Enhancing patient outcomes

Improving the pathways of care through clinical engagement and collaborative action

February 2011
“Integration of health care services helps to ensure that the care provided by EMS does not occur in isolation, and that positive effects are enhanced by linkage with other community health resources and integration within the health care system.

EMS provides out-of-facility medical care to those with perceived urgent needs. It is a component of the overall health care system. EMS delivers treatment as part of, or in combination with, systematic approaches intended to attenuate morbidity and mortality for specific patient subpopulations.”

The ACAP Vision

ACAP places a focus on forward-looking aspects in the delivery of Emergency Medical Services (EMS) and the facilitation of the paramedic's healthcare role. ACAP’s vision is for EMS to be integrated with other health services so as to create a seamless system of care beginning at the point of need – the patient.

The paramedic practitioners and EMS systems of the future should ensure a rapid response providing appropriate levels of care to each patient presentation, and contribute a vital community resource for prevention, evaluation, care, triage, referral and advice.

Access to paramedic practice should form an integral part of the care regime available to patients in an inter-professional model of healthcare practice founded on the contributions from a dynamic mixture of professional and related staff at all stages of the patient journey.
Executive Summary

1. The Australasian College of Ambulance Professionals (ACAP) is the professional body representing paramedics engaged in the delivery of out of hospital emergency healthcare in Australasia. ACAP is thus uniquely positioned to provide insights into the role of Emergency Medical Services (EMS) in the continuum of care.

2. Every day patients are placed at risk of harm within the health-care system. These risks are particularly notable in EMS delivery where paramedics often must care for patients under adverse operating conditions and without any patient history. Clinical judgements must be made that may profoundly affect overall patient outcomes and the interventions by paramedic practitioners pose significant risks.

3. EMS has changed dramatically in recent years. Paramedic practice has evolved as a unique discipline combining medicine, public health and public safety and modern EMS involves medical care provided by professionally qualified practitioners. These developments have been built on a strong evidence base demonstrating the capacity to enhance patient outcomes through appropriate clinical interventions.

4. The ACAP vision for EMS is based on the premise that EMS is an essential part of primary healthcare and its seamless integration into healthcare will better meet patient needs that might otherwise remain unfulfilled. Paramedics can provide a variety of community health services that are crucial in the provision of more comprehensive care, especially in rural and remote communities bereft of hospital and medical facilities.

5. ACAP endorses the philosophical approach to healthcare outlined in the 15 National Health and Hospitals Reform Commission (NHHRC) Healthcare Principles and recommends the translation of those principles into the EMS environment. Given those principles, it is inexplicable how paramedics have remained unrecognised as health professionals and EMS has been ignored as part of the healthcare reform process.

6. Embracing the NHHRC principles should see EMS forming not only part of the local healthcare system but also meshed into the fabric of the community. Collaborative engagement in the assessment and evaluation of EMS delivery as part of healthcare will facilitate the delivery and benefits of inter-professional practice and holistic care.

7. ACAP recognises that formidable challenges remain in healthcare delivery especially in rural and remote Australia. These include issues of equity and access, demographic coverage, safety and quality, as well as other workforce and resource issues that impact on patient outcomes. The health system should provide suitably rapid EMS responses under universal minimum access standards and with the levels of care appropriate to the circumstances of each patient.

8. Determining who may champion change and drive innovation in objective terms raises the dilemma of on-going stakeholder participation and engagement. Silo-based solutions are inadequate and no one group or individual holds all the answers. However, paramedics can assist in identifying and resolving many of these issues because on a daily basis they must deal with the delivery of a significant part of currently unrecognised EMS healthcare.

9. Beyond their roles in emergency care, paramedics moreover hold competencies that can provide prevention, evaluation, care, triage, referral and health advisory services that can be mobilised to enhance community healthcare resources. Access to the expertise of professional paramedics thus should form an integral part of the care regime available to all patients. This should form part of an inter-professional model of healthcare practice based on a dynamic mixture of professional contributions at all stages of the patient journey.
10. In ACAP’s view, the omission of EMS as a key component of the healthcare system represents a grave oversight in the current health reform process. A nationally driven policy perspective is needed that properly integrates EMS into healthcare and incorporates the research and other inputs of the paramedic profession into best practice considerations.

11. Just as a building is only as stable as its foundations, or a chain as weak as its weakest link, so too are patient outcomes largely dependent on the quality of initial care. The quality and safety of EMS interventions can play a pivotal role in later patient outcomes.

12. Meeting the ACAP vision of healthcare requires significant changes in the way EMS is funded and administered. It will need advice from the best available minds and committed knowledgeable leadership within government and the profession to bring the already demonstrated benefits of paramedic practice to the community. Many issues need to be addressed within EMS to improve patient outcomes including:
   - Sustainable funding models under minimum national access and equity principles;
   - Education, clinical training, staff recruitment and retention;
   - Safety and quality standards and the minimisation of patient risk in primary care;
   - Extended community care models in remote and low-volume settings;
   - Clinical governance, service accreditation and practitioner registration;
   - Adequacy of evidentiary data collection to assess patient outcomes, support service evaluation and underpin research; and
   - Infrastructure integration including communication networks and dynamic referral to manage external events and cope with capacity constraints.

13. ACAP strongly believes that these issues cannot be considered in isolation and would benefit from the support envisaged to come from well-constituted lead clinician groups. At the same time, a collegiate approach is needed and EMS practitioners must be involved in contributing their expertise in conjunction with other health professionals so as to create a seamless system of care beginning at the point of need – the patient.

14. To fulfil that promise ACAP supports mechanisms that will facilitate the research and systematic dissemination of best practice guidelines across healthcare. There must be an holistic ‘outcomes’ focus, participation from a variety of fields, a minimum of hierarchical and practice barriers and a willingness to identify, prioritise and implement innovative models of coordinated care. The lead groups (however constituted) should also devote a proportion of their energies and resources to the examination of more speculative pilot studies - subject to appropriate risk management practices that will ensure public safety.

15. While the service goals envisaged by ACAP appear to align with the objectives proposed for the lead clinician groups there are distinct differences in EMS delivery between national issues (such as clinical practice guidelines, patient safety and competency frameworks), and local operational issues dealing with local conditions and resource implications. Only by incorporating the input of paramedic clinicians at both the national policy levels and at the operational service delivery level can the best patient outcomes be achieved.

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**Australasian College of Ambulance Professionals**

The *Australasian College of Ambulance Professionals* (ACAP) is the professional body representing paramedics engaged in the delivery of out of hospital emergency medical care. ACAP has an abiding interest in policy matters that affect the access, equity, quality and effectiveness of Emergency Medical Services (EMS) in Australasia.

ACAP activities encompass programs of professional development, voluntary regulation, publication and other professional activities designed to enhance the standards of EMS and thereby better protect the health and safety of the community.

Paramedics have a unique perspective of patient needs and other matters associated with the patient journey and service interface issues that arise across both metropolitan and rural environments. The profession holds an in-depth knowledge of the vagaries of providing emergency care under real-life conditions and with varying infrastructure support levels.

Through its expert practitioner membership ACAP thus embodies the views of the most significant group of practitioners engaged in primary EMS delivery throughout Australasia. These expert views need to be harnessed through the existing and proposed advisory mechanisms being proposed by government.

**ACAP philosophy of healthcare**

ACAP endorses the basic principles for healthcare espoused by the National Health and Hospitals Reform Commission (NHHRC).¹ In keeping with these principles, ACAP has articulated a vision for EMS and paramedic practice as a lead statement to this submission.

Within this vision, the primary goal of ACAP is to help develop the full potential of EMS as part of a health system that will deliver quality healthcare to all members of the community. ACAP activities are directed towards fostering policies and practices that will benefit patients through the integration of EMS with other healthcare programs.

To achieve these objectives, ACAP believes that healthcare policy should:

- recognise the benefits of holistic care delivered by health professionals operating in a multidisciplinary / inter professional practice environment;
- ensure an equitable health system by providing EMS according to need and regardless of race, creed, gender, location or economic circumstances;
- establish funding arrangements at Federal, State and Territory levels that facilitate the delivery of integrated healthcare services and minimise duplication of effort by optimising the use of available physical and human resources;
- ensure responsiveness, quality and high service standards through governance structures, practitioner and community engagement that recognises the legitimate role of stakeholders in the planning and delivery of healthcare.
- provide adequate educational opportunities for the recruitment, training and professional development of EMS practitioners that will ensure a competent and sustainable workforce; and
- provide a national regulatory regime for the accreditation of service providers and the independent registration of paramedics that together will ensure consistent service standards and public safety.

Paramedics zealously guard their status as Australasia’s most trusted profession,² and have embraced professional and ethical standards intended to ensure the maintenance of that position. As a profession they want to provide a level of patient care that ranks with world’s best practice.

Nonetheless ACAP notes that EMS practices in several Australian jurisdictions have been subject to Government Inquiries in the recent past. Unfortunately the catalysts for many of these Inquiries have been associated with public concern at managerial or operational deficiencies³⁴ such as provider responses⁵ rather than being aligned with patient outcomes under health service performance standards and indicators.

However, these developments show the need to examine a number of policy, governance and practice issues which to date have not been adequately addressed by the health reform process or captured within government datasets.

The paucity of data related to pre-hospital patient outcomes and the need to integrate information on the total patient journey has been confirmed through direct discussions with the Australian Institute of Health and Welfare (AIHW).⁶ More research is needed but that will depend on proper recognition of EMS as an integral component of healthcare.

Patient safety in EMS is another issue that has been poorly studied and documented. The uncontrolled nature of much of EMS delivery creates servicing challenges that increase the risks of adverse events. Even so, the available data is inadequate to hold significant opportunities for improvement. Collaborative action is needed to better identify pre-hospital patient safety incidents and practices that affect overall patient outcomes.

ACAP is focussed on the need to facilitate the healthcare role of paramedics in the interests of the patient. ACAP wants to see EMS integrated with other health services so as to create a seamless system of care beginning at the point of need. This level of integration will only occur with the direct involvement of expert paramedic clinicians within the advisory, policy and operational governance framework of healthcare delivery.

**Placing EMS delivery into perspective**

Australians rely heavily on paramedics and EMS service providers to respond to emergency and other medical incidents that occur away from established hospital emergency facilities.

The Productivity Commission reports⁷ that Ambulance service organisations attended 2.93 million incidents nationally in 2008-09 (not including figures from the NT). Nationally the Commission notes that in 2007-08 (latest available figures) some 84% of hospital; emergency department patients in triage category 1 arrive by ambulance, air ambulance or helicopter rescue service and 47.9% in triage category 2.

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⁷ Government of Western Australia, *St John Ambulance Inquiry: Report to the Minister for Health, Department of Health, October, 2009* (St John Ambulance Inquiry or Joyce Inquiry)
Total reported revenue of ambulance service organisations in Australia was $1.98 billion in 2008-09. These figures do not include private or defence-related commitments. Nationally, revenue (in real terms) increased each year from 2004-05 to 2008-09, with an average annual growth rate of 6.0 per cent.\(^8\)

Those basic statistics shows the significant impact of the EMS sector, which at some stage or other will touch the life of nearly every person in the community – and for some many times – with the average Australian needing EMS care up to 16 times in their lifetime. It graphically demonstrates the ubiquitous impact of EMS and the need for better integration with the hospital and broader health system.

Better understanding of the concern held by the profession at the present isolation of EMS from national healthcare policy may come from an examination of the current environment of EMS delivery across different jurisdictions.

While prevention and broader healthcare roles are embodied within the EMS job description and paramedic skill set, the popular perception of the role rarely reflects these elements. Community perceptions remain largely fixed on EMS as consisting of an ambulance vehicle and its crew responding to an emergency and taking the patient to a hospital. Many policymakers and EMS providers hold similar perceptions of the EMS role and key performance indicators consistently focus on response times and emergency service parameters to the relative exclusion of other indicators of healthcare outcomes.

It is disconcerting to find this lack of understanding of EMS in a recent report prepared by the NHHRC\(^9\) dealing with the Australian Healthcare Agreements and performance benchmarks. The NHHRC document uses the term “emergency” almost exclusively in the context of hospital-based services, the word “ambulance” appears twice referring to a transport vehicle and the term “paramedic” does not appear at all. Statistical datasets related to EMS, patient healthcare and occupational classifications likewise are deficient to assess patient outcomes from initiation of need/care. So much for EMS handling nearly 3M incidents annually!

EMS services and costs are not covered by Medicare even though nearly all the clinical interventions performed by paramedics would attract a Medicare rebate if performed by a practitioner with a provider number. Somewhat similarly, in the United States the federal government through its Centers for Medicare and Medicaid Services, only pays for EMS if a patient is transported to a healthcare facility – with that historical policy commonly leading to perverse treatment outcomes.

These one-dimensional role perceptions arise from the early beginnings of EMS based mainly on transport and emergency responses to public safety and life-threatening events. But the functions of EMS have undergone a sea change. The role of paramedics has evolved swiftly until today they are the primary practitioners in the delivery of advanced out of hospital emergency medical care.

The niche view of EMS and paramedics has had other ramifications. Rather than forging a partnership in care, practitioner involvement in many cases has been limited to fleeting and aperiodic interaction with hospital emergency department staff, interaction with other hospital and community health facility staff during patient transfers, and some educational and clinical training experiences.

There is no doubt that patient outcomes have been compromised to an unquantified degree by the disconnection of EMS from the healthcare and the welfare support systems.

\(^8\) Ibid
In rural settings there are further considerations such as the lack of other resources to which patients might attend or be appropriately referred. Paramedics may be the healthcare providers most likely to be called on for a variety of more routine health needs. Not surprisingly, professional paramedic-delivered services may be more useful the more remote the community.

Remoteness has other consequences including that EMS in rural areas historically has been carried out on a volunteer basis and with widely variable standards of care far more than most other healthcare jobs. This in turn has marginalised the perceptions of EMS because of the challenges in gaining qualifications and maintaining paramedic competencies as a volunteer, ensuring quality control, developing sustainable career structures or establishing a professional identity and professional leadership.

The result is a common focus on emergency patients and a more simplistic care regime at a time when community paramedics should be available to fulfill a more widely defined role because local hospitals, GPs, primary care providers and other health services are disappearing or are being overwhelmed.

The demand for emergency services is largely driven by external events and as occurs with medical practitioners and nurses, it may prove difficult to maintain a professional paramedic presence in areas of low volume demand. One answer may be the greater use of paramedics in an interdisciplinary mode to supplement primary care services and other healthcare personnel.

The use of paramedic in an extended care mode in clinics, hospitals, and elsewhere can fill gaps in community healthcare needs while allowing paramedics to maintain their skills and being available to respond to emergencies for which they are uniquely qualified. There is now an International Roundtable of Community Paramedicine (IRCP) which recognises a variety of such practices and systems around the world.10

As the benefits of other models of care and appropriate interventions have come to be better recognised and supported by evidence-based practice, educational and practice requirements likewise have expanded to keep pace with new procedures and advances in technology.11 The professional preparation of paramedics now involves university degree and advanced level Masters and Doctoral programs in addition to on-going competency and continuing professional development requirements. There are moves to formalise the roles of community paramedics by establishing specific training programs.

The rate of practice development in EMS appears to have been more rapid than the legislature, governments, practitioners and related health professionals can readily absorb, with varying misconceptions remaining about the functions of EMS and clinical interventions performed by paramedics. The result is a fragmented landscape for EMS delivery which may be summarised (in part) as follows:

- Funding arrangements vary between jurisdictions, but all government-sponsored providers rely in part or in whole on government funding obtained through a variety of mechanisms including levies12 and subsidies.
- There is no consistent funding base for EMS and services may be free for residents of a given jurisdiction13 or reimbursed under a user-pays principle14 or recouped in whole or part by insurance.15 Distinctions are also commonly made between emergency and non-emergency (transport) situations.

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11 http://www.ohsonline.com/articles/44867/
14 http://www.ambulance.vic.gov.au/Main/home/Membership/Membership-Cover/Billing-Policy.html
• EMS is notable for having a higher proportional contribution from volunteers than other healthcare sectors (excluding overtly volunteer entities). The involvement of volunteers and uncontrolled service demands make the operational management and quality control of EMS delivery far more complex than many other health services.

• A growing number of private operators service particular industry sectors. Independent emergency services are subcontracted or maintained by major corporate entities e.g. mines, oil rigs etc. These ventures employ paramedics (and other healthcare professionals) outside the ambit of the traditional public sector EMS providers and without the benefit of a national regulatory framework.

• Australian private sector agencies contract to Australian Government Departments and international agencies to provide EMS care and consultancy services overseas. For example, Aspen Medical employs more paramedics than the ACT Ambulance Service and provides professional hospital and EMS personnel nationally and internationally.

• Aero-medical services are provided by an array of public and private sector organisations - most notably by various community helicopter providers and the Royal Flying Doctor Service. In some cases the costs are captured – in other cases they are not.

• The administration of EMS varies from jurisdiction to jurisdiction – ranging from being a subset of an Emergency Services Department\(^\text{16}\) to a subset of a government Health Department or a private corporate entity contracted to government.

• There is no nationally accepted and independent framework for the accreditation of service providers and the public sector EMS infrastructure providers work under different (albeit similar) clinical practice guidelines and operational metrics.

• There currently is no nationally accepted regulatory framework for defining the scope of practice or for the registration of paramedics. Paramedic practice stands apart from other health professions with practitioners credentialed by their respective employers. Paramedics are not enabled to practice independently outside the bounds of their State-authorised agency - which could disadvantage patients.

• Legislative and operational constraints make it difficult for paramedics to move and retain their professional standing. Flow-on effects include the impacts on potential cross-border integration and operational issues, more difficult recruitment of personnel and restrictions on mobility and career development.

• There is no nationally recognised and independent framework for community engagement and complaint mechanisms for either service providers or individual paramedic practitioners such as is provided for other health practitioners.

• Australian Defence Force (ADF) personnel have no direct links to or comparable education and qualification standards with their civilian counterparts. One consequence is the potential loss of defence medics from the healthcare workforce upon their retirement from the ADF because there is no clear post-military career pathway and no portability of qualifications. Within the services the picture is no better and ADF medics have limited career options or promotion opportunities unless they move out of their medic role.

• Chronic paramedic staffing shortages are reported in several jurisdictions which have resulted in continuing problems of service errors, absenteeism, stress-related illnesses, high staff attrition rates and industrial unrest. Evidence of excessive overtime and long shifts indicates that paramedics are consistently working in a fatigued state equivalent to being over the government mandated alcohol limit, and therefore not in a fit state to drive or administer treatment.

EMS education is in a state of flux although many programs are partly conducted in conjunction with Medical and Nursing programs. Clinical training and continuing professional development needs raise problems that are shared with other health professions. There are indications that some EMS providers do not regard clinical training placements as falling within their “core business” role and this adversely impacts the availability and quality of clinical training – and subsequently patient care.

It should be clear from the foregoing summary that the EMS environment in Australia remains fragmented and isolated from the mainstream of healthcare policy. That is unfortunate since EMS should not stand alone but be considered in the context of its role as (often) the first point of community contact for emergency primary healthcare.

**Highlighting the omission of EMS from healthcare**

The 2.93 million incidents handled nationally in 2008-09 shows the significant impact of EMS on the community. One therefore might think that the provision of EMS and the role of paramedic practitioners would figure prominently in national healthcare reform.

That’s not the case, and the almost total omission of EMS from the healthcare debate or recognition of paramedics as health professionals is a matter of continuing concern. From a public policy perspective it is inexplicable. Even the occupational classifications under the Australian and New Zealand Standard Industry Classifications (ANZSIC) do not conform with current international guidelines, making comparative performance studies less relevant.

The disengagement of EMS from broader healthcare policy is both counterproductive and difficult to reconcile with the community perceptions that it forms a vital component of the healthcare system. It has resulted in a relative lack of accountability through the absence of public reporting under internationally recognised healthcare oriented Key Performance Indicators (KPIs).

Reporting of EMS should cover not only response times and emergency service indicators but also other indicators that deliver appropriate measures of quality and cost-effectiveness in healthcare terms.

These performance-related deficiencies have been identified on several occasions, and in the recent Performance Audit Report of the ACT Ambulance Services (ACTAS) it was noted: 17

> ACTAS did not have a sufficiently comprehensive performance management framework by which to manage and monitor performance of service delivery. This makes it difficult for management to fully assess, monitor and report on performance.

ACAP believes that EMS should be funded and held to account no less rigorously than other healthcare practitioners and service providers.

The situation demands a more strategic and national vision that properly integrates EMS with the healthcare system and engages paramedic practitioners in the task of optimising the pathways of care. Through suitable interactions and expert advice from practitioners the healthcare system may move towards achieving an effortless interface between service platforms and treatment by relevant health professionals with the timely and accurate transfer of patients and the information crucial to effective patient outcomes.

Particular efforts therefore should be made to ensure an holistic approach to healthcare delivery. Advice should be sought from knowledgeable persons drawn from the practising members of the professions that form the healthcare team (not just physicians) as well as educational and research institutions and groups such as ACAP in the determination of broader healthcare policy.

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“It’s so horribly simplistic – it doesn’t involve technology, doesn’t involve enormous capital investment, doesn’t involve restructuring healthcare bottom to top, and doesn’t involve government legislation. What it does involve is profoundly courageous and powerful leaders, compassionate caregivers, and the fearless humility to admit when one is wrong”

John Lewis

Operational service delivery

A further example of the unique role of public sector EMS delivery is provided by the operational demands of service delivery and the public expectations that every call for assistance will elicit a suitable response.

Paramedics often must triage and work in small, poorly lit spaces under chaotic conditions that involve heightened personal risk and a range of high level stressors. Emergency scenes are not a controlled environment like a hospital or diagnostic clinic. Operating with limited time, human and medical resources, and having to deal with panicked family members and curious bystanders in sometime physically dangerous conditions unfortunately can give rise to adverse events and poor patient outcomes through both provider and practitioner error.

The best diagnostic, hospital and emergency facilities in the world are of little value if the patient is dead on arrival. It is an undeniable fact that the interventions performed by paramedics are often what stabilises and keeps patients alive until they can reach more definitive care.

These elements of operational practice are among the strong reasons why paramedics should be part of the healthcare governance and policy advisory team. Paramedics form a highly expert body of practitioners who can speak from experience and with the benefit of available research, of the issues associated with the delivery of out-of-hospital emergency care.

Clinical training of health professionals

The profession is conscious of the increasing demands on today’s paramedic to meet community expectations for consistently high quality care - both under the umbrella of traditional EMS providers and as practitioners within the wider industrial and community settings envisaged by the NHHRC.

Clinical training is an important part of practitioner development and ACAP is conscious of the impact of this training on public safety. Paramedics must be competent to execute complex and risky procedures whenever the need arises. It is axiomatic that emerging practitioners should receive appropriate clinical training through placements that will ensure they can enter the workforce and exercise their skills at an appropriate level.

In its Discussion Paper of December 2008 the NHWT18 raised a number of issues facing educational institutions and health services that provide clinical placements. It acknowledged the pressures placed on existing service providers by the growing demand for clinical placements as well as the diversity and at times, inconsistent processes involved in clinical placement activities.

The paper noted that:

“Clinical training is a significant part of health education and essential to the development of the requisite practical skills. Responsibility for this training is currently split between education providers and the health sector; however, there is no clear delineation of respective roles and obligations. There is also a significant gap in the knowledge of current training load, distribution of placements and health service capacity, and disparate funding arrangements across different health settings. A starting point is to map what is currently known about clinical training activity and placement capacity in order to consolidate a national approach.”

ACAP supports the current policy move towards holistic and integrated multi-disciplinary care with expanded career pathways and inter-professional learning opportunities. In that context, clinical placement demands must be balanced across the broadest range of settings by taking into account:

- patient-focussed care within suitable safety and quality frameworks;
- student needs including geographical, financial and family requirements;
- improved access through enhancing placement capacity;
- suitably comprehensive contributions from all stakeholders (including all tiers of government, employers, educational providers and professional associations);
- well-structured placements that offer true workplace mentoring and professional development and training experiences that facilitate communication, team work and learning; and
- effective supervision and clinical education pathways.

Reforms announced by COAG on 29 November 2008 provided funding for a number of health workforce initiatives including support for the training of health professionals, establishing more effective, streamlined and integrated clinical training arrangements, and investigating funding approaches and incentives to ensure clinical training is delivered in the most cost efficient manner.

COAG agreed to establish a new national agency to manage these initiatives with a specific focus on implementing workforce reform, and operating across the health and education sectors, complementing jurisdictional responsibilities in health and being able to devise solutions that integrate workforce planning, policy and reform with complementary reforms to education and training.

It was envisaged that the agency would take a major role in the planning, coordinating and funding of professional entry clinical training across all disciplines to ensure increased capacity whilst achieving quality, efficiency and effectiveness in an integrated and educationally effective manner with appropriate support for planning, coordination and supervision at regional, local and health service levels. Other aspects were the development of new structural arrangements that would attach clinical training funding to students in whatever service setting they train, thus ensuring the training outcome and enabling an expansion into non traditional settings.

ACAP welcomes the proposals for enhanced development of clinical training opportunities and improved data collection, but notes the apparent dissonance between these objectives and the proposed practices associated with certain jurisdictional EMS providers (notably Victoria) that are divorced from the plans for other health professions and the general policy landscape.

Paramedics need to be engaged and provide input to these developments through enhanced consultation and direct involvement in the policy-setting bodies.

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19 National Health Workforce Taskforce (2009): Clinical training - Data management system
Funding and resource allocation

There is no doubt that funding and resource constraints will continue to play a pivotal role in determining the current activities and future of EMS and healthcare delivery generally. Successive reviews over several years have identified funding as a key issue, while research has suggested a number of options for reforming Australian funding systems.

Currently there is no uniform approach to funding, access, and administration of out of hospital emergency medical care in Australia. Funding arrangements vary between jurisdictions with a combination of direct state or territory revenues, subscription schemes, insurance and user charges. Some EMS provider services (e.g. Ambulance Victoria) are reported to have serious current revenue problems and deficits exceeding $25 million (media reports February 2011).

ACAP is gravely concerned by the noticeable absence of any reference to or recognition by the current health reform process of the role and funding of EMS. The omission of EMS as a key component of the healthcare system raises the strong likelihood that the capacity of paramedics and the EMS system to deliver better and more equitable emergency care will not be given adequate attention in determining national healthcare policies, funding and governance arrangements.

As the Australian Institute for Primary Care has noted:

Australia does not have a nationally consistent approach to the funding and delivery of Ambulance services. There are significant risks to the medium and long-term capacity of Ambulance services to meet demand pressures. There are, however, significant opportunities to introduce a national reform program to improve the sustainability and performance of Ambulance services. This program should involve development of an equitable activity based funding model, backed by agreement on a national system of funding. For example, imposition of an additional Medicare levy component of 0.3% would provide sufficient funds for all Australian Ambulance services, at a cost of about $3.30 per week for a person on average all-time weekly earnings.

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

Emergency events hold no respect for jurisdictional boundaries and the consideration of issues such as EMS funding form yet another area where a national focus is needed with informed input from the paramedic profession. Those issues should be addressed through consistent policy, collaborative research, national policy development and innovation.

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20 Queensland Treasury, Department of Premier and Cabinet and Queensland Health, Queensland Ambulance Service Audit Report, December 2007
21 Australian Institute for Primary Care, Factors in Ambulance demand: options for funding and forecasting, La Trobe University, April 2007
22 Paper to The Department of Health and Ageing relating to the Inquiry into Health Funding, The Australian Council of Ambulance Authorities, Flinders Park, South Australia, August 2006, (Table 1 p7) http://www.aph.gov.au/house/committee/has/healthfunding/subs/sub148.pdf
24 Ibid
**Practical responses to achieve EMS integration**

How best to achieve EMS integration is not clear but ACAP holds the view that health professionals generally have a responsibility to act ethically and competently, communicate clearly, and empower patients to take an active role in managing their health in a relationship of mutual respect. Given that an evidentiary base for best practice is present, the key to better healthcare is effective information dissemination and communication.

Paramedic practitioners must be enabled to participate effectively in multidisciplinary teams to realise these shared objectives, ranging on the one hand from working under demanding conditions with law enforcement and emergency response units to the seamless transfer of patients to other expert medical staff in a definitive health service environment.

At all times paramedics and other health professionals must recognise and value the important roles and challenges faced by patients, their colleagues and support staff and the infrastructure service provider (hospital, EMS provider and other services).

There needs to be appropriate sharing of information and a level of transparency and mutual support that will ensure informed decisions in dealing appropriately with complex health needs. There must be an end to buck passing on matters such as ‘access block’ and ‘ramping’. Other service options need to be explored (such as paramedic triage to referral rather than transport to a hospital Emergency Department) by drawing on the practical expertise and experience of the professional paramedic workforce.

Service providers (akaAmbulance Services, Hospitals and Clinics) play an important role. When it comes to patient care within the EMS environment, the relationship between the paramedic practitioner and infrastructure provider or other health professional must be a mutual endeavour in the knowledge that while the paramedic carries particular professional skills, competencies and professional obligations, the infrastructure service provider plays an essential part in practitioner support through communications, transport and other services.

The paramedic profession carries a particularly deep understanding of emergency medical practice performed “in extremis” that provides insights into best practices. Paramedic practitioners and researchers hold a unique body of knowledge and practical experience that enables them to inform other healthcare professionals, administrators and policy makers in developing operational and clinical practices that will enhance patient care.

As often the first persons to treat people in distress, paramedics are acutely aware of the impact of demographic changes, community expectations and changing health needs.

ACAP’s vision of healthcare is firmly fixed on a dynamic and changing world and a health system that delivers value for money. To meet this goal the most effective technologies and practices must be used based on appropriate data. Effective governance and leadership must be based on long-term strategic policies and projections of supply and demand; it must respond to changing demographics and healthcare practices; and retain the flexibility to take advantage of technological advances.

Achieving these aims will require truly integrated research, evaluation and consultation processes well beyond the current levels of engagement between EMS and other areas of healthcare.

Much has been said about hospitals and emergency care, but healthcare should start with the patient and not at the hospital or clinic door - and the clinical interventions performed by paramedics often are what keep patients alive until they can receive more definitive care.
Recognising the existence of a problem is often the first step in solving the problem. In this regard a simple but fundamental shift in attitude is needed from which subsequent actions will flow. ACAP therefore strongly recommends that:

*The State and Federal governments designate EMS as a significant and integral component of healthcare with funding and other policy matters considered within the context of the delivery of a primary healthcare service.*

From this commitment and as part of government’s broad accountability to the community, the Commonwealth, States and Territories must then act to ensure appropriate recognition and a base stream of national funding that will ensure universal minimum access to EMS within a health system that delivers seamless and high quality patient care from the first stages of need.

Freed of erroneous perceptions that EMS provision is primarily linked to a reactive transport role, service standards should be considered from the perspective of how best to support paramedic practitioners in providing optimal pathways of care.

For example, consideration of EMS as a health service has the potential to facilitate cooperation with the National E-Health Transition Authority\(^{25}\) in the implementation of national electronic health records and their integration with EMS activities, with potentially earlier improvements to service quality and patient outcomes.

Considering EMS within the context of healthcare outcomes will enable better policy development and assessment of equity, funding and cost-effectiveness under a regime of relevant data collection and performance indicators.

**Engaging stakeholders, EMS and paramedics**

ACAP recognises that formidable challenges remain in healthcare delivery especially in rural and remote Australia. These include issues of equality and access, demographic coverage, safety and quality, as well as other workforce and resource issues that impact on patient outcomes. The health system should provide suitably rapid EMS responses under universal minimum access standards and with the levels of care appropriate to the circumstances of each patient.

Determining who may champion change and drive innovation in objective terms raises the dilemma of on-going stakeholder participation and engagement. Silo solutions are inadequate and no one group or individual holds all the answers. However, paramedics can assist in identifying and resolving many of these issues because already they must deal with the delivery of a significant part of unrecognised healthcare on a daily basis. Currently there is no effective national engagement of paramedics in the National Health strategy, demonstrated by the lack of recognition of EMS or the paramedic profession in the health debate.

Beyond their roles in emergency care, paramedics moreover hold competencies that can provide prevention, evaluation, care, triage, referral and health advisory services that can be mobilised to enhance community healthcare resources. Access to the expertise of professional paramedics thus should form an integral part of the care regime available to all patients. This should form part of an inter-professional model of healthcare practice based on a dynamic mixture of professional contributions at all stages of the patient journey.

Just as a building is only as stable as its foundations, or a chain as weak as its weakest link, so too are patient outcomes largely dependent on the quality of initial care. The quality and safety of EMS interventions can play a pivotal role in later patient outcomes. In ACAP’s view, a nationally driven policy perspective is needed that properly integrates EMS into healthcare and incorporates the research and other inputs of the paramedic profession into best practice considerations.

Meeting the ACAP vision of healthcare requires significant changes in the way EMS is funded and administered. It will need advice from the best available minds and committed and knowledgeable leadership within government and the profession to bring the already demonstrated benefits of paramedic practice to the community. Many issues need to be addressed within EMS to improve patient outcomes including:

- Sustainable funding models under minimum national access and equity principles;
- Education, clinical training, staff recruitment and retention;
- Safety and quality standards and the minimisation of patient risk in primary care;
- Extended community care models in remote and low-volume settings;
- Clinical governance, service accreditation and practitioner registration;
- Adequacy of evidentiary data collection to assess patient outcomes, support service evaluation and underpin research; and
- Infrastructure integration including communication networks and dynamic referral to manage external events and cope with capacity constraints.

ACAP strongly believes that these issues cannot be considered in isolation and would benefit from the support envisaged to come from well-constituted lead clinician groups. At the same time, a collegiate approach is needed and EMS practitioners must be involved in contributing their expertise in conjunction with other health professionals so as to create a seamless system of care beginning at the point of need – the patient.

To fulfil that promise ACAP supports mechanisms that will facilitate the research and systematic dissemination of best practice guidelines across healthcare, There must be an holistic ‘outcomes’ focus, participation from a variety of fields, a minimum of hierarchical and practice barriers and a willingness to identify, prioritise and implement innovative models of coordinated care.

The lead groups (however constituted) should also devote a proportion of their energies and resources to the examination of more speculative pilot studies - subject always to appropriate risk management practices that will ensure public safety.

Determining the membership of the advisory or ‘lead clinician’ groups also poses a challenge, and in concert with general community views, ACAP believes that the groups should include persons drawn from stakeholder populations extending beyond the traditional medically oriented cohorts. The issue is healthcare and public policy and funding, transparency and engagement.

The pool from which the membership is drawn should be developed through a process that calls for expressions of interest similar to the general call for participation in the appointment of members of the registration boards under the Australian Health Professions Regulatory Agency. Membership should be for a suitably long but limited term, with options for replacement, reappointment and progressive (partial) turnover to maintain continuity and foster renewal.

While the service goals envisaged by ACAP appear to align with the objectives proposed for the lead clinician groups there are distinct differences in EMS delivery between national issues such as clinical practice guidelines, patient safety and competency frameworks, and local operational issues having to deal with local conditions and resource implications. Only by incorporating the input of paramedic clinicians at both the national policy levels and at the operational service delivery level can the best patient outcomes be achieved.
**Glossary**

The following terms are used in this paper.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACAP</td>
<td>Australasian College of Ambulance Professionals</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>NHHRC</td>
<td>National Health and Hospitals Reform Commission</td>
</tr>
<tr>
<td>Paramedic</td>
<td>A professional person whose education, training and skills enable them to provide a range of out of hospital emergency procedures and medical care</td>
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