Submission to:
Australian Government
Productivity Commission

Delivering Quality Care:

Response to the Interim Report of the Productivity Commission

Ray Bange OAM

September 2025

“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
8 September 2021
Medical Coordinator
WA Country Health Service

Executive Summary

The goal of healthcare should be centred on providing timely and appropriate care that meets the needs of communities and individual patients, regardless of location. Primary healthcare investment is a critical factor in preventing and managing chronic conditions, which pose a significant healthcare burden for our aging populations.

The author welcomes the Productivity Commission's Interim Report and its focus on breaking down silos to create a more efficient and effective care economy. The three draft recommendations are strongly supported.

The draft recommendations provide a firm structural blueprint for a more efficient care economy. To breathe life into this structure, the Commission must look to the workforces that can deliver it.

This submission argues that the full potential of these reforms will only be realised by strategically integrating an underutilised asset: the paramedicine workforce. Community paramedicine represents a paradigm shift from reactive responses to a more mobile, integrated health service, directly addressing the core inefficiencies identified in the report.

The author contends that paramedics can provide the essential operational link to make the proposed regulatory alignment, collaborative commissioning, and prevention investment framework function successfully.

The submission proposes enhancement of local workforce capacity by mobilising the paramedicine workforce, leveraging the expertise of GPs through multidisciplinary care, and augmenting the overall pool of available healthcare practitioners.

The submission subsidiary recommendations include:

a) Support for the addition of other regulated (registered) allied health professions to the list of eligible health professionals;

b) Support for the addition of paramedicine as a regulated allied health profession to be formally included in the list of eligible participating health professionals; and,

c) Support for review and removal of unnecessary regulatory and documentation barriers that act as impediments to practice for otherwise eligible professions.

Paramedicine is not just an emergency service; it is a versatile, scalable, and proven solution for delivering care, managing demand on hospitals, and providing preventive health in the community.

By explicitly designing the final recommendations to include and fund the paramedicine workforce, the Productivity Commission will ensure its proposed reforms translate into tangible productivity gains and better outcomes for all Australians.

Contents

The author

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

About this submission

2. The Australian Government Productivity Commission (PC) released an Interim report on Delivering quality care more efficiently and is seeking comments through a public consultation before adopting a final strategy.
3. High-quality care services across all community sectors are fundamental to individual well-being and economic participation. While innovation and choice have expanded in recent decades, the PC report outlines that the care system is under increasing pressure from a changing population to deliver sustainable, high-quality services.
4. This is seen to require a move away from siloed decision-making toward a more integrated approach to enhance efficiency and care quality. The report outlines three key opportunities to boost productivity in the care economy.
5. The first is a proposal for greater alignment of safety and quality regulation to reduce costs, improve workforce mobility, and empower care users. The second advocates for embedding collaborative commissioning to strengthen local partnerships and tailor care to community needs.
6. Finally, a call is made for a new National Prevention Investment Framework to strategically fund initiatives that prevent problems from escalating, thereby improving outcomes and reducing future demand for acute services.
7. Collectively, these interconnected reforms are presented as a strategy to create a more efficient, sustainable, and person-centred care system. It is suggested that by breaking down sectoral barriers, these measures would protect vulnerable individuals, direct resources to frontline services, and ensure the care economy can meet future challenges.
8. The author supports these general principles and the need to address the importance of the health workforce and innovative workforce solutions. Of significant, yet often overlooked, potential is the formal mobilisation of the paramedicine workforce beyond the common perception of their roles in emergency ambulance and event service response.
9. Paramedics can bridge gaps in the system, reduce hospitalisations, and support preventive care, aligning with the report's themes of integration and productivity. Paramedics possess skills that are highly applicable to community-based care, including advanced assessment, triage, and treat-and-refer capabilities.
10. Integrating these professionals into collaborative commissioning models and primary care teams could substantially alleviate pressure on hospital emergency departments, provide more appropriate care for patients with non-urgent conditions in their homes, and improve health outcomes in underserved communities.
11. Leveraging this existing skilled workforce represents a pragmatic opportunity to enhance system capacity, improve patient flow, and deliver more integrated and cost-effective care. Working alongside other health and care providers as part of multidisciplinary teams, they can deliver care in diverse healthcare settings, including chronic, aged, palliative and mental health care.

12. Australia lags behind Aotearoa New Zealand, where legislation has been passed to recognise the independent professional role of paramedics for funding support from the Accident Compensation Corporation (ACC). [1] The national (NZ) consultation paper proposing the formal inclusion of paramedics as recognised treatment providers paid particular attention to how that policy setting would improve patient access.

    > *"…Paramedics were widely regarded as having skills that are complementary to other health professionals in general practice, so having them assist was expected to improve patient access while relieving pressure on the health system and GPs in particular."* [2]

13. The submission is split into two main sections. Part 1 briefly discusses the paramedicine workforce, and Part 2 directly addresses the Interim Report recommendations.

Part 1 – Understanding Australia's Paramedicine Workforce

14. Australia has been slow to mobilise the paramedicine cohort in Australia as independent registered healthcare providers. Their contemporary capabilities as health professionals are not adequately reflected in the regulations, workforce datasets (para 16) and other documentation that permeate the health and care system. They appear most in association with the operational settings of the jurisdictional ambulance services.
15. The result is that paramedics are often omitted from lists of professions for various policy proposals, practice engagement, funding and support mechanisms. This creates barriers to engaging paramedics in primary care and other community and hospital settings.
16. An example of such an omission was the recent $77.35M *Grant Opportunity GO 6901 Stream 6 PHN Commissioning of Multidisciplinary Teams,* where advice was initially given to a PHN that paramedics were not included as eligible professionals.[3] Following my direct intervention, the Department of Health and Aged Care (sic) subsequently advised:

    > *"...The identified professions listed in the grant opportunity guidelines are provided as examples, with the guidelines stating that 'multidisciplinary teams include…'. As such, paramedics are not excluded from this initiative. We will update the FAQ document to include a FAQ to specify that paramedics are eligible to be commissioned..."*

17. Paramedicine should be seen as a discrete health workforce and engaged as one of the key stakeholder groups in policy deliberations on funding and healthcare delivery, consistent with their capabilities as registered health practitioners.
18. The Paramedicine Board of Australia (PBA) has defined the qualifications and capabilities required for paramedic registration, emphasising their autonomy and alignment with other regulated health professions.
19. The author proposes that legal status should be reflected in workforce datasets, policies and regulations so that paramedicine is included in the recognised Allied Health Professions (AHPs) pillar for workforce planning, alongside the other two pillars of Medicine and Nursing/Midwifery.

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[1] Hon Matt Dooley, ACC regulatory changes will improve access to treatment, Beehive Website, New Zealand Government, 12 August 2024. https://tinyurl.com/3dzx6svz Accessed 13/09/2025

[2] Changes to ACC regulations for Chinese Medicine, Paramedics and Audiometrists, Summary of submissions for each proposal, Ministry of Business, Innovation and Employment | Hīkina Whakatutuki, Aotearoa New Zealand Government, https://tinyurl.com/2wpxwmds Accessed 13/09/2025.

[3] Bange R, Forgotten, omitted, overlooked, or excluded - but certainly missing, The Paramedic Observer, Facebook, 15 April 2024. https://tinyurl.com/mv2uucz Accessed 13/09/2025.

The registered paramedicine cohort

20. Paramedicine is a popular health profession growing at about 5% annually. Australian Health Practitioner Regulation Agency (Ahpra) registration data show paramedicine with 26603 registered practitioners in Australia at the end of June 2025 *(Figure 1).*

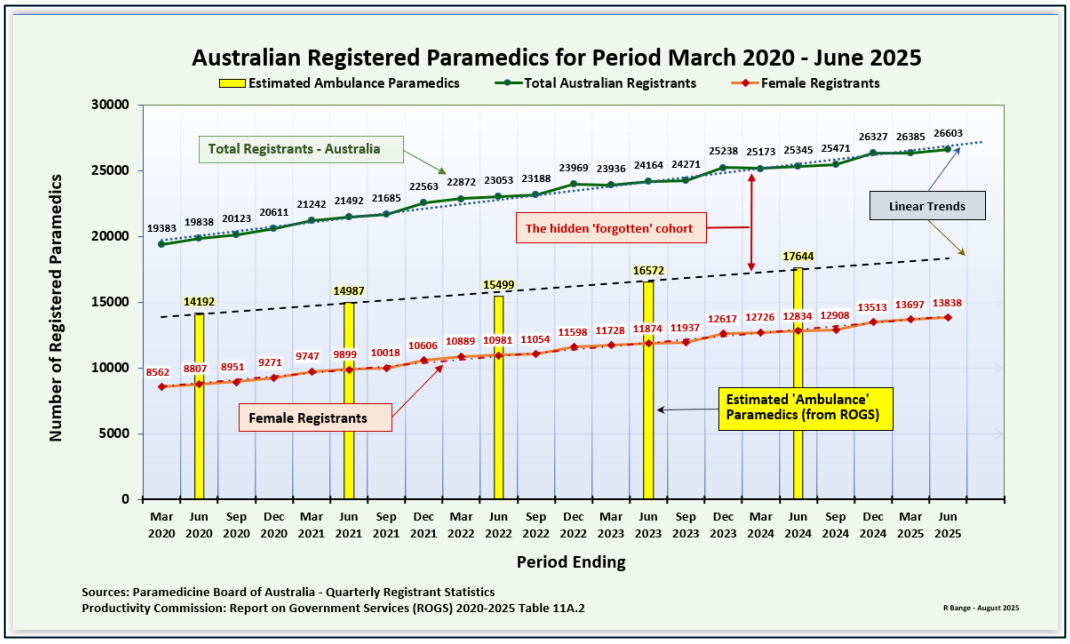

Figure 1. Australian registered paramedics

21. Analysis of PBA statistics and the annual Report on Government Services 2025 (ROGS) indicates that in June 2024 more than 7700 registered paramedics (~30%) did not work for jurisdictional ambulance services *(Figure 2).*[4] Assuming the same percentage applies, this figure would have grown to more than 8000 non-ambulance practitioners by June 2025.

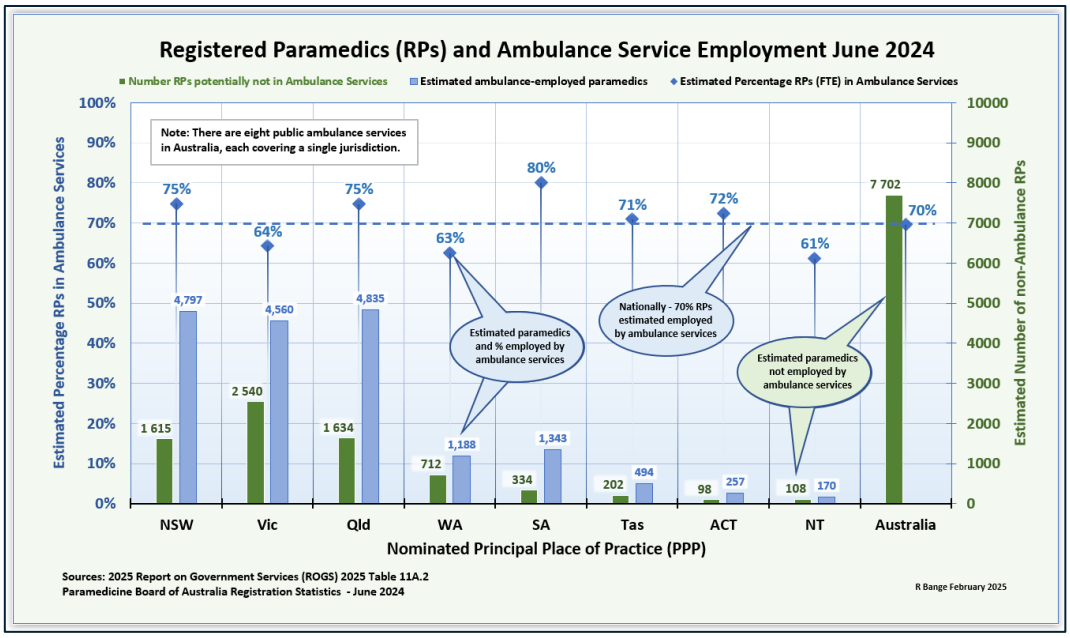

Figure 2. Estimated deployment of Australian paramedics

[4] Bange R, *Report on Government Services (ROGS) 2025,* The Paramedic Observer, Facebook, 10 February 2025, https://tinyurl.com/542b43k7 Accessed 13/09/2025.

22. Examination of the National Health Workforce Dataset suggests that about 85% of registrants were employed as paramedics in 2023.[5] This data needs to be treated cautiously because of the wide variation in numbers across segments of data. The definition of *'employment in the registered profession'* is also subject to individual interpretation in voluntary surveys. For comparison, Ahpra data show that at 30 June 2025, the percentage of non-practising registered paramedics was 3.2%.[6]

23. Typical of the historical barriers and outdated documentation that have created silos of practice and limited the wider mobilisation of paramedics, the PC Report on Government Services (ROGS) 2025 also fails to adequately distinguish between a paramedic's professional role and their employment by an ambulance service or other organisation.

24. This conjoint perception is evident from statements like: *"Across jurisdictions, ambulance service organisations are an integral part of the health system. The role of paramedics has expanded over the past decade to include assessment and management of patients with minor illnesses and injuries to avoid hospitalisation."* That statement effectively conflates a provider with an independently registered practitioner.

25. Elsewhere, ROGS 2025 data provides a misleading picture of paramedic employment. Part E: Health Section 11 Table 11A.3, citing Ahpra data, provides a tabulation of registered paramedics for the eight Australian jurisdictions. It shows the 458 (July 2024) paramedics with no nominated Principal Place of Practice (PPP) – but listed as 'other'.

26. ROGS provides no direct correlation between ambulance services' operational staff and employed paramedics *(Figure 2).* While there is a statement that qualified ambulance officers must be registered paramedics, the inclusion of Ahpra data covering the same jurisdictions as the ambulance services (and removal of the no PPP title) creates the misapprehension that registered paramedics work only for the ambulance services or that the public ambulance services employ all registered paramedics in Australia.

27. These anomalies show that we need better alignment of workforce data in a consistent framework. Moreover, we are wasting a valuable resource by not using paramedics to their full potential at a time when there is a widely reported shortage of healthcare workers. The (inefficient) failure to deploy them more widely across the health system reduces the professionals available to care for our communities and limits patient access to care.

28. Currently, paramedics are best known for their ambulance service roles where they are welcomed into homes daily. However, due to outdated historical guidelines, outdated regulations and funding rules, they are often left out of AHP workforce datasets.

29. While the versatility of paramedics to work across diverse health settings is well-established in the United Kingdom (UK) with paramedics working across the health and care domains, Australia is losing hundreds of paramedics who are being recruited to fill workforce shortages in the UK, Canada, and the U.S. health systems.[7]

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[5] *Paramedicine Practitioners Factsheet*, HealthWorkforceData, Department of Health and Aged Care, Australian Government. https://tinyurl.com/3tvpksun Accessed 12/09/2025.

[6] Bange R, *Registered Paramedics in Australia – June 2025*, The Paramedic Observer, Facebook 27 August 2025. https://tinyurl.com/2nyf5vyn Accessed 13/09/2025.

[7] Office of Healthcare Professionals Recruitment, New Paramedics Coming to Nova Scotia from Australia, Nova Scotia Government, 25 April 2024. https://tinyurl.com/y46duvyh Accessed 14/09/2025.

30. To deliver quality healthcare, we need to utilise our workforce resources effectively.[8] Paramedics are available to address these workforce gaps by ensuring they not only work as emergency responders but also are engaged in preventive and community-oriented care that creates a more efficient and accessible system for everyone.
31. The evolving role of the paramedic, technological changes, and research findings into best practice interventions have all contributed to raising the educational requirements and practice competencies of paramedics. Australian paramedics must hold accredited university degree-level qualifications (or equivalent) for registration.
32. Those paramedics working in ambulance services initiate and monitor advanced medical interventions like surgical airways, needle thoracostomies and endotracheal intubation. They administer multiple medications, including highly restricted agents.
33. Paramedics routinely take complex patient histories, undertake detailed physical examinations, and perform differential diagnoses of patient conditions as an integral part of practice. They deal with patients having chronic health conditions and those in aged and palliative care, as well as those presenting with mental health problems.
34. On a per-capita basis, Australia is a leader in international paramedicine research at Master's, Doctoral and post-doctoral levels with publications in Tier 1 journals. The Australasian College of Paramedicine publishes an internationally peer-reviewed journal, *Paramedicine'* to foster best practice.
35. Students pursuing higher degrees come to Australia from across the world, including Canada, the Middle East, Taiwan, the UK and the United States of America.
36. Victoria University and the Victorian Government have jointly announced a $20 million investment to establish a Centre of Excellence in Paramedicine based at the university's Sunshine Campus and expected to open in 2026.[9]
37. The U.S. National Library of Medicine has recognised the robust research base for paramedicine by including paramedicine within the Medical Subject Headings (MeSH).
38. Acknowledging the extent of paramedicine research activities, the Australian Bureau of Statistics, Stats NZ, the Australian Research Council and the NZ Ministry of Business, Innovation and Employment have included paramedicine as a specific field of research within the Australian and New Zealand Standard Classification of Research.[10]

Paramedics in Australia's provider services

39. Australia has six government agencies and two private contracted ambulance services operating on a jurisdictional basis as public services which cater for patients regardless of age, gender, ethnicity or economic status. Underwritten by governments and supported by specific legislation in all jurisdictions except Western Australia (WA) and the Northern Territory (NT), these services employ paramedics as their principal operational workforce.

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[8] Bange R, *Unleashing the potential of our health workforce*, The Paramedic Observer, Facebook 5 November 2024. https://tinyurl.com/56nwz329 Accessed 13/09/2025.

[9] Bange R, *Victoria University Centre of Excellence in Paramedicine*, The Paramedic Observer, Facebook, 2 February 2024. https://tinyurl.com/2u6b33jy Accessed 12/09/2025.

[10] Bange R, *ANZSRC – Final Classifications to include Paramedicine*, The Paramedic Observer, Facebook, 1 July 2020. https://tinyurl.com/5a5nxfsk Accessed 14/09/2025.

40. A plethora of smaller private service providers employ paramedics for various health and care services, including urgent care centres, aeromedical and rescue operations (RFDS, local and international), special events and film support, on industrial sites, in the military and for non-emergency patient transport (NEPT).

41. There is little consolidated information about the employment and service operations of the private providers. This is an identified gap in service data that could facilitate the creation of suitable registries to advance best practice and improve efficiency.[11]

42. At this time, there is no mandatory national accreditation and compliance framework for either public or private paramedic service providers, nor is there an equivalent framework to the UK Care Quality Commission.[12] However, the Australian Commission on Safety and Quality in Health Care has developed the National Safety and Quality Health Service Standards Guide for Ambulance Health Services.[13]

43. The discrepancies in workforce data (paras 21-27, 41) and the absence of a national compliance framework (para 42) underscore the need for appropriate frameworks.

44. Paramedics working in ambulance services engage in an immense variety of care situations, including disaster and emergency response, chronic care, mental health, palliative care and drug-related responses. Contrary to popular belief, emergency responses involve less than 50% of the total ambulance callouts *(Figure 3).*

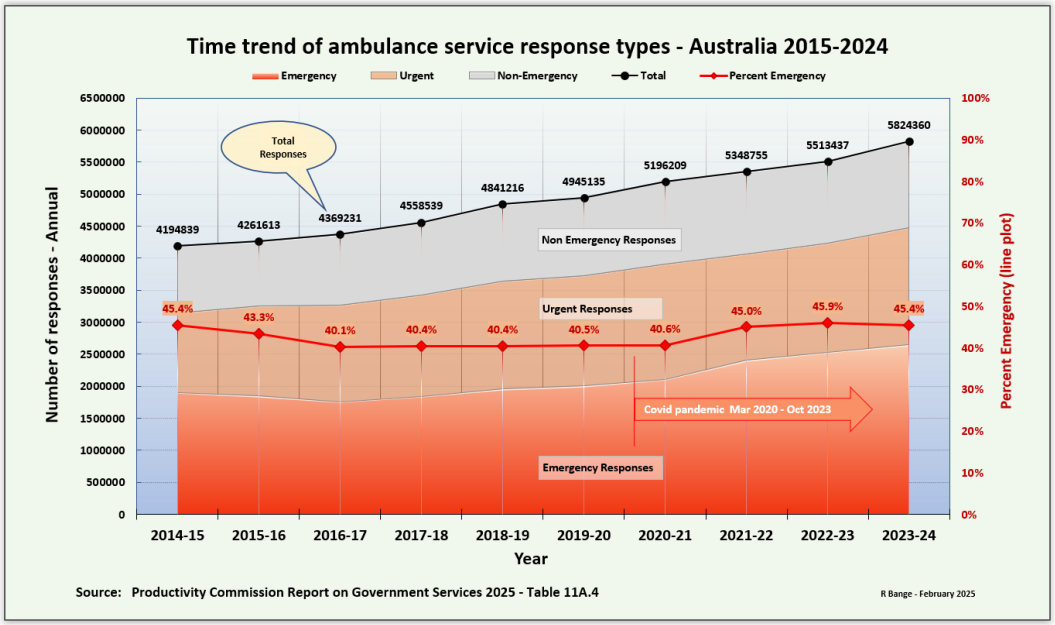

Figure 3. Time trend of Australian ambulance service responses

[11]Bange R, *Australian Framework for clinical quality registries*, The Paramedic Observer, Facebook, 17 January 2023. https://tinyurl.com/bdk4c3sy Accessed 14/09/2025.

[12] Bange R, *St John Ambulance commissioned as NHS Auxiliary Service*, The Paramedic Observer, Facebook, 11 August 2022. https://tinyurl.com/49fa5rxd Accessed 14/09/2025

[13] *National Safety and Quality Health Service Standards Guide for Ambulance Health Services,* Australian Commission on Safety and Quality in Health Care. (2024). https://tinyurl.com/4mu65fty Accessed 14/09/2025.

45. These changing healthcare trends have been recognised by the development of new evidence-based models of care, which take various forms but are commonly described under the general heading of Community Paramedicine (CP).[14, 15, 16]

Mental health

46. The report of the Royal Commission into Victoria's Mental Health System[17] and the Mental Health Report of the Productivity Commission[18] highlighted the need for more effective and equitable mental health care and support across Australia.

47. Common themes across all recent health reviews are that there should be a shift towards prevention and early intervention through the primary health care setting, including the provision of integrated services close to home. The Social Determinants of Health, including housing and the role of GPs and community health services supported by mental health specialists, are also being better recognised.

48. In 2020 the Australasian College for Emergency Medicine analysed why Australia's health system is failing to meet the urgent needs of people presenting to hospital emergency departments for mental health care. [19]

> *"While there is much that emergency physicians and other emergency department staff can do to improve the experience for people seeking help in a mental health crisis, they cannot do it alone. ACEM will advocate for governments to invest in alternative models of emergency mental health care and divert some people to more appropriate crisis services, whilst ensuring that emergency departments provide high-quality care for the cohort of patients who need us."*
>
> *Foreword - Nowhere Else to Go - September 2020*
> *Australasian College for Emergency Medicine*

49. The clear message is that action is needed to build and sustain a functioning, integrated mental health system across the spectrum of care. The ACEM report sees investment in mental health workforce development as essential, including staff capabilities, skill mix and role diversification.

50. The author proposes that the engagement of community paramedics (CPs) be included under a national practice and provider framework. The growing recognition of the need for different pathways of care reinforces the need for establishing systems that will ensure consistency in the delivery and reporting of care outcomes that will assist in greater efficiency.

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[14] McMaster University Media, *CP@clinic program expands reach in Australia with new funding*, Hamilton, Ontario, 1 April 2024. https://tinyurl.com/ycxcze6m Accessed 13/09/2025

[15] Bange R, *Community Paramedicine,* The Paramedic Observer, Facebook, 23 September 2021. https://tinyurl.com/52kk3tkf Accessed 14/09/2025.

[16] Bange R, *Mobilising the paramedic workforce,* The Paramedic Observer, Facebook, 31 August 2021. https://tinyurl.com/ycy2nr9z Accessed 14/09/2025.

[17] Royal Commission into Victoria's Mental Health System*, Final Report, Summary and Recommendations,* Parl Paper No. 202, Session 2018–21, State of Victoria https://tinyurl.com/3yu2rezbt Accessed 14/09/2025.

[18] Productivity Commission 2020, *Mental Health, Inquiry Report no. 95*, Canberra, #0 June 2020. https://tinyurl.com/d9z82fec Accessed 13/09/2025.

[19] Duggan M, Harris B, Chislett WK & Calder R. 2020. *Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments*. Mitchell Institute Commissioned report 2020, Victoria University. ISBN 978-0-6488001-1-8 https://tinyur l.com/272r7as8 Accessed 14/09/2025.

Long-term, aged and palliative care

51. The final report of the Royal Commission into Aged Care Quality and Safety[20] contained 148 recommendations, ranging from how to regulate it to how to fund it and how to ensure its workforce is equipped to provide the necessary care.

52. Most ambulance services have significant engagement with aged care and palliative care patients. This ranges from responses to minor injuries to more major matters such as falls and life-threatening emergencies in the home and aged care settings.

53. Research into the scope of practice of paramedics and the role they could play in rural health service delivery by Thompson et al identified that paramedics in the rural environment are a highly underutilised health resource.[21]

54. The key point is that paramedics are accustomed to working with patients in aged care and palliative care situations, whether as employees of an ambulance service or as independent practitioners working in collaboration with GPs and other professionals.

Community paramedicine and healthcare in the home

55. No one service solution is likely to work for all situations, be it bespoke community paramedicine or Hospital in the Home. The concept of Hospital in the Home has existed overseas for many years and a recent example from Scotland[22] provides good insights that might be replicated across other jurisdictions.

56. For other examples of local community healthcare, one need look no further than the award-winning community paramedicine program in South Australia[23] and developments in Canada[24] where there is now a Standard CAN/CSA-Z1630 on '*Community Paramedicine Framework for Program Development*.[25]

57. Proactive engagement of CPs to provide screening for heart disease and diabetes and early referral in geriatric assessment are aspects of care that could improve patient outcomes. Screening and patient monitoring via community blood pressure and blood glucose level checks is easily within the skillset of a paramedic and could form part of the community-based clinical outreach programs of a GP or ACCHO Clinic.

58. Another example of paramedic engagement in community-based care is the Health Canada '*Action Plan on Palliative Care.'*[26] The Action Plan aims to improve the quality of life for people with life-limiting illnesses and enhance access and health care system performance (or in other word, enhance efficiency).

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[20] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect*, Royal Commission into Aged Care Quality and Safety, February 2021. https://bit.ly/3eAeNze Accessed 14/09/2025.

[21] Thompson C, Williams K, Morris D, Lago L, Kobel C, Quinsey K, Eckermann S, Andersen P and Masso M (2014), *HWA Expanded Scopes of Practice Program Evaluation: Extending the Role of Paramedics Sub-Project Final Report*, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

[22] Cantley P., *Hospital at Home,* Wordpress Blog December 2020. https://tinyurl.com/4hm7z2m8 Accessed 13/09/2025.

[23] Bange R., [@ParamedProf], *Congratulations to the Community Paramedics Program team at Ceduna*, Twitter {X}, 23 November 2019. https://tinyurl.com/mssp62uw Accessed 13/09/2025.

[24] Dainty K 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, Vol 53, Issue 5, October 2018 (3455-3470). https://doi.org/10.1111/1475-6773.12855 Accessed 13/09/2025.

[25] CSA Group, *Community Paramedicine: Framework for Program Development*, June 2017 https://www.csagroup.org/article/cancsa-z1630 Accessed 15/09/2025

[26] Health Canada, *Action Plan on Palliative Care*, Government of Canada, 20 August 2019. ISBN: 978-0-660-31796-0 https://tinyurl.com/yhdzsz35 Accessed 14/09/2025.

59. Building the capacity to provide palliative care is a feature of a compassionate and comprehensive health system, especially for underserved populations. For an aging population with an increasing incidence of chronic diseases, it is an area of need.

60. There is strong evidence supporting the effectiveness of community paramedicine programs in reducing the level of emergency calls, improving chronic disease management, and enhancing access to other pathways of community-based care.

61. An international group collaborating and sharing ideas to integrate paramedics into primary care and the use of paramedics in chronic disease management is the International Roundtable on Community Paramedicine (IRCP).[27]

62. In Australia, the former Health Workforce Australia funded several pilot projects to assess the value of CPs along with an independent evaluation. The evidence was that paramedics can provide a range of appropriate care that is highly beneficial and cost-effective – a finding in common with almost every study internationally. Spelten et al. provide an excellent summary and evaluation of a CP program in Australia.[28]

63. Along with this powerful evidence supporting CP is the need for long-term funding beyond pilot projects and mechanisms to ensure continuity and consistency of care. Involvement of paramedics in the design and management system is important, while implementation requires a commitment to change and effective program support.

64. Policymakers must resolve the complexities of long-term sustainable funding via government, private insurance and out-of-pocket fees to deliver proactive patient-centred care close to home that is preventive rather than reactive responses that require more intensive and more expensive (i.e. less efficient) care.

Overcoming embedded perceptions – the implementation challenge

65. An issue to overcome in the mobilisation of paramedicine is the embedded perception of paramedics as being restricted to employment by ambulance services (paras 23-28). The omission of a workforce from a nominated list creates a situation where that workforce becomes *"out of sight – out of mind".* It's a variation of unconscious proximity or affinity bias[29] where there is a tendency to recognise contiguous groups.

66. This skewed treatment may be unintentional, but can have significant consequences in not mobilising the best available workforces in building health workforce teams because of a lack of interaction and knowledge of the skill sets of (the overlooked) professions. This is a strong reason why a revised and inclusive national framework is desirable.

67. Existing funding and regulatory arrangements constrain the engagement of paramedics in flexible models of care; limit the capacity for team-based care, and present financial and professional barriers to practice.[30, 31]

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[27] International Roundtable on Community Paramedicine (IRCP). http://www.ircp.info/ Accessed 15/09/2025

[28] Spelten E et al, *Community Paramedicine in Australian community health - Implementation of the CP@CLINIC program*, La Trobe University, 26 February 2023. https://tinyurl.com/5ckzy3pj Accessed 14/09/2025.

[29] Tammy Xu, *Unconscious Bias: 16 Examples and How to Avoid Them in the Workplace*, Built In Newsletter, 16 May 2022. https://bit.ly/2lyEpmK Accessed 14/09/2025

[30] McKeown M, *Hansard Transcript of Evidence (p8)*, Vice President, Rural Doctors Association of Tasmania, Inquiry into Rural Health Services in Tasmania, 26 November 2021. https://tinyurl.com/5cjm4mf9 Accessed 14/09/2025.

[31] Nott S, *Hansard Transcript of Evidence (p27)*, Rural Health Director of Medical Services NSW, Inquiry into Rural Health Services in Tasmania, 17 May 2022. https://tinyurl.com/knz62kh6 Accessed 14/09/2025.

68. When it comes to healthcare services, government payments (generally) are based on delivery by a healthcare professional registered with Medicare, which currently does not include paramedics. If MBS arrangements changed to enable CPs to claim for the delivery of health care services, other arrangements would be updated accordingly. Similarly, payments might be made for services provided by other AHPs

69. Many of these barriers to recognition should have been removed when paramedicine became a registered health profession in 2018 under the Ahpra umbrella. More positive action is warranted to increase capacity by using these practitioners within the mainstream of primary care.

70. These changes are feasible, as shown by the ACC developments in New Zealand (para 12), the 'Unleashing' consultation and the Victorian government's commitment to fund the education and employment of paramedic practitioners.[32]

Part 2 – Integrating Paramedicine for efficiency gains

Facilitating provider change and multidisciplinary care

71. Throughout England, paramedics are becoming an integral part of the core general practice model funded under the Additional Roles Reimbursement Scheme (ARRS). The strategy of expanding the provision of primary care through the engagement of ARRS personnel was based on enriching the skill mix of the general practice team and enabling GPs to *'work at the top of their license'*.

72. The professions initially selected for ARRS roles were chosen for pragmatic reasons:

    a) There would be sufficient supply;
    b) There is projected strong practice demand;
    c) The tasks performed would help reduce GP workload, improve practice efficiency and deliver NHS Long Term Plan objectives; and
    d) They are relatively new roles and can demonstrate additional capacity

73. The author suggests a further reason for including paramedics in these teams is their capacity to work in unstructured environments and for holding high public trust. Patient trust is important in delivering care, and paramedics have been voted one of Australia's most trusted occupations on many occasions.[33]

74. Modifications to the ARRS have been made during the implementation stages with more practice roles added at the request of Primary Care Networks. These networks can now recruit from seventeen practitioner groups to make up the multidisciplinary workforce they need *(see NHS website for more details*[34]*)*.

75. With the growth of paramedic employment in primary care, UK Clinical Commissioning Groups became aware of practices asking for guidance and support on their integration into general practice and developed appropriate guidelines.

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[32] Premier of Victoria, *Australia's First Paramedic Practitioners One Step Closer*, Victorian Government, 19 February 2024. https://tinyurl.com/5hbsvt8p Accessed 13/09/2025.

[33] *The most trusted professions in Australia,* Readers Digest Survey 2021. *https://tinyurl.com/2s4nz6wd* Accessed 14/09/2025

[34] NHS England, *Additional Roles: A quick reference summary*, National Health Service, 16 May 2023. https://tinyurl.com/2hke958b Accessed 13/09/2025

76. To facilitate the wider mobilisation of paramedics, Australia could develop similar literacy or guideline materials to support the engagement of paramedics. To understand why this is needed, one needs to appreciate that many health professionals (and policymakers) remain unaware of the capabilities of today's university-educated paramedics.

The PC Consultation Draft Questions

77. **Draft recommendation 1.1 The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users.**

78. **Response:**
An aligned regulatory framework is a prerequisite for maximising the value of practitioners and service providers across the care economy. The PC proposal is thus strongly supported to reduce complexity, enhance workforce mobility, improve safety, and enhance efficiency.
   a) Paramedics are already registered under Ahpra and meet rigorous national standards but there is no mandatory accreditation and compliance frameworks for private and public service providers (paras 41-43).
   b) Currently, varying scopes of practice and recognition between the Commonwealth, States and areas of practice inhibit paramedic deployment (paras 14-17, 23-29). The absence of paramedicine from AHP workforce datasets and wider recognition in aged care and NDIS workforces is illogical.
   c) The proposed "*national registration system and single portal"* should explicitly include paramedics wishing to work in roles spanning the health domain including mental health, aged care, disability, and primary healthcare settings.
   d) The development of a *"single (potentially modular) set of practice and quality standards"* for aged care and NDIS should include modules for paramedic-led services (e.g., in-home acute care, complex wound management, palliative support). This would standardise and assure the quality of care in these sectors.
   e) The *"standardised quality and safety reporting framework*" must be designed to capture the outcomes of telehealth, mobile, and community-based interventions, not just facility-based care, to properly evaluate home-based healthcare and other paramedicine models of care.
   f) Formal inclusion of paramedics in unified worker screening and registration systems with the recognition of paramedics as eligible providers under NDIS and aged care funding models, and private health insurance coverage.
   g) Acknowledging the effective regulation of practitioners, the national framework should cater for the mandatory accreditation and compliance monitoring of both public and private paramedic (aka ambulance) service providers.
   h) The framework should include the ambulance services sector as well as practitioners in developing public health prevention strategies and resources for vulnerable populations. Many fall-related mortalities occur in a patient's home, yet there is limited insight into home environments. Ambulance services responding to millions of callouts annually have a unique opportunity to navigate and report on community and home situations to help develop best practices.[35]

[35] Deprey SM, Biedrzycki L, Klenz K. *Identifying characteristics and outcomes that are associated with fall-related fatalities: multi-year retrospective summary of fall deaths in older adults from 2005-2012*. Inj Epidemiol. 2017; 4(1): 21. https://tinyurl.com/m25n2mk5 Accessed 15/09/2025.

79. **Draft recommendation 2.1 Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings.**

80. **Response:**

The author endorses the focus on collaborative commissioning to reduce fragmentation, particularly between Primary Health Networks (PHNs), Local Hospital Networks (LHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs).

a) The education of paramedics prepares them to be the ideal "integrators" for collaborative commissioning. They represent a versatile generalist health workforce able to physically and digitally connect care across hospital, primary, and community settings.
b) Joint Governance Plans: The mandated “agreed plans of work” between LHNs and PHNs should explicitly include reference to Community Paramedicine Programs. These programs have been proven to reduce potentially preventable hospitalisations.
c) Funding Flexibility: The dedicated funding for collaborative commissioning should allow its use for funding of paramedics within PHNs or ACCHOs. These paramedics can:manage high-risk patient cohorts identified by GPs or hospitals.
d) Provide hospital-in-the-home services, facilitating early discharge and preventing readmission.
e) Conduct urgent but non-life-threatening home visits, diverting cases from EDs
f) Data Sharing: Ambulance services and paramedics can generate rich, real-time data on patient status in the community. Integrating this data into the proposed *“data-sharing arrangements”* is crucial for effective joint needs assessments and evaluation.

81. **Draft recommendation 3.1 Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure**

82. **Response:**

The PC focus on the need for investment in preventive care is supported. The value of prevention through the use of paramedic interventions to reduce hospitalisations, improve medication adherence, and enhance well-being has been demonstrated by many pilot studies locally and internationally.

a) Despite the success of these community paramedicine pilots, the translation into long-term funded programs as an integral component of the health system has not been implemented in Australia.
b) Patient self-management is an important factor in long-term care. Educating patients about their chronic diseases is a vital part of provider service and support to help patients manage their conditions in their own homes.
c) Computerised chronic care management systems can help to provide digital records with automated cross-checks and patient information and consent provisions. These can be integrated with primary care and other facilities to ensure effective follow-up.
d) System integrity and interoperability are paramount to guard against system failure or compromise. A proportion of key patient data should be regularly transferred to backup systems and hard copy records as well as providing information to patients.

e) Establishing a National Prevention Investment Framework is a critical and long-overdue reform. The author agrees that investment must be based on a rigorous assessment of value that captures long-term, cross-sectoral benefits.

f) Community paramedicine has been demonstrated as a highly effective vehicle for delivering primary and secondary prevention, particularly for hard-to-reach and vulnerable populations. It moves prevention from a concept to an actionable, frontline service.

g) The Prevention Framework Advisory Board must select and use evaluation tools, such as the Health Intervention Impact Calculator (HIIC), that can model the broad benefits of preventive interventions like paramedicine engagement. These benefits include:
    i. Health gain: (e.g., HALYs saved through falls prevention).
    ii. Equity and access: Reaching isolated and disadvantaged cohorts.
    iii. Fiscal impact: Reducing future hospital and aged care expenditure.
    iv. Social impact: Improving patient well-being and workforce participation among carers.

h) The Board should prioritise and recommend funding for evidence-based paramedicine programs that deliver prevention in the community, such as:
    i. Falls risk assessments & home modifications:
    ii. Chronic disease monitoring & education: Secondary prevention to avoid acute exacerbations.
    iii. Medication management reviews: Improving adherence to prevent complications.

i) The funding mechanism must be flexible enough to fund these mobile, community-based services, which often do not fit traditional fee-for-service medical models.

Abbreviations / Definitions

The following abbreviations and definitions are used in this submission.

ACCHO	Aboriginal Community Controlled Health Organisation
AHP	Allied Health Profession/Professional/Practitioner (context governs)
Ahpra	Australian Health Practitioner Regulation Agency
ARRS	Additional Roles Reimbursement Scheme (UK)
CP	Community Paramedicine /Paramedic(s) (context governs)
GP	General Practice/Practitioner
NHS	National Health Service (UK)
LHN	Local Hospital Network
PBA	Paramedicine Board of Australia
PHN	Primary Health Network/s
RFDS	Royal Flying Doctor Service
ROGS	Report on Government Services (Productivity Commission)
UK	United Kingdom