is to meet the challenges of the future, it will need to move beyond a concentration on specialist medicine and acute care beds, to a system that employs a diverse health workforce, and which has a stronger focus on primary and community care closer to home.

Despite access limitations, primary care remains the most immediate source of health services for many communities and particularly those in rural and remote regions. Primary care also plays a key role in reducing the load on tertiary hospital services and acute care and specialist services.

Workforce shortages in health broadly correlate with higher rates of chronic disease, potentially preventable hospitalisations, and shorter lives. In rural areas, local GP appointments may not be feasible due to a paucity of practitioners and long delays in obtaining appointments.

Difficulty in accessing primary health care often means that the first interaction with the health system for older people is for an acute episode, such as a stroke, heart attack or major fall.

Good primary health care services can help in preventing these acute events. An example of proactive care is the reduction of the burden of disease through health screening and health education that can be undertaken by paramedics.

The jurisdictional divide in healthcare funding and delivery unfortunately also sees little mention by the Australian Department of Health and Aging of the state and territory ambulance services which are significant patient contact points and service providers, especially for smaller communities.

GP services have typically consisted of medical practitioners, nurses, and administrative staff. Faced with complex arrangements for funding of practice-based AHPs, many medical practices have been slow to take account of changes in workforce education and capabilities and broader adoption of interdisciplinary practice through the enhanced scope of practice from an expert AHP workforce.

We need to engage a range of workforce disciplines and skills close to home, and to foster interprofessional practice to realise the best health outcomes. Generalist skills are needed in developing a multidisciplinary team approach that mobilises a range of practitioner competencies able to better address chronic conditions as our population ages.

In rural areas Registered Nurses, Nurse Practitioners and paramedics may be the most qualified local health professionals available to cater for unscheduled and acute care events. They are also the health professionals most able to complement and support a GP and maximise the patient care available from a health clinic through collaborative support and referrals.

AHPs can play a key part in primary care and the prevention, management, and treatment of chronic disease. However, despite their numbers and contributions to health, data on the AHP workforce and their services is sparse. While many expert bodies have called for better patient and practitioner data, it has not been forthcoming.

The registered paramedicine cohort

Paramedicine is a significant cohort within the AHP category and practitioners are widely distributed across Australia. Nonetheless, as noted above, detailed data on practice conditions are not available, and direct enquiries to the Australian Institute of Health and Welfare disclose that they have little engagement in the collection and analysis of data on paramedics and their practice.

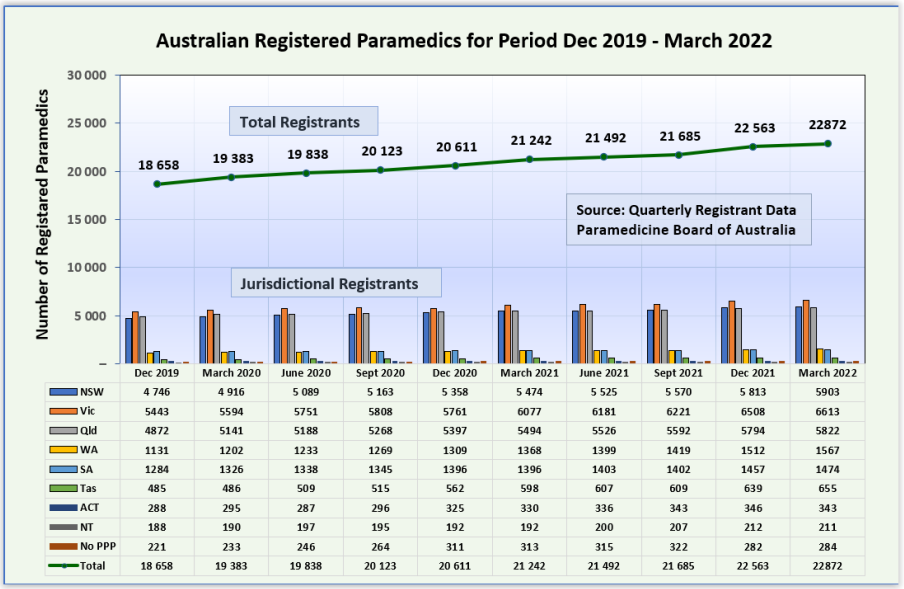
This data gap affects policy and decision-making and potentially disadvantages communities. It is difficult to assess the impacts of funding and other initiatives on the health system in the absence of relevant data. The situation is particularly bad for paramedicine, given that the profession currently has about 23,000 practitioners yet is consistently missing from document lists and statistics.

The most accessible workforce data on paramedicine are the basic statistics from the Australian Health Practitioner Regulation Agency and Paramedicine Board of Australia (PBA) registration data.

Related operational data for ambulance services (which employ many paramedics) are available from the annual Report on Government Services (ROGS) published by the Australian Productivity Commission. The report is based on data from member services provided by the Council of Ambulance Authorities.[9] Ambulance services also publish annual reports, but these have limited information on matters such as diversity and number of registered paramedics employed.

While the PBA regularly publishes the latest statistical summary of all registered paramedics, ROGS only covers the subset of paramedics employed by government-funded public ambulance services. It does not include military medics and other government services or the contribution of non-government-funded services from various private aeromedical and land-based service providers and individual practitioners working across other health settings from hospitals to industrial settings.

The PBA data is a limited dataset with age, gender, and jurisdictional location - but little published data on rurality or practice settings. Activity-level data is not collected through the Medical Benefits Scheme. More complete data is essential for effective health workforce planning.



	Dec 2019	March 2020	June 2020	Sept 2020	Dec 2020	March 2021	June 2021	Sept 2021	Dec 2021	March 2022
NSW	4 746	4 916	5 089	5 163	5 358	5 474	5 525	5 570	5 813	5903
Vic	5443	5594	5751	5808	5761	6077	6181	6221	6508	6613
Qld	4872	5141	5188	5268	5397	5494	5526	5592	5794	5822
WA	1131	1202	1233	1269	1309	1368	1399	1419	1512	1567
SA	1284	1326	1338	1345	1396	1396	1403	1402	1457	1474
Tas	485	486	509	515	562	598	607	609	639	655
ACT	288	295	287	296	325	330	336	343	346	343
NT	188	190	197	195	192	192	200	207	212	211
No PPP	221	233	246	264	311	313	315	322	282	284
Total	18 658	19 383	19 838	20 123	20 611	21 242	21 492	21 685	22 563	22872

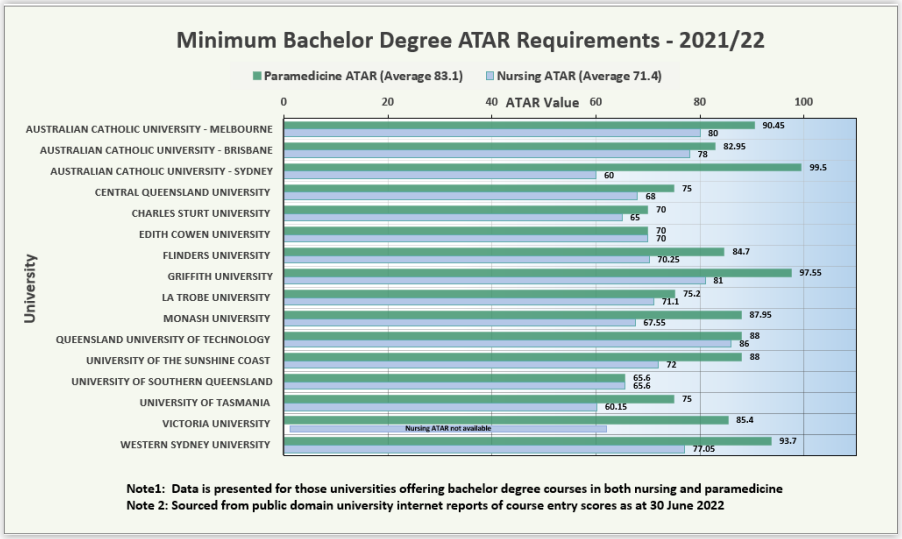
The PBA's most recent statistical summary of registered paramedics showed Australia had 22872 paramedics at the end of March 2022 with 655 in Tasmania.

Estimates for June 2021 prepared from PBA statistics and the annual ROGS report indicate that more than 6500 registered paramedics (~30%) did not work for jurisdictional ambulance services. Only estimates can be made because ambulance services do not transparently report the number of registered practitioners they employ and the COVID pandemic has distorted recent recruitment patterns that are not yet reflected in ROGS statistical reports.

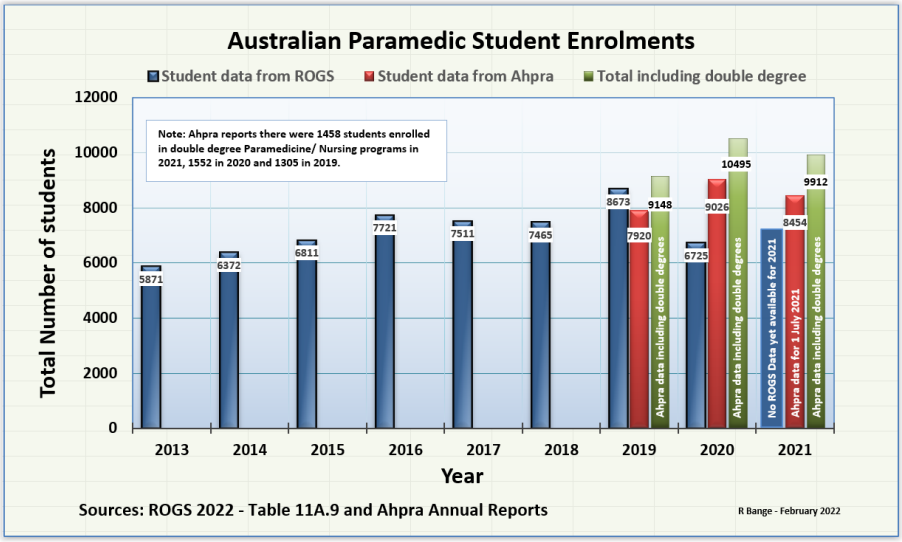
The number of paramedics employed in jurisdictional ambulance services will see an increase in 2022 because of significant recruitment under the COVID pandemic, the impact of recent Parliamentary inquiries, and recent boosts in health funding across jurisdictions including Tasmania.

[9] Productivity Commission, *Report on Government Services (ROGS)*, Australian Government, Canberra, 1 February 2022. https://bit.ly/34ppuSc

Paramedicine is a popular university program, with the number of Australian graduates annually substantially exceeding the past patterns of demand from the jurisdictional ambulance services.



Program popularity can be seen in the ATAR scores for those universities providing nursing and paramedicine courses. For this subset of enrolments, the paramedicine ATAR is consistently higher.



Nationally, university enrolments continue to grow steadily with a total of 8454 paramedicine students in 2021 (or 9912 if one includes students enrolled in double degree courses).

There are some discrepancies in data between the ROGS, the Australian Health Practitioner Regulation Agency and national Labour Force reports.

These discrepancies and poorly articulated descriptors in the Australian and New Zealand Standard Classification of Occupations (ANZSCO) reinforce the need for better data collection and a contemporary description of paramedicine as a registered health profession independent of employers - as was recently made clear by the Tasmanian government.[10]

[10] Bange R, *Tasmanian Health Legislation (Miscellaneous Amendments) Bill 2022,* The Paramedic Observer, Facebook, 7 May 2022. https://bit.ly/3ydasKF

There is no doubt about the sustainability of the paramedic workforce, with annual graduation rates now exceeding 2,500. Based on past recruitment levels, the author expects that as many as 1500 graduates annually will not gain immediate employment within the ambulance sector - adding to the number of practitioners already available to work elsewhere across the health sector.

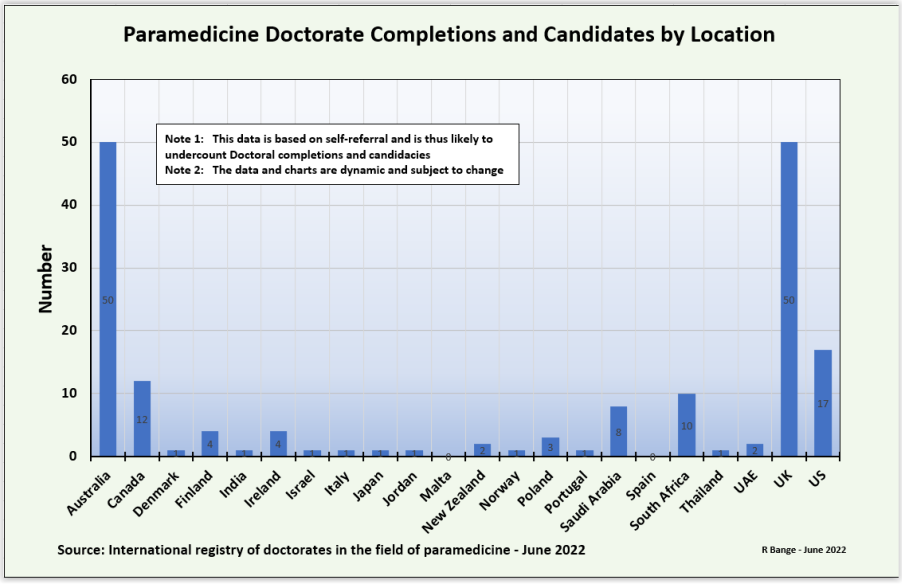
If these paramedics are not employed within health, there will be a significant loss in the human resources available for Tasmanian communities desperately seeking more health professionals. Many paramedics are moving offshore, and London Ambulance Service alone employs well over 500 paramedics recruited over recent years from Australia and New Zealand.

Not only do our communities suffer from this loss of expertise, but the inability to apply their hard-won knowledge and skills is a grievous blow to the self-funded graduate paramedics who may have spent $30-40,000 and several years on their undergraduate and postgraduate university education.

Supporting paramedicine research

Not commonly appreciated are the leadership activities and advanced research being undertaken by paramedics, where Australia and New Zealand are leading programs of research at Master's, Doctoral and post-Doctoral levels. This research is being conducted at universities and in conjunction with ambulance and other health and care services throughout both countries.

Paramedics are recipients of multiple Churchill Fellowships and other significant awards, including a national Westpac Future Leaders Scholar award in 2022.[11] A recent New Zealand example is the Te Tohu Whaioranga Rangahau (Tauira Rata Excellence in Research) award by the TeOhuRata (Māori Medical Practitioners Association) for work on understanding and improving patient experience.



Tasmania should ensure that the profession is fully engaged and supported to continue the ground-breaking work by paramedics that is already improving the health of patients with better care as research is translated into practice. This research may be fostered by proactive involvement of paramedics within the health system and sponsorship of funding and wider aggregation and sharing of data to inform research.

[11] *Westpac Future Leaders Scholar: Matt Wilkinson-Stokes,* Westpac Scholars, 2022. https://bit.ly/3adlF65

A case study – vaccination

Despite having the capacity to increase the available primary care health workforce by mobilising the paramedicine cohort, the employment of paramedics across health has been inhibited by numerous impediments to practice, many of which are a hangover from a bygone era.

Not least is the ingrained perception that paramedics work only with ambulance services, thereby overlooking the tertiary educational pathway and scope of contemporary paramedic practise, which sees advanced clinical interventions within the skillset of today's registered paramedics.

Existing funding and regulatory arrangements also constrain flexibility in terms of employment and engagement in both routine and innovative models of care; they limit the capacity for team-based care; they present financial and professional barriers to practice.[12, 13]

A key public health issue arising from the COVID-19 pandemic is that of vaccination. In 2017 the author proposed that Australian jurisdictions review the legislative and policy restraints dealing with paramedics administering vaccines. With only nominal cost impacts, this move could have seen the removal of existing impediments to enable paramedics to become vaccinators if they wished.

The proposed steps were intended to empower registered paramedics as being eligible health professionals to become vaccinators - subject to the same training and certification requirements as (say) nurses and nurse practitioners. Governments have been slow to respond.

Some dual-qualified (e.g., paramedicine/medicine, paramedicine/nursing) practitioners do hold the requisite vaccination certification via their alternate registration. In Victoria, emergency orders have been promulgated to authorise paramedics (and others) as vaccinators in response to COVID-19.[14]

Paradoxically, paramedics have been deployed to support vaccination staff in the rare event of adverse reactions and several paramedics have held key roles in Australia's vaccination response. An example is paramedic Toby Keene (PhD) who is the Senior Director, Case Management and Outbreak Response (COVID-19 Response) with ACT Health Canberra. Dr Keene previously held the positions of Director Outbreak preparedness and Response (COVID-19 Response) with ACT Health and Assistant Director, Immunoglobulin with the National Blood Authority Australia.

The key issue is that different jurisdictions have provisions under their various regulations covering vaccination that effectively restrict paramedics from even undertaking the minor training needs that are well within their capabilities as health practitioners.

The regulatory provisions regarding vaccination are examples of where Tasmania can take a lead in removing unnecessary barriers that are disincentives to paramedic practice.

Many other practice restrictions are unchanged from years ago – and their existence reflects the consequence of job descriptions and specifications often being built around professional silos - with paramedicine and other AHPs being forgotten when it comes to workforce planning and staffing (also see page 19).

[12] McKeown M, *Hansard Transcript of Evidence*, Vice President, Rural Doctors Association of Tasmania, Inquiry into Rural Health Services in Tasmania, 26 November 2021. https://bit.ly/3nDsWPJ

[13] Nott S, *Hansard Transcript of Evidence*, Rural Health Director of Medical Services NSW, Inquiry into Rural Health Services in Tasmania, 17 May 2022. https://bit.ly/3Gt4o4C

[14] Bange R, *COVID-19 vaccination - Victorian paramedics*, The Paramedic Observer, 24 March 2021. https://bit.ly/3L7v9fT

Embedding paramedicine in primary care – the ARRS

In England, GP practices work together with mental health, social care, pharmacy, hospital, and voluntary services in their local areas in groups of practices known as Primary Care Networks (PCNs).[15] The PCNs are analogous to the Australian Primary Health Network (PHN).[16]

PCNs build on existing primary care services and enable personalised, coordinated and more integrated health and social care for people close to home. Clinicians describe this as a paradigm change from reactively providing appointments to proactively caring for people.

More than 99% of GP practices in England are part of a PCN, who sign up to the Network Contract Directed Enhanced Service which details their core requirements and entitlements.

A significant component of the GP contract agreement is the Additional Roles Reimbursement Scheme (ARRS). The ARRS provides for the addition of reimbursable practice roles to enable each PCN to add various AHPs to make up the multidisciplinary workforce they need. PCNs can decide the distribution of roles required and are encouraged to engage community-based partners if they don't directly engage a practitioner.

The reimbursable roles are clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics. The selection of these professions is based on there being sufficient supply and because the tasks being performed will help reduce GP workload, improve practice efficiency, and deliver NHS Long Term Plan objectives.

By 2024, paramedics are expected to have become an integral part of the core general practice model throughout England. Yet Australia does not even recognise paramedicine in primary care.

An underlying feature of the ARRS is the recognition of AHPs as a valuable part of the primary care team, while the specific nomination of first contact community paramedics acknowledges the role of paramedicine in primary care and multidisciplinary teams.

> *"Paramedics have so many complementary skills and in primary care, there are many areas where paramedics can complement the rest of the primary care team, not least acute care, but also, domiciliary visiting and follow up to the same that may well enable patients to stay in their own home rather than be admitted to hospital. In addition, this framework offers an opportunity for paramedics to develop their skills and develop more sustainable careers."*
>
> *Professor Simon Gregory,*
> *Director of Education and Quality,*
> *Health Education England*

This multidisciplinary practice regime is consistent with the move towards supporting an aging population and caring for increasingly complex patients with chronic conditions by providing care close to home and keeping more people out of hospitals.

Such approaches are increasingly being adopted overseas[17, 18, 19] and represent a strategy of community engagement that the author recommends Tasmania implement.

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[15] *Primary care networks explained*, TheKing'sFund. https://bit.ly/3maa3CK

[16] *What Primary Health Networks are*, Department of Health, Australian Government. https://bit.ly/39UbSxM

[17] Bange R, *Paramedics and Palliative Care in Canada*, The Paramedic Observer, Facebook, 28 June 2022. https://bit.ly/3bRXdrq

[18] Bange R, *Paramedicine and palliative care,* The Paramedic Observer, Facebook, 6 March 2022. https://bit.ly/3nDQL9W

[19] Bange R, *Community paramedicine evaluated in Ontario*, The Paramedic Observer, Facebook, 14 May 2019. https://bit.ly/3yAwYNZ

Fostering the engagement of paramedicine with General Practice

For better care and sustainability, funding models need to be flexible to make it easier for rural GPs, nurses and midwives, dentists, pharmacists and other AHPs to provide primary health care across the gamut of health including mental health, disability services, aged care and palliative care.

Mechanisms are needed that recognise the totality of the health workforce and the roles the various professions can play in delivering these health services that ensure the wellbeing of people.

Past funding arrangements have favoured acute care to the detriment of primary health care. The arrangements constrain flexibility in terms of employment, the scope of practice and models of care; limit the capacity for team-based care; and present financial and professional barriers to health professionals, especially those who work in rural and regional Australia.

Innovations might include a range of funding models including modified fee-for-service; activity-based funding and bundled payments; capitation; blended funding; or pooled funding.

An Australian model that partly reflects the ARRS framework is the Australian Government Workforce Incentive Program - Practice Stream (WIP).[20, 21] This scheme is administered by Services Australia and provides financial incentives to help general practices with the cost of engaging nurses, AHPs and/or Aboriginal and Torres Strait Islander health workers and health practitioners. While the WIP offers a mechanism to develop a multi-disciplinary, patient-centred health system, it is complex and limited in scope.

The form of engagement is determined by the practice and the eligible health professional, and the arrangement may be through direct employment, contracted, casual or other means. The full cost of engaging some health professionals is not covered by the incentive payments and other complex eligibility conditions apply (for details of the WIP see the full Guidelines).

It's notable that the general description of the scheme provides a listing of 15 AHPs and uses the terminology of 'including'- but the WIP Guidelines unambiguously list the same 15 professions as being the specific eligible professions (Section 1.3 page 27). Neither list includes paramedicine which is one of the most complementary professions available for many GP practices.

Another support scheme is the Health Workforce Scholarship Program administered by the Rural Doctors Workforce Agency Network (represented in Tasmania by the HR+ agency in Launceston), which is available for eligible health professionals looking to upskill their skills and services. Here again the Guidelines (inconsistently) omit paramedicine from the list of eligible health professions.

Paramedics can rapidly and independently assess situations and patients, diagnose and make decisions, intervene, manage and develop operational plans. Paramedics communicate well with GPs and nurses and are known for their empathy with patients. The evidence from many pilot studies locally and overseas is that community paramedic programs have been highly successful.[22]

These omissions of paramedicine have significant ramifications, including the loss of benefits that could flow from the strategic mobilisation of an expert available workforce that is already highly respected from its engagement with ambulance services. It's an omission that dramatically reflects the forgotten status of the profession when it comes to workforce planning and utilisation.

It's a situation that must change through the explicit formal recognition of paramedicine.

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[20] *Workforce Incentive Program Practice Stream*, Department of Health and Aged Care, Australian Government. https://bit.ly/3mtqhao

[21] *Workforce Incentive Program Guidelines*, Department of Health and Aged Care, Australian Government, 1 January 2020. https://bit.ly/3Aj4gQp

[22] Nolan MJ, Nolan, KE, Sinha,SK, *Community paramedicine is growing in impact and potential*, Canadian Medical Association Journal, 28 May 2018. https://bit.ly/3FtwVG3

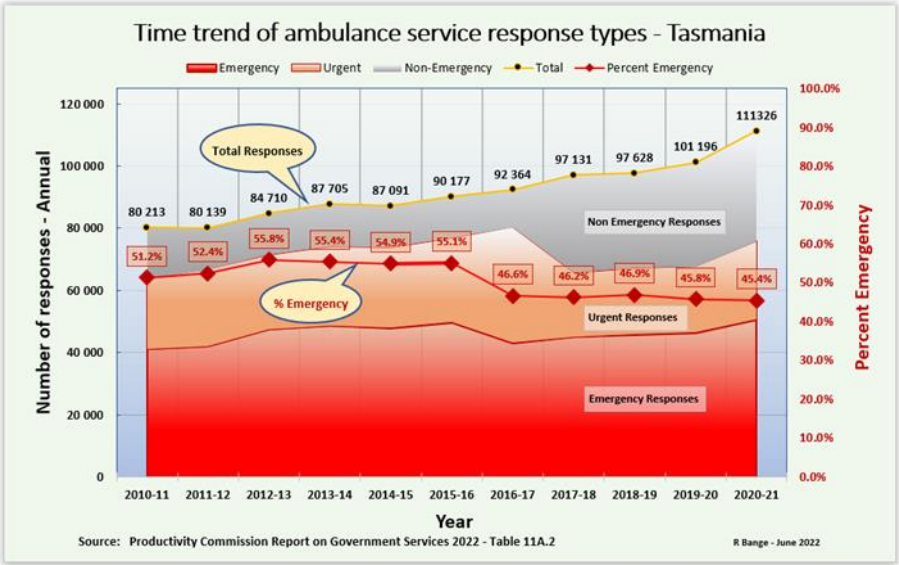
Paramedicine and the ambulance service

Paramedics are best known for their highly visible role in working for ambulance services. That dominant image often leads to confusion between the service role and the practitioner role. Paramedics are independently registered health professionals, and like a nurse or other AHP, they may work across a variety of employment settings consistent with their competencies.[23]

The ambulance service is an essential community service. Most patient attendances are not acute emergency cases demanding a 'lights and sirens' response[24] and across Australia, the ambulance services provide a wide variety of urgent and non-emergency support within the community.

Wider use of paramedics across health and in primary care will not alter their employment and effective work within the ambulance sector. The diversity of paramedic deployment in the UK sees ambulance services vying with other public and private sector employers to engage paramedics.

However, greater mobilisation of the paramedicine cohort holds the prospect of enhanced interagency and rotational work with hospitals and other care agencies including urgent care centres, mental health, and palliative services. This should result in better overall patient care.



In the words of the Medical Director of the largest (geographical) ambulance service in the world:[25]

"It's past time that we stopped conceiving of paramedics as two people who turn up in an emergency ambulance and take you to hospital and started viewing paramedicine as the art of bringing good medicine to tough situations, wherever that arises."

Dr Paul Bailey
Medical Director
St John Ambulance (WA) 8 September 2021

[23] Behnaz Schofield et al, *Exploring how paramedics are deployed in general practice and the perceived benefits and drawbacks: a mixed-methods scoping study,* BJGPOpen, Royal College of General Practitioners, 13 May 2020. https://bit.ly/3DwRkcz

[24] Productivity Commission, Report on Government Services (ROGS), Australian Government, Canberra, 1 February 2022. https://bit.ly/34ppuSc

[25] Bailey, Paul (@WAAMBMEDIC), https://twitter.com/WAAMBMEDIC/status/1435553728254267395, Twitter, 8 Sept 2021.

Reforming the health practice landscape

Despite nearly every Australian being cared for at some time by a paramedic, there is a surprising lack of understanding of the education and skillsets of contemporary registered paramedics. This detachment extends to health professionals, policy advisors and workforce planners.

It was disconcerting that paramedicine was omitted from the final report of the National Rural Health Commissioner[26] in June 2020, with no assessment of the capabilities or scope of practice of the profession. That omission (Report: page 47) is astounding when one considers that the Commissioner is required to consider the needs of the entire rural health workforce.

The report ignored the contributions already being made by paramedics in the private sector across the width and breadth of Australia which benefits communities in rural and regional areas.

It is a serious lost opportunity in human and economic terms in the face of the serious shortages in the allied health workforce and the service gaps identified in the Commissioner's 2020 report - which need to be addressed.

A compounding factor is the widely varying perception of paramedics as health professionals by both local and International Medical Graduates. Many overseas practitioners come from regions where the paramedicine profession is less mature, and the educational pathways and skillsets are less well developed than in Australia.

There is a need to update these GPs and their professional bodies on the effective implementation of paramedics within clinical practice settings through suitable practice literacy modules. While this might be best done at a national level, it may also be actioned at a state (Tasmanian) level.

Documented studies show that many benefits can flow from holistic care delivered by health professionals operating in a multidisciplinary environment. These benefits have been well-demonstrated by community paramedicine programs which have consistently shown positive outcomes in pilot studies and whose implementation in Ceduna (SA) has won plaudits.[27]

The South Australian Community Paramedic Pilot Program uses paramedics who work solo and independently from the mainstream local emergency ambulance service. While the principal focus is primary health care, the paramedics also provide clinical backup to the state ambulance service.

The community paramedics bring valuable services to the general population, working closely with GPs, Community Nurses, Aboriginal Health Services and other Government and non-Government Agencies to connect people to the most appropriate points in the health service.

However, a drawback with the Ceduna program is the complex and ephemeral nature of funding. Adequacy and longevity of funding are needed to properly implement community paramedicine.

More extensive information on the options for using paramedics in innovative programs of healthcare across a wide variety of settings is available in submissions provided by the author (and others) to the current Legislative Council inquiry into rural health services in Tasmania.[28]

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[26] Bange, R, *Final report of National Rural Health Commissioner*, The Paramedic Observer, Facebook, 17 July 2020. https://bit.ly/3tpPNQp

[27] SA Health, *Excellence in Strengthening Partnerships – SA Health Awards 2019,* Government of South Australia. https://bit.ly/2QEYpR1

[28] Bange R, *Meeting the healthcare needs of rural Tasmanians (Submissions 54a and 54b),* Inquiry into Rural Health Services in Tasmania, Legislative Council Government Administration Committee 'A', March/August 2021. https://bit.ly/3aqXuRz

Ramifications of the current lack of paramedic recognition

Although the engagement of paramedics throughout the health sector is growing rapidly in the UK and other jurisdictions, their involvement outside the ambulance sector has been slow to develop in Australia. Disappointingly, there has been little formal acknowledgement of the clinical interventions for which contemporary paramedics are qualified.

They routinely take complex patient histories, undertake detailed physical examinations and ECGs, and perform differential diagnoses of patient conditions as an integral part of practise. Paramedics are increasingly using point-of-care ultrasound in diagnosis.

They initiate and monitor advanced interventions like surgical airways, needle thoracostomies and endotracheal intubation and administer multiple medications, including highly restricted agents. They deal with patients having chronic health conditions and those in aged and palliative care as well as those persons presenting with mental health and drugs of addiction problems.

Among the outcomes of the lack of formal government recognition of paramedicine are:

- The absence of comprehensive workforce planning and data collection.
- The omission of paramedicine from the list of health professions recognised by the Government and other bodies for scholarships - and other practice support mechanisms.
- Employers and other health professions remain appreciably unaware of the skillsets of contemporary paramedics and the opportunities to engage them in multidisciplinary practice.
- Discriminatory treatment in job specifications through designated profession job descriptors unrelated to the functional job roles – and which are within the paramedic skillset.
- Regulations for the handling of medications and use of scheduled medications are restrictive and the provisions to carry, store, and administer a scheduled medicine generally are not currently available to paramedics working outside the jurisdictional ambulance service model.

Removing impediments and fostering engagement

When considering the available health and care resources to support primary and advanced care, the criteria for professional engagement might be based on:

- Size and sustainability of the professional cohort.
- Advanced education and competencies in different practice environments.
- The scope of practice capacity to meet patient and community needs in practice.
- The flexibility of practitioners to work across rural and remote areas.

Paramedicine amply meets those criteria and it's inexplicable that governments haven't acted to facilitate the wider use of paramedics within health. We need health practitioners with their expertise to work across healthcare settings where there is an acknowledged shortage of staff, especially in rural and regional areas.

There has been lacklustre engagement of paramedics outside the ambulance services. This surprising oversight is believed to arise in part from a lack of knowledge about the skillsets and education of contemporary paramedics. As registered health practitioners, paramedics should be empowered to work anywhere in healthcare for which they hold the relevant competencies.

Embedded perceptions of role mean that paramedic engagement throughout health is limited not so much by the capabilities of practitioners, but by issues such as public and professional awareness and as noted elsewhere, outdated and unnecessary impediments to practice.

In the UK, paramedics increasingly work in primary, mental health, aged care, and urgent care settings, either via direct employment or on rotation from ambulance services and other service providers and private agencies.[29] Appropriately educated paramedics are now also prescribing medications in primary care clinics and hospitals.

To foster general practice engagement of paramedics, Health Education England commissioned a Paramedic (Specialist in Primary and Urgent Care) core capabilities framework to provide advice to potential practitioner groups on the role of paramedics and their integration into general practice.

The framework includes background on the current education and regulatory framework for paramedics, employment and supervision, tools to help guide appraisal, career and salary progression, and recommendations for continuing professional development to meet paramedic registration requirements.

The framework has been warmly welcomed by health leaders and other health professions:

> *"Paramedics have unique capabilities which allow patients to receive the right care, at the right time - whether in a hospital, a primary care setting or in their own home. I am therefore delighted to support the launch of this framework. This will ensure the ongoing development of paramedic practice, and the transformation of services for the benefit of patients and the public. Using this framework, paramedics will be supported to continue to develop competencies and capabilities across a wide range of areas, including core clinical skills, communication, person-centred care, public health and leadership."*
>
> *Suzanne Rastrick*
> *Chief Allied Health Professions Officer*
> *NHS United Kingdom*

To summarise, paramedics working within primary care in the UK and internationally (and in numerous pilot studies in Australia) have shown that they possess the knowledge, leadership and competencies needed to work throughout the health domain including in primary care.

Community paramedics can monitor chronically ill patients and screen for developing conditions and deterioration; and they can lead acute home visiting services requiring effective triage and access to electronic patient records, underpinned by robust clinical governance; and engage in clinical audits.

Tasmania should adopt policies that engage paramedicine in primary care services including online, video and face-to-face consultations. The question is how that might be implemented given the complexity of health funding arrangements, the current separation of Commonwealth/State responsibilities and gaps in funding and practitioner recognition.

To facilitate better engagement, Australian jurisdictions should collaborate in the development of nationally agreed materials to support the wider employment of paramedics within health as independent health professionals.

While Tasmania could begin immediately with action to remove impediments to practice that are locally based, a taskforce approach in consultation with all jurisdictions is suggested to ensure articulation of the necessary changes at a national level.

[29] St John Ambulance, *Annual Report and Accounts for the year ended 31 December 2021*, St John Ambulance, Sheffield. https://bit.ly/3AwamjZ

The ANZSCO anomalies

From a future health perspective, poor occupational classifications can distort job descriptions, position vacancies and advertisements, as well as skew workforce placements and statistics. Misleading descriptors also may lead to the omission of paramedicine from health policy considerations and inhibit their wider deployment.

An example of the impact of outdated documentation is provided by the Australian and New Zealand Standard Classification of Occupations (ANZSCO).

Paramedics presently are not classified in ANZSCO under a Health or Allied Health professional category. Instead, they are placed under the category of Major Group 4 Community and Personal Service Workers | SUB-MAJOR GROUP 41 Health and Welfare Support Workers | MINOR GROUP 411 Health and Welfare Support Workers | UNIT GROUP 4111 Ambulance Officers and Paramedics.

Classifying autonomous paramedics as Health and Welfare Support Workers is anomalous. It does not reflect the contemporary practice regime of nationally registered health professionals who daily make life and death assessments and perform complex health interventions. Other aspects of the ANZSCO classification are also not consistent with the national regulatory framework and title.

A more relevant classification to suit a professional role would be to have a new ANZSCO MINOR GROUP classification within the Major Group 2 Professionals| SUB-MAJOR GROUP 25 Health Professionals | MINOR GROUP 255 Registered Paramedics. The classification taxonomy might be:

Major Group 2 Professionals
SUB-MAJOR GROUP 25 Health Professionals
MINOR GROUP 255 Paramedics

This would align paramedics appropriately with their Ahpra registered colleagues as:

MINOR GROUP 254 Midwifery and Nursing Professionals

MINOR GROUP 253 Medical Practitioners

MINOR GROUP 252 Health Therapy Professionals

MINOR GROUP 251 Health Diagnostic and Promotion Professionals

Through appropriate channels, Tasmania should work with the profession, the Australian Bureau of Statistics, and the Australian Government Department of Health to review the classification of paramedicine as a discrete and independently registered health profession, with the adoption of practitioner descriptors and classifications that properly reflect the contemporary education and role of paramedics as a Level 1 profession.

In the interim, the Government might review related Department of Health workforce documentation and position descriptions to ensure they reflect contemporary professional descriptions for paramedics. The matter of role relevance also applies to other areas of service delivery where AHPs may be involved just as much as other health practitioners.

In a related move, Tasmania might also take a lead in reviewing position descriptions and job specifications generally, to reflect the importance of work-related functional activities and the required skillsets and experience for healthcare roles rather than nominating a particular profession (unless required for specific clinical purposes).

Recommendations

The overarching objective in care should be the provision of right care – right place – right time, focusing on the needs of the patient. To this end, the author supports the underlying philosophy of 'taking healthcare to the patient' and the general principles embodied in the Exposure Draft.

The author draws attention to the importance of sustainability and the interdependent nature of factors that extend across primary care and a range of other health and social care services.

These factors include the complex interaction of the social determinants of health and policies that affect the overall health of our communities. In normal (non-pandemic) times the healthcare system has a limited impact on overall human health.[30]

As part of the implementation of the Exposure Draft strategy the Tasmanian Government might reaffirm its commitment to a *'Health in All Policies'* approach that identifies and considers how decisions across all major policy areas affect health, and in turn, how improved community health can support the goals of those sectors.

The following recommendations reflect ways to support the Tasmanian Healthcare Future strategy.

1. Recognition of paramedicine as a national health workforce

That the Tasmanian Government formally recognise paramedicine as part of the available health workforce for statistical, policy, planning, and development purposes and seek adoption of that position across Commonwealth, State and Territory jurisdictions.

This commitment would see paramedicine identified in policy and media documents as a discrete health workforce - potentially aligned with Allied Health or as a separate professional cohort.

The paramedicine profession should then be engaged consistently as one of the key stakeholders in policy deliberations on healthcare and overarching health policy.

2. Review of ANZSCO paramedic descriptors

That the Tasmanian Government, through appropriate channels, actively engage with the profession, the Australian Bureau of Statistics, and the Australian Government Department of Health and Aged Care to review the classification of paramedicine as a discrete and independently registered health profession, with the adoption of practitioner descriptors and classifications that properly reflect the contemporary education and role of paramedics as a Level 1 health profession.

Recognising the importance of flexibility in implementing the Healthcare Future strategy, the Tasmanian Department of Health might review related documentation and position descriptions to ensure they reflect contemporary professional descriptions for paramedics and facilitate the appointment of paramedics and other AHPs to positions within the system on a functional basis.

More generally, job descriptions within the Department of Health should be reviewed to minimise profession-based descriptors other than when needed for clinical purposes, to ensure appointments are made on merit from across the spectrum of health and care practitioners.

[30] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020), *Health equity in England: The Marmot Review 10 years on*, Institute of Health Equity, London. https://bit.ly/3NIunH3

3. Mobilisation of paramedicine across the health domain

That the Tasmanian Government make representations at a federal level to ensure the mobilisation policy for paramedics includes eligibility for federal programs of practice support, scholarships and incentive programs intended to foster rural and remote practice on a basis no less significant than that for other AHPs.

This policy might see financial incentives provided to foster paramedics upskilling in low-acuity specialties and accepting roles in rural locations. The Commonwealth might be approached to expand scholarship programs to those working within both the private and public sectors.

To support the engagement of paramedics in primary care, the author recommends the enhancement of the Australian Government Workforce Incentive Program - Practice Stream (WIP), with the specific inclusion of paramedicine as an eligible AHP.

The scheme itself should be reviewed to simplify the conditions of use and enable long-term engagement and reimbursement of costs including overheads. The experience of the UK Additional Roles Reimbursement Scheme should be considered in this review.

4. Identify and remove unnecessary impediments to practice

That the Tasmanian government support the establishment of a multi-jurisdictional task force to explore the impediments to practice by registered paramedics at both jurisdictional and national levels, with the objectives of enabling access to MBS/PBS provider programs, referral pathways, prescribing rights, access to electronic health records, and other elements of independent practice.

In the immediate short to medium term, Tasmania should independently examine unnecessary barriers to paramedic practice within the state, with the inclusion of paramedicine in workforce studies, review of drugs legislation and review of Ambulance Service and related Acts.

5. Promote the engagement of paramedics in primary care

That Tasmania commits to developing an information dissemination program regarding the use of paramedics in multidisciplinary practice settings in both the public and private sectors. The materials should embrace employer groups; professional associations; the Australian Institute of Health and Welfare; the Australian Bureau of Statistics; and the Productivity Commission.

Particular attention should be paid to working with the Rural Doctors Workforce Agency Network (or the relevant responsible agency network) to ensure the inclusion of paramedicine as an eligible profession for various workforce support programs, and in Workforce Needs Assessment.

Tasmania should collaborate with other jurisdictions and the Commonwealth in distributing these practice materials, including toolkits, that identify paramedicine as a health profession whose members can provide health care services across a wide variety of practice and community settings.

These practice guidelines on the role of paramedics and their integration into general practice, primary and other care settings (e.g., hospitals, clinics) might draw on the experience and materials developed in the UK for Clinical Commissioning Groups and the UK College of Paramedics.

6. Engagement of paramedics across practice environments

That the Department of Health actively explores the wider use of paramedics to meet workforce needs in the state's public hospitals and other public health and care settings including longer-term senior citizen and aged care, palliative care, and mental health care.

With rural hospitals under pressure in having medical practitioners available to attend, paramedics can play a significant role in urgent and emergency presentations and priority might be placed on recruiting paramedics who can complement existing resources with their acute care expertise.

As an interim step, workforce planning could incorporate information and incentives to assist primary healthcare providers in transitioning their workplaces to optimise the use of paramedics.

7. Appointment of a Chief Paramedic Officer

To ensure adequate consideration of paramedicine within the health system, Tasmania should appoint a Chief Paramedic Officer as part of the peak leadership team within the Department of Health.

If a Chief Paramedic Officer is not appointed, then the role of the Chief Nurse/Allied Health Advisor (or equivalent at the time) should incorporate specific references to paramedicine and the substantive position(s) made open to registered paramedics.

8. Support for the Extended Care Paramedic role

That Tasmania provides support for the public ambulance service and the University of Tasmania University (or other selected centre) for paramedicine education programs in developing the Extended Care Paramedic cohort including their formal educational and practice foundations.

The recommendations from previous Tasmanian Health and Ambulance Service Inquiries should be considered, with the greater use of Extended Care Paramedics having a scope of practice enabling contemporary practice interventions and the administration of medications to potentially reduce avoidable conveyances to hospital.

9. Support for the Paramedic Practitioner role

That Tasmania supports the use of Paramedic Practitioner roles within primary care, community and other health centres in identified areas of need. That support might extend to permanent adoption and funding of Community Paramedicine programs through stand-alone practitioner engagement or by supplementing existing community and nurse practitioner initiatives.

Abbreviations / Definitions

The following abbreviations and definitions are used in this submission.

AHP	Allied Health Profession/Professional
Ahpra	Australian Health Practitioner Regulation Agency
ARRS	Additional Roles Reimbursement Scheme (UK)
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ECP	Extended Care Paramedic/s
ED	Emergency Department
GP	General Practice/Practitioner
NHS	National Health Service (UK)
PBA	Paramedicine Board of Australia
PCN	Primary Care Network (UK)
ROGS	Report on Government Services (Productivity Commission)
UK	United Kingdom
WIP	Workforce Incentive Program

Registered Paramedic - A professional health care practitioner registered under the National Registration and Accreditation Scheme and whose education and competencies empower the individual to provide a wide range of patient-centred care and medical procedures in diverse settings including out of hospital scheduled and unscheduled care situations.

Extended Care Paramedic – a title commonly used to describe a paramedic who has undergone additional training in low acuity patient assessment and treatment.

Community Paramedic – a broad term used to describe any paramedic who has undergone additional training in low acuity patient assessment and treatment. Such paramedics may work in conjunction with primary care providers such as GP clinics or in Emergency Departments and other health settings.

Paramedic Practitioner – a paramedic who has undergone additional training and been granted an autonomous scope of practice, including the right to prescribe medications and work independently of a paramedic (aka ambulance) service.