Submission to:
Health and Environment Committee
Queensland Legislative Assembly

Creating Pathways to Better Health

A submission highlighting the importance of mobilising paramedicine to support the delivery of sustainable Health Services in Queensland

December 2021

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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.

Paramedic Service – A provider of health care and related services using paramedics as the principal practitioner resources (public entities are commonly known as ambulance services).

Executive Summary

The overarching objective in care should be the provision of right care – right place – right time, focusing on the needs of the patient, rather than professional or institutional structures.

The author suggests that minimising the barriers to access will encourage early and appropriate patient engagement with the healthcare system. The combination of community programs, telehealth, and in-person visits to provide care in the home is likely to minimise these barriers.

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 that are projected to increase.

One of the dangers inherent in inquiries and reviews is the consideration of the status quo and embedded perceptions of workforce groups and professions - rather than examining the options available to foster innovation and fill gaps in care. One of the embedded perceptions is that paramedics work only for ambulance (aka paramedic) services.

To encourage early assessment and provide patient-centred care, the author advocates the philosophy of 'taking healthcare to the patient'. To assist in this process, better mobilisation of the paramedicine workforce is proposed to increase the available practitioner resources in fulfilling that goal.

The submission recommendations cover (inter alia):

a) Enactment of a contemporary legislative and regulatory framework covering the QAS;
b) A commitment to service accreditation;
c) Expanding the use of Extended Care Paramedics - reflecting contemporary practice;
d) Supporting the creation of Community Paramedic roles, allowing patients to be comprehensively assessed, treated, or referred from their own home;
e) Recognising paramedicine as a key stakeholder group within the health workforce;
f) Formally incorporating paramedicine in workforce data collection and planning;
g) Appointment of a Chief Paramedic Officer to the peak Health Department policy team;
h) Removing unnecessary impediments to practice for paramedics to facilitate their engagement in hospital settings and within primary and other care facilities;
i) 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 support local communities at a primary care level; and,
j) Providing toolkits and other resources to Workforce Agencies, GP clinics and other healthcare agencies and providers to advise them on how best to use the available Allied Health Practitioner and paramedicine workforce; and
k) Ensuring access to financial incentives and support for paramedics in rural practice.

Contents

The author

The author of this submission is Adjunct Associate Professor Ray Bange OAM, and the submission is made in a personal capacity. Professor Bange is an independent researcher and policy advisor. He is an Executive Committee member of the Australian Health Care Reform Alliance and has contributed to the work of the Services for Australian Rural and Remote Allied Health, the National Rural Health Alliance and the Consumers Health Forum of Australia.

Professor Bange holds Adjunct Associate Professorial appointments from Central Queensland University and the University of the Sunshine Coast. He is the recipient of an Order of Australia Medal awarded for contributions to paramedicine, education, and the community.

Overview

On 17 November 2021, the Queensland Legislative Assembly agreed that the Health and Environment Committee (Committee) would inquire and report on the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system.

The Health and Environment Committee is a portfolio committee of the Queensland Legislative Assembly with responsibility for Health and Ambulance Services, Environment, Great Barrier Reef, Science and Youth Affairs.

The committee also has a monitoring and review function in relation to the health complaints system, including the performance of the Office of the Health Ombudsman, the Australian Health Practitioner Regulation Agency and the 15 registered health practitioner National Boards.

The terms of reference for the Inquiry are outlined in *Appendix A*. They encompass the engagement of nursing and allied health professionals (AHPs), including paramedicine, as part of the service delivery mix in protecting public health in various models of community care.

The Inquiry is being conducted in the context of unprecedented changes in health service delivery occasioned by the COVID-19 pandemic and significant policy developments at a national level, including the consultation and implementation of the National Primary Health Care 10 Year Plan.[1]

The 10-Year Plan 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.[2] Under the Long-Term National Health Plan, the Australian Government is committed to implementing a health system that is more person-centred, integrated, efficient and equitable.

While those high-level policy goals are laudable objectives, their execution will depend not only on the capacity of jurisdictions and accessible physical facilities but also the availability of an adequate health workforce and innovative means of service delivery.

The needed innovations may include suitable funding models for a range of telehealth and primary health care services, covering medical practitioners and allied health, pharmacists, nursing, mental health services and better support for rural and remote communities.

[1] *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*, Department of Health, Commonwealth of Australia, October 2021. https://bit.ly/3lc5SH2

[2] *Australia's Long Term National Health Plan*, Department of Health, Commonwealth of Australia, August 2019. https://bit.ly/3cVEQzf

This submission does not attempt to cover the full scope of the Inquiry. It emphasises the provision of workforce resources and the capacity of the paramedicine profession to service overall community needs. It examines the mobilisation of paramedics and their current and potential roles through both public and private healthcare services.

The submission highlights the flexibility and capacity of paramedics to work independently and as members of a team in multidisciplinary settings. The submission thus also highlights impediments to practice and explores the ways by which paramedics might be mobilised better to deliver optimal care within the community.

A challenging and changing landscape

Australia's health system is facing significant challenges, including an ageing population and an ageing health workforce. Changes in disease patterns, including a growing level of chronic disease, and multi-morbidity along with increasing patient expectations are driving demands for more complex and long-term care.

Health budgets are coming under pressure as the cost of care rises, putting additional stress on the health system and exacerbated in Queensland by the access challenges of providing care across metropolitan and sparsely populated regions.

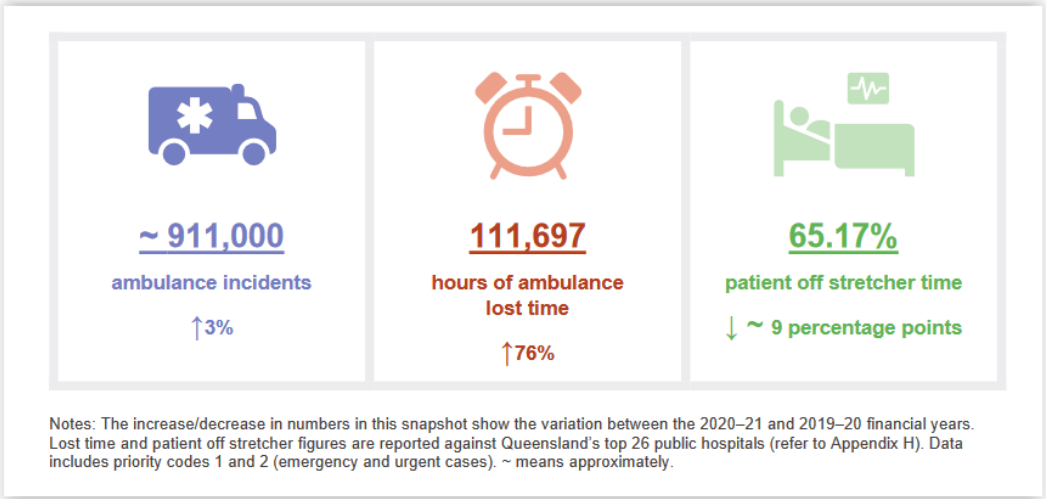
Internal departmental memoranda have disclosed concerns at significant burnout potential and workload pressures while independent studies have disclosed the enormous pressures on the Queensland health system.

In December 2021, the Queensland Audit Office (QAO) released a report that questions whether the workload of the state's public health employees is "unsustainably high". The QAO identified the increasing demand[3] for services, even before the challenges of the coronavirus pandemic, because of population growth, an ageing population and the increasing complexity of cases.

> *"The health sector in Queensland has had a challenging task during the months since COVID-19 emerged. Even before it had to cope with the challenges the pandemic presented, it was dealing with increasing demand for its services. This has continued, with demand exceeding supply in some cases.*
>
> *One effect of this is the growth in the unused leave balances of our frontline health workers since 2020–21.*
>
> *The wellbeing of the workforce is a significant issue that could impact the sustainability of the health sector. This will be a major challenge for the Department of Health when Queensland's borders open in December 2021.*
>
> *It is important to have enough hospital beds to manage demand. It is even more important that we have a highly energised health workforce to cope with the risk of a COVID-19 outbreak. High leave balances indicate the workload of our health workers may be unsustainably high."*
>
> *Health 2021 (Report 12: 2021–22) page 19*
>
> *Queensland Audit Office, December 2021*

[3] Queensland Audit Office, *Health 2021: Report 12: 2020-22*, Queensland Government, December 2021. https://bit.ly/30HeYEt

The QAO report spells out the extent of Queensland's ambulance ramping crisis with paramedics collectively spending nearly 112,000 hours ramped outside 26 of the state's top public hospitals during 2020-21 – a 76 per cent jump on the previous financial year.



The Queensland Ambulance Service (QAS) continues to be directly impacted by COVID-19 and by increasing demand for health services. In addition to its usual work, the QAS has taken on additional commitments, including:

- rapid deployment of seven fever clinics—QAS staff provided over 12,000 staff hours in 2020–21 to operate seven QAS fever clinics. This was in addition to business-as-usual activity and was resourced through redeployment of staff and using overtime as a rostering method;
- hotel quarantine relocation transports; and
- assistance/attendance at vaccination centres.

Acknowledging these unprecedented pressures, the Queensland government[4] has said it will direct an extra $200 million to help the state's hospitals tackle an ongoing surge in COVID-19 cases driven by the highly contagious Omicron variant. The funds are to be directed to four key areas:

- increased costs in responding to rising COVID cases;
- capital works;
- support for out-of-hospital care; and
- support for virtual models of care including virtual care hubs and IT platforms such as Health Direct helplines and online portals.

On a more positive note, the uptake of telehealth for mental health services during the pandemic has revealed that the pandemic greatly accelerated the adoption of telehealth by clinicians and that maintaining telehealth mental health care has the potential to improve access to care.

[4] The Honourable Annastacia Palaszczuk, *$200 million boost for COVID fight*, Media statement, Queensland Government, 20/12/2021. https://bit.ly/3e7rArD

Long Term Sustainable Health

On a macro scale, improving community health must look at overall health outcomes involving more than advanced medical interventions. These outcomes are more determined by systemic issues and social policies and prevention and primary care. Achieving a sustainable health system requires consideration of climate change as a determinant of health and requires attention to both patient-level processes and different requirements at each level of the health system.

These principles underpinned the Sustainable Health Review by the Western Australian Government[5] which developed eight enduring strategies and 30 recommendations, seeking to drive a cultural shift from a predominantly reactive, acute, hospital-based system – to one with a strong focus on prevention, equity, early child health, end of life care, and seamless access to services at home and in the community through the use of technology and innovation.

The strategic framework for value-based health care transformation provides a guide for supporting the consideration of climate change and its impacts on health and health care. [6]

These developments at national and jurisdictional levels show growing acceptance that the health of the population is significantly impacted by policies spanning the social and economic environments, commonly referred to as the Social Determinants of Health (SDOH).[7] The influence of the SDOH on longer-term emotional and physical health outcomes has been well established by Marmot and other researchers.[8]

The COVID-19 pandemic has brought the issues of access and equity into sharp focus. Measures such as lockdowns, social distancing and cancellations of routine care are expected to have a greater long-term impact upon those already facing inequality.

The dire staffing situations imposed by the COVID-10 pandemic raises the danger that short term and temporary responses may prevail. Long term sustainability requires a more holistic definition of health care which acknowledges that the health system extends beyond hospitals and is strongly interdependent with primary care and a wide range of health and social care services.

The purpose of outlining these factors is to emphasise the complex interactions and influence of policies that affect the overall health of our communities

The author proposes that as part of the present Inquiry, the Queensland Government affirms its commitment to a *'Health in All Policies'* approach that identifies how decisions across all major policy areas affect health, and in turn, how improved health can support the goals of those sectors. It is a prudent strategy that applies to all jurisdictions including the Commonwealth.

[5] Sustainable Health Review. (2019). *Sustainable Health Review: Final Report to the Western Australian Government,* Department of Health, Western Australia. https://bit.ly/3pksiIF

[6] Hoban E, Haddock R, Woolcock K. (2021). *Deeble Issues Brief No. 41, Transforming the health system for sustainability: environmental leadership through a value-based health care strategy*, Australian Healthcare and Hospitals Association, Canberra, Australia. https://bit.ly/32aTnFe

[7] Social determinants of health - the social and economic factors and conditions in which people are born, grow, live, work, and age, that are known to be the most powerful determinants of population health. World Health Organisation, https://bit.ly/3eUnNyF

[8] Sir Michael Marmot, *Fair Society, Healthy Lives*, *The Marmot Review* www.ucl.ac.uk/marmotreview The Marmot Review, February 2010 ISBN 978-0-9564870-0-1 https://bit.ly/2z8U5PS

Primary Care, General Practice and Allied Health

The Australian Government defines primary health care as being the first contact a person has with the health system, including General Practitioners (GPs), nurses and midwives, AHPs, pharmacists, dentists, and Aboriginal and Torres Strait Islander Health Practitioners.

Despite access limitations, primary care remains the most immediate source of health services for rural and remote communities. Primary care plays a significant role in reducing the reliance on hospital services such as acute care and specialist services.

Relevant but little mentioned in many strategy documents and planning scenarios are the jurisdictional ambulance services or privately engaged paramedics who are significant patient contact points, especially for smaller communities and in industrial settings.

Workforce shortages 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 GP services being overwhelmed, with extended appointment times.

One outcome of the difficulty in accessing primary health care is that the first interaction with the health system for older people is often for an acute episode, such as a stroke, heart attack or major fall. Accessible primary health care services can help in preventing such acute events.

Typical GP services have consisted of medical practitioners, nurses, and administrative staff. Many practices have been slow to take account of changes in workforce education and capabilities and the enhanced scope of practice from an expert AHP workforce and interdisciplinary practice.

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

AHPs represent more than a quarter of the health workforce and can play a key part in primary care and the prevention, management, and treatment of chronic disease, leading to a reduction in preventable hospitalisations.

Despite their numbers and contributions to health, reliable data on the AHP workforce and their services is sparse which affects the quality of policy and decision making when it comes to ensuring equitable access to care and identifying where and what care is most needed.

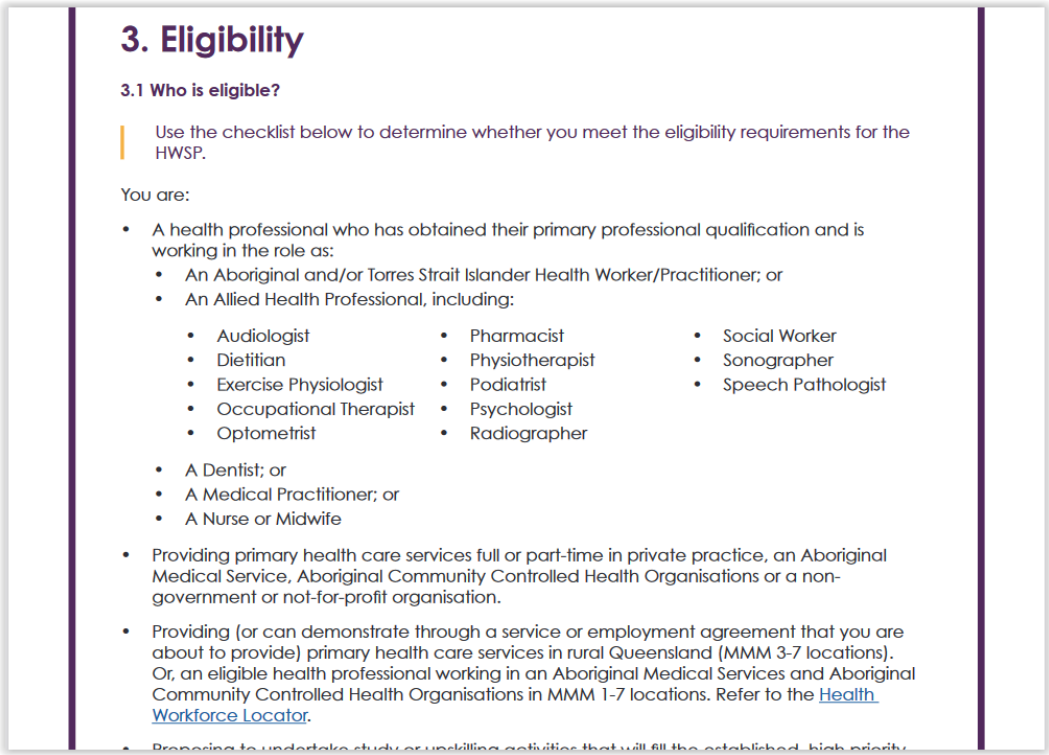
Limited workforce data is available for the regulated AHPs, but the situation is worse for the self-regulated AHPs. The absence of data reduces the capacity to explore and address community AHP needs, which anecdotally are prominent in those communities with the highest levels of perceived workforce and service gaps.

It is generally agreed that there is a widening gap in workforce distribution between rural and metropolitan regions for AHPs. Although the need for practitioners may vary from region to region, the biggest perceived workforce gaps across rural and remote Queensland are for psychology, speech pathology, and occupational therapy. More generally, however, the author suggests the biggest need is for people – qualified health professionals able to work as teams.

For rural communities, there is little support for people with severe mental illness and consequently limited consultation with potential service consumers. Telehealth has been highlighted during the pandemic but that has also served to identify gaps in digital access and the inability of disadvantaged people with mental health issues to even be online let alone able to access online appointments.

Nationally, there has been a greater focus on allied health with the release of the National Rural Health Commissioner's (NRHC) report on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia.[9] As well as strengthening the office of the NRHC, new leadership appointments include a Chief Allied Health Officer.

A disconcerting feature of the NRHC report was that in framing the recommendations, the (then) NRHC excluded consideration of paramedicine as an available health workforce despite its significant numbers.[10] The omission of paramedicine from datasets and (typical) lists of AHPs is not uncommon - such as for the Commonwealth-funded Health Workforce Scholarship Program by some Rural Workforce Agencies (RWAs).[11] A paramedic looking for support wouldn't be encouraged to apply.



3. Eligibility

3.1 Who is eligible?

Use the checklist below to determine whether you meet the eligibility requirements for the HWSP.

You are:

- A health professional who has obtained their primary professional qualification and is working in the role as:
  - An Aboriginal and/or Torres Strait Islander Health Worker/Practitioner; or
  - An Allied Health Professional, including:
    - Audiologist
    - Dietitian
    - Exercise Physiologist
    - Occupational Therapist
    - Optometrist
    - Pharmacist
    - Physiotherapist
    - Podiatrist
    - Psychologist
    - Radiographer
    - Social Worker
    - Sonographer
    - Speech Pathologist
  - A Dentist; or
  - A Medical Practitioner; or
  - A Nurse or Midwife
- Providing primary health care services full or part-time in private practice, an Aboriginal Medical Service, Aboriginal Community Controlled Health Organisations or a non-government or not-for-profit organisation.
- Providing (or can demonstrate through a service or employment agreement that you are about to provide) primary health care services in rural Queensland (MMM 3-7 locations). Or, an eligible health professional working in an Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations in MMM 1-7 locations. Refer to the Health Workforce Locator.
- Proposing to undertake study or upskilling activities that will fill the established high priority

[9] National Rural Health Commissioner, *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia, June 2020,* Australian Government. https://bit.ly/3qc5zxn

[10] Ibid (page 47)

[11] Bange R, *Health Workforce Strategy 2040 – Tasmania*, The Paramedic Observer, Facebook, 14 December 2021. https://bit.ly/32g39G8

Paramedicine currently has 21,685 registered practitioners nationally, yet direct enquiries to the Australian Institute of Health and Welfare (AIHW) disclose that this key body (which is responsible for collecting and disseminating Australian health and welfare data) has little involvement in the collection and analysis of data on paramedics and their practice.

The role of AHPs in primary health is not always well defined or governed, and is often not understood or utilised effectively within health services or the community.[12] One potential outcome of that lack of knowledge is the inadequate integration of allied health staff into local clinical teams to enhance the viability of small rural allied health practices.

There is a continued need for strategies aimed at attracting and retaining AHPs in rural areas. Just as for medical practitioners, AHPs need to be supported through their development by providing rural career paths and progression and ongoing professional development for sustainability.

Incentives to increase the attractiveness of rural and regional areas are sometimes piecemeal and focus on specific elements of the system rather than a holistic approach. While the federal government will wipe the university debt of doctors or nurse practitioners from January 2022 (subject to conditions), that otherwise worthy proposal[13] does not sufficiently acknowledge that AHPs are essential in providing multidisciplinary care within communities.

Better ways to improve access to allied health care and integrate this workforce sector are needed with primary care networks, hospital and health services, aged care services, disability services, schools and other community services. Funding is needed for health education, increasing health literacy and health promotion and workforce policies need to accommodate the growth of public, not for profit and private service capacity.

The situation is even worse when one considers paramedicine. As a generalist AHP, there are few ways in which the services of an independent practitioner are funded by the government, whereas for other AHPs there are established reimbursement schemes and Medicare numbers.

Faced with funding and regulatory barriers, there have been few community-based paramedicine practices established in Australia beyond the aeromedical, event and industrial sector contract services. One example of a generalist community service is the HMS Collective in Victoria which is a paramedic led service supported by nurses, general practice and other AHPs and which has a focus on Disability, Aged Care and Help.[14]

Funding of the HMS operations is through NDIS payments, My Aged Care, Out-of-pocket fees and donations, with payments made to the collective service entity. Unlike other practitioners, there is no recognition that the paramedic can directly sign off items for payment.

To facilitate the development of such initiatives, a review of funding models is required, including the fee-for-service model, to recognise the cost of servicing patient groups. Measures are also needed to optimise regulatory frameworks surrounding both service delivery and payments.

[12] Hal Swerissen, Stephen Duckett (2018), *Mapping primary care in Australia*, Grattan Institute. https://bit.ly/3slftzA

[13] Stephanie Dalzell, Claudia Long, *Government to lure doctors and nurses to rural, regional and remote areas by slashing university debt*, ABC News, 7 December 2021. https://ab.co/3phcm9H

[14] HMS Collective, *Our Services.* https://bit.ly/3Jcyqun

Expansion of the allied health rural generalist pathway is currently being explored by Services for Rural and Remote Allied Health (SARRAH). In that respect, one may envisage paramedicine as an existing generalist AHP cohort that needs support through engagement and collaboration to develop shared training, placement, and employment models. There should be direct recognition of paramedicine for reimbursement of medical services delivered by a registered health practitioner.

Health Workforce Needs Assessments

Health Workforce Queensland is a not-for-profit, non-Government Rural Workforce Agency (RWA) with a focus on the primary health workforce in Queensland. It is a member of the Rural Workforce Agency Network (RWAN) comprising seven jurisdictional RWAs and was formed in 2017 to administer remote and rural health workforce programs, and to provide a structured approach to strategic and operational opportunities and challenges and to address workforce shortages.

The Australian Department of Health provides funding of their workforce programs for the:

- Rural Health Workforce Support Activity;
- Health Workforce Scholarship Program; and
- More Doctors for Rural Australia Support Package.

The Health Workforce Stakeholder Group (HWSG) comprises members drawn from a range of health disciplines and who offer advice and insights into the health professions and locations in remote and rural Queensland that are most in need. The HWSG provides input to the annual Health Workforce Needs Assessment which provides a narrative about the current and emerging workforce issues for each health discipline.

The annual Health Workforce Needs Assessment is produced as a state-wide report with four regional workforce summary reports. The regional reports are geographically aligned with the four remote and rural Primary Health Networks (PHNs) and are a reference for organisations to assist with their health workforce and service planning activities:

- Western Queensland HWNA
- Northern Queensland HWNA
- Central Queensland, Wide Bay & Sunshine Coast HWNA
- Darling Downs & West Moreton HWNA

The author's examination of the RWA's past workforce assessment performance, based on published materials, is that the consortium consists of seven independent agencies with duplication and different approaches that don't demonstrate particularly good engagement with stakeholders other than the medical profession and related service providers. This may reflect the origins of the RWAN.

Community engagement is not significant and there is an acknowledgement of the dearth of data on allied health. Mention of paramedicine in minimal and meaningful engagement with the profession through representative Colleges is not indicated.

A 2020 KPMG evaluation report[15] is illuminating. KPMG didn't recognise paramedics by profession, nor did it discuss the ambulance sector, although KPMG did mention AHPs. Among the KPMG observations was that RWA engagement with allied health was in its infancy.

Mention was made of enhanced scopes of practice for AHPs which is akin to the role of a community paramedic or paramedic practitioner. Pilot studies in Australia and increasing practice overseas have found significant benefits in the use of community paramedics.

This enhanced scope of practice may be recognised through regulatory mechanisms (i.e. through formal qualifications) with the assumption that the use of such practitioners will increase access to health services for rural and remote communities. As KPMG noted:

> *"These strategies are most widely reported on in the context of the nursing profession, and evidence exists indicating nurses in more advanced primary care roles are positively associated with increased patient satisfaction, reduced hospital admissions and reduced mortality rates. Additionally, these roles are either cost-neutral or even slightly cost-reducing. In Australia, legislative and regulatory steps have been taken towards strengthening the role of advanced nursing and midwifery disciplines through recognition of the 'nurse practitioner', thus removing barriers to extensions in their scope of practice.*
>
> *A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role has emerged as a way to expand the scope of practice for nurses in order to improve access to healthcare, particularly for remote, marginalised and vulnerable populations. Based on the most recent available data, there are 1,604 nurse practitioners endorsed in Australia and this number is growing. For example, between 2014 and 2017, the total number of nurse practitioners with general or provisional registrations has increased by 43.4% from 1,085 to 1,556 (an average annual growth of 12.8%)."*
>
> *KPMG: Review of the Rural Health Workforce Support Activity Final Report (pp 162-163)*

Paramedics across Queensland daily are engaged in managing mental health, chronic conditions, end of life/palliative care and multi-disciplinary team-based care. Given the intersection between public health and private health in both metropolitan and rural settings, the Workforce Needs Assessment is important for several purposes, including various forms of support for those estimated 1500 Queensland paramedics not working for the QAS. The author opines that allied health must be given greater prominence and that paramedicine representatives be included in consultations.

[15] KPMG, *Review of the Rural Health Workforce Support Activity Final Report*, Department of Health, https://bit.ly/3smQGLv

What about the ambulance service?

Queensland is fortunate in having a single public ambulance service that spans the whole state and is an integral part of the health system operating under the portfolio of the Minister for Health and Ambulance Services.[16] It is staffed by well-educated professionals who are acknowledged as being among the best in the world. QAS emergency response services are available to residents of the state free of charge.

The increased load being imposed on the QAS has resulted in current moves to recruit an extra 108 frontline officers to meet the growing demand for services. These staff members are proposed to be in service by March 2022.[17] They supplement an additional 179 staff recruited this financial year.

The role that ambulance (aka paramedic) services can play in improving population health and wellbeing is increasingly being acknowledged. In February 2017, the UK Association of Ambulance Chief Executives (AACE) launched a joint consensus statement committing the NHS ambulance trusts to increased collaboration in supporting improved health and wellbeing.[18]

NHS England's Medical Director, Professor Sir Bruce Keogh at the time said: “The vision for the Ambulance Service: ‘2020 and beyond’ includes an increasing role in prevention and health promotion. This consensus statement reflects the evolving role of the Ambulance Service as a mobile healthcare provider using the richness of expertise residing in its workforce."

The AACE has now published a Discussion Paper: Developing a Public Health Approach within the Ambulance Sector.[19] It comes as the impacts of the COVID-19 pandemic see a rise in demand for health services, including the ambulance sector.

This paper outlines the importance of public health and prevention within the ambulance sector, what is meant by a public health approach, and ways this agenda can be progressed.

One of the key lessons is the role of prevention in helping people live longer in good health, and to lessen the burden on health and social care resources. There is a growing unfilled demand for human and physical resources and the pressures on healthcare are becoming more concerning as evidenced by indicators such as long wait times for medical treatment and elective surgery, bed block in hospitals, and ramping of ambulances in jurisdictions across Australia.[20]

In addition to recognising the wider role of ambulance services as part of a health and care system with the capacity to moderate demand on the NHS, the UK has seen significant mobilisation of the paramedic workforce as individual practitioners within primary care.[21]

[16] Queensland Cabinet and Ministerial Directory, *Minister for Health and Ambulance Services.* https://bit.ly/3mkZ2iO

[17] The Honourable Mark Ryan, *More than 100 extra ambulance officers to hit the road*, Media statement, Queensland Government, 19/12/2021. https://bit.ly/32ibicO

[18] Association of Ambulance Chief Executives, *Working together with ambulance services to improve public health and wellbeing, Consensus Statement*, 7 February 2017. https://bit.ly/3v3mraJ

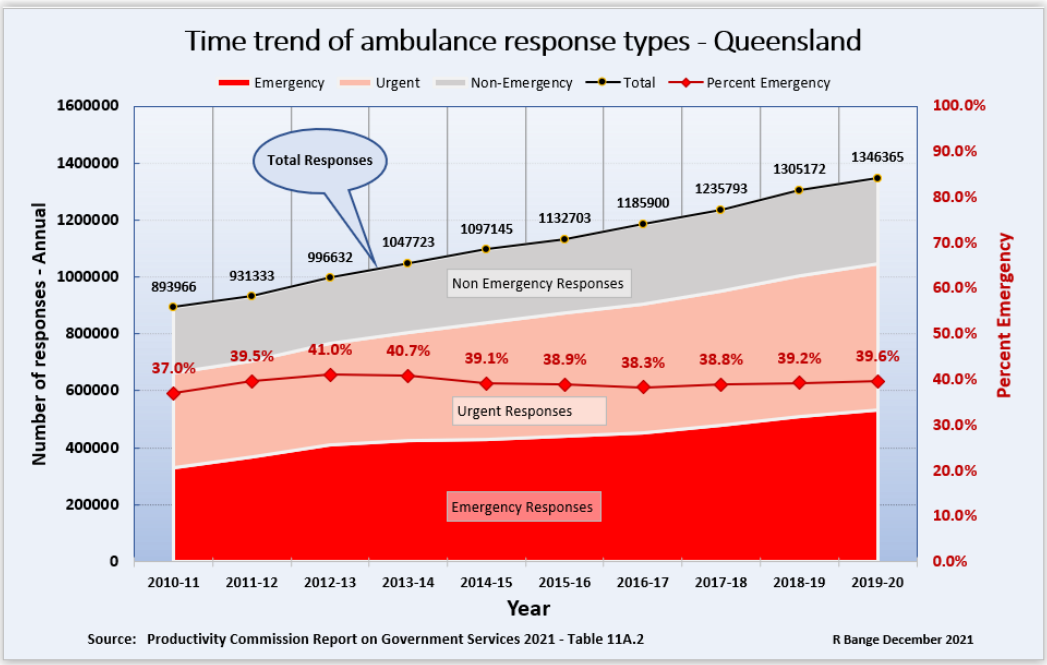
[19] Association of Ambulance Chief Executives, *Discussion Paper: Developing a Public Health Approach within the Ambulance Sector*, May 2021. https://bit.ly/3yppjkw

[20] Paul Hayes, *Calls for whole-of-system approach to ease ambulance ramping crisis*, NewsGP 16 April, 2021. https://bit.ly/3f2bFMv

[21] Bange R, *A Roadmap to Practice,* The Paramedic Observer, 22 March 2021. https://bit.ly/3fxbwQf

In some jurisdictions this expansion of care to the community by ambulance services is being implemented using various models of community paramedicine.[22]

Looking at Queensland, the time trend of ambulance service responses[23] shows that most patient attendances are not acute emergency cases demanding a 'lights and sirens' response. Less than 40% of responses are classified as an emergency and there is a growing number of urgent and non-emergency responses. In essence, the QAS is increasingly providing a vital public health service along similar lines to the service commitments of UK ambulance services.



Perceptions of the QAS need to go beyond the role of a pre-hospital emergency care provider operating in a silo. An appropriately funded ambulance (aka paramedic) service that is widely distributed across the state is uniquely positioned to respond to population-based health initiatives, health promotion and community-based health management needs aligned with the SDOH.

The author thus proposes that policymakers embrace the concept of the QAS providing broader healthcare responses through the delivery of out-of-hospital care in diverse situations (whether in the field, a healthcare facility or at home) and under conditions at times of unscheduled emergency.

While this scope of service may be delivered through policy decisions, it is recommended that the remit of the QAS be enshrined in relevant legislation. At the same time, legislative amendments might be considered that recognise paramedicine as an independent health workforce.

[22] KatieN.Dainty et al, *Home Visit-Based Community Paramedicine and Its Potential Role in Improving Patient-Centered Primary Care: A Grounded Theory Study and Framework*, Health Services Research, October 2018. https://doi.org/10.1111/1475-6773.12855 https://bit.ly/3ypAz0o

[23] Productivity Commission, *Report on Government Services (ROGS),* Australian Government, Canberra, 28 January 2021. https://bit.ly/2KUC4zw

Supporting a broader QAS role is not enough, and the government should also take steps to expand the health workforce by facilitating the use of paramedics more widely throughout the health domain. Although paramedics are best known for their highly visible role working for ambulance services, they are independently registered health professionals, and like a nurse or other AHP, their expertise should be used in a variety of employment settings consistent with their competencies.[24]

The breadth of paramedic deployment across the health sector in the UK sees ambulance services compete with other public and private sector employers to employ paramedics just as they do for other health professionals. Wider engagement of paramedics across health in Queensland will not affect the ambulance sector but will increase available resources, diversity and professionalism.

Greater mobilisation of the paramedicine cohort holds the prospect of enhanced interagency and rotational work with hospitals and other care agencies[25, 26] including GP practices, urgent care centres, mental health, and palliative services. Providing healthcare that is close to the community should help to ensure the right care, right patient, and right time.

Sir Michael Marmot's Build Back Fairer report also highlights the importance of working together to strengthen the public health approach to health and wellbeing across communities.

The pandemic has shown that much can be achieved given the right policy settings. We currently have an opportunity to build a better health and economic system that recognises the social determinants of health and incorporates a prevention-oriented strategy.

These principles align with national policies that envisage the growth of integrated out-of-hospital care to cater for an aging population and increasing incidence of chronic conditions that are seen to be largely preventable, with the burden particularly acute in rural and remote areas.

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

> *"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*

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

[25] Australian Health Care Reform Alliance, *Health Workforce Policy Position Paper*, 28 June 2016. http://bit.ly/292oxB3

[26] Gardiner F W, Bishop L, de Graaf B, Campbell J A, Gale L, Quinlan F. (2020). *Equitable patient access to primary healthcare in Australia*. Canberra, The Royal Flying Doctor Service of Australia. https://bit.ly/3qtsNxk

Expanding the traditional use of Paramedics

Paramedics working for the QAS are already engaged in a variety of health and care activities in addition to applying their expertise in emergency response, trauma care and resuscitation.

Within the ambulance services, the 'low acuity' paramedic specialists are commonly known as Extended Care Paramedics (ECPs)[27] whose expertise embraces additional medications and skills.[28]

Judicious expansion of this role to cater for low acuity 000 calls could reduce the number of Emergency Department (ED) presentations. This might replicate the operational practices of the London Ambulance Service[29] that enables patients to be treated safely in the community.

This pattern of care and practice activities has been demonstrated nationally and internationally by effective diversion and referral programs with ECPs increasingly recognised as frontline healthcare practitioners. Pilot projects funded by the former Health Workforce Australia[30] have also shown the benefits of community and extended paramedic care.

Relevant accredited[31] university educational programs are already available in Australia and could be expanded. These include programs from Deakin Medicine in an articulated format that qualify paramedics at Community Paramedic/ECP (Graduate Certificate), Primary Care Paramedic (Graduate Diploma), Paramedic Practitioner (Master) and Consultant Paramedic Practitioner (Doctor) levels.

In 1996 the United States National Highway Traffic Safety Administration published the Emergency Medical Services Agenda for the Future which has provided aspirational guidance for more than a generation. The EMS Agenda included the following vision statement which broadly parallels several observations made above viz:

> *"Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net."*

The author suggests these views remain just as relevant today as they were in 1996, and similar principles should apply to the role of the QAS in the same way that they are being pursued with success in other jurisdictions in the UK and Canada.

[27] Matt Wilkinson-Stokes, *A taxonomy of Australian and New Zealand paramedic clinical roles*, Australasian Journal of Paramedicine: 2021;18. https://doi.org/10.33151/ajp.18.880.

[28] See, for example, the guidelines for Extended Care Paramedics in New Zealand, or similar roles in the Australian Capital Territory, New South Wales, Queensland, South Australia, and other services.

[29] London Ambulance Service, *Advanced Paramedic Practitioners – Urgent Care*, Association of Ambulance Chief Executives. https://bit.ly/37iPEUQ

[30] Thompson C, Williams K, Morris D, Lago L, Kobel C; Quinsey K, Eckermann S, Andersen P, Masso M, *HWA Expanded Scopes of Practice program evaluation: Extending the Role of Paramedics sub-project: final report,* (2014). Australian Health Services Research Institute. 376. https://ro.uow.edu.au/ahsri/376

[31] Australasian College of Paramedic Practitioners, *ACPP Accredited Programs: Seamless Followship and College Recognition as a Paramedic Practitioner*. Australasian College of Paramedic Practitioners. https://bit.ly/3vk6T2Z accessed 13/03/2021.

Reimagining the role of paramedics in healthcare

Healthcare begins with the patient, wherever and however the need arises.

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.

One of the unexpected situations met by the author is the perception of AHPs and paramedics by International Medical Graduates (IMGs) whose medical qualifications are from outside of Australia or New Zealand and who are practising as GPs. Although impacted by the COVID-19 pandemic, these IMG practitioners have commonly been placed to work in rural and regional areas.

A considerable number come from regions where the paramedicine profession is less mature, and the educational pathways and skillsets are less well developed than in Australia. In concert with some local medical practitioners, there is a need to update these GPs on the capabilities of paramedics within clinical practice settings through suitable practice literacy modules. While this might be best done at a national level, action can be taken immediately at a state and territory level.

The Australian paramedicine cohort

The pervasive image of paramedics is one of the practitioners working alongside nurses and medical practitioners in ambulance services and search and rescue operations. That emergency and unscheduled care role is highly significant, but as registered health professionals, paramedics may also be engaged across the spectrum of health in other community and primary healthcare roles.

The misapprehension that paramedics work only for ambulance services has resulted in Australian governments being slow to mobilise paramedics as regulated health practitioners in a similar way to medical practitioners and nurses. It is extraordinary that paramedicine commonly is not listed in Government documentation as a health or allied health professional. At the same time, it is not surprising given the dearth of AHP practitioners and paramedics working in health policy areas.

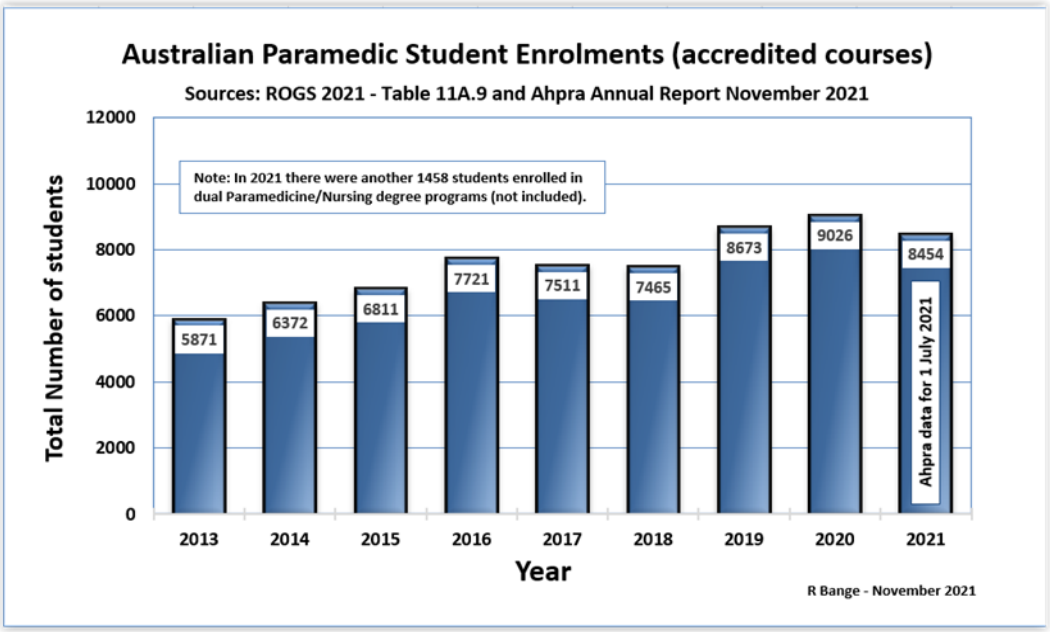
The paramedicine workforce should be considered as independent practitioners within an integrated healthcare system so that the community can benefit from their expertise.

Queensland should provide support for the QAS as a major public sector employer, as well as facilitate the mobilisation of individual registered paramedics across other care settings.

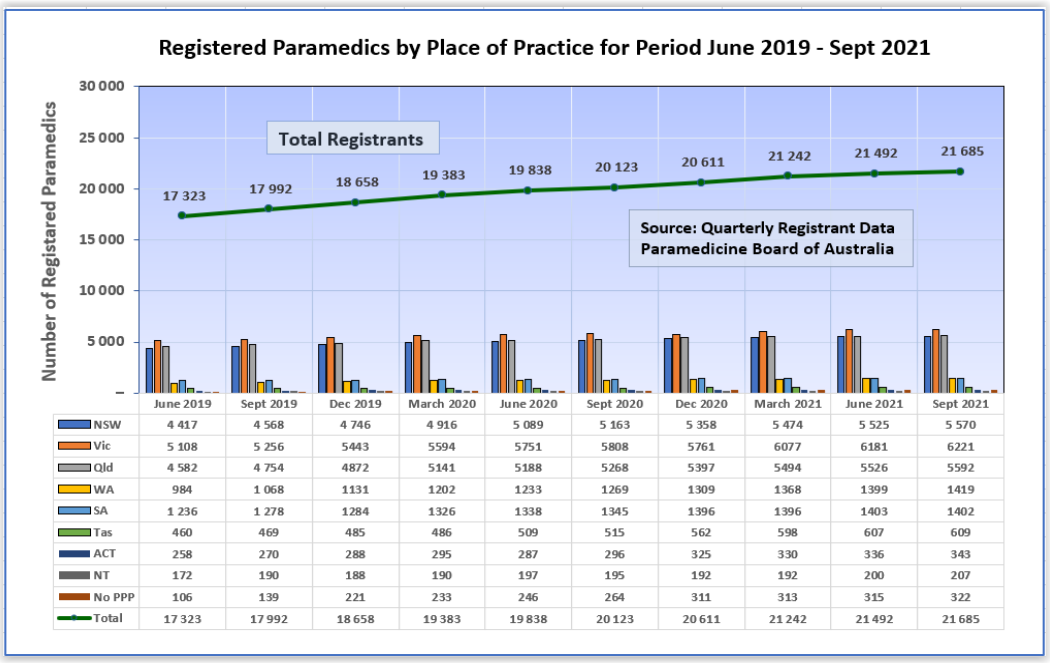
The most comprehensive and readily accessible workforce data on paramedicine are the Australia Health Practitioners' Regulation Agency (Ahpra) registration data and the data from the annual Report on Government Services (ROGS) published by the Australian Productivity Commission. ROGS only covers the subset of paramedics employed by jurisdictional ambulance services (e.g. QAS) and does not encompass private-sector providers or military paramedics.

The Ahpra 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 and the AIHW has little involvement in data collection and reporting (page 11). More comprehensive paramedicine data is essential when considering health workforce planning.

Nationally, university enrolments for paramedicine have grown steadily with a total of 8454 students in 2021 (Ahpra Annual Report 2021). There is no doubt as to the viability of the paramedicine course programs, subject to the continued employability of practitioners within the health workforce.



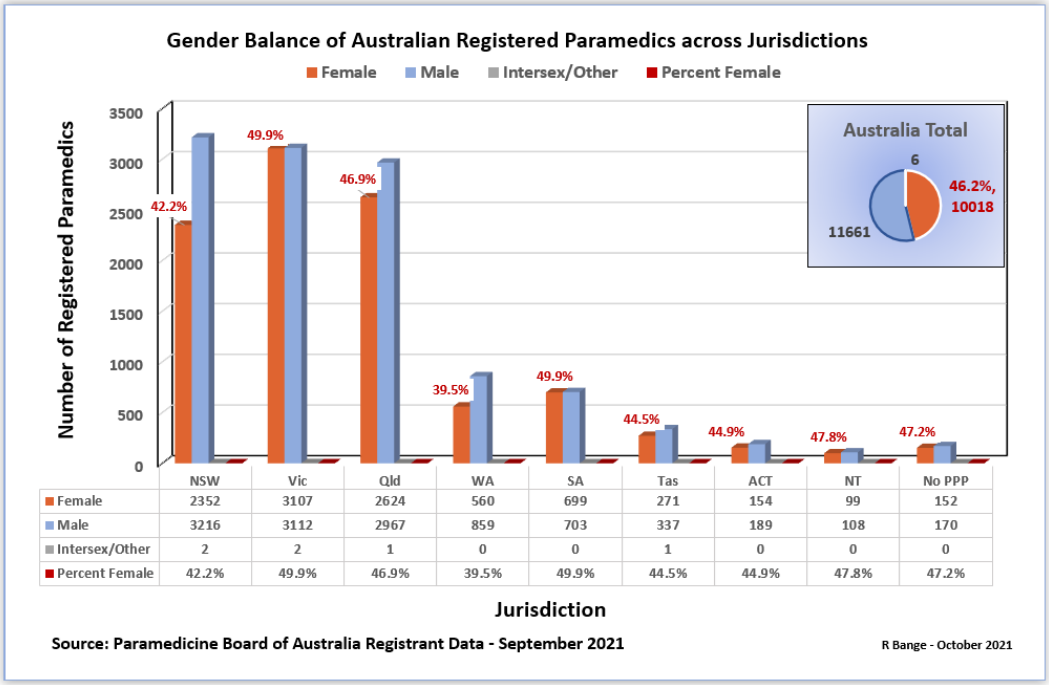
The Paramedicine Board of Australia's most recent statistical summary for 30 September 2021 shows Australia has 21685 registered paramedics. Matching data from Paramedicine Board statistics and the annual ROGS[32] indicate that about 28% of these paramedics do not work for jurisdictional ambulance services. This translates to an estimated 1500 'private' paramedics in Queensland.



	June 2019	Sept 2019	Dec 2019	March 2020	June 2020	Sept 2020	Dec 2020	March 2021	June 2021	Sept 2021
NSW	4 417	4 568	4 746	4 916	5 089	5 163	5 358	5 474	5 525	5 570
Vic	5 108	5 256	5443	5594	5751	5808	5761	6077	6181	6221
Qld	4 582	4 754	4872	5141	5188	5268	5397	5494	5526	5592
WA	984	1 068	1131	1202	1233	1269	1309	1368	1399	1419
SA	1 236	1 278	1284	1326	1338	1345	1396	1396	1403	1402
Tas	460	469	485	486	509	515	562	598	607	609
ACT	258	270	288	295	287	296	325	330	336	343
NT	172	190	188	190	197	195	192	192	200	207
No PPP	106	139	221	233	246	264	311	313	315	322
Total	17 323	17 992	18 658	19 383	19 838	20 123	20 611	21 242	21 492	21 685

[32] Bange R, *Report on Government Services (ROGS) 2021*, The Paramedic Observer, Facebook, 1 February 2021. https://bit.ly/32xgCWD

As the number of registrants increase, the proportion working outside the ambulance sector is likely to approach one in every three practitioners. The profession is better balanced on a gender basis than many other health occupations and the geographical distribution across the state is relatively good – helped by the significant employment by the QAS and its widely distributed station network.



	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	No PPP
Female	2352	3107	2624	560	699	271	154	99	152
Male	3216	3112	2967	859	703	337	189	108	170
Intersex/Other	2	2	1	0	0	1	0	0	0
Percent Female	42.2%	49.9%	46.9%	39.5%	49.9%	44.5%	44.9%	47.8%	47.2%

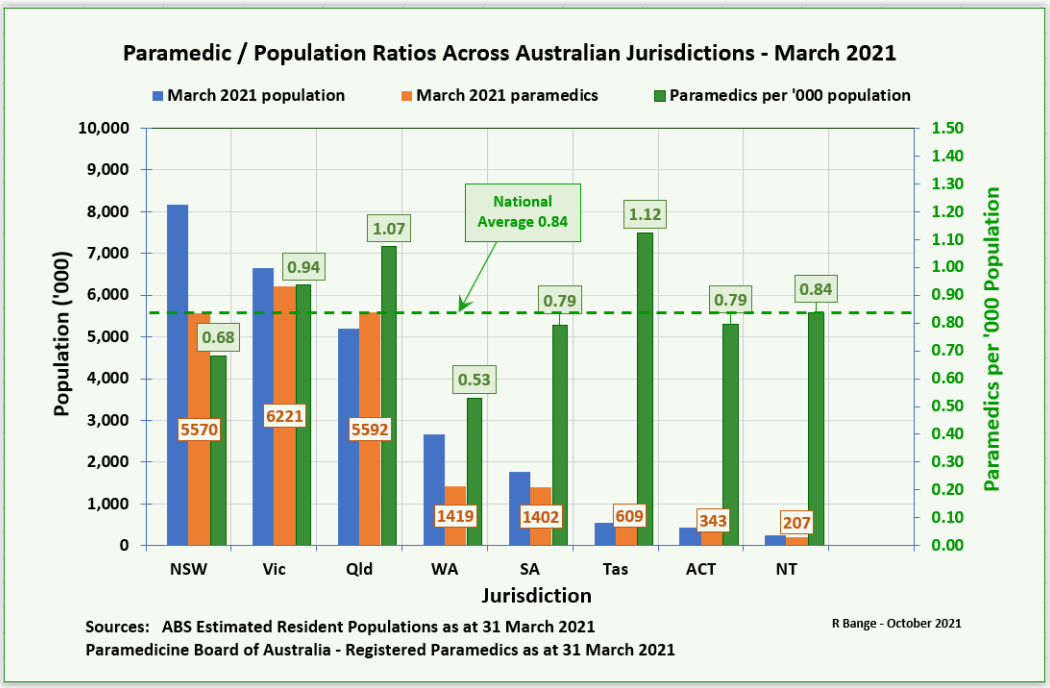
Paramedicine is a highly regarded and popular program of university study with the number of graduates annually substantially exceeding the previous pattern of demand from the public ambulance services. An indication of the relative course popularity can be seen in the ATAR scores for those universities providing nursing and paramedicine courses. For this subset of enrolments, the paramedicine ATAR is consistently higher.

The pandemic has brought changes as governments have responded in various ways including by bringing forward recruitment plans and supplementing existing staff numbers (page 7). In the current state of flux, the dynamics of these moves and their longer-term outcomes is still to be determined.

Longer-term, with annual graduation rates now exceeding 2,500 and based on past service recruitment, the author estimates that 1500 or more graduates annually may not gain immediate employment within the public ambulance service sector. These graduates will add to the number of registered practitioners already available to practice elsewhere across health - provided administrative, regulatory and perception impediments were not present.

The number of paramedics in Queensland on a population basis show the capacity of the profession to respond to demand, but the wider mobilisation of paramedicine is currently inhibited by impediments to practice, many of which are a hangover from a bygone era.

In an era where well-documented current and future shortages exist in the health workforce, the capacity of paramedicine is there and should be used.



If these registered paramedics are not employed within the health sector, there may be a significant loss in the human resources available for our communities that are desperately seeking more health professionals. Many paramedics already have moved 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, but the potential inability for paramedics 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 on their university education

Among the impediments to practice is the ingrained perception that paramedics work only with ambulance services, overlooking the educational pathways and scope of contemporary paramedic practice and the advanced clinical interventions undertaken by today's registered paramedics.

Existing funding and regulatory arrangements also constrain flexibility in terms of employment, the scope of practice, and engagement in flexible models of care; limit the capacity for team-based care, and present financial and professional barriers to practice. These impediments span both state and national issues and often have cascading implications.

For example, Department of Veterans' Affairs (DVA) arrangements for the provision of health care to DVA clients are based on the Medicare Benefits Schedule (MBS). Thus, when it comes to health care services, these are based on delivery by a health care professional recognised and registered with Medicare, which currently precludes their provision by paramedics. If MBS arrangements changed to enable community paramedics to claim for health care services, DVA arrangements would be updated accordingly.

Another example of outdated regulatory limitations can be seen with the issue of vaccination and highlighted by the COVID-19 pandemic. In 2020 the author proposed that existing legislative and regulatory provisions on vaccination in all jurisdictions be reviewed and that steps be taken to facilitate paramedics becoming authorised vaccinators - subject to the same training and certification requirements as nurses and medical practitioners.

There are few cost implications as this would simply mean removing existing impediments to training and practice to enable paramedics to become vaccinators if they wished. As it happens, some dual-qualified practitioners (paramedicine/medicine, paramedicine/nursing) have held the requisite vaccination certification via their alternate practitioner registration.

Despite the obvious benefits, governments were slow to respond. Paradoxically, paramedics initially were deployed to support vaccinators by being available to exercise higher-level care and restricted medications in the rare event of an adverse reaction.

Victoria was among the first jurisdictions to promulgate emergency orders to authorise paramedics to administer the COVID-19 vaccine/s. The Pharmacy Guild of Australia has also offered access to their vaccination training programs via the Australasian College of Paramedic Practitioners.

Only recently have jurisdictions moved to facilitate the administration of vaccines by paramedics as well as several other categories of health care workers – but usually only in the form of special and time-limited regulatory orders rather than enduring general recognition as vaccinators. The key issue is that different jurisdictions have had restrictions under their various regulations covering vaccination that prevented paramedics from even undertaking the minor training needed.

Other practice restrictions are unchanged from years ago – and their existence reflects the situation of paramedicine often being forgotten when it comes to individual workforce and practice considerations. The Commonwealth omission arises presumably because they don't (generally) employ or fund paramedics or ambulance services, and the states and territories previously were only accustomed to dealing with paramedicine through the lens of an ambulance service.

Embedded perceptions mean that paramedic engagement is limited not so much by the capabilities of practitioners, but by issues such as public and professional awareness. To overcome such perceptions requires leadership at a senior level such as that able to be provided by a Chief Paramedic Officer (CPO) as one member of the peak policy team within the Health Department.

In this case, paramedicine does stand apart from other AHPs because of the complex operation of the state's public ambulance service separately from the individual practice of paramedics across other service providers and employers such as GP clinics, urgent care centres, hospitals, mental health, aged care and palliative care providers.

Summarising the ramifications of the forgotten profession

While longer-established professions like nursing are universally recognised as having a role in primary healthcare, there has been little formal acknowledgement of the clinical interventions for which contemporary paramedics are qualified. As noted above, historical barriers also remain that impede the wider engagement of paramedics within healthcare.

Paramedics hold exceptional skills as evidenced by those working in ambulance services, universities and other research and clinical roles. They routinely take complex patient histories, undertake detailed physical examinations and ECGs, and perform differential diagnoses of patient conditions as an integral part of practice. Increasingly paramedics are using point of care ultrasound.

They initiate and monitor advanced interventions like surgical airways, needle thoracotomies 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 presenting with mental health problems and drugs of addiction. Above all, their education is oriented to managing exigent situations.

We need practitioners who hold such expertise to contribute to community healthcare settings where there is an acknowledged shortage of professional staff.

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

- the absence of comprehensive workforce planning profiles and data;
- the omission of paramedicine from the list of health professions recognised by Governments and other bodies for scholarships - and other practice support and payment mechanisms;
- employers and other health professions remain appreciably unaware of the skillsets of contemporary paramedics and the opportunities to engage them in multidisciplinary practice;
- limiting available workforce resources in job specifications through work descriptors unrelated to the functional job roles – and which are within the paramedic skillset; and,
- 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.

Embedding paramedicine in primary care – the ARRS

A further example of the employment of paramedics across health can be seen in England, where GP practices work together with the community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas in groups of practices known as Primary Care Networks (PCNs). The PCN is like the clustered practice models of care in Wales, Scotland and Northern Ireland. They are somewhat analogous to the Australian Primary Health Network (PHN).

PCNs build on existing primary care services and enable the provision of personalised and more integrated health and social care for people close to home. Over 99% of GP practices in England are part of a PCN, who sign up to the Network Contract Directed Enhanced Service (DES) 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 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 can engage community-based partners if they don't directly engage a practitioner.

The ARRS expands the General Practice Charter of 1966 that successfully established nurses and receptionists within general practice. An important feature of the arrangement is the 100% reimbursement to create additional capacity across five nominated primary care roles, being clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics.

By 2024 first contact community paramedics are expected to have become an integral part of the core general practice model throughout England.

An underlying feature of the ARRS is the general recognition of AHPs as a valuable part of the primary care team - while the specific inclusion of 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 practice regime is consistent with current moves 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. It's an approach that should be considered for Australia but requires specific recognition and nomination of eligible professions.

To foster practice development, Health Education England commissioned a Paramedic (Specialist in Primary and Urgent Care) core capabilities framework to support those paramedics working in primary and urgent care. It also provides advice to practitioner groups on the role of paramedics and their integration into general practice. No such framework or advice is available in Australia.

The framework enables health services to specify minimum standards for clinical employment and placement; it sets out clear expectations about what paramedic specialists can do, recognising that these practitioners must be adaptable and not constrained by protocols or prescriptions for practice.

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 facilitate the wider mobilisation of paramedics in primary care, including rural and remote settings, Australian jurisdictions might collaborate in the development of nationally agreed materials to support the wider engagement of paramedics as independent health professionals across a variety of practice and community settings.

With the recent changes to COAG - and the unknown future status of various peak health policy bodies - the author proposes that the Committee might address the mechanisms needed to implement this goal. National consistency is desirable with a task force approach suggested and consultation with all jurisdictions to ensure articulation at a national level, but Queensland might begin with unilateral action to remove barriers to practice that are locally based.

Reforming the health practice landscape

Although the preceding discussion has shown that the wider engagement of paramedics throughout health is well-recognised in the UK, that deployment has been slow to develop in Australia.

The overriding message is that there needs to be effective mobilisation of the paramedicine workforce across all health and care settings including hospitals and in primary care. This should supplement their continuing and expanding advanced practice roles in the ambulance services.

Among the mechanisms to achieve those objectives might be:

- establishment of a national task force to facilitate independent paramedic practice;
- access to MBS and NPS schedules for appropriately credentialled paramedics;
- eligibility of paramedics for rural and remote student and practitioner support;
- the preparation and distribution of paramedicine-related employment materials;
- the appointment of a Chief Paramedic Officer at both jurisdictional and national levels; and,
- enhanced provider performance reporting and better longitudinal patient journey data.

The author acknowledges that legislative and other changes would be needed to implement all these recommendations which span both jurisdictional (Queensland) and national responsibilities. For example, the introduction of advanced practice models of care and the use of paramedics in general practice, urgent care and hospital settings (among others) will be impacted by the various state Drugs Poisons and Controlled Substances (DPCS) regulations for the handling of medications.

On the other hand, the registration of paramedics is a national issue spanning all practice settings, and the recommendations on innovative funding of multidisciplinary practice and health and care centres may embrace a national commitment as well as jurisdictional commitments.

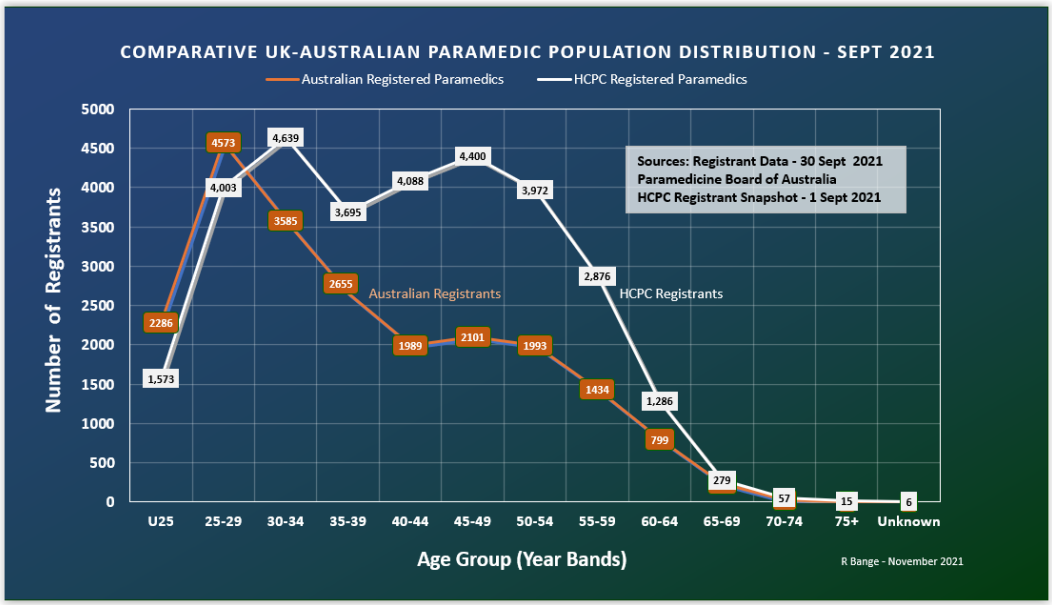
Recommendations

The days of home visits by GPs are disappearing, even in rural regions, with time, distance and economics making those practices increasingly difficult. At the same time, there is an acceptance that patient-centred care close to or in-home reaps significant benefits for older patients with chronic health conditions.

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 broadening the remit of the QAS.

Paramedics working within primary care in the UK and internationally (and in pilot studies and embryonic developments in Australia) have shown that they possess the knowledge, leadership and complex skills needed for home visiting as well as patient engagement in clinic operations. An increasing number of UK paramedics are qualified as independent prescribers.

As of 1 September 2021, there are 1016 Registered Paramedics with Independent Prescribing status and 978 with Supplementary Prescribing status in the UK. Australia has proportionately more paramedics and more highly educated and younger paramedics than other jurisdictions, and we should grasp the opportunity to use them effectively and provide career progression within health.



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.[33]

The author proposes that Queensland set a lead by adopting policies that engage paramedicine in primary care services including online, video, and face-to-face consultations. The question is how that might be achieved given the complexity of health funding arrangements, the current Commonwealth/State responsibilities and gaps in funding and recognition of the practitioner in established policy documentation and regulations.

That objective may be achieved in part by removing unnecessary barriers to practice and mobilising the paramedicine workforce to increase the capacity of the GP cohort in primary care thus enabling care close to home and reducing unnecessary presentations to hospitals. Those actions should allow appropriately credentialled paramedics to better care for our communities.

More generally, Queensland should actively engage paramedics within the public health system beyond the present valuable but limited role of employment within the ambulance service.

[33] Burns J, *Paramedic-led acute home visiting services in primary care,* Journal of Paramedic Practice VOL. 13, NO. 6, 8 June 2021. https://doi.org/10.12968/jpar.2021.13.6.238

Recommendation 1 - An overarching policy commitment on health

That Queensland formally adopt a 'Health in All Policies' approach based on the principles of sustainable development and climate-related health outcomes. This strategy should be aimed at improving the economic, social, environmental, and cultural well-being of all community members by implementing policies and actions designed to achieve long term wellbeing goals.

Recommendation 2 – A review of QAS related legislation

That a review of the Queensland Ambulance Service Act 1991 be undertaken, with the drafting of the Act provisions from the perspective of legislation that retains regulatory rigour, but which empowers the QAS as a collaborative provider of healthcare services with the capacity to provide emergency and unscheduled response in out-of-hospital settings.

The legislation covering the provision of QAS and paramedic-related care should include the capacity for registered practitioners and other personnel to collaborate with and undertake exchange and interchange engagements with the QAS and for the mobilisation and engagement of external accredited health service providers as supplementary resources.

Explicit reference should be made to collaboration with institutions of higher learning (universities) with affirmative statements that foster appropriate sharing of human and physical resources, performance data and other clinical and operational matters (as appropriate). Support for research activities should be included within the nominated objectives for the service.

Recommendation 3 – A commitment to service accreditation

That in addition to relevant legislative enabling provisions, the QAS and the Queensland Department of Health should take appropriate action at state and national levels to implement a regime of accreditation and licensing of all ambulance (paramedic) service providers that complements the registered status of paramedics. Accreditation standards should include mandatory equipment, staffing, clinical governance, performance standards and transparency of public reporting.

Where relevant, this accreditation should extend to any subsidiary patient transport functions.

Recommendation 4 – A commitment to funding

That the Queensland government provide ambulance service funding at a suitably greater than the national average per capita level and continue to make representations to have the provision of ambulance services funded as an essential service through a base stream of national funding.

Recommendation 5 – A commitment to extended services

That the QAS facilitate the provision of out of hospital care by community paramedics and extended care paramedics holding prescribing rights,

Recommendation 6 – Recognition of paramedicine as a discrete health workforce

That the Committee recommend that the Queensland government and other jurisdictions including the Commonwealth formally recognise paramedicine as part of the available health workforce for statistical, policy, planning, and development purposes.

This commitment should see paramedicine identified in policy and media documents as a discrete professional health workforce – aligned with Allied Health – and with paramedicine engaged as one of the recognised stakeholders in policy deliberations on health policy and primary care strategy at state, territory, and national levels.

Recommendation 7 - Mobilisation of paramedicine across the health domain

That to ensure effective workforce mobilisation and long-term sustainability, the Committee recommend the mobilisation policy for paramedicine include eligibility for 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 to paramedics upskilling in low-acuity specialties and accepting roles in rural locations.

To support their engagement in primary care, Queensland should seek 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 for the employment of AHPs. The experience of the UK Additional Roles Reimbursement Scheme (ARRS) should be considered in this review.

Recommendation 8 - Identify and remove unnecessary impediments to practice

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

In the immediate short to medium term, Queensland should examine unwarranted barriers to practice at the jurisdictional level and ensure the incorporation of paramedicine within workforce studies under both state and RWA activities.

Recommendation 9 - Promote the engagement of paramedics in primary care

That the Committee support the development of a national 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.

Queensland should engage with the Commonwealth in distributing these materials, including toolkits, that identify paramedicine as a health profession whose members can work across a wide variety of practice and community settings.

These practice guidelines on the paramedic integration into general practice, primary and other care settings might draw on the experience and materials developed in the UK for Clinical Commissioning Groups and the UK College of Paramedics.

Recommendation 10 - Support for engagement of paramedics in practice environments

That the Committee recommend the Department of Health explore how to use paramedics more widely to meet workforce needs in hospitals, clinics and other health and care settings including longer-term senior citizen and aged care, palliative care and mental health care.

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

Recommendation 11 - Appointment of a Chief Paramedic Officer

That to ensure adequate consideration of paramedicine, the Committee recommend the appointment of a Chief Paramedic Officer as part of the peak leadership team within the health and social welfare domains. This appointment should stand apart from the operational role of the Commissioner for the Queensland Ambulance Service.

The role may encompass high-level strategic advice on professional issues in the integration and delivery of paramedic services; and include workforce planning in association with other professional groups, educational institutions, professional bodies, and practitioners and service providers in the private sector.

If a Chief Paramedic Officer is not appointed, then the role of the Chief Allied Health Officer, or equivalent, should incorporate specific references to paramedicine and the substantive position made open to paramedics.

Recommendation 12 - Support for Paramedic Practitioner roles

That the Committee recommend the piloting of Paramedic Practitioner roles within the community and other health centres in identified areas of need with a view to adoption as a new model of care.

Recommendation 13 - Support for development of paramedic education programs

That the Committee support the development of university programs of education for Extended Care Paramedic and Advanced Paramedic Practitioner cohorts including their educational and practice foundations, with the greater use of these paramedics having a scope of practice enabling advanced assessment, interventions and prescribing of medications.

Abbreviations / Definitions

The following abbreviations and definitions are used in this submission.

AHP	Allied Health Profession/Professional
Aphra	Australian Health Practitioner Regulation Agency
ARRS	Additional Roles Reimbursement Scheme (UK)
DES	Network Contract Directed Enhanced Service (UK)
DVA	Department of Veterans' Affairs
ECG	Electrocardiogram
ECP	Extended Care Paramedic/s
ED	Emergency Department
GP	General Practitioner
HWA	Health Workforce Australia (now closed)
HWSG	Health Workforce Stakeholder Group
NHS	National Health Service (UK)
LHN	Local Hospital Network
PCN	Primary Care Network (UK)
PHN	Primary Health Network
QAO	Queensland Audit Office
QAS	Queensland Ambulance service
ROGS	Report on Government Services (Productivity Commission)
RWA	Rural Workforce Agency
RWAN	Rural Workforce Agency Network
SARRAH	Services for Australian Rural and Remote Allied Health
SDOH	Social Determinants of Health
UK	United Kingdom
WIP	Australian Government Workforce Incentive Program - Practice Stream

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, working outside the standard Ambulance service framework, 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.

Appendix A - Inquiry Terms of Reference

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

That the Health and Environment Committee inquire into and report to the Legislative Assembly by 31 March 2022 on

1. the provision of:
   a. primary and allied health care;
   b. aged and NDIS care;
   c. the private health care system;
   and any impacts the availability and accessibility of these services have on the Queensland public health system

2. in conducting this inquiry, the Health and Environment Committee should consider:
   a. the current state of those services (outlined in 1) in Queensland;
   b. bulk billing policies, including the Commonwealth Government's Medicare rebate freeze;
   c. the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas; and
   d. the availability of medical training places at Queensland universities, compared to other jurisdictions